

# Business Insurance

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

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## Regulators discuss new drafts of fronting program model law

SAN FRANCISCO—State insurance regulators are considering two new proposals to limit fronted reinsurance arrangements.

One proposal, endorsed by representatives of Georgia, New York and North Carolina, is similar to earlier drafts that ban certain transactions and specify minimum contract requirements.

Another, more liberal draft is being proposed by Iowa Insurance Commissioner David Lyons. This measure calls for what Mr. Lyons describes as "minimal" regulation.

*Continued on next page*

## Trade pact to expand coverage options in Mexico

By JUDY GREENWALD and MICHAEL BRADFORD

WASHINGTON—The North America Free Trade Agreement could lead to a broader array of property/casualty and health coverages in the previously highly restricted Mexican market.

Several major U.S. insurers and brokers plan to take advantage of a more liberal Mexican market by expanding existing operations or making new investments.

The Mexican economy is vibrant and growing, observers say. With the trade agreement expected to encourage more investment by American industry, U.S. insurers are expected to "follow the flag" into the Mexican market.

One particularly significant potential growth area in Mexico for several large U.S. insurers and brokers is employee health and pension benefits. Until now, the Mexican government has essentially provided most employee benefits, but a move toward privatization is expected.

Insurance buyers in Mexico would benefit from the broader array of coverages available. But the agreement is expected to have little overall effect on the U.S. insurance industry—at least for some time.

Among the insurers that say they may invest more in Mexico are American International Group Inc., CIGNA Corp., Chubb Corp., Metropolitan Life Insurance Co. and Reliance National Insurance Co.

Among the brokers considering expansion are Alexander & Alexander Services Inc. and Marsh & McLennan Cos. Inc.

But the \$3.5 billion Mexican life and non-life insurance market is tiny compared with its \$453 billion U.S. counterpart. Interest in the market will certainly grow, but observers do not expect it to draw significant amounts of capital out of the U.S. market.

Generally, the trade agreement aims to phase out barriers to trade in goods and services in

*Continued on page 27*

## Bush vows second-term action

### President 'fighting' for tort reform

By MARK A. HOFMANN

WASHINGTON—A second Bush administration promises few surprises on tort reform or health care issues.

President Bush would stay the pro-business course on tort reform, lobbyists say, and that is just the impression the president tried to create last week.

"I'm fighting to reform our legal system, to put an end to crazy lawsuits," President Bush said in accepting the Republican nomination.

"If that means climbing into the ring with the trial lawyers, let me just say

Round 1 starts tonight," he said to the crowd.

Mr. Bush also touched on health care—an issue some observers say could bring to the surface some tensions in a second term—in the speech.

"I have a plan to provide affordable health care for every American, controlling costs by cutting paperwork and lawsuits and expanding coverage to the poorest of the poor," Mr. Bush said.

In a second term, Mr. Bush would deviate little from his basic market-based approach to health care, observers predict.

"I think there will be some health-care reform proposal enacted during the first 100 days of a new administration. But it will not likely be as sweeping under Bush as it would under Clinton," he said.

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George and Barbara Bush are cheered by fellow Republicans at a rally during last week's Republican convention.

## Psychologists fault managed care

By LOUISE KERTESZ

WASHINGTON—The American Psychological Assn. is taking dead aim at the managed care industry in the escalating conflict over how to provide quality mental health care at a reasonable cost.

In a report issued last week, the APA decried "the failure of the managed care companies to sufficiently control cost and furnish adequate care."

As an alternative to managed

care, the association is proposing to help employers implement what it calls "integrated care." Employers that use the system—which involves directly contracting with providers—could receive free help from APA consultants.

Critics of the proposal claim that psychologists simply want to be employed in larger numbers in evolving managed mental health care arrangements.

The APA already is working with some transportation and

communications companies, said Bryant Welch, its executive director of professional practice.

"I don't think we should let middlemen broker communications between" employers and providers, Mr. Welch said.

Managed mental health care firms were quick to denounce the psychologists' report. They insist that managed care has substantially cut costs for employers while widening access to care for employees.

"The APA has declared war on

managed care. Their view is they can kill managed care over the next two years," said Nick Cummings, chairman and founder of American Biodyne Inc., a managed mental health care firm based in South San Francisco, Calif.

"They've been openly hostile" to managed care, said Mr. Cummings, a past APA president. "The APA has taken an atavistic stance. I'm sorry to see it."

The APA's position is "retro-

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## Shot through with problems

### A partial success, vaccine injury fund faces case logjam, funding shortfalls

By LAURA MAZZUCA

WASHINGTON—A federal compensation system set up five years ago to offer people injured by childhood vaccines an alternative to the tort system is now mired in case backlogs, underfunding and adversarial legal tactics.

It is, in short, a microcosm of the system it was designed to replace.

The Vaccine Injury Compensation Trust Fund was created by the National Childhood Vaccine Injury Act of 1986 as part of a "no-fault" system designed to compensate victims while indemnifying the manufacturers of

these drugs and the physicians who administer them.

To some extent, it has succeeded. Drug companies say that vaccine costs have stabilized, and fewer suits are being brought against them outside the fund.

The system's success in reducing lawsuits against manufacturers may one day make it a model for a no-fault liability system for developing and testing an AIDS vaccine (see story, page 21).

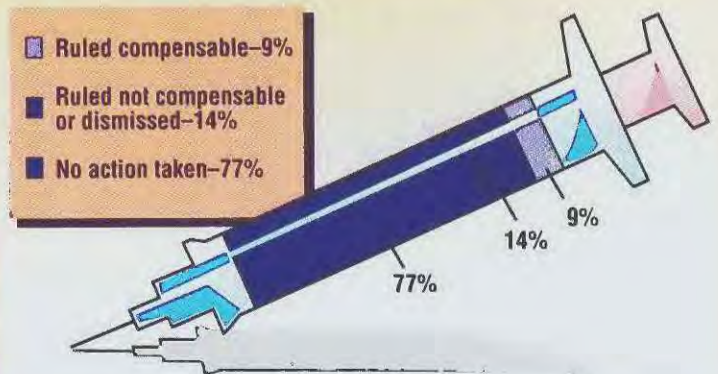
"It seems to have fulfilled the public-policy issue," said Marc H. Rosenberg, vp-federal affairs for the Insurance Information Institute in Washington. "It's meeting its broad principles."

But even the fund's supporters concede that it has done nothing to make low-limit liability insurance more available to drug companies.

And people trying to collect damages through the system say that the Department of Health

### Compensation fund backlog

More than 75% of the 4,374 claims filed with the Vaccine Injury Compensation Program as of June 16 are awaiting action.



Source: Vaccine Injury Compensation Program

GRAPHIC BY CHRIS ROY

and Human Services, which acts as the defendant in claims proceedings, rejects or dismisses many cases, forcing claimants to

hire costly expert witnesses for a lengthy appeal—just like in the tort system.

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Update

## 2 new fronting plans discussed

Continued from previous page

tion, like prior approval of some transactions and authorization of intervention by non-domiciliary regulators to solve problems when a domiciliary regulator does not act. The proposal, which would exempt some captives, emphasizes reporting and disclosure rules.

Members of a five-person drafting committee discussed the proposals during a recent meeting of National Assn. of Insurance Commissioners' subgroups (BI, June 15).

In a memo to members of the NAIC's Reinsurance Task Force, Mr. Lyons said: "I know this does not go as far as models we have considered to date," but added he believes the proposal would attract wide support. However, a spokesman for the Risk & Insurance Management Society Inc. faults the proposal for, among other things, exempting too few captives.

The task force is soliciting comments on the two drafts from regulators as well as members of an industry advisory group.

The regulators hope to develop a "workable" model law on which the entire task force and parent committee can vote at the NAIC's fall zone meeting Sept. 20-22 in Cincinnati.

## Navistar settles PBGC suit

WASHINGTON—Navistar International Corp. will pay the Pension Benefit Guaranty Corp. \$20 million in cash, plus a secured note and common stock, to settle charges that the company sold its Wisconsin Steel division to evade pension liabilities.

The PBGC in 1982 sued Navistar, then known as International Harvester Corp., contending that the Chicago-based company sold its steel unit in 1977 to Envirodyne Industries Inc. to unload more than \$60 million in unfunded pension obligations (BI, Jan. 11, 1982). In 1980, Envirodyne, a small, financially ailing Chicago firm, terminated the plans. The PBGC was unable to recover funds from Envirodyne.

In 1988, U.S. District Court Judge James D. Moran ruled that Navistar was responsible for Wisconsin Steel's pension liabilities, but left the amount of liability unresolved.

In addition to the cash payment, Navistar will provide a \$36.5 million secured note—to be paid over 10 years—and 3.5 million shares of its common stock, currently worth about \$6.4 million. The PBGC values the settlement at about \$65 million.

## Antitrust defendants file briefs

WASHINGTON—The U.S. Supreme Court should review the insurance antitrust litigation despite the Justice Department's recommendation against review, industry defendants said in two memorandums filed with the court (BI, Aug. 17).

A Justice Department brief, which describes the litigation as a "complex and important case," underscores "the need for this court's immediate intervention." The brief was filed Aug. 14 on behalf of most of the defendants.

Insurance industry defendants have asked the Supreme Court to overturn the 9th U.S. Circuit Court of Appeal's ruling reinstating the litigation after it had been dismissed by a trial judge.

The Supreme Court is expected to decide in early October whether to consider the case.

The defendants' nine-page brief points out that the Justice Department "acknowledges that the (9th Circuit) was simply wrong in holding that the domestic insurers forfeited antitrust immunity when they acted in concert with foreign reinsurers that were not subject to state regulation."

Separately, British reinsurers filed a response brief focusing on the issue of whether the state attorneys general who brought the case "have antitrust standing to challenge alleged restraints in the London reinsurance and retrocessional reinsurance markets."

Attorneys for defendant Winterthur Reinsurance Corp. of America plan to file another response this week.

## Lloyd's Council resignations

LONDON—Five working members and two external members of the 28-member Council of Lloyd's of London will resign at year end, allowing new blood to join the council, which will be reduced to 21 members next year.

The resignations come as the Aug. 28 deadline nears for Lloyd's members to return their ballots on a vote of confidence in the council (BI, Aug. 3). Others want all current council members to resign, regardless of the outcome of the vote.

Of the council members who work in the market, eight will be leaving the council at year end—the five who are resigning and three who are retiring when their terms expire. Among those resigning are Lloyd's Chairman David Coleridge and Deputy Chairman Richard Hazell.

Of the eight Lloyd's members on the council who do not work in the market, two are resigning and two are retiring, while four will continue on the council.

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## Errors & omissions

• Surplus lines broker Swett & Crawford closed a small office in Columbus, Ohio, and consolidated the operations into its offices in Detroit and New York. The office changes were incorrectly reported in the Aug. 17 issue.

• Health Providers Insurance Co. of Utah is a subsidiary of Health Providers Insurance Co. The name of the subsidiary was incorrectly reported in the Aug. 17 issue. In addition, the parent has an A- rating from A.M. Best Co.

# Room for compromise on dividend limits eyed

By MEG FLETCHER

A key regulator's comments that highly capitalized insurers could be allowed to pay larger "extraordinary dividends" than other insurers may signal new regulatory flexibility on this issue.

State insurance regulators are continuing to discuss alternative regulations limiting the size of insurers' extraordinary dividends—those that insurers can pay without prior regulatory approval.

Insurers generally object to the current standard, which is contained in a 1986 National Assn. of Insurance Commissioners

model law. In addition, some states want to know if laws and regulations currently on their books will pass the NAIC's muster for accreditation purposes.

Regulators attending a meeting of an NAIC subgroup in San Francisco earlier this month received one regulatory staff report that included suggestions for treating highly capitalized insurers differently from others.

Regulators also discussed staff analyses of previous alternatives proposed by insurers and heard new industry proposals.

No formal action was taken on the issue.

Under the NAIC's model Holding Company Act for insurers,

regulators must approve all extraordinary dividends, which are defined as those that exceed "the lesser of" 10% of surplus or:

• Net gains from operations for life/health insurers.

• Net income excluding realized capital gains with a two-year carryforward for property-casualty insurers.

Since mid-June, the NAIC Financial Regulations Standards and Accreditation Committee has reviewed several alternatives. It has endorsed as substantially similar to the standard in the 1986 model law two alternatives proposed by Earl Pomeroy of North Dakota, some existing

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# Fraud-ring suspect nabbed

## Work comp insurer wins concessions from medical clinic

By LOUISE KERTESZ

LOS ANGELES—California employers and insurers claimed two important victories last week in their battle against workers compensation fraud.

Zenith Insurance Co. of Woodland Hills dropped its racketeering suit against Wellington Medical Corp. in exchange for Wellington's agreement to abide by strict protocols in dealing with workers comp claimants.

Also last week, California Department of Insurance fraud investigators arrested Jorge

Coronado, who Insurance Commissioner John Garamendi alleges is the leader of a major workers comp fraud ring that bilked employers and insurers out of \$100 million in the past 18 months.

In California's first racketeering lawsuit over workers comp claims, Zenith had charged Wellington, another clinic, attorneys, five claimants and others with conducting a scheme to file fraudulent claims (BI, Feb. 3).

Dr. Byron Crawford, the Los Angeles psychiatrist who owns Wellington, had pleaded no con-

test to contempt charges by the Workers Compensation Appeals Board in July 1990. Dr. Crawford agreed to pay the board \$20,000. He allegedly employed unqualified personnel to "ghostwrite" medical-legal evaluations of workers comp claimants that were submitted to insurers or self-insured employers.

In 1991, Dr. Crawford lost his appeal of a WCAB decision that involved another allegation of ghostwritten medical-legal workers comp reports.

Wellington and several other

Continued on page 29

## Profit on American Re sale

# Aetna gain less than expected

By JUDY GREENWALD

HARTFORD, Conn.—Aetna Life & Casualty Co. says it will report to shareholders a \$50 mil-

lion to \$75 million profit on the \$1.4 billion sale of its American Re-Insurance Co. subsidiary to leveraged buyout specialist Kohlberg, Kravis Roberts &

Co. (BI, April 20).

Some analysts—but not Aetna—had estimated the sale would net the insurer a \$200 million profit on a generally accepted accounting principles basis.

An Aetna spokesman said that although it will post just a \$50 million to \$75 million profit on a GAAP basis, the insurer will report a \$425 million to \$450 million gain on the statutory accounting basis used by state insurance regulators.

The deal, which is expected to be completed later this year, received the Delaware Insurance Department's approval Aug. 14.

Observers also note the sale will free up needed capital to help Aetna's troubled mortgage

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## Reinsurance brokers to be listed

The deadline is approaching to return questionnaires to be listed in the upcoming *Business Insurance* directory of reinsurance intermediaries.

The annual directory will be published in the Oct. 26 issue, which will include a spotlight report on reinsurance topics. Both U.S.- and Bermuda-based reinsurance intermediaries will be included. There is no charge to be included in the directory; however, companies must fill out and return a questionnaire provided by *Business Insurance*.

If you would like a questionnaire, please request one by calling Cindy Bloom at 312-280-3195.

The deadline for returning questionnaires is Sept. 14.

## Inside

✓ Tort reform advocates must enlist a broad coalition of support, this week's editorial says. **PAGE 8**

✓ Captives may help companies manage the impact of the retiree health care accounting standard, a consultant suggests. Copy from the Vermont Captive Insurance Assn. conference begins on **PAGE 10**

✓ Financially struggling Danish insurer Hafnia Holdings A/S split into two companies last week. **PAGE 23**

✓ Analyst Leonard M. Wilson shares some thoughts on brokers' upbeat second-quarter results. **PAGE 31**

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# L.A. earthquake claim potential set at \$80 billion

By JOANNE WOJCIK

LOS ANGELES—Insurance claims triggered by a major earthquake in the Los Angeles area are likely to be much greater than previously estimated, a new study reveals.

The study estimates that earthquake-related losses would reach \$80 billion: \$43 billion for indirect losses—like business interruption and death and personal injury claims—and \$37 billion for structural damage.

This is twice the amount previously estimated by insurance industry engineering experts, according to the authors of "Business Interruption Effects of a Major Earthquake in the Newport/Inglewood Fault Zone."

And, the study was based on an earthquake measuring 6.8 on the Richter scale, considerably weaker than the 7.4 Landers earthquake that jolted the Yucca Valley in June (BI, July 6).

The study focused on damages that would result from an earthquake along the Newport/Inglewood Fault, because it runs through the heart of Los Angeles and along the Orange County coast.

While previous earthquake damage estimates focused almost exclusively on physical damage and direct economic costs, the

new study also considered post-earthquake repercussions, like business interruption.

The study also looked at business interruption losses that are likely to occur outside of Los Angeles, since the city is an integral part of the global economy.

The study, conducted by Professors Peter Gordon and Harry W. Richardson of the University of Southern California's School of Urban and Regional Planning, was commissioned by the Washington-based Earthquake Project. The project, a consortium of insurance industry companies and trade associations seeking to reduce the risks of a catastrophic earthquake in the United States, did not exercise any editorial control over the study.

The findings were presented Aug. 10 in Washington at a hearing on earthquake hazard mitigation and insurance conducted by a House Science, Space and Technology subcommittee.

Industry experts hope the findings will help take some of the steam out of the attacks by regulators and other critics on insurance companies over their reserving practices.

Insurers are bolstering their reserves so they can respond to catastrophic losses from disasters.

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# Employers considering alternatives to hospitals

By SARA MARLEY

Employers increasingly are turning to alternative hospital facilities to control the cost of caring for patients who are seriously ill but are expected to recover.

These facilities—many of which have evolved from long-term care and rehabilitation centers—say they can offer the same care that hospitals provide for half of the cost.

But some employers are hesitant to use the facilities until they see more evidence that these facilities can reduce health care costs.

Utilization review could help answer many of those concerns, say UR providers and benefit consultants.

Some employers also are deterred by the lack of a specific accreditation process for the facilities.

Alternative care—most commonly associated with hospices, home health care and outpatient surgery centers—has expanded to so-called step-down hospital facilities where patients can recover from surgery, receive intravenous medication or be weaned from a ventilator.

The facilities care for patients who require nursing care or rehabilitation services but no longer need the acute or diagnostic care of a full-service hospital. And, because the alternatives do not support high-cost surgery, obstetrics or emergency room units, their costs are as much as 50% less than the costs incurred by traditional hospitals, providers say.

Those savings are passed on to health care payers,

and a growing number are taking advantage of those savings.

Alternate hospital facilities also claim to be a more appropriate and comfortable place for patients to recover.

"This is going to be our patients' home for a few months," said Kathleen M. Griffin, chief operating officer of American Transitional Hospitals Inc. of Houston.

"We form a relationship with the patients. They have the same nurses, the same therapists. The family is involved."

"We've found alternative approaches to be more cost-effective and a more effective means of treatment," said Robert J. Grams, director of benefits and compensation for Phoenix-based Circle K Corp.

The convenience store chain has used these step-down units as well as hospice and home care when recommended by its case managers, he added.

"We want to move (patients) out of the high-intensive (hospital) to a step-down facility, as long as the patient's medical condition is not adversely impacted," commented Ann Duderio, manager of health and welfare benefit plans at Jostens Inc. in Minneapolis.

"We write our plan so the case manager has some leeway to provide for alternative care proposals," she said.

A provider of a different type of alternative care said that employers and insurers "have to get out of the classic mindset that traditional hospital care is

*Continued on page 25*

**'We've found alternative approaches to be more cost-effective,' says Mr. Grams.**

# Nicotine patch dispute

Suit seeks reimbursement of treatment costs from insurer

By LAURA MAZZUCA

CHICAGO—A woman has filed a lawsuit against her group health insurer for refusing to reimburse her for the cost of physician-prescribed nicotine patches.

The suit, believed to be the first involving coverage for nicotine patches, was filed Aug. 12 in Cook County Circuit Court in Chicago by Lisa M. Barnaby, a secretary at the law firm of Holstein Mack & Klein.

Ms. Barnaby seeks full reimbursement of the cost of the patches from Principal Mutual Life Insurance Co., which underwrote her group health insurance coverage.

A nicotine patch typically

costs between \$45 and \$60, and lasts about two weeks. A course of treatment could cost between \$500 and \$1,000, said Robert A. Holstein of Holstein Mack & Klein, which filed the suit on behalf of Ms. Barnaby.

The suit also seeks class-action status on behalf of all others denied coverage by Principal for physician-prescribed nicotine patches.

The suit says that Ms. Barnaby's doctor prescribed the nicotine patch "to prevent plaintiff's future use of nicotine-containing agents so as to reduce her risk of serious heart and lung disease."

Since "nothing within Principal's policy description limits the coverage... of drugs and medi-

cines requiring a physician's prescription," she should receive reimbursement for the cost of the patches, the suit contends.

According to the lawsuit, the policy promises reimbursement for prescription drugs used in "medically necessary care." Medically necessary care is defined in the policy as "any confinement, treatment or service that is prescribed by a physician and considered by us to be: necessary and appropriate and non-experimental or non-investigational and not in conflict with accepted medical standards."

The suit argues that nicotine patches "have worldwide medical acceptance as effective therapeutic treatments to pre-

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# Pollution liability climbs corporate ladder

Authorities' strategy: Seek indictments against executives

By JOANNE WOJCIK

**ABA** SAN FRANCISCO—Companies with hazardous waste exposures beware: State and federal environmental authorities are seeking criminal indictments against executives believed responsible for pollution.

In fact, one U.S. Justice Department prosecutor says he tries to go as high up the corporate ladder as possible to show that the government means business.

"It is a crime for the 'person in charge' of a facility to fail to make an immediate report... to a national response center if there's a large spill or discharge

of any kind of a CERCLA hazardous substance," said John E. Schulz, an attorney with Bronson, Bronson & McKinnon in San Francisco.

CERCLA is the Comprehensive Environmental Response, Compensation and Liability Act, better known as Superfund.

Just who a "person in charge" is was purposely left undefined, though. That makes it possible for the U.S. Environmental Protection Agency and the U.S. Justice Department "to go after just about anybody," he said in a session at the annual American Bar Assn. meeting held here Aug. 7-12.

For example, in *U.S. vs. Carr*, the 2nd U.S. Circuit Court of Appeals upheld the Superfund

conviction of a civilian employee at a military base who supervised the improper disposal of paint cans.

The employee, the maintenance foreman on the firing range at Fort Drum near Watertown, N.Y., ordered several range workers to dump the paint cans in a nearby water hole. The cans eventually started to leak, and one employee blew the whistle, according to Mr. Schulz.

"The maintenance foreman was prosecuted under (the Resource Conservation and Recovery Act), the Clean Water Act and two counts under Superfund," he said. Eventually, "He was acquitted of everything except the Superfund charge that

*Continued on page 14*

# No concensus reached in ad injury decision

By JOANNE WOJCIK

**ABA** SAN FRANCISCO—A recent California Supreme Court decision has not settled the dispute over whether the advertising injury endorsement in pre-1986 comprehensive general liability policies provides broad coverage for unfair business practice claims.

Insurer attorneys maintain the July 30 decision in the so-called Bank of the West case is conclusive.

And, some insurer attorneys even suggest the decision is an indication that California's high court may be ready to curb abuses in applying the doctrine that any ambiguity in policy wording should be construed in favor of the policyholder.

However, policyholder attorneys argue that the ruling does not conclusively limit coverage under the advertising injury en-

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## Montrose defense ordered

LOS ANGELES—Seven liability insurers have a duty to defend policyholder Montrose Chemical Corp. in pollution lawsuits after a California appeals court last week rejected their request for a rehearing of an earlier ruling.

Following the original July 22 ruling, four of the seven defendants—American Motorists Insurance Co., Insurance Co. of North America, National Union Fire Insurance Co. and The Travelers Indemnity Co.—requested a rehearing.

Admiral Insurance Co., Canadian Universal Life Insurance Co. and Centaur Insurance Co. did not petition for a rehearing of the case.

From 1960 to 1986, the insurers wrote general liability coverage for Montrose, a now-defunct producer of DDT.

Travelers may seek review by the State Supreme Court, said Douglas Hallett, an attorney at Coudert Bros. in Los Angeles, representing Travelers.

Montrose and the same seven insurers were the parties in a landmark Feb. 27 decision that policyholders can tap all general liability insurance policies from the time pollution begins until the liability is known (BI, March 9).

—By Sara J. Harty

# Three receive promotions, three others join staff at BI

Three members of *Business Insurance's* Chicago staff have been promoted, while three others have joined the Chicago staff, Editor James M. Burke announced.

Sarah Harty, 25, has been promoted to associate editor. Ms. Harty, who has been a staff reporter since October 1990, joined *BI* in 1989 as an editorial assistant. She previously worked as a claims representative for The Travelers Insurance Co.

She received a bachelor's degree in English from the University of Notre Dame in Notre Dame, Ind.

Ms. Harty can be reached at 312-649-5262.



Ms. Harty



Ms. Polster



Ms. Welyki



Ms. Bloom

Sarah Polster, 25, was promoted to copy editor from directory editor, a post she has held since October 1990. Previously, she was a free-lance writer and research assistant for Advertising Age in Chi-



Ms. Roberts



Ms. Dziubek

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**ITT HARTFORD**

ago, which like *BI* is published by Crain Communications Inc.

Ms. Polster replaces Kathryn Larrabee, who left to attend a graduate creative writing program at the University of Michigan.

Ms. Polster received a bachelor of arts degree in journalism from the University of Wisconsin at Madison in 1989.

She can be reached at 312-649-5441.

Kathy Welyki, 26, succeeds Ms. Polster and will be responsible for the directories that appear regularly within *BI*, as well as the annual *Business Insurance* Directory of Buyers and the annual *Managed Care Market Report*.

Ms. Welyki has been a member of the Advertising Age staff since 1984, first as editorial assistant, then as administrative assistant to the editor and finally as research assistant.

She received a bachelor of business administration degree from Loyola University of Chicago.

Ms. Welyki can be reached at 312-649-5279.

Cindy Bloom, who joined *BI* in January as an editorial assistant, has been promoted to assistant directory editor.

Ms. Bloom, 24, formerly was the marketing director for a Chicago eye care center. She received a bachelor of arts degree in advertising from Michigan State University in East Lansing.

She replaces Karen Armaganian, who now works in the publishing department of the American Medical Assn.

Ms. Bloom can be reached at 312-280-3195.

Sally Roberts, 22, joins *BI* as a staff reporter. Ms. Roberts, who interned this summer at *BI*, also was an intern for Vance Publishing Corp. in Overland Park, Kan.

Ms. Roberts holds a bachelor of science degree in journalism from the William Allen White School of Journalism and Mass Communications at the University of Kansas in Lawrence. She replaces Lori Block, who left the magazine in June.

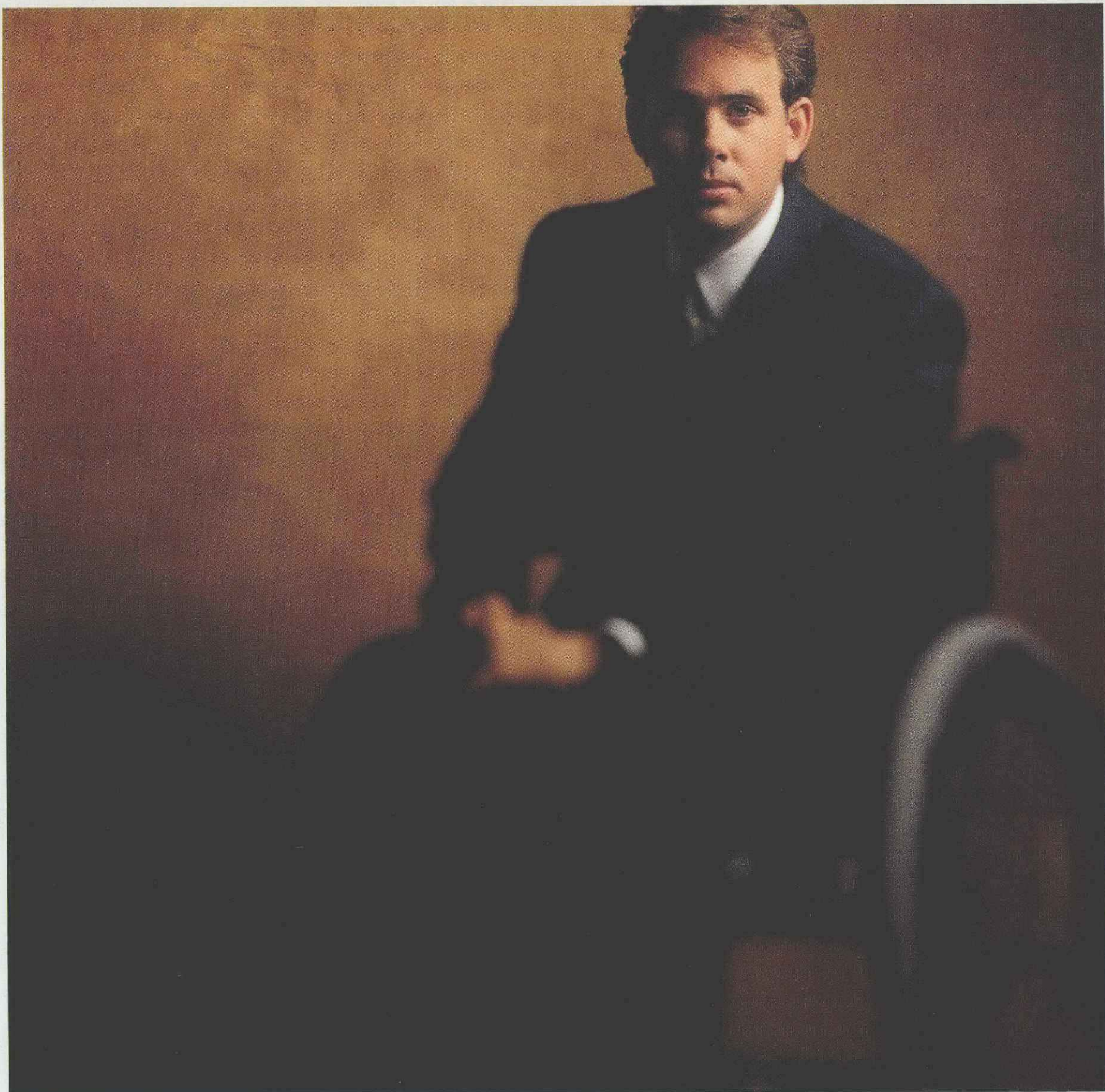
Ms. Roberts can be reached at 312-649-5482.

Kerry A. Dziubek, 23, has joined *BI* as editorial assistant, replacing Ms. Bloom.

Ms. Dziubek received a bachelor of arts in communications and rhetorical studies at Marquette University in Milwaukee. She also served as associate director of Marquette's Summer Debate Institute.

She can be reached at 312-649-5398.





## If he can't do the job, it could be your fault.

He meets the job qualifications. The question is: Does your company meet the employment requirements under the Americans with Disabilities Act?

On September 24th, Wausau Insurance is holding a national satellite conference so Wausau customers and other interested companies can gain insight on the employment perspective of the Americans with

Disabilities Act. A panel of experts will discuss compliance with the law and how it may impact workers compensation.

Forty sites across the country will receive the satellite conference. Businesses and other organizations with satellite access can receive it at their own locations.

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# Poll finds workers prefer flexible benefits

By SARA J. HARTY

## Benefit Beat

Flexible benefits would be preferred by nearly two-thirds of employees whose current plans do not offer flexible benefits, a new survey reports.

During the telephone interviews conducted by the Gallup Organization for the Employee Benefit Research Institute, the 1,000 people interviewed were not told that flexible benefit plans are generally used to cut the amount of money companies spend on benefits.

Three-fourths of those surveyed said that either their employer or their spouse's employer did offer employee benefits. Of those, 57% said their plan was "flexible."

Four out of 10 surveyed reported that if offered two jobs with identical salary and benefit level except that only one job offered flexible benefits, that would have a great deal of influence on their choice. Another 44% said it would have some influence; 12% said it would have very little influence and 4% no influence.

When asked to choose the three benefits they would most like to see in a flex plan, 62% chose health care plans, 32% chose pension plans, 27% selected vacation days, 24% selected 401(k) plans and 21% chose life insurance.

Other options picked by less than 20% of those surveyed were disability insurance, cash above salary, health care reimbursement accounts, dependent care assistance benefits and dependent care reimbursement accounts.

When asked to choose the three items they would be least likely to choose, 42% chose dependent care reimbursement accounts, 34% chose dependent care assistance benefits, 24% each chose life insurance and cash above salary, 22% chose 401(k) plans and 20% chose health care reimbursement accounts. Less than a fifth of respondents said they would not pick vacation days, disability insurance, pension plans or health plans.

Almost three-fourths of respondents, 73%, said they would participate in a benefit program that allowed them to set money aside for health or child care expenses if offered. On average, they reported that they would contribute 7.4% of their income to such a plan.

Copies of "Public Attitudes Toward Flexible Benefits, 1992," are \$25 for EBRI members and \$75 for non-members. The full report is \$75 for members and \$275 for non-members. Contact Kim Thorpe, EBRI, 202-775-6315.

## HMO satisfaction

In general, employers are satisfied with the HMOs they have chosen for their employees.

Almost seven in 10 employers in the San Francisco Bay area reported that they were very satisfied with their HMOs' financial health. The other 30% said they were somewhat satisfied, according to a survey and report by A. Foster Higgins & Co. Inc.

Half of 50 or so surveyed employers said they were very satisfied with HMO administration, 46% were somewhat satisfied and 4% were not at all satisfied.

Surveyed employers were less satisfied with HMO service.

Some 44% called service to employers very satisfactory; 54% said somewhat satisfactory; and 2% said not at all satisfactory.

Likewise, the quality of service to employees was judged very

However, only 29% of participants say they have a structured policy to encourage HMO enrollment; the remaining 71% stay neutral. Employers that provide incentives to enroll in the HMO show an average 49% participation rate. For employers that keep contributions equal for all plans, the HMO enrollment average is 37%.

When asked what type of health plan would be dominant in five years, 36% named the individual practice association, staff or group model HMO; 34% said a point-of-service, open-ended HMO; 20% said a PPO; 8% said an indemnity plan with utilization review features; and 2% said a corporate medical center.

Only 10% of employers re-

ported that they did not have an HMO. Most of these were smaller organizations with a traditional indemnity plan.

Copies of the report are available free from Robbie Brewster, A. Foster Higgins & Co. Inc., 345 California St., San Francisco, Calif. 94101; 415-296-3252.

## Help for non-profits

Information on insurance and health care arrangements will soon be available for non-profit entities.

The National Center for Community Risk Management & Insurance, a Washington-based group that helps non-profit organizations with risk management and employee benefit issues, has

begun a project to make organizations more aware of insurance arrangements now available.

The center also will attempt to evaluate the current health care system as it works for non-profit groups and suggest reforms to benefit non-profit organizations, said Craig Olswang, deputy director for health policy and benefits and director of the project.

Efforts will include:

- A directory of health insurance resources for non-profit groups, which will be available later this year.

- A national conference on health benefits for non-profit organizations next March.

For more information, contact Mr. Olswang at 202-785-3891. ■



**It's hard to find the responsiveness you need with some case management services.**

## Dividend rules

Continued from page 2

laws in New York and Missouri, and a proposed law in New Hampshire (BI, June 15).

But, insurers, bankers and state legislators generally want a higher threshold, like the one in a previous model act: "the greater of" 10% of surplus or net income.

NAIC President William McCartney, who has been overseeing the NAIC committee's discussion of the issue, remains adamantly opposed to reviving the more generous standard in the previous model act.

But he said at the San Francisco meeting that, in his personal view, "We probably could treat highly capitalized, historically profitable companies differently from other companies."

"I believe the NAIC is considering the point that we made all

along that there is a difference between well-capitalized companies and companies that are not that well-capitalized," said attorney Thomas Player, who represents the Capital Management Coalition, a 20-member group of primarily life insurers.

Mr. McCartney's public acknowledgment of his personal position is a "positive" development, said Lenore S. Marema, vp-legal and regulatory affairs for the Alliance of American Insurers in Schaumburg, Ill.

She hopes that the NAIC may be able to finish the list of alternatives acceptable as substantially similar to the current NAIC model law at a meeting Sept. 20-22 in Cincinnati.

Mr. McCartney, for his part, said he was unsure whether the NAIC could move that fast.

Meanwhile, the NAIC staff recommended its own alternative for

regulators if they decide the current model law should allow dividends in excess of 10% of surplus without approval under certain circumstances.

Minimum qualifying provisions, which were not discussed in open session, could include:

- Performing a historical analysis of profitability, preferably over three to five years, to prevent manipulation of financial data.

- Capping dividends in the range of 15% to 25% of surplus to ensure that a change in company direction is not accompanied by excessive one-year dividend payouts.

- Excluding realized capital gains—net of realized capital losses—from net income.

- Restricting dividends payable to earned surplus and imposing a 15-day prior-notice provision for all dividends.

"We believe that the provisions for historical profits, exclusion of realized capital gains, earned surplus and prior notice would be a reasonable trade-off for a higher cap," the staff said in an Aug. 11 report. "The combination of these provisions would provide more flexibility for more profitable companies while placing adequate constraints on less profitable companies."

Lewis E. Melahn, Missouri's insurance director, said he is "hopeful" that regulators are back on track with their philosophical commitment to accepting individual states' approaches to this issue, as long as the approaches are substantially similar to the 1986 NAIC model law. But, he has been "frustrated" by ongoing efforts to hammer out technical language that regulators can accept as being similar to the current model.

More restrictive prior approval

standards for extraordinary dividends allow states to prevent dividend payments that could jeopardize the solvency of an insurer, regulators contend (BI, June 15; April 20).

Dividends do not cause insolvencies, but they can be "an indication of cash flow pressures from the parent that are driving the insurer's operations," which may not be in policyholders' best interests, said Terry Boyer, NAIC director of financial analysis/surveillance, in an Aug. 12 report to the committee. The report analyzed dividend payment patterns of several insurers.

Insurers, though, say that if current restrictions are not loosened, they will find it more difficult—and expensive—to attract capital, which in turn could reduce capacity.

"If you artificially cap a return to investors based on a percentage of surplus, you put the insurance industry at a disadvantage in the capital markets," said coalition representative Mr. Player, an attorney with Neely & Player in Atlanta.

Unlike regulators, industry representatives have developed some consensus on the issue.

"I think for the first time the industry as a whole is unified in their belief that there should be a distinction between well-capitalized and under-capitalized companies," Mr. Player said.

Groups that support that contention include the American Council of Life Insurers and the Alliance.

Other approaches suggested by insurers include various formulas based on a company's surplus or net gain from operations, a net leverage test and a risk-based capital approach.

None of those options sat well with regulators.

Using a risk-based capital approach would cause "real problems," said Mr. McCartney. He noted that the ratio produced after the application of risk-based capital formulas cannot be used as both a threshold for regulatory intervention—as it is designed to be—and be used to regulate extraordinary dividend payments.

Mr. Melahn had other criticisms about the industry's suggestions for regulating dividend payments. Some industry representatives have suggested that insurers be allowed to pay dividends at levels that are two to three times what they are actually now paying, which he does not think is appropriate.

However, both regulators and insurers support a related regulation that would outline the process a state insurance commissioner should follow in ruling on an insurer's request for permission to pay an extraordinary dividend. Their common goal is to make investors more comfortable by limiting regulators' ability to intervene in insurers' dividend payments.

The NAIC currently is drafting such a measure.

In the meantime, time pressure is mounting for a resolution of the issue as legislators in many states who want to change current laws on prior approval of extraordinary dividends face bill-filing deadlines this fall.

Only 14 states have enacted the 1986 model act that contains the NAIC's current prior approval standard for extraordinary dividends, says an Alliance study.

Many other states now require the "greater than" test in the previous model law, which the NAIC will not accept when accrediting a state insurance department's solvency regulation program, Ms. Marema emphasized. ■



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## Opinions

# Tread gently with tort reform

**T**ORT REFORM IS one of our favorite subjects. We unabashedly endorse reasonable tort reform efforts. For example, we support caps on punitive damages that juries can award, and we would like to see joint and several liability eliminated.

However, to achieve any of these goals, tort reform advocates must enlist a broad coalition of support. While many of the arguments expressed by groups that favor civil justice reform are persuasive, we were a bit chagrined at a recent study prepared by AUS Consultants on behalf of the American Tort Reform Assn. (BI, Aug. 17).

The study, which is based on a complicated economic model, concludes that litigation filed against lawyers, accountants and other professionals in connection with failed savings and loans will cost the economy \$17.8 billion annually for the next five years. These costs would be reduced, ATRA argues, if joint and several liability were abolished and defendants were only held liable for the portion of the S&L losses their misconduct actually caused.

The goal of the study is worthy. The Resolution Trust Corp. and other federal agencies are trying to reach into the deep pockets of the nation's accounting and law firms in an attempt to recover some of the billions of dollars lost in the S&L debacle. We're convinced that professional firms are being forced to settle out of court for amounts that exceed the true cost of their misconduct.

But tying the tort reform movement to the collapse of S&Ls is a poor lobbying strategy. Nothing will raise the blood pressure of the average taxpayer more than the thought of the billions that will be paid out in the S&L mess. To the average Joe, the accounting firms that did not catch huge shortfalls in S&L reserves should be held totally liable, no matter what evidence



eventually is presented in the courtroom.

Those who want to reform the tort system must assure the public that change is needed to make the system work better for all Americans, not just to protect big business, insurance companies and the like. By linking tort reform to the S&L crisis, we're afraid the study may make many believe the latter.

Those who favor tort reform are quick to point out that the civil justice system represents a delicate balance between compensating those who are injured and protecting the rights of the defendants. That balance also exists in the effort to enact tort reform: Those seeking change must give examples of abuse in the system without alienating the public.

## Letters

# Veterans' benefits don't burden employers

To the editor: The May 25 article, "Veterans' Bill Targets Employers," expressed several concerns about the proposed Uniformed Services Employment and Re-employment Rights Act, which would replace the 52-year-old Veterans' Re-employment Rights law.

Most of the USERRA's provisions, including some of the employee benefit provisions about which you have expressed concern, are simply more explicit restatements of the VRR law. As head of the agency that would be charged with enforcing the USERRA, I would like to address your concerns:

- Treatment of pension entitlement. A returning veteran who meets the VRR law's eligibility criteria is entitled to be treated as if he or she had remained continuously employed for all seniority-related purposes, including pension entitlement, as set forth in the 1977 decision *Alabama Power Co. vs. Davis*, which applied to defined benefit plans. The application of the ruling to defined contribution plans remains unsettled.

The USERRA would treat defined contribution and defined benefit plans equally with respect to the rights of returning veterans. As your article recognizes, this treatment of defined contribution plans may have adverse tax consequences. The problem is expected to be resolved by amending the Internal Revenue Code, not by depriving veterans of their entitlement. The proposed Revenue Act of 1992, H.R. 11, which was approved by the House, contains language focusing on this issue (BI, July 13).

- Health insurance. Under the VRR law and the USERRA, an employer is required to provide benefits like health

insurance during military training or service if the employer provides such benefits to other employees or on other types of leaves of absence. Thus, your complaint that this USERRA provision requires new benefits is unfounded.

Your article also mentions that the USERRA would permit a person entering military service to elect continued health insurance through the civilian employer for 18 months or the period of service, whichever is shorter. Employees leaving jobs for various reasons, including military service, already have such a right under COBRA. Thus, this provision is not a new burden on employers, except perhaps for very small employers to which COBRA does not apply.

As under COBRA, the employee making this election is required to pay the premium associated with the coverage.

It should be noted that many employers voluntarily continued health care cover-

age for the dependents of reservists who served in Operations Desert Shield and Desert Storm.

When Congress enacted the VRR law in 1940, one senator noted that "the lives and property of employers as well as everyone else in the United States are defended by (military) service." Those words are as true today as they were in 1940. Certainly, the costs the employers are required to pay are small compared with the ultimate price that military personnel are sometimes required to pay.

This obviously is a very complicated law. We encourage your readers to contact us with specific questions about the VRR law and/or the USERRA. My staff can be reached at 202-523-8611.

**Robin L. Higgins**  
Acting Assistant Secretary for  
Veterans' Employment and Training  
U.S. Department of Labor  
Washington

# Litigate comp dispute in court, not press

To the editor: The article, "Comp Policyholder Sues Insurer for Lack of Service" (BI, Aug. 10), involving Liberty Mutual Insurance Co. is an example of a publication allowing itself to be used by a debtor attempting to win through the press what it cannot win in court.

You devoted several columns to what is an old-fashioned premium collection case. The facts are this: One, this former policyholder has failed in its obligation to pay hundreds of thousands of dollars in premiums, and two, many of the arguments made by the policyholder have already been rejected by the court. As for loss prevention services, had your

reporter reviewed the court records, she would have seen that the employer actually canceled appointments made by Liberty Mutual to provide such services in the two years the account was insured by us. We fail to see how this case can be characterized as "breaking new ground."

We do not intend to engage in further comment over a matter that is pending in court, but the facts and accusations accepted by you as true are inaccurate.

**Daniel P. Heldman**  
Senior Vp  
Mid-Atlantic Region  
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# Captive may blunt FAS 106 impact

By MICHAEL SCHACHNER

BURLINGTON, Vt.—Companies seeking to manage the impact of the new retiree health care accounting standard on their financial statements may want to explore using a captive for pre-funding, a risk management consultant suggests.

But, while funding retiree health benefits with a captive is worth considering, many regulatory and tax barriers may still stymie employers, said J. Brady Young, a principal in Boston with Tillinghast, a Towers Perrin Co. unit.

Specifically, a captive must be tax-effective for the parent to even consider using it. "That's the whole key to a captive program. It has to be practical. It must provide a tax deduction, and it must achieve tax breaks on funding," said P. Bruce Wright, a lawyer at LeBoeuf, Lamb, Leiby & McRae in New York.

Messrs. Young and Wright spoke at the Seventh Annual Vermont Captive Insurance Assn. conference, held here Aug. 11-14.

Tax consequences should not be the only factor considered, though. Since retiree medical plans are subject to the rules of the Employee Retirement Income Security Act of 1974, there are strict limits on how related companies, like captives, can be used to fund bene-

fits, Mr. Young explained.

Also standing in the way: Only a handful of states permit captives to fund employee benefits, either on a direct or reinsured basis. Thus, whether a captive can be used depends on the state in which it is domiciled.

Under ERISA, captives in non-U.S. domiciles cannot be used to directly fund benefit programs.

"There are many hurdles under ERISA and state regulation to using captives for funding FAS 106 liabilities. But if these hurdles can be cleared, captives are a way of getting what can be a huge liability off the financial statement," Mr. Young said.

"It's certainly worth looking into at a time when the cost of risk related to employee benefits is at least five times as great as property/casualty costs for most U.S. companies," he said.

Mr. Young was referring to the new retiree health care accounting standard set by the Financial Accounting Standards Board.

FAS 106, which goes into effect for large employers for plan years beginning after Dec. 15, will require employers to accrue as an expense against earnings retiree health care liabilities from the date a person is hired until he or she becomes eligible for benefits. In addition, the obligation must be reported on the company's balance sheet.

A company may decide to pre-fund its retiree health care obligations in light of FAS 106, and a captive may be a cost-effective funding option, Mr. Young said.

"First, a company must determine whether it has any motivation for funding these benefits in advance," Mr. Young said. "Public utilities, government contractors or anyone else working on a cost-plus basis may want to build the pre-funding cost into their cost structure."

However, a more likely motivation is that prefunding removes the liability from the organization's financial statement.

"It doesn't look good to certain audiences to have a huge liability sitting there," Mr. Young said. "In some cases, this liability can be larger than a company's net worth."

Once a company is willing to consider prefunding the obligation, it then must explore which financing approach to use.

"You have to know how the move will be treated from a tax perspective. Getting a tax deduction is the primary reason why you would want to take money out of earnings to pre-fund future liabilities," Mr. Young said.

Next, the funding mechanism—captives included—cannot violate ERISA's definition of a prohibited transaction.

For example, one of the most difficult hurdles for a captive to clear is the so-called "50% rule," which requires that benefits-related premiums constitute 50% or less of the premiums paid to the captive by the parent.

"FAS 106 liabilities are often very large. If the captive's premiums for property/casualty are \$5 million, the use of a captive for

FAS 106 purposes would be very limited," Mr. Young said.

Among group captives, tax laws may provide a barrier. Captive manager International Risk Management Group is seeking a private letter ruling from the Internal Revenue Service that would allow multiple employers to pre-fund their FAS 106 liabilities through a group captive as long as no single participant controls more than 10% of the captive's premiums.

The request, which the IRS still

is examining, would allow participants to deduct the premiums they pay from their taxes, said Jack Ryan, president of American Risk Management Corp., a Fort Lee, N.J.-based unit of IRM.

Leonard Crouse, director of captive insurance with the Vermont Department of Banking, Insurance and Securities, moderated the session. Its coordinator was Leta Finch, director of the Vermont Insurance Institute.

## Vermont meeting grows into captive big leagues

BURLINGTON, Vt.—Nearly 500 people attended the Seventh Annual Vermont Captive Insurance Assn. conference here Aug. 11-14, making it the largest captive insurance gathering in the world, its organizers boast.

In seven years, the meeting has grown from a roundtable discussion among a few dozen people to one of the most sophisticated and best-attended captive insurance conferences anywhere.

Brokers, captive managers and reinsurers from the United States and abroad were among those at this year's meeting.

Howard Dean, who took over as Vermont's governor after the death of Gov. Richard Snelling last year, delivered the keynote address. He took the opportunity to outline his administration's position on captives.

"As the largest U.S. domicile for captives, we remain committed to this industry," he said. "Over the remainder of my term I will push to reduce our tax rates to compete with other states. Cost and price are factors when selecting a domicile, but it's good regulation that's most important, and we have that here," Gov. Dean said.

Also during the conference, Betsy Costle was appointed commissioner of the Vermont Department of Banking, Insurance and Securities. She replaces Jeffrey P. Johnson, who resigned from the post to take a position with the St. Johnsbury, Vt., law firm of Primmer & Piper.

Ms. Costle previously had been the Vermont deputy commissioner of securities.

Vermont, which became a captive domicile in 1981, currently has 247 licensed captives.

Next year's meeting is tentatively set for Aug. 10-13 in Burlington. For more information contact Diane Leach, Executive Director, Vermont Captive Insurance Assn., P.O. Box 763, Stowe, Vt. 05672; 802-253-2263; fax: 802-253-2353.

—By Michael Schachner



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# Why federal 'gorilla' will win on solvency

By MICHAEL SCHACHNER

BURLINGTON, Vt.—Several major roadblocks continue to stand in the way of legislation that would establish federal oversight of insurer solvency regulation, an insurance industry attorney says.

Nevertheless, the federal government still may play a role in insurance solvency regulation because Congress' biggest proponent of federal insurance oversight will not give up his fight, says Robert H. Myers Jr.

Mr. Myers, an attorney in the Washington office of Neely & Player, addressed "One Big Gorilla or 50 Monkeys—the U.S. Regulatory Environment" during a session at the Seventh Annual Vermont Captive Insurance Assn. conference, held Aug. 11-14.

Mr. Myers called Rep. John Dingell, D-Mich., the "gorilla" in the debate over whether the federal government or the states should regulate insurance company solvency.

Rep. Dingell, chairman of the House Energy and Commerce committee, introduced legislation in April that would allow insurers the option of being regulated by a new federal agency, which would set solvency standards for U.S. and

Under the bill, all federally certified insurers would be members of a pre-funded national guaranty association not backed by the federal government.

In addition, all certified insurers would be exempt from state solvency regulations, but would still be governed by state rate and form regulations.

It is this separation of rate and solvency regulation that makes H.R. 4900 unworkable, according to Mr. Myers.

"This would result in a conflict between the demand to hold rates down at the state level and the demand for solvency at the

*Continued on next page*

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## "Practice Guidelines: Quality or Quagmire?"

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FRIDAY, OCTOBER 2, 1992, HYATT REGENCY, PHOENIX, AZ

#### AGENDA:

##### "Practice Guidelines: A Movement at the Crossroads"

**Robert H. Brook, MD, ScD, FACP**, Director of the Health Sciences Program at the RAND Corporation, explains why this moment in American health care presents the greatest opportunity — and greatest perils — in the emergence of practice guidelines as a dominant quality tool.

##### "Clearing the Smoke Around Practice Guidelines"

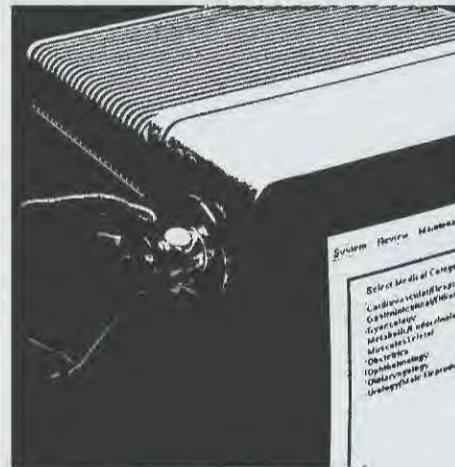
Just what are guidelines? Are they different from critical pathways and practice protocols? How do they fit into outcomes measurement and quality improvement? **Marilyn J. Field, PhD**, Study Director at the Institute of Medicine, will draw on recent IOM studies to clarify these terms and compare the various practice guideline approaches underway at government, medical association, and private enterprise levels.

##### "Making the Government's Practice Guidelines Practical"

The federal government issued its first practice guideline (on pain management) last March, with fifteen more to come. **R. Heather Palmer, SM, MB, BCh**, reports on her efforts as a consultant with the Agency for Health Care Policy and Research to track compliance with those guidelines.

##### "Guidelines Applied: The Variety of Uses in Canada and the U.S."

Representatives of four organizations describe their varied uses of guidelines, including retrospective review of practice patterns, prospective inpatient admission criteria, and continuous quality improvement (CQI). The potential impact on malpractice claims is also addressed. Panelists are **Nick Kalansky**, President of Seven Oaks Hospital in Winnipeg, Manitoba; **Susan Andrews, MBA**, Executive Director of the



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Program for Quality in Health Care in Vermont; **MaryAnn Stump, RN**, Director of Quality Improvement at Blue Cross, Blue Shield, Blue Plus of Minnesota; and **Camilla R. Madson, MPPM**, a consultant with the Institute for Healthcare Quality. **W. Alan Backley** of Ernst & Young, Toronto, will moderate the discussion.

##### "Physicians as Allies: Gaining the Trust of Caregivers"

In any application, a critical success factor in guidelines is acceptance from medical staff. How to build medical collaboration into guidelines efforts is outlined by panelists: **Eugene S. Ograd II, MD, JD**, AMA Practice Parameter Partnership representative; **William J. Morton, MD, JD**, President of the American Board of Quality Assurance and Utilization Review Physicians (ABQAURP); **A. Bruce Campbell, PhD, MD, FACP**, Vice President of Medical Programs at Scripps Institutions of Medicine & Science; and **W.C. Williams III, MD, FAAFP**, President of the National Association of Managed Care Physicians. **Thomas J. Kuhlman, MS**, of Towers Perrin is panel moderator.

##### "Guidelines at Work: Lessons from the Real World"

How have practice guidelines worked for organizations using them today? What are the challenges and rewards of their implementation, and what can be learned from experience? Key developers and users comprise the panel, including **H. Nancy Sokol, MD**, Associate Director of the Clinical Guidelines Program at Harvard Community Health; **Gary T. McIlroy, MD**, CEO of Health Risk Management, Inc.; **Jacqueline Kosecoff, PhD**, Executive Vice President of Value Health Sciences, Inc.; and **Mark S. Tanen**, Director of the Health Care Group at Phoenix Systems, Inc. The moderator is **George T. Morrow II, JD**, of William M. Mercer, Inc.

#### REGISTRATION INFORMATION:

To qualify for the advance registration fee (\$245), registration forms and payment must be received by the Institute for Healthcare Quality conference office by FRIDAY, SEPTEMBER 11, 1992. Registrations received after that date will be subject to the on-site registration fee of \$325.

Payment by credit card (VISA, MasterCard, American Express) is accepted by mail, facsimile, telephone, and at the on-site conference registration desk.

Please direct all registration correspondence and requests for information to:

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Practice Guidelines Conference  
8000 West 78th St.  
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FAX: 612/829-3578

overseas insurers (BI, April 20).

"John Dingell is determined to make federal insurance regulation his congressional legacy. For this reason alone, his bills are the ones to watch. But (the current one) won't pass. It's replete with conflict and overlap between the states and the federal government," Mr. Myers said.

An outline of Rep. Dingell's proposed legislation, H.R. 4900, calls for the establishment of a Federal Insurance Solvency Commission that regulates certified insurers, reinsurers and others for solvency.

As it's currently written, captives and risk retention groups would be exempt from the bill's scope. This exemption is a concession to the captive industry, according to Mr. Myers, who noted that when Rep. Dingell introduced federal insurance solvency regulation proposals last year, captives and other alternative risk financing mechanisms would have been included.

Mr. Myers said Rep. Dingell, in response to opposition last year, is trying to "throw a bone" to just enough people to get his package approved.

In order to become certified under H.R. 4900, an insurer would have to comply with certain capital and surplus requirements, investment standards, accounting and actuarial practices, management standards, fiduciary duty requirements and public disclosure requirements, among other mandates.

**'John Dingell is determined to make federal regulation... his legacy,' says Robert H. Myers Jr.**

## Solvency

Continued from previous page federal level," he explained.

Three other key barriers are also standing in the way of passage of the Dingell bill, according to Mr. Myers:

- The national guaranty fund. "This fund may not be backed by the full faith and credit of the U.S. government, but there's no way Congress wants to be responsible for another industry bailout similar to the savings and loan bailout," he said.

- Federal and state conflicts. "The prospect of dual regulation is opposed by both Congress and the insurance industry. This bill is replete with such conflicts.

We have counted as many as 21 overlaps of federal and state regulation. Our experience with federal pre-emption of state regulation, especially (the Employee Retirement Income Security Act) demonstrates that federal pre-emption can create a regulatory morass," said Mr. Myers.

- Cost. The FISC would cost approximately \$300 million per year to run. This cost would be assessed against the insurance industry and would ultimately be passed on to consumers.

Also before Congress is S. 1644, introduced last year by Sen. Howard Metzenbaum, D-Ohio.

This bill proposes to establish,

among other things, an insurance regulatory commission, minimum solvency standards, accreditation for state insurance departments and a federal liquidator for failed insurers.

"There have been no hearings on this. T in Congress on this," Mr. Myers predicted. "In the future, elements of both the Dingell and Metzenbaum bills may be combined. But for now, the Dingell bill is the one to watch."

Several other speakers said the federal government should stand clear of regulating insurance given its track record with other industries and the problems federal regulation would cause.

"Several states are already go-

rillas. We don't need another," said David Farmer, vp-federal affairs with the Alliance of American Insurers in Washington. "Most people would rather have the market regulate itself, but unfortunately, that isn't a choice."

However, Mr. Farmer said, "Absent a major market failure, we will not have federal insurance regulation coming out of the 103rd Congress either."

Jeffrey P. Johnson, who resigned last week as commissioner of the Vermont Department of Banking, Insurance and Securities, said: If this industry were just starting out, if the slate was completely clean, then I would support federal regulation. But

the slate's not clean. And besides, by and large, insurance is better regulated than any other financial industry."

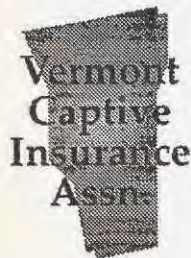
Mr. Johnson criticized Rep. Dingell for basing his beliefs that the industry needs federal solvency oversight on "a few major insurer failures."

Patrick Foley, vp and associate general counsel with American International Group Inc. in New York, also spoke at the session. Thomas Grilli, executive vp and chief financial officer with American Risk Management Corp. in Fort Lee, N.J., was moderator and Kathryn Westover, senior vp with American Risk Management, was the session coordinator. ■

# Bright future is seen for captives

By MICHAEL SCHACHNER

BURLINGTON, Vt.—Despite the disappearance of a clear underwriting cycle, captive insurance programs are here to stay because they are much more efficient risk financing vehicles than commercial insurance, an insurance industry actuary says.



Most existing captives were formed because commercial insurance was either too expensive or unavailable to their owners. But most future captives, he said, will be formed to let their owners play a larger role in loss control and to insulate them from market insecurity.

"The historic driving force for captives, which was high insurance rates, doesn't appear to be coming back. Industry results are too good for there to be a significant turn in the market," said Robert Brian, senior vp with Conning & Co. in Hartford, Conn. "But other driving forces

for captives will always be there. I'm talking about loss control, solid risk financing and allowing for the owner to play an internal role in the captive's activities."

Despite persistent soft market conditions, captives are worthwhile because they can return more than 85% of premiums to participants, said Mr. Brian, who spoke at a session at the Seventh Annual Vermont Captive Assn. conference, held Aug. 12-14.

"Commercial insurance isn't efficient. It's money out the window," said Mr. Brian. "Captives are effective in purchasing reinsurance and can reduce adminis-

trative costs."

Another reason captives will thrive is that they permit participants to implement innovative loss control strategies, said Mark Hinkley, a senior vp with Transamerica Reinsurance Co. in Stamford, Conn.

"Good captives allow for innovation. As an owner, you're close to the strategy, the opposition and your loss exposures. You can identify remedies much faster than if you're insured," said Mr. Hinkley, who also spoke at the session. "It's a simple application of an age-old concept: If you're close to the risk, you'll have better results."

An additional reason why captives have a vital future is because, as the traditional commercial insurance market realigns itself, captives can insulate companies from market insecurity.

"We're seeing more globalization; London's influence is vastly

**'Captives really allow for the vagaries of the commercial market to be dealt with,' says Mr. Hinkley.**

diminished; and there's far more segmentation by class, line and price. Conversely, a captive is steady," said Mr. Hinkley.

He called captives "the last thing" the insurance industry ever wanted to see flourish. Insurers view captives as "a substitute for themselves," said Mr. Hinkley, who predicted more changes in the commercial market, possibly very soon.

"There is going to be more regulation whether you like it or not," Conning's Mr. Brian told the audience. "(State regulators) are stepping up their oversight of insurance and federal (regulatory) action is likely by the year 2000. More than 250 commercial insurers have gone under in the past few years, which beckons more intervention."

"Thus, captives and other alternative markets are here to stay. In fact, I believe they'll play a bigger role than they do now."

"Captives really allow for the vagaries of the commercial market to be dealt with," added Mr. Hinkley. "Basically, you're putting your money where your mouth is, which increases the chances of better business. When you put your money where someone else's mouth is, you're reliant on them."

Hugh Rosenbaum, a principal with the Tillinghast division of Towers Perrin in Stamford, Conn., said captives have a "great" future because they are "the best insurance business going."

Worldwide, the captive industry will blossom as word of captive successes works its way through the insurance-buying community, said Mr. Rosenbaum. "The information on captives will improve and a more universal definition of what a captive is and what it can do will become known."

He also said more favorable tax rulings may be forthcoming from various domiciles. "But what ensures the future of captives is the skill of those promoting them. There's a tremendous amount of momentum building behind the captive movement," Mr. Rosenbaum said.

While asserting that the future for captives is predominantly bright, Mr. Rosenbaum acknowledged that there are still a few factors that could cause a decline in captive formation.

"If conventional insurers really start courting the business that's going to captives, a substantial number of potential captive owners could stay in the commercial market," he said.

Two other factors that could harm captive growth are the National Assn. of Insurance Commissioner's staunch opposition to fronting arrangements as well as the relatively high cost of running a captive, according to Mr. Rosenbaum.

While captives still offer owners efficiencies and a good return on investment, operating costs are increasing, he said.

"I get the feeling that owners and users of captives are getting fed up with the high cost of running a captive. The so-called team of service providers continues to grow, and if it gets to the point where costs exceed losses, then there'll be hesitation," said Mr. Rosenbaum.

To remedy this, he forecast more self-management of captives. "I think there's going to be less reliance on contract service providers," Mr. Rosenbaum pointed out.

Thomas LoPizzo, director of group services with the Vermont League of Cities and Towns in Montpelier, moderated the session.

George Chaffee, president of Skandia International Risk Management (Vermont) Inc. in Burlington and a former Vermont insurance regulator, coordinated the session. ■

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## Advertising injury

Continued from page 3  
dorsement.

"The Supreme Court of California has simply recognized that previous courts had gone way too far out on a limb," said L. Neal Ellis Jr., an attorney with Hunton & Williams in Raleigh, N.C., during a session on "Insurance Coverage of Business Torts" held during the American Bar Assn. annual meeting in San Francisco.

The court logically determined that "unfair competition" is limited to the common law definition of "palming off" or passing off a competitor's goods as one's own, he said.

"It could not possibly have been the intent of insurers to extend the concept of unfair competition as broadly as" to include "virtually every fraudulent unfair business practice," Mr. Ellis asserted.

CGL policies that include the advertising injury endorsement restrict coverage to injury arising out of eight common-law torts, he explained: libel, slander, defamation, invasion of privacy, copyright infringement, piracy, plagiarism and unfair competition.

The court also agreed with insurer arguments that the underlying litigation must be directly connected to the policyholder's advertising activities, Mr. Ellis pointed out.

In the case before the California Supreme Court, which stemmed from the Bank of the West's settlement of consumer litigation arising from a premium financing operation, there was no direct advertising to consumers.

The bank had advertised only to insurance agents, who were offered a commission to offer the bank's premium financing program to consumers.

Customers did not even know the bank was involved until they received a notice of the loan's acceptance by the bank. The notice sent to customers included a disclosure of terms, which included interest rates of more than 126%, as well as substantial fees and penalties.

Some of the consumers attempted to pay off the loans early to avoid paying the excessive interest charge, but the Bank of the West did not permit prepayment.

In response, the consumers filed a class-action suit in federal court seeking damages under the federal Truth in Lending Act, the Unfair Business Practices Act and a state statute that prohibits excessive liquidated damages. The plaintiffs also alleged that the loans were unconscionable and that the bank had breached the covenant of good faith and fair dealing.

The bank settled the suit out of court by paying \$500,000 in restitution to the affected consumers.

It then filed a claim with its insurer, Industrial Indemnity Co., a unit of Crum & Forster Inc., which denied coverage.

Bank of the West lost its coverage suit at the trial court level, but the California 1st District Court of Appeal in November 1990 reversed that ruling and awarded coverage to the bank.

The appeals court ruled that because "unfair competition" was not defined in the policy, the policy was ambiguous (*BI*, Dec. 3, 1990).

Industrial Indemnity sought review by the California Su-

preme Court, which agreed with the trial court (*BI*, Aug. 3).

Prior to the state's high court ruling in the case, California courts have traditionally held that the phrase "unfair competition" as used in an insurance policy should have the same meaning as is provided by the California Business and Professions Code.

Section 17200 of that code defines "unfair competition" to mean and include "unlawful, unfair or fraudulent business practice and unfair, deceptive, untrue or misleading advertising," or

just about any unlawful or unfair business practice, said Thomas W. Johnson Jr., an attorney with Irell & Manella in Newport Beach, Calif.

Mr. Johnson spoke at an ABA session titled "Cutting Edge Insurance Coverage: Four Emerging Issues Which Impact Your Corporate Client."

While insurer attorneys view the California Supreme Court's decision as pretty much cut-and-dried, some policyholder attorneys do not believe the Bank of the West ruling is the last word on advertising injury coverage.

"I don't think the Supreme Court has slammed the door" on advertising injury coverage disputes, Mr. Johnson said. Rather, "the court suggested that there may be coverage if the underlying case is a lawsuit between competitors."

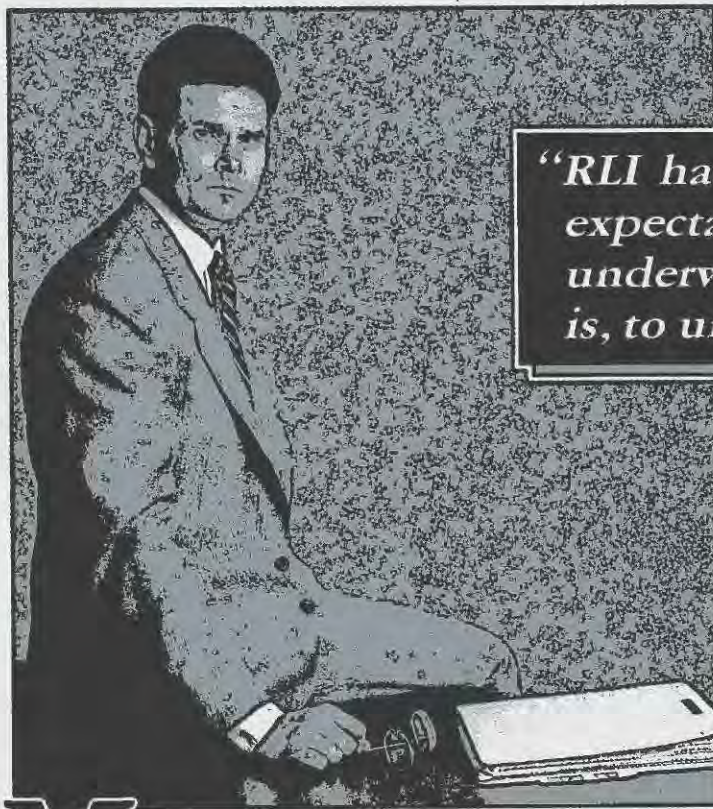
Mr. Johnson noted that after receiving its claim from Bank of the West, Industrial Indemnity asked, "Where's the competitor? This is not a lawsuit filed by a competitor."

In addition, the court found that the sum that Bank of the West paid to consumers was not damages as defined by the policy, but merely

restoration of interest that was overcharged, according to Mr. Johnson.

Furthermore, since the Bank of the West case did not involve true advertising activities, but merely a failure to disclose information, "there would not have been coverage even if there had been unfair competition," he pointed out.

"In order for there to be advertising injury coverage, something has to occur in the course of the named insured's advertising program," added Mr. Johnson. "But Bank of the West did not even make contact with consumers." ■



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# Health care workers with HIV

## Treat them fairly, employers are told

By JOANNE WOJCIC

**SAN FRANCISCO**—Health care workers who test positive for HIV should be given the benefit of the doubt that their exposure occurred during work, health care experts suggest.

Otherwise, these workers risk a loss of livelihood in addition to the threat to their lives, because most health care facilities will not employ individuals who are HIV-positive.

In addition, health care employers have an obligation to protect the health and livelihood of their employees from the increasing risk of AIDS, health care experts say.

And, workers who contract the human immunodeficiency virus, which causes AIDS, should be treated with AZT to slow the onset of the disease, just as those who step on a rusty nail are given a tetanus shot to prevent lockjaw, the experts say.

These issues were addressed during two separate sessions held during the recent American Bar Assn. annual meeting in San Francisco.

At one session, "AIDS and the Health Care Worker," speakers focused on the importance of risk management in preventing the spread of AIDS among health care workers and the difficulty in proving work-related exposure to qualify for workers compensation benefits.

During "AIDS: Insurance and Employment Issues Related to Health Care Workers with HIV Disease," insurance industry experts and legal professionals discussed the impact of HIV on employment opportunities and on the health care delivery system overall.

An estimated 70,000 health care workers nationwide have tested positive for HIV, according to Benjamin Schatz, executive director of the National Program for HIV Positive Health Care Workers, which is based in San Francisco.

In response to those statistics, the national Centers for Disease Control in Atlanta in July 1991 issued guidelines urging all physicians and dentists who perform "exposure-prone" procedures to determine their HIV status and refrain from performing those procedures if they test positive.

However, professionals who refrain from working often face the threat of financial ruin if they are unable to receive workers compensation benefits, other experts point out.

And, questions still remain about the extent to which workers comp laws cover work-related HIV exposure, both in terms of lost wage benefits and medical treatment.

Utah is the only state so far that has amended its workers compensation laws to cover health care workers who contract HIV in the workplace, according to Lisa A. Murphy, vp and assistant general counsel to the National Council on Compensation Insurance, which is based in Boca Raton, Fla.

The Utah statute also provides guidelines for the establishment of a date of injury—something that has triggered controversy in other jurisdictions.

Unlike other workers comp cases, in HIV exposure cases "the date of injury has nothing to do with objective reality," said Patricia L. Hastings, an attorney in private practice in San Francisco.

"Did it occur when the needle prick occurred?" she asked.

In addition, many health care workers infected with HIV do not develop AIDS symptoms until 10 or 15 years after exposure, long after the five-year statute of limitations on filing workers comp claims has expired, she said.

Even in California—where workers comp statutes governing HIV exposure are more liberal than those of most states—proving work-related exposure that occurred before a reliable HIV detection test was developed in 1985 is still difficult, according to Ms. Hastings.

And, while health care workers are forced to fight for their rights to benefits under the workers comp system, health care facilities increasingly are routinely testing workers to screen out those who test positive for HIV.

Eventually, as health care workers are forced to leave the profession, there will be too few health care workers to care for AIDS patients, health care experts lament.

The only solution is to increase preventive measures for health care workers and to protect the privacy of those who are exposed to prevent discrimination both on and off the job, asserted Norton H. Cohen, an attorney with Miller, Cohen, Mattin, Ice & Geary in Southfield, Mich.

And when workers are exposed to HIV from a needle prick or some other contamination source

on the job, they should be provided access to aziothymidine, or AZT, as a prophylactic measure, Mr. Cohen added.

Just as it is unlikely that any employer or health insurer would object "to paying for a tetanus shot for a worker who stepped on a rusty nail...there is no rational basis for distinguishing between the tetanus shot example and the AZT example in the case of a health care worker exposed to HIV," he said.

"As health care workers have an obligation to provide care to AIDS patients, health care institutions have an obligation to provide up-to-date (safety) controls to protect workers," agreed Rita Fahrner, a registered nurse at San Francisco General Hospital.

Among the safety measures that hospitals can use are protective clothing, like gloves and masks, and stringent procedures for the disposal of used syringes.

No level of HIV testing of health care workers can stop the spread of AIDS, in part because there is a long latency period between exposure and when a worker tests positive for HIV, she said.

Ms. Fahrner compared the latency period to that experienced by shipyard workers exposed to asbestos during the 1940s.

The session was moderated by Stuart J. Baron, president of the Workers Compensation Claims Control Co. in Los Alamitos, Calif., and Matthew B. Schiff, an attorney with Kovar, Brittain, Sledz & Morris in Chicago. ■

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## Pollution indictments

*Continued from page 3*  
he was the "person in charge" of this facility."

That conviction was upheld on appeal.

"We don't like to prosecute low-level employees, particularly when the higher-ups are more responsible," said Stephen A. Mansfield, an assistant U.S. attorney in Los Angeles.

Therefore, federal prosecutors will go up the corporate ladder during their investigation, sometimes offering immunity to lower-level employees to obtain convictions, he said.

The objective "is going after the highest-level employees who were knowledgeable participants in the crime," Mr. Mansfield said.

The Justice Department begins with an undercover investigation. Then it obtains search warrants and conducts "sweep" in-

terviews of employees during the searches.

Those investigations often uncover other federal crimes, like perjury during grand jury testimony, Mr. Mansfield said.

To avoid criminal prosecution, employers should make sure that a report is made as soon as possible after a hazardous-waste spill, Mr. Schulz advised.

In addition, decide "who's going to be the person in charge, so that whatever happens at whatever time of day or night, the report gets made," he said. Otherwise, "Once a spill occurs without a report being made, then EPA can go after (people other) than the person in charge."

In *U.S. vs. Carr*, "somebody else at the same military base could have also been charged," Mr. Schulz said.

Maintaining good records and using an outside auditor also is important, asserted Joseph A. Darrell, a defense attorney with Thelan, Marrin, Johnson & Bridges in San Francisco.

Mr. Darrell encouraged employers to consider having outside consultants monitor corporate compliance with environmental laws, since "it's difficult to do a self-evaluation" and "it can be used as evidence against you."

Employers also should avoid giving the appearance of non-compliance by, for example, leaving empty drums lying around, he said.

Over the last four years, the EPA has collected more in criminal and civil fines against employers than it had throughout its entire history, pointed out George Hayes, section chief in the EPA's regional office in Atlanta.

Penalties can be sizable. Earlier this year, Rockwell Interna-

tional Corp. of Pittsburgh agreed to pay an \$18.5 million fine for violations of the Clean Water Act and the RCRA related to the Rocky Flats nuclear weapons plant near Denver. Rockwell managed the government plant from 1975 to 1989.

"Environmental compliance is becoming big business for prosecutors," Mr. Hayes said.

The EPA recently also began taking a "multimedia approach" by citing companies under more than one regulation, according to Mr. Hayes.

For example, in northern Indiana's Calumet River area, "we used all the statutes we had available, and we took a comprehensive look at each source (of pollution) once we found one problem to make sure we were identifying all the problems."

Charges are being filed against Inland Steel Industries Inc. under the federal Clean Water Act, the Clean Air Act, RCRA and the Solid Waste Disposal Act.

And Bethlehem Steel Corp. is being charged with violations under the Toxic Substance Control Act, RCRA and the Clean Water Act, for alleged illegal discharges into Lake Michigan, according to Mr. Hayes.

"We want to make sure that our enforcement actions are commensurate with the conduct at issue," he said.

For example, the EPA recently obtained a conviction against the president of a Chicago company that authorized the dumping of cyanide into Lake Michigan, killing a huge number of fish.

"Those kinds of serious violations require a serious response," Mr. Hayes said.

The panel was moderated by William A. Gillen Jr., an attorney with Shackelford, Farrior, Stallings & Evans in Tampa, Fla. ■

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# Executive Life's failure spurs fiduciary questions

By JOANNE WOJCIK

**ABA** SAN FRANCISCO—Pension plan sponsors should demonstrate care when selecting annuity providers to avoid Labor Department suits like those filed against sponsors that bought Executive Life Insurance Co. annuities, legal experts say.

Deciding to terminate a pension plan is strictly a business decision, but the selection of an insurer to underwrite annuities for pension plan participants is governed by the Employee Retiree Income Security Act, some experts believe.

Yet some legal experts question whether plan sponsors are capable of judging the solvency of insurance companies that underwrite annuities.

And pension plan termination rules set by the Pension Benefit Guaranty Corp. do not require employers to select the "safest" insurer, they argue.

As far back as 1986—five years before Executive Life failed—the Labor Department considered the selection of an annuity provider "a fiduciary act under ERISA," explained Ann Combs, deputy assistant secretary of labor.

And ERISA requires "fiduciaries to discharge their duties solely in the interest of the participants and beneficiaries, prudently and for the exclusive purpose of providing benefits," she added.

Ms. Combs spoke during a session that discussed the standards for purchasing insurance contracts after the Executive Life collapse at the recent American Bar Assn. convention in San Francisco.

The Labor Department has sued a total of six companies that bought Executive Life annuities.

At the heart of these cases is a "prudence rule," which requires fiduciaries to "discharge their duties with the skill and prudence available at the time," explained E. Preston Rutledge, an attorney who represents ELIC.

"It isn't that they did anything bad or evil," said Mr. Rutledge, who is with Crowell & Moring in Washington. "It's that they didn't do anything."

Indeed, Ms. Combs' chief criticism of some of the targeted plan sponsors was that they did not ask enough insurers to bid on the annuity contracts.

"It's not a bright-line test. There's no right or wrong selection. There's no one insurance company that is the correct insurance company to choose," she said. "It's the process that's important."

"As long as you can demonstrate that you make the decision in participants' best interests and not in the corporate interest, then you have satisfied your fiduciary responsibility."

Employers that carefully evaluate insurers will not be held liable if the annuity provider they select later fails, said Ms. Combs. "It's a point-in-time decision."

Among the questions that pension plan sponsors should ask when selecting an annuity provider are:

- What is the insurer's claims-paying ability?

This is especially important because an annuitant whose pension plan has been terminated is no longer covered by the Pension Benefit Guaranty Corp., Ms. Combs explained.

- How financially stable is the

company?

In the case of ELIC, for instance, plan sponsors should have inquired about the insurer's junk-bond portfolio, according to Ms. Combs.

- Is there a safer insurer available?

However, some legal experts disagree that plan fiduciaries should be expected to know more than insurer rating organizations when judging an insurer's solvency.

"Given the complexity of insurance company accounting practices, can plan fiduciaries, however expert they may be, really be expected to do a better job than the rating organizations themselves have done?" asked Timothy C. Russell, an attorney with Sonnens-

chein, Nath & Rosenthal in Washington, who moderated the discussion.

Furthermore, while the PBGC requires employers to purchase annuities when they terminate pension plans, "the rules don't require solicitation of bids," pointed out Mr. Rutledge. Nor do they require that the safest insurer be selected.

In fact, in the 1981 preamble to the PBGC's proposed regulation governing plan terminations, the agency said that concerns over insurer insolvency were not warranted because insurers are regulated by the states and therefore annuitants would be covered by state guaranty funds, he said.

"Employers feel they are being attacked for a process that everyone engaged in at the time," he asserted. "ELIC was highly rated in the late 1980s," when most of the companies sued by the government bought their annuities. ■

# ABA attracts thousands

**ABA** SAN FRANCISCO—Hillary Clinton, wife of Democratic presidential nominee Bill Clinton, and an immediate past chairwoman of the American Bar Association's Commission on Women in the Profession, delivered a keynote address at the group's annual meeting.

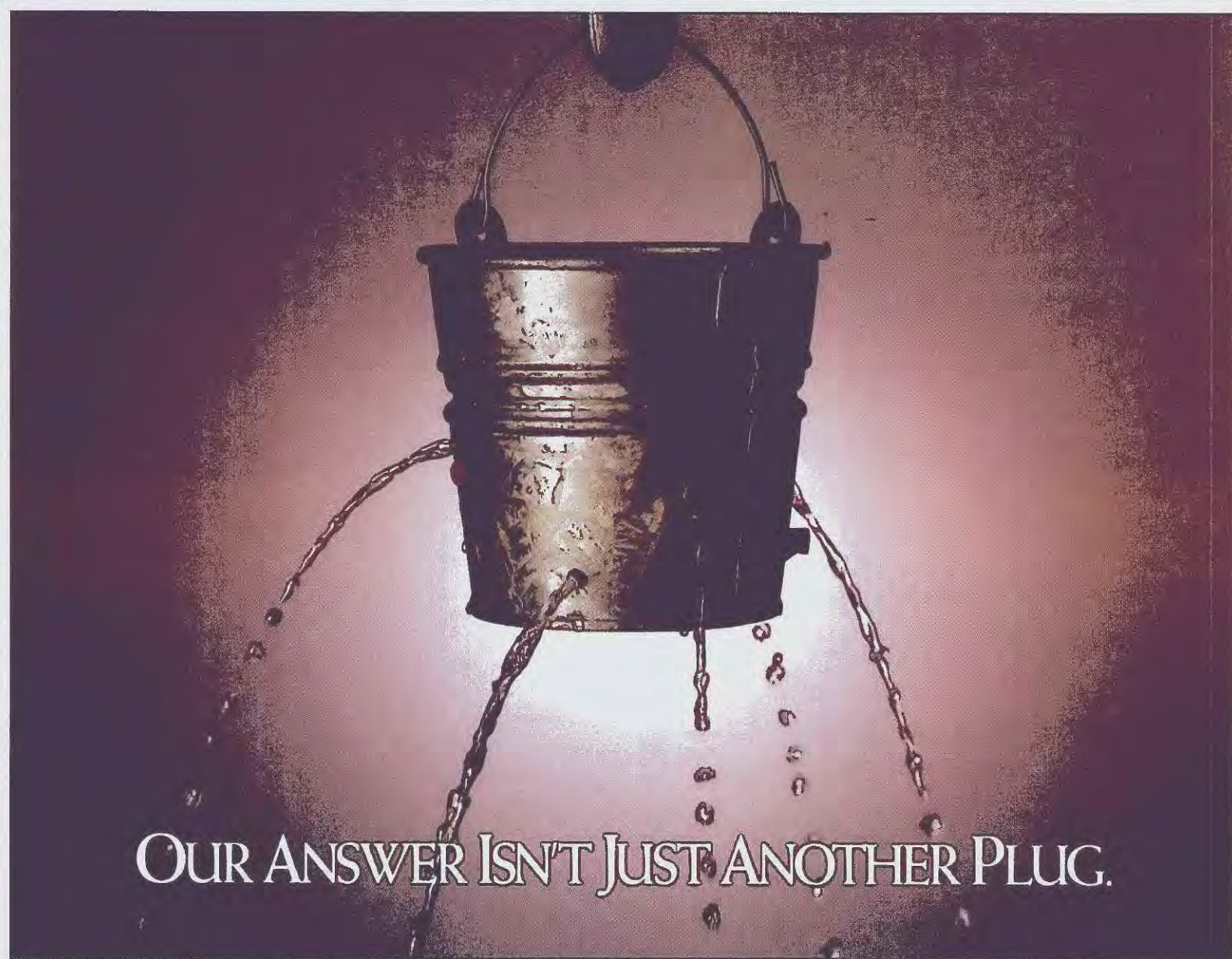
Approximately 11,500 lawyers were pre-registered for the convention held here Aug. 6-12. Nearly double that amount, though, were expected to descend on the City by the Bay. A final headcount is still being tallied.

In addition to the hundreds of sessions on legal issues during the week-long meeting, ABA's policymaking House of Delegates voted to delete a rule prohibiting attorneys from engaging in ancillary business.

The House of Delegates, in a controversial move, also voted to support abortion rights.

Next year's annual meeting will be held Aug. 5-11 in New York.

For more information, contact Lillian Smith, Meetings Information Coordinator, at the American Bar Assn., 750 N. Lake Shore Drive, Chicago, Ill. 60611; 312-988-5000.



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# For The Best In Life—And Health.

## APA proposals

*Continued from page 1*  
 gressive," said Dr. Richard Kunnes, chief operating officer of Prudential Psychiatric Services, a unit of Prudential Life Insurance Co. of America in Roseland, N.J.

Providers running the program is "like the fox guarding the chickens," argued Dr. Kunnes. "After all, it was the providers that caused the problem (of unbridled costs) in the first place."

"We can't trust all providers across the board (to make) judicious decisions," said David Levine, vp of marketing and account management at Human Affairs International Inc., a managed mental health care firm based in Salt Lake City and a unit of Aetna Life & Casualty Co.

On the other hand, executives at managed health care firms say they agree with most of what the

APA recommends for improving mental health care while reducing costs.

Dr. Kunnes, in fact, characterized the group's prescriptions for improving care as "old hat."

The general recommendations "almost mirror part of HAI's business plan," said Mr. Levine. "(The psychologists) try to create an enemy, and the enemy isn't us."

The APA's suggestions are not very different from "what a good managed mental health care company would provide," said Peter Sterman, vp for managed care services for Preferred Health Care Ltd.'s western region in Irvine, Calif.

Prudential Psychiatric Services "would heartily endorse" most of the recommendations, Dr. Kunnes said.

The controversy seems to stem from psychologists "wanting a bigger piece of the pie," Dr. Kunnes

said. "While psychologists and hospitals are not excluded from the continuum of care" in a managed mental health care network, "they are not the largest piece," Dr. Kunnes explained.

"Psychologists have been somewhat eclipsed in the current managed care environment," agreed Dr. Roger Taylor, national leader for health care consulting for The Wyatt Co. in Washington.

Psychiatrists "took a dominant role initially" in early managed care arrangements, and "the current outpatient environment focuses on the least costly provider"—the psychiatric social worker.

The APA's report is "a mixed message," Dr. Taylor observed. "It blasts managed care" while it "recommends that psychologists should be put in the driver's seat in future managed care arrangements."

But, he said, "I don't think it's realistic to think that the middle-

man organization will go away. Employers are not going to want to manage (their mental health care benefits) directly." In fact, psychologists who contract directly with employers will often play middleman roles in monitoring treatment.

The APA's position "may be a strong and important play by psychologists to make sure they will not be excluded from that middleman organization," Dr. Taylor said.

The APA began assessing managed care two years ago. Following what it characterized as widespread complaints about managed care, the group began a "nationwide dialogue" with corporations, government, institutions and advocacy groups, the managed mental health care industry, insurers and mental health care providers.

Fifty-eight corporations participated in structured interviews, followed by roundtable discussions

held throughout the United States.

Through this process, the APA says it learned that: "Today's system is in crisis and has reached a breaking point. Patients are denied access to care in the name of cost control. Providers are forced to spend more time administering managed care rules and less time treating patients."

"And corporations are still subject to spiraling costs without getting the benefits high-quality mental health care can provide to employee effectiveness. Corporations, providers and patients are demanding reform of the system."

Providers are responding by "developing coordinated groups and organized systems of care that contract directly with business," the APA said. "This integrated approach is part of the new generation of health care."

In its report, the group recom-

*Continued on next page*

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Continued from previous page  
mends that business, providers and employees:

- "Develop a joint venture... that addresses the needs of corporations, employees and mental health providers alike."

- "Develop model benefit designs and provider networks that attack the abuse of inpatient psychiatric care, encourage the use of cost-effective outpatient care and support a full continuum of alternative treatments utilizing highly trained providers."

- "Create systems of care that focus on quality."

- "Expand the role of psychological principles in the corporate environment."

- "Generate a grass-roots discussion with psychologists that helps them develop business practices that allay the confusion corporations feel."

- "Develop a system of practice benchmarking and outcome studies that presents corporations with explanations of how care is given and what should be expected, and documents the value of psychotherapy."

This proposal would not discard managed care, the APA's Mr. Welch said. Instead, it is "taking some of the more reasonable managed care principles" and developing "a hybrid" model.

The flaw in managed mental health care is that "most managed care companies provide the barest, barest amount of mental health care," said Mr. Welch. "When you look at the kind of problems our members treat, they're not providing ample benefits to meet patient needs."

The benefit plan design marketed to employers by managed mental health care firms—typi-

cally coverage for 20 or fewer outpatient sessions— "turns insurance principles on their head," he said.

Managed mental health care firms' approach is, "We'll treat your mild problems—that many (individuals) could afford out of pocket—but if you have something more serious, your insurance company pays nothing," he said.

Mr. Welch also said utilization review at managed care companies has "just gotten out of control." Some firms do reviews as frequently as every three sessions of psychotherapy, and many every six sessions, he said.

"We recommend utilization review only on longer-term outpatient care," he said. "Psychotherapy has to take place in an environment of trust, and if you are a patient about to tell someone the intimate details of your

life," you want assurance that it will remain confidential and "the sense that this relationship (with the therapist) will endure."

But a person performing utilization review might intervene and recommend stopping after a few sessions, Mr. Welch said.

In those cases, "the benefit is inadequate." And managed care firms "are less than candid with patients and employers in acknowledging that." The process can "become terribly destructive of people," he charged.

In response, Prudential's Dr. Kunnes called the APA's assessment "very upsetting." "There are a number of significant errors and non-facts" in the APA's report, he said.

Dr. Kunnes conceded that, among managed care firms, "there are the good, the bad and the ugly." But, he said, "The better programs significantly in-

crease access (to care)."

Better programs, for instance, feature toll-free numbers operating 24 hours a day, seven days a week, he said. In non-managed systems, employees might have to search through the phone book to find care, he pointed out.

Managed care firms insist they do not restrict access to care. Mental health care benefits are "generally enhanced" by a comprehensive managed mental health care program, contends Preferred Health's Mr. Sterman.

The APA is not seeking the demise of managed mental health care firms, said Mr. Welch. "We hope we're supporting those companies that would like to offer a higher-quality product. If the effect of integrated care is to push managed care companies into a higher-quality product, we'd be delighted to see that happen." ■

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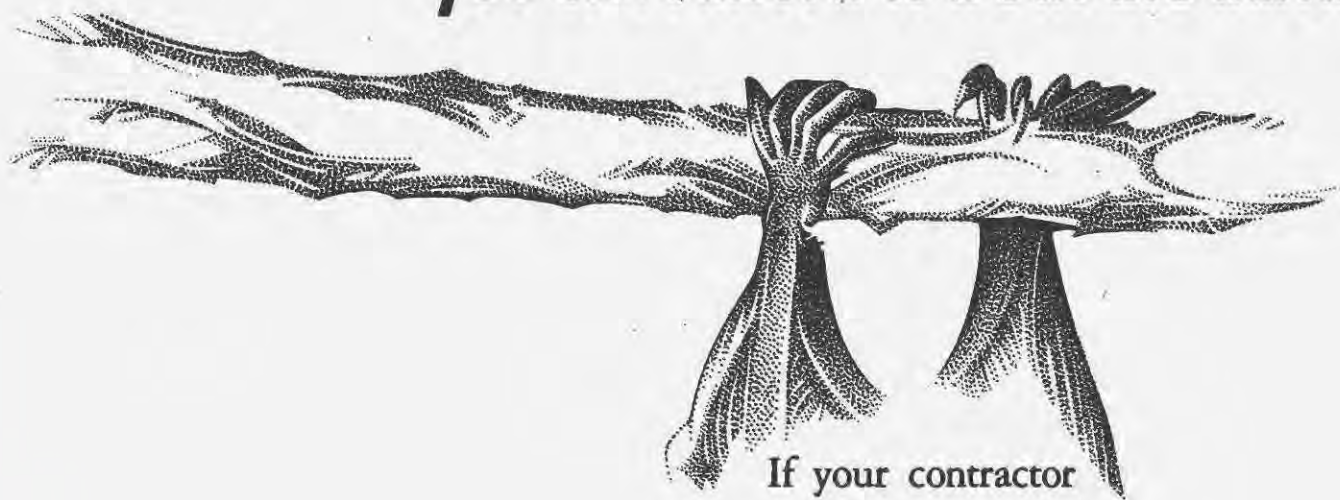
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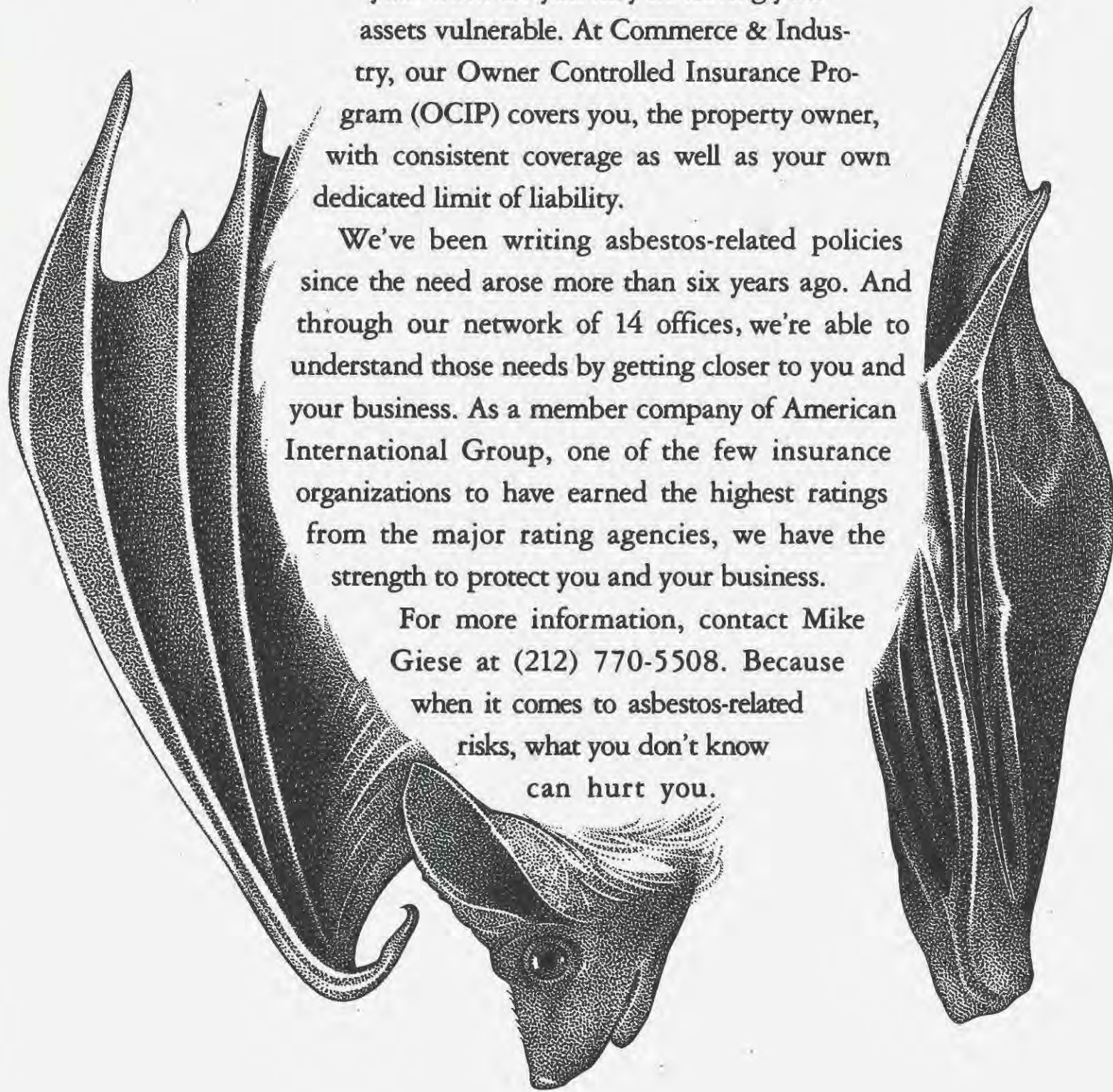
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# Mental health benefits

By Howard Savin

LIKE MOST AMERICAN INDUSTRIES, mental health care operates in a marketplace. Costs for mental health and substance abuse benefits are escalating rapidly—even faster than medical/surgical costs—and now exceed \$15 billion annually for private-sector employers. With money tight, employers have instituted a number of strategies to contain the rising costs. These strategies have included greater employee cost-sharing and the use of health maintenance organizations, preferred provider organizations and hospital bill audits.

But as a practicing clinical psychologist, I suggest that employers, in their own self-interest and that of their employees and the employees' dependents, need to do more—not spend more but do more—to influence the design and operation of the mental health and substance abuse care marketplace.

As buyers, employers should clearly advise psychologists, psychiatrists and other providers of mental health care to reform the systems we use to organize, deliver and finance services. This article includes a suggested checklist of actions to implement the needed reforms. But first, consider these facts:

- In recent years, this country has experienced a sharp escalation in inpatient psychiatric services, resulting in large increases in the proportion of employers' premium dollars devoted to these services.

Television ads in major cities urge parents to send their problem adolescents, and even

## Employers should help shape reform in the marketplace

pre-adolescents, to hospital and residential treatment centers. Admissions and hospitalization for adult personality disorders are encouraged as well. As a result of this promotion, corporate benefit plans and union welfare programs are subsidizing a great deal of unnecessary hospitalization, which represents much waste and inefficient use of available resources.

- Employees who require mental health services that are not received because of benefit limitations utilize the general health care delivery system 300% more than other employees. Treatment frequency increases for hypertension, esophageal problems, cirrhosis of the liver, cardiac and gastrointestinal disorders among the individuals not receiving treatment for needed mental health problems. Absenteeism, short- and long-term disability claims and workers compensation claims also increase.

As a result, the bottom line of your annual financial reports is reduced by a substantially greater amount than indicated by any line item on mental health benefit costs. This problem will probably worsen as employers comply with the Americans with Disabilities Act.

- Psychiatrists, psychologists and other mental

health care providers in many areas are engaged in turf battles that do little to improve patient care and nothing to control costs. As a result, mental health care has fallen behind general health services in the movement toward a new generation of managed care, which would force psychiatrists, psychologists and other mental health professionals to establish practice guidelines, to clarify what constitutes effective therapy and to define treatments of choice.

Psychiatrists and psychologists are, by and large, highly motivated professionals who are devoted to their patients and see to it that they are nurtured and well-tended. With most patients, we administer just the right amount of services in the right settings. But like everyone else, we are human beings with the same moral and ethical standards, strengths and weaknesses as others.

When we are urged by families and friends to admit patients to hospitals, we do not always allow our professional judgments to get in the way of admission.

When we are implored to keep patients in hospitals to the fullest extent permitted by their insurance plans, we do not always adamantly resist such pleas.

When we find hospitalization as the path of least resistance, we do not always resist, even when we know that treating most mental health care patients outside their normal environments reduces treatment success rates.

We need reforms to ensure that the right patient is treated in the right place, at the right time. This

*Continued on next page*

# Crisis management plans

## A toxic chemicals manufacturer prepares to handle a leak

By The Insurance Institute of America

The following question and answer are drawn from the curriculum for the Associate in Risk Management designation awarded by the Insurance Institute of America. They represent the type of question asked—and the possible answers—in one of the three examinations for the A.R.M. designation.

This month's exercise, drawn from a recent national examination in ARM 55—Risk Control—goes beyond the accepted general principle that all organizations should practice crisis management planning. This example explores why and how specific crisis management plans need to be tailored to particular facilities and to the perils to which they are especially vulnerable.

**Q:** A manufacturer of industrial chemicals has riverside storage tanks that can hold up to 20,000 gallons of toxic chemicals ready for shipment. The manufacturer's risk management professional recognizes that a crisis management plan is needed in case the toxic products escape from the storage tanks.

- Describe three specific aspects of an appropriate crisis management plan for this manufacturer in case toxic products escape from its

### A.R.M. exercises

riverside storage tanks.

- For each of the aspects described in your answer above, explain whether the crisis management plan for an escape of toxic products is likely to differ from a crisis management plan for a fire at the same facility.

- Briefly explain how scenario analysis and the Program Evaluation Review Technique (PERT) each might be useful to this manufacturer in planning its recovery from a major spill of toxic chemicals from its storage tanks into the river. (Describing other aspects of a crisis management plan also earned full national examination credit.)

**A:** At the most general level, all crisis management plans are essentially identical: They strive to protect an organization's personnel, production facilities, organizational structure, markets and financial resources in the wake of major accidents caused by any peril.

- For toxic products escaping from riverside storage tanks, three specific aspects of an appropriate plan would include: focus on evacuating the manufacturer's personnel and endangered members of the public from the storage area, minimizing the harm from the escape of toxic

materials, and notifying authorities responsible for potential environmental pollution or other harm to the public.

- If a fire were to strike the riverside storage tanks, plans for evacuating endangered people probably would be the same for both the fire and for escaped chemicals because both events would threaten all people equally. For a fire, however, the second aspect of crisis planning—containing escaped potential contaminants—could be significantly different because the contaminants from a fire (principally spent extinguishants and other wastes from the fire) probably require different containment strategies than do toxic chemicals. Furthermore, a fire is likely to require notifying different authorities than those who should be alerted to spills of environmentally dangerous chemicals.

- Scenario analysis and PERT are two of several system safety techniques that are both useful in analyzing how accidents may occur and how their frequency or severity may be reduced.

Scenario analysis is a non-quantitative technique for visualizing or otherwise imagining—often as a group exercise—how accidents may strike a particular facility or operation, frequently under worst-case

conditions. For planning recovery from a major spill of toxic chemicals into a river, scenario analysis would help in picturing circumstances where adverse weather, a labor union strike, a series of unrelated catastrophes or other unusual circumstances might make containment and cleanup operations especially difficult. Scenario analysis also could then be used to plan ways of overcoming these special difficulties.

PERT is a relatively simple quantitative technique for projecting the time required to complete various independent components of a plan or project, and for allowing time for each component so that all parts of the plan or project are ready when needed. PERT could be most useful in scheduling the various aspects of a plan to capture and remove toxic chemicals spilled into the river, to rebuild any damaged facilities and to resume normal operation at this manufacturer's riverside storage tanks. ■

The sample questions and answers used in this column are taken from the Associate in Risk Management designation curriculum of the IIA. For more information on the content of the A.R.M. program, write Dr. G.L. Head, Vp, Insurance Institute of America, P.O. Box 314, Malvern, Pa. 19355.

## Mental health care

*Continued from previous page*  
offers the best hope for corralling costs while ensuring quality care. Studies have confirmed the suspicions of many third-party payers that much of the variation in substance abuse costs is determined more by the availability of empty beds and inpatient insurance coverage than by patients' needs for lengthy hospital stays.

The New England Journal of Medicine reported recently that recidivism was reduced when alcoholics were detoxified as inpatients rather than through attendance at Alcoholics Anonymous meetings. That's true. But does it require a 28-day inpatient detox program when three to five days will do?

Unnecessary hospitalization is one symptom of unmanaged care, but not the only one. In the field of mental health, a properly constructed managed care plan, incorporating lessons learned from earlier efforts, can reduce costs and enhance the quality of the services funded by employers.

Some corporate benefit managers and trustees of union health and welfare plans have learned how to design and price such a competitive and workable mental health/substance abuse product.

For those still looking for help toward managing these benefits, let me suggest a 10-point checklist for contracting for managed mental health services:

- The managed mental health care firm you select should be able to demonstrate cost-effective, high-quality management over a minimum of five years. Your due diligence should eliminate firms with less experience. Know the firm's financial strengths. Be sure its management team represents a

broad range of experience in dealing with mental health care providers and the mental health services system. The firm should have a good reputation for patient friendliness.

- The benefits provided for mental health care and substance abuse services should allow adequate therapy and treatment, and thereby cut the use of unneeded general medical services.

- The basic components of the managed mental health care program should include a gatekeeper interfacing with your employee assistance program, if you have one; a provider network including all mental health professional disciplines; and a case management system including on-site utilization and concurrent reviews as necessary, pre-discharge planning and follow up.

- The firm must be willing to assume full risk or share risk. It must agree to offer total global price arrangements or partial-risk plans, as desired by the employer. It should be flexible in meeting buyers' needs.

- Make sure the managed mental health care firm allows only the most qualified mental health professionals to become providers of care. Psychiatrists should be board-certified or board-eligible. Psychologists should meet the standards required for listing in the National Register of Health Care Providers in Psychology.

- Check the managed care organization itself for the practice standards it requires of providers and its quality assurance system. Be sure it conducts random charge reviews and hospitalization audits.

- Unlike a "risk-carrier," the managed care firm is not predisposed to over-admit or to over-utilize inpatient services. But that does not eliminate the need for a managed care firm to have a

state-of-the-art utilization review system. Visit the UR site and check intake, referral and all other procedures.

- What about under-utilization? Check the inpatient utilization rates. If they are low—under 36 days per 1,000 lives annually—is this offset by a high utilization rate of outpatient visits, which are desirable from both a quality of care and costs standpoint in a risk-assuming managed mental health care firm?

- The firm's management reports are critical to the employer's understanding of expenditures and quality safeguards. Require data from the claims processing and provider review systems which will enable you to monitor trends and assess the appropriateness and effectiveness of specific interventions.

- Examine the working relationships among the various professionals and employees of the firm, the programs offered for continuing education of providers, the internal systems of communication and the environment to ensure a smooth-running operation.

I believe that providers and purchasers have an equally important stake in ensuring cost-effective, high-quality health care services. ■



Howard Savin is executive vp of Achievement & Guidance Centers of America Inc., a managed mental health care firm based in Newtown, Pa.

# The Chernobyl of insurance

## An insider offers kiss-and-tell look at Executive Life

**"Broken Promises: The Inside Story of the Failure of Executive Life"**

By Vic Modugno  
Published by Pacific Insurance Press, 4455 Torrance Blvd., Suite 337, Torrance, Calif. 90509-2806

\$24.95

By Kevin M. Quinley

WHEN INVESTMENT firms underwrite an issue of new corporate shares, they issue solemn-looking notices called tombstones. With the demise of more insurance companies, the idea of a "corporate tombstone" has assumed a new, grimmer, meaning. The financial

### Books & Ideas

tailspin of an insurer must figure in every risk manager's nightmares.

Although property and casualty insurance has received much attention for financial distress, the staid world of life insurance has been tainted as well. Before Mutual Benefit Life Insurance Co., there was Executive Life Insurance Co. Its story typifies much of the greed and avarice that we now disavow of the go-go 1980s.

"Broken Promises" is a sad story about a life insurance company that failed (BI, April 15, 1991). It is an anatomy of an insurance disaster that led to reduced or eliminated benefits for policyholders, pension plan participants and bond owners. Executive Life stands as the Chernobyl of the life insurance industry.

Author Vic Modugno is a Fellow of the Society of Actuaries. He ought to know a thing or two about Executive

Life, since he worked there as an associate actuary from 1986 until 1990. Looking at the situation from inside the fishbowl is a daunting task, and Mr. Modugno strives to retain objectivity. Yet in many ways, "Broken Promises" is an insurance version of the kiss-and-tell genre more associated with tabloid newspapers.

What can risk managers and benefit managers learn from the tale of Executive Life? For one, it should make them more willing to check the financial status of the insurance companies they do business with. And, it would encourage them to examine financial statements and take the assurances of rating organizations with a grain of salt.

Much of "Broken Promises" is anecdotal, focusing on the personality traits and peccadilloes of various Executive Life principals. Actuaries, insurance regulators—everybody waits in line for his turn at culpability.

Although the book touts itself as a

"devastating new book on the life insurance industry," it is unlikely that this glimpse into seamy Executive Life is representative of an entire industry. In this regard, the book's claims seem overblown and its title casts an ironic tone on what it purports to be. At nearly \$25 for a paperback, this post-mortem of an insolvency seems pricey, given its narrow appeal. But for those with morbid fascination for failed enterprises, it will have much page-turning allure. ■

Kevin M. Quinley is vp of risk services for MEDMARC Insurance Co. Inc. and subsidiary Hamilton

Resources Corp., both of Fairfax, Va. Mr. Quinley holds the Chartered Property & Casualty Underwriter and Associate in Risk Management designations.



# Mental injury from bomb threat not compensable

Does a psychological injury arising out of a co-worker's anonymous bomb threat to the employer demanding an employee's dismissal provide a basis for an alleged psychological injury under the Workers Compensation Act? The Court of Appeals of New Mexico ruled that it did not.

The workers compensation claimant in this case was employed by a municipal school as a teacher's aide. A co-worker of the claimant made an anonymous bomb threat to the school that demanded that the claimant be fired. Allegedly, the bomb threat resulted from the personal animosity of the co-employee against the claimant for reasons unrelated to the claimant's employment.

### Legal Briefs

The claimant alleged she sustained a psychological injury arising out of the bomb threat and filed for workers compensation. The claim was denied. On appeal, the claimant argued that the setting of her employment increased the risk of the assault, thereby bringing her claim within the compensation law. But the court said that the claimant was not entitled to compensation because the "positional-risk" doctrine she cited only applied where the assault was not motivated by personal animosity toward an individual worker.

The court said when the origin of an assault arises because of private or personal reasons, and the worker's employer had not engendered or exacerbated the quarrel or facilitated the assault, the assault should not be compensable.

*Bader-Roudeau vs. Truth or Consequences*, Court of Appeals of New Mexico, Dec. 27, 1991 (BI/04.S.-\$10)

*These abstracts were prepared by Mayo H. Stiegler. Copies of these decisions are available by sending a \$10 check payable to Mayo H. Stiegler to Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590. List the number for each opinion.*

## Vaccine fund

Continued from page 1

"The (fund's) original intent was to be fair, expedient and relatively simple, but I don't think it's any of these now," said Marion Ray, a lawyer with Hunt & Wilson in Charleston, W.Va., who represents claimants.

Other problems exist as well. Under the 1986 law, doctors who vaccinate children are required to report adverse reactions to federal health authorities and to distribute information on childhood diseases and vaccines before inoculation.

In addition, the law directs the federal government to promote the improvement of existing vaccines and to develop safer vaccines.

But it is difficult—if not impossible—to tell how many doctors actually report adverse reactions.

And, until a consumer group sued last year, the HHS had published no information for doctors to give parents on the risks and benefits of mandated childhood vaccines.

Federal efforts to improve vaccines have been slow, too. Recently, for instance, the Food and Drug Administration approved the manufacture and sale of a new, apparently safer vaccine for pertussis, or whooping cough. Based on a formula that has been available in Japan since 1981, the drug is still approved only for the last two doses of the five-part DPT vaccine.

In the meantime, the number of post-1988 vaccine injury cases in the compensation system continues to grow—from just one in 1989, to 31 in 1990, 121 in 1991 and 135 in 1992. These cases join the more than 4,000 cases already pending that were filed before the fund was established in 1988.

Starting in 1982, news stories detailed the plight of children injured by vaccines. Since then, lawsuits against drug makers have attributed injuries to four vaccines that children in most states are required to receive: diphtheria, pertussis and tetanus, known as DPT; measles, mumps and rubella, known as MMR; diphtheria-tetanus; and polio vaccine.

These vaccines have been associated in medical literature with a spectrum of reactions in infants and children, ranging in severity from shot-site swelling and fever to seizures, brain damage and death.

The pertussis component of the DPT vaccine is especially controversial in the medical community. Reports of adverse reactions date back to the 1940s.

### Millions paid out

The Vaccine Injury Compensation Program was designed to compensate victims, control the rising costs of vaccines and to encourage drug companies to remain in the business (*BI*, Feb. 1, 1988; Dec. 14, 1987).

Similar compensation programs have been established in Great Britain, Japan, West Germany, and other countries, all of which—unlike the United States—have since stopped recommending the pertussis vaccine because of safety concerns.

To be eligible for compensation under the U.S. fund, a person's reaction must meet the criteria contained in a vaccine injury table.

Since 1990, when the first awards were granted, the fund has paid out \$248.8 million for

477 cases. This figure includes damages and attorneys' fees, which the fund pays even if compensation is denied.

Initially, drug companies believed that the U.S. fund would discourage product liability suits against them and make commercial insurance more available.

Now their opinions are mixed. One leading maker of the DPT vaccine—Lederle Laboratories in Wayne, N.J.—is "cautiously optimistic" about the fund, said a spokesman for the American Cyanamid Co. unit.

Vaccine-related lawsuits against Lederle have fallen from more than 300 in 1988 to a total of only 20 since then, the spokesman said.

The atmosphere for vaccine manufacturers has improved enough for Lederle to develop and receive FDA approval to manufacture ACEL-IMUNE, a reportedly safer DPT vaccine.

And Merck & Co. Inc., manufacturer of the MMR vaccine, has launched a new vaccine division, said Timothy D. Proctor, associate general counsel of the Rahway, N.J.-based company.

But because claimants can still turn to the tort system if they are not satisfied with awards from the fund, commercial liability insurance for drug companies has remained scarce.

Both Lederle and Connaught Laboratories, a Swiftwater, Pa., manufacturer of polio and DPT vaccines, say that the cost and availability of liability insurance has not substantially changed since the law went into effect in 1988.

And while Lederle has been named in fewer lawsuits since the fund was established, the manufacturer's spokesman would not say whether the more recent suits sought greater damages than the pre-fund cases.

### Major flaws

Drug manufacturers and the fund's administrators generally support the system. Many of them, though, readily admit that the program has major flaws, especially underfunding and case overload.

The program's compensation fund is broken down into two categories: one for injuries incurred before October 1988, when the fund was created, and one for injuries after that date. Awards to those injured before 1988 are financed through federal revenues, while an excise tax on vaccine sales fund compensation for post-1988 injuries.

For the post-1988 injury fund, things are going well. Reserves exceed \$521 million and excise taxes add another \$10 million per month, according to fund statistics.

But pre-1988 injuries make up the bulk of the cases in the system and funds to compensate them are rapidly being depleted.

While Congress has appropriated \$80 million annually through this year to finance the pre-1988 portion of the fund, that amount is not enough to compensate the more than 4,000 cases that are slowly wending their way through the system.

Congress originally anticipated no more than 1,000 cases and planned funding accordingly, said Gary Golkiewicz, a lawyer acting as chief special master for the U.S. Claims Court. In that role, he makes a final ruling and determines the amount of awards from the fund.

Instead, the fund was deluged with almost 3,000 cases in September 1990 alone, he said. The

# Vaccine fund could be expanded

## States successful with variations on no-fault theme

By LAURA MAZZUCA

When the Vaccine Injury Compensation Program was established in 1987, many observers viewed it as a large-scale experiment in applying no-fault principles to medical and product liability cases.

Using a table of vaccines and injuries as a yardstick to determine compensability seemed fair, especially because the table and many of program's operations were pieced together as a compromise among representatives of the pharmaceutical industry, the medical field and the consumer groups.

Since then, however, the table has come under fire from both claimants—who believe it is too narrow—and administrators—who believe it is too broad.

"That injury table was created with a severe shortcoming of scientific data," said Thomas E. Balbier Jr., administrator of the Vaccine Injury Compensation Program in Washington. "It was also a political compromise. Congress knew it was very lenient."

The Vaccine Injury Compensation Committee, composed of representatives from all sectors involved in the program, currently is holding hearings dealing with proposed changes to the table (see story, page 1).

In fact, the compensation program itself was authorized only through the end of 1992 and must be reauthorized by Congress, Mr. Balbier said. Legislation to continue appropriations for the fund through next year is currently pending.

The historical roots of the vaccine compensation fund can be traced to the "swine flu" scare in 1976, when the federal government agreed to accept liability for personal injury or death resulting from adverse reactions to the swine flu vaccine. This agreement indemnified the four manufacturers who were ordered by the government to mass-produce the vaccine, said Mark H. Rosenberg, vp-federal affairs for the Insurance Information Institute in Washington.

The government's push to vaccinate all Americans against swine flu backfired when no epidemic occurred, and vaccination-related claims against the government topped \$300 million within the first year, far exceeding the \$135 million that Congress had appropriated.

The swine flu vaccine compensation program, which was officially terminated in 1991, awarded more than \$92 million in claims settlements. The others were dismissed or deemed non-compensable.

deadline for filing pre-1988 claims was Jan. 31, 1991.

As of Aug. 4 of this year, 4,383 cases were in the system, 4,095 of them for pre-1988 injuries, according to program statistics.

The original law stated that these cases must be processed and decided within 240 days from the date of filing, or 420 days if the decision is appealed.

This was a realistic goal before the avalanche of claims were filed, Mr. Golkiewicz said. But with thousands of cases still unheard, it became impossible to process a case in that length of time.

"That's what we've been laboring under," he said, noting that cases that have been in the system for years are "probably just getting started now."

Because of the heavy case load, Congress has extended the "suspension time" to 780 days—or more than two years—from the date of the initial decision, up from the original eight months, said Thomas E. Balbier Jr., administrator of the Vaccine Injury Compensation Program.

Although he admitted that the case load is onerous, "the court has tremendously accelerated the pace," said Mr. Balbier. Some 60 pre-1988 injury cases are now on the docket of the U.S. Claims Court, which awards compensation, each month.

Conversely, there is no backlog of post-1988 cases.

### Many not compensated

After an injury or death, parents file a claim with the Claims Court. The special master reviews the claim before sending it to the Department of Health and Human Services. The department then recommends that the court either award compensation or not.

Once an injury or death is deemed compensable, a damage hearing is held by the court.

Fewer than half of the claimant receive compensation, fewer than many originally expected.

Of the 958 cases heard from 1989 to Aug. 4 of this year, only 373 were deemed compensable, with the awards ranging from \$120 to \$4 million. The remaining 585 have been dismissed or deemed non-compensable.

The overall average injury award for a pre-1988 case is \$1 million.

For pre-1988 injuries, the fund pays only future unreimbursed medical expenses not covered by insurance, like custodial, institutional or home nursing care; special education; vocational training; psychological therapy; and related expenses.

The 1986 law sets a settlement for a death of \$250,000 plus attorneys' fees, which are capped

Since then, states adopting variations on the no-fault theme have been more successful.

Virginia and Florida, for example, have adopted no-fault programs to indemnify obstetricians and gynecologists against malpractice suits connected with birth defects, Mr. Rosenberg said.

Virginia, which enacted its no-fault law in 1987, requires obstetricians and gynecologists, as well as all other practicing physicians, to contribute to a compensation fund as part of the state's licensing fee, said a spokeswoman from the American Academy of Pediatrics in Elk Grove Village, Ill.

Florida, which enacted its no-fault law in 1988, requires only obstetricians and gynecologists to contribute to its compensation fund as part of the licensing fee.

Like the federal vaccine compensation fund, damages filed in these two states must coincide with a table of injuries to be compensable.

Similar legislation now is pending in New York state.

The Florida and Virginia no-fault funds have resulted in lower liability insurance costs in those states, Mr. Rosenberg said.

However, the injury tables used for birth defects by those states are far more specific than the one used to determine vaccine injury, so there is little dispute about whether an injury qualifies for compensation, he added.

Whether the federal Vaccine Injury Compensation Program is reauthorized has broad implications. Because the fund is the only no-fault insurance system applying to the pharmaceutical industry, drug manufacturers see it as a safe haven for developing other vaccines, Mr. Balbier said.

Asked whether the fund could indemnify the makers of a future vaccine for AIDS, the vaccine program's Mr. Balbier would say only that such a drug could be accommodated by broadening the scope of the existing program or by establishing a separate program to cover only that drug.

New York-based Bristol-Myers Squibb Co. recently offered to donate to the U.S. government all research on its HIVAC-1e AIDS vaccine if the government would assume responsibility for future liability. Talks are currently under way between the company and the government.

However, in order to accommodate an AIDS vaccine under the current no-fault system, legislators would "have to change the statute significantly," Mr. Rosenberg said. "But that's not to say you couldn't use a similar model."

at \$30,000 for pre-1988 cases.

The fund will pay all economic damages for post-1988 claimants. Awards for pain-and-suffering and attorneys' fees are capped at a total of \$250,000.

Why are so many cases rejected?

Medical records accompanying many of the pre-1988 claims were insufficient, and many of these claims were dismissed voluntarily by the claimants, Mr. Balbier said.

"On the whole, the system is very fair for the petitioner," he said.

Many claimants offer a different explanation. They say the system is skewed in favor of the government and the drug manufacturers.

"The Justice Department lawyers are putting you through all the same hoops as defense lawyers did (in the tort system)," said Thomas G. Wilson, a Charleston, W.Va., lawyer who chairs the vaccine litigation group of the Assn. of Trial Lawyers of America. "(The fund) evolved into a traditional litigation situation because the plaintiff is fighting everything," he said.

### Claimants' costs mount

To appeal cases that have been deemed non-compensable, par-

Continued on next page

## Vaccine fund

Continued from previous page  
ents need to hire expert witnesses, said Ann Millan, director of Dissatisfied Parents Together, a Vienna, Va.-based consumer group that was instrumental in getting the 1986 compensation law passed.

Several experts may be needed, depending on the type of harm done to a child.

And that's not all. Claimants must also present "life care plans" to determine the cost of long-term care for a disabled child. These plans, developed by actuaries, cost between \$5,000 and \$8,000 each, Ms. Millan said. Court filing fees, the cost of traveling to Washington and "miscellaneous" expenses can reach \$10,000 or more, she said.

These expenses are deducted by the \$30,000 maximum attorney's fee, which makes lawyers reluctant to take these cases.

Because of the expense—and

the pre-1988 fund shortfalls—"we can't get lawyers to take the cases anymore," Ms. Millan said.

Under this system, even a straightforward death case can be expensive to litigate.

Janet Ciotoli, a registered nurse in Endicott, N.Y., filed her claim in October 1988, when the fund's case load was still manageable.

Her son, Richie, died in 1983, 33 hours after receiving his first DPT vaccine. The case seemed clear-cut: The death certificate, she said, listed irreversible shock from a "probable DPT reaction" as the cause of death.

But her case was initially rejected by the HHS, and Ms. Ciotoli had to appeal in the U.S. Claims Court. She won.

Although Ms. Ciotoli's case was settled within 13 months of filing, expenses like expert witness fees still totaled \$22,000, she said.

And, cases can be much more complicated.

Like Ms. Ciotoli, Jim and Marge Grant of Beaver Dam, Wis., filed a claim in October 1988.

Their son Scott, now 31, is a spastic quadriplegic who was left physically and mentally impaired by seizures after receiving the DPT vaccine as a baby. A civil suit they brought years ago failed for lack of adequate medical records.

The Grants' case was deemed compensable and a final settlement amount was determined by the court in 1990. But the HHS opposed the decision, and took the issue to an appellate court in February 1991. A decision was finally handed down in June 1992.

Ms. Grant expects to receive the first monthly compensation check of \$2,600 sometime this month—almost four years after filing with the "no-fault" system.

The Grants, who are both in their 60s and who still care for Scott, hope the monthly payment will be enough to cover their son's future medical expenses when they can no longer care for him. Plaintiffs who receive awards through the fund relinquish all rights to other government aid, like medical assistance programs.

### Tightening the rules

If fund administrators have their way, it may be more diffi-

cult for plaintiffs to collect through the fund in the future.

Vaccine committee hearings are currently under way to consider revising the fund's table of injuries, the list of symptoms and timetables that define who can receive compensation.

"There is a very legitimate concern that the vaccine injury table is not the best that it could be," Mr. Balbier said.

Such changes, which are subject to public hearings and are ultimately approved by the Office of Management and Budget, could include tightening the time span for injuries; eliminating some injuries; and indemnifying other vaccines for diseases like influenza, chicken pox and hepatitis B, he said.

But even with the fund's faults, most observers do not expect a deluge of rejected cases to come flooding into the court system.

To date, only 28 petitioners have elected to reject the judgment of the claims court, fund statistics show. Only 10 of those people said they intended to sue.

The fund also has built-in safeguards against massive civil lawsuits. According to the law, post-1988 plaintiffs cannot file a lawsuit against a vaccine manufacturer or physician until federal compensation is either denied, or offered and subsequently refused.

And for post-1988 cases, the

plaintiff's attorney must prove causation and amount of damages, and then pursue a separate action on punitive damages, Mr. Wilson of ATLA said. "It's hard to put together a case."

Most claimants say that such restrictions make it easier for victims to collect from the compensation fund, despite its flaws.

Some families, though, do go to court.

Edwin E. and Susan E. Hodges of Costa Mesa, Calif., filed a claim with the fund in 1990. Seven years earlier, their 12-week-old daughter, Cara, died four hours after receiving her first DPT vaccine. The case was rejected by the compensation system because Cara "didn't live long enough" to develop many of the symptoms set out in the table of injuries, Mr. Hodges said.

The Hodges appealed the decision in the compensation system and were again turned down. Their case is now pending in the U.S. Court of Appeals in Washington.

Under the restrictions imposed by the fund, the suit is filed against the secretary of the HHS. If the Hodges win, the \$250,000 flat death payment will come from the fund.

But the amount doesn't matter to Mr. Hodges. "It's not a money issue. Whether we got \$250,000 or \$250 million, it won't bring Cara back," Mr. Hodges said. "We just want our day in court." ■

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## For the Record

### Banks can sell insurance in small Kentucky towns

FRANKFORT, Ky.—The Kentucky Insurance Department will likely appeal a federal judge's decision that it must issue insurance license applications to national banks operating in small Kentucky towns.

Even though the U.S. Court of Appeals for the District of Columbia determined in February that the National Bank Act's "small-town exemption" had been repealed in 1916 (*BI*, Feb. 17), U.S. District Court Judge Joseph M. Hood ruled Aug. 4 the exemption is still in effect. Therefore, national banks may sell insurance in Kentucky towns with populations of less than 5,000, he ruled.

The decision requires the Kentucky Insurance Department to issue insurance license applications to all banks requesting them and says that it cannot turn the banks down for a license just

because they are banks.

The ruling stems from a 1991 lawsuit filed by the Kentucky Bankers Assn. in Louisville and three national banks. The plaintiffs argued that federal law permits them to sell life, health, fire and other insurance but that state insurance regulators had blocked those sales.

### State work comp funds in bad shape: Alliance

SCHAUMBURG, Ill.—The Alliance of American Insurers' latest analysis of the financial condition of state workers compensation funds supports its position that such funds are not a "cure-all" for workers comp problems.

Eight workers compensation state funds have become "insolvent" since 1984, and the financial condition of six other work comp funds has deteriorated over the same period, according to the report, "Workers Compensation State Funds: Disappearing Capital."

In 1984, there were 19 state funds—13 competitive and six exclusive funds—and all but the Washington state fund reported that they were solvent, the Alliance says.

But, the report shows that six funds were "insolvent" by the end of 1990: Colorado, Montana, North Dakota, Ohio, West Virginia and Wyoming.

In addition, by mid-1991, the Nevada fund reported it was "insolvent," and Minnesota regulators took over operation of that state's fund in 1992 because of sharply declining surplus.

The Alliance also says funds in six other states reported a weakening of their capital position since 1984: Arizona, California, Maryland, Michigan, Pennsylvania and Utah.

However, spokesmen for state funds disagree with the Alliance's conclusions, saying the

funds are not designed to maintain large surpluses.

The Alliance's analysis is based on data published by the American Assn. of State Compensation Insurance.

Copies of the report (No. R-00016-0792) are available from Alliance Customer Service Department at 708-330-8587. The report is free to Alliance members but costs non-members \$10.

### Phone fraud cover offers \$1 million limit

HARTFORD, Conn.—The Travelers Insurance Co. has introduced a policy to protect companies from remote-access telephone fraud.

The product, believed to be the first of its kind, is geared toward Fortune 500 companies with their own phone switching equipment.

The coverage protects companies from outside hackers who gain access to internal phone systems and then charge calls to the company.

Illegal charges made 30 days before and 30 days after the billing date cutoff in the month the fraud is detected are covered.

Limits of up to \$1 million per company are available. Deductibles are 10% of policy limits.

Premiums start at \$2,500 for \$50,000 of coverage and increase to \$49,400 for \$1 million of coverage. But, a 15% discount is available if the coverage is added to a crime policy written by Travelers.

The telephone fraud coverage also can be written separately.

### United HealthCare announces stock split

MINNEAPOLIS—United HealthCare Corp. of Minneapolis has announced a two-for-one stock split for all shares outstanding as of Sept. 1.

The additional shares, which will be distributed Sept. 15, will not reduce the annual per share dividend amount. ■

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## INTERNATIONAL

## Losses at Hafnia prompt restructuring

By ALINE SULLIVAN

LONDON—Danish insurer Hafnia Holdings A/S split into two companies last week after trading in its stock was suspended.

The Danish insurer has been struggling after it and Norwegian insurer UNI Storebrand A/S agreed to drop their bid to acquire Skandia Holding A.B. of Sweden. Skandia opposed the move. Skandia later offered to acquire Hafnia, but Hafnia's institutional investors rejected that offer (BI, May 11; April 20).

Hafnia is transferring all assets to a new unit, Hafnia Holding of 1992

A/S. The company, with equity capital of about 5.9 billion kroner (\$1.05 billion), will operate Hafnia's property/casualty and life insurers as well as its banking operations.

Parent Hafnia Holdings will be left with liabilities of 6 billion kroner (\$1.07 billion), resulting in a net debt for the two companies of about 100 million kroner (\$17.8 million).

Hafnia's insurance units will continue to pay claims. However, the parent has stopped debt payments.

The deficit exists despite the 1.9 billion kroner (\$339 million) raised through a stock offering last month (BI, Aug. 3; July 13).

Before the stock offering, Hafnia's net debt was about 400 million kroner (\$71.4 million). Since then, the company has suffered an unrealized loss of 700 million kroner (\$124.9 million) on its investment in Danish insurer Baltica Holding A/S and Skandia as well as 500 million kroner (\$89.2 million) in unrealized losses on investments in Danish securities.

Increased provisions for financial guarantee losses will cost 250 million kroner (\$44.6 million), while the company's July and August operating losses are expected to total 150 million kroner (\$26.8 million).

Analysts said Hafnia appears to

be seeking potential buyers for its insurance units by separating them from the parent's debts. Proceeds could then be used to pay some of the debt, while creditors may assume debt in exchange for equity in the remaining insurance operations.

"Hafnia wants its insurance companies to continue as a going concern until it can find a buyer for them," said Michael Wheelhouse, an insurance analyst at Hoare Govett in London. "But the Danish government isn't going to allow these companies to operate with a bust holding company for very long. Hafnia probably has about three months."

Baltica and Skandia may seek to buy some of Hafnia's operations, particularly its life insurance operations, said Angus Runciman, an analyst with BNP Securities in London. Hafnia, which owns 34% of Baltica and 14.8% of Skandia, has been negotiating to sell those stakes.

"There may be political pressure in Denmark for Baltica to take over some of Hafnia," he said. "There should be a Danish answer to this problem because Danish interests" blocked Skandia's offer.

Standard & Poor's last week lowered Hafnia's claims-paying ability rating to BB from BBB. ■



AP/Wide World Photo

## QE2 to remain in drydock for more than a month

LONDON—The Queen Elizabeth 2 may be unable to carry passengers until late September as a result of damage suffered when the ship was grounded earlier this month.

A spokesman for Cunard Steamship Co. P.L.C. said it is still too early to quantify the business interruption claim (BI, Aug. 17).

After the ship hit a submerged rock Aug. 8 in shallow waters off the coast of Massachusetts, Cunard thought the ship would be seaworthy by Aug. 18, missing only two transatlantic voyages. But hull damage has turned out to be far worse than originally thought.

Cunard now expects the QE2 to miss six transatlantic crossings and one cruise from Britain to Madeira and back.

Altogether, 10,000 passengers will be affected, the company's spokesman said. Based on a minimum fare of more than \$1,000 per passenger, the cancellations will cost more than \$10 million. However, Cunard says that most of the passengers who have contacted the company said they will reschedule their voyages.

Hull and business interruption coverage for the Cunard fleet is led by the British insurer Commercial Union P.L.C.

A Commercial Union spokesman said its priority was to ensure that repairs to the vessel were carried out as quickly as possible. CU declined to give any estimate of losses except to say that business interruption would be more costly than hull damage.

—By William Pitt

## U.K. insurers post gains

## But Royal, CU and General Accident continue to report first-half net losses

By WILLIAM PITT

LONDON—Britain's leading insurers are reporting improved first-half results, but sharp rate hikes in the United Kingdom still are not offsetting recession-related claims and have not returned insurers' results to the black.

Only three of the seven largest U.K. insurers have reported their half-year results: Royal Insurance Holdings P.L.C., Commercial Union Assurance Co. P.L.C. and General Accident Fire & Life Assurance

Corp. P.L.C. All three reported net losses, but the losses were smaller than in the first half of 1991.

In General Accident's case, the improvement was dramatic: For the first half of this year, General Accident reported a pretax loss of 21.2 million pounds (\$40.4 million at the appropriate exchange rate), an 80% improvement over a loss of 105.2 million pounds (\$170.8 million) for the first half of 1991.

Uniquely among the three companies that have reported so far, General Accident managed to make a profit of 9.5 million (\$18.1 million) in the second quarter. Neil Robertson, General Accident's chief general manager, interprets this as confirmation that "the remedial action we have taken is proving effective."

These actions include rate hikes for major U.K. lines of business.

For Royal Insurance, the biggest non-life insurer in Britain, the burden of domestic mortgage indemnity claims continues to depress results. Royal has a 20% share of the U.K. mortgage indemnity market, which protects home lenders from a fall in the market value of mortgaged properties. A claim is triggered when the mortgage holder is unable to keep up repayments and the property is repossessed.

Repossessions have been growing in Britain as unemployment soars and those laid off are unable to make mortgage payments.

Domestic mortgage indemnity claims saddled Royal with 100 million pounds (\$190.4 million at the appropriate exchange rate) in underwriting losses in the first half of this year. Much of this loss was at-

Continued on next page

## Middleton rumored to be new Lloyd's chief executive

By STACY SHAPIRO and GAVIN SOUTER

LONDON—Industry observers in London are speculating that the Council of Lloyd's will name Peter Middleton as the market's next chief executive.

However, Lloyd's will not comment on numerous news reports in the United Kingdom that Mr. Middleton, chief executive of travel group Thomas Cook Ltd., tops the list of candidates.

The identity of the new chief executive will be announced after the council's next meeting on Sept. 9.

Mr. Middleton would succeed Alan Lord, who retired as chief executive in June. The post was left vacant in anticipation of upcoming

## LONDON

changes in governing structure.

The duties of chief executive currently are being filled by three Corporation of Lloyd's executives until a new chief executive is appointed. They are: John Gaynor, head of finance; Andrew Duiguid, head of market services; and Bob Hewes, head of regulatory services (BI, Feb. 24).

Mr. Middleton, named chief executive of Thomas Cook in December 1987, helped its parent, Midland Bank P.L.C., negotiate the travel agency's sale for 200 million pounds (\$377.4 million at appropriate exchange rates) to LTU, one of Ger-

many's largest package-tour operators.

Before joining Thomas Cook, he spent 16 years in the British government's Foreign and Commonwealth Office.

The person who becomes chief executive will sit on the Market Board, which will oversee the development of Lloyd's business, according to the new plans for Lloyd's governance drawn up by a committee headed by Sir Jeremy Morse and approved by the council (BI, July 6).

Unlike Mr. Lord, the new chief executive will not be charged with drafting and implementing regulations, a task that will be taken over by a head of regulation who will oversee a new Regulatory Board.

Continued on next page

## Underwriting loss triggers fall in Allianz stock

By DON LEWIS KIRK

MUNICH—Allianz A.G. Holding's stock has tumbled dramatically after the huge insurer reported its 1991 underwriting loss of 1.78 billion deutsche marks (\$1.17 billion at the appropriate exchange rate).

That loss compares with an underwriting gain of 182 million deutsche marks (\$100.5 million) in fiscal 1990/1991.

The Munich-based insurance group's stock dropped to 1,675

deutsche marks (\$1,151) per share on Aug. 17, compared with 1,695 deutsche marks (\$1,165) per share a week earlier. However, that's still down from 1,785 deutsche marks (\$1,218) per share shortly after the results were announced and from an April high of 2,238 deutsche marks (\$1,410).

Despite the underwriting loss, Allianz reported a 4% gain in after-tax net income to 1.05 billion deutsche marks (\$687.6 million), up from 1.01 billion deutsche

marks (\$555.9 million) in 1990, largely on the strength of investment income gains.

Total premium volume, fueled by Allianz's expansion into the former East Germany and consolidation of its investment in Fireman's Fund Insurance Co. in the United States, rose 27% to 48.7 billion deutsche marks (\$31.95 billion).

Noting that U.S. insurers traditionally report underwriting losses, Allianz pointed out that it absorbed 625 million deutsche

marks (\$407.6 million) in underwriting losses in 1991 by consolidating Fireman's Fund's results.

Despite the gains in net profits and premium volume, fears of dividend cuts fueled a sell-off.

Allianz says it is not worried about the underwriting loss. The company acknowledges that the burden of its expansion into eastern Germany and other nations is showing but contends that the effect is not significant enough to warrant concern.

"Fears are unsubstantiated,"

an Allianz spokesman said. "We've got a brilliant market position. Of course there are problems. We have to make headway in a market that didn't exist before. In the next years, we expect to spend nearly 2 billion deutsche marks (\$1.36 billion at current exchange rates) to bring (East German) business up to (West German) standards. But no one looks at the benefits. We gained over 3 million deutsche marks (\$1.97 billion at ap-

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**U.K. insurers**

*Continued from previous page*  
 tributable to what Royal called its "prudent approach" to reserving. The company has incurred DMI claims of 90 million pounds (\$171.3 million) over the past 18 months, and earmarked reserves of 325 million pounds (\$618.6 million) in the first half of this year to cover future claims.

Soaring claims also have lowered Royal's solvency margin, the net worth of the company as a percentage of its net non-life premiums. In March of this year, Royal's solvency margin had slipped to 29%, compared with 40% at the end in 1991.

Royal's solution, announced on Aug. 13, was to spin off its life insurance business from Royal Insurance P.L.C. and form a new subsidiary of Royal Insurance Holdings. Royal Insurance P.L.C. complained that, under the previous arrangement, its net worth was being depleted by life insurance loans unrelated to its non-life business.

The result was to boost the solvency margin of Royal Insurance P.L.C.—the non-life insurer stripped of the life operations—to 40% as of June 30.

By contrast with Royal, CU has had a much easier time, though the Irish Republican Army bomb that nearly destroyed its London head-

quarters in April ensured that 1992's first half was not uneventful.

CU incurred net claims of 15 million pounds (\$28.6 million) from the bomb blast, but still managed an improved performance over last year's first half. Pretax operating losses were 18.1 million pounds (\$36.6 million), down 26% from 26.3 million (\$39.3 million) in 1991.

The main difference between CU and Royal is CU's insignificant exposure to DMI claims. Its underwriting loss from this class of business was 4.5 million pounds (\$8.6 million) in the first half of this year.

Nevertheless, CU lamented that other "recession-related" losses were higher. Theft claims rose 37%

to 27 million pounds (\$51.4 million).

CU was not alone in feeling the impact of the IRA bomb on its bottom line. General Accident paid out 6 million pounds (\$11.42 million) net of reinsurance to the victims of bomb damage, and Royal paid out 11 million (\$21 million) net.

More worrisome to British insurers than the prospect of further IRA bombs is the prospect that continental European insurers may target the U.K. market and drive rates down again.

Angus Runciman, an insurance analyst at BNP Securities in London, warned continental insurers like Germany's Allianz A.G. Holdings or France's UAP Group may

turn their attention to the U.K.

UAP currently has scarcely any presence in the U.K. non-life market, but Allianz writes U.L. business through subsidiary Cornhill Insurance P.L.C. A ferocious drive to win market share as a unified market for insurance evolves in Europe has already pushed rates down for commercial lines business throughout most of Europe.

Mr. Runciman noted that continental insurers have not lost money on mortgage indemnity insurance. If they decide to target the U.K. market, the rate increases that British insurers have struggled so hard to achieve may quickly collapse, he warned.

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**LONDON**

*Continued from previous page*  
**Lloyd's wins dismissal**

A group of U.S. members of Lloyd's of London will appeal a ruling by a New York federal judge that their suits charging Lloyd's violated U.S. securities and racketeering laws must be heard in English courts.

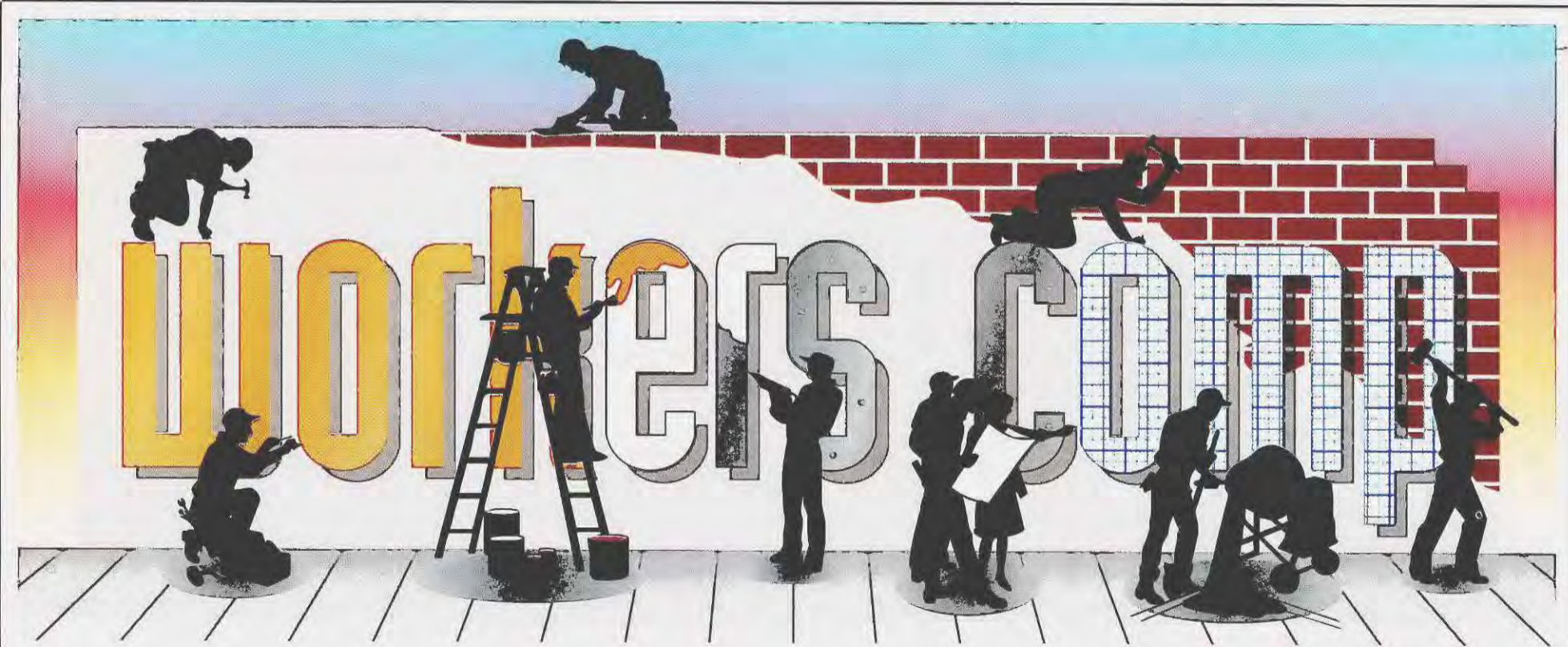
The agreements the members signed when they joined Lloyd's compelled them to seek any redress in England, U.S. District Judge Morris E. Lasker ruled last week.

Granting a motion by Lloyd's, Judge Lasker dismissed suits by U.S. members charging managing agents and members' agents with violating U.S. securities laws and the Racketeer Influenced and Corrupt Organizations act (BI, Sept. 16, 1991).

All 115 members have incurred severe losses. The members, represented by Proskauer Rose Goetz & Mendelsohn in New York, will appeal the decision.

The members suit alleges "that Lloyd's and their managing and members' agents solicited their investment in syndicates with false representations, downplaying the risks and exaggerating the benefits associated with such investments."

Upon joining Lloyd's, all members are required to sign agreements that any dispute with Lloyd's will be heard in England under English law, the judge noted. "Plaintiffs went to England to become members of a distinctively British entity, invested in syndicates operating out of London and entered numerous contracts, all of which stated plainly that Lloyd's affairs and plaintiffs' investment would be administered in English courts and English arbitration."



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## Alternative care

Continued from page 3  
the best."

And, most employers are "extremely receptive once they see what is available in subacute care," said Mary Hanley, president of Cincinnati-based Health Service Affiliates, a preferred provider organization that provides ancillary services including dialysis; home health care; intravenous therapy; laboratory work; and physical, speech and respiratory therapies.

All health care payers are increasingly interested in "finding an appropriate place of treatment," said Erick Hanson, vp-payer relations at Deerfield, Ill.-based Caremark Inc.

The Baxter International Inc. unit, which will be spun off by year-end (BI, July 20), will provide products and services for

home health care, AIDS care, women's health care, physical therapy and prescription services.

Indeed, "Acute medical and surgical treatment that was traditionally inpatient is leaving that setting at supersonic speed," said Lance Hoxie, director of ambulatory care accreditation services of the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, Ill.

"These programs are becoming more prevalent. To a great extent they can enhance recuperation," said Kathy Fliehler, vp of review at the Sunderbruch Corp., a utilization review vendor based in West Des Moines, Iowa.

Among the largest alternative site providers is Vencor Inc., which operates 20 hospitals nationwide for intermediate-term acute hospital care, up from 13

at year-end 1990. Its net revenue soared to \$135 million in 1991 from \$79.8 million in 1990 and \$29.1 million in 1988.

Most of Vencor's patients come out of hospital intensive care units, and 80% are dependent on life-support systems when they arrive. The average stay at a Vencor hospital is 80 days.

Vencor claims it can care for these patients for about half the amount charged by hospitals.

"There are a number of people in hospitals who fall through the cracks. They don't really fit into the intensive care units they are in, but they are much too ill to be in any bed but a hospital bed," said Michael Barr, co-founder and vp-operations.

The Louisville, Ky.-based company, which was founded in 1985, was the first to open a hospital just for catastrophically ill patients, Mr. Barr said.

"We are modeled after burn hospitals and children's hospitals," he said. "We are a specialty hospital, but our specialty is severely ill patients."

American Transitional, which operates both a facility in Houston that shares a site with a nursing home and a stand-alone alternative care hospital in Dallas, provides post-surgical and ventilator care, rehabilitation for extremely ill patients and chemotherapy.

Costs at American Transitional range from 20% to 40% of the costs at acute care hospitals, and the average length of stay is 65 to 90 days, Ms. Griffin said.

American Transitional has completed negotiations to acquire Synergos Inc., a Santa Ana, Calif.-based provider of neurological treatment centers in Phoenix, San Francisco and Seattle, according to President

and CEO Bob Crosby. ATH is still conducting a market analysis to determine which of the facilities can be converted to transitional care hospitals.

The firm, founded in 1987, plans to acquire at least two new hospitals this year and four in 1993.

Eight years ago, The Hillhaven Corp., which operates more than 300 nursing centers in 34 states, began developing inpatient rehab units within existing nursing homes. Today, more than 40 Hillhaven facilities offer subacute medical care and rehabilitation as alternatives to acute care or rehabilitation hospitals, said Chris Marker, president of the Tacoma, Wash.-based company.

That number could expand to as many as 80, including a stand-alone alternative hospital facility, Mr. Marker said.

Continued on next page

## Allianz

Continued from page 23

propriate exchange rate) in premiums for what amounts to 440 million deutsche marks (\$288.7 million)."

In 1990, Allianz gained a dominant position in the East German market when it acquired the former state insurance monopoly Staatliche Versicherung. At that time, competitors charged that the Allianz deal was monopolistic. Since then, however, Allianz has incurred substantial expenses in building a new insurance network.

German banks, including the largest, Deutsche Bank, express concern about Allianz's position. At the beginning of August, Deutsche Bank analysts told investors that potential returns on Allianz shares were highly overrated. While Allianz expected returns on 1991 shares to amount to 40.85 deutsche marks per share (\$27 at the year-end 1991 exchange rate), DB Research—a subsidiary of Deutsche Bank—maintained that 26 deutsche marks (\$17.19) per share was more realistic.

Oliver Gunter, a Frankfurt analyst for Bank of Liechtenstein, says he expects the stock to drop as low as 1,400 deutsche marks (\$959.60).

In addition to the July 28 report of underwriting losses, analysts say another warning sign of trouble at Allianz is the planned reduction in its workforce to 5,000 from 10,000 in its East German offices.

Allianz claims it's a matter of how you look at it. "These aren't ordinary losses," the spokesman says. "We are pouring millions into training and technology. As far as we are concerned, losses in connection with our East German operation have nothing to do with the way we do business. As far as the workforce is concerned, we are just taking people out of the office and making them part of our sales force. They aren't losing their job, just getting another one."

Allianz's underwriting losses are due to its international scope, according to the spokesman. "When you work in as many markets as we do, it's not unusual to have underwriting losses. However, our investments more than compensate. More than 50% of our business is done abroad."

Allianz says underwriting losses in East Germany have resulted in part from a government ceiling on premiums that is 20% below the West German level.

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# Alternative care

Continued from previous page

"Hillhaven will never compete with acute hospitals for medically complex patients," Mr. Marker said.

However, the company "is able to provide subacute medical and rehabilitation services at a significant cost savings to payers (over what) they have traditionally experienced within hospital settings," he said.

Rehabilitation in an acute care hospital costs between \$1,000 and \$1,500 per day, said Lane Bowen, vp of Hillhaven's rehabilitation division.

Hillhaven can cut those daily costs to between \$225 and \$275 for intensive nursing with some rehabilitation services; to between \$375 and \$425 for intensive subacute rehabilitation services; and to \$550 for intensive medical care for patients with head trauma or who are ventilator-dependent.

Other health care payers are looking for more evidence that alternative hospital care facilities can live up to their cost-saving claims and will not make up for cheaper services by inflating lengths of stay.

"Out-of-hospital care is not necessarily less expensive. We have to wait and see if that proves to be true," said Ron Dettmer, master printer section manager of the Printing Industries Assn. of Southern Ohio.

The group sponsors two health care plans that cover home care, nursing homes and hospice care

on a case-by-case basis, Mr. Dettmer said.

"We're not using (alternatives) now," said Carl Verdane, manager of corporate employee benefits at GAF Corp. in Wayne, N.J. "It's something fairly new. We might use them in the future if they're as good as we think they might be."

Some health care payers are covering the cost of these facilities only on a case-by-case basis, and others are even beginning to rewrite health plans to specifically cover facilities, said Rylla Riverman, Western region sales executive with Ethix Corp. of Portland, Ore., a managed care firm.

"We are advising clients to look at some of these areas that were never covered before" under their health plans, like alternative hospital care, skilled nursing and home health care, said Deirdre Kelly, a consultant with TPF&C in Atlanta, a Towers Perrin Co. unit.

And, provisions are "starting to be written in" health plans to specifically cover the cost of alternative hospital care, said Caremark's Mr. Hanson.

In particular, "Self-insureds may be more apt to" and cover the cost of care provided by alternative hospital facilities, said Terri Mizel, central division director for case management for Intracorp in Lisle, Ill.

"Self-insurers are far more flexible, more innovative," agreed Ms. Hanley of Health Services Affiliates.

"The insurance industry is

pretty slow to move. The practice of medicine is ahead of insurers," Caremark's Mr. Hanson said.

Health insurance policies "still dictate health care," he continued. That could be eliminated if "payers better understood the delivery of care across the continuum of an illness."

Still, despite the enormous savings that are possible by using alternative care facilities, employers should examine these providers carefully before turning to them, benefit consultants and employers caution.

"If it's priced marginally below the original treatment, they're going to make (it) up on volume of services or number of days," said Michael McGarvey, managing director of Alexander & Alexander Consulting Group Inc.'s Health Strategies Group.

A managed care firm should monitor length of stay to determine whether keeping a patient in a higher-priced hospital bed but for a shorter period of time would be more cost-effective, he said.

But, employers, insurers and HMOs should "focus not just on price when contracting with an alternative care facility," said Ms. Fliehler of Sunderbruch. Rather, health care payers should look at quality of care, access to primary physicians, the available technology and performance history.

She also pointed out that utilization review for alternative hospital facilities and traditional hospitals differs.

Sunderbruch is less inclined to implement review procedures for

alternative facility stays like preadmission requirements, length of stay determinations concurrent review.

"It is more patient-specific. You have to look at the patient's resources and condition, his insurance and family support. It's not as purely clinical as a hospital review," Ms. Fliehler said.

"The degree of variation is much greater. Hospital stays vary within a limited range," she said.

Many employers and insurers also are reluctant to cover the cost of alternative hospital facilities because of the lack of specific accreditation for such facilities.

Ms. Hanley cautioned that "it's relatively easy and relatively lucrative for substandard providers" to start up such facilities.

The facilities respond that their industry is so new that there is no specific accreditation for them to obtain.

As a result, many of the facilities are working on obtaining some sort of accreditation—as a hospital, for example—even though they do not fit squarely into that mold. Some also are devising their own standards.

For example, Vencor hospitals are licensed and accredited as full-service hospitals, Mr. Barr said.

Most utilization review vendors require that alternative care facilities be certified as hospitals, nursing homes or rehabilitation centers, even if these facilities do not solely provide those services.

Self-insured Circle K requires all providers to obtain some sort of accreditation.

"We want some assurance the

facilities are indeed legitimate," Mr. Grams said.

However, some UR vendors are willing to make exceptions for quality providers.

"Sometimes when we find a facility that may not have accreditation, we will recommend a patient be placed there because (the provider's) reputation or our past working relationship tells us they can deliver the quality of care," Intracorp's Ms. Mizel said.

While the JCAHO does not have a specific accreditation for alternative health care facilities, it can credit them by tailoring the accreditation process to fit the provider, Mr. Hoxie said.

The JCAHO accredits organizations rather than specific services, but it has changed its accreditation procedures to keep up with the health care marketplace, Mr. Hoxie noted.

More providers are expanding their range of services to include combinations that cross traditional boundaries, he said.

For example, the JCAHO has developed standards for mental health, long-term care, hospitals, home health care and ambulatory care. But now home health care providers are adding infusion centers for intravenous treatment, and head trauma and spinal injury rehabilitation centers are offering mental health services to help patients learn to cope with life after their injuries.

"What we have seen is a reconfiguration, a blending of entities. More and more organizations offer services that span the spectrum of accreditation," Mr. Hoxie said. ■

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### IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS COUNTY DEPARTMENT, CHANCERY DIVISION IN THE MATTER OF THE LIQUIDATION OF UNITED DIVERSIFIED CORPORATION NO. 88 CH 6942 NOTICE

PLEASE TAKE NOTICE that on June 8, 1992 an Order of Liquidation With A Finding of Insolvency was entered against United Diversified Corporation by the Honorable Robert D. Ericsson, Judge of the Circuit Court of Cook County, Illinois. Stephen F. Selcke, Director of Insurance for the State of Illinois is the statutory and court appointed Liquidator of United Diversified Corporation.

TAKE FURTHER NOTICE that pursuant to the order of liquidation, all rights and liabilities of United Diversified Corporation and its creditors, policyholders, if any, and all other persons or entities who may have a claim against its assets are fixed as of June 8, 1992, unless otherwise provided by a subsequent order of the court.

TAKE FURTHER NOTICE that any and all persons, partnerships, corporations, associations, estates, trusts and governmental units having or claiming to have any accounts, debts, claims or demands against United Diversified Corporation or claiming any right, title or interest in or to any funds or property of United Diversified Corporation in the possession of the Liquidator are required to file a Proof of Claim with the Liquidator on or before 4:30 p.m. Chicago Time, December 1, 1992.

TAKE FURTHER NOTICE that the form of and required content of all proofs of claim are described in the Illinois Revised Statutes, 1991, Chapter 73, Paragraph 821. Proofs of claim, together with supporting documents, if any, are to be filed with and may be secured from the Special Deputy Liquidator of the United Diversified Corporation, 222 Merchandise Mart Plaza, Suite 1450, Chicago, Illinois 60654. Filing shall occur upon receipt of Proof of Claim by the Liquidator. The Liquidator further reserves all rights to any and all defenses of United Diversified Corporation concerning such claim. All Proofs of Claim must be duly sworn to before an officer authorized to take oaths.

THE LAST DATE FOR THE FILING OF PROOFS OF CLAIMS WITH THE LIQUIDATOR AT THE ABOVE MENTIONED OFFICE OF HIS SPECIAL DEPUTY LIQUIDATOR IS DECEMBER 1, 1992 AT 4:30 P.M. CHICAGO TIME. NO PERSON HAVING OR CLAIMING TO HAVE ANY CLAIMS AGAINST UNITED DIVERSIFIED CORPORATION SHALL PARTICIPATE IN ANY DISTRIBUTION OF THE ASSETS OF THE COMPANY UNLESS THE CLAIMS ARE FILED WITH THE LIQUIDATOR ON OR BEFORE DECEMBER 1, 1992 AT 4:30 P.M.

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## Free trade pact

Continued from page 1

North America, eliminate barriers to investment, and strengthen the protection of intellectual property rights.

Eliminating tariffs and other trade barriers is expected to create an open market of more than 360 million people and more than \$6 trillion in annual output.

Until now, the Mexican insurance market has been highly restrictive, with foreign insurers and brokers forbidden to hold majority ownership of Mexican companies.

Under the trade agreement—precise terms of which have not been released—U.S. and Canadian insurers could gain access to the market in one of two ways:

- They could form joint ventures with Mexican insurers, holding up to 30% equity participation by 1994 and 51% by 1998. Full ownership would be allowed by the year 2000. There would be no aggregate or individual limits on market share for U.S. or Canadian firms.

- They could set up subsidiaries, subject to aggregate market share caps of 6% that will gradually increase to 12% in 1999 and to individual market share caps of 1.5%. These limits would be eliminated on Jan. 1, 2000.

U.S. and Canadian companies that now have stakes in Mexican insurers also could increase their current minority stakes to 100% ownership by Jan. 1, 1996.

And, intermediaries, including brokers and service vendors like claims adjusters, could set up subsidiaries with no ownership or market share limits.

U.S.-Canadian trade is not expected to be affected much by the agreement because few barriers now exist.

Congress still must enact a bill implementing NAFTA. Consideration of such legislation will not begin until early 1993.

President Bush says he supports the agreement. But, Democratic presidential nominee Bill Clinton has said he would have to review how NAFTA would protect U.S. jobs and environmental standards before taking a position.

CIGNA Senior Vp Jim McCarty, who has followed the issue for two years, said he is confident Congress will approve the agreement regardless of who is in the White House.

"I think it's got a very good chance of making it through Congress with or without the president," he said.

"I think there's enough general support building up" to carry it through, he said. "I'm much more optimistic about it now than I was six months ago."

"A lot of people want this to happen, so there's going to be a lot of people looking for its approval," said Jack Perez, senior vp of A&A Services and chief executive officer of its Latin America/Caribbean region.

Several factors make Mexico attractive to U.S. business, including new economic opportunities and the country's proximity to the United States, Mr. Perez said.

"It's going to be a growing opportunity," he said. "These are interesting times."

There is large potential for growth in the Mexican insurance market, agreed Henry Parker, a consultant to Chubb Corp.'s chairman who served as a government adviser on NAFTA.

For example, bringing per-capita insurance spending in Mexico up to Spain's level would increase total premiums twelvefold to \$42 billion from \$3.5 billion. That would make Mexico the sixth-lar-

gest insurance market in the world, immediately behind France, said Mr. Parker, who is a retired Chubb managing director and senior vp.

The Mexican insurance industry "has been relatively protected and has shied away from any outside competition," said William O'Neill, senior vp of Standard & Poor's Corp. in New York.

But, if U.S. manufacturers move more operations to Mexico as they are expected to if NAFTA is signed into law, many U.S. property/casualty insurers will "follow the flag," Mr. O'Neill predicted. The same will be true of brokers, he added.

Significant growth also could come in employee benefits like group health and pension plans, Mr. McCarty said. Mexican officials have indicated they will move toward privatization of these benefits over the next few years.

This could be an even bigger attraction to U.S. insurers than Mexico's property/casualty business, he said. U.S. insurers "have a lot of things they can bring into" the employee benefit market because of their long experience in this area, Mr. McCarty said.

Mexico is a potential growth area for group health and life, as well as individual coverages, agreed a spokesman for the Washington-based American Council of Life Insurers, which represents 600 life and health insurers. NAFTA will improve the Mexican economy, creating a larger middle class, and there "will be a need of us," he said.

But, only a few insurers and brokers are expected to begin investing in Mexican firms initially.

"I think you'll see insurance companies probably buying out their local partners, and I think you'll see changes in the brokerage side as well," predicted Katherine Kanga, an M&M vp based in New York.

"I do not think there will be a major rush of U.S. companies into Mexico," said CIGNA's Mr. McCarty. He predicted 10 or 12 companies will enter the market over the next three years.

J.D. Dawson, owner of broker Dawson y Correa, which has offices in Mexico City and Las Colinas, Texas, said he expects major U.S. brokers to seek majority ownership in Mexican brokerages by the end of the decade as would be allowed under NAFTA.

"There will be an eight-year growing-up period for the Mexican brokers to get tough and get ready for the big guys coming in," he said.

But, "The major American brokers are here to some extent anyway," he said. "They have relationships with Mexican brokers."

The overall effect on U.S. insurers, though, will be insignificant, some insurance experts believe.

"I'm not sure what it really means," said Harry Fong, director of research and senior analyst with Conning & Co. in Hartford, Conn.

Few U.S. insurers and brokers have operations in Mexico, he said. "I would say it's going to be an insignificant amount of activity."

While companies like AIG and M&M might become further involved in the Mexican market, the business they will generate probably would be quite modest, Mr. Fong said. "I just don't see a lot for the industry."

Gloria Vogel, first vp and insurance analyst with Lehman Bros., agreed. "Not that many companies have any interest or desire a relationship with Mexico."

Insurance buyers in Mexico—including U.S. companies with Mexi-

can operations—stand to gain from the trade pact.

"From my perspective, I think it will certainly open up the market to the extent that we will see probably a better range of insurance products on the Mexican market because of NAFTA," commented Douglas Smith, senior vp and manager of the international department at Johnson & Higgins in New York.

For multinational buyers in particular, NAFTA would result in better services and a better range of products, he said. "There'll be more room to maneuver."

NAFTA will eventually "increase competition against all companies" in the Mexican insurance market, said Ronald J. Anderson, chairman of the International Insurance Council in Washington and a senior vp at AIG's American International Underwriters unit.

And that is "always good for the buyer," he said.

Multinational buyers would no longer be restricted to purchasing the traditional insurance products available in the Mexican market, Mr. McCarty said. "They'll be able to buy a much broader range of products."

U.S. risk managers, however, are uncertain of the impact on their companies' Mexican operations.

"We're kind of watching it," said Thomas W. Ludwick, risk manager at Farah Inc. in El Paso, Texas. "We're not sure how it will affect us."

Farah operates to facilities in Mexico.

The agreement is not a big topic among risk managers further east in Texas either, pointed out James E. Green, risk manager at Justin Industries Inc., a western footwear manufacturer in Fort Worth.

It does not come up much at local meetings of the Risk & Insurance Management Society Inc. and there have been no seminars about the impact of the treaty, Mr. Green said.

"In the sense of re-thinking our strategic planning in risk management, we think it will have no significant impact on us," said Robert Ozment, director of corporate and employee insurance at Ford Motor Co. in Dearborn, Mich.

"We've already got facilities there with insurance in place," Mr. Ozment noted, adding that any new operations could easily be added to the company's current insurance program.

Ford operates several facilities in Mexico, including a large engine plant and an operation that produces Escort automobiles that are shipped back to the United States.

Meanwhile, several international insurers and brokers say they anticipate increasing their stakes in response to NAFTA.

"AIG has long had a significant presence in the Mexican insurance market, and we will now be permitted to move to majority ownership within a few years," noted Maurice R. Greenberg, AIG's chairman and chief executive officer.

AIG looks forward "to bringing our resources to serve the needs of this rapidly growing market economy on our own doorstep," Mr. Greenberg said.

Chubb, which holds a minority interest in Mexican insurer Equitativa Seguros S.A., has not decided by how much it will increase its stake. But "clearly," Mr. Parker said, "we're going to go up a lot higher than the 30% that we now have."

For CIGNA—which now holds a 49% interest in Seguros CIGNA—the trade pact gives it "a very clear-cut path to move toward ma-

ority ownership," Mr. McCarty said.

Earlier this month, MetLife announced a joint venture partnership with Banco Santander in Seguros Genesis, a Mexican insurer that sells both life insurance and pension products. MetLife and Banco Santander own a 49% interest in Seguros Genesis, with the remainder held by Mexican investors.

As a result of the agreement, "We could now have in due course a greater position" in Genesis, said William G. Poortvliet, executive vp in charge of MetLife's international operations.

"We think it's very positive," he said of NAFTA.

Joe Graziano, a senior vp with Reliance National Insurance Co. in New York, said: "We're very close to completing an investment in one of the Mexican companies and plan to conduct business in Mexico as soon as we're able."

The Mexican company, which Mr. Graziano would not identify, will write specialty property and casualty insurance, including large risks, directors and officers insurance, and some accident and health coverage.

Mr. Graziano said Reliance will acquire a 30% stake in the company, the maximum permitted under the agreement.

M&M, which has a correspondent relationship with Mexican insurance broker Bouchier Marquard Zepeda, "would probably look at" taking an equity stake, Ms. Kanaga

said.

A&A has had a correspondent relationship with a Mexican broker, Asesores Kennedy Agence de Seguros S.A., since 1976, Mr. Perez noted. "This gives us an opportunity to invest in Mexico, which is something we've been very interested in doing."

"We view this as a very favorable opportunity to invest in a country," he said.

Aetna Life & Casualty Co. plans to continue with its joint venture in Mexico.

In February, subsidiary Aetna International Inc. entered into an insurance joint venture with Valores de Monterrey S.A. de C.V., a Mexican insurance holding company. Under the agreement, Aetna acquired 10% of each of two VAMSA subsidiaries, one a multi-line insurer and the other a bonding company.

NAFTA "shouldn't impede us in any way, and it might, in fact, make it easier to grow with our business there," said an Aetna spokesman.

Several companies have contacted Russell Miller Inc. about "how they might develop their business" because of the trade pact, said Russell R. Miller, chairman of the San Francisco investment bank that specializes in the insurance industry.

"I think it's just going to take time for people to understand the process and to see what business advantages might develop," he commented. ■

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**Nicotine patch**

*Continued from page 3*

vent cancer, heart failure, emphysema and other life-threatening illnesses."

The suit charges the Des Moines, Iowa-based insurer with breach of contract, consumer fraud and deceptive trade practices because its policy does not specifically exclude the cost of nicotine patches from reimbursement, Mr. Holstein said.

Principal Mutual's denial of the claim is particularly ironic because the insurer offers non-smokers policy discounts, and the costs to treat lung or heart diseases associated with smoking far outstrip the cost of the patch, he said.

"Why deny a \$500 claim that could perhaps save hundreds of thousands of dollars on an individual?" he asked.

Principal Mutual had not received official notice of the lawsuit

and cannot comment on the claim or its policy regarding coverage for nicotine patches, a spokeswoman said.

The nicotine patch, which has generated strong consumer interest since the U.S. Food and Drug Administration approved its sale last November, releases a specific amount of nicotine through the skin directly into a patient's bloodstream to wear the patient from the drug. Patches are typically prescribed as part of a behavioral modification program for smoking cessation (BI, March 16).

Although nicotine patches are considered a prescription drug, the issue of coverage is fuzzy because patch usage is generally coupled with a smoking cessation program or other behavior modification program, which are typically not covered under standard health insurance plans, said a spokesman for the Health Insurance Assn. of America in Washington.

While some group health insurers—including Aetna Life & Casualty Co., Travelers Corp. and Blue Cross & Blue Shield plans—cover the cost of the patch, large self-insured employers are considered more likely to cover patches.

Insurers that do reimburse patients for the cost of the patches usually add limitations similar to those imposed on prescription nicotine gum. In these cases, insurers will cover nicotine patch costs only when an individual's medical condition—like heart disease, emphysema, cancer or bronchitis—necessitates that the individual stop smoking.

So far, "there is no consistent position" among insurers on whether to cover the cost of nicotine patches, said Mary Case, a partner with Kwasha Lipton in Fort Lee, N.J.

But in general, group health insurers are gradually becoming more specific in their exclusions of prescription drugs—not necessarily because of the threat of litigation, but because drugs are "one of the fastest-growing components of the health care expense," she said. ■

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## GOP platform

Continued from page 1

ton," said Bill Custer, director of research for the Employee Benefit Research Institute in Washington.

But even modest reform could lead to new calls for taxes on employee benefits, say health care experts. And that could lead to a rift between those in the administration who oppose all new taxes and those more concerned with taming the budget deficit.

At their Houston convention last week, Republicans specifically adopted the market-based health reform plan the administration put forward earlier this year (BI, Feb. 3). Their platform categorically rejects the "play-or-pay" plans favored by leading Democrats like presidential nominee Bill Clinton (BI, July 20) and Rep. Daniel Rostenkowski, D-Ill. (BI, Aug. 19, 1991).

Such plans, the platform declares, would require a "massive increase in payroll taxes that would destroy hundreds of thousands of jobs." Citing research by GOP staffers for the Congress' Joint Economic Committee, the platform estimates that such taxes would cost 712,000 jobs.

The platform also criticizes the Democratic health care proposals as relying on government, rather than private sector, initiative.

On the tort reform front, the Bush administration has advocated several measures designed to discourage lawsuits, including a "loser pays" rule and measures to encourage alternative dispute resolution (BI, Feb. 10). Vice President Dan Quayle has led that administration's effort to adopt these reforms.

In fact, the administration's health care and tort reform positions dovetail in one plank of the platform. The plank repeats the president's call for caps on non-economic damages in medical malpractice lawsuits as part of a larger health care reform package.

Business lobbyists are by no means certain just what President Bush would do—or attempt to do—in either of these areas. Much will depend on the mood of the 103rd Congress, which could contain 150 new members when it convenes next January, they say.

"Basically, I see it as steady as you go," said David M. Farmer, vp-federal affairs in the Alliance of American Insurers' Washington office.

"Much of it is going to depend on the composition of the next Congress," said Peter A. Lefkin, vp-federal affairs for Fireman's Fund In-

urance Co. in Washington.

President Bush's own priorities could also be a factor. In a second term, his personal interest would remain focused on international rather than domestic issues, predicts Mr. Lefkin.

"It depends a lot on who George Bush decides he is in his second term," concurs Ellen Goldstein, director-health care policy at the Assn. of Private Pension & Welfare Plans, a benefits lobbying group in Washington.

The GOP platform indicates that George Bush has decided to be the "health care president" if he wins a second term.

President Bush came out of the Houston convention with a GOP platform that pulls few punches on health care. Branding a single-payer system "costly, coercive" and "imported from abroad," the GOP dismisses it as a "prescription for misery."

That same tone carried over into the acceptance speech.

"We don't need my opponent's plan for a massive government takeover of health care, which would ration care and deny you the right to choose your doctor. Who wants a health-care system with the efficiency of the House post-office and the compassion of the KGB?" he asked, repeating a widely noted line he had used a few weeks earlier (BI, Aug. 10).

Instead, the party adopts the president's position on capping medical malpractice damages and follows the administration in calling for:

- "Creating new tax credits and deductions to help low- and middle-income Americans." Low-income people who work would receive vouchers rather than tax credits.

- "Providing insurance security for working Americans by requiring insurers to cover pre-existing conditions."

- "Making health insurance premiums fully deductible for the self-employed." Only 25% of the premium currently is deductible.

- "Making it easier for small firms to purchase coverage for their employees. The proposal would allow small businesses to form health insurance purchasing pools to make insurance more affordable. It would also guarantee the availability and renewability of insurance for small firms, set premium standards, pre-empt state mandated-benefit laws, establish minimum coverage plans and require states to establish risk pools to spread risks broadly across health insurers."

The platform also called for creating a uniform claim and data system, and for community health centers to provide care in "medically underserved" areas. The Republicans called on Americans to exercise "good judgment" in their behavior to prevent disease and injury.

The Democratic platform, by contrast, provides a much longer list of goals, though no details on how its proposed universal care program would be run or funded (BI, July 20).

The Democrats promise a "uniquely American reform of the health care system to control costs and make health care affordable; ensure quality and choice of health care providers; (and) cover all Americans regardless of pre-existing conditions."

The Democrats also promise to cut waste, "improve primary and preventive care, including child immunization... provide expanded education on the relationship between diet and health; expand access to mental health treatment services; provide a safety net through support of public hospitals; provide for the full range of reproductive choice—education, counseling, access to contraceptives and the right to a safe, legal abortion; expand medical research; and provide long-term care, including home health care."

Despite those sharply differing positions, several lobbyists say compromise would be likely in a second Bush administration.

"Battle lines are drawn more sharply pre-election than post-election," observed Frank McArdle, a consultant with Hewitt Associates in Washington.

"There still will be a great push for health care reform and the likelihood of a compromise increases in a second Bush administration. Bush would have more leverage because he's not seeking re-election. Congress will have to deal with him," said Mr. McArdle.

"By and large, the Republicans are closer to one another in what they'd like to do on health care reform. Congressional Republicans and Bush will work together nicely" during a second Bush administration, predicted Mr. McArdle.

About a fifth of the 435 incumbent representatives have either retired by choice or been defeated in primaries. And redistricting has shifted political power from traditionally liberal Northeastern and Midwestern states to more conservative—and more Republican—Southern and Western states.

Even conservatives, though, could

feel pressure to move quickly on health care reform.

"Health care has become such an important issue that a newly elected congressperson will have to be able to say by next June, 'We did X,' " whatever "X" might happen to be, said Mr. Custer of the Employee Benefit Research Institute.

"I wouldn't be surprised to see some suggestion of capping fees," said Stuart J. Brahs, vp-federal affairs in the Principal Financial Group's Washington office.

Another possibility: treating a portion of employee benefits as taxable income. This idea could be revived as a way to control costs, Mr. Brahs said, on the theory that people would be less likely to acquiesce to higher costs if money came out of their own pockets.

Earlier this year, the administration floated the idea of taxing benefits beyond a certain point. The idea ran into immediate trouble, and it died quietly (BI, Feb. 3; Jan. 20).

Both Richard Darman, President Bush's budget director, and Treasury Secretary Nicholas Brady have supported the idea of taxing benefits, noted Ms. Goldstein of APPWP. Both men, however, are under fire from those who oppose all new taxes.

Given that President Bush has vowed to shake up his cabinet if he wins a second term, the fate of Messrs. Brady and Darman might

help indicate whether a benefits tax will be suggested again.

EBRI's Mr. Custer noted that no one should expect any indication of whether a tax is in the offing until after the election. "You don't talk about tax increases in an election year."

If there is some suspense over the direction health care reform might take in a second Bush administration, there is next to none over the fate of tort reform.

"Our legal system is costing consumers \$300 billion a year," Vice President Dan Quayle said in his acceptance speech.

"The litigation explosion has damaged our competitiveness; it has wiped out jobs; it has forced doctors to quit practicing in places where they are needed most," said the vice president, who heads the President's Council on Competitiveness. The council has served as the administration's main vehicle for promoting changes to the civil justice system.

"Every American knows the legal system is broken—and now is the time to fix it," he said.

"I think the clear message we've been hearing out of Houston is that they'll continue to press for medical liability reform and civil justice reform on both the state and federal level," said Martin F. Connor, president of the American Tort Reform Assn. in Washington. ■

## Workers comp

Continued from page 2

medical clinics responded to Zenith's suit by suing Zenith, other insurance companies and a major hotel chain. The clinics charged them with antitrust violations and conspiring to drive out of business providers that care for minority workers who suffer from workplace injuries and illnesses, including stress.

Wellington last week agreed to dismiss its lawsuit against Zenith, to pay the insurer an undisclosed amount of cash and to drop more than \$1 million in workers comp medical claims filed with Zenith.

In its agreement with Zenith, Wellington—which admitted no wrongdoing—also agreed to specific business practices that "should serve as a basis for legislative reform that will eliminate the potential for abuse and will assist genuinely injured workers in obtaining the legitimate benefits to which they are entitled," said Zenith Chairman Stanley Zax in a statement.

According to the agreement:

- Wellington will refrain from deceptive and misleading advertising. Specifically, it will state in its advertising that an employer has a right to control the treatment of a work-related injury for up to 30 days and to investigate workers comp claims for up to 90 days.

- Wellington will state in 12-point boldface type in advertising the penalties for making a fraudulent workers comp claim.

- Zenith will not pay for more than one initial comprehensive medical-legal evaluation per claimant, unless the claimant receives written consent from Zenith. The insurer also will not pay for medical-legal evaluations unless the physician who performs the evaluation has "a license in the particular specialty relevant to that service."

California law requires insurers and self-insured employers to pay for an injured worker's medical-legal reports, which cost an average of more than \$1,000 each, even if a claim is denied.

- Zenith will not pay for treatment that is given prior to 30 days from the date an employer receives a workers comp claim notice or prior to the employer's learning that Ze-

nith has denied the claim, whichever occurs first.

- Zenith will not pay for medical-legal evaluations performed prior to 90 days after it has received the claim or before it notifies the claimant that the claim has been denied, whichever occurs earlier.

- Charges for medical-legal evaluations "shall not exceed the direct charges for the physician's professional services," other medical services and reasonable costs.

Wellington will also provide the names of all professionals "upon whose work it relied in sending the bill, including a statement under penalty of perjury regarding the amount of time" spent by each person in treating the injured worker, Zenith said.

In the other workers comp fraud-related action, Mr. Coronado, the alleged leader of a workers comp fraud ring, was charged with 25 felony counts last week and jailed in Los Angeles.

Mr. Coronado's firm, Spanish Marketing, allegedly acted as a "capping" and referral service for clinics and attorneys operating so-called "work comp mills."

About 15 Spanish Marketing employees are suspected of recruiting individuals—typically those seeking unemployment insurance at the state Employment Development Department office—to file fraudulent workers comp claims.

Spanish Marketing is charged with helping individuals to complete workers comp claim forms, though they did not have work-related injuries. The company allegedly then referred the claimants to clinics and attorneys, who then reimbursed Spanish Marketing for those referrals.

The Insurance Department estimates that each Spanish Marketing recruiter coerced at least one person each day to file a false claim. Insurance companies settled those claims for an average of \$20,000.

Among the charges against Mr. Coronado: conspiracy to commit insurance fraud, conspiracy to file false insurance claims, conspiracy to solicit workers compensation claims and conspiracy to solicit clients for attorneys. ■

## American Re sale

Continued from page 2

portfolio.

Once completed, the deal could be the largest leveraged buyout to date in the insurance industry.

An Aetna spokesman said that analysts had estimated Aetna would earn \$200 million from the sale on a GAAP basis when they took the \$1.1 billion value of American Re at year end, subtracted it from the \$1.4 billion sale price and determined the sale would net \$300 million on a pretax and \$200 million on an after-tax basis. But, he noted, the gain on the sale is based on American Re's book value at the time the deal is concluded. American Re's book value has increased to more than \$1.2 billion.

In addition, Aetna is putting aside \$75 million to cover American Re losses that exceed a certain amount. Aetna will decide after the deal is completed whether the \$75 million will be placed in an unearned premium account or be used to buy a reinsurance policy. And, another \$50 million has been deducted to

account for unforeseeable changes that could arise at the closing.

Despite the reduced accounting gain, "the money is still in our pockets." Aetna will gain \$1.2 billion in cash plus \$200 million in "non-cash considerations" from the deal. The \$200 million, he said, reflects \$100 million in subordinated debt, \$70 million in preferred stock and \$30 million in common stock in a new holding company, American Re-Insurance Corp.

This amounts to an 8% to 9% stake in the new company, said the spokesman. If the new company eventually sells stock to the public as expected, there may be additional gains to Aetna as a result.

The spokesman also said that the \$425 million to \$450 million gain on a statutory basis is more significant than the GAAP profit. "This is an accounting issue, and frankly, there's no economic incentive to have a large GAAP gain," he said.

The gain on a statutory basis will be much larger than on a GAAP basis because statutory accounting

does not take into account goodwill, deferred acquisition costs or deferred costs, the spokesman explained. American Re, for instance, is now carried on Aetna's GAAP books with roughly \$130 million in goodwill, which it will no longer have with the sale.

The Aetna spokesman said the insurer decided to sell the unit to reduce its exposure to the cyclical property/casualty business.

Analysts say that while the market cycle may have been a factor, more relevant was Aetna's mortgage portfolio. Of the \$1.1 billion in mortgage loans scheduled to mature in the first half of the year, \$829 million was not paid as scheduled.

Analysts also say the appeal of freeing up capital with the sale was also a factor.

"I think it's a capital issue," said Gloria Vogel, first vp with Lehman Bros. in New York. Aetna is anticipating the promulgation of risk-based capital rules, and wants to make its capital base as strong as it possibly can, she said. ■

## Earthquake study

Continued from page 3

insurers like a major Southern California earthquake, said a spokesman for the Assn. of California Insurance Cos. in Sacramento.

However, regulators want to crack down on what they see as excessive reserving, he said, referring to California's controversial Proposition 103, which insurers say inhibits their reserving capability by limiting their profits.

"We hope the findings will penetrate the political consciousness of regulators and they'll see that reserves and surplus serve a purpose," he said.

The study's findings are significant also because they say that more than 40% of likely earthquake losses will stem not from property damage, but from business interruption losses, said Mr. Gordon, an author of the study.

However, the study did not calculate what portion of these losses, estimated at \$33 billion, would be covered by insurance.

"The impact on the insurance industry may not be as great (at least at present), because many of these business interruption losses are not insured," the study says.

But if claims stemming from the recent Los Angeles riots are any indication, most business owners—even if they do not have earthquake insurance—have business interruption coverage for damages caused by fire or gas

main explosions stemming from an earthquake, according to Patricia Lombard, executive director of the Western Insurance Information Service, the Los Angeles-based arm of the Insurance Information Institute.

"Anyone who has a package policy has business interruption

### More than 40% of earthquake losses could stem from business interruption.

coverage," she said. "Anyone who has any degree of sophistication makes sure they have it."

Only 11% of the claims from the Los Angeles civil unrest were for structural damage, Ms. Lombard pointed out.

For example, only 63 of the 1,126 riot claims—which totaled more than \$70 million—reported by Los Angeles-based Farmers Insurance Group were for structural damage, according to a WIIS report.

These figures show that "the bulk of the riot claims were for business interruption losses," she said.

While the earthquake study damage figures may seem large, they may actually underestimate the damage a major earthquake in the Los Angeles basin is likely

to cause, according to USC's Mr. Gordon. "We were being conservative."

Furthermore, "Our estimates incorporate the business-activity consequences of building and structure damage and some associated lifeline damage, but do not fully account for losses associated with potential disruptions to infrastructure or lifeline systems, both local and interregional," the study authors acknowledge.

Infrastructure-related business losses "may amount to several additional billion dollars."

The study also found, among other things, that a major earthquake could cause a loss of 264,625 person-years of employment, or approximately 3.85% of the region's 1990 employment.

"Although dollar losses are potentially the most significant employment variable for the insurance industry, job losses have at least equivalent importance in the political arena," the study says.

About 62% of the job losses are likely to occur within the fault zone, while 27% will be lost elsewhere in the Southern California region.

Damage caused by shaking will account for 61% of the job losses and fire damage will account for 36.5%.

For more information about the study or to obtain a copy, contact the Earthquake Project at 202-659-6506.

## Low rates cut U.K. brokers' earnings

By GAVIN SOUTER

LONDON—First-half profits at two of the world's largest brokers, Sedgwick Group P.L.C. and Willis Corroon Group P.L.C., fell by more than 20% from 1991 levels.

Both companies cited continuing low rates in the United States as a major reason for the fall in profits.

At Sedgwick, pretax profits for the first six months of 1992 fell 21% to 51.7 million pounds (\$98.4 million at the appropriate exchange rate) from 65.3 million pounds (\$106.1 million) in the first six months of 1991.

Gross revenues totaled 349.6 million pounds (\$665.5 million), down 2% from 355.7 million pounds (\$577.7 million) in the first half of last year.

"The second quarter has been a disappointment, and the rest of the year may not be any easier," said Sedgwick Chairman David Rowland.

Despite higher rates in some

areas of the London market, profits have been held back by low rates in the United States, Mr. Rowland said.

"The rating environment in the U.S. continues to cause us concern. Renewal terms for standard business fell compared with last year," he said.

The first-half dividend per share was also reduced to 3 pence (6 cents) from 4 pence (8 cents), and the final dividend will be "not less than 3 pence," compared with 8 pence (13 cents) in 1991.

Sedgwick's share price plummeted on the news of the dividend cut. The shares opened last Tuesday at 1.44 pounds (\$2.78 at current exchange rates), but closed at 1.12 pounds (\$2.16) after the results were announced that day.

The share price had failed to recover late last week.

Willis Corroon's first half pretax profits dropped 22% to 54.1 million pounds (\$103 million) in 1992 from 69.4 million pounds

(\$112.7 million) in 1991.

Gross revenues totaled 345.7 million pounds (\$656.8 million), down 1% from 347.6 million pounds (\$564.5 million) in 1991's first half.

Like Sedgwick, Willis Corroon expects no profit gains in the second half of 1992.

"As a result of world insurance and financial market factors, together with the cost of our long-term investments, our 1992 profits will be below those achieved in 1991," said Executive Chairman Roger Elliott.

Several factors hurt the results, he said, including lower interest rates, adverse foreign exchange rates, "the worst U.S. insurance market for many years" and reduced demand due to the worldwide recession, Mr. Elliott said.

Willis Corroon maintained its 6.6 pence (12.5 cents) per-share dividend. Its share price fell 18 pence (34 cents) to 1.68 pounds (\$3.24) immediately after the results were announced. ■

## Second-quarter commentary

Continued from page 31

breather is not surprising.

**Analyst:** Revenues advanced 3% in the quarter, with insurance brokerage revenues increasing only 2%. Expenses rose about 4%, which we think is a good showing. Nevertheless, profit margins are under pressure.

**Broker:** We are aggressively managing our company. Production is doing great, as I already indicated. We believe that our cost controls are working beautifully. In other words, everything that we should be doing, we are doing. Shareholders want earnings growth, something we recognize. Were we not in such a hostile environment, the operating effects of management efforts would be dramatic. In a hard market, we will be well-situated to achieve potent

earnings leverage.

**Analyst:** On the subject of profitability, the pending acquisition of Frank B. Hall & Co. Inc. by Aon Corp. is another step in the concentration of the brokerage industry. With this acquisition, Aon emerges as an international competitor. Will this increased concentration lead to keener competition amongst the large international brokers and correspondingly retard any recovery in profits on the next cycle?

**Broker:** We think that service and productivity are the twin keys to operating profit. If we deliver effective service and pay attention to our cost structure as a permanent feature of our management culture, our profit margins should respond to the leverage of rapidly advancing commissions and mo-

derately advancing expenses. Competition among the leading brokers has always been intense. As client needs have become more sophisticated, the competition has proceeded along the lines of increased professional capability. Slippage in profitability can be attributed to the soft market. What other industry can you think of where prices have declined in absolute terms since 1980?

**Analyst:** One last question: As always, we solicit your opinion on when pricing in commercial lines will turn.

**Broker:** After surveying our people, we have to believe that a genuine hardening in the market is still some distance in the future. 1993 is a possibility, but we are not planning for it. Maybe by 1994 there will be enough pain. ■

## Update

### Lloyd's council resignations

Continued from page 2

The other eight council members are non-Lloyd's members nominated by the Bank of England. Three new non-Lloyd's members will be nominated at year end.

Although many Lloyd's members say they will cast a vote of support for the council, several executives—including Malcolm McKinsey, junior deputy chairman of the Lloyd's Underwriting Agencies Assn.—have called on all members to resign. These executives favor letting David Rowland, who is expected to become chairman next year, choose his own council members.

Mr. Rowland would not say whether he had any role in the resignations. He pointed out, though, that all council members who resign must take a "sabbatical year" before returning to the council. This is a "major technical problem," he said.

### Nevada rules on pre-emption

LAS VEGAS, Nev.—Insecticide manufacturers that follow federal labeling and packaging laws cannot be held liable under more stringent state laws, the Nevada Supreme Court has ruled.

While the Nevada high court found that the federal Insecticide, Fungicide and Rodenticide Act does not expressly pre-empt state liability or tort claims, the court did find an implied pre-emption.

"The opinion is a huge victory for the pesticide industry," said Katherine Latimer, a lawyer with Spriggs & Hollingsworth in Washington. She represented Velsicol Chemical Corp. in the Nevada case, *Davidson vs. Velsicol Chemical Corp.*

She added that the ruling is consistent with a recent tobacco liability ruling from the U.S. Supreme Court (*BI*, July 29) in that it tells manufacturers that follow federal pesticide labeling and packaging laws that they "are doing all that they can do under the law."

The U.S. Supreme Court ruled that some claims against tobacco companies are pre-empted by federal laws, while others are not.

The Nevada case began when a homeowner sued an exterminator and the pesticide manufacturer over misapplication of a pesticide. A claim against the exterminator was settled. The Supreme Court ruling throws out the portion of the suit against the manufacturer for failure to warn, but other allegations are still pending.

### Installation triggers CGL cover

CHICAGO—Property damage—as the term is used in comprehensive general liability policies—occurs when a defective product is installed, not when harm from that product later manifests itself, the 7th Circuit Court of Appeals ruled recently.

The ruling came in a coverage dispute between two insurers and a wholly owned subsidiary of Eljer Industries Inc. in Dallas, which is facing several lawsuits from a polybutylene pipe system it made from 1979 to 1986. The pipe has been found to deteriorate when subjected to hot water with a high chlorine content.

Eljer says that the ruling will enable it to tap \$15 million more in coverage. But Liberty Mutual Insurance Co., the primary insurer from 1979 to 1988, says it will actually get money back from Eljer as a result of the ruling. Liberty Mutual says it has paid \$9 million of the \$10 million in coverage which is available to Eljer for the claims. The insurer continues to defend Eljer for underlying claims.

Travelers Indemnity Co. of Illinois, which wrote excess coverage from 1982 to 1986, declined to comment.

Five percent of the 500,000 to 750,000 pipes installed in homes are expected to generate lawsuits, court papers say. An Eljer spokesman said losses were likely to exceed \$50 million; its lawyers told the court that losses would be in the hundreds of millions.

The court ruled that "the incorporation of a defective product into another product inflicts physical injury in the relevant sense on the latter at the moment of incorporation." The decision overturned a lower court's finding that the property damage occurred when the leak occurs or, if a homeowner fixes the pipe before it leaks, when the pipe is repaired or replaced.

Liberty Mutual and Travelers said they are reviewing the ruling.

### Briefly noted

A federal district court in Cincinnati has approved a class-action settlement of claims related to **faulty heart valves** manufactured by Shiley Inc., a unit of Pfizer Inc. The settlement will cost Pfizer between \$165 million and \$215 million to pay for research, medical consultation and compensation for an estimated 51,000 heart valve recipients and their spouses. Some of the cost likely will be covered by insurance. . . . Thirty insurers are paying homeowners who suffered losses in the October 1991 **Oakland fires** \$151 million in excess of policy limits after some homeowners complained that agents did not tell them they were underinsured, a California Insurance Department survey of 44 insurers found. About one-third of the claims for destroyed homes are unresolved, the study also said. Insured loss estimates from the fires have risen to \$1.3 billion from \$1.1 billion. . . . A federal bankruptcy court last week approved **First Executive Corp.**'s reorganization plan, which would transfer \$260 million in assets to policyholders of subsidiary Executive Life Insurance Co. ELIC's sale was approved earlier this month. . . . A 13-member syndicate of lenders, led by Chase Manhattan Bank N.A., have agreed to guarantee a \$550 million backup credit facility for the **Equitable Life Assurance Society of the United States**. The one-year facility is larger than the \$400 million credit line Equitable previously said it would set up (*BI*, Aug. 17). . . . The **U.S. Export-Import Bank** is taking over administration of its export credit insurance program from privately held FCIA Management Co. Inc. The bank says it will be able to manage the program more economically by bringing administration in-house.

# Two cheers for the second quarter

By LEONARD M. WILSON  
Special to Business Insurance

**M**OST OF THE publicly owned brokers have reported their second-quarter results (BI, Aug. 10). Interestingly, earnings reports generally exceeded expectations despite the unremitting soft market. Rejoicing is not yet in order, given that earnings momentum for insurance brokers remains pretty anemic. But any upbeat result in today's environment is worth savoring.

Marsh & McLennan Cos. Inc. benefited from generally solid cost controls as well as a pronounced rise in its investment management operations.

Cost savings from a corporate restructuring began to affect the bottom line of Alexander & Alexander Services Inc. in the quarter.

Arthur J. Gallagher & Co. still continues to post impressive gains in self-insurance services through its Gallagher Bassett Services Inc. subsidiary.

Hilb, Rogal & Hamilton Co. managed expenses particularly well in the quarter.

The dialogue that follows is a composite of management comments gleaned after the release of quarterly results. While there is not much optimism about a turn in commercial property/casualty insurance rates, brokerage managements are adapting operations to the realities of difficult pricing.

**Analyst:** Let's start out with premium rates. Are you detecting even the most subtle changes for the better here in the United States?

**Broker:** It's more of the same. Pricing competition grinds on. We estimate that pricing deflation in the quarter was around 5%, a figure embedded for the past six to eight quarters. Yes, we are seeing rising rates in aviation, marine and energy coverages as well as workers compensation. But the lion's share of commissions are tied to lines that are highly competitive.

**Analyst:** So competition is not getting worse?

**Broker:** Not overall, but we still see companies quoting aggressively on many

risks where it almost seems as if they have reverted to cash flow underwriting. You follow the numbers more closely than I do, but it strikes me that the underwriters had reasonably decent second-quarter reports. They didn't suggest the kind of distress that would produce more sensible pricing.

**Analyst:** What is the status of insurance markets outside North America?

**Broker:** Quite mixed, but appropriately described as improving. Rates on direct insurance are advancing in the United Kingdom and in some of the countries in Western Europe. Australia, despite a recession and chronic overcapacity, is also experiencing a firming in pricing on commercial lines.

**Analyst:** We are under the impression that reinsurance rates in the United States are stable.

**Broker:** There is little movement in reinsurance markets. Primary company retentions have not changed, and pricing is accurately described as stable, but not advancing. Maybe retentions will have to drop before reinsurance rates increase. This may not happen soon, and we would say that reinsurance capacity in North America is more than adequate. So demand is probably the key issue in this segment.

**Analyst:** We read almost daily about the troubles of the London market and Lloyd's in particular. What is the state of reinsurance pricing across the Atlantic?

**Broker:** Well, capacity has tightened markedly in the area of excess-of-loss coverage. Placing is very difficult, but we have found markets and have simultaneously benefited from the advance in prices. Our international reinsurance commissions are up nicely year over year. We expect the tightness to persist. London market wholesale brokerage is another beneficiary of our effective placing. We recorded very satisfactory gains in this area during the quarter.

**Analyst:** Can we turn to new business? Production has been a mainstay for the public insurance brokers in this cycle. Are you meeting your plan?

**Broker:** New business amounted to around 11% to 12% of last year's commis-

sions as a base. This is in line with our goals, and frankly is gratifying in the light of continuing premium rate deflation and the long soft market. Our producers are geared to the ongoing needs of generating new business. Lost business is running at about 5%, so what we define as net new business is holding at 6% to 7%—a critical contribution to our results.

**Analyst:** Most companies lament the glacial pace of economic recovery. How is the economy affecting brokerage results?

**Broker:** We have felt the recession in specific areas. Commercial real estate, normally an important source of business, is depressed. Premiums that reflect economic activity through variables like inventories and payrolls are not growing as rapidly. On balance, we worry about the soft market more than the sluggish economy.

**Analyst:** Some industry observers think that benefit consulting has lost its steam. What sort of gains did you achieve in the quarter, and do you face a period of consolidation in benefits consulting?

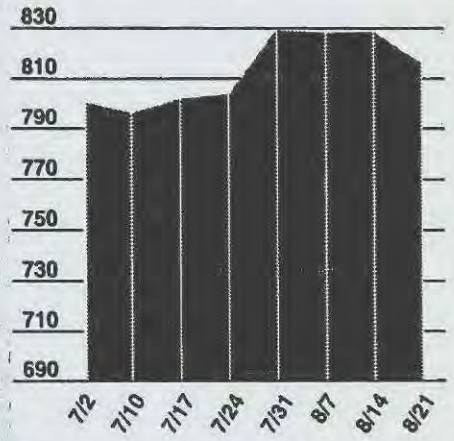
**Broker:** Consulting revenues increased around 4% in the quarter, well below the pace of the past few years. You have observed in past columns that companies can defer large-ticket expenditures, and are doing so in the consulting area. Others have commented on the absence of new legislative initiatives as a factor that reduces demand for consulting services and the need to redo benefit plans. We are more optimistic and believe that over time this area of our activities can still expand at 10% or better annually. Inevitably, after a long period of fast growth, the current

Continued on page 30



Leonard M. Wilson is a senior vp with Lazard Asset Management Inc. He is a member of the New York Society of Security Analysts.

## BI Insurance Index



Base = 100 on Dec. 29, 1978  
Source: Nordby International Inc.

Insurance industry stocks sank last week, as the Business Insurance Index fell 12.3 points to 816.1 on Aug. 21 from 828.4 on Aug. 14. Advancing issues were led by Tokio Marine & Fire, up 23.6%; Reliance Group Holdings, up 11.1%; and Frank B. Hall, up 9.1%. Declining issues followed Safeguard Health Enterprises, down 12.1%; Harleysville Group, down 10.6%; and Poe & Associates, down 8.0%. The most active issue was U.S. Healthcare, 6.0 million shares traded. The BI Index was down 1.0%; the NYSE Composite was down 1.1%; the Standard & Poor's 500 fell 1.2%; and the Dow Jones 30 Industrials fell 2.3%.

## British Issues

Aug. 20 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High-Low pence
Comm Union	472	N/M	31.5	6.7	475-472
Genl Accident	429	N/M	35.7	8.3	440-428
Gdn Royal Exch	129	N/M	10.0	7.8	129-126
Royal	168	N/M	7.0*	4.2	173-168
Sun Alliance	243	N/M	19.0	7.8	247-242
<b>Brokers</b>					
Bradstock	93	10.4	6.3	6.8	98-93
CE Health	251	14.5	34.5	13.7	292-251
Hogg Group	114	6.9	10.9	9.6	126-114
JIB Group	111	8.2	10.0	9.0	120-111
Lloyd Thompson	179	17.9	6.0	3.3	185-179
Lowndes Lmbt	239	9.3	16.8	7.0	249-239
PWS Holdings	33	3.8	5.3	16.1	33-31
Sedgwick Grp	113	8.8	8.0*	7.1	144-110
Steel Brl Jones	175	8.7	17.7	10.1	195-175
Willis Corroon	170	10.7	17.6	10.4	191-170

Source: Philip Olsen, London \* Estimated

# BI Industry Stock Report

AUGUST 17, 1992 THROUGH AUGUST 21, 1992

BROKERS	Price	Weekly % change	Year to Date % change	Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value	Price	Weekly % change	Year to Date % change	Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value			
				High	Low										High	Low									
Alexander & Alexander	NYS	23.88	-1.04	16.46	25.25	18.00	97	1.00	4.19	99	13.10	1.82	NAC Re Corp	OTC	29.00	0.00	-7.94	33.00	21.75	199	0.16	0.55	13	18.90	1.53
Gallagher Arthur J. & Co	NYS	25.00	4.17	11.73	25.50	19.00	266	0.64	2.56	18	5.88	4.25	National Re Corp.	NYS	20.50	0.61	N/A	23.63	17.00	34	0.12	0.59	11	N/A	N/A
Frank B. Hall	NYS	3.00	9.09	-29.41	5.50	3.00	273	0.00	0.00	-3	1.95	1.54	Navigators Group	OTC	33.00	-1.49	-19.51	48.25	30.50	24	0.00	0.00	18	13.52	2.44
Hilb, Rogal & Hamilton	NYS	13.75	0.00	3.77	15.50	11.00	37	0.40	2.91	21	3.56	3.96	Nobel Insurance LTD.	OTC	4.63	-5.13	15.63	6.00	3.50	38	0.00	0.00	3	7.76	0.60
Marsh & McLennan	NYS	79.25	1.28	-2.61	83.75	70.00	393	2.68	3.38	18	28.00	2.83	NWNL Companies	NYS	41.38	2.48	32.93	43.75	22.13	138	1.48	3.58	12	62.65	0.66
Poe & Associates	OTC	11.50	-8.00	-4.17	16.00	11.25	76	0.40	3.48	15	2.82	4.08	Ohio Casualty Corp.	OTC	63.00	2.02	27.27	63.00	43.50	145	2.68	4.25	10	18.00	3.50
<b>BROKERS AVERAGE</b>			0.9	-0.7						24			Old Republic Int'l	NYS	20.13	-5.29	13.38	22.50	15.00	1287	0.40	1.99	7	33.09	0.61
<b>CONGLOMERATES &amp; HOLDING COMPANIES</b>													Orion Capital Corp.	NYS	38.63	-1.59	22.13	39.50	27.38	57	0.92	2.38	6	43.50	0.89
Berkley W.R. Corp.	OTC	35.00	-1.41	14.75	36.25	23.50	80	0.36	1.03	12	36.95	0.95	Phoenix RE Corp.	OTC	11.00	-2.22	4.76	12.25	8.50	6	0.20	1.82	22	13.30	0.83
Berkshire Hathaway Inc.	NYS	9325.00	-1.84	3.04	9325.00	254.69	0	0.00	0.00	31	7270.00	1.28	Provident Life	OTC	27.25	0.93	17.20	28.00	18.00	78	1.00	3.67	12	39.50	0.69
ITT (Hartford Group)	NYS	66.63	-0.19	15.37	70.63	50.00	968	1.84	2.76	13	112.05	0.59	Re Capital Corp.	ASE	13.00	-0.95	-9.57	17.25	12.50	5	0.24	1.85	16	16.07	0.81
Sears (Allstate)	NYS	41.50	-0.30	9.57	48.00	32.50	2795	2.00	4.82	11	34.50	1.20	Reliance Group Holdings	NYS	5.00	11.11	21.21	5.88	3.50	89	0.32	6.40	3	6.40	0.78
<b>CONGLOMERATES AVERAGE</b>			-0.9	10.7						17			RLI Insurance Corp.	NYS	21.13	0.00	28.03	21.38	14.00	4	0.52	2.46	9	14.41	1.47
<b>INSURERS/REINSURERS</b>													St. Paul Companies	NYS	73.00	-3.31	0.17	80.75	57.13	418	2.72	3.73	7	86.60	0.84
AEON NV	NYS	37.38	0.67	-6.79	37.75	28.69	23	1.14	3.05	7	N/A	N/A	SAFECO Corp.	OTC	51.63	0.00	5.90	53.38	36.13	682	1.64	3.18	13	51.65	1.00
Aetna Life & Casualty	NYS	40.00	-6.16	-9.09	47.00	31.88	818	2.76	6.90	8	87.60	0.46	SCOR U.S. Corp.	NYS	15.88	-0.78	3.25	18.88	13.13	93	0.28	1.76	9	11.19	1.42
Allied Group Inc.	OTC	25.50	-2.86	50.00	26.25	16.25	77	0.64	2.51	8	19.85	1.28	Seibels Bruce Group	OTC	6.00	0.00	9.09	8.75	4.00	128	0.36	6.00	-3	10.60	0.57
American General	NYS	50.00	0.25	12.36	50.38	39.00	743	2.08	4.16	11	60.00	0.83	Selective Ins. Group	OTC	21.25	2.41	26.87	23.50	15.00	31	1.12	5.27	9	30.75	0.69
American Heritage Life Ins	NYS	31.75	3.25	3.67	32.25	21.28	4	0.84	2.65	16	N/A	N/A	Statesman Group Inc.	OTC	7.25	-3.33	26.09	8.13	4.38	376	0.00	0.00	4	2.48	2.92
American Indemnity/Fin'l	OTC	5.75	-4.17	21.05	9.25	4.50	1	0.08	1.39	8	12.93	0.44	Tokio Marine & Fire	OTC	47.13	23.61	-8.50	55.25	32.25	38	0.00	0.00	-	70.93	0.66
American International	NYS	94.25	-3.33	-4.19	99.38	78.63	1444	0.56	0.59	12	99.30	0.95	Torchmark Corp. (s)	NYS	50.50	4.48	30.89	50.50	32.75	452	1.04	2.06	15	40.95	1.23
Aon Corp.	NYS	46.50	1.64	17.35	49.75	34.75	530	1.68	3.61	12	39.70	1.17	Transamerica	NYS	42.88	-1.72	7.52	46.75	35.13	152	2.00	4.66	22	55.00	0.78
Argonaut Group	OTC	28.75	-0.86	21.05	30.25	21.75	40	0.84	2.92	8	20.96	1.37	Transatlantic Holdings	NYS	37.25	-0.33	-4.18	39.63	29.00	69	0.24	0.64	11	18.38	2.03
AVEMCO Corp.	NYS	24.50	-1.01	-2.00	28.00	21.50	12	0.40	1.63	24	9.55	2.57	Travelers Corp.	NYS	21.13	-4.52	-2.31	23.75	17.25	844	1.60	7.57	9	59.00	0.36
Baldwin & Lyons Inc	OTC	32.00	1.99	24.27	33.00	22.75	0	0.48	1.50	8	24.29	1.32	Trenwick Group Inc.	OTC	29.13	-0.43	2.19	30.75	23.00	56	0.72	2.47	10	21.71	1.34
Chandler Insurance	OTC	4.38	-2.78	34.62	7.63	2.13	3	0.00	0.00	34	5.95	0.74	United Fire & Casualty	OTC	42.25	0.60	40.83	42.25	28.34	0	1.00	2.37	9	35.39	1.19
Chubb Corp.	NYS	74.88	-2.76	-2.76	78.63	60.75	647	1.60	2.14	12	72.95	1.03	Unitrin	OTC	36.50	-1.35	2.10	38.50	31.00	181	1.20	3.29	13	37.23	0.98
CIGNA Corp.	NYS	51.63	-5.28	-15.54	61.75	41.50	603	3.04	5.89	11	117.15	0.44	UNUM Corp.	NYS	43.63	-1.13	7.72	45.00	28.01	323	0.64	1.47	13	37.70	1.16
CNA Financial Corp.	NYS	90.00	-3.49	-8.16	104.50	78.50	73	0.00	0.00	9	70.23	1.28	US Facilities Corp.	OTC	9.75	5.41	-34.45	19.00	8.25	229	0.00	0.00	7	9.58	1.02
Continental Corp.	NYS	33.38	-3.26	20.81	34.75	23.25	484	2.60	7.79	23	40.00	0.83	USF&G Corp.	NYS	12.75	-3.77	75.86	15.00	5.63	866	0.20	1.57	-15	12.30	1.04
EXEL Ltd.	NYS	36.50																							

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