

Business Insurance

Reporting Weekly For Corporate Risk, Employee Benefit and Financial Executives / \$4

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Blues to answer Senate charges on work for federal health plan

WASHINGTON—Bernard Tresnowski is scheduled to testify today before a Senate panel investigating the Blue Cross & Blue Shield Assn.'s oversight of its member plans and of its handling of federal employee health plans.

The president of the Chicago-based national group will answer allegations made Friday by the staff of the Senate Permanent Subcommittee on Investigations regarding the association's contracts with the federal government. The staff report says the han-

Continued on next page

Reform bills: Recipe for disaster?

By JERRY GEISEL

WASHINGTON—Health care reform as developed by House Democratic leaders would devastate employers' ability to control health care costs, while a Senate bill would be only slightly less damaging, benefit managers say.

Employers' costs could explode under the House measure, which could more than triple the size of the federal Medicare program. Because Medicare underpays providers, physicians and hospitals will be even more aggressive in jacking up charges to privately insured patients to recoup losses from treating Medicare patients.

An expanded Medicare program "is a recipe for disaster for employers," said Sean Sullivan, president of the National Business

House bill	Senate bill
Employers with 100 or more workers pay 80% of premiums starting in 1997. Smaller firms have until 1999.	If 95% coverage target not met by 2002, employers with 25 or more employees would pay 50% of premiums.
Must offer an indemnity plan and a managed-care plan.	Must offer an indemnity plan, an HMO and a point-of-service plan.
Employers that offer benefits beyond the guaranteed percentage would have to keep doing so for five years.	No provision.
Eliminate use of flex plans and flexible spending accounts for health benefits.	Similar to House bill.
2% tax on health premiums and self-insurance.	1.75% tax on health premiums and self-insurance.
No provision.	25% tax on health plans with cost increases above certain levels.
Limited integration with health care benefits.	Commission would study feasibility of integration.

GRAPHIC BY KIM ROME

- Work comp integration is still alive in health care bills, and employers are gearing up for a fight.... page 21
- Rep. Jack Brooks is pushing harder than ever to get antitrust reform into a health care bill.... page 22

Coalition on Health in Washington.

"It is a huge cost shift to employers," said Fred Hamacher, vp of compensation and benefits at Dayton Hudson Corp. in Minneapolis.

Both House and Senate bills would also boost employers' costs by levying new premium taxes and virtually wiping out flexible benefit plans.

The Senate proposal would also put a new tax on health plans

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California regulators say 'nyet' to Russian insurer

By DOUGLAS McLEOD

LOS ANGELES—Russian capitalism may not be a bad idea in theory, but California regulators aren't happy with one apparent example of it.

That example is OMSTRAK Insurance Co., which claims to be controlled by a Russian government entity but which is being operated from a Beverly Hills office by several businessmen with ties to previous offshore insurance company failures.

OMSTRAK reports having more than \$100 million in assets, consisting mainly of lead and zinc ore and mining rights in the Caucasus region of southwest Russia. While this level of assets would make OMSTRAK one of the largest insurers in Russia, several sources familiar with the Russian insurance market say they've never heard of the company.

The California Insurance Department issued a cease and desist order against OMSTRAK last month, charging that it is soliciting business from out-of-state brokers without a license or surplus lines authority. A hearing is scheduled for this week.

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Car dealers call MEWA a lemon

By MICHAEL SCHACHNER

Their suit latest problem for operator of many failed plans

ATLANTA—An Orlando-based insurance entrepreneur with a checkered regulatory history and ties to more than 10 failed multi-employer health and welfare plans stands accused of steering a self-insured Georgia MEWA into bankruptcy through fraud and self-dealing.

In a lawsuit pending in federal court in Atlanta, M.L. Vaughan and his third-party administration firm, Dealers Association Plan, are charged with fraud and breach of fiduciary duties in the formation, operation and dissolution

of the now-defunct Georgia Independent Automobile Dealers Assn. Welfare Benefit Plan.

The suit, among other things, seeks to force Mr. Vaughan, either personally or through his corporate holdings, to return the more than \$3.5 million that plan sponsors contributed from the time the MEWA was created in 1986 until it went out of business at the end of 1991 with more than \$600,000 in unpaid claims still on its books.

The three plaintiffs, all beneficiaries whose claims were denied by the failed plan, also seek punitive

damages for fraud, unspecified damages under federal racketeering laws, and their legal fees.

Mr. Vaughan is also the subject of an ongoing criminal grand jury investigation in U.S. District Court in Orlando. His request that all civil suits be stayed until the criminal proceedings are over was recently denied by U.S. District Judge Orinda Evans. Mr. Vaughan is appealing that ruling.

In response to the lawsuit, attorneys for Mr. Vaughan say that the plan sponsors are at fault because they were unwilling to

properly fund the MEWA. They maintain that Mr. Vaughan operated within the law and his running of the Georgia MEWA did not violate the Employee Retirement Income Security Act. Lastly, they say MEWAs are inherently troubled.

But, according to the lawsuit, Mr. Vaughan set up and administered 10 other failed MEWAs since the 1970s, including one now being liquidated in North Carolina.

The state of Georgia issued a

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Lessons and blame abound in retirement fund fiasco

By RODD ZOLKOS

Chicago Housing Authority management may be as much to blame for the misappropriation of millions of dollars from agency pension funds as the risk manager accused of taking the money.

Ultimately, risk management observers say, it was the housing agency that not only put an employee with slight experience and no related educational background in charge of its risk and benefit management program but also allowed him to function with little oversight.

Not all public housing authorities are lax in their oversight of the risk management and insurance purchasing function, as evidenced by the Los Angeles Housing Authority's rigorous search for a new risk manager.

John D. Lauer, the CHA's 29-year-old director of risk management and benefits, stands accused of misappropriating more than \$17 million from the agency's pension

funds and of selling insurance to the authority even as he ran its risk management program (BI, June 27).

Outside risk management experts say they are surprised by the latitude Mr. Lauer evidently enjoyed, particularly in a public-sector position.

That the CHA, one of the country's largest housing authorities and an entity with significant claims exposure, would put someone with no risk management experience in Mr. Lauer's position also has raised eyebrows.

The CHA's approach certainly stands in stark contrast to that of another major housing authority, in Los Angeles, where agency officials last week interviewed candidates for the job of risk manager.

Los Angeles Housing Authority officials are operating from a set of minimum requirements that will guarantee the hiring of an industry veteran. What's more, whoever

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What the Los Angeles Housing Authority is looking for in risk management candidates:

Four-year degree in 'occupationally related' field.

Four years recent, verifiable work experience with responsibility in at least two of these areas:

- risk determination and evaluation
- insurance selection or procurement
- property or liability claims administration
- insurance accounting
- safety administration
- self-insurance administration

Updates

Senate panel examines Blues

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dling of parts of the Federal Employee Health Benefits Program overseen by the association and its member plans contains: "evidence of poor management; extravagant expenditures; little interest in detecting health care fraud; inadequate oversight by the BC/BS Assn.; and, especially as it applies to the Office of Personnel Management, ineffective regulation of the contract by senior government officials."

Today's hearing is the latest in a series of inquiries launched more than two years ago by Subcommittee Chairman Sam Nunn, D-Ga., into the operation of various Blues plans (BI, July 13, 1992). The panel examined the factors that led to the insolvency of the West Virginia Blues plan and held hearings on the financial practices of plans in Maryland, New York and the District of Columbia.

As a result, the subcommittee staff issued several recommendations for improving the operation of the Blues plans. These included greater federal and state regulatory oversight of the plans, a review of the tax status granted the BC/BS Assn. and its constituent plans, and the development of uniform solvency standards for Blues plans.

A spokeswoman for the association disputed much of the subcommittee's report, saying, "We are discovering many, many serious errors in it" and questioning some of the methodology used.

Aetna, CIGNA add to reserves

HARTFORD, Conn.—Big additions to environmental liability reserves sharply reduced the second-quarter earnings of Aetna Life & Casualty Co. and affected the earnings of CIGNA Corp.

Aetna added \$64 million, giving it reserves of \$334 million, and CIGNA added \$32 million, making its total about \$775 million.

Neither insurer would predict if they would be forced to strengthen environmental liability reserves in the future as Wall Street analysts expect. Both said the current charges were taken when clearer information became available in the quarter.

Overall, Aetna's second-quarter net income fell 9.6% to \$132 million from \$146 million in 1993. CIGNA's second-quarter net income rose 53.4% to \$135 million from \$88 million.

Meanwhile, CNA Financial Corp. in Chicago reported a net loss of \$36.2 million in the second quarter compared with net income of \$74.8 million in the same period in 1993. The loss is attributable to catastrophe losses and net realized investment losses, said Chairman and CEO Dennis H. Chookaszian.

Also, Continental Corp. reported that second-quarter net income fell 91.8% to \$5.9 million from \$71.8 million in 1993. Continental attributed the fall to capital losses.

18 breast implant cases settled

MIDLAND, Mich.—Dow Corning Corp. has reached settlements with 18 women whose breast implant liability cases were pending in the District Court of Harris County, Texas.

All of the plaintiffs had opted out of the proposed \$4.75 billion global settlement of breast implant litigation and had trial dates scheduled during the opt-out period, which ended June 17, said Jim Jenkins, vp, secretary and general counsel of Dow Corning.

Dow Corning decided to settle rather than pursue trials during the opt-out period, he said. Terms of the settlements were not disclosed.

More than 12,000 women chose not to take part in the global settlement, casting doubt on its viability (BI, July 18; Sept. 13, 1993).

Crackdown on debts to Lloyd's

LONDON—Lloyd's of London is going to crack down on thousands of members who can pay their losses but refuse to do so.

Next month, Lloyd's Council will vote on a report on debt collection from dissenting members being drawn up by Bernard Bradford, a retired banker formerly responsible for reducing bad debts at National Westminster Bank, and Philip Holden, partner at law firm Dibb Lupton Broomhead.

Lloyd's Chief Executive Peter Middleton and Chairman David Rowland said last week that they don't know the extent of the problem. But, Lloyd's has reported that 661.6 million pounds (\$1.02 billion) of the Central Fund's 904 million pounds (\$1.39 billion) was earmarked at the end of last year to pay unrecovered losses (BI, May 23).

"We will be fair as we can possibly be to those who have demonstrated their willingness to pay but can't. But we wish to be as firm and determined to those who have demonstrated an unwillingness to pay but can," said Mr. Rowland.

Mr. Rowland also announced last week that he would extend his chairmanship for another year after his contract is up December 1995. Deputy Chairman Richard Keeling will step down at year end.

Shell charge covers explosion

HOUSTON—Shell Oil Co.'s chemical operation took a \$233 million second-quarter special charge, largely due to losses from an explosion at a thermoplastics plant in Belpre, Ohio.

A spokesman said the charge was expected to cover restoration of the damaged units and claims related to the May 27 explosion. Asked about insurance, Bill Thompson, Shell's manager of investor relations, would say only that some of the damage is covered.

Shell is a member of property insurer Oil Insurance Ltd. and its affiliate, liability insurer Oil Casualty Insurance Ltd.

It was not clear how much of the charge was explosion-related because the charge also includes the writeoff of idle assets and losses from the sale of Agripro Biosciences Inc., a seed business.

The Belpre plant explosion killed three workers and disrupted production at the plant for months (BI, June 6).

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Broker results looking up

New business helps increase first-half revenues, profits

By SALLY ROBERTS

Brokers cite strong new business growth as a major catalyst behind improved earnings in the first half of 1994.

In addition, higher rates on coastal property boosted first-half revenues at many brokers.

All but one of the seven publicly held insurance brokers reported increases in both gross revenues and net income for the first six months of 1994; Alexander & Alexander Services Inc. was the lone exception. In fact, all but two of the brokers reported double-digit increases in profits: Arthur J. Gallagher & Co. reported an 8.3% increase, while A&A reported a \$6.6 million loss.

Despite the lingering soft commercial property/ca-



1st Half

sualty market, brokers aggressively pursued new business during the first half.

"Two to three years ago, we didn't focus on new business," said Robert H. Hilb, president of Glen Allen, Va.-based Hilb, Rogal & Hamilton Co.

At times, brokers "try to find excuses not to do things that we should be doing," he said. Now producers are focusing on producing and "it's working."

"Good new business was ahead of plan and solid retentions were better than expected" in the first half, noted Patrick G. Ryan, chairman and chief ex-

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Baxter, Armour in court seeking cover for AIDS fund

Tainted blood suit may settle

By MICHAEL SCHACHNER

CHICAGO—Baxter International Inc. and Rhone-Poulenc Rorer Inc. say they have reserves adequate to fund a \$140 million to \$160 million proposed settlement fund for hemophiliacs who say they contracted the AIDS virus from tainted blood-clotting medication made by the two companies.

Units of both companies, meanwhile, are still suing to get insurers to fund at least part of the proposed settlement. Any settlement

would have to be approved by U.S. District Judge John Grady in Chicago, who is overseeing the consolidated litigation.

Last week, the units—Baxter's Hyland division and Rhone-Poulenc's Armour Pharmaceutical Co.—and lawyers for a small group of hemophiliacs struck a deal that would pay as many as 6,000 hemophiliacs about \$25,000 to \$30,000 each.

Each person would retain the right to opt out of the proposed settlement and pursue claims individually. If more than 150 peo-

ple opt out, though, Baxter and Armour could withdraw their offer.

Besides Baxter's Hyland division, which is based in Glendale, Calif., and Collegeville, Pa.-based Armour, other defendants in the negligence suit were Miles Inc. of West Haven, Conn., Alpha Therapeutic Corp. of Los Angeles and the National Hemophilia Foundation.

Hemophiliacs have filed hundreds of lawsuits after contracting HIV in the early 1980s after tak-

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Senate action moves Superfund one step closer to reauthorization

By MARK A. HOFMANN

WASHINGTON—How the proposed Environmental Insurance Resolution Fund would be financed should become evident this week as the House Ways and Means Committee hammers out the funding portion of the Superfund reform bill.

Superfund reauthorization passed another major hurdle last Wednesday when the Senate Environment and Public Works

Committee approved S. 1834, its version of the reauthorization bill. The 13-to-4 vote came after the committee defeated an amendment that would have eliminated retroactive liability for polluters.

The Senate bill next stops at the Finance Committee, which must approve the tax portions of the measure. The committee has set no date to consider the bill.

On the House side, the Ways and Means Committee agreed to take up H.R. 3800, the House Su-

perfund reauthorization bill only after what several sources describe as arm-twisting by Democratic leaders anxious to give the White House a legislative victory.

Only several weeks ago, Chairman Sam Gibbons, D-Fla., had indicated that he was in no rush to deal with the bill because of lingering doubts about how effectively the Superfund program works (BI, Aug. 1).

Rep. Gibbons and other com-

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Deadline nears for surplus lines directories

Business Insurance will publish two directories in the Sept. 26 issue, which also will contain a Spotlight Report on the surplus lines insurance market.

One directory will list underwriting managers, managing general agents and surplus lines brokers. The second will list surplus lines insurers and insurers that specialize in writing excess liability coverages.

To be listed in the directory of insurers, surplus lines insurers must write at least 50%, or \$10 million, of their gross premiums on a direct, non-ad-

mitted basis; excess insurers must write at least 50% of their volume, or \$500,000, of gross premiums in excess liability insurance.

There is no charge to be included in the directories. Companies that wish to be listed must fill out and return a questionnaire provided by *Business Insurance*. Companies eligible to be listed in either directory that have not yet received a questionnaire should request one from Associate Directory Editor Kerry Dziubek at 312-280-3195.

The extended deadline for returning the questionnaires is Aug. 26.

Inside

• The idea of outsourcing some risk management functions should not scare risk managers, this week's editorial says. **PAGE 8**

• Japanese regulators are moving toward reforms that would give foreign insurers greater access to Japan's market, but the insurers say reform efforts are going too slowly and not far enough. **PAGE 17**

• A long-awaited House of Lords decision will make it harder for underwriters to void contracts. **PAGE 17**

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Risk managers would welcome federal oversight of self-insurance

By JOANNE WOJCIK



free from any regulation except that of their state of domicile.

Yet the NAIC, by way of its accreditation program, is in fact attempting to regulate risk retention groups, contends Mr. Waters. To become accredited, state insurance departments must meet certain criteria, including some involving substantive regulation.

Vermont was denied accreditation in 1993 because its laws did not conform to the NAIC model act on risk retention groups (*BI*, Sept. 27, 1993).

Typically states regulate risk retention groups as they would a licensed property/casualty insurer. Vermont, though, treated them as captives.

Since then, the state's law has been changed in ways that officials hope will assuage the concerns of the regulators (*BI*, July 11).

Still, if a compromise cannot be reached, lawmakers there and several members of the NRRRA are

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VAIL, Colo.—Captives and other self-insurance mechanisms eventually will be regulated by the federal government, while the traditional insurance industry will be able to choose between federal and state regulation, a group of risk managers predicts.

Such a dual system would be welcome because state insurance regulators have become an obstacle to self-insurance, the risk managers contend.

In fact, the National Risk Retention Assn. is one of several groups and individuals considering suing the National Assn. of Insurance Commissioners over its attempts to regulate risk retention groups.

"The NAIC cannot step in and override federal regulation," asserted Jay B. Waters, director of corporate risk management for Forest City Enterprises Inc. in Cleveland, during a panel discussion at the Colorado Assn. of Captive Entities' recent annual conference.

Under the federal Risk Retention Act, risk retention groups are

Will policyholders invest at Lloyd's?

New corporate capital fund explored

By ADRIAN LADBURY

LONDON—A Lloyd's of London managing agency plans to tap policyholder and institutional investments to launch a corporate capital vehicle to invest in its syndicates next year.

Cater Allen Syndicate Management Ltd. hopes to launch a \$20 million to \$30 million dedicated corporate capital fund, called Atlantic Syndicate Capital Ltd., that would invest in four of its five syndicates for the 1995 underwriting year.

The majority of the policyholder money will be provided by large U.S. industrial and commercial clients of syndicate 190. The syndicate, which will be renumbered 1235 next year, is a leading

Lloyd's underwriter of U.S. casualty and property risks.

The agency and its investment bankers say policyholders mainly are seeking an investment opportunity. They also are interested in the fund because it would allow them to "get closer to the management" of their risk.

Lloyd's does not object to the policyholder investments, a Lloyd's spokesman said. In fact, at least one Lloyd's policyholder, a shipowner, has put up money for syndicate investment, he said.

Cater Allen and other Lloyd's agencies are interested in the concept because it would give them a more stable and long-term capital base than the current system.

The managing agent has hired

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Keeping the faith

Faith Wohl touts benefits of telecommuting to work to employers, employees

By MARK A. HOFMANN

WASHINGTON—In just the last few months, fewer federal workers are heading south each morning on Interstate 270 from western Maryland to their offices in nation's capital.

And fewer federal workers are heading south each morning on I-5 toward Los Angeles offices.

Although the decrease is tiny, Faith A. Wohl believes it could be a harbinger of a potentially significant change in workplace patterns—the adoption of telecommuting by business and government.

As director of the Office of Workplace Initiatives in the General Services Administration, Ms. Wohl is heading up two critical work/family programs for about 650,000 federal workers.

Before taking that post in January, she had been director of workforce partnering at DuPont Co. and one of Corporate America's most influential advocates of family friendly workplaces.

She is the "very strong conscience of the field," said Fran Sussner Rodgers, chief executive officer of Boston-based consulting firm Work/Family Directions Inc.

Management resistance can wear work/family advocates down, but "after a little dose of Faith Wohl, no one ever doubts that their work is important and worth fighting for," said Ms. Rodgers.

At Wilmington, Del.-based DuPont, Ms. Wohl helped create family leave, child care and elder care programs and flexible scheduling.

Upon her retirement last November, DuPont's senior vp-human resources, John D. Ogden, praised her for understanding "the implications of the changing demographics of the U.S. workforce, and (realizing) that greater productivity and employee satisfaction would be achieved once the company formally recognized the need for all of us to balance our professional responsibilities against the very real demands of family life.

As head of the Office of Workplace Initiatives, Ms. Wohl is overseeing an effort to take federal workers off the interstate highways and put them on the information superhighway by way of four telecommuting centers near Washington.

Tragedy jumpstarted the program in January. It had just commenced in suburban Washington



Photo by Glenn McLaughlin

"If it gives one family a gift of four hours a week, that is wonderful."

when the Los Angeles earthquake struck Jan. 17. Within two weeks, three federal telecommuting centers were up and running.

"We were determined to use that opportunity as another way to test the value of telecommuting as a part of the federal workplace," she said.

She also wants to see telecommuting take root in the private sector as workers and managers struggle to meet the demands of the next decade.

Telecommuting affords scheduling flexibility, one facet of what Ms. Wohl calls the "whole issue of quality of life."

As housing prices drive employees further and

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Preventing insurer fraud

By SAMEERA KHAN

Crime bill contains anti-fraud measures

WASHINGTON—Legislation that would make defrauding an insurance company a federal crime is moving closer to passage in Congress.

The bill, which cleared the House-Senate conference committee earlier this month, is part of a larger crime bill that lawmakers are expected to approve this session.

H.R. 665, The Insurance Fraud Prevention Act, primarily targets

internal fraud, in which criminal acts like embezzlement could trigger an insurer's insolvency, rather than fraud perpetrated by policyholders, like filing false or inflated claims.

The measure calls for strong federal criminal and civil penalties against persons who are found guilty of committing internal fraud against insurance companies.

The law would make it a federal

crime to: misappropriate funds, premiums or money from an insurer; file false financial information and deceive insurance regulators about the financial solvency of an insurer; and obstruct or impede the proper administration of insurance regulation.

Violators would face up to 10 years in prison for these offenses, and up to 15 years if their actions

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Wellness weaknesses

A typical wellness program reimburses employees up to \$300 for:

- Blood cell counts
- Cholesterol tests
- Mammography
- Pap smears
- Prostate screening
- Routine physicals
- Sigmoidoscopy
- Urinalysis
- Well child & immunization

But experts say there is little guarantee of results if the program doesn't provide:

- Full coverage of services
- Behavioral risk programs like commercial diet plans and smoking cessation included
- Screening follow up to ensure that people get treatment or change their behavior



Checkup on wellness

Wellness programs not realizing full potential, report says

By DEBORAH SHALOWITZ COWANS

Many employer-sponsored wellness programs do not go far enough to prevent disease and may not be producing the savings in health care costs possible with such programs, a new report suggests.

Group or individual behavior modification programs are among the most successful ways to reduce health risk factors among employees, but many company wellness plans do not cover these

programs, the report shows.

Instead, employer-provided wellness benefits often cover routine physicals and blood pressure, cholesterol or other types of screenings.

These kinds of programs do not go far enough to really prevent disease, according to one of the report's authors.

"The one significant pitfall that this research uncovered is...you'll have companies offering screenings...and then not offer a follow-up intervention after the screening," stated Joe Gitchell, an

associate with Bethesda, Md.-based Corporate Health Policies Group Inc., one of two consulting firms that compiled the report.

The 440-page report, "Health Promotion & Disease Prevention Programs: Rx for the 1990s?" was published last month by Corporate Health Policies in conjunction with Marketdata Enterprises Inc. of Valley Stream, N.Y. The researchers interviewed employers, groups representing health care providers and wellness program vendors. The researchers also ana-

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Tainted

Continued from page 2

ing contaminated blood-clotting substances known as Factor VIII and Factor IX. These products were produced with plasma provided by thousands of blood donors. More than 200 of the suits are currently pending in the United States, Canada and Europe.

It is estimated that half of the 20,000 hemophiliacs in the United States alive at the time these products were being sold were infected with the human immunodeficiency virus. More than 2,000 have died of AIDS since then.

The defendant companies say they have lost only one of the dozen or so AIDS negligence cases that have gone to jury trials nationwide.

Baxter and Armour say the settlement was in the best interest of the companies, those infected with HIV and the families of those who have died from AIDS. "Establishing a settlement fund is in the best interests of all concerned and is preferable to protracted litigation," Armour said in a statement.

Meanwhile, Miles, Alpha and the hemophilia association chose

not to settle the suits.

"While some individuals, for good reason, may opt out, we feel this settlement is a good first step toward resolving this morass of litigation," said David S. Shrager of Shrager, McDaid, Loftus, Flum & Spivey, the Philadelphia law firm that represents the hemophiliacs.

The settlement does not depend on Armour and Baxter succeeding in their coverage action, said Mr. Shrager. "Solvency and coverage are not conditions of the settlement."

Both companies have liability insurance, though neither would offer much detail on insurance for the settlement.

Armour is in litigation and negotiations with its insurers, a spokeswoman confirmed. Details of the litigation were not available.

"At this point, all we can say is that we're adequately reserved for the settlement and we are continuing to negotiate and litigate with various insurers," a Baxter spokeswoman said.

One critical issue in the litigation is expected to be whether the AIDS negligence actions are product liability actions, which Baxter's insurers say were excluded under its commercial general lia-

bility coverage, or related primarily to services.

In February, Baxter filed suit in Los Angeles Superior Court seeking to force hundreds of liability insurers to defend and indemnify it against claims by hemophiliacs infected by the AIDS virus (BI, March 21).

That suit is still pending. Among the insurers named in that suit are: Zurich Insurance Co.; Columbia Casualty Co., a unit of CNA Insurance Cos.; American International Group Inc.; Chubb Corp.; Fireman's Fund Insurance Co.; The St. Paul Cos. Inc.; Lloyd's of London syndicates; and many foreign insurers.

"Zurich-American provided no coverage for this sort of claim against Baxter. Therefore we will not contribute to the reported settlement," said a spokeswoman.

A spokesman for St. Paul said his company "had only small layers of Baxter's coverage in 1984-1985, and 1985-1986, and we're not even certain whether Baxter's loss will reach our layers."

A spokeswoman for Chubb, which is based in Warren, N.J., also said coverage written for Baxter "in the late 1970s and early 1980s was high-level excess coverage that we don't expect will be reached." ■

Investing

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New York investment bank Houlihan, Lokey, Howard & Zukin to help raise up to \$30 million among major U.S.-based Cater Allen clients and institutional investors.

J.T. Atkins, managing director at the investment bank, said that the bank planned to distribute the preliminary prospectus for Atlantic Syndicate Capital Ltd. to interested investors last Friday.

If investors show minimum interest of \$20 million, the bank will start work on a more detailed prospectus in time for a September private placement to close in mid- to late October. As long as Lloyd's approves the project, Atlantic Syndicate Capital could be investing in Cater Allen syndicates in 1995.

All but one of the corporate capital vehicles launched at Lloyd's last year were structured as investment trusts that invested in a wide range of syndicates run by a variety of managing agents (BI, Nov. 8, 1993; Nov. 1, 1993).

The exception to the rule was Hiscox Dedicated, launched by managing agency Roberts & Hiscox Ltd., which invested only in its own syndicates. Other managing agents have publicly stated that they are investigating seeking dedicated corporate capital for 1995, but Cater Allen appears to be farthest down the road and certainly the first to claim strong policyholder interest.

"What is unique about our effort is that a lot of existing insurance clients of Cater Allen are very interested in participating in this project. A lot of Cater Allen clients are Fortune 500 companies and are very happy with their relationship with Cater Allen. When Robin Gilkes, chairman, and some of his managers first floated the

idea they got a very good response," said Mr. Atkins.

"Having to reconstitute the capital base every year is a nonsense. It's very difficult to run a company like that," said Mr. Gilkes. "Essentially, we are going back to the future. Twenty years ago, members took big limits and stuck with their syndicates year in, year out, so that in practice there was much greater continuity than today," he explained.

Lloyd's was disappointed by the amount of corporate capital that arrived from the United States in 1994, but this year will be different, Mr. Atkins said. Lloyd's received \$35 million in capital last year from three U.S. investment trusts.

"Last year, Bermuda was the place to invest in. This year I believe it will be Lloyd's; it's a better investment. Rates are up, capacity is now under control and there is no doubt that Lloyd's is a unique opportunity."

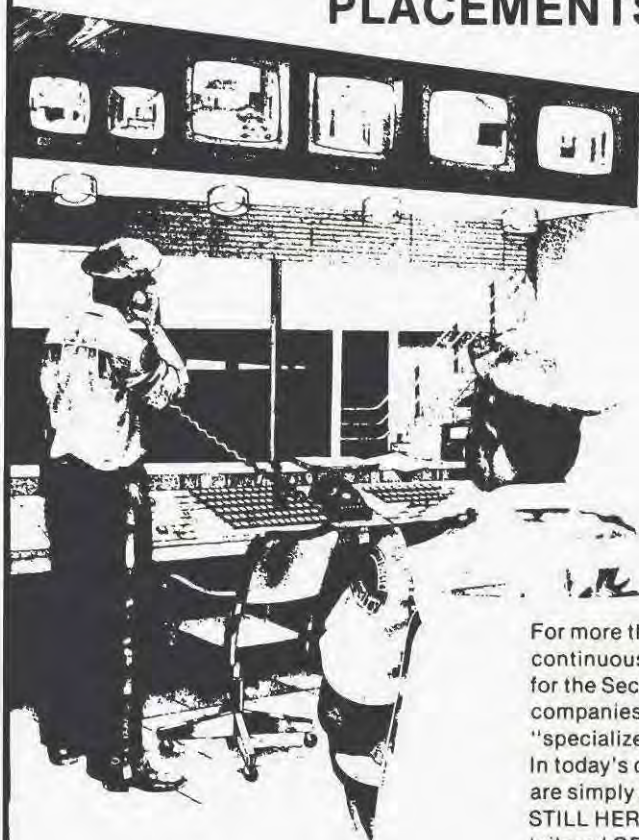
Mr. Atkins believes the dedicated route would be superior to the "broad brush" approach of an investment trust because it allows the investor to "get closer to the management and underwriter."

Atlantic Syndicate Capital, which would be a U.K.-based corporation, would invest 90% of its capital in equal amounts in Cater Allen syndicates 55, 190 and 322, with the rest in syndicate 375.

The fund would not have to remain dedicated, however. The trust's charter would allow it to invest 25% elsewhere, if desired, in 1996 and 1997. After that, it could invest in any syndicates.

"But we hope that Cater Allen syndicates will perform as they have historically and so we will remain with them. If they do not and the directors believe they are underperforming, then we would shift investment elsewhere," said Mr. Atkins. ■

A BRIEF MESSAGE ABOUT INSURANCE PLACEMENTS FOR



- Security Guards,
- Patrol Services,
- Detective Agencies,
- Armored Car Service,
- Alarm Monitoring and
- Alarm Installation

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For the Record

FELA permits suits for fear of AIDS

NEW YORK—Employees that come within a "zone of danger" of contracting AIDS at work—but do not actually get sick—can recover under the Federal Employers Liability Act for stress related to the fear of AIDS, the 2nd U.S. Circuit Court of Appeals ruled.

The unanimous ruling by a three-judge panel upholds a 1993 jury verdict that the Long Island Rail Road was liable for a worker's fear that he had contracted AIDS. Railroad worker John Marchica pricked his finger on a used hypodermic needle and was ultimately awarded \$126,000 (BI, May 10, 1993; March 1, 1993).

"This is quite important for railroad workers and employers. It says emotional injuries are actionable under FELA so long as there's a common law zone of danger, which is roughly defined as a reasonable immediate risk," said James Ruane of Altier & Barasch, the New York law firm that represented Mr. Marchica.

FELA enables workers not covered by workers comp to recover in cases of employer negligence.

CGL policy excludes 'predictable' pollution

NEW ORLEANS—Commercial general liability policies do not cover damage from pollution that predictably results from deliberate action, the 5th U.S. Circuit Court of

Appeals has ruled.


The pro-insurer ruling last week upheld a lower court ruling that Meridian Oil Production Inc. was due no coverage from Hartford Accident & Indemnity Co. for a \$5.4 million jury award. That award came in a suit by an Oklahoma man whose land was contaminated when Meridian ruptured a water purifier while drilling an oil and gas well.

Equating Meridian's actions to a "reckless driver who careens down a busy street while blindfolded and later claims he had good intentions but didn't see the stop signs," the court said the damage could not be considered unexpected. CGL policies exclude coverage for damage from pollution that is not "sudden and accidental."

The court also rejected a claim by Meridian, an El Paso Natural Gas Co. unit, that Hartford Accident failed acted in bad faith.

Information in brief

EPA Administrator Carol Browner has revealed a plan to change the way the EPA regulates six industries. Under the plan, industry representatives will participate on special teams that will emphasize pollution prevention in particular industries rather than regulation of specific pollutants. The industries include automobile, electronics and computers and iron and steel making. . . Georgia Insurance Commissioner Tim Ryles recently won a four-way Democratic primary. Republican John W. Oxendine was unopposed and will face Mr. Ryles in November. ■

A still life painting featuring a brown and tan patterned snake coiled on the left side, its head facing right. On the right side, there is a vibrant red apple with a short stem and several green leaves. The background is a dark, muted green. The entire scene is framed by a dark, textured border.

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Experimental treatment information sought

Most benefits professionals have faced employee health claims for experimental medical treatments and would like to see an independent agency created to determine whether those procedures should be considered experimental, a new survey finds.

Sixty-one percent of benefits professionals said that participants in their plans have either requested coverage for an experimental treatment or have filed a claim for experimental services already rendered, according to the International Society of Certified Employee Benefit Specialists of Brookfield, Wis.

Sixty-nine percent of the 564 respondents said they would welcome a new technology assessment agency to determine which procedures are experimental and, therefore, would not be covered.

Melody A. Carlsen, associate director of research for the International Foundation of Employee Benefit Plans, which co-sponsors the CEBS program with the Wharton School at the University of Pennsylvania, was surprised by "how widespread an issue this is among group health plans."

And, the apparent support for a new agency pointedly underscores the guidance that plans need in assessing which treatments to

cover, she said.

Sixty percent of those surveyed represent self-funded plans, which have traditionally been "very adamant" about maintaining control over plan decisions, said Ms. Carlsen. "I think this (survey result) makes a pretty important statement of how confusing an issue this is."

Ms. Carlsen said she envisioned such an agency combining the efforts already underway by various groups, like the National Cancer Institute and the American Medical Assn., to evaluate the effectiveness of medical treatments that some consider experimental.

Currently, 76% of the largest plans with which the respondents are associated exclude coverage for experimental treatments, while 8% do not. In the other cases, respondents were unsure whether coverage was excluded.

The plans base their determinations of what is experimental on various criteria, with some plans using more than one criterion: 37% defer the determination to a recognized independent third party, like the American Medical Assn.; 34% rely on opinions in

Benefit Beat

medical journals; another 34% tie their exclusions to factors like whether the treatment is still undergoing clinical trials; and 21% defer to a named group of medical experts, like a local board of practitioners.

The survey found that 18% of plans specifically name the procedures that are excluded. Among those plans, 37% exclude high-dose chemotherapy with autologous bone marrow transplant, a controversial breast cancer treatment that has spawned numerous coverage lawsuits.

Still, 19% of plan sponsors have covered the cost of experimental treatments outside of their group health plans, the survey found. The respondents did not explain why.

A free copy of "Group Health Exclusions for Experimental Procedures" is available from the IF-EBP's public relations department at P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6710, ext. 219.

—By Dave Lenckus

Minnesota savings

Market competition among managed care plans in Minnesota is dramatically reducing the state's employee health plan costs, according to data on Minnesota's 1995 health plan renewals.

Five out of six health plans offered to nearly 60,000 state and University of Minnesota employees and their dependents will increase rates by 1% or less, and one plan is decreasing its rates by 25%. The remaining plan is raising rates by 6.3%

By contrast, average health care cost increases for 1995 are expected to be about 8% for most Minnesota health plans, according to estimates by the benefit consulting division of Deloitte & Touche in Minneapolis.

Kathleen Burek, acting manager of the State Employee Insurance Program, said 1995 marks the sixth year in a row that the state's health care cost increases have been significantly lower than the national average.

Barring any change in health

plan enrollment, Minnesota will save at least \$3.7 million in medical care costs, she estimated. The state spends about \$144 million annually on medical care for employees and dependents, she said.

The low renewal rates are not due to alterations in benefit plan design or changes in employee demographics, Ms. Burek said. Rather, she attributed the state's success to its strategy of tying employer contributions to the lowest-cost health plan available to employees in a given region.

"We have a proven system in place for encouraging plans to keep their rates low," she said. The state pays all of the cost for single coverage for employees who select the lowest-cost plan in the county where they work.

Because so many employees choose the low-cost plan, all health plans compete to offer the lowest rates, she said.

For example, Medica Premier, a gatekeeper model HMO, formerly was the highest-cost plan in the Twin Cities area. But, with its 25% rate reduction for 1995, it will become the low-cost plan, replacing Group Health, a staff model HMO in the Twin Cities. Medica Premier also will replace the state's self-insured health plan as the low-cost plan in 19 counties outside the Twin Cities area.

The state offers two other group model HMOs—Medica Primary and MedCenters—as well as a small HMO in Two Harbors, Minn., called First Plan HMO.

Employees will have the opportunity to switch plans during the state's open enrollment period this October. Medica's 25% rate reduction may cause a major shift in enrollment, Ms. Burek predicted.

—By Christine Woolsey

More Delta job cuts

ATLANTA—Delta Air Lines is planning to eliminate 4,500 full-time jobs, or more than 20% of its Airport Customer Services division.

The cutbacks are part of its overall campaign to eliminate 12,000 to 15,000 jobs by June 1997 (BI, June 20; May 30).

A Delta spokesman said em-

ployees first will be given a choice of taking an enhanced early retirement, leave of absence or flexible voluntary severance plan before the airline makes cuts to reach its goal of eliminating 4,500 positions. The company expects to make these additional staff cuts between mid-October and the end of the year, he said.

Employees in Delta's Airport Customer Services division are responsible for baggage and cargo handling, administration, staffing ticket counters and fueling planes, the spokesman said.

—By Judy Greenwald

California EAP

SACRAMENTO, Calif.—California is now offering its more than 160,000 state employees and their dependents the nation's largest employee assistance program served by a single vendor.

The new program, which became effective July 1, is provided by Medco Behavioral Care Corp. of South San Francisco and will run for at least three years.

Under the program, which offers state employees in about 40 California counties access to about 3,000 EAP specialists, state workers and their families can obtain a wide range of EAP services from Medco-affiliated behavioral health care professionals, including counseling designed for multicultural populations and uniformed personnel. Certain state employees located outside California will be eligible to participate.

Bob Clifford, assistant chief-benefits and training division within the state's department of personnel administration, said the state chose Medco from an open bid process.

"The contract went up for bid and Medco offered the best price. We really don't have any experience with them, but there's a certain amount of good faith one has in entering into a contract like this. We're confident their assessment and referral capabilities will meet our needs," he said.

Prior to entering into a deal with Medco, the state contracted with Occupational Health Services for EAP services.

—By Michael Schachner

August 22

a red letter day
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Crime

Continued from page 3

jeopardized the financial stability of an insurance company and rendered it insolvent. Courts also could impose fines of up to \$50,000 for each offense under the act.

The Fraud Prevention Act also would impose penalties on people convicted of a felony involving dishonesty or a breach of trust who later willfully engage in the business of insurance. Anyone who permitted such a person's participation in the business of insurance could also be fined or imprisoned for up to five years.

Under the act, only those individuals convicted of such felonies who later receive written consent of an authorized insurance regulator would be allowed to engage in the business of insurance.

The insurance industry, which has lobbied long and hard for this federal law, is intent on seeing it passed.

Dennis Jay, executive director of the Coalition Against Insurance Fraud in Washington, said the

legislation is partly a result of the five years of hearings conducted by House Energy and Commerce Committee Chairman John D. Dingell, D-Mich., who sees a recurring link between insurer insolvencies and insurance fraud.

"Overall, this is a much-needed law. It will send a signal that this type of white-collar crime will not

'Making the law is one thing, but effectively enforcing it makes all the difference,' says Tom O'Day.

be tolerated and is not a victimless crime," said Mr. Jay.

While the federal government should not be involved in investigating day-to-day insurance fraud cases, a federal law will help crack down on cases involving bogus insurers, he said. So far, state statutes mainly determine what is considered insurance fraud.

"Every time there is a bogus insurance company out there, it erodes consumer confidence in the insurance system in this country," Mr. Jay said.

Jim Long, North Carolina's insurance commissioner and former president of the National Assn. of Insurance Commissioners, said the legislation would give more power to state regulators and broaden their ability to combat insurer fraud.

The Fraud Prevention Act will fill the gaps between the various state laws and strengthen a regulator's hands by bringing indictment at the federal level and making trials speedier, he said. In the federal system, unlike the state system, no parole is available, a feature that meets with Mr. Long's approval.

However, Tom O'Day, associate vp of the Alliance of American Insurers, said he thinks a lot of existing laws at the federal and state levels can be used to combat insurance fraud. "The issue is that of enforcement. Making the law is one thing, but effectively enforcing it makes all the difference," he said. **EI**

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Opinions

Making outsourcing work

OUTSOURCING.

The "O" word tends to inspire fear and loathing among risk managers. It conjures up images of entire risk management departments from top to bottom being unceremoniously dumped and replaced by the very outside advisers who used to serve them.

But is the reality as awful as such stories would lead one to believe? We think not.

Certainly there are cases of risk management staff—and, in some cases, risk managers—being replaced by an outside consultant or broker. It's been the consequence of downsizing forced by managements seeking to control costs and increase profits. It is occurring throughout corporations, largely in areas that depend on professional services, such as accounting, legal, pension administration and so on. In other areas, it's simply called layoffs.

But, as several observers said in our Aug. 1 Spotlight report on risk management, those instances in which a risk manager was replaced by an outside adviser are typically short-term situations while a permanent replacement is sought.

"People tell me they have been laid off due to outsourcing, but even though I don't tell them this, I already have a search assignment from their former employer," said the head of an executive search firm specializing in risk management.

If it were otherwise, we would be among the first to declaim hiring outsiders to run a risk management department. While such service providers may have the skills to perform the job, no outsider has the same firsthand knowledge of a company's dynamics and risks, nor the same sense of purpose in protecting its assets, as the risk manager.



Brokers and consultants seeking to provide outsourcing services to risk management staff must recognize that strong risk managers are critical to the success of their efforts and are best positioned to coordinate their help where it is needed most. If these advisers are not working with a strong risk manager with adequate support staff, the program will suffer and they'll pay the price by losing the account.

It also is incumbent upon risk managers to make that point to their superiors, to improve how risk management is viewed in their organization and to prove their own worth.

Letters

ARM exercise slights talents of aging workers

To the editor: I was very disappointed to read the ARM Exercises article "Limiting Losses from Aging Workers" in the July 11 issue of *Business Insurance*—all the more so because the authorship was shown as the Insurance Institute of America, which I have always associated with academic excellence.

The article links aging with decreased productivity even though the question doesn't state that the veteran artists and designers are less effective. In fact, the reverse is generally true: Older workers are usually more productive and more efficient than their younger counterparts.

I had hoped that such stereotypical generalizations were consigned to the editorial wastebaskets. I think a retraction is called for. The article doesn't meet the standards of the Insurance Institute of America.

Jerome Trupin

Trupin Insurance Services
Scarborough, N.Y.

George L. Head, vp of the Insurance Institute of America, responds: You are quite correct that the July 11 ARM Exercises should have made clear that older employees are often more valuable and productive than younger ones. In fact, it is precisely because veteran employees' contributions are so vital to many organizations' success that any factor that threatens

this contribution becomes an increasingly important hazard for these organizations.

Your point would have strengthened the central theme on which the ARM examination for this "exercise" focuses. As a group of highly prized employees advances in age, no matter how productive they may now be, the day grows nearer when an employer must recognize that their eventual departure from the organization—for whatever reason—is likely to impose significant losses on that organization. The ARM study material notes that, ideally for everyone, each employee's retirement should occur just before his or her job skills and productivity decline significantly. However, if this ideal timing cannot be achieved, the employer becomes more directly threatened by the kinds of losses described in the July 11 exercise.

This particular ARM exam question did not give the average age of the firm's art-

ists and designers. If their average age is 65, it certainly is correct to emphasize these employees' continuing value more than the possibility that their skills may have already declined. If their average age is 90, however, it is time to give close attention to the losses that their continuing employment would probably bring to both employee and employer. Can we also agree that, somewhere between age 65 and 90, the increasing average age of any organization's workforce becomes a growing risk management concern? If you will grant this, I will agree in return that there may be some exceptionally vigorous artists or designers age 102 who, if they wish, should remain in this company's workforce. From my personal perspective at age 53 and as a three-year member of the American Assn. of Retired Persons, I hope to be one of these. I suspect, Jerry, that you hope to be one, too.

More false memory suits to come

To the editor: It was heartening to see the article on false memory syndrome (*BI*, June 27).

In my opinion, only the tip of the litigation iceberg is now apparent. Being a psychotherapist myself who has managed the inpatient and outpatient care of more than 3,000 individuals under the care of several hundred providers, I have too often seen functioning human beings debilitated by well-meaning therapists.

The caveat is not the credential of the therapist but rather the approach to therapy that is critical in creating false memories. Therapists who believe one must recall all childhood trauma and "abreact"—that is, relive the trauma—are the most likely to create false memories.

This is especially true when part of the

therapy is for the client to read one of the several "survivor" books on the market and when imagery and hypnosis are used as "recovery" techniques.

Though I have observed more therapists in lower levels of training using these techniques, there are also many at the highest levels of training—including those with Ph.D.s and M.D.s—using such techniques.

At my practice, we believe the risk of iatrogenic damage by such therapists is sufficient that we will not knowingly provide coverage for such treatment.

Douglas Mould, Ph.D.

Clinical Director
Preferred Mental Health Management
Wichita, Kan.

Letters continued on page 10

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THURSDAY, OCTOBER 20, 1994

- Registration & Continental Breakfast
- NEW INITIATIVES FOR CONTROLLING WORKERS COMPENSATION HEALTH CARE COSTS
- DISABILITY MANAGEMENT
- LUNCHEON SPEAKER - ALLEN IAMPAGLIA, RISK MANAGER, CITY OF GLENDALE, ARIZONA
- EMPLOYER CASE STUDIES
 - ▶ IN-HOUSE CASE MANAGEMENT WORKS
 - ▶ CARPAL TUNNEL SYNDROME CASES DON'T HAVE TO COST AN ARM
 - ▶ THE TRUTH AND CONSEQUENCES OF COMBATTING FRAUD
- FINANCING ALTERNATIVES FOR WORKERS COMPENSATION: HOW TO EVALUATE AND DECIDE WHICH FINANCING METHOD IS RIGHT FOR YOUR COMPANY
- Reception

FRIDAY, OCTOBER 21, 1994

- Continental Breakfast
- DEALING WITH CONTESTED CLAIMS
- CUMULATIVE TRAUMA DISORDERS: CONTROLLING THE WORKERS COMPENSATION MONSTER
- ESTABLISHING AND MANAGING THE CLAIMS AUDIT PROCESS
- LUNCHEON SPEAKER - DOUGLAS MCCOY, RESIDENT VICE PRESIDENT, COMMERCIAL LINES, THE TRAVELERS CORPORATION
- APPLYING TOTAL QUALITY MANAGEMENT TO WORKERS COMPENSATION: UTILIZING BENCHMARKING TO STREAMLINE THE WORKERS COMPENSATION PROCESS

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Letters

High court review may increase sale of bank annuities

To the editor: American consumers and businesses are well served by the Supreme Court's decision to review the 5th Circuit's ruling barring federal banks from offering annuities (*BI*, June 13). The 5th Circuit ruling is inconsistent with the weight of authority that annuities are not insurance contracts. Further, uniform application of the principle underlying the 5th Circuit ruling that annuities are not "necessary" to banking and therefore not allowed would result in

an inflexible American banking system unable to change in response to customers' changing needs.

An annuity is an investment contract that may be but is not necessarily associated with an insurance contract. A retirement annuity offered by an insurance company is not an insurance contract. It does not involve a pooling of pure loss exposures and does not involve a guarantee or indemnity of loss. Payment of an annuity is not triggered by, or conditioned upon, a loss. Indeed, an annuity contract is the complete opposite of an insurance contract in that it involves speculative risk as opposed to pure risk and is designed to liquidate the principal and interest of its subscribers, whereas an insurance contract is designed to accumulate a principal sufficient to pay all losses of its subscribers. While the maturity date, payout period and

amount of an annuity may be based on life expectancies and rely on the actuarial underpinnings of life insurance, payment is triggered not by a loss but by reaching a specified maturity date.

A March 10, 1994, opinion by the New York Court of Appeals, *New York State Assn. of Life Underwriters Inc. vs. New York State Banking Department, et al.*, was with the weight of authority on this issue, citing similar principles in distinguishing insurance from annuities. More importantly, the court found that the term "necessary" should be afforded a flexible meaning, pointing out that necessity in the conduct of business affairs and the execution of express powers is not an absolute. Rather, there is usually more than one mode of executing an express authority. No one mode can therefore be considered an indispensable necessity in

the exercise of express powers.

It is not in the public interest to impede the ability of banks to adjust rapidly to changes in the demand and expectancies of their customers for investment and credit services.

Fortunately for New York consumers, the March 10, 1994, opinion in New York is further founded in specific provisions of New York law, which are absent in federal law to which the 5th Circuit ruling applies. Therefore, annuities are expected to become increasingly available to customers at state chartered banks throughout New York state. This growing opportunity for New York banking customers will hopefully not be adversely affected by the Supreme Court review, though the review could produce the same benefit for banking customers nationwide as is now available in New York.

The writer is both a public mem-

ber of the New York State Banking Board, New York's bank regulatory agency, and president of the New York Chapter of the CPCU Society. The opinions expressed are those of the writer and not those two organizations.

Lindsay Newland Bowker
New York

Negative attitude toward 'child-free'

To the editor: Your July 25 article "Family Perks of No Benefit to Many Employees," in itself reflects the negative attitude toward employees who have no children.

I am single and never have I considered myself "childless." Rather, I think of myself as "child-free."

Julie Cole
LaPorte, Ind.

MEWA

Continued from page 1

cease-and-desist order against the GIADA plan and Mr. Vaughan's firm in 1991, two months before the MEWA failed.

The Atlanta suit alleges that Mr. Vaughan, as president and primary shareholder of DAP and affiliates Dealers Insurance Co. and Dealers Underwriting Services, grossly misrepresented the health plan he sold to the 658 members of the independent car dealers association.

Mr. Vaughan and DAP, the suit alleges, subsequently mismanaged the program into its ultimate ruin, along the way reaping millions of dollars in profits.

Specifically, the suit alleges that Mr. Vaughan lied about his ERISA expertise when selling the plan, failed to do actuarial studies once the plan was established and breached his ERISA fiduciary duties by allowing plan finances to deteriorate so that no legitimate reinsurers would cover the plan.

The plaintiffs are asking Judge Evans to certify the suit as a class action that would encompass all of the hundreds of plan beneficiaries with unpaid claims.

At the heart of the suit are allegations that the fees and commissions collected for various administrative, brokerage and reinsurance services were excessive and concocted to generate income for the Vaughan network of companies.

As a fee for administering the plan, DAP charged 17% to 19% of the plan's contributions. The suit labels these fees "excessive," and accuses Mr. Vaughan of "unjustly" profiting by having Dealers Underwriting Services collect a 10% brokerage commission for placing GIADA's reinsurance with Delphi International Insurance Co., a Cayman Islands firm created, owned and op-

erated by Mr. Vaughan.

The suit states that Delphi charged high premiums and Mr. Vaughan had an incentive to deny claims that would have to be paid by Delphi. The suit asserts that Delphi was only created to give the impression that there was real reinsurance behind the MEWAs administered by Mr. Vaughan.

Delphi, court papers suggest, was put together in 1987 with help from Costas Takkas, who has long been affiliated with people with regulatory problems in the United States and the Caymans. Since its inception, Delphi has been managed by Mr. Takkas, formerly of Delta Management Ltd. and now a director with International Insurance Management Corp.

In a letter to Mr. Vaughan, David Woodard, a London intermediary who brought Messrs. Vaughan and Takkas together, noted that Delphi was established very quickly with the help of Mr. Takkas and Gilbert Connolly, then deputy superintendent of insurance. Mr. Connolly later became Cayman's superintendent of insurance, but now faces criminal corruption charges for allegedly accepting favors from the principals of suspended Olympus Fire & Casualty Ltd., which was also managed by Mr. Takkas (*BI*, Feb. 14; Sept. 20, 1993).

In response, Mr. Takkas said in an interview that he has had no contact with "the people in Orlando" for more than a year. "I don't believe the officers of Delta did anything wrong." He declined to comment further.

John Darwood, Cayman's deputy inspector of insurance who took over for Mr. Connolly earlier this year and was not on the island during Delphi's run, said Delphi was suspended in June 1993 for failing to provide statutory reports. He acknowledged that the government's file on Delphi "is somewhat lacking

in documentation and reporting information." An investigation into Delphi is under way, he added.

In response to allegations of impropriety in using Delphi as a reinsurer, Harrison Slaughter, a partner in the Orlando firm of Leventhal & Slaughter, which represents Mr. Vaughan personally, said by the late 1980s self-insured MEWAs had become such poor risks that reinsurance was either unavailable or overly expensive.

"The reinsurance rates this plan had were going to go up by 47%. Even though it wasn't set up for reinsuring MEWAs, Delphi was used with all good intentions. The idea was to save this plan and others like it," Mr. Slaughter said.

In various filings, Mr. Vaughan's lawyers say he performed all his fiduciary functions related to the cre-

is untrue. I can think of at least two instances where Vaughan recommended a contribution increase and they put in more than he asked for," said Mr. Gross.

The lawsuit points out that the GIADA plan did not suffer a unique fate in the hands of Mr. Vaughan. According to court papers, the GIADA plan is but one of 11 similar MEWAs that Mr. Vaughan set up during the late 1970s and 1980s that has since failed either under Mr. Vaughan's administration or shortly after trustees removed him as a TPA. Only one Vaughan-controlled MEWA—the Independent Auto Dealers Assn. of California—is still viable.

"This plan is running fine because it has received the necessary financing," asserts Mr. Slaughter.

Meanwhile, nothing is running fine at the Carolinas Independent Automobile Dealers Assn. Plan, which covered the employees of North and South Carolina dealerships. It was taken over by the North Carolina Insurance Department in 1992, some \$450,000 behind in claims.

The Carolinas plan was "insolvent from its inception in 1985," said Alex Spencer, senior deputy commissioner with the North Carolina department. "It never had proper funding." He said Mr. Vaughan was removed as a TPA in 1990.

To pay claims, North Carolina regulators have assessed plan members. Some dealers have paid voluntarily, while others have resisted and now face legal action by the Insurance Department. The plan currently has less than \$60,000 in assets.

So far, the regulators have failed to pin any of the responsibility for that failure on Mr. Vaughan. "We've dug into this, but haven't found anything to go after him on. All his business has looked legitimate to us," said Joyce Stevens, a regulatory specialist with the North Carolina department.

The Florida Insurance Department has also taken regulatory action against Mr. Vaughan and DAP on at least two occasions. In April 1988, Florida regulators found DAP to be administering MEWAs without a certificate of authority. A state court judge later ordered DAP to obtain that certificate, and DAP ignored the order, said Bob Prentiss, a lawyer with the department.

Thus, in November 1992, the Insurance Department issued an order to show cause against DAP, charging the company with operating without a certificate of authority for several years despite the court's order. In addition, the state said DAP's oversight of the GIADA Plan was in violation of a statute prohibiting an unauthorized Florida company from doing business out of state.

'MEWAs are self-fulfilling prophecies of failure,' says Harrison Slaughter.

ation and administration of the GIADA plan, and it is the plan's members, not Mr. Vaughan, who are ultimately responsible for the failure.

"Our legal position is that as a TPA, Mr. Vaughan handled this book of business properly. His ownership of Delphi did not cause this plan to go under," Mr. Slaughter said.

"If you look at MEWAs, they're self-fulfilling prophecies of failure. They could never be capitalized enough to pay for all the sick people they hoped to cover.

"These people should have pursued another form of insurance," Mr. Slaughter said.

"The basic flaw with MEWAs and the reason why so many have gone bankrupt is that members aren't willing to assess themselves the necessary amount to make them work," added Dave Dunlap of Pennington & Haben in Tallahassee, Fla., which is representing DAP as a corporate entity. "The fault lies with the auto dealers, who were unwilling to bite the bullet and bear the expense of operating this type of plan."

Andrew Gross, a partner with Slater, King & Gross in Atlanta, which represents trustees of the plan, said assertions by Mr. Vaughan's lawyers that the plan's sponsors are responsible for the MEWA's failure because of insufficient financing are "flat-out wrong."

"The trustees relied entirely on Vaughan. They did what they were advised to do and any claim that they rejected Vaughan's recommendations for increased contributions

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OMSTRAK

Continued from page 1

Ilya Bond, OMSTRAK's corporate affairs director, reacted angrily to the California department action, calling it "insulting." He said the company would protest to Russian diplomats in the United States.

"It's a very draconian action, which is typical of this department," Mr. Bond said.

"This type of commerce is exactly what Washington is trying to promote," he added. "We are trying to increase trade and cooperation between two peoples that have had missiles pointed at each other."

Mr. Bond said that OMSTRAK is not widely known because it was only recently licensed in Russia and because it has deliberately kept a low profile to avoid antagonizing competitors in the Russian market.

OMSTRAK, also known as First Ossetian International Insurance Co., began operating earlier this year from an office in Beverly Hills that Mr. Bond describes as a branch of its Moscow headquarters.

OMSTRAK officials in this office include:

- John Lepire, president of OMSTRAK's U.S. division.

His California broker's license was revoked in 1990 and reissued on a restricted basis after regulators found that his partnership, LRO Insurance Services, had placed business with two non-admitted insurers without a surplus lines license.

Separately, a company operating from Mr. Lepire's office suite last year solicited auto insurance for the now-defunct Association Insurance Co. Ltd., a Cayman Islands insurer run by Anthony J. Damoulis. At the time, Mr. Lepire denied producing business for AIC (*BI*, Sept. 20, 1993).

- Roman Gorodnitsky, an OMSTRAK director.

Mr. Gorodnitsky and Mr. Bond previously operated Greater Indemnity & Casualty Insurance Co. Ltd., a company based—but never actually licensed—in the Turks & Caicos Islands, according to Insurance Department documents.

The California department barred Greater Indemnity last year after it was unable to confirm the value of

its assets or the existence of a trust account for U.S. policyholders.

A large portion of Greater Indemnity's assets consisted of stock in its parent company, LA Entertainment Inc. The parent later changed its name to Gerant Industries Inc. and has since filed for Chapter 11 bankruptcy protection.

Greater Indemnity also reported a policyholders trust account containing LA Entertainment stock, held by Burns Philp Trustee Co. (Canberra) Ltd., an Australian firm. Burns Philp (Canberra) has since been placed in receivership.

Mr. Bond blamed Greater Indemnity's failure on its California surplus lines brokers.

Calls to Mr. Gorodnitsky and Mr. Lepire were referred to Mr. Bond and to John Sebastianelli, a San Francisco lawyer who declined comment.

In a liquidation petition filed against Greater Indemnity in June, the California department notes that Mr. Gorodnitsky and Mr. Bond are also directors of America Pacific Insurance Co. of New Zealand.

In addition to its previous role as a 100% reinsurer of Greater Indemnity, APIC is also the founding minority partner of OMSTRAK, according to a March 31 OMSTRAK

financial statement obtained by *Business Insurance*.

OMSTRAK's 51% majority partner is Sadonsky Lead-Zinc Group of Enterprises, also known as Kombinat, a mining corporation controlled by the government of the Russian republic of North Ossetia, the financial statement says.

The insurer's corporate history is somewhat complex: OMSTRAK was registered as a Russian-American joint venture in North Ossetia in December 1993, the statement said.

Earlier this year, the insurer was made a subsidiary of a newly formed Nevada holding company, also called OMSTRAK, of which Valentin Gutnov, a Moscow-based OMSTRAK official, is president and Mr. Gorodnitsky is secretary. The Nevada corporation was created from the Chapter 11 bankruptcy reorganization of Weaver Arms Corp., a California company, the statement reports.

OMSTRAK was issued an insurance license by the federal insurance regulatory service of Russia on June 17, "valid on the territory of (the) Russian Federation," according to company documents.

OMSTRAK's original incorporation documents say the company was formed with a "charter fund" of

\$209.8 million, including:

- \$108.6 million in lead and zinc ore and mining rights contributed by Kombinat and representing a 51% stake in the company.

- \$101.2 million in "monetary, intellectual and real property" contributed by APIC and representing a 49% stake. This property is not further described in the statement.

However, a March 31 balance sheet, audited by The Lebowitz Accountancy Corp. of Los Angeles, reports total assets of only \$112.1 million for the Nevada holding company and its insurance subsidiary.

This total includes \$108.6 million in Kombinat mineral rights; \$2.6 million in stock of America Pacific Group, APIC's parent; and \$25,000 in cash. The statement also refers to "trademarks, patents, intellectual properties, computer programs and equipment" contributed by APIC, though the balance sheet does not show the value of these assets separately.

The statement also reports that APIC may act as a fronting insurer for OMSTRAK in the United States and may provide quota-share or excess-of-loss reinsurance for the Russian company.

OMSTRAK promotional material

projects that it will write nearly \$50 million in earned premiums in its first two years of operation, achieving profits equal to 16.2% of revenues on a mix of commercial and personal property/casualty insurance and reinsurance business.

Coincidentally, APIC projected exactly the same mix of business and profit margins in its own promotional material.

Mr. Bond could not be reached for comment on the OMSTRAK financial statement.

In an earlier interview, he said OMSTRAK had \$119 million in initial capital, mainly from the republic of North Ossetia and consisting of government-guaranteed leases, mineral rights, equipment and real estate. He also said the 49% minority stake in OMSTRAK is held by "20 or 30" international shareholders.

Along with its property/casualty business, OMSTRAK may also write life/health coverage, Mr. Bond said, adding the insurer is in the process of setting up a trust account for U.S. policyholders that may contain real estate, marketable securities, bonds or Treasury bills.

Meanwhile, he said, the insurance company will fight the California cease and desist order. **BI**

Worker seeks review of state disability ruling

By DAVE LENCKUS

ST. PAUL, Minn.—A disabled Minnesota man is asking the state's highest court to review a ruling that a state law protecting disabled workers from job discrimination does not require his former employer to create a new job for him.

The July 26 request was filed 11 days after the appellate court unanimously upheld a lower court ruling interpreting Minnesota's 1986 Human Rights Act, which is similar to the 1992 federal Americans with Disabilities Act.

The state law requires employers to make reasonable workplace accommodations so otherwise qualified disabled persons can perform their job duties. Employers are exempt if the accommodations would create undue hardships for the companies.

The plaintiff, Arnold Helgerson Jr.,

is afflicted with systemic lupus erythematosus. During flareups, the chronic disease causes extreme fatigue, joint and back pain, nausea and pleurisy, or inflammation of membranes around the lungs. But, with proper medication and rest and by limiting emotional stress, the symptoms can be reduced to mild fatigue and joint pains.

Mr. Helgerson worked on the production line at the Albert Lea, Minn., plant of polypropylene twine manufacturer Bridon Cordage Inc. from 1981 to 1987. Employees there must work 12-hour shifts daily. During each shift, workers must perform several different tasks in all phases of twine production, including some repetitive heavy lifting.

The company designed the job-rotation system to avoid employee repetitive motion injuries, fatigue and boredom, court papers say.

After Mr. Helgerson was diagnosed with lupus in December 1986, he asked Bridon for job accommodations based on his doctor's recommendations.

According to court papers, he asked for a temporary transfer to a day shift and for a reduction in his daily work schedule to eight hours. He also asked to be excused from several tasks because they aggravated his condition. Those tasks accounted for eight to 10 hours of a normal 12-hour shift.

Bridon refused, and Mr. Helgerson resigned in August 1987. He filed a complaint with Minnesota's Human Rights Department, which unsuccessfully tried for more than four years to resolve the dispute.

He filed suit in 1992. He is seeking back pay of about \$150,000, which can be trebled under state law, and attorneys fees, according to plaintiff attorney Michael C. Zender of Alderson, Ondov, Leonard, Sween & Rizzi of Austin, Minn.

Mr. Zender explained that Mr. Helgerson did not sue under the ADA because:

- The ADA was not enacted until five years after the alleged job discrimination.

- The case would first have to be handled by the Equal Employment Opportunity Commission, which would have further delayed the case since the ADA did not become effective until 1992.

- There is some doubt whether the ADA would apply to cases that were pending before the law was enacted.

In the case, Bridon argued it would suffer an undue hardship if it accommodated Mr. Helgerson because it would be creating a new job unlike any other at the plant.

And, "By creating the new job, it put other employees at risk," because they would have to perform the work that he could not, said defense attorney Mary C. Leahy of

Hoversten, Strom, Johnson & Rysavy of Austin, Minn.

The trial court granted summary judgment to Bridon last September, and the appellate court, in a 3-0 ruling, upheld the decision on July 5.

The appellate court also ruled that Bridon did not violate the state disability statute when it refused to transfer Mr. Helgerson to a day shift, which, under a labor/management agreement, is awarded based on seniority. The statute's provisions on making reasonable accommodations do not apply to bona fide seniority systems, the appeals court ruled.

Mr. Helgerson's attorney has asked the Minnesota Supreme Court to review the ruling on several points.

Mr. Zender said the case marks the first time that Minnesota courts have ruled that employers do not have to create a new job to reasonably accommodate a disabled worker. He also says Mr. Helgerson's request would only have modified his job—not created a new position.

Despite concerns about whether Mr. Helgerson could sue under the ADA, including whether the statute of limitations has run out, Mr. Zender will "keep open the option" if the Minnesota Supreme Court refuses to review the case.

Arnold Helgerson Jr. vs. Bridon Cordage Inc., Minnesota Court of Appeals; No. CO-94-39.

Superfund

Continued from page 2

committee members also questioned the wisdom of an administration proposal in which 70% of the EIRF's funds would come from retroactive taxes on property/casualty insurers and 30% from a prospective tax. The EIRF would pay those held responsible for polluting Superfund sites a portion of their cleanup costs if they agreed not to sue their insurers.

Some insurers favor the administration plan, others want the EIRF funded entirely by a prospective tax, and still others have their own funding designs. Many insurers remain adamantly opposed to the EIRF in any form and would prefer to replace the retroactive liability arrangement with public funding.

Despite Rep. Gibbons' change of heart, opponents of the administration plan vow to keep on fighting.

"We are very convinced that the EIRF is unworkable in the long run," said David M. Farmer, senior vp-federal affairs for the Alliance of American Insurers in Washington.

Even if Ways and Means and the full House approve a bill quickly, he added, it is extremely unlikely that the Senate could act before the August recess begins in few days, and thus action would be delayed until after Labor Day.

The Senate Environment and Public Works Committee, however, spent

little time in debate before acting on S. 1834, which is sponsored by Committee Chairman Max Baucus, D-Mont. The committee's ranking minority member, Sen. John Chafee, R-R.I., expressed sympathy for those concerned with the fairness of imposing retroactive liability on polluters but stopped short of saying he would try to abolish such liability.

"The problem is repeal of retroactive liability is not going to happen. The votes are not there. It's not going to happen this year and it's not going to happen next year," he said.

"I don't think it's necessary to admit defeat just because the numbers aren't there" to abolish retroactive liability," said Sen. Robert Smith, R-N.H. "The root causes of (Superfund's) failure must be addressed."

But when Sen. Smith introduced his amendment to eliminate retroactive liability, he found that his colleagues on the committee were not swayed by his arguments. The amendment fell on a 12-to-5 vote.

A vote on another Smith amendment dealing with liability, however, failed by the narrowest of margins. The measure would have required policyholders who refused EIRF settlements and who consequently lost their court cases against their insurers to pay all of their insurers' legal costs. The amendment lost by a 9-to-8 vote. But the committee's bill would require that unsuccessful policyholders pay 40% of their insurers' legal fees. **BI**

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Regulation

Continued from page 3

considering litigation asserting that the NAIC is violating the federal Risk Retention Act, according to Mr. Waters.

"The real issue is whether the NAIC has the ability to override federal regulation," he said.

The commissioners have been asserting their authority over captives and other self-insurance because "they're scared for their jobs, because they have not done the best job in the world of regulating the industry," Mr. Waters said.

The accreditation process itself is an attempt to forestall federal regulation, said Lucille "Lucky" Gallagher, risk manager for Greeley, Colo.-based Monfort Inc., and president of the Risk & Insurance Management Society Inc.

Under legislation being developed by the staff of Rep. John Dingell, D-Mich., in collaboration with RIMS, a new federal insurance office would be created to regulate foreign insurers and reinsurers doing business in the United States (BI, May 23).

Domestic insurers, risk retention groups and other captives also could obtain federal licenses, but such participation would be voluntary. And captives that seek federal licenses would be required to post substantially less capital than domestic insurers that write third-party business.

Federally licensed insurers would be exempt from state regulation.

The bill will also define "professional risk manager," said Mr. Waters. "Maybe the NAIC doesn't know who we are, but Dingell knows it," he quipped.

"I hate to say this, but I really think that the federal government will come out ahead on regulation of the alternative market," predicted Gerald J. Ciardelli, risk manager for Jostens Inc. in Minneapolis and RIMS' vp-governmental affairs.

Rep. Dingell's staff is producing "something that's going to be viable, intelligent and meaningful, that's going to put something into the industry instead of just adding layers and

layers of needless regulation and needless costs," he said.

The objective is "to do the same thing for captives that the Risk Retention Act attempted to do for Risk Retention Act companies, and that is to pre-empt the states and put the regulation of captives at the federal level," said John Kezer, a former Colorado insurance commissioner and president of CACE.

RIMS jumped at the chance to participate in writing the bill after legislative director Paul Brown was approached in May by Rep. Dingell's staff to help draft a trimmed-down version of the Michigan Democrat's 1993 federal insurer solvency legislation, Mr. Ciardelli said.

"It's much easier to get something in a bill when you're involved in the process from Day One as opposed to having an existing draft and then later coming into it," he explained.

And the difference between working with Dingell's staff and working with the NAIC has been remarkable, according to Ms. Gallagher.

"In one meeting, we were able to get through to those people at the federal level what captives were and how businesses used them," she said.

"How many years have we been trying to get this message through to the NAIC?" she asked rhetorically.

Many risk managers should welcome federal regulation of the alternative markets since their overtures seeking reasonable governance by the NAIC have been largely ignored, she suggested.

Approaching regulators at the recent NAIC meeting in Louisville, Ky., did not go well, Ms. Gallagher said. "It was appalling to me the way those commissioners treated the people from our group."

Despite risk managers' concerns, she said, the NAIC still proposed legislation like a fronting bill that would have, in its first draft, made it more difficult for companies to buy retrospectively rated and large-deductible workers comp programs.

"Every time it seems we get three steps forward, we take four steps back," said Ms. Gallagher, who moderated the panel. "They don't understand that we are consumers of insurance—large consumers." **BI**

Helping spread the risk

Alternative market may be blessing in disguise for industry

By JOANNE WOJCIK



VAIL, Colo.—The growth of the alternative market is helping to save the reinsurance industry from the losses it has suffered as a result of insurers' cash-flow underwriting practices in the 1970s and the recent spate of natural catastrophes, says a reinsurance executive.

"I personally believe that the existence of the alternative market will probably have a profound impact on stabilizing" the financial results of the reinsurance industry, said Al Beer, senior vp at New York-based American Re-Insurance Co.

Rather than viewing the alternative market as a threat, "I think the insurance industry should be thankful for the alternative market movement because absent the alternative market movement, the post-1988 performance of the industry probably would have been significantly worse," he said.

If significant premium volume hadn't fled to the alternative market in the early 1980s, insurers "would have taken on much more risk than they should have, and I think they would have run into some serious problems," Mr. Beer told a group of captive owners and alternative market service providers at the recent Colorado Assn. of Captive Entities annual meeting.

While the insurance industry relied on investment income to pay claims during the high-interest and high-inflation late 1970s, it soon fell

behind the curve when interest rates dropped and losses climbed, Mr. Beer recounted.

As a result, the reinsurance marketplace was cut in half, with the Reinsurance Assn. of America reporting only 54 companies operating in 1994, compared with more than 120 companies in 1982.

"More companies went out of business than currently exist today," he said.

But, while the number of reinsurers has shrunk, the remaining companies are writing more business.

Primary insurers are assuming greater net lines, and reinsurers' market share is growing. While the reinsurance industry wrote about \$8 billion in premiums in 1982, it now writes about \$16 billion, Mr. Beer estimated.

The most logical explanation for the growth of reinsurance premium volume is the emergence of the alternative market, to which many insurers and reinsurers are now catering, he said.

Many reinsurers are coming to realize that alternative market mechanisms are just sophisticated risk-funding mechanisms that have formed in response to the volatility of insurance rates and capacity, Mr. Beer said.

"The insurance industry failed to realize its role. For the commercial insurance buyer, the primary function of insurance and/or reinsurance

is financial stabilization," he said. "The principle is to trade that known loss to stabilize financial performance."

Unfortunately, many commercial insurance buyers found that the "insurance industry would actually introduce more financial instability through its premium than the client would experience through its own loss experience."

As buyers took the business of financial stabilization into their own hands by developing alternative markets, the insurance industry finally started to realize that it had to learn the language of the financial community to survive, he said.

For example, "asset liability matching has just recently come in vogue, but frankly it's the basis for running a financial services company," Mr. Beer said.

"It was the alternative market that shook the insurance industry into recognizing its purpose—to bring capacity and capital to stabilize financial performance," he said.

"The alternative market is nothing but a sophisticated funding mechanism," and "the decisions to set up alternative markets are boardroom decisions" that go beyond finding the most capacity for the best price, explained Mr. Beer. "This is clearly an extension of the financial performance of the underlying insured."

"The insurance industry is finally recognizing what its primary function is, and how that function has to be changed," he said. **BI**

More buyers may be flocking to alternative market than before

By JOANNE WOJCIK



VAIL, Colo.—The alternative market is substantially larger than previously imagined and may comprise as much as 80% of major casualty business worldwide, a risk management expert estimates.

And, the volume of business consumed by the alternative market has freed up commercial insurers' capacity for other risks, thus increasing competition and keeping rates down.

"This enormous infusion of alternative market capacity stabilizes market cycle turns," said Michael Murphy, president of RiskCap, a Denver-based captive manager and self-insurance service provider.

Global risk financing has reverted to "the oldest and surest insurance mechanism in the history of insurance: self-insurance," agreed Jonathan Crawley, president of Sphere Drake Underwriting Management (Bermuda) Ltd., a Bermuda-based captive reinsurer.

The two spoke at a session during the annual Colorado Assn. of Captive Entities conference held recently in Vail, Colo.

"Historically speaking, when there was no insurance, there was self-insurance," Mr. Crawley explained. "In those heady times before merchants and traders invented the theory that the premiums of the many should pay for the losses of the few, everyone was a self-insurer."

"Then came insurance and then came reinsurance, and now over 25% of the world's (property/casualty risks) have reverted to self-insuring," estimated Mr. Crawley.

If property business is subtracted, the entire mix of alternative market

mechanisms—including captives, trusts, pools, large-deductible and retrospectively rated plans—collectively finances as much as 80% of the world's major liability exposures, Mr. Murphy contends.

Even conservative insurance industry estimates place the alternative market's premium volume at \$80 billion annually, making it five times the U.S. reinsurance industry's net written premiums of \$14.9 billion; five times as large as Lloyd's of London's total capacity of \$15 billion; and about half the size of the world's total property/casualty industry surplus of \$163 billion, he said.

"The momentum to the alternative market is simply too overwhelming for the insurance industry to withstand," he said. "The alternative market has become a black hole where large volumes of property/casualty premium have disappeared."

Unless self-insurance loses its luster, "my guess is that by the end of the decade, the vast majority of all large commercial casualty risks will be in the alternative market," Mr. Murphy predicted. And commercial insurers will be left with the balance of small mom-and-pop casualty risks and specialty lines, such as directors and officers liability, he said.

Only 20% to 40% of casualty accounts with annual premiums totaling \$2 million or more are still being written by primary insurance companies, he said.

"The insurance industry's future is behind it," Mr. Murphy said, because "the alternative market is no longer the alternative market. The alternative market is the primary in-

surance industry."

Some insurers and reinsurers have managed to head off their imminent extinction by restructuring their services to capitalize on the booming self-insurance market, he said.

For example, "some direct reinsurers like General Reinsurance, which historically would never talk to a reinsurance intermediary, are now talking to retail brokers to sell their products," he said.

Other reinsurers are marketing exclusively to captives and other self-insurers, he said, citing Mr. Crawley's company as an example.

"And the more progressive primary companies have unbundled their services and they're now selling, fronting, offering excess insurance, third-party administration, loss control," Mr. Murphy said. "They're beginning to realize they can make more money selling self-insurance services than they ever made in underwriting profits on those same accounts."

Ironically, many of these "are the same reinsurers that wouldn't return our calls in the early '80s and wouldn't dream about writing stop-loss coverage for self-insurance programs," he added.

Other financial service providers also are shifting their marketing focus from traditional insurers to the alternative market.

"We have Big Six accounting firms that have risk management consultants," he said. "We have domicile counsels that are now doing feasibility studies."

These reinsurers, excess insurers, consultants, brokers, program managers, attorneys and actuaries don't really care if they're working on a captive, a trust, a pool or a qualified

Continued on next page

Vail attracts 75 CACE members

VAIL, Colo.—Approximately 75 alternative market industry enthusiasts attended the fourth annual conference sponsored by the Colorado Assn. of Captive Entities July 20-22 in this Rocky Mountain ski town.

In addition to featuring general sessions on issues affecting the alternative market worldwide, the conference gave attendees the opportunity to become better acquainted with Colorado's new captive law.

The state's 1972 captive law, which was the oldest in the nation, was completely rewritten earlier this year to streamline the application process and to permit the formation of employee benefit captives (BI, April 18).

The rewrite started two years ago when discussions with CACE, captive owners and service providers revealed that it inhibited the growth of Colorado's fledgling captive industry, explained Alan Schmitz, an attorney with Hall & Evans in Denver who helped draft the legislation.

Next year's conference will also be held in late July in Vail, though a date and location have yet to be determined.

For more information, contact the Colorado Assn. of Captive Entities, c/o RiskCap, 1571 Race St., Denver, Colo. 80206; 303-388-5688.

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Wellness

Continued from page 3

lyzed federal surveys, surveys conducted by associations and benefit consultants and published literature on health promotion and disease prevention.

The problem with many employer-provided wellness programs is that "the ball gets started... then the ball gets dropped," Mr. Gitchell said.

"This could be a result of employers providing (health promotion/disease prevention) mostly for employee relations reasons instead of for truly controlling health costs," the report suggests.

Although most employers do not offer broad health promotion and disease prevention programs, many employers offer one or more health promotion activities, according to a federal survey cited by the report.

According to the U.S. Office of Disease Prevention and Health Promotion's 1992 National Survey of Worksite Health Promotion Activities, 52% of the 1,507 employers surveyed offered health risk assessments; 42% offered physical activity and fitness programs; and 40% offered information or activities to help employees stop smoking.

Some employers develop their own worksite wellness programs, though many rely on managed care organizations, hospitals, non-profit organizations or outside vendors for wellness program design, the survey found.

Mr. Gitchell cautioned against the assumption that managed care organizations provide extensive preventive care and health promotion services. For example, based on material supplied to the researchers by the Group Health Assn. of America, the report notes that less than 40% of HMOs offer without limits general health education, nutrition counseling, smoking cessation classes, injury prevention education, sexually transmitted disease prevention education, routine physicals or prenatal care. More than 60% of the HMOs either require some cost-sharing for these health promotion and preventive care services or do not offer them at all.

Hospital-based health education programs most often include diabetes education, CPR and prenatal health education. Hospitals offer health education primarily for marketing reasons in a competitive health care market, the report notes.

Quantifying health care costs sav-

ings or improved health from wellness programs remains a problem, according to the report.

Of the 51 health promotion vendors interviewed by Marketdata, 53% could not document wellness savings with hard data. Only 43% said they could document savings with hard data and 4% were unsure.

However, the report points out that wellness programs "have been hampered by the fact that much of what they prevent is long latency illness and premature death. While the public health and public policy implications of these outcomes are extremely favorable, they are not as appealing to employers and providers interested in containing health costs in the short term."

Diana Murray, senior manager of group insurance for Sara Lee Corp. in Chicago, agrees. "It's very hard to quantify health care savings because (wellness is) very long term. What you really have to do is quantify life-

style changes."

The report also includes:

- Several sections about smoking cessation programs. The report provides information on numerous smoking cessation products and services, including: nicotine chewing gum; the nicotine patch and transdermal drug delivery systems; commercial programs such as Smoke Stoppers and Smokers International; acupuncture; hypnosis; and non-profit programs such as those sponsored by the American Lung Assn., the American Cancer Assn. and the American Heart Assn. The report includes price and contact information for many of these programs.

- Several sections on diet and weight loss programs. The report includes demographic information on overweight Americans and dieters. It also lists contact information on several self-help groups, such as the National Assn. to Advance Fat Accep-

tance and Food Addicts Anonymous.

The report also reviews the leading commercial weight loss chains and their revenues; the use of artificial sweeteners and diet soft drinks; and programs that use very low calorie diets, such as Ultrafast and Optifast.

- An eight-page directory of HP/DP organizations and contacts, such as magazines, catalogue publishers, trade associations and vendors.

- Brief case studies of corporate, hospital and HMO wellness programs. The case studies, which do not use formal names, summarize programs and in some cases costs.

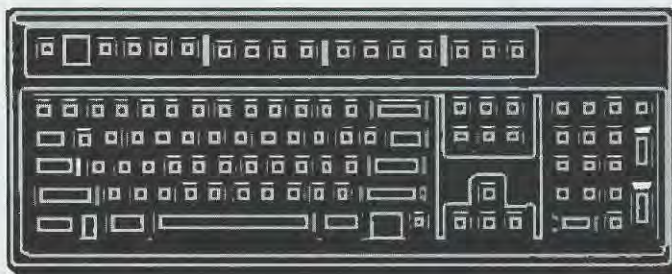
- Demographic data on the health status of Americans. For example, citing information supplied by the National Center for Health Statistics, the report noted that from 1950 to 1990 the death rate from respiratory cancers almost quadrupled. During the same period the death rate from chronic obstructive pulmonary dis-

ease nearly quintupled.

The report also noted that in 1987, 26% of people older than 20 were overweight; by 1991, 28% of adults were overweight.

On the positive side, from 1950 to 1990 the death rate for heart disease was cut in half and the death rate from alcohol-induced causes declined from 8.4 per 100,000 in 1980 to 7.2 per 100,000 in 1990.

The report, "Health Promotion & Disease Prevention Programs: Rx for the 1990s?" is available from Marketdata Enterprises, Inc., 181 S. Franklin Ave., Suite 608, Valley Stream, N.Y. 11580; 516-791-6579; fax: 516-791-7759. The complete 440-page report costs \$1,750; Business Insurance subscribers will receive a 20% discount to \$1,400 if they mention reading about the study in the magazine. A free listing of the report's table of contents is available by fax or mail.



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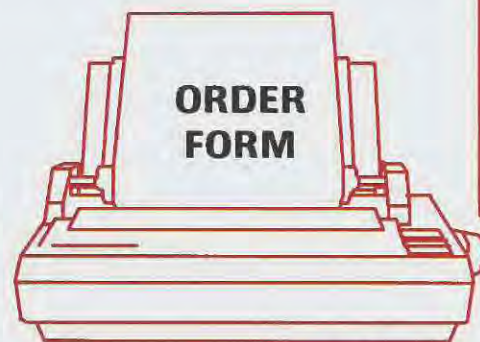
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Business Insurance®

Markets

Continued from previous page
self-insurance plan, Mr. Murphy said.

There is a growing understanding that the spectrum of alternative market mechanisms "not only have common denominator reasons for being formed, they also have common denominator issues relative to taxes, accounting, regulation."

Until recently, the separate evolutionary cycles of each distinct self-insurance mechanism over the past 30 years have resulted in a fragmented view of the alternative market, Mr. Murphy said.

"Now we can see the big picture, we're beginning to understand that the alternative market has forever changed the landscape of the global risk financing industry on both the insurance and the self-insurance side."

"When I grew up as a career risk manager... self-insurance was an orphaned sister, thought of as a tail to major casualty insurance. But I would submit that that tail is not only wagging the dog, but it is threatening to eat the dog." ■

Brokers

Continued from page 2

ective officer of Rollins Hudig Hall Group Inc. in Chicago.

Other brokers, including Marsh & McLennan Cos. Inc. and Gallagher, also cited new business as a large contributor to their first-half results.

"There is a certain amount of musical chairs" going on with accounts, pointed out Michael Smith, senior vp at Lehman Bros. in New York. "New business for one broker is lost business for someone else."

One area in which many brokers did not receive much help during the first half was investment income.

At Gallagher, investment income fell 57.6% from 1993 levels. Part of that decline can be attributed to a \$23 million repurchase of common stock for reissuance in connection with its stock option plans, said J. Patrick Gallagher, president and chief operating officer of the Itasca, Ill.-based broker.

This reduced the company's funds available for investing, he explained. Other factors were a depressed overall market and a restructuring of its managed funds due to Financial Accounting Standard 115, which resulted in some losses. FAS 115 requires most fixed-income securities to be reported at market value.

"The return is down, but we haven't lost capital," Mr. Gallagher said.

Investment income fell 26% at Acordia Inc. to about \$3 million in the first half from about \$4 million last year.

"Last year, we sat on much greater operational cash, prior to the (American Business Insurance Inc.) acquisition," explained Robert S. Schneider, senior vp and controller of the Indianapolis-based broker. Instead of more cash for investments, Acordia "now has operational profits from ABI."

A&A's fiduciary investment income for the first six months was down 16.7% to \$23.5 million from \$28.2 million in 1993, said Frank R. Wiczynski, corporate secretary for A&A in New York.

"It's purely (interest) rates, which is out of our control," he said.

M&M's fiduciary investment income is down \$7 million, said J. Michael Bischoff, vp-corporate development in New York. Mr. Bischoff said expects investment income to "turn positive" in the third quarter due to an increase in short-term interest rates.

Higher coastal property rates helped to offset that decline and produce 8.2% revenue growth at M&M. Offices in the Atlantic states, the Southeast and the West Coast

outperformed other U.S. offices during the second quarter due to the increased demand and rates for property catastrophe coverage, Mr. Bischoff said.

Indeed, many of the brokers reported that offices in coastal areas had strong performances in the first six months due to the higher property rates. But, they also note that these accounts do not account for a large portion of their business.

The approximately eight HRH offices in coastal areas are seeing an effect on revenues from higher property rates, but it's only 5% to 6% of the total business, said Mr. Hilb. It helps, but "it can't carry us."

Individual results for the publicly held brokers follow:

Marsh & McLennan

First-half revenues increased 8.2% to \$1.76 billion from \$1.62 billion in 1993.

Net income also increased, jumping 11.5% to \$215.9 million from \$193.7 million in 1993. First-half 1994 profits include a \$10.5 million charge M&M took in the first quarter to recognize its obligations under FAS 112, which requires companies to account for post-employment benefit liabilities like workers compensation, disability and severance benefits.

Direct retail brokerage revenues increased 3.4% in the second quarter of 1994 compared with a 1% increase in the first quarter after excluding \$25 million in income M&M received from the sale of shares it held in ACE Ltd. and Centre Reinsurance Holding Ltd. of Bermuda.

The increase in insurance services revenues is a result of strong new business and higher insurance rates in the coastal property catastrophe areas during the second quarter, Mr. Bischoff said.

Consulting revenues, including those from unit William M. Mercer Cos. Inc., increased 5.1% in the first six months of 1994 to \$452.9 million from \$431.1 million in 1993. Mr. Bischoff said that while each consulting practice reported growth in the first six months, general management consulting and compensation consulting showed the strongest growth.

Revenues from The Putnam Cos., M&M's Boston-based investment management subsidiary, increased 28.6% in the first six months to \$304.8 million from \$237.1 million.

Rollins Hudig Hall

For the first six months of 1994, revenues at RHH increased 13.9% to \$701.1 million from \$615.5 million in 1993.

Pretax profits increased 14.8% to \$99.8 million from \$86.9 million in 1993. As an Aon Corp. unit, RHH

reports only pretax profit rather than net income.

Much of RHH's growth can be attributed to its reinsurance and wholesale business—generated by its Aon Risk Services Inc. and Nicholson Leslie Group units—whose revenues alone increased 37.3% in the first six months of 1994 to \$174.2 million from \$126.9 million in 1993.

Retail brokerage revenues generated from RHH Co. Inc. and Aon Specialty Group Inc. increased 10.2% to \$444.4 million from \$403.4 million in the first six months of 1993.

The only low spot for RHH came from reduced benefit consulting rev-

enues generated by its Godwins International Inc. subsidiary. Revenues for the first six months were down 3.2% to \$82.5 million from \$85.2 million in 1993. Benefit consulting has been "under pressure due to the uncertainty in the marketplace," Mr. Ryan said. However, he says he is "quite optimistic" that Godwins is moving toward more growth in the second-half.

Alexander & Alexander

First-half revenues fell a modest 1.3% to \$658.1 million in 1994 from \$666.7 million in 1993.

A&A took a \$6 million charge in the second quarter to cover the cost of reinsurance it obtained to cover liabilities from ongoing obligations for Sphere Drake Insurance Group, which it sold in 1987 (BI, July 11). That contributed to a \$6.6 million net loss for the first six months compared with a \$26.3 million profit a year earlier.

Mr. Wiczynski noted that second-quarter revenues are "slightly up" when adjusted for lower foreign exchange rates and sold operations during the second quarter of 1993.

However, operating income fell

55.6% to \$19.8 million from \$44.5 million for the first six months, which can be attributed mainly to the "shortfall" in the broker's U.S. risk management and insurance services operations, he said.

A&A hopes to make significant investments to improve its U.S. operations with \$200 million in capital from American International Group Inc. (BI, June 13). Shareholders approved the investment at a July 15 special meeting.

Late last week, A&A Inc., A&A's U.S. retail brokerage unit, signed a letter of intent to sell its personal lines business to Florham Park, N.J.-based Personal Lines Insurance Brokerage Inc.

First-half broker results

In millions of dollars

Broker	Gross revenues	% change from 1993	Net income (loss)	% change from 1993
Marsh & McLennan	\$1,756.6	8.2%	\$215.9	11.5%
Rollins Hudig Hall ¹	701.1	13.9	99.8	14.8
Alexander & Alexander	658.1	-1.3	(6.6)	NM
Acordia	186.1	68.8	12.7	15.1
Arthur J. Gallagher ²	161.9	7.4	9.9	8.3
Hilb, Rogal & Hamilton ²	71.4	1.4	7.4	36.5
Poe & Brown	50.8	8.2	6.5	124.0

¹Pretax ²1993 figures restated NM-Not meaningful
Source: Company reports

GRAPHIC BY MIKE GARVEY

Acordia

For the first six months of 1994, revenues jumped 68.8% to \$186.1 million from \$110.3 million in 1993. Net income also increased during that half, rising 15.1% to \$12.7 million from \$11.0 million in 1993.

Mr. Schneider said the increased revenues "by far" are attributable to the 1993 acquisition of ABI and the April acquisition of Pettit-Morry Co. But, "buried in there is good news," he added. Internal business growth is continuing to rise and contributed about 5% of Acordia's revenue growth in the company for the first six months.

Acquisitions were also the catalyst behind an 80.3% increase in expenses, Mr. Schneider said. Total expenses for the first six months increased to \$163.5 million from \$90.7 million in 1993.

"We're very pleased with the results from the acquisitions. The ABI companies and Pettit-Morry are ahead of what was projected," Mr. Schneider said.

Arthur J. Gallagher

Revenues rose 7.4% in the first six

months of 1994 to \$161.9 million from \$150.8 million in 1993. Net income also increased in the half, rising 8.3% to \$9.9 million from \$9.2 million in 1993.

Strong new business accounted for the company's revenue gains as commission and fee income increased 10.9% over the first six months of 1993. That increase more than offset a 57.6% decrease in first-half interest income to \$3.3 million in 1994 from \$7.8 million in 1993.

Gallagher Bassett Services, the third-party administration subsidiary, "continues to be a success," Mr. Gallagher said.

Additionally, the broker's first-quarter acquisitions—Youngstown, Ohio-based Donald P. Pipino & Associates Inc. and Wayne, N.J.-based Steel Agency—"have been a significant contributor" to the company's results so far in 1994. 1993 results have been restated to include these acquisitions on a pooling of interests basis.

Hilb, Rogal & Hamilton

Revenues increased 1.4% during the first six months of 1994 to \$71.4 million from \$70.4 million in 1993.

Net income fared better, increasing 36.5% to \$7.4 million from \$5.4 million in 1993.

Mr. Hilb attributed the flat revenues to the flat property/casualty insurance market and said that profits were higher due to continued expense control programs.

In addition, new business production improved during the first six months, and coastal offices also received a boost from higher property insurance rates, which helped increase profits, he said.

Poe & Brown

Revenues at the Tampa, Fla.-based broker increased 8.2% in the first six months of 1994 to \$50.8 million from \$46.9 million in 1993. Net income catapulted 124% to \$6.5 million from \$2.9 million in 1993.

Investment income for the first six months vaulted 248% to \$3.5 million from \$999,000 in 1993. A majority of this is attributable to the \$1.3 million in investment gains made in the first quarter from the sale of shares it held in paper manufacturer Rock-Tenn Co. of Norcross, Ga.

Excluding the extraordinary gain, profits still would have climbed 79.4%, said Timothy L. Young, vp, treasurer and chief financial officer. Mr. Young recently replaced Cory Walker, who is now a producer.

Total expenses were down 4.2% at Poe & Brown to \$40.1 million for the first six months from \$41.9 million in 1993. **BI**

Trigon Blue Cross & Blue Shield says Virginia probe unfounded

RICHMOND, Va.—Trigon Blue Cross & Blue Shield does not expect an investigation into its calculation of hospital copayments to have "a significant impact on financial strength or the continued ability to pay claims and meet operating expenses."

The Richmond, Va.-based health insurer, formerly named BC/BS of Virginia, changed its calculating method Jan. 1. It previously passed on savings negotiated with providers to customers as reduced premiums rather than reduced copayments. Like all other insurers and HMOs in Virginia, it now calculates copayments on the basis of discounted fees it has negotiated with hospitals.

Attorney General James Gilmore said late last month that "an investigation is ongoing" into the Blues' pre-1994 practices. The remarks followed published leaks from his de-

partment that examiners were looking into whether the insurer received "kickbacks" from hospitals when policyholders paid copayments in excess of the amount negotiated between the insurer and the provider between 1991 and 1994. The same anonymous sources claimed the Blues had committed as many as 2,700 violations of state law, each of which could result in fines of \$1,000 to \$5,000. No charges or complaints have been filed against Trigon.

"We have not knowingly committed any violation of state laws," said Trigon Chairman and CEO Norwood H. Davis Jr. Trigon has more than \$600 million in surplus, and "statements that the company's financial stability is threatened because of the situation are erroneous."

The Attorney General's Office did not return phone calls.

—By Mark A. Hofmann

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ASK A CASUALTY ACTUARY

Search required to find best consultant for job

Q

We are about to go out to bid for our actuarial consulting work. If you were in our position, what questions would you ask the various bidders to help you better discern which consultant would best serve your needs? How can we find out which consultants are

located in our area?

A

First, it would be helpful to clearly define what your needs are. In a general sense, your needs can be simply stated: You need appropriate actuarial conclusions that are clearly communicated. Based on this definition, the questions you should ask potential consulting firms

should fall into one of two categories:

How can I be better assured that the findings presented will be appropriate?

How can I be confident that these findings will be clearly communicated and easily understood?

There are numerous issues that affect the appropriateness of the findings you will receive from an actuarial consultant.

The following are some general questions to ask the bidders.

- Are you a Fellow or Associate of the Casualty Actuarial Society? Are you a member of any other professional organizations? If so, what requirements do these organizations have, if any, to assure that members have an in-depth knowledge of property/casualty insurance and claims?

- How much prior experience have you had:

- ✓ In performing this type of study (reserves, funding, cost allocation, etc.) for this type of claim (workers compensation, general liability, auto, homeowners, professional liability etc.)? For other types of claims (specify)?

- ✓ In doing actuarial analyses (of any type) for this type of claim?

Break down each of the above by the type of role you served in completing these studies (e.g. consulting, internal insurance company, bureau).

- How many years of consulting experience do you have? Provide a percentage breakdown of your consulting experience by:

- ✓ Type of claim (and state, if relevant).

- ✓ Type of study.

- ✓ Type of client (public, corporate, hospital, etc.)

- ✓ Any combination of the above that would be specific to the work to be performed.

- Provide a breakdown of hours for the specific staff who will be performing the analysis.

- What peer review procedures will be used in checking the appropriateness of the methods, assumptions and selections which will affect the results?

- Do you have loss experience for similar types of risks and similar types of claims? Describe the extent of this information. How will you determine to what extent you will rely on this external information vs. our own experience in arriving at your findings?

- Briefly and generally describe the full range of types of actuarial methods that could be applied in performing this study. Which of these methods do you intend to use? Not use? Explain.

There may be other questions relevant to your individual situation. Don't hesitate to ask prospective actuarial consultants how they will handle specific aspects of the project, such as changes in case reserving practices or changes in underwriting procedures.

Another issue that is often key in affecting the appropriateness of the findings of an actuarial study is the form in which they will be presented. This should be determined in advance by discussion with the prospective

Largest casualty actuarial consulting firms

By number of Casualty Actuarial Society members

Firm	Number of CAS members (5/9/94)	Number of CAS members (4/1/92)	Offices (CAS members) (Ranked by number of Casualty Actuarial Society members as of May 9, 1994)
Tillinghast/ Towers Perrin	91	101	Weatogue, Conn. (16); Atlanta (12); Arlington, Va. (8); Philadelphia (7); St. Louis (7) Boston (6); Dallas (4); Toronto (4); Irvine, Calif. (3); London (3); San Francisco (2); Chicago (2); Denver (2); Hamilton, Bermuda (2); Jacksonville, Fla. (2); Minneapolis (2); New York City (2); Montreal (2); Hong Kong (1); Saddle Brook, NJ (1); San Antonio, Texas (1); Stamford, Conn. (1); Paris (1)
Milliman & Robertson Inc.	60	49	New York City (10); Wakefield, Mass. (10); Brookfield, Wis. (9); Pasadena, Calif. (7); Radnor, Pa. (5); West Paterson, N.J. (5); Irvine, Calif. (3) Atlanta (2); Minneapolis (2); Seattle (2); Denver (2); Dallas (1); Mason, Ohio (1); San Francisco (1)
Coopers & Lybrand	39	27	Atlanta (7); Chicago (7); New York City (6); Toronto (4); Parsippany, N.J. (3); Boston (2) Los Angeles (2); Philadelphia (2); Seattle (2); Wayne, Penn. (2); Dallas (1); San Francisco (1)
Mercer/Marsh & McLennan Cos. Inc. and affiliates	31	21	New York City (11); Columbus, Ohio (5); Chicago/Deerfield, Ill. (3); Philadelphia (3); Atlanta (2); Irvine, Calif. (2); Washington (2); Montreal (1); Los Angeles (1); Minneapolis (1)
Ernst & Young	30	28	Philadelphia (11); Chicago (5); Atlanta (4); New York City (4); Los Angeles (2); Seattle (2); Boston (1); Hamilton, Bermuda (1)
KPMG Peat Marwick	16	10	Radnor, Pa. (4); New York City (3); Chicago (2); Dallas (2); Hartford, Conn. (2); Atlanta (1); Hamilton, Bermuda (1); Los Angeles (1)
Deloitte & Touche	13	9	Hartford, Conn. (6); Washington (4); Chicago (3)
Arthur Andersen & Co.	12	4	Hartford, Conn. (3); New York City (3); Philadelphia (3); Chicago (1); Milwaukee (1); San Francisco (1)
The Wyatt Co.	11	23	Chicago (2); Toronto (2); Dallas (1); London (1); San Diego (1); San Francisco (1); Southfield, Michigan (1); Washington (1); Wellesley Hills, Mass. (1)
Price Waterhouse	7	5	Hartford, Conn. (5); Chicago (1); Dallas (1)

Source: Casualty Actuarial Society

GRAPHIC BY JOHN HALL

consultant and probably should cover such issues as:

- Is a point estimate or a range of estimates to be presented? If a range is presented, will the assumptions that underlie each estimate in the range be clearly spelled out?
- Will estimates be presented at different confidence levels?
- Will the confidence levels presented be appropriate to the purpose at hand?
- Will the value of investment income be presented?
- What caveats and restrictions on distribution will probably be part of the report?
- What will happen to the fees for the engagement if there are major problems and inconsistencies in the data provided? If these problems make it necessary to redo a significant part of the study, how will that affect fees?
- For clients whom you have served for a number of successive years, have you experienced any general patterns in terms of whether your prior estimates have proved to be too low, too high or randomly low or high?
- What proportion of your clients are repeat clients?

The clarity and lucidity of the prospective consultants' answers (whether oral or written) to the above questions should provide you with an idea of their abilities to communicate in clear and understandable terms.

You should also request copies of some of the consultants' prior reports (clients' names could be blanked out) and of sample articles or papers written by the consultant as further evidence of these skills. Such sample reports will also provide you with clues as to the ease of understanding exhibits and tables and the form in which results might be presented.

A final issue in the communications area relates to the consultants' prior experience in presenting findings to some of the audiences that may also be recipients of the analysis. Such audiences can include regulators, auditors, investment analysts, lawyers and tax advisers.

Obviously, each of these specialists has a unique vocabulary and set of concerns, and effective communication with them is often dependent on having

prior experience in working with them. To the extent that this is a need in your case, you may want to explore this with each prospective consultant.

In answer to your last question, the accompanying chart includes a compilation of the largest casualty actuarial consulting firms and their office locations. In addition to the firms shown in the chart, there are many consultants who are not associated with a firm that has seven or more members of the Casualty Actuarial Society.

The best way to obtain information on these firms is to order a copy of the latest Casualty Actuarial Society yearbook. Copies are \$40. Contact the Casualty Actuarial Society, 1100 North Glebe Road, Suite 600, Arlington, Va. 22201; 703-276-3100. The yearbook provides the names, addresses and phone numbers of listed firms. **EBI**

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

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

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



Mr. Sherman

Continental Bank Corp. in Chicago, answers questions on employee benefit plans.

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

Juggling work and family

By Paige Landsman

THE INCREASING NUMBER OF employees with family responsibilities is a fact of life in today's business world. The statistics are dramatic:

- Dual-income families make up a much larger share of the workforce than ever before.
- Women are the largest growing sector in the workforce, with almost 60% of all women in the country working in 1993, compared with 38% in 1963.
- Approximately 75% of all women in childbearing years are in the workforce.
- 57% of dual-income families have children under 18 years old.
- As life spans increase, more employees are helping to care for elderly relatives.

Behind these statistics are stories of individual employees juggling jobs with family obligations. For many the struggle is especially difficult because they work in companies with human resource policies established decades ago when men comprised the overwhelming majority of the workforce.

Recognizing the magnitude and significance of the nation's demographic shift, many innovative employers have taken the lead in revamping their policies and offering alternatives to help employees better manage their lives. Their motivation is not that it's the nice thing to do. These organizations are reaping very real business benefits of improved morale and productivity, as well as reduced absenteeism and turnover. Employers that are not offering flexibility and support lose valued employees to competitors that offer alternatives.

Flexible work schedules is one strategy companies are adopting to help reduce stress in employees coping with competing schedules. In a recent survey, Coopers & Lybrand found that 60% of participants offer flexible work schedules to accommodate employees with family obligations. By the year 2000, approximately 80% of companies are expected to consider flexible work schedules as part of doing business.

The growing number of businesses offering flexible work schedules is a positive sign that companies are recognizing the benefits of responding to the increasing number of working parents in the marketplace.

Flexible scheduling, and changing attitudes help balance demands

For example, allowing working spouses to coordinate work schedules to accommodate their child-care responsibilities results in less time resolving family issues at work. In addition, flexible work schedules provide employees with a greater sense of autonomy in their work environment, which often results in improved morale.

Flexible work arrangements include:

Job sharing. Two part-time employees share the responsibilities, salary and benefits of one job. Benefits include:

- ✓ Retaining employees who are unable to work full time.
- ✓ Broadening the base of skills and experience brought to the position.
- ✓ Providing continuous coverage during vacations or other absences.

Compressed work week. Employees work longer hours for fewer days (i.e., a 10-hour workday, four days a week, rather than an 8-hour workday, five days a week). Benefits include:

- ✓ Maintaining the same number of hours worked, with compensation and benefits unaffected.
- ✓ Extending hours of service.
- ✓ Increasing productivity by enabling employees to take care of personal business during non-work time.

Flex hours. Employees work the hours required to get the job done as long as the time worked adds up to a pre-determined number of hours. A vacation allows employees to determine their work schedules as long as they work designated "core" hours. Benefits include:

- ✓ Maintaining the same number of hours worked with no changes in salary or benefits.
- ✓ Boosting morale and productivity by enabling employees to better manage personal or family schedules.
- ✓ Extending hours of service.

Working from home. Employees can work at home a percentage of the time. Benefits include:

- ✓ Maintaining the same number of hours worked, with no changes in salary or benefits.
- ✓ Improving productivity by reducing interruptions and distractions and, in some cases, allowing employees to work during their own peak hours.

Helping employees find affordable and dependable child care is another way companies are responding to the needs of their changing workforce.

Employer-assisted child care is proving to be an important recruitment and retention tool. Our study indicated that 24% of survey participants offer child care services to employees.

Seventy-five percent of these employers say these services are having a positive impact on morale; 62% report that this support is having a positive impact on retaining employees; and 54% report a positive effect on reducing absenteeism.

In light of the positive feedback, helping provide child care is clearly a smart business decision.

Child care options include: Onsite child care facilities; a child care facility close to the company; child care center shares with other companies in the vicinity; a money voucher system in which the company allots each employee a monthly amount to help pay for child care services; a contract with a local child care center to ensure space for employees' children at a discount; resources and referrals to educate employees on child care issues and help them find local licensed child-care providers; a dependent care assistance plan that allows employees to set aside pre-tax dollars from their salaries for child care; a sick care program to allow employees with mildly sick children to leave them at the facility while the parent goes to work; and an emergency center where employees can bring their children when their regular day care arrangements break down. **BI**



Paige Landsman is an associate in the executive compensation consulting practice of Coopers & Lybrand's human resource advisory group in New York.

Comp benefits awarded despite horseplay

The fact that an employee was injured as a result of the instigation of horseplay did not preclude an award of benefits under workers compensation law, according to a Missouri appellate court.

Elwanda Pullum worked at a chicken processing plant. She and two other employees were trimming chicken with poultry scissors. They were working around a box in which chickens were packed in ice. One of the employees picked up a piece of ice and threw it at another, striking her. That employee threw her right hand up, and her scissors went through Ms. Pullum's arm, severing a nerve. It appeared that even though warned against such horseplay, employees occasionally put ice on others and were not terminated for it. Ms. Pullum filed for and was awarded workers compensation.

On appeal, the employer argued that Ms. Pullum's injury did not arise out of and in the course of employment, but from horseplay that was contrary to the employer's rules. The court said that most jurisdictions now allow recovery by a victim who did not participate in the horseplay which caused the injury. The court also concluded that Ms. Pullum's injury occurred in the course of her

Legal Briefs

employment while she was fulfilling the duties of her employment. The award was affirmed.

Pullum vs. Hudson Foods Inc., Missouri Court of Appeals, Feb. 18, 1994 (BI/02/S.-\$10).

Arbitration disagreement

A provision in a casualty insurance policy providing for an appraisal of loss did not create an agreement to submit the matter to binding arbitration, according to the District Court of Appeals of Florida.

American Reliance Insurance Co. issued a casualty insurance policy to The Village Homes at Country Walk. The policy provided that if either party disagreed on the value of the property or the amount of loss, either could make a written demand for an appraisal of the loss. The policy also provided that if there was an appraisal, the insurer retained its right to deny the claim. Country Walk was severely damaged by Hurricane Andrew. Country Walk sued to recover benefits under the policy. The insurer moved to dismiss the suit and to

compel arbitration. The trial court ruled against the insurer.

The appellate court said that the policy clause on appraisal was not an enforceable arbitration agreement, as it lacked mutuality of obligation. "The very essence of an arbitration is an agreement to be bound by the factual determination of the arbitrator," the court pointed out, "and thus end the factual controversy." Here the court said, the insurer's reservation of its right to deny the claim destroyed the mutuality of obligation and was incompatible with the goals of arbitration. The trial court decision was affirmed.

American Reliance Insurance vs. Village Homes, District Court of Appeal of Florida, Feb. 8, 1994, *Rehearing Denied* March 15, 1994 (BI/02/Au.-\$10).

Suicide survivor benefits

Does a worker's suicide which was not related to a work-related injury which gave rise to workers compensation benefits bar continuation benefits to a survivor? The Supreme Court of Kentucky ruled that it did not.

Everette Leslie injured his back in a work-related accident in 1987. He married

in 1988 and filed a workers compensation claim thereafter. On June 13, 1989, and before an award was rendered, Mr. Leslie committed suicide. His widow was substituted as a party-plaintiff. An administrative law judge held that Mr. Leslie's death was not work-related, and thus death benefits were inappropriate. However, the judge awarded continuation benefits to his widow. The Compensation Board and Court of Appeals affirmed the award.

The state supreme court said that, if the compensable condition was a work-related injury and the suicide was unrelated to that injury, then the suicide was irrelevant and benefits may be continued pursuant to Kentucky law. The award was affirmed.

Advance Aluminum vs. Leslie, Supreme Court of Kentucky, Jan. 31, 1994 (BI/05/S.-\$10). **BI**

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

INTERNATIONAL

U.K. ruling is aid to policyholders when disputing voided policies

By ADRIAN LADBURY

LONDON—A long-awaited House of Lords decision making it more difficult for insurance underwriters to void contracts will redress what some lawyers say was an imbalance between insurers and policyholders in a vital area of insurance law.

Until the recent decision, an underwriter who had received incomplete or incorrect underwriting information could later void a contract, even if the misstated or missing information did not actually influence the underwriting decision. All the insurer needed to show was that a "prudent underwriter" would not have written the business.

Now, following the Law lords' July 26 ruling in *Pan Atlantic Insurance Co. Ltd. vs. Pine Top Insurance Co.*, an insurer will not be able to void a contract unless he can prove that he actually was "induced" to underwrite based on the missing or misstated information.

"If the misrepresentation or non-disclosure of the material fact did not in fact induce the making of the contract, the underwriter is not entitled to rely on it as grounds for avoiding the contract," said Lord Mustill.

The new law thus requires underwriters to prove they actually were influenced. London insurance lawyers and people in the market say that while the ruling involves a reinsurance contract, it will help primary policyholders, too.

"By adopting (the) argument that the actual insurer must show he was induced by the misrepresentation or non-disclosure, the House of Lords has disposed of the heresy that the actual underwriter can avoid giving evidence about his underwriting decision (and how he reached it) in cases where he asserts non-disclosure or misrepresentation," said Ince & Co., the law firm that represented Pan Atlantic.

Earlier cases that adopted the prudent underwriter standard transferred the risk of bad underwriting onto the insurance buyer, said Peter Rogan, a partner with the firm. "That was absurd. The House of Lords have reflected the commercial realities by shifting it back toward insurers. When disputes arise, this will be significant. But it will never be a substitute for careful broking and good security selection."

Another law firm specializing in insurance disputes, Barlow Lyde & Gilbert said, "A major criticism—that an insurer could use the prudent underwriter test as a charter for bad underwriting and cherry pick after the event by retaining only those contracts which were profitable

Continued on next page

Foreign insurers in Japan want bolder reform sooner

By KATE McILWAINE

TOKYO—Amid a climate of deregulation in some Japanese industry, insurance reform efforts are moving ahead very slowly and currently fall short of changes that are needed, foreign insurers charge.

A package of new regulations from the Ministry of Finance contains some insurance-related provisions set to take effect at the start of the next fiscal year, April 1, 1995.

But major reforms of the insurance industry are yet to be finalized and industry sources say the Finance Ministry has released only a skeleton framework of its reform proposals.

Foreign insurers and brokers

say they hope the Diet, the Japanese parliament, approves some form of deregulation before April 1, 1995, so it would take effect by April 1, 1996.

Increased policyholder protection is an important element of the preliminary reform proposals presented to the Finance Ministry by the Insurance Council. Created by the Japanese government, the council is an advisory body that is made up of academics, representatives of the insurance industry, employers and labor unions, explained Yoshiki Amamoto, manager of the international department at the Marine & Fire Insurance Assn. of Japan.

Among the council's reform recommendations are:

- Raising the minimum capital

requirements to 1 billion yen (\$9.97 million) from the current 30 million yen (\$298,950).

- Allowing life insurers to own more than 50% of non-life companies and vice versa. Composite insurers, or companies that offer both life and non-life, would still be banned.

- Allowing cross-ownership of more than 50% among insurance companies and banks, trust and securities companies.

- Setting up a system to transfer insurance contracts of an insolvent insurance company or allow them to merge with another company.

- Permitting brokers—which now provide only add-on services, like risk management and con-

Continued on page 19

Export credit directive

By MARIA KIELMAS

BRUSSELS, Belgium—Exporters would have an easier time comparing the premiums on long-term export credit insurance guarantees under a proposed European Commission directive.

Designed to facilitate cooperation among exporters in different European Union nations, the proposed directive would establish common principles for state-supported medium- and long-term export credit insurance guarantees and premiums.

The directive would make it easier to compare the guarantee premiums and would make the first decisive steps toward introducing more equal premiums for

European Union trying to harmonize conditions, premiums among nations

the same export insurance policy.

Despite a qualified approval from export credit insurers, some insurers worry that the proposal could hinder E.U. exporters at a time when competitors from Australia, Canada, Japan and the United States are receiving greater support from their own government credit agencies.

The proposed directive focuses on three main elements, said an E.U. statement published last month:

- The guarantee conditions in insurance contracts, including the types of risk covered, the percent-

age of the loss covered and all the other rules that together constitute the quality of the guarantee.

- The premium. The statement did not provide further details, but insurers say that they expect the premium to be calculated in a way that will greater reflect the risk involved.

- The availability of coverage for different countries, which varies according to the creditworthiness, and economic and political stability of the country and the extent of cover already given for each country in the insurers' over-

Continued on page 19

S&P claims-paying rating troubles Sphere Drake

LONDON—Sphere Drake Holdings Ltd. is disappointed that Standard & Poor's Corp. has not raised the BBB claims-paying ability rating of its London-based insurance subsidiary.

The BBB rating for Sphere Drake Insurance P.L.C. was unchanged when S&P's rating was released last week.

Sphere Drake contends that the rating should be higher based on 1993 net income of 11.7 million

pounds (\$17.3 million) and a capital injection from its parent last year of 20 million pounds (\$29.6 million), said Richard Gray, finance director of Sphere Drake. The additional capital helped boost the company's capital and surplus 41% to 106.2 million pounds (\$157.1 million) at year-end from 75.4 million pounds (\$114.2 million) at year-end 1992.

Mr. Gray also contends that an S&P press release on the ratings

contained inaccuracies.

S&P said that Sphere Drake Insurance "is the subject of some uncertainty as it may have to repay up to 57.5 million pounds (\$88.6 million at current exchange rates) of debt to the Alexander & Alexander Services Inc. group by June 1995, while remaining partially reliant upon A&A to honor long-term obligations under indemnities provided in 1987."

But, S&P did not say in the

press release that the debt is not held by the insurance company but by a separate subsidiary known as Sphere Drake Acquisitions (U.K.) Ltd. and thus has no effect on the insurer's balance sheet, Mr. Gray said.

He also said S&P did not emphasize that almost all of that debt will be offset by A&A under an indemnity agreement the brokerage made when it sold Sphere Drake in 1987.

However, S&P did say that "a very substantial part of the debt will be offset by the indemnities."

The rating agency added that A&A's financial weakness had raised questions about its ability to reimburse Sphere Drake, but concerns have been reduced following A&A's recently announced purchase of \$200 million of reinsurance for that exposure (BI, July 18).

—By Stacy Shapiro

First on the Bloc

Poland to phase in private pensions in coming years

By MARIA KIELMAS

WARSAW, Poland—In a first for the former East Bloc nations, Poland is trying to reform its national social security system and introduce private pensions.

But, Deputy Minister of Employment Leslaw Nawacki said a recently announced reform plan will take 10 to 20 years to implement.

The government aims to have a twofold pension system, one compulsory and one voluntary, a spokesman for the Ministry of Employment said.

Under the compulsory system, employers and employees would be required to contribute to a pension fund. The size of these contributions is still undetermined. Individuals could also choose to pay into any other pension plan or arrangement, the

spokesman said.

New private pension funds would be regulated and guaranteed by the state, said Mr. Nawacki.

The government is looking for ideas from private pension plans in other countries, such as Chile, though it would be impossible to simply copy another country's system, the spokesman observed.

Poland's low average salary—about 5.5 million zlotys (\$242) per month—makes the introduction of private pension plans problematical if they must be affordable to most people. "The average citizen will hardly be able to afford them," he said.

Poland's total annual social security bill is 80 billion zlotys (\$3.5 billion), a sum equivalent to the current budget deficit, the spokesman said. Poland's national budget consists of 500 billion zlotys

Continued on page 19



Photo by Patrick Doherty/Image Bank

Eventually businesses like this Warsaw restaurant will have to contribute to pension plans. But the changes will take effect over the next 10 to 20 years.

INTERNATIONAL

U.K. ruling

Continued from previous page and avoiding the rest—now appears to have been resolved."

One practical consequence of the ruling is that insurers may keep a closer eye on their underwriters, said London law firm Clifford Chance.

Charles Catt, managing director of NAC Re International Services Co. Ltd. in London, agreed. "It is without a doubt going to make life more difficult for reinsurers and will obviously make people more cautious about what they look at and what is

on the slip terms."

But Stephen Matanle, chief executive of Bowring Worldwide Insurance Brokers Ltd., said "the lords have done the market a service by introducing a fairer test in this area. If this reduces the number of disputes, as everyone hopes it will, clients will benefit."

In what lawyers say is a less important part of the decision, the law lords decided what constitutes "materiality" in the case of a misrepresentation or non-disclosure. Only misstatements or omissions of "material" facts can be used as the basis for voiding a contract.

The law lords ruled that a fact presented by a broker does not have to have a "decisive influence" on the final decision of the underwriter to be material, thus upholding the interpretation of Section 18 (2) of the Marine Insurance Act 1906 given by the Court of Appeal in *Container Transport International Inc. vs. Oceanus Mutual Underwriting Assn. (Bermuda) Ltd.* "Every circumstance is material which would influence the judgment of a prudent insurer in fixing the premium or determining whether he will take the risk," reads the 1906 Act.

"A circumstance may be material

even though a full and accurate disclosure of it would not in itself have had a decisive effect on the prudent underwriter's decision," said Lord Mustill in the lords' recent judgment.

Ironically for underwriters, the changes in the law came in a case won by an underwriter. The unanimous ruling by the five lords enables Pine Top to void excess-of-loss casualty reinsurance coverage it provided to PAIC in 1982.

Pine Top ceased paying PAIC's claims in 1985, after it investigated the information provided by Butcher, Robinson & Staples of London in 1982, when the broker per-

sued the reinsurer to renew PAIC's coverage. Figures given to Pine Top showed Pan Atlantic's outstanding losses were \$235,768, when the total of paid and outstanding losses was actually \$468,168. In March 1987, PAIC sued for payment of its claims.

The commercial court ruled in favor of Pine Top, which argued that the insurer's misrepresentation and non-disclosure voided the reinsurance contract, and PAIC appealed. The appellate court upheld the lower court's decision. PAIC then appealed to the House of Lords, which heard the case in February and March. **EL**

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NOTICE

NEW YORK CITY TRANSIT AUTHORITY NOTICE CM-975

The New York City Transit Authority is seeking to retain an Insurance Broker to furnish professional brokerage services in providing Owner-Controlled insurance coverage for the Authority's Department of Capital Program Management's four (4) 63rd Street/Queens Boulevard Connection construction contracts. The Owner-Controlled Insurance Program (OCIP), or Wrap-up concept embodies a single general liability insurance program for all involved entities, including the Authority as the owner and all contractors, as well as a single worker's compensation program for all contractors. The Authority will solely determine whether it is cost-effective, or otherwise advantageous to the Authority to accept contractor-supplied insurance for the four (4) construction contracts in lieu of the broker-proposed insurance which is the subject of this contract. The services are to be performed by a New York State-licensed Insurance Broker. For further information see the Request For Proposal (RFP), available free of charge by calling the Material Division's Bid Desk at (718) 694-3191 or 3192. The approximate total value of the four construction contracts is \$300 to \$400 million, and the duration of the contracts is seven (7) years, with additional time to be required for close-out issues, such as claims resolution.

The factors the Authority will consider in evaluating proposals are: experience in relevant areas, such as past performance with public or private agencies on similar projects in terms of cost control, quality of work, and compliance with performance schedules; experience and professional qualifications and designations (e.g. CPCU, ARM) of assigned personnel; demonstrated qualifications regarding acquisition and administration of OCIP's; a minimum of two (2) years experience in planning, developing, marketing and administering OCIP's; cost of services to be provided (based upon fees as proposed in the Price Proposal); quality of the Proposal as reflected in the clarity, organization and responsiveness of the Proposal documents; other resources and capabilities within the Broker's firm, including safety and loss control, claims management, management information/reporting capabilities, and other services; project staffing including subcontractors; a demonstrated understanding of the Authority's needs/desires with respect to an OCIP; adequacy and completeness of the Proposal with regard to all matters called for in the RFP; and the quality of the presentation.

The Minority/Women-owned Business Enterprise Goals for this project are 0%. A Pre-Proposal Conference will take place on August 8, 1994, at 130 Livingston Street, 10th floor, in Conference Rooms 3/4 at 10:00 AM. All inquiries must be received by the Authority by August 8, 1994, 4 P.M. local time, and should be directed to the individual at the address below. The Closing Date for the receipt of proposals is August 29, 1994, at 12:00 Noon, local time. Proposals are to be addressed as follows:

New York City Transit Authority
A/E Consultant Services, Procurement
130 Livingston Street, Room 6030E
Brooklyn, NY 11201
Attn: Ken Sultanof
Telephone: (718) 694-4106

PLEASE NOTE: Proposers are fully responsible for the delivery of the proposals in a timely manner. Reliance upon the U.S. Mail or other carriers is at the Proposer's risk. Late Proposals will not be accepted, nor will telephonic (facsimile) proposals.

Disadvantaged Business Enterprises will be given full opportunity to submit proposals and will not be subjected to discrimination on the basis of race, religion, color, sex or national origin in consideration of award. A full description of these and all other provisions are included in the proposal documents.

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UNIVERSAL UNDERWRITERS GROUP

The Specialists

INTERNATIONAL

Japan

Continued from page 17
sulting, for clients—to act more as intermediaries between policyholders and insurers.

- Setting up a registration system for brokers. Agencies are currently the dominant method of product distribution, and many companies use so-called "tied" agents to place their insurance. In Japan, a tied agent is employed by the corporation to place all of its insurance with a single insurer, usually one with which the corporation has shareholding ties.

- Requiring insurance contracts to have a cooling-off period—usually seven to 14 days before the policy is implemented in which the purchaser can negate the contract—to protect policyholders.

- Treating foreign insurers as domestics "to the extent possible."

To do this, the council recommends that Japan's two primary insurance statutes—the Foreign Insurers Law and the Insurance Business Law—be consolidated, with special provisions included to recognize the different legal status of foreign insurers.

- Dropping the requirement that non-life insurers use the expense loading calculated by industry rating bureaus.

Instead, an advisory expense rate would be set and insurers would need not notify the Finance Ministry of deviations from that rate. Non-life insurers would still have to use bureau-calculated premium rates.

Many foreign insurers and the American Chamber of Commerce of Japan say the council's proposals would not give foreign insurers true access to the Japanese market.

Few foreign insurers would speak for attribution because the discussions are at a sensitive stage. "It's likely to be re-regulation, not deregulation," one executive said.

Ironically, the 1993 withdrawal of U.S.-based Continental Corp. from Japan may be one reason the nation's regulators are reluctant to throw the market wide open. Some sources say Japanese regulators do not want to allow access to insurers that may later decide to quit the market.

The Insurance Council has not indicated that "any substantive liberalization of the insurance market is planned," said Kimio Morisaki, who is vp of Zurich Insurance Co. in Tokyo and vice chairman of the Foreign Non-Life Insurance Assn. "We feel the failure to adequately reform the insurance market only serves to protect... the interests of the leading (Japanese) insurance companies."

He was especially critical of a proposal to let both life and non-life companies enter the so-called "third area," the market for accident, sickness and nursing care insurance.

This is the market where foreign insurers have enjoyed their greatest penetration to date. Foreign insurers fear their market share will erode in this market—before the two primary markets are liberalized—if domestic life and non-life companies are allowed into a market that they say is "not life or non-life."

Fire and other lines of coverage should be liberalized before the third area market is opened up, said Pascal Paoli, chairman of the FN-LIA and general manager of Assurances Generales de France S.A.'s Tokyo branch.

Mr. Morisaki also faulted a proposal to let insurer associations regulate themselves. The Marine & Fire Assn., which recently changed its rules to allow foreign companies to join, is still dominated by domestic companies, he said.

"With critical, industry-level decisions being made by these top insurers, the voice of the small to medium-sized domestic insurer is clearly silenced," he said. Regulation by the industry association would "amount to allowing our largest competitors to police and restrict our activities."

Foreign insurers are concerned that the proposed self-regulation by organizations like the Marine & Fire Insurance Assn. would increase rather than decrease regulation of foreign companies, Mr. Paoli concurred.

Because Japanese statutes provide only the framework, leaving much of the substance of legislation up to a system of Cabinet Orders and Ministerial Ordinances, foreign insurers need to be consulted in the development of the ordinances, said Mr. Morisaki.

Foreign insurers are concerned the Insurance Council's proposals would still leave the industry "highly regulated," said Theresa T. Carney, regional vp of business development with CIGNA Insurance Co. in Japan and chairwoman of the insurance subcommittee of the American Chamber of Commerce in Japan.

Much of the "meat" on the proposals has not yet been made available and foreign insurers want some input on the final proposals, she said.

In a series of position papers, the Chamber has argued that foreign insurers' access to Japanese markets is restricted by the "keiretsu" system, in which major corporations are linked through cross-shareholdings with other companies, including insurers.

"These structural barriers, looked at in totality, have proven almost unsurmountable to small foreign and domestic insurance companies," said the Chamber. The strict regulation of product pricing and design means foreign insurers could not use product innovation to gain market-share.

The Chamber urged the Finance Ministry to eliminate the structural barriers, deregulate primary life and non-life lines of insurance before deregulating the third area and liberalize the approval process for new ratings and products to allow product differentiation and innovation.

Foreign insurers have put their views strongly to both the Ministry of Finance and to a recent U.S. trade delegation, said Mike E. Ingle, chief executive of Sedgwick Far East Ltd. in Tokyo.

Discussions are "in progress," but nothing has been finalized, he said.

Another foreign insurance company executive said discussions were "hot and heavy," though it was unlikely the Diet would have firm proposals to vote on during the fall session.

For all the insurer concern about market reform, brokerages may not notice much difference.

Stephen Roder, a partner at KPMG Peat Marwick in Tokyo, said recently at the 1994 Australasian Insurance Forum in Hong Kong that he expected product and tariff deregulation to be minimal.

"Full-scale product and tariff deregulation is just too much for corporate Japan to swallow, and the main aggressor, the United States, has not been able to make a compelling case," said Mr. Roder, who estimates that foreign insurers control about 3% of the Japanese insurance market.

Foreign brokers are represented in Japan, but they are "not really broking at all, but simply servicing their global clients locally in Japan," he said. He expects the agency, rather than a brokerage, system will continue to apply.

Poland

Continued from page 17
(\$22 million).

These figures provide a somewhat distorted picture since the real size of budgets in Eastern European countries are difficult to determine.

Under the present social security system, employees pay 48% of their gross annual salaries into the state-run social security and pension system, which is a holdover from the

days of the communist governments. Pensions and sickness benefits are paid by the state.

The new proposals for sickness benefits envision a system in which the employee would be paid benefits for the first 35 days of sickness by the employer, with any future sickness benefits met by the state system. The proposals would apply to both private-sector and government employees.

Mr. Nawacki also announced that the government next year plans to

introduce a new system of unemployment and health insurance.

Under these programs, employees and employers both would pay into a new state-regulated employment fund. Benefits paid out would depend on the employees' length of service and salary. This system is unlikely to come into force until the middle of 1996, he said.

Meanwhile, the Sejm, Poland's parliament, has appointed a special commission to examine all aspects of social security and pension reform.

Exports

Continued from page 17
all portfolio.

In each area, the overall aim is to define a "best practice" approach to export credit insurance based on European experience to date. Key points include:

- The overall objective of setting premiums and regulating country coverage so that overall premium income reflects risk and broadly covers the long-term costs arising from claims.

- The principle that a proportion of loss is left with either the exporter, the export credit authority or both, so that operators of the system have a consistent incentive to make responsible judgments on when to grant coverage.

- The progressive alignment of premium and country cover, so distortions of competition among member state exporters are reduced. This would prevent exporters in one country from paying more for coverage than conditions warrant while exporters elsewhere pay less.

"Far from being a straitjacket on the member states and their agencies, the directive would still leave them a wide degree of freedom to operate different policies under different conditions," the E.U. statement said. "Members' state assurers are allowed considerable leeway to diverge from the principles laid down, provided that they notify the commission and other member states, sometimes after the event but sometimes in advance."

The statement and directive, which should be published later this

year, is the culmination of more than two years of study by groups directed by Dominique Truffrau-Barriant, deputy director of international business at the French state export credit insurer, COFACE.

E.U. members have been working on ways to harmonize credit insurance since 1960. In 1970, the European Commission issued a directive on credit insurance harmonization, but this was widely ignored.

In the so-called "Truffrau report" issued in February 1994, the groups recommended that any E.U. harmonization proposals for export credit insurance should be limited to things that have a financial impact on the exporters or their bankers.

Among the areas the report suggested for further discussion: an exhaustive list of losses that could be covered; the percentage of the total value of the risk that would be covered; a classification of countries according to political risk and creditworthiness; and the waiting period for claims payment. The report said these recommendations were to be used as the basis for discussion among member states.

A spokeswoman for German export credit insurer Hermes Kreditversicherung said the E.C. directive was not in accordance with the proposals for harmonization outlined in the Truffrau report. Hermes is studying the statement, but the European Commission seems to be proposing rigid coverage limits, she said. "It is not possible to say to a country that you are not allowed to export more than so much."

Hermes believes some things should be left on a more informal level and that the harmonization of

credit insurance policies does not mean all countries should have a uniform policy. "Harmonization means getting closer but within certain margins," the spokeswoman said, noting that differences in coverage for exporters will remain, reflecting each country's national interests.

At the U.K. Export Credit Guarantee Department in London, a spokesman said the ECGD is pleased overall with the work of the Truffrau report and welcomes a system of premiums that reflect the cost of any particular risk.

The ECGD is concerned that if any E.U. directive stipulates that only a certain percentage of a risk may be covered, instead of 100% as at present, then this would affect the competitiveness of European exporters at a time when other government export credit insurers, such as the U.S. Export-Import Bank and Canada's Export Development Corp., offer exporters 100% of coverage. The ECGD is the only E.U. state export credit insurer that offers 100% coverage to exporters.

Italy's state credit insurer, Sace, regards the proposals as positive. "We have supported every proposal and we are in favor of common principles," said Dominico Colletta, Sace's E.C. representative.

He said that as E.U. members move toward a common foreign policy, differences in insuring political and credit risks in various countries will lessen.

Paris-based COFACE agreed with all of the recommendations of the Truffrau report but could not comment on the E.U. statement, a spokeswoman said.

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Authority

Continued from page 1

gets the job will work within a structure that provides a well-defined chain of command and considerable oversight in the process of procuring insurance coverage.

Those factors were apparently lacking in Chicago, where the Securities and Exchange Commission, the U.S. Attorney's Office and the CHA itself all are investigating the dealings of Mr. Lauer, who has been suspended without pay pending termination.

The SEC has named him in a civil complaint stemming from the possible loss of the pension funds in a bogus securities scam and charged him with misdirecting up to \$4 million of that money for his own use. Mr. Lauer, though, as yet faces no criminal charges.

In conducting an investigation for the CHA, attorneys are looking not just at Mr. Lauer's activities in managing the pension funds but at his insurance activities as well, including allegations that the risk manager made tens of thousands of dollars acting as an agent for an insurance company to which he awarded CHA business.

"We are investigating those reports and allegations, but we haven't reached any determinations yet," said Mark Pollack, a partner with Jenner & Block in Chicago. "We're going to investigate the procurement process entirely to determine whether all insurance that was purchased was appropriate and necessary."

He wouldn't comment on what sort of internal CHA controls Mr. Lauer may have been subject to in procuring insurance and handling claims.

"We're cooperating fully with the U.S. Attorney's Office in the course of the investigation and relaying any information to them that we think might merit their attention," Mr. Pollack said.

Federal oversight of insurance procurement activities through the Department of Housing and Urban Development, which funds public housing agencies like the CHA, is limited at best.

"They're supposed to get competitive bids on their insurance," said a HUD official in Washington. "We assume they are doing that correctly."

Certainly that's the case at the Los Angeles Housing Authority, where "everything goes out to bid," said Caroline Chung, the authority's acting risk manager and a candidate for the permanent position.

"Traditionally the housing authority has gone through an RFP process where we send out a request for (proposals on) the various coverages," she said.

A questionnaire Ms. Chung sends to bidders helps fill in the gaps and answer any questions that might not be covered in the proposal about coverages and services.

Points are awarded to proposals based on factors including price and coverage terms, and the bids are then evaluated by agency staff. Next, the authority's board of commissioners makes a preliminary review of the evaluations and asks questions about the bids.

After the commissioners' questions are answered, the risk management staff drafts a report for the authority's executive director, who reviews it and forwards it to the appropriate committee of the board before it moves to the full board of commissioners for approval.

"At any time in that process it can go back out for RFP again," Ms. Chung said. "So there are no clear winners until it is approved until the chairman signs it. It's kind of

nice because it takes out any question of impropriety. It's a nice system of checks and balances."

Attention to risk management has paid dividends in the Los Angeles authority's loss experience, which she said is "below industry averages given our exposure."

"The first day I looked at the claims, I thought, 'Where are the rest of them?'" she said. "I attribute that to our loss control programs in place."

Ms. Chung has been acting risk manager for the Los Angeles authority since the beginning of the year, replacing Albert Alvarez, who spent eight years in the post before leaving to become risk manager for the Housing Authorities Risk Retention Pool in Vancouver, Wash.

Unlike Mr. Lauer, who reportedly impressed Chicago Housing Authority officials with pension consulting work he'd done for the agency in 1990 but brought no risk management experience, Ms. Chung, though only 31, had a considerable risk management background.

Her resume includes risk management stints with Occidental Petroleum Corp., Security Pacific National Bank and a joint venture involved in the construction of the Los Angeles area's rail transportation system.

In seeking a permanent risk manager, Los Angeles Housing Authority officials put a premium on experience. Minimum qualifications for

the job include a four-year degree in an "occupationally related field" and four years of recently verifiable work experience involving responsibility for two or more of the following areas: risk determination and evaluation; insurance selection or procurement; property or liability claims administration; insurance accounting; safety administration, including both employee safety and loss prevention; and self-insurance administration.

The CHA's Mr. Lauer's educational background—he has a journalism degree from Marquette University in Milwaukee—and his lack of risk management experience isn't unheard of in public sector risk management.

In its most recent "State of the Profession" survey, compiled in 1992, the Public Risk Management Assn. found that only 34.1% of respondents with bachelor's degrees took their degrees in business administration.

Of the 32.5% of the survey group with master's degrees, public administration and business administration were the most common majors—together making up over half the group.

"I'm not sure that having a journalism degree would disqualify you from being a risk manager, but it's one of the more unusual backgrounds," said Dennis Kirschbaum, PRIMA's executive director.

As for Mr. Lauer's lack of prior

risk management experience, Mr. Kirschbaum said, "I wish I could say that it was incredibly unusual but we certainly have a lot of members who get into risk management through a very unusual route."

Many of the group's members had backgrounds in general administration or purchasing before being named to risk management positions, he said.

While Mr. Lauer's age surprised some, youth alone isn't a concern in selecting a risk manager if it's combined with the right sort of experience, said Bill Perry, president of Logic Associates Inc., a New York-based risk manager recruiting firm.

"There is no harm in the world in a young person having tremendous responsibility," Mr. Perry said. "We see that all over the country."

The questions raised by the CHA and Mr. Lauer turn more toward the authority's management than Mr. Lauer's youth, he said.

"I saw it as a lack of perception, a lack of understanding of what a quality risk manager should be," Mr. Perry said. "If you don't perceive it and you don't understand it and you don't think highly of the profession, then you open the door to trouble."

Michael R. Levin, a consultant with Towers Perrin in Chicago, said he was surprised by the lack of oversight Mr. Lauer evidently enjoyed at the CHA.

"This fellow had highly unusual

freedom to do the sorts of things he did for the public sector," Mr. Levin said. "Usually there's all sorts of multiple checks and balances and so forth."

The situation is far different in the private sector, where "they tend to have more latitude even than this guy had."

"Risk managers are just a bastion of a lot of arcane, very technical areas, and I'm not saying they are, but it's easy for a person to do all sorts of things," Mr. Levin said.

As the CHA continues to move toward dismissing Mr. Lauer, the housing authority has named two staff members to administer the risk management and benefits functions on an interim basis, and has transferred both from the agency's legal department to the office of the chief financial officer, said Katie Kelly, the CHA's chief of staff.

Ezio Morici, manager of risk management at the CHA, is heading the risk management operation for the time being, while Robert Lewis, a CHA benefits analyst, is the interim benefits head, Ms. Kelly said.

Oversight of risk management was moved from the legal department to the chief financial officer's office because "it needed some interim supervision," Ms. Kelly said.

"There isn't any plan right now to put (risk management) back within the legal department," she said, but noted that within organizations "anything can change." **BI**

Wohl

Continued from page 3

further away from their big city workplaces, workers are growing concerned about "frenetic pace of their daily existence and what it's doing to their children, what it's doing to their health, what it's doing to their marriages," she said.

Workers are realizing—more quickly than managers—that without a certain quality of life, it is very difficult to be quality workers.

Telecommuting could play a key role in easing stress and encouraging productivity, said Ms. Wohl. "If it gives one family a gift of four hours a week, that is wonderful."

The telecommuting project is only part of a job that includes overseeing the child care program for the federal workforce. Her 17-person office works closely with the regional network of child care coordinators in each of the 10 General Service Administration regional offices.

Currently, 97 centers provide day care to 6,000 children, and 35 to 40 more centers are scheduled to open in the next three to four years. All centers must be accredited under the standards of the National Assn. for the Education of Young Children.

Ms. Wohl says the mission of the office, which replaced the old Office of Childcare and Development Programs, is "driving changes in the federal workplace that enable our changing workforce to be fully effective."

She said the office is to be guided by the spirit of the National Performance Review and its so-called "reinventing government" report (BI, Sept. 13, 1993).

"Government needs to be a model employer" she says. But government initiatives are not widely publicized. In fact, Ms. Wohl said, until she took the job she "did not know of how much the federal government has already done in trying to develop good programs."

So good are those programs, she said, that part of her duties is marketing, getting the word out about federal efforts and encouraging private companies to follow suit.

Ms. Wohl—who keeps her home

in Landenberg, Pa., near Delaware—found out how flexible her employer could be during a difficult first few weeks on the job.

After her husband died suddenly, she found herself commuting during a particularly harsh winter.

Encouraged by her superiors to "exemplify the work of your office," she began telecommuting some days. Now, though her travel schedule has been hectic, Ms. Wohl says that whenever "I'm going to be in the office for a whole week, I like to have a day in the middle of the week to work from home."

Telecommuting, she stressed, is not just working from home. Some people just cannot function efficiently doing that. Her \$6 million federal pilot program includes setting up telecommuting centers with computers and fax machines.

The Washington area centers, located in Hagerstown and Waldorf, Md., and in Fredericksburg and Winchester, Va., have proved to be so successful that each is considering expansion or establishing a satellite office in a neighboring town or county, says Ms. Wohl.

The four sites contain a total of 68 workstations, and are used by about 130 federal civilian and military employees, each of whom works from a telecommuting center one or two days a week.

Ms. Wohl foresees this program going nationwide, particularly since it has proved its value in earthquake ravaged Los Angeles. She also foresees a greater private sector emphasis on telecommuting.

"We would like to envision a telecommuting center that's in a sort of neighborhood or Main Street environment that not only would service the needs of the people who work in it one or two days a week but could become a resource hub for all the homebound telecommuters in that environment," she said.

Centers would include meeting rooms, provide a place for couriers to drop off and pick up packages, and maybe facilities for video conferencing.

Not that she envisions empty offices: Many people will only telecommute a couple of days a week.

But even that degree of telecommuting will pay handsome benefits.

For example, the technique cuts auto emissions and thus makes it easier for communities to meet air quality standards mandated by the Clean Air Act. But to Ms. Wohl, the quality of life issues are even more decisive.

"If you look at the complexity of people's lives, if you look at the ability of bringing services back to the community, if you look at reduced congestion on the roads and reduced use of energy, there's a long list of things that believe me are not unique to Washington and L.A., although both of those cities offered a really good place to test some of this," she says.

It's good for the businesses that rely on telecommuting as well, she says. According to Ms. Wohl, people who work outside the normal office environment tend to be more productive because they face fewer interruptions and distractions, aren't bothered by meetings and don't spend time socializing with coworkers.

It will also bolster local economies: "By putting people back into the Main Street U.S.A. environment instead of the isolated downtown city core that's going to be good for the vendors, stores and services of small towns."

Natural disasters "have reminded us of fragility of the whole plan we have to get people to work," she says. From Hurricane Andrew to the Los Angeles earthquake and all of the floods, wildfires and winter storms that have wracked the country in recent years, "people are starting to see how easy it would be to compromise the daily patterns of life and commerce we depend on."

The pilot program has led Ms. Wohl and her employees to look at new questions about telecommuting. These include the best locations for centers, how to evaluate telecommuting's effectiveness and how best to train people to handle it.

The telecommuting experiment exemplifies one of Ms. Wohl's guiding principles. "I am a great personal advocate of finding ways to reduce stress on people."

Once a working mother, she now has grandchildren in day care. "I've lived personally all these issues."

One work/family area likely to be-

come more important in the near future is elder care (BI, July 25).

Though child care and care for the elderly may appear similar, Ms. Wohl cautions that the two are really quite different. And that raises "big questions" about on-site elder care as a workplace benefit.

"If you have a group of 20 2-year olds, there will be some variation, but they're essentially at the same stage in life," she says. They're all growing up, they'll become 3-year-olds.

But a group of 20 80-year-olds will display a wide range of mental and physical abilities, she says. "The only thing you do know is you don't know that all of them will become 81," says Ms. Wohl. There is one other irrevocable fact: All will deteriorate.

It's also "almost impossible" to project who will need eldercare and when, she points out.

However, an elder care referral service such as what she oversaw at DuPont proved to be "a powerful tool." In addition to providing employees with valuable information about the type of care an elderly parent would need for a particular illness and whether home services would be needed, the referral service also provided a "wonderful compassionate source of information and counseling." **BI**

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Reforms

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with cost increases that exceed certain targets. That tax not only would boost costs, but may saddle benefit managers with a mountain of rules and ultimately prove to be unworkable.

And both measures would require employers to offer traditional indemnity plans. Even firms that have switched completely to more cost-effective managed care programs like health maintenance organizations, would have to resurrect their indemnity plans, which many benefit managers consider to be dinosaurs.

In sum, benefit managers say, health care reform legislation—at least as currently drafted—could mean a new surge in health care costs just as employers have finally begun to control costs.

"We are going to end up as big losers," said Robert Dankmyer, vp-corporate benefits at Marriott Corp. in Bethesda, Md.

"Employers are going to get clobbered with extra taxes and costs," said Mr. Sullivan, of the National Business Coalition on Health.

These concerns come as new delays and uncertainties cloud congressional consideration of health care reform legislation.

While House Democratic leaders had earlier pledged consideration of a proposal by Majority Leader Rep. Richard Gephardt, D-Mo., by the end of this week, they now say final action may not come until next week.

Rep. Gephardt, who developed the proposal to be considered by the full House, had not unveiled the complete version of his bill as of late last week, contrary to earlier promises.

In fact, rumors fueled by lobbyists were circulating last week that Rep. Gephardt would withdraw his proposal and present a new one more along the lines of the bill by Senate Majority Leader George Mitchell, D-Maine. Rep. Gephardt's aides only would say that the drafting process is continuing.

Sen. Mitchell on Aug. 4 unveiled the legislative language of his bill, numbering more than 1,300 pages, though not an explanatory report.

As drafting continued, a number of key issues were yet to be resolved. The most important of these is whether the House bill would provide financial relief to employers that offer health care benefits to employees retiring before they are eligible for Medicare.

The outline to the Gephardt proposal says some assistance would be provided for current retirees, but provides no details.

The Clinton administration had originally proposed that the federal government pay 80% of early retiree health care obligations, a huge windfall for Rust Belt companies like automakers and steel producers, which have promised billions of dollars in health care benefits to early retirees.

Meanwhile, President Clinton began a new media blitz to drum up support for health care reform legislation. Last week, he devoted much of a press conference to health care reform, while he also began an advertising campaign—paid for by the Democratic National Committee—to push for enactment of legislation.

At the same time, President Clinton said he could accept both the Gephardt proposal, which would require all employers to pay 80% of health insurance pre-

miums and achieve universal coverage by 1999 (BI, Aug. 1), and the Mitchell proposal, even though the measure would not assure universal coverage—an element of health care reform that the president earlier said that he would never compromise on.

The Mitchell proposal's goal is to increase the percentage of the population with health insurance—currently between 83% and 85%—to 95% by the year 2000. To reach that target, the measure would subsidize insurance premiums for lower-income individuals. It also would cap premium costs in specific categories—such as part-time workers—for employers offering coverage for the first time to all employees. That employer subsidy would continue for five years.

If that 95% target were not met and Congress took no other action, an employer mandate would start in 2002 in states where less than 95% of the population had health insurance. The mandate would require employers to pay 50% of health insurance premiums. Employers with fewer than 25 employees, though, would be exempt.

In the press conference last week, President Clinton dodged the question of how he could support such two different bills, especially the Senate bill.

"I'm not going to get into being a legislator," he said.

As lawmakers prepare to debate the House and Senate proposals, employers are growing increasingly concerned that health care reform will significantly raise their costs.

Employers point to a number of provisions in the House and Senate reform proposals, including:

- **Medicare Part C.** Under the House proposal, the federal Medicare program, which now covers only the elderly and disabled individuals, would be greatly expanded. This expanded program, known as Medicare Part C, would be opened up to uninsured, low-income individuals and employees working for companies with fewer than 100 employees. The government would subsidize premiums for individuals with lower incomes. With this expansion, Medicare could cover more than 100 million people, up from the current 36 million.

Benefit managers say Medicare now controls its costs by underpaying health care providers. Providers then pass the shortfall on to privately insured patients.

"Medicare shifts dollars onto my health care budget," said Bob Bonin, manager of benefits administration at First Chicago Corp.

If Medicare were tripled in size, the problem of cost-shifting to employers could explode.

"It is going to be a huge cost-shift, and is something that hasn't but should be focused on," said Edward J. Davey, director of health and welfare at Buck Consultants Inc. in New York.

- **Premium taxes.** Both measures would directly increase employer costs by imposing a new federal tax on health insurance premiums and self-insurance plans. The House bill would set the premium tax at 2%, while the Senate bill calls for a 1.75% tax.

- **Flexible benefit plans.** Both House and Senate bills would wipe out the funding of health care benefits through all types of flexible benefit programs. This ban would include premium conversion plans, in which employees pay a portion of premiums with pretax contributions, and flexible spending accounts, in which em-

ployees transfer pretax contributions to FSAs to pay for uncovered medical expenses.

Wiping out the tax advantages of flex plans would increase both employee and employer costs.

Employees' costs would jump because they would have to pay for health care premiums and medical expenses with aftertax dollars.

Employers' costs also would rise if health care premiums and expenses could not be funded through flex plan arrangements. That is because with pretax contributions no longer being allowed to pay for health care premiums and expenses, employees' gross

'Employers are going to get clobbered with extra taxes and costs,' says Sean Sullivan.

incomes—which are the base for determining Social Security payroll taxes paid equally by employers and employees—would increase.

- **Benefit plan taxes.** The Senate bill would impose a 25% tax on health plans whose annual cost increases exceed certain targets. The tax, which would be paid by employers and insurers, would be triggered if a plan's annual cost increase was greater than the rise in the Consumer Price Index, plus two percentage points.

A benefits plan tax could be unworkable, benefit managers say. They note that a mountain of rules and regulations covering a variety of issues—changes in employee

demographics, company size, fees paid to administrators and consultants, just to name a few—would be needed to implement the tax.

"It is going to be a very significant administrative burden. That is not something we need," said Michael Pikely, corporate actuary and benefits consultant at Hartmarx Corp. in Chicago.

- **Any willing providers.** The House bill would require certain managed care organizations to contract with providers that meet their contract terms and quality standards if there are openings for those providers. The Senate bill lacks a similar provision.

While the impact of the proposal has been exaggerated—it would not require, contrary to some assertions, health maintenance organizations to take on providers they don't need—employers say the requirement could interfere with the delivery of care.

HMOs, says Marriott's Mr. Dankmyer, could be forced to retain physicians who may not work well in a group setting. "The notion of working as a team could go out the window," he said.

A slew of other provisions in the two bills also could increase employers' health care costs.

Employers, for example, are concerned about provisions in both bills that would require companies to offer multiple health care plans to employees. The House bill would require employers to offer a traditional indemnity plan and a managed care plan, while the Senate bill says employers would have to provide three plans: an indemnity plan, an HMO and a point-of-service plan.

While major employers often offer both managed care and indemnity plans, they might not offer all

three types of plans at all company locations.

"Offering three health plans in locations with just eight or nine employees" is not something companies would relish and would prove costly, said First Chicago's Mr. Bonin.

In addition, managed care programs, especially POS plans, are not widely available in all parts of the country.

"Legislators don't seem to be aware of that basic fact," said Marriott's Mr. Dankmyer.

In particular, benefit managers say they can understand why legislators would want to require employers to offer health plans, like preferred provider organizations or POS programs, that give employees the choice of receiving care from a plan's network of providers or their own, albeit with higher levels of cost-sharing.

But they say it would be terrible health care policy to compel employers to provide high-cost traditional indemnity plans that offer employees unlimited choice of providers.

"It is fair to require choice. But why unlimited choice? Those kinds of plans are what got us in trouble in the first place," said Dayton Hudson's Mr. Hamacher.

Finally, benefit managers worry that in the last-minute rush to pass legislation, Congress will put together huge bills in such haste that many details will not be clarified, making it difficult for employers to know exactly how they would have to comply.

"The bills are going to be so massive that it could be difficult just understanding what is expected in terms of compliance," said Nina Falci, benefits supervisor at Engineering Research Associates Inc. in Vienna, Va. **BI**

Work comp still in limbo

Employers protest, labor supports efforts to include it in reform

By MEG FLETCHER

WASHINGTON—Employers oppose proposals to alter the state-based workers compensation system that still are part of the health debate as floor votes near in both chambers of Congress.

Joined by insurers, brokers and agents, employers are stepping up their phone calls, letters and faxes to legislators in hopes of raising the profile of workers comp and nipping any changes in the bud.

Specifically, industry groups and employer coalitions want Congress to view workers comp changes as "a killer issue"—one that would kill any health care bill—and they want to expose what they call the myth of small-business support for altering the workers comp system.

They face an uphill battle. The Clinton administration has long viewed the workers comp changes as having the political potential to offset small-business opposition to an employer mandate. And the House Democratic Caucus similarly sees the changes as a source of "relief for small businesses."

Employers small and large dispute the claim that business would benefit from changes like requiring injured workers to receive care only through their usual health plan or a special state-designated facility.

"I know of no groups or statistics that support cost savings for small business by including workers comp in national health care," said Earlyn Church, vp of Superior Technical Ceramics Corp., a St. Albans, Vt., manufacturer with 100 employees. She is also chairwoman of the National Assn. of Manufacturers Risk

Management Committee and a NAM director.

Including workers comp would increase costs for all employers, Ms. Church said.

For example, providers would be more inclined to consider ailments work-related if employers had less of an opportunity to question that conclusion.

Offsetting increased employee benefit costs with workers comp medical savings is "a bogus bargaining chip," said Mark Stuart, executive assistant at lobbying and research organization UBA Inc., which chairs the Employer Coalition on Workers' Compensation. The coalition includes nearly all major small business groups.

But Rep. Earl Pomeroy, D-N.D., points out, "There is tremendous appeal to (saying) to small employers upset about new mandates that we're giving you a break on your workers comp premium."

He recently co-authored a letter signed by 28 House Democrats and eight Republicans opposing the "well-intentioned but ill-conceived proposal to combine workers compensation insurance with health insurance."

Both the current Senate bill and the current House bill outline workers comp changes. More detailed language is expected soon from House Majority Leader Richard Gephardt, D-Mo. Senate Majority Leader George Mitchell, D-Maine, released his detailed language late last week.

Both bills would set up commissions to study the feasibility of completely integrating workers comp by transferring financial responsibility for workers comp to health plans, among other things. The Senate bill calls for a report by the year 2000, while the House wants it in two years, and added a requirement that Congress should vote on it.

In addition, the Senate bill appears to extend to health plans and providers an obligation employers currently face to report suspected cases of occupational disease to the Occupational Safety and Health Administration. "It looks like a backdoor attempt to increase reporting requirements to OSHA," said Tom O'Day, associate vp with the Alliance of American Insurers.

Employers generally fear such reports could be used to target OSHA's enforcement actions.

The House bill also outlines several other measures, which closely track measures in a bill adopted by the House Education and Labor Committee (BI, July 11).

Under the House bill, state laws governing workers' choice of doctor would be pre-empted so workers could receive their medical care for work-related injuries from the health plan from which they receive their regular benefits. Each health plan would be required to have "occupational health care providers."

Injured workers could, though, "unilaterally" choose to go to state-designated "occupational health centers of excellence."

In an apparent effort to prevent cost-shifting, the bill would stop providers from charging more to

Continued on next page

Comp

Continued from previous page
treat work-related injuries than other injuries.

It is not entirely clear how the House bill would have employers rated for the medical and indemnity or wage-loss portions of workers comp.

In his outline, Rep. Gephardt said, "Employers would continue to purchase experience-rated workers compensation insurance from insurers."

And, in a July 25 letter, Rep. William D. Ford, D-Ky., chairman of the Education and Labor Committee, and Rep. Pat Williams, D-Mont., said the panel's bill "does not provide for community rating of workers compensation premiums" and would emphasize the importance preserving an employer's individual record.

Yet congressional aides say that the medical portion would be community-rated and only the lost-wage portion experience-rated, according to spokesmen for the employer coalition and several insurance industry trade groups.

If that is not done immediately, it must eventually be done to simplify the system, they say.

"I think the industry's discussion is substantively accurate," Mr. Pomeroy added.

Community rating of medical costs, which constitute about 41% of all workers comp costs, would significantly reduce the income of many insurers and agents, said Robert Rusbuldt, vp of federal affairs for the Independent Insurance Agents of America.

James Ellenberger, assistant director for the AFL-CIO's department of occupational safety and health, dismisses the issue as a

"red herring" and called statements that a portion of workers comp would be community-rated "flatly inaccurate."

Reaction to Rep. Gephardt's workers comp proposal was predictable, with employers opposing it and labor supporting it.

The Risk & Insurance Management Society Inc. opposes it because "it takes away from employers the ability to control workers comp costs," said Lance Ferris, chairman of RIMS' Employee Benefits Legislation Committee and corporate risk manager for Zurich-American Insurance Group in Schaumburg, Ill.

Overall workers comp costs

'The major problem is the inclusion of more than the drafters intended,' says Gregory A. Saxum.

would rise 15% to 30%, estimates Tom O'Day, associate vp with the Alliance of American Insurers, an insurance industry trade group.

"The major problem is the inclusion of far more than the drafters might have intended or believed," said Gregory A. Saxum, director of workers compensation for Eastman Kodak Co. in Rochester, N.Y. The medical side of a workers comp claim raises questions—and provides answers—about the cause of a claim, extent and degree of disability, need for and appropriateness of medical care and apportionment of disability.

Also, liberal access to providers, including those at an occupational

health facility, invites "spurious claims, trial bar manipulation with litigation for profit, system gaming and fraud," said Robert B. Stegert, vp-casualty claims for Marriott Corp. in Bethesda, Md.

"The best and balanced answer is managed care organizations certified by the state that have vigorous oversight as far as practice parameters and dispute resolution," Mr. Stegert said.

For its part, the AFL-CIO backed the Gephardt legislation as a way to control health costs. The labor organization's long-term goal, however, continues to be full integration of the workers compensation system and elimination of insurers who "are riding a golden horse and don't want anyone to upset it," said the AFL-CIO's Mr. Ellenberger.

The final wording of the House legislative proposal also may resolve other uncertainties. On the House side, these include the role of self-insured employers, case managers and state workers compensation administrators.

In an interesting twist, neither bill uses for its workers comp section the Title X designation introduced by President Clinton and referred to, until now, by other committees. The new Senate bill uses Title IX and the House bill outline uses Title XI.

That "clever" change "makes it more difficult for us, since 'Strike Title X' has been our slogan and even the (insurance industry) coalition's name," said Joel Wood, vp-government affairs for the Council of Insurance Agents & Brokers (BI, July 11).

"It's a perfect example of how the congressional leadership is attempting to dodge the bullets directed at their heads," Mr. Wood said. **BI**

Antitrust reform in one health bill

By MARK A. HOFMANN

WASHINGTON—House Judiciary Committee Chairman Jack Brooks, D-Texas, isn't slowing down in his efforts to reform the McCarran-Ferguson Act.

In fact, he's pushing harder than ever to scale back the antitrust protections provided to insurers by the federal law.

Rep. Brooks last week replaced the antitrust section of H.R. 3600, the House's health care reform bill, with the text of H.R. 9, the Insurance Competitive Pricing Act of 1994.

H.R. 9 would limit insurers' ability to engage in certain joint activities without violating antitrust law, while stopping short of outright repeal. Health care reform bills approved by several congressional committees would have repealed health insurers' McCarran-Ferguson exemptions but not affected property/casualty insurers.

But there's no guarantee that any health care reform bill will contain H.R. 9: House Majority Leader Richard Gephardt, D-Mo., has given no indication whether he will accept H.R. 9 as the antitrust language of the House's health care reform package.

Rep. Brooks offered H.R. 9 as a substitute to H.R. 3600's antitrust language after Rep. Hamilton Fish, R-N.Y., the ranking GOP member of the Judiciary Committee, offered his own amendment to the health care reform bill. Rep.

Fish's bill would have removed all mention of the McCarran-Ferguson Act from H.R. 3600.

Rep. Fish said the bill's repeal of McCarran-Ferguson protections for health insurers was "overly broad" and "inconsistent with both the letter and the spirit" of H.R. 9, which provides certain "safe harbors" for joint activities undertaken by property/casualty insurers.

Before a vote could be taken on Rep. Fish's amendment, Rep. Brooks announced his "reluctant" opposition to the Fish measure. Instead, he offered H.R. 9 in its entirety as a replacement for the health care bill's McCarran-Ferguson language. He said that the "progress we've made in forging a

'This controversial amendment surely won't add any votes to the bill,' says David M. Farmer.

balanced product" that reduces antitrust protections "should not be disregarded."

The Judiciary Committee voted 20-15 to replace the health care reform bill's antitrust language with H.R. 9. Members voted exactly as they had when they approved the bill 11 days earlier (BI, July 25). All the Republican members opposed H.R. 9 in both votes. Only freshman Rep. David Mann, D-Ohio, broke with his fellow Democrats to vote against H.R. 9 both times. Rep. Mann's district is

home to several medium-sized insurers.

Reforming the McCarran-Ferguson Act has split the property/casualty industry, with the American Insurance Assn., the Council of Insurance Agents & Brokers, the Independent Insurance Agents of America and the National Assn. of Insurance Brokers supporting change and all other producer and insurance company groups opposing it. As a result, reaction to Rep. Brooks' maneuver was mixed but predictable.

"I think it's terrific," said Texas Insurance Commissioner J. Robert Hunter, former head of the National Insurance Consumer Organization and a longtime advocate of repealing the McCarran-Ferguson Act. He called the health care reform bill an "appropriate" vehicle for H.R. 9.

"The legislation the committee inserted into (H.R. 3600) goes well beyond the scope of anything related to health care and is best left to live—or hopefully die—on its own," said David M. Farmer, senior vp-federal affairs for the Alliance of American Insurers in Washington. "The addition of this controversial amendment surely won't add any votes to the president's bill."

The Judiciary Committee also addressed medical malpractice liability reform in its review of H.R. 3600. The panel approved limiting attorneys' fees in malpractice cases to one-third of damages but defeated an amendment to limit non-economic damages in such cases to \$350,000. The malpractice reforms fall short of what the administration originally sought. **BI**

Updates

Resin plant explosion insured

NORTHBROOK, Ill.—Lawter International Inc. is fully insured for damage and business interruption stemming from a July 15 explosion and fire that destroyed a portion of a month-old resin manufacturing plant in Pleasant Prairie, Wis.

The specialty chemical firm had an all-risk policy written by Zurich American Insurance Co. with a \$35 million per occurrence limit. While the cause of the explosion is still under investigation, William S. Russell, vp-finance for Lawter, said property damage is estimated at \$3 million to \$4 million. There were no serious injuries.

Business interruption claims will not be determined until the plant resumes operations, which could take up to six months, Mr. Russell said, adding that any claims will be covered under the all-risk policy.

Unitrin ratings under review

CHICAGO—A.M. Best Co. has placed the ratings of Chicago-based Unitrin Inc.'s insurance units under review with negative implications after a \$2.6 billion hostile takeover bid from American General Corp.

Unitrin, the holding company of several property/casualty and life/health insurers, received the unsolicited \$50.38-a-share offer from American General last month. After Unitrin's board rejected the proposal, American General last week announced its bid.

Unitrin announced Thursday that its directors had adopted a "poison pill" anti-takeover plan and on Friday charged that the deal would violate federal antitrust laws.

Best placed the Unitrin units' ratings—which range from A- to A++—under review after noting that American General has said Unitrin is overcapitalized by \$1.4 billion, raising the possibility that it might pull funds out of the units to reduce acquisition-related debt.

Ratings of American General were not placed under review.

Unitrin, whose subsidiaries include Trinity Universal Insurance Co. and Pyramid Life Insurance Co., generated \$534 million in life/health premiums and \$522.2 million in property/casualty premiums in 1993.

Retiree health care accounts

WASHINGTON—The Senate Finance Committee last week approved an amendment that would extend for five more years a 1990 federal law that allows employers—on a tax-free basis and without terminating their pension plans—to transfer surplus pension plan assets to a special account to fund retiree health care benefits.

Under the 1990 law, which is due to expire next year, employers may transfer surplus assets to a so-called 401(h) account to pay current retiree health care expenses for that year.

However, that law contains certain restrictions that limit the appeal of retiree health asset transfers. For example, pension plan participants must be vested before a transfer is allowed.

The amendment, approved as part of trade legislation, would allow the transfers through the end of the year 2000.

Briefly noted

The Los Angeles earthquake did \$7.2 billion in insured property damage, estimates the Property Claim Services Division of the American Insurance Services Group. PCS estimates that 300,000 claims will ultimately result from the quake... Today is the deadline for employers to opt out of a \$13 million ITT Hartford Insurance Group settlement of a lawsuit that alleges that thousands of Texas employers were overcharged for workers compensation coverage... A bill limiting the product liability of general aviation aircraft manufacturers needs only President Clinton's signature to become law. The House approved S. 1458 on Aug. 3 one day after the Senate gave its final approval to the bill, which sets a single 18-year standard of repose for small planes, including those currently flying, unless a suit has already been filed... Philip L. Wroughton, former chairman of Marsh & McLennan Inc., has been named vice chairman of the parent company, Marsh & McLennan Cos. Inc. ... William H. Bolinder, chief executive officer at Zurich-American, has been appointed to the corporate executive board of Swiss parent company Zurich Insurance Company. His new responsibilities will include the U.S. and Canada and international industrial business, risk engineering and the specialties underwriting office... Former Lloyd's of London chairman David Coleridge will retire from his job as Chairman of Sturge Holdings P.L.C. at the managing agency's annual general meeting in February 1995. He will be replaced by Lord David Poole... Eleven Lloyd's of London run off syndicates, managed by four underwriting agents with 1.95 billion pounds (\$2.99 billion) of capacity under management and 103 staff, have been transferred from Merrett Underwriting Agency Management Ltd. to Whittington Syndicate Management Ltd. The combined run off operation will have roughly 2.4 billion pounds (\$3.68 billion) open year capacity under management. The Merrett Group, which no longer actively underwrites, will now concentrate on its loss adjusting, computer services and other insurance based services... Standard & Poor's Corp. moved Alexander & Alexander Services Inc. off CreditWatch for its subordinated debt and affirmed a BB- rating... William F. Poe, founder and former chairman and chief executive officer of Poe & Associates for 37 years, retired as chairman of Poe & Brown Inc. Mr. Poe, 62, will remain a director with the company... Half of the Big Six accounting firms last week took advantage of a new state law permitting general partnerships in New York to shield partners from liability in certain cases by reincorporating as limited liability partnerships... The Connecticut Hospital Assn. has filed a lawsuit seeking to have a 6% state sales tax and 11% gross earnings tax now levied on hospitals overturned as violating the Employee Retirement Income Security Act.

Markets

Merged HMO to be in Top 10

RANCHO CORDOVA, Calif.—Foundation Health Corp.'s planned purchase of Intergroup Healthcare Corp. for \$720 million will propel the Rancho Cordova, Calif.-based managed care company into the ranks of the nation's largest health maintenance organizations.

Foundation Health currently provides managed care services to about 551,000 HMO and preferred provider organization members. The Intergroup acquisition will add about 480,000 HMO and PPO members.

Combined, the two will be the nation's eighth-largest general service HMO, with more than 1 million members in 10 states.

Under the proposed transaction, Foundation Health will also acquire Intergroup's majority shareholder, Thomas-Davis Medical Centers P.C.

That company employs 190 physicians who provide services to 130,000 Intergroup members and other patients through 15 primary care centers and seven urgent care centers in Arizona, as well as two behavioral health centers and one surgery center. All the centers are either owned or leased by TDMC.

The combination of Foundation Health and Intergroup and TDMC, both of which are based in Tucson, together with recently announced Foundation Health HMO acquisitions pending in South Florida and Colorado, will create a managed care company with annual revenues of more than \$2.4 billion.

Daniel D. Crowley, Foundation Health's president and chief executive officer, said the merger offers "strategic benefits," including "expanded opportunities to cross-sell Foundation's specialty services products, including mail-order pharmacy, group term life insurance and workers compensation."

The purchase also allows Foundation Health to expand "throughout the South and West in markets with opportunities for continued growth," he said.

Intergroup offers coverage in Arizona, Utah, New Mexico, Colorado, Nevada and Nebraska through its HMO and Gem Insurance operations. Foundation Health operates HMOs in California and Louisiana and services government employees enrolled in a CHAMPUS program in Texas and Louisiana. The company is applying for additional HMO licenses in Central Florida, Alabama, Oklahoma and other

areas of Louisiana and Texas.

Market analysts were a bit surprised by the terms of the deal, which calls for a stock-for-stock transaction valued at about \$720 million. Foundation Health will acquire TDMC and its 62.6% interest in Intergroup for about \$444 million in value of Foundation Health common stock in a tax-free pooling of interests. Each of the remaining 3.6 million shares of Intergroup stock will be exchanged in a purchase transaction at the option of the Intergroup shareholders for \$65 in value of a new series of preferred stock convertible into Foundation Health common stock at 22% conversion premium and a dividend rate of 6%.

In general, analysts said the deal would be beneficial to Foundation Health, but some noted that the \$65 per share price was at the high end for recent HMO acquisitions.

Foundation Health also will assume employee options for 600,000 shares of Intergroup stock.

Intergroup President and CEO Rick Barrett, TDMC CEO Glen Randolph, TDMC President Dr. Timothy Peterson and TDMC Medical Director Dr. Ross Henderson will continue in their current positions.

MetLife, PhyCor team

WESTPORT, Conn.—MetLife HealthCare Management Corp., an affiliate of Metropolitan Life Insurance Co., has entered into a business arrangement with PhyCor Inc., operator of multispecialty medical clinics.

MetLife HealthCare, based in Westport, Conn., operates health maintenance organizations in 15 markets. Under the agreement, Nashville, Tenn.-based PhyCor will provide physician networks and medical management in six U.S. markets where MetLife HealthCare has or is introducing a managed care product.

PhyCor operates or has agreements in principle with 21 multispecialty medical groups in 13 states, each run under long-term agreements with physician groups. About 1,000 doctors are affiliated with PhyCor.

Sanus to buy ETHIX

Sanus Corp. Health Systems, a unit of New York Life Insurance Co., announced that it will acquire The ETHIX Corp., a Portland, Ore.-based managed care firm with more than 700,000 PPO enrollees in 12 states.

Together, ETHIX and Sanus will serve more than 1.7 million managed care customers.

Managed comp venture

BOSTON—Liberty Mutual Insurance Co. and Healthsource Inc., a managed health care company with HMOs in the Northeast, Midwest and Southeast, have entered into a joint venture to use managed care services to control workers compensation medical and indemnity costs for New Hampshire businesses.

The program was made available to businesses in the voluntary workers compensation market July 1.

The two companies estimate the program will save New Hampshire businesses about 20% on the medical portion of workers comp costs and 10% on overall workers comp costs. The program will see Boston-based Liberty Mutual combining its occupational health and safety and disability management expertise with Concord, N.H.-based Healthsource's medical management experience.

Liberty Mutual will continue to offer managed care and claim services as well as financial and actuarial advice to its New Hampshire customers.

Healthsource will provide medical management and network services designed specifically for workers comp for customers participating in the program.

Liberty Mutual's program is part of "LibertyWorks," the insurer's national workers compensation managed care network.

As part of LibertyWorks, Liberty Mutual has been offering employers another workers comp managed care product called "Ultra" that involves partnerships with HMOs that have occupational injury expertise.

Liberty Mutual has so far teamed up with Cypress, Calif.-based PacificCare Health Systems Inc. and Blue Cross & Blue Shield of Massachusetts HMOs to offer that product (BI, Feb. 28).

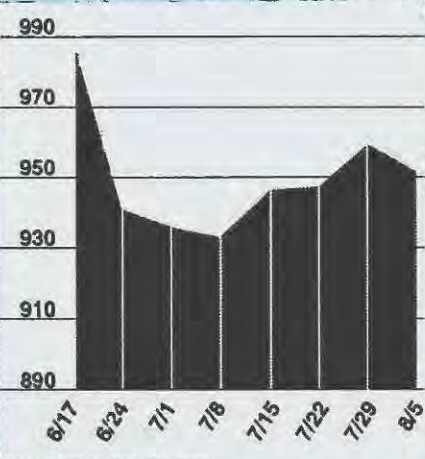
Consulting firm bought

NEW YORK—New York Life Insurance Co. has acquired benefit consulting and 401(k) administration firm ADQ Inc.

The acquisition is part of New York Life's program of comprehensive services to support outsourced corporate benefits, including investment management, consulting, 401(k) administration and employee information and education systems.

Established in 1970, Waltham, Mass.-based ADQ Inc. will combine with New York Life's asset management unit, which manages retirement plan investments.

BI Insurance Index



Base = 100 on Dec. 29, 1978
Source: Nordby International Inc.

Insurance stocks tumbled last week, as the Business Insurance Index lost 7.9 points to 951.3 Aug. 5 from 959.2 on July 29. Advancing issues for the week were led by: Unitrin, up 18.8%; Zenith National Insurance, up 8.5%; and USF&G Corp., up 7.8%. Declining issues for the week followed: Phoenix Re Corp., down 10.5%; Seibels Bruce Group, down 8.6%; and SCOR U.S. Corp., down 6.4%. The most active issue was U.S. Healthcare, 6.9 million shares traded. The BI Index fell 0.8%; the Dow Jones 30 Industrials lost 0.5%; the NYSE Composite fell 0.1%; and the Standard & Poor's 500 fell 0.3%.

British Issues

Aug. 4 Companies	Price pence	P/E*	Div. pence	Yield %	1 week high-low
Comm'l Union	545	17.3	31.0	5.7	550-539
Gen'l Accident	602	12.0	34.4	5.7	609-594
Gdn Royal Exch	186	12.0	9.5	5.1	187-185
Independent	239	7.8	10.4	4.4	243-239
Royal	259	11.3	9.4	3.6	259-251
Sun Alliance	318	14.3	18.4	5.8	326-318
Brokers					
Bradstock	98	11.0	6.9	7.0	98-94
Fenchurch	155	12.1	9.0	5.8	155-152
CE Health	304	10.8	20.0	6.6	305-302
JIB Group	147	12.9	9.4	6.4	147-143
Lloyd Thompson	171	11.5	8.4	4.9	171-171
Lowndes Lmbtr	384	12.1	18.8	4.9	384-383
Nelson Hurst	156	15.3	7.0	4.5	156-156
PWS Holdings	38	N/M	2.5	6.6	38-38
Sedgwick Grp	172	19.1	7.5	4.4	172-167
Steel Brl Jones	117	N/M	11.3	9.6	117-117
Willis Coroon	142	13.0	8.3	5.8	146-142

Source: Philip Olsen, London * Actual 1993 figures

BI Industry Stock Report AUG. 1, 1994, THROUGH AUG. 5, 1994

BROKERS	Price	Weekly		Year to date % change	Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt./Bk. value	Price	Weekly		Year to date % change	Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt./Bk. value	
		% change	% change		High	Low								High	Low		% change	% change							
ACEordia Inc.	NYS	25.38	1.00	3.05	28.75	21.00	92	0.60	2.36	13	10.22	2.48	Mutual Risk Mgmt. Ltd.	NYS	24.25	0.00	-19.17	32.75	21.13	133	0.28	1.15	15	5.71	4.25
Alexander & Alexander	NYS	19.50	-1.27	-1.89	25.63	14.00	776	0.10	0.51	-	6.73	2.90	NAC Re Corp.	OTC	28.25	0.89	-3.00	37.00	24.00	210	0.16	0.57	15	19.24	1.47
E.W. Blanch Holdings Inc.	NYS	20.38	1.24	17.27	23.50	15.75	77	0.32	1.57	18	4.10	4.97	National Re Corp.	NYS	25.38	-3.79	-17.14	37.13	24.25	30	0.16	0.63	10	17.51	1.45
Gallagher Arthur J. & Co.	NYS	32.25	1.98	-9.79	37.13	28.13	98	0.88	2.73	16	7.52	4.29	Navigator's Group	OTC	17.50	2.94	-50.00	39.00	16.00	80	0.00	0.00	-11	16.99	1.03
Hibb, Rogal & Hamilton	NYS	12.13	1.04	-7.62	15.13	11.13	102	0.48	3.96	16	4.51	2.69	Nobel Insurance Ltd.	OTC	7.75	-1.59	1.64	8.50	6.63	59	0.20	2.58	5	6.84	1.13
Marsh & McLennan	NYS	85.38	0.15	4.92	91.88	77.00	427	2.90	3.40	17	16.76	5.09	NWNL Companies	NYS	31.50	-3.82	-3.08	38.75	27.00	313	0.90	2.86	11	23.97	1.31
Poe & Brown	OTC	21.88	0.57	21.53	22.75	16.88	14	0.40	1.83	16	3.02	7.24	Ohio Casualty Corp.	OTC	30.75	-0.40	-3.53	36.00	26.50	369	1.46	4.75	13	23.84	1.29
BROKERS AVERAGE			0.7	3.9					2.3	14			Old Republic Int'l	NYS	22.38	-1.10	-0.56	27.63	21.50	210	0.48	2.15	8	23.57	0.95
ACE Ltd.	NYS	23.50	0.53	-22.95	36.00	22.75	321	0.44	1.87	-31	28.74	0.82	Orion Capital Corp.	NYS	33.00	-3.65	6.88	37.50	28.63	103	0.72	2.18	9	27.43	1.20
Acceptance Insurance Cos.	NYS	13.63	3.81	17.20	15.63	11.13	41	0.00	0.00	16	9.65	1.41	Penn-America Group Inc.	OTC	8.00	3.23	4.07	9.50	6.50	4	0.00	0.00	9	6.21	1.29
AEGON N.V.	NYS	57.25	4.57	4.57	58.50	46.00	11	2.95	5.14	11	34.71	1.65	Phoenix Re Corp.	OTC	23.50	-10.48	-14.55	38.25	18.50	976	0.30	1.28	8	19.99	1.18
Aetna Life & Casualty	NYS	50.00	-3.38	-17.01	66.25	49.75	2772	2.76	5.52	-8	71.84	0.70	Provident Life	NYS	28.00	3.23	-11.46	31.88	24.38	289	1.04	3.71	-11	26.38	1.06
Allied Group Inc.	OTC	28.50	-3.39	14.00	32.75	22.75	119	0.60	2.11	7	10.45	2.73	Re Capital Corp.	OTC	12.50	-2.91	-8.26	15.50	12.25	57	0.32	2.56	12	16.88	0.74
Allmerica Prop. & Casualty	NYS	15.50	-3.13	-28.05	22.16	14.25	106	0.16	1.03	10	56.97	0.27	Reliance Group Holdings	NYS	5.25	-4.55	-32.26	10.38	4.88	1000	0.32	6.10	7	4.22	1.24
Allstate Corp.	NYS	25.63	2.50	-13.87	34.25	22.63	1158	0.72	2.81	16	18.43	1.39	RLI Corp.	NYS	23.50	2.17	-12.15	27.75	20.63	78	0.56	2.38	-46	22.91	1.03
American General	NYS	28.25	-1.31	-0.88	36.50	24.88	1448	1.16	4.11	22	22.09	1.28	St. Paul Companies	NYS	42.13	-1.46	-6.13	49.00	37.69	73	1.50	3.56	9	57.64	0.73
American Heritage Life Ins.	NYS	17.75	3.65	-4.70	24.63	16.50	40	0.66	3.72	11	12.42	1.43	SAFECO Corp.	OTC	54.63	-1.35	0.00	65.75	48.50	775	1.96	3.59	10	41.59	1.31
American Indemnity/Fin'l	OTC	10.75	4.88	-17.31	16.25	10.00	6	0.24	2.23	4	16.18	0.66	SCOR U.S. Corp.	NYS	11.00	-6.38	-12.87	16.88	10.13	27	0.36	3.27	-	16.68	0.68
American International	NYS	92.25	-2.12	4.68	100.25	81.75	1750	0.46	0.50	15	45.25	2.04	Seibels Bruce Group	OTC	2.00	-8.57	-14.29	2.19	0.31	55	0.00	0.00	-	1.90	1.05
American Re Corp.	NYS	29.75	6.25	5.31	37.50	23.50	124	0.00	0.00	16	14.80	2.01	Selective Ins. Group	OTC	27.00	5.88	-10.74	31.00	23.00	66	1.12	4.15	14	23.11	1.17
Aon Corp.	NYS	33.50	0.75	4.15	39.00	30.00	472	1.28	3.82	11	33.10	1.01	Sphere Drake Holdings	NYS	15.50	-1.59	-6.06	21.63	14.63	80	1.12	0.77	7	12.17	1.27
Argonaut Group	OTC	29.31	1.96	-3.89	35.50	26.25	40	1.16	3.96	9	27.65	1.06	Statesman Group Inc.	NYS	15.00	0.84	20.00	15.25	10.25	225	3.10	0.67	6	8.65	1.73
AVEMCO Corp.	NYS	15.25	1.67	-18.67	21.25	13.75	82	0.44	2.89	11	8.13	1.88	TIG Holdings	NYS	19.25	1.32	-14.92	28.00	17.25	525	2.20	1.04	17	18.49	1.04
Baldwin & Lyons Inc.	OTC	14.75	-2.48	-0.84	16.25	13.75	2	0.24	1.63	9	12.59	1.17	Titan Holdings Inc.	NYS	9.25	-2.63	-14.94	13.38	7.75	29	0.25	2.70	8	8.93	1.04
Berkley W.F. Corp.	OTC	38.25	1.32	16.79	48.00	32.00	104	0.44	1.15	16	28.12	1.36	Tokio Marine & Fire	OTC	64.13	-0.39	16.75	67.00	49.25	7	3.41	0.63	-	57.72	1.11
Berkshire Hathaway Inc.	NYS	19100.00	-2.55	17.00	19750.00	15150.00	0	0.00	0.00	-	8115.28	2.35	Torchmark Corp.	NYS	40.00	2.89	-10.61	59.75	36.75	425	1.12	2.80	10	17.35	2.31
Capital Re Corporation	NYS	22.56	-0.28	-12.38	28.50	18.50	15	0.20	0.89	9	21.66	1.34	Transatlantic Holdings	NYS	55.00	-1.57	3.04	61.50	45.38	58	-3.36	0.65	14	29.60	1.86
Capsure Holdings Corp.	NYS	12.88	-0.96	-4.63	19.38	12.50	202	0.00	0.00	12	13.08	0.98	Travelers Corp.	NYS	33.38	0.75	-14.15	49.50	31.00	3197	0.60	1.80	8	33.35	1.00
Chubb Corp.	NYS	73.50	-1.84	-6.52	93.25	70.75	861	1.84	2.50	26	46.59	1.58	Trenwick Group Inc.	OTC	38.13	-2.56	-1.61	47.75	33.25	94	1.00	2.62	13	26.00	1.47
CIGNA Corp.	NYS	67.00	-2.01	5.93	74.00	57.00	1113	3.04	4.54	14	78.23	0.86	United Fire & Casualty	OTC	49.00	18.79	15.29	50.75	38.50	3748	60	3.27	35	38.90	1.26
CNA Financial Corp.	NYS	61.75	-0.60	-21.59	90.00	60.88	61	0.00	0.00	-16	77.92	0.79	Unitrin	OTC	48.13	3.77	-8.33	60.13	43.00	411	0.96	1.99	12	27.55	1.75
Continental Corp.	NYS	15.75	1.61	-42.99	33.38	14.13	779	1.00	6.35	-68	38.99	0.40	US Facilities Corp.	OTC	12.75										



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