

Business Insurance

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

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Heathrow fire losses covered, say airport authority insurers

LONDON—Any losses from a fire Friday morning in London's Heathrow Airport should be adequately covered by insurance, according to insurers for the British Airports Authority P.L.C.

The fire at Terminal 1, which serves domestic and intra-European flights, began about 4:30 a.m. and led to flight cancellations and delays at the country's busiest airport for several hours. Fire officials last week were investigating whether the fire started in duct systems in the ceilings.

See Updates on next page

Insurers ordered to reveal stance on similar claims

By JUDY GREENWALD

SANTA ANA, Calif.—A California appellate ruling that insurers must provide claims handling history during pretrial discovery in a contract dispute is a significant victory for policyholders that could provide them with a potent weapon in coverage litigation with insurers.

The decision in *Pfizer vs. The Superior Court of Orange County* permits policyholders to uncover and take advantage of inconsistencies in insurers' claims handling. Previously, this type of pretrial discovery generally was allowed only in bad-faith cases.

The decision also could encourage insurers to become more consistent in their claims handling, policyholder attorneys say.

Insurer attorneys warn, however, that providing extensive claims handling histories in contract dispute cases could prove costly for insurers. In addition, they warn the ruling could open up policyholder records in other claims to wide scrutiny.

If upheld, the decision by the California Court of Appeal's 4th Appellate District is expected to be influential nationwide, because of California's leadership in insurance litigation, attorneys say.

An appeal of the decision was filed last week with the California Supreme Court.

According to the Oct. 29 decision, which was certified for publication Dec. 1, the case stems from lawsuits filed against New York-based Pfizer Inc. and its Shiley Inc. unit stemming from alleged defects in its Bjork-Shiley Convexo/Concave artificial heart valve.

Litigation ensued between Pfizer and its insurers regarding the insurers' duty to defend and indemnify Pfizer in the underlying tort litigation, with the trigger of coverage an issue

in dispute.

As part of the litigation, Pfizer had sought three categories of information from the insurers: the identities of other manufacturers of medical devices other than heart valves that had notified the insurers of potential or pending claims; the types of devices involved in those claims; and the event that had triggered potential coverage.

The insurers objected to providing this information and a lower court denied Pfizer's motion to compel discovery.

In overturning that decision and ruling in Pfizer's favor, the three-judge panel of the Court of Appeal concluded that contrary to the insurers' assertion, the information Pfizer sought is relevant because the occurrence clause in the comprehensive general liability policy is ambiguous.

The court also rejected the insurers' argument that Pfizer's request invaded the privacy of other policyholders. "This is a minimal intrusion into the privacy of corporate insureds," the appeals court held.

The appellate panel also rejected the insurers' claim that providing this information would be "extremely burdensome."

The insurers "are not required to physically sort through every file in each insurer's possession," the panel said. "While it still may necessitate review of numerous files involving many products, in this electronic age, much of this can be done via computer records."

The decision said that while Pfizer's request for information is now "overbroad," it can be limited to the same time period as its policies.

Between the time the appeal was filed and the appellate decision was published, all but The Home Insurance Co., which filed the appeal with the

See Pfizer on page 14

Lloyd's relief criticized

NAIC questions N.Y. move to ease security requirements

By MEG FLETCHER

SEATTLE—New York's plan to ease securitization requirements for Lloyd's of London syndicates writing U.S. business is unexpectedly encountering strong opposition from other regulators.

The National Assn. of Insurance Commissioners is seeking a new financial examination of Lloyd's of London and a formal opinion on the legality of offering the market retroactive relief.

The NAIC decided to take those steps after a behind-the-scenes faceoff last week with the New York Insurance Department during the NAIC's quarterly meeting in Seattle.

Ultimately, NAIC regulators in other states took several steps to scale back New York's Lloyd's relief plan, at least for now. However, regulators said they are willing to consider providing

more relief if the examination and legal opinion support it.

Essentially, several other states refused to follow New York's lead without more proof of Lloyd's syndicates' financial soundness, though they previously had followed New York's lead on trust fund issues.

Those states are acting on behalf of themselves and the NAIC's International Insurance Department, which 14 states expressly rely on by statute to determine which non-U.S. insurers meet current standards for acceptable insurers. The names of accepted insurers are published quarterly.

At last week's meeting, Mark Presser, deputy

bureau chief of New York's Property and Casualty Insurance Bureau, initially opposed the NAIC's actions as unnecessary while the issue moved through three NAIC subgroups. Mr. Presser was at the

See New York on page 25

Deregulation plan advances

Regulators unveil formal commercial lines proposals

By MEG FLETCHER

SEATTLE—The National Assn. of Insurance Commissioners is advancing the much-awaited movement to streamline commercial insurance regulation by issuing its formal policy recommendations for public comment.

The 23-page white paper is broader in scope and better organized than previous drafts, while also providing more specifics for identifying large buyers eligible to be exempt from most current regulatory protections and requirements.

A working group of the NAIC finalized the policy paper and

submitted it to the Special Committee on Regulatory Re-engineering during the NAIC's quarterly meeting in Seattle last week.

Early reaction to the insurance regulators' proposals is generally enthusiastic across a wide range of industry participants.

The committee is now asking for public comment on the paper during the next three months as a first step toward implementing the proposed changes.

However, before the white paper's promise becomes a reality, other NAIC subgroups must develop proposals for implement-

ing the various aspects of deregulation and then individual states must adopt them.

During the NAIC's 2 1/2-year drafting process, a consensus has emerged that "opportunities exist for the streamlining and rebalancing of commercial insurance regulation," according to the white paper.

When compared with previous versions, "the latest white paper contemplates stronger reliance upon competition as a regulator of rates, rather than a formal approval process," said Alan Wickman, acting chairman of the working group that drafted the paper.

See Proposal on page 25

ISO giving insurers options for covering Year 2000 risks

By GAVIN SOUTER



NEW YORK—The Insurance Services Office Inc. plans to introduce a series of exclusions and endorsements by April 1

that will address coverage of Year 2000 losses in standard property and liability insurance poli-

cies.

Primary insurers will be able to offer corporate buyers coverage specifically for their Year 2000-related exposures. However, among the new wordings are also total exclusions for the risk under general liability and property policies.

The wordings already have been filed with state regulators; 18 states so far have either approved them

or responded according to state law.

The exclusions are a disservice to policyholders, said Scott K. Lange, director of risk management at Microsoft Corp. in Redmond, Wash.

"You buy insurance to reduce uncertainty. You want to respond to a problem that your organization faces, and if the insurance industry takes the position that every time they can see something that falls into that category they eliminate it, they really haven't done much for their customers," Mr. Lange said.

The Year 2000 problem may be regarded as a product defect and should be covered, he said. Instead, however, many insurers will likely adopt the exclusion in the same way that they adopted environmental coverage exclusions in the 1980s, he predicted.

The availability of the ISO exclusions will give insurance companies the flexibility to offer or exclude the Year 2000 coverage as they wish, said

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Updates

Fire hits Heathrow terminal

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A BAA spokeswoman said damage is confined to Terminal 1 and is restricted to the roof area and to some smoke and water damage. She said the rest of the terminal's structure is "virtually unaffected."

By Friday afternoon, airport officials were hopeful Terminal 1 would be operating near normal by the weekend, though they said flight delays could persist for several days.

Willis Corroon Group P.L.C. is the BAA's broker. A Willis Corroon spokesman said BAA is insured for property damage and business interruption risks, but he was unable to give details of the limits of coverage.

The lead insurer for the coverage is London-based Royal & Sun Alliance Insurance Group P.L.C. A spokesman for the insurer said Friday it was too early to report anything about the size of claims from the fire, but he emphasized that Royal & Sun Alliance is "adequately" reinsured in the London market.

The largest claim from the incident is likely to be property damage to Terminal 1, as airlines' business interruption policies usually have a deductible of seven to 14 days. Some flights had to be canceled, but schedules are expected to return to normal before business interruption coverage is triggered.

Heathrow is the BAA's largest facility.

Bill to limit Year 2000 liability

SACRAMENTO, Calif.—A California lawmaker is preparing tort reform legislation that would limit software makers' liability for Year 2000 problems.

Under the so-called "millennium bug bill," damages resulting from a computer date failure would be limited to bodily injury and "costs reasonably incurred to reprogram or replace and internally test the relevant computer system, computer program or software, or internal hardware timer."

Some critics say the bill would eliminate the possibility of recovering "consequential damages," such as the cost of lost meat should a freezer turn off at midnight on Dec. 31, 1999.

However, John Sullivan, president of the California Assn. for Tort Reform, which is sponsoring the bill, said, "We don't want to see legislation that disrupts existing contracts" that might provide such relief.

"We support the concept of preventing these disputes from becoming tort litigation," he said.

The bill is expected to be introduced when the California Legislature reconvenes Jan. 5, according to a spokesman for Assemblyman Brooks Firestone, R-Los Olivos, the bill's author.

Meanwhile, the Securities and Exchange Commission plans to issue additional guidance on what public companies must disclose about their Year 2000 exposure. The SEC issued its initial guidance in a staff legal bulletin released in October.

Maryland fund offers dividend

BALTIMORE—The Injured Workers Insurance Fund, a major workers compensation insurer in Maryland, will pay out \$10 million in dividends to eligible policyholders.

The dividend is expected to average between 12% and 18% of a policyholder's annual premium.

"We are pleased to be able to pay this dividend to our policyholders," IWIF Chief Executive Officer Paul M. Rose said in a statement. "The dividend is a way to materially thank those policyholders who work in partnership with IWIF to prevent and limit the losses attributable to workplace injuries."

IWIF will pay the \$10 million dividend to policyholders over the next two years. Individual policyholders' dividends will be calculated using a sliding scale based on the policyholder's premium and loss ratio.

Dividend amounts will be determined early next year after IWIF has calculated individual policyholders' loss experience during 1997.

IWIF writes about \$100 million annually in workers comp premiums for Maryland employers.

Employer loses comp ruling

SPRINGFIELD, Ill.—An Illinois trucking firm will have to pay additional workers compensation premiums after the state's high court declined to review an appellate ruling.

The Illinois Supreme Court's decision earlier this month not to review *Wausau General Insurance Co. vs. Kim's Trucking Inc.* lets stand an Illinois Appeals Court ruling earlier this year that the Palos Heights, Ill.-based hauling firm was required to provide workers comp coverage for outside haulers with which it contracted, unless those contractors could demonstrate proof of their own insurance.

The Lisle, Ill.-based insurer had claimed the trucking company owed it more than \$33,000 in additional premiums for policies written for the 1991-92 and 1992-93 policy years. The case involved about 15 contracted employees.

The appeals court held that because Kim's Trucking, which hauls asphalt, sand, stone and excavated materials, is engaged in "carriage by land," it is involved in an extrahazardous pursuit requiring workers compensation insurance for its employees and contractors unless they can show they have the coverage. Earlier, a trial court had ruled for Wausau in a summary judgment.

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Errors & omissions

• Due to a typographical error, a chart on page 3 of the Dec. 8 issue incorrectly reported the benefit consulting revenue growth of Aon Consulting. The correct increase was 115.6%.

Workers taking stock of savings

More employees put 401(k) funds in equities, survey finds

By ROBERT KAZEL

Employees' 401(k) and other savings plan investments continue to mount, and Americans continue to invest more heavily in stocks.

So says a survey released today by New York-based William M. Mercer Inc.

The survey also found that participants in 401(k) or similar savings plans have an average of 8.2 investment options, up from 7.7 last year. Most employers surveyed have added new choices in the past two years.

Employees investing more frequently in the stock market are far from securities experts, but they commonly have a good deal of knowledge, said Brian C. Ternoey, Mercer principal in Princeton, N.J., and author of the study.

"They're not investing blindly, but they don't fully understand," Mr. Ternoey said. "They're not MBA candidates. But they know more than they ever have."

For all plans surveyed, non-highly compensated plan members deferred an average of 6% of their pretax income to plans this year. For highly compensated em-

ployees, the contributions averaged 6.9% of pay. The average for all employees is 6.4%, up from 6.1% last year, Mercer said in a release.

The survey results, which reflect data from 455 employers with defined contribution plans and total retirement plan assets of \$324 billion, found employees have more than twice the number of investment options that they had in 1990. In most cases, the new options are equity funds; use of equity funds rose to 44% of total plan assets last year from 38% in

See Investing on page 26

Reinsurers' growth to come from smaller cedents: Report

By JUDY GREENWALD

Reinsurers that want to compete successfully in the future must recognize that more of their business will come from smaller insurers and adapt to meet their needs, a new report contends.

"Primary companies are saying they're going to buy less reinsurance over the next five years, and that occurs in all lines of business except for homeowners," observed Mary Ann Godbout, an assistant vp with Conning & Co. in

Hartford, Conn.

As a result, small insurance companies will account for a growing share of reinsurers' business, according to the 160-page report, "A Portrait of Reinsurance: Back to Basics and Beyond, 1997," which Ms. Godbout authored based on a survey of primary insurers and reinsurers.

Another factor influencing the reinsurance industry is globalization, as geographic barriers delineating traditional reinsurance markets are blurring, according to

another analysis of the reinsurance industry issued recently by New York-based reinsurance intermediary Guy Carpenter & Co. Inc.

The Conning study concludes that in spite of industry changes, reinsurers still can successfully compete by following specific strategies.

One is by recognizing the differences between what small insurers and larger insurers want, says the Conning report.

See Reinsurers on page 15

Merging banks dabble in insurance

By SARAH GODDARD

ZURICH, Switzerland—The combination of Swiss financial services giants Union Bank of Switzerland and Swiss Bank Corp. is likely to also be felt in the Swiss insurance market.

Both banks are involved in *allfinanz* ventures to distribute insurance products via their branch offices in Switzerland and Europe, and both also have insurance company executives on their boards of directors.

Although some analysts speculated that the banks may be involved in risk securitization projects, they were not aware of specific deals, and the banks declined to comment.

See Banks on page 24

Pressure to drop EMLICO case alleged

BOSTON—Massachusetts Insurance Commissioner Linda Ruthardt told a state legislative panel that her boss pressured her not to reopen the controversial 1995 redomestication of General Electric Co.'s Electric Mutual Liability Insurance Co.

In testimony before Massachusetts House Post Audit and Oversight Bureau investigators, Ms. Ruthardt said former Consumer Affairs Secretary Nancy Merrick told her in June 1996 not to pursue the EMLICO matter further, a spokesman for Ms. Ruthardt confirmed. The testimony was given in a closed meeting this year but came to light last week in Boston newspaper reports.

Ms. Ruthardt also testified that Ms. Merrick said she was acting at the behest of former Gov. William F. Weld's office. After the conversation, Ms. Ruthardt said she called one of Gov. Weld's legal advisers, who told her the governor's office had made no such request and that she should "do the right thing," the spokesman said.

After a public hearing in late June 1996, Ms. Ruthardt decided not to reopen the EMLICO case but to pursue fraud allegations against the insurer as part of a confidential exam of former EMLICO affiliate Electric Insurance Co. (BI, July 8, 1996). The decision was not influenced by the conversation with Ms. Merrick, Ms. Ruthardt's spokesman indicated.

Ms. Merrick, now a state superior court judge, could not be reached. A spokesman for Ms. Merrick was quoted in The Boston Globe last week denying that she had tried to influence Commissioner Ruthardt.

A spokesman for GE, EMLICO's sole policyholder, said, "There was never any improper assistance that was granted (to GE) by anyone in the (Weld) administration."

EMLICO declared itself insolvent after moving to Bermuda in 1995, triggering charges from its reinsurers that the move had been plotted by the insurer and GE to take advantage of the island's favorable liquidation laws.

—By Douglas McLeod

Inside

• Employers should try to work with the new safety enforcement program of the Occupational Safety and Health Administration rather than hastily sue over the plan, this week's editorial says. **PAGE 8**

• Critics say a promise of insurance refunds in advertisements by the California insurance commissioner simply is a re-election move. **PAGE 13**

• Anticipated growth in Argentina has prompted a U.S. fund to invest \$50 million in two insurers. **PAGE 19**

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Campus risks demand attention to loss control

By GAVIN SOUTER

Fire walking, binge drinking and bungee jumping don't make most risk management departments' lists of exposures, but they are just a few of the diverse risks faced by university risk managers.

In addition to oddball risks, risk managers at higher education institutions also face a volatile cocktail of everyday risks normally peculiar to specific industries.



PHOTO: PHOTODISC

Campus facilities such as laboratories present challenges for college and university risk managers.

As a result of these diverse and special risk concerns, several university risk managers, insurers and brokers are seeking to increase their loss control efforts to minimize liability exposures.

University risk managers often have to face a much wider array of loss control concerns than their peers in industry and commerce, said Ken Hoffman, director of the office of risk management at the University of Pennsylvania in Philadelphia.

"In manufacturing, you make a widget, and you sell it and make a profit. At higher ed institutions, we educate students and promote research. A lot of the infrastructure behind that is very complex and constitutes a lot of people and bricks and mortar, but it does not necessarily create anything," he said.

Risks from standard activities include: travel and driving risks, chemical risks in laboratories, construction, the use of power tools by students, medical and blood handling risks at infirmaries and university hospitals, and the usual slip-and-fall risks that make up the bulk of a university's liability claims, Mr. Hoffman said.

"At universities you have students, and students present a lot of challenges. They are at a point in their life where they think that they are invincible, and they like to do things that are fun," said Andy Roth, contracting/insurance coordinator at the University of Akron in Akron, Ohio.

Those activities can include university-sanctioned activities, such as bungee jumping and rock climbing, or non-sanctioned and hazardous activities, he said.

"So you have to try and educate the students to make them aware of the risks," Mr. Roth said.

See Campus on next page

State comp ruling not retroactive

By ROBERTO CENICEROS

SACRAMENTO, Calif.—A court's recent modification of an earlier decision will not force the reopening of thousands of California workers compensation claims involving disputed vocational rehabilitation settlements.

California's 2nd District Court of Appeal's original Nov. 5 decision in *Miguel A. Estrada vs. Workers' Compensation Appeals Board* essentially outlawed the inclusion of cash settlements for disputed vocational rehabilitation benefits.

Such settlements reached with employees and contained within compromise and release agreements have been a standard industry practice permitted for more than a decade by the state Workers' Compensation Appeals Board, according to the California Workers Compensation Institute in San Francisco. Under the practice, an employee accepts a lump-sum payment in exchange for releasing an employer from further liability.

The Los Angeles court had applied its ruling retroactively to such cases. But on Nov. 25, the court modified its order, saying it did not intend its decision to apply retroactively.

Employer groups were "very much concerned about the retroactive application of the decision, but the revision seems to have diminished the concern," said Joseph Markey, president of the Sacramento-based California Self Insurers Assn.

Among other things, retroactive application could have led to new litigation over previously closed cases and forced the recalculation of losses and experience modifications, according to the Assn. of California Insurance Cos. and the American Insurance Assn.'s regional office in Sacramento.

The court decision still is not favorable for employers, but if it applies only to cases going forward, then employers and insurance companies know what to expect and can make adjustments, said Mark Webb, assistant vp for the AIA in Sacramento. "Had it been a retroactive application, it would have truly opened a Pandora's Box."

Estrada applies in cases where there is a dispute over benefit levels but not whether an employee was injured or is entitled to receive benefits, experts say.

The ruling does not preclude settlements for vocational rehabilitation benefits under cases covered under a finding that questions the existence of an injury, said ACIC President Barry Carmody.

Other facts of Mr. Estrada's claim are unremarkable, observers said. He was a lithographer employed by Corporate Graphics when he filed an adjudication of a claim with the Board in 1989, court records show. He suffered repetitive stress injuries to his head, neck, back and legs and demanded rehabilitation.

The claim was contested, and Mr. Estrada signed a compromise and release agreement, settling claims for VRTD, or vocational rehabilitation temporary disability.

That led to a later dispute questioning whether the vocational rehabilitation aspects of the C&R were enforceable.

The appeals court agreed with an earlier ruling by a workers compensation judge that the vocational rehabilitation aspects were not enforceable.

Miguel A. Estrada vs. Workers' Compensation Appeals Board; California Court of Appeal, 2nd Appellate District; No. B107353, Nov. 5, 1997.

Don't bully with muscle

Broker consolidations should benefit clients: Greenberg

By GAVIN SOUTER

NEW YORK—The insurance industry's new "megabrokers" should be careful how they wield their newfound clout with insurance markets if they want to serve their clients' best interests, an insurer executive cautions.

If brokers simply use the leverage to pry larger commissions out of insurance companies, policyholders will be the ultimate losers, warned Maurice R. Greenberg, chairman and chief executive officer of American International Group Inc. in New York.

In addition, a reinsurer executive says that if brokers raise the

cost of buying insurance, clients simply will exit the traditional insurance market in favor of lower-cost alternatives.

Savings realized from broker consolidation should be passed on to buyers, says Maurice R. Greenberg.

Consolidation in the insurance brokerage industry should provide less costly service to clients,

Mr. Greenberg said.

It should lead to lower expenses, and the savings should be passed on to policyholders, he said during a session at a conference in New York earlier this month. The conference, sponsored by Coopers & Lybrand L.L.P., addressed change in the property/casualty insurance industry.

However, if the large brokerages—as some fear—use their power to squeeze larger commissions out of insurers, the policyholders will suffer, he said.

"If the brokerage community tries to leverage that strength against the underwriting commu-

See Clout on page 10

Advertisers honor former chairman

Gertrude R. Crain, the late chairman of Crain Communications Inc., has been named as one of three new inductees into the American Advertising Federation's Advertising Hall of Fame, where she will join her late husband, company and *Advertising Age* founder G.D. Crain Jr., who was inducted in 1975.

Advertising Age is a sister publication to *Business Insurance*.

The AAF also selected Young & Rubicam Chairman Emeritus Alex Kroll and Paul Schrage, longtime senior executive vp and chief marketing officer for McDonald's Corp.

Mrs. Crain, who died July 20, 1996, spent 40 years at Crain and served as the company's chairman from 1974 through 1996. AAF judges said Mrs. Crain was honored for her work in helping to boost the advertising business.

"She was one of the most powerful forces for good that we have ever had," said the judges.

All three will be inducted in ceremonies set for March 31 at the Waldorf-Astoria in New York.

Mr. and Mrs. Crain become the second husband-wife team in the AAF Hall of Fame. Stanley Resor, longtime J. Walter Thompson Co. president, and his wife, Helen Lansdowne Resor, a famed advertising copywriter, were jointly inducted in 1967.



Mrs. Crain

A different kind of strength

Accident victim forfeits award for pledge of safety program

By MICHAEL BRADFORD

CORPUS CHRISTI, Texas—The oilfield blast that ended John Caballero's days as a triathlete didn't take away his Ironman spirit.

In a move his attorneys say is unprecedented, Mr. Caballero gave up a \$30 million punitive award in his case against Esenjay Petroleum Corp., the company found liable for the gas well explosion that left him unable to run another step.

Instead of taking the money, Mr. Caballero decided he would rather see Corpus Christi, Texas-based Esenjay develop a safety program that would help prevent similar accidents from occurring.

"I wouldn't want anyone else to go through what I did," Mr. Caballero said last week in a telephone interview.

In fact, most oilfield workers wouldn't have made it through, he added. "My survival was attributed to my high level of physical fitness."

The 1995 explosion, which occurred because a pressure regulating device called a wraparound was improperly installed in the well, left Mr. Caballero with permanent and disabling injuries. He suffered brain damage, vision and hearing loss, broken vertebrae, a crushed foot and ankle and a dislocated hip.

A 42-year-old father of two daughters who has been married for 20 years, Mr. Caballero can no longer work, much less compete in an event like the



A work injury ended John Caballero's ability to compete in triathlons.

Ironman triathlon he was training for when the accident occurred.

That event, held annually in Hawaii, requires competitors to swim 2.4 miles, bicycle 112 miles and run a 26.2-mile marathon in a day.

While it would have been his first entry in the Ironman competition, Mr. Caballero had participated in several triathlons in Texas and Louisiana and separately had run seven marathons. In the triathlons, he regularly finished in the top three for his age category.

"Now, I can't run," he said. "My foot had to be reconstructed. They were going to amputate it, but they were so busy sewing my head up that when they got back to my foot, it had a pulse."

The accident happened as Mr. Caballero, a Victo- See Award on page 26

Campus

Continued from page 3

A major concern for university risk managers is binge drinking, a problem especially in the spotlight after some highly publicized recent binge drinking-related deaths and other incidents at several campuses throughout the country, he said.

"It is an area that institutions are struggling with from a loss control standpoint," Mr. Roth said.

In an effort to deter the problem at Akron, the university is giving students educational talks and literature on the subject, he said.

It also is trying to alleviate the problem by encouraging students to take part in non-drinking related activities, such as sports, Mr. Roth said.

Risk managers should adopt the strategy of changing the behavior of students by persuasion rather than coercion, agreed Edward M. Holins-

ki, vp and vice chair of the global higher education department at J&H Marsh & McLennan of Michigan Inc. in Detroit.

that are not their usual occupation, such as students driving vans, Mr. Holinski said.

J&H Marsh & McLennan devel-

'We are looking at how each institution is dealing with the problems and trying to see which is the most viable approach,' says Ken Hoffman of a group loss control effort.

"University risk managers have so many more people to deal with than many other risk managers...and it is such a broad group. So you have to try and change behavior rather than take a more authoritative approach," he said.

Loss control efforts have to be targeted at a diverse range of people who are often engaged in activities

oped a computer-based training program on van driving that it distributes to universities, he said. The interactive 30-minute program runs through safety issues and includes a test.

The University of Pennsylvania and the 14 other members of the Genesis Ltd. association captive are trying to address loss control issues

by establishing a list of best practices for the wide range of risk management problems they all face, said Mr. Hoffman.

"We are looking at how each institution is dealing with the problems and trying to see which is the most viable approach," he said.

The best practices will enable the risk managers to obtain loss control advice from one another that is not always freely available from insurers, Mr. Hoffman said.

While highly protected risk insurers can provide excellent property loss control services, liability loss control services vary among insurers, he said.

Often, the universities themselves can provide the best loss control advice, said Tom Tenerowicz, vp at Sedgwick of New England Inc.

"You sometimes find that the universities have people that know more about the subject than the insurance carriers do," he said.

For example, one of Sedgwick's university clients had ergonomics experts who worked with the insurer to implement a program throughout the university to combat the risk of carpal tunnel problems, Mr. Tenerowicz said.

More often, universities are struggling to introduce liability-related loss control measures without much help from insurers and brokers unless they pay for the extra services, said Keith R. Shakespeare, chief operating officer of the Canadian Universities Reciprocal Insurance Exchange in Oakville, Ontario.

Because most universities operate under tight budgetary constraints, many are reluctant to pay for the extra services, he said.

CURIE, which has about 50 members, is increasingly offering loss control advice to members in an effort to improve loss control, Mr. Shakespeare said.

Again, some of the advice is for unusual activities. For example, a student council at one member university planned to have a self-confidence building program that would conclude with a walk across hot coals, he said.

"The university came to us and said this had been suggested and asked us whether we thought it was a good idea. We said it wasn't and discussed the liabilities with them. They then decided it wasn't a good idea either," Mr. Shakespeare said.

Other less exotic but more hazardous loss control problems are frequently presented to CURIE that would not fall within the ambit of most loss control engineers at HPR insurers, he said.

For example, one university Mr. Shakespeare visited had chemistry labs that stored chemicals alphabetically.

"That might make them convenient to find, but it does not take into account the fact that some chemicals stored next to each other might cause an explosion if they are mixed together," he said.

Insurers' loss control engineers usually are not trained to address both property and liability issues, said Mr. Holinski of J&H Marsh & McLennan.

"If you look at something like dormitory safety, an insurer may come in and look at the vulnerability of the dorms from a property standpoint but say that they are not qualified to deal with life safety issues," he said.

Arkwright Mutual Insurance Co. set up a separate education unit in 1995, and its loss control engineers try to look at life safety issues as well as the standard fire protection issues, said Mary Breighner, national director of Arkwright Education in Cincinnati.

"Life safety and property loss control frequently go hand in hand at universities," she said.

For example, the use of Halogen lamps in student dorms present life safety and fire protection issues, Ms. Breighner said.

The lamps are popular with students because they are cheap, convenient and bright, she said. However, the bulbs heat up to much higher temperatures than the bulbs in traditional incandescent lamps, and through misuse, Halogen lamps have created hundreds of fires. Fires have resulted, for example, when students dry clothes over them or drape them with material to create a romantic ambiance at night, she said.

To address the problem, Arkwright has distributed 5,000 leaflets on the dangers of the lamps to students, Ms. Breighner said.

Earlier this month it held a workshop with Northeastern University in Boston for risk managers and safety officials that demonstrated how similar lighting could be obtained from other, safer lamps, she said.

BI

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Prescription benefits costs rising: Segal

By ROBERT KAZEL

Benefit Beat

The cost to employers of providing prescription drug benefits is soaring, a new study says.

According to statistics gathered by The Segal Co., a New York-based benefit consulting firm, the average annual per-employee cost of drug claims in 1997 will be \$430, a 17.5% increase over 1996 costs.

In addition, Segal is predicting an increase of about 16.3% in employers' prescription drug claims costs next

year, with an average cost of \$500 per employee.

"I thought the PBMs (prescription benefit management firms) could get these trend rates down and keep them down," said Edward Kaplan, Segal vice president and consultant in New York.

Instead, the tendency of drug prices to remain high has remained surprisingly strong, he said. Last year, em-

ployers experienced a 13% rise in prescription claims costs, the 1996 Segal survey found.

Various factors are keeping drug prices high, Mr. Kaplan said: price inflation; the number of prescriptions being written for more expensive drugs; an aging population using more drugs; doctors writing more prescriptions generally; and drug companies advertising to consumers.

Of the 22 employers with prescription drug plans that Segal studied, prescription benefit costs for all 22

increased this year, Mr. Kaplan said.

A national retail chain with 20,000 employees that Segal surveyed reported \$1.65 million in drug costs between September 1996 and August 1997, up 43.5% from the year-earlier period.

Faced with the failure of PBMs to dramatically lower costs, some employers are instituting higher copayments for non-generic drugs, mandatory generic substitutions or mandatory discount mail-order drug delivery.

Another study on pharmacy costs found an average increase of 11% over the last plan year.

The study, by New York-based consultant William M. Mercer Inc., found 54% of companies responding said their prescription drug costs were increasing faster than their overall medical costs; only 16% said medical costs were increasing faster.

Mercer discovered, though, that despite rising costs plan sponsors are satisfied with the job PBMs are doing. Ninety-three percent reported being very satisfied with pharmacy access, 62% were very satisfied with mail-order services, and 58% were very satisfied with claims processing.

Mercer found that while 96% of active workers are covered by a drug program, only 58% of survey respondents offer pharmacy benefits to all retirees.

For a single free copy of the Segal report, "Update on Escalating Costs of Prescription Drug Plans," contact Vp Mary Feldman, 212-251-5029. A single free copy of the Mercer study, "Fast Fax Survey on Pharmacy Benefits," may be obtained by contacting Sarah Markfield, 212-345-7584.

Care gatekeeping

The gatekeeper system is alive and well in health care and generally satisfies cost-conscious patients, a new report says.

The Washington-based Center for Studying Health System Change found that 91% of 9,264 physicians surveyed reported doing at least some gatekeeping for patients. This included most solo and two-physician practices, group practices and staff-model HMO doctors.

Gatekeeping was classified by the researchers as such whenever the doctor's prior approval was required for a specialist to be consulted.

In a study of 12 U.S. metropolitan areas, the center found an average of 40% of respondents' patients were part of gatekeeping arrangements. Results by geographic area ranged from a low of 31% in Greenville, S.C., to a high of 62% in Boston.

The high level of gatekeeping surprised researchers, said Dr. Robert St. Peter, a pediatrician and senior medical researcher at the center.

On average, pediatricians most frequently act as gatekeepers, doing so for 52% of their patients. Forty percent of general internists act as gatekeepers.

Gatekeeping is not a bad trend so long as patients are comfortable with the arrangement.

"There are a lot of people willing to limit their choice of physicians if it means saving money," he said.

But, according to the center, 16% of patients worry that they will not be referred to the right specialists should they need them. Those patients willing to pay a premium for the right to leave the gatekeeper structure and get direct access to specialists can be expected to do so in the future, he said.

Some states are considering legislation that would allow patients to bypass gatekeepers to see some specialists, and Florida and Georgia have passed laws requiring that patients have direct access to dermatologists, according to the center.

A majority of primary care physicians—82%—told the center that they are always able or almost always able to obtain referrals for their patients to high-quality specialists. Still, about one-fifth of doctors report having trouble getting access to specialists, even when medically necessary.

The report, in Data Bulletin No. 7, can be obtained free by calling 202-554-7549, or can be accessed on the World Wide Web at www.hschange.com.

See Benefit Beat on next page

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Quackenbush refund ads spark questions

By ROBERTO CENICEROS

SACRAMENTO, Calif.—Cries of “Show me the money” are dogging Insurance Commissioner Chuck Quackenbush after a series of television advertisements in which he states billions of dollars in insurance refunds are available for consumers.

According to one Quackenbush advertisement, the money purportedly is available from insurers' liquidated assets, automobile insurance rebates, restitution awards, class-action lawsuits and settlements with insurers.

However, the ads are puzzling California insurance industry executives who are unaware of the availability of the money. The local media is criticizing Mr. Quackenbush, alleging he is using a \$1 million consumer outreach campaign merely to

posture for re-election.

In the 30-second television commercials, the commissioner says the money is available because his department has cracked down on insurers that have ripped off consumers.

But last week the Los Angeles Times reported that, according to the commissioner, much of the billions he refers to is actually \$1.8 billion in 86 separate accounts that state liquidators are administering. Time periods for making claims in 84 of those 86 accounts have run out, according to the Times. The paper also reported that much of the auto insurance rebates from Proposition 103 have already been paid out or are tied up in litigation.

The Insurance Department did not return calls from *Business Insurance* seeking to verify this report.

However, the department issued a press release reiterating the claims made in Mr. Quackenbush's television spots. The press release also stated that “the facts are: there is \$1.3 billion total amount in auto insurance rebates, there is a total of \$1.8 billion due to conservation of bankrupt insurance companies and finally, millions of dollars have been recovered for consumers due to the aggressive action of the Department of Insurance in both restitution awards and class-action settlements.” The statement did not address the Times' reporting.

The Times then followed its story with an editorial saying the Quackenbush advertisements were only boosting his political aspirations and not helping consumers. The Times isn't alone in wondering where the money is.

At least one member company of the Sacramento-based Assn. of California Insurance Cos. has received numerous telephone calls wondering what money is available, said Barry Carmody, ACIC president. But as of last Wednesday, he hadn't received a list of available money from Mr. Quackenbush.

Furthermore, the state comptroller puts out a detailed listing of money and accounts available for items such as consumer refunds. But Mr. Carmody said nothing has shown up there, either.

“One of our companies has received a number of calls, and I don't know what to tell them, because (the Insurance Department) doesn't have a list or any kind of inventory of what it is they are talking about,” Mr. Carmody said. “I frankly am at a loss for words and don't have a

list.”

Meanwhile, insurance and political observers in Sacramento say they assume Mr. Quackenbush will be running for re-election next November, and with a primary election scheduled in June, it is not unusual for an elected official to posture early in the game.

Marin County Supervisor Harold C. Brown, a 52-year-old Democrat, former insurance agent and a cousin of former Gov. Jerry Brown has announced his intention to seek the commissioner's office.

Consumer advocate and Proposition 103 author Harvey Rosenfield, 45, has also said he is considering running for Mr. Quackenbush's office.

“The question is, ‘Do I want to trade my position as an advocate on many different issues or be an advocate for consumers in government,’” Mr. Rosenfield told *Business Insurance*. **BI**

Benefit Beat

Continued from previous page

Medication reminder

DALLAS—A little nagging can be good for the soul—and the body.

That's what the Southern Baptist Convention decided a year ago when it turned to ValueRx, its prescription benefit management firm, to use its “medication adherence” program to coax members into taking their medication.

The Baptists' annuity board, which administers health benefits and retirement plans for about 20,000 pastors and staff, realized its prescription drug costs were high and wanted to increase medication usage where appropriate to head off unneeded hospitalizations and surgeries, said Donna Van Hooser, insurance operation department head.

“They feel so good they don't think they need it,” she said of people who stop taking their medication.

The Baptists agreed to join Plymouth, Minn.-based ValueRx's program, which is free of charge and designed to reduce drug non-compliance through gentle reminders via telephone. According to the PBM, U.S. companies lose more than \$100 billion a year because of drug non-compliance, and people stopping prescribed medication use are responsible for 10% of hospital admissions.

After about a year, ValueRx showed the Southern Baptist Convention data indicating that for those workers or retirees reached by telephone, 78% resumed using their medications.

Andrea Barry, manager of employee benefits at Elmhurst, Ill.-based Keebler Co., also began the compliance reminder program in July for about 1,200 of Keebler's workers who have chronic medical conditions. “Sometimes people do forget to do things on a regular basis,” she said.

Among all of its participating clients, ValueRx reports a 74% success rate for putting people back on their medications.

The compliance program has put out 48,000 calls since it began in November 1996, said Kyle Vance-Bryan, director of pharmacotherapy assessment and disease management at ValueRx.

The program works with ValueRx's mail-order drug service by automatically detecting when a patient has failed to refill a prescription, Mr. Vance-Bryan said. The company is able to reach 80% by telephone, and of those reached, 75% are mailed new drug shipments, he said.

The program concentrates on chronic diseases, such as diabetes, depression, heart disease, allergies and asthma, among other ailments. **BI**

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Opinions

Work with OSHA on safety

THERE ARE SOME PROBLEMS with the Occupational Safety and Health Administration's new workplace safety enforcement program, which gives most of the targeted employers an opportunity to escape comprehensive inspections and heavy fines.

But, the program's deficiencies are not significant enough for employers to miss this opportunity to fix safety and health problems at their worksites with a minimum of government intrusion.

And, we disagree with employer representatives who have suggested that employers, either individually or through an association, ought to wage a court fight over OSHA's authority to implement this program, called the Cooperative Compliance Program. There is reason to believe OSHA is open to reasonable suggestions for modifying the program without employers resorting to costly litigation.

OSHA has targeted about 12,000 employers in the most hazardous industries for the program, unveiled late last month. The 500 with the worst safety records will receive comprehensive inspections. Most of the remaining targeted employers could avoid the inspections and fines by making a top-down commitment to safeguarding their workers. Among other things, those employers would have to agree to implement formal safety and health plans.

At the companies OSHA has targeted, at least 7% of their employees in 1996 lost at least one workday due to a work-related injury or illness. The national average is 3.6%. But, that measure does not take into account whether those workers lost one day or 101 days.

We agree with employers that OSHA could have done a better job of targeting employers by focusing on those with injury severity rather than injury frequency problems.

Even an OSHA spokeswoman readily conceded that targeting employers based on the severity of injuries at their worksites would be a better approach.

But, she said such a measure would be difficult to devise.

We disagree. We think a better measure could be a ratio of the number of hours a company's workers lost during a year due to injuries and illnesses compared with the total number of hours a healthy workforce would have worked.

Of course, such a formula might need to be tweaked to take into account, for example, light-duty return-to-work programs.

There's reason to believe OSHA would be open to modifying the formula.

That's because the current formula already is a big improvement over the one OSHA used in some pilot programs. Employers in those programs rightfully complained about OSHA targeting employers based solely on the number of injuries at worksites, without taking into account the size of employers' workforces. That obviously put large employers at a significant disadvantage to smaller employers.

Employers should be encouraged that OSHA recognized its mistake in the pilot programs and that the agency acknowledges the current targeting formula is not as good as it gets.

For that reason, any talk of litigation is premature. Employers instead should direct their energies into showing OSHA how to adjust its sights.

In the meantime, the current formula is not untenable.



Even some employer representatives have said it will help OSHA do a reasonably good job of snaring employers with significant workplace safety problems.

Employers' other objection to the program is overstated. A major prerequisite for participating in the program is agreeing to establish a safety and health program. Employer representatives describe that requirement as "coercive," "underhanded" and "contradictory" because the agency currently has no authority to instruct employers to establish such programs.

The fact is that targeted employers do not have to join the program, so it is hardly coercive. True, there is a price to pay for not joining the CCP, but a month ago, targeted employers did not have any alternative to comprehensive inspections and fines.

Results from pilot CCP programs show a strong link between increased workplace safety and the establishment of safety and health programs, according to OSHA. And, as Lance J. Ewing, chairman of the Health and Safety Committee of the Risk & Insurance Management Society Inc., said, many employers already have recognized that such a program is the key to improving workplace safety, regardless of whether the approach is a government mandate.

The requirement indeed may be contradictory, as OSHA will not and indeed cannot fine CCP participants if the agency finds during some verification inspections that the participants have implemented inadequate safety and health programs. Instead, the agency said its inspections will focus only on the end result of the programs: whether there are any hazards in the workplace.

That criticism clouds the big picture: Many employers with workplace safety problems now have an opportunity to fix those problems largely through a home-grown approach with a minimum of government intervention. Employers should not discount the opportunity the program offers them to avoid major penalties—both monetary and in public relations.

We urge employers to take advantage of the program. In the end, it will be a far more efficient and effective business decision than taking a pass on it.

Letters

MCOs must beware of vicarious liability

To the editor: Regarding the Nov. 10 article, "Plans Rely on ERISA Shield," the managed care industry needs to be more concerned with recent court trends on ERISA pre-emption than David Manoogian's fear of legislation by "wily state rascals."

Unless devolutionists somehow reanimate the Articles of Confederation, state laws cannot override federal.

Managed care organizations are protected by the ERISA pre-emption when a utilization reviewer commits an error of judgment, when the MCO itself credentials a negligent provider, et cetera. The courts say that these steps are not subject to state law because they relate to the way in which plan benefits are administered. MCOs remain at risk, however, where a provider is negligent and the facts warrant a judicial finding that

the MCO was vicariously liable because it held out to the claimant that the provider was its agent or employee.

Increasingly, plaintiffs' lawyers allege vicarious liability, and defendants' lawyers must show that providers acted for themselves, not as agents or employees of the managed care organization.

Nathaniel B. Taft
White Plains, N.Y.

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Mass tort litigation predicted to continue

By MICHAEL PRINCE

NEW YORK—Mass tort suits are expected to continue to hit U.S. companies, costing them billions of dollars and diverting time and resources from their businesses.

"It's not all bad news, but mostly," said Jonathan Bank, a partner with Chadbourne & Parke L.L.P. in Los Angeles.

Despite a slowdown in the past decade in the number of suits filed, Mr. Bank said, the number will continue to be high and much higher than the number of lawsuits filed against companies outside the United States.

Mr. Bank spoke as part of a panel at the Managing Change in the Property-Casualty Industry conference in New York, sponsored by Coopers & Lybrand L.L.P.

Low public opinion of insurance companies is one reason Mr. Bank cited for the large awards against businesses in mass tort suits. Jury verdicts won't change, he said, until the public has a better impression of insurers, which juries know ultimately foot the bills.

As the insurers look to reinsurers for reinsurance payments, a schism has developed between the two, Mr. Banks said. As a result, sometimes

an alliance forms between the insurer and policyholder aimed against the reinsurer.

For example, if an insurer loses in a coverage dispute with the policyholder, the insurer can go directly to its reinsurer, he said. But if a suit is settled, it's harder for the insurer to obtain reinsurance payment. So, he said, sometimes the insurer and pol-

'It's not all bad news, but mostly,' Jonathan Bank says of mass tort lawsuits hitting U.S. companies.

icyholder work a settlement so that the insurer can more easily obtain reinsurance payment.

Donald Sullivan, vp-risk management for Baxter International Inc. in Deerfield, Ill., said mass tort exposures can come from unexpected areas. For example, the health care products manufacturer has been named in litigation as a result of a company it acquired but that no longer marketed silicone breast implants. Baxter now faces a large ex-

posure to the class-action suit brought by women with the implants.

Mr. Sullivan estimates Baxter faces \$1 billion in liability, of which 75% is covered by insurance.

"Basically the system works," he said, as Baxter has collected or has commitments for two-thirds of the insurance coverage. Baxter is negotiating the remainder.

Despite the insurance coverage in the silicone suit, the litigation has hurt the company in a number of ways.

Suits divert key workers from their jobs for long periods. "These people should be doing other things" than working on the suit, he said.

Also, mass tort suits immediately hurt the company's profitability and damage cash flow for years. This causes the stock price to drop.

When a mass tort suit hits, he said, a risk manager needs to take immediate action, he said.

"You cannot afford to bury your head in the sand," he said. "You need to address this as soon as possible."

He recommends that a company team with its insurer and work together to limit the damage.

Perry K. Huntington, senior vp of environmental claims for AIG Technical Services Inc. in New York, also spoke at the session.

Phillip N. Ben-Zvi, principal with Coopers & Lybrand L.L.P. in New York, moderated the panel discussion. **BI**

Work comp market must adjust: Panel

Managed care practices promoted

By MICHAEL PRINCE

NEW YORK—Workers compensation insurers need to implement more managed care practices and other innovations to remain successful, executives say.

Taking those steps is especially important in a market where low premiums and increasing medical costs might cause some players to fail, according to two workers comp experts.

Edmund Kelly, president and chief operating officer of Liberty Mutual Insurance Co. in Boston, said workers comp has become extremely profitable in the past five years. But the success is not because of anything workers comp underwriters have done, he said.

For a few years, medical inflation was lower than overall inflation. But more importantly, the rate of medical inflation was much lower than forecast in the early 1990s. As a result, premiums and reserves based on these projections were set higher, leading to large profits.

Mr. Kelly and the other panelists spoke at a New York conference, Managing Change in the Property-Casualty Industry, sponsored by Coopers & Lybrand L.L.P.

Mr. Kelly said that if the industry does not become more efficient, the profitable years might end.

Workers comp rates have dropped to the point where making a profit could be difficult.

"To compete in the workers comp field, cut price," is how Mr. Kelly described the market. He added that a number of insurers have dropped their rates very low; that, combined with the increase in medical costs projected for 1998 and beyond, could put them out of business.

The solution, he said, is applying to workers comp managed care principles, which he said have been proven to reduce medical costs. But he emphasized managed care cannot mean simply the cheapest care.

To succeed with managed care will require gathering and analyzing data, he said. "Data and information will be our greatest asset," he said.

"He who dies with the most data wins," he added.

ManagedComp Inc. has been successful in using managed care to reduce workers comp costs, said James Walter, president and chief executive officer. He said the clients of the Waltham, Mass.-based company

have seen a reduction in their costs per claim and fewer lost work days by applying managed care concepts to workers comp.

ManagedComp believes the key to reduce costs is moving responsibility for managing patients' care to the doctor's office, Mr. Walter said. Because the majority of workers comp expense is lost time, the focus of any program should be returning the employee to work as soon as possible. This requires control by the treating physician, who determines when the patient can work again.

Mr. Walter said his company has reduced lost work time while also lowering the amount spent per claim for its clients. It has done this by putting employees in a network of high-quality, occupational physicians while providing these physicians with feedback on their performance.

Dwight Davis, president and chief operating officer of Wausau Insurance Cos. in Wausau, Wis., said a number of trends are working to change the workers comp environment:

- Medical inflation is increasing and is predicted to increase for the next few years.

- The workforce is aging, creating more costly workers comp claims.

- The definition of disability is expanding to include more illnesses, such as stress and chronic fatigue syndrome.

- The exclusive remedy doctrine has been eroding.

- The number of workers comp insurers is increasing.

Mr. Davis said Wausau has succeeded by integrating occupational and non-occupational disabilities into a 24-hour coverage program. To achieve success, he said, insurers need to develop a team approach among employers, employees and providers, including maintaining open communication.

Also, coordinated data-gathering and analysis are important. The goal of the programs should be on returning the employee to work as quickly as possible.

As a result of the integrated programs, their customers have improved return-to-work results, increased productivity and lower administrative costs, he said.

Richard Fein, managing principal with Coopers & Lybrand, moderated the session. **BI**

Blue Shield of California targets domestic violence

SAN FRANCISCO—Blue Shield of California is trying to get the message out to stop domestic violence.

The San Francisco-based insurer has taken the lead among health care companies in the state by holding discussions on domestic violence and distributing information to other businesses, says Donna Norton, manager of the national workplace resource center on domestic violence at the Family Violence Prevention Fund.

Non-health care businesses in the state, including the Gap, Levi Strauss & Co. and McKesson Corp., already have internal programs on domestic violence. Nationwide, Polaroid Corp. and American Express Co. have launched efforts to combat abuse, says Marianne Balin, a public affairs specialist who developed

Blue Shield's \$150,000 program.

Domestic violence is the leading cause of injury to women in the United States, with almost 4 million women physically abused by their husbands or boyfriends every year. It results in hundreds of millions of dollars in health care costs annually that are borne by employers' benefit programs, according to the Pennsylvania Blue Shield Institute.

Since launching its Domestic Violence Initiative Oct. 1, Blue Shield has received 16 requests for information from benefit managers at California companies, Ms. Balin said.

Blue Shield is distributing a packet with guidelines on talking to victims and setting up informational sessions on domestic abuse.

—Crain News Service

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ISO

Continued from page 1

Eric Goldberg, counsel at the American Insurance Assn. in Washington.

Policyholders that wish to be covered for the Year 2000 problem will be able to choose from a range of wordings offered by insurers or the specific Year 2000 insurance products that some insurers have launched over the past year, he said.

"There are hundreds of different insurers selling general liability coverage, so policyholders should be able to shop around for the product they want to buy," Mr. Goldberg said.

Most reinsurers have not yet said whether they will cover this exposure for insurance companies. Several reinsurance executives say they likely will follow the coverage terms that primary insurers provide.

The Year 2000 exposure arises from the practice of programming computers with only two digits to indicate the year. Computer experts say that unless many computers are reprogrammed, internal clocks will treat the year 2000 as the year 1900, which could wreak havoc in many systems the computers are designed to control (BI, Oct. 20).

Risk managers and insurers fear the chaos could lead to significant liability or property losses. Automated fire suppression or alarm systems, for example, could fail to operate, resulting in bodily injury and property damage claims.

As a result of insurers' concerns about their potential exposure, ISO has issued five new wordings addressing the coverage. The wordings would apply to any new or renewed policy that contains the language.

General liability insurers will have four options under the new ISO wordings:

- Total exclusion of computer-system related losses "due to the inability to correctly recognize, process, distinguish, interpret or accept the year 2000 and beyond."
- Exclusion of losses from products and completed operations but coverage for premises risks.
- Exclusion of coverage except for specific sites.
- Maintenance of the existing general liability wordings, which are regarded as broadly covering Year 2000 losses.

Most insurers maintain that the existing property policies do not

cover Year 2000 exposures. Nevertheless, ISO plans to introduce a specific exclusion as well as an endorsement that will provide limited business interruption coverage of up to \$25,000 for losses caused by Year 2000 problems.

The property exclusion is broader than the general liability exclusion and excludes coverage for losses "due to the inability to correctly recognize, process, distinguish, interpret or accept one or more dates or times. An example is the inability of computer software to recognize the year 2000."

The Independent Insurance Agents of America Inc. is concerned that the exclusions are too broad and will deny coverage to policyholders that have reprogrammed their systems to avoid the problem but nevertheless suffer a loss, said Todd Muller, assistant vp of consumer and technical advocacy. The IIAA plans to meet soon with ISO to

discuss the issue, Mr. Muller said.

The exclusions will limit the coverage provided, said Eugene Anderson, senior partner at Anderson, Kill & Olick P.C., a policyholder law firm in New York.

"It seems to me incongruous that

'It seems to me incongruous that takers of risk would greet a new problem by excluding it,' says Eugene Anderson.

takers of risk would greet a new problem by excluding it," he said.

Policyholders likely will not be able to make claims under policies in place when their computer systems were installed, he said.

"The standard liability policies

are triggered by the damage, so it would be the policies in effect in December 1999 and January 2000 that are affected," Mr. Anderson said.

However, depending on the wordings insurers include in directors and officers liability and errors and omissions policies, policyholders may be able to make Year 2000-related claims under those policies, he said.

The ISO exclusions are the first widely circulated Year 2000 exclusions for primary policies in the United States.

The Assn. of British Insurers last month issued draft exclusions for Year 2000-related losses in product liability and professional liability policies (BI, Nov. 17).

Reinsurers as a group generally have taken a more disjointed approach to the exposure.

Reinsurers likely will welcome the clarity that the ISO wordings

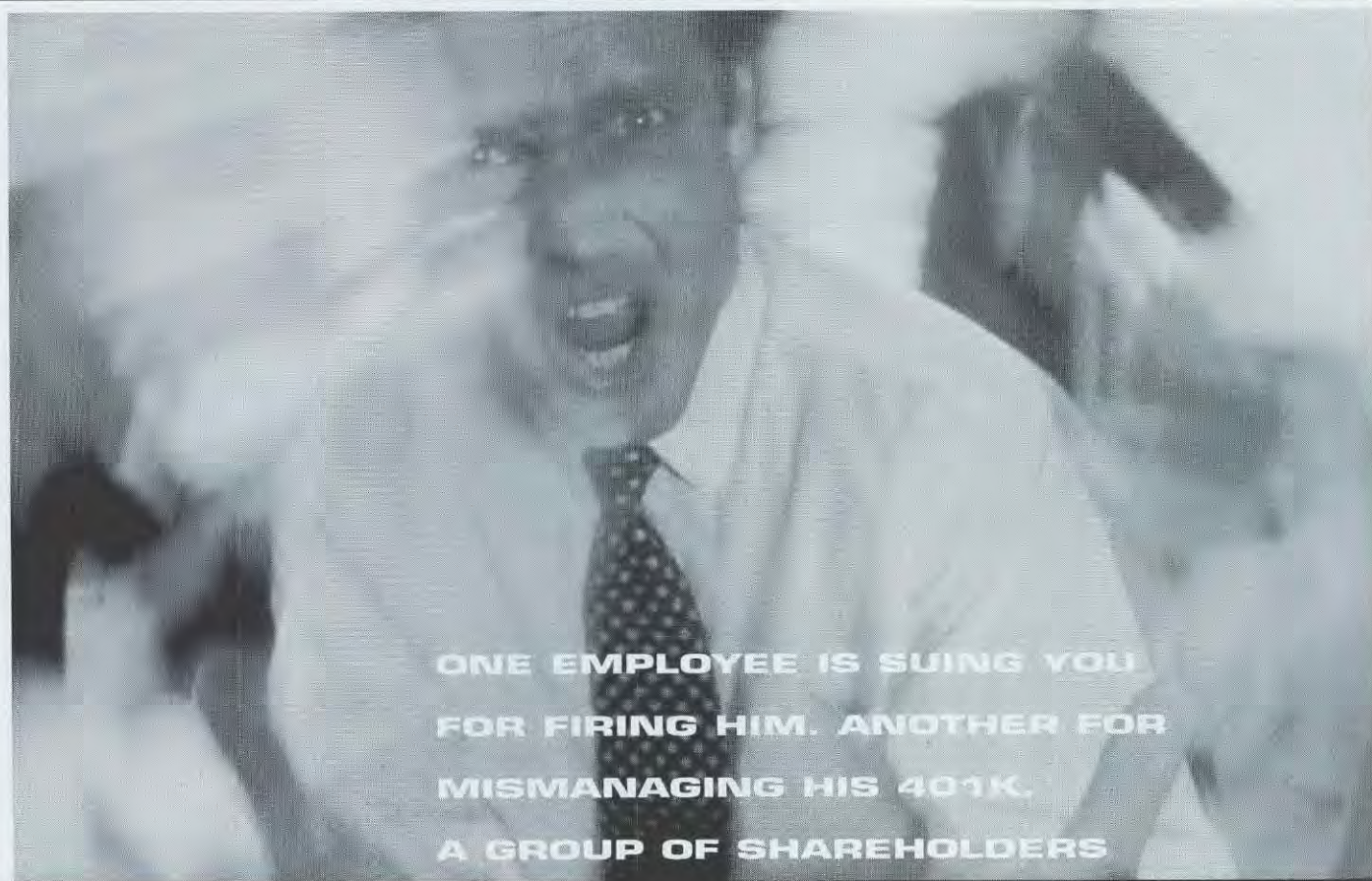
will bring, said Tom Greene, senior vp in the specialty division of Chartwell Reinsurance Co. in Stamford, Conn.

"I think that everybody is very nervous about the problem, and I think that ISO's attempt to address it is good news from an industry viewpoint," he said.

In the competitive market, reinsurers likely would not risk losing primary company's business by trying to exclude Year 2000 coverage included in any primary policies, Mr. Greene said.

Constitution Reinsurance Corp. likely would follow any coverage provided under primary policies, said Bard E. Bunea, chairman and chief executive officer of the New York-based reinsurer.

"If one of our reinsureds tells us that they are covering the problem, I would think that we would go along with that, depending on the overall relationship," he said. **B**



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Pfizer

Continued from page 1

Supreme Court, had settled the litigation with Pfizer for an undisclosed amount.

The Home's appeal to the state Supreme Court argues in part that the appellate panel's finding that the occurrence clause is ambiguous misconstrues the Supreme Court's 1995 decision in *Montrose Chemical Corp. vs. Admiral Insurance Corp.* (BI, July 10, 1995). In that decision, the court held the occurrence clause was unambiguous, according to The Home's brief.

"The Court of Appeal's decision and this court's treatment of it could have a tremendous economic impact on coverage litigation," the insurer's brief adds.

The Pfizer decision is significant for policyholders, attorneys say.

"It's the first California case to

state clearly that evidence of a carrier's interpretation of a policy provision in one case is relevant in another case where the provision is ambiguous," said policyholder attorney Barry Weinstein with Meredith, Weinstein & Numbers in San Francisco.

"In the past, this type of discovery was generally limited to bad faith cases," but this is a "pure" case involving a contract dispute without a bad faith claim, he said.

"A number of trial courts have been throwing up their hands not knowing what to do" on this issue because of confusing language in earlier opinions, said Pfizer attorney Martin D. Katz of Troop, Meisinger, Steuber & Pasich in Los Angeles, who has asked the appellate court to publish the decision.

"As a result, how well or how poorly one does in a case turns in part on the particular judge and this really goes a long way toward eliminating that as a factor, which it

should," said Mr. Katz. "So from that standpoint it is an incredibly important opinion," he added.

"This could substantially expand coverage available for insureds un-

der standard policies where the insurer carrier has argued in other jurisdictions or other cases that a particular policy provision provides coverage for a particular claim," said David Goodwin, a policyholder attorney with Heller Ehrman White & McAuliffe in San Francisco.

But insurer attorney R. Gaylord Smith, of Lewis D'Amato Brisbois & Bisgaard in San Diego, characterized the decision instead as one that "arms the policyholders with a new

'I think it's going to force the insurance companies to really tighten up their programs and make sure everybody's doing it the same way,' says Guy Kornblum.

weapon to inflict great pain upon insurers in the discovery process" in ordinary breach of contract cases.

Other attorneys, however, say the decision will encourage insurer consistency in handling claims.

"It appears to impose a pretty substantial burden on insurance carriers

to be first, extremely careful that responsible decision-makers are making well-reasoned and consistent coverage determinations and, secondly, I think the cost of responding to this type of decision is obviously going to create an additional incentive for carriers to settle coverage disputes," Mr. Weinstein said.

The decision ventures beyond what has been done before "because you're really using the insurance company's own method of handling the claim to establish they didn't know what it was doing in the first place," said Guy Kornblum, a policyholder attorney with Bailey & Kornblum in San Francisco.

If two different units of the same insurance company handle a claim differently, it is evidence that whatever contract language it was relying on was not carefully drafted and fraught "with all kinds of potential for misapplication," Mr. Kornblum said.

He noted that in large insurance companies that handle many claims there may be poor communication and technical skills in policy interpretation and application.

"I think it's going to force the insurance companies to really tighten up their programs and make sure everybody's doing it the same way," he said. "If they're wrong, at least they'll be consistently wrong."

The decision formally recognizes policyholders should be given the opportunity to satisfy themselves that insurers' treatment of their claim is consistent with the handling of other policyholders' claims, said David Mulliken, a policyholder attorney with Latham & Watkins in San Diego.

For years, he added, insurers have resisted efforts to provide this information. It has given them "a great luxury to respond on a piecemeal basis depending on the leverage that they feel they enjoy in each particular coverage dispute," said Mr. Mulliken.

However, one insurer attorney predicts the decision could have "unintended consequences" for policyholders.

"What insurers have historically done is to try and preserve the confidentiality of all their policyholders' information, not to protect any interest that the insurers have, but to be faithful to the macro interest of their own policyholders," said Barry R. Ostrager, an attorney with New York-based Simpson, Thacher & Bartlett, who had represented Travelers Property/Casualty Corp., one of the insurers that had settled in the litigation.

"It's not in the general interest of insurers or policyholders to have litigants in one case rummaging through the confidential records of other policyholders," said Mr. Ostrager, who said he believes the decision is inconsistent with prior case law in California.

Mr. Smith of Lewis D'Amato Brisbois & Bisgaard said he disagrees with the court's opinion that providing this information will not be burdensome for insurers.

Most insurers "are not geared to making these kinds of searches under existing computer programs," so it will be very expensive for them to deal with these kinds of discovery requests "which we would now expect to see with great frequency," he said.

"We deal with these types of requests in bad faith cases frequently and they are very onerous to comply with," Mr. Smith added.

Pfizer Inc. et al. vs. The Superior Court of Orange County; Aetna Casualty & Surety Co. et al., Real Parties in Interest, California Court of Appeal, 4th Appellate District, Division Three; No. G021411.

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MERGERS & ACQUISITIONS

Companies seeking
targets to add value

Assessing the motive behind the merger

Experts see desire to boost profits, trim expenses driving future deals

By REGIS COCCIA

Merger and acquisition activity in the U.S. commercial property/casualty insurance industry set records in the past two years, and such activity is expected to continue into 1998.

Industry observers foresee more high-profile transactions through-

out the industry but a cooling of M&A activity among reinsurers, which set a frenetic pace in 1996.

Among major 1997 deals:

- SAFECO Corp.'s \$2.8 billion acquisition of Indianapolis-based American States Financial Corp. The combination was expected to create the nation's 12th-largest property/casualty insurer.

Seattle-based SAFECO bought American States from Lincoln National Corp., which wanted to focus

on life insurance and other businesses (BI, June 16).

- Zurich Insurance Group's merger with B.A.T. Industries P.L.C.'s British American Financial Services unit.

Although the merger, expected to be completed late in 1998, will create one of the world's largest insurance and asset management companies, the deal will give Zurich a greater market penetration in the United States for its financial ser-

vices businesses (BI, Oct. 20). The combined group's main U.S. insurance subsidiaries will include Farmers Group Inc. and the Zurich Insurance Group-U.S. companies, including Maryland Insurance Group and ZC Insurance Co. and Zurich Reinsurance Centre Inc.

- Mercantile & General Reinsurance Co. of America's merger into Toa-Re Insurance Co. of America.

Toa-Re's parent, Tokyo-based Toa Fire & Marine Reinsurance Co. Ltd., agreed to buy M&G Re of America from Swiss Reinsurance Co. for



about \$200 million (BI, Nov. 3). Toa-Re and M&G Re of America, both based in Morristown, N.J., have operated under common management since 1982.

"1997 was a big year for mergers and acquisitions in the commercial P/C market in both the primary company and reinsurer segment," said John L. Ward, chairman and chief executive officer of Ward Financial Group, a Cincinnati-based investment banking and consulting firm specializing in insurance.

The M&A transactions of 1996 and this past year typically have been driven by competition and desire to cut costs and increase market share, but those factors will not be the major forces behind future acquisitions, Mr. Ward said.

"As I look forward, I don't see a compelling reason for that trend to continue at that pace," he said. "Going forward, more companies will look at mergers and acquisitions but for a different reason."

Publicly held insurers, for example, are "under a lot of pressure to deliver shareholder returns," he pointed out. As a result, more companies may look to acquire operations to increase profitability.

However, an investment banker who spoke on condition of anonymity believes there will be more insurance industry consolidation to control costs, but it will be situation-specific.

"I see consolidation to bring some cost-efficiencies to the market continuing," he said, citing ongoing competition for business.

There was "a big dropoff on the reinsurance side in '97 from '96," he noted, adding he foresees some smaller reinsurance deals taking place in the coming year. "Nowadays, everyone's willing to consider something for the right price."

Mr. Ward also expects less M&A activity among reinsurers in the future. "Reinsurance will be relatively stable for the foreseeable future. It's a very consolidated segment. There's just not that much more to be consolidated."

Among insurers, "I would expect more M&A activity in '98 attributable to troubled situations," such as a lack of capital, he said.

"The landscape still supports further consolidation," particularly among insurers with \$2 billion to \$3 billion in premium, said Kenneth S. Zuckerman, vp and senior analyst at Moody's Investors Service in New York. "The middle tier really has some decisions to make going forward and may be ripe for M&A."

BI

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Know the nooks and crannies of niches

Sometimes revamping and reintroducing a product can bring marketing success

By TODD J. BEHME

Chiseling out a niche amid all the firms focusing on specialty marketing takes patience and thick skin.

Insurance companies and agents involved in niche business say developing successful programs—even in best-case scenarios—takes time and commitment. They also emphasize that to win over clients, producers must become experts in the businesses they're trying to insure.

Those producers also have to know the risks their clients face.

For example, a specialized book of yacht business made information about Hurricane Bob critical to an agency far from the Atlantic coast.

The Federau Group of Okemos, Mich., itself was in no danger, but clients' yachts might have been.

Using computers and ZIP code maps, the agency located insured yachts that might be in the 1991 storm's path through the mid-Atlantic region. The agency then called harbors it thought the storm would strike and got boats belonging to clients moved.

Because of its specialty in the business, the agency knew enough about yachts and the risks to which they are exposed—such as extreme weather—to make the calls.

The agency in suburban Lansing, Mich., has annual premium volume of about \$35 million. About a third comes from its half a dozen or so programs and the rest from a general book, President Douglas Federau said.

Another one of its specialties is insuring facilities such as towers for broadcast and cellular telephone companies. Before that took off, however, the agency first contacted numerous insurers to try to sell them on developing products for the broadcasting niche.

"It was just an absolute nightmare" finding the right insurer partner with the right people, Mr. Federau says.

Agents trying to sell underwriters on a new program need to make sure they speak with decision-makers, he advised, adding, "You've got to be really patient."

Mr. Federau noted there is a difference between policy and program niches and emphasized it's much more involved to get a program go-

ing, in part because setting up a program involves talking to multiple underwriters.

The agency made some mistakes along the way. For example, it learned quickly that broadcast companies owning many facilities would not go for the agency's original intent of covering only facilities in areas with the lowest exposure to weather-related losses.

"We just learned all kinds of lessons," he said, including the fact that broadcast companies wanted more than just their towers insured.

Mr. Federau said the agency's program business is growing faster than other business. "That's where we see our future."

He noted that niche marketing allows for better knowledge of the competition, more focused marketing and faster development of producers, because they can quickly learn the language of the client's business and quickly begin bringing in returns.

"Because he talks the language, he's going to have a much better success ratio, assuming he has sales aptitude," Mr. Federau said.

He and others emphasized the importance of understanding a client's

business. "They want to talk to somebody who *knows*," he said, noting it will be clear to a customer after only the first few minutes of questions whether the producer is familiar with the client's business.

"Everybody has less time," he said. But companies interested in specialty business must make time.

Articles about niche marketing make it sound easier than it is, says Raymond T. King Jr., a consultant outside Philadelphia who worked for Insurance Co. of North America, now CIGNA Corp., and also for Morefar Marketing Inc., a unit of American National Group Inc.

"You've got to recognize it's going to take time" and resources, including money, said Mr. King, who now works with E.W. Siver Insurance Consultants in St. Petersburg, Fla.

He recommends taking time for basic research on an area that might provide a niche.

To find ideas, one can lock in one's community and decide if there's an insurance need to fill, Mr. Federau said.

"We're constantly thinking, 'Who's done a good job at what?' " or where is a bad job being done, he said.

Underwriters look for specific things in program business.

"We're looking for agents who have some expertise and often some critical mass," said Douglas Morrill, director of marketing and product development for commercial programs at The Hartford Financial Services Group Inc. in Hartford, Conn.

The Hartford invests in product and development research but depends on agents to know the exposures in a particular area, he said.

Mr. Morrill cited four key things he looks for in program business:

- **Pricing.** The Hartford runs all ideas through an internal return-on-equity model in trying to determine if it can make money on a product. He did add, though, that some analysis can be subjective, especially if little or no loss data is available.

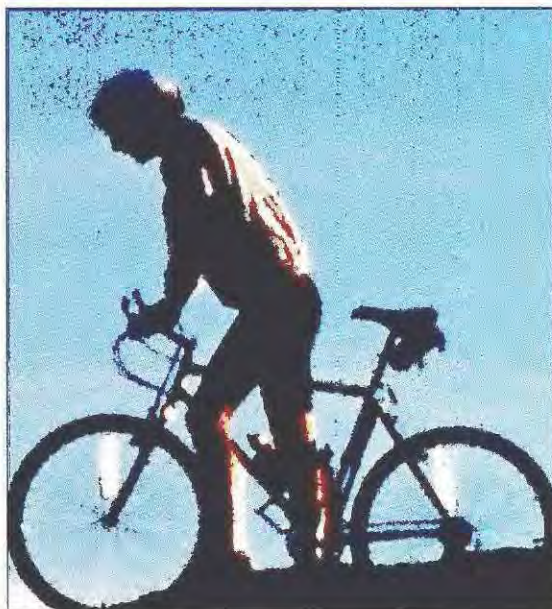
- **Product.** Mr. Morrill said successful programs have a coverage "hook" and meet a specific need. Cost-containment features, such as loss control or claims services, also are key elements The Hartford wants to bring to its program business.

- **Production.** For agents serious about a particular program, "they have to be willing to step to the plate and make an investment as well," he said.

- **Partnership.** "We like to get everyone involved and committed to the success of the program." That

Continued on next page

GET THE BROADER VIEW.



Continued from previous page

might include, for example, the underwriter, agent and group or association involved.

Another underwriter also looks at specific things.

GA Pro 1, a Philadelphia-based division of General Accident Insurance Co., is about 14 months old and writes about \$100 million a year in gross premiums in about 15 programs, said Thomas G. Cole, senior vp. Its specialty areas include programs for the Exhibit Designers of America, the Asian American Hotel Owners Assn. and the National Assn. of Wholesaler-Distributors.

Among the criteria Pro 1 uses, the insurer likes to be in areas where competition is limited. That allows Pro 1 to develop underwriting standards and price policies in line with exposures, Mr. Cole said.

Pro 1 also wants to be in area where General Accident can add value, he said, such as claims service—"something that makes us different and is needed by the insured."

Mr. Cole agrees that program development takes time. Even in a best-case scenario, he said, "It takes at a minimum six to nine months to put a program together."

He, too, believes in knowing his clients' businesses, with Pro 1 program managers specializing in the areas in which they work.

Niche marketing also can involve

simply delivering more effectively something already out there, Mr. King said. For example, while there are plenty of lawyers professional liability programs, many are written using the same exclusions and rating formula, he said. A niche player, by contrast, could decide to target solo practitioners and simplify the application process for them.

Reinventing a product is what led to EduGuard, a policy that covers schools and colleges against the loss of tuition because of a student's accident or illness or a parent's job transfer or unemployment.

Glenn W. Clark is chief executive officer of Rockwood Programs Inc., a Wilmington, Del.-based subsidiary of E.W. Blanch Holdings Inc. At a trade show in 1995, he met the people selling the product, then marketed as a personal lines product after a school endorsed it.

Mr. Clark thought it would sell better if it was offered to the schools as a commercial lines product. Such distribution would allow a better spread of risk and a premium of less than 1% of a school's tuition revenue, he said.

He rewrote the form to make it a commercial lines product, and the product was renamed EduGuard. A potential customer base and who makes schools' insurance-buying decisions was researched; rough data projecting losses was put together.

TIG Insurance Co. in Dallas agreed to underwrite EduGuard, which is for private grade and high schools, private colleges and trade schools. Because of the complexity of purchasing decisions at large, public universities, Rockwood is not including them as potential targets.

After beginning a little more than two years ago, Mr. Clark said Rockwood has 2,600 prospects out of a pool of 40,000 schools and colleges.

Rockwood, which uses independent agents to market the program, also hopes to sell EduGuard to student loan lenders, which would mean a student forced to leave school would not have to borrow again, as the policy would pick up the cost of another term in school.

Rockwood has a 1998 goal of writing \$2 million in EduGuard premiums, and "we have every confidence of making that," Mr. Clark said, adding the figure would rise substantially if any lenders bought policies.

"I want EduGuard to be *the* way people think of tuition insurance."

However, anyone looking into niche marketing should be prepared to make a lot of trips to the plate before getting a hit.

"If you're a person who takes rejection personally, it's not the business for you," Mr. Clark said.

But, "sometimes you can learn as much from a 'no' as you can from a 'yes,'" he said. **BI**

If there's an exposure, coverage will follow

By MICHAEL BRADFORD

A rain-soaked golfer is trying to calm his nerves in the country club restaurant with a glass of wine after a sudden downburst brought his tournament to an early end.

His first sip is bitter; the wine is spoiled.

Driving home, he spots a tanning salon and decides to dry out. Unfortunately, he falls asleep in the tanning booth while the operator takes a long lunch. Scorched and enraged, he walks stiff-legged to a pay phone next door to call his lawyer.

The electrical current running through the phone somehow short-circuits and the hapless golfer receives a jolt.

A bad day?

Not so bad for the country club, restaurant, tanning salon and telephone owner. Their insurance agents and brokers have made sure they are covered for such mishaps.

In the continuing competitive marketplace, agents and brokers are leaving no niche unturned. The

scramble for business demands that they create new programs to offset the loss of others and the effect of dampened rates that existing coverages bring.

"We're always looking for little niches," said David Price, senior vp at Burns & Wilcox Ltd., a wholesale broker based in Farmington Hills, Mich.

Mr. Price stressed, however, that "we need a reason" to introduce a new program. There has to be a need for the coverage, and simply putting together a program to better a competitor's price isn't enough.

Other agents and brokers point out that a new program can be an entry into providing coverages for a policyholder's other risks.

That's one of the reasons for a program developed to protect restaurants against spoilage and other risks related to their wine cellars.

"Just to go in at a different angle," advised James Brooks, president of J. Edward Gay Jr. Agency Inc. in East Hampton, N.Y.

"A lot of people have programs for restaurants," he said. "We don't think enough attention has been

See *Niche* on page 14J

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Niche

Continued from page 14I
paid to wine cellars."

"That's our niche," Mr. Brooks said, and by offering the coverage, the agency has found a way to discuss other coverage needs with restaurant owners. The agency began offering the coverage around six months ago.

The coverage, written by Chubb Corp., pays restaurant owners for wine cellar losses that include spoilage and breakage.

Marketing the program means pulling out the Zagat Survey of restaurants to identify the "white linen" establishments in the agency's area that are likely to serve wine, Mr. Brooks said.

Similarly, beer lovers may be interested to know that microbreweries have a new source of coverage through wholesaler K&K Insurance Group Inc. in Fort Wayne, Ind.

Product recall, spoilage and boiler and machinery coverages are written for microbreweries on an admitted basis by TIG Insurance Co. In addition, liability limits up to \$26 million are available to microbreweries.

Product development was spurred

by K&K personnel.

"One of our employees had an interest in the product," said Eric Taylor, director of marketing and new product development at K&K. "It took almost a year to put the program together."

Burns & Wilcox has found a niche within the restaurant business by targeting small, independent establishments as prospects for an insurance program that protects against food recalls and claims related to contaminated servings. If a restaurant is closed because a worker or patron contracts hepatitis, for example, the coverage underwritten at Lloyd's of London would make up lost income to specified limits.

Mr. Price said independent restaurants are targeted because franchise operations generally purchase such coverage through their franchisers.

The country club where the hapless golfer was soaked could be protected from loss of revenue due to such weather under a policy provided by Fairway Underwriters Inc., a managing general agency in Lowell, Mass.

The MGA's Rainguard product, which is underwritten by several insurers, covers losses related to events such as canceled tournaments or for

entire seasons, explained Fran Coulter, president of the agency.

For event coverage, the policyholder "establishes the amount of insurance and chooses the amount of rain and time of day it would occur. If it rains over that amount, we cut them a check," he explained.

To cover longer periods, a policyholder can specify from two to 365 days. Many course owners buy coverage for weekends when their losses would be greatest from a washout of play, Mr. Coulter noted.

Fairway Underwriters also has begun offering its clients coverage for hole-in-one contests. The tournament sponsor determines the value of the prize offered and buys coverage according to that amount.

"We don't like to do anything under 100 yards," Mr. Coulter said of insuring short par-three contests.

If the scorched golfer sought recompense for his extended stay in the tanning bed, the salon owner would be covered if a policy written by K&K were in force.

The claims-made liability coverage is written on a non-admitted basis for salons that offer tanning and other personal appearance or spa services, such as hair cutting, nail work, massages and body wraps, that result in a claim.

Limits to \$1 million are offered under the program, which covers general liability and professional liability risks.

Mr. Price said Burns & Wilcox offers coverage for tanning salons as well, also to \$1 million limits but on an occurrence form. The coverage is written by Union America Insurance Co.

Occurrence-based coverage responds to bodily injury claims that occur during the policy period, regardless of when the file is claimed. For a tanning salon, coverage would be provided for claims related to patrons' medical disorders that could have been caused by the tanning

equipment but develop after the policy period expires.

Tanning salons aren't the only personal appearance businesses with business risks.

It is possible that the hapless golfer, during such a calamitous day, might have come away with at least a clipped ear if he had let a barber straighten out his tangled mane.

Such nicks, though, have been covered for decades under policies provided by Hairdressers Agency Inc. in Jericho, N.Y., said Lyn White, underwriting assistant.

As grooming technology has progressed, the agency has begun offering coverage that protects electrologists from personal liability risks. Hairdressers Agency continues to provide traditional coverages for nail salons and beauticians.

A beautician's policy covers claims such as those related to inadvertent discoveries of new hair colors—"if a beautician dyed someone's hair brown but it came out purple," Ms. White explained.

The coverages are written by The Connecticut Indemnity Co.

If the fictitious golfer's day had been real, the electrifying phone call could have triggered coverage available from K&K.

The coverage, written by Great American Insurance Co. for independent providers of pay phones, pays up to \$5 million on liability losses and covers the cost of replacing damaged phones. The liability portion also covers claims related to phone users who are injured by muggers, for example, while using a phone in an area that might be poorly lit.

"An agent was doing it on a small scale in Texas," Mr. Taylor said of the phone coverage. "We tweaked it and took it on a national scale."

K&K has a lot of experience developing niche products, many related to sports and entertainment businesses.

The wholesaler recently introduced coverage for concessionaires in fixed facilities at sporting events. The general liability coverage is written to limits of \$26 million.

K&K also recently kicked off a martial arts program that provides coverage for schools that teach self-defense skills. Liability limits of \$500,000 and \$1 million are written for all martial arts except kickboxing, Thai boxing, savate and any styles that use weapons as classroom aids.

Even if agents aren't building new programs, they are looking for ways to improve existing offerings.

The American Agency Inc. in Overland Park, Kan., for example, is offering an automated loss control course for ambulance drivers as part of various coverages marketed to ambulance companies.

The CD-ROM-based program consists of 10 chapters that drivers must complete in a specified time. Emergency driving, intersection management, parking and infectious diseases are among the topics drivers must study.

"It's available to all our policyholders," said Howard Handler, president of The American Agency.

Policyholders buy various coverages, with liability limits generally written to \$5 million by several insurers, Mr. Handler said.

Another coverage the unlucky golfer could have triggered would have involved the condition of his home and best friend had he left them in the care of a Pet Sitters of America member.

Burns & Wilcox provides the association with a coverage program that pays various pet- or sitter-related claims.

"If the dog escapes and gets run over," Mr. Price explained. "Or if burglars break in because the sitter forgot to lock the door."

All of which goes to show that it pays to check the front door. And the weather. **BI**

Benefits of bad weather

El Nino brings niche opportunities

By MICHAEL BRADFORD

El Nino has been blamed for everything from early snowstorms to bad hair days, but the meteorological disturbance is helping the industry with niche weather insurance products.

"Everybody is concerned about the amount of rain they are going to have, particularly on the West Coast," said Fran Coulter, president of Fairway Underwriters Inc., an insurance agency in Lowell, Mass.

Fairway Underwriters offers golf courses coverage that protects against losses from a single event to an entire golfing season. El Nino has blown some new business into the managing general agency's offices.

Mr. Coulter said calls have increased from West Coast golf course owners. "They really have picked up," he said of the inquiries from that part of the country.

In other areas, however, course owners seem to be taking their chances and retaining the risk. "It hasn't had much effect anywhere else," he remarked.

"We're seeing a lot of interest because of El Nino," echoed Harold P. Mollin, president of Customized Worldwide Weather Insurance Agency Inc. in Manhasset, N.Y.

The agency has placed business for filmmakers and producers of television commercials who are

worried about the nasty weather El Nino could bring to the West Coast.

El Nino has given a boost to a new company that Mr. Mollin and other investors launched last month.

New York-based Worldwide Weather Trading Co. is offering "weather hedges" to businesses with revenues that are affected by weather (*BI*, Dec. 1). Companies establish coverage amounts and specify the weather conditions that will trigger payment on the hedges. The hedge contracts' cost is based on factors including the type of weather event.

For example, a heating oil company might want to protect against a loss of revenue due to a warm winter and lowered demand for its product. It could buy a hedge triggered if the temperature rises to a certain point for a specified period.

The hedges are not capital market products but are backed by insurance and reinsurance that Worldwide Weather Trading purchases. If the hedge is triggered, Worldwide Weather pays it and is indemnified by its insurer.

Gas and electric utilities, heating oil suppliers, agricultural companies and others are wondering what effect this year's weather phenomenon will have on their businesses, Mr. Mollin said.

That made the timing right for Worldwide Weather Trading, which already has sold some contracts. "El Nino has made it more viable," he said.

Look at benefits of digital images

By Jeff Lawson

IT'S FUNNY HOW time changes our perception. In the early 1970s, consumers were introduced to the first "digital" alarm clock: Instead of the familiar face and hands, numbered panels flipped over every minute. Today, however, we've come to associate "digital" with cutting-edge technology. Everything from music CDs to cellular phones are promoted as technologically superior to their predecessors because of their digital format—and in many cases, they are.

In the property/casualty insurance industry, digital photographic imaging products can certainly offer advantages to companies' claims operations. But going digital can be a costly and complex endeavor if an insurer doesn't fully understand its needs and the digital solutions available.

The advantages of digital photographic imaging and

IT Perspective

electronic transfer are numerous. The claims process is streamlined. What took days can now take hours, even minutes, resulting in increased productivity and volume. File management software not only indexes and archives digital photos but also makes it easy to integrate a claims document with its corresponding digital photos. As a result, an insurer can minimize paperwork, simplify archiving of images and reduce operating costs. If things go as intended, all of this leads to improved customer satisfaction, loyalty and retention.

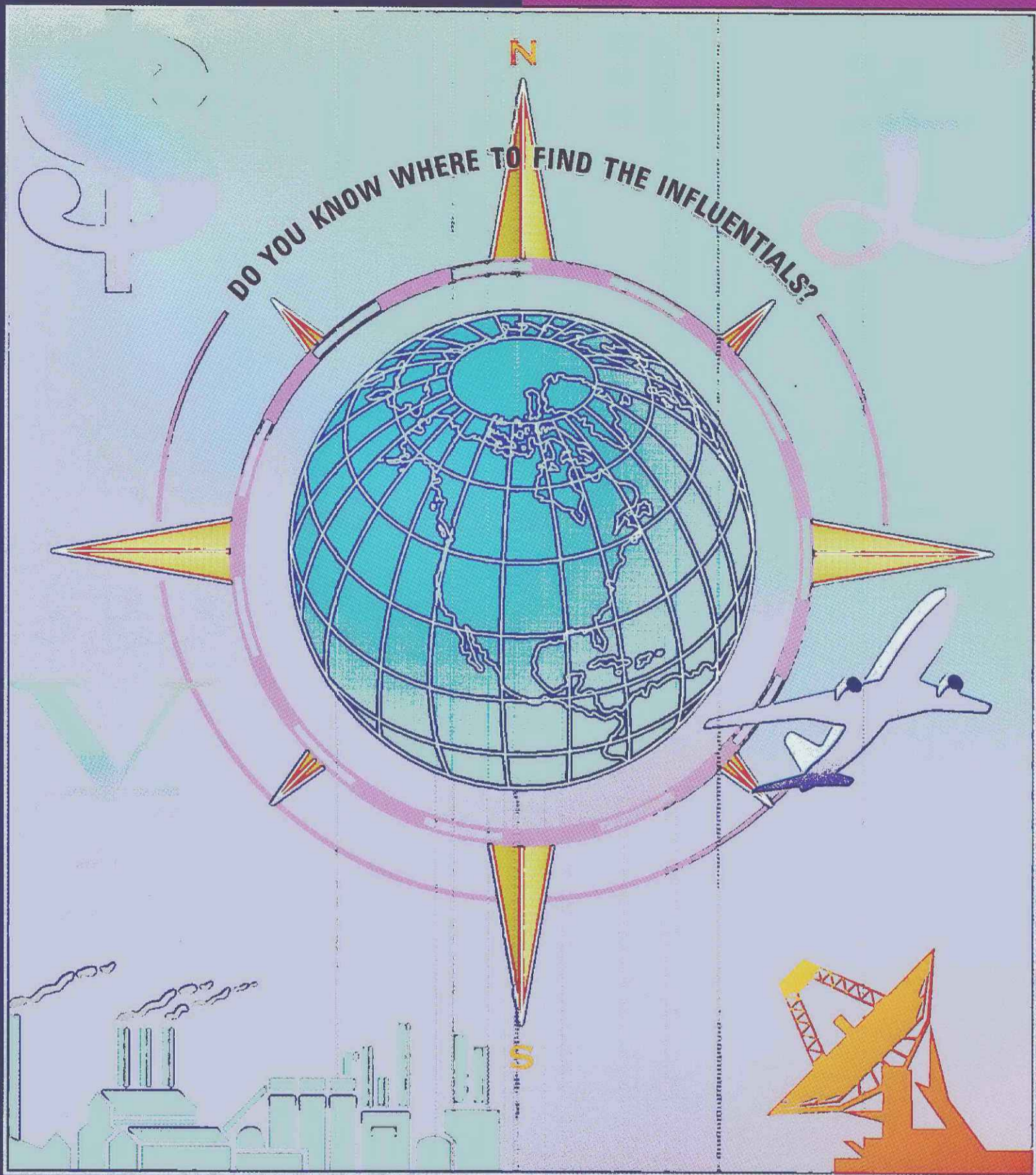
So, how does an insurance company find the digital imaging solution that best achieves these benefits? Ultimately, the investment made in time and money will depend on the approach the insurer takes when digitizing its claims operation.

While the advantages are

undeniable, an insurer can make costly mistakes if it chooses a digital solution without assessing all the hard and hidden costs. Before starting to shop, an insurer should take time to assess its operations. What specifically are its requirements from a digital imaging system? What are the company's existing system capabilities in terms of file management and electronic document transfer?

How many claims offices does the insurer have? How many photos does the company deal with in a typical day, week or year? How sophisticated are the company's current computer and telecommunication systems and the people who work on them each day? What level of quality is required in the images the company uses? Last but not least, how much can the insurer afford to spend to make the digital transition? Answering these

See **Digital** on page 14L



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Digital

Continued from page 14J
 questions will help an insurer determine its best approach and choose the most logical, cost-effective digital solution.

Today, a digital camera suitable for claims costs between \$600 and \$1,000. System software will cost several thousand dollars. Plus, it's \$200 for each memory card capable of holding approximately 40 images at medium resolution. Multiply all of those costs by the number of claims offices, and an insurer will have an idea of the minimum cost to digitize its claims operation using

digital cameras.

Surprisingly, insurers often overlook the fact that they don't need digital cameras to create a digital transfer and file system. The alternative is a digital scanning solution, where companies use a photo scanner to convert an instant photo or conventional 35-millimeter photograph into the desired digital format.

Purchasing digital cameras, hardware and software is only the start. An insurer must consider the ancillary costs at every step in the process. Taking a photo with a digital camera is somewhat more complex than traditional point-and-shoot instant photography, so each

claims adjuster will require three to five hours of training. Batteries will average \$2 a day, or \$520 per year, per camera. Service and maintenance also cost considerably more for digital cameras.

Finally, no matter what approach an insurer takes, the company may need to upgrade its telecommunications and system memory and buy new computers and additional software.

In simple dollars and cents, a claims operation needs to take between 4,000 and 5,000 pictures each year to break even on a digital camera investment. If an insurer produces that volume of images annually, the benefits will justify the

price. If claims offices don't generate such volume, consider the digital scanning alternative.

Compared with digital cameras, a "hybrid" system using a scanner can provide an affordable and practical transition into digital photographic imaging. The price of a high-quality scanner is one-half to one-fourth the cost of a digital camera. System software is approximately \$1,300—again, considerably less than the software required for a digital camera. Claims adjusters can continue to use the cameras they already have, so there's no additional cost and no additional training required.

Scanning one or more photos

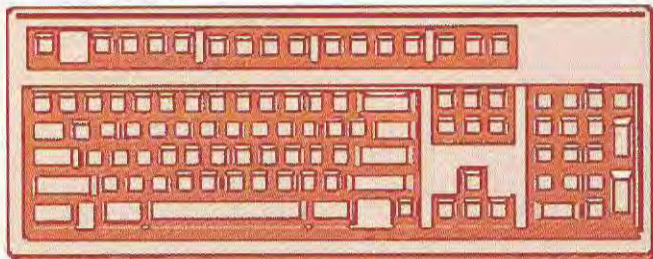
into an electronic file takes about a minute and is less complex than transferring a picture from a digital camera and matching it to the appropriate computer claim file.

While digital cameras continue to evolve at a tremendous pace, traditional film still provides the most pixels per square inch and therefore the best picture quality. In fact, the resolution quality of an instant photo scanned at 200 dots per inch is on average 40% higher than an expensive digital camera's resolution.

Small details in a photograph are often crucial in determining the cause and extent of damage on a claim. In those instances, the superior resolution of film still is the preferred choice over a digital image; film ensures that an insurer has the detail to make an accurate, informed claims decision. In addition, with a tamper-proof instant photo, an insurer always has a hard copy of the image on file as back-up for indisputable documentation.

When all is said and done, a scanner-based digital system can cost 50% less than a comparable system using digital cameras, and end results—increased business productivity, customer satisfaction and customer retention—still are achieved.

One last piece of advice: Ask for help. With any new technology, it pays to consult an expert. Without guidance, it's easy for an insurer to make a less-than-optimal investment that can hurt the company's operation. An insurer's best chance for success is to form a partnership with an imaging specialist who knows the technology and the insurance industry, someone who can offer alternatives. Only then will an insurer understand all the costs involved with digitizing insurance claims systems and be able to make the most educated and cost-effective digital decisions. **BI**



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Business Insurance



Jeff Lawson is general manager of Polaroid Business Imaging, a division of Cambridge, Mass.-based Polaroid Corp.

Insurer Topics

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Reinsurers

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For instance, "Developing equity relationships or strong partnering arrangements with reinsurers is more important to small insurers than to large insurers," says the report. "These types of linkages say that smaller insurers value close, stable and ongoing reinsurance relationships."

Small insurers also are particularly interested in buying multi-year contracts, preferably of at least three years, the Conning report says.

"It is clear that flexibility and variety in products and services are what customers want," says the report.

Large insurers rate claim services as most important, while small insurers seek underwriting and actuarial services first, Con-

ning found.

The report also says a shift toward reinsurance buying becoming more of a financial decision than a "purely" insurance-based one will continue "as primary insurers gravitate to managing risk more comprehensively—just as their own clients are doing."

In addition to satisfying the traditional critical success factors, Conning's report says other strategies reinsurers must adopt to survive and succeed in the future include: avoiding underpriced business and practicing strong underwriting; using sophisticated technology; expanding internationally; and buying back stock.

Both the Conning and Guy Carpenter reports discuss capital markets' prospects for becoming a force in risk financing.

The Conning report says the

capital markets "are making inroads to providing new risk protection arrangements, and primary insurers express no fundamental reason to avoid them. The result is that capital markets is both

'Traditional reinsurance boundaries have faded,' says a global analysis of reinsurance from Guy Carpenter.

a threat and an opportunity for reinsurers."

The Guy Carpenter report, "Global Reinsurance Analysis 1997," says the financial impact of a \$50 billion to \$100 billion loss "could be the spark that ignites the broad acceptance" of capital

market instruments and other alternative sources of capital.

Discussing the globalization of reinsurance, the Guy Carpenter report's authors say that the reinsurance markets in Bermuda, Europe, the United Kingdom and United States represent a single global industry. The report analyzes each of these markets individually.

"Traditional reinsurance boundaries have faded, and competition for top-line premium growth and risk diversity is driving expansion. Reinsurers today are less defined by geographic region than they are by global presence."

While both primary insurers and reinsurers have focused on a "growth-through-acquisition strategy," reinsurers have focused primarily on buying other reinsurers, says the report, much of which is derived from Guy Carpenter's proprietary Reinsurance

Composite Study.

Meanwhile, "Capitalization levels remain a major issue that likely will continue as long as ceding companies continue to prefer having a smaller group of select reinsurers (possessing substantial surplus) on their programs," Guy Carpenter's report says.

"A Portrait of Reinsurance, Back to Basics and Beyond, 1997," is available for \$495 by contacting Lisa Pesci at Conning & Co., CityPlace II, 185 Asylum St., Hartford, Conn. 06103-4105, 888-707-1177 or 860-520-1521.

Copies of Guy Carpenter's Global Reinsurance Analysis 1997 are available at no charge by calling Celia Sam at 212-323-1334; fax: 212-313-4550, e-mail: cpsam@guycarp.e-mail.com. The report also can be downloaded from the Guy Carpenter World Wide Web site at www.guycarp.com.

New York approves blood product suits

ALBANY, N.Y.—New York law now allows hemophiliacs who took contaminated blood-clotting products through which they contracted the HIV virus that causes AIDS to sue the products' manufacturers.

Since the early 1980s, thousands of hemophiliacs have contracted the human immunodeficiency virus and AIDS through tainted blood-clotting products.

Some of the blood collected to make these products contained HIV until the products were purified of the virus in the mid-1980s.

Earlier this year, a settlement ended a class-action suit against the manufacturers (BI, May 12). Under the terms of the settlement, each of the nearly 6,000 class members will receive \$100,000. But hundreds of class members opted out in order to pursue individual suits.

About 75 New York residents who opted out of the settlement now can pursue their suits under the new law, signed Dec. 1 by Gov. George E. Pataki.

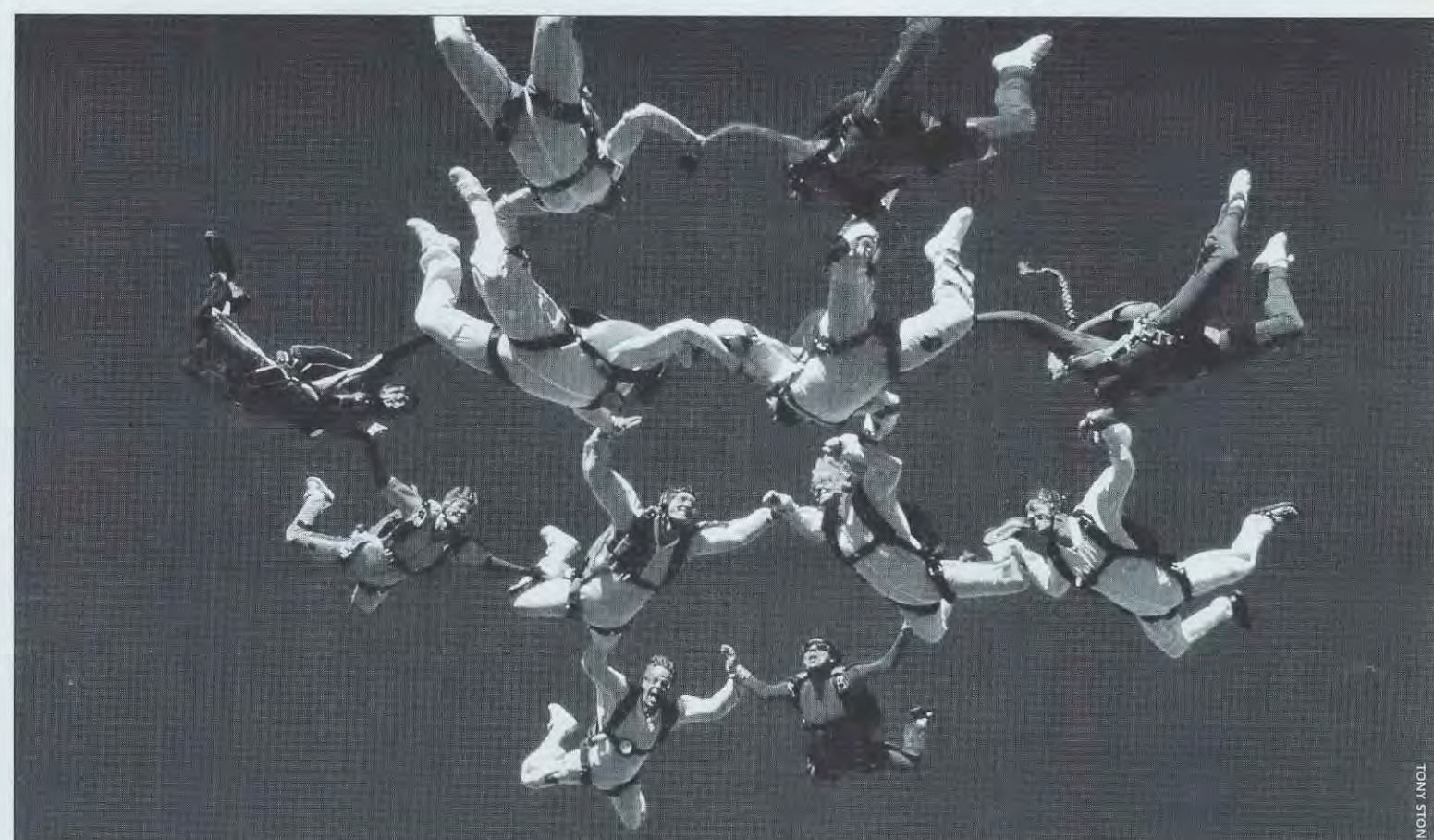
Under the new law, people infected with HIV or their survivors have until Dec. 1, 1999, to file a suit.

Without the law, these claims would have been dismissed under the old New York statute of limitations.

In a written statement, Gov. Pataki said the law is needed to "ensure that the innocent victims of this terrible tragedy have their day in court."

The statement also says that many of the hemophiliacs did not originally file suits because they feared the "publicity and stigma" a suit could bring.

A spokesman for the products' manufacturers said that despite the settlement, the manufacturers maintain they are not liable for anyone's infection and will defend themselves against any new suits.



TONY STONE

Risk is better undertaken with plenty of support

The acquisition of Sphere Drake by Fairfax is now complete. Sphere Drake's future as part of the Odyssey Re Group is secured. Combining financial security, global flexibility and market experience, Odyssey Re Group joins the ranks of the world's leading players. Backed by the Group's guarantee and capital of US \$900 million and our improved CPA ratings (S&P A-), Sphere Drake's security matches the best in the market place.

When you're in the risk business, it's good to have partners you can rely on.

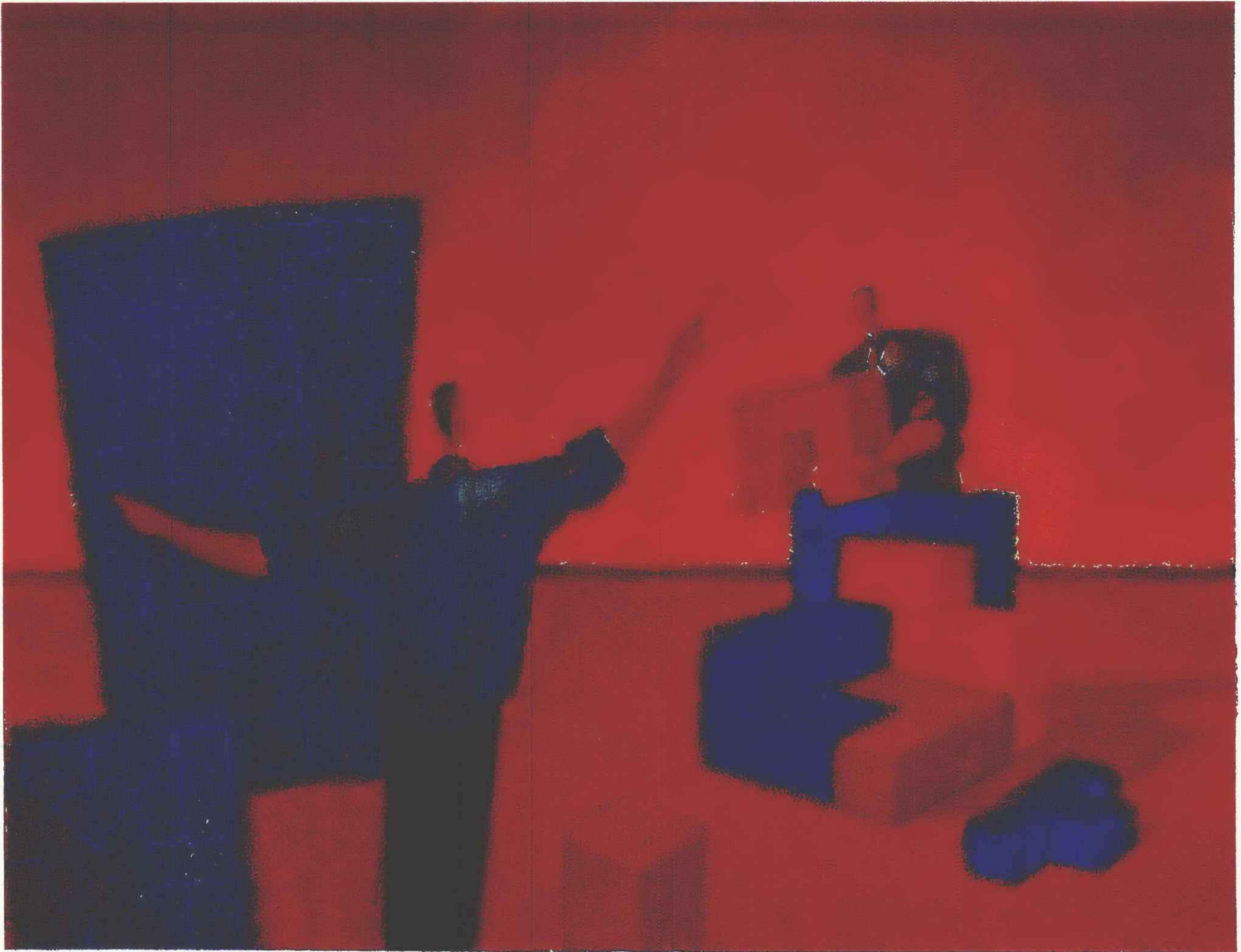


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Medicare HMOs help employers, retirees

By Tom Anderson

IN THE FIGHT AGAINST the rising cost of retiree medical benefits, more and more companies are finding an ally in Medicare HMOs for group retirees.

Medicare HMOs save companies money by dramatically reducing or even eliminating the need for supplemental Medigap insurance. They do this by offering retirees services that go way beyond what traditional Medicare covers.

A Medicare HMO is like getting Medicare and Medicare supplements combined—and for less money.

The challenge

The costs of retiree health benefits are growing in more ways than one. Not only are rising medical costs making it more expensive to insure retirees, but there also are simply a lot more of them to insure. By the year 2030, retirees will account for 22% of the nation's population.

Add to that new accounting requirements that force companies to account for the future expense of retiree health care on their financial statements, and there is a potentially huge drain on a company's bottom line.

Typical retiree medical plans rely on two sources of coverage to meet retirees' health care needs: Medicare and some form of supplemental "Medigap" insurance. A 1996 A. Foster Higgins & Co. Inc. report of employer-sponsored health plans found that the average cost of providing Medicare supplemental coverage was \$1,874 per retiree per year. And many services Medicare doesn't cover are the ones seniors care about most, including:

- Most routine and preventive health care.
- Eyeglasses and hearing aids.
- Most outpatient drugs.
- Most services outside the United States.

You keep paying and paying

Not only are companies seeing the direct cost of retiree medical benefits go up year after year, but also—thanks to the Financial Accounting Standards Board, which issued Financial Accounting Standard 106 a few years ago—companies no longer can account for their costs on a pay-as-you-go basis; they must accrue the present value of all future retiree health care liability on their financial statements. That doesn't look so good on a company's balance sheet.

Companies are looking for ways to get this situation under control. One obvious way is to scale back

coverage offered to retirees, or to stop promising to cover future retirees. These "solutions" are fraught with risk for employees and employers, but companies have had a hard time coming up with a better answer.

A sensible solution

That was before Medicare HMOs came along. While Medicare covers some of the basic necessities of health care, Medicare HMOs cover a lot more. From preventive care to prescription drugs to eyeglasses, group Medicare HMOs cover more of the services seniors really use.

Most Medicare HMOs offer comprehensive benefits for no premium. These benefits are funded by the federal government, which pays HMOs to provide Medicare benefits, and by a retiree's Part B premium. Although comprehensive, some employers found that HMOs' limitations on benefits, such as annual prescription drug limits, did not meet the needs of their retirees. Now many Medicare HMOs are willing to offer unlimited prescription drug benefits designed exclusively for group retirees in exchange for a small premium.

From an employer's point of view, Medicare HMOs offer a clear advantage. All these additional services come at a price substantially lower than a Medicare supplement that would provide similar coverage. That means less money going out, and less FAS 106 liability to report.

Here's an example:

An average employer pays about \$1,800 per retiree per year for coverage beyond Medicare. With a Medicare HMO, employers can reduce that payout to only about \$400 without decreasing coverage the retiree enjoys.

Not only does that save the company about \$1,400 per retiree per year, it also can reduce its FAS 106 liability substantially.

Expanded benefits

In a Medicare HMO, the government pays the HMO to provide health care coverage, rather than directly paying a portion of retirees' medical bills.

The HMOs' ability to provide more services at a lower cost enables them to offer benefits that typically would require coverage by a Medigap policy.

What do retirees get when they are enrolled in a group Medicare HMO? Quite a lot, actually.

In most respects, it's just like being in any other HMO. While details differ from plan to plan, basically everything is paid for, except for nominal copayments

for office visits and prescriptions. Routine preventive care is covered, as are the basics of Medicare, including hospital stays, diagnostic tests and durable medical equipment.

In addition, retirees enjoy reduced paperwork and a system focused on helping them get the care they need. Some Medicare HMOs offer special benefits designed exclusively for seniors, such as travel benefits for "snowbirds," so their coverage goes wherever they do, and personal service representatives who are always there to answer retirees' questions.

Everybody wins

With Medicare HMOs, everybody wins.

Employers win because they are getting more for less: richer benefit packages, substantial cost savings, and greatly reduced FAS 106 liability.

Just as important, employers win by being able to continue offering retiree medical benefits. By honoring this commitment to past employees, the company gains the respect and loyalty of its present workforce.

So far, most employers offering Medicare HMOs are doing so on an optional basis. Retirees can choose to stay in their indemnity plans or join the HMOs. However, as managed care gains more acceptance and Medicare HMOs become available to a greater percentage of the population, more employers may make this their only option.

Retirees win by gaining convenient access to medical benefits far beyond what they would get under traditional Medicare. With the additional services many HMOs offer, retirees are finding ways to enjoy healthier, more active retirements.

The high cost of health care for those over 65 is one of the greatest challenges facing industry and government. Medicare HMOs take the best principles of managed care and apply them to this problem. The results so far—better care at a lower cost—have been extraordinary. **B1**



Tom Anderson is vp of Medicare programs for United Health-Care Corp. in Minneapolis.

Patient health key to that of managed care

Case management has proven best to provide good outcomes

By Sue Sedaka and Vi Karr

The managed care model has clearly demonstrated that it can contain the rise of health care costs. For several years now, the rate of inflation for health insurance premiums has declined for payers of employer-sponsored plans.

Most experts are only too willing to attribute this statistic to the fact that managed care plans have replaced traditional indemnity plans as the primary choice for health care coverage by employers and their employees.

But it's not enough anymore to save money. With HMOs under attack for "rationing" health care, improving patient outcomes is now recognized as an essential component in any health care delivery system.

The challenge for employers is to find true cost-efficiencies in the health insurance they provide to

their employees by offering health care that controls the costs to the company and protects against claims of restricting necessary care, keeps people on the job and promotes good medical outcomes.

The lesson we have learned is that managed care saves money, but only by re-engineering the managed care model can we save money and deliver better patient care.

Managed care at the crossroads

Managed care is at a critical point in its evolution. For the past year, it has been the subject of a loud chorus of criticism from consumers, politicians and members of the news media who are concerned about quality medical care and patients' access to it. They are questioning the legitimacy of managed care practices such as:

- Gatekeeper primary care physicians.

- Closed provider networks.
- Reimbursement systems that reward physicians for withholding care.
- Mandated length of hospital stays.
- The determination of "medical necessity" by insurance policy design rather than clinical assessment.

Are these procedures truly working to improve health care and manage costs, or are they really just ways in which health care is rationed? Are these policies simply major "hassle factors" that keep people from getting the care they need? Are the cost savings from the managed care model being used to improve care and reduce premiums, or are they diverted into cash bonuses and stock options each year to HMO executives and large dividends to their stockholders? Does passing the financial risk to the physician result in better care management or just less care?

Ultimately, the question is, "What are we really See **Outcomes** on next page

Outcomes

Continued from previous page
managing—health care or health care profits?"

The health care consumer's question—"Is managed care producing better outcomes?"—is still unanswered.

How can HMOs coordinate the mass of data they have on patient care to actually measure the results of a total care plan? Various disease management programs have made a start, but the results are still unknown.

While managed care has created a new way to manage the utilization and cost of health services, it apparently has failed to create a new model for how health care is coordinated to achieve the best outcomes.

Into this picture emerges a new model that challenges the existing managed health care system and seeks to find greater efficiencies and better outcomes.

The disease state management "episode of care" approach grew out of an orthopedic demonstration project with an independent practice association-model HMO.

The episode of care approach has been used with great success for the past two years in the Western United States, and the model now extends to multiple diagnostic categories.

The premise for the disease state "episode of care" concept is simple: the best management strategy that has proved successful in providing superior patient

The premise for 'episode of care' is simple: the best strategy that provides superior outcomes and controls cost is case management.

outcomes and simultaneously controlling costs is case management. This is because case management must develop a case plan incorporating all of the individual patient's needs throughout all the layers of required medical care.

Instead of a cookie-cutter approach to standardized health care paths, each patient is evaluated and a plan is developed that takes into account individual needs.

This approach historically has been reserved for catastrophic cases with potential runaway costs, achieving great success and improved patient satisfaction and outcomes.

If the "episode of care" is applied to high-volume, routine cases, though, similar results can be achieved. In addition, the episode of care concept expands this role to enhance outcomes through innovative uses of technology in treatment and care delivery, information system management and interactive education. It also adds the role of procurement to the case manager's responsibilities.

Finally, the episode of care approach generates the type of outcome data that documents its superiority to traditional approaches in terms of better outcomes and higher patient satisfaction. Moreover, this outcomes data can be utilized to forecast what type of treatment alternatives are suited to a specific patient while the decision-making is in process.

The concept of disease state "episode of care" management could offer the managed care industry a solution that has proved quite elusive in this decade. If widely implemented, this could represent a cohesive strategy for savings by placing the organizational emphasis on properly managing patient care. In short, it seeks to manage a patient's overall health care experience and all of the inputs to that process in an "every side wins" solution.

The episode of care

An episode of care is defined as a specific disease

state condition or event that has a quantified time frame and requires multiple care delivery systems to achieve the clinical goals established.

The episode of care concept involves packaging the medically necessary products, services and outcomes data to meet the individual needs of the patient and can demonstrate clear evidence of the care delivery's effectiveness.

Savings are achieved by implementing case management, leveraging technological advances in health care delivery and utilizing progressive procurement strategies that unbundle many services to allow controlled margins and resultant cost savings.

This new model for health care delivery was created to meet the demand for continued improvement in the care and cost-effective management for high-volume disease states, medical events and surgical procedures while demonstrating consistent quality in the health care experience by all participants. It also makes the primary care or specialty physician an advocate for their patients.

The episode of care management strategy assumes that the fundamental service essential in safely altering health care delivery patterns in any patient care event is case management. Indeed, empirical evidence shows that for every \$1 invested in case management services, claims costs can be reduced by \$10 or more. From that starting point, an entire approach to managing patient care was developed that intrinsically re-engineers the care delivery process.

The episode of care consists of the following five principles:

- **Clinical choice confirmation.**

Thorough patient evaluation is performed before a surgical event or as a situation confirmation in medical cases. Understanding the actual situation confronting the patient, physician and payer ultimately will result in targeted care and cost-effective outcomes. Furthermore, this process actively involves the patient in their own care plan and assures that their particular situation and needs are addressed. The case manager who is performing the assessment and is viewing the "big picture" can serve as the patient's advocate with other components of the delivery system.

During this process, assessments of the patient's clinical, psychosocial and financial situation establish an appropriate individualized pathway. Patient engagement and advocacy assures their close involvement in pathway decisions; compliance with specific disease-state education, such as preventive and coping strategies; caregiver identification; and the development of recovery expectations.

- **Case management services.**

This component offers the most effective care delivery options to the patient, physician and payer. An advocate and an administrator must be available to assure that all safety and care delivery issues have been effectively coordinated through the duration of the episode.

Additionally, any unexpected event is managed immediately, which provides continuity between the original payer and reinsurer as appropriate. Determination, coordination and procurement of all professional services, facility stays, technologies, equipment and products are required to fulfill the individualized episode of care pathway established.

- **Care substitution.**

As the episode of care is planned, all opportunities to substitute less expensive and more beneficial care options are considered. The approach of "care substitution" is the exact opposite of "care subtraction" to reduce costs. Care substitution can include, for example, home care with appropriate attendant assistance—supplemented by appropriate patient and family health education—instead of long hospital stays.

- **Comprehensive outcomes data.**

Collection, analysis and reporting of individual case and aggregate population outcomes address the episode of care's clinical, financial and satisfaction concerns. Reliable and valid collection tools and analytical methodologies offer comparisons with data

from national, regional and other governing organizations.

The predictive algorithms and care delivery pathways developed from the data offer physicians and payers clear guidance in determining which patients are appropriate candidates for aggressive outpatient options or more conservative facility care. Clinical, humanistic, financial and satisfaction factors are all separately evaluated in the outcomes data collection process.

- **Case rate pricing structure.**

The final component of this unique approach to managed care is fixed monetary reimbursement for the entire episode of care. This single flat rate includes all of the individual elements, including the procurement of all necessary medical products and services and the execution of case management services.

Indeed, part of re-engineering the care delivery process involves the procurement infrastructure. The episode of care approach takes the facilities' bill for a patient and separates all of the pieces, thereby allowing individual components of the care—for example, medical devices and prosthetic joints—to be purchased in a competitive manner.

By reimbursing hospitals for specific inpatient costs and then going directly to manufacturers for acquiring the individual components of care delivery, the patient is able to receive customized care and the net costs are significantly reduced.

In fact, the episode of care process typically can reduce payers' overall costs for currently unmanaged events of patient care by 15% to 25%. Moreover,

The episode of care process typically can reduce payers' overall costs for unmanaged patient care events by 15% to 25%.

based on our first 300 orthopedic joint replacement episodes of care for which outcome studies were conducted, 98.4% of patients were highly satisfied with their care. These 300 cases resulted in savings to the payers of nearly \$6 million.

With the evolution of managed care at a crossroads, the charge to re-engineer the health care delivery model may be the best hope for improving patient care while at the same time continuing to save money for employers.

Built on the premise that independent, third-party case management is the only proven strategy for simultaneously saving money and improving the management of patient care, the "episode of care" seeks to apply these proven techniques to routine, high-volume medical cases.

This new approach offers employers an excellent return on investment by saving money on premiums while delivering improved patient outcomes. This means a better quality of life for employees and their employers. **BI**

Sue Sedaka is vp of managed care and Vi Karr is chief operating officer for MedSmart International, a Costa Mesa, Calif.-based company that provides episode of care management services to managed care organizations, self-insured employers and insurance companies.



Ms. Sedaka



Ms. Karr

INTERNATIONAL

Global Briefs

Dennis Mahoney, 47, has been named chairman and chief executive officer of Aon Group Ltd., the London-based reinsurance and wholesale brokerage operation of Aon Group Inc. Mr. Mahoney, former deputy chairman and CEO of Alexander Howden Group Ltd. and most recently deputy chairman and CEO of Aon Group Ltd., succeeds **Alan Colls**, 56, who is retiring. The appointment is effective Jan. 1. . . . Lloyd's of London investment trust **LIMIT P.L.C.** reported a pretax profit of £10.2 million (\$16.5 million) for the six months that ended Sept. 30, a 34% increase over the prior year period. A £2.3 million (\$3.7 million) increase in investment income and a £3 million (\$4.9 million) gain from the sale of capacity in certain Lloyd's syndicates more than made up for a £2.4 million (\$3.9 million) provision for losses on syndicates LIMIT supported in 1994 that have since ceased writing new business. LIMIT said it will increase the amount of business it places with Lloyd's Bankside and Janson Green syndicates. . . . **Abtrust Lloyd's Insurance Trust P.L.C.**, which spreads its investment over many Lloyd's syndicates, has joined the Assn. of Lloyd's Members. ALIT Chairman Peter Gray said joining the ALM is a demonstration of the trust's intention to provide capital to, rather than manage, Lloyd's syndicates. . . . The **Channel Island of Jersey** has approved a draft law to set up a Financial Services Commission. When the commission becomes operable, expected next summer, it will replace Jersey's Finance & Economics Committee. Among other tasks, it will promote Jersey as an offshore insurance and captive center. . . . Stockholm-based **SINSER Holding Ltd.** has plugged a gap in its global captive management network by setting up **SINSER (Guernsey) Ltd.** in St. Peter Port, Guernsey. The unit was created through SINSER's acquisition of Spread Insurance Management Ltd. from Reads Holdings Ltd. . . . Also in Guernsey, Italian insurer **Assicurazioni Generali S.p.A.** has set up Generali International Ltd., through the acquisition of the Sun Alliance International Life Assurance Co. Ltd. . . . Newly authorized London-based reinsurer **Liberty Re**, a unit of Boston-based Liberty Mutual Group, has opened a representative office in Stockholm, Sweden, with the appointment of Stig Aggevall as its regional representative for the Nordic countries. Prior to joining Liberty Re, Mr. Aggevall spent 17 years as managing director of Kolniska Nordiska, a Stockholm-based unit of Cologne Re. . . . Rating agency A.M. Best Co. has raised its rating of Japanese insurer **Sumitomo Marine & Fire Insurance Co. Ltd.** and its U.S. branch to A++ from A+; both ratings are in its top "superior" category. Best said the change reflects the insurer's "superior capitalization, leverage and consistently excellent underwriting results". . . . A.M. Best Co. has assigned an initial A+ rating to Japan's only domestically licensed professional reinsurance company, **TOA Fire & Marine Reinsurance Co. Ltd.** It said the rating reflects TOA Re's superior market position and capitalization, its superior investment yields compared with most of its peers, and its excellent solvency margin and liquidity. . . . The French government will issue details on its privatization plans for **Groupe des Assurances Nationales** "within the next few days," said Finance Minister Dominique Strauss Kahn. He also said the government report will assess why the insurer had large losses between 1992 and 1996. In a statement, GAN denied Paris newspaper reports that it had underestimated losses for these years.

U.K. terrorism market softens

By CAROLYN ALDRED

LONDON—Increased competition and relatively light losses—not a recent meeting between Britain's prime minister and the leader of Northern Ireland's Sinn Fein party—are responsible for softer pricing in the U.K. terrorism insurance market, underwriters say.

The leading market for U.K. terrorism coverage, Pool Reinsurance Co. Ltd., last month announced rate discounts of 20% for city locations and 40% for other locations.

Pool Re was created by the British government and insurance industry in 1993, following a massive contraction in reinsurance capacity for U.K. terrorism risks after 1992 IRA bombings in the City of London.

Under the facility, U.K. insurers provide up to £100,000

(£165,900) of property coverage for terrorism risks. Pool Re, which is backed by the government, provides additional coverage excess of that amount, funded by rates determined by geographic area. Policyholders are required to insure all of their property with Pool Re, or none at all, to achieve a better spread of risk.

A claims-free year has led to the rate discounts, according to Pool Re Chief Executive Leslie Lucas, who noted the discounts do not reflect the status of any recent peace talks.

"By and large rates reflect our claims experience. We cannot second-guess the terrorism threat," said Mr. Lucas.

Underwriters agree, noting that the softening market is a result of a lack of recent losses and increased competition. Falling rates do not reflect a
See Terrorism on page 21



PHOTO: AFP
Sinn Fein President Gerry Adams, right, was in London last week to meet with U.K. Prime Minister Tony Blair, who is not shown.

Argentina draws capital

Insurers get \$50 million investment

By GAVIN SOUTER

BUENOS AIRES, Argentina—The growth potential in the deregulated Argentinian health care and workers compensation insurance markets is prompting a \$50 million investment in two local insurers.

International Managed Care Advisors' investment in two insurance subsidiaries of Banco de la Provincia de Buenos Aires will be IMCA's first investment in a company outside of the United States, said Mark H. Tabak, president and chief executive officer of IMCA in New York.

IMCA was founded last year as the health care arm of Insurance Partners L.P., a \$540 million private-equity fund established in 1994 to invest in insurance-related ventures.

The investment will help boost Banco Provincia's financial strength and man-

agement, said a statement by Alberto Fernandez, president of Gerenciar, the division of Banco Provincia that oversees its insurance holdings.

"IMCA is a valued partner that will enhance the financial strength and the management team of Gerenciar," the statement said.

The bulk of the new investment will be used to set up a new health care insurer, Provincia Salud.

IMCA will pay \$35 million for a 40% stake in Provincia Salud, Mr. Tabak said.

The new health insurer initially will target business in the capital city and then expand to write business throughout the province of Buenos Aires, he said.

In addition to providing capital, IMCA will provide consulting to the local managers on managed care issues, Mr. Tabak said.

"We want to take advantage of the market."
See Argentina on next page

S&P revises Lloyd's rankings

System will assess relative performance

By SARAH GODDARD

LONDON—Standard & Poor's Corp. is revamping and renaming its ranking system for syndicates trading at Lloyd's of London.

S&P in London last week unveiled an enhanced version of its syndicate rankings and renamed the service Lloyd's Syndicate Performance Measures. The five-tiered "crown" ranking system, introduced in 1994, has been replaced by three categories of "bells."

S&P has been criticized in the past for alleged inaccuracy in its crown rankings, partly because users mistook them for ratings. The crown rankings, as well as the revamped system, look at a syndicate's longevity prospects rather than financial strength and claims-paying ability.

The mixed capital base of limited and unlimited liability capacity behind syndicates means it is impossible for S&P to rate the financial strength of individual syndicates, said Kevin Willis, S&P's director in charge of producing the new performance measures.

To clarify the point, Lloyd's requested the new service be renamed, said an S&P spokesman.

Ina Barker, executive director of the Assn. of Insurance & Risk Managers, welcomed the enhanced service, saying that for corporate insurance buyers, the "bottom line is security." An increasing number of U.K. risk managers are looking at ratings and similar services because "the security of the service providers is critical" over the long term, she said.

The syndicate performance measures sit alongside the A-rating that S&P gave the overall Lloyd's market in October. Oldwick, N.J.-based A.M. Best Co. gave the market an A rating (BI, Oct. 6). S&P's highest rating is AAA and Best's is A++.

Under S&P's new system, a syndicate can receive up to three bells relating to its performance compared with what S&P determines is a nominal average syndicate in the market. One bell corresponds to "no better than market-level performance"; two bells means "better than market-level performance"; and
See Lloyd's on next page

Fighter jets in plane covered as cargo

By EDWIN UNSWORTH

LONDON—Although the giant Russian military cargo plane that crashed in a Siberian city earlier this month was uninsured, claims for its cargo of two jet fighter planes will be more than \$50 million.

London aviation underwriters confirmed the 11-year-old Antonov-124 cargo aircraft, which was totally destroyed when it crashed Dec. 6 into a residential area

of Irkutsk, was not insured.

However, Russian state arms exporter Rosvooruzheniye had purchased \$50 million of insurance from Russian insurer Ingosstrakh for the cargo of two Sukhoi-27 fighter planes. The jet planes had been sold and were en route to Vietnam.

Matthew Day, business development director at broker Willis Corroon Aerospace, said London insurers likely reinsured the coverage written.
See Plane on next page



PHOTO: AFP
A claim of more than \$50 million is expected for two fighter jets ruined when this uninsured cargo plane crashed in Siberia.

INTERNATIONAL

Lloyd's

Continued from previous page
three bells represents "significantly better than market-level performance." The measures will be updated annually.

Of the 135 syndicates to which S&P so far has assigned performance measures, 59 were given one bell, 46 two bells, and 30 have three bells.

S&P could not assign a performance measure to 16 syndicates because they had not been trading long enough to amass sufficient data, said Mr. Willis.

Seven ratios have been taken into account when preparing the bell performance measures, two more than for the crown system. In addition to gross and net claims ratios, expense and investment return ratios and the development of capacity by underwriting year, S&P now has factored in the levels of underwriting profitability and reserving adequacy.

Performance measures have been assessed using the syndicate results for the closed years 1991 to 1994, plus publicly available information on the open 1995, 1996 and 1997 years.

if any, across the relevant previous years of account rather than attributing all of it to the 1992 year.

Mr. Willis noted that "the average three-bell syndicate is twice

as large as a one bell, and two-bell syndicates are twice as large, on average, as an average one-bell." In fact, the average capacity of one bell syndicates is £42.9 million (\$70.8 million), average for two bell syndicates is £84.1 million (\$138.8 million) and average for three bells is £104 million (\$171.6 million). This seemed to reflect the pattern of "the larger the enterprise, the better (the policyholder) can expect for security," commented Mr. Willis.

Pressure from the Lloyd's market has led to the reduction of the number of ranking categories in the performance measures.

There had been "a gratuitous differentiation at the lower levels" of the crown system among syndicates, according to Mr. Willis, who added that the designations in the new system are "probably more conservative than in the past."

Mr. Willis conceded that a heavily underperforming syndicate still would be awarded the same

number of bells—one—as a syndicate that meets the market average.

But Mr. Willis defended the decision to change the number of categories, saying that "from the policyholder's perspective, the market rating is very important... the performance measures are looking at different characteristics of the market," and indicate to the policyholder "whether the lead syndicate will be around to service the business in the years ahead."

Lloyd's Syndicate Performance Measures are available at a cost of £1,950 (\$3,218) for the full service or £75 (\$124) per syndicate report from Roma Greening, Standard & Poor's, Garden House, 18 Firsbury Circus, London EC2M 7BP, 44-171-826-3652.

'The larger the enterprise, the better (the policyholder) can expect for security,' S&P's Kevin Willis says of the rating agency's new syndicate performance measures.

With the reinsurance of pre-1993 liabilities into Equitas Ltd., some syndicates were able to release funds from reserves, while others had to pay additional reinsurance-to-close premiums to Equitas.

S&P has smoothed the skew in figures related to the pre-1993 business by spreading the effects,

as large as a one bell, and two-bell syndicates are twice as large, on average, as an average one-bell." In fact, the average capacity of one bell syndicates is £42.9 mil-

Argentina

Continued from previous page
tage of the privatized health care market in Argentina and leverage the experience of IMCA," he said.

The Argentinian health care system is changing, which should mean a marked increase in the size of the private health care market, Mr. Tabak said.

About 40% of the population is covered by the state system, which provides largely hospital-based free health care, he said.

"But the costs are out of control, so the government is encouraging privatization," Mr. Tabak said.

So far, the main vehicles outside the state system have been a limited number of plans based on employee and employer payroll contributions, called Obras Sociales and Provincial Sociales, he said.

In 1997, the government allowed employees more choice among the plans, and the govern-

ment is expected to deregulate the system within the next two years to allow employees to enroll in other private health care plans, Mr. Tabak said.

The remaining \$15 million of IMCA's investment will be in

'Costs are out of control, so the government is encouraging privatization,' says Mark H. Tabak.

Provincia A.R.T., a workers comp managed care company affiliated with Banco de la Provincia.

"The money will primarily be used to expand the business by enhancing the management information systems and service of A.R.T.," Mr. Tabak said.

A.R.T. has 1.1 million members,

mainly in the city of Buenos Aires. Like its health insurer counterpart, the workers comp insurer intends eventually to expand throughout the province.

Argentina first introduced a U.S.-style workers compensation system in 1996 (BI, June 10, 1996).

IMCA, which to date has invested in one other company, which is in the United States, plans to increase its international expansion, Mr. Tabak said.

The investment company currently is contemplating investments in Brazil and Mexico, he added.

Latin America is potentially a fruitful area for health care investments, said Paul H. Warren, managing partner of IMCA and a partner at Insurance Partners.

"From a health care development and investment perspective, we continue to believe that Latin America holds more than a few exciting possibilities for us," he said. **BI**

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Plane

Continued from previous page
ten for the cargo.

The plane crashed seconds after takeoff from a military air base. It failed to gain proper altitude and plowed into an apartment building. There were unconfirmed reports that the pilot had reported losing power in two engines.

The death toll from the crash reached 67, including all 23 people aboard the plane and 44 people on the ground. As of last week, however, the toll was expected to rise,

because at least 25 people on the ground were unaccounted for.

If past Russian practice is an indicator, liability payments to families of victims in the plane and on the ground will be small.

About 50 Antonov-124s have been built, and they are flown by the Russian military and private operators.

This was the fourth crash of an An-124 over the past five years, according to Paul Hayes, a director of Airclaims Ltd., a London-based specialist loss adjuster. However, he said, there is no evidence of a common fault linking any of the

crashes and the known incidents surrounding each loss have been different.

However, after this month's crash, the Russian military has grounded all of its An-124s until the inquiry into the latest incident is complete. The order does not apply to the approximately 20 An-124s in use by private Russian operators in non-military cargo roles.

Andrei Kokoshin, the state military inspector-secretary of the Russian Security Council, warned against drawing any "hasty conclusions" about the cause of the crash. **BI**

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Terrorism

Continued from page 19
renewed confidence by underwriters in the Irish peace process as a result of a controversial Dec. 11 meeting between Sinn Fein leader Gerry Adams and Britain's Tony Blair.

Meanwhile, an "alternative market" for terrorist coverage at Lloyd's of London continues to thrive, with underwriters vowing to match Pool Re's rate reductions.

Syndicate 33, managed by Hiscox Syndicates Ltd., is boosting its terrorism capacity for 1998 to £100 million (\$165.9 million) from £45 million (\$74.7 million) for individual properties. In addition, Hiscox last month launched a new U.K. Terrorism Policy to be managed outside of Lloyd's at the company's Kent, England, offices.

According to Philip Perry, the syndicate's terrorism underwriter, the policy offers coverage at rates 20% lower than Pool Re's new rates; allows policyholders to choose the locations they insure, as opposed to Pool Re's all-or-nothing approach; and provides broker commissions of 20% rather than Pool Re's 2.5%.

Because a special terrorist service unit outside Lloyd's is managing the policy, regional brokers can obtain quotes and bind coverage directly without having to go through a

Lloyd's broker, Mr. Perry pointed out.

Policyholders will continue to benefit from cheaper terrorism insurance rates as more players, particularly Lloyd's underwriters, write terrorism coverage in 1998 outside of the Pool Re facility, he noted.

Mr. Perry acknowledged that he is reducing rates in response to Pool Re, but added that he thinks Pool Re "is premature in reducing rates."

"The general feeling is very much that the whole Irish peace negotiations are up in the air at the moment," he added.

Fellow Lloyd's underwriter Bernie De Haldevang also expressed concern about the uncertainty of the Irish situation.

"The risk could be considered worse as the situation is a lot more unpredictable," he said, adding that Pool Re's "lowering of rates is untimely."

However, Mr. De Haldevang, underwriter for syndicate 1028, also plans to continue to "attract business" despite the continuing uncertainty.

Syndicate 1028, managed by Wellington Underwriting Agencies Ltd., has formed an internal consortium with fellow syndicate 672 to provide up to £50 million (\$83 million) of terrorism cover per risk, which can be increased by additional lines. **BI**

U.K. grocery chain goes on alert after small bombs found

By CAROLYN ALDRED

LONDON—Employees of a U.K. supermarket chain have been cautioned to be extra vigilant after the discovery of several explosive devices planted near supermarkets throughout the London area recently.

Police think the small bombs are the work of someone known as the "Mardi Gra" bomber, who mounted a similar campaign against branches of Barclays Bank P.L.C. in 1995 and 1996. During the two-year period, six parcel bombs were sent to branches of the bank, but no financial demands ever were made, and the campaign ceased as abruptly as it started, a Barclays Bank spokeswoman confirmed.

Similarly, no demands have been made in the latest series of incidents, and it is not clear why the chain, Sainsbury P.L.C., has been singled out, a Sainsbury spokesman said.

Six suspicious packages have been found, though two were discovered to be false alarms. They were found in or near six different stores. One was found near a bus stop next to a store; others were found varying distances—one was about 500 yards away—from the locations.

Several of the bombs have exploded, but no one has been seriously injured. However, the incidents have resulted in several of the stores being evacuated and surrounding areas cordoned off, said the spokesman.

Sainsbury, one of the largest British retailers, has told employees in all its 381 stores to be alert for suspicious packages. The company also "is stepping up security arrangements," said the spokesman, who would not pro-

vide details.

Sainsbury would not comment on whether it is insured for the incidents, but most standard property/casualty insurance policies cover this type of incident, according to the Assn. of British Insurers and market executives.

Although British insurers introduced a terrorist exclusion several years ago for losses of more than £100,000 (\$165,900), terrorist attacks are specified as being politically motivated.

"This type of incident would be covered under a standard fire (property) policy as malicious damage," said Philip Terry, terrorism underwriter with Lloyd's of London syndicate 33, managed by Hiscox Syndicates Ltd.

"If it is an act specifically against a company rather than a government, it is covered by a standard fire policy as malicious damage," agreed Leslie Lucas, Chief Executive of Pool Reinsurance Co. Ltd., the mutual reinsurance company set up by the U.K. insurance industry to cover terrorist risks.

Supermarket chains and other retailers often, however, take out separate coverage against malicious damage such as product tampering because they are perceived to be a high risk, said Lloyd's underwriter Bernie De Haldevang, a deputy underwriter of syndicate 1028.

The syndicate, managed by Wellington Underwriting Agencies Ltd., provides terrorism and other coverage for a "lot of big retail chains" and even considers providing business interruption coverage when an incident does not involve any physical damage, such as the precautionary evacuation of a store, said Mr. De Haldevang.

Agency to merge syndicates

Wellington underwriters would work in partnership

LONDON—Wellington Underwriting Agencies Ltd., one of Lloyd's of London's largest underwriting agencies, is planning to break with tradition when it merges all its syndicates to form one of the largest syndicates in the market.

In a departure from Lloyd's normal practice of having one active underwriter solely responsible for a syndicate, the agency will seek permission from Lloyd's to run the new syndicate through a partnership of five underwriters.

"We believe that this will be the first time that a Lloyd's syndicate will

be led by a partnership of underwriters, each taking collective responsibility, rather than one single active underwriter," said Julian Avery, Wellington's managing director.

The new syndicate, to be formed by merging syndicates 51, 672 and 1028, will, subject to Lloyd's approval, begin underwriting in January 1999 with an estimated capacity of £500 million to £550 million (\$829.5 million to \$912.5 million), according to Mr. Avery.

Raymond Dumas, currently active underwriter for syndicate 1028, will be senior partner in the new arrange-

ment, he said. Under the partnership arrangement, the underwriting partners will be jointly responsible for all business underwritten and will share jointly in underwriting profits.

"The enlarged business will meet brokers' and customers' demands for security, service and long-term relationships while at the same time generating significant economies of scale," said Mr. Avery.

The agency has discussed its proposals with Lloyd's, but a formal application to merge the syndicates will be made in the spring, Mr. Avery said.

—By Carolyn Aldred

Not all of E.U. in compliance

BRUSSELS, Belgium—Although the directives established to create a single European insurance market were adopted in 1994, not all member countries have fully adopted and implemented the measures.

Spain is the only member state that to date has failed to notify the European Commission how it intends to implement the Third Non-Life and Life Insurance Directives.

In addition, parts of the directives have not been implemented in France, Belgium and Finland, according to a memo the commission recently released on the single market.

The European Commission already has referred Spain to the European Court of Justice for its failure to implement the directives and has begun several infringement proceedings for incorrect application of the directives

against other member states, the memo notes.

The commission has notified France that its implementation of the directives is incomplete. The items in violation, the memo says, are: a failure to apply the directives to mutual societies offering insurance in France; a French requirement that regulators receive prior notification of policy conditions; and a requirement that insurance policies underwritten in France be drafted exclusively in French, without taking into consideration policies covering large risks or cases when applicable law may not be French law.

Notification also has been sent to Belgium because Belgian legislation excludes insurance for workplace accidents from compliance with the E.C. directives. The commission considers these risks covered by the directive when they are insured by private insur-

ance companies, as opposed to state-run compensation schemes. The commission cited a similar problem with Finland's regulation of private workers comp coverage.

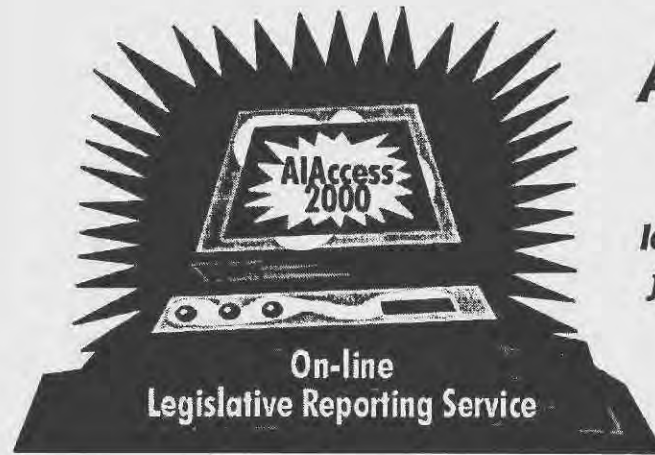
The Commission also has advised Germany that its amended social legislation indirectly violates the non-life directive.

The German amendment allows an employee to benefit from health insurance contributions paid by his employer only if the insurance company solely underwrites health insurance.

In all the infringement cases, the commission's objective is to ensure conformity with European Union law as rapidly as possible, and—apart from Spain's situation—problems can often be resolved through discussions with member states before the case reaches the Court of Justice, the memo notes.

—By Carolyn Aldred

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Vice Presidents, Directors, Managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations	15,387
Sub-total	28,694
Associations	305
Government, Unions and Educational Institutions	1,046
Commercial Consumers	
Sub-total	30,045
Insurance Agents and Brokers	8,462
Insurance Companies	7,336
Accountants, Actuaries, Attorneys & Consultants	2,823
Adjusters, Appraisers, TPA's, Captive Managers & Health Care Providers	1,648
Others Allied to the Field	915
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Non-qualified/Paid Subscriptions	31
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TOTAL CIRCULATION	51,262

★ Source Business/Occupational breakdown of qualified circulation, May 26, 1997 Issue, as submitted to BPA for June 1997 BPA Publisher's Statement

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IN THE SUPREME COURT OF BERMUDA CIVIL JURISDICTION
IN THE MATTER OF SCOTTISH & COMMONWEALTH INSURANCE COMPANY LIMITED and IN THE MATTER OF THE COMPANIES ACT 1981

NOTICE IS HEREBY GIVEN that, by an Order dated 13 November 1997 made in the Supreme Court of Bermuda and by an Order dated 14 November 1997 made in the High Court of Justice in the above matter, a meeting was ordered to be convened of the Scheme Creditors (as defined in the Scheme of Arrangement hereinafter mentioned) of the above named company (hereinafter called the "Company") for the purpose of considering and, if thought fit, approving (with or without modification) a Scheme of Arrangement proposed to be made between the Company and the Scheme Creditors (as therein defined) and that such meeting will be held at Chamber of Commerce, Front Street, Hamilton, Bermuda on 2 February 1998 commencing at 10:00 am at which place and time all such Scheme Creditors are requested to attend.

The Scheme Creditors may vote in person at the said meeting or they may appoint another person, whether such person is or is not a Scheme Creditor, as their proxy to attend and vote in their place and are requested to complete the Form of Proxy and return it to the Company at Dorchester House, 7 Church Street, Hamilton HM11, Bermuda (facsimile number 441 295 3480) Attn: Jennifer Woods. The Form of Proxy must be received by 5:00 pm on 15 January 1998.

Each Scheme Creditor or his proxy will be required to register his attendance at the meeting prior to its commencement. Registration will commence at 9:00 am.

By the Orders, the Courts have appointed Paul Anthony Brereton Evans or failing him Richard Patching to act as Chairman at the said meeting and have directed the Chairman to report the result of the meeting to the Courts.

Copies of the Scheme of Arrangement and the Explanatory Statement required to be furnished pursuant to Section 100 of the Companies Act 1981 of Bermuda and Section 426 of the Companies Act of 1985 of Great Britain Forms of Proxy for use at the meeting and the Claims Form are available from the Company's offices at the above address.

The Scheme of Arrangement will be subject to the subsequent sanction of the Courts.

Dated this 25 day of November 1997.

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LEGAL NOTICE

IN THE HIGH COURT OF JUSTICE (ENGLAND) CHANCERY DIVISION
IN THE MATTER OF SCOTTISH & COMMONWEALTH INSURANCE COMPANY LIMITED and IN THE MATTER OF THE COMPANIES ACT 1985

Bushfire losses may rise

By YVETTE HIGGINS

SYDNEY, Australia—Bushfires that have burned about 700,000 acres in New South Wales so far are expected to cost Australian insurers less than \$10 million Australian (\$6.7 million).

However, the loss could increase as Australia prepares for its traditionally worst period for bushfires during the dry, hot summer weather.

The fires, whose cause has not been determined, started Nov. 26 and have hit northern New South Wales and areas south and southwest of Sydney, burning mainly isolated and sparsely populated bushland and rural areas.

There are no known commercial losses; some farmers suffered livestock losses and fence and property damage and are likely to have coverage under agricultural or crop insurance policies, said a spokesman for the Melbourne-based Insurance Council of Australia, which represents most of the nation's non-life insurers.

Eleven homes have been destroyed, 20 have been severely damaged and 200 have suffered minor damage, the spokesman said.

Early estimates put insured property and home contents damage claims at \$5 million to \$10 million Australian (\$3.4 million to \$6.7 million), but he said the figure could increase because the bushfire season has just started, and January traditionally is the worst month for fires.

The Australian Nuclear Science and Technology Organisation, a federal statutory authority that operates a nuclear reactor at Lucas Heights, 19 miles southwest of Sydney, shut down the reactor Dec. 2 for 24 hours as a precaution because fires were burning near the facility's perimeter, about 700 feet from the buildings, a spokesman for the organization said.

The ANSTO spokesman said the fire risk was low because the surrounding property was "back-burned" to remove nearby flammable undergrowth.

ANSTO owns the reactor and surrounding research facilities that manufacture radio isotopes and other products for the medical and electronics industries.

ANSTO has property coverage but does not buy business interruption coverage, the spokesman said, because the reactor is only part of the organization's operations. Staff were transferred to other projects while the reactor was shut down.

The Insurance Council spokesman said despite the publicity on the lack of insurance after the 1994 bushfires in outlying Sydney suburbs (*BI*, Jan. 17, 1994), some homes destroyed at Menai, a suburb 19 miles south of Sydney that borders bushland, were uninsured.

Losses have not reached the same level as in the 1994 fires, when insurers paid out \$56 million Australian in claims, he said. The actual insured losses in 1994 were well below initial estimates.

"If this year is anything like the fires in 1994, 22% of homes were uninsured and 50% had no contents insurance," the Council spokesman said. While commercial losses were low in 1994, most of them were insured. **BI**

New move to recoup care costs may raise rates

LONDON—Premiums for certain commercial liability coverages may rise as a result of U.K. government recommendations.

Earlier this month, Secretary of State for Health Frank Dobson issued new guidelines to National Health Service Trusts to help them more easily recoup the costs of treating accident victims.

Although the state-backed medical providers are able to recover up to £2,949 (\$4,859) per case in treatment costs under the Road Traffic Act 1988, few have done so because of the complex administration involved.

Mr. Dobson announced mea-

sures that will simplify the collection process and said new legislation pushing the onus for paying the medical costs onto insurers will be introduced "when Parliamentary time permits."

No one is sure how much money is due to the Trusts under this legislation, said a spokesman for the Assn. of British Insurers, though the government has estimated the amount that can be claimed at £100 million (\$164.8 million) each year. Last year, NHS Trusts recouped just £13.9 million (\$22.9 million), according to government figures.

Spread over the 25 million motorists in the country, an extra

£100 million in costs to insurers will amount to a very small rise in personal automobile premiums, said the ABI spokesman.

But the move may be an indicator that the government will look to insurers to reimburse more of the medical costs that the NHS Trusts now incur.

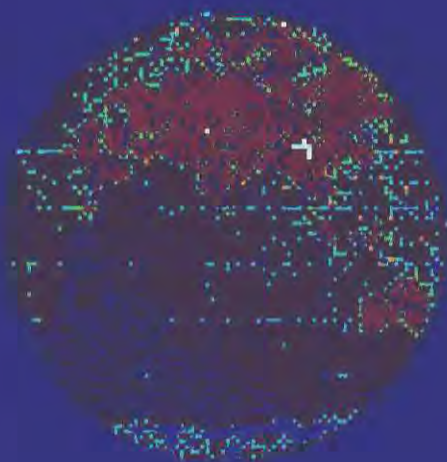
"The general view on this sort of thing is, yes, in the future there is some chance that employers' liability insurers will be asked to pay relevant hospital costs," said Danny Gibson, employers' liability underwriter at Octavian Syndicate Management Ltd.

A Law Commission consulta-

tion paper on the costs of treatment for personal injury cases issued last year suggested that NHS Trusts should recoup all medical costs where a "tortfeasor" or "legal wrongdoer"—an employer, for example—was involved in the injury. At the time, liability specialists estimated that up to £600 million (\$988.6 million) could be recouped from the insurance industry.

If this happens, it will mean that insurers' costs and reserves will have to be increased, said Mr. Gibson, and those changes "will have to be reflected in premiums."

—By Sarah Goddard



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Banks

Continued from page 2

United Bank of Switzerland, as the new combined entity will be called, will be a leading force in private banking, institutional asset management and investment banking, with 1.32 trillion Swiss francs (\$926.64 billion) of assets under management.

In a joint statement, the two banks said that globalization and deregulation of international financial markets had provided the impetus for the deal, while consolidation in the financial services industry had helped make size "an increasingly critical factor." Under the proposed terms, SBC shareholders will hold 40% of the new bank, with the majority balance held by UBS shareholders. SBC Chairman Mathis Cabiallavetta will head up the newly combined company.

UBS has more of a presence than SBC in the insurance sector, holding stakes in two Swiss insurers as well as full ownership of another insurer.

SBC's insurance involvement is limited to an "allfinanz" arrangement with Zurich Insurance Group, in which SBC distributes life and non-life personal lines insurance products through its branch banking network. Although it is a cooperative arrangement, rather than a formal joint venture, Zurich separately owns more than 5% of SBC's shares.

In 1996, SBC wrote 384 million Swiss francs (\$269.6 million) in life premiums through this arrangement. In late 1996, SBC began distributing non-life products, as well.

SBC has stated it has no plans to directly enter the insurance business, because "the costs required... directly outweigh the potential benefits," the bank's 1996 annual report says.

Despite that stated intention, though, insurance influences are found on the company's board of directors, which includes Rolf Hueppi, chairman of Zurich, and Rolf Schauble, chairman of Baloise-Holding, parent of several insurers.

In contrast with SBC's stance, UBS

has been more eager to enter the insurance sector. In 1996, UBS launched a joint venture with Swiss life insurer Rentenanstalt A.G. The venture, called UBS Swiss Life A.G., was created as an "allfinanz" venture, selling life products via the bank. On Jan. 1, 1997, it was expanded to offer pension funds.

Capitalized at 40 million Swiss francs (\$28.1 million), UBS Swiss Life recently has been expanding to sell insurance via bank branches in the Netherlands and Germany.

UBS also has a 30.4% holding in National Versicherung A.G. in Basel, a small insurer capitalized at 35 million Swiss francs (\$24.6 million), and fully owns U.K. pension fund asset manager PDFM Ltd., whose holdings include a 26.1% stake in London broker Sedgwick Group P.L.C. and 22% of Willis Corroon P.L.C.

In addition, Manfred Zobl, chairman of Rentenanstalt, is a member of the UBS board of directors, and UBS is expected to complete its acquisition of 25% of the insurer by the beginning of next year.

Of the three insurance representatives sitting on the boards of the two banks, only Mr. Zobl had been proposed as a member of the board of the combined entity as of last week. This has been interpreted by some analysts as an indicator that the Zurich link with SBC may be severed if the banks' merger is approved.

Zurich representatives declined to comment last week.

Some analysts speculated that the two banks, like many other financial institutions, also are exploring insurance via capital markets risk financing and securitization projects.

Swiss banks historically have been secretive about their operations, however, and the banks would neither confirm nor deny this.

"I don't know of anything, but I imagine SBC would have (been involved)," said Roderick Strutt, a consultant in the property/casualty risk management practice at consulting firm Tillinghast-Towers Perrin in London.

If the combined bank wanted to get into the risk securitization area, "it will be a stronger and major player," said Mr. Strutt.

Trevor Petch, an insurance analyst with London-based Robert Fleming Securities, agreed it is "quite likely" that SBC has been involved in alternative risk transfer products. In particular, he suggested that its link with Zurich Insurance Group may have served as an entree to this market.

Although the new organization will have sufficient capital, "it is really a question of whether they can get the teams of people together" to be active in the alternative risk financing market, said Oscar Tymon, a director of Centre Reinsurance Representatives Ltd. in London, a unit of Zurich Insurance Group.

Rival Swiss bank Credit Suisse, which earlier this year acquired Winterthur Swiss Insurance Co., has been a leader in the Swiss market for capital markets transactions.

Credit Suisse has not shown any concern about competition in this area from the combined company, said Willy Hersberger, head of corporate marketing at Swiss Re New Markets, the alternative risk transfer division of Swiss Reinsurance Co., based in Zurich. He predicted that the new UBS organization's priorities will be combining the two banks' retail networks, rather than focusing on new capital market products.

Meanwhile, the consolidation in the Swiss financial services industry last week added fuel to rumors that Credit Suisse will merge with Swiss Re.

The possibility was raised at the time Credit Suisse acquired Winterthur and now "has the ring of truth," according to Nick Bunker, insurance analyst with HSBC James Capel in London. Such a move would assure Credit Suisse remains in the forefront of capital markets deals in the insurance industry, in light of potential new competitors, he explained.

Swiss Re and Credit Suisse, however, issued a joint statement late last week saying the merger rumors were "entirely without foundation." **BI**

Datebook

JANUARY

JAN. 11-12. Forum on Global Business: Risks, Rewards and Realities in Washington, sponsored by Liberty Mutual Group. No registration fee. Lori Zetlin, Liberty Mutual Group, 175 Berkeley St., Sixth Floor, Boston, Mass. 02117-0140; 617-574-5657.

JAN. 12. Capitalizing on the New Revolution in Third-Party Captives conference in New York, sponsored by the IBC Group P.L.C.; \$1,095. IBC USA Conferences Inc., 225 Turnpike Road, Southborough, Mass. 01772-1729; 508-481-6400.

JAN. 13-14. Property/Casualty Insurance Joint Industry Forum in New York, sponsored by nine insurance associations. \$595. Diane Portantieri, Insurance Information Institute, 110 William St., New York, N.Y. 10038; 212-669-9203.

JAN. 14-15. Designing & Implementing Internal Web Sites for Benefits conference in Atlanta, sponsored by Coopers & Lybrand L.L.P., The Kwasha Lipton Group and Logical Design Solutions Inc.; \$1,295 for conference only, \$1,695 for conference plus one workshop, \$1,995 for conference plus two workshops, \$2,195 for conference plus three workshops. International Quality & Productivity Center, 150 Clove Road, P.O. Box 401, Little Falls, N.J. 07424-0401; 800-882-8684 or 973-256-0211.

JAN. 17. CPCU Exam Review Day for parts 1-10 in Schaumburg, Ill., sponsored by Northwest Suburban and West Suburban CPCU Chapters. Before Jan. 2: \$50; after Jan. 2: \$70. Judy Smith, Farmers Insurance Group, 2245 Sequoia Drive, Aurora, Ill. 60506; 630-907-3279.

JAN. 21-22. Performance Measurements for Strategic Planning in Insurance Companies conference in New York, sponsored by Price Waterhouse and the International Quality & Productivity Center; \$1,295 for the conference only, \$1,695 for the conference plus one workshop, \$1,995 for the conference plus two workshops. International Quality & Productivity Center, 150 Clove Road, P.O. Box 401, Little Falls, N.J. 07424-0401; 800-882-8684.

JAN. 21-24. Self-Insurance Institute of America Inc. Employer Executive Forum in Palm Springs, Calif., sponsored

by the SIIA; \$1,395 for first attendee, \$1,195 for second attendee, \$1,595 for non-members. SIIA, 17300 Redhill Ave., Suite 100, Irvine, Calif. 92714; 800-851-7789.

JAN. 22-23. Delivery System Integration conference in McLean, Va., sponsored by the Institute for Behavioral Healthcare, the Academic Partnership, the Partnership for Delivery System Integration and CentraLink; Before Jan. 8: \$795; after Jan. 8: \$995. CentraLink-D, 4370 Alpine Road, Suite 108, Portola Valley, Calif. 94028; 650-851-8411.

JAN. 22-23. D&O Liability and Insurance Symposium in New York, sponsored by the Professional Liability Underwriting Society; \$775 for members, \$900 for non-members; PLUS D&O Symposium, 4248 Park Glen Road, Minneapolis, Minn. 55416; 800-845-0778 or 612-928-4644.

JAN. 22-23. Property & Casualty Insurance Companies Partnering with Banks and Financial Institutions conference in Orlando, Fla., sponsored by Global Business Research Ltd.; \$1,795 for the conference plus workshop, \$1,295 for the conference only. Conference Administrator, Global Business Research Ltd., 775 Sunrise Ave., Suite 260, Roseville, Calif. 95661; 800-868-7188 or 916-773-3236.

JAN. 25-27. Insurance.com: Competing in the Digital Marketplace forum in Scottsdale, Ariz., sponsored by IVANS. \$525, \$1,000 for two company attendees, \$500 for each additional registration. Clare DeNicola, IVANS, 777 W. Putnam Ave., Greenwich, Conn. 06830; 203-532-2109.

JAN. 26-27. Insurance Coverage Litigation: Recovery in the 1990s and Beyond program in New York City, sponsored by the Practising Law Institute. \$895. Practising Law Institute, 810 Seventh Ave., New York, N.Y. 10019; 800-260-4PLI.

JAN. 26-28. Advanced Capital Allocation Techniques for Insurance Companies conference in New York, sponsored by Ernst & Young L.L.P. \$2,985 for conference and two workshops. ICM Conferences Inc., 303 E. Wacker Drive, 20th Floor, Chicago, Ill. 60601; 312-540-3010.

JAN. 26-29. Outsourcing Employee Benefits and HR Functions conference in San Diego, sponsored by Buck Consultants and New York Life Benefit Services; Qualified registrant: \$1,595 for conference plus two workshops, \$1,295 for conference plus one workshop, \$895 for conference only; standard registrant: \$1,995 for conference plus two workshops, \$1,695 for conference plus one workshop, \$1,295 for conference only. International Quality & Productivity Center, 150 Clove Road, P.O. Box 401, Little Falls, N.J. 07424-0401; 800-882-8684 or 973-256-0211.

JAN. 27. RIMS Orange Empire Chapter 19th Annual Risk Management Conference in Brea, Calif., sponsored by the Orange Empire Chapter of RIMS; \$75 each for first two attendees; \$60 each additional attendee. Maury De Bont, Risk Management Analyst, Southern California Edison, 2244 Walnut Grove Ave., Room 249, Rosemead, Calif. 91770; 626-302-1085.

The Datebook is compiled from notices sent to Business Insurance. Notices should be sent at least eight weeks in advance to Datebook, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590. Please include the cost to attend the meeting, if any, and information on registration. Business Insurance reserves the right to select meetings of interest to its readers and cannot guarantee that notices will be printed. Datebook listings also are available on the World Wide Web at www.businessinsurance.com.

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New York

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meeting in place of New York Insurance Superintendent Neil D. Levin. Mr. Levin, whose background is primarily in securities rather than insurance, rarely attends the meetings.

The issue "dominated" closed-door discussions at the start of the NAIC meeting, said Louisiana Insurance Commissioner James H. Brown, who chairs the NAIC's Surplus Lines Task Force.

On Dec. 2, Mr. Levin announced plans to ease the major securitization requirement as of Dec. 31 by allowing syndicates to fund their gross liabilities at 50% rather than the current 100%.

That easing would apply "to all surplus lines business funded by the Lloyd's United States situs surplus lines trust funds and written on or after Aug. 1, 1995," according to the New York announcement.

The New York agreement also included Lloyd's promise to increase the funding of the Lloyd's American Joint Asset Trust Fund to \$200 million from \$100 million effective Jan. 1, 1998.

Fueling the debate over policy was a feeling among other regulators that they should have received more notice. Several learned about New York's arrangement only a day or two before it was made public.

In addition, regulators disliked the perception that Mr. Levin was telling other insurance commissioners what to do, which "offended" them, Mr. Brown said.

Regulators' inability to reach a consensus solution underscored the contentiousness of the dispute and necessitated two postponements of the NAIC's International Insurance Department Review Group.

The issue stemmed from a request on behalf of about 150 Lloyd's syndicates writing U.S. business that the New York Insurance Department and the IID reduce their trust fund requirements for surplus lines business by year end.

Two years ago, Lloyd's financial problems prompted New York to increase its oversight, including requiring substantial increases in U.S.-based trust funds and syndicate-specific reporting (*BI*, May 29, 1995).

For example, the syndicates writing U.S.

'The NAIC has always ceded to our judgment. We don't know why there is a difference here today,' apart from 'turf battles,' says John Calagna.

business were required to fund their gross liabilities at 100% and place \$100 million in the Lloyd's American Surplus Lines Joint Asset Trust Fund. Those liabilities totaled slightly more than \$1.1 billion at the end of September.

At a Nov. 4 meeting in New York, Lloyd's spokesmen asked for relief by year end. According to a Nov. 19 memo by IID Manager Rob Esson, Lloyd's explained that "that the reason for the urgency was that the 1995 year of account (the first including the 100% gross surplus lines trusts) needed, by U.K. law, to be reinsured to close at the end of 1997." In addition, Mr. Esson wrote, the Lloyd's spokesman said "that the RITC process would result in severe cash flow problems for Lloyd's."

The deadline for Lloyd's syndicates to ob-

tain the RITC for 1995 is approximately the end of February, said John Calagna, a spokesman for the New York Insurance Department.

The cash flow problems related to syndicate owners' need to pay RITC premiums and have "absolutely" no impact on their claims-paying ability, said Peter Lane, managing director of Lloyd's America Ltd.

"Lloyd's financial problems are not so serious that it would face problems in paying claims," concurred Illinois Insurance Department's Chief Deputy Director Arnold Dutcher, who represents the state on several NAIC surplus lines subgroups.

Overall, implementation of the New York agreement would have freed up roughly \$600 million in cash, according to Lloyd's Mr. Lane.

In contrast, the NAIC's leaner relief proposal will allow syndicates to fund at the 50% level, but only for the 1998 year, and requested a legal opinion about the appropriateness of the retrospective reduction for their listing in 1995, 1996 and 1997.

While California supports the concept of New York's arrangement, it questions the retroactivity portion and thinks it was "ill advised" to announce the changes before bringing the issue to other NAIC regulators, said Sherwood Girion, chief of the financial analysis division for the California Insurance Department.

The New York Department's legal counsel supported the retroactive reduction, though the attorney did not write a legal brief on the issue, said Mr. Presser.

In addition, the current NAIC proposal gave Lloyd's three years to double its joint asset trust fund to \$200 million. However, there would be no phase-in period if retrospective reductions were allowed in the future.

The NAIC proposal also calls for Lloyd's

syndicates to bring their U.S. trust funds into compliance with the NAIC trust agreement requirements "as expeditiously as prudently possible," noting that such compliance is a condition for eligibility for IID's quarterly list of eligible non-U.S. insurers.

In addition, NAIC regulators requested "an in-depth and on-site investigation of the structure and workings of Lloyd's," which will be summarized in a written report. The investigation will likely be conducted early next year.

NAIC regulators also modified IID's plan of operation to vest the rule-making authority regarding trust levels and exemptions with the chairmen of the NAIC's Surplus Lines Task Force and a Special Issues Committee, its parent.

Mr. Brown of Louisiana and a spokesman for the New York Department both had predicted the NAIC would likely adopt Mr. Levin's arrangement (*BI*, Dec. 8).

"What he (Mr. Levin) did was perfectly within his authority," said Alaska Insurance Director Marianne K. Burke in an interview. However, "I did feel that I did not have an awful lot of time to digest it," she said.

"The NAIC has always ceded to our judgment," said Mr. Calagna. "We don't know why there is a difference here today," apart from "turf battles."

"We welcome the steps that the NAIC is taking," said Lloyd's spokesman Mr. Lane. He is convinced other regulators also will develop the same level of confidence in Lloyd's that New York regulators have. "I think we are seeing here a coming together."

"I'm just very pleased we were able, in a short period of time, to get a lot of states up to speed" on the issue, Ms. Burke said. Also, "the lines of communication have been much more clearly delineated." **BI**

Proposal

Continued from page 1

"In terms of forms, it didn't walk away from prior approval but asked the Commercial Lines Committee to consider how self-certification could work," said Mr. Wickman, administrator of the Nebraska Insurance Department's actuarial division.

The concept of self-certification typically requires insurers to annually certify that they are following state laws, rather than having them annually file all forms with regulators.

To streamline both rate and form regulation, the paper recommends that "the NAIC replace the prior model rating laws with a single model that will address both rate and form filing."

However, it also recommends giving each state commissioner the authority to adopt a flexible, cost-efficient approach for rate regulation without stipulating what that approach should be. Options include prior approval, flex rating and a use-and-file approach, among others.

As part of deregulation, the white paper also proposes exempting some large commercial buyers from most laws or regulations governing the form and content of commercial insurance policies.

According to the paper, to be eligible for "Exempt Commercial Policyholder" status, a company must self-certify that it meets two of these characteristics:

- Has a net worth of more than \$50 million.
- Has net revenues or sales of more than \$100 million.
- Employs more than 500 persons, or is part of a holding company that has more than 1,000 employees in the aggregate.
- Procures its insurance through the use of a risk manager, who is either employed or retained.
- Has aggregate annual insurance premiums of more than

\$500,000.

- Is a not-for-profit, or public entity with an annual budget or assets of at least \$45 million.

- Is a municipality with a population of more than 50,000.

The parameters were developed using research provided by a variety of sources, including the Risk & Insurance Management Society Inc.

Drafters also asked the Commercial Lines Committee to prepare a self-certification statement for an exempt policyholder to sign that confirms it knows its insurance is unregulated.

"Mandatory coverages, such as auto and workers comp, must still provide for the substantive rights or protections accorded individuals," as specified under various statutes, the paper says. However, "the ECP and its insurer would still be free to negotiate all other terms and conditions of these policies."

"One of the most important opportunities that this package seizes upon relates to multistate considerations" affecting buyers and brokers, the white paper's authors say.

Drafters recommended that the new NAIC model rating law allow a commissioner to waive state requirements for corporate policyholders that are primarily located in another state.

In addition, they recommended that the NAIC "facilitate efforts by states to achieve greater uniformity in cancellation, non-renewal and other statutory requirements."

The white paper also offers proposals for eliminating what it calls "significant problems" with surplus lines regulation.

The panel recommended that state regulators expand lists identifying hard-to-find coverages that are automatically eligible for surplus lines placement. That would eliminate prior searches in the admitted market, as most state laws require proof that three admitted insurers have declined the risk before it can be

placed in the surplus lines market.

It also recommended several ways to simplify the allocation and payment of surplus lines taxes, though that issue has historically been a problem for state regulators who fear losing tax income for their state.

The white paper also addresses ways to streamline insurer licensing procedures, such as through the development of reciprocal agreements among states and a streamlined application process.

It also recommends simplifying producer licensing, through use of the Producer Information Network, a database of license and regulatory information on agents, as well as exploring mod-

'The paper recommends a very good, broad, conservative approach to deregulation,' says Anne Allen.

el reciprocal agreements between states and eliminating countersignature laws.

Early indications are that representatives of risk managers, brokers and insurers are enthusiastic about the NAIC's final streamlining proposal.

"The paper recommends a very good, broad, conservative approach to deregulation," said Anne Allen, assistant director of government affairs for New York-based RIMS. "It doesn't have as many concrete proposals as earlier drafts did, but it does allow for exploration of a number of options."

The National Assn. of Insurance Brokers "is very pleased and excited about the possibility for change that the white paper offers," said Anne Flanagan, director of state affairs for the Washington-based organization.

"Our concern is that the ball stay in the air and the momentum keep going. We hope the NAIC remains committed," Ms. Flanagan said.

The white paper is "positive," said Phillip Schwartz, vp-financial reporting and associate general counsel for the American Insurance Assn. in Washington.

Larry Kibbee, vp with the Alliance of American Insurers in Schaumburg, Ill., said, "We think it is a great product."

Mary Cannon Veed, an attorney with Peterson & Ross in Chicago specializing in reinsurance, predicted that there will be "a groundswell" of interest in streamlining regulation among state insurance regulators. Small states that adopt such forms of flexible regulation will have "a competitive edge in recruiting new industry and business," she added.

Regulators from New York and Virginia, however, questioned the appropriateness of some characteristics used to define exempt commercial policyholders.

For example, they felt the term "risk manager" was too vague and lacking in credentials.

They also questioned exempting large policyholders from some laws, such as requiring bankruptcy protections for third-party claimants. Those concerns were passed on to the Commercial Lines Committee to consider.

A copy of the white paper is available through the NAIC's web site at www.naic.org or by calling Mike Barth or the publications department at 816-842-3600. Comments should be directed to Mr. Barth at the NAIC's headquarters in Kansas City, Mo.

In other action at the meeting, regulators:

- Elected Glenn Pomeroy of North Dakota president; George Reider Jr. of Connecticut vp; and George Nichols III of Kentucky secretary/treasurer. Mr. Nichols is the first African-American to

be elected as an officer of the 126-year-old organization.

- Voted to revert to the pre-1997 arrangement of scheduling its Executive Committee meeting before its formal plenary, or voting, session at its four quarterly meetings beginning next year.

In 1997, the NAIC changed the order to enhance deliberations because the experimental schedule typically added three months to the approval process.

The latest change was made because some regulators felt the change had caused unacceptable delays. However, they also adopted new procedures to guarantee that model laws are given adequate consideration before adoption, including requiring the Executive Committee to consider all model laws, regulations and policy papers separately rather than as part of a consent agenda.

- Awarded second-round accreditations to Alaska, Missouri, Nebraska and Texas.

The accreditation program requires that every accredited state be re-reviewed every five years. There are now 49 accredited insurance departments—excluding New York and Nevada—and 13 of those 49 have received their second-round accreditations.

The accreditation review group also approved "exposing" a model law to public comment for two years before it can become a future standard required for accreditation.

- Approved sending a letter informing the Securities and Exchange Commission that most annuity or life insurance policies with an equity-indexed component are closer to being "fixed products" rather than variable ones and should be regulated as insurance rather than securities.

- Delayed an Executive Committee vote on a codification project to standardize insurer accounting and referred two controversial issues to an ad hoc task force of state regulators who will be chosen by NAIC President Glenn Pomeroy.

Award

Continued from page 3

ria, Texas-based employee of Schlumberger Well Services, was perforating tubing at the well. The explosion threw him 30 feet into an area of pipes.

Although Travelers/Aetna Property Casualty Corp. paid workers compensation benefits, Mr. Caballero decided to sue Esenjay. While a suit against his employer would have been barred under Texas workers comp law, an injured worker can sue a third party that controls the work environment where an injury occurs. Esenjay, the well owner, had hired crews that installed and later reinstalled the wraparound.

The manufacturer of the wraparound, ERC Industries Inc. of Houston, was a defendant in Mr. Caballero's suit but was found by the jury to have no responsibility in the accident.

Mr. Caballero said in a statement read by his wife at a recent news conference that the suit was filed not only to "compensate me for the medical expenses I incurred, lost wages and other damages that resulted from my injuries," but also "to prevent anyone else from having to endure the pain, suffering and disfigurement that I have had to go through."

In June, a state court jury in Corpus Christi awarded Mr. Caballero \$12.3 million in actual damages.

Mr. Caballero's attorney, David Perry of the Corpus Christi firm Perry & Haas L.L.P., told the jury during the second phase of the trial—held to determine any punitive damages—that Mr. Caballero would give up any award if Esenjay would agree to develop a safety plan.

Mr. Perry asked the jury to "come up with an amount that would be an incentive" for Esenjay to accept the offer, said Joseph Barrientos, an attorney with Perry & Haas.

The defendant responded quickly after the \$30 million punitive award

was announced.

"Esenjay told us as soon as it was over that they wanted to do it," Mr. Barrientos said.

Esenjay sees the plan as an opportunity to improve safety, according to Jeffrey Pollicoff, an attorney with the Houston firm Pollicoff, Smith, Myers & Remels L.L.P. in Houston. Esenjay hired Mr. Pollicoff after the trial to coordinate insurance issues.

A small operation with fewer than a dozen full-time employees, Esenjay often subcontracts for work such as the job Mr. Caballero was performing when he was injured.

'If some good can come from my experience, then that becomes less hurtful,' says John Caballero.

"Esenjay has been a relatively safe company," said Mr. Pollicoff, who has represented the company in various matters for several years. "This is the first time that I can remember them being sued on a personal injury matter."

The company was eager to embrace the idea of a safety plan, he added. "They said, 'Yes, let's go ahead and get even safer.'"

Mr. Pollicoff said if the option had not been available, there would have been more legal wranglings over who would have paid the punitive award.

Punitive damages are insurable in Texas, and when the award was announced, Esenjay's excess liability insurer filed a reservation of rights, indicating it did not believe the damages were covered in its policy. The insurer, Illinois Union Insurance Co., a Chicago-based CIGNA Corp. unit, wrote a \$15 million excess layer.

The Illinois Union coverage was above \$1 million in primary coverage written by Fulcrum Insurance Co. in New York and a \$5 million

umbrella written by United National Insurance Co. in Bala Cynwyd, Pa.

Mr. Barrientos said an amount less than the \$12.3 million actual damage award "was negotiated and settled," but the amount is confidential as part of the agreement.

Two other defendants settled claims against them before the trial began.

Fish Oil Well Services Inc. of Tuleta, Texas, provided the crew working the site, and R.W. Dirks Petroleum Engineer Inc. of Beeville, Texas, provided engineering services at the site. Each paid Mr. Caballero \$2 million in settlement agreements.

Mr. Barrientos said liability coverage for the two companies funded those settlements. Fish Oil's coverage was written by Ranger Insurance Co. in Houston, and R.W. Dirks had insurance underwritten by The St. Paul Cos.

Mr. Pollicoff said it is uncertain how much the safety plan will cost to develop and implement, but it should be in place early next year. W.A. Bateman, a Midland, Texas-based engineer, is developing the plan.

Mr. Pollicoff said a portion of Mr. Caballero's settlement was used to pay for drafting of the plan but that Esenjay would bear the ongoing cost.

Attorneys for Esenjay and Mr. Caballero agree that the incident occurred because of a lack of guidance on procedures for the wraparound installation. One aim of the safety plan will be to develop those types of procedures.

In his news conference statement, Mr. Caballero said: "If some good can come from my experience, then that experience becomes less hurtful. Make no mistake, what happened is still painful.

"The money I have received will take care of my medical expenses and lost wages, but nothing can put me back to the way I was before the injury. But I am glad that the chances others will suffer as I have will be diminished." **BI**

with risk: aggressive, conservative or somewhere in between.

Eleven percent of plans are offering life-cycle funds now, compared with 7% last year, the report said.

The expansion of life-cycle approaches to investing could significantly change the way employees view 401(k) plans. Now, virtually all employees configure the distribution of their 401(k) plan money through allocation percentages, said Mr. Ternoey. For example: 60% to stocks, 30% to a bond fund, 10% to a short-term Treas-

A relatively high number of plans are offering so-called 'life-cycle' funds that fit an employee's stage of life or investment strategy, says Brian C. Ternoey.

sury fund.

"What we've found is a lot of people don't particularly buy that approach," Mr. Ternoey said. "A lot of people just more naturally relate to what (life-cycle) profile they fit."

But the Mercer report notes that while life-cycle investing is spreading in popularity, only 2% of total employee-directed assets are in life-cycle funds. "This year they have arrived," the report observes, "although not quite with a bang."

Mr. Ternoey also makes these points in the report:

- The 401(k) plan world will be swept by Internet and intranet fever. Among the plans sponsors surveyed, more than half will be using Internet or Intranet technology within two years, and many of those will use the technology for transaction processing.

- "Sponsors like the Internet because so much more information can be provided on a screen than over the phone," he writes. "The biggest potential drawback is implementation problems; a software glitch can completely undermine technological glitz."

- Increased employee education should lead to more investment in equity funds, particularly as the education begins to look

more and more like actual investment counseling.

- Automatic enrollment—signing up employees for plans unless they expressly refuse participation—is the best hope for boosting plan participation rates above the average participation rate of about 75%.

Copies of the report, "Survey on Employee Savings Plans 1997," may be purchased for \$75 by contacting William M. Mercer Inc. at 800-333-3070.

Updates

Oxford to post 1997 loss

NORWALK, Conn.—Oxford Health Plans Inc. said it will report a fourth-quarter net loss of \$120 million and a net loss for the year following the ordered addition of \$164 million to its New York subsidiaries' medical claims reserves.

The New York Insurance Department directed Oxford to make the \$164 million addition. The company also said last week it intends to increase the medical claim reserves of its non-New York subsidiaries by a still undetermined amount.

Oxford, formerly a stock analysts' favorite, reported a \$6.6 million net loss for the nine months ended Sept. 30, compared with \$67.6 million in net income for the comparable period a year ago. The company blamed the performance on adjustments it made as receivable writeoffs because of late billing and termination of accounts, which were the result of computer problems (BI, Nov. 10).

The stock's price dropped after its Tuesday announcement, closing at \$16.56 Thursday, which was about a 23% drop from its Monday closing price of \$21.38. The stock had reached an all-time high of \$89 in July.

Oxford Chairman Stephen F. Wiggins said in a statement: "We are cooperating fully with the New York State Insurance Department. In addition, we believe these steps will enhance our prospects for returning to profitability. We are now in the process of instilling greater discipline, hiring more seasoned management and refining our processes to eliminate the mistakes of our past."

Tobacco legal fee cap sought

WASHINGTON—Congress should cap the hourly fees paid to attorneys who helped devise the proposed settlement between tobacco companies and 40 state attorneys general, says the author of a bill that would provide such a cap.

Rep. Scott McInnis, R-Colo., told members of the House Judiciary Committee's Court and Intellectual Property Subcommittee last week that private attorneys' fees in the case should be limited to \$150 per hour. He said lawyers acting on behalf of some states in the proposed \$368.5 billion settlement have contracts paying them as much as 25% of any money recovered as fees. Rep. McInnis said the settlement would thus prove to be a "huge windfall for a few plaintiffs' lawyers."

Reps. McInnis, Chris Cox, R-Calif., and Paul McHale, D-Pa., introduced H.R. 2740, which would cap lawyers fees at \$150 per hour plus expenses, shortly before Congress' year-end recess. The bill also calls upon attorneys to detail how they spent their billable time charged under the settlement.

Not all witnesses agreed with Rep. McInnis. For example, Alan Morrison, a staff attorney with Public Citizen Litigation Group, a consumer activist group founded by Ralph Nader, argued that such a cap would be unconstitutional.

The proposed settlement, unveiled in June, would require cigarette makers to pay \$368.5 billion over 25 years to settle suits brought by the states in an effort to recover smoking-related Medicaid costs (BI, June 23). In return, the tobacco companies would receive immunity from most class-action suits. Any settlement must receive congressional and presidential approval.

Briefly noted

The U.S. Supreme Court will review a 6th U.S. Circuit Court of Appeals decision that absolved parent companies from having to pay **Superfund cleanup costs** at sites used by their subsidiaries. The U.S. government sought review in *U.S. vs. CPC International Inc.*, noting that other circuit courts have held that companies can be required to clean up subsidiaries' sites if the parent company controlled operations at the site. . . . The U.S. Chamber of Commerce plans to launch a major public relations and lobbying effort to counter the influence of the plaintiffs' bar next year. A spokesman for the Washington-based business group said that while the project is still in the planning stage, the chamber's new chief executive, Tom Donohue, has made dealing with the effect of the trial lawyer lobby on business one of his chief priorities. . . . Charles "Chip" Kahn, majority staff director of the House Ways and Means Health subcommittee, will join the **Health Insurance Assn. of America** next month as chief operating officer and will succeed current HIAA president Bill Gradison in January 1999. . . . A judicial panel on multi-district litigation has assigned the federal suits involving **diet pills** to U.S. District Judge Louis C. Bechtel in Philadelphia. Pill takers have filed numerous suits against the manufacturers of the pills this year since studies showed they caused heart-valve irregularities. . . . **Protection Mutual Insurance Co.** of Park Ridge, Ill., has acquired TSB Loss Control Consultants Inc. of Rome, Ga. TSB Loss Control specializes in industrial emergency response personnel training. . . . A Texas state court judge has reduced the jury award against **Beverly Enterprises Inc.** to \$54 million from \$83 million in the death of a resident of a Texas nursing home it formerly owned (BI, Dec. 1). Beverly still plans to appeal the case. . . . **New York-based Financial Security Assurance Holdings Ltd.**, holding company for financial guarantee insurer Financial Security Assurance Inc., said it has purchased 1,187,500 of its own common shares for about \$33.9 million. The repurchased shares will be held as treasury stock. . . . Home Holdings Inc. will not pay the **\$11.6 million interest payment** to bond holders due today on time. The company has a 30-day grace period from the due date before it is in default. In June 1997, Home also failed to pay the interest on time but made the payment before it was in default. . . . **Chubb Corp.** Executive Vp Robert P. Crawford Jr. and Senior Vp Edward Dunlop are retiring at the end of the year, the company announced. Mr. Crawford also was president of Chubb & Son Inc., while Mr. Dunlop was worldwide field operations manager of Chubb's property/casualty business. At the same time, Chubb elected Thomas F. Motamed and Michael O'Reilly executive vps and Glenn A. Montgomery and Andrew A. McElwee Jr. senior vps. Mr. Motamed also will fill the newly created position of chief operations officer of Chubb's property/casualty business.

Investing

Continued from page 2
1995.

While 95% of plan sponsors offered some kind of common stock equity fund in their savings plan, some types of funds were more available for investment than others.

Actively managed domestic growth funds, the survey found, are offered by 82% of sponsors, up from 77% last year, while domestic indexed funds such as those designed to mirror the performance of Standard & Poor's 500 Index are offered by 48%, the report said. The availability of international equity funds has more than tripled in the past three years, with 67% of employers that offer 401(k) or other savings plans now offering them.

Mr. Ternoey said that a surprising finding this year is the relatively high number of plans offering so-called "life-cycle" funds. These are balanced by spreading investments among several funds that fit an employee's stage of life or that match his or her investment strategy. Funds can be allocated depending on how an employee fits an investment profile and how comfortable he or she is


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