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'Til death, or parole, do us part: Couple of swindlers face jail terms

KANSAS CITY, Mo.—A husband and wife team of insurance swindlers is facing jail time after being convicted of operating a network of bogus companies and scheming to bribe public officials in three states.

A federal jury earlier this month convicted Ferrell Travis Riley and his wife, Cheryl S. Coon, on racketeering, conspiracy, obstruction of justice and other charges.

Prosecutors charged in a 1994 indictment that Mr. Riley and Ms. Coon bilked policyholders of more than \$28 million through See Updates on next page

TIG to not renew unprofitable accounts

By ROBERTO CENICEROS

Part of plan to focus on more risk transfer, fewer services

NEW YORK—In an effort to improve its profitability in the competitive property/casualty market, TIG Holdings Inc. said its commercial insurance operations will not renew a group of policies that require extensive administrative support and are unprofitable.

The New York-based holding company said last week it will consolidate two of its commercial insurance divisions that write some of the affected business, while also trimming 550 jobs, or

28% of its workforce.

The insurer would not disclose how many of the staff cuts would be made at the headquarters office and how many would be made at branch locations.

Company officials would not confirm reports that Greg Springer, senior vp-commercial insurance responsible for marketing and general management of commercial lines, is resigning.

TIG will combine its specialty commercial insurance and work-

ers compensation divisions to form a new division called commercial specialty programs. TIG wrote \$253 million in workers compensation premiums last year, and \$355 million in other commercial lines. The statutory surplus for all of TIG Holdings for 1995 amounted to \$952 million.

Policyholders that will not be renewed include: those whose programs have large retentions in which TIG provides excess coverage and administers claims within

the retention; customized workers compensation programs in states where costs remain high, as well as some accounts in other states; and unprofitable transportation lines will be cut. None of the business will be canceled mid-term.

But TIG is not retreating from any entire classes of business and no broker and agent relationships will be severed as a result of the changes, the company stressed.

The move also does not affect

operations at its TIG Reinsurance Co. and TIG Excess & Surplus Co. subsidiaries.

In addition to dropping certain commercial accounts, TIG wants to shift more administrative functions like claims handling to brokers and third parties so it can cut overhead.

"This particular move is different from anything we have done before," said Chairman and Chief Executive Officer John Rotenstreich in an interview. "We have decided to surgically go through our

See TIG page 22

Crash probe to set liability

Rail companies insured for possible claims from crash

By GAVIN SOUTER and MARK HOFMANN

SILVER SPRING, Md.—The Maryland Mass Transit Administration has \$200 million in liability insurance to cover claims arising from the train wreck that killed 11 people traveling on a commuter train Feb. 16.

Other rail companies involved in the crash and the railcar manufacturers also have extensive liability insurance coverage.

An investigation by federal safety officials is expected to determine which parties may be liable for crash claims.

CSX Corp., the Richmond, Va.-based track owner and train operator, and Amtrak in Washington, which owned the train that the commuter train crashed into, both

have \$75 million in liability coverage from Bermuda facilities managed by Aon Corp.

However, gross negligence would likely be necessary to pull in liability coverage other than Maryland MTA's, which runs the Maryland Rail Commuter Service, said Stephen Mangano, finance director of the MTA.

In the wake of the crash, emergency federal safety rules were enforced and the Maryland Department of Transportation announced more stringent safety measures for trains under its jurisdiction, which include MARC trains.

Maryland MTA has liability coverage led by syndicates at Lloyd's of London, said Mr. Mangano. The MTA has a \$10 million retention and has liability cover-

age up to \$200 million.

The same coverage also indemnifies CSX in most instances. CSX owns the stretch of track where the crash occurred and also operated the commuter train under a contract with MARC.

"There are three parties involved here: Amtrak, CSX and our service. Our agreement with CSX indemnifies CSX for everything with the exception of their crew and gross negligence," Mr. Mangano said.

CSX and Amtrak both have liability coverage with Bermuda-based Transportation & Railroads Assurance Co. Ltd. and Railway Assn. Insurance Ltd.

TRAC offers coverage limits of \$25 million excess of \$25 million while RAIL offers limits of \$50 See Trains on page 4



The Feb. 16 crash of this Maryland Rail Commuter Service train with an Amtrak passenger train killed 11 people, including passengers trapped in a burning car on the commuter train.

UFG official pleads guilty, cooperates in investigation

Admits to helping embezzle funds, defraud finance firm

By DOUGLAS McLEOD

NEW YORK—A former officer of Underwriters Financial Group Inc. is cooperating with a federal investigation of the defunct brokerage after pleading guilty to charges that he helped embezzle client funds and defraud a premium finance company.

Mark Bailine, UFG's former vp-finance, pleaded guilty earlier this month to charges of conspiracy and making false statements, including preparing phony UFG financial reports for the Securities and Exchange Commission.

In carrying out the alleged schemes, Mr. Bailine was assisting other UFG employees, including "co-conspirators" who signed the broker's SEC filings from 1992 through 1994, federal prosecutors allege.

Though the co-conspirators are not named, the UFG officials who signed the SEC filings were Donald Ferrarini, UFG chairman and president; Bruno Rumignani, executive vp; Howard Miller, se-

nior vp; and Burton Matfus, treasurer.

Mr. Matfus, to whom Mr. Bailine reported, committed suicide last May as UFG's finances unraveled. UFG and its brokerage subsidiary, UFG International Inc., have since filed for bankruptcy.

Seth Farber, assistant U.S. attorney, declined to comment on the investigation.

Mr. Miller referred questions to his lawyer, who could not be reached. Mr. Rumignani, Mr. Ferrarini and Mr. Ferrarini's lawyer, Shephard Lane, also could not be reached.

Mr. Bailine faces a maximum sentence of five years in jail on each of the two counts against him, though his actual sentence may be less under federal sentencing guidelines that take cooperation into account.

He is cooperating with "all aspects" of the investigation, said his lawyer, Lawrence Rolnick, with Lowenstein, Sandler, Kohl, Fisher & Boylan of Roseland, N.J.

Formerly known as B.R.I. Coverage Corp., the bro- See UFG on page 20

Ohio bill to target managed care firms

Insurance officials would have oversight

By MEG FLETCHER

COLUMBUS, Ohio—A draft bill now being circulated for comment would make Ohio the first state to give insurance regulators exclusive statutory authority to oversee all managed care entities.

Support is building among employers, insurers and health maintenance organizations in Ohio for the proposed "Managed Care Uniform Licensure Act," which also would require all managed care entities to meet more complex solvency and operating requirements, some of which now only apply to HMOs.

Making insurance regulators the sole regulators of managed care offers several potential advantages to employers. First, more streamlined and stricter regulation may create a more stable market. Second, keeping regulation at the state level may give employers more chances to lobby regulators and make regulation more market-specific.

"This is the first effort of its kind in the country," said David J. Randall, deputy director of the Ohio Insurance Department, which is seeking comments on the draft and expects it to be introduced next month.

The proposal is designed to create "a more level playing field, to foster competition, and to ensure the necessary consumer protec- See Ohio on page 23

Updates

Crooked couple faces jail

Continued from previous page

several firms they operated, including Meadowlark Insurance Co. and Commercial Indemnity Assurance Co. of the Dominican Republic; M&M Management Co. of Kansas City; and Magnolia Acceptance Co., a Kansas City-based premium finance unit (BI, Dec. 5, 1994).

The two also plotted to bribe a Missouri Insurance Department director and actually paid bribes to former Wyoming Insurance Commissioner Gordon Taylor and James R. Wining, a business associate. Mr. Riley also bribed a Maryland official in charge of a state self-insurance program, prosecutors charged.

Mr. Riley faces a statutory maximum sentence of 85 years in jail and Ms. Coon faces 75 years, though actual sentences will likely be lower under federal sentencing guidelines. The two were also ordered to forfeit about \$1.5 million in assets and were hit with fines totaling more than \$2 million each.

Both were released on bond pending sentencing.

Mr. Riley is separately being sued by Chase Manhattan Corp. for his involvement in a U.S. Virgin Islands property insurance placement with Commercial Indemnity and another insurer he operated (BI, Jan. 31, 1994).

Energy firm to appeal award

DECATUR, Texas—Mitchell Energy & Development Corp. plans to appeal a \$204 million jury award—including \$200 million in punitive damages—to eight Texas families who claim the company's gas wells contaminated their groundwater.

The state court jury found that natural gas and hydrogen sulfide gas in the water corroded plumbing and appliances in the homes of the Wise County families. Seven of the eight families sued the The Woodlands, Texas-based energy company in 1995 and the other filed suit in 1987. Judge John Fostel is expected to approve the award today.

Mitchell Energy maintains that the groundwater was contaminated by bacteria from human and animal waste. "We are completely shocked by the verdict," a spokesman said.

If an award is upheld, Mitchell Energy will almost certainly have to wrangle with insurers that wrote policies over several decades to determine whether coverage for pollution claims is available. Some of the wells have been in place since the 1950s.

"They have insurance coverage and I imagine they will seek coverage under the policies," said Bill Keffer, a lawyer for the families with Gardere & Wynne in Dallas. But the energy company and insurers will have to determine whether pollution exclusions apply, he noted.

Mitchell Energy still faces 27 similar lawsuits and would not comment on its insurance.

Medco sues drug stores

BALTIMORE—A federal court in Baltimore will hear Merck-Medco Managed Care Inc.'s case after the pharmacy benefit management company filed suit last week against four pharmacy chains operating in Maryland.

Montvale, N.J.-based Medco is accusing them of violating antitrust laws by conspiring to deny Medco a \$266 million contract.

In December, the state of Maryland canceled a contract with Medco that was to begin Jan. 1 (BI, Jan. 1).

The action came after several large retail drug chains said they would not take prescriptions from state employees covered by Medco because Medco's intended reimbursement rate was too low. The state plans to rebid the contract.

The pharmacy chains named in the suit are Camp Hill, Pa.-based Rite Aid Corp., Baltimore-based NeighborCare Pharmacies Inc., Washington-based Giant Food Inc. and Mechanicsville, Va.-based EPIC Pharmacy Network Inc.

A Rite Aid spokesman denied any wrongdoing and called the Medco suit retaliatory.

Confed units to stay separate

ATLANTA—Confederation Life Insurance Co.'s Canadian and U.S. operations will remain separate for the purpose of compensating policyholders and pursuing claims against a bankrupt Confed credit unit, overseers for the failed company agreed last week.

Under Canadian liquidation laws, the two estates could have been joined in Canada, which would have forced Confed's Canadian liquidator to handle all winding up affairs of both the U.S. and Canadian branches of the company. That option was bypassed because it would have led to costly "extensive cross border litigation" that could have spanned 10 years, said Bob Sanderson, president of Peat Marwick Thorne Inc. in Toronto, the agent for the liquidator of Confed.

Meanwhile, Victor Palmieri, first special deputy rehabilitator of Confed (U.S.), said that now that the separation issue has been resolved, his group will file within 60 days a formal rehabilitation plan for Confed (U.S.) in state court in Michigan, where Confed's U.S. rehabilitation is being administered.

Confed (U.S.) has about \$6 billion of liabilities and only \$5.4 billion in assets. It received \$165 million (\$225 million Canadian) from the Canadian liquidator as part of the recent deal in order to resolve claims.

Confed (U.S.) is also pursuing, at least \$600 million in a lawsuit against 27 former directors and officers of Confed, Harris Trust & Savings Bank and Ernst & Young related to money that was allegedly removed from trusts designed to protect U.S. policyholders and replaced by promissory notes written by Confederation Treasury Services Ltd., which is currently in bankruptcy proceedings (BI, July 3, 1995).

See Updates on page 22

Skandia America Re sold

New Canadian parent expected to strengthen reinsurer

By SALLY ROBERTS

After a canceled initial public offering and two rejected buyout offers, Skandia America Reinsurance Corp. has a new parent.

A pending all-cash \$230 million buyout by Fairfax Financial Holdings Ltd. of Toronto is expected to strengthen the reinsurer, after years of downsizing and the lack of long-term commitment from its Swedish parent, analysts say.

Since the cutbacks began in 1992, Skandia America's statutory surplus has shrunk nearly 23% to \$312.8 million at Dec. 31, 1995 from \$404.4 million at year-end 1991.

Publicly traded Fairfax, which

turned a 1994 profit of \$38.1 million Canadian (\$27.2 million) on revenues of \$634.9 million Canadian (\$452.6 million), has concentrated on the Canadian insurance market, including its 1994 purchase of Continental Insurance Co. of Canada (BI, Sept. 19, 1994). Fairfax also owns an investment management company, a majority stake in a claims adjusting firm, a Barbados reinsurer, and two small U.S. insurance units.

"The acquisition of Skandia America Reinsurance represents an excellent opportunity to expand Fairfax's presence in the U.S.," said V. Prem Watsa, its chairman and CEO, in a release.

Stockholm-based Skandia In-

surance Co. Ltd. said the sale of the U.S. unit is in keeping with its strategy of reducing long-tail exposures in its reinsurance operations. "If we had kept SARC, it would have been necessary to substantially increase the volume of business in order to enable the company to generate a satisfactory yield in the future," said President and CEO Bjorn Wolrath in a release. Skandia instead will now focus on the variable annuity market within the United States.

Several recent moves to strengthen or sell its U.S. reinsurance unit fell through. In 1992, Skandia pulled the plug at the last minute on an estimated \$162 mil-

See Skandia on page 22

U.S. brokers prevail in still-soft market

Top public brokers raise revenues, profits

By SALLY ROBERTS

If the U.S.-based publicly held brokers were competing in a race in 1995, it was an uphill run all the way.

Soft property/casualty pricing continued in 1995, forcing brokers to focus again on new business development, cost containment and acquisitions to improve results.

At the same time, risk managers continued to take advantage of the buyer's market and shop among brokers to find the best price, value and service.

"This forces brokers to up the ante in order to keep the business,"

said Jay Cohen, an analyst with Merrill Lynch & Co. Inc. in New York. In 1995, "it got even more competitive."

Despite the tough conditions, revenues rose at six of the seven, as did profits.

"The current rate environment and the lack of an inflation environment is causing brokers to concentrate on their profit margins," said Michael J. Cloherty, vp-finance for Arthur J. Gallagher & Co. in Itasca, Ill. Brokers are therefore becoming more effective in handling business and are concentrating on productivity.

"The U.S. has completed its ninth year of a down cycle, and it's soon to begin its 10th year," said J. Michael Bischoff, vp-corporate development for Marsh &

See Brokers on page 6

State funds safety innovation

By ROBERTO CENICEROS

SALEM, Ore.—Oregon employers hope that a new state program to fund innovations in workplace ergonomics will pay off in fewer injury claims.

Oregon's Department of Consumer and Business Services' Workers Compensation Division is accepting applications from employers in the state for \$100,000 grants to research and develop solutions for "intractable" ergonomics problems.

One Oregon employer applying for a grant is Woodford-Marco Manufacturing Inc. The Forest Grove-based manufacturer has seen its process for making folding doors take a toll on employees'

shoulders, arms and wrists.

The company has followed several steps to reduce repetitive motion injuries recommended by the Oregon Occupational Safety and Health Administration consultants. But those suggestions—worksite adjustments and duty rotations—haven't helped, said Kevin Emerick, safety director for the manufacturer, which employs about 150 workers.

Mr. Emerick is hoping the state's unique grant program might help the company solve the problem.

The state, which has allocated \$3.9 million for the grants, is hoping the grant recipients will discover innovative solutions that can be applied industrywide.

See Oregon on page 16

Deja vu all over again

New coverage suits build on old cases

By JOANNE WOJCIK

PHOENIX—Many of the same arguments that pitted policyholders against insurers in the environmental arena are coming into play in other insurance coverage battles.

But unlike 20 years ago, when there was little established precedent to determine such issues as "trigger" and the definition of an "occurrence," there's a lot more ammunition in today's war of words.

And insurers and policyholders alike are tapping into the huge body of case law spawned by landmark asbestos and environmental liability insurance coverage disputes to support their cases.

Two recurrent themes that originated in environmental coverage cases emerge in just about every insurance coverage suit brought today: "What is the trigger of coverage?" and "Was the damage expected or intended?"

In fact, the determination of whether a policyholder expected or intended to cause harm has become such a hot button issue in coverage litigation today that the recent Mealey's Emerging Insurance Battles Conference in Phoenix dedicated an entire session to it.

And just about every speaker who took the podium at the two-day conference for insurance cov-

See Lessons on page 21

Inside

- Everyone wins with the use of Medicare HMOs, one of this week's editorial says. **PAGE 8**
- Nissan North America describes its reasons behind two separate Hawaii captives. **PAGE 10**
- Richard Inserra describes Union Carbide's integrated risk financing program in Perspectives. **PAGE 14**
- Environmental, hull and cargo losses are insured in the grounding of the Sea Empress. **PAGE 17**

Departments

- Advertiser Index.....20
- Ask a Benefit Manager.....14
- Benefit Beat.....6

- Classifieds.....18
- For the Record.....11
- Insurance Services Guide.....19
- International.....17
- Letters.....8
- Opinions.....8
- Perspectives.....14

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Medical treatment, costs all over the map: Survey

Course of treatment depends almost entirely on location

By ROBERT KAZEL

A new report that shows medical treatments and costs vary dramatically and erratically from city to city may vex benefit managers hoping to keep a lid on health care costs.

With the inconsistency in medical procedures and hospitalizations, employers also can have great difficulty predicting national health care trends.

The authors of the report, "The Dartmouth Atlas of Health Care," say the solution is making individuals wiser health care consumers to better discern among costly treatment options. Toward that end, they suggest, corporations may become more active in educating workers on health options

so employees can take more responsibility for their care.

Asserting that "geography is destiny," researchers at Dartmouth Medical School in Hanover, N.H., conclude that doctors' choice of medical procedures often depends more on local tradition and norms and the quantity of nearby hospital beds than on shared professional criteria.

"By and large, what we see in the atlas is how you get treated depends on where you live," said Dr. Elliott S. Fisher, associate professor of medicine at Dartmouth Medical School and Veterans Administration Medical Center and an author of the report.

The Dartmouth atlas used national Medicare data, but its findings apply to patients of all ages,

Dr. Fisher said. Among its findings:

- Women in Elyria, Ohio, were 33 times more likely to undergo breast-sparing surgery for breast cancer (removal of only part of the breast) than their counterparts in Rapid City, S.D., who underwent many more total mastectomies.

- Patients in Stockton, Calif., were eight times more likely to undergo balloon angioplasty for a blocked artery than those in Buffalo, N.Y.

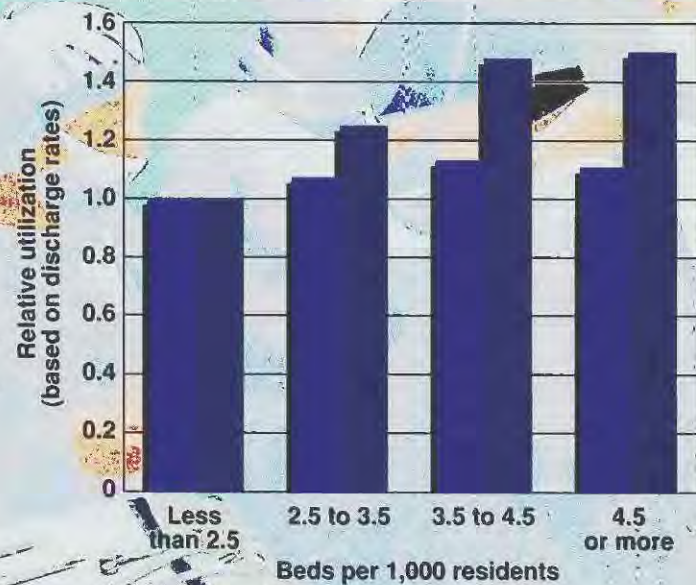
- Those suffering lower back pain in Kingsport, Tenn., were seven times more likely to receive surgery as patients in Provo, Utah.

- Patients in Joliet, Ill., were more than four times more likely to undergo coronary artery bypass

See Report on page 20

Have hospital, will admit

Conditions requiring surgery Conditions where doctors have a lot of discretion in treatment



Source: Dartmouth Atlas of Health Care

GRAPHIC BY KIM ROME

CIGNA, EXEL teaming up to offer new programs

Venture offering multiline, multiyear products

By DOUGLAS McLEOD

HAMILTON, Bermuda—CIGNA Property & Casualty Insurance Co. and EXEL Ltd. are teaming up to offer large-limit multiyear property/casualty package programs to large commercial policyholders.

The project is evidence of growing interest among Fortune 500 companies in simpler, more consolidated risk financing programs, brokers say.

The two insurance companies last week announced the formation of two new units, CIGNA Risk Solutions and X.L. Risk Solutions, which will jointly underwrite the programs.

The facilities will offer a variety of products, ranging from monoline multiyear coverages to a multiyear package of coverages that could include property, general liability, directors and officers liability, marine and aviation lines.

The insurers will provide combined annual limits of up to \$400 million and term limits of up to \$1 billion for three- to five-year programs, with sublimits for the various exposures. The coverages are intended to attach excess of large self-insured retentions and are aimed principally at the top tier of Fortune 500 companies.

CIGNA units will issue admitted policies where companies require them, while non-admitted policies will be issued by X.L. Insurance Co. Ltd. CIGNA and X.L. will then reinsure various parts of the risks with one another.

"The new products will allow companies to address a broad range of exposures under one multi-year custom package, thus lowering insurance costs and providing greater stability of coverage terms and limits," Robert J. Cooney, X.L.'s president, said in a statement. "These custom packages will take less time to administer, enabling insureds to direct their efforts to risk management activities that reduce or eliminate the causes of loss."

The insurers also stand to pick up new lines of business from existing and new clients, officials of the two insurers noted.

Dennis P. Kane, president of CIGNA's Special Risk Facilities unit, said he expects growth of the new programs to be gradual.

Some aggressive corporations will move quickly to multiline, multiyear packages, but "those folks, I think, will be relatively few initially."

Others, he predicted, will start with a monoline multiyear program and gradually add coverages to the package, or will start with a basic property and liability package but place specialty lines like D&O separately for now.

Mr. Kane likened the product to risk financing innovations of a quarter century ago, like captives and paid-loss retro programs that took years to become standard products in the marketplace.

"Our long-term view is that this multiline, multiyear package with big blocks of capacity from the ground up is the kind

See Facilities on page 22

Growing comp role for managed care

Use of managed care varies widely by state

By MEG FLETCHER

CAMBRIDGE, Mass.—More states are allowing companies to use managed care techniques to control workers compensation medical costs, though the movement still faces obstacles.

Among those opposed are some labor unions, which want to ensure that workers receive adequate care, and some doctors, who think being left out of managed care networks could cost them patients, according to panelists at a recent Workers Compensation Research Institute conference.

In recent years, more than 35 states have added laws or regulations allowing new cost containment techniques or considered doing so, the WCRI concluded last year (BI, Dec. 25, 1995).

Just what the states allow varies widely. Some require companies or insurers to use managed care techniques, while others allow only limited use of managed care and require that employees be allowed to opt out, said Stacey M. Eccleston, a WCRI analyst who compiled the latest data and wrote the study (see chart, page 13). In addition, some states permit the use of managed care even without specific approval.

Most states, though, allow only limited use of managed care.

Underscoring the need for managed care was a 1990 study that compared workers compensation and Blue Cross medical charges, said Kate Kimpan, director of re-

search and education unit at the Minnesota Department of Labor & Industry.

Researchers found that workers comp medical costs were double those of group medical costs for many ailments, especially those, like many back injuries, that cannot be objectively verified, said Ms. Kimpan, who is also the WCRI's first visiting fellow.

Minnesota legislators responded to the findings by adopting reform measures in 1992, which led to a heavily regulated, "managed care lite" program, she said.

Managed care organizations have to be certified and have to take on a risk "for life," without capitation. In addition, employees retain their choice of physician in Minnesota, a concession that reflects the strength of organized labor in the state.

Early data show improvements, including voluntary market premium rate drops of 5.6% for 1995 and effectively 14% for 1996, she said.

While Minnesota's study encouraged insurers and employers to lobby for managed care in other states, the movement also spawned complaints from labor unions and physicians.

Workers in North Carolina, for instance, complain that "rogue" managed care networks will provide "cheap" treatment and push recuperating workers back to work sooner than they should, said Christopher Scott, president of the North Carolina AFL-CIO in Raleigh.

"My plea would be, let's get the bad actors out of the system before they start," he said.

See Managed on page 13

Work comp care quicker, more costly

By MEG FLETCHER

Treating back injuries costs more and requires more medical services but takes less time in the workers compensation system than outside it, a new study finds.

Providers typically use a "sports medicine" approach to try to get people injured on the job back to work quickly and thereby reduce wage-loss payments, the California Workers' Compensation Institute in San Francisco concludes in a new report.

But average treatment costs for an on-the-job back injury run 30.1% higher in the workers comp system than in the group health care system—\$1,205 vs. \$842—said the CWCI, which analyzed 22,656 industrial back injury cases and 14,712 group medical claims with 1990 and 1991 treatment dates.

By type of ailment, the discrepancy was

greatest for soft-tissue injuries, like sprains and strains: Workers comp medical costs of \$1,143 exceeded group health care costs by 56%. Soft-tissue ailments constitute 87% of industrial back injuries and consume 82% of back treatment costs.

The workers comp cases entailed "more total visits to the physician, more procedures during the course of treatment, more procedures per visit and more visits per week," the study found.

Although treatment of back injuries is more intense under the workers comp system, the duration is shorter. About 75% of all medical treatment for work-related back injuries was provided during the first 120 days of care; in group medical cases, only 60% was. And medical care concluded within 30 days of treatment in 64% of the work-related cases, compared with only 40%

of back claims covered under group medical.

The study also found that workers comp relied more heavily than group medical did on consultations with specialists, magnetic resonance imaging, CAT scans, X-rays or other radiology and physical medicine.

For example, during the first 120 days of care, health care providers spent \$2 million on MRIs and CAT scans for workers comp claimants compared with \$700,000 for group medical claimants (see chart).

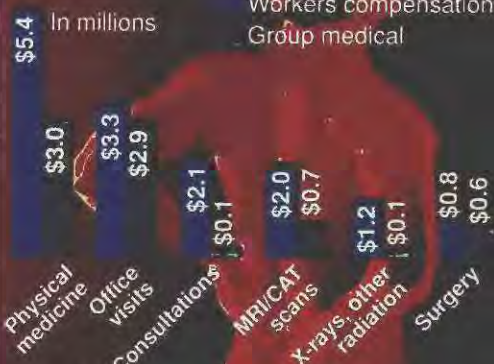
The research calls into question whether aggressive medical treatment coupled with short-term, modified duty is a cost-effective way to get employees back to work.

Copies of the CWCI analysis are available for \$5.80 each, including tax and shipping, from CWCI, 120 Montgomery St., #1300, San Francisco, Calif. 94104.

Bad backs

Costs for a range of services were much higher in the workers comp system than outside it.

Workers compensation Group medical



Source: California Workers' Compensation Institute

Trains

Continued from page 1
million excess of \$50 million.

CSX is self-insured up to \$25 million and Amtrak also carries a substantial self-insured retention.

The crash occurred in the late afternoon of Feb. 16 as the Washington area was hit with yet another snowstorm.

Investigators say that as the engineer of the MARC train approached the Kensington, Md., station, he did not see a signal cautioning him not to travel more than 30 mph.

The train was traveling at more than 60 mph when the engineer apparently saw either the Amtrak train traveling in the opposite direction or a red signal about three miles out of the Kensington station. There wasn't enough distance between the two trains to avoid a crash, and the MARC train struck the Chicago-bound Amtrak train at about 40 mph.

The MARC train burst into flames. Eleven people on the MARC train, including the engineer and two other crewmen died. Most of the fatalities were caused by burns or smoke inhalation.

Liability issues arising from the crash will likely hinge on investigations by the National Transportation Safety Board, which could take several months to complete its report on the crash, Mr. Man-

gano said.

Apportioning blame for the crash will then likely be resolved in court, said transportation lawyer Hyman Hillenbrand, a partner in the Miami office of Kroll & Tract.

And even if the NTSB investigation apportions blame, that conclusion is not admissible in court. Only the facts uncovered by the investigation can be used, said Mr. Hillenbrand.

"It's very difficult to ascertain liability until there is a thorough investigation. There are all kinds of things that could enter into the case that we don't know about yet," Mr. Hillenbrand said.

The manufacturer of the cars and the company that delivered the cars to MARC have product liability coverage in place, officials at the companies say.

A spokeswoman for New York-based Sumitomo Corp. of America said all of the cars met federal safety regulations at the time of delivery in 1987 and 1991, and met the MARC specifications.

The cars were built by Japanese manufacturer Nippon Sharyo.

The Federal Railroad Administration slapped emergency safety rules on all passenger trains last week in response to the Silver Spring crash. Among other things, the agency ordered all U.S. commuter trains to inspect every window and door escape on every car within 60 days. The passengers

who died all were in the first car, where the front doors and an emergency window exit were rendered inoperable because of the crash, and other emergency exits failed to operate as well.

Passenger railroads were given 45 days to develop a safety plan for push-pull trains, trains like MARC Train 286 in which there's no locomotive in front.

The state of Maryland went even further later in the week, when Transportation Secretary David Winstead announced that every window on the MARC system's 110 commuter cars will be replaced with an emergency exit window. This replacement program will cost about \$1.5 million. The state will also test all trains within 60 days to make sure windows and emergency exits can be opened. In addition, the visibility of MARC trains' emergency exit doors will be upgraded and emergency instructions posted, all at cost of roughly \$5 million.

Meanwhile, the U.S. Senate could vote as early as this week on S. 1318, an Amtrak authorization bill that would cap punitive damages stemming from railroad accidents to \$250,000 or twice compensatory damages, whichever is greater. The House approved its own Amtrak bill late last fall. The House measure, H.R. 1738, would cap punitive damages at \$250,000 or three times economic damages, whichever is greater. Unlike the

Senate bill, H.R. 1788 also would cap non-economic damages at \$250,000. Differences between the bills will have to be reconciled by a conference committee if the Senate approves its measure.

Late last week, a group of consumer activist groups called on the Senate to drop the liability provisions in its bill. Robert Creamer, executive director of Illinois Public Action in Chicago, held that the liability caps would "even limit punitive damages for saboteurs such as the Sons of the Gestapo in any civil action that might arise from an accident like the Arizona Amtrak derailment last year" (BI, Oct. 16, 1995). Sons of the Gestapo—a previously unheard of group—claimed responsibility for that fatal derailment.

Meanwhile, in the fifth major train wreck in February, a Southern Pacific Railroad freight train derailed last week in Tennessee



The Maryland Mass Transit Administration has \$200 million in liability insurance to cover claims arising from the train wreck earlier this month.

Pass near Red Cliff, Colo., killing two crew members and spilling more than 50,000 gallons of sulfuric acid.

A spokeswoman for the NTSB said that the train was traveling at 64 mph, more than four times the 15 mph speed limit in Tennessee Pass.

NTSB investigators were trying to determine the exact cause of the crash late last week. **BI**

Hot line offers medical advice over the phone

By ROBERT KAZEL

Benefit Beat

EAGAN, Minn.—Employees of companies throughout Minnesota may soon be able to dial a telephone hot line to get medical advice, common prescriptions and a sympathetic ear—and to avoid routine visits to the doctor's office.

The hot line is a joint project of St. Louis Park, Minn.-based HealthSystem Minnesota, an integrated care system that includes a hospital, clinics and primary care physician net-

work, and Blue Cross & Blue Shield of Minnesota, based in Eagan, Minn. It has been running on a test basis since January 1995 for Blue Cross/Blue Shield patients of the HealthSystem clinic.

Both insurer and provider are now looking at how the service can be sold throughout Minnesota and

around the nation.

The service, Care On Call, is a round-the-clock telephone number answered by registered nurses who give advice on everyday health problems and discuss care options using guidelines developed by doctors. They also are authorized to write prescriptions for common ailments, such as conjunctivitis, based on conversations with callers. Records of the call are sent via computer or fax to the patient's primary care doctor.

Blue Cross/Blue Shield sees the telephone service as a way to stay ahead in the battle for managed care customers in Minnesota, said Colleen Reitan, president of First Integrated Holding Co., which was set up to manage the hot line's development in 1993.

Unlike telephone health hot lines run by health maintenance organizations, Care On Call is not designed to act as a gatekeeper; it is not mandatory for any plan member or clinic user to talk to a nurse before making an appointment to see a doctor. But most callers are interested in solving their problem over the phone and not coming in, Ms. Reitan said. Plan sponsors benefit because calls to the hot line cost about \$12 to \$25, versus \$65 for a typical doctor's office visit.

Care On Call will be expanded so it can be used by more patients of HealthSystem Minnesota and eventually is expected to be offered as a product to other third-party payers and large group practices. By July, the service will be offered to other Blue Cross/Blue Shield plan sponsors, said Ms. Reitan.

By next January, she said, it is hoped that the software, training materials and medical guidelines developed for the hotline—at a cost to Blue Cross/Blue Shield and HealthSystem Minnesota of \$4 million—will be offered nationally for sale.

Employee satisfaction

A nationwide survey of hundreds of U.S. corporations could place plan sponsors in a better position to deal strategically with HMOs and point-

of-service plans by arming them with customer service information.

CareData Reports Inc., a New York research firm that will conduct its third annual poll of managed care enrollees this year, will send out an estimated 175,000 questionnaires to employers in about 20 regions, said Dr. Tod Cooperman, president.

The surveys will be sent to plan sponsors in May and participating companies will get back reports for their employees in September, he said. The regional compilations of data will be sold to health plans, consulting firms and brokerage companies as a means to compare how employees rated managed care firms against one another.

The surveys are distributed to employees by their employers, and participation is voluntary. Participation has been about 40%, Dr. Cooperman said.

Employees are asked questions on how much they like their plan's services, quality of medical care, access to care, choice of physicians, primary care doctor, pharmacy benefits, and their ability to contact the plan and get questions answered.

Last year, CareData reported on 47 plans, with 81 employers, in five regions (BI, Nov. 13, 1995).

The company is trying to work closely with business health coalitions to interest more firms in participating in the survey.

Last year, employee participation in CareData's survey gave Los Angeles-based Southern California Edison Co. data by which to judge its managed care plans, said Pam Krol, the electric company's health plan manager. Nearly four out of 10 of the company's employees are in health maintenance organizations, and the rest are in a POS plan.

"We found the report incredibly helpful in identifying concerns," Ms. Krol said. The survey revealed, for instance, that retirees did not dislike managed care as much as the company had feared—even though they tended to call with complaints because they had more free time during the day. **BI**

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Brokers

Continued from page 2

McLennan Cos. Inc. "The market is difficult, but it's one we're used to operating in."

"I'm not one to bellyache about the soft market," said Patrick G. Ryan, chairman and CEO of Aon Group, the Aon Corp. unit formerly known as Rollins Hudig Hall Group Inc. "I think it can be good for the soul."

It may also be good for Aon Group, where revenues rose nearly 20% and pretax profits 28% in 1995.

While most brokers do not see the market turning, at least one thinks a turn is a bit more likely.

"We still have a glimmer of hope," said Robert H. Hilb, chairman and CEO of Hilb, Rogal & Hamilton Co. "It's hard for us to believe that we can continue along with this rate level with what is hidden in lack of reserves."

Growth through acquisition remained a key broker strategy in 1995.

Aon Group led the pack with 22 acquisitions, most of them overseas. Acordia, Gallagher, HRH and Poe & Brown Inc. also completed numerous deals. The two biggest acquisitions, however, were of the U.S. offices of London brokers.

Alexander & Alexander Services Inc. last year acquired most of the U.S. offices of Jardine Insurance Brokers Inc. for roughly \$54 million (BI, Sept. 18, 1995). And Acordia Inc. acquired substantially all of the U.S. operations of Hogg Group for \$50 million (BI, Jan. 9, 1995).

A hint that consolidation among the top ranks would continue came at the end of the year when Inchcape P.L.C. announced plans for divesting

Bain Hogg, the world's No. 11 brokerage. However, Inchcape later decided to seek a public stock offering of Bain Hogg rather than sell it whole to other bidders (BI, Dec. 25, 1995; Dec. 18, 1995).

Ultimately, the six major global brokerages will be thinned to only three or four, said Sax Riley, chief executive of Sedgwick Group P.L.C. of London. Where does he think Sedgwick will fit? He won't say directly. "We would obviously like to be bigger. The question is, does anything fit our strategy?"

"It would not surprise me at all" if there were an acquisition between two of the world's largest brokers in 1996, agreed Mr. Cohen of Merrill Lynch. "Having sold its life insurance business, Aon is a likely acquirer in '96," he predicts. "It has had a fairly successful track record."

Individual broker results follow:

Marsh & McLennan

Strong performances in consulting and investment management fueled a 9.9% rise in revenues to \$3.79 billion in 1995 from \$3.45 billion in 1994. Likewise, profits grew 8.5% to \$402.9 million from \$371.5 million in 1994.

A 21.9% gain in revenues from The Putnam Cos., M&M's Boston-based investment management unit, amounted to \$750 million in revenues, up from \$615.4 million in 1994. Consulting revenues rose 13.2% to \$1.1 billion from \$933.1 million in 1994.

Modest revenue gains from M&M's insurance service unit, however, reflect the continued competitive market. Revenues rose 4.1% to nearly \$2 billion from \$1.9 billion in 1994.

"While it may be gloomy in the U.S., it's optimistic internation-

ally," Mr. Bischoff said. The general downward trend in pricing overseas was offset by new business development, he added.

Aon Group

A blend of internal growth and acquisitions secures its No. 2 slot in world rankings, ahead of Sedgwick (see related story).

Revenues for Chicago-based Aon rose 19.6% to \$1.7 billion in 1995 from \$1.42 billion. Pretax income rose 28.8% to \$204.6 million from \$158.8 million.

Broken down by specialty lines, retail brokerage revenues in-

pretax charge of \$17.6 million related to the October acquisition of certain U.S. operations of Jardine Insurance Brokers. They also include a first-quarter pretax gain of \$28.7 million related to the 1995 sale of Alexsis Inc.

Excluding sold operations and acquisitions, gross revenue rose 4.4% in 1995, said Alan Kershaw, vp and treasurer. He credits a "record level of new business," higher customer retention rates and a "dramatic turnaround" in its U.S. retail brokerage and consulting units.

Operating margins—the difference between operating income

1995 revenues got a push from Southeastern Group Inc.'s two health maintenance organizations and indemnity health plan business, which Acordia began marketing and administering during the second half of 1994, said Mr. Sheridan.

Arthur J. Gallagher

A record level of new business development, higher account retentions, plus a surge in investment income, pumped up Gallagher's 1995 gross revenues 12.1% to \$412 million from \$367.7 million in 1994. Profits also soared, rising 20.6% to \$41.5 million from \$34.4 million in the prior year.

While commissions and fees increased 10.6% to \$395.9 million last year from \$358.0 million in 1994, investment income surged 65.8% to \$16.1 million, compared with \$9.7 million in 1994.

Gallagher's new overseas operation, Risk Management Partners Ltd., also contributed to the broker's year-end results, Mr. Clougherty said. During the fourth quarter, the broker established small RMP offices in the United Kingdom and in Scotland.

Gallagher also acquired seven firms in 1995. Most recently, it acquired Shadow Agency Inc., a Minneapolis-based full-service agency that specializes in construction, manufacturing and distributing companies.

Hilb, Rogal & Hamilton

Aggressive sales and a number of acquisitions contributed to the 5.2% growth in revenues in 1995 to \$148.1 million from \$140.8 million in 1994. Net income rose more modestly, increasing 3.8% to \$11.8 million from \$11.4 million.

Fourth-quarter earnings dipped 5.3% from 1994 levels, a decline Robert H. Hilb, chairman and CEO of the Glen Allen, Va.-based broker, attributed to subsidizing a pension plan of an agency HRH acquired.

Other than that, Mr. Hilb said, "We've finally gotten to the point where we're above rather than behind in the top line. We were able to just about outsell the softness (of the market) and loss of business."

Revenues also received a boost from 14 acquisitions HRH completed in 1995.

Poe & Brown

Acquisitions and internal growth led to a 4.7% increase in gross revenues last year to \$106.4 million from \$101.6 million in 1994. Net income also rose, increasing 9.5% to \$14.8 million in 1995 from \$13.5 million in 1994.

The Tampa, Fla.-based broker acquired eight agencies in 1995, which contributed 50% to the revenue increase, said James A. Orchard, vp, treasurer, and chief financial officer. **B**

1995 broker results

(in millions of dollars)

Broker	Gross revenues	% change	Net income	% change
Marsh & McLennan	\$3,788.0	9.9%	\$402.9	8.5%
Aon Group	1,701.3	19.6	204.6 ¹	2.9
Alexander & Alexander	1,282.4	(3.1)	64.0	141.6
Acordia	555.1	34.7	23.6	(18.1)
Arthur J. Gallagher	412.0	12.1	41.5	20.6
Hilb, Rogal & Hamilton	148.1	5.2	11.8	3.8
Poe & Brown	106.4	4.7	14.8	9.5

¹ Pretax
Source: Company reports

GRAPHIC BY KYLE LOCKWOOD

creased 19.8% in 1995 to \$993.7 million from \$829.3 million in 1994. Reinsurance and wholesale brokerage revenues increased 23.3% to \$457 million from \$370.6 million in 1994. Consulting revenues increased 12.8% to \$250.6 million from \$222.2 million.

In addition to the numerous acquisitions in 1995, U.S. retail brokerage operations reported "high single-digit" increases in internal growth, Mr. Ryan said.

"Overall, Aon Group continues its expansion of insurance services as opposed to pure brokerage," he said. "It's a strategy that is fueling growth in both revenues and profits."

This strategy continued into 1996 with the formation of a new unit, Aon Risk Resources-Midwest, which establishes and services group-purchasing programs for alternative risk financing, pools, captives and others.

Alexander & Alexander

Despite achieving its goal of significantly improving operational margins, revenues for the year dipped 3.1% to \$1.28 billion from \$1.32 billion in 1994.

On the other hand, the New York-based broker posted a \$64 million profit in 1995, compared with a \$153.8 million loss in 1994.

Net income received a boost from a 17.6% drop in expenses to \$1.2 billion from \$1.4 billion in 1994—a result of the broker's restructuring efforts.

Results include a fourth-quarter

and total revenues—at A&A Inc., excluding sold operations and acquisitions, were between 6% and 7%, Mr. Kershaw said, after breaking even in 1994. Additionally, operating margins at Alexander Consulting Group Inc., which were "slightly negative" in 1994, were 6% in 1995, Mr. Kershaw said. Overall, the company's operating margins, excluding sold operations, acquisitions and one-time charges, were 10.8%, compared with 2% in 1994.

Acordia

The events of 1995 were a bad mix for Indianapolis-based Acordia. While acquisition-fueled revenues jumped 34.7% to \$555.1 million from \$412.2 million in 1994, profits tumbled 18.1% to \$23.6 million from \$28.8 million in the prior year.

"1995 was a year unlike the previous five," in which Acordia reported at least 15% increases in earnings, said Patrick M. Sheridan, executive vp and chief financial officer. Acordia attributes the most of the profit decline to the weak California market—specifically workers compensation, construction and managed care lines—and to a reorganization of six of its Indiana operations into three.

The integration of Bain Hogg Robinson Inc., which Acordia acquired a year ago, also resulted in lower-than-anticipated revenues due to an unexpected number of BHR producers leaving.

Slips in U.S. erode Sedgwick returns

LONDON—Weak results in Sedgwick Group P.L.C.'s biggest market helped drag down profits, before tax and exceptional items, 3.4% to £91.2 million (\$144.1 million at average exchange rates) in 1995 from £94.3 million (\$144.3 million) in 1994.

Gross revenue was virtually flat—£931.5 million (\$1.47 billion) compared with 931.3 (\$1.42 billion) in 1994—ranking Sedgwick as the world's third-largest brokerage, down from No. 2 a year earlier.

Its U.S. revenue fell 3.4% to £380.1 million (\$600.6 million) from

£393 million (\$601.3 million) and the company's U.S. pre-tax profit declined 11.3% to £38.9 million (\$61.5 million) from £43.3 million (\$66.2 million). Despite those declines, Sedgwick said U.S. retail insurance and reinsurance brokerage services maintained good underlying results in a competitive market and that growth in new business was "encouraging."

Brokerage commissions and fees fell 0.8% to £880.9 million (\$1.39 billion) from £888.7 million (\$1.36 billion) in 1994. Among the factors the brokerage cited for that show-

ing were uncertainty over the future of Lloyd's of London and continuing lack of consumer confidence in the U.K. personal financial services and pensions sector.

Revenue from the United Kingdom market slipped 1.3% to £312.3 million (\$493.4 million) from £316.5 million (\$484.2 million), though reduced expenses and higher interest income helped lift pre-tax profit to £44.6 million from £41.3 million.

Soft conditions, chiefly in the energy and marine markets, dragged down earnings, the brokerage said.

—By Edwin Unsworth

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Opinions

All win with Medicare HMOs

HOW MANY federal programs are there that simultaneously save the government, employers and retirees money?

Not many, we suspect, but one that clearly does is Medicare risk HMOs. As we reported last week, enrollment and interest in Medicare risk HMOs is exploding and for good reason: everyone wins.

Under this arrangement, HMOs contract with the government to provide Medicare benefits to retirees. The federal agency that administers Medicare gives the HMOs 95% of what the government thinks it would cost to provide Medicare benefits to retirees. While a 5% cost reduction might not sound like much, it translates into hundreds of millions of dollars of savings for the government.

But the biggest winners are retirees and employers. Because HMOs typically can provide benefits at a much lower cost than the traditional and highly inefficient Medicare program, the HMOs often can afford to offer additional benefits, like prescription drug coverage, and still make money. In many cases, the HMOs don't even charge an additional premium for the enriched benefits.

Retirees who don't have employer-provided health care coverage can easily save \$1,000 a year on premiums they now spend on individual Medigap policies. And when retirees move from corporate-provided Medicare supplemental plans to HMOs it can significantly reduce employers' retiree health care liabilities.

Sounds too good to be true? It isn't. Retirees know a good deal when they see it: about 1 million of them in 1995 alone moved into risk HMOs from the traditional Medicare program. Employers, too, are catching on and are promoting risk HMOs to their retirees.



HEY! MIND IF I BORROW THAT PHONE NUMBER, PAL?

If anything, the one problem with Medicare risk HMOs is the way rates are set. HMOs in high-cost areas of the country may be getting paid too much by the government, while government payment rates may not be enough in lower-cost areas of the country. That is something Congress should look into.

But that problem aside, Medicare risk HMOs are working well and saving money. We hope that government, employers and HMOs do even more to get the message across on how retirees can benefit from this program.

Getting doctors on same page

AS IF MORE evidence was needed, a new study illustrates that there remains plenty of room in the health care market for cost savings and greater efficiency.

The study, conducted by researchers at the Dartmouth Medical School, found that medical treatments and costs vary widely—and erratically—by location. Even in neighboring cities, a specific procedure will be handled differently by doctors and result in differing costs. That often can mean higher health care expenses for employers in a community with higher treatment costs.

To make sure the most cost-effective care is being provided, more communication is needed in the medical community and with consumers.

The researchers could find little cause for the variations, chalking them up largely to "how you get treated depends on where you live."

One possible reason for the different treatment patterns, they say, is the volume of hospital beds in a doctor's community. In communities with greater capacity,

there is an almost knee-jerk tendency to hospitalize a patient who has a condition for which that is an option. In a community with fewer beds, the same condition may be treated on an outpatient basis.

How can such variations in treatment patterns and costs be brought more in line? The key is communication.

For medical associations and managed care organizations, better communication of treatment patterns and protocols is needed. This could help make a doctor aware of prevalent and less costly alternatives for treatment.

For employers, as the Dartmouth researchers suggest, communicating more information about health care choices to employees can make them better consumers. If faced with a condition for which treatment is discretionary, they can consider all the options, not just the one that will fill a hospital bed.

In this era of managed care, online communications and electronic media, there is little excuse for doctors to be acting if they were alone in the wilderness.

Letters

Missouri not getting privileged rights: CIGNA

To the editor: I was surprised by the way you characterized Missouri's letter on CIGNA Property & Casualty Insurance Co.'s restructuring in your Feb. 17 article, "Missouri Strikes Deal for CIGNA Policyholders."

Let me clear up any confusion your readers may have from your description.

Missouri policyholders will have no more rights than any other policyholder as we implement our corporate restructuring. Missouri's Feb. 10 letter acknowledged our rights to proceed with the restructuring plan, including the division of the Insurance Co. of North America, which we implemented on Feb. 12. The letter, importantly, raised no issues that we were transferring policies in a way that required policyholder novation. The letter further outlines reasonable timelines to notify policyholders and to resolve any objections or questions that Missouri policyholders may raise.

In light of the increased financial protection and enhancements to our final plan, we anticipate that we will quickly comply with these guidelines and resolve any questions that arise among our customers in Missouri.

For the record, we worked with Penn-

sylvania to come up with procedures for notifying policyholders in all states—including the estimated 200 or so policyholders in Missouri—within 45 days of the restructuring. We view this as nothing more than an insurance company's agreement to work with its customers.

Also, contrary to the statements in your article, California has assured CIGNA it doesn't view the procedural steps outlined in the Missouri letter as the kind of additional benefit considered in the clause you cited from the California order approving the restructuring. I trust this reassures your readers that our restructuring is moving forward without delay.

Ed K. Ota Jr.
Assistant General Counsel
CIGNA Property & Casualty
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Philadelphia

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Aetna Life & Casualty Co.: Richard L. Huber, director, indirectly purchased 5,000 shares of common at \$72.00 each on Dec. 7, 1995. He now directly and indirectly holds 6,000 common.

Aetna Life & Casualty stock closed at \$72.75 a share on Feb. 16.

American International Group Inc.: M. Bernard Aidinoff, director, purchased 112 shares of common at \$92.13 each on Dec. 5, 1995, and now directly holds 7,422 common.

Lloyd Bentsen, director, purchased 112 shares of common at \$92.13 each on Dec. 5, 1995, and now directly holds 1,810 common.

Marshall Cohen, director, purchased 112 shares of common at \$92.13 each on Dec. 5, 1995, and now directly holds 1,575 common.

Barber B. Conable, director, purchased 112 shares of common at \$92.13 each on Dec. 5, 1995, and now directly holds 4,725 common.

Martin S. Feldstein, director, purchased 112 shares of common at \$92.13 each on Dec. 5, 1995, and now directly and indirectly holds 11,893 common.

Evan G. Greenberg, vp, acquired by gift 107 shares of common at an unreported price on Dec. 20, 1995. Mr. Greenberg indirectly acquired by gift 324 shares of common at an unreported price that same day and now directly and indirectly holds 17,758 common.

Maurice Raymond Greenberg, chairman, disposed of by gift 969 shares of common at an unreported price on Dec. 20, 1995. Mr. Greenberg indirectly acquired by gift 646 shares of common at an unreported price that same day and now directly and indirectly holds 16,863,443 common.

Carla Anderson Hills, director, purchased 112 share of common at \$92.13 each on Dec. 5, 1995, and now directly and indirectly holds 2,636 common.

Frank J. Hoenemeyer, director, purchased 112 shares of common at \$92.13 each on Dec. 5, 1995, and now directly holds 12,739 common.

John I. Howell, director, purchased 112 shares of common at \$92.13 each on Dec. 5, 1995, and now directly and indirectly holds 57,097 common.

Dean P. Phypers, director, purchased 112 shares of common at \$92.13 each on Dec. 5, 1995, and now directly holds 8,919.

Ernest Edward Stempel, director, exercised an option for 7,867 and disposed of by gift 118 shares of common between \$36.44 and \$64.58 each from Dec. 7 to Dec. 20, 1995, and now directly and indirectly holds 11,140,577 common.

AIG stock closed at \$99.00 a share on Feb. 16.

Argonaut Group Inc.: George A. Roberts, director, disposed of by gift 19,100 shares of common at an unreported price on Nov. 30, 1995. Mr. Roberts indirectly acquired by gift 1,000 shares of common at an unreported price that same day and now directly and indirectly holds 254,514 common.

Argonaut Group stock closed at \$34.25 a share on Feb. 16.

Chubb Corp.: Henry U. Harder, director, disposed of by gift 300 shares of common at \$97.25 each on Nov. 30, 1995, and now directly and indirectly holds 51,922 common.

Chubb stock closed at \$100.88 a share on Feb. 16.

Hilb, Rogal & Hamilton Co.:

Insider Trading

John C. Adams, vp, disposed of by gift 2,000 shares of common at an unreported price on Dec. 4, 1995, and now directly and indirectly holds 87,000 common.

HRH stock closed at \$13.13 a share on Feb. 16.

Humana Inc.: Wayne T. Smith, president, disposed of by gift 9,709 shares of common at an unreported price on Nov. 29, 1995, and now directly and indirectly holds 422,401 common.

Karen A. Coughlin, vp, exercised an option for 6,000 shares of common at \$5.15 each on Dec. 1, 1995, and sold them at \$27.00 each on Dec. 1, 1995, and now directly and indirectly holds 22,697 common.

David A. Jones, chairman, exer-

cised an option for 38,000 and disposed of by gift 35,100 shares of common at \$8.91 from Dec. 7 to Dec. 13, 1995, and now directly and indirectly holds 9,505,190 common.

Humana stock closed at \$25.75 a share on Feb. 16.

Marsh & McLennan Cos. Inc.: Lawrence J. Lasser, director, sold 5,000 shares of common between \$90.38 and \$91.00 each on Jan. 31, and now directly and indirectly holds 92,000 common.

Gregory F. Vangundy, officer, exercised an option for 459 shares of common at \$67.25 from Dec. 1 to Dec. 7, 1995, and sold them at \$89.25 each from Dec. 1 to Dec. 7, 1995. Mr. Vangundy indirectly exercised and option for 1,541

shares of common at \$67.25 each on Dec. 1, 1995. To cover expenses of the transaction Mr. Vangundy turned in 1,541 of them for \$87.25 each on Dec. 1, 1995, and now directly and indirectly holds 28,964 common.

Philip L. Wroughton, director, sold 702 shares of common at \$89.38 each on Dec. 14, 1995, and now directly and indirectly holds 28,964 common.

Marsh & McLennan stock closed at \$94.75 a share on Feb. 16.

RLI Corp.: Gerald D. Stephens, president, purchased 800 and disposed of by gift 100 shares of common between \$24.50 and \$24.75 each from Dec. 14 to Dec. 28, 1995, and now directly and indirectly holds 440,899 common.

RLI stock closed at \$25.13 a share on Feb. 13.

Safeco Corp.: Boh A. Dickey, of-

ficer and director, exercised an option for 10,000 shares of common at \$14.31 each on Jan. 29. To cover expenses of the transaction Mr. Dickey turned in 4,031 of them for \$35.50 each on Jan. 29, and now directly and indirectly holds 47,976 common.

Roger H. Eigsti, chairman, exercised an option for 3,000 shares of common at \$16.88 each on Dec. 26, 1995, and now directly and indirectly holds 106,508 common shares.

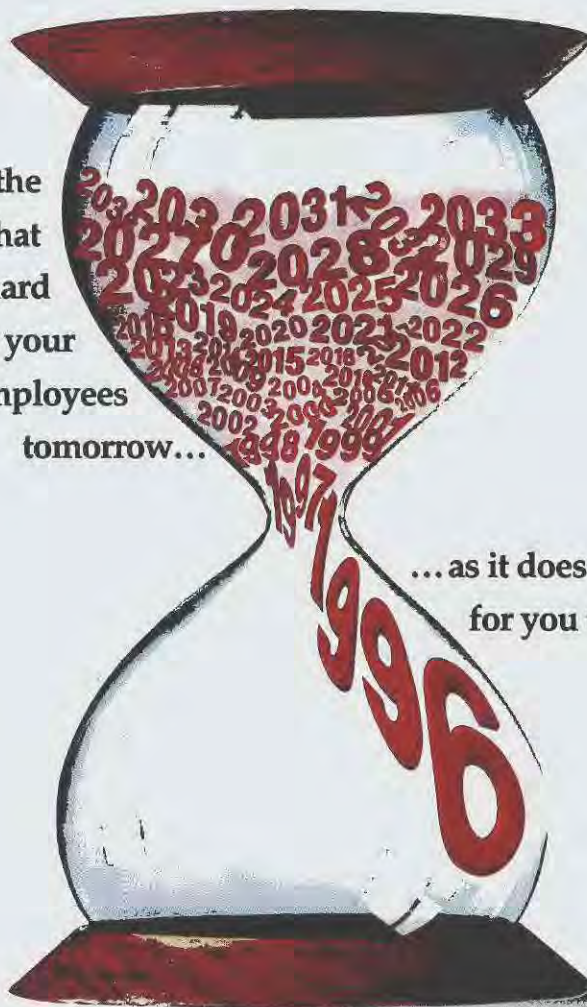
Safeco stock closed at \$38.25 a share on Feb. 16.

Insider Trading, compiled by Invest/Net Trading Group Inc. of Fort Lauderdale, Fla., from reports filed with the Securities and Exchange Commission, tracks stock sales and purchases by insurance industry directors and officers. The column is distributed by Tribune Media Services Inc.

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Sutter Health learns lesson in control

By ROBERTO CENICEROS

KAILUA KONA, Hawaii—For Sutter Health System, the creation of a captive insurer didn't come without surprises.

But five years after forming Sutter Insurance Services Corp. in Honolulu, Michael Evans, Sutter Health's vp of risk management, describes it as a success.

The captive provides Sacramento, Calif.-based Sutter Health—a 27,000-employee health care organization that includes hospitals, physician groups and an HMO and covers about 300,000 lives—with greater control over claims handling and risk management.

Control "frankly will be very important to you. At least in our estimation, it should be important to you," Mr. Evans advised companies thinking of forming a captive.

"One of the things we do now before something becomes a legal claim, we provide defense costs up front," Mr. Evans said at the 1996 Hawaii Captive Insurance Forum.

"We get legal counsel, when it's appropriate, from day one. Even

For five years, captive insurer has helped the company manage risks and handle claims with greater flexibility

when somebody is whispering about a lawsuit," he said.

Legal counsel is particularly important in volatile areas like discrimination, including sexual harassment, wrongful termination and other employment-related areas, he added. "Those risks don't go away because they are not insured. You still have to deal with them and this is a mechanism that allows you to do that."

While greater flexibility in handling claims is one of the positive aspects of forming a captive, there may be less to other commonly cited advantages than meets the eye.

"Direct access to reinsurance. I have heard a lot of comments about how that is such a big selling point," said Mr. Evans. "Frankly, I don't know it's all it's cracked up to be."

Such access is an asset, he said, "but don't lose sight of the fact that you really aren't necessarily changing the vagaries in the in-

surance market. You are merely moving its position, so now you are in the vagaries of the reinsurance market instead of the (primary) market."

Access to reinsurance alone would not convince Sutter Health to form a captive today, Mr. Evans said.

Sutter formed its captive in 1991, when a medical malpractice insurance crisis, capitation agreements and rapid industry change were all reshaping exposures and eroding profit margins.

The captive insurer initially wrote hospital professional liability, miscellaneous errors and omissions liability and automobile coverage.

As for relying on a captive to reduce insurance costs—another commonly cited advantage—he was cautious.

"First off, for those of you who have set up captives, I'm not going to tell you anything new," Mr. Evans said. "Those of you who haven't, don't look for (cost savings) in the first couple of years. It probably is not going to happen."

As in the commercial insurance

business, it takes time to truly realize the possible costs and savings, the risk manager explained. "I can tell you, however, we are very happy with the Sutter captive and it has been very financially successful. But that does not mean it has come without some costs."

When the captive was formed, Sutter's risk management department got more "assertive" about how claims were defined and managed, he explained. But that can initially appear as an increase in claims filed and a mismatch with the capital "pot" set up by actuaries.

"Once you get assertive about dealing with these claims, you find there are a couple of things that go on," he said.

"Your TPA is reserving all these newly defined claims, so it begins to look like something is going on there. Is the pot getting bigger? And what we asserted was, 'It's not getting bigger. It's merely reallocating itself. We are finding out earlier about claims.' What that does to your financial bottom line, I can tell you, the first couple

of years is not fun to deal with," said Mr. Evans.

Delivering that news to upper management is not a pleasant task when promised savings from the program are "not showing up all of a sudden," Mr. Evans explained.

Deriving the maximum advantage from a captive requires a good loss reporting database, he stressed.

"I can assure you, if you don't do that, the losses will ultimately come back and haunt you. Again, you are not all that different from an insurance company just because you are insuring yourself," said Mr. Evans.

"If the losses are there, you are going to have to pay them and be aware of that because that can be a real unpleasant surprise," he said.

No matter how successful the captive, some costs are inescapable.

"If you are not willing to invest up front in good risk management programs, don't buy a captive," the risk manager warned. "A captive insurer is not going to cure a bad loss picture. That is not what it is set up to do and it won't do it for you. So make certain you have good risk management programs in place." **BI**



Product risks call for a new Nissan captive

By ROBERTO CENICEROS

KAILUA KONA, Hawaii—When Nissan North America Inc. decided to self-insure its product liability exposures through a Hawaii captive, it opted to create a new facility rather than expand an existing one.

Significant differences in business objectives, regulatory oversight, profit motives and capitalization all weighed in favor of segregating the risk from its existing captive, which covered extended service agreements sold by Nissan dealers, the company's risk manager said.

"The profit motive for the extended service contract was high. We wanted to make money doing this," explained Dean A. Reynolds, director of risk management, and human resources and administration for Nissan North America in Torrance, Calif.

"For product liability, our profit motive was minimal," he said. "We had no interest in making money off ourselves. It's sort of like if you pay your kids to do laundry or

Extended service coverage has different risks, rewards

chores...you have not really improved your household income."

Mr. Reynolds discussed his company's use of multiple captives during a panel discussion at the 1996 Hawaii Captive Insurance Forum, titled "Do I Need More Than One Captive?" Most questions from the audience, though, focused on how the company's extended warranty captive worked.

Nissan established the product liability captive, Nissan Motor Insurance Corp., in December 1992. The previous year it had set up warranty captive Nissan Motor Casualty Insurance Co.

Mingling the warranty risks with its product liability risks was not an option, Mr. Reynolds said.

"The business are really managed differently," he said. "Product liability is really a corporate managed operation. The extended service contract program is managed as a sales operation. Separation for us means very simplified legal, financial and administrative reporting.

Finally, a combination actually would mean higher cost to us."

Higher costs would result because the two lines have different capital-to-surplus ratios, Mr. Reynolds said.

The captive for extended warranties relies on external sources of premium while insuring external risks. In contrast, the product liability facility relies 100% on internal capitalization, he said.

A captive with external risk requires more capital than a company managing its own risk, Mr. Reynolds said. Mingling of the two exposures would raise the capital requirements for both, not just one, he contended.

Financing was not the only problem, noted Mr. Reynolds; there also are regulatory differences. Auto dealers and ultimately their customers rely on the extended war-

ranty coverage, making it a consumer issue. By contrast, the product liability coverage is there only to protect Nissan's financial exposure.

"This has an interesting angle at least from a regulatory viewpoint," Mr. Reynolds said. "Although this has not been tested because we have never had any problems with it...we always figured if Nissan runs out of money in its product li-

ability program and has to pay its own claims it is still Nissan. So it doesn't have the same level of regulatory concern and oversight that it would if this (warranty) program ran out of money and you have outside customers. You have a real consumer issue. In general, that is why we have a higher capital surplus in the extended service program."

Many audience questions at the

forum focused on how this extended warranty captive worked.

The captive was formed after the automaker decided to offer extended service warranties for non-Nissan used cars its dealers sold.

This essentially amounted to underwriting third-party business, Mr. Reynolds said, but the captive is able to overcome a prohibition against such practices because it is set up as a reinsurer. Additionally, Nissan has an "affiliated" relationship with the auto-dealers.

The extended service warranties are issued by a fronting insurer and reinsured by the captive, which helps Nissan's program qualify under various state license requirements.

Nissan already had a separate self-funded extended service warranty program for its own cars. Combined with the newer program for non-Nissan autos, the company can now provide dealers' customers with one-stop shopping. That has increased Nissan's share of the markets for both new and used car extended-warranties. **BI**



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Captives that turn profits

KAILUA KONA, Hawaii—Third-party business might be a window of opportunity for some captive owners, but the risk of long-tail liabilities can outweigh the returns, one risk manager says.

"If your suppliers and customers really need a type of coverage that they can't get elsewhere I think that is a real positive reason to look at external business," said Pam Rogers, director of risk management for Nestle USA Inc. in Glendale, Calif. "I had that situation once before and I'm looking at that now, where I've got some suppliers who are just having a really difficult time with workers compensation risk and we need those suppliers for our commodities and the corporation may be willing to take on some additional risk. But in general, I'm not too in favor of third-party business. If our corporation wants to diversify its risk portfolio I'm not sure that a captive insurance company writing third-party business is the best way to go about it."

Ms. Rogers participated on a panel, "The Captive as a Profit Center," during the 1996 Hawaii Captive Insurance Forum.

The meeting, sponsored by the Hawaii Captive Insurance Council, was held Jan. 24-26 at the Ritz-Carlton, Mauna Lani on the island of Hawaii.

The date and location of the next forum has not yet been determined. For more information, contact the Hawaii Captive Insurance Council, 808-524-3800.

Court orders fund to pay asbestos claims

PHILADELPHIA—The Pennsylvania Insurance Guaranty Assn. will have to indemnify a bankrupt asbestos manufacturer for each individual claimant lawsuit it submits to the guaranty fund, the 3rd U.S. Circuit Court of Appeals ruled last month.

The PIGA cannot limit the manufacturer's recovery to one claim filed under each of three policies written by its bankrupt insurer, according to a unanimous three-judge opinion that reversed a lower court's finding.

H.K. Porter Co., which made asbestos products from 1958 to 1984, faced claims valued at more than \$590 million when it filed for bankruptcy in 1991.

Porter had liability coverage through three policies issued by the Integrity Insurance Co., which was declared insolvent in 1987. The policies each had limits of \$5 million per occurrence and \$5 million annual aggregate, for a total of \$15 million in coverage.

PIGA then became responsible for paying the claims within its statutory limit of \$300,000 per claim, subject to a \$100 deductible, but refused to do so.

Porter filed suit in February 1993 seeking the full \$15 million, plus legal fees and expenses, and won at the district court level.

On appeal, though, the court ruled that the PGA law provided policyholders with indemnity for each claim raised. The court cited several reasons for its decision, including legislative intent.

The narrow ruling mirrors the outcome Union Carbide Corp. obtained when it sued the Connecticut Insurance Guaranty Assn. over death and injury claims from the 1984 poison gas disaster in Bhopal, India, that killed more than 2,000 people (BI, Feb. 11, 1991), the appeals court said.

PIGA probably won't seek further review of this issue, said Mark Hamilton, an attorney with Zimmer, Kunz P.C. in Pittsburgh.

H.K. Porter Co. Inc. vs. Pennsylvania Insurance Guaranty Assn., 3rd U.S. Circuit Court of Appeals, No. 95-3182.

EBRI study tracks source of health cover

Most U.S. citizens under age 65 receive their health insurance through an employment-based plan, a new study says.

The Employee Benefit Research Institute found that 64% of the 228.1 million Americans under age 65 were covered through an employment-based plan in 1994.

The study also found that 17.3% of the non-elderly had no health insurance in 1994, while 16.3% was covered by public health insurance and the rest had non-employment-based private coverage during 1994.

The findings were based on the tabulations of the federal government's March 1995 Current Population Survey.

Although the survey showed 64% of the non-elderly had employment-based coverage in 1994, compared with 60.8% in 1993, EBRI cautioned that the increase reflected changes in CPS questions and a change in EBRI methodology.

Dallas Salisbury, EBRI's president, said the report underlined three significant facts: the economy has been sufficiently strong to hold insurance coverage relatively stable; the Medicaid program has continued to expand its protection; and the continuing level of those without insurance makes it clear there is still going to be pressure for small-group market reform, portability of benefits and other issues.

For the Record

Train derailment losses partially self-insured

ST. PAUL, Minn.—Insured losses from a Burlington Northern Santa Fe Railroad freight train derailment earlier this month in St. Paul, Minn., will be less than \$25 million and will be at least partially self-insured.

The train derailed Feb. 14 in a rail yard, slamming into six stationary Canadian Pacific Ltd. cars and a tower containing about 25 people, causing nine injuries.

A spokesman for Burlington Northern said total damages are not likely to hit either of its two Bermuda excess liability policies: \$25 million excess of \$25 million from Transportation & Railroads Assurance Co. Ltd.; or \$50 million excess of \$50 million from Railway Assn. Insurance Ltd.

Burlington Northern retains the first \$10 million of each loss, though the spokesman could not give details of its coverage between that level and \$25 million. The railroad's risk management department would not comment.

Tom Parsons, risk manager with Canadian Pacific in Montreal, said "one would expect" Burlington will compensate CP for the damage, "but it's too early to say anything more."

The Burlington Northern train was carrying 89 cars and two locomotives and en route to Galesburg, Ill., from Minneapolis. It derailed in the CP rail yard, struck the CP cars and then propelled those cars into a CP tower. Seven CP rail workers were injured, as were two Burlington crew members.

Sheila Stuckey named next PRIMA president

ARLINGTON, Va.—Sheila Stuckey, risk manager of the New Airport Project Team in Austin, Texas, will be the next president of the Public Risk Management Assn.

The New Airport Project Team is a group of Austin city employees and consultants in charge of building a new Austin-Bergstrom International Airport. Ms. Stuckey previously was the risk manager for the city of Austin.

Ms. Stuckey in June will succeed Abigail Hudgens, risk and benefits manager for the city of Knoxville, Tenn.

Ms. Stuckey is completing a two-year term as vp of PRIMA's Region VI. Ms. Stuckey also has served on numerous PRIMA committees and held every position in the Texas PRIMA chapter, including president.

Ms. Stuckey has a bachelor's degree in chemical engineering; she also holds the Associate in Risk Management and Certified Safety Professional designations.

PRIMA also will install two other new officers at its June conference in Baltimore: Daniel J. Cullen, risk and employee benefits manager for Ann Arbor, Mich., as vp of Region III; and Joey Page, risk manager for Plano, Texas, as vp for Region VI.

Information in brief

Prices of the nation's leading prescription drugs rose 4.6% last year, the National Assn. of Chain Drug Stores reported last month. That was the highest increase in drug prices in three years and nearly twice the general inflation rate for 1995. The association's price index, which tracks 500 top drugs, found prices rose 4.1% in 1994. . . . The board of directors of New York-based **TIG Holdings Inc.** has authorized an additional increase of 1.25 million shares in the company's stock repurchase program. Including this latest

amount, the board has authorized the purchase of 6.3 million shares since March 1994, of which 4.1 million shares have already been bought for a total of \$91 million. . . . Armonk, N.Y.-based **MBIA Inc.**, parent company of financial guaranty insurer **MBIA Insurance Corp.**, has completed the sale of 3.86 million shares of common stock at \$74.375 per share, a total of \$287.1 million. . . . **Partner Reinsurance Co. Ltd.** may repurchase up to \$5 million of the company's stock, the board of di-

rectors announced. Meanwhile, the catastrophe reinsurer has appointed Graham Dimmock as executive vp. Mr. Dimmock was previously managing director of Employers Re International Ltd. in London. . . . **General Re Corp.** will spend up to \$300 million to repurchase company stock as part of a program that began in 1987. Since the start of the program General Re has spent \$1.7 billion repurchasing company stock. . . . The directors of **Hilb, Rogal & Hamilton Co.** have authorized the broker to repurchase up to an additional 1 million shares of its common stock. The company initially authorized a repurchase program of up to 1.9 mil-

lion shares in late 1990, and almost 1.7 million of those shares have been purchased. . . . Financial guarantee reinsurer **Enhance Financial Services Group Inc.**, based in New York, said Swiss Reinsurance Co. has agreed to purchase 1 million of its common shares for \$24.48 a share, or \$24.48 million, which amounts to about 5.6% of Enhance's outstanding shares. . . . The **Council of Insurance Agents and Brokers** has taken charge of the operations of the National Assn. of Casualty & Surety Executives. NACSE's function will be assumed by a new council committee called the Council of Insurance Company Executives. ■



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Managed

Continued from page 3

For their part, doctors are responding to the rise of managed care around the country by supporting "patient protection acts" in Texas (BI, July 24, 1995), Arkansas and other states.

These bills typically would require managed care plans to disclose more information to patients by dropping so-called gag orders and require plans to contract with any doctor willing to meet their conditions.

Eric J. Oxfeld, assistant general counsel at the American Insurance Assn. in Washington, contends that the bills appear to be designed to protect their physicians' livelihoods by making managed care techniques harder to imple-

Calling a New York pilot program managed care 'is like throwing a saddle on a pig and calling it Secretariat.'

ment, rather than to protect patients.

Though the proposals do not directly address medical care under workers comp, "they threaten to make managed care arrangements economically unviable or put such constraints on their use that the ability of comp to piggy back on these arrangements may be in danger," the insurance company lobbyist said.

"It's too early to say whether

the physician protection acts will be effective politically," Mr. Oxfeld said, though he expects insurers and employers will work together to oppose them.

Another problem for managed care plans treating injured workers is extensive state operating and reporting requirements, he said.

The motivation for such rules can be a lack of understanding, a desire to protect workers or even a desire to see the plans fail, he said.

In fact, he said, state officials in New York have created a pilot program for workers comp care that one state official described to Mr. Oxfeld as: "Calling the New York pilot (program) managed care is like throwing a saddle on a pig and calling it Secretariat."

Continuous improvement a goal of work comp system

By MEG FLETCHER

CAMBRIDGE, Mass.—A "continuous improvement" process that includes quantitative performance measurements is needed to replace the historic cycle of crisis-reform-crisis in state workers compensation systems, says the head of the Workers Compensation Research Institute.

At this time, "many states in the public policy arena are in the post-reform glow of success," having improved their workers comp systems considerably, said Executive Director Richard A. Victor, at the WCRI's recent annual issues and research conference.

They have met the challenges of five years ago, when several states shared common problems such as double-digit cost growth, higher medical costs, expanding residual markets and inefficient regulation.

However, it took the combined efforts of state regulators and legislators, governors, insurers and employers to solve those problems by reducing injuries, hastening return to work and cutting costs.

"At the same time, worker representatives have been fighting hard to protect adequate benefits for injured workers, while making some compromises for a more affordable system to protect jobs," Mr. Victor said.

"Today, workers compensation systems look quite different. They look quite healthy by comparison—imperfect but serving the needs of the vast majority of injured workers very well," despite the fact that some states have lower benefits, he said.

In addition, the "single-minded" debate of the past, which focused on price discounts and utilization review, is now more sophisticated, he said. "Today, it is about medical management of disability, access to quality care and management of utilization to find adequate costs and quality of care."

From an employer's perspective, "the outlook for workers comp is very positive," agreed Robert B. Stegert, vp of casualty claims for

Marriott International Inc. in Bethesda, Md. For example, Marriott had an aggregate 30% decrease in workers compensation costs in Georgia, Massachusetts and Oregon between 1992 and 1995 policy years.

"American business has certainly continued to keep the spotlight on costs, but most employers I talk with feel much has been accomplished," Mr. Victor said. As a result, many of those employers are shifting their focus onto other areas. The danger with that, according to Mr. Victor, is that such inattention may allow other interested parties, such as worker representatives, to lobby for and obtain greater benefits, which would increase costs and thereby spawn the historic crisis-reform-crisis cycle again.

"We need to be identifying and measuring what really worked," to sustain that success, he said. It is also necessary to understand how to manage innovation for the future to continue improving, he said.

Benchmarking is one of the key tools to achieving continuous improvement, according to Ann Clayton, director of the Florida's Workers' Compensation Division. She defines that as "the systematic and continuous measurement of system or process outcomes resulting in continuous improvement that leads to superior qualitative performance."

Unfortunately, attempts to improve workers comp system outcomes have involved adopting comparative techniques that rarely lead to continuous improvement, such as seeking to achieve an average or to compete with a neighboring state, she said.

"Performance benchmarking is more than simple comparisons," she said. It requires establishing performance measures, identifying the data needed and establishing a timely and accurate process to collect it, gathering essential data and reviewing baseline data—with team brainstorming—to identify how the organization can use the data to improve its processes, she said.

"If you can't measure it, you can't manage it" is a guiding rule at the Wisconsin Workers' Compensation

Division, said Administrator Gregory C. Krohm.

Wisconsin uses data extensively to help manage its operations, including keeping track of the timeliness of benefit payments to workers.

The state requires that 80% of all lost-time payments be made within 14 days of the last day worked, because "slow payment is a leading cause of litigation," he said. Wisconsin's rate of litigated cases is a relatively low 9%, though he wants to get it down to 6%.

Wisconsin also uses its data to follow up on insurer activities and issues "report cards" to keep them informed about their performance. Insurers take the bad reports seriously, because they like to use good reports as marketing tools, he said.

Data, which can be collected by state workers comp administrators, must be viewed in the context of both time of the event and accident year, suggested Roger J. Thompson, a director with Travelers Insurance Co. in Hartford, Conn.

Elements an insurer typically considers include when the claim report was written, when the employer was notified of the claim and when the first indemnity payment was made. In addition, insurers keep track of average amounts paid to date, case closure rate and the extent of litigation.

However, data collectors also should consider combining benchmark data with medical care information and employee and employer satisfaction with the system, Mr. Thompson said.

Sounding a contrary view was Theresa J. Whitmarsh, chief operating officer of the Washington State Fund. The crisis-reform-crisis cycle has little "to do with good data and a lot to do with politics," she said.

While economists may favor incremental improvement, it is hard to get the attention of a high-profile politician with such a message. "Incremental improvement and politicians just don't go together." She also warned that continuous improvement may make it impossible "to get out of the box" in terms of thinking about problems.

How states handle managed care



Source: Workers Compensation Research Institute

GRAPHIC BY KIM ROME

States setting fees

Medicare-type fee schedules helping more states control work comp costs

By MEG FLETCHER

CAMBRIDGE, Mass.—More states are trying to control workers compensation claims costs by adopting physician fee schedules based on those used by Medicare.

Within the past year or so, Hawaii, Michigan, North Carolina, South Carolina and Washington have adopted schedules based on Medicare's resource-based relative value calculations. Those five states, along with Minnesota, Pennsylvania and West Virginia, bring the total number of states using physician fee schedules to eight.

Other states, including Florida and Ohio, are considering similar schedules, said Philip L. Burstein, an economist with the Workers Compensation Research Institute, earlier this month at the group's annual issues and research conference.

Overall, 40 states use general fee schedules, according to the Cambridge, Mass.-based WCRI.

Tying fee levels to the Medicare levels, though, goes a step further. Medicare's fee limits, which take into account factors such as a doctor's time and training, are designed to better compensate general practitioners for routine care and cut compensation for specialists.

Medicare fees are calculated by first multiplying each of the Medicare-defined "relative value units" for different types of physician services, for different types of practices and for malpractice insurance costs by a number designed to account for regional cost variations. Then the three resulting figures are added together and multiplied by a number set by law.

The RBRVS approach offers several advantages, including flexibility, lower administrative cost and price incentives for cost-effective, quality care, the WCRI's Mr. Burstein said.

But savings can be elusive. Medicare has estimated that up to 50% of price reductions may be offset by providers changing their billing and practice patterns by, for example, increasing the number of times a service is rendered.

The eight states using Medicare-based fees for doctors treating injured workers calculate the fees in various ways. Some states have tried to soften the impact on specialists.

In all cases, though, the states pay a multiple of the Medicare rates—a "conversion factor" in the parlance of the Medicare program—ranging from 110% in Hawaii to 160% in North Carolina and South Carolina.

In Pennsylvania, the first state to adopt Medicare-based fees, the figure is 113%. That state's adoption of Medicare-based rates is considered the primary reason behind a 6.7% premium reduction that saved businesses an estimated \$300 million per year (BI, Nov. 15, 1993).

"There is absolutely nothing that requires that the fees stay low," Mr. Burstein emphasized.

Setting fees even 25% above Medicare levels would cut fees in 28 states from 3% to 42%, the WCRI estimates.

North Carolina "decided to go to RBRVS because of inconsistencies in what they (doctors) charge," said J. Randolph Ward, commissioner of the North Carolina Industrial Commission in Raleigh.

Some doctors' charges were too high, while others were too low, he said.

The state set fees well above Medicare rates because officials were concerned about depriving injured workers of access to quality care, he said.

Minnesota took a unique approach to adopting an RBRVS schedule, which included the politically sensitive step of decreasing reimbursement to specialists like surgeons, said Kate Kimpan, director of the research and education unit at the Minnesota Department of Labor and Industry.

No data is available, though, about whether Minnesota's approach actually leads to fewer surgeries, said Ms. Kimpan, who also is the WCRI's first visiting fellow.

Work comp crisis keeps eyebrows raised

CAMBRIDGE, Mass.—The workers compensation crisis may have passed in most states, but interest is still high in research by the Workers Compensation Research Institute.

About 260 people gathered in Cambridge at the WCRI's annual issues conference, Feb. 13 and 14, to hear researchers discuss a variety of topics, including benchmarking

goals, managed care and medical fee schedules.

The organization, founded in 1983, is an independent, not-for-profit research organization providing sophisticated, objective information about public policy issues involving workers comp systems.

The WCRI does not take positions on the issues; instead seeking to pro-

vide data and analysis to policymakers. Its recent work has focused on effective ways to control medical costs, reduce litigation, streamline administration and ensure adequate and equitable benefits and return-to-work incentives.

The WCRI can be reached at 101 Main St., Cambridge, Mass., 02142; 617-494-1240.

Better products on demand

By Richard M. Inserra

THE RISK FINANCING NEEDS of large companies will lead to a radical transformation of the services and products offered by the traditional insurance market in the next few years. Corporations will lead by adopting a strategic risk financing mindset, pushing the markets to respond to their risk financing needs, and implementing cutting-edge programs.

Due to the complexity of this strategic risk financing frontier and the pressure to operate with lean staffs, companies may utilize the expertise of innovative advisers and markets. The traditional tools and mindsets of the insurance broker and underwriter are rarely able to help.

Union Carbide recently implemented an integrated risk financing program that more efficiently finances a significant portion of its liability and property risks.

When I came to Union Carbide in 1991, its business was undergoing a significant reorganization. Union Carbide, like other large companies, was playing the traditional insurance game. We bought as much insurance as we considered prudent at the available market price, while insurers tried to sell as little insurance as possible at the highest price. Eventually, it became clear that this approach was adding little value.

With the company intent on reducing all costs, it was quite a challenge to find a new financing approach that would reduce our cost of risk. Thinking "outside the box" was essential since the traditional insurance game could not produce the cost cuts we wanted. I sought advice from brokers, insurers and other risk managers. Ultimately, a specialized operation consisting of professionals in risk modeling, finance, accounting, tax, insurance and program negotiation helped bring our vision to reality.

Union Carbide discovers what may be a better way to finance and integrate risks

About two years ago, Union Carbide's chief financial officer, treasurer and I began examining new concepts and tools designed to help large companies better manage fortuitous risk. We started reviewing the benefits of finite insurance.

In retrospect, we were actually using finite insurance to describe a new financial orientation to manage risk. We examined capital market concepts, such as portfolio theory—a sophisticated approach that lets investors classify, estimate and control both the amount and the kind of expected risk and return—as a practical means to improve the efficiency and realize the benefits of insuring hazard risks.

We also investigated how optimal layers of more than one type of risk created portfolio efficiencies—achieved by blending various property, liability, business interruption and boiler and machinery risks and determining what the probability was of a loss across the different insured layers—and how these efficiencies were enhanced over time. While our first discussions may have been theoretical in nature, the program Union Carbide ultimately implemented actually reflects these portfolio efficiencies.

Probably the most important message from initial discussions was the need for a change in mindset. Union Carbide needed to stop buying insurance and start selling its risks. That may seem like a simple change, but it creates new challenges for risk managers. What risks should be sold? What are the optimal layers of risks? If I sell the risks as a package can I get more in return? For how long should I sell the

risks? What should I seek from the buyer of the risks? What is the buyer of the risks providing? Is it an insurance policy or access to capital? What about risks other than hazard risks?

Union Carbide hired Alexander Capital Consultants, a division of Alexander & Alexander Services Inc., to thoroughly analyze our risk profile and recommend a financing program to meet the company's objectives, one of which was to reduce our cost of risk in anticipation of favorable experience. Losses were analyzed and financial impacts associated with aggregate loss scenarios were examined. The results were put into the context of probability. The analysis focused on the quantification and realization of the portfolio benefits discussed in our initial meetings.

We ended up with a written report summarizing the analytical work and observations regarding practical market reactions as well as an outline of the accounting and tax issues that Union Carbide would need to address. A strategy was presented to the company's CFO, its treasurer, and its accounting, legal and tax departments. Theory was translated into a practical approach.

We approached three markets about implementing the approach: Swiss Reinsurance Co.; Centre Reinsurance Holdings (Bermuda) Ltd./Zurich Insurance Group; and American International Group Inc.

Our strategy, selling risk, made the process vastly different than most insurance marketing. Union Carbide knew what layers of risk it wanted to sell. We knew the risk trade-offs of retaining risk, as opposed to selling more risk, and we also knew the potential portfolio benefits that should be provided by the markets. Of equal importance was our decision regarding the amount of capital (i.e., insurance limits)

See *Financing on next page*

ASK A BENEFIT MANAGER

Educating workers on retirement should be a priority in 1996

Q

What do you think is one of the key issues facing benefit managers in 1996? What should we be focusing on and what should we be concerned about?

A

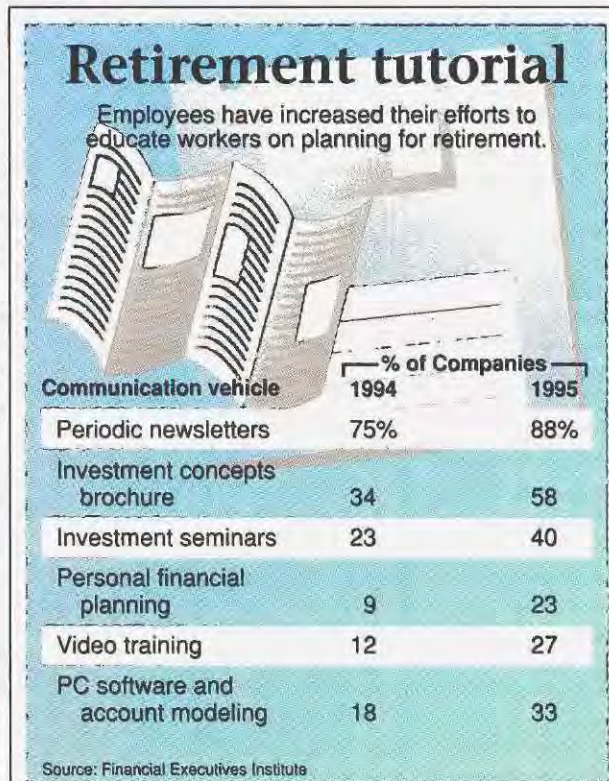
Just like any other year, I believe we face many challenges and opportunities in 1996. The area of retirement plans will provide its own challenges and opportunities. 1995 was a phenomenal year for the stock market with run-of-the-mill S&P 500 Index funds achieving returns of 37.5%. I

am not a financial expert, but I am willing to predict that 1996 will not produce similar rates of return. The potential event that I am concerned about from the perspective of a defined contribution plan sponsor is a stock market correction. And even more important than a stock market correction, I am concerned about defined contribution plan participants' reaction to a market correction. What I have seen in the past in defined contribution plans is employees transferring out of equity funds when the stock market drops. This scenario identifies the need for defined contribution plan participant financial education.

As 401(k) plan participant account balances grow and as 401(k) plans increasingly become employees' primary retirement plan—35% of employers in a recent Hewitt Associates L.L.C. survey indicated that their 401(k) plan was their "primary" retirement plan—there is a growing need for financial and

retirement planning education.

A survey conducted by the Financial Executives Institute's Committee on Investment of Employee Benefit Assets shows the increasing efforts being taken by their members in educating their employees. Shown below is a summary of the survey results that compares the percent of companies' use of various educational/communication vehicles during the past two years:



GRAPHIC BY JOHN HALL

This same committee developed a list of six basic topics that every education program should make sure its participants understand. These include:

- The importance of saving for retirement.
- The advantages of defined contribution plan participation.
- Goal setting before and during retirement.
- Asset allocation.
- Managing risk and return.
- Understanding the objectives and characteristics of defined contribution plan investment options.

If our plan participants understand these concepts, we will all feel a great deal better about how our plan participants invest in our plans.

Financial and retirement planning education can come from many sources and at varying costs. With many plans switching to mutual funds, the mutual funds provide a lot of information at little or no cost.

Most of the mutual funds provide newsletters, usually at no cost, to their investors. Some provide additional financial educational information, including booklets, brochures and videos.

Many of the mutual funds and many other organizations offer PC-based software for financial and retirement planning. The main focus of a great deal of the available software is demonstrating the potential gap that may exist between desired retirement income and one's potential retirement income at current saving rates. Much of this software also helps individuals understand his or her risk characteristics related to their investments. I personally endorse the use of this type of software, since it is a "hands-on" opportunity for individuals and it brings their situation "to life." With increased use of PCs in the work environment and at home, the use of PC-based software is reasonable and usually

See *Key issue on next page*

Financing

Continued from previous page
required to financially manage adverse results.

Did we share this knowledge with the markets? No. We only gave them the coverage and loss information data we analyzed and a description of the structure we wanted to implement. Two of the three markets responded within the parameters developed in our technical study. In addition, these two insurers, Swiss Re and Centre Re/Zurich also contributed their own creative approaches, some of which were included in the next round of negotiations.

Even considering the twists suggested by the markets, we were able to quantify the financial impacts of various structures and compare those alternatives to the features in the original design. The process was dynamic, with all of the parties trying to address our objectives.

At the end of the day, both Swiss Re and Centre Re/Zurich provided acceptable programs. For a number of reasons, Union Carbide decided to proceed with Swiss Re.

It would be inappropriate to describe the details of the program, but it is important to highlight its major aspects.

The three-year agreement with Swiss Re provides reinsurance to Union Carbide's Bermuda insurance subsidiary—Westbridge Insurance Ltd. It covers property, business interruption, boiler and machinery, related consequential loss as well as general liability. Because of the multi-line and multi-year aspects of the

program, the pricing took into account the portfolio benefits across coverages and time and returned those benefits to Union Carbide.

Swiss Re provided net third-party capital (including reinstatement options) in excess of \$150 million without the need for costly and unpredictable reinsurance. Union Carbide will pay, in cash, premiums comparable to those paid to the conventional markets.

If the integrated program is loss free after the initial three years, Union Carbide is to receive future potential

With Union Carbide's risk dynamics and the pricing efficiencies, it was an approach that couldn't be ignored.

value of up to three-fourths of what it would have been paying into the conventional market.

If loss experience is poor, Union Carbide will pay about one-fourth more than it paid to the conventional market.

The integrated program has total limits of \$200 million, or \$25 million per property or liability loss, or \$50 million for a combined property and liability loss.

In effect, the program provides for up to four combined property/liability losses or eight property or liability losses over the three-year period.

Based on our underlying risk profile, Union Carbide

has about a 75% chance of "winning" and only a 25% chance of "losing" (i.e., incurring higher costs) under this program. With our risk dynamics and the pricing efficiencies, it was a risk financing approach that couldn't be ignored.

The program is a practical manifestation of our belief in the concept of strategic risk financing. And while there are still a number of market participants saying that this is not new or that they did something similar 20 years ago, that's like saying that a 1975 car is the same as a 1995 car. The risk and financial quantification concepts and tools that exist today have and will continue to radically change the risk financing frontier.

Is this the end? Absolutely not. In the future, I see this program covering new exposures and expanding into financial market risks. This should be a natural progression.

If we used financial market theories to improve the efficiency of hazard risk management, then it seems clear that this same approach can be used to combine interest rate, foreign exchange and hazard risks. Our shareholders deserve nothing less. **BI**



Richard M. Inserra is assistant treasurer of Union Carbide Corp. in Danbury, Conn.

Key issue

Continued from previous page
well received.

One of the most effective approaches to education are formal training programs that include spouses. Education of both the employee and spouse brings a teaming approach to financial and retirement planning. The combination of the "in class" program with PC-based software mentioned above is ideal. The participant can learn concepts in the classroom and has the opportunity to apply many of the concepts in the software. Also, the software is dynamic and can be modified as events change.

The bottom line in education is to do education on an ongoing basis. It appears that our tendency is to use the rifle approach, that is, for a single, one-time education/communication campaign and do little or nothing afterward. That one large dose of education

One of the most effective approaches to education is a formal training program that includes spouses.

may be needed, but continuing, ongoing communication is absolutely necessary.

From the legal perspective, we should feel somewhat better about our education and communication regarding our retirement plans and financial and retirement planning education. The reason for this is the Department of Labor interpretive bulletin regarding education materials. This bulletin provides guidance to retirement plans where employees are responsible for investment elections.

The bulletin essentially addresses the question: Where is the line between investment "education" and investment "advice" that could subject a plan provider to fiduciary liability with regard to a participant's investment decisions? This bulletin does not provide a clear-cut test for distinguishing between education and advice but instead gives four safe harbors of the types of information that generally will not be considered investment advice under ERISA's fiduciary rules. The four safe harbors provided in the bulletin are plan information, general financial and

investment education, asset allocation models and interactive investment materials. Prior to this bulletin, many employers were most concerned about the asset allocation models. Employers can now feel better about giving employees asset allocation models.

A side note related to this bulletin is the applicability of ERISA Section 404(c), which establishes circumstances under which a plan sponsor will not be subject to certain fiduciary liabilities because a participant has exercised independent control over the assets in their individual account. The bulletin does state that Section 404(c) relief is not dependent on a plan sponsor offering or providing investment advice. The bulletin further stated that the bulletin should not be used to draw conclusions on Section 404(c) issues. The marketplace for record keeping and investment services for 401(k) plans is extremely competitive. Providers of service are aggressively seeking business in this area. As vendors attempt to distinguish themselves, we can expect innovations in services. Vendors are moving toward providing more interactive, online services for participant account management and education.

Some innovations include Fidelity's introduction of a "voice recognition" system on its automated voice response system. This will eliminate the need for a touch-tone phone. Fidelity opened its World Wide Web site last February where it offered information on its retail investment services. In June, it introduced its new Workplace Savings service on America Online to provide personal investment planning services to 401(k) and 403(b) plan participants. In September, Fidelity introduced interactive retirement worksheets to assist participants in determining items such as asset allocation mixes. Users can also download mutual fund prospectuses and view graphics on mutual fund performance.

Other organizations have and are developing such capabilities on the Internet, including transactional capabilities. Efforts are being focused on developing security measures on the Internet to avoid security breaches. The Internet will continue to be developed and will offer increasing opportunities for investment education.

As our employees become increasingly computer-oriented, there will be increased demand for computer-oriented use and communication. While it may be somewhat early for some organizations to use the Internet as a communication vehicle, this is an area we should be exploring for use for employees.

We will all benefit by having a better-educated workforce regarding financial and retirement planning.

The more efficient and effective investment of 401(k) plan assets should result in larger account balances available at retirement. With a carefully structured goal, employees will feel much more comfortable and satisfied with their futures. Organizations will avoid the pressure for improved or increased benefits to help employees to retire. We will also avoid having employees work longer than they intended if they have adequate funds to retire.

The Internet will continue to be developed and will offer increasing opportunities for investment education.

Financial and retirement planning is a "win-win" situation for employers and employees.

Material in this article does not constitute accounting, tax, investment, legal or business advice. You should review your specific situation with professional advisers. **BI**

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

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

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



Mr. Nirtaut

Oregon

Continued from page 2

To be considered for the grants, "the problem has to be an industry-wide problem; it cannot be limited to a specific worksite," explained David Onheiber, lead re-employment consultant for the Workers Comp Division in Salem.

Once a proposed solution for repetitive motion injuries has been approved and developed, an additional \$100,000 will be available to actually purchase needed equipment and implement the proposal.

But employers needn't bother applying for the grants in hopes of winning funds for ergonomic programs or equipment that already exist.

"We really want to encourage innovation and the creation of new solutions," said Mr. Onheiber.

Woodfold-Marco's Mr. Emerick

would like to use grant money to fund the invention of an automated aid for its hinge-attachment process. Currently, employees stand at worksites manually pressing vinyl hinges into grooves running along the length of the accordion-like folding doors.

The company has been reluctant to allocate its capital to develop an automated process that may or may not work.

"We don't want to put money into it until we see something that works and nobody wants to put work into it unless they are getting paid," Mr. Emerick said.

The state appears more willing to take such risks. However, all research—including failures—must be available for other employers in the state to evaluate.

Mr. Emerick is currently investigating how he will meet the criteria that the proposed solution must be applicable to an entire in-

'We don't want to put money into it until we see something that works,' says Kevin Emerick.

dustry. While accordion-door manufacturers are rare, he is exploring whether other wood product companies—such as furniture manufacturers—might also benefit from his company's solution.

Applications must be submitted to the Workers Compensation Division by March 29. Application is limited to Oregon employers, but that includes any company that has employees who are subject to the state's workers comp laws. Self-insured companies are also eligible.

A group of employers with the same problem can jointly apply for a grant, Mr. Onheiber said.

Companies must also provide data showing they have a history of attempting to help injured workers return to work, which is a key focus of other department efforts.

In addition, recipients of grants for research and development also must put up their own funds in an amount equaling 10% of the research project. In addition, winners of the subsequent "product grant" must contribute an amount based on a sliding scale equal to 5% to 50% of the cost of implementation, depending on employer size, Mr. Onheiber said.

Information and grant application packages can be obtained by contacting the Worker's Compensation Division's Benefits Section Re-employment Assistance Unit at 503-945-7585. **BI**

Quality efforts paying off for design firms

Liability costs are up to 33% lower

By MICHAEL SCHACHNER

Architectural and engineering design firms, because they operate on ultrathin margins, must aggressively pursue all risk management strategies to control professional liability losses, says a new study.

Large U.S. design firms that employ total quality management programs have professional liability costs that are nearly one-third lower than similar organizations without them, Johnson & Higgins found.

Its survey of 200 architectural and engineering firms also found that those with full risk management and legal staffs have professional liability costs 23% lower than those that do not. Other ways to reduce losses include using alternative dispute resolution and entering into construction contracts that require the service buyer to share responsibility for preventing losses.

Companies that engage in "TQM"—which generally entails a formal program in which people, time and money are dedicated to ensuring quality—get results, the survey said.

About 60% of design firms have TQM programs, including 93% of those with annual revenues greater than \$250 million. Conversely, only 55% of smaller firms do.

David Collings, a vp in J&H's construction group in Atlanta, said TQM generally begins with an evaluation of customer perceptions of service and the appointment of a leader within the company who is responsible for quality, including client relations and workforce evaluation.

"Clearly, firms involved in TQM and other risk management initiatives are getting payback. However, many have yet to pursue aggressively all the risk management strategies that could yield even greater savings," said Mr. Collings.

He emphasized the importance of ADR and "partnering" between the contractor and the service buyer on loss prevention.

"By nature, design firms have thin margins and not a lot of capital to absorb losses. While they need to avoid betting the farm on one project, they almost have to, so management of risk must be interwoven into what they do. And, ADR and partnering should be pushed for in all contracts," said Mr. Collings.

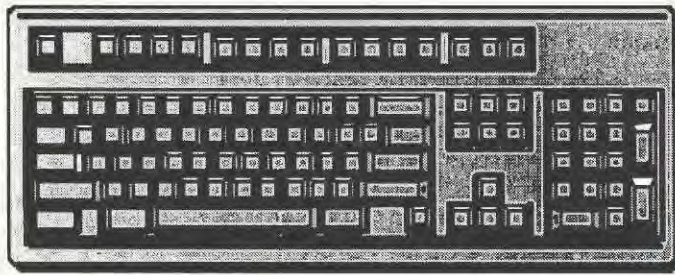
The survey finds that design firms need to protect themselves as much as possible from losses because professional liability claims are rare—an average of 2.48 per firm per year—but expensive—\$643,000 each on average, including defense costs.

Of note, architects and engineers actually pay more on average to defend a claim than to settle it: \$137,000 for defense vs. \$122,000.

The survey also found that total professional liability costs for firms without total quality programs averaged 1.16% of revenues compared to 0.8% for those with them.

Large companies are more likely to require other parties to share responsibility for loss prevention, according to the study. Nearly 20% of the largest firms do so on all contracts.

Copies of the survey are available to design firms only by calling David Collings at Johnson & Higgins in Atlanta at 404-586-8327.



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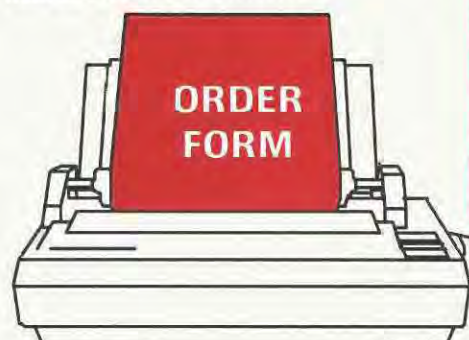
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Trim fat for healthy Equitas

Lloyd's must cut expenses to ensure its survival, analysts say

By SARAH GODDARD

LONDON—If Lloyd's doesn't take some basic cost-cutting steps to lower its operating expenses, Equitas—the market's proposed runoff reinsurer—may be in jeopardy before it ever gets off the ground, warns syndicate analyst Chatset Ltd.

"Lloyd's needs a much more aggressive attitude to employment," said analyst John Rew. "Costs must be cut." About half of the Equitas premium is earmarked for the future running of the reinsurer, a large part of which is to cover employment expenses. This is "too big a provision," according to Mr. Rew.

He contends that staff numbers should be cut by about 50% to 75%, which would save between £500 million (\$775 million) and £600 million (\$930 million). The Lloyd's community in general "do pay themselves terribly well and have a high head count," said Mr. Rew.

Lloyd's financial woes are reducing confidence in the institution, said Charles Sturge, also a Chatset analyst. Insurance buyers—particularly from the United States—are concerned about Lloyd's security, and Mr. Sturge cited anecdotal evidence of insurance buyers instructing their brokers to reduce the involvement of Lloyd's syndicates in their programs.

A direct result has been lower capacity utilization in 1994 and 1995. Mr. Sturge anticipates that only about 50% of Lloyd's 1995 stamp capacity of £10 billion (\$15.5 billion) will be used by the

time the year closes in 1998, although Chatset is predicting that the year will still show profits of around £890 million (\$1.4 billion).

However, Chatset says the overall profit figure, which takes in to account the amounts Lloyd's members will pay in the special levy for the establishment of Equitas and members' personal expenses, may be optimistic. Investment income may well be down for both the 1994 and 1995 underwriting years, lowering the amount of profits. Chatset is predicting that 1994 will show a profit of about £1 billion (\$1.55 billion).

'Lloyd's needs a much more aggressive attitude to employment,' says John Rew.

Mr. Rew explained that only half of Lloyd's £20 billion (\$31 billion) in funds can be invested—the rest is accounted for by debtors like syndicates, brokers and names. In 1994, Lloyd's investments produced £282 million (\$437.1 million) in investment income, said Mr. Rew. And investment income is going to be well under the expense levels projected for Equitas Ltd., the proposed reinsurance vehicle for the market's pre-1993 liabilities.

Even the savings from cutting staff would still leave the settlement fund about £500 million short of the amount it needs for the market's recovery plan to succeed, Mr. Sturge estimated. The minimum required on top of the £2.8 billion (\$4.34 billion) currently on offer is £1 billion, he said.

That money could come from three sources, he said: £350 million (\$542.5 million) more from managing agents; £350 million from brokers; and £300 million (\$465 million) more from errors and omissions underwriters.

The high profits due to come into Lloyd's over the next three years, including £1 billion for 1993, will result in profit commission to managing agents between 12.5% and 15%—about £600 million. In light of that, said Mr. Sturge, the current proposed contribution of managing agents to the R&R plan is "totally inadequate."

Mr. Rew agreed, adding that names are going to see little—if any—of the profits from 1993 to 1995 underwriting, since it is being swept up into Equitas and used to pay things like deferred cash calls. "So why should agents take profit commission?" he asked.

The analysts' feeling about brokers is that they should be contributing, at least from a moral standpoint, "although the prospects are not too good," admitted Mr. Sturge.

E&O underwriters should increase their contribution to more than £1 billion to reflect their lack of success

See Chatset on next page

Legal aftershocks from 1989 quake

City appeals coverage ruling

By KATE TILLEY

SYDNEY, Australia—In the latest chapter of a dispute dating back to Australia's 1989 Newcastle earthquake, the Newcastle City Council plans to appeal to Australia's highest court to force its insurer to pay millions of dollars in claims.

The council will seek permission to appeal to the High Court of Australia a Feb. 2 New South Wales Appeal Court ruling that the council's insurer at the time, Sydney-based GIO General Ltd., is not liable for claims from people injured when city-approved buildings collapsed during the quake.

Reversing decisions by the New South Wales Supreme Court, the appeals court found that the claims related to professional liability, not public liability, and were not made within the policy period.

The court also found that Australia's Insurance Contracts Act of 1984—which prevents an insurer from denying claims on late notification alone, providing it was notified "as soon as was reasonably practical after the insured became aware of the facts"—did not apply to a dispute over whether a claim was filed within the proper policy period.

Greg Heys, Newcastle's lord mayor, said the council decided to appeal because it felt the appeals court did not follow previous interpretations of the act.

GIO had appealed two prior decisions that found it liable for property and business interruption claims arising from damage to the Newcastle Workers' Club (BI, May 22, 1995).

A part of the club's roof collapsed in the Dec. 28, 1989, quake, resulting in 12 deaths. The club originally sought \$67 million Australian (\$50.5 million at current exchange rate) in property damage and business interruption costs.

The council last year agreed to settle for \$8.5 million Australian (\$6.4 million) claims from the club, but the payment has not yet been made by its insurer. Interest is expected to bring the sum to \$9.6 million Australian (\$7.2 million).

The council sought indemnity under its public liability policy, which had a \$20 million Australian (\$15 million) limit for public and product liability and \$10 million Australian (\$7.5 million) limit for professional liability. GIO argued that the claim was a professional indemnity claim and notice was not given within the required time frame.

Under the policy, public liability was written on an occurrence basis, while professional indemnity coverage was on a claims-made basis, meaning the insurer had to be notified within the policy period—which ended on Dec. 31, 1989—or within a reasonable time after the expiration of the policy. The appeal's court ruled that the activities of the council, in approving buildings, was professional in nature and fell under its professional indemnity coverage.

The council argued it had notified the insurer by faxing to the GIO a copy of a July 1990 press clipping in which a barrister had said at an inquiry into the deaths that the council may be partly responsible by authorizing unsafe additions to the club.

Mr. Heys said it was "totally unreasonable" of GIO to "walk away" from the council's claim and contended the council was entitled to indemnity under the insurance policy.

Kevin Kinsella, GIO manager-commercial insurances, said the insurer "stands by the umpire's decision" and that the appeals court decision vindicated GIO's argument.

Mr. Kinsella said the appellate decision considered, among other issues, whether the insurer had been notified of a professional indemnity claim within the required time frame.

Judge Michael Kirby, one of the three appeal judges, wrote that the policy was "an orthodox claims-made policy." He said that type of policy favored the insurer but said that was "reflected in the premiums fixed and paid."

While Australia's Parliament may want to change the Insurance Contracts Act to allow such policies to extend to circumstances like those of the Newcastle City Council, it would have "significant implications for reinsurance" and reduce the availability of such cover in the Australian insurance market, Judge Kirby wrote for the court in a 22-page judgment.

But, Kevin Gibbons, an attorney with Sydney law firm Phillips Fox, which represents the Newcastle

See Quake on next page

Spill worsens as rescue delayed

Cargo and hull losses and pollution damage covered by insurance

By EDWIN UNSWORTH

MILFORD HAVEN, Wales—Insurers are still trying to assess their exposure to claims from the grounding of an oil tanker off the Welsh coast earlier this month, though its condition worsened during the week it remained on the rocks.

Which underwriter or self-insured entity will bear the brunt of the insurance claims depends on the extent of damage to the vessel and the amount of cargo lost, as well as the pollution damage caused by the spilled oil. None of these factors could be clearly ascertained last week, though rescuers last Wednesday finally managed to refloat the Sea Empress and move her alongside a jetty where her remaining oil cargo could be transferred to other vessels.

Since the tanker ran aground Feb. 15, hopes of bringing it into port to offload its cargo of 38.2 million gallons of North Sea crude oil were successively raised and dashed as a result of continued bad weather conditions.

A spokesman for the Joint Response Centre at Milford Haven, which represents all parties involved in the pollution control and rescue effort, said that by the time the Sea Empress had been moved to the jetty, about 19.1 million gallons of oil, or half her original cargo, had been spilled. The rest of the cargo was due to be offloaded to other vessels last Friday.

The long rescue effort created uncertainties for insurers as the extent of damage to the supertanker and cargo leakage of crude oil worsened each day. At various times since the Feb. 15 grounding, the 3-year-old vessel has been refloated, but bad weather conditions prevented it from being towed or offloaded.

White Plains, N.Y.-based Texaco Inc.,



After running aground on Feb. 15, the tanker Sea Empress leaked about 19.1 million gallons of North Sea crude oil off of the Welsh coast before being refloated last week and slated to offload the remainder of its cargo.

which owns the cargo of crude oil, self-insures its cargo exposures through its Bermuda-based captive insurance company, Heddington Insurance Ltd.

The Sea Empress is owned by Alegrete Shipping Co., which is a unit of Norwegian-owned Seatankers but operated by Glasgow, Scotland-based Acomarit U.K. Ltd.

Liability coverage for Seatankers is placed with Assuranceforeningen Skuld, an Oslo, Norway-based protection and indemnity club, which provides limits of around \$15 million.

Under the 1969 Civil Liability Convention, in which the United Kingdom participates, the shipowner's liability for pollution damage will be less onerous than if the accident had occurred in U.S. waters.

After the shipowner's insurer pays the first \$15 million of liability costs, up to 60 million Special Drawing Rights (\$88.2 million), would be paid by the International Oil Pollution Compensation Fund. The IOPCF, which is administered by the International Maritime Organization, an arm of the United Nations, is funded by contributions from oil companies linked

to the volumes of oil received by sea.

If liability costs exceed what is available from these two sources then a smaller contribution could be made from the Contract Regarding a Supplement to Tanker Liability for Oil Pollution Fund, or Cristal. This is a voluntary fund to which oil companies contribute.

In contrast to the limited liability exposure in the case of the Sea Empress, Exxon Corp. was ordered by a jury to pay \$5 billion in punitive damages to about 15,000 plaintiffs following the 1989 Exxon Valdez spill. That accident, in Alaska's Prince William Sound, involved less oil spilled than by the Sea Empress, or nearly 11 million gallons.

Another Norwegian insurer, UNI Storebrand A/S, led the shipowner's \$30 million coverage for the Sea Empress' hull and machinery. It has a 30% share of the coverage, with the London insurance market providing 19% of the risk, and other markets providing smaller amounts.

By the time the Sea Empress was moved to a jetty last week, oil had begun to pollute beaches as well as wildlife and bird reserves on two nearby islands. BI

Report

Continued from page 3

grafting than those in Grand Junction, Colo.

In many cases, Dartmouth researchers could find no obvious reason for the disparities, especially for cities near each other. In a previous study cited in the Dartmouth report, for instance, Boston doctors were found to be much more likely to hospitalize patients than physicians in New Haven, Conn., despite the closeness of the areas demographically and geographically. Per capita hospital expenditure for acute care for Boston patients was twice as much as in New Haven, the study found.

Whether a doctor chooses to admit a patient or treat a condition outside the hospital often depends on the locality's hospital capacity, the report found. In other words, in cities where large numbers of hospital

beds are available, physicians tend to use discretionary cases to fill them—a result of ingrained, often subtle practices that have developed over time. In the case of Boston and New Haven, Boston had 11 acute care hospitals while New Haven had two, the report noted.

Admitting practices were especially variable for conditions such as pneumonia, chronic obstructive heart disease, gastroenteritis and congestive heart failure.

The report found little evidence, however, that communities with more medical resources, greater health care expenditures and more inpatient care have lower mortality rates.

An implication for business, according to Dr. Fisher, is that patients need to participate more vigorously in their treatment decisions and their employers must help them become smarter health care consumers.

No one is better able to choose

among treatment options than the patient, he said, because scant consensus often exists on what the "best" treatment is. Conditions for which more than one treatment option often exists include arthritis of the hip and knee, cataracts, gallstones, herniated discs and menopausal symptoms, the report said.

"Right now, many health plans manage utilization by utilization review, but that's just as flawed as letting the physician do it," Dr. Fisher said. And to put medical decisions in the hands of "a nurse at the end of a telephone" is even worse, he said.

What is needed is a radical change in the patient/doctor relationship in which the patient and doctor share informed treatment decisions, Dr. Fisher said. This can come only through giving patients objective information, possibly through videotapes or videodiscs that clearly explain alternatives. Such materials can be made available by doctors or

employee benefit departments, which need not be concerned about becoming liable for giving medical advice, he said.

"I think it clears up liability," he said. "It shifts liability from the (health) plan and assures patient decision-making."

Benefit managers also will find the Dartmouth atlas useful in working within business health coalitions, Dr. Fisher said. By using the atlas to benchmark cities' level of health resources, companies will be able to persuade hospitals to reduce excess capacity and, if Dartmouth's research is correct, hospitalization rates as a result.

Copies of the Dartmouth study, "The Dartmouth Atlas of Health Care," may be obtained from its publisher, the American Hospital Assn., by calling 800-242-2626. The price is \$295 for AHA members and \$350 for others. It will be available April 1.

UFG

Continued from page 1

kerage was privately held by its top officers until 1992, when it became a public company in a merger with Chippewa Resources Corp., an oil and gas concern. Renamed UFG, the company divested the energy assets and continued the brokerage business of B.R.I. with the former B.R.I. partners as top officers and major shareholders (BI, Sept. 27, 1993).

The firm had long been battling financial troubles, which came to a head last year with Mr. Matfus' suicide and allegations that UFG had defrauded Lake Success, N.Y.-based CPF Premium Funding Inc. of about \$5 million by submitting phony premium finance applications in the names of clients (BI, July 24, 1995).

UFG International filed for bankruptcy protection last August and its parent company followed suit on Dec. 11 (BI, Aug. 28, 1995).

In the December filing, Mr. Ferrarini estimated UFG's assets at \$6.9 million and its liabilities at \$15.6 million, saying he could only estimate because the FBI had seized most of UFG's records last August.

Court appointed trustees for both companies have waived attorney/client privilege to allow a lawyer now working for the UFG International estate to testify before a federal grand jury investigating the firm.

Federal criminal charges filed in January allege that Mr. Bailine conspired with other UFG officials to:

- Embezzle returned premiums owed to UFG clients and additional premiums collected from clients and owed to insurers.
- Embezzle funds deposited by clients to cover claims under self-insured retention programs administered by UFG.
- Embezzle up to \$350,000 collected from policyholders and owed to a now-defunct Lloyd's broker.
- Defraud premium finance companies, including CPF Premium Funding, by forging client signatures on premium finance applications and pocketing the loan proceeds.
- Create bogus accounting records to cover up the alleged fraud, including two sets of books, one showing UFG's true accounts payable and one with false entries to be used in preparing UFG's publicly filed financial statements.

One aim of the alleged conspiracy was to conceal UFG's poor financial condition from stock market investors, prosecutors charge.

After going public in 1992, UFG in 1994 raised about \$4 million in a private placement of preferred stock and warrants. Charging they were misled about UFG finances, shareholders sued the company and its top officers last year.

The American Stock Exchange suspended trading of UFG stock last spring and delisted it in August. **BI**

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ADVERTISER INDEX

Issue of February 26

ADVERTISER	PAGE #
AIG Corporate	5
Burnham Systems	19
Business Insurance	7,12,16,20
Carvill America, Inc.	4
Goldman Sachs Investment	11
Keycorp Management	9
Reliance National	24
Underwriters Safety & Claims	6

Lessons

Continued from page 2

erage strategists drew from their environmental experience when describing winning—or, in some cases, losing—tactics.

History also is repeating itself in that the insurance industry is responding to coverage requests for newly emerging torts in much the same way it did to claims for asbestos and environmental coverage, most speakers at the Mealey's conference concluded.

"As business gets hit by new liabilities, it looks to its liability insurers," to which it thought it had transferred many of these risks, said Robert Chesler, a policyholder attorney with Lowenstein, Sandler, Kohl, Fisher & Boylan in Roseland, N.J., who served as the conference chairman. "Unfortunately, many of us now believe that the basic reaction of the insurance industry is to deny coverage," he said.

Coverage for employment practice liabilities is just one example, he said. "What we're seeing is something we've seen in environmental cases in the past," Mr. Chesler said. "The insurance industry ultimately responded with absolute coverage exclusions, and now the insurance industry is responding in the same way by putting absolute employment exclusions in CGL policies."

And just as insurers began offering policyholders pollution liability endorsements after barring CGL coverage for such risks, they are now carving out the risk and selling riders for employment practices liability exposures, Mr. Chesler pointed out.

"As the insurance industry sees new liabilities coming, they don't try to adapt the policy and expand the policy's coverage; rather, they cut out coverage," he said. "I think this is a serious problem for our society."

To circumvent exclusions for employment practices, many employers have begun tapping their CGL personal injury

endorsements, which typically cover discrimination, humiliation, defamation and many other injuries frequently alleged by plaintiffs in employment-related disputes.

In response, Mr. Chesler said, some CGL policies are barring all bodily or personal injury "arising out of and in the course of employment by the insured."

Following another pattern set in environmental coverage cases, insurers have already fired the next salvo against policyholders facing employment practices liabilities: The expected or intended argument.

A number of courts have held that certain types of intentional acts, such as terminating a person's employment or sexual harassment, are so inherently likely to cause injuries that the intent to harm must be inferred or presumed, wrote Peter Kalis, a policyholder attorney with Kirkpatrick & Lockhart in Pittsburgh, in a paper presented at the Mealey's conference by Matthew Jacobs, a partner in the policyholder firm's Washington office.

Insurers have also used many other defenses that were successful in the environmental context to ward off policyholder claims stemming from such exposures as lead paint, sick buildings and electromagnetic fields, according to Irene Sullivan, an insurer attorney with Skadden, Arps, Slate, Meagher & Flom in New York.

For example, when large corporate and institutional policyholders were hit with mandates to stop polluting and to clean up contamination on adjacent properties, insurers asserted that these were not "damages" as defined by the CGL policy, but rather a form of "equitable relief," she explained.

Likewise, a court order to establish a medical monitoring fund for a class of plaintiffs alleging injury by anything from breast implants, to tobacco to electromagnetic fields will likely meet with the same response, Ms. Sullivan said.

The subject of coverage "triggers," which attracted much attention in environmental litigation, also arise in just about every liability coverage case, ac-

cording to Ms. Sullivan.

And, as would be expected, insurers and policyholders each push for trigger theories that favor them.

For example, policyholders might seek a continuous trigger in sick building syndrome cases, while an insurer might seek a manifestation trigger, Ms. Sullivan said.

A continuous trigger calls into play all policies on a risk during the period of first exposure through manifestation. In contrast, if a manifestation trigger were applied, coverage would not begin until symptoms are actually apparent to the outside world.

The injury-in-fact trigger was recently applied in Dow Corning Corp.'s silicone breast implant coverage litigation (BI, Feb. 19). Under an injury-in-fact trigger, coverage begins at the onset of internal disease, regardless of whether it is outwardly visible.

The pollution exclusion, already invoked in lead paint liability cases, will come up again for claims alleging bodily injury or property damage from sick building syndrome and electromagnetic fields, most coverage litigators believe.

Some experts say this transfer of tactics from environmental cases to other types of liability coverage litigation reflects larger problems in society as a whole.

"The real problem here isn't necessarily the relationship between the insurer and the insured, but the irrational liability schemes that must, in good faith, be passed on to the insurer," said Mr. Chesler of Lowenstein, Sandler. "We are witnessing in many ways the death of the CGL policy in response to the rising tide of litigation in society," he said.

"I say it is a societal problem because the whole concept of strict liability is based on the ability of corporations to abdicate those risks to the insurance industry, which then spreads them equally across society as a whole," Mr. Chesler opined. "If corporations are unable to use insurance to spread the risk of strict liability, the whole scheme is called into question." ■

Internet publishing raises legal questions

Copyright violations are possible

By JOANNE WOJCIK

PHOENIX—The advertising injury endorsement in commercial general liability policies may respond to intellectual property lawsuits filed against companies that publish on the World Wide Web, legal experts say.

"Many companies have their own home pages and some even encourage their employees to have pages of their own," according to William Lard, general counsel for SunSoft Inc., a software publisher in Los Angeles.

But these companies must be careful about how and what they publish on the World Wide Web, Mr. Lard warned those attending the Mealey's Emerging Insurance Battles Conference earlier this month in Phoenix.

For example, a company whose home page connects to other, related, home pages via a hypertext link may be sued for copyright violations.

"If I create a home page and I have my copyrighted material on that page with my trademark, and someone unilaterally links up to it, this raises the question of whether they're publishing and they're violating my copyright," he said.

"This begs the question of whether there is a need to monitor the materials that are placed on other home pages," Mr. Lard observed.

Companies that publish home pages also must pay attention to the laws of every jurisdiction with access to the Web, he said, pointing to online information service CompuServe Inc.'s recent wrangle with German anti-pornography laws as an example.

'Is the bulletin board provider liable for those who libel others online' using its service? asks William Lard.

Other exposures may arise for companies and organizations that provide Internet bulletin board services, pointed out David Steuber, a policyholder attorney with Troop, Meisinger,

Steuber & Paisch in Los Angeles.

"Is the bulletin board provider liable for those who libel others online" using its service? Mr. Lard queried.

"And should that bulletin board provider be treated like a publisher or a common carrier?"

The advertising injury endorsement will likely be called in to play when and if disputes like these arise, Mr. Steuber predicted.

So far, insurers have successfully fought off policyholders attempts to win coverage under this endorsement by persuading the courts to narrowly construe the definition of advertising. Courts generally have ruled that advertising injury coverage applies only to wrongful acts committed in the course of advertising. The injury must arise out of one or more of the following offenses:

- Oral or written publication of material that slanders or libels a person or organization or disparages a person's or organization's goods, products or services.
- Oral or written publication of material that violates a person's right of privacy.
- Misappropriation of advertising ideas or style of doing business.
- Infringement of copyright, title or slogan.

Since the World Wide Web was developed specifically to permit companies to "advertise" on the Internet, which had been free from commercialization, Web publishing will likely be treated as advertising by the courts, legal experts predict.

But that doesn't mean that insurers will willingly hand over coverage.

"The fact that there are allegations involving a specifically enumerated advertising injury does not guarantee there will be coverage," said Robert Kavanaugh, an insurer attorney with Lillick & Charles in San Francisco.

As an example, Mr. Kavanaugh pointed to a 1989 case, *Phoenix Controls Systems Inc. vs. Insurance Co. of North America*, in which an Arizona state court ruled that there was no obligation to defend the policyholder in a copyright infringement lawsuit because the policyholder had acted intentionally in marketing computer programs created by someone else as his own.

However, that decision was later reversed by the Arizona Court of Appeals, which found there was not sufficient evidence of the policyholder's intent to cause harm.

Toxic tort today, coverage fight tomorrow

By JOANNE WOJCIK

PHOENIX—The new wave of toxic tort litigation washing over Corporate America today will trigger a flood of coverage disputes tomorrow, a policyholder attorney predicts.

"Corporate America, for better or for worse, will always be a potential toxic tort target," says Matthew Jacobs of Kirkpatrick & Lockhart in Washington.

"There is a well-trained cadre of plaintiffs lawyers out there who made their living on litigating asbestos cases," he said to those attending the Mealey's Emerging Insurance Battles Conference earlier this month in Phoenix.

Now that most of the lucrative asbestos personal injury cases have run their course, those lawyers are staking out new and bigger game.

Speculation abounds as to what will be their next target. Lead paint, tobacco, electromagnetic radiation and medical devices all have the potential of becoming "the next asbestos," he said, warning that Corporate America also faces other previously unknown exposures.

For instance, claims for repetitive stress injuries, also known as cumulative trauma disorders, are finding their way into the courts after practically overwhelming the no-fault workers compensation system. In 1993 alone, said Mr. Jacobs, 200 RSI product liability suits were filed in federal and state courts against computer manufacturers such as Apple Computer Corp., AT&T Corp., NCR Corp., International Business Machines Corp. and Wang Laboratories Inc.

"RSI went beyond being just a workers compensation issue as soon as workers discovered they could only recover lost wages and medical costs," he pointed out. "They couldn't recover pain and suffering damages." But they soon learned that "if they turned their claims against product manufacturers, they become product li-

bility matters, which have the potential to pay bigger dividends," he said.

Some of the complaints may sound familiar to companies that have faced toxic tort actions in the past:

- Plaintiffs alleging that their exposure to, and long-term use of, such products as computer keyboards have caused cumulative trauma disorders like carpal tunnel syndrome.

- Lawsuits alleging bodily injury as a result of "sick building syndrome."

- Lead paint claims—already the subject of many insurance coverage disputes (BI, Jan. 29)—target numerous companies in the housing industry from construction to property management. While claimants usually sue paint manufacturers, they also often name apartment owners and "anybody who has anything to do with the sale and manufacture of lead paint," Mr. Jacobs said.

Dow Chemical Corp.'s need to mount a defense against its subsidiary's mounting breast implant liabilities shows how easy it can be for good plaintiffs lawyers to pierce the corporate veil and hold corporate owners responsible, Mr. Jacobs said.

And while Dow Corning Corp. may have won the first round in the battle for liability insurance to pay defense costs (BI, Feb. 19), there are still coverage cases pending that involve Bristol Myers Squibb, Mentor Corp., The Cooper Cos. and Baxter Healthcare Corp.

The first coverage suit related to a tobacco liability claim was recently filed in Canada by Imperial Tobacco Ltd., according to Mr. Jacobs.

The suit, filed Jan. 12 against American Home Insurance Co. and Commercial Union Insurance Co., seeks to recoup defense costs and a declaration that Imperial Tobacco's liability insurers have an obligation to defend the company in an ongoing case called *Caputo vs. Imperial Tobacco Ltd.* The defense costs in the case already exceed \$1.3 million, accord-

ing to Mr. Jacobs.

"This is the first coverage case filed by a tobacco company seeking coverage for underlying liabilities," he said.

Litigation over exposure to electromagnetic fields also is sparking some coverage questions. "These claims take two forms: They can be for claims for property damage or bodily injury," he said.

Utilities may be able to tap their liability coverage to pay property damage claims by plaintiffs who assert their homes diminished in value as a result of their proximity to high power transmission lines or power stations, he suggested. And electrical product makers may look for coverage for bodily injury suits stemming from long-term exposure to electromagnetic radiation, he said.

In fact, as courts expand the definition of "bodily injury in the underlying damage cases, they also are expanding its definition in the resulting insurance coverage actions," he said.

"Our firm is litigating a case (in New York) on behalf of a Wall Street broker-dealer against one of the largest property/casualty carriers in the country seeking coverage for emotional distress and mental anguish claims that have arisen out of underlying actions by investors who sued our client when their investments went south," he said.

"The 'hook' is the emotional distress and mental anguish claims, which can trigger bodily injury coverage in some states," Mr. Jacobs said.

"New York state's highest court has concluded that emotional distress, absent physical manifestation, constitutes bodily injury," he said.

"If every emotional distress claim that's being alleged in this new wave of toxic torts is considered bodily injury, there's going to be a heck of a lot of corporate policyholders seeking coverage under their comprehensive general liability policies," he predicted. ■

TIG

Continued from page 1

book of business and make sure the risks that we are writing and the method of distribution we are using and their costs conform to our profit objectives."

The changes are designed to help the insurer move closer to its goal of a 15% return on equity from its current 10%, he explained.

To do so, TIG mainly needs to cut labor-intensive classes of business that require a "brick and mortar branch office structure," said Don Hutson, president and chief operating officer of the holding company.

It is impossible to maintain that structure in today's soft market, he said. "And we didn't see any possibility of the market changing from a pricing standpoint."

Lower investment returns are also a factor in the company's decision.

Mr. Hutson said that nationwide, TIG currently has about 60 "RMS programs," in which commercial policyholders maintain a large retention and the insurer services the claims for a fee. The company plans to slash nearly 50% of those accounts.

"Those are very expensive administrative businesses to handle," he said. "We are retaining some of that business, and we are restructuring our field organization and our company. And if we write that business, we will write it in one of our other product lines where we are set up to handle it from a central location."

Specific lines underwritten in the RMS programs can include workers compensation, liability and transportation risks.

TIG's RMS program was established before the initial public offering that spun TIG off from Transamerica Corp. in 1993, Mr. Hutson explained. The program was developed with an expensive branch of-

fice network and high administrative costs to service policyholders.

Also scaled back will be "custom comp" programs, which are large workers compensation accounts that have been designed to meet a particular customer's needs. While businesses in California, Colorado and a couple of other unidentified states will feel the greatest impact, specific custom comp accounts in other states also face non-renewal.

"Custom comp is very labor intensive, high claim cost, high administrative cost—particularly if it is customized in today's pricing," Mr. Hutson explained.

As with the RMS programs, those accounts will be "surgically taken out at renewal," he said. "We will manage them until renewal and work with the broker and the client as that business runs off at renewal."

Among transportation or trucking accounts, selected risks will be cut over the next year, Mr. Hutson said.

TIG officials would not say what the proposed non-renewed accounts amount to in premium volume.

Beyond the administration-heavy business it is shedding, TIG also will not renew certain commercial accounts that have produced sizable losses, though it did not specify any accounts.

"We will manage all of the relationships, the claims, whatever the case may be, and we will work with the current agent or broker and the client to move that account to another market at renewal," Mr. Hutson said.

"We believe that TIG Holdings and all of its subsidiaries are good at risk transfer," said Mr. Rotenstreich, who added that it no longer wants to imitate brokers or third-party administrators. "We want to be in the insurance business."

"We probably will be best at severity risks, as opposed to frequency risks, because frequency risks typi-

cally require a great amount of administration," he said. "We will be in high frequency lines where the agent, for example, might be a better administrator than we are, in which case we will be the risk taker and he will be the administrator."

Armed with its new philosophy, TIG expects its commercial business to increase, but in selected areas.

For example, Mr. Hutson noted that TIG handles about \$200 million annually in premiums from sports and leisure-related specialty business placed by K&K Insurance Group Inc., a unit of Aon Corp. TIG oversees the program with only a few people. "That is the type of thing we are moving to replicate," he said.

The insurer is also interested in growing its book of program business, placing coverage for associations and industry groups. The ability to standardize a policy and take advantage of economies of scale make those lines more appealing.

"We want to manage business on a portfolio basis as opposed to having a branch office network of underwriters individually looking at paper," Mr. Hutson explained. "That is very expensive. You can manage 100 (similar) accounts, but it's very difficult to manage one."

The moves put TIG at the forefront of companies that need to restructure to succeed, an analyst says.

"I think they just want to focus their efforts on business that they have a better opportunity to make their return objectives on," said Alan Levin, managing director with Standard & Poor's Corp. in New York. "They're a very return-on-equity oriented company and have a strong desire to achieve that, and it's a very difficult business (environment) out there. They want to get away from the undifferentiated businesses."

TIG shares closed Friday at \$31.75 on the New York Stock Exchange, down from \$32.00 Thursday. **BI**

Skandia

Continued from page 2

lion initial public offering of 51% of Skandia America's shares (BI, Oct. 5, 1992). Later that year, it rejected two buyout offers from Head Insurance Partners L.P., including one for \$550 million. It also scaled back the operations of Skandia America (BI, Nov. 2, 1992).

James F. Dowd, who resigned as CEO of the unit after the failed IPO in 1992 and returned to the post last year, will remain at the helm. He returned in part to help decide the future of the reinsurer, including options such as another IPO and rebuilding the company.

"We went through the process of working with an investment banker and in the course, Fairfax came to our attention and indicated an interest in Skandia America Reinsurance. We then proceeded to put together the transaction," Mr. Dowd said in an interview.

As part of the Skandia America purchase, Fairfax is buying its Hudson Insurance Co. and Skandia Canada Reinsurance Co. units. The buyout will not include property insurer Capital Assurance Co. Inc., a Skandia America unit that will remain part of Skandia Insurance.

Fairfax will pay \$229.6 million, which is 81% of Skandia America's statutory surplus without Capital Assurance.

As part of the deal, Skandia Insurance is adding 400 million Swedish krona (\$59.4 million) to its claims reserves to indemnify Fairfax against possible shortfalls in Skandia America's current reserves or reinsurance recoverables.

In 1995, Skandia America, excluding Capital Assurance, had gross written premiums of \$205 million,

total assets of nearly \$1.3 billion and a statutory surplus of \$283.5 million.

Skandia America, which now offers treaty and facultative property/casualty coverage, is considering expanding into other areas as part of a business plan it is now developing, said Mr. Dowd.

Analysts say the acquisition is straightforward, giving SARC a committed parent in Fairfax and Skandia Insurance the means to reduce its reinsurance exposures.

"If Skandia wanted to develop (its reinsurance) business seriously, it had to commit to its development, and it was unwilling to do so," summed up Tim Dawson, an analyst with Hoare Govett Ltd. in London.

That presented problems for its reinsurance unit. If it is known its owner was not committed, he asked, "how reliable is SARC as a business partner?"

SARC, which has not been "a very muscular competitor recently," now "is in good hands"—with a disciplined and profit-minded parent committed to industry for the long term, said Mike Morrissey, CEO of Firemark Group Inc. in Morristown, N.J. "I think it will make Skandia a stronger competitor."

Fairfax's Mr. Watsa, "in my opinion, is an investment genius of the first order," Mr. Morrissey said, describing him as "the Warren Buffett of Canada."

While the deal is not big enough to disrupt the reinsurance market, the fact Mr. Watsa is "investing in a good second-tier company, is cause enough for some optimism," he said. "If (the reinsurance business) didn't look good, he would have put his money elsewhere."

Fairfax's Canadian holdings are: Commonwealth Insurance Co. of Vancouver, B.C., which specializes in commercial property and oil and gas

insurance; Federated Insurance Co. of Canada in Winnipeg, Manitoba, which writes a range of commercial coverages; trucking industry specialist Markel Insurance Co. of Canada in Toronto; the Continental operations in Toronto; catastrophe reinsurer Wentworth Insurance Co. of Barbados; Lindsey Morden Claims Services Ltd., a Toronto-based claims adjuster and loss management service firm; and Hamblin Watsa Investment Counsel, a Toronto-based investment management firm.

Fairfax's two U.S. insurance units are specialty property/casualty underwriters: Commonwealth Insurance Co. of Seattle; and Ranger Inc. of Houston.

Fairfax plans to finance the purchase of Skandia America through issues of equity and long-term debt. The deal, subject to regulatory approval and other closing conditions, should be completed in May. **BI**

Facilities

Continued from page 3

of thing customers will gravitate to," Mr. Kane said.

Others in the market agree: The CIGNA/X.L. announcement follows last year's unveiling of a multiline, multiyear high excess program, dubbed "Beta," that was developed by Alexander & Alexander Services Inc. and underwritten by Swiss Reinsurance Co.

Other large insurers are working on their own versions of such packages, market observers say.

"The large segment of commercial insureds represented by the Fortune 500 is moving in the direction of trying to consolidate their purchasing power," said Edward K. Guzik, managing director with Alexander

Updates

Merrett names get £9.5 million

LONDON—Members of the Merrett 418 (1985) Names Assn. will receive an interim payment of £9.5 million (\$14.7 million) from the Lloyd's agency, underwriter and auditors.

High Court Justice Cresswell last week ordered Merrett Underwriting Agencies Management Ltd., Merrett Syndicates Ltd. and Stephen Merrett to pay 80% of the award, of which Mr. Merrett personally must pay £500,000 (\$772,000). Syndicate auditor Ernst & Whinney—now part of Ernst & Young—will pay the other 20%.

In a 1995 ruling, the judge found that Mr. Merrett and the agencies deliberately concealed from members of syndicates 417 and 418 the extent of potential losses and acted negligently in closing the 1982 underwriting accounts from both syndicates into 1983, 1984, and 1985, when the account was finally left open (BI, Nov. 6, 1995).

E&O underwriters for the agencies have denied coverage and the dispute will now go into arbitration.

Because joint and several liability applies, Ernst & Young could end up paying more than 20% of the award. The firm, though, could only be liable for damages relating to the closing of accounts, not the concealment.

Superfund support aired

WASHINGTON—Prospects for a bipartisan Superfund bill in the House of Representatives are on the upswing following an exchange of letters between two key lawmakers.

House Commerce Committee Chairman Thomas Bliley, R-Va., and the committee's ranking minority member and former chairman—Rep. John D. Dingell, D-Mich.—exchanged a series of letters earlier this month indicating that both support comprehensive rather than piecemeal Superfund reform. On Feb. 14, Rep. Dingell wrote that he is "committed" to enacting comprehensive reform this year and asked that "all issues" be put on the table for negotiation. Rep. Bliley responded two days later expressing his willingness to discuss "any constructive, concrete proposals" from committee members and the Clinton administration, adding that "I see no reason that we cannot have bipartisan Superfund legislation sent to the president in 1996."

State Farm cuts draw response

BLOOMINGTON, Ill.—Two State Farm Group units will not be able to raise rates as they had expected after they announced plans to non-renew thousands of property policies in Florida unless policyholders buy state-sponsored wind coverage.

Beginning Aug. 1, State Farm Fire & Casualty and State Farm General Insurance Cos. will not renew 16,300 commercial property policies in Palm Beach and Hillsborough counties and in the parts of Dade, Broward and Pinellas counties not eligible for coverage through the Florida Windstorm Underwriting Assn. It will consider renewing 5,700 other commercial policies in areas of Dade, Broward and Pinellas that are eligible for wind coverage, if the property owner buys it from the FWUA. The companies also will not renew about 68,000 residential policyholders in the same area, though they will consider selling wind-excluded coverage to purchasers participating in the FWUA.

Florida Treasurer and Insurance Commissioner Bill Nelson responded by revoking two of the companies' rate increases, including a 13.8% hike approved earlier this month and 7.7% to 27.3% increases given last summer on various types of policies.

Briefly noted

The California Department of Corporations is suing Lloyd's of London alleging violation of securities laws and fraudulent misrepresentation. The suit seeks up to \$110 million, including the repayment of \$100 million paid by California members. . . . The American Academy of Actuaries predicts that premiums would rise only 2% to 5% if legislation to curb pre-existing medical condition exclusions was enacted. That is lower than the 10% to 30% estimates from the Health Insurance Assn. of America (BI, Feb. 12). . . . A federal judge in Anchorage, Alaska, last week denied Exxon Corp.'s motion for a new damages trial in the Exxon Valdez oil spill suit. . . . The Communications Workers of America ratified the three-year labor pact reached last month with Bell Atlantic Corp. (BI, Jan. 29).

Capital Consultants in New York. "This represents a strategic shift in the direction of the market."

Brokers generally viewed the announcement favorably.

"Multiline, multiyear and one-stop shopping should take something out of the cost," said Bob Murphy, A&A managing director for U.S. marketing in New York. "Presuming the pricing reflects that, it should be a very interesting development to our clients," he said, adding that it means "building a long-term relationship, not just talking about it."

"It's a holistic approach," observed Norman Barham, executive vp with Johnson & Higgins in New York. "It's what a lot of clients are looking for."

"It's definitely an important alternative for large risk management

clients to consider," added Timothy J. Mahoney, vice chairman of Marsh & McLennan Inc. in New York.

CIGNA and X.L. started discussing the program about two years ago and were still discussing details of the packages with a sample group of potential policyholders as recently as three weeks ago, CIGNA's Mr. Kane said.

The announcement comes only two weeks after the Pennsylvania Insurance Department approved a CIGNA reorganization plan that splits the company into active and runoff operations (BI, Feb. 12).

CIGNA and X.L. representatives say the timing of the announcement was not dictated by the reorganization plan's approval, though an X.L. spokesman said it was "fortuitous" that the reorganization issue was resolved. **BI**

Ohio

Continued from page 1

tions," said Mr. Randall, who oversaw drafting of the bill during the past year.

"All types of doctors, hospitals, and even manufacturing companies themselves are setting up partnerships to manage health care, but don't fit into the current regulatory structure," said Tom Hart, managing director of public policy services for the Ohio Manufacturers' Assn. in Columbus, one of the groups asked to comment on the draft.

In most states, insurance departments are the main regulators of managed care entities. However, in Minnesota and some other states, the health departments assume that primary role. In Ohio, regulatory authority is shared, with the Health Department being required to certify to the Insurance Department whether an HMO has an adequate provider network.

"A number of state insurance departments have asserted their jurisdiction through bulletins or letters, but what Ohio's insurance department and legislation is doing is making it perfectly clear," said Chris Petersen, vp-state affairs for the Health Insurance Assn. of America in Washington.

There is some disagreement about just which agency—and, in fact, which government—ought to oversee managed care.

The consensus among regulators in the National Assn. of Insurance Commissioners is that such risk-assuming entities are engaged in insurance and subject to state authority.

Doctors may disagree. During the 1995 congressional debate over a failed budget bill that would have overhauled Medicare (BI, Oct. 6, 1995), physician groups sought greater federal control of provider organizations, which are owned and operated by either doctors or hospitals or both.

"It was unclear who had authority to regulate them," said Mr. Petersen.

"The states have to get out front and make sure they control the situation before it is a problem," said Doug Freeman, president and CEO of Medical Benefits Mutual Life Insurance Co. The Newark, Ohio, indemnity insurer plans to establish a risk-bearing HMO that would be regulated under the proposed rules.

Employers, insurers and HMOs are all offering at least preliminary support for the Ohio measure. HMOs particularly support the proposed elimination of prior approval of their

group rates and provider contracts. Insurers do not need such prior approval.

The 66-page proposal would establish two-tiered regulation, depending upon whether the entities assume risk.

A risk-bearing entity would need a certificate of authority as a "Health Insuring Corporation" to conduct business in the state. Managed care entities that do not bear risk—as many of the preferred provider organizations in Ohio do not—would simply be required to register.

The proposal would bring under departmental regulation some physician hospital organizations, as well some dental and vision programs, said JadyDeGiralomo, president of the Ohio HMO Assn. in Columbus. Physician hospital organizations combine physicians, hospitals and other medical services into a single organization that contracts with insurers and/or HMOs to provide a full spectrum of health care services for a capitated fee.

Dozens of non-risk bearing health care entities affiliated with hospitals would have to register under the proposal, said Kelly Leahy, staff legal counsel for the Ohio Hospital Assn.

To ensure solvency, the proposed bill would require all managed care entities to have total admitted assets of at least 110% of liabilities. In addition, minimum net worth requirements vary: \$500,000 for those offering supplemental services; \$1 million for those offering basic health services; and \$1.5 million for those offering both types of services.

The proposal would also:

- Require managed care entities to offer the same benefits that HMOs and other insurers now are required to offer.

- Require provider contracts to explain how disputes will be resolved.

- Prohibit limiting medically necessary services or penalizing providers for offering to assist an enrollee in seeking reconsideration of denied or limited benefits.

- Set minimum utilization review standards and requires managed care entities to file an annual report outlining their activities and data.

- Require entities to have quality assessment and improvement systems that allow for an ongoing evaluation of services rendered.

The department's initiative "is more a prospective, pro-active measure, rather than a response to a failed company," said Mr. Hart of the manufacturers' association.

"Regulators have had direct, negative experience with undercapitalized HMOs and under-

funded MEWAs, which left thousands of Ohioans without coverage and responsible for their own medical bills," regulator Mr. Randall said, referring to multiemployer welfare arrangements.

The bill would benefit employers, he said. "They would be dealing with organizations that have the wherewithal to meet their obligations."

The Health Action Council of Northeast Ohio, a group of Cleveland-area businesses, hopes the proposed bill will provide access to quality data.

"All purchasers—whether corporate or individual—should have access to such quality information, regardless of size," said Patrick J. Casey, the council's executive director. "Corporate entities are becoming informed purchasers, rather than mere payers. Access to quality information is a key component to making them informed."

Supporters of the bill include the Columbus-based Ohio HMO Assn., which said that the Ohio Insurance Department's efforts "were consistent with the NAIC's efforts to foster equivalent regulation of all risk-bearing entities at the state level."

On a national level, the HIAA supports the concept of the Ohio bill, too. "We don't want to see a market where a (provider service network) or other alternative entity escapes regulation," Mr. Petersen said. They should have to meet the same requirements, including capital and surplus, consumer protection and coverage.

Ohio hospitals and doctors say they favor protecting consumers, but have misgivings about the proposal.

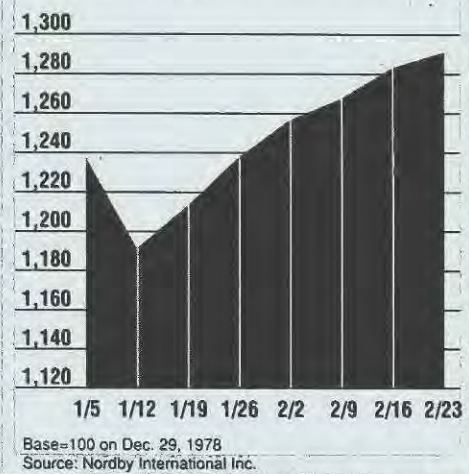
"We are not opposed to the legislation, per se," said a spokeswoman for the Ohio State Medical Assn.

What the doctors group doesn't want is underwriting or reserving requirements so high that small players are forced out of the market, she said. "We think there may be a need for some differentiation between large HMOs and insurance companies and smaller entities" covering only 500 or 1,000 people.

"It doesn't appear to be that onerous at this point in time," said Ms. Leahy of the hospital association.

"If an entity is an integral part of a marketing strategy, it is appropriate that it register," said John Callender, senior vp of the hospital association. But registration may just cause unnecessary paperwork if an entity is a small group of specialists affiliated with a hospital. **BI**

BI Insurance Index



PCS catastrophe options

As of Feb. 23			
Call spread	Price bid/ask	Call spread	Price bid/ask
Eastern September 1996			
40/60	5.4/6	40/60	4/5
50/70	4/6	80/100	2/4
80/100	2.5/4.0	200/250	1.8/2.5
Northeast Dec. 1996			
40/60	1.2/1.7	10/20	1/1.8
Texas June 1996			
Total volume: 70 Total open interest: 1,720			
For information on PCS cat options, call 312-435-3674.			
Source: Chicago Board of Trade			

British Issues

Feb. 22	Price	P/E	Div. %	Yield	1 week
Companies	pence		pence	%	high—low
Comm Union	617	9.6	35.3	5.7	617—598
Genl Accident	646	9.2	38.8	6.0	656—646
Gdn Royal Exch	247	9.5	11.3	4.6	247—245
Independent	429	9.5	13.8	3.2	441—429
Royal	389	6.5	20.0	5.1	389—374
Sun Alliance	389	8.4	21.3	5.5	389—378
Brokers					
Bradstock	65	10.8	7.1	10.9	65—65
Fenchurch	125	8.4	10.6	8.5	126—125
CE Heath	161	10.1	12.5	7.8	161—154
JIB Group	99	10.4	9.4	9.5	99—98
Lloyd Thompson	172	10.6	11.3	6.6	172—172
Lowndes Lmbt	145	7.8	11.0	7.6	147—145
Nelson Hurst	170	11.3	9.5	5.6	172—170
Sedgwick Grp	137	10.9	8.1	5.9	137—122
Steel Bri Jones	41	5.1	5.6	13.6	42—41
Willis Corroon	154	14.0	8.3	5.4	155—153
Source: Philip Olsen, London *Actual. Others estimated.					

BI Industry Stock Report FEB. 19, 1996, THROUGH FEB. 23, 1996

BROKERS

	Price	Weekly % change	Year to date % change	Annual High	Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
Accordia Inc.	NYS	28.375	0.44	-4.62	33.88	23.50	375	0.8	2.82	17	14.00
Alexander & Alexander	NYS	19.125	-2.55	0.66	26.44	18.00	486	0.1	0.52	13	19.17
E.W. Blanch Holdings Inc.	NYS	24.5	0.51	4.81	25.25	16.50	110	0.4	1.63	18	4.93
Gallagher Arthur J. & Co.	NYS	37.125	-3.57	-0.34	39.25	32.50	89	1.16	3.12	15	6.48
Hilt, Rogal & Hamilton	NYS	13.825	3.81	1.87	14.38	10.50	57	0.6	4.40	17	1.21
Kaye Group Inc.	NDO	7.625	0.00	-4.69	10.75	6.75	0	0.1	1.31	8	NA
Marsh & McLennan	NYS	98.25	3.69	10.70	101.63	76.13	908	3.2	3.26	18	19.95
Poe & Brown	NDO	25	-0.50	0.50	25.50	21.00	40	0.48	1.92	15	5.15
BROKERS	AVERAGE		0.2	1.1					2.7	17	

INSURERS/REINSURERS

	Price	Weekly % change	Year to date % change	Annual High	Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
ACE Ltd.	NYS	47.75	4.09	20.13	50.38	23.00	750	0.00	0.00	0	22.45
Acceptance Insurance Cos.	NYS	14.875	1.71	0.00	17.50	13.13	449	0.3	2.02	30	10.76
AEGON N.V.	NYS	43.625	1.45	-0.85	46.75	27.25	60	1.08	2.48	16	17.28
Aetna Life & Casualty	NYS	71.875	-1.20	3.79	76.75	51.88	2342	2.76	3.84	33	48.85
AFLAC Inc.	NYS	48.625	0.52	11.78	49.50	36.13	823	0.52	1.07	14	17.58
Allied Group Inc.	NDO	40.75	1.24	13.19	40.75	25.75	246	0.68	1.67	8	21.81
Allmerica Prop. & Casualty	NYS	26	-0.48	-3.70	27.13	18.25	92	0.16	0.62	11	19.87
Allstate Corp.	NYS	45.5	2.82	10.64	46.00	26.13	4714	0.85	1.87	11	18.75
American Financial Group	NYS	32.75	-2.96	6.94	34.50	22.88	169	1	3.05	31	24.94
American General	NYS	36.75	0.68	5.38	39.13	30.38	1304	1.3	3.54	14	17.03
American Heritage Life Ins.	NYS	21.875	-3.85	-4.37	23.88	16.25	29	0.72	3.29	11	12.51
American Indemnity/Fin'l	NDO	10.5	7.69	5.00	13.25	9.00	1	0.3	2.86	-4	15.92
American International	NYS	100	1.01	8.11	103.38	66.75	4199	0.34	0.34	19	34.66
American Re Corp.	NYS	39.875	-5.90	-2.45	45.00	32.75	928	0.32	0.80	-22	16.77
Aon Corp.	NYS	53.875	-0.92	8.02	55.38	33.63	609	1.36	2.52	15	18.30
Argonaut Group	NDO	34.25	0.00	5.38	35.00	28.88	35	1.32	3.85	15	29.91
AVEMCO Corp.	NYS	15.5	0.81	-3.13	18.25	14.63	48	0.48	3.10	17	6.28
Baldwin & Lyons Inc.	NDO	16.3125	-5.43	0.38	18.00	14.25	211	0.32	1.96	8	13.90
Berkley W.R. Corp.	NDO	48.125	-2.28	-10.47	55.50	34.50	136	0.48	1.00	18	34.46
Berkshire Hathaway Inc.	NYS	35200	7.32	9.66	35200.00	21500.00	1	0.00	0.00	74	10089.11
Capital RE Corporation	NYS	33.75	1.12	9.76	34.13	22.00	197	0.24	0.71	11	22.30
Capsure Holdings Corp.	NYS	17.25	2.99	-2.13	18.13	12.38	24	0.00	0.00	16	14.61
Chubb Corp.	NYS	99	-1.86	2.33	104.38	57.00	1490	1.96	1.98	13	48.92
CIGNA Corp.	NYS	120.25	2.23	16.46	124.50	68.25	1412	3.04	2.53	42	80.46
CNA Financial Corp.	NYS	117.125	0.54	3.19	123.25	71.63	139	0.00	0.00	10	71.13
EMC Insurance Group Inc.	NDO	13.25	-1.85	-3.64	15.25	9.75	6	0.58	4.23	9	11.13
EXEL Ltd.	NYS	71.125	2.89	16.84	71.13	41.75	312	0.4	0.56	0	31.47
Fremont General Corp.	NYS	23.75	-3.06	-3.06	26.25	12.63	129	0.6	2.53	9	19.04
Frontier Insurance Group	NYS	31.5	0.40	-1.56	33.75	20.25	44	0.48	1.52	13	14.65
Gaisco Inc.	ASE	9.75	-2.50	-14.29	12.38	8.31	102	0.05	0.51	14	3.98
General RE Corp.	NYS	145.875	-2.83	-5.89	158.25	123.88	1791	2.04	1.40	15	59.35
Guaranty National Corp.	NYS	13.875	-0.89	-9.78	19.00	13.75	63	0.5	3.60	15	11.60
Harleysville Group	NDO	27	-5.26	-16.60	33.00	23.75	346	0.76	2.81	9	20.72
Hartford Steam Boiler	NYS	50.375	-1.71	0.75	52.50	40.88	107	2.28	4.53	16	14.68
HCC Insurance Holdings	NYS	48.875	8.01	32.09	49.00	21.75	277	0.00	0.00	23	15.86
ITT Hartford Group	NYS	52.75	3.69	9.04	52.75	47.38	2480	1.6	3.03	11	45.46
Lincoln National	NYS	55.625	0.00	3.49	57.00	38.88	823	1.84	3.31	12	28.90
Markel Corp.	NDO	87	6.10	15.23	90.50	44.50	58	0.00	0.00	14	25.71
Meadowbrook Insur. Group	NYS	28.25	-8.87	-15.67	33.88	24.00	96	0.08	0.28	21	NA
Mid Ocean Ltd.	NDO	39.375	-5.12	6.06	43.00	24.88	176	0.25	0.63	0	22.18
Mutual Risk Mgmt. Ltd.	NYS	44.375	-4.05	-3.01	46.50	26.63	147	0.4	0.90	20	9.72
NAC Re Corp.	NYS	33.75	-0.37	-6.25	39.00	28.25	35	0.2	0.59	10	18.23

Company	Exchange	Price	Weekly % change	Year to date % change	Annual High	Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
National Re Corp.	NYS	34.5	3.76	-9.21	38.13	28.25	61	0.2	0.58	12	17.05	2.02
Navigators Group	NDO	17.75	-1.39	0.71	19.75	12.75	109	0.00	0.00	17	10.21	1.74
Nobel Insurance Ltd.	NDO	12.375	-1.00	8.79	12.75	8.63	26	0.2	1.62	6	6.84	1.81
Ohio Casualty Corp.	NDO	37.125	-4.50	-4.19	40.00	29.00	429	1.6	4.31	13	23.64	1.57
Old Republic Int'l	NYS	34.625	-3.48	-2.46	36.50	23.63	668	0.52	1.50	10	25.79	1.34
Orion Capital Corp.	NYS	46.125	1.65	6.34	46.25	34.25	151	1	2.17	10	26.00	1.77
Partner Re Ltd.	NDO	29.75	-2.46	8.18	30.63	19.75	1115	0.00	0.00	0	20.37	1.46
Penn-America Group Inc.	NDO	12.875	4.04	-9.65	15.50	7.00	68	0.16	1.24	9	6.40	2.01
Philadelphia Cons. Holding	NDO	20.25	2.53	24.62	21.88	12.00	5	0.24	1.19	14	9.05	2.24
PXRE Corp.	NDO	25	-1.96	-5.66	29.75	21.00	199	0.72	2.88	5	21.27	1.18

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