

Business Insurance

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

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EMLICO's Bermuda liquidators fighting to maintain control

HAMILTON, Bermuda—Electric Mutual Liability Insurance Co.'s Bermuda liquidators have gone to court there and in the United States to block efforts by the Massachusetts Insurance Division to regain control of the insurer's estate.

The joint liquidators, partners of Coopers & Lybrand L.L.P., obtained a Bermuda Supreme Court order Jan. 9 reaffirming EMLICO's status as a Bermuda company winding up under Bermuda law. The liquidators' petition—filed under seal—followed a Jan. 5

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Health care costs flat in '97: Study

By JERRY GEISEL

A shift of more employees into managed care and the vestiges of fierce price competition among HMOs helped keep employers' health care plan costs nearly stable in 1997.

Group health care costs for active and retired employees rose a scant 0.2% to \$3,924 per employee on average in 1997, according to a survey of 3,915 employers to be released this week by benefit consultant William M. Mercer Inc. in New York.

Total health care costs include employer and employee premium contributions for medical, dental, prescription drug, mental health and vision care.

The survey—the largest of its kind and now in its 12th year—was launched by A. Foster Higgins & Co. Inc., a subsidiary of Johnson & Higgins that was folded into Mercer last year as part of J&H's acquisition by Mercer parent Marsh & McLennan Cos. Inc.

Health care costs for active employees and retirees at large companies—those with at least 500 employees—rose a modest 0.9% to an average of \$4,369 per employee in 1997.

Health care costs among smaller companies dipped 0.7%, falling to an average of \$3,357 per employee.

See Costs on page 10

Ice losses to grow Business interruption claims to boost U.S. storm toll

By MARK A. HOFMANN and MICHAEL PRINCE

The full extent of insured losses from the ice storm that raked northern New England, New York and parts of Canada over the past two weeks may not be known for some time.

Domestic insured property damage appears likely to be relatively light. The Property Claim Services division of the American Insurance

Services Group last week provided an unofficial preliminary estimate of \$75 million to \$125 million.

Business interruption claims, which the PCS does not track, however, are just beginning to hit insurers.

"You don't know of the extent of the business interruption losses until some weeks after a catastrophe," said Sean Mooney, senior vp and economist for the Insurance Information Institute in New York.

Kevin Barry, area assistant vp with broker Arthur J. Gallagher & Co.'s Valhalla, N.Y., office, agreed there could be a significant time lag before the full extent of business interruption losses is known.

Mr. Barry said his three clients in the northern New York area—two public entities and one religious institution—did not report claims when he spoke with them last week. People in the storm

See Storms on page 24

Power outages, property damage to generate Canadian claims

By GAVIN SOUTER and ALINE SULLIVAN

While some observers predict that the scale of the losses from devastating ice storms could lead to rate increases for Canadian policyholders, others say plentiful capacity in the Canadian market will keep rates down.

Insured damage from the storms that froze much of southern Quebec over the past two weeks could top \$600 million Canadian (\$418.9 million), according to the Insurance Bureau of Canada.

Many of the losses will be homeowners and personal auto claims, but significant commercial and industrial claims are expected, too, insurers and brokers say.

Rates for most types of non-life coverage in Canada, which have declined about 6% in the past six months, should at least recover this year and may rise further, said Stephen Harris at the Lloyd's North America Unit in London.

"We should see some substantial gains

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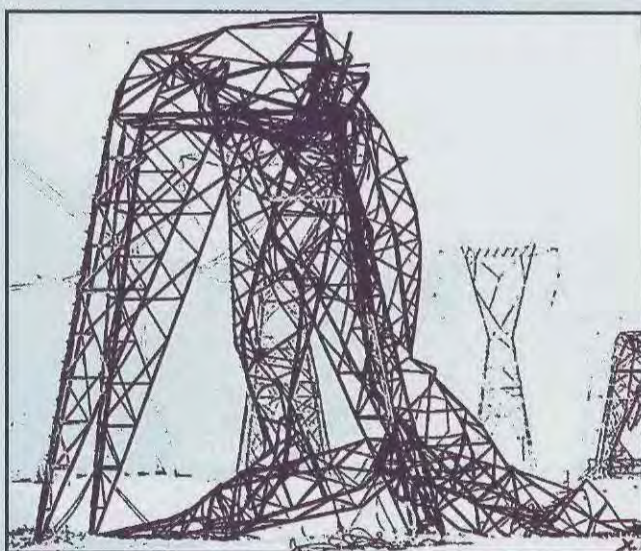
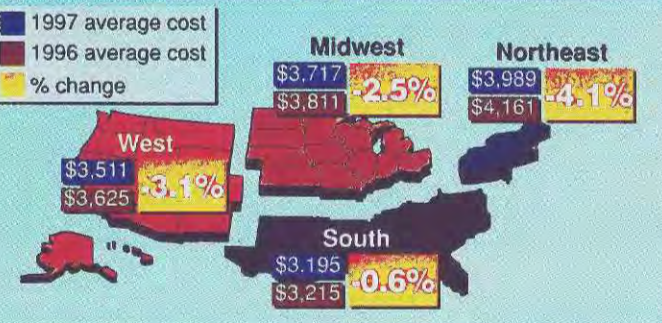


PHOTO: AFP

The ice storm that gripped the Northeast and parts of Canada this month toppled power lines near Montreal.

Costs holding steady

Health care plan costs by region



Health care plan costs by plan type

	1997	1996	% change
Traditional indemnity	\$3,521	\$3,739	-5.8%
Point of service	3,481	3,494	-0.4
Preferred provider organization	3,321	3,293	0.9
Health maintenance organization	3,165	3,185	-0.6

Total health care costs



Regional and individual plan costs are for active employees only; total plan costs include employees and retirees. Source: William M. Mercer Inc. GRAPHIC BY MIKE GARVEY

Chicago employers pool their pull Group formed to negotiate HMO rates, get quality data

By ROBERT KAZEL

CHICAGO—Eight large employers in the Chicago area are forming a purchasing group to jointly negotiate with health maintenance organizations to gain lower rates and obtain data on quality and efficiency.

This is the first time that members of the Chicago Business Group on Health, a federation of large employers seeking to improve health care, have moved ahead with joint negotiations to purchase coverage. It is the culmination of about a year of meetings

meetings that will continue this week in an effort to get more employers interested.

The CBGH, formed in 1983, has grown to 80 private and public employers. Its work to date has mainly been teaching area businesses how to be savvy managed care customers and surveying employers on health care satisfaction. Nine years ago, the coalition also began a preferred provider organization called EPIQual that currently has 106,000 subscribers in the Chicago area.

"We believe the health care system needs to redouble its efforts

said Larry Boress, executive director of CBGH. Mr. Boress also will serve as executive director of the Healthcare Purchasing Group, which will be established as a non-profit subsidiary of the Midwest Business Group on Health, the 11-state parent coalition of CBGH.

Motivating the creation of the new purchasing group were the absence of comprehensive information about Chicago-area health plans on which to base rational decisions; the need to standardize data collection, rate negotiation and cost containment; and im-

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Updates

Liquidators fight to keep control

Continued from previous page

Massachusetts Supreme Judicial Court ruling that EMLICO's redomestication was invalid and that the insurer never legally left the state (*BI*, Jan. 12).

Despite the Massachusetts ruling, the Bermuda court concluded that the joint liquidators continue to control the estate and that "no third party (may) purport to act on behalf of (EMLICO) or interfere with the exercise by the joint liquidators of their powers."

The liquidators also filed suit in U.S. District Court in Boston to remove the Insurance Division's receivership action against EMLICO to federal court. No hearing date has been set for the removal action.

Meanwhile, Bermuda Finance Minister Grant Gibbons announced that government has no power under the Bermuda Companies Act of 1981 to send EMLICO back to Massachusetts.

Instead, "we are working closely with Bermuda's insurance regulators to find out whether there is some way that the government can help facilitate a reasonable solution," he said.

Expanded PPD study sought

SACRAMENTO, Calif.—California's Commission on Health and Safety and Workers' Compensation last week asked the Rand Corp. to study the claims data of self-insured employers to broaden its study of California's permanent partial disability rating system.

Employers criticized a commission-funded Rand report released last fall because it did not contain information on self-insureds. Rand researchers said the study did not contain information on self-insureds because the state does not collect that data and that information has not been available.

In addition, employers were disappointed that the Rand report proposed further study to improve California's PPD system and faulted the report because it relied on recession-era data (*BI*, Nov. 24, 1997). A Rand representative said last fall that further study would be appropriate because the research organization needed five years of data and California has only recently moved out of its economic slump.

Now plans call for Rand to solicit data from self-insured employers by working through the state's Department of Industrial Relations Self Insurance Plans in Sacramento. Preliminary results could be available by the end of June, according to Rand sources, and the report could be completed by the end of September.

A contract for Rand to explore self-insured claims history is still undergoing legal review, said Christine Baker, executive officer for the San Francisco-based commission. But members of a commission policy committee now weighing Rand's research—with an eye to adjusting PPD benefit levels—want information on how self-insureds' claims-management practices impact wage loss and return-to-work. Employers wanted conclusive results from Rand research because they are concerned about the costs of changing PPD benefits.

Rand's original study found that within the first five years of reporting permanently disabling injuries, California's workers lose an average of 40% in wages, yet gain slightly more than one-third of that money back in benefits.

If self-insured companies show superior results over insured companies in returning employees to work, then the practices of self-insureds could become recommendations for statewide policy, commission sources said.

Appeal to delay implant trial

NEW ORLEANS—A Louisiana silicone breast implant trial is on hold while Dow Chemical Co. appeals an August 1997 jury verdict that had found the company negligent in testing the silicone used in implants, a federal judge has ruled.

U.S. District Court Judge Yada Magee's Jan. 15 order comes less than a week after the judge ruled the plaintiffs would not have to re-prove Dow Chemical's negligence in suing individually.

The case, known as the Spitzfaden case, was the first U.S. class-action silicone breast implant case set to go to trial. But Judge Magee dismantled the class action in December, saying the 1,800 representatives' cases were too dissimilar.

In last week's rulings, the judge said the decertification was a technical issue only and not intended to nullify the August verdict. But, these cases will not be heard until appeals have been completed. The Spitzfaden trial was set to resume Jan. 20.

The August 1997 verdict came after a jury found Dow Chemical guilty of negligence, fraud, concealment and conspiracy for failing to adequately test silicone used in implants and, in turn, for failing to disclose the dangers of silicone. It was the third time plaintiffs had pierced the corporate veil that otherwise shielded Dow Chemical from thousands of injury claims that have been filed against its unit, Dow Corning Corp. (*BI*, Aug. 25, 1997).

GM loses witness ruling

WASHINGTON—A court in one state cannot bar a person from appearing as an expert witness in another state even if that person had signed a non-disclosure agreement, the Supreme Court ruled in a product liability case last week.

The case, *Baker vs. General Motors Corp.*, involved a former GM employee named Ronald Elwell who had agreed not to appear as an expert witness against GM in product liability suits as part of a wrongful discharge settlement. A Michigan state court issued an injunction barring Mr. Elwell—an expert on fuel systems—from testifying against his

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Errors & omissions

• A Jan. 12 story reported that Kaiser Permanente is changing the arbitration process it uses to settle malpractice complaints by members of its managed care plans. The changes apply only in California.

Home in Chapter 11

Reorganization of Home Holdings to benefit policyholders

By GAVIN SOUTER

NEW YORK—The Home Insurance Co. would have more money to pay claims under a proposed bankruptcy reorganization of its holding company, says the regulator overseeing the defunct insurer's runoff.

In a deal negotiated among regulators, bondholders, and affiliated insurers, Home Holdings Inc. entered Chapter 11 bankruptcy protection on Jan. 15, the day it was scheduled to make an overdue interest payment to bondholders.

Under Home Holding's reorganization proposal, Zurich Insurance

Group would take ownership of Home Holdings Inc. once it emerges from Chapter 11. However, the holding company would have no outstanding liabilities, and Zurich would take on none of The Home's liabilities as a result of the deal, Zurich executives say.

If the complex reorganization plan is approved, The Home would no longer have to pay biannual dividends to Home Holdings for the holding company to pay \$11.6 million interest payments to bondholders and future principal payments.

The deal also would provide future tax advantages to The Home as a result of the net operating loss of

Home Holdings once it emerges from Chapter 11.

"If the proposed plan is confirmed, it will ultimately benefit the insurance company in two ways. The first is the elimination of the future dividend request to fund the public debt obligation, and the second is that The Home will participate in the tax benefits of the transaction," said David Nichols, the examiner appointed by the New Hampshire Insurance Department to oversee the runoff of The Home.

Under the reorganization, the bondholders of Home Holdings would receive new notes with a val-

See The Home on page 25

Aetna charges dialysis fraud

By DOUGLAS McLEOD

NEW YORK—The nation's largest provider of kidney dialysis services is facing new charges that it engineered an array of phony billing schemes that defrauded insurers of hundreds of millions of dollars.

Aetna Life Insurance Co. charges in a massive civil racketeering suit that Fresenius Medical Care A.G. and its National Medical Care Inc. unit systemati-

cally plundered Aetna over several years through double billing and bogus claims for services that were unnecessary or never performed.

Among many examples of these claims, Aetna cites NMC bills for purported treatment of a man who already had died and alleged outpatient services for a woman who was hospitalized at the time.

NMC carried out the schemes by controlling a vast network of outpatient clinics and related service

companies and by paying kickbacks to doctors and independent clinic owners to sell unneeded NMC products and services, the suit alleges.

Also named in the complaint is former NMC parent W.R. Grace & Co., which collected a \$2.1 billion dividend from NMC when it sold the company to Fresenius in 1996. The suit seeks to freeze the \$2.1 billion, charging it represents proceeds of the fraud.

See Aetna on page 26

Fel-Pro family-friendly benefits to stay for now despite sale

By DEBORAH SHALOWITZ COWANS

SKOKIE, Ill.—Employees of Fel-Pro Inc. generally will continue to enjoy the company's family-friendly benefits for the next two years despite the company's planned sale to a much larger manufacturer.

Fel-Pro often has been cited as one of the best companies to work for because of benefits such as a subsidized onsite day care center,

a subsidized onsite summer camp and a free onsite fitness center. The Skokie, Ill.-based automotive parts maker has about 2,700 employees.

The buyer, Southfield, Mich.-based Federal-Mogul Corp., also an automotive parts maker and distributor, has about 13,000 employees.

Federal-Mogul is paying \$225 million in common stock and \$495 million in cash for Fel-Pro. Federal-Mogul expects to take an esti-

mated \$15 million to \$20 million pretax restructuring charge as a result of the sale.

The two companies announced the agreement last week. The deal is expected to close in early March.

Fel-Pro employees were assured last week that "nothing's going to change at all in the short term," said Arlis McLean, vp of human resources. Most of Fel-Pro's benefits will be maintained throughout

See Fel-Pro on page 14

Tort reform bills coming in Florida

By MICHAEL BRADFORD

TALLAHASSEE, Fla.—Florida tort reform advocates and opponents alike are expected to find some favorable provisions in legislation that will be introduced in the state Senate and House early this year.

The Florida Senate said it will draft a tort reform bill by Jan. 26, now that it has completed a series of meetings to hear testimony from businesses, plaintiffs

lawyers and others. The meetings began in September and concluded Jan. 9.

The House is expected to wrap up similar hearings this month and introduce a bill early in the legislative session that begins March 3.

Tort reform advocates and those who oppose reforming Florida's civil justice system both can claim some successes from the hearings. The legislative drafts are expected to call for changes in the state's

civil justice system that appeal to both sides.

The Senate version, among other things, would remove vicarious liability and joint and several liability under certain conditions. Punitive damage awards also would be split between plaintiffs and the state.

Those changes and others were part of the Florida Accountability and Individual Responsibility Act, a bill that died during the 1997

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Inside

- Regulators in Massachusetts and Bermuda can help restore their credibility by returning EMLICO's liquidation to the Bay State, this week's editorial says. **PAGE 8**
- Unlimited liability names at Lloyd's of London oppose a move by corporate investors to give themselves more representation on the Council of Lloyd's. **PAGE 21**

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Lawyer says order may aid Y2K claims

By GAVIN SOUTER

EATONTON, Ga.—A cease-and-desist order by regulators against a Georgia bank not up to speed with Year 2000 compliance could give other companies new ammunition in their bid to obtain insurance coverage for upgrading their systems, a policyholder attorney contends.

"The fact that regulatory agencies now have the power to shut you down if you are not compliant makes already good claims much stronger," according to Matthew L. Jacobs, a partner with Kirkpatrick & Lockhart L.P. in Washington.

As a result of the cease-and-desist order, Kirkpatrick & Lockhart is now advising its clients to file claims with their property insurers to pay for any computer upgrades that are required to comply with regulatory orders.

However, insurers likely will reject those claims, arguing that policyholders did not suffer damage as defined under a property insurance policy, contends Lori S. Nugent, a partner with Blatt, Hammesfahr & Eaton in Chicago. The cease-and-desist orders

were slapped on a rural Georgia bank holding company, Putnam-Greene Financial Corp. in Eatonton, and its three bank subsidiaries last November by the Federal Reserve Board, the Federal Deposit Insurance Corp. and the Georgia Department of Banking.

Regulators determined that the banks' antiquated computer system would not be able to calculate interest payments correctly after the year 2000, said Joe Hudson, executive vp of Farmers & Merchants Bank, one of Putnam-Greene's subsidiaries.

Putnam-Greene was installing a new, Year 2000-compliant computer system when the regulators inspected the banks, he said. "And by the time the cease-and-desist orders were issued, we were Year 2000-compliant," Mr. Hudson said.

Consequently, none of the banks was closed.

Putnam-Greene sees the computer upgrade as a cost of doing business and does not plan to file an insurance claim to cover those expenses, Mr. Hudson said.

However, other banks should



See Year 2000 on page 25

Reproduction help

Aetna may spur health plans to review coverage

By JUDY GREENWALD

Managed care plans may revisit how they cover in vitro fertilization treatments in the wake of Aetna U.S. Healthcare's revision last week of a prior decision to withdraw coverage.

Aetna earlier this month announced that as of April 1 it was stopping coverage of IVF and other advanced assisted reproductive techniques, which it offered as part of its basic benefits coverage.

But last week, the health maintenance organization said

it was clarifying its position and will continue to cover in vitro fertilization treatments, but only for employers that select it as an option and pay an additional premium. Some people have opted for the Aetna U.S. Healthcare plan offered by their employer specifically to take advantage of the benefit.

Aetna's reluctance to offer the coverage as part of basic coverage stems from its high cost, which can run \$8,000 or more per treatment.

Proponents of the coverage say, however, that on a per-em-

ployee basis, the cost is not significant because of the relatively few employees who use these treatments.

Although the decision of an employer to offer coverage of infertility treatments is voluntary and often based on corporate philosophy, that could change with several efforts under way.

One is a push by employees to have infertility defined as a disability under the Americans with Disabilities Act, in which a failure to provide benefits could

See Infertility on next page

Coverage for infertility treatment

(Employers with 500 or more employees)

Type of Plan	Any service	Professional services	Drug therapy	Artificial insemination	In Vitro fertilization
Indemnity plans	41%	35%	28%	15%	13%
Preferred provider organizations	44	37	31	15	14
Point-of-service plans	49	42	31	18	17
Health maintenance organizations	58	53	39	26	19
Weighted average total	49%	42%	32%	19%	16%

* Plans weighted together based on employees enrollment in each plan for 1998. Source: William M. Mercer Inc. Image Bank

IT takes center stage at forum

By PAUL D. WINSTON

NEW YORK—Information technology is a hot issue for property/casualty insurers, which are spending millions of dollars annually to assure they are immune from Year 2000 problems, up to date with new technology and able to take advantage of Internet marketing opportunities.

In a broad-ranging discussion of current industry issues, a panel of property/casualty insurance and reinsurance executives discussed the Year 2000 issue among other topics. The panel discussion was part of the 1998 Property/Casualty Insurance Joint Industry Forum held Jan. 13-14 in New York.

"We expect to have everything ready by the end of 1998, at a modest cost," Douglas W. Leatherdale, chairman, president and chief executive officer of The St. Paul Cos. Inc. of St. Paul, Minn., said of the insurer's Year 2000 computer overhaul.

St. Paul began to assess its system exposure to this problem about 10 years ago, "because we had some smart IT people," he said.

One of the insurer's main concerns now, Mr. Leatherdale said, is that its various vendors will not be prepared, leading to a disruption in service.

In addition, "the liability exposure is a big question mark," See Forum on page 25

Ruling allows captive deduction

Decision second in recent months allowing tax break for captive premiums

By DOUGLAS McLEOD

WASHINGTON—For the second time in recent months, a federal court has ruled that premiums that a company's subsidiaries pay to its wholly owned captive are deductible.

A judge with the U.S. Court of Federal Claims in Washington ruled last month that units of Kidde Industries Inc. may deduct premiums paid to Kidde's Bermuda captive in the late 1970s.

The ruling follows a November decision in which the U.S. Tax Court allowed similar deductions to Hospital Corp. of America, now part of Columbia/HCA Healthcare Corp. (BI, Nov. 17, 1997). Both rulings are in line with the

landmark 1989 Humana Inc. decision by the 6th U.S. Circuit Court of Appeals.

Kidde, a manufacturing conglomerate that formerly had 15 corporate divisions and 100 subsidiaries, has since sold its operations to Hanson North America Inc. of Woodbridge, N.J.

During the product liability crisis of 1976, Kidde shifted its coverage to Kidde Insurance Co. Ltd., a newly formed Bermuda captive for which units of American International Group Inc. provided fronting services.

The company paid AIG premiums of \$25.3 million in 1977 and 1978, but the Internal Revenue Service allowed deductions only for \$4.3 million retained by AIG

and for amounts KIC actually paid in claims.

Kidde later sued for a refund based on deductions for the full premiums.

In his Dec. 31 ruling, Judge Roger B. Andewelt found that Kidde may not deduct premiums paid through June 1978 because Kidde had an indemnity agreement with AIG backing reinsurance ceded to the captive.

After that agreement terminated, though, Kidde was entitled to deductions for premiums paid by its subsidiaries but not by the parent itself or its corporate divisions, the judge ruled.

In allowing deductions for the subsidiaries' premiums, the judge found that:

- KIC was adequately capitalized and the captive insurance arrangement was not a sham.
- The captive program was con-

sistent with "commonly accepted notions of insurance."

While KIC differed from a commercial insurer—having, for example, no employees or Bermuda office and operating through a management company—the differences aren't enough to deny deductibility, the court found.

• Risk shifting and risk distribution occurred for the subsidiaries but not for the parent or its corporate divisions.

The Kidde ruling is significant because it was decided by the Court of Federal Claims and thus sets a nationwide precedent beyond the 6th Circuit jurisdiction of *Humana*, said Brett Gold, a lawyer with Baker & McKenzie in New York.

Kidde Industries Inc. vs. The United States, U.S. Court of Federal Claims; No. 447-88T.



A firefighter moves cattle to safety near Entiat, Wash., during a forest fire. Suppression policies actually have increased the risk of such fires, according to a new ISO study. PHOTO: KTR

Firefighting strategy raises wildfire risk

By MARK A. HOFMANN

The law of unintended consequences has led to an increasing wildfire peril for insurers and policyholders alike, according to a new study by the Insurance Services Office Inc.

Wildfire once was thought to be a problem primarily for Western property owners. But, as ISO's report, "The Wildland/Urban Fire Hazard," points out, the peril actually extends nationwide.

While there has been a long-term decline in the number of acres that wildfires burn annually, that drop "reflects fire suppression policies aimed at extinguishing wildfires as soon as possible," notes the report.

The unintended consequence of a policy of extinguishing fires as quickly as possible has been an accumulation of brush and other vegetation—which previously would have been consumed in a longer-burning fire—that serves as fuel for future fires.

"Without periodic natural fires or active measures to reduce fuel, the risk and potential intensity of future fires increase," according to the report.

At the same time the potential risk of fires has increased because of increased brush, the population of areas at risk also has swelled, noted John J. Kollar, ISO's vp-actuarial services and research department.

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Infertility

Continued from page 3
be seen as biased.

Moreover, a spokesman for the American Society for Reproductive Medicine in Washington said it will seek legislation to be introduced this year in Congress mandating infertility coverage.

To date, 13 states require health insurers and HMOs to cover some form of infertility insurance, but their provisions vary widely and do not necessarily include coverage of IVF treatment. They are: Arkansas, California, Connecticut, Hawaii, Illinois, Maryland, Massachusetts, Montana, New York, Ohio, Rhode Island, Texas and West Virginia.

Self-insured employers, however, are exempt from state regulations under provisions of the Employee Retirement Income Security Act, though they would be subject to a federal law.

According to the current Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans of employers with 500 or more employees (see story, page 1), on a weighted average basis, 21% of them obtain coverage for in vitro fertilization through their health care plans, while 50% have coverage of some form of infertility treatment in general.

A paper released by William M. Mercer Inc. last year estimates that as of 1995, the cost to employers of adding IVF treatment to a standard health care benefits package would be \$2.79 per member per year, and the premium would be \$3.14.

In announcing that Aetna now plans to offer advanced reproductive technology services as an optional rider, Michael J. Cardillo, president of Aetna U.S. Healthcare, said the company is proud to have been a pioneer in voluntarily offering these benefits as part of its basic coverage.

"However, we recognize that deci-

sions on benefits ought to be made by the employers who ultimately must fund them," he said.

"It gives the employer more discretion over the design of the benefits in its HMO," just as it now has for its POS and PPO plans, said Mary Case, a principal with the Kwasha Lipton Group of Coopers & Lybrand in Fort Lee, N.J. She anticipates Aetna's action will encourage other HMOs to re-examine whether this benefit should be included in basic coverage.

Infertility treatment coverage varies among managed care companies.

Norwalk, Conn.-based Oxford Health Systems Inc., for example, continues to offer advanced infertility coverage as part of its basic coverage in New York, with various monetary limits. But HIP Health Plan of New York has not offered IVF coverage for several years, a spokeswoman said.

Dr. Mitzi Krockover, vp of women's health for Louisville, Ky.-based Humana Inc., which offers IVF coverage

as an optional rider, said, "It's definitely on our radar screens in a big way." She said she does not anticipate the company will eliminate it as an option, noting that competitive forces in the markets in which it operates will be a factor in how it proceeds.

Managed care companies are "all under a lot of pressure for bottom-line numbers," said Jim Berger, senior vp at Aon Consulting in New York. "I think they're all going to be looking at big-ticket items that will come under the scrutiny of their medical directors and their financial people."

He added that most employers that provide coverage "do it either because their senior management either has a personal experience, or they just have a very pro-life view of the world."

"It's a very expensive benefit and, unfortunately, it's one of those things where often if there is a benefit, there's more of an inclination to use it, even if the statistics (for success) are pretty pessimistic," said Helen Dar-

ling, manger-international compensation and benefits for Stamford, Conn.-based Xerox Corp., which offers infertility coverage under its fee-for-service plan.

"To me, this is a pretty mainstream medical practice for people who want to have children and are having difficulty," said Suzanne Mercure, manager of benefits administration for Rosemead, Calif.-based Southern California Edison Co., which also offers coverage.

"My impression is many large employers do incorporate infertility treatment but try to limit the exposure, because of concern that if they don't, the cost could be significant," said Susan Margolis, a benefit consultant with Buck Consultants Inc. in New York. An example of such limitations, she said, could be limits on the number of covered treatment cycles.

Meanwhile, efforts are under way to have the courts declare infertility a disability under provisions of the Americans with Disabilities Act, which could create the argument that refusing coverage is discriminatory.

The ADA defines disability as a condition that substantially limits a major life activity, and courts are wrestling with the issue of whether reproduction falls into that category, with a mixed record to date.

A case scheduled for argument in the U.S. Supreme Court in March, *Abbott vs. Bragdon*, could have some impact. While it involves a woman denied dental treatment because she is HIV-positive, her attorneys are seeking to establish she is covered under the ADA because her HIV status means she cannot procreate due to the risk of passing on the disease to her baby and surviving to raise a child.

Ruling in her favor, the federal appellate court in Boston had concluded she is disabled.

The ADA, however, only calls for "reasonable accommodation" for those with disabilities, and that does not necessarily include offering coverage for advanced infertility treatments, noted Terri Finesmith Horwich, a Chicago-based attorney with Bostick, Bush-Joseph & Horwich who specializes in reproductive technology and adoption cases. Employers and health care companies still would be entitled to apply reasonableness and medical necessity tests, she said. **BI**

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BI opens new offices

Two *Business Insurance* reporters have opened new offices for the magazine in the United States.

Associate Editor Michael Bradford now is based in New Orleans, where he will continue to report on risk management, self-insurance and news in the Southeastern United States, among other topics. Mr. Bradford recently was based in the Dallas bureau, which is now closed.

Mr. Bradford's new address is 2726 Prytania, #6, New Orleans, La. 70130. His phone number is 504-269-9988; fax is 504-269-0858.

Associate Editor Sally Roberts now is based in Denver, where she will continue to report on agent and broker issues and employment liability risks among other topics and oversee the monthly Agent/Broker Topics section. She most recently was based in Chicago.

Ms. Roberts can be reached at 777 E. Speer Blvd., Denver, Colo. 80203-4214. Her phone number is 303-698-7601; fax is 303-733-2244.

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More employers offer child care benefits: Survey

U.S. employers increasingly are introducing child care benefits to attract and retain workers, a new survey finds.

The study, in which Coopers & Lybrand L.L.P. polled 171 employers of all sizes, found 43% offered child care benefits last year, significantly up from 30% in 1996.

Not-for-profit employers were the most likely to offer child care. Sixty-one percent of not-for-profit companies offered child care. The second-most likely to have child care was the business service sector, at 57.1%, followed by financial services, at 48%.

Least likely to offer child care was the wholesale/retail sector, at 23.1%, Coopers & Lybrand found.

About 61% of all respondents said offering child care benefits helped employee retention, while more than half said it improved productivity.

Benefit Beat

Employer size also was a factor, with about 73% of companies with \$1 billion or more in revenue offering child care services, compared with about 18% of those with less than \$10 million in revenue, the study shows.

Relatively few employers who offer child care benefits—only about 17%—actually had on- or off-site subsidized child care facilities. Much more common were benefits, such as flexible spending accounts, that could be used for outside child care, or referrals to outside child care.

Elder care is less common and dropped in popularity last year compared to 1996, Coopers & Lybrand found. Fourteen percent of respondents provided elder care in 1997,

down from 18% the year before. Company size was a key determinant here, as well, with 46% of companies with \$1 billion or more in revenue offering elder care benefits, while only 5% of companies with less than \$10 million in revenue offering it.

Elder care mainly consisted of referrals, though some companies—a third or less—offered counseling, support groups and partially subsidized elder care services.

The employment sector most likely to offer elder care was financial services, at 32%. Least likely were the government, wholesale/retail and transportation/utilities sectors, with no respondents in these three reporting having a program.

Although the incidence of elder care programs decreased slightly—and even though only 4% of employees were reported to be using elder care

programs—the report noted “this figure will undoubtedly increase as elder care services become a more established HR practice in the years ahead.”

The survey also found that 17% of responding employers had a telecommuting program as part of flexible work schedules. That compares with 7% in 1996. About seven out of 10 cited employee morale as a motivation, while 68% cited productivity.

About nine out of 10 companies allowing telecommuting gave employees a computer to use at home, the survey found, and almost three-fourths provided a phone line.

A copy of the report, “Employment Practices and Programs: 1997” may be purchased for \$220 by contacting Michelle Lawrence at Coopers & Lybrand, 212-259-1406.

—By Robert Kazel

Banking on benefits

SAN FRANCISCO—The Federal Reserve Bank of San Francisco has revised its benefit offerings in an effort to remain competitive with the private sector.

“The financial market is really expanding and booming, and we want to make sure as a quasi-government agency we’re as competitive as the private sector,” said Kathy Colbourn, benefit manager for the bank.

So with the help of a benefit consultant, the bank set out to answer some core questions: What is our total compensation strategy? How do our benefits match our goals? What benefits do our employees truly want?

The bank last year enlisted consultant Towers Perrin to study every division of the bank to come up with ways to attract employees.

Acting on the consultant’s benefit recommendations, the bank already has added more work-life benefits. These include dependent care, which entitles the employee to a voucher for private day care or up to 10 days at the Children First Center, a large local child care facility.

The bank also has begun forums on elder care and nutrition, Ms. Colbourn said. A transit program, giving all workers \$30 a month toward public transportation, also was begun.

In November, when the bank has its open enrollment period, it will unveil a flexible benefits program that will give employees the chance to choose such optional benefits as tuition reimbursement and extra vacation days. All of the bank’s 2,800 employees will be eligible for the new cafeteria benefits plan.

Ms. Colbourn reports that for the first time, potential employees are seeking work at the bank because they are interested in its work-life benefit offerings.

—By Robert Kazel

Lunch seating

McLEAN, Va.—Greg Oelerich now has an easier time dining in his employee cafeteria with one of his favorite lunch companions—his 18-month-old son, Max.

When Max became “a challenge to hold onto for lunch,” Mr. Oelerich became the catalyst behind a new family-friendly convenience offered by his employer, McLean, Va.-based Federal Home Loan Mortgage Corp.

Mr. Oelerich suggested early last year through an employee comment box that Freddie Mac purchase high chairs for the employee cafeteria.

Six high chairs appeared in the lunchroom a few months later. This non-traditional amenity cost Freddie Mac the price of the chairs, a company spokesman said.

Mr. Oelerich said he sees more children dining with his co-workers since the addition of the high chairs. “It creates a little fun in the middle of the day.”

A spokeswoman for Corporate-Family Solutions, a Nashville, Tenn.-based work and family services company, said: “This is truly an idea whose time has come. What Freddie Mac is doing shows how creative companies can be.”

Children are a familiar sight at Freddie Mac. The company has no in-house day care, but parents may bring their children to the office on days when their usual day care service is unavailable, the Freddie Mac spokesman said. “We have a pretty young company,” he said.

Other family-friendly programs Freddie Mac offers include an adoption benefit and a lactation program.

—By Amanda Milligan

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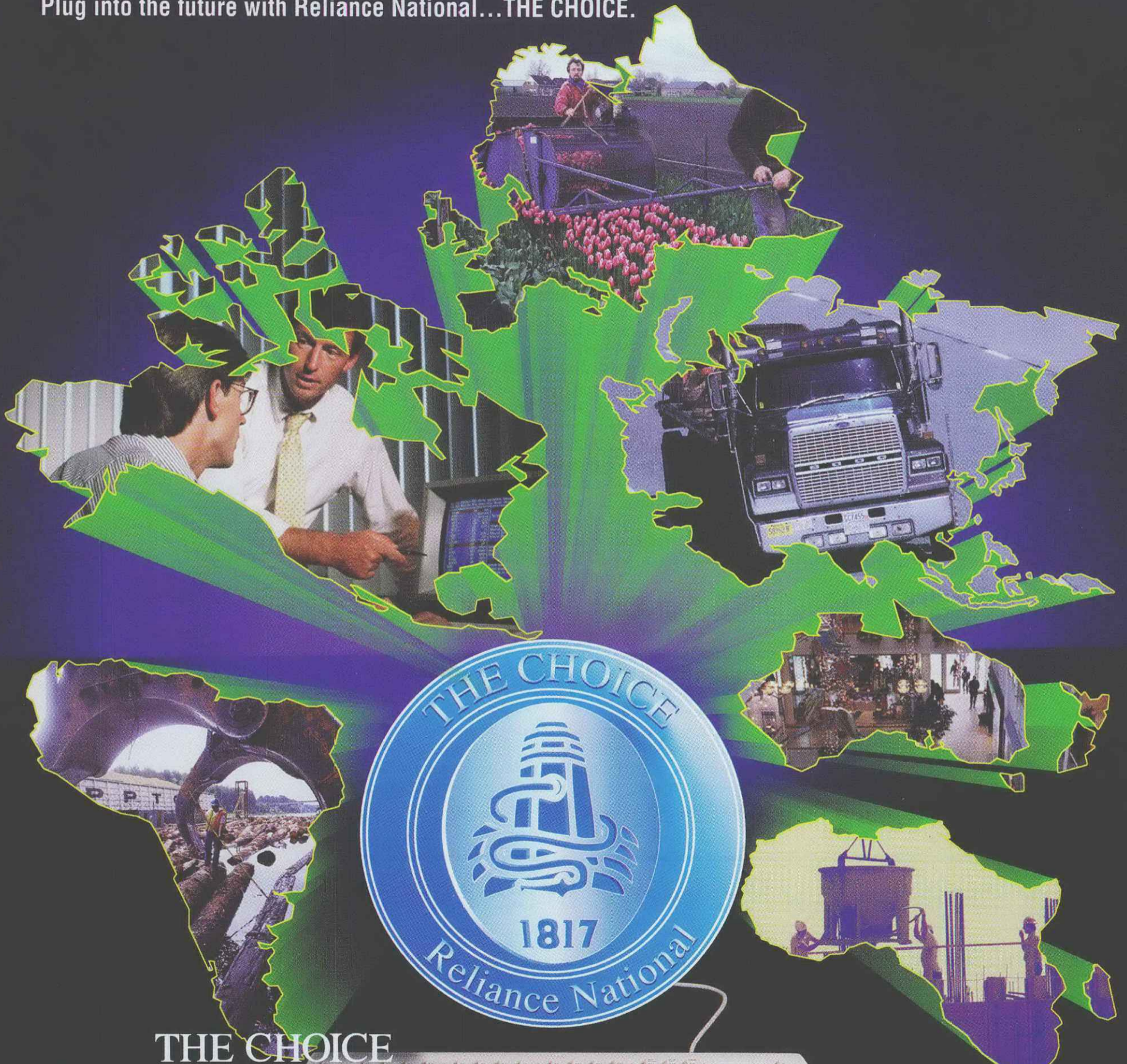
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Opinions

Grab chance to fix mess

MORE THAN two years after Electric Mutual Liability Insurance Co. jumped offshore and declared itself insolvent, the mess of its liquidation just keeps getting worse.

Massachusetts' highest court has ruled that the move was illegal, and Insurance Commissioner Linda Ruthardt has finally acted to put the company in receivership.

EMLICO's Bermuda liquidators, partners of Coopers & Lybrand, have countered with a Bermuda Supreme Court order that EMLICO remains a Bermuda insurer despite the Massachusetts ruling and that "no third party (may) purport to act on behalf of the company or interfere with the exercise by the joint liquidators of their powers." The liquidators also sued in the United States to remove Ms. Ruthardt's receivership petition to federal court.

Meanwhile, the Bermuda Ministry of Finance issued a press release saying it is powerless, in any event, to send the General Electric Co. insurer back to Massachusetts.

If this case could be more spectacularly botched—in both jurisdictions—it's hard to imagine how.

The debacle has already undermined confidence in Massachusetts regulation. Ms. Ruthardt has been roundly criticized for many of her actions, including her apparent reliance on a dictionary and EMLICO's own lawyers for her conclusion that state law allows redomestication to a foreign country.

Reinsurers, meanwhile, cite evidence suggesting that EMLICO misled Ms. Ruthardt about its financial condition as part of a plan to liquidate in a jurisdiction more favorable to GE than Massachusetts. This evidence includes a document showing that EMLICO consulted London lawyers before the move for advice on sites for a possible winding-up, including Bermuda.

Other documents obtained by Massachusetts regulators in a fraud probe show that EMLICO lawyers were in touch with Coopers & Lybrand partners in Bermuda before the redomestication on the subject of a "proposed action plan for EMLICO restructuring." The probe ended before it could be learned what, if anything, EMLICO and Coopers & Lybrand discussed before the fact about an eventual liquidation.

Massachusetts regulators now have a chance to redeem themselves by aggressively working to regain control over the EMLICO estate. That end will be difficult to achieve, though, without the cooperation of Bermuda authorities, and that cooperation sadly appears unlikely if Bermuda's current attitude is any indication.

From the start of this affair, the Bermuda government has pointedly sat on the sidelines, insisting it was aware of the risk of EMLICO's insolvency when it admitted the



company and that alleged misrepresentations to U.S. regulators are not its problem. That's an unusual position for a country whose insurance industry relies in large measure on its image as a well-regulated domicile and on the support of U.S. companies and regulators.

Bermuda Finance Minister Grant Gibbons now says the government has no power under the Bermuda Companies Act to send the insurer back.

EMLICO opponents strongly disagree, however, and cite a provision of the Companies Act giving the Bermuda registrar authority to seek a court order staying the liquidation. Opponents also argue—and EMLICO, in its own court filings, has conceded—that the Bermuda attorney general's office could bring its own proceedings to quash the redomestication, which had been conditioned on a valid approval by Massachusetts.

If and when Commissioner Ruthardt goes to court in Bermuda to halt the liquidation, the government there should support her.

So far, though, it has shown no sign of doing any of this. Although one can readily understand any nation wishing to defend the integrity of its institutions, little of how EMLICO case was handled bears defending, we believe.

If they act properly, Massachusetts and Bermuda regulators can still untangle the EMLICO mess and return the company for liquidation in Massachusetts, where it belongs. In doing so, they would move a long way toward restoring their own credibility.

Letters

Industry should support research in cat models

To the editor: I found *Business Insurance's* Jan. 5 interview with Reinsurance Assn. of America President Franklin W. Nutter, "Pushing Change Before Weather Does," to be a timely and important commentary on the need for the insurance industry as a whole to become more involved in developing scientific assessment of natural hazards.

I agree that the insurance industry should take a stronger lead in researching and validating underwriting models. Arkwright Mutual Insurance Co. is heavily in-

involved in natural catastrophe research and model verification.

Mr. Nutter observes that natural catastrophe models developed by modeling companies are the primary tool used by the U.S. insurance companies to estimate the potential impact of natural disasters on their business. While this is indeed an effective approach, I would also like to point out that, based on our experience, the models have such limitations and shortcomings that any user of these models should have on-staff expertise to under-

stand and interpret the results properly.

Thank you for including this important insurance industry subject in your magazine. Continued dialogue within the industry is the most expedient way to motivate insurance companies to support the research needed to validate natural catastrophe models.

Klaus Gebhardt
Senior Vp
& Chief Underwriting Officer
Arkwright Mutual Insurance Co.
Waltham, Mass.

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Costs

Continued from page 1

Looking at only active employees, health care costs for all employers actually declined 2.9% in 1997 to an average of \$3,594 per employee.

While the negligible change in health care costs is good news for employers, the four-year run of cost stability clearly is nearing an end, for several reasons.

One factor that kept health care costs stable last year was another big migration of employees into lower-cost managed care plans from more expensive traditional indemnity plans.

Enrollment in traditional indemnity plans in 1997 plunged to 15% of all active employees, down from 23% in 1996 as more employers—especially those with the most costly indemnity plans—dropped them.

In the past year, the proportion of large employers offering traditional indemnity plans plummeted to 35% from 52%.

"The shift to managed care plans occurred by and large with larger employers with expensive indemnity plans, who, for whatever reason, had been hanging on to those plans and finally let go," said John Erb, a Mercer consultant in Miami.

Indeed, with large employers facing a roughly \$450-per-employee cost difference between traditional indemnity plans and health maintenance organizations—the least expensive type of managed care—employers' health care costs can plunge in one year with a big shift of employees to managed care.

But with 85% of all active employees in managed care plans, the opportunity to shift sizable numbers of employees into those lower cost plans from indemnity plans is about over.

In fact, many of the remaining traditional indemnity plans actually cost less than managed care

plans because they may offer only bare-bones coverage or are offered in rural areas where health care costs are low, the survey notes.

The reason traditional indemnity plan costs for active employees dropped 5.8% last year to an average of \$3,521 per employee was not because those plans have suddenly become cost-efficient.

Instead, many more of the traditional plans offered in 1997 provided less generous benefits and

The opportunity to shift sizeable numbers of employees into managed care plans is largely over.

were offered in parts of the country that had lower costs compared with many of the indemnity plans offered in 1996.

"We're comparing two significantly different groups of employers," the survey notes.

When the survey examined just those employers that maintained traditional indemnity plans in 1996 and 1997, those employers' indemnity plan costs for active employees rose an average of 4.1% per employee.

That compares with a 3.8% increase for employers who maintained a preferred provider organization in both years, a 3.4% rise for those offering a point-of-service plan in both years and a 0.3% cost increase for employers maintaining health maintenance organizations in 1997 and 1996.

Aside from the ending of the enrollment shift to managed care from indemnity plans, costs also are likely to be moving up in the year ahead as HMOs that have in recent years held rates artificially

See Costs on page 12

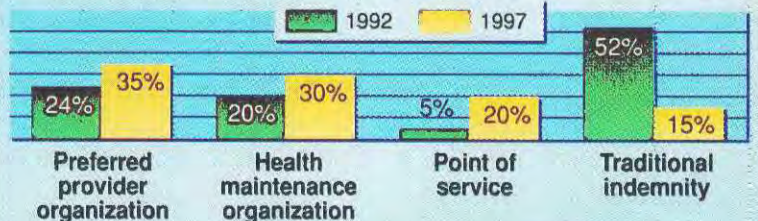
Group health care plan costs by employer size*

	1997	1996	% change
All employers	\$3,594	\$3,703	- 2.9%
10-499	3,280	3,405	- 3.7
500-999	3,853	3,589	7.4
1,000-4,999	3,733	3,844	- 2.9
5,000-9,999	3,898	3,686	5.8
10,000-19,999	3,889	3,953	- 1.6
20,000 or more	3,839	4,090	- 6.1

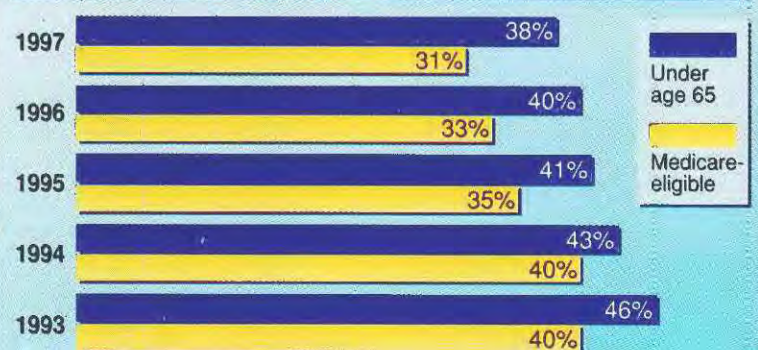
*For active employees

How managed care has grown

Percent of employees enrolled in each major type of health care plan



The decline in the percent of employers offering retiree health care coverage*



* For employers with at least 500 employees
Source: William M. Mercer Inc.

GRAPHIC BY JOHN HALL



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Costs

Continued from page 10

low to win market share now raise rates to improve their financial results.

"Given that many of the HMOs—and HMO-based POS plans—in the country posted losses in 1997, it seems unlikely that they will be able to hold down rate increases over the next few years," according to the survey.

Overall, surveyed employers expect HMO rate increases this year to be on the order of 4%.

Still, employers have been the winners as HMOs in many parts of the country have held down rates to increase their share of the market.

For many employers, HMO premium rates in 1997 were lower than those charged in each of the past three years. For example, HMO costs for active employees averaged \$3,165 per employee in 1997, compared with \$3,185 in 1996 and \$3,385 in 1994.

That effort to improve market share has paid off for HMOs. Last year, 30% of employees were enrolled in HMOs, while 20% were enrolled in point-of-service plans, typically offered through an HMO. In 1992, just 20% of employees were in HMOs, and only 5% were in POS plans.

Regionally, the biggest gains in managed care enrollment occurred in the Midwest and the South.

In the Midwest, PPOs covered 38% of employees in 1997, up from 33% in 1996, while POS enrollment climbed to 18% of employees from 14%. HMO enrollment, though, stayed nearly even, increasing to 25% from 24%.

In the South, 28% of employees were enrolled in HMOs last year, up from 23% in 1996, while POS enrollment climbed to 17% from 12%. Enrollment in PPOs—the dominant health care plan in the South—was unchanged in 1997 at 40% of employees.

HMOs have the biggest market penetration in the West, where in 1997 they covered 41% of employees, up from 39% in 1996, and the lowest penetration in the Midwest where the plans covered 25% of employees last year.

Other survey findings, all involving employers with at least 500 employees include:

- For active employees, traditional indemnity plan costs in 1997 decreased 4.3% in 1997 and averaged \$3,759 per employee.

Traditional indemnity plan costs were highest among employers in the Northeast, averaging \$4,303 per employee, a 1.7% decline.

Traditional indemnity plan costs were lowest in the West, averaging \$3,169 per employee, down 5.3% from 1996. Just 6% of employees working for large companies in the West are covered by traditional indemnity plans, the only area of the country where traditional indemnity plan enrollment is in single digits.

In the Midwest, traditional indemnity plan costs averaged \$3,893 per employee, a 0.6% decrease. Traditional indemnity plan costs in the South averaged \$3,234, a 4.3% decrease.

- POS plan cost averaged \$3,588 per employee in 1997, up 0.1% over 1996.

POS costs were highest among large Northeastern employers, averaging \$3,672 per employee, a decrease of 0.1%. POS costs were lowest in the South averaging \$3,443, down 0.3% from 1996.

POS plan costs in the West averaged \$3,627 per employee, up 1.1%, while POS costs in the Midwest increased 2.5% to \$3,537.

- PPO costs among large employers in 1997 averaged \$3,518 per employee in 1997, an increase of 2.4%.

Northeast employers had the

South, averaging \$3,010, up 0.4% from 1996.

PPO costs among Midwestern employers increased 0.2% and averaged \$3,708 per employee. In the

Because many HMOs and HMO-based POS plans posted 1997 losses, 'it seems unlikely that they will be able to hold down rate increases over the next few years,' the survey says.

highest PPO costs, which averaged \$4,022 per employee, a 7.6% increase. Average PPO costs in the Northeast leaped because many of the employers implementing the plans last year were in the high-cost New York-New Jersey metropolitan areas, Mr. Erb said. PPO costs were lowest in the

West, PPO costs averaged \$3,733, up 3.7%.

- HMO costs for large employers in 1997 averaged \$3,307 per employee, a 1.3% decrease.

HMO costs were highest among Northeastern employers, averaging \$3,713 per employee, down 1.2%, while Southern employers

had the lowest HMO costs: an average of \$3,053 per employee, which was a 1.5% increase.

In the West, HMO costs averaged \$3,108 per employee, a 1% decrease, while HMO costs in the Midwest averaged \$3,360, a 0.6% decrease.

- Twenty-seven percent of employers pay the full HMO premium for employees' single coverage, while 10% pay the full premium for family coverage.

Among plans that require contributions for single HMO coverage, employee contributions average \$39 a month. For family coverage, employees pay an average of \$127 a month.

- Eighty-three percent of employers said they agreed with the statement, "HMOs are effective in controlling our costs," an increase from 78% in 1996.

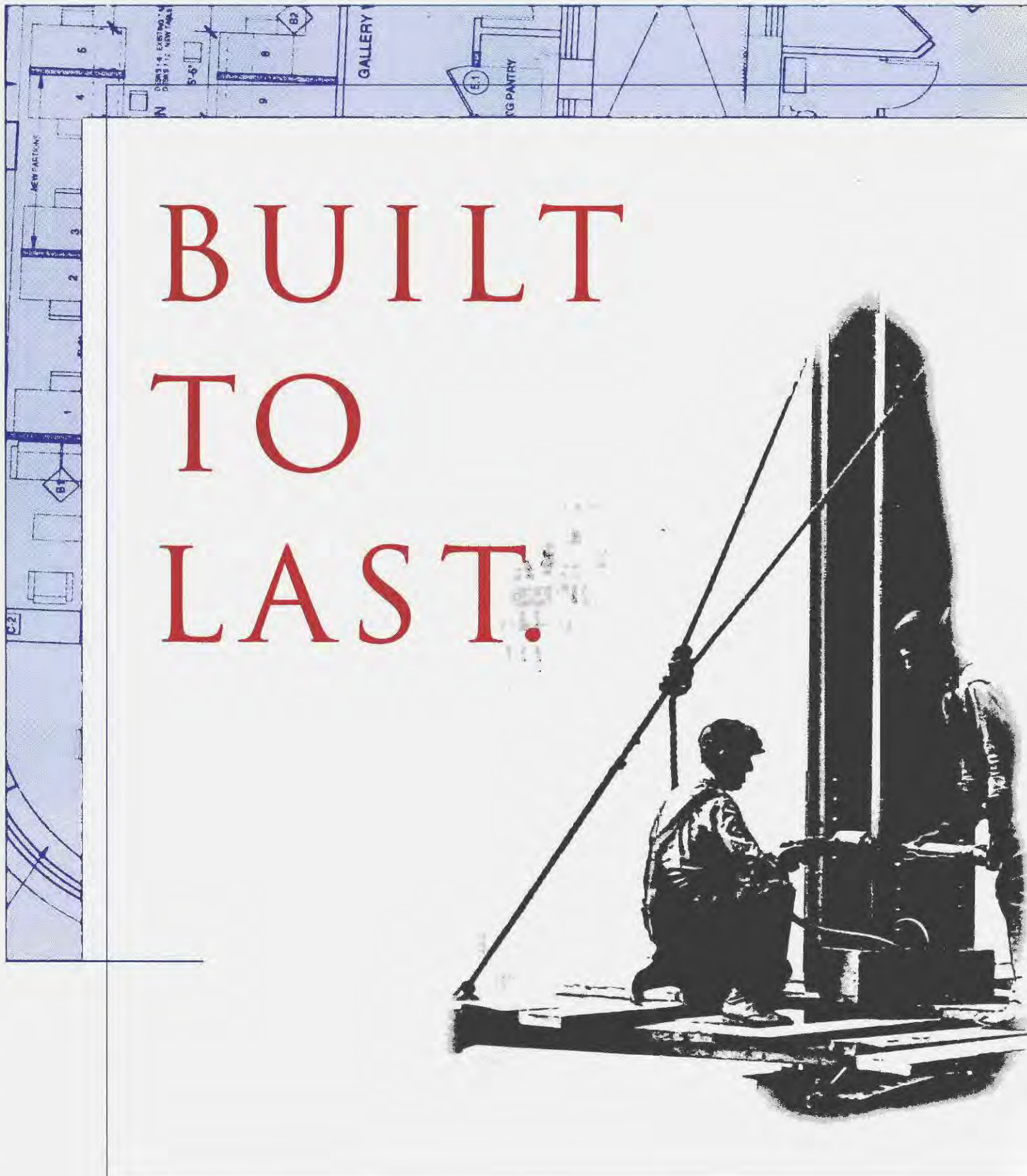
- Dental plan costs averaged \$431 per employee in 1997, up 1%

from 1996. Dental plan costs were highest in the West, averaging \$514 per employee and were the lowest in the South at an average of \$343 per employee. In the Midwest, dental plan costs averaged \$419 per employee, while in the Northeast, dental plan costs averaged \$439.

The median annual dental plan deductible is \$50.

- Nearly one-third of large employers either offer an on-site fitness center or subsidize membership in a health club.

Copies of the "Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans" will be available in early March from Tara Lewis, William M. Mercer Inc., 1166 Avenue of the Americas, 28th Floor, New York, N.Y. 10036, 212-345-2451. The cost is \$500, and prepayment is requested.



Retiree health care costs dip

Moving retired workers into managed care cited as key factor in 1% decline

By JERRY GEISEL

Employers, with a powerful assist from managed care, saw retiree health care plan costs drop in 1997.

The drop was the first since A. Foster Higgins & Co. Inc., now absorbed into benefit consultant William M. Mercer Inc., began measuring retiree health plan costs in 1993.

In 1997, retiree health care plan costs for employers with at least 500 employees declined 1% from 1996 to an average of \$3,149 per retiree, according to the Mercer survey.

Costs fell sharply for health care plans offered to retirees under 65,

declining 4.3% to an average of \$4,985 per retiree. Costs rose a modest 1.9% over 1996 for Medicare-eligible retirees to an average of \$1,910 per retiree.

The big shift of retirees to lower-cost managed care plans from expensive traditional indemnity plans, especially health maintenance organizations, is a key factor in helping employers better control retiree health care costs.

"Get your retirees into managed care. It works," said John Erb, a Mercer consultant in Miami.

Employers are picking up on that message. Last year, 26% of early retirees with employer-provided coverage were enrolled in HMOs, up sharply from 15% in

1996. Early retiree enrollment in preferred provider organizations jumped to 25% from 21%.

At the same time, early-retiree

ly retirees declined to 45% from 51%.

Retirees 65 and older eligible for Medicare also have followed their

In light of employers increasingly dropping retiree health coverage, 'it is not surprising that the government is looking for a solution,' says John Erb.

enrollment in traditional indemnity plans fell to 30% from 48% as the number of employers offering traditional indemnity plans to ear-

younger colleagues into managed care plans, though not to quite the same extent.

For example, last year, 25% of

Medicare-eligible retirees with employer-provided coverage were enrolled in PPOs, up from 17% in 1996, while the number of retirees enrolled in so-called Medicare risk HMOs climbed to 11% from 8%.

The number of employers offering Medicare-risk HMOs rose slightly to 39% from 38% in 1996. That's almost double the 21% of employers that offered risk HMOs in 1995.

As retirees move into managed care plans from traditional indemnity plans, the cost savings can be dramatic.

For example, in the West, where 89% of early retirees and 75% of Medicare eligible retirees were enrolled in managed care plans, health care costs in 1997 averaged \$2,652 per retiree.

By contrast, in the Midwest, where 62% of retirees under 65 and 30% of those eligible for Medicare were enrolled in managed care, health care costs averaged \$3,306 per retiree, or more than \$650 per retiree higher than in the West.

But a growing number of employers are taking the ultimate step to control retiree health care costs: They are eliminating the plans.

Since 1993, the number of employers offering retiree health care plan coverage has declined steadily.

For example, last year, 38% of employers with at least 500 employees offered health care plan coverage to early retirees, down from 40% in 1996 and 46% in 1993.

Among employers with at least 5,000 employees, the drop-off in the number of companies offering retiree health plan coverage has been especially sharp.

For example, last year among employers with at least 5,000 employees, 57% offered coverage to early retirees, and 48% provided coverage to retirees eligible for Medicare.

That's a sharp decline from 1993, when 71% of employers with at least 5,000 employees offered health care coverage to early retirees, while 63% provided coverage to Medicare eligible retirees.

"That's a lot of future retirees losing coverage. It is not surprising that the government is looking for a solution," said Mr. Erb, referring to a new Clinton administration proposal that would allow retirees as young as 55 in certain cases to enroll in Medicare by paying monthly premiums of roughly \$300 to \$400 (BI, Jan. 12).

Among employers still offering retiree health care plans, most employers require retirees to pay a significant share of the premium.

For example, 80% of employers offering individual coverage to retirees under 65 require retired workers to pay all or a portion of the premium.

Where premium costs are shared for individual coverage, premium contributions average \$118 a month, while the average monthly contribution paid by early retirees for family coverage is \$227.

For individual coverage for Medicare-eligible retirees, the average monthly retiree contribution is \$84, while the average monthly contribution for family coverage is \$143.

Just 20% of employers with early retiree health care plans pay the entire premium for individual coverage, while 16% pay the entire premium for family coverage.

In addition, 27% of employers offering health care plans for retirees eligible for Medicare pay the full premium for individual coverage, and 19% pay the full premium for family coverage. **BI**

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Fel-Pro

Continued from page 2

this year, and some will be kept for two years, she said.

For example, Federal-Mogul agreed to keep Fel-Pro's day care center open through this year, she said. The center can accommodate 35 children.

Fel-Pro's summer camp program, which can accommodate up to 200 children, will be open at least this summer and the next, Ms. McLean said.

The fitness center will be kept open for a minimum of two years.

Fel-Pro's medical, dental and life insurance plans will continue through 1998, after which employees may join one of Federal-Mogul's medical plans, according to Ms. McLean.

This should be good for employees, agree a Federal-Mogul

spokeswoman and Ms. McLean, because Federal-Mogul's medical benefits are more generous than Fel-Pro's.

For example, the employee's portion of the monthly premium for family medical coverage under Fel-Pro's plan is \$115, while the premium for a comparable plan from Federal-Mogul is \$50, according to the Federal-Mogul spokeswoman.

For single coverage, the employee's portion of the premium under Fel-Pro's plan is \$38, while the premium for a comparable plan from Federal-Mogul is \$16.

"I think our employees will be happy to go to the Federal-Mogul medical plan in 1999," Ms. McLean said.

Federal-Mogul also offers employees a wellness benefit that Fel-Pro does not.

The wellness program allows employees and dependents to

spend a set amount of company money each year on services such as immunizations and physicals.

Fel-Pro's owners have pledged that a portion of the proceeds from the company's sale will fund for another five years a college scholarship program the organization offers, Ms. McLean noted. Under this program, children of employees are eligible for \$3,500 annually for college tuition.

Fel-Pro for another two years will continue to give \$1,000 savings bonds to children born to employees, Ms. McLean said.

A few of Fel-Pro's benefits will change shortly after the sale is completed, though.

Fel-Pro will terminate its profit-sharing plan and, subject to Internal Revenue Service approval, all employees may participate in Federal-Mogul's 401(k) and cash balance pension plans.

Fel-Pro employees will be able to roll over profit-sharing balances into the 401(k) plan, an individual retirement account or take it as cash.

The Federal-Mogul spokeswoman pointed out that some Fel-Pro employees may have stock option opportunities from Federal-Mogul that they didn't have from privately held Fel-Pro.

Steve Rabinowitz, a principal at The Kwasha Lipton Group in Fort Lee, N.J., said that when a large industry leader acquires a smaller company in the same industry, "the usual approach is to fold (the benefits) into what they have." Mr. Rabinowitz did not comment specifically on the Fed-Pro/Federal-Mogul deal.

Both companies agreed that career opportunities for Fel-Pro employees will be enhanced by the sale because Federal-Mogul is a much larger company.

Florida

Continued from page 2

legislative session. A study last fall by Tort Reform United Effort showed the FAIR Act could cut tort costs by \$1 billion in Florida. TRUE, a coalition of business and professional groups and local governments, represented members at the House and Senate hearings.

The state Senate will meet Feb. 5-6 to amend its draft legislation.

"I'm cautiously optimistic," said E. James Brainerd, vp and general counsel for the Florida Assn. of Insurance Agents in Tallahassee. Reform advocates never have had as much momentum heading into a legislative session, he added.

The chairman of the Senate Select Committee on Litigation Reform, John McKay, could not be reached last week. The committee decided by consensus on several law changes that would be in the draft, including:

- Eliminating vicarious liability of automobile owners if they carry insurance with limits specified in the law. Rental car companies would need a \$1 million umbrella policy for each vehicle to escape vicarious liability. Under Florida's current vicarious liability law, vehicle owners are liable for accidents, regardless of the driver.

- Abolishing joint and several liability in cases involving non-economic damages of \$25,000 or less.

- Raising the standard of proof to "clear and convincing evidence" in determining punitive damages from the current standard of "a preponderance of evidence."

- Splitting punitive damages. The claimant would get 65% of an award and the state 35%. The state's portion would be exempt from attorneys fees.

- Codify federal Rule 11 regarding frivolous lawsuits so that it applies to cases heard in state courts. The Florida statute would apply during all phases of a trial, allowing portions of a suit to be declared frivolous.

- Disallowing any claim in which a claimant was found to be more than 50% at fault and intoxicated. One measure of intoxication would be the state's blood-alcohol test.

- Establishment of a statute of repose that bars lawsuits related to products more than 12 years old. The law would apply to products delivered on or after July 1, 1998.

The Senate's bill is not expected to contain caps on attorneys fees.

The Academy of Florida Trial Lawyers, which represented plaintiffs attorneys at the Senate and House hearings, could not be reached late last week for comment.

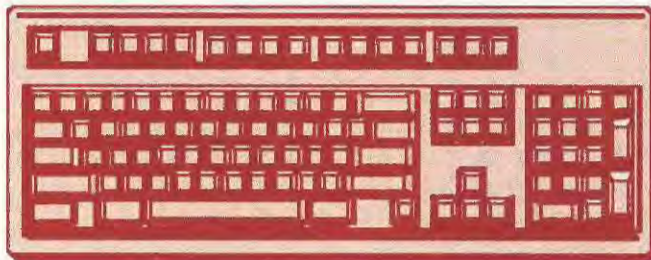
Reform advocates are hoping further changes will be made when the Senate considers amendments.

Stiff opposition to changes in vicarious liability from trial lawyers resulted in the requirement for rental car companies to carry a \$1 million umbrella policy per vehicle, explained Jodi Chase, an attorney with the firm Broad & Cassel and a lobbyist for Associated Industries of Florida, a 7,000-member business group based in Tallahassee.

Requiring the umbrella policy would give trial lawyers a "pot of \$1 million" to go after in accident cases, Ms. Chase said. If the requirement stands, some rental car companies will find it cheaper to take their chances with vicarious liability than buy the insurance, she added.

"That pretty much guts the whole thing," Ms. Chase said of the umbrella requirement. "I suspect the umbrella is going to come out" when amendments are added, she suggested.

Overall, the Senate's draft should favor advocates of reform, she said. "It's a vehicle and a really good start. This is the absolute least that we will get, and we will probably get more than this when the day is done. We feel pretty good about it." **BI**



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Consumer/Customer Relations



Competition drives insurers to pump energy into premium service

If customers ask for it, insurers will try

By MICHAEL BRADFORD

It takes more than price for insurers to stand out in today's fiercely competitive market.

Buyers want more than the lowest quote. Responsiveness, top-drawer service and a willingness to put together programs and services that meet their needs are what risk managers expect.

Insurers have gotten the message. "It's more important in this market, because the customer has maximum options," said Peter Conway, president of CNA Risk Management

in Chicago, a division of CNA Insurance Cos. He makes it clear that "we have to find a way to do what the customer wants" when handling business or courting a new account.

Risk managers confirm that low prices are fine, but they want more than a money-saving quote.

"Soft can only go so far," said Jim Green, risk manager at Justin Industries Inc. in Fort Worth, Texas.

Instead, underwriters know they have to differentiate themselves. "Insurers are trying to find ways from a marketing standpoint to be different," he said. "I've found that they

are open to a lot of suggestions."

Insurers have to be particularly responsive to buyers in a soft market if they expect to expand, agreed William J. Kelly, senior vp and risk manager at J.P. Morgan & Co. Inc. in New York. "Everybody not only wants market share but wants to grow. That can be difficult in this market."

Mr. Kelly said insurers are "more willing to entertain new or different exposures" at a time when they are scratching to expand in a continuing soft marketplace.

At least one insurer has gone so far

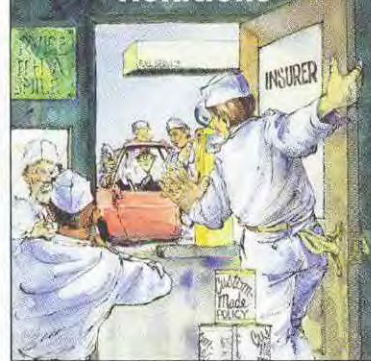
as to put its money where its mouth is when touting its superior service.

Mr. Green said that during recent renewals, an insurer offered the Texas footwear manufacturer a \$50,000 guarantee that it would "outperform the previous carrier."

All that was needed to collect the cash at the end of the policy period was Mr. Green's written notice that service had been subpar. Mr. Green still was weighing the offer earlier this month.

Two other insurers offered Justin a different kind of guarantee. Each said it would write an aggregate stop-

Consumer/Customer Relations



loss cover that calls for the insurer to pick up losses above a certain limit. And, the insurers promised, if losses did pierce the limit, they also would participate in some of the loss below the limit.

Insurers acknowledge they have to do more than provide reasonable prices and mediocre service these days. It takes a hook to reel in new accounts, and insurers' bait is willingness to listen to needs and fill special requests as best they can.

Hartford Specialty Co. gets a handle on buyers' needs through a "customer council" it formed, explained Ray Sprague, senior vp at the Hartford, Conn.-based insurer.

The council is made up of risk managers—Hartford Specialty customers and others who are not—who meet with the insurer twice a year to provide input on products, service and other needs and concerns, he said.

While pricing is the most talked-about topic in the marketplace, it isn't necessarily what risk managers are bringing up as a priority, Mr. Sprague said. "They put their highest priority on cost containment, mainly loss control."

Mr. Sprague said risk managers indicate that they see insurers as having "very good risk assessment capabilities but feel they fall short in providing solutions" to prevent losses related to those risks. "We're spending a lot of time working on those solutions," he said.

Mr. Conway said CNA Risk Management also has spent a lot of time developing loss control and other services. Return-to-work programs, medical cost management and others that help lower costs are constantly refined, he said.

Hartford Specialty's attentiveness to customers' needs and its responsiveness in trying to meet those needs has helped the company achieve a high customer-retention rate, Mr. Sprague said. Specialty services are just as important as customized products, he emphasized.

In many companies, risk management departments have been downsized, Mr. Sprague pointed out. "They are looking for some assistance to ease their administrative burden" that grows heavier when they have fewer staffers, he noted.

CNA Risk Management has emphasized its claims-paying flexibility as an attraction for workers compensation insurance buyers.

"CNA Risk Management has its own claims organization with 32 offices in the U.S.," said Mr. Conway. "That is unique."

See **Customer** on page 14D



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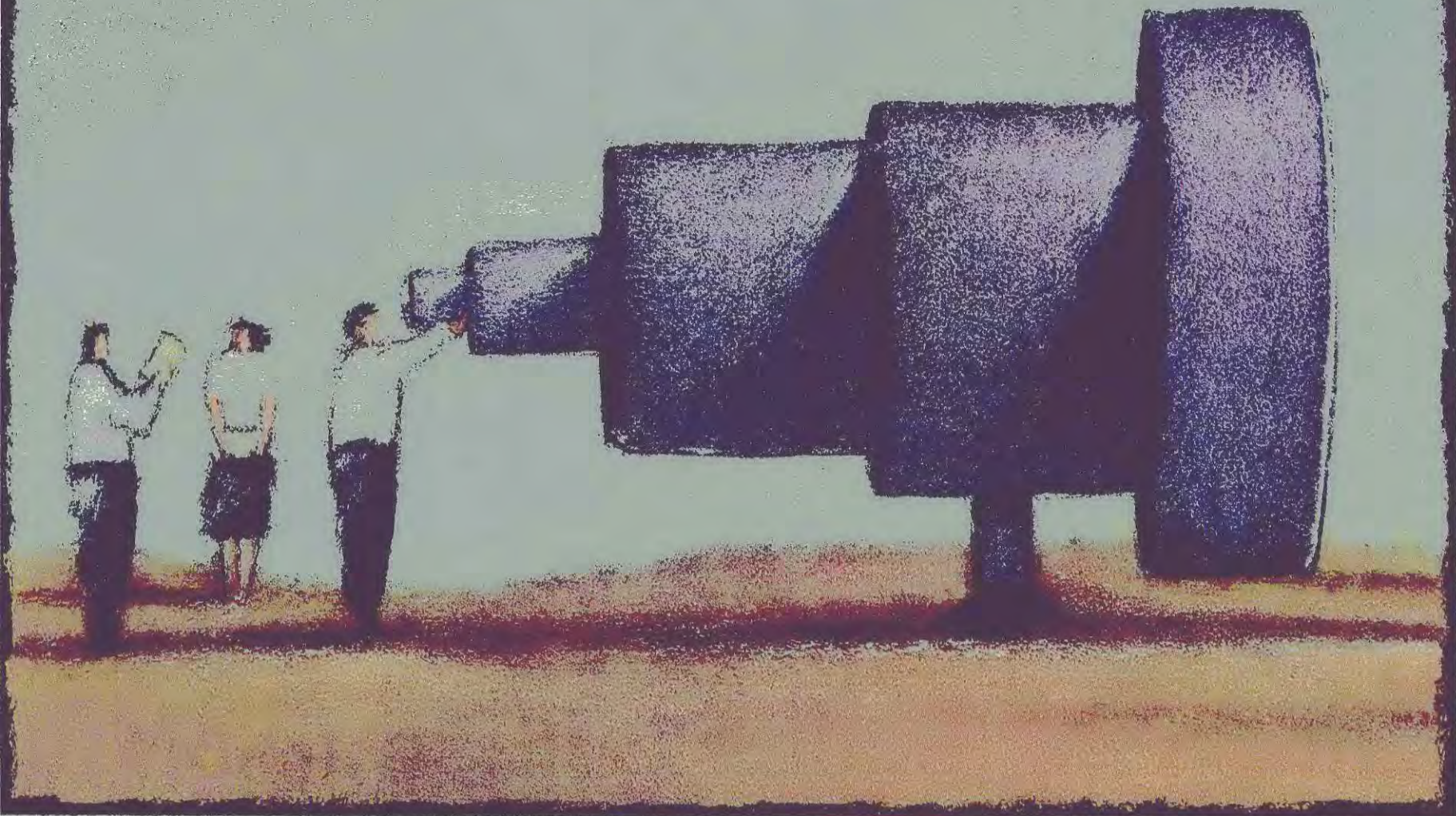
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Jan 19	Information Resource: Risk Management	IT Consumer/Customer Relations	Jan 7
Jan 26			Jan 14
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Customer

Continued from page 14B

"We can pay claims in all 32 locations, as we do for some customers, or in a series of locations as they designate," he explained. If a client wants claims paid out of a single office, that can be arranged as well.

Or, if the customer desires, a claims-handling facility will be set up at the client's location, Mr. Conway added, "with an office on their premises."

Mr. Conway said CNA Risk Management is looking for ways to provide consistent levels of service to customers with global operations.

Risk managers ideally would like products and services "to behave the exact same way in Peoria, Paris and Peru," Mr. Conway said. That's a tall order considering geographical, cultural and legal differences across the globe.

"We're working on bridging those things," he said. If large clients are adamant about having universal products and services that make risk management easier, "someone will eventually break the code and supply it," Mr. Conway predicted.

Chicago-based CNA Insurance Cos. gets high marks from J.P. Morgan's Mr. Kelly on its efforts to tie together claims and underwriting "so the client can count on a relationship with the underwriting side that

will not be lost when a claim comes in."

Mr. Kelly said it is so important to have an arrangement that allows claims and underwriting departments to work together that he insists such service be provided by J.P. Morgan's insurers.

How attentive insurers are to customers' needs these days is illustrated by the response the investment bank received last year to its request for a coverage traditionally shunned by insurers, Mr. Kelly pointed out.

J.P. Morgan was able to put together \$400 million in excess coverage against catastrophic losses from securities traders' unauthorized acts (*BI*, Aug. 11, 1997).

Mr. Kelly worked with London-based broker Minet Group, now part of Aon Group Inc., to put the program together. The coverage, with an attachment point of \$100 million, is led by American International Group Inc.

Such coverage has been scarce until recently. FMR Corp., better known as Fidelity Investments, was able to put together similar insurance in a program that includes finite risk and conventional insurance.

But underwriters, until recently, have stayed away from risks related to unauthorized trading because of the difficulty in assessing how likely an employee might be to commit such an act.

While financial institutions historically have accepted those risks as part of business, huge losses such as the \$1.3 billion collapse in 1995 of Barings P.L.C.—because of unauthorized moves by a trader in Singapore—have generated interest in the coverage.

"AIG, for one, is clearly trying to introduce new products to address issues as they arise," Mr. Kelly said. "They are sort of a leader in innovation."

National Union Fire Insurance Co. of Pittsburgh, Pa., an AIG unit, prides itself on its flexibility, according to Greg Flood, president of the insurer's management liability division in New York.

A major directors and officers liability underwriter, National Union constantly faces situations unique to particular corporations, Mr. Flood explained.

Meeting those special needs solidifies the customer relationship, he said.

"We prefer doing that," Mr. Flood said, referring to structuring tailor-made coverages, because a policy that meets specific needs encourages a long-term relationship.

National Union and other insurers know it is important to sell loss control as well as coverage.

As an example, he explained that the insurer provides as an adjunct to its coverage access to public relations firms that specialize in "crisis com-

munication" to help keep a loss from spiraling out of control (*BI*, Sept. 23, 1996).

The company handling communications for a policyholder during a crisis is able to analyze the situation, determine the potential impact and communicate the facts of the situation in a way that is understandable and unlikely to cause undue damage to the policyholder.

"We've found that people who employ crisis communication firms in those periods of distress are better able to communicate to the public," Mr. Flood said.

National Union's D&O policyholders also have access to a panel of defense attorneys located across the country. With "sort of a 911 call," policyholders are in touch with attorneys right away, "rather than scrambling around trying to find someone on their own," said Mr. Flood.

Technology increasingly is being used by insurers to make risk managers' lives easier.

Arkwright Mutual Insurance Co. is working on an online service center that technology-savvy risk manager Louis J. Drapeau is happy to help test.

Mr. Drapeau, manager-insurance and risk management at The Budd Co. in Troy, Mich., said the insurer was especially attentive in getting input from potential users of the system.

"I'm impressed that they didn't just roll something out," said Mr. Drapeau. "They designed it with the customer in mind and had us help them develop it."

"When it's up and running full-tilt, it will be a tremendous service help to us," Mr. Drapeau said. Lots of paperwork, mail and telephone calls likely will be eliminated as the system performs administrative tasks related to the insurer's accounts.

Mr. Drapeau said Arkwright's password-protected system has the potential to provide an array of services.

For the moment, users testing the system have the ability to transmit certificates of insurance and perform other "normal service requests" an insurer or buyer might transact.

Plans call for the system to allow online distribution of loss prevention reports, "a great time and paper saver for us," Mr. Drapeau noted. It also will allow "sharing of location values and things like that" as it is developed further, he added. "But basically, its potential is unlimited."

Mr. Drapeau said his department generally is not demanding of insurers. "If things are going well and everything is like it should be, we don't request a lot of information from most of our insurance carriers. If we're talking to the insurance company, usually something bad has happened." **BI**

GET THE BROADER VIEW.



Attention to service key to keeping customers happy

By Gale Davis

IT Perspective

NOW THAT'S SERVICE! Instantly comes to mind whenever expectations have been met or exceeded. Just the thought that someone took an extra step to make an experience more enjoyable or life a little easier truly makes for a satisfied customer. It's such a refreshing variation from the norm when a business considers the customer's wants and needs rather than just the bottom line.

Customer relations should play a crucial role in every business. Good customer service leads to good customer relations. This means establishing and maintaining positive experiences throughout the life cycle of every customer relationship.

Despite how good a product is, it has no value if there are no customers. Many businesses face this hardship or potential demise for various reasons. A common root cause is the lack of customer focus, with contributing factors including the lack of quality, service or follow-through.

Additionally, competition should not go unmentioned. After all, if one business can't satisfy its customers, plenty of other businesses can.

A direct line to customer satisfaction begins by taking the initiative to understand the wants and needs of customers—actually hearing what they say and then performing to meet those needs. It sounds simple enough, yet many companies, while proclaiming about quality and being customer-driven, turn a deaf ear to the voice of the customer.

The key to good customer relations is a company that believes in service. Yet this is very difficult to achieve without intensive efforts and support by management. Customer feedback proves invaluable when simply implemented into standard business operations.

Therefore, you must identify customer needs to determine possible strategies to gain the competitive edge. Being good is not good enough. You've got to be better.

In what ways can your service enable the customer to improve or enhance something they value? The task is to identify customer needs and problem situations for which your service is appropriate. It is the customer who determines value by analyzing the benefits over the cost. Two key ways to add value: Provide an unusual level of



THE QUALITY INSURANCE CONGRESS

product support, and include special product features, with service being the primary value-added feature. No longer is it enough to have the right product and price. How well does your customer service compete to satisfy?

Consumer expectations

It's no secret that insurance customers don't think the insurance industry is focused on

their needs.

Extensive research conducted by The Quality Insurance Congress shows that the industry's customers rated this industry well below other financial institutions in terms of industry performance and customer satisfaction.

The research, conducted in the spring of 1996, surveyed more than 1,600 large, medium-sized and small customers, based on premiums, to assess customer expectations and compare the results against the current performance of the insurance system.

The research has allowed The QIC to provide the insurance industry with the customer's perspective on the service issue. The results were clear: Customer service remains overlooked in the insurance industry.

The QIC released this research nationally and has offered companies educational opportunities, including cost-effective tools and methodologies aimed at customer-specific quality improvements.

The history of the insurance industry demonstrates the

qualitative changes that have taken place since 1920 and allows us to understand the need for change.

As buyers became better educated in insurance, they no longer supported the transaction-oriented process that existed prior to 1960. Customer expectations and needs increased, which led to an expansion of products and services.

As the demand for customer service increased, customers started to request that their services be unbundled and more value-added so they could customize the product to suit their own needs.

Then, as a result of the Product Liability and Risk Retention Act passed in 1986, many customers began to form risk retention groups and insure themselves. Other alternatives to insurance also began to surface.

Changes to come

In the '90s, the customer wants the industry not only to meet its expectations but also to exceed them. Buyers are seeking resolutions to problems. Brokers

See **Service** on next page

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Service

Continued from previous page
are being forced to find suppliers that can provide solutions or develop the expertise themselves and provide the service for a fee. Companies are pushing vendors into "partnerships" and "core supplier" concepts, and risk managers are applying the same concepts.

Changes will be aimed at lowering the cost of insurance transactions and subsequent service while improving the value of new and existing products and services. Now is the time for change if the system of insurance is to ever provide better-quality processes, products and services.

The common denominators of customer dissatisfaction still remain. In essence, the customer cries: "Why can't I get my policy in a reasonable amount of time? Why can't I get a bill that I can easily read and understand? Why am I paying for costly rework? A little service, please!"

Customers do not perceive enough benefits in what they are

buying; therefore, is it any wonder that price is the buyer's current determining factor in evaluating performance and satisfaction?

Who, then, will take the lead to meet customer needs and expectations? Many new players are entering the field, and competition is getting stronger. To develop or increase the competitive edge without relying on premium price reductions, it is essential to go back to the basic design of customer relations. Have you identified the needs and expectations of your customers? What are you doing with that information? Unless you meet those needs better, your customers will defect, and potential customers will pass you by. The point is, the need exists to be both perceptive and creative when thinking about customers' needs and expectations. The opportunities are unlimited.

New research needed

The lack of substantial improvement throughout the insurance industry has prompted additional research.

The QIC recently formed a strategic partnership with the Risk & Insurance Management Society Inc. to develop a process called the "Quality Scorecard" designed to evaluate the insurance industry's performance (BI, Jan. 12). This rigorous and validated seven-step research process identifies the primary drivers of customer-perceived quality and satisfaction. The process evaluates each driver's impact on perceived quality and assesses individual suppliers' performance on these drivers by utilizing 3,500 risk managers, chief executive officers and treasurers collectively from each customer organization to assess suppliers' performance and quality.

This will be a first-ever customer-driven system for scoring the insurance industry's ongoing ability to satisfy its customers. The suppliers include insurers, reinsurers, insurance agents, brokers and third-party administrators. This opportunity to determine the standards of performance will challenge the industry to perform to those standards.

The goal of the project is to bring customers directly into the process of enhancing the North American commercial property/casualty insurance industry. Customers of insurance providers will complete a questionnaire that will define key performance criteria and evaluate those criteria as they reflect the output of products and services through established research methodologies.

The Quality Scorecard will:

- Determine what customers want and need.
- Rate the insurers according to how well they meet those wants and needs.
- Provide the means to compare the level of satisfaction to previous research results.
- Be used to focus industry efforts around customer issues.
- Present the opportunity to see who is performing well and what they are doing.
- Present the opportunity to see who is not performing well and why not.
- Allow the industry to benchmark improvements in customer satisfaction.

The Katie School of Insurance

at Illinois State University in Normal will analyze and report the data as well as administer the entire project of the Quality Scorecard. The Katie School specializes in academic programs and research projects focused on insurance and risk management. The results will be released in April at the RIMS Annual Conference & Exhibition in San Diego.

Are you willing to embrace change in pursuit of continuous improvement? If so, face the challenges, review the published results and take action. It's time to get focused on the customer. If your company isn't changing, it's failing. To succeed, an insurer has to do more than follow. It has to lead. **BI**



Gale Davis is membership committee resource for The Quality Insurance Congress in Nashville, Tenn.

Personal contact, campus involvement aid recruiting

By TIFFANY KOHL

The insurance industry should pursue premium talent vigorously and get involved in activities that link companies to potential employees, a recruiter and educators say.

College students are showing the most interest in reinsurance, risk management consulting, property/casualty underwriting and brokering, one college president said.

According to a recruiter and professors, insurers should spend more time on campuses than just career days, dig deeper than traditional interviews allow and look for lifelong learners who can listen well, are prepared for rapid changes and already have shown interest in the industry with an insurance major and internship.

Michael Van Grinsven, assistant director of recruitment and campus development for Northwestern Mutual Life Insurance Co. in Milwaukee, said that though a lot of companies are using electronic tools such as the Internet to recruit, he has found it extremely important for a company representative to talk with students.

"What it comes down to is a relationship or a connection with someone in the company, be it a recruiter, manager or agent," he said.

It's not enough to send representatives to career day or to have students learn about a

company on the Internet, he said.

To break the traditional image of an insurance agent as a middle-aged male, it's essential to send younger agents to campus to spend time with students and to get involved with campus clubs and activities so the students recognize the company.

Mr. Van Grinsven said the best way to test students' abilities is to give them a practice project akin to what they would be doing for the company, such as a sample market survey. He sends prospective interns and employees to interview friends and strangers about insurance.

"Most people can intellectually think about something, but not till you do it can you get a feel for doing it," he said. "Another activity that's been effective is having students look up our Internet site and select two or three things that stand out. Then they present that information to us, maybe with handouts or a slide."

Mr. Van Grinsven said those activities help students learn more about the company on their own rather than listening to a pitch from a company representative. Students benefit by learning what to expect, and the company gets insight about their communication skills.

He said he's interested in how students have paid for their education and the amount of financial responsibility they have undertaken. Potential employees take a sales aptitude test that measures courage and or-

ganization and an entrepreneurial quotient test that gives feedback on independence and spirit.

"Qualities I look for are courage, a good vocabulary, responsibility and communication skills," he said. "They need

'Qualities I look for are courage, a good vocabulary, responsibility and communication skills,' says Michael Van Grinsven of Northwestern Mutual Life.

to listen as much as they talk and understand what they hear."

Insurance industry recruiters also can interact with students by speaking to classes, mentoring and providing internships, said Lisa Gardner, a professor who occupies the Gerald D. Stephens Chair in Bradley University's risk management and insurance program in Peoria, Ill.

"Scholarship support provides a way to get interest and attention on campus," she said. "Contact the local development officer at a college or university and offer to assist them, and get to know professors and others on campus who are interested."

Ms. Gardner emphasized that though students are interested in a wide range of jobs, priorities such as being close to family may outweigh salary for students.

"Many are interested in a career that improves people's lives," she said.

A record crowd at two job fairs in the last two years and an enrollment goal reached early for Bradley's new risk management and insurance major

this year have made Ms. Gardner feel positive about opportunities for 1998.

She said her students were prepared for careers because they have a fundamental understanding of risk management and insurance, team-building skills, proficiency in word processing, spreadsheet, database management and electronic mail as well as written and verbal communication skills.

Sandra Gustavson, head of the department of risk management and insurance at the University of Georgia in Athens, said students today are interested in finding a long-lasting job that is right for them.

"I think recruiters lose students by pressuring them to make a decision in one day or so," she said. "They should provide at least a week."

Ellen Thrower, president of The College of Insurance in

New York, said dramatic changes are occurring in preparation for work in the industry. Foreign language, familiarity with other cultures, computer knowledge and a strong grounding in finance are skills growing rapidly in importance.

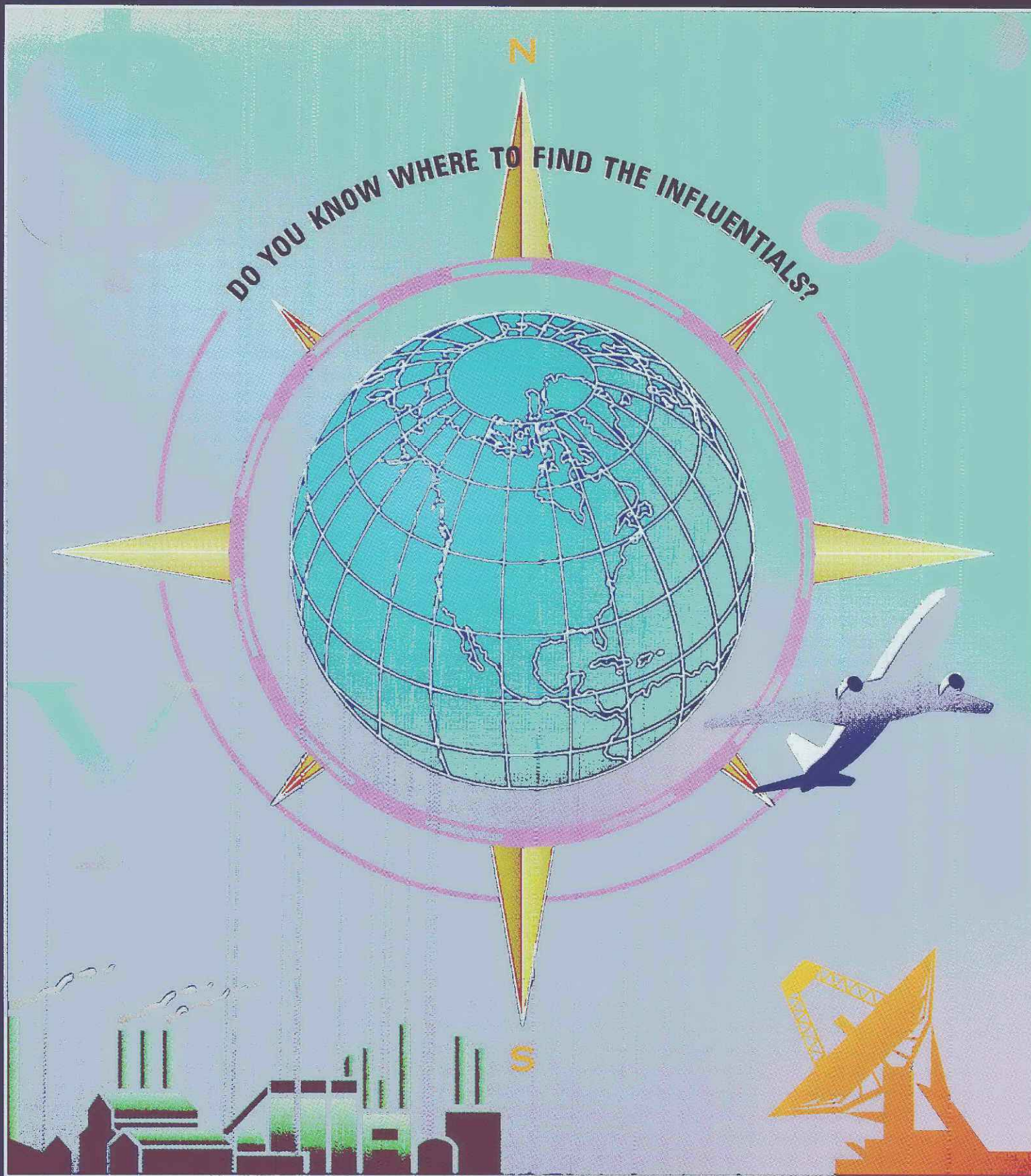
"It is essential to know more than how to turn the computer on and off and word process. You must know how to access and analyze data, and people in the industry need to be comfortable with changes," she said. "A fundamental understanding of finance, banking and economics wasn't essential 10 years ago. Insurance was a far more simple process."

Ms. Thrower said property/casualty underwriting, brokering and risk management consulting are popular among students.

Also, "reinsurance is the area where I've seen the largest growth in student interest in the last two years. It's an area that attracts innovative, curious and creative persons," she said.

In 20 years in the industry, Ms. Thrower said she has never seen a more exciting time for young people with the right skills. More companies are now searching for students who have studied insurance and risk management.

"People who major in insurance tend to stay longer and move faster," she said. "It's a change from the past, where lots of companies didn't see the difference in hiring a liberal arts grad. Many of our graduates have multiple job offers."



1997/98

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Settling for keeping the policyholder?

Insurers weigh customer relations among factors in deciding whether to fight claims

By MICHAEL PRINCE

Keeping policyholders happy is an important consideration for insurers in deciding whether to settle or fight claims.

Attorneys on the front lines of such disputes say insurers often settle with policyholders in order to maintain relationships, and brokers also often play a key role in resolving disputes amicably.

Insurance companies "want to maintain good relations with their insureds," noted Shaun Baldwin, a partner with the law firm Tressler, Soderstrom, Maloney & Priess in Chicago who represents insurers. "It's important with them to get renewal business and minimize any kinds of conflicts."

When a policyholder files a bad-faith suit, "it tends to put a strain on their relationship," Ms. Baldwin pointed out.

But insurers also look at many other factors in claims disputes. Those include the amount of premium the policyholder pays, the policyholder's attitude toward settling, the cost of continuing the litigation, the risk of losing the customer if the suit continues, the cost of setting a bad precedent, the risk of bad publicity and the impact on the insurer's combined ratio, observers say.

For example, an insurer may agree to settle a claim whose value is less than the premium on the policy, whereas the company might fight a claim that is many times the premium amount.

Maintaining good customer relations does enter into insurers' litigation strategy, said Harold Moskowitz, a partner with the insurer defense firm of Wilson, Elser, Moskowitz, Edelman & Dicker in New York.

In some cases, "the insurer will pay a claim that they might not otherwise pay," he said. The business strategy "will certainly influence the litigation."

Despite the difficulties involved, insurers can do several things to maintain a client relationship while litigating over a claim, insurer attorneys said.

To have a good relationship, "you have to be up front and honest

with policyholders" at the outset, said Lori Nugent, a partner with Blatt, Hammesfahr & Eaton in Chicago.

Also, "trying to maintain the professional business relationship while litigation is ongoing is very important," Ms. Baldwin added. "Just because a case is in litigation does not mean the attorneys have to be involved in other areas not in dispute," she said.

Eugene Anderson, a partner with New York-based policyholder law firm Anderson Kill & Olick P.C., said he thinks insurers do not care about relationships with policyholders.

Many policyholders have "a limited corporate memory" that "permits insurance companies to get away with this," he said.

For example, he said, a policyholder may decide never to conduct business with a certain insurer, but a few years later, that decision might fade from memory, or the person who made that decision may have left the company.

While policyholder suits have increased in some areas, litigation is down in others, lawyers said.

Intellectual property and advertising injury claim suits are up, for example, because the law on coverage is not well established in these areas, Ms. Baldwin said. On the other hand, suits involving environmental claims have decreased as most state courts have clearly stated rules on policy interpretation.

The heat generated by a suit varies by the attorneys involved, she said. Bad-faith suits "can be more contentious" than coverage suits, as bad-faith actions allege wrongdoing by the insurance company, she noted. The amount at stake also is larger, as punitive damages can be awarded.

The soft market has strengthened some insurers' resistance to paying claims in an effort to keep loss ratios in check, added Richard Archer, a claims resolution consultant in Santa Barbara, Calif.

He said insurer/policyholder disputes are more contentious than ever, as more money is at stake because of large product liability suits and the higher value of property.

Insurers and policyholders do agree that the broker plays an important role in resolving any dis-

pute.

"The broker may be able to articulate to the insurer better than the insured" what the concerns are, said Michael Brady, a partner with Ropers, Majeski, Kohn & Bentley in Redwood City, Calif., who represents insurers.

Inside insurance companies, a wall typically separates underwriters and claims handlers. Observers say brokers can breach that wall because they generally know both groups of people.

"The catalyst has to be the broker" to bridge the two sides, Mr. Archer said.

Dennis Connolly, senior vp with the special claims department of J&H Marsh & McLennan in New York, said policyholder attorneys sometimes hire brokers, such as himself, to help resolve disputes so the policyholder's law firm maintains an aggressive image rather than appear willing to negotiate with the insurer. In this role, brokers act as the "good cop" to the "bad cop" played by the law firm.

The broker can help resolve any conflict "by explaining the thinking of each party to the other," Mr. Connolly said. Also, a broker can defuse any animosity that may have arisen between the insurer and policyholder.

The broker also can "dampen unrealistic expectations" of both sides, Mr. Connolly said. This includes explaining to policyholders that they might not collect as much from the insurer as they expected.

And because the broker generally has more experience with claims than the policyholder, "a broker can educate the insured as to what the litigation environment is all about," he said.

Another role of the broker is to "make sure you have the right parties talking to each other," he said.

For example, in one negotiation in which Mr. Connolly was involved, a general counsel and senior outside attorney for a major policyholder met a junior claims attorney to discuss a multimillion-dollar environmental claim. The claims attorney lacked authority to settle such a large claim. Mr. Connolly said the best way to resolve claims is to arrange a meeting with senior negotiators from both sides and dispense with the preliminary

meetings of their underlings.

Attorneys for insurers said their clients often settle disputes with policyholders to maintain the relationship.

Insurance companies "look at their bigger picture and consider all kinds of business factors with insureds in deciding to pay a claim or settle," Ms. Baldwin said.

Dick Blatt, a partner with Blatt, Hammesfahr & Eaton in Chicago, agreed. "There is more to business than litigation," he said. "Commercial considerations apply, and often they should."

Mr. Anderson, the policyholders' attorney, sees it differently, however. Insurers rarely pay claims they don't think their policies cover, he said. "It is done very infrequently, and the amounts are unbelievably modest," he said.

Insurers sometimes consider the policyholder's perspective, but a far greater factor in settling is whether it helps the insurer, said Mr. Archer, the claims consultant.

"I don't think it's a matter of keeping policyholders happy as it's looking at a pragmatic business approach and saying, 'This we'll pay, and this we'll fight,'" he explained.

Insurers' lack of concern stems from the frayed ties between policyholders and insurers caused by industry consolidation. "Relationships are a casualty in the merger and acquisition mania," he said.

Terry Gilbreth, vp of risk management for Safeway Inc. in Oakland, Calif., said some insurers won't resolve a dispute if the claim is significantly larger than the premium paid. In such a case, "they could care less" if the policyholder is upset, Mr. Gilbreth said.

For example, Mr. Archer said an insurer would more likely settle a \$50,000 claim from a policyholder that pays \$1 million a year in premiums than a \$50 million claim from the same policyholder.

One policyholder negotiating tactic is a threat to switch to a competing insurer.

The threat "is an economic factor the policyholders like to remind" insurers of, Ms. Baldwin said.

"There is no relationship today that is fixed in stone," Mr. Moskowitz noted.

One twist on that policyholder strategy is staying with the insurer

Consumer/Customer Relations



in order to keep the threat alive. "I've seen that happen enough times to say that's the norm," Mr. Archer said.

Mr. Anderson disagreed, however, and said it's not a strategy he uses, "because they don't care." Claims people don't talk with underwriters and aren't threatened by a policyholder bolting to a competitor, he said.

"There is no other example of a product I know of in which the people making delivery of the goods can treat customers like hell and not hear from the sales department," he said.

From the policyholder's perspective, Mr. Archer said attention from the insurer's senior management sends a signal that the insurer takes the claim seriously.

An insurer can help keep its customers happy by opening personal contacts with policyholders to explain the insurer's position, setting forth the legal basis for a coverage decision and inviting brokers into the process, Mr. Moskowitz explained.

He added that one way to avoid litigation with policyholders is through mediation. One such facility is the New York-based Center for Public Resources, a non-profit organization founded in 1979 by 40 insurers. The member insurers have agreed to non-binding mediation with any policyholder that requests it.

"It provides a forum for an out-of-court procedure" for discussing and resolving disputes without litigation, Mr. Moskowitz said.

Another way cases get resolved is by having the insurer pay the claim, in exchange for the policyholder buying a new policy, J&H Marsh & McLennan's Mr. Connolly said.

"The opportunity to do a little mutual benefiting absolutely should be something that is considered," he said. **BI**

Insurer Topics

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AAIS site expands

BENSENVILLE, Ill.—Complete lists of countrywide forms and endorsements now are available through the expanded World Wide Web site of the American Assn. of Insurance Services.

The site, at www.aais.org, lists form numbers and names for all 17 AAIS commercial and personal lines programs, the Bensenville, Ill.-based AAIS said in a release. Also available on the site are announcements and past articles from the AAIS quarterly

IT Briefs

magazine, Viewpoint. The AAIS plans to make more information available. Site visitors also can get information on the 1998 AAIS Annual Conference, set for April 5-7 in Del Mar, Calif., the release said.

New NAI lobbyist

DES PLAINES, Ill.—Julie A. Conway has been named director of government relations for the National

Assn. of Independent Insurers.

Ms. Conway will work to convey the message of NAII members on Capitol Hill and to "expand and enhance the NAII political action committee," the Des Plaines, Ill.-based NAII said in a statement.

New RAA member

GREENWICH, Conn.—Risk Capital Reinsurance Co. has joined the Reinsurance Assn. of America.

Greenwich, Conn.-based Risk Capital Re's president and chief ex-

ecutive officer, Mark D. Mosca, is now on the RAA's board of directors.

Another development for the RAA is a new and improved World Wide Web site at www.reinsurance.org, according to a release. Industry reports, news and information on state and federal issues pertinent to reinsurers are part of the expanded content and redesign of the new site.

Users will find a simple, fast and easy-to-navigate, the RAA said in the release. New features will be added frequently, and the site will be updated continually. **BI**

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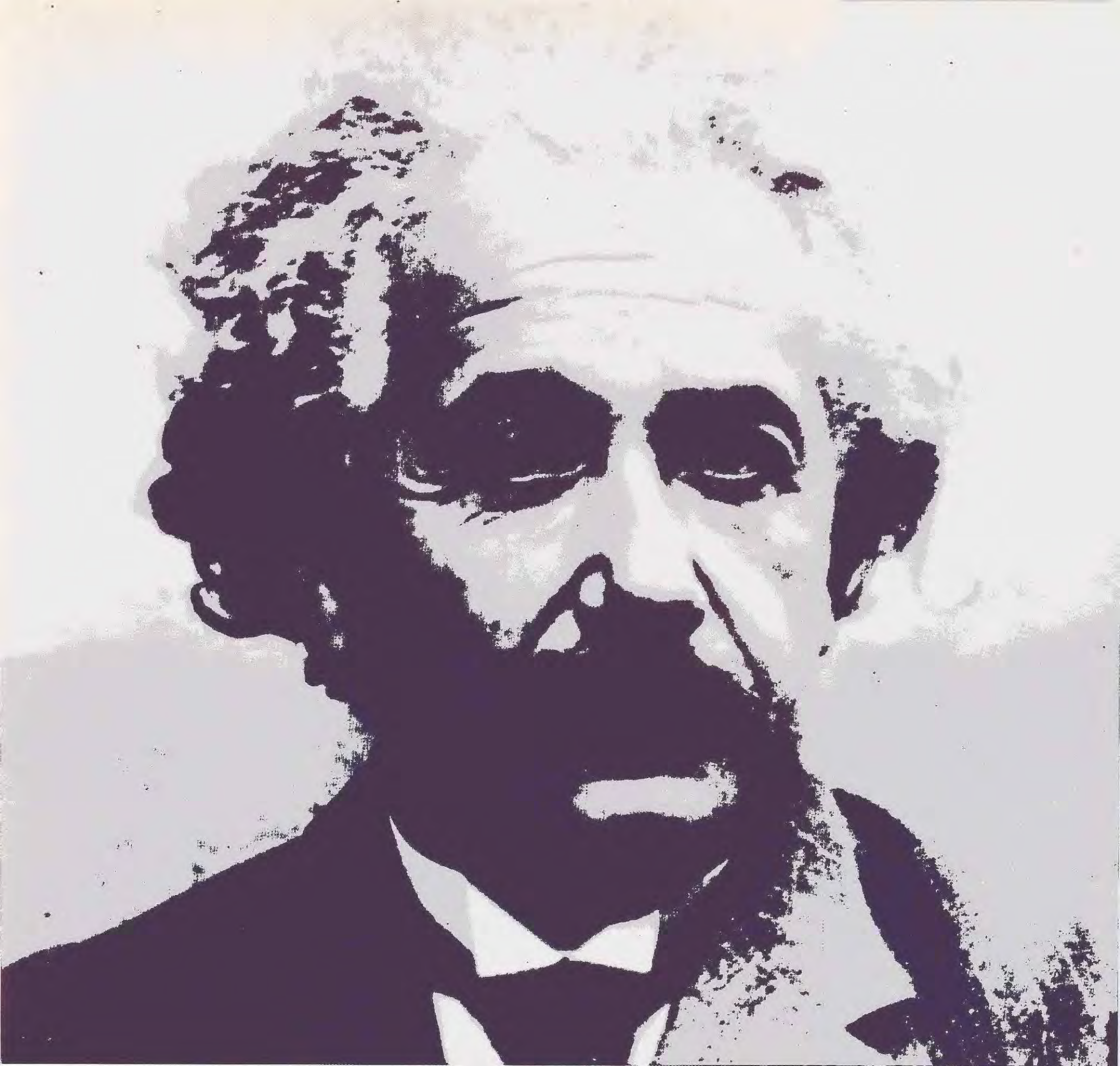
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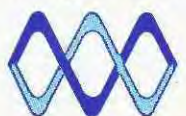
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ASK A BENEFIT MANAGER

Q What do you see as the major benefit issues in 1998?

A 1998 will be another challenging year for benefit professionals. Strategic planning is absolutely critical as always, and we will need to deal with ongoing legal compliance.

We also should be keeping an eye on Washington, as there has been discussion on a number of benefit issues.

We should also be keeping an eye on the financial markets. We have had three good years of investment returns, but there has been increasing volatility, and I am confident this volatility will continue.

We need to continue our efforts in educating employees about investments and retirement planning.

Some of the key issues for 1998 are discussed here.

• **Legal compliance.**

Don't forget about the legislation that was passed late in 1996 that will become effective in 1998.

The Newborns' and Mothers' Health Protection Act requires a minimum hospital stay of 48 hours for normal vaginal delivery and 96 hours for Caesarean section birth.

Also, the Mental Health Parity Act does not allow separate lifetime or annual limits for mental illness, unless limits are not less restrictive than those for physical illnesses. Separate copayments and deductibles are allowed. Three federal agencies issued interim regulations in December regarding mental health parity.

A leftover from the Small Business Job Protection Act is that the Section 415 definition of compensation includes elective deferrals to 401(k), 403(b) and 457 plans and salary reduction under Section 125 plans.

Also, the Health Insurance Portability and Accountability Act requires that coverage certificates include all covered dependents commencing in July.

Also, in 1998, there is Medicare Part C, called Medicare + Choice, which will offer managed care and other options to retirees. There may be savings opportunities for both employers and retirees in these programs.

Also, don't forget about the annual limit changes, such as the limit for 401(k) contributions, which increases to \$10,000, as well as the changes in the Social Security amounts and Medicare limits.

• **Future legislation.**

Beyond implementing changes required by previous legislation, it is always good to attempt to anticipate new legislation that may be passed in 1998.

Because there will be congressional elections in 1998, expect there to be some focus on legislation that will position the politicians well for the elections.

The latest talk is that President Clinton's staff is working on the fiscal 1999 budget and that two specific items that are under consideration are child care and incentives to encourage small businesses to set up pension programs. The idea of retirement income adequacy is becoming an issue in Washington.

Look for continued focus on health care quality. Previously proposed legislation (Patient Access to Responsible Care Act) included various consumer protection provisions and an amendment of ERISA that would allow suits under state tort law against administrators of employment based health plans. Also, President Clinton's Advisory Commission on Consumer Protection and Quality in the Health Care Industry is scheduled to release its full "bill of rights" report in March.

• **Health care.**

Last year in my column, my crystal ball was working very well, and I predicted increases in health care costs.

Health care costs are increasing in 1998 in the range of 3% to 8%. The main driver for the cost increase is due to the bottom lines of the managed care organizations. Their earlier efforts to obtain market share by holding the line on prices (or in some cases decreasing prices) ultimately impacted the bottom line.

The stock market has punished those organizations with poor earnings. From my perspective, it is too early to tell what will happen to health care costs in the near future. It somewhat hinges on what Washington and the states do in the area of health care legislation. There has been more talk about regulating HMOs, but there is nervousness about "Clinton" health care reform. If there is damaging legislation, look for more of the same in 1999—3% to 8%. If there is tough legislation, look for 5% in 1999. Watch Washington.

As I indicated last year, I was happy to see increased efforts on quality improvement. I hope the health plans continue down this path. The employer coalitions are pushing quality, and the health care plans are in many cases doing the same. Improved quality will result in lower costs in the long run.

I would encourage you to monitor your plan's prescription drug costs. As the baby boomers are aging, they are using more prescription drugs. Also, the pharmaceutical companies are spending increasing amounts on advertising (\$1 billion in 1997) and are influencing the purchasing habits.

If you do not have a managed prescription drug plan, it may be a good idea to consider such a plan in order to control your prescription drug costs.

• **Employee investment and financial planning education.**

Do more!

Last year I recommended that employers increase employee education in the area of investments and financial planning.

This has continued to be a hot area, and employers continue to focus on it. With the amount of assets employees have in 401(k) and profit-sharing plans, it is imperative that they are properly educated in this area.

I am happy with what I saw in October and November when overseas activities impacted the stock market. Overall, I did not observe employees bailing out of equities when the market dropped.

I see continued instability overseas, which may also impact the domestic equities market. Employees need to be reminded they are investing for the long term.

• **Long-term care.**

The HIPAA legislation provided for tax-free benefits, within certain limits, for employer-provided long-term care coverage.

Also, premiums for individual coverage are deductible by the employee. Although this change in tax status makes long-term care more attractive to employees, I have not seen employers extending employer-provided long-term care in 1997.

As our employee population ages, the need for long-term care becomes more real. Educating employees about long-term care would be useful. This could be part of a financial planning program.

• **Technology.**

The Internet! Use it if you can.

Access to employee information via the Internet is a reality. I strongly encourage you to determine if this is possible. Both viewing benefit information and processing transactions is possible.

Also, the Internet provides us with a very rich and inexpensive approach to communicating with employees.

Some other uses of technology include posting summary plan descriptions and employee benefit

statements on the Internet.

Communication is critically important in benefits, and the Internet gives us a very effective communication tool.

• **Disability plan.**

Disability insurers have experienced very high claims during the past few years.

The result has been that some insurers have moved out of the disability business, and those remaining have been increasingly restrictive regarding plan provisions and the degree to which guarantee issue policies are provided.

As the baby boomers age, we can expect to see an increased incidence of disability, which will increase our disability plan costs.

The likelihood of disability while employed is greater than death while employed.

While there is some doubt about how much the baby boomer group has saved for retirement, this group may be working longer, which will increase the incidence of disability.

We need to ensure at a minimum that our plans provide the benefits that our employees will need and will provide this coverage at a reasonable cost. This means in part that the design of our plans do not motivate employees to stay off the job and that rehabilitation procedures are in place to get our employees back to work quickly.

• **Strategy.**

We cannot forget that the role of our benefit programs is to attract and retain the employees needed in our business. We need to ensure that our benefit programs are meeting this need.

We should be checking with our recruiters and line managers to ensure that our benefit programs are meeting our needs.

It may not be a bad idea to survey your employees to determine if your benefit program is meeting their needs. We too often attempt to guess at what employees want in their benefit program rather than ask them.

In addition to program design, we need to ensure that our programs are being administered in the most efficient manner. It is critical that we effectively balance program design with administrative efficiency.

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.

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

This month's column on employee benefit management issues is written by Dennis J. Nirtaut, managing director of compensation and benefits for Andersen Worldwide S.C. in Chicago. Christopher E. Mandel, director of risk management at PepsiCo Restaurant Services Group in Louisville, Ky., 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.



Business Insurance risk management information resources

The Risk Management Information Resource section is an editorial compilation of current informational and educational materials on topics of interest to risk management, financial and insurance executives.

The listings are published as an editorial service by *Business Insurance*; there is no charge to list materials in the section. The materials, all of which may be obtained free of charge to *BI* readers, are organized under 15 headings.

Employee Benefit Information Resource listings appeared in the Jan. 5 issue of *Business Insurance*.

To receive any of the informational materials listed in this section, please write the item numbers of those materials on the reader service coupon that is printed in the section. Fill out the remainder of the coupon and mail it to:

Business Insurance Reader Service Center
650 S. Clark St., Sixth Floor,
Chicago, Ill. 60605-1702

All requests must be received before **April 15** to be processed.

AUTOMATED SYSTEMS AND SOFTWARE FOR AGENTS AND BROKERS

■ The Insurance Institute of America provides a flier on the **Associate in Automation Management program**. Request item 101.

AUTOMATED SYSTEMS AND SOFTWARE FOR INSURERS

■ A booklet explaining **interactive voice response technology**, including a glossary of terms, is provided by Information Products Inc. Request item 201.

CAPTIVES

■ A booklet on **captive company formation** is available from the Meadowbrook Insurance Group. Request item 301.

■ An overview of the **1986 Liability Risk Retention Act** that discusses risk retention groups, purchasing groups and related issues is presented by the Risk Retention Reporter. Request item 302.

COMMERCIAL PROPERTY/CASUALTY INSURANCE

■ Wilson, Elser, Moskowitz, Edelman & Dicker offers a **state-by-state analysis of laws** regarding human resources, civil rights and discrimination. Request item 401.

■ Swiss Re America has published an analysis of **global premium volume** broken down by country. Request item 402.

■ A report reviewing the **outlook of the insurance market** and analyzing major coverage lines is available from Sedgwick Noble Lowndes. Request item 403.

■ A booklet that details **property and casualty insurance courses and programs** is offered by the American Institute for CPCU and the Insurance Institute of America. Request item 404.

■ ECS Underwriting offers an explanation of issues and trends in **environmental insurance**. Request item 405.

■ A study that forecasts **property/casualty results** for the U.S. and other major global marketplaces is available from Swiss Re America. Request item 406.

■ The American Assn. of Insurance Services offers a catalog that describes its **programs and services**. Request item 407.

■ The Insurance Institute of America provides an overview of the three-course **Program in General Insurance**. Request item 408.

■ A report of recent developments in the laws regarding **issues of litigation and analysis**, including commentary on special points of interest, is offered by Claussen Miller P.C. Request item 409.

■ **Global market trends** and analyses of coverage lines and major industry segments are discussed in a report by J&H Marsh & McLennan Inc. Request item 410.

■ Great American Insurance Co. offers a **liability insurance guide** for non-publicly traded companies. Request item 411.

■ A group of **exposure sheets** featuring claims scenarios, exposure lists and guides for a wide variety of coverages is available from ECS Underwriting. Request item 412.

■ An article that proposes an industry-wide position on **genetic testing** is available from Lincoln Re. Request item 413.

■ A flier describing the **Chartered Property Casualty Underwriter program** is offered by the American Institute for CPCU. Request item 414.

■ A report that compares the **limits of liability** purchased by similarly sized companies within major industries is provided by J&H Marsh & McLennan Inc. Request item 415.

■ Guy Carpenter & Co. Inc. offers a report on the evolution of employment practices liability exposure and the options available for responding to **EPL risk**. Request item 416.

■ A newsletter offered by Mound, Cotton & Wollan discusses decisions and developments in **insurance and reinsurance law**. Request item 417.

■ A brochure from Nils Publishing Co. ex-

plores events and trends of **regulatory activity** in state and federal insurance. Request item 418.

■ Wilson, Elser, Moskowitz, Edelman & Dicker provides a state-by-state analysis of **punitive damages and unfair claims settlement practices**. Request item 419.

FIDELITY & SURETY

■ Far West Bond Services presents a pamphlet on the **basic principles of surety bonds** and issues to consider before purchasing a bond. Request item 701.

■ A flier that details the **Associate in Fidelity and Surety Bonding** designation program is offered by the Insurance Institute of America. Request item 702.

FINANCIAL SERVICES

■ A flier available from the Insurance Institute of America outlines the **Associate in Insurance Accounting and Finance program**. Request item 801.

■ A newsletter containing various articles on **securities litigation** is available from Wilson, Elser, Moskowitz, Edelman & Dicker. Request item 802.

INTERNATIONAL

■ A collection of articles that address the legal considerations of **foreign corporations doing business in the United States** is available from Wilson, Elser, Moskowitz, Edelman & Dicker. Request item 904.

■ Duff & Phelps Credit Rating Co. offers a report that discusses **rating the claims-paying ability of insurers** operating in emerging market countries. Request item 905.

■ A report examining the challenges and opportunities faced by **Latin American insurers** is presented by Duff & Phelps Credit Rating Co. Request item 906.

LOSS CONTROL/PEOPLE

■ A booklet that offers an overview of **risks and costs associated with major types of cardiovascular disorders** and their treatments is provided by American Re-Insurance Co. Request item 1001.

■ Future Industrial Technologies provides **instructional safety cards** for injury prevention and behavioral safety training. Request item 1002.

■ Total Lowback Care Management Company provides a booklet describing a **return-to-work program** designed to lower workers compensation costs for companies whose workers are prone to back injury. Request item 1003.

■ A report on legal developments in the area of **employment law**, including summaries of recent cases and tips on prevention, is presented by Wilson, Elser, Moskowitz, Edelman & Dicker. Request item 1004.

LOSS CONTROL/PROPERTY

■ A brochure on the **Associate in Loss Control Management program** is offered by the Insurance Institute of America. Request item 1101.

■ Intercargo Insurance Co. provides a discussion of ways to **reduce cargo losses** in warehouses and trucks. Request item 1102.

■ A report from Swiss Re America provides an analysis of **insured losses worldwide** from catastrophes in 1996. Request item 1103.

MARINE

■ A brochure on the **Associate in Marine Insurance Management program** is offered by the Insurance Institute of America. Request item 1201.

REINSURANCE

■ Swiss Re America provides a report that evaluates the adequacy of **non-proportional reinsurance** against natural catastrophes in major marketplaces around the world. Request item 1301.

■ Standard & Poor's offers a report providing commentary and analysis on the **Bermuda market**, including articles on catastrophe and finite reinsurance, captives and high excess liability coverage. Request item 1302.

■ NAC Reinsurance Corp. offers an article discussing **initiatives in claims processing** and electronic contracting. Request item 1303.

■ A collection of articles examining several types of **claims that may have a potential impact on the insurance industry** is available from the American Re-Insurance Corp. Request item 1304.

■ Guy Carpenter & Co. Inc. offers a **global reinsurance analysis** that discusses global expansion, growth through acquisition and the securitization of insurance risk. Request item 1305.

■ A newsletter that examines **legislative and regulatory developments** affecting reinsurance buyers is presented by NAC Reinsurance Corp. Request item 1306.

■ Duff & Phelps Credit Rating Co. offers a report that discusses the rating rationale of an entity formed for the purpose of **securitizing property catastrophe exposure**. Request item 1307.

■ A quarterly journal issue that features articles relating to **life and health insurance** has been published Lincoln Re. Request item 1308.

■ NAC Reinsurance Corp. offers a discussion of the legal and practical issues of **reinsurance contracts**. Request item 1309.

■ A **global reinsurance survey**, including a list of the world's leading reinsurers and commentary on global markets, is available from Standard & Poor's. Request item 1310.

■ Gill & Roesser Inc. offers a **glossary of selected reinsurance terms**. Request item 1311.

■ A flier that outlines the **Associate in Reinsurance program** is offered by the Insurance Institute of America. Request item 1312.

RISK MANAGEMENT

■ Willis Corroon offers a guide to **environmental regulations**, risk management and insurance. Request item 1401.

■ A newsletter providing information on plan documents and **outsourcing medical benefits subrogation** is available from Strategic Recovery Partnership Inc. Request item 1402.

■ Wilson, Elser, Moskowitz, Edelman & Dicker presents a report on recent legal developments in the area of **health care**. Request item 1403.

■ Executive Risk offers publications on **risk management procedures** for health care providers. Request item 1404.

■ A paper on what to look for and what to ask when **reviewing legal bills** is presented by the ICALM Group. Request item 1405.

■ A report on **toxic tort, latent injury and environmental issues** is offered by Wilson, Elser, Moskowitz, Edelman & Dicker. Request item 1406.

■ An article from Sigma Actuarial Consulting Group Inc. explains a **confidence interval** and how losses are estimated. Request item 1407.

■ A newsletter offering techniques for **preventing, minimizing and financing environmental risks** is provided by Sedgwick Environmental Services. Request item 1408.

■ The ICALM Group offers a **checklist of action items** for hotel management personnel with legal, financial, risk management and catastrophe planning responsibilities. Request item 1409.

■ A report outlining **environmental risks** in terms of mergers and acquisitions is available from Willis Corroon. Request item 1410.

■ Strategic Recovery Partnership Inc. offers a quarterly newsletter with topics relevant to **subrogation**. Request item 1411.

■ The ICALM Group offers a checklist to assist in the **evaluation of claims and litigation management procedures**. Request item 1412.

■ **Accountants' liability** is the topic in a report presented by Wilson, Elser, Moskowitz, Edelman & Dicker. Request item 1413.

■ A booklet examining **risk management procedures for employment practices** is available from Executive Risk. Request item 1414.

■ A booklet addressing issues such as risk management concerns, **actual claim occurrences**, upcoming events, success stories and latest breakthroughs is offered by Penco. Request item 1415.

■ **Fair debt collection practices** is the topic of a brochure offered by Strategic Recovery Partnership Inc. Request item 1416.

■ **Product liability** is covered in a report from Wilson, Elser, Moskowitz, Edelman & Dicker. Request item 1417.

■ The absolute pollution exclusion in commercial general liability policies is examined along with **environmental exposures in construction projects** in a paper by Willis Corroon. Request item 1418.

■ Sigma Actuarial Consulting Group Inc. offers a newsletter that presents an overview of the requirements of **GASB 10**. Request item 1419.

■ An overview of **insurance coverage and environmental tort cases** is provided in a booklet by the American Re-Insurance Co. Request item 1420.

■ Wilson, Elser, Moskowitz, Edelman & Dicker presents a report on **D&O and fiduciary liability**. Request item 1421.

■ Criteria for **understandable legal bills** are presented by the ICALM Group. Request item 1422.

■ An outline of the **Associate in Risk Management program** is offered by the Insurance Institute of America. Request item 1423.

■ A bulletin is available from NAC Reinsurance Corp. that analyzes **emerging liability and insurance coverage issues** facing international insurers. Request item 1424.

■ The ICALM Group presents an article on **litigation management** and successful client/counsel relationships. Request item 1425.

Business Insurance

Information Resource

To obtain copies of literature and information about products and services listed in the Jan. 19 info section, simply indicate the key numbers for the items you want and mail the coupon to:

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B <input type="checkbox"/> Financial Mgt	E <input type="checkbox"/> Loss Prevention Mgt
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Continued from page 18

Executive Risk offers a booklet focusing on risk management procedures for employment practices. Request item 1426.

A paper prepared by Willis Corroon examines contaminated property transactions and the risk management considerations. Request item 1427.

A guide to reducing legal costs through communication is presented by the CALM Group. Request item 1428.

A plan to minimize potential losses through effective risk management and appropriate insurance is outlined in a handbook from the Chubb Group of Insurance Cos. Request item 1429.

Wilson, Elser, Moskowitz, Edelman & Dicker offers an article on how hotels, shopping centers, security providers and landowners can guard against liability in premises security lawsuits. Request item 1430.

An article discussing the value of a cash flow analysis is available from Sigma Actuarial Consulting Group Inc. Request item 1431.

The ICALM Group offers a guide to successful and cost-effective litigation management. Request item 1432.

Avert Inc. provides a white paper that outlines requirements enacted under the 1996 amendments to the Fair Credit Reporting Act when using public records in the applicant screening process. Request item 1433.

A newsletter giving advice on managing and controlling costs for small to medium-sized businesses is available from Liberty Mutual Group. Request item 1434.

Articles dealing with employment-related lawsuits, policy recommendations and guidelines for prevention programs are outlined by the Brennan Group Co. Request item 1435.

A paper from Sigma Actuarial Consulting Group Inc. discusses the theory and uses of loss triangles. Request item 1436.

CNA presents a newsletter advising risk managers how to fight insurance fraud within their companies. Request item 1437.

A report on dental malpractice is offered by Wilson, Elser, Moskowitz, Edelman & Dicker. Request item 1438.

A booklet supplied by NAC Reinsurance Corp. analyzes emerging liability and insurance coverage issues affecting the D&O, E&O and EPLI markets. Request item 1439.

BNA Books presents a fact sheet defining sexual harassment is under federal law as well as how to deal with sexual harassment situations. Request item 1440.

A study by MetLife examines the financial loss to businesses as a result of decreased productivity by employees who are also caregivers. Request item 1441.

A report discussing major rating issues related to the Lloyd's of London market is offered by Duff & Phelps Credit Rating Co. Request item 1442.

An overview of current environmental regulations in certain industrial and developing countries is provided by American Re-Insurance Co. Request item 1443.

The ICALM Group offers a list of questions to keep in mind when evaluating when and where to conduct claim audits. Request item 1444.

Claussen Miller P.C. presents a report for design professionals examining the legal issues impacting the practice of architecture and engineering. Request item 1445.

Risk management issues for corporate insurance buyers are addressed in an article by the Liberty Mutual Group. Request item 1446.

A paper by MMI Cos. Inc. discusses how to prevent professional liability claims relating to cancer and cardiac diagnoses in the physician office setting. Request item 1447.

Brochures are available from MetLife that provide brokers with reference tools relevant to their business, such as Internet capabilities, travel tips and time management. Request item 1448.

Wilson, Elser, Moskowitz, Edelman & Dicker offers a report on medical malpractice defense. Request item 1449.

A bulletin presented by NAC Reinsurance Corp. that provides analysis of

emerging liabilities and insurance coverage issues. Request item 1450.

A paper describing the use of predictive models to manage risk in industrial organizations is provided by The Reliability Group. Request item 1451.

A report that discusses recent legal developments and cases concerning various liability coverages is supplied by Wilson, Elser, Moskowitz, Edelman & Dicker. Request item 1452.

A quarterly newsletter that explores various risk management issues is available from Crawford & Co. Request item 1453.

RISK MANAGEMENT INFORMATION SYSTEMS

A paper from Pyramid Services Inc. outlines a four-step quality control program to help risk managers consolidate and deliver accurate company data to clients. Request item 1501.

Deloitte & Touche L.L.P. presents a step-by-step guide for testing RMIS software. Request item 1502.

Dorn Technology Group Inc. offers a paper exploring the necessity of adhering to data standards, improving data quality and workable solutions for effective management of risk and claims data. Request item 1503.

An overview of the RMIS marketplace in 1997 is offered by Deloitte & Touche L.L.P. Request item 1504.

Structured Financial Associates Inc. offers a diskette that presents the definition and technical functions of structure use in an individual claim. Request item 1505.

SELF-INSURANCE SERVICES

A brochure from Insurance Claims Auditing and Professional Services Inc. explains how to determine if a self-insured health or other benefit plan needs a claim audit. Request item 1604.

A directory of companies that provide products and services for self-insured employee benefits or workers compensation plans is available from the Self-Insurance Institute of America Inc. Request item 1606.

WORKERS COMPENSATION

Colorado Compensation Insurance offers a brochure on designated provider discounts and Cost Containment Certification. Request item 1701.

An article dealing with workers compensation in California, including information on undocumented workers, is available from the Rehabilitation Professionals Inc. Request item 1702.

A report on travel management is provided by International SOS Assistance. Request item 1703.

Gates McDonald provides a newsletter focusing on changes and events in unemployment compensation and workers compensation. Request item 1704.

The Rehabilitation Professionals Inc. have presented an article about defending and arguing psychiatric claims in California. Request item 1705.

A pamphlet produced by Colorado Compensation Insurance highlights the benefits of return-to-work programs and provides ideas on implementation. Request item 1706.

The settlement of vocational rehabilitation benefits in California is the topic of an article available from the Rehabilitation Professionals Inc. Request item 1707.

Aholm & Monahan offers a quarterly law update on Illinois claims-handling techniques and issues. Request item 1708.

A brochure presented by Colorado Compensation Insurance details an experience modification rating for in-state policyholders. Request item 1709.

An article provided by the Rehabilita-

tion Professionals Inc. describes the consequences to an employer when a late offer of modified or alternative work is made. Request item 1710.

Aholm & Monahan offers a resource manual on handling and defending Illinois claims. Request item 1711.

Medical and legal issues, auditing claims and fraud prevention are discussed in an employer's guide to worker's compensation insurance in Colorado presented by Colorado Compensation Insurance. Request item 1712.

Rehabilitation Professionals Inc. presents an article detailing the duty of the employer to investigate modified or alternative work. Request item 1713.

Strategies for using workers compensation information in the hiring process is outlined in a booklet by Avert Inc. Request item 1714.

The employer's role is explained in a brochure about managing claims and reducing litigation published by Colorado Compensation Insurance. Request item 1715.

Intracorp provides a study of individuals who have experienced work-related injuries or illnesses. Request item 1716.

A pamphlet that discusses and tests knowledge of absenteeism is available from Martin Dennison Press. Request item 1717.

A paper describing the effects of an inadequate notice of potential eligibility is provided by the Rehabilitation Professionals Inc. Request item 1718.

Richard B. Frank & Associates offers a management bulletin for training managers and supervisors. Request item 1719.

Frequently asked questions about underwriting workers compensation insurance are described in a pamphlet available from Colorado Compensation Insurance. Request item 1720.

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INTERNATIONAL

Global Briefs

The next insurance license that China awards to a foreign insurer will go to a British company, according to Margaret Beckett, U.K. trade and industry minister, who issued the statement during a recent visit to China. Ms. Beckett said that she had positive indications the license would be awarded in the near future, according to news reports the DTI confirmed. . . . The severe storms that clobbered Britain between Dec. 24, 1997, and Jan. 4, 1998, could have caused insured damage of up to **£650 million** (\$1.06 billion), according to London-based broker Willis Faber & Dumas Ltd. Breaking down the storm claims into last year and 1998, the broker says the estimated claims for this year alone of up to **£500 million** (\$817.5 million) could rank as the fifth-most costly natural disaster on record in Britain. . . . Members of the **London International Insurance & Reinsurance Market Assn.** and the **Institute of London Underwriters** have voted 75% in favor of merging the two organizations. A final vote on the merger will take place at two special meetings once terms of a union have been decided, though the two organizations meanwhile will work more closely together. . . . Specialist international reinsurance broker **PWS Holdings P.L.C.** of London has reported a 41.8% rise in pretax profits for the year ended Sept. 30, 1997, to **£1.1 million** (\$1.8 million). Brokerage revenues improved by 3.2% to **£10.9 million** (\$17.6 million), the broker reported. . . . Paris-based broker **Gras Savoye S.A.** has formed a new unit, **Inspace S.A.**, to offer insurance and reinsurance brokerage services as well as risk management consulting for space and space-related risks. . . . Lloyd's of London managing agency **Liberty Syndicate Management** has appointed Tom Corfield as underwriter-designate for syndicate 190. Mr. Corfield recently joined the syndicate as a property underwriter and will take responsibility for the whole syndicate following the retirement this summer of John Wetherell. . . . **AXA Re UK P.L.C.** has promoted Sarah Peters to underwriter in the U.K. property division of its facultative department. She joined AXA Re in 1996 as an assistant underwriter. . . . Standard & Poor's Corp. has lowered its claims-paying ability rating and issuer credit rating on the Indonesian government-owned insurer, **P.T. Asuransi Jasa Indonesia**, to BBB- from BBB. S&P said the downgrading reflects the continued turmoil in the Indonesian economy and financial markets. . . . **Swiss Reinsurance Co.** is reorganizing to distinguish its various regional market operations. Beginning July 1, the Zurich-based reinsurer's European and Asia/Pacific non-life operations will be structured into two divisions: Europe and Asia. Latin American operations, which currently are linked to the Southern Europe division, will become a separate division. At the same time, the life and non-life operations of Union Reinsurance Co., a wholly owned subsidiary, will be merged into Swiss Re. The group is also creating a separate division, Reinsurance & Risk, which will be headed by executive board member Bruno Porro as chief reinsurance and risk officer. . . . **The Hartford Financial Services Group Inc.** has paid \$20 million to buy 49% of **The People's Insurance Co. Ltd.** in Singapore. Meanwhile, Hartford Re Co. has opened an office in Miami to serve the Caribbean and Latin America.

Names oppose Council change

By SARAH GODDARD

LONDON—Unlimited liability names at Lloyd's of London strongly oppose a proposal by limited liability investors that would alter names' representation on the Council of Lloyd's. About 60% of Lloyd's estimated 1998 capacity of **£10.13 billion** (\$17.01 billion) is provided by corporate investors, which underwrite on a limited-liability basis. As a result of their majority, the Lloyd's Corporate Capital Assn., a body representing those members, has called for reforms to Lloyd's Council to better reflect the market's changed capital structure. Currently, two members of the

19-member council represent corporate investors, including former unlimited liability members who have converted to limited liability status. Five traditional names sit on the council.

"This unnecessary segmentation should be replaced by a single external constituency, with appropriate safeguards for the minority as it continues to fall in size," proposes the LCCA in a statement. External constituents would be the limited and unlimited liability investors who are not working members of Lloyd's. But groups representing tra-

ditional names rebut the LCCA's proposal.

Members of the High Premium Group, a body representing unlimited liability names each supplying **£1 million** or more capacity, condemned the LCCA proposal as an aggressive plan to serve the limited-liability corporate investors at the expense of the unlimited-liability individual investors.

"I see no reason why corporate capital can't work alongside unlimited capacity," said Lady Delves Broughton, chairman of the HPG and a former

member of the Lloyd's Council. "Members invited corporate capital to join them, not to evict them, which is what they seem to want to do," she said.

Lady Delves Broughton, whose seven-year term on the council representing external members ended last year, said it is "extremely unhelpful for the LCCA to continually attack unlimited names and create disharmony."

The Assn. of Lloyd's Members, which counts two corporate capital vehicles among its members, described the LCCA's proposals as "potentially harmful to the market's unique position in the insurance industry and largely irrelevant to the

See Names on page 23

LLOYD'S

Risk management urged for U.K. lawyers

By CAROLYN ALDRED

LONDON—In the wake of more lawsuits and steep rate increases for professional indemnity coverage, U.K. lawyers must begin better managing their liability risks, according to a new report.

A report published last week by a Law Society task force concluded that risk management and new insurance arrangements are needed to reduce lawyers' costs and enhance the profession's reputation.

The Indemnity Insurance Review Group, chaired by lawyer John Appleby, issued its report weeks after an announcement that the Solicitors Indemnity Fund, which insures the professional liability risks of all law firms in England and Wales, is massively underfunded.

The SIF, a mutual insurance fund that has provided the mandatory **£1 million** in coverage since its formation in 1987, faces an estimated **£454 million** (\$739.8 million) shortfall, despite 50% rate hikes last year.

Although a majority of the Appleby review group recom-

mends preserving some form of mutual insurance arrangement, most favor multiple insurance funds to underwrite various law practice risks.

The Council of the Law Society will consider the Appleby report later this month and early February, when it will decide on a consultation process. The review group recommended making the report available to all law firms for a four-month consultation period. The changes would require new regulations and likely would not be implemented until sometime in 1999.

Ultimately, the findings of the review group could mean the end of the SIF and possible closure of law firms with poor loss experience.

Among its recommendations, the Appleby report concludes that "it can no longer be the case that cover is available to all members of the profession irrespective of their claims record."

The group also recommends:

- Maintaining compulsory professional indemnity coverage of **£1 million** (\$1.7 million)

See Lawyers on page 23

Zurich scraps Asian venture

Interest in region remains high

ZURICH, Switzerland—Zurich Group will continue to look at opportunities to expand its reach in Asia, despite the collapse earlier this month of acquisition talks with Hong Kong-based Peregrine Investments Holdings Ltd.

Peregrine, one of the largest financial services companies in Hong Kong, collapsed just days after Zurich pulled out of a proposed deal to buy 24% of Peregrine's stock, originally valued at \$200 million before the collapse of Asian stock markets (BI, Nov. 24, 1997).

Speaking at a news conference to launch celebrations for Zurich's 150th anniversary, Chairman Rolf Hueppi said the company will continue to look for growth opportunities in insurance and asset management in Asia. But he could give no details on the sorts of investments Zurich will make or when the organization anticipates

growing in the region.

A spokesman for Zurich said the company was not taking an "opportunistic approach" to investing in southeast Asia and instead is looking at a long-term strategy.

The initial agreement with Peregrine had contained a clause saying the deal could be renegotiated if circumstances changed before it was finalized. The collapse in the Hong Kong stock market resulted in a plunge in the value of Peregrine's shares, said the spokesman.

Subsequent renegotiation between Zurich Centre Investments, the New York-based private equity unit of Zurich Group, and Peregrine did not produce an agreement, and the talks collapsed Jan. 9.

The investment house went into liquidation the next Monday with estimated liabilities up to \$1 billion.

—By Sarah Goddard

Explosion rocks Malaysian plant

By MARIA KIELMAS

BINTULU, Malaysia—An explosion that shut down a petrochemical plant in Malaysia is expected to cost the owner millions of dollars.

Shell MDS (Malaysia) Sdn. Bhd., a subsidiary of the Royal Dutch/Shell Group, still was assessing the damage to its middle distillates plant in Bintulu, Sarawak, Malaysia, after the Dec. 25 explosion.

Although the plant remained closed last week, Shell MDS early this month denied local press reports that the plant would be shut down permanently.

An investigation into the cause of the explosion still

is under way, according to a Shell MDS spokesman in Bintulu.

Shell has not released any information on its insurance coverage or possible third-party property damage or liability claims by local residents affected by the fire.

The plant, which was constructed in 1993 and was the world's first middle distillates synthesis plant, produces annually 517,000 tons of products such as kerosene, naphtha, paraffin and gas oil from locally produced natural gas.

Shell's broker for the risk is Miller Energy Ltd., a division of London-based Miller Insurance

See Explosion on page 23



GRAPHIC BY MIKE GARVEY

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Sub-total	28,694
Associations	305
Government, Unions and Educational Institutions	1,046
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Sub-total	30,045
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Others Allied to the Field	915
Total Qualified	51,229
Non-qualified/Paid Subscriptions	31
Single Copy Sales	2
TOTAL CIRCULATION	51,262

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

Names

Continued from page 21

In a statement, the ALM said the LCCA proposal "would potentially subject the Council of Lloyd's to dominant market forces and reduce its independence." The ALM is concerned that the council's independence could be threatened by an imbalance in favor of limited liability members.

In addition to the two corporate representative and the five traditional names, the council consists of six working name representatives and six persons with no relation to Lloyd's who are approved by the Bank of England.

The ALM sees Lloyd's strengths of flexibility and a diverse and independent capital base as being threatened by a trend of corporate capital providers increasingly becoming syndicate managers as well. The LCCA was unavailable for

comment on the proposal.

A Lloyd's spokesman said that these concerns currently are being studied by a working party looking into investors' voting rights and representation. The working party, chaired by former Bank of England director Pen Kent, is expected to make its recommendations this spring.

One reason the proportion of unlimited liability names is dropping is that those names don't have access to the new breed of corporate syndicate introduced to Lloyd's four years ago, said Edward Vale, an ALM consultant.

Provisional figures for the 1998 year of account show that 28 of the 155 syndicates underwriting this year are "dedicated," meaning that the capacity of each one comes from one corporate investor.

Although Lloyd's still has to collate the final figures, about £1.4 billion (\$2.35 billion) of the 1998 capacity is provided this way, representing about 14% of Lloyd's un-

derwriting capability.

Unlimited liability names are unable to join these syndicates, though corporate capital has access to all the syndicates that names can participate on, pointed out Lady Delves Broughton. "It does seem unfair when there is one central fund carrying the risk totally of Lloyd's," she added.

Mr. Vale proposed that all syndicates should have a mix of capital sources to provide a natural balance, suggesting that half the capacity should be provided by traditional non-aligned names.

Dedicated syndicates currently are not being scrutinized by names, their agents or spread corporate investors who invest in a mix of syndicates and so may not be subject to the same sorts of "checks and balances" to which mixed and traditional capacity are exposed, he said. Ultimately this could impact on Lloyd's central fund, the fund of last resort for paying claims of failed syndicates. **BI**

Lawyers

Continued from page 21

for all law firms operating in England and Wales.

• Mandatory risk management procedures as part of any new insurance system for law firms.

Among the proposed procedures are measures reflecting law firms' practice and exposure to suits and appointment of a risk management partner to ensure compliance.

• Disciplinary action against law firms that fail to comply with established risk management standards.

"Stricter risk management criteria for all firms should be applied from the very outset, and the possibility of disciplinary action against firms should be considered," the report concludes.

Firms with very poor claims records "would be given a period of two years, under strict supervision, in which to demonstrate that they had introduced risk management systems," the report explained, adding that those failing to improve their claims records "would no longer be insured by the fund."

An uninsured firm would be unable to continue to practice, the report noted.

Until now, law firms' "approach to risk management has been at best informal and at worst non-existent," the report stated.

Although the review group looked at the possibility of lawyers seeking traditional insurance coverage in the market, the report said disadvantages such as reduced bargaining power and the possibility of a hardening market outweighed the advantages, which include greater freedom and competition. Similarly, the group said a master policy held by the Law Society had more disadvantages than advantages.

Although the majority of the group concluded that a mutual insurance arrangement remained the best option, it concluded that "SIF in its current form does not represent the best method of providing indemnity for the future."

Most of the group recommended adopting multiple mutual insurance funds, as proposed by consulting firm Whittington Insurance Services Ltd., which provided independent advice to the review group.

Under the multiple fund system, a member's annual contribution would be made to a fund established for the legal discipline the member practices, such as property law, for example. Reinsurance would be arranged for each fund, with a provision permitting additional member contributions before reinsurance became effective. In the event of catastrophic losses, a fund of last resort similar to Lloyd's of London's Central Fund would be available. The guaranty fund would be supported by levies on member law firms, and each fund would be administered by an appointed insurance industry professional.

Elizabeth Mullins, managing director of the SIF, welcomed the group's conclusion that a mutual arrangement remained the best solution for insuring law firms. However, she noted that a multifund system is "a more complex structure with practical and cost implications."

SIF plans to scale its premiums to reflect differing risks later this year and can achieve "exactly the same aims" in differentiating between business sectors, she said.

"We need a rigorous comparison of costs between setting up a multifund and the consequent running off SIF and reforming SIF," Ms. Mullins said.

She also agrees that risk manage-

ment should play a greater role.

Mike Walton, insurance operations director for Whittington, a subsidiary of Lloyd's underwriting agency Murray Lawrence Holdings Ltd., welcomed the review group's recommendation of a multifund arrangement.

SIF's current disadvantage is that it "has no penalties for bad claims experience," he noted.

Prior to the Appleby report, huge rate hikes and SIF's continuing poor results had prompted many law firms to call for permission to buy primary coverage in the open market.

"I have no problem with having to buy professional negligence cover, and I have no problem paying high rates if I have a poor claims record, but I object to subsidizing the entire legal profession," said John Heller, senior partner of Hammonds Suddards, a law firm with offices in London and Leeds.

Following the latest SIF rate hikes, Hammonds Suddards is paying £812,000 (\$1.3 million) for £1 million of cover for each and every claim, with a £150,000 (\$244,425) individual and £450,000 (\$733,275) aggregate retention, said Mr. Heller.

That figure includes a discount of £19,000 (\$30,960) for the firm's low-risk work and a low-claims discount of 12%, he added.

Law firms should be able to buy insurance as they do their other goods and services, Mr. Heller said.

SIF is a mutual "which cannot choose its members" because it must provide all law firms with coverage. Therefore, firms with good claims experience are "being penalized for the bad habits of others," said Mr. Heller.

Many lawyers blame recent rate increases on the increasing incidence of property-related litigation following the slump in U.K. property prices in the 1990s. They claim that SIF has failed to discriminate sufficiently between those firms with good and poor loss records.

Peter Bonner, a lawyer specializing in criminal work in Lewisham, South London, said his "premiums went up substantially this year" and represent a substantial cost to his firm, Peter Bonner & Co., even though "it's practically unheard of for a criminal lawyer to be sued."

"We are subsidizing others in the profession, and it is quite a drain on resources," said Mr. Bonner, 99% of whose work is funded by Legal Aid, a government agency that assists citizens unable to pay for legal help.

As a result, Mr. Bonner is "relieved that the Law Society is researching alternative ways of providing insurance."

However, Stella Currie, a lawyer in London specializing in property work, is concerned that people are looking for an easy answer. Until the property recession earlier this decade, property lawyers had a very low incidence of claims and effectively subsidized other areas of law, she said.

Reg Brown, a leading Lloyd's of London professional indemnity underwriter, points out that while some law firms might well benefit from buying coverage in the open market, "the profession as a whole would not be better off."

Mr. Brown said he "would be delighted if lawyers want to come to the market" but warned that "they won't save any money."

"How is it that a mutual fund with no competition, and therefore, no advertising, marketing or brokerage costs, can get itself into the position it is in? How would market insurers, who need to make a profit and have additional costs, do any better?" he asked. **BI**

Oil fund to pay claims in barge spill

By EDWIN UNSWORTH

LONDON—Third-party liability claims from an oil spill off the United Arab Emirates will be paid by an international fund or the insurers of the barge that caused the spill, according to fund officials.

The barge, the 11,000-metric ton capacity Pontoon 300, ran aground Jan. 7 and sank in about 65 feet of water near Dubai. About 5,000 tons of fuel oil is believed to have leaked before salvage workers sealed off cargo tanks and began pumping the remaining oil to other vessels. The UAE's Wam news agency said the oil spill covered at least 25 miles of the UAE's coastline.

No insurers for the barge have yet come forward, and the barge operator has not been identified.

However, the International Tanker Owners Pollution Federation

has sent representatives to the site to determine the extent of the damage. The representatives are going there on behalf of the International Oil Pollution Compensation Fund, set up in 1971 under an international convention to compensate participating countries for losses resulting from oil spills. Individual countries contribute to the fund based on the amount of oil they import. The UAE is a fund member.

Under the 1969 Civil Liability Convention set up under the auspices of the International Maritime Organization, the barge's owners or its insurers would be called on first to pay any claims, based on a formula that calculates the limits of compensation in relation to the size of the vessel.

The IOPCF would meet third-party liability claims above this amount, or all claims if the vessel's owners or

its insurers cannot pay, up to a maximum of about \$90 million.

Joe Nichols, technical manager of the tanker owners' federation, said damage from the spill still was relatively localized and that the cleanup process is "well in hand." As of last Thursday, there was "very little oil remaining at sea," he said.

Mr. Nichols said claims for compensation are expected to arise out of temporary damage caused to local fishing and tourism and from the shutdown of two desalination plants in the UAE. However, he was unable to estimate the level of claims likely to result from the spill.

Meanwhile, a second barge, the Karar 2, lost some oil in the same area while under towage on Jan. 14. However, Mr. Nichols said the spill was limited to around 20-30 tons before the barge was towed into port. Details were not available last week.

Explosion

Continued from page 21

Group Ltd. Graham Clarke, managing director of Miller Energy in London, said, "It's a miracle that no one was badly injured." Mr. Clarke would not comment on any insur-

ance arrangements.

Twelve people working at the plant were injured, though not severely, during the explosion late Dec. 25, which ignited two product

The Dec. 25 explosion at the Shell plant ignited two storage tanks, creating a fire visible 6 miles away.

storage tanks containing naphtha and kerosene. The fire was visible more than 6 miles away, local reports said. Some 220 firefighters, 70 of which had to be flown in to the location, brought the fire under control 17 hours later.

Shell said in a statement Dec. 26 that the plant would be shut down for safety and security reasons and for damage control and assessment.

Inspection can only take place around the periphery of the plant, Mr. Clarke said. Access to the plant itself is impossible, as the plant is not yet gas-free. He expects it will take several weeks before loss adjusters and company personnel can enter the plant. Shell has appointed Singapore-based Steege Kingston as loss adjusters.

According to Shell, the company began working on its gas-to-liquids conversion plant in Malaysia in

1989. The Bintulu plant, which cost \$750 million to build, began production in May 1993, Shell said. The Bintulu plant's output is exported mainly to Japan, Australia and Europe.

A fire one month after the plant opened shut it down until September 1993, but production has continued without interruption since then, the company said.

"There is no relationship between that fire (in 1993) and this one," said Jack Jacometti, technical/commercial manager at Shell International Gas Ltd. in London, a division of Royal Dutch/Shell.

The main risks associated with the Bintulu plant were safety and the commercial risk of marketing the specialty products, Mr. Jacometti said. He declined to give more details until the investigation into the accident is complete.

A neighboring liquefied natural gas facility, owned by Malaysia LNG Sdn. Bhd., also was closed down temporarily as a precaution, but production resumed Dec. 26 once the Shell plant fire was under control, a company spokesman confirmed.

Shell MDS is a joint venture of Royal Dutch/Shell, which holds 60% and operates the plant; Diamond Gas Holdings, a subsidiary of Japan's Mitsubishi Corp., which has 20%; Malaysian state oil company Petronas, which has 10%; and the Sarawak regional government, which has 10%. **BI**

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Canada

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as a result of this storm," he said.

"Reinsurance rates will be the first to be affected," said Andre Mancini, vp at the Underwriters Adjustment Bureau in Montreal. "Then we will see about the rates for direct business. It will take at least a month before we know what the real effects will be."

But other insurers and brokers say that competition among insurers in Canada is so strong that the ice storm losses will not affect rates.

"We see new companies coming in to Canada every year. . . the competition has been so strong for the past year, year and a half that we won't see any change in 1998," said Gilles Corriveau, managing executive at Sedgwick Ltd. in Montreal.

Plentiful capacity in Canada should easily curb any pressure to increase rates by insurers that suffer large losses from the storms, agreed Karen Barkley, senior vp of commercial and industrial risks at CIGNA Insurance Co. of Canada in Toronto.

Damage to commercial vehicles, roof collapses, and some business interruption and service interruption claims will likely pour in once businesses start functioning again this week, they say.

However, the company that likely suffered the worst property damage, provincial power company Hydro-Quebec, is likely uninsured for damages to its power lines and pylons.

Hundreds of pylons collapsed under the weight of inches of ice-coating during the storm, cutting off electricity to more than a million homes and businesses.

Much of southern Quebec remained without power late last week almost two weeks after a devastating ice storm set in on Jan. 5.

At its peak the storm cut off power to 1.4 million households and businesses in eastern Canada, leaving three million people without light or heat.

At least 15 people have died, mostly in traffic accidents or from carbon monoxide poisoning as they tried to heat their homes.

Downtown Montreal was virtually closed down for much of last week as businesses complied with government requests not to open in order to conserve power.

Total damage of at least \$1 billion Canadian (\$698.1 million) was estimated Wednesday by the Insurance Bureau of Canada. Of that, at least \$600 million Canadian is insured. Both figures could rise much higher if the weather suddenly warms up, turning the threat of flooding into a reality.

AXA Canada Inc. in Montreal had

received about 300 commercial claims last week, but it is expecting many more to be filed once businesses reopen this week, said Alain Lessard, vp of commercial lines.

"The type of claims we are seeing are for commercial vehicles where they have been damaged by falling trees and branches, some fires, and some theft-related claims that are due to the fact that alarms are not going off because there is no electricity," he said.

Some property damage claims due to roof collapses at farm buildings are also being filed, Mr. Lessard said.

As well as the structural damage, the collapsing roofs have caused livestock losses as animals are killed under the falling debris. Also, animals are dying due to lack of ventilation because of the power outages, he said. At one farm, 600 hogs died.

The largest claim filed so far with AXA is for the inflated roof of a golf driving range in Laval, which collapsed, causing \$750,000 Canadian (\$523,575) in property damage, Mr. Lessard said.

The driving range also will claim business interruption losses, but most businesses will not be able to file a business interruption claim because they have not suffered property damage, he said.

"Normally for a loss to be paid on a business interruption policy, there has to be property damage. A general power failure isn't normally insured against," Mr. Lessard said.

Despite the closure of many businesses due to power failure, few will be able to make business interruption claims, agreed Claude Boudreault, insurance and risk manager at SNC Group Inc. in Montreal.

SNC suffered no significant damage, and its main manufacturing plant in Montreal did not suffer any loss of power, he said.

The SNC head office in Montreal was closed most of last week to comply with government requests, Mr. Boudreault said.

"There is going to be business interruption damage, but nothing which is claimable under an insurance program," he said.

Alcan Aluminum Ltd. will make a claim on its business interruption program after one of its smelters in Beauharnois shut down after losing power, said Pierre Catudal, director of risk and insurance management.

"We don't know the amounts yet, but it was one of the smallest smelters in our group," he said.

Alcan's insurance program includes most of the major North American and European commercial insurers, Mr. Catudal said.

Some policyholders in the affected area have service interruption coverage—in addition to business interruption coverage—that will pay out

due to power outages, said Sal Zisa, property casualty claims manager for J&H Marsh & McLennan Inc. in New York.

The New York office, which services policyholders throughout North America, had received about half a dozen service interruption claims last week, he said. "It is not something which is bought frequently," Mr. Zisa said.

And many industrial plants will have their own generators so they will not be affected by the Hydro-Quebec outages, said Mr. Corriveau of Sedgwick.

Still, service interruption is a well recognized coverage in Canada and insurers are expecting claims once power has been restored and policyholders can accurately determine for how long they were out of power, said Ms. Barkley of CIGNA.

The policies carry a time deductible which can vary from 24 hours to 30 days depending on the wording, she said.

Most of the claims filed with insurers, however, will be for personal lines losses, insurers and brokers say.

Commerce Group Insurance Co. in Saint-Hyacinthe, Quebec, is expecting 100,000 personal claims and another 6,000 to 8,000 commercial claims, said Pierre Pelland, vp marketing at the ING Canada unit.

About 60% of the personal lines claims will be for food ruined in refrigerators and freezers due to power outages, he said.

The level of property losses will not be known until after the sometimes foot-thick ice melts and possibly causes floods and leakages, Mr. Pelland said.

"The crisis for the people living in the properties is now. The crisis for our company claims-wise is still to come," he said.

Generally, details concerning the extent of insured damage throughout Quebec remain sketchy. "No one knows the extent of the commercial claims yet because most of the brokers' offices are still closed," said Mr. Harris at Lloyd's.

"As long as the weather stays cold, we should be fine. But the Montreal area is dead flat; flooding could bring in huge claims," he said.

Montreal and its surrounding area was the hardest hit. The storm shut down 80% of Montreal's transportation network for electricity, forcing the local government to declare a state of emergency and curtail access to the city's downtown area.

Officials at Hydro-Quebec do not expect full power to be restored until the end of this week.

Parts of New Brunswick and Ontario also were affected. A state of emergency was declared for six days in Ottawa, and government offices shut down. **BI**

the accumulation of fuel and development in hazardous areas pose particular challenges for insurers, as well as government agencies responsible for fire prevention, mitigation and suppression.

"In broad perspective, the challenges and their respective solutions fall into two categories. The first category consists of socioenvironmental challenges associated with the unprecedented accumulation of fuel and population growth in areas prone to wildfire. The solutions to those challenges involve mitigating potential losses through increased understanding of fire behavior, public education, fire-safe building codes, landscaping ordinances and the like.

"The second category consists of the risk decision challenges insurers face in underwriting properties exposed to the wildfire hazard—challenges much like the ones insurers

face in underwriting properties exposed to hurricanes, earthquakes and other natural hazards.

The solutions to those challenges, according to ISO, include: developing and implementing appropriate underwriting guidelines; measuring and managing the aggregate amount of wildfire exposure in an insurer's book of business; managing the geographic distribution of exposures to prevent excessive concentration in any single area or contiguous areas prone to wildfires; and educating agents and insureds about loss mitigation," according to the report.

Single copies of "The Wildland/Urban Fire Hazard" cost \$75 plus applicable sales tax for non-ISO members and can be ordered by calling ISO's Customer Service Department at 800-888-4ISO (4476).

Storms

Continued from page 1

area are "still doing a lot of digging out," he said.

One longer-term concern from this weather condition is the impact of ice buildup on roofs, he said.

Arkwright Mutual Insurance Co. of Waltham, Mass., is receiving "quite a few claims, a significant volume of service interruption losses, interruption of electric utility service," said Jeff Smrek, vp-claims.

Mr. Smrek said the insurer has received many reports that lost power has meant business losses, including supermarket food spoilage losses. Arkwright has additional concerns that potential water leakage losses and water damage losses could arise, he said.

'From what we can gather, people are still getting claims together,' a spokesman for Utica Mutual says.

Yet property damage was not widespread, even in battered Maine.

While there are no estimates of property damage, the state and local governments last week were estimating \$6.2 million in storm-related costs, primarily for services, half of which was overtime, said a spokesman for Maine Gov. Angus King.

Utilities were among the hardest-hit businesses throughout the region. A spokeswoman with Central Maine Power in Augusta said more than 100,000 poles and miles of wire were downed. Hundreds of transformers also were damaged, she said.

She said the power company had yet to determine the losses, which she said are self-insured. She added that the company faced the added expense of extra worker hours to fix the downed lines and poles.

In response to the damage to utilities, Maine Sen. Susan Collins sent a letter to Housing and Urban Development Secretary Andrew Cuomo on Jan. 14 requesting that HUD consider using Community Development Block Grants to help defray "the already enormous expenses, already in excess of \$30 million, being incurred by Maine's utility companies in restoring power to the citizens of my state."

Other businesses weathered the storm relatively unscathed.

L.L. Bean Inc. in Freeport, Maine, had not sustained any losses by late last week, said Steve Hewitt, director-risk management.

The storms' only impact was a loss of power to a few call centers and distribution areas, not the retail stores. As a result of the storm, Bean eliminated one shift Jan. 9 and part of a shift Jan. 10. "Doesn't appear to be much, if any," business losses, said Mr. Hewitt.

Another Maine company, Bath Iron Works Corp., suffered no damage to its facility, said a company spokeswoman. It did, however, cancel some shifts in the plant because employees were unable to get there. The company expects to make up the down time in the future. Bath Iron Works has no business interruption insurance coverage but does not expect any financial losses, she said.

None of Portland, Maine-based Hannaford Bros. Co.'s 148 supermarkets in eight states suffered property damages. About a dozen of the company's 46 Maine stores lost power but have now replaced it with portable generators, a company spokeswoman said. She said the lack of power caused some spoiled food, but the amount of the loss had not been esti-

mated by late last week.

David Allen, account executive with the Portland, Maine, office of broker Hyland-MacLean Group, said he had not yet received any claims because most people are too concerned with their own homes' problems to file business claims.

"A full assessment of damages has not yet been done," he said last week.

Insurers reported primarily personal lines losses. Boston-based Liberty Mutual Insurance Co. had received "very few commercial claims reports to date" but about 1,500 personal lines claims—about 1,300 were homeowners—from its offices in Canada and northern New England, a spokesman said last week.

"The storm will have a long tail in terms of claims costs, and our people are estimating that to be between \$5 million and \$7 million," he said.

Late last week, State Farm Insurance Group of Bloomington, Ill., was projecting losses of about \$22.3 million from 14,800 storm-related claims: \$11.5 million from 7,600 claims in Maine, New York, and Vermont and the rest from Ontario, Canada, said a company spokesman. He emphasized that the numbers are "very preliminary."

Columbus, Ohio-based Nationwide Insurance Group was estimating \$5.5 million in claims last week—\$5 million from New York and \$500,000 total from Maine, New Hampshire and Vermont, said a spokesman. "We expect to see claims being reported for some time," he added.

Utica Mutual Insurance Co. in Utica, N.Y., had not projected losses by late last week. "From what we can gather, people are still getting claims together. They're assessing their situations, we're starting to receive some claims. Some of our adjusters are going up to take a look at what's going on and what we'll need to do," a Utica spokesman said. "If any of our policyholders in the storm-affected area happen to miss a policy payment in the next month, we're holding any notices of cancellation. With all they've got to deal with, we didn't want to make anything more stressful for them."

Union Mutual Fire Ins. Co. in Montpelier, Vt., had received 320 claims worth about \$430,000 by last Thursday, said John Corning, senior vp-claims. "We have not heard much from the state of Maine, so most of our claims are from Vermont, mainly homeowners' claims," he said.

Another segment of Vermont's insurance industry—the captive insurance business—suffered little impact from the storm despite the fact that many captive management offices are in Burlington, which is in one of the worst-hit areas of the state. Most offices remained open throughout the storm, albeit sometimes with a skeleton staff, according to several captive managers.

Regarding the storm's impact on another key Vermont industry, Sam Cutting Sr., a maple syrup producer at Dakin Farms in Ferrisburg, Vt., said the storm damaged its 1,000 trees and that he won't be able to draw sap from them this year. It is still too early to tell the long-term impact the storm had on the trees, he said. In addition to damage to trees, Dakin suffered damage to its network of tubing used to collect the valuable tree sap.

A spokeswoman for the Vermont Chamber of Commerce in Montpelier emphasized that the storm's impact on Vermont as a whole was light.

"Statewide, for the most part, Vermont is fine. The problem we're having is convincing people outside of Vermont that we're open for business. The majority of Vermont did not suffer damage from this storm. The roads are open, the power's on and all the things you think about for Vermont in the wintertime are going strong," she said. **BI**

Fire

Continued from page 3

For example, nine of the 11 California counties that experienced population growth of 150% or more during the period 1970-1996 are in forest regions. "One thing that did surprise me was that I didn't realize how much the population has moved into some of the hinterlands, where the exposure is," said Mr. Kollar.

"We've been concerned about this risk over time. It goes back to the time of the Oakland fire" that caused an estimated \$1.7 billion in insured property damage to that California city and surrounding areas in 1991, he said. He credits insurers with "pushing" ISO toward examining the wildfire hazard in more depth.

The report notes that "together,

Inspiring others to aid community

Thirty-five pages of inspiring reading is available from the Insurance Information Institute.

Yes, the III, better known for its statistical reports on the business of insurance that are very useful as references but not gripping reading, has just published a report that is indeed inspiring. Entitled "Empowering Communities, a Sampling of the Insurance Industry's Contribution to Community Development," the report details how property/casualty and life/health insurers, agents and brokers and their trade associations are engaged in a variety of programs to support minority, inner-city and low-income communities.

You will be astounded at the programs insurers and agents and brokers fund, staff and manage to improve the lives of inner-city and low-income populations across the country. It's a far cry from the stereotypical insurance agent who joins a civic organization primarily to rub shoulders with potential clients.

The projects detailed in this publication run the gamut of urban and civic organizations, health and safety programs, business development projects, community improvement and development programs, education programs and employee volunteer activities.



Kathryn J. McIntyre

The urban and civic organizations the insurance industry supports include the United Way, Habitat for Humanity, Neighborhood Reinvestment Corp., Urban Leagues, Rotary Clubs, Kiwanis Clubs, local fire departments, public libraries and hospitals.

Health and safety programs supported also include drug/alcohol abuse prevention programs, funding for AIDS education and mobile health vans, prenatal care centers and health care for homeless children.

Among business development projects are mentoring programs and funding minority business organizations, while community development programs also encompass rehabilitating houses and providing mortgages.

Education is supported not only through donations to scholarship funds and granting individual scholarships but also by funding programs for preschoolers, afterschool programs, literacy programs and new insurance programs at institutions of higher learning.

And employees of insurance companies, agents and brokers and trade associations are fixing meals for the homeless, tutoring those who can't read, delivering meals to shut-ins and helping to staff homes for victims of domestic violence.

The III report isn't just a chest-pounding puff piece for the industry to congratulate itself on its good deeds. Half the publication is devoted to "model programs," the vignettes of which are intended to inspire others in insurance—or any business, for that matter—to introduce similar programs.

It's not only the largest institutions involved in this vital community work. Smaller agencies and insurers are spearheading big projects, too.

The report also documents efforts to employ more minorities in the insurance business, which has a long way to go to diversify its employee population.

The catalyst for this report also is very interesting. After the wave of church fires in the summer of 1996, representatives of insurance trade groups, companies and agent organizations met with Vice President Al Gore and Federal Emergency Management Agency Director James Lee Witt to determine how to raise public consciousness about arson and to assist houses of worship in buying adequate property/casualty insurance. In the process, Vice President Gore asked what the insurance business was doing to improve relationships with minorities. To answer him, a survey was sent out to the leading insurance associations. The new report highlights the survey results.

At a time when the prevailing political opinion is that government should do less, not more, the contributions of the insurance business to minority, inner-city and low-income communities are more important than ever.

And, to be fair, improving the lives of communities is good for the insurance business. As the III report says, "An improved community is a better risk and a better business opportunity."

Publisher and Editorial Director Kathryn J. McIntyre and Editor Paul D. Winston write columns on alternate weeks.

Coalition

Continued from page 1
 improvement of care delivery by HMOs through such means as customer satisfaction surveys.

"We thought the time was right that the purchasers needed to come together," Mr. Boress said. "The larger the group we have and the more name-brand employers we have, the more effective we can be."

The area employers that have signed on so far are: ABN AMRO Chicago Corp., First Chicago NBD Corp., Ford Motor Co., Jewish Federation of Metropolitan Chicago, the Northern Trust Co., the State of Illinois, the University of Chicago and Zenith Electronics Corp. The companies together represent about 97,000 local employees.

The buying group will negotiate with HMOs during the first quarter of this year, aiming to reach common quality standards, performance incentives and uniform pricing.

The negotiations aim to produce a core benefits package that also may be modified to suit individual employers. While the group will negotiate the core package, among other things, each employer will enter into its own contract with the managed care plans.

Requests for information from HMOs are expected to be out in March, followed by data collection and HMO performance guarantees to be issued by June. The new quality standards, performance incentives and pricing would be in effect for Jan. 1, 1999, renewals.

The new coalition will look to well-established employer purchasing groups in California, St. Louis, Minneapolis-St. Paul and Massachusetts to serve as role models for the Chicago group, Mr. Boress said. Although there is no way to know how much

plan sponsors can save through joint negotiation, he said some employers in other cities have achieved 8% to 12% cost reductions through cooperation.

Some coalitions have attained substantial savings through joint negotiations or the creation of their own managed care networks. For example, The Alliance, a Denver-based purchasing group, has 80,000 member lives and 150 employers in a PPO and says its members saved \$14 million in health care costs in 1996.

The Alliance also supervises four HMOs, measuring their quality quarterly, issuing report cards annually.

Standard, objective information about HMO quality is overdue in the Chicago market, employers say.

"The employees are obviously counting on us, and we're counting on the HMOs (for data)," said Mary Ann Hagerty, corporate benefit manager and senior vp at ABN AMRO in Chicago. "I think this will give us a standard tool."

ABN AMRO, which offers three HMOs in the Chicago area, already provides its employees with annual report cards listing HMOs' National Committee for Quality Assurance scores and consumer satisfaction survey findings. But joining the CBGH effort will yield even broader information, Ms. Hagerty said.

"When the word gets out, we'll have a lot more employees that are interested in working with us," she said.

Costs and quality issues were foremost on the mind of State of Illinois officials, who represent the largest employer in the new group. With about 30,000 employees in the Chicago area and about 40% to 50% enrolled in HMOs, the state sees the purchasing group as a way to make a positive, proactive step toward improving HMOs—one that doesn't involve "a lot of (government) mandates," said

Lynn Zehnder, benefit manager for the State of Illinois.

"We're not doing this simply as a cost or price issue," she said. "We've tried to be on the cutting edge of ideas. It's exciting."

Compelling the HMOs to be more efficient also should lead to lower pricing over time, she said.

Anticipated increases in HMO rates helped usher Chicago-based Northern Trust into the purchasing group, said Joyce Cook, vp of benefits planning.

Northern Trust, with 75% of its 5,600 Chicago-area employees in managed care, is concerned that HMO cost pressures are resuming and that "the controlled days may be behind us," she said. It will be important for Northern to identify how much HMO profit is unnecessary through new shared information, she said.

HMOs will be asked to supply "a laundry list" of information, including satisfaction data, clinical outcomes, NCQA accreditation status and Health Plan Data and Information Set, or HEDIS, ratings, said Jim Foreman, managing principal of the Chicago office of Towers Perrin. The group has contracted with Towers Perrin to assist in setting up the buyers group, including the creation of report cards based on HMO-supplied data.

HMOs may welcome the new group because while it will introduce a new standard of accountability, it also will reduce their overhead by eliminating redundancy in the bidding and evaluation process, Mr. Foreman said.

A spokeswoman for United Health-Care of Illinois, one of the area's largest HMOs, called the purchasing group "a good business opportunity for us."

"We're interested in it," the spokeswoman said. "We're especially interested if it reduces any kind of paperwork."

Year 2000

Continued from page 3
 consider filing claims when upgrades are made to meet regulatory requirements, said Mr. Jacobs of Kirkpatrick & Lockhart.

"It is just like receiving a compliance order or administrative order from state or federal authorities to clean up in compliance with CERCLA," he said, referring to the 1980 federal law that created Superfund.

Last year, the Federal Financial Institutions Examination Council, a panel composed of financial institution regulators, issued Year 2000 examination procedures to determine whether financial institutions and their customers would suffer as a result of the millennium problem.

The procedures were designed to

help regulators discern whether financial institutions have Year 2000 computer problems, whether their customers will be affected and whether the institutions have taken corrective action.

The Year 2000 problem derives from the former programming practice of using two digits to record the year. It is feared that unless computers are reprogrammed or replaced, many will read the year 2000 as the year 1900, and the systems they govern might crash on Jan. 1, 2000.

The banking regulators' action will be most helpful to banks seeking to claim for the cost of system upgrades from their insurers if those banks view their own systems as Year 2000 compliant but still have to make upgrades to comply with specific FFIEC requirements, said Mr. Jacobs.

Policyholders likely will be able to

make claims on property policies as they would have suffered damage under the definition of a property policy if they had to shut down because of regulatory requirements, he said.

However, insurers likely will reject those claims, saying Year 2000 compliance is a cost of doing business, Ms. Nugent said.

"Normal business practices that are needed to comply with government regulations would not generally meet the definition of claims or occurrence in an insurance policy," she said.

Unlike in pollution cases, where policyholders often claim for costs to clean up a site that was polluted decades ago to meet modern environmental standards, Year 2000 regulations deal with a problem foreseen for several years, Ms. Nugent said. "You are looking at companies that failed to deal with a known risk."

The Home

Continued from page 2
 ue of about \$70 million and other interest-paying notes, contingent on tax savings, in exchange for the existing notes, valued at \$280 million.

The new notes would be issued by Home Holdings and Zurich Centre Group would buy them in a tender offer after the Chapter 11 filing.

The bondholders would likely achieve more certainty under the new plan than under a previous reinsurance contract, said Mr. Feldman.

The previous reinsurance contract, issued by Zurich, would only pay out after The Home's assets were exhausted, which could have taken many years, he said. Bondholders might have feared that regulators would stop all dividend and principal payments, Mr. Feldman said.

Once Home Holdings emerges from Chapter 11, it would transfer all of the outstanding stock of The Home to a New Hampshire limited liability company that would be owned by the senior creditors of Home Holdings and managed by a company jointly owned by Zurich Centre Resource and Trygg Hansa SPP Group, the previous owner of Home Holdings and its subsidiaries.

Home Holdings, which still operates a land management business, would have tax advantages from its historic net operating loss and would be owned by Zurich.

The beneficiaries of the plan's tax advantages would be Home Holdings bondholders, Trygg Hansa and The Home.

Overall, the present value benefit to The Home is at least \$60 million, said Louis Feldman, vp at New York-based Zurich Centre, who worked on the deal.

"This is an economic benefit to

The Home. It is not a benefit that is going to show up in their statutory figures, but it is still a benefit," he said. "And the runoff operations of the insurance company will continue unaffected."

Depending on the future tax advantages, the deal would provide Home Holdings bondholders with something less than half the payments they would be eligible for under the old notes, Mr. Feldman said.

The bankruptcy reorganization proposal is the culmination of several months of negotiations among Zurich, Trygg Hansa, the bondholders and New Hampshire regulators.

In December, the first part of the deal was put in place when Trygg Hansa transferred its stake in Home Holdings to a bank trust as a prelude to the restructuring (BI, Dec. 1, 1997). Shortly afterward, The Home said it would take advantage of a 30-day grace period to pay the interest payment due Dec. 15.

Aetna

Continued from page 2

Aetna itself has paid tens of millions of dollars of fraudulent NMC claims, and other insurers and the federal Medicare program have been similarly damaged, the suit says.

None of the defendants has yet filed an answer to the complaint, and spokeswomen for Fresenius and Grace said the companies would not comment. Fresenius has denied similar allegations in other legal actions described in its Securities and Exchange Commission filings.

Aetna officials and their lawyer could not be reached.

Founded in 1968, NMC is the country's largest dialysis provider, operating through more than 600 wholly owned outpatient clinics and dozens more independently owned clinics that it manages under contract. One out of five U.S. dialysis patients, or about 43,000 people, get treatment in facilities under NMC's control, according to the Aetna complaint.

NMC also owns units that sell dialysis-related products, perform diagnostic testing and provide home care services. NMC itself is a subsidiary of Lexington, Mass.-based Fresenius National Medical Holdings Inc., an intermediate holding company of Fresenius A.G. of Bad Homburg, Germany.

FNMH reported net revenues of \$2.25 billion in 1996.

The Aetna complaint is only the latest controversy for NMC, which has been a frequent target of government investigations and lawsuits since 1995.

The company disclosed in 1995 that the federal Health and Human Services department's Office of the Inspector General had served it with five subpoenas in an inquiry into possible violations of the federal False Claims Act and an anti-kickback statute. The subpoenas covered several areas of NMC's operations, including treatment, testing and billing procedures that also are the focus of Aetna's fraud charges.

Last July, the OIG also subpoenaed NMC records of a number of Medicare patients, the company's SEC filings report.

The investigation has not produced any criminal or civil charges, but NMC has posted a \$150 million letter of credit to secure possible liabilities to the government arising from the probe, the company reported.

In addition:

- The OIG issued another subpoena in 1996 for NMC documents in a separate investigation of possible false Medicare claims from two NMC diagnostic testing units.

- NMC has been hit with half a dozen federal whistle-blower lawsuits in Florida, Pennsylvania, Delaware and New Jersey. The suits, all filed under seal with limited exceptions, generally allege that NMC violated the false claims and anti-kickback statutes by over-billing Medicare and inducing physicians to overuse its services.

- NMC sued the federal Health Care Financing Administration in 1995 after HCFA ruled that Medicare is the primary payer for patients affected by the Omnibus Budget Reconciliation Act of 1993. HCFA had reversed its own earlier ruling that employer health plans should be primary payers for an 18-month period, after which Medi-

care would take over. NMC favored the original decision, as employer plans pay at a higher rate.

NMC won a preliminary injunction against the HCFA ruling in 1995. Its motion for a permanent injunction still is pending, according to its SEC filings.

- NMC sued the government in 1995 over sharp cutbacks of Medicare coverage for intravenous nutritional therapy for dialysis patients. The treatment, intradialytic parenteral nutrition, or IDPN, produces a large part of NMC's revenues. A federal judge dismissed the suit, though, and referred the dispute for administrative action, where NMC continues to pursue it, the company says.

NMC's Medicare receivables for IDPN claims totaled about \$153 million as of last Sept. 30.

The NMC practices targeted in many of these actions also form the

medical director a direct financial interest in prescribing as many NMC products as his patient population could possibly absorb—whether or not they were needed," Aetna claims.

Physicians who owned clinics NMC managed got an extra benefit through NMC's payment of "hang fees," based on the number of IDPN nutritional treatments administered at the clinics, the suit adds.

The fraudulent claims themselves, amounting to tens of millions of dollars for Aetna alone, involve a wide variety of alleged schemes, according to the insurer. They allegedly include phony bills for:

- Nutritional therapy. While insurers normally cover the therapy for dialysis patients who can't absorb nutrients from food, NMC systematically administered the treatments to patients who didn't need them and produced phony paperwork to support its claims.

Aetna cited nearly a dozen cases of patients who received nutritional therapy even though they could eat normally and suffered no gastrointestinal symptoms such as nausea or weight loss. In one case, NMC gave the treatments to a man whose doctor had found no digestive problems and had actually encouraged the man to lose weight. The same doctor a month later signed a statement of medical necessity for the treatments, saying the man suffered chronic gastrointestinal problems; the form falsely described the man as five inches taller than his actual height to conceal the fact that he was overweight, Aetna claims.

Lab work by LifeChem, which reportedly performs blood tests on 25% of all U.S. dialysis patients. NMC and LifeChem made a practice of running "complete blood series" on patients—a procedure consisting of 19 tests—and then performing several of the same tests individually, effectively double billing for the work.

- Tests performed by NMC's Diagnostic Services Division. NMC administered a variety of tests—including bone density tests and electrocardiograms—several times more frequently than they are normally called for. The company performed the tests without orders from patients' physicians, and the doctors often never saw the results, the suit says.

- Home care services purportedly provided by doctors and registered nurses, when in fact NMC used less expensive unlicensed "technicians."
- Various services that in fact were never rendered. Aetna cites a 1994 case in which NMC billed the insurer for a month of nutritional therapy for an Ohio man who had already died.

Along with these alleged schemes, NMC also made a practice of billing Aetna anywhere from two to seven times over a period of up to six months for the same charge, the insurer says.

In some cases, Aetna had already paid the original claim and ended up paying twice. In other cases, it had denied coverage and NMC continued to submit the bills on the chance that Aetna would pay them by mistake and save NMC the trouble of going through normal claim review procedures, the suit says.

The complaint charges the defendants with violations of the Racketeer Influenced and Corrupt Organizations law, common law fraud and conspiracy. **BI**

The Aetna complaint is only the latest controversy for NMC, which has been a frequent target of government investigations and lawsuits since 1995.

basis of charges in the Aetna complaint, which the insurer filed in U.S. District Court in New York last month.

In addition to NMC, Fresenius and Grace, the suit names several NMC units: Bio-Medical Applications Management Co. Inc., which manages dialysis centers; NMC Homecare Inc. and Home Intensive Care Inc., which provide home infusion, respiratory therapy and other services; and NMC Diagnostic Services Inc., Biotrax International Inc. and LifeChem Inc., which perform diagnostic and laboratory testing, including blood tests.

Aetna accuses NMC of using near-monopoly power in the dialysis field to generate a wide array of fraudulent claims.

NMC has "gained immense power to exploit both patients and the health insurance community by removing any meaningful alternatives," Aetna alleges. "Many patients are forced to use NMC facilities and to accept treatment programs that are driven by NMC's schemes to expand the consumption of its products."

"Having gained control over so large a portion of the nation's dialysis centers, and having acquired or formed companies that provide all of the ancillary services that could possibly be billed in connection with dialysis treatments, NMC has used its resulting power to ensure that bills are generated and revenues received for services far in excess of what is legitimately needed—including procedures that threaten the well-being of NMC's patients," Aetna charges.

NMC has been able to carry out the alleged schemes in part because it pays kickbacks to doctors to help produce the fraudulent claims, Aetna charges.

The dialysis company has disguised the alleged payoffs by signing "medical director" contracts with doctors who treat large numbers of patients at NMC clinics, Aetna says.

Under these contracts, physicians have been paid fees based on a percentage of their dialysis centers' earnings. Doctors also have collected "add-backs," consisting of a share of the profits earned by NMC's LifeChem unit on lab services billed out of the doctors' clinics, the suit says.

"In other words, NMC gave each

Updates

GM loses witness ruling

Continued from page 2

former employer without GM's permission.

A federal court in Missouri allowed Mr. Elwell to testify in a product liability case involving a fatal fire in a Chevrolet Blazer manufactured by GM. General Motors sought to block the testimony because of the Michigan injunction, and the 8th U.S. Circuit Court of Appeals agreed that the injunction was binding on other states.

The Supreme Court unanimously ruled that the injunction was not enforceable. Justice Ruth Bader Ginsburg wrote that Michigan "cannot reach beyond the Elwell-GM controversy to control proceedings against GM brought in other states, by other parties, asserting claims the merits of which Michigan has not considered."

In other action last week, the court declined to hear two cases that could have clarified the scope of its 1996 decision in *Medtronic vs. Lohr*, in which the justices held that the fact that the federal Food and Drug Administration has reviewed a medical device doesn't automatically protect the manufacturer from product liability cases.

The Supreme Court justices also declined to get involved in a pair of employment cases that revolve around the question of who constitutes an "employee" for purposes of protection under Title VII of the Civil Rights Act, which deals with sexual discrimination.

U.S. won't appeal creditor ruling

CHICAGO—The federal government will not seek to overturn a potentially far-reaching Illinois federal district court ruling that undercut the government's efforts to push its liability claims against an insolvent insurer ahead of all other claims.

The government's Jan. 5 decision, though, does not necessarily indicate how the government will proceed in other insurer bankruptcies, said Justice Department attorney Robin M. Richardson.

In the case, U.S. District Court Judge Ruben Castillo last fall upheld a provision in Illinois' insurer liquidation statute that gives guaranty funds' claims and the government's liability claims equal priority for payment purposes.

The government argued the provision violated a 1993 U.S. Supreme Court decision and that therefore the entire statute was invalid (*BI*, Oct. 27, 1997).

If the government had prevailed, federal liability claims would have taken priority over policyholders' and guaranty funds' claims against insolvent insurers. The case had national implications because all states have similar insurance company liquidation laws.

Judge Castillo, though, did not rule on how an insolvent insurer's estate must treat the government's contingent liability claims. A contingent claim is one the government has never filed for a variety of reasons—for example, if the claim has not been identified yet.

The Illinois Insurance Department in December asked the 7th U.S. Circuit Court of Appeals for a ruling on contingent claims. The Insurance Department considered those claims barred in the current case, but it was concerned that the government would try to seek coverage for such claims in other receiverships, said Peter Gallanis, Illinois' special deputy receiver.

Given the government's decision not to appeal Judge Castillo's ruling, the department will decide within a few weeks whether it wants to press its appeal.

Texas, tobacco firms settle

AUSTIN, Texas—Tobacco companies have agreed to pay the state of Texas about \$15 billion over 25 years to settle a suit seeking restitution for smoking-related Medicaid claims before it went to trial.

The Texas agreement, announced Friday by state Attorney General Dan Morales, is the third such settlement to be reached with a state.

Cigarette makers have already agreed to pay Mississippi \$3.6 billion and Florida \$11 billion to settle suits seeking reimbursement for smoking-related Medicaid costs. Jury selection in a fourth state suit, brought by Minnesota, is scheduled to begin this week.

Briefly noted

Trenwick Group Inc. of Stamford, Conn., plans to acquire Sorema (U.K.) Ltd. in London from Sorema N.A., the reinsurance arm of French insurer Groupama. Trenwick, which will acquire the company for "approximately book value," said it will increase the capital of Sorema (U.K.) to more than \$125 million after the deal. . . . Louisville, Ky.-based Humana Inc. and Woodland Hills, Calif.-based WellPoint Health Networks Inc. are seen as the leading candidates to buy **Prudential Insurance Co. of America's health care business**, though the insurer still may decide not to sell (*BI*, Nov. 17, 1997). A Prudential spokesman had no comment on the reports but said the process will be concluded by the end of the first quarter. . . . Blue Cross & Blue Shield of Maryland and Blue Cross & Blue Shield of the National Capital Area formally affiliated Friday under a new holding company called **CareFirst Inc.** Regulators late last month gave their conditional approval to the holding company, which will be in Owings Mills, Md. (*BI*, Jan. 5). . . . **John E. Fisher**, chief executive officer of Columbus, Ohio-based Nationwide Insurance Group from 1981 to 1992, died at age 68 last week.

