

Business Insurance

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

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Labor Department clarifies status of health FSAs under portability law

WASHINGTON—The Labor Department has clarified that health flexible spending accounts meeting two conditions are not subject to group health plan requirements set by the Health Insurance Portability and Accountability Act of 1996.

The act had provided no exception for health FSAs, leading many employers to believe health FSAs came under the heading of group health plans, and thus the rules governing group health plans, notably certificates of coverage and special enrollment rights.

See Updates on next page

AIG gains financial products unit

By DOUGLAS McLEOD

NEW YORK—American International Group Inc.'s planned takeover of American Bankers Insurance Group Inc. promises big benefits for both companies, analysts agree.

The \$2.2 billion acquisition, the biggest in AIG's history, will expand AIG's product lines while giving it access to a vital distribution system of banks and financial institutions. American Bankers, meanwhile, will get the benefit of AIG's strong credit rating and access to overseas markets.

"I think it's a very well-conceived deal," observed Michael Morrissey, chairman and chief executive officer of Firemark Group Inc. in Morristown, N.J. "This is a beautiful fit for (AIG)."

"It's a great way to get into a specialty business," said Vandana Sharma, associate director with Standard & Poor's Corp. in New York, referring to American Bankers' niche in credit-related insurance products. AIG traditionally does well "doing things that are not your mainstream lines of business."

AIG last month announced its deal to acquire American Bankers, the Miami-based holding company for several insurance units including American Bankers Insurance Co. of Florida; American Bankers Life Assurance Co. of Florida; the Voyager Group of property/casualty and life/health insurers; and insurance units in Mexico, Argentina, Puerto Rico and the United Kingdom.

American Bankers has specialized in financial insurance products, including credit insurance and extended warranty programs. It also writes group accident and health coverages.

Direct written premium volume for the group totaled \$1.51 billion in 1996, while net written premium volume

See AIG on page 12

Banking on a new niche

American International Group Inc.'s planned takeover of American Bankers Insurance Group Inc. will expand AIG's product lines and distribution channels.



AIG
Year-end 1996
Net written premium \$9.27 billion
Policyholder surplus \$9.58 billion



American Bankers Insurance Group
Year-end 1996
Net written premium \$577.7 million
Policyholder surplus \$348.5 million

AIG and American Bankers

Year-end 1996
Net written premium \$9.85 billion
Policyholder surplus \$9.93 billion

Source: A.M. Best Co.

GRAPHIC BY ADAM DOI

Drafting history debated

Policyholders, insurers spar over intentions behind pollution exclusion

By DAVE LENCKUS

After studying the genesis of pollution exclusions in general liability insurance policies, two state supreme courts late last year ruled in favor of policyholders by narrowing the scope of the absolute pollution exclusion.

The Illinois and Massachusetts high courts ruled the exclusion does not bar coverage for carbon monoxide-related bodily injury claims that do not involve "traditional environmental pollution." After all, the courts found, cleanup costs resulting from gradually and abruptly occurring pollution were the only insurable, contaminant-related risks that insurers sought to exclude when the industry introduced the 1970 and 1985 pollution exclusions (*BI*, Dec. 1, 1997; Nov. 24, 1997).

As the decisions demonstrate, the nearly 30-year battle over the scope of the pollution exclusion is far from over. Policyholders and insurers remain sharply divided—even when interpreting the same evidence—over the intentions of the insurance industry.

Insurers, not surprisingly, protest that the Illinois and Massachusetts courts awarded policyholders coverage that insurers had specifically barred in the absolute pollution exclusions.

See History on page 23

The pollution exclusion debate

- 1966** Insurers launch occurrence-based CGL policy to cover abrupt and gradual losses
- 1970** Insurers adopt sudden and accidental pollution exclusion
- 1980s** RCRA and CERCLA ignite coverage battles over gradual pollution claims
- 1986** Insurers adopt absolute pollution exclusion
- 1993** New Jersey high court rules insurer deceit over drafters' intent weakens 1970 exclusion
- 1993** Florida Supreme Court reverses own pro-policyholder ruling after reviewing pollution exclusion history
- 1996** Alabama Supreme Court reverses own pro-insurer ruling after reviewing pollution exclusion history
- 1997** New Jersey ruling influences state supreme court decisions weakening absolute exclusion

GRAPHIC BY ADAM DOI

Texas providers to launch network

By MICHAEL BRADFORD

DALLAS—Texas employers are wary but hopeful that they may benefit from a giant network of physicians and hospitals being formed to provide managed care services.

WellSpan Healthcare Network, with about 7,000 physicians and about 70 hospitals on board, is expected to begin operations early this year. Initially it will negotiate managed care contracts on behalf of its members, relieving doctors and hospitals of the burden of striking deals with various plans.

Eventually, the network plans to license a health maintenance organization so it also can contract directly with employers to provide services.

But, "we don't anticipate that for some time to come," said a spokes-

woman for WellSpan. "Initially, it will not be stressed that WellSpan will contract with employers."

"For employers, it should be a seamless change for them," she said of the network's launch in 1998.

The idea behind WellSpan, she explained, is to create a stable health care network in which hospitals and doctors have more say in how their contracts with the plans are structured.

WellSpan will offer its members an array of administrative and accounting services.

The network, which took more than 50 physicians 18 months to develop, is jointly owned by a consortium of hospitals and a physicians' group. Its membership's revenue from managed care plans totals about \$550 million annually and the network represents 2

million covered lives.

While employers don't expect any short-term benefits from the network, experts say the arrangement may eventually be able to provide managed care at lower rates and allow employees greater provider choice.

"It could ultimately, if it is done right, lead to lower premiums," said Dr. Arlen Collins, senior medical consultant at Scheur Management Group, a Newton, Mass.-based managed care management and consulting company.

WellSpan's move to get an HMO license is a good one and eventually could mean lower costs for employers, Dr. Collins said. "My feeling is that physicians need to own the lives. Essentially being the insurer without the middleman is, long-term, a very good strategy."

See Network on page 26

Fen-phen suits bring in doctors

But drug makers still are primary targets

By MICHAEL PRINCE

Plaintiffs suing pharmaceutical companies for alleged injuries from diet drugs increasingly are figuring physicians into their legal strategy.

The number of lawsuits against physicians who prescribed either fenfluramine or dexfenfluramine in combination with phentermine is growing and is predicted to rapidly mount in 1998.

Defense attorneys and medical malpractice insurers said the doctors are being drawn into the litigation for three reasons.

First, the doctors are made codefendants in suits against the drug makers

to keep the suits in state court and therefore unconnected with the consolidated federal suits. If a doctor who lives in the same state as the plaintiff is named in the suit, it cannot be transferred by the drug makers to federal court from state court. All U.S. federal cases have been consolidated for pre-trial purposes with U.S. District Judge Louis Bechtle in Philadelphia.

Secondly, the doctors might be made defendants to provide quick money to the plaintiffs' attorneys so they can finance the much larger and more expensive litigation against the drug makers, they said. Plaintiffs' attorneys believe that individual doctors

would be more likely to settle suits early rather than go through protracted litigation.

But perhaps most importantly, the doctors might be brought into the litigation to force them to testify on behalf of plaintiffs in the suits against the drug makers.

"There is a potential for conflict between the manufacturers and the physicians," said Joseph Loughlin, vp of Frontier Insurance Co. and head of the company's medical malpractice claims unit in Rock Hill, N.Y.

It is a well-established litigation strategy to name multiple defendants in suits and hope one turns against the other, said Matthew Biscan, a partner with Hall & Evans L.L.C. in Denver.

See Fen-phen on page 12

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Updates

Portability rules clarified

Continued from previous page

Last week, the Labor Department clarified that FSAs are exempt from the group health plan requirements, provided that they meet two conditions: The health FSA's maximum benefit does not exceed two times the employee's salary reduction election—or, if greater, the amount of the salary reduction election plus \$500. The employee also must have other coverage available under a group health plan and that coverage is not limited to excepted benefits.

The clarification is "a big positive," said Chip Kerby, a consultant with William M. Mercer Inc. in Washington. "Wisdom prevails here, and the agencies decided that most health FSAs are not going to be treated as group health plans," he said.

The Labor Department also issued a clarification as to when so-called "late enrollees" cannot be subject to an 18-month pre-existing condition exclusion by group health plans. An individual cannot be treated as a late enrollee if he or she enrolled in a group health plan after HIPAA's effective date and was denied coverage under the plan before HIPAA's effective date based on a health status factor.

Under the clarification, such people would be subject to a maximum 12-month pre-existing condition exclusion.

The clarifications appeared in the Dec. 29, 1997, Federal Register.

Ruling benefits policyholders

SAN FRANCISCO—Insurers must pay the cost of investigating polluted sites to fulfill their duty to defend policyholders under standard commercial general liability insurance policies, California's Supreme Court ruled last week.

The court also ruled that insurers must incur the defense costs even when a loss is alleged to have occurred beyond the policy period if some of the damage occurred when coverage was in effect, according to court documents.

That portion of the court's decision in *Aerojet-General Corp. vs. Transport Indemnity Co.* goes beyond pollution cases. It also impacts other types of coverage disputes, such as those stemming from construction damage, said Scott P. DeVries, a partner in the San Francisco office of Nossaman, Guthner, Knox & Elliott, which represents Aerojet.

In its Dec. 29 decision, the court also ruled in favor of insurers, in part, by saying they can allocate pollution investigation costs to the policyholder if their policies specifically state that the policyholder will incur the cost. However, very few policies written during the 1950s, 1960s and 1970s had such language, Mr. DeVries said.

Pollution investigation expenses can include the costs of determining the existence, nature, extent and effect of discharging a hazardous substance, according to the ruling.

The case stems from Aerojet's litigation against 54 insurers. The aerospace and defense manufacturer has sought coverage and legal defense under 245 policies dating back to 1950 after state and federal officials and private parties sued the company. Aerojet said it has paid \$26.6 million for investigating pollution at a Sacramento, Calif., facility.

The Supreme Court upheld an appellate court ruling that Aerojet does not have insurance coverage because it knew it had polluted, said Richard L. Seabolt, a partner in the San Francisco office of Hancock Rothert & Bunshoft, which represented the insurers.

KKR boosts Rhine Re capital

BASEL, Switzerland—Kohlberg Kravis Roberts & Co. is injecting 100 million Swiss francs (\$69 million) into Rhine Reinsurance Co. Ltd. and its newly established sister company in Bermuda.

KKR, a New York-based leveraged buyout firm, bought Basel, Switzerland-based Rhine Re for an undisclosed sum early last month (*BI*, Dec. 8, 1997).

Rhine Reinsurance Co. (Bermuda) Ltd. has been set up with 75 million Swiss francs (\$51.8 million) in capital and will write retrocessional business for Rhine Re in Basel.

The Bermuda company will likely write a broader range of coverages, including non-traditional reinsurance, in the future, said Max Furrer, chairman of Rhine Re. Rhine Re in Basel writes a broad book of reinsurance worldwide.

The remaining 25 million Swiss francs (\$17.3 million) will be used to increase the capital of Rhine Re in Basel to 175 million Swiss francs (\$120.8 million).

The capital likely will be increased further by investments from the management of Rhine Re, Mr. Furrer said.

A new holding company, RR Holding Co. Ltd., has been established in Zug, Switzerland, for the Basel and Bermuda units.

Aon to buy French broker

PARIS—Aon Risk Services France, a unit of Aon Corp., has offered to buy the remaining 46.15% of Paris-based retail broker Societe Generale de Courtage d'Assurance that it does not already own.

The offer of 800 French francs (\$133.60) per share makes the deal worth about \$20 million, an Aon spokesman confirmed. On Dec. 12, the last day SGCA shares were traded before the Paris Stock Exchange suspended the trading on account of the offer, SGCA's share price was 784 francs (\$130.92).

Three minority shareholders in SGCA—Assurances Generales de France, with 20%; AXA-UAP Group, with nearly 10%; and Cie. Financiere de Paribas, with 9%—have agreed to sell their shares to Aon.

Aon acquired a 53.85% stake in SGCA when the Chicago-based broker bought Alexander & Alexander Services Inc. in 1996.

The Aon spokesman said that if Aon France manages to control at least 95% of the voting rights of SGCA, it will seek to delist the stock. Combined, Aon France and SGCA would rank among France's largest brokers, based on 1996 commissions of 350 million francs (\$58.5 million).

Officials at SGCA could not be reached last week.

See Updates on page 26

PARCA foe drafting bill

Measure would place fewer restrictions on managed care

By ROBERT KAZEL

WASHINGTON—A congressman is drafting a less restrictive bill to replace the sweeping managed care reform legislation that has garnered the support of about half of the House of Representatives.

The new measure, which Rep. Harris Fawell, R-Ill., has not yet introduced, would provide moderate protections for health maintenance organization patients, com-

pared with the much broader patient rights that are part of the Patient Access to Responsible Care Act of 1997 (*BI*, Nov. 17, 1997).

Rep. Fawell is strongly opposed to the so-called PARCA bill, which was drafted by Rep. Charlie Norwood, R-Ga. He has circulated letters to colleagues warning that passage of PARCA would mean escalating costs and increased regulation.

The congressman's replacement

bill, which he said he is still drafting but would like to introduce early this year, would:

- Encourage health plans to provide participants more information, because an informed plan participant is "a necessary ingredient in a dynamic and focused private health care market."

"There's a general feeling by the consumer that he's in the dark (about managed care)," Rep. Fawell said.

See Fawell on page 14

N.Y. ruling on hazards exclusion may have broad reach: Lawyer

By MARK A. HOFMANN

BUFFALO, N.Y.—Products hazards exclusions in comprehensive general liability policies do not automatically bar coverage for all asbestos-related bodily injury claims, according to New York's highest court.

The New York Court of Appeals' unanimous decision in *Frontier Insulation Contractors Inc. vs. Merchants Mutual Insurance Co. et al.* should have an im-

act beyond New York, said a lawyer who has followed the case.

"This is the first high court to address the availability of premises operations coverage for asbestos-related claims. Given that it's New York, and given that it's a unanimous opinion, it is bound to have influence beyond New York's borders," said Mitchell F. Dolin, a partner in the Washington law firm of Covington & Burling.

Mr. Dolin filed an amicus brief

in the case on behalf of Lancaster, Pa.-based Armstrong World Industries Inc. and seven other companies that either "once manufactured, handled, installed, fabricated, sold and/or used asbestos-containing materials," according to the brief.

"The standard form language used to define the 'products hazard' appears both in policies that exclude coverage for the products hazard and in policies that

See Ruling on page 6

Company blamed in blast

NTSB report also faults parent, cites poor training, oversight

By ROBERTO CENICEROS

SAN JUAN, Puerto Rico—Insufficient employee training and supervision at the San Juan Gas Co. Inc. and its parent are among the factors to blame for a deadly 1996 explosion, a preliminary U.S. government report says.

Also, the parent, Houston-based Enron Corp., knew since 1985 that the gas company's operations did not comply with

pipeline safety requirements and recommended industry practices, and it failed to require the gas company to comply with those requirements and practices, the National Transportation Safety Board found in a report abstract the agency released. The NTSB investigates pipeline-related tragedies.

San Juan Gas, which supplies propane through underground distribution pipes, contends that

the report has many shortcomings. The NTSB has not shown any forensic evidence to back its assertions, a company spokeswoman said. Enron referred telephone calls to its San Juan subsidiary.

The Nov. 21, 1996, blast killed 33 people and injured 69 others, according to the NTSB report released Dec. 16. It also destroyed a six-story commercial building

See Explosion on page 26

RenaissanceRe buys Nobel units

DALLAS—RenaissanceRe Holdings Ltd., the Bermuda property catastrophe reinsurer, is buying the Dallas-based operating units of primary property and casualty insurer Nobel Insurance Ltd. for \$54.1 million.

While Renaissance has existing primary property insurance subsidiaries in Bermuda and Florida, the Nobel deal is its first purchase of an existing insurer in the United States.

Nobel is the Bermuda holding company for Dallas-based Nobel Insurance Co., which writes surety coverage and property/casualty

coverage for explosives and propane companies, low-value dwellings, and trucking companies. Nobel Insurance Co. is licensed in all states and in 1996 had gross written premiums of \$83.7 million.

Under the terms of the deal, Renaissance will buy the operating units, and the holding company will be liquidated. Renaissance will provide \$8.9 million in financing to wind up the holding company, with that financing expected to be repaid through the sale of Nobel's assets, said John Lummis, senior vp and chief fi-

nancial officer.

Also, Renaissance has purchased an undisclosed amount of additional reinsurance from American Re-Insurance Co. and Inter-Ocean Reinsurance Co. Ltd. to cover Nobel's past liabilities, he said.

Earlier last year, Renaissance established its first U.S. subsidiary, DeSoto Insurance Co., to write a portion of business from the Florida Joint Underwriting Authority, which covers hurricane risks. In 1996, it set up Glencoe Ltd. in Bermuda as a surplus lines primary property insurer.

—By Gavin Souter

Inside

- Take a look at what *Business Insurance* thinks will be in and out of style in the industry this year. **PAGE 8**

- For the first time in history, corporate capacity at Lloyd's of London will be more than that provided by traditional names. **PAGE 19**

- Kathryn J. McIntyre, in the debut of a new *BI* feature, tells the story of a rehabilitation hospital executive who applies risk management thinking to violence. **PAGE 25**

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Pushing change before weather does

Shifts in global climate should spur insurers to challenge assumptions, industry leader says

At first glance, Franklin W. Nutter might seem an unlikely leader in the public debate over climate change. After all, insurance industry figures rarely assume high-profile roles in controversies in which the industry is not the direct focus.

But Mr. Nutter, president of the Reinsurance Assn. of America in Washington, has become recognized as the U.S. insurance industry's most visible spokesman on the issue as he has outlined the insurance industry's stake in climate change to industry groups and beyond, with his opinions winning favorable comment in the mass media.

Mr. Nutter recently spoke with Washington Editor Mark A. Hofmann about how he became interested in the subject of climate change and what insurers and risk managers can do to better understand what a changing climate means for them and what they can do to meet the challenges presented by such change.

Q: What first piqued your interest in the subject of climate change?

A: Like nearly everyone in the insurance industry that's interested in property insurance, Hurricane Andrew was a real wake-up call in looking at issues associated with weather and climate.

The reinsurers, notably the European-based reinsurers, had for some time focused a lot of research attention on natural hazards and natural events.

They probably would be considered as leading authorities in the insurance industry on scientific assessment on natural hazards, including climate-related ones.

The RAA represents U.S. domestic companies, but a number of them are owned by Europeans, notably Swiss Re and Munich Re, who have probably been thought leaders in this entire area.

So I think it's a combination of the wake-up call of Hurricane Andrew as well as the fact that the reinsurers seem to have a particular expertise in this area and therefore it became appropriate for us to look at it.

I guess a third thing is that one of the continuously high priorities for the RAA has been ad-

ressing the question of how natural catastrophe costs are financed. The RAA, as early as the early 1970s, was promoting federal legislation in this area, and we continue to feel it's a priority that needs to be addressed.

Why do you think U.S. insurers and reinsurers were slower to get interested in this issue than their European counterparts?

I make two distinctions. The first is that European insurers and notably the reinsurers have been very interested in studying the causes of climate change. The U.S. insurers have been much more interested in looking at the effects of climate change.

That's been the historical pattern in the U.S. industry, if you look at other public policy issues. It tends to drive the industry toward mitigation or loss reduction strategies.

For instance, in automobile and highway safety, the U.S. insurance industry has really been a leader in focusing on seat belts and air bags and that kind of thing. Historically, the industry

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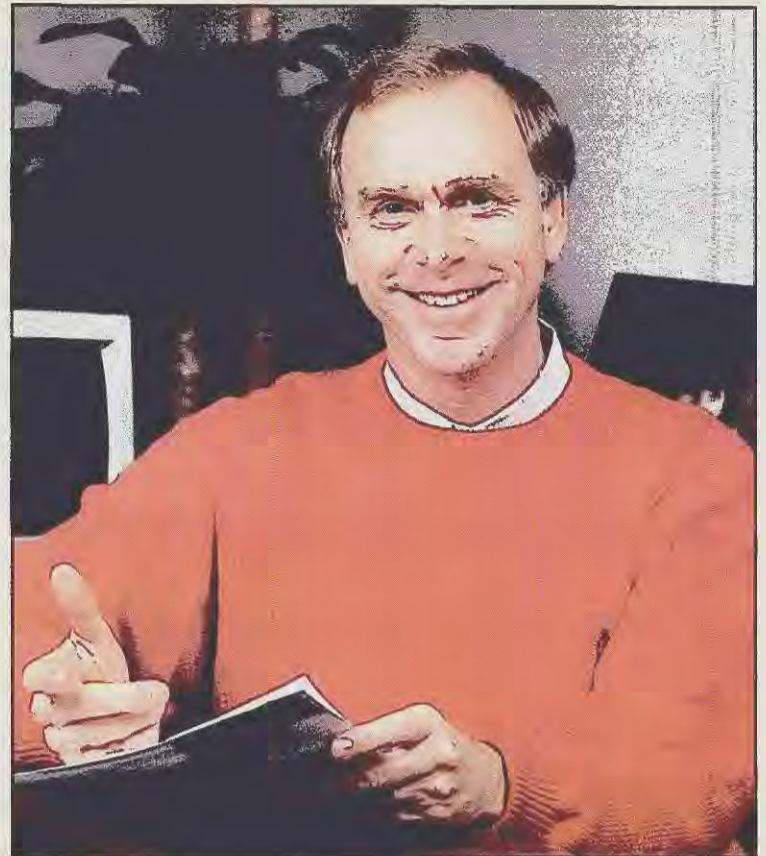


PHOTO: DAVID HITTLE

Merger may happen too fast: Regulators

SEATTLE—State insurance regulators are concerned that they might not have enough opportunity to raise questions about the possible merger activities of two major property/casualty information and rating agencies.

South Dakota Insurance Director Darla L. Lyon said recently that regulators are con-

NAIC

cerned that talks about merging activities of the Insurance Services Office Inc. with the National Council on Compensation Insurance Inc. soon may be accelerated by the departure of NCCI's top executive.

In July, the boards of directors of both organizations authorized talks to explore the feasibility of cooperative business arrangements, ranging from joint ventures to a merger.

In mid-October though, the NCCI announced that President William Hager is resigning from the organization in February (BI, Oct. 13). David Kocher, NCCI's chief of operations, has been serving as interim president since mid-October, while Mr. Hager is acting as a consultant.

Ms. Lyon predicted earlier this month that there may be some action within the first six months of next year on the proposal to merge some or all activities of those organizations to avoid the NCCI staff from being "left hanging."

However, an NCCI spokeswoman said last week that Mr. Hager's departure in February will have no impact on discus-

sions with ISO.

The talks, which began in the fall, have included a visit by New York-based ISO representatives to the NCCI headquarters in Boca Raton, Fla. As a next step, "we would be expecting that the ISO board will be making some proposal to the NCCI board committee," the NCCI spokeswoman said.

An ISO spokesman added only that the talks were "ongoing."

Ms. Lyon asked regulators to voice their concerns during a closed-door session at the recent meeting of the National Assn. of Insurance Commissioners in Seattle.

"What we are trying to do is get a handle on regulatory concerns," which will be described in a letter that will be sent to the information and rating organizations, Ms. Lyon said during the open portion of the Commercial Lines-Property and Casualty Insurance Committee meeting, which she chaired.

She also heads the NAIC's Workers Compensation Task Force.

Regulatory issues include preserving public access to reports at a reasonable cost and gauging the NCCI's willingness to continue producing some reports though there may not be a significant demand for them, she said in an interview.

If a merger goes forward, regulators also are concerned about the potential impact of having a monopolistic rating agency.

Most regulators have authority to designate the information and rating organizations in their states.

—By Meg Fletcher

Light season might secure market for catastrophe bonds

By RODD ZOLKOS

Having safely weathered the mild 1997 hurricane season, buyers of a watershed catastrophe bond deal sold in June will realize big returns.

The success of those buyers also could pay dividends for the nascent cat bond market.

Already, capital markets' role as a forum for transfer of insurance risks seems poised to grow as the new year begins.

Among transactions on the horizon, Centre Reinsurance Co. of New York is said to be preparing to come to market during the first quarter of 1998 with a \$120 mil-

lion catastrophe bond offering tied to both hurricane and earthquake exposures. Centre Re officials refused to comment on their catastrophe bond plans.

"In the sense that (USAA bond investors) were successful, it's probably just what everyone's been a little bit more," said Robert W. Montgomery, managing director at Sedgwick Lane Financial L.L.C. in Chicago. "Especially if the returns that USAA paid are available again, I'm sure a lot of people would be interested in it."

"The good news is a broad base of investors have had a good experience on these, and that bodes

well for the future," agreed Andrew J. Kaiser, vp and head of the insurance products group at Goldman Sachs & Co. in New York. Goldman Sachs has been involved in underwriting cat bonds for USAA, Tokio Marine & Fire and St. Paul Re. Although San Antonio-based United Services Automobile Assn. was not the first issuer of cat bonds, its June 1997 deal to secure a \$400 million reinsurance layer for East Coast hurricane risks was the largest to date and attracted considerable investor interest (BI, June 23, 1997).

As with other cat bond deals, See Bonds on page 14

Clinton to promote child care

Employers might get tax breaks for centers, other efforts

By DEBORAH SHALOWITZ COWANS

WASHINGTON—Employers can expect President Clinton to ask them to step up their support of child care in his State of the Union address this month.

Although specifics about the President's child care initiatives still are under discussion, the administration proposal is expected to include tax breaks for employer-sponsored child care centers and possibly other endeavors, such as referral services.

In a recent briefing for White House reporters, White House spokesman Mike McCurry said the president's child care proposal "will be a good, solid initiative that will extend tax relief to Americans who need it and will extend some help to employers who, in a good conscious way, think of ways of helping their employees with the burdens of child care."

Mr. McCurry, who said the president will make public his initiative in the State of the Union address, declined to elaborate.

Also, the Treasury Department is expected to announce soon who will participate in a private-sector group that will examine how businesses can provide child care and other ways to help support employees dealing with this issue, according to a Treasury Department spokesman.

The inclusion of a child care proposal in President Clinton's State of the Union address would "improve considerably" the chances that child care legislation would be enacted, said Frank McArdle, a Washington-based consultant with Hewitt Associates L.L.C.

See Care on page 26



President Clinton will offer a child care proposal in his State of the Union address later this month.

Nutter

Continued from previous page
has been a leader in the United States in fire hazard reduction and prevention.

So, the U.S. industry has had a natural instinctive reaction to major issues in looking how you can mitigate those losses.

Europeans are interested in looking at mitigation, of course, but they tend to go one step beyond, and I think they do largely because of the role that science plays in their corporate strategies.

Both Munich Re and Swiss Re, for instance, have geoscience departments, people on their staffs who are scientists. They routinely consult with academics in the field. They have integrated natural sciences into their corporate planning and their corporate strategies in a way that U.S. insurers have not.

I think that tends to bring them more into that realm of trying to understand the causes of climate change because they have people there who are capable of that, who have the skills to do that.

Have they historically approached things this way?

Absolutely. Well before Hurricane Andrew they had scientists on their staff who were part of their corporate leadership.

Are there any U.S. insurers with such scientists on their staffs?

I can think of one. For a few years, Chubb Corp. had a natural scientist on its staff. He left about a year and a half ago to go with one of the catastrophe modeling firms.

Now the only company that I know of that has a scientist on its staff is Employers Reinsurance, which is, of course, one of our member companies. He was hired from the Bermuda Biological Station, again, to try to bring that scientific perspective in.

U.S. insurers bring science into their corporate activities indirectly in this sense: Since Hurricane Andrew and the Northridge Earthquake, the catastrophe modeling firms have become prominent in providing advice and consultation to insurers. The catastrophe modeling firms have an impressive array of scientists on their staff, natural scientists who study nothing but climate, weather, seismology, as well as actuaries.

From an insurance perspective, is there any aspect other than an apparent increase in atmospheric temperatures that should concern insurers?

I think the thing that should be of concern to insurers is the fact that we have a changing climate. It's not one specific aspect of it, whether its global warming or even natural variability. It's the fact that our climate does change and scientists are predicting

that we're in a period of significant change.

Bill Gray, a professor at Colorado State University, is routinely quoted in the press about his predictions about the hurricane season. One of the things he said is we are in a period, probably a 20-year period, of increased hurricane activity in the Atlantic basin, he believes as a result of natural variability, not global warming.

But the point is this: Insurers rely up on their ability to predict the economic consequences of future events. That's how premiums are set; that's the kind of assessment they do of their own exposures. In a period of changing climate, when the very basis of their decisions may be changing, then they need to have a better understanding of climate change and what that may mean about the assessments they're making about their exposures and their premiums.

So it goes back to what I think is the fundamental point about insurance, and that is making an assessment today about the economic consequences of future events. The fact that the future events may not be a linear progression of the past, but in fact may have changed as a result of natural variability, or human activity or whatever, is an important thing to be taken into consideration.

How should U.S. insurers and risk managers respond to the challenge of climatic change? Should actions tak-

en to deal with climate change be taken within the larger context of catastrophe mitigation?

Clearly, mitigation is a long-term, valuable strategy for the insurance industry, and the industry is, I think, doing a good job in placing emphasis on that through the Institute for Business & Home Safety in Boston.

That's the former Insurance Institute for Property Loss Prevention?

That's right. This organization has now focused its attention just on natural catastrophes. It has some very impressive new programs focusing on building codes and model cities that are doing a good job at mitigation and encouraging homeowners to do the right thing. I'm sure there are a number of insurers that are giving their policyholders good advice about how to mitigate losses from natural catastrophes.

What is the specific role for risk managers?

I guess it would be this: In addition to the mitigation that we just talked about, certainly companies that are relying upon catastrophe modeling to make an assessment of their exposures and their rates really should make an effort to understand the scientific basis on which some of those models are based, and the assumptions that are made. It would help

them have a better understanding of what the science community is telling modelers and others.

It seems to me that our industry is probably first in line after those who are victims of catastrophe themselves in feeling the effects of climate and weather because of the claims we pay and the extraordinary focus we have on the protection of property.

Therefore, we become very much a valuable tool in assessing the effects of change and weather events—tornadoes, hurricanes, Nor'easters—those kinds of things. Therefore, it becomes incumbent upon us to contribute to better understanding of those things.

For example, I commend the companies that are funding the Risk Prediction Initiative, which is based in Bermuda. There are 12 insurers and reinsurers that are funding scientific research looking not at insurance but looking at what do we know about climate and weather, what are the historical patterns, what are the return and recurrence periods.

I do think the industry has a role in funding research that focuses on weather and climate so that we can benefit from that knowledge and frankly, that the public can benefit from a greater understanding of that.

Countries attending the Kyoto summit agreed on a reduction of greenhouse gases. Ratification of the Kyoto treaty by the U.S. Senate, however, appears highly unlikely in its current
See Nutter on page 6



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Nutter

Continued from page 4
form. Do you believe that there could be a market-oriented way acceptable to the business community to reduce gases?

The RAA has not taken any position, nor anybody I know of in the U.S. insurance industry, on what would be appropriate targets for emission controls or whether there ought to be emission restrictions. No position on taxing fossil fuels, no position on reducing fossil fuels—so I would say that is all well beyond what we have dealt with.

I would say, however, is that if in fact the climate is being affected by the use of fossil fuels, then among the various factors affecting climate, we should try to have a better understanding of that. We

should participate in the forum where that's discussed.

We should try and understand whether in fact the burning of fossil fuels is in fact warming the climate in a way that interferes with climate mechanisms, because we have such a vested interest on understanding climate and weather, a vested economic interest as well as just good corporate citizens.

I don't know that the industry is likely to play a role in the treaty discussions or the debate in the Senate at this point.

Can the insurance industry play a role as "honest broker" among the various parties in the global warming debate?

In terms of the general discussion, I would go back to what I said earlier. Our industry's interests is so intertwined with climate and weather. The threat of natural

events drives the demand for insurance products. The coverage that the industry writes, if not responsibly written, can threaten the financial viability of companies.

It seems to me that we can't just stand on the sidelines with respect to the general understanding—whether it's among public policymakers or our own policyholders, corporate or individual—about this.

That's why I do think we ought to do a couple of things. One is to fund, where appropriate, research in the scientific community to try to get a better understanding of this. There are a lot of things we clearly don't know about how the climate system works.

The second thing that the industry has modestly done but I think it could do more of, is that there are a tremendous number of government programs where you have

monitoring of climate, satellite systems, where you have climate and weather-related research. Frankly, I think it behooves our industry to step forward and support government programs that provide valid information, that are used by our industry and would be helpful in understanding the issues in the debate.

I'm not driven to this because of conclusions I have or our companies have drawn about climate and global warming.

I'm drawn to this issue by the fact that our interests are so intertwined with climate and weather. We play such an important role in being an intermediary for translating the economic consequences of external events, including climate-related events, that we ought to play a role in helping understand the status of the science and to promote better science in this area. B1

Ruling

Continued from page 2
 provide such coverage subject to an aggregate limit. In a policy without an exclusion, the standard form definition determines which claim payments are subject to aggregate policy limits," added Mr. Dolin.

An attorney on the other side of the case wasn't so sure of the decision's impact beyond New York.

"Clearly this is a decision by the New York Court of Appeals, which will be followed by the courts of New York state. Whether it will govern the laws of other jurisdictions will need to be decided on a case-by-case basis in those jurisdictions," said Howard S. Rosenhoch, a partner in the Buffalo, N.Y., law firm Jaeckle Fleischmann & Mugel. Mr. Rosenhoch represents Merchants Mutual.

The case before the New York high court involved Frontier Insulation Contractors Inc., a Buffalo-based industrial and commercial insulation contractor that had used asbestos insulation between the 1920s and 1970s. During the mid-1990s, Frontier was named as a defendant in 21 lawsuits alleging bodily injury and damages.

But Frontier's CGL insurers, Merchants Mutual and Utica Mutual Insurance Co., held that the products hazards exclusions in their policies meant they had no duty to defend or indemnify Frontier in the personal injury suits. Products hazards exclusions generally apply to certain products-related claims involving accidents that occur after the policyholder has relinquished possession of the product to others and away from premises owned, rented or controlled by the policyholder.

Frontier sued its insurers in state court in December 1994. A state superior court held that Merchants Mutual had to defend and indemnify Frontier in 18 of the actions and that Utica had to do the same in 15 of the actions. Frontier settled out of the court with a third CGL insurer before the case was decided by the appeals court.

But in April of last year, the New York Court of Appeals for the Fourth Department disagreed in a 3-2 decision. The majority write that "because none of the underlying complaints alleges any cause of action sufficiently removed from the allegedly defective and injurious nature of the asbestos to warrant classifying Frontier's liability as something other than a 'products hazard,'" the insurers had no duty to defend and indemnify the contractor.

But the seven judges of the state's highest court found for Frontier.

The insurers "contend that all of the claims in the underlying complaints fall wholly within the policies' exclusions for product hazards because they all allege that bodily injuries resulted from exposure to Frontier's asbestos products. This claim misses the mark, however, because the focus in determining whether a product-hazard exclusion applies is not simply whether an insured's product caused the loss at issue, but rather 'is dependent on the location of the accident and the possession of the product.' Defendants' argument fails to appreciate that an exclusion for product hazards governs only one subset of product liability claims," wrote Judge Vito Titone for the court.

The case was remitted to the appellate division for consideration of other issues in the case.

Frontier Insulation Contractors Inc. vs. Merchants Mutual Insurance Co. et al., State of New York Court of Appeals, No. 254, Dec. 22, 1997.

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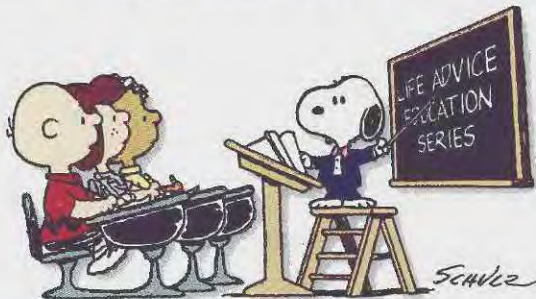


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Opinions

BI best bets for 1998

IN THE TRADITION of the Oracle at Delphi, the Great Karnak and the Psychic Connection Hotline, *Business Insurance* again presents its annual list of what will be "in" and "out" in the worlds of risk management, employee benefits and commercial insurance for the next 12 months.

Like those other soothsayers and crystal ball gazers, sometimes we get it right and sometimes we're off the mark. Looking back on 1997, though, our predictions at the start of the year had more hits than misses. So we gamely give it another try in this, our 11th annual divination on the year to come.

Be they amazing feats of clairvoyance (or just safe bets), our accurate predictions for 1997 included: More consolidation in the property/casualty and managed care industries; increased corporate investment in Lloyd's; additional anti-managed care legislation; shrinking employee benefit departments; and reduced tolerance for junk science in the courtrooms, among others.

But we also had our share of flubs and faulty conjectures, including predictions of: passage of incremental Superfund reform; growth of medical savings accounts; passage of federal product liability reform; an end to state efforts to regulate risk retention groups; and no more rumors of Aon Corp's next acquisition.

Our take on the ins and outs of the new year follows:

IN: Mental health benefit parity.

IN: Employer ergonomics initiatives.

IN: Purchasing Year 2000 coverage.

IN: Catastrophe bonds issued by insurers and reinsurers.

IN: More legislation targeting managed care practices.

IN: State surcharges on hospital bills.

IN: Consolidation among European Union insurers.

IN: Commencement of commercial lines deregulation.

IN: Multiyear, multiline insurance products.

IN: Integrated disability management services.

IN: Regional brokers.

IN: Risk managers enrolling in graduate school to learn more about financial markets and financial products.

IN: Brokers promoting outsourcing.



OUT: Rich Medicare HMO benefits at little extra cost.

OUT: Certification of class action settlements.

OUT: El Nino's hurricane-dampening effect.

OUT: Efforts by employers to withdraw from multiemployer plans.

OUT: 401(k) participant calm amid stock market turmoil.

OUT: Independence for Willis Corroon Group P.L.C.

OUT: Global settlement of tobacco litigation.

OUT: Hidden investment fees for savings plan participants.

OUT: Comprehensive product liability reform.

OUT: Insurance industry apathy over climate change.

OUT: Separation of banking and insurance.

OUT: Congeniality among J&H partners and retirees.

Letters

Keep an open mind toward benefits of MSAs

To the editor: As a 20-year veteran of the health benefits industry, I agree that there are inefficiencies to be wrung from our current health care system before health insurance can be cost effective for employers (*BI*, Dec. 8). Yet, I strongly disagree that allowing employees the freedom to see whatever doctor they choose is an inefficiency of plan design. What is an inefficiency of plan design is our current industry focus on low-deductible policies and first-dollar charges for medical bills.

The reality is that rising premiums and declines in private health insurance have poised our industry on the brink of revolution and, whether we like it or not, sweeping changes in plan design are under way.

The movement is toward empowering individuals to take more control of their health care costs, and a first step in this direction was the enactment of medical

savings accounts (MSAs) by Congress in late 1996.

This is the first major health reform legislation passed in more than a decade, yet our industry, as a whole, has failed to embrace and support MSAs. I am constantly perplexed by the fierce opposition to any new legislation, programs or benefits that offer choice—and make changes—to our current managed care health insurance system.

Critics within our industry who are quick to point out the downsides of MSAs easily forget that, not more than a decade ago, our current managed care system was scrutinized, contested and positioned as the demise of the health care industry. Yet today, managed care is held up as the answer to our health insurance woes.

Unfortunately, in their swift disapproval of MSAs, they are doing a serious disservice to the 40 million Americans who have no health insurance. MSAs offer a new option to make health insurance affordable and attainable, giving individuals and small businesses the freedom to take control of their health care expenses.

MSAs are dismissed as "complex," the bottom-line reality is that they are simple to understand and, most importantly, make financial sense. A turnkey MSA provider shops around for the best low-premium, high-deductible plan and then sets up the policy and the MSA account.

The financial benefits for the individual and small business owner far surpass the traditional policy: MSA contributions are tax-deductible, interest earned is tax-deferred, and qualified medical expenses can be paid immediately using tax-free dollars. And money remaining in the MSA at year's end is rolled-over—accumulating tax-deferred interest over the lifetime of the policy.

Most puzzling is the argument that putting health care responsibility back in the hands of the individual will drive up medical costs. Our country is based on freedoms and giving consumers responsibility for their health care. Making decisions about which medical providers to frequent and leveraging immediate payment for services to negotiate price breaks gives them the freedom to take control of their health care expenditures.

I realize MSAs may not be a blanket solution for everyone, but, my question to you and your readers is, "At a time when health insurance premiums are on the rise and private health insurance policies are on the decline, what's so wrong about giving people another choice to help them afford and control their health care expenditures for themselves and their families?"

Allen Wishner
Chief Executive Officer
Flexible Benefit Service Corp.
Chicago

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Reporting weekly on corporate risk,
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**Q: IS IT BETTER TO EMPHASIZE SERVICE,
VARIETY, OR INNOVATION?**



Fen-phen

Continued from page 1

Mr. Biscan is a medical malpractice defense attorney defending a small number of physicians in diet pill litigation. But in this case, it's unusual "to turn themselves at odds with other parties traditionally their allies," he said referring to the usual close relationship between doctors and drug companies.

In response to the growing number of suits against physicians, medical malpractice insurers are meeting to discuss defense strategy and share

information.

Figures on how many suits have been filed against doctors are not available. But Paul Rheingold, a partner with the New York firm of Rheingold, Valet & Rheingold P.C. who represents several plaintiffs in such suits, estimates the number could be in the hundreds.

To date, no jury has delivered a verdict in a case against a physician. One case against a doctor in Florida, however, was settled last year for \$250,000, the policy limit.

Plaintiffs are making the following charges against physicians, according to Mr. Rheingold: failing to prop-

erly examine the patient before prescribing the drugs, not properly warning the patient of the possible side effects of the drugs, failing to properly monitor the patient taking the drugs, and not performing tests on patients who complained of problems while taking the drugs.

The counter-strategy of the drug makers putting the blame on physicians is possible, the attorneys said, but more difficult, because the drug makers want to maintain good relations with the doctors who prescribe their drugs. It can be done, "but it has to be subtle," said Mr. Rheingold.

Fenfluramine and phentermine in-

dividually received U.S. Food and Drug Administration approval for use in weight loss. Doctors for years, however, have prescribed the drugs together to millions of people in the combination known as Fen-Phen. But studies released in July showed that the drug combination, as well as combining dexfenfluramine in combination with phentermine, causes heart-valve abnormalities.

Wyeth-Ayerst Laboratories, a division of Madison, N.J.-based American Home Products Corp., manufactured fenfluramine and marketed it under the name Pondimin, and dexfenfluramine and marketed it under the name Redux. Wyeth-Ayerst withdrew the drugs from the market after the release of the studies (BI, Sept. 29, 1997).

In response to the growing number of Fen-Phen and Redux suits against physicians, medical malpractice insurers have been holding meetings to "share resources" and provide "a united defense," said Mr. Loughlin of Frontier. Frontier insured the physician who settled the Florida suit.

Doctors can defend themselves by saying, "We didn't know there were side effects when we prescribed these drugs," said Mr. Biscan.

Miles McGrane, a partner with McGrane & Nosich in Coral Gables, Fla., who represents doctors in these suits, agrees with that strategy. "You could defend and say they were only doing what pharmaceutical companies said it's OK to do," said Mr. McGrane, who represented the Florida doctor who settled.

To support this defense, doctors could rely on material the drug makers provide to promote the Fen-Phen combination.

One such piece is a videotape and accompanying booklet distributed to doctors and "made possible by an unrestricted educational grant provided by Wyeth-Ayerst Laboratories."

The booklet says "one strategy to reduce side effects of both fenfluramine and second-generation noradrenergic agents is to use them in low dose combinations." Noradrenergic agents include phentermine.

"Promotional literature that suggests some use of a combination would be an aid in the defense of doctors," Mr. Biscan said.

A spokeswoman for Wyeth-Ayerst would not comment on the videotape or booklet.

Despite the growing number of suits, defense attorneys say the drug makers, not the physicians, still are the primary targets of litigation.

"I really think that's where the claims will wind up," said Mr. McGrane. "The doctors will be bit players."

The liability of physicians varies with their type of practice, lawyers said. Physicians who worked at diet clinics or who held themselves out as weight-loss experts could have a more difficult time defending themselves than doctors who only prescribed diet pills to a few patients.

Weight-loss specialists are held to a higher standard of care than general practitioners, Mr. Biscan said, which makes their defense harder.

The main question with the litigation is "what did the doctors know and when did they know it," Mr. Biscan said. A specialist in weight-loss would be held to knowing more than an ordinary doctor about the drug combination's possible side effects, he said. **BI**

AIG

Continued from page 1

totalled \$577.7 million. Direct written premium is the aggregate amount of premiums other than reinsurance. Policyholder surplus for the group stood at \$348.5 million at the end of 1996, according to figures published by Oldwick, N.J.-based rating agency A.M. Best Co. By comparison, AIG companies wrote \$13.31 billion in direct 1996 premiums and had net written premium volume of \$9.27 billion. AIG policyholder surplus in 1996 was \$9.53 billion. Best figures show

Under the terms of the deal which AIG will treat as a purchase for accounting purposes, American Bankers shareholders will receive AIG stock equal to \$47 per share giving the deal a total value of \$2.2 billion. Under some circumstances shareholders may elect to receive \$47 per share in cash instead.

The transaction is initially based on the \$104.56 per share closing price of AIG stock as of Dec. 16, but will finally be based on the average price of AIG's shares for the 10 days before closing. If the price of AIG stock drops from the Dec. 16 level, AIG has the option of making up the difference with additional stock or cash.

The deal, subject to regulatory approvals, is expected to close early this year.

American Bankers will operate as a subsidiary of AIG, and its current management team will remain in place, AIG announced. The acquisition is AIG's biggest to date. AIG paid \$1.26 billion for International Lease Finance Corp. in 1990.

AIG Chairman Maurice R. Greenberg called American Bankers "a fine company with product lines that complement but do not overlap those of AIG."

"Particularly overseas, AIG will be able to open significant new op-

portunities for American Bankers," Mr. Greenberg said in a statement. "AIG's top credit ratings should also provide an important benefit to American Bankers."

Analysts agreed the deal is a good one for both companies.

Mr. Morrissey noted that the merger expands AIG's "non-agency" distribution system of banks and other financial institutions.

"Bank distribution is a critically important area in the future for all sorts of financial products, and this is a brilliant move for AIG," he said. "Sometimes these things just leave me scratching my head, but this one made me wonder, 'Why didn't I think of that?'"

The purchase price, amounting to roughly 2.8 times American Bankers' book value, is "high but not crazy," he added. "Given the importance of enhancing one's position in bank distribution and other distribution systems, it's quite reasonable."

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Bonds

Continued from page 3

such as those issued by St. Paul Re, Swiss Reinsurance Co. and Tokio Marine & Fire Insurance Co. Ltd., the USAA deal involved the use of a special-purpose reinsurance company to issue the bonds and provide a reinsurance contract.

The USAA catastrophe bonds were issued by Residential Reinsurance Ltd., a Cayman Islands company USAA created in 1996. Residential Re is managing the bond proceeds and administering the \$400 million reinsurance contract it provided USAA.

The reinsurance contract covered USAA for a loss from a single Category 3, 4 or 5 hurricane resulting in insured losses between \$1 billion and \$1.5 billion to USAA policyholders in

an area stretching from Texas, around the state of Florida and north along the Atlantic Coast to Maine.

The one-year bonds don't come due until June, so while the 1997 hurricane season has passed, the reinsurance contract remains in force until the bonds mature.

"Our reinsurance contract is on an annual basis through June, so even though the hurricane season is, in all effect, over, that contract would extend through June," a USAA spokesman said. Until that contract expires, USAA officials will not determine whether they would repeat the cat bond approach.

In exchange for relatively healthy returns, most of the USAA bonds' investors risked the loss of principal if a hurricane of the specified level occurred.

Even a significant loss to those early cat bond investors, however, might

not have slowed growing interest in the cat bond market, said Richard L. Sandor, chairman of Hedge Financial Products Inc. in Chicago.

The hardening reinsurance market

'1997 has been an excellent year for the growth of insurance derivatives,' says Richard L. Sandor.

resulting from such catastrophe losses could, in fact, spur the cat bond market's further development, he said.

"If in fact there had been a catastrophe, it might have boosted the issuance, because reinsurance rates

might have risen," he said.

The risk securitization market is "in maturation," according to Mr. Sandor. In addition to the USAA deal, signs of that maturation include: new cat bonds set to come to market, more investment banks entering to underwrite those issues, new players in insurance derivatives and record open interest in the Chicago Board of Trade's catastrophe options.

"I think we're seeing a resounding growth in (the risk securitization) market, and we're also seeing a set of investors that have done well," Mr. Sandor said. "1997 has been an excellent year for the growth of insurance derivatives, and we expect the pattern to continue in 1998," he said.

Although the 1997 hurricane season was far milder than forecast, it is inappropriate to question with the benefit of hindsight whether USAA's deal was a wise one, said Mr. Kaiser.

"If you're going to hedge those exposures, you're going to hedge," he said. "You're hedging it because the consequences of the event are catastrophic."

Even in the face of a mild 1997 hurricane season, the CBOT's cat options market showed healthy growth, further reflecting the interest in risk securitization, according to Mr. Montgomery.

"By and large, even though at the Board of Trade we might not have lived up to all the hopes we had a year ago at this time, we had a very good year," Mr. Montgomery said. "Since the end of the hurricane season we've been very busy here."

Particularly noteworthy, he said, was a Dec. 10 deal for 2,000 contracts. "It was, I believe, the largest trade that we've done down here," Mr. Montgomery said. "Certainly the largest one recently." **BI**

Fawell

Continued from page 2

• Set up "due process grievance procedures" to settle issues of medical necessity and prior authorization for each plan.

This would not, as PARCA would, allow patients to sue health plans and plan sponsors in court for punitive and other damages allowed under state laws for personal injuries incurred in connection to services received through their health plans.

• Promote state-of-the-art science in health care. Mr. Fawell could not say how his bill would accomplish this goal.

• Enable small businesses and self-employed workers to gain the advantages of economies of scale by joining together in "association health plans" (BI, July 7, 1997). This is a carry-over from an earlier proposal by Rep. Fawell to amend ERISA so that alliances of small businesses, through established trade associations, could self-insure their health care plans or purchase health insurance on a group basis and be exempt from state benefit mandates and other state requirements. Instead, these association plans would be regulated by the federal Department of Labor.

That earlier proposal was included in the Balanced Budget Act approved last year by the House of Representatives. A Senate approved budget bill lacked a similar provision, and a conference committee ironing out differ-

ences between the two bills dropped the Fawell provision.

In a letter last month to fellow congressmen, Rep. Fawell said an analysis by Washington health care attorney and consultant William Schiffbauer concluded PARCA would create 336 federal statutory requirements.

"The PARCA bill just goes so very far," Rep. Fawell said. "It has 41 pages—not patient protection, just provider protection."

The measure, according to Rep. Fawell, is "heavy-handed government regulation that would end managed care in the free market" by making the plans so expensive that many employers could drop coverage.

Among other things, PARCA, also known as H.R. 1415, would:

• Require health plans to provide coverage for services delivered by all health care professionals certified under state law.

• Provide patients a point-of-service coverage option for a higher premium and higher per-service costs. The government would decide how much of a POS plan premium employers could shift to employees.

• Limit employers' ability to establish preferred provider networks. Under the measure, an employer that selects a hospital and its accredited physicians to be in its network could not bar other physicians from being in its network because they were not affiliated with or did not have admitting privileges to the hospital with which it contracted.

• Prohibit medical providers, in many cases, from receiving managed care bonuses when they deny service to people seeking health care. It would still allow some capitation practices.

Rep. Fawell, chairman of the House Subcommittee on Employer-Employee Relations, which considers ERISA matters, admits to being baffled about why some 123 Democrats and 91 Republicans have signed on as co-sponsors of PARCA.

Rep. Fawell said the only explanation for the House bill's popularity is that congressmen aren't paying attention to its content.

"One has to spend a lot of time reviewing it to understand it," he said.

A companion bill in the Senate has drawn far less attention and has not come up for a vote.

A spokesman to Rep. Norwood said the congressman supports Rep. Fawell's idea for association health plans but thinks his opposition to PARCA is misguided.

"Our bill is a conservative Republican approach," the spokesman said. Only HMOs that improperly deny patients out of their "paid-for" benefits and cause harm would find themselves in court, he said.

The Norwood spokesman also criticized a recent report by actuarial consulting firm Milliman & Robertson that estimated PARCA could raise health insurance premiums an average of 23%, or a maximum of 39%. "Everybody out there has the wackiest numbers and statistics," he said, adding the study must be viewed as

"total bunk."

Michael Sturm, an actuary with the Milwaukee office of Milliman & Robertson and a co-author of the study, defended the report as being as close to the truth as possible considering what he called the vagueness of Rep. Norwood's bill.

"The bill is very ambiguously worded, and the report we put out has a range of estimates," he said. "Write me a good bill and I'll write you a report that has a lot tighter numbers."

He also disputed an assertion by Rep. Norwood's spokesman that the study was bankrolled by the managed

care industry, asserting that it was sponsored by Bentonville, Ark.-based Wal-Mart Stores Inc. in an effort to gauge the bill's effect on employers.

"We don't think our bill will drive up costs," Rep. Norwood's spokesman said. However, he added, the bill is so complex there is no way to be sure what cost effects it will have, and that some employers would most likely see a savings while others might see increases.

He also left open the possibility for compromise with Rep. Fawell, saying "there may be room for common ground as the session develops." **BI**

McDonald joins Walter Industries

Comings & Goings: Buyers

W. Michael McDonald has joined Walter Industries Inc. as director of risk management for the home builder and financial services company based in Tampa, Fla.

Mr. McDonald, 53, is responsible for insurance, safety and loss prevention programs at the company. He joined Walter Industries after working as director of risk management for Value Rent-A-Car in Boca Raton, Fla.

He replaces Thomas C. Mosier, who retired in August. He reports to Dean Fjelstul, senior vp and chief financial officer.

Mr. McDonald earned a bachelor's degree in economics from North Carolina State University. He holds the Associate in Risk Management designation from the Insurance Institute of America.

Earl D. Varney has been named risk manager for The Vanguard Group of Investment Cos. in Malvern, Pa.

Mr. Varney, 41, takes the position after serving as risk manager at Wilmington Trust Co. in Wilmington, Del.

At The Vanguard Cos., Mr. Varney is responsible for insurance and risk management at the \$300 billion Vanguard Group Inc. mutual fund operation and for affiliated companies in brokerage, trust services, investment advisory and real estate management businesses.

He reports to Frederick Teufel, controller.

Mr. Varney earned a bachelor of science degree from

Brown University and a master of business administration degree from The Wharton School at the University of Pennsylvania.

He is a member of the Delaware Valley Chapter of the Risk & Insurance Management Society Inc.

David Hennes has been promoted to director of risk management at The Toro Co., a Bloomington, Minn.-based maker of outdoor products.

Mr. Hennes, 45, was manager of corporate risk and insurance, a position he has held since joining the company in 1995.

He will continue to oversee risk management and insurance functions at Toro.

He reports to J. Lawrence McIntyre, vp and general counsel.

Mr. Hennes earned a bachelor of arts degree in English from the University of Minnesota and a master of business administration degree from the University of St. Thomas in St. Paul, Minn.

He holds the Associate of Risk Management and the Chartered Property & Casualty Underwriter designations.

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Protecting agents' interest in bank alliances

Report outlines partnership options and ways agencies can avoid problems

By AMANDA MILLIGAN

Realizing they can no longer prevent banks from selling insurance, many agents and brokers are looking at ways to turn competitors into allies.

In 1996, the Supreme Court ruled in *Barnett Bank of Marion County N.A. vs. Nelson, Florida Insurance Commissioner* that states cannot prohibit banks from sell-

ing insurance in towns of 5,000 or fewer people. Agents initially feared losing business to banks, but many have cast those fears aside and are taking steps to stay competitive.

According to a recently released white paper on bank/agency partnerships commissioned by the Washington-based Council of Insurance Agents & Brokers, several opportunities arise from blending these two very different institutions. For example, banks can

provide an extensive customer base and financial stability, while agencies can offer valued expertise about products banks are eager to market.

"The agent's products may fit and complement the way the bank operates," said the white paper's author, John Pottridge, president and chief executive officer of Pottridge & Associates, an Alexandria, Va.-based consulting firm that advises agents on how to build and maintain relation-

ships with banks. "Agents have turned the corner on the old paranoia. They're looking at the opportunities."

The 19-page white paper, titled "Selling With Banks: What Agents and Brokers Need to Know," outlines five methods in which an agency can align themselves with a bank. However, according to the white paper, agents must examine each option carefully to determine which may suit their needs.

"You can't 'cookie-cut' the ar-

rangements," Mr. Pottridge said. "The option has to fit the agent's circumstance."

Because of the complexity of laws, contracts and organizational issues associated with an agent/bank alliance, he cautions against a hasty arrangement.

Joel Wood, vp-government affairs at the Council, said banks are "losing turf on traditional banking products," such as credit cards. As a result, banks are beginning to offer unconventional products, such as insurance, to their customers with the hopes of cross-selling. "In a macro sense, banks have been losing their products to other industries," he said.

But trend-savvy agents also are seeking out the marketing opportunities the *Barnett* decision provides, Mr. Wood said. "There's nothing in current (federal) legislation that is going to reduce or scale back the integration by many agents and brokers to affiliate with a bank or be bought out."

"Both sides took some time to decide what they could do in terms of *Barnett*," said Coletta Kemper, director of industry affairs for the Council. "With change, there are also opportunities."

A recently released survey of independent agents found a majority willing to explore joint ventures with banks (see story, page 14D).

According to the white paper, the options for cooperation between agents and banks are:

• **Referrals.**

Banks referring potential clients to an agent is the most basic form of cooperation. Informal in structure and regulation, the referral method is also the least risky, according to the white paper. Although no cost is involved in a referral, there's not much commitment to future business, either. This stage may be a steppingstone to a more intensive alliance.

• **Sharing customer lists.**

The most common form of agent/bank joint venture involves sharing customer lists. A bank brings an established, conservative platform and tremendous customer opportunity to a joint venture, Mr. Pottridge said. The question really is, "Can the bank and the agency share the customer?" he said. Historically, because of the differences in their products and services, this hasn't been an issue, however. "It's better to share than to just have the leftovers," Mr. Pottridge said.

Because the customer list is a valued commodity of both institutions, though, agents should consider cost, confidentiality and client relations. Mr. Pottridge said his firm recommends a two-year mutual confidentiality agreement during the life of the joint venture to ensure this asset is protected.

• **Lease agreements.**

The third form of cooperation between banks and agents the white paper outlines is a lease

See **Banks** on page 14D

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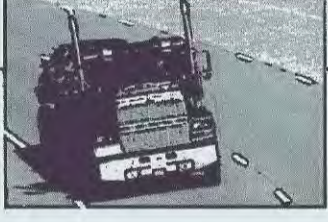
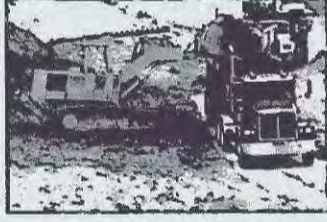
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Agent/Broker Topics

Banks

Continued from page 14B agreement. This method of alliance, which some states do not permit, involves the agent leasing office space within a bank. Some states ban the practice, and other states' consumer protection laws keep these arrangements under strict control.

"The states have picked up the gauntlet," Mr. Pottridge said. "Federal legislation is still languishing in the halls of Congress."

Until all states comply with the same rules, Mr. Pottridge said it is imperative for agents seeking to form an alliance with a bank to un-

derstand the laws and regulations of each state in which they want to do business. He recommends starting with the state department of insurance and the banking commissioner's office.

• **Joint marketing.**

Joint marketing is the most formal and the most regulated method of an agent/bank joint venture. Under this arrangement, the agent offers insurance to the bank's clients, and the bank supports the agent's efforts with marketing resources. The bank, in turn, receives a portion of the generated commission.

The white paper recommends specific contracts with respect to sharing commissions. While mutu-

al trust is crucial to the success of the partnership, it is not a substitute for an airtight contract, Mr. Pottridge said. He urges agents to enlist the help of an attorney.

• **Selling the agency.**

Selling an agency to a bank is the highest level of involvement the two institutions can achieve. "Changes in the law have made this the option of choice for agents who want to retire, leave the business or guarantee the future of the agencies," according to the white paper. However, the previously independent agent may become subservient to the demands of the acquiring bank's board of directors or CEO.

For banks, it makes sense to buy an agency to acquire insurance ex-

pertise, says Jim Kilbride, chairman and CEO of Morse, Payson & Noyes Insurance in Portland, Maine.

In June, Mr. Kilbride announced his agency's intention to sell to a state-chartered bank. By October, the agency, founded in 1882, finalized the deal. Although Morse, Payson & Noyes and the bank had considered such an arrangement prior to *Barnett*, Mr. Kilbride credited the ruling with streamlining the process.

The decision to sell the 125-employee agency was not made overnight, however. It took a year and nine months from the start of the talks to the close of the contract, he said. The bank approached his agency, spent a lot of time understanding the insurance product and ultimately decided to purchase it because of the potential expertise Morse, Payson & Noyes offered to the bank's customers, Mr. Kilbride said.

"Banks in conjunction with agents will be extremely competitive," Mr. Kilbride said. "On their own (selling insurance), I don't think they will do very well."

Before forming an alliance with a bank, Mr. Pottridge recommends that agents prepare themselves systematically for the partnership:

- Have a strategic plan.
- Understand the cultural differences between the banking and insurance industries.
- Have a plan on how to approach or respond to the bank.
- Allow enough time to build a trusting relationship.
- Plan sufficient financial resources, establish a budget and evaluate personnel needs.
- Get some help in evaluating and establishing the potential alliance.

"The mistake they (agents) make is attempting to do it all (themselves)," Mr. Pottridge said.

The Council's Ms. Kemper also recommends that, after an alliance has been finalized, each side appoint a liaison. These liaisons smooth the transition and ensure clear communication between the agent and the bank, she said.

"It's important to get people to understand the corporate cultures and to get them to work together," she said.

Blending the sales-oriented mindset of the agency with the service-focused view of the bank is another task to which each side must be committed, the white paper noted.

Mr. Pottridge warns not to expect established employees in either institution to change their mindsets. By evaluating strengths and weaknesses in each institution, the allied sides then can train employees in needed areas of improvement.

Focusing efforts on internal issues also will smooth transitions for each side's customers. Because the word of the agent is extremely important, it is critical to pick the right time to tell the client, Mr. Pottridge advised. He recommends at least having a letter of intent before informing others outside the institution.

The Council's Mr. Wood agreed that agent/bank partnerships are driven by customer service. "At the end of the day, it's all about providing a value-added service to the consumer," he said.

Copies of the white paper may be obtained from the Council for \$10 for members and \$50 for non-members. Contact Wendy Slagle at the Council at 202-783-4400 for more information.

Agents eager to explore ventures with banks: Survey

Insurance agents and banks are eager to explore cooperation opportunities, according to a recently released survey.

Paul Buse, vp of Washington-based Risk Management Services and one of the survey's three authors, said the partnering of agents and banks is "the hot topic in the agency community."

Seventy-one percent of insurance agencies expressed a moderate or high interest in starting a joint venture, according to the survey, titled "Selling Insurance through Banks: Agent and Banker Perspectives and Strategies." The Independent Insurance Agents of America and the American Bankers Assn. sponsored the survey.

Joint ventures are a good move for both institutions because they require less up-front capital and less risk, Mr. Buse said.

"We see the joint venture as something very positive," Mr. Buse said. "By making a joint venture, you stand less of a chance of damaging the (corpo-

rate) culture."

A joint venture also can facilitate more formal alliances. "It's all very new," Mr. Buse said. "I think people are leaning into a formal arrangement with a joint venture."

Mr. Buse encourages establishing a "top-down" approach to joint venturing, where bank officials gradually begin purchasing commercial or personal insurance from the agency with which the banks are partnered. This approach can generate sales by fostering a genuine belief in the insurance products, he said.

"Agents need to figure out where they can hit some singles before trying for the big home run," he said.

The survey respondents represented 7% of all banks and 4% of insurance agencies.

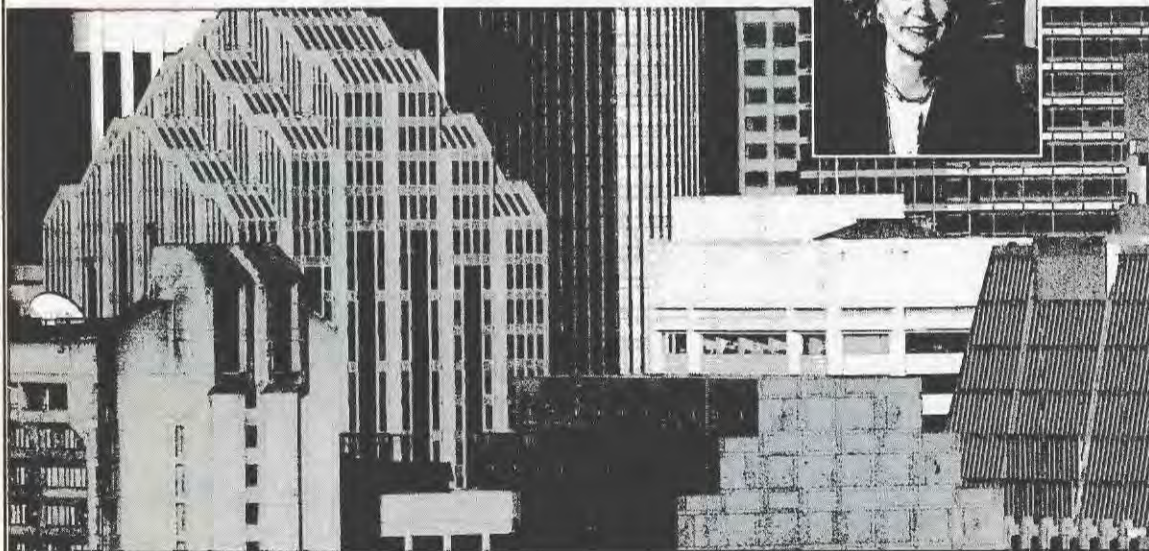
For a copy of this survey, call ABA Customer Services at 800-338-0626 or IIAA's Distribution Center at 800-261-4422. The price is \$89 for ABA and IIAA members and \$129 for non-members.

—By Amanda Milligan

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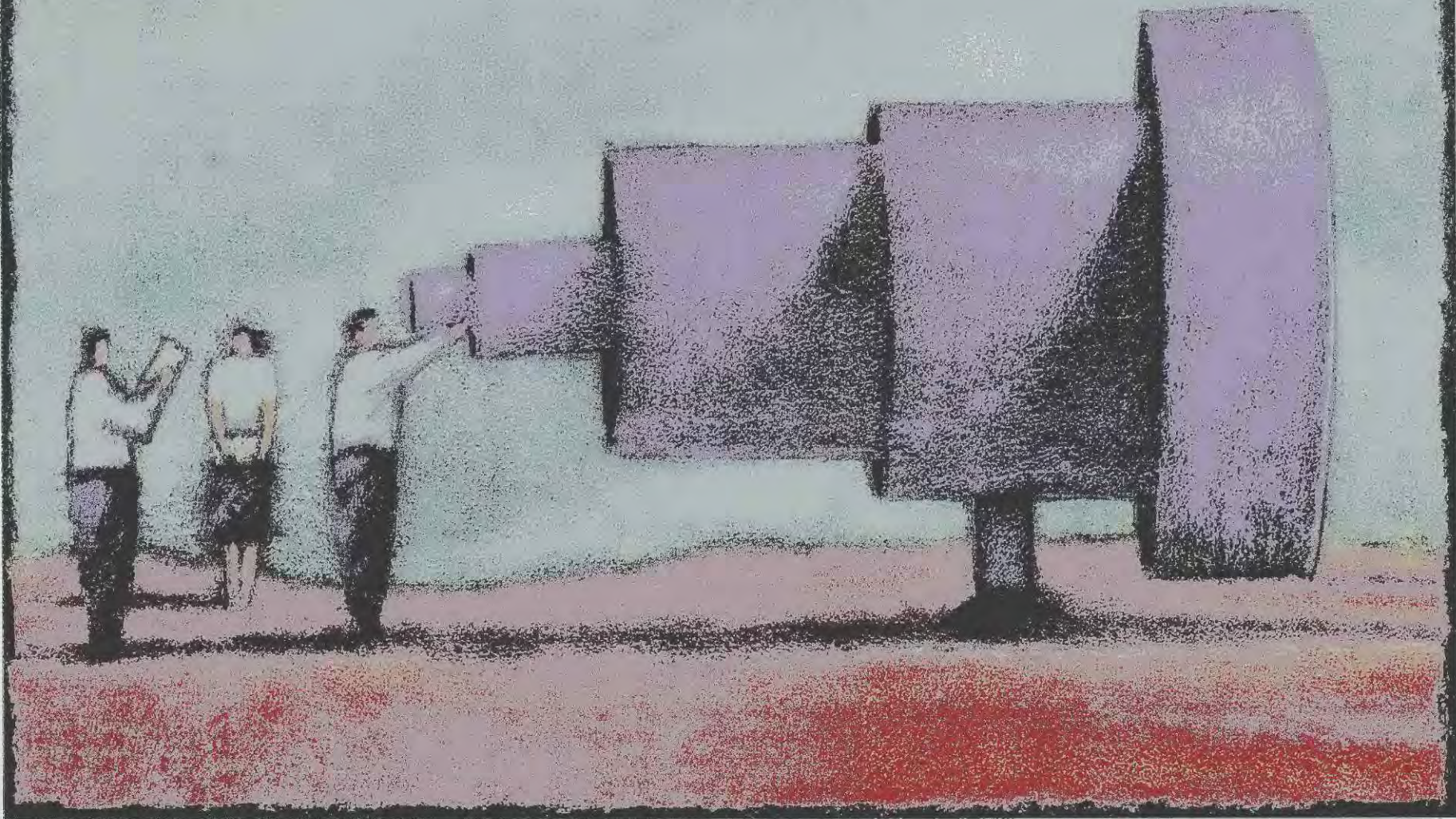
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Buyer takes fix-'em-up companies and does just that

By REGIS COCCIA

As more insurers seek to boost top-line growth through acquisitions, one insurance holding company is finding success with a strategy of acquiring and turning around small, underperforming insurers.

National Affiliated Corp., an Alexandria, La.-based holding company specializing in niche life and health insurance products, is in the process of buying several such companies and plans to market its products through independent agents and brokers.

NAAC predicts its 1998 revenues, reflecting the acquisitions, will jump to \$104.9 million from \$10.6 million in 1997. Net income is expected to jump to \$17.9 million in 1998 from \$3.6 million last year, the company says.

Among the companies that NAAC plans to acquire early in 1998 are: Chadds Ford, Pa.-based Conestoga Life Assurance Co. and affiliate American Sentinel Insurance Co., which write a variety of specialty life and health insurance products; North Bethesda, Md.-based Maryland Southern Life Insurance

Co.; and an unidentified insurer whose acquisition by NAAC is awaiting regulatory approval.

Conestoga Life wrote more than \$6.1 million in premium and carried an A.M. Best Co. rating of B, or adequate, as of year-end 1995. Maryland Southern Life had less than \$5 million of capital at year-end 1995 and did not meet Best's rating requirements, according to the Oldwick, N.J.-based rating agency.

NAAC also plans to buy a small A-rated insurer for about \$50 million during the next year, said T. Brent Chapel, chairman of The Southern Group, a North Bethesda, Md.-based life insurance holding company that is NAAC's majority owner. NAAC is looking to buy underdeveloped companies with capital and surplus between \$2 million and \$50 million, he said.

The company's model for acquiring underperforming insurers and making them profitable through restructuring is Conseco Inc., according to Mr. Chapel.

Conseco, a Carmel, Ind.-based holding company incorporated in 1979, operates several life insurers and provides investment management and other administrative services. Conseco posted nine-month

1997 revenues of \$1.48 billion and net income of \$395.9 million. Its assets as of Sept. 30 exceeded \$33 billion.

NAAC has hired Conseco subsidiary Conseco Capital Management Inc. to evaluate the Maryland company's portfolios of acquisition targets and provide asset management services.

"We're looking for significant return on equity through reduction of expenses and to improve portfolio performance," Mr. Chapel said.

NAAC believes it can help underperforming life/health insurers turn a profit by streamlining their opera-

tions and focusing on niche products, he said.

"We take our post-acquisition plan and apply it to their financial statements," Mr. Chapel said of prospective targets. If NAAC does not project a return on equity of at least 30%, he said, "we won't buy it."

Once a company is acquired, however, NAAC's major focus is to develop products sold through agents, Mr. Chapel said.

"Our basic marketing plan is niche products," such as non-standard life insurance, he said.

One example of the business

NAAC may pursue through its acquired companies is writing life insurance policies for guests at hotel chains.

Although the holding company plans to market products through independent agents and brokers, it also will explore the possibility of direct sales, potentially via the Internet, as a way to reduce operating expenses.

"Methods that cut additional cost out allow you to be competitive," he noted.

NAAC has two wholly owned subsidiaries through which it writes and markets niche life, accident and health business: National Affiliated Investors Life Insurance Co. and National Affiliated Marketing Co. **BI**

Insurer M&A expected to continue

By REGIS COCCIA

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

Industry observers foresee more high-profile transactions throughout the industry but a cooling of M&A activity among reinsurers, which set a frenetic pace in 1996.

Among the major deals announced in 1997:

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

Seattle-based SAFECO bought American States from Lincoln National Corp., which wanted to focus on life insurance and other businesses (BI, June 16).

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

Although the merger, expected to

be completed late in 1998, will create one of the world's largest insurance and asset management companies, the deal will give Zurich a greater market penetration in the United States for its financial services businesses (BI, Oct. 20). The combined group's main U.S. insurance subsidiaries will include Farmers Group Inc. and the Zurich Insurance Group-U.S. companies, including Maryland Insurance Group and ZC Insurance Co. and Zurich Reinsurance Centre Inc.

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

Toa-Re's parent, Tokyo-based Toa Fire & Marine Reinsurance Co. Ltd., agreed to buy M&G Re of America from Swiss Reinsurance Co. for about \$200 million (BI, Nov. 3). Toa-Re and M&G Re of America, both based in Morristown, N.J., have operated under common management since 1982.

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

firm specializing in the insurance industry.

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

"As I look forward, I don't see a compelling reason for that trend to continue at that pace," he said.

"Going forward, more companies will look at mergers and acquisitions but for a different reason," he said.

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

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

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

"The soft market is a double-edged sword. Prices are low, but nobody's making any money," he said.

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

Mr. Ward also expects less future M&A activity among reinsurers.

Among primary insurers, "I would expect more M&A activity in '98 attributable to troubled situations," such as an insurer's lack of capital, Mr. Ward said. "Streamlining and focusing on core businesses are common topics in boardrooms today."

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

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Take time to research sales force automation

A company's requirements, the cost and the ease of use are among areas to evaluate

By Sidney C. Lejfer

SALES FORCE AUTOMATION is a hot topic. Managements of many companies in the insurance industry are in a frenzy, trying to select and implement a product as soon as possible. Today's business environment is extremely competitive, creating tremendous pressure to increase sales, decrease cost and provide excellent customer service.

In order to stay competitive and meet the demands of today's business world, insurance agents and brokers need to apply technology to their sales and marketing functions.

As agents and brokers develop their sales force automation requirements, they will have to consider the various needs of different departments, including sales, marketing, accounting, customer service and administration. Each group within the organizational tree, including staff, management and executives, will have different requirements.

Determining a company's requirements is the first step in finding the appropriate software product. Agents and brokers will need to determine whether a low to middle-market product like ACT!, GoldMine or SalesLogix meets their needs. Or they may need to select a high-end enterprise automation product like Aurum, Saratoga or Siebel that will also offer the ability to integrate existing business systems and customize any areas specific to the agency's business.

During the decision process, the company needs to decide whether it has the resources and commitment to implement one of these high-end SFA products. Although one of the high-end products may be the right software, it may not be the right solution. Agents may find one of the lower-end products that address 75% to 90% of their needs a better solution.

When a company considers a software product, it is just that, a piece of software. It has been designed and written to perform a function. Each of the products a company evaluates will have strengths and weaknesses.

The solution is the end result in implementing a software product. Achieving that end result requires a tremendous amount of financial and human resources. What may be an excellent software choice for an organization may not be the best solution because of all the variables, including commitment, timeline, cost, complexity, data structure, implementation, maintenance and support.

A/BT Perspective

Commitment from the agency's or brokerage's management is critical. Choosing an automation system is a major step. A company has a lot riding on this system. Is the organization committed from top to bottom to this project? This commitment includes, but not limited to, financial commitment. Human resources and management support are

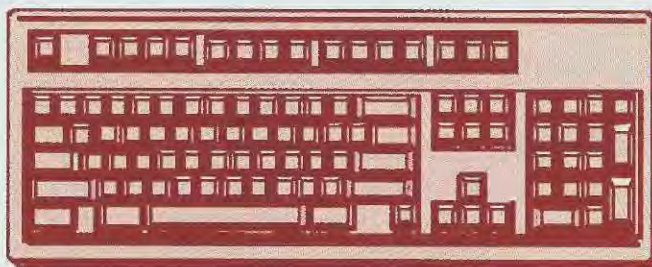
just as necessary and valuable as cash resources. Is management is a question that must be answered before starting on this

Make sure the technology the company will use, including operating systems, network communications and Internet applications, will be in place a year from now.

committed to make the right product the right solution? This journey. OK, now the CEO says he is

committed to the project. Will his commitment sustain a three-month implementation period, six months, one year? For larger companies, an enterprise-wide project could take over a year. Can the agency or brokerage wait for the time it takes to get the system off the ground? Is the company going to lose momentum from its staff?

Make sure the technology the company will use—including operating systems, network communications and Internet applications—is going to be in place one year from now. Don't spend all this time developing a system and then find out the
See Automation on next page



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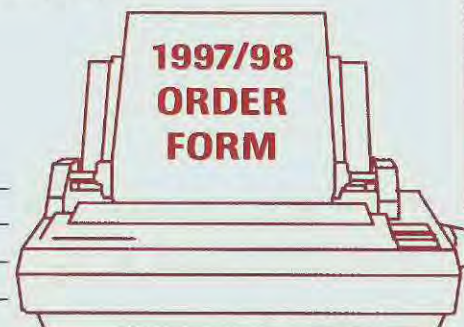
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Automation

Continued from previous page
 underlying technology structure within the company is going to change.

Cost is obviously a consideration. An agency or brokerage may be able to justify the cost of a software product if it can be the right solution. But, is the additional cost of upgrading a software product to meet the company's needs worth it? That is something an agency or broker and its client should have to decide.

Weigh the features and power of a high-end product against the ease of use. If the product is too complicated, the learning curve may be unacceptable and the staff may not use the product. This is an example where a software product can do everything the company needs but the organization can't get over the complexity hurdle.

Most of the high-end products on the market reside on a client/server database. The cost of purchasing and maintaining these database systems must be evaluated. The lower-end products reside on a platform that is bundled with the product and much easier to maintain. This is already changing,

however, as the lower-end products are beginning to support client/server databases. Determining the appropriate scope of the company's solution will require a detailed planning process. Agencies will need representation from all the departments involved at various levels. This planning process should be done regardless of the software product. Keep in mind the higher-end products are more complex and will require more planning.

The flexibility of these systems requires time to implement. How much customization will it take to get a company where it wants to go? Does the agency or brokerage have the time and patience to wait for this customization and development?

What happens when the vendor upgrades the underlying product? Is the customization updated or does the company have to start all over again?

Training is an extremely important part of the process. All important staff should be trained in using the product. The more complex and comprehensive the product, the more training is needed. This has to be considered in evaluating the appropriate solution.

An enterprise-wide sales force automation system will require maintenance at different levels. Management should be prepared to staff the following:

- Sales force automation system administrator. This person is responsible for the overall maintenance of the system.
 - Database administrator. This person is responsible for maintaining the underlying database.
 - Help desk. This person is responsible for handling all end-users' questions.
- Agencies and brokerages will have to allocate appropriate

Management should plan to hire system and database administrators and a person to answer questions.

resources to support their sales force automation systems.

With the cost of hardware decreasing all the time, this may not be as important as it used to be. Companies need to determine their network, processor, memory and hard drive requirements. Keep in mind that a \$200 upgrade per computer for 200 computers would be \$40,000. In the total picture, it may not be much but definitely worth considering.

In evaluating the appropriate sales force automation software product for one's organization, make sure it will provide the best solution. If an agency considers all the factors detailed above, does its due diligence and weighs all its options, it will make an educated decision. Remember, the best automation software product may not be the best solution.

Sidney C. Lejfer is president of Success Automation, Waltham, Mass.-based consulting and training organization that specializes in sales force automation. Mr. Lejfer can be reached via e-mail at success@sfatrain.com.

A/BT Briefs

IIAA lobbying

WASHINGTON—The Independent Insurance Agents of America has been named the top-rated insurance lobbying group in Washington in a Fortune magazine survey.

Members of Congress and senior White House aides were among the 2,165 people who evaluated the clout of 120 top interest groups, labor unions and associations in Washington, a release said.

The survey, conducted by the Mellman Group and Public Opinion Strategies, placed IIAA higher than any other insurance lobbying groups, and 27th out of 120.

Other insurance industry groups among the 120 were: the Health Insurance Assn. of America, which ranked 30th; the American Insurance Assn., 42nd; and the American Council of Life Insurance, 44th.

"Independent agents are getting a huge bang for their lobbying buck when you compare IIAA's government relations budget with those of behemoths" such as the American Assn. of Retired Persons, the AFL-CIO and the American Trial Lawyers Assn., which rank in the top five of the Fortune survey and whose lobbying budgets "dwarf" that of the IIAA, IIAA President Bud Wilson said in a statement. Mr. Wilson is chairman of the Wilson Insurance Agency Inc. in Chula Vista, Calif.

The Alexandria, Va.-based IIAA represents more than 300,000 independent insurance agents and agency employees nationwide.

Ethics awareness

BRYN MAWR, Pa.—During March 1998, more than 200 companies, professional societies and associations in the insurance and financial services industry will participate in Ethics Awareness Month.

Ethics Awareness Month is a national education program that was created in 1990 to build industry awareness of ethical issues.

Sponsors of Ethics Awareness Month are The American College, the American Society of Chartered Life Underwriters & Chartered Financial Consultants, the American Institute for Chartered Property Casualty Underwriters and the CPCU Society. CPCU and CLU/ChFC chapters will host programs with speakers and discussions on ethics.

Other insurance companies that endorse Ethics Awareness Month have planned to strengthen their commitment to a corporate ethics code and publish related articles in employee publications, according to the

American Society of CLU & ChFC.

For more information on Ethics Awareness Month '98 or to receive materials on the nationwide program, contact: Ethics Awareness Month, PR Department, American Society of CLU & ChFC, 270 S. Bryn Mawr Ave., Bryn Mawr, Pa. 19010; 610-526-2500.

AICPCU/IIA chief

MALVERN, Pa.—Norman A. Baglini, chairman and chief executive officer of the American Institute for Chartered Property Casualty Underwriters, the Insurance Institute of America and the Insurance Institute for Applied Ethics, will retire Aug. 15 after 25 years with the Malvern, Pa.-based institutes.

"Being part of the institutes for almost a century has been a deeply rewarding personal and professional experience. I strongly believe in the institutes' mission, values, people and educational programs," Mr. Baglini said in a recent statement.

He plans to pursue teaching and writing in the field of applied business ethics, the AICPCU said in a release.

Mr. Baglini will be a visiting professor of business ethics, risk management and insurance at Temple University's School of Business and Management in Philadelphia beginning in September, where he plans to teach a new course called "Ethical Management of Financial Services Organizations."

A search committee will choose the next CEO of the institutes.

Online applications

MECHANICSBURG, Pa.—Applications for medical malpractice coverage for physicians and surgeons now can be downloaded directly from PHICO Group Inc.'s site on the World Wide Web.

Insurance brokers and consumers may download approved, state-specific coverage forms from the site, according to the Mechanicsburg, Pa.-based insurer. The company will accept completed forms via mail or fax.

"We're looking to make the application process as convenient as possible for brokers and potential customers," PHICO President and Chief Executive Officer Barry Persofsky said in a statement.

PHICO offers medical malpractice coverage for hospitals and other health care providers. Its physician and surgeon coverage is available in 39 states and applications are pending in Puerto Rico and 11 states.

For more information, visit PHICO's World Wide Web site at www.phico.com. **BI**

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Agent/Broker Topics

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Universal Service Agency	14F

BI listing of employee benefit information resources

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

■ A survey of technologies, offered by Price Waterhouse, is authored from the data manager's perspective and provides information that can be used to integrate the **actuarial process**. Request item 204.

■ The American College offers a descriptive guide about the Registered Employee Benefits Consultant and Registered Health Underwriter **professional designations**. Request item 501.

■ A newsletter from Aon Consulting discusses the temporary tax regulations impacting mid-year **cafeteria plan** elections. Request item 502.

■ A report from the International Foundation of Employee Benefit Plans examines the feasibility of **economically targeted investing** through the partnership of public and private pension funds. Request item 503.

■ **Employee benefit provisions that are contained within the Taxpayer Relief Act** are explained in a fact sheet presented by Buck Consultants Inc. Request item 504.

■ A paper providing information on the impact of the **Americans with Disabilities Act** on employers, employees and insurers is available from CNA. Request item 505.

■ CorporateFamily Solutions offers an article outlining the benefits to both employees and employers by being a **family-friendly company**. Request item 506.

■ **Human resources and benefits** issues are explored in a newsletter offered by Aon Consulting. Request item 507.

■ **Long-term care underwriting, claim administration and policy design** are some of the topics discussed in a manual offered by Duncanson & Holt Group. Request item 508.

■ **Medicare changes** introduced in the Balanced Budget Act are described in the fact sheet offered by Buck Consultants Inc. Request item 509.

■ Developments and corporate solutions to problems associated with **work-life benefits** are discussed in a newsletter published by CorporateFamily Solutions. Request item 510.

■ Duncanson & Holt Group offers a manual providing an overview of the global **long-term care** marketplace, including discussions of demographics, government programs and private insurance. Request item 511.

■ A catalog with information regarding the **Certified Employee Benefit Specialist designation program** is available from the International Foundation of Employee Benefit Plans. Request item 512.

■ A series of pamphlets discussing major **life events** and choices facing individuals in these situations is available from MetLife. Request item 513.

■ An annual guide to underwriting **individual long-term care** insurance is provided by Duncanson & Holt Group. Request item 514.

■ RLI Insurance Co. offers an article about the benefits to the employee and corporation provided by executive **supplemental medical insurance** plans. Request item 515.

■ MetLife provides a booklet that answers questions about how the federal **Family and Medical Leave Act** may relate to employee benefit programs. Re-

quest item 516.

■ A manual provided by Duncanson & Holt Group addresses **stop-loss insurance** from an underwriter's point-of-view. Request item 517.

■ A ReliaStar Financial Corp. booklet presents an analysis of the health of each state's **population**. Request item 518.

■ A booklet available from Sedgwick Noble Lowndes provides a checklist for employers to ensure **compliance** with current-year employee benefit issues rules. Request item 519.

■ A guide to the claim process and the differences between the claim process for **long-term disability** and other insurance products. Request item 520.

■ The Segal Co. supplies an annual reporting and disclosure calendar that indicates general **reporting and disclosure** requirements applicable to employee pension and welfare benefit plans. Request item 521.

■ Sedgwick Noble Lowndes offers a survey of senior corporate executives that measures opinions on topics such as **Medicare, managed care and 401(k) investor education**. Request item 522.

■ The Self Insurance Exchange Inc. provides a guide for **third-party administrators** and marketing departments about adapting to a changing marketplace. Request item 523.

■ Standard & Poor's provides a **managed care report** that features ratings, rationales and financial data for 42 domestic health care organizations. Request item 524.

■ A pamphlet surveying health insurers and HMOs to measure the annual change in the factors used to adjust **health claims** when pricing future health insurance risks is available from Sedgwick Noble Lowndes. Request item 525.

■ Towers Perrin provides a study identifying key **health plan performance evaluation** criteria and benchmark data based on the performance of several U.S. health plans. Request item 526.

■ A study offered by Intracorp explores the attitudes and perspectives of the American worker regarding **personal health**. Request item 527.

■ A handbook that addresses how some **COBRA** laws are being interpreted is offered by Sedgwick Noble Lowndes. Request item 528.

■ A study aimed at employers that identifies strategic issues relevant to employer **health benefit spending** is offered by Towers Perrin. Request item 529.

■ A quarterly newsletter from the International Society of Certified Employee Benefit Specialists explores **employee benefit issues and trends**. Request item 530.

■ An article discussing key considerations in **voluntary payroll deductions for benefit products** is available from Monumental Life Insurance Agency. Request item 531.

■ A survey of retirees' attitudes about **Medicare HMOs** is available from Towers Perrin. Request item 532.

■ A pamphlet from the International Foundation of Employee Benefit Plans lists publications and materials designed to assist employers with the **communication of benefits**. Request item 533.

■ **Social Security and Medicare program benefits** are summarized and criteria explained in an annual fact sheet published

by BNA Books. Request item 534.

■ Child & Elder Care Insights Inc. offers a booklet aimed at employers and employee assistance providers that gives an overview of **dependent care** benefits. Request item 535.

■ A disk that helps users connect with **benefits-related World Wide Web** sites is available from Midwest Legal Services. Request item 536.

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

■ Aetna International Group Benefits presents an annual **international manual of benefits** offered in the public and private sectors of countries around the world. Request item 901.

■ A bulletin published by Baker &

McKenzie highlights global labor, **employee benefits** and employment issues. Request item 902.

■ A newsletter produced by Globex International discusses **international** events and developments involving benefits and related subjects. Request item 903.

■ A paper offered by T.E. Brennan addresses self-insurance and ways that employers can reduce **health costs**. Request item 1601.

■ A newsletter on new developments for **health plan professionals** is available from Corbel. Request item 1602.

■ A booklet available from ENCOMPASS Health Management Systems addresses frequently asked questions of **benefits managers**. Request item 1603.

■ A brochure available from Insurance

Claims Auditing and Professional Services Inc. explains how to determine whether a self-insured health or other benefit plan needs a **claim audit**. Request item 1604.

■ A Self Insurance Exchange Inc. pamphlet for vendors interested in reaching **self-insured workers compensation and benefit programs** highlights key marketing tips, including product and buyer information. Request item 1605.

■ 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.

■ Strategic Recovery Partnership Inc. offers a newsletter discussing congressional initiatives that may affect **self-funded health care plans**. Request item 1607.

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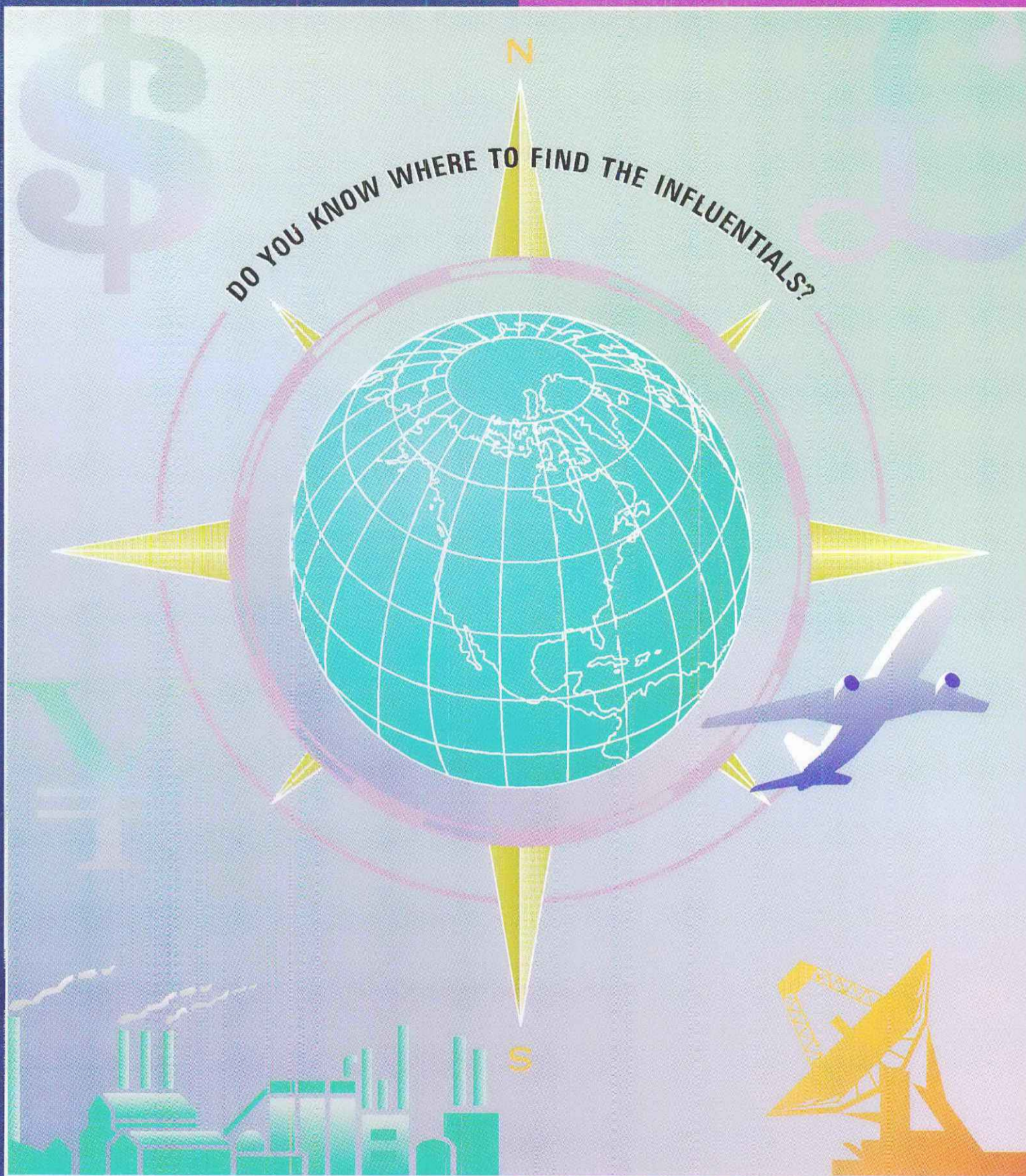
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Mexico maturing as insurance market

Insurance companies and brokers even can function as agents of change

By Bruce Cohen

THE OPENING OF THE MEXICAN insurance market earlier this decade eliminated most tariffs and sparked enormous investment by foreign insurers. Insurers and brokers have responded by developing new insurance products and risk management services to facilitate capital flows into Mexico.

Meanwhile, with more choices and more buying power, Mexican businesses are becoming more demanding insurance buyers as they seek to compete globally.

In addition, a more sophisticated and fluid economy has rewarded Mexican insurers and brokers that offer professional service, creativity and financial strength.

Here's a look at some of the most recent developments in Mexico's insurance market, including examples of how Mexico's insurance sector is evolving to meet the changing needs of insurance buyers.

In some areas, notably in facilitating investment in infrastructure and privatization initiatives, the industry is functioning as an agent of change.

- **Environmental awareness.**

A more pragmatic approach toward commerce by Mexico's environmental authorities and an active role by the insurance industry have led to the expanded use of environmental risk management techniques in the country.

Tax credits now encourage companies to buy environmental protection equipment, and Mexican authorities have been flexible with companies that have environmental liabilities but perform internal audits and implement viable cleanup programs.

Meanwhile, the insurance market is helping promote awareness of pollution exposures through seminars and by establishing alliances with environmental consultants and brokers.

Insurers now are offering first- and third-party cleanup coverages previously not available in Mexico. A number of international insurers see environmental risks as a long-term opportunity and are writing more EIL policies in Mexico.

- **Extended warranties gain.**

An idea from Spain—extended warranty programs—is getting a great deal of attention in Mexico.

Although the December 1994 peso crisis slowed the introduction of product guarantees in Mexico, manufacturers and distributors of durable goods now market extended warranty products more aggressively, and these plans are becoming increasingly popular among Mexican consumers.

The development of the warranty market underscores the growing sophistication of Mexico's corporate insurance buyers, who must carefully communicate the tax-planning implications to other financial executives and work with the marketing and sales departments on pricing, distribution, product differentiation and advertising to take full advantage of these products.

- **Seizing opportunities.**

Although many of the anticipated reforms to Mexico's social security system took effect July 1, 1997, a number of these important changes have yet to be widely communicated to industry or the general public.

As a result, the insurance sector has assumed the role of educating businesses and consumers about the implications of reforms in the life and health, retirement and workers compensation areas.

For instance, actuarial consultants are helping human resource managers improve their major medical expense programs by using government incentives—specifically, tax rebates to promote the

use of the growing private health care system.

Insurers also have responded by offering insured benefit programs, otherwise not available in Mexico, that provide coverage for natural childbirth, vision and dental care to companies with too few employees to self-administer their health care plans.

Reforms to social security's life insurance and retirement segments have led to the development of new private pension funds and life annuity products by insurers and banks. It is anticipated that they will continue to develop more sophisticated financial products for commercial consumers and individuals.

In workers compensation, reforms currently give employers the flexibility to address short-term disability and medical expense responsibilities through a single program that covers non-work-related medical expenses. Thus, Mexico's human resources executives may lay the foundation of a system that provides 24-hour worker benefits.

Other likely outcomes are a wider array of products and services, keener competition among brokers and insurers, and continued enhancements to employee benefit programs to attract and retain the best talent.

- **Industry facilitates initiatives.**

The insurance sector is helping facilitate the opening of Mexico's highways, ports, railroads, power generation and telecommunications sectors to private investment.

As part of the due diligence process, Mexican and foreign companies have retained risk management experts to review contractual obligations, evaluate areas of liability that previously did not exist and design manuscript coverages to protect their large capital outlays. Insurers and brokers in Mexico responded quickly to privatization opportunities by introducing coverages for more complex risks, such as transmission and distribution lines for the telecommunications industry.

In addition, as a result of increased shipping options and more widespread competition in the transportation industry, risk managers are pushing transport companies to assume more responsibility for loss prevention.

Although Mexican law still imposes minimal liability on transport companies for cargo losses, some now provide delivery guarantees and link their compensation to the security of their clients' shipments.

Meanwhile, a number of insurers have shifted away from offering traditional risk transfer approaches to more sophisticated cash-flow programs that include loss prevention consulting services.

- **More reinsurance offerings.**

In Mexico, brokers have played an especially important role in owner-controlled reinsurance, especially in the property area, generating millions of dollars in savings for policyholders.

For several years, multinationals based outside Mexico have been using controlled programs to obtain less expensive insurance; now, Mexico's financial and industrial groups also have access to these arrangements.

In light of competition from international insurers and brokers, the country's domestic insurers now are offering large amounts of capacity and broader coverages to Mexico's large insurance buyers. Consequently, Mexican insurers have become more comfortable with a wider range of risk management approaches, including captives and other risk-funding tools.

The resulting savings have leveled the playing field and are helping Mexican businesses become more competitive domestically and internationally.

- **Managing liability exposures.**

In all segments of its economy, Mexico is adopting a

wide array of risk management approaches from the global insurance industry.

In Mexico's health care sector, for example, there is a greater awareness of professional liability, notably medical malpractice.

Further, the importance of U.S., U.K. and Canadian investment in Mexico is raising awareness of errors and omissions and directors and officers liability.

The recent availability of these policies to Mexican companies has removed executive risks as a possible barrier to conduct business globally.

As Mexico's legal environment evolves, integrated and finite risk products now becoming more popular in the United States may be tailored to address the product, currency, financial and political risks specific to Mexico.

- **Facilitating investment.**

A recent industry innovation—the use of bonds rather than insurance policies, to guarantee title to real property—is helping facilitate the flow of business into Mexico.

Well-documented land management records and relatively few real estate transactions have enabled Mexican surety companies to create a more cost-efficient solution to protect land purchases, especially for businesses based outside Mexico that are required to have a guarantee to secure project financing.

Another product custom-made for Mexico combines a locally admitted property and liability package policy with a stand-alone foreign master contract. The program is designed for U.S. and Canadian companies that have a single large international investment—in Mexico.

There are numerous other similar developments as well. In auto insurance, the driver's reliance on Mexican insurance for claims services has created an opportunity for insurers to offer other products, such as emergency road service for large corporate fleets.

- **Mexican brokers, insurers grow differently.**

Someone once commented, "I have seen the future of the Mexican insurance industry because I have seen the U.S."

While that may be true today, it may be so only for the next three to five years. Quite rapidly, Mexico is closing the "sophistication gap" that existed in the insurance sector when the market was closed.

In fact, a number of major recent industry developments in Mexico parallel those occurring elsewhere in North America and in Europe.

These include the consolidation of insurers and brokers and the heavy investment in technology by both sectors.

Pressure on margins is a global phenomenon that includes Mexico. The country's insurers and brokers are addressing this challenge by increasing market leverage, achieving greater operating efficiencies, and by working to differentiate themselves more effectively.

A key difference between Mexico's brokers and insurers is that many of the country's largest brokers have established global ties through mergers and strategic alliances. Meanwhile, large Mexican insurers have chosen to be more self-reliant.

Time will tell how this approach will affect Mexican insurers' ability to maintain continuing innovation in products and services to meet the evolving needs of businesses operating in Mexico's unique legal, financial and cultural environment. **BI**



Bruce Cohen is resident vp of J&H Marsh & McLennan in Mexico City.

Workers comp law protects contractor: Court

In a case of first impression, the Supreme Court of Mississippi ruled that a general contractor and subcontractor were entitled to immunity from suit under the exclusive remedy provision of the workers compensation law in a suit by an employee of a subcontractor that had workers comp insurance.

Brasfield & Gorrie General Contractor Inc. was the general contractor for the construction of a mall. Brasfield subcontracted the structural steel work to FaBarc Steel Supply Inc. Thereafter, FaBarc contracted with Model City Erection to do portions of the steel work. Brasfield contractually required FaBarc to obtain workers' compensation coverage for FaBarc's employees. FaBarc, in turn, required Model to purchase such insurance for Model's employees. David Crowe, an employee of Model, was injured on the project. He filed a workers comp claim and received benefits from Model's insurer. Mr. Crowe then filed a negligence suit in a federal court against Brasfield and FaBarc. The defendants sought to have his suit dismissed on the ground that workers compensation was his sole remedy. The federal trial court ruled against Mr. Crowe and dismissed his negligence suit. The 5th U.S. Circuit Court of Appeals, however, requested the Supreme Court of Mississippi to rule on the immunity-from-suit issue.

The state Supreme Court held that the exclusive remedy provision of the state's workers compensation act does protect the general contractor and the subcontractor when the subcontractor has workers' compensation insurance for its injured employees. Justice McRae dissented, concluding that state law granted an employee or his dependents the right to sue at law "any other party."

Crowe vs. Brasfield & Gorrie Contractor, Supreme Court of Mississippi, Dec. 19, 1996 (BI/01/O.-\$10).

Lawsuit over third-party claims approved

May a policyholder sue its insurer, claiming a breach of an implied covenant of good faith, because of the insurer's bad-faith handling of third-party claims? The Supreme Court of South Carolina ruled that it could.

Tadlock Painting Co. was covered under a commercial general liability insurance policy issued by Maryland Casualty Co. The claims involved under this policy arose from damages caused to about 90 cars during Tadlock's industrial painting for Cargill Inc. Tadlock notified Maryland of the claims. What followed were months of discussion regarding whether Maryland would provide coverage. The dispute was not resolved, and Tadlock ended up personally settling each of the claims for under \$50, the deductible amount. Tadlock then brought this suit seeking damages from Maryland, claiming the insurer had acted in bad faith, causing Tadlock to lose further business from Cargill. A jury awarded Tadlock \$15,552 in actual damages and punitive damages of \$200,000.

On appeal, Maryland argued that a policyholder can bring a bad faith action only if the insurer has breached some express contractual provision. But the court disagreed, stating that a bad faith action exists separately from an action in contract. Thus, the court said Tadlock could seek consequential damages allegedly suffered because of the insured's bad-faith handling of third-party claims.

Tadlock Painting Co. vs. Maryland Cas. Co., Supreme Court of South Carolina, July 15, 1996 (BI/04/M.-\$10).

Injury in answering page compensable

An Ohio appellate court awarded workers compensation benefits to an employee injured while he was answering an electronic page from his employer while on call.

Darrell Durbin was employed by American Sentry Protection Service as a security guard. He was assigned to the "R&R reserve team" and as such did not have a fixed, permanent assignment or job location. He was on call for periods of each day, seven days per week, to fill various shifts and assignments that became open due to sickness or emergencies. He received notice of assignments from an electronic pager supplied by his employer. On Dec. 18, 1992, while he was within paging range, and while returning from a personal trip during an on-call period, he received a page from his employer. He exited the highway to reach a pay telephone. While stopped in traffic, he was struck in the rear

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by another automobile and injured. He filed for compensation, but the Industrial Commission denied him benefits. The trial court also denied benefits.

The appellate court concluded that Mr. Durbin's injuries, received while answering a page from his employer during an on-call period, were sustained in the course and arose out of his employment. The court rejected the employer's argument that the injuries were excluded from benefits because they occurred while he was going to or coming from work. The court emphasized that here Mr. Durbin was not simply going to or coming from work. "His 'on-call' status," the court said, "meant he was in effect at work while responding to an employer page during those periods." The court noted that Mr. Durbin's leaving the highway to answer the employer's page was a substantial part of the service for which he was employed. Mr. Durbin was awarded benefits.

Durbin vs. Ohio Bureau of Workers Compensation, Court of Appeals of Ohio, June 26, 1996 (BI/01/Au.-\$10).

Baby-sitting not compensable

Child care services furnished to a workers compensation claimant while she was hospitalized for a work-related injury are not a "compensable medical benefit," according to the Colorado Court of Appeals.

Dana Kurziel sustained a knee injury in a work-related accident and required hospitalization. She purchased a \$300 airline ticket to enable her sister to come to Colorado and watch her children while she was hospitalized. Ms. Kurziel sought temporary disability benefits and medical benefits through a workers compensation claim. She included the \$300 cost of the airline ticket in her claim. The administrative law judge found that \$300 was a reasonable amount for baby-sitting services for one week and ordered the employer and its insurer to pay Ms. Kurziel that amount. The Industrial Claim Appeals Office reversed the administrative law judge and denied the claim.

The appellate court said that the child care services here were not "medical" in nature because they did not relieve the symptoms or effects of the injury and were not directly associated with Ms. Kurziel's physical needs. In addition, the court said they were not "incidental" to medical treatment because such services were not provided as part of an overall home health care program designed to treat Ms. Kurziel's condition. The court agreed that the \$300 award for child care services should be set aside.

Kurziel vs. Pet Fair Inc., Colorado Court of Appeals, Oct. 24, 1996. Reconsideration denied Dec. 27, 1996 (BI/01/S.-\$10).

Liquidation losses not business income

Loss of business income does not include losses arising out of liquidation of a company's inventory in a warehouse after a fire that destroyed its retail store, according to the Supreme Court of Nebraska.

Thrift Mart Inc. operated a store in Omaha, Neb., that was destroyed by fire in 1989. Thrift reported the fire to its insurer, State Farm & Casualty Co. The insurance policy provided coverage for debris removal, loss of business personal property and loss of business income. Thrift decided to cease operations of its retail store and then liquidated its warehouse inventory. State Farm tendered payment of about \$30,000 for debris removal and loss of business personal property but denied coverage for the warehouse liquidation loss. Thrift brought this suit for breach of contract, seeking an additional \$3.6 million for the liquidation losses. The trial court ruled for State Farm.

The appellate court concluded that the losses arising out of the warehouse liquidation did not fit within the policy definitions of "business income" and were not covered under the insurance policy's loss of business income provision. The court emphasized that the business income loss was intended to cover expenses arising from disruption during the continuing operation of the business at a temporary site or during the relocation of the business to a new site if operations cannot continue where the fire

occurred. The trial court decision was affirmed.

Thrift Mart vs. State Farm, Supreme Court of Nebraska, Jan. 10, 1997 (BI/05/Au.-\$10).

Plan changes approved under ERISA

Employers may adopt, modify or terminate welfare benefit plans established pursuant to the Employee Retirement Income Security Act, according to the 9th U.S. Circuit Court of Appeals.

In this case, about 400 present and former salaried employees of Teledyne Industries Inc. contended that the employer violated ERISA when it imposed a monetary cap on the amount it would pay for medical insurance and for retired employees. When the plan was established in 1972, it provided that upon retirement of any salaried employee within 15 or more years of continuous service, it would pay the entire health care insurance premium for retired employees. The employees filed a class action against Teledyne but lost in the trial court.

The appellate court noted that the insurance booklet provided employees said that the contract shall be the controlling document. The court then noted that the contract reserved to the employer the right to modify or terminate employee welfare benefits. The court rejected the employees' argument that the disclaimer should be ineffective because it was not contained in the booklet distributed to the employees. But the court said this disclaimer clearly stated that the contract was the controlling document and that the contract was available for review by any employee who wished to see it. Therefore, the court said the reservation was effective. The trial court decision was affirmed.

Pisciotta vs. Teledyne Industries Inc., 9th U.S. Circuit Court of Appeals, Aug. 5, 1996 (BI/05/M.-\$10).

Current spouse vests at retirement

Surviving spouse benefits in an ERISA plan vest in a participant's spouse on the date when he retires, according to the 4th U.S. Circuit Court of Appeals.

At issue in this case was whether a plan participant's ex-spouse or his current spouse was entitled to surviving spouse benefits under an ERISA plan. Paul and Vera Hopkins were married in 1960 and divorced in 1986. In the divorce order, Ms. Hopkins was not awarded a portion of Mr. Hopkins' pension but was granted alimony. After the divorce, Mr. Hopkins remarried Sherry Hopkins. Upon Mr. Hopkins' retirement, he became eligible for fixed income, and under the plan, if his spouse survives him, she will receive 50% of his fixed income for the remainder of her life. In 1994, Vera Hopkins obtained a judgment against Mr. Hopkins for about \$15,000 in past-due alimony. She also sought a Qualified Domestic Relations Order, which would enable her to collect this money and current alimony from Mr. Hopkins' pension. The trial court ordered that Vera Hopkins and not Sherry Hopkins be made the payee of the Surviving Spouse Benefits. Vera Hopkins then brought this action, seeking a declaration by the court that the court order was a QDRO entitling her to surviving spouse benefits. The case was transferred to the federal court, which ruled against Vera Hopkins.

The court of appeals noted that a QDRO must relate to a benefit "payable with respect to a participant." The court concluded that surviving spouse benefits vest in a participant's current spouse on the date the participant retires. Thus, because Sherry Hopkins was a "beneficiary," not a "participant," Vera Hopkins' surviving spouse order did not relate to a benefit "payable with respect to a participant," the court said. As a result, Vera Hopkins' surviving spouse order was not a QDRO, the court said. The trial court decision was affirmed.

Hopkins vs. AT&T Global Information Solutions Co., 4th U.S. Circuit Court of Appeals, Jan. 24, 1997 (BI/02/S.-\$10). **BI**

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

INTERNATIONAL

Global Briefs

Willis Corroon Group P.L.C. has completed the acquisition of a 31.72% stake in France's largest independent insurance broker, Paris-based Gras Savoye & Cie. Patrick Lucas, Gras Savoye's president, will join the board of Willis Corroon as a non-executive director subject to shareholders' approval at the group's annual general meeting April 15. . . . One of the largest syndicates at **Lloyd's of London** has been created through the merger of Hiscox syndicates 52 and 625. New syndicate 33 will have 1998 premium capacity of £360 million (\$601.8 million). Its underwriter, Robert Childs, said syndicate 33's enlarged capacity "will answer calls from brokers for better access, competitive pricing, bigger lines and a multiline capability". . . . Lloyd's of London has suspended broker **Anthony Frost** for six months following findings of misconduct by a Lloyd's disciplinary hearing. Mr. Frost also was fined £10,000 (\$16,700) and ordered to pay costs of £40,000 (\$66,900). Mr. Frost admitted that while he was chairman of Citicorp Insurance Brokers Ltd., which subsequently became Nelson Hurst Marine Ltd., he made a secret profit of \$150,000 on a contract placed for the Panama Canal Commission in April 1990. Nelson Hurst returned \$150,000 plus interest to the PCC in April 1996. . . . **Zurich Insurance Co.** and **B.A.T Industries P.L.C.** have signed a definitive agreement on the merger of their financial services businesses announced last October. The financial services and insurance interests of the two companies will be transferred into a new Zurich, Switzerland-based company, Zurich Financial Services Group, which will be owned 57% by Zurich's shareholders and 43% by B.A.T shareholders, slightly different from the 55/45 split expected at the time of the merger announcement (*BI*, Oct. 20, 1997). . . . **Finsbury Underwriting Investment Trust P.L.C.** is acquiring the 85% it does not already own of Wren Holdings Group P.L.C., a managing and members agency. FUTT said the acquisition, conditional on approval of Lloyd's and its own shareholders, is intended to create an enlarged group that can better benefit from medium and longer-term opportunities. . . . **Jardine Lloyd Thompson Group P.L.C.** is buying the 51% of Bermuda brokerage Triangle Holdings Ltd. it does not already own for £1.8 million (\$3 million) in stock and cash. JLT bought 49% of Triangle in 1994 with an option to buy the remaining shares after three years (*BI*, July 4, 1994). . . . **Sedgwick Group P.L.C.** has announced two European acquisitions. It has agreed to buy Dextra, a Norwegian retail insurance broker. Dextra will be merged with the existing Sedgwick Norge A.S. to create the second-largest brokering firm in Norway. Sedgwick also has acquired Dannenburg Holding B.V., which trades as Brusselers Consultancy B.V., a Netherlands-based pension consultant. Brusselers will be merged into the existing Sedgwick Noble Lowndes business in the Netherlands this year. Sedgwick did not disclose the value of either acquisition, saying the purchases were of minimal cost. . . . **ACE U.K. Ltd.** has appointed **Per Englesson** as space underwriter for the Ariel/Sturge aviation syndicates that ACE manages at Lloyd's of London. Mr. Englesson previously was lead space underwriter for Skandia International in Stockholm, Sweden. . . . **Hans Terje Anonsen** has been appointed deputy chairman of Aon Group Ltd.'s marine division in London. Mr. Anonsen will be responsible for marine hull, construction, liability and protection and indemnity. Mr. Anonsen previously was managing director and partner of Norwegian Insurance Partners A.S., an Aon joint venture in Norway.

Insured cat losses fall in '97

By EDWIN UNSWORTH

MUNICH, Germany—Insured damage from natural catastrophes in 1997 fell by about 50% from the year before, according to a recent report by Munich Reinsurance Co. Munich Re, which released the figures last week, maintains that 1997 was a year with "exceptionally" few natural disasters. They caused overall losses of an estimated \$30 billion, half as much as in 1996. Insured losses are estimated at \$4.5 billion, again half those in 1996. "Generally low insurance density in the countries that were hit by natural catastrophes" is why 1997 insured losses were only about 15% of the total, the Munich-based reinsurance company said. However, Munich Re warned that while insurers and the rest of the world were fortunate in terms of the number of natural disasters in 1997, such luck is not likely to last. "Even radical environmental protection measures cannot prevent the occurrence of ever more and ever costlier catastrophes" See *Disasters on next page*



PHOTO: AFP
Flooding such as this in southwest Poland devastated areas of Europe in 1997 and was among the year's costliest catastrophes.

Lloyd's capacity mostly corporate

By EDWIN UNSWORTH

LONDON—Corporate members of Lloyd's of London, for the first time since being admitted in 1994, will provide the majority of the market's annual capacity this year. According to figures the market released last week, Lloyd's 1998 underwriting capacity will total £10.13 billion (\$17.01 billion), down about 1.6% from £10.30 billion (\$17.64 billion) in 1997. Corporate members will account for £6.0 billion (\$10.07 billion) of 1998 capacity, or 59% of the total, compared with 44% in 1997. The shift in the proportion of capacity provided by corporate members rather than individual names is in line with Lloyd's long-term expectations and the market's move to increase corporate investment. The steady drop in the number of individual names from its peak of just more than 32,000 in 1988 has continued. The number of Lloyd's names, individuals who invest in the market on an unlimited liability basis, in 1998 has fallen to an estimated 6,835, accounting for 40% of Lloyd's capacity, compared with 9,959 names supplying 56% of capacity in 1997. While corporate and individual

investors will provide about 99% of Lloyd's 1998 capacity, the remainder will come from other investors, including 1,105 former unlimited liability names who will continue underwriting but on a limited liability basis. They have taken advantage of conversion vehicles set up for this purpose. Meanwhile, Samsung Fire & Marine Insurance Co. Ltd. has become the first South Korean insurance company to establish a Lloyd's syndicate. SF&M and its London subsidiary, Samsung Insurance Co. of Europe Ltd., have provided £10 million (\$16.8 million) of capital to support an initial £4 million (\$6.7 million) of underwriting capacity for 1998 for new syndicate 1210. SF&M, South Korea's largest non-life insurer, said it is eager to develop syndicate 1210 to write non-marine risks of clients of the Samsung group outside of Korea and for other Korean interests abroad. It said two of Lloyd's main attractions are its network of international licenses and the underwriting experience and expertise available. Murray Lawrence Corporate Ltd. will manage the new syndicate. David White will be the active underwriter; Richard Chown will be his deputy. **BI**

Rivals resolve battle to buy AGF

By MARIA KIELMAS

Allianz A.G. Holding and Assicurazioni Generali S.p.A. have announced a final agreement on their rival bids to acquire Assurances Generales de France. The agreement ends a heated battle for control of the French insurer. While Munich, Germany-based Allianz will take over AGF, the agreement expands Generali's share of the German and French insurance markets (*BI*, Dec. 22, 1997). In separate statements issued late last year, Allianz, AGF and Generali said the main points of the agreement include the following: • Generali will acquire 80% of the shares of Aachen-er & Munchener Beteiligungs A.G., in which Allianz and AGF both hold minority stakes. Generali negotiated late last year to obtain a larger share of AMB. Trieste, Italy-based Generali will buy each AMB share at 210 deutsche marks (\$118), about 20% more than AMB's average price during the past three months. AGF and Allianz said in their statements

that they do not regard their stakes—33.5% and 5%, respectively—as "strategic." Although the statements made no mention of agreements with other AMB shareholders through which Allianz has an indirect holding in AMB, Generali said the agreement "allows the company to reach a longstanding objective, that of obtaining a prominent position in the German market." The resulting company, AMB Generali, will be Germany's third-largest insurer. AMB had gross premiums of 16 billion deutsche marks (\$8.96 billion) in 1996. • AGF will acquire directly or indirectly 100% of AMB's Royal Netherlands Life Insurance Co., AMB's Netherlands-based subsidiary. • Generali will acquire three French insurance subsidiaries that AGF recently acquired through its purchase of Athena Assurances. While AGF will retain Athena units in Spain and Portugal, Athena's French subsidiaries—GPA-Vie, GPA-IARD and Proxima—will become part of Generali See *Generali on next page*

Ruling upholds liquidation deadlines

By CAROLYN ALDRED

LONDON—Policyholders and other creditors must adhere to claims deadlines enforced by insurer liquidators, the U.K. Privy Council has ruled. A decision by the Privy Council, which consists of eminent members of the British Commonwealth and hears appeals for former British colonies, overturned a Bermuda Court of Appeal judgment that would have allowed creditors to obtain court-approved extensions to deadlines set by scheme of arrangement administrators. If the Court of Appeal judgment had not been overturned, creditors in the United Kingdom and Bermuda could have sought court permission to extend any deadline set by a scheme of arrangement administrator. The Privy Council's judgment in *Kempe vs. Ambassador Insurance Co.* is good news for all parties involved in schemes of arrangement, said Chris Galyer, a lawyer

with London law firm Eversheds. "A lot of insolvency practitioners were holding their breath" after the Court of Appeal judgment, said Philip Hertz, a senior associate in the London office of law firm Cadwalader, Wickersham & Taft. "The particular issue that is of concern is the ability to put in place a scheme of arrangement to provide an estimate of liabilities and a cutoff date. The setting of a cutoff date is one of the essential features of such a scheme," said Paul Evans, a partner in the London office of Price Waterhouse. This would leave it "always open for a creditor to approach the court and make the final crystallization of liabilities very difficult," said Mr. Evans. Had the appeal failed, "creditors could continue to come forward and appeal estimates," noted Philip Singer, a partner of the national insurance insolvency practice of Coopers & Lybrand in London. With no final cutoff deadline, any rein-

insurance or insurance runoff becomes longer and more complex, said Mr. Singer, a leading reinsurance insolvency practitioner. "You can't have effective setoff if numbers vary, and it is difficult to give debtors a discharge," he added. The case came about after the liquidation of Bermuda-based Mentor Insurance Ltd. in 1985, for which Charles Kempe and Nigel Hamilton were appointed joint liquidators. After an initial payout of 25 cents on the dollar—a total of \$78.2 million—the liquidators proposed setting up a scheme of arrangement to prevent the liquidation going on for many, many years. The principal feature of the scheme was to impose a strict deadline for filing claims, after which creditors would be barred from participating in the liquidation. A claims-filing deadline of June 30, 1993, was set. If the scheme's administrators See *Runoffs on next page*

Runoffs

Continued from previous page
rejected a claim, a written statement of the reason was to be sent to the creditor within 21 days of the rejection. A creditor then would have 21 days after receiving the administrators' statement to apply to the court for any assessment to be altered or reversed.

On Nov. 17, 1994, Mentor delivered a written statement rejecting all but \$79,000 of a \$1.2 million claim filed by Ambassador Insurance Co., also in liquidation.

The time for appealing the assessed claim expired on Dec. 8, 1994. Because of an administrative lapse, Ambassador did not file a summons until Dec. 16, 1994. A judge rejected Ambassador's request for the court to order an extension on the ground that the court had no jurisdiction to do so. But the Court of Appeal reversed the decision and extended the time for appealing.

Mentor's liquidators appealed this decision, resulting in a Privy Council hearing before Lords

Steyn, Hoffman, Cooke, Saville and Mr. Justice Gault.

In their judgment, the Lords ruled that while the sanction of the court is necessary for a scheme of arrangement to become binding, "it is not enough to enable one to say that the court—rather than the liquidators who proposed the scheme or the creditors who agreed to it—has by its order made the scheme."

"It is of course true that the sanction of the court is by no means a formality. Furthermore, in giving its sanction, the court has an inherent jurisdiction to correct any obvious mistakes in the document which sets out the scheme," their Lordships continued.

But the court "cannot alter the substance of the scheme and impose upon the creditors an arrangement to which they did not agree. The question of whether the time limits in the scheme are fixed or flexible is in their Lordships' opinion one of substance," the Privy Council judgment states.

"If creditors felt that in providing fixed time limits the scheme was creating traps into which the unwary might fall, the time to raise

this question was when the scheme was under consideration or by way of objection when the court was asked to give its sanction," the judgment continues.

Although the Privy Council judgment is specific to a scheme of ar-

rearrangement within a liquidation in Bermuda, it has put a lot of lawyers' and accountants' minds at ease.

No one was sure that the now overturned Appeal Court judgment would not have impacted other schemes of arrangements. It would certainly have undermined the use of cutoff schemes, practitioners agree.

By overturning Bermuda's Court of Appeal judgment, the Privy

Council "confirms the practical importance of so called cutoff schemes as a means of bringing to a speedy close liquidations of insolvent non-life insurers," according to Mr. Galyer.

"The purpose of a cutoff scheme

The ruling 'confirms the importance of so-called cutoff schemes as a means of bringing to a speedy close liquidations of insolvent insurers,' says Chris Galyer.

would have been diluted" had the Appeal Court decision stood, agreed Mr. Singer.

"Scheme administrators would have been more cautious as they would have had to bear in mind that the court could always extend deadlines," he noted.

It also would have made the prospect of cutoff schemes for solvent companies less attractive, said Mr. Singer, referring to a new move gaining ground in London to apply

cutoff schemes to solvent insurers and reinsurers.

The Privy Council decision likely will encourage those advocating the use of cutoff schemes for solvent insurance companies in runoff, noted Mr. Galyer.

Mr. Evans of Price Waterhouse, who is the prospective scheme administrator under one of the first cutoff schemes for a solvent insurance company, agreed that the Privy Council decision is reassuring.

A scheme of arrangement for Scottish & Commonwealth Insurance Co. Ltd. was published late last month; creditors are due to vote on it Feb. 2, said Mr. Evans.

Mr. Evans predicts increasing use of cutoff schemes for solvent companies in order to accelerate closure of a runoff, a view others share.

"A lot of people are proposing cutoff schemes for solvent companies. It allows a company to discharge its liabilities and still retain something for the shareholders," said Mr. Hertz of Cadwalader.

"A lot of people are trying to get (such schemes) off the ground," agreed Mr. Singer. **BI**

Disasters

Continued from previous page
worldwide," according to Munich Re.

Munich Re said future natural disasters are likely to be much more costly because of the increasing concentration of population and property values in high-risk zones and the greater susceptibility of modern industrial societies to disruption in their infrastructures.

Comparing figures for the 1960s with those of the past 10 years, the number of major natural catastrophes was three times larger in the 1990s, the reinsurer pointed out.

Also, after adjusting for inflation, the global economic cost was eight times as much and the cost to the insurance industry 14 times as

Future natural disasters are likely to be much more costly due to development in high-risk zones, Munich Re says.

much when compared with the 1960s.

Munich Re said 530 catastrophe loss events occurred in 1997, well

below totals from earlier in the decade, which ranged from 580 to 300.

The death toll from natural disasters in 1997 was approximately 13,000, compared with 12,000 lives lost the year before. The largest number of lives lost last year came from a series of earthquakes in Iran, which caused more than 2,300 deaths.

Windstorms were the most frequent natural catastrophe, accounting for 170 of last year's events, but the costliest event of 1997 was summer flooding in Central Europe (BI, July 28, 1997).

Although economic losses from these floods reached about \$5.3 billion, a "sizable" proportion of agri-

cultural losses and damage to buildings and infrastructure was not insured, so insurers paid claims of only about \$800 million, Munich Re said. That's about 18% of 1997's insured catastrophe losses.

The El Nino effect, due to a warm ocean current off the Pacific coast of South America, was blamed for a number of catastrophic events in 1997, the reinsurer said, including forest and brush fires in Indonesia and more recently in Australia, floods in South America and Somalia and hurricanes along the Pacific coast of Mexico.

However, it says that if El Nino was the "scapegoat of the year," it should also in fairness get credit for the extremely low hurricane activi-

ty in the North Atlantic and Caribbean.

Dr. Gerhard Berz, meteorologist and head of Munich Re's Geoscience Research Group, said of the figures, "The fact that extreme atmospheric events accounted for such a large proportion of the losses is further evidence for us of the expected change in the environment and climate in many regions of the world."

He added that the outcome of negotiations at the climate summit in Kyoto, Japan, represents "an important but still inadequate" step toward Munich Re's longstanding call for comprehensive and speedy measures to curb man-made changes in the environment. **BI**

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Generali

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in a deal valued at 15 billion French francs (\$2.5 billion).

AGF, in conjunction with an Italian holding company, had acquired Athena for 12 billion French francs (\$2.0 billion) when in December they completed the acquisition of Athena's parent company, Paris-based financial and industrial conglomerate Worms & Cie. The October 1997 bid for Worms & Cie. was seen as the catalyst for the takeover offers for AGF

(BI, Oct. 20; Oct. 13).

GPA-Vie, GPA-IARD and Proxima wrote combined gross premiums of 6.3 billion French francs (\$1.05 billion) in 1996. The deal will give Generali more than 4% of the French life and property/casualty market.

• Generali will have rights to block Allianz's sale of any AGF insurance assets over the next 24 months.

The statements did not address the future of political risk and credit insurer Coface, in which AGF has a controlling interest. French Finance Minister Dominique Strauss Kahn is expected to rule on the matter.

A Generali spokesman said the company will request shareholders' permission at a Jan. 10 meeting to raise 4 trillion lire (\$2.3 billion) to finance the acquisitions. This figure is comparable to the amount Generali said it would need to raise when it first launched in hostile bid on Generali but is considerably less than the 25 trillion lire it said it would need as the bidding progressed (BI, Dec. 1).

An Allianz spokesman said that plans for financing its takeover of AGF have not been altered.

AGF spokesmen were unavailable for comment. **BI**

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INTERNATIONAL

E.U. ruling raises pension liability questions

By CAROLYN ALDRED

LUXEMBOURG—A recent European Court of Justice ruling could make employers in the European Union liable for pension payments to part-time workers employed as far back as 1976.

While some lawyers and pension experts think the ruling is broad enough to encompass many workers in private pension plans, others think its scope might be much more narrow.

At issue is the extent of E.U. employers' liability for past pension benefits to part-time workers who were excluded from private pension plans due to gender discrimination.

In the United Kingdom, which imposes a two-year limit on past pension liability in cases of discrimination, some observers say test cases pending before the House of Lords may help clarify the issue. However, others say the House of Lords may need to refer those cases to the European Court of Justice.

The Luxembourg-based court, which comprises judges from E.U. member countries, ruled last month in *Mary Magorrian vs. the U.K. Department of Health and Social Services* that part-time employees who have suffered indirect gender discrimination may claim additional pension benefits as of April 8, 1976, the date of a previous landmark ECJ judgment.

The European Court of Justice also ruled in *Magorrian* that E.U. law pre-empts British national rule. Therefore, the House of Lords may decline to rule on the test cases and instead send them directly to the European court.

If the *Magorrian* ruling is found to be relevant to other part-time pension claims, it could present enormous administrative and financial problems for company pensions, said Bill Birmingham, manager of benefits services of the National Assn. of Pension Funds.

The ruling could "cost employers considerable sums and increase liabilities on pension funds considerably, especially funds for companies no longer in business," he said. In those cases, the "only way to meet the additional liabilities would be at the expense of other (fund) members," he added.

It also "would mean a fair degree of administrative chaos, as it is unlikely that most earning records,

particularly for part-time workers, back to 1976 would have been kept," said Mr. Birmingham.

British law recognizes the rights of part-time workers to join occupational pension plans after a series of ECJ judgments that ruled part-timers could not be excluded from pension plans due to indirect sexual discrimination.

However, under British law, companies found to have discriminated against part-time workers only have to pay pensions based on those workers' last two years of employment.

In a series of test cases brought by trade unions, the House of Lords is expected to decide the legality of this two-year limit, as well as other issues in U.K. law, such as the six-month limitation period by which employees must lodge a claim after leaving employment.

Due to be heard within the next few months, the cases are representative samples of some 60,000 indirect pension discrimination claims originally filed with the Birmingham Industrial Tribunal. The test cases raise various issues relating to the exclusion of part-time employees from pension plan membership.

Industry observers differ on the likely impact of the recent ECJ ruling. Some pension experts argue the *Magorrian* case is unusual and involved part-timers who were members of their company plans throughout their employment, not excluded employees, and will have no bearing on more general cases.

Some lawyers, meanwhile, point out that the ruling was wide enough to pertain to other situations, while the Trades Union Congress thinks it will strongly help its case in the House of Lords.

"We are hoping that the *Magorrian* judgment will help the case" for part-time employees in the House of

Lords hearing, said a TUC spokeswoman.

The NAPF's Mr. Birmingham thinks many pension funds will wait for the U.K. test cases to be resolved. But he warns that the House of Lords may be forced to refer the cases directly to the European Court, resulting in further delay of about 18 months.

Under the E.C. Treaty of Rome, national courts are required to refer any issue of community law to the ECJ. The new ruling raises sufficient doubts surrounding what is national law and community law for the House of Lords to refer the test cases, said Mr. Birmingham, NAPF's manager of benefits services.

In *Magorrian*, the two female plaintiffs had worked initially as mental health officers in the Northern Ireland health sector. On changing from full-time employees to part-time employees, due to growing family commitments, they were forced to drop their MHO status, which had entitled them to enhanced pension benefits after age 50.

The Belfast Industrial Tribunal ruled that exclusion from MHO status because of part-time rather than full-time service was unjustified, indirect sex discrimination, as a much smaller proportion of women than men were full-time MHOs on retirement.

The Tribunal referred the matter of time limits to the ECJ. European law does not specify time limits so that national time limits would apply. However, the ECJ found that in this case a back date of two years would have no effect on the women's benefits, as it would not allow them to reach the 20-year threshold required under the plan's rules.

The *Magorrian* ruling "potentially will have a big impact," said Richard Malone, a director at bene-

fit consulting firm Sedgwick Noble Lowndes Ltd. in Croydon, England.

However, Mr. Malone said most people are waiting to see what happens with the House of Lords case.

"Our view is that the facts in this case can't be taken as a general principle," he said, adding that only a resolution to the Birmingham test cases will put the issues of part-time pensions beyond doubt.

The *Magorrian* judgment "could have a substantial impact," said Roger Lewis, head of the pension practice with London law firm Eversheds.

The European Court's ruling is "very broad; it makes general statements and does not limit itself to the one situation," Mr. Lewis pointed out.

Mr. Lewis agreed that many employers were awaiting the *Magorrian* decision and the House of Lords ruling on the Birmingham cases.

"Increasing numbers of (occupational pension) schemes have opened up to part-timers. But it is not universal; a lot of companies have been waiting upon the decisions of this case and the House of Lords. It is a developing area of law," he said.

Many obstacles to successful claims remain. Because the law is based on indirect sexual discrimination, a claimant still would have to prove unfair treatment based on gender before proceeding with a pension claim. Many former employees may be unwilling or unable to afford payment of their own contribution over a long period.

"It is a difficult question as to what employees would have to contribute," said Mr. Lewis.

Meanwhile, the *Magorrian* case did not tackle the six-month limitation issue, which bars any claim not submitted within six months of the discrimination occurring or the last date of employment. **BI**

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Policyholder wins dispute over quake claim notification

By YVETTE HIGGINS
and KATE TILLEY

SYDNEY, Australia—Australia's highest court ruled last month that an insurer cannot underwrite a claims-made policy without providing coverage equivalent to a claims-made-and-notified policy.

The court's determination in favor of the policyholder ended a long legal battle over professional liability claims arising from the 1989 Newcastle earthquake.

Eddie Stewart, Newcastle City Council's financial services manager, said the decision reassured the council it had the right coverage in place and had interpreted its policy correctly.

Sydney, Australia-based GIO General Ltd. provided liability insurance for the council at the time of the quake but refused to pay claims arising from damage to the Newcastle Workers' Club, where nine people died.

The insurer argued that the claims were made after the policy had expired. The council did not renew its policy after Dec. 31, 1991, and did not file claims until after that, when claims were made against the council for personal injury and property damage.

The council argued that the claims were legitimate. A 1990 inquiry into the deaths included evidence that a barrister considered the council responsible for the deaths and other injuries because it had approved structural extensions that

were unsafe (BI, May 22, 1995).

A copy of a newspaper article on the inquest was faxed to the insurer, which the council, and now the High Court of Australia, considered sufficient notification of a potential claim.

While the council won the initial dispute, heard in the Supreme Court of New South Wales, GIO won an appeal in the Court of Appeal (BI, Feb. 26, 1996).

The council then took the case to the High Court, where it was successful in the Dec. 2 judgment.

Ruling unanimously, the five High Court judges rejected the insurer's argument. GIO had said that because the council's liability policy was a claims-made policy only, rather than a claims-made-and-notified policy, the policyholder had to give notice of claims, rather than just circumstances leading to potential claims, to the insurer while the policy was in force.

The council and the insurer now will consider a settlement. The policy limit was \$10 million Australian (\$6.5 million). The council already paid \$8.5 million Australian (\$5.5 million) to the Newcastle Workers' Club in an out-of-court settlement.

Tim Griffiths, a partner from Sydney-based law firm Abbott Tout, which represented GIO, said the case shows an "expansive approach" by the High Court "to correct legislative drafting errors" through using documents other than the law itself. **BI**

Broker pay highlighted

Speaker questions ethics of incentives, dividends

By KATE TILLEY

SYDNEY, Australia—Compensation agreements between some brokers and insurers may hurt some underwriters and will become an important issue, a risk manager says.

Richard Reddaway, chairman of the U.K.'s Assn. of Insurance & Risk Managers, and group insurance manager for Glaxo Wellcome P.L.C., questioned the ethics of incentive payments to brokers for volume business and dividends from insurers for profitable accounts.

Speaking at the recent annual conference of the Assn. of Risk & Insurance Managers of Australasia, he said many risk managers, having agreed on broker fees, are "blissfully unaware" of other financial arrangements.

He said Sedgwick Europe disclosed in its annual report that some insurers paid "incentive efficiency payments at the end of their accounting year, recognizing the benefits to them of receiving large premium volumes from a single source."

Insurers also paid for the prompt transfer of premiums to them. In Australia, however, the Insurance (Agents & Brokers) Act prevents brokers from receiving payments from insurers based on business volume or amount of premium remitted.

Mr. Reddaway said the Sedgwick report showed "certain insurers also pay a dividend

reflecting the profitability of their account" with Sedgwick.

"In the United States, we are seeing certain insurers becoming preferred insurers and having agreements with the multinational brokers because of the larger volumes of business going to those companies," he said.

The New York-based Risk & Insurance Management Society Inc. is sufficiently concerned to establish a working party to look at the problem, Mr. Reddaway noted.

While it "may not yet be a big issue here (in Australia)," there will be a major industry debate on the issue, he predicted.

Shareholders are demanding more ethical business dealings, Mr. Reddaway said. Glaxo Wellcome, for example, had no internal audit until the early 1990s and was prompted to have one only by the recommended standards included in the 1992 Cadbury Code of Best Practice in the United Kingdom.

Mr. Reddaway said the increased emphasis on corporate governance is "beneficial, and I'm all for it." He noted that the Australian Stock Exchange has issued new rules requiring public companies to provide information in their annual reports on their risk management strategies and called that "very healthy."

As part of the corporate governance emphasis, risk managers need to know more about their organizations' suppliers, he said.

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History

Continued from page 1

Particularly frustrating, insurer attorneys say, is that the state courts relied on a version of the drafting history of pollution exclusions that bears little resemblance to actual events.

The industry long has held that it rarely covered gradual pollution claims under pre-1970 comprehensive general liability insurance policies. Gradual pollution, insurers argued, in most cases resulted from routine business practices and should have been expected and, therefore, was uninsurable. To end any debate over pollution coverage, the 1970 sudden and accidental pollution exclusion clarified the industry's indemnity position and barred liability coverage for insurable gradual pollution claims. A separate exclusion was designed to bar coverage for any claim relating to an oil spill.

Some might be tempted to pass off insurer criticism of the Illinois and Massachusetts analysis of the exclusions' evolution as merely sour grapes by the losing party.

However, policyholder attorneys agree that the courts' history lesson is, at least in some ways, not accurate.

"They got the right result for the wrong reason," observed policyholder attorney Eugene Anderson.

Policyholder and insurer attorneys alike credit Mr. Anderson, a partner with Anderson, Kill & Olick P.C. in New York, with leading the assault against the insurance industry's pollution exclusions.

For their part, policyholder attorneys argue that insurers in 1970 did not receive regulatory approval to bar coverage for all gradual pollution losses. The sudden and accidental pollution exclusion, policyholders contend, only clarified that such losses were not insurable if they were "expected" or "intended."

The history of pollution coverage is not easily pieced together.

The documentation is so copious and emanates from so many sources that attorneys on both sides say all the material supporting one side or the other cannot be reconciled. In addition, each side can offer plausible explanations about why the other side's evidence is a product of smoke and mirrors.

Indeed, two other state supreme courts that reviewed the history of the sudden and accidental pollution ex-

clusion later reversed their pro-policyholder opinions on rehearing. The Florida Supreme Court in 1993 reversed an initial pro-policyholder decision, and the Alabama Supreme Court in 1996 also reversed a pro-insurer ruling (*BI*, Jan. 6, 1997).

Those courts considered only the pollution coverage available in pre-1986 policies containing the sudden and accidental pollution exclusion.

The Illinois and Massachusetts decisions indicate that the drafting and regulatory history of the sudden and accidental pollution exclusion could continue to play an important role in pollution coverage litigation.

For that to happen, though, policyholders will have to continue to persuade courts—to insurers' dismay—to look beyond the language of the policy and factor in the pollution exclusions' drafting and regulatory history.

At least one insurer attorney gives policyholders good odds. The reason: Insurers do not always present courts with their own version of the history of pollution coverage, even when policyholders submit their own version, said Edward Zampino, a leading archaeologist of documents that support insurers' version of the pollution exclusions' drafting and regulatory history.

That happens because the insurance industry is not a "monolith" in terms of defense strategies, explained insurer attorney Laura Foggan, who often submits amicus briefs in pollution coverage cases on behalf of the Insurance Environmental Litigation Assn.

In some cases, including the Illinois case, insurers do not want to "lend credence to the gambit by policyholders" to draw courts into considering the "irrelevant" history of pollution coverage, said Ms. Foggan, a partner with Wiley, Rein & Fielding in Washington.

To place the 1970 exclusion in its appropriate context, the evolution of the general liability insurance policy throughout the 20th Century has to be considered.

After years of trying to develop a general liability insurance policy that covered both abruptly and gradually occurring losses, the insurance industry in 1966 introduced the occurrence policy. The policy explained "an occurrence means an accident, including injurious exposure to conditions," that causes unexpected and unintended bodily injury and property damage.

Insurers maintain that "accident" in industry parlance always meant an event with an abrupt, or sudden, element—regardless of some pre-1966 court decisions that "accident" also meant gradually occurring incidents.

How broad policyholders' coverage was under the 1966 occurrence policy is a key point of contention between policyholders and insurers in their explanations of how the 1970 pollution exclusion affected coverage.

Each side accuses the other of trying to build its case by taking out of context some remarks that insurer executives of that era made about how new forms and exclusions would affect coverage.

In its accompanying explanation of the 1970 pollution exclusion, the insurance industry said the exclusion was designed to clarify the limited pollution coverage that was available under the 1966 occurrence policy.

Insurers never intended to cover pollution losses when policyholders dumped hazardous material as a part of their routine business practices, even if the government authorized those disposal methods, insurers argue.

That is because chemical companies knew long before the government did that their chemical disposal methods were harming or likely would damage the environment, said Mr. Zampino, a partner with Cozen & O'Connor in Newark, N.J.

Insurers point to various contemporaneous law journal articles in which academicians agreed that under the 1966 CGL policy, pollution damages were expected or intended. Therefore, the articles conclude, the damages are not insurable if they were a probable result of a policyholder's actions.

Speeches by insurer executives, including Gilbert L. Bean of Liberty Mutual Insurance Co., show that insurers rarely considered gradual pollution damages insurable losses, Mr. Zampino said.

For example, in amicus briefs to various courts, insurer attorneys often cite a 1959 law journal article in which Mr. Bean discussed both the 1955 version of the accident policy and the contemplated occurrence policy.

Mr. Bean wrote that covering gradual property damage "involved considerable moral hazard" for insurers. Insurers should not write such policies "without the protection of a strong requirement that coverage apply only if the gradual property damage were in-

advertent." "By limiting coverage to that injury or damage which is 'caused by accident,' insurers expected that they were eliminating coverage not only for conduct deliberately intended to injure or damage someone, but for irresponsible and willful conduct, borne of gross indifference to the public safety which results in foreseeable injury or damage."

Summing up Mr. Bean's comments and those that other insurer executives made during that era, Mr. Zampino said: "These guys were talking about unique events, not routine polluting events. And, they were not talking about pollution cleanup. They were talking about aberrational situations resulting in compensatory claims."

Insurers would cover, for example, the loss of a farmer's steers poisoned by a stream that a policyholder unintentionally polluted, Mr. Zampino said.

Insurers contend that the 1970 sudden and accidental exclusion clarified that there rarely had been coverage for gradual pollution losses resulting from routine chemical disposal practices.

Not so, counter policyholder attorneys, who also point to remarks made by insurance industry executives to support their case.

Policyholder attorneys also like quoting Liberty Mutual's Mr. Bean and even call him "policyholders' best friend."

For example, Mr. Bean told a group of underwriters in 1965: "Perhaps it is (in) the waste disposal area that a manufacturer's basic premise-operation coverage is liberalized most substantially. Smoke, fumes or other air or streams pollution have caused an endless chain of severe claims for gradual property damage."

"You can't read that stuff and walk away thinking that the industry didn't intend to provide gradual pollution coverage as long as the policyholder was not intentionally trying to pollute," says policyholder attorney William Greaney, a partner with Covington & Burling in Washington.

Not only do insurers cover fortuitous losses resulting from routine business practices, the insurance industry also is founded on covering such losses, policyholder attorneys argue.

Insurance is designed to cover even losses resulting from a policyholder's negligence, which is not a willful act,

policyholder proponents say.

As for insurers' argument that most companies should have known their chemical disposal practices likely would cause environmental damage, that "arm-chair quarterbacking 30-years-later approach" has not won over juries, Mr. Greaney said.

Mr. Anderson questions how insurers now can make this "should have known" argument after marketing themselves, for example, to chemical producers as chemical industry experts. For example, he pointed to a 1962 Aetna Casualty & Surety Co. advertisement that claims "many leading chemical companies rely on" the insurer's staff, "insurance experts who really understand the problems of the chemical industry." The ad states "some of these men are specialists in helping to prevent accidents."

As for insurers' pollution coverage intentions in 1970, policyholder attorneys have two theories.

Mr. Greaney believes the industry intended to bar gradual pollution coverage but misrepresented its intentions to regulators so it could win regulatory approval more easily.

Mr. Anderson supports the theory that insurers in 1970 were trying to jump on the bandwagon in the surging environmentalism movement and demonstrate they did not support willful polluters. He said the industry began misrepresenting the purpose of the sudden and accidental exclusion only after federal pollution liability laws triggered an avalanche of policyholder claims for coverage of gradual pollution losses.

Even so, Mr. Anderson acknowledges that some policyholder evidence does not square with his theory. All of the evidence "simply does not hang all together."

For example, during a 1970 underwriting conference, an underwriter in the audience asked a speaker how the industry could rationalize offering gradual pollution buyback coverage if the industry contended it did not cover most gradual pollution claims in the first place.

The speaker, Robert Young, an underwriting manager with Employers Mutual Liberty Insurance Co., responded that the issue "hasn't been raised, to my knowledge, to any of our underwriters. I suspect it may be raised, but it is something that I would just as soon keep quiet about."

And, Aetna counsel S.B. Guiney states in a memo to Aetna public rela-

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JAN. 17. CPCU Exam Review Day for parts 1-10 in Schaumburg, Ill., sponsored by Northwest Suburban and West Suburban CPCU Chapters; \$70. Judy Smith, Farmers Insurance Group, 2245 Sequoia Drive, Aurora, Ill. 60506; 630-907-3279.

JAN. 21-22. Performance Measurements for Strategic Planning in Insurance Companies conference in New York, sponsored by Price Waterhouse and the International Quality & Productivity Center; \$1,295 for the conference only, \$1,695 for the conference plus one workshop, \$1,995 for the conference plus two workshops. International Quality & Productivity Center, 150 Clove Road, P.O. Box 401, Little Falls, N.J. 07424-0401; 800-882-8684.

JAN. 21-24. Self-Insurance Institute of America Inc. Employer Executive Forum in Palm Springs, Calif., sponsored by the SIIA; \$1,395 for first attendee, \$1,195 for second attendee, \$1,595 for non-members. SIIA, 17300 Redhill Ave., Suite 100, Irvine, Calif. 92714; 800-851-7789.

JAN. 22-23. Delivery System Integration conference in McLean, Va., sponsored by the Institute for Behavioral Healthcare, the Academic Partnership, the Partnership for Delivery System Integration and

CentraLink; \$995. CentraLink-D, 4370 Alpine Road, Suite 108, Portola Valley, Calif. 94028; 650-851-8411.

JAN. 22-23. D&O Liability and Insurance Symposium in New York, sponsored by the Professional Liability Underwriting Society; \$775 for members, \$900 for non-members; PLUS D&O Symposium, 4248 Park Glen Road, Minneapolis, Minn. 55416; 800-845-0778 or 612-928-4644.

JAN. 22-23. Property & Casualty Insurance Companies Partnering with Banks and Financial Institutions conference in Orlando, Fla., sponsored by Global Business Research Ltd.; \$1,795 for the conference plus workshop, \$1,295 for the conference only. Conference Administrator, Global Business Research Ltd., 775 Sunrise Ave., Suite 260, Roseville, Calif. 95661; 800-868-7188 or 916-773-3236.

JAN. 24-26. Traffic Expo '98 in Long Beach, Calif., sponsored by the American Traffic Safety Services Association; \$215 for member delegates, \$335 for non-member delegates. American Traffic Safety Services Association, 5440 Jefferson Davis Highway, Fredericksburg, Va. 22407-2673; 540-898-5400.

JAN. 25-27. Insurance.com: Competing in the Digital Marketplace forum in Scottsdale, Ariz., sponsored by IVANS. \$525, \$1,000 for two company attendees, \$500

for each additional registration. Clare DeNicola, IVANS, 777 W. Putnam Ave., Greenwich, Conn. 06830; 203-532-2109.

JAN. 26-27. Insurance Coverage Litigation: Recovery in the 1990s and Beyond program in New York City, sponsored by the Practising Law Institute. \$895. Practising Law Institute, 810 Seventh Ave., New York, N.Y. 10019; 800-260-4PLI.

JAN. 26-28. Advanced Capital Allocation Techniques for Insurance Companies conference in New York, sponsored by Ernst & Young L.L.P. \$2,985 for conference and two workshops. ICM Conferences Inc., 303 E. Wacker Drive, 20th Floor, Chicago, Ill. 60601; 312-540-3010.

JAN. 26-29. Outsourcing Employee Benefits and HR Functions conference in San Diego, sponsored by Buck Consultants and New York Life Benefit Services; Qualified registrant: \$1,595 for conference plus two workshops, \$1,295 for conference plus one workshop, \$895 for conference only; standard registrant: \$1,995 for conference plus two workshops, \$1,695 for conference plus one workshop, \$1,295 for conference only. International Quality & Productivity Center, 150 Clove Road, P.O. Box 401, Little Falls, N.J. 07424-0401; 800-882-8684 or 973-256-0211.

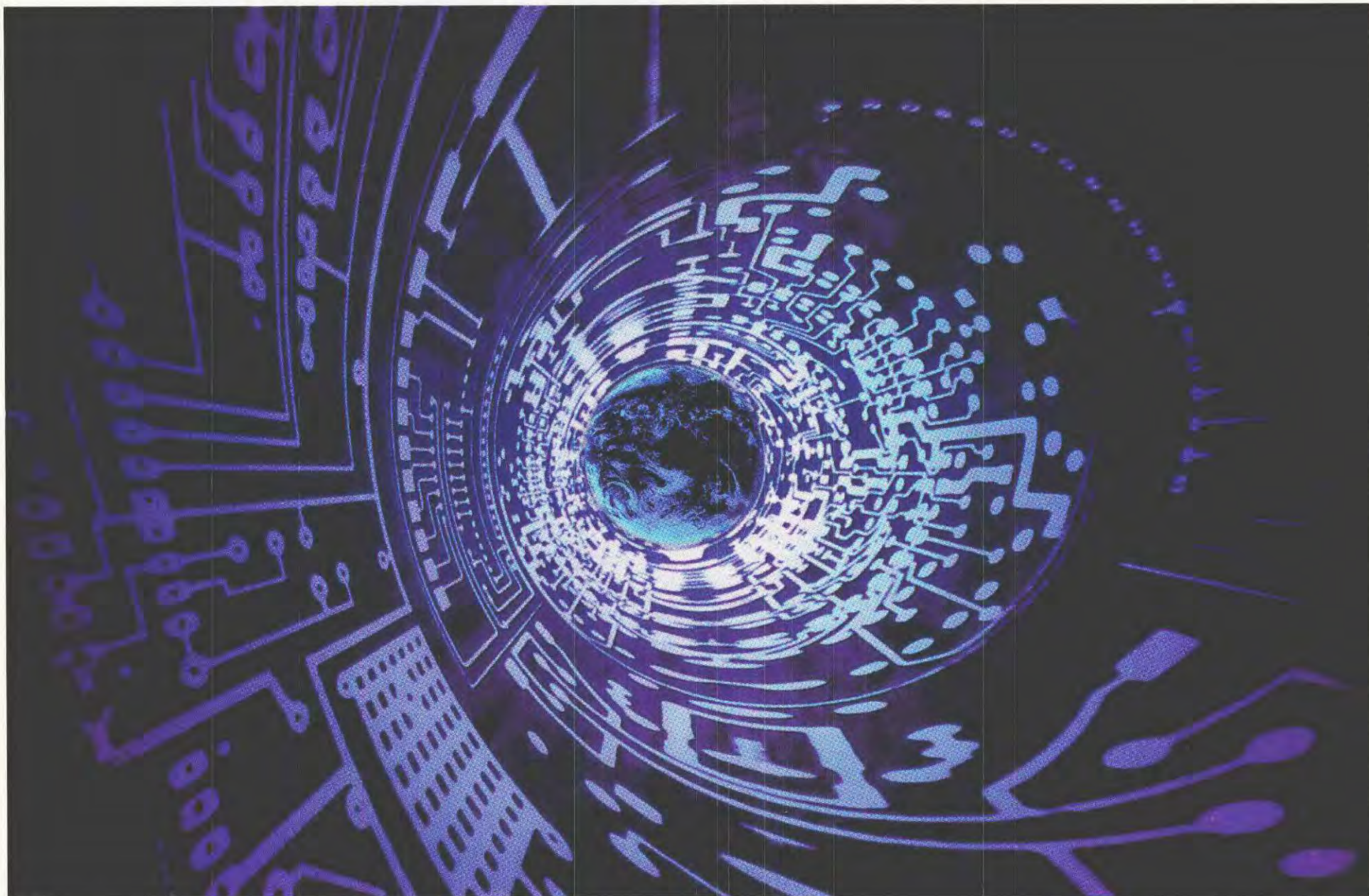
JAN. 27. RIMS Orange Empire Chapter 19th Annual Risk Management Confer-

ence in Brea, Calif., sponsored by the Orange Empire Chapter of RIMS; \$75 each for first two attendees; \$60 each additional attendee. Maury De Bont, Risk Management Analyst, Southern California Edison, 2244 Walnut Grove Ave., Room 249, Rosemead, Calif. 91770; 626-302-1085.

JAN. 27-28. Automation & Technology Conference for Independent Agents in Orlando, Fla., sponsored by the Florida Assn. of Insurance Agents; \$195. FAIA, P.O. Box 12129, Tallahassee, Fla. 32317-2129; 850-893-4155.

JAN. 27-28. Self-Insurance Institute of America Inc. MGU/Excess Insurer Executive Forum in Palm Springs, Calif., sponsored by the SIIA; \$595 for first attendee, \$495 for second attendee, \$895 for non-members. SIIA, 17300 Redhill Ave., Suite 100, Irvine, Calif. 92714; 800-851-7789.

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A commitment to end community violence

History

Continued from page 23

tions: "We don't want to concede that there is a cutback in coverage because this is tantamount to admitting that all such cases are now covered, where as some of them may not be."

Policyholder attorneys, according to Mr. Zampino, are scraping the bottom of the evidence barrel with those citations. Neither Mr. Young nor Mr. Guiney was involved in drafting the exclusion, he points out.

And, insurers can offer a "buyback" that provides coverage they had not written previously, Mr. Zampino said.

Regardless of how insurers intended to handle pollution losses beginning in 1970, they represented to regulators that gradual pollution coverage would continue, policyholder attorneys contend.

The explanations that insurance rating bureaus submitted to regulators along with the exclusions state that "coverage is continued for pollution- or contamination-caused injuries when the pollution or contamination results from an accident."

Speeches by insurance executives as well as memos and letters they sent to colleagues and regulators at the time the 1970 exclusion was introduced and even later show that the insurance industry intended to bar coverage for only intentional gradual pollution, policyholder attorneys say.

One document is a letter written by a Travelers Indemnity Co. executive to the West Virginia insurance commissioner in August 1970. The writer, Richard C. Reeves, assistant secretary of the insurer's government affairs division, explains why Travelers opted not to use the phrase "sudden and accidental" in its version of the 1970 pollution exclusion. Travelers instead barred coverage if the discharge of contaminants was "expected or intended" or if it resulted from any condition in violation of a government rule.

"We believe the results of the two phrases are the same, but we feel that the positive wording that we have used will be clearer to the insured," Mr. Reeves wrote.

Policyholder attorneys have deposed Mr. Reeves, now 67 and retired, several times about the letter. He was most recently deposed a year ago.

Mr. Reeves said he does not remember much about that letter. "I can't put myself back in those same shoes."

However, regarding the "expected and intended" language, he did say: "I think it's more than an instantaneous thing" that would be covered. "Beyond that, I better not guess."

He noted that other individuals, including a Travelers underwriter named Thomas A. Jackson, contributed to the letter.

In a Jan. 13, 1982, letter to the New York insurance commissioner, Mr. Jackson, then a secretary in Travelers' product management division, explicitly reiterated that the "sudden and accidental" language did not bar coverage for gradual pollution losses.

Mr. Jackson was responding to objections the department had raised about the gradual pollution coverage that Travelers wanted to write. Travelers, like other insurers at that time, was beginning to develop an environmental impairment liability insurance for unexpected losses resulting from gradual pollution.

In his letter to Mark Presser, a property and casualty examiner with the Insurance Department, Mr. Jackson wrote that "there is nothing which prevents gradually occurring events from being considered to be 'sudden and accidental' as long as there is no intent to cause injury or damages."

That exchange between the department and Mr. Jackson was triggered by a 1971 New York state law that prohibited insurers from writing gradual pollution insurance. The

state's Legislature repealed the law later in 1982.

Insurers see two problems with the Travelers letters: The writers were not involved in drafting the pollution exclusion that most other insurers used. And, an internal Travelers document states the insurer offered broader pollution coverage under its exclusion than the industry at large offered under the sudden and accidental pollution exclusion, Mr. Zampino said.

"Is there occasionally going to be a document where the person just didn't get it?" said Mr. Zampino, referring to insurer executives whom he said did not understand what the exclusions' drafters had intended. "Sure, but they're not dispositive."

The "smoking gun" in the coverage battle, according to Mr. Zampino, is a collection of 50 to 60 affidavits from individuals who were regulators in 1970. Those former regulators testified that they knew gradual pollution claims generally were not covered before 1970 and that the 1970 exclusion barred coverage for the few gradual pollution losses that had been insurable. The coverage change was so insignificant that a premium reduction was not warranted, some testified.

For example, former New York regulator Henry L. Lauer testified in two affidavits that the New York Insurance Department understood that the term "accident" referred to an abrupt event and that an insurance rating bureau's explanatory material of the 1970 exclusion was not confusing. "Nor did it mislead us into believing that 'sudden' meant 'gradual.'"

Mr. Lauer, a 38-year veteran of the department, retired in 1995 as chief of its Property and Casualty Insurance Bureau.

Not all of the regulators who gave affidavit testimony remembered the events surrounding the exclusion approval processes in their departments so clearly. Their testimony amounts to conjecture that their insurance departments would have adopted the pollution coverage arguments that insurers are making today, policyholder attorneys say.

In particular, the attorneys point to the affidavits of former regulators from Florida, Indiana, Nevada, Pennsylvania and Washington. All testified they either do not recall the submission of the pollution exclusion or were not involved in reviewing it.

Mr. Greaney said that according to accounts from some regulators, many of whom are elderly now, insurer attorneys manipulated them into making those statements. Playing on those former regulators' pride, Mr. Greaney said, the insurer attorneys essentially told them: "Do you know what that cabal of policyholder attorneys are saying? You and others were bamboozled and didn't do your jobs."

Affidavits from other regulators, including Richard J. Schultz Jr., a rate and policy examiner in Pennsylvania, contradicts pro-insurer testimony by several other Pennsylvania regulators.

But, policyholder attorneys also are not above using affidavit testimony from regulators with limited recall.

James C. Schmitt, a deputy superintendent with Missouri's Insurance Department in 1994, testified in 1994 he did not recall the exclusion. He stated, though, that the department rarely granted insurance industry relief by approving coverage restrictions. It preferred either rate adjustments or legislative action.

He recalled the department only once restricted coverage, and that did not involve pollution.

The testimony of Messrs. Schultz and Schmitt are only a few discordant voices in an otherwise harmonious regulatory choir, said Mr. Zampino.

And, only a few regulators do not remember the pollution exclusion submissions, he said. Even so, their recollection of what sudden and accidental meant to them is valuable, he said. "Do you disregard that regula-

tor's very specific recollection of how he understood terminology even though he doesn't recall a piece of paper?"

Plus, the regulators who support insurers testified for no remuneration, unlike some policyholder witnesses, Mr. Zampino said.

Mr. Anderson said the only remuneration policyholder witnesses received covered transportation expenses and, in states that allowed it, reasonable fees for witnesses who were established consultants.

Then there is the case of Samuel H. Weese, a former West Virginia insurance commissioner and possibly the only regulator who held hearings on the 1970 exclusion. Both policyholder and insurer attorneys at some point have claimed that either his 1970 written decision approving the sudden and accidental exclusion or one of his affidavits in recent years support their cases.

In his August 1970 decision, Mr. Weese said he approved the sudden and accidental exclusion because insurers maintained it did not narrow but only clarified existing coverage.

The findings "are as close as you get" to a smoking gun for policyholders, Mr. Anderson observed.

Mr. Weese reiterated those conclusions nearly two decades later in two separate affidavits, one in November 1988 and the second in January 1991.

But, 18 months after the second affidavit, Mr. Weese supported insurers' interpretation of the exclusion.

He explained in a July 1992 affidavit that he entered the hearings with the "belief" that there generally had been no gradual pollution coverage under pre-1970 policies. Therefore, after the hearings, he "assumed that the exclusion did not alter coverage."

In an interview, Mr. Weese reflected on the significance of his role in the debate over the exclusion.

"I don't think now the hearings did anything to clarify the issue debated in the litigation" underway today over the meaning of the sudden and accidental pollution exclusion.

Mr. Weese acknowledged that his 1970 decision and subsequent affidavits "probably were" inconsistent. He attributed that to the way attorneys posed their questions as well as to the attorneys' "insolence."

"I wasn't attempting to match my wits with counsel, who were trying to get results for their particular side," he said.

He declined to reconcile his 1970 decision and his testimony in his subsequent affidavits.

The exclusion is "not a subject I really feel even that qualified to discuss anymore," he said.

Mr. Weese, who is president of The American College in Bryn Mawr, Pa., said he has been involved in only the life and financial services side of the industry for 15 years. "I shouldn't be a deciding voice for either side. There ought to be better documents out there other than my own."

Mr. Greaney expressed sympathy for Mr. Weese and other former regulators. "He and others have been basically used by counsel."

Summing up the mountain of material both sides have piled up, University of Virginia law Professor Kenneth Abraham, whom both sides have quoted in court briefs, said: "There's something in the history for both sides."

Mr. Abraham also criticized both sides for tactics such as presenting material out of context. They also have engaged in "a fool's game" of relying on insurer executives' speeches from that era, which only triggers an "endless progression" of interpretations of those comments.

"It's like an arms race," he observed. "No one probably thinks they'll get an advantage from it. They have to do it to make sure the other side doesn't get the advantage." **BI**



Kathryn J. McIntyre

Kathleen passionately believes that violence is a public health issue, and she is an ardent advocate for reducing violence to improve the life of the community and to help control the public and private funds spent on health care.

"We feel the injuries from gun violence are preventable, one of the few that are," she explains.

Kathleen leads a three-pronged approach against violence: political advocacy on legislation, raising awareness of the problem through the media and educating those whose lifestyles put them at risk of violent attack.

No one law will make a difference, Kathleen says, but she advocates, for example, requiring safety locks on guns to help prevent accidents, especially those involving children. She also is concerned about the poorly made "junk guns" that are easily brought into the United States. And she is greatly concerned by the increasing number of states that permit concealed weapons.

Schwab also tries to raise the public's understanding of the problem through the media. Schwab, for example, invites the media when it hosts events, such as an annual dinner for survivors of handgun violence and their families.

Kathleen believes public outrage over violence is necessary to bring about the legislative changes that will reduce violence in our communities. "If we really decided enough is enough, the American people could do something about it."

While testifying on legislation and raising public awareness are very important, I am most intrigued by Schwab's program called "In My Shoes."

Once a month, Schwab hosts a day for first-time juvenile offenders to introduce them face-to-face to patients in wheelchairs and their care givers to see the toll violence can exact on the human body. Schwab staff explain in graphic detail the effects of spinal cord and traumatic brain injuries. Most effective, however, are the personal stories told by former Schwab patients who have suffered permanent disabilities due to violence. Plenty of kids' lives have been changed by this experience.

Now, Schwab is in talks with the Chicago Board of Education to determine how to bring the "In My Shoes" program to a larger audience of Chicago students.

It's not just kids in gangs who are the victims of violence, Kathleen points out. "They are little kids, older people or people in the wrong place at the wrong time."

While committed to working to prevent violence, Kathleen notes that Schwab has promoted other public policy issues that are really risk management issues, including seat belt legislation, the use of air bags and maintaining the 55 mph speed limit. While safety advocates lost on the speed limit, fewer patients at Schwab are the victims of auto accidents than violence.

But what if Schwab were successful in its risk management efforts and fewer victims of violence needed its services? Who would use the hospital, including the new building that will open in March to expand both outpatient and inpatient services?

Kathleen has a vision that Schwab could then focus its energies on serving the elderly, promoting more assisted living instead of nursing homes for those disabled by the ailments that accompany old age.

"I'd like to see Schwab spend time on assisted living, to save and reduce health care expenditures in the private and public sector," Kathleen says.

There's that risk management thought process again.

This begins a weekly feature by Publisher and Editorial Director Kathryn J. McIntyre and Editor Paul D. Winston, who will write columns on alternate weeks.

Explosion

Continued from page 2

and damaged surrounding structures. A gas leak caused by excavation caused the explosion, the report found. The source of fuel for the explosion was propane and air that leaked from a plastic gas service pipe and "probably migrated underground" into the destroyed building, the NTSB found.

Attorneys representing survivors have now filed 250 lawsuits, said plaintiffs attorney Francisco M. Troncoso, a partner in the San Juan firm of Troncoso & Becker (BI, Dec. 2, 1996).

The NTSB's preliminary report comes as favorable news to plaintiffs who are seeking to move their lawsuits from local jurisdiction to federal court. "It's pretty damning," Mr. Troncoso said.

San Juan Gas declined to comment on the litigation because it is ongoing.

The preliminary report also criticizes Puerto Rico's Public Service Commission because "In 1995 and 1996, the PCS found numerous probable violations in the gas company's compliance with pipeline safety requirements, but the Commission did not require timely, effective corrections."

The U.S. Department of Transportation Research and Special Programs Administration/Office of Pipeline Safety also is criticized for failing to monitor Puerto Rico's pipeline safety program.

But the criticism for not properly training employees was leveled against Enron and San Juan Gas.

"The gas company's employees were not properly trained in testing

for leaks: They did not test correctly, and they did not find and repair the leak," the report said. Gas company employees who received telephone reports of gas odors failed to provide callers with effective instruction on the dangers and protective measures because "neither employee training or supervision were adequate."

The NTSB preliminary report also states that "Enron Corp. did not provide a working environment that encouraged the employees of the gas company to follow its operating policies and practices strictly, and it did not oversee employees' actions

The gas company's employees were not properly trained in testing for leaks, the NTSB preliminary report says.

enough to identify and correct unsafe practices."

Before the explosion, Enron had begun to correct some deficiencies in the gas company's operations. But Enron's attempt "was neither timely nor sufficient," the report said.

Contributing to the deaths was San Juan Gas' failure to adequately inform citizens and businesses of the dangers of propane gas and safety steps to take when a leak is suspected, the NTSB also found.

The San Juan Gas spokeswoman pointed out that her company had not provided propane to the destroyed building for several years. She criticized the NTSB's report for failing to

address the actions of a third-party contractor who was working in the area just prior to the explosion and damaged the gas pipe responsible for the leak.

Additionally, the report does not provide evidence of gas migration from the broken pipe to the destroyed building. The conclusions are all based on probable cause, she said.

"There was this leaky pipe and we all agree with that," she said. "But what path did the propane take to get to the building? That is not defined. How do you know it's propane if you can't show how it got there? It is cause and effect, so we are missing some of the pieces that actually point to propane as being the cause of the explosion."

Additionally, San Juan Gas believes its employees acted responsibly before the blast when the utility company received telephone calls complaining of gas smells in the area around the destroyed building, the spokeswoman said.

"When we got a call to come out and investigate, we did, and we believe our employees acted prudently and diligently," she said. "We disagree that they were not trained."

Among other safety recommendations, the NTSB suggests that Enron require the San Juan Gas Co. to include emergency plan procedures for its employees to determine when a building should be evacuated. In addition, the Department of Transportation should require that San Juan Gas Co. ensure that abandoned pipelines are properly disconnected and purged of propane, the report said.

The San Juan Gas spokeswoman said the company has implemented those recommendations. **BI**

Network

Continued from page 1

Scheur Management Group has helped put together similar networks, and Dr. Collins said WellSpan is among the largest such operations. "With that many docs and hospitals, that is relatively unique."

Marianne Fazen, executive director of the Dallas/Fort Worth Business Group on Health, said WellSpan's size could be a plus for employers in terms of provider choice.

"A big complaint has been restricted access to hospitals and especially to doctors," Ms. Fazen said. "This sounds like it would increase access for employees."

"Choice is such a big thing," agreed Sandy Lutz, an analyst with Rauscher Pierce Refsnes Inc. in Dallas. "This would offer an alternative to employers who say they don't have enough choice."

However, she added, some employers may not opt for such a large network, preferring a smaller arrangement with a more manageable stable of choices for workers.

Benefit managers aren't yet sold on WellSpan.

"We haven't made any kind of decision about whether we will be doing any direct contracting with them," said Marcia MacLeod, manager of benefits development at Electronic Data Systems Corp. in Plano, Texas.

"We're obviously interested in quality health care delivered on a

'I think we're watching, but we're not totally convinced they have it all together,' says EDS' Marcia MacLeod.

more efficient basis," she added, but in the north Texas market, "that's yet to be proven. I think we're watching, but we're not totally convinced they have it all together."

George Crowling, regional health care manager at GTE Corp. in Irving, Texas, said he will give WellSpan plenty of time to mature before considering whether to contract with the network.

"Many large employers have been

burned by taking the new kid on the block to save a few bucks" and then having it fall apart, he said. "A good deal is only a good deal if it works."

Mr. Crowling said he can't see any advantages the new arrangement could offer his company in the near term. "We already have contracts" with managed care companies that the network will deal with, he pointed out.

He said structuring the network to provide HMO services to employers raises some questions. If a WellSpan HMO were subsidized by money paid to the network by other plans, that could give WellSpan an unfair advantage.

"If that is tested, it could raise (Federal Trade Commission) concerns," Mr. Crowling said.

Ms. Lutz of Rauscher Pierce Refsnes also said antitrust concerns could arise. "Certainly with that big of a share of the market, it could raise questions," she said. "Especially if there is a sharing of prices among providers."

The WellSpan spokeswoman said antitrust concerns have been addressed. "If we truly felt there was an antitrust issue, we wouldn't have done this," she said. **BI**

agree.

Bruce Reed, the president's director of domestic policy, told reporters after the White House Conference on Child Care in October that the president believes child care "is not a problem that government can solve on its own."

"The child care system is treated a lot differently than the health care system in this country," Mr. Reed said. "In most businesses, some kind of health care is provided. That's not nearly as common with respect to onsite child care or subsidized child care by businesses. So it's very important to engage the private sector and to get them to recognize that this is in their bottom-line interest as well." **BI**

Care

Continued from page 3

However, "the open issue will be what would it cost in terms of revenue and will there be tax legislation to which it could be attached," he added. Mr. McArdle said he does anticipate that some sort of tax legislation will be offered next year to which the proposal could be attached.

Earlier this year, the Senate passed a bill, S. 82, that would have given employers tax credits for establishing child care facilities. However, the provision was dropped from the budget bill during negotiations with the House (BI, Aug. 4, 1997).

A spokeswoman for Sen. Herbert Kohl, D-Wis., said that in October at the White House Conference on Child Care, the Treasury Department supported Sen. Kohl's proposal.

However, Karen Nussbaum, director of the Working Women's Department of the AFL-CIO in Washington, noted that "there's a big question of whether tax credits for business actually result in more child care centers."

"The lack of a tax credit is not what's preventing people from starting" child care facilities, she said. "While tax credits may be one way to stimulate more investment, businesses will simply have to provide more."

The administration seems to

Updates

Oxford agrees to fine

NORWALK, Conn.—Oxford Health Plans has agreed to pay \$3.5 million in fines and restitution to New York regulators to settle charges of wrongdoing.

Norwalk, Conn.-based Oxford, which has been struggling to recover after losing 62.6% of its stock value in the market drop of Oct. 27 (BI, Nov. 3, 1997), along with operating subsidiary Oxford Health Plans of New York, on Dec. 22 was fined \$3 million by the New York Insurance Department for violations of state insurance law, and the parent and its subsidiary agreed to pay \$500,000 to customers and care providers whose claims were allegedly wrongfully denied.

The fine stemmed from a state investigation into delays in Oxford's payments to doctors, hospitals, other providers and customers.

The investigation began in May at the request of Gov. George E. Pataki and covered Jan. 1, 1995, to Nov. 1, 1997.

The investigation report faulted Oxford for erroneous denial of valid claims and numerous other rule violations. The health plan has blamed computer conversion problems for much of its problems.

Oxford Chairman Stephen F. Wiggins said in a statement, "With this report behind us, we can continue to focus on revitalizing our organization."

Allied Mutual order stayed

DES MOINES, Iowa—A state judge has temporarily stayed an Iowa Insurance Department order that requires Allied Mutual Insurance Co. to help notify policyholders of a dissident candidate for its board of directors.

Iowa Insurance Commissioner Therese M. Vaughan on Dec. 19 ordered Allied Mutual to take one of several possible steps to inform its policyholders of the candidacy of David Schiff, publisher of New York-based Schiff's Insurance Observer and a critic of Allied Mutual management. The mutual insurer had earlier refused to notify its policyholders or provide Mr. Schiff with a policyholder list for proxy mailings.

After the order, Allied Mutual filed a petition to block its enforcement, and a Polk County District Court judge on Dec. 23 stayed the order pending the outcome of a judicial review.

Blues' merger tentatively OKd

WASHINGTON—Regulators have given approval to a merger of two Blue Cross/Blue Shield plans in the Washington area subject to certain conditions.

Maryland Insurance Commissioner Steven Larsen and interim District of Columbia Commissioner of Insurance and Securities Regulation Patrick E. Kelly gave their conditional approval late last month to a "business combination" between BC/BS of Maryland Group Hospitalization and Medical Services Inc., which does business as BC/BS of the National Capital Area.

Among the conditions set for approval are that the holding company created by the combination be licensed as a non-profit service plan; that an accounting be taken of both plans' assets within 60 days of closing to provide a basis for distributing any charitable assets to the respective jurisdiction if the plans convert to for-profit entities in the future; and that each board in the holding company system have two independent, public members.

The two plans announced their desire to merge early last year. After the regulators gave their conditional approval to the plan, the Maryland plan issued a statement saying that "officials of both companies are presently reviewing the independent and collective impact of the commissioners' orders to determine whether the original business goals can be achieved."

Meanwhile, a Washington-based consumer group called the Fair Care Foundation announced that it would seek judicial review of the merger approval, claiming that the plan worked more to the benefit of the plans' managers than to the public.

Sears sticking to cuts

HOFFMAN ESTATES, Ill.—Sears, Roebuck & Co. plans to follow through fully on its previously announced benefits cutbacks, despite the planned departure of Sears' top benefits manager and reports that the retailer might give in to retiree pressure.

Sears confirmed last month that James Bronson, 54, will retire later this year as vp of benefits. But a spokeswoman for Sears denied that his departure had any connection to the benefit cuts.

Picketing has broken out at some 20 to 25 Sears stores nationwide since Sears announced it would scale back its premium contributions for retirees' supplemental health benefits, eliminating contributions altogether for those who become Medicare-eligible and retire after 1999 (BI, Sept. 29, 1997). Sears also said it would gradually reduce retiree life insurance coverage over the next decade to \$5,000 from the current average of \$17,000.

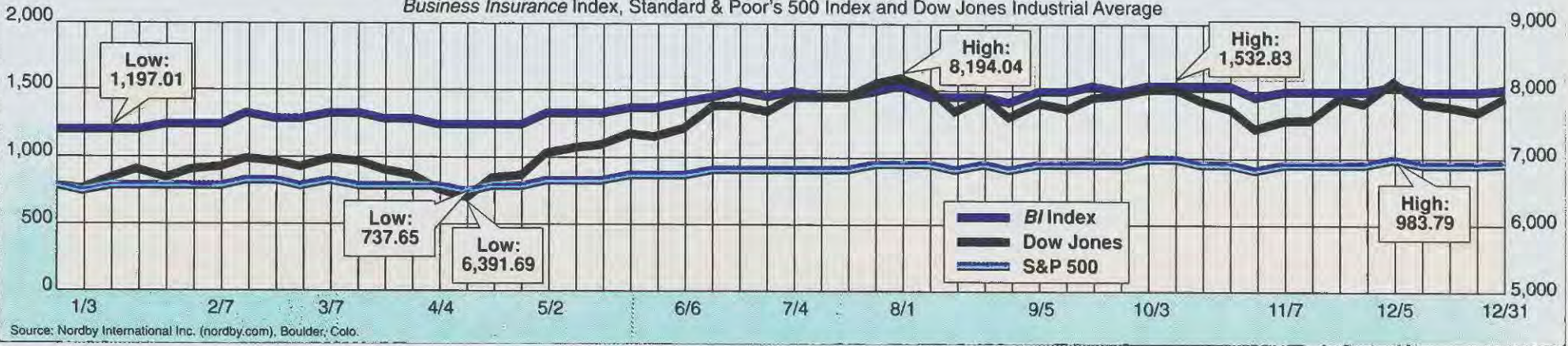
The life insurance cut prompted some Sears retirees to sue Sears, alleging that the retailer had violated the Employee Retirement Income Security Act by planning a cutback after supposedly promising secure life insurance to its retirees as long as they had made contributions as employees (BI, Nov. 17, 1997).

Briefly noted

Merrill Lynch & Co. Inc. will pay \$1.9 million to settle a suit brought by investors who bought bonds issued by Orange County, Calif. The investors charged that Merrill Lynch and other investment banks misled them about the risks of buying the bonds prior to the county's bankruptcy in 1994. . . Robert E. Edmonson will become vp of Aetna International's Global Health Unit and work to spread managed care principles in Latin America. He recently stepped down as chief executive officer for Omni Healthcare, a Sacramento, Calif.-based health maintenance organization.

1997 in review

Business Insurance Index, Standard & Poor's 500 Index and Dow Jones Industrial Average



Source: Nordby International Inc. (nordby.com), Boulder, Colo.

GRAPHIC BY MIKE GARVEY

The BI Index began 1997 at 1,202.98, reached a low of 1,197.01 on Jan. 10 but proceeded to climb throughout the year. Its high of 1,532.83 came on Oct. 10, and it closed the year at 1,517.58, up 26.2%. By comparison, the S&P 500 Index started the year at 756.79, dipping to a low of 737.65 on April 11 and hitting a high of 983.79 on Dec. 5. The Dow Jones Industrial Average, meanwhile, experienced more fluctuation.

Ex-attorney guilty in insurer failures

Jury convicts former Philadelphia lawyer of fraud, looting companies

PHILADELPHIA—A federal jury in Philadelphia has convicted Allen W. Stewart, a former partner with a prominent Philadelphia law firm, on 135 counts of mail fraud, wire fraud, money laundering and racketeering.

After a six-week trial, the jury found Mr. Stewart, a former partner with Morgan, Lewis & Bockius, guilty of carrying out a scheme that drove Summit National Life Insurance Co. and Equitable Beneficial Life Insurance Co. into insolvency (BI, Jan. 27, 1997).

In addition to creating false assets of the insurers to conceal their insolvency, Mr. Stewart looted the companies of millions of dollars to purchase, among other things, a \$1.6 million mansion in California, a \$51,750 grandfather clock and other antiques.

"He just sort of pulled out money through the back door," said Linda Dale Hoffa, the assistant U.S. attorney who prosecuted Mr. Stewart.

Pennsylvania regulators placed both insurance companies in liquidation in 1994, the year after Mr. Stewart sold the companies.

The jury also ordered the forfeiture of \$29 million of Mr. Stewart's assets.

The federal government can collect this forfeited money from Mr. Stewart's personal assets as well as his ownership of the Conestoga Life Assurance Co, according to Ms. Hoffa.

A sentencing hearing before U.S. District Judge Harvey Bartle is scheduled for early March.

Mr. Stewart could face 14 to 17 years in prison along with millions of dollars in fines.

—By Michael Prince

Ohio law sets managed care standards

COLUMBUS, Ohio—Gov. George V. Voinovich on Dec. 16 signed a bill that establishes industry standards for managed care plans in the state.

The Physician-Health Plan Partnership Act sets baseline industrywide standards for managed care plans—known as "health insuring corporations"—specifying patient protections and physician contracting standards.

Under the law, plans will have to follow

new requirements protecting patients' access to covered health care services, including broad access to emergency services, specialists and non-formulary drugs.

The law also establishes a standardized process for resolving patient grievances, including requiring outside review if a plan denies coverage for certain terminally ill enrollees.

The measure also essentially makes plans responsible for the actions of their utilization

reviewers and requires each plan to implement a quality assurance program.

In addition, provider-related measures require creation of a uniform credentialing form, acceptance of osteopaths and a ban on "gag" clauses, which prevent providers from discussing all treatment options with patients.

Most major provisions of the measure go into effect Oct. 1, 1998.

—By Meg Fletcher

PCS catastrophe options

As of Dec. 31		Call spread bid/ask	Price bid/ask
National Annual 1997			
30/50	—/—	—/—	—/—
60/80	—/1.5	—/—	—/—
National Annual 1998			
40/60	11.0/13.0	—/—	—/—
60/80	7.0/8.3	—/—	—/—
80/100	6.0/7.0	—/—	—/—
National December 1997			
5/15	—/—	—/—	—/—
5/25	—/7.5	—/—	—/—
Southeast September 1998			
40/60	2.5/3.5	—/—	—/—
60/80	1.5/2.5	—/—	—/—

Total volume: 128 Total open interest: 19,495
For information on PCS cat options, call the Chicago Board of Trade at 312-435-3674.

Source: Chicago Board of Trade

British Issues

Companies	Price	P/E	Div. %	Yield %	52-week high—low
Comml Union	852	13.0	35.8	4.2	912—630
Genl Accident	1047	7.0	35.4	4.2	1158—729
Gdn Royal Exch	334	4.8	11.2	3.6	350—257
Legal & Gen	534	13.8	11.6	2.7	551—363
Royal & Sun	615	21.0	19.7	4.0	651—429

Brokers	Price	P/E	Div. %	Yield %	52-week high—low
Lmbt Fenchurch	107	7.4	8.4	10.1	138—101
Lloyd Thmpson	179	14.9	10.8	7.5	206—151
Sedgwick Grp	142	11.6	7.4	5.2	171—115
Willis Corroon	148	16.8	6.6	5.6	165—116

Note: All prices and fundamentals as of Dec. 30.

Source: Nordby International Inc. (nordby.com), Boulder, Colo.

BI Industry Stock Report DEC. 29, 1997, THROUGH DEC. 31, 1997

BROKERS							INSURERS/REINSURERS							HEALTH MAINTENANCE ORGANIZATIONS									
Company	Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)	Company	Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)	Company	Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)			
Aon Corp.	NYS	58.63	-4.69	41.55	58.63	40.25	583	Enhance Financial Services	NYS	59.50	5.54	63.01	59.50	34.25	114	St. Paul Companies	NYS	82.06	1.00	39.98	85.50	57.63	346
E.W. Blanch Holdings Inc.	NYS	34.44	3.77	71.12	35.69	19.75	171	Everest Reinsurance	NYS	41.25	8.91	43.48	43.00	26.00	342	SCOR	NYS	47.75	0.92	38.91	52.13	34.00	5
Gallagher Arthur J. & Co.	NYS	34.44	-1.43	11.09	38.25	29.75	38	Executive Risk Inc.	NYS	69.81	-1.85	88.68	72.75	34.63	33	SAFECO Corp.	NDO	48.75	2.50	23.61	55.38	36.50	1239
Hill, Rogal & Hamilton	NYS	19.31	1.98	45.75	19.63	12.50	35	EXEL Ltd.	NYS	63.38	7.30	67.33	65.19	36.88	500	SCPIE Holdings Inc.	NYS	28.94	4.75	44.69	32.13	19.13	NA
Kaye Group Inc.	NDO	6.63	3.92	26.19	9.00	4.38	12	Fremont General Corp.	NYS	54.75	4.53	76.61	55.00	25.38	180	Seibels Bruce Group	NDO	7.50	-4.76	-9.09	9.63	5.88	48
Marsh & McLennan	NYS	74.56	5.67	43.39	80.00	51.38	741	Frontier Insurance Group	NYS	22.88	10.24	19.61	39.25	18.38	1038	Selective Ins. Group	NDO	27.00	3.85	42.11	28.38	18.31	146
Poe & Brown	NDO	44.63	8.25	68.40	47.00	25.50	11	Gainsco Inc.	NYS	8.50	3.03	-11.69	10.19	8.00	134	Tera Nova Insurance Co. Ltd.	NYS	26.25	3.96	22.09	30.00	18.00	301
Sedgwick Group PLC	NYS	12.31	-0.51	18.67	13.25	9.38	34	General RE Corp.	NYS	212.00	2.73	34.39	221.25	151.00	432	TIG Holdings	NYS	33.19	4.12	-2.03	38.00	26.38	620
Willis Corroon Corp.	NYS	12.31	-3.43	7.07	13.50	9.75	221	Gryphon Holdings	NDO	16.75	0.75	18.58	17.75	13.00	10	Tokio Marine & Fire	NDO	57.75	3.82	23.86	66.00	41.25	102
AVERAGE			2.03	36.46				Harleysville Group	NDO	24.00	3.23	57.38	27.50	14.38	79	Torchmark Corp.	NYS	42.19	6.80	67.08	42.81	25.00	657
								Hartford Steam Boiler	NYS	55.19	1.96	19.00	56.69	44.00	52	Transatlantic Holdings	NYS	71.50	0.97	33.23	76.56	50.88	55
								HCC Insurance Holdings	NYS	21.25	-0.29	-11.46	32.69	-18.06	592	Travelers Property	NYS	44.00	5.39	24.38	45.00	31.38	730
								ING Groep N.V.	NYS	42.31	3.20	20.04	53.00	38.88	232	Travelers Group	NYS	53.88	4.48	78.10	57.38	29.19	5781
								IPC Holdings Ltd.	NDO	32.19	-0.58	43.85	32.88	22.25	86	Trenwick Group Inc.	NDO	37.63	3.79	22.03	39.63	30.75	44
								Hartford Financial Services	NYS	93.56	6.93	38.61	93.56	64.88	662	Unico American Corp.	NDO	12.25	0.00	12.64	14.13	9.63	1
								LaSalle Re Ltd.	NDO	35.38	1.80	20.94	36.13	26.00	91	United Fire & Casualty	NDO	44.25	-0.56	25.53	47.00	29.75	3
								Life Re Corp.	NYS	65.19	2.56	68.77	65.19	37.38	29	Unitrin	NDO	64.63	3.82	15.92	68.50	48.50	149
								Lincoln National	NYS	78.13	4.52	48.81	78.13	49.00	456	UNUM Corp.	NYS	54.38	5.58	50.52	54.38	33.63	731
								MAIC Holdings Inc.	NYS	28.13	0.90	66.05	30.50	15.13	52	USF&G Corp.	NYS	22.06	4.44	5.69	25.50	15.63	1242
								Markel Corp.	NYS	156.13	1.75	73.47	161.13	88.00	7	Vesta Insurance Co.	NYS	59.38	3.15	89.24	64.50	30.88	76
								MBIA Insurance Group	NYS	68.81	4.39	31.98	67.25	45.44	392	Zenith National Ins.	NYS	25.75	-1.90	-5.94	28.75	24.63	21
								Meadowbrook Insur. Group	NYS	26.06	5.57	24.11	26.63	20.25	97	AVERAGE			2.61	32.21			
								Mid Ocean Ltd.	NYS	54.25	-1.59	3.33	66.75	44.13	254								
								MMI Cos. Inc.	NYS	25.13	0.25	-22.09	32.75	20.75	54								
								Mutual Risk Mgmt. Ltd.	NYS	29.94	3.90	61.82	29.94	16.75	185								
								NAC Re Corp.	NYS	48.81	5.68	44.10	52.88	33.25	261								
								Navigators Group	NDO	18.78	1.18	2.91	22.50	15.75	8								
								Nobel Insurance Ltd.	NDO	13.13	-0.94	4.48	15.38	11.88	74								
								NYMagic Inc.	NYS	27.56	0.46	53.13	29.81	17.63	14								
								Ohio Casualty Corp.	NDO	44.63	2.00	25.70	51.00	34.00	160								
								Old Republic Int'l	NYS	37.19	0.85	39.02	40.19	24.63	511								
								Orion Capital Corp.	NYS	46.44	4.94	51.94	51.00	30.00	195								
								Pariner Re Ltd.	NYS	46.38	4.07	36.40	46.38	30.75	437								
								Penn-America Group Inc.	NDO	20.50	9.70	90.70	21.75	10.38	54								
								Philadelphia Cons. Holding	NDO	17.75	-4.05	52.69	23.25	11.25	44								
								PXRE Corp.	NYS	33.19	-1.12	34.09	34.00	24.00	39								
								Reliance Group Holdings	NYS	14.13	6.60	54.79	15.13	8.75	389								
								Reliastar Financial Corp.	NYS	41.19	3.78	42.64	41.19	27.00	437								
								Renaissance Re Holdings Ltd.	NYS	44.13	4.44	33.71	50.00	32.50	66								
								Risk Capital Holdings	NDO	22.25	0.56	14.84	23.38	16.00	1								
								RI Corp.	NYS	49.81	2.71	49.25	50.25	30.50	49								

Top advancing issues: Frontier Insurance Group, Humana Inc., Penn-America Group Inc. Leading decliners: Baldwin & Lyons Inc., Seibels Bruce Group, Argonaut Group. Most active issue: Oxford Health Plans. The BI Index rose 2.8%; the Dow Jones 30 Industrials gained 3.0%; the S&P 500 increased 3.6% and the NYSE Composite gained 3.6%. Average P/E: Brokers, 27.1; Insurers/reinsurers, 37.3; HMOs, 20.0.

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