

# Business Insurance

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

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## Maternity stay backlash grows

Bill would mandate minimum inpatient stay

By JERRY GEISEL

WASHINGTON—The backlash against ever-shortening hospital stays for childbirth has reached Congress.

Bipartisan legislation introduced last month in the Senate and House would require all health care plans, including self-funded plans, to generally provide at least 48 hours of inpatient care for the mother and infant following a vaginal delivery and 96 hours of inpatient care following a Caesarean section.

The legislation, modeled after measures enacted this year in Maryland and New Jersey, and a soon-to-be introduced bill in Cali-

fornia, comes in the wake of an ongoing trend by many health insurers and HMOs that new mothers and their infants be discharged from a hospital 24 hours after an uncomplicated vaginal delivery and 72 hours after a C-section.

Nationally, hospital lengths of stay for childbirth have been in a free fall for more than 20 years. The average length of stays for both vaginal and C-section births have plunged by nearly 50% during that period. In 1992, the most recent year for which complete statistics are available, a woman giving birth by vaginal delivery spent an average of 2.1 days in the

See Maternity on page 22

## California ruling may widen cover

Court upholds continuous trigger

By ROBERTO CENICEROS

SAN FRANCISCO—Policyholders may have an easier time obtaining coverage for pollution claims following a recent California Supreme Court ruling adopting the "continuous trigger" of coverage in cases of continuing or progressively deteriorating injury or damage.

The July 3 decision in *Montrose Chemical Corp. vs. Admiral Insurance Co.* means that insurers that wrote comprehensive general liability policies in effect from the time pollution first begins until damage or bodily injury is discovered may be liable to provide a defense.

Unanimously, the seven justices rejected an argument that insurance companies have long made that only the CGL policy in effect when personal injury or property damage is first discovered should be triggered.

Outside the trigger of coverage dispute, Admiral Insurance Co. also argued that the coverage should be voided because Montrose allegedly was aware of its potential liability when it bought the coverage. That issue is expected to be considered by the trial court. The high court ruling dealt only with a motion for summary judgment, not with actual liability.

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## Hurricane activity may rise

Insurers and risk managers heed scientists' warning but say the forecast comes too late to avoid exposure

By MICHAEL SCHACHNER  
and LEE VELKER

Just three years since the worst hurricane in history hit the United States, risk managers and insurers are in for a potentially wicked season of tropical storms, according to a study by a group of atmospheric scientists.

The 1995 hurricane season has all the trappings of being a bad one, the group contends. Several key atmospheric and climatic conditions point to above-average hurricane activity between now and September. In a worst-case scenario, as many as three severe hurricanes could hit somewhere in the United States this year.

These projections were issued recently by the group of researchers at Colorado State University led by William Gray, a professor of atmospheric science.

Mr. Gray has been issuing similar hurricane forecasts for the past 11 years with a fair degree of accuracy, and his group believes 1995 could be one of the most active years for tropical storms in the last 25 years.

The Colorado State University group is basing its prediction for above-average storm activity this year on three factors that generally are considered to be the main determinants of Atlantic and Caribbean hurricanes:

- Rain and moisture in the Western Sahel portion of Africa.

Decades of drought across countries like Mauritania, Senegal and Mali have produced mainly weak hurricane seasons.

This year, though, the rainy season in the Sahel has been very active. Scientists believe that it is in the Western Sahel that hurricanes form and gather strength and then move westward, where they pick up even more power and moisture before becoming full-scale hurricanes in the South Atlantic.

- The dissipation of El Niño, a warm water current that periodically builds up in the equatorial

## Cat losses, weak investments blamed for insurers' low returns

NEW YORK—Massive catastrophe losses and only marginal growth of investment income caused property/casualty insurers' after-tax income and return on net worth to plummet in 1994, the Insurance Services Office Inc. reports.

Following a record 1993, "forces largely outside the industry's control," primarily the Northridge earthquake and declining stock and bond markets, eroded aggregate net income by 47.7% to \$10.1 billion in 1994 from \$19.3 billion in 1993, while causing its

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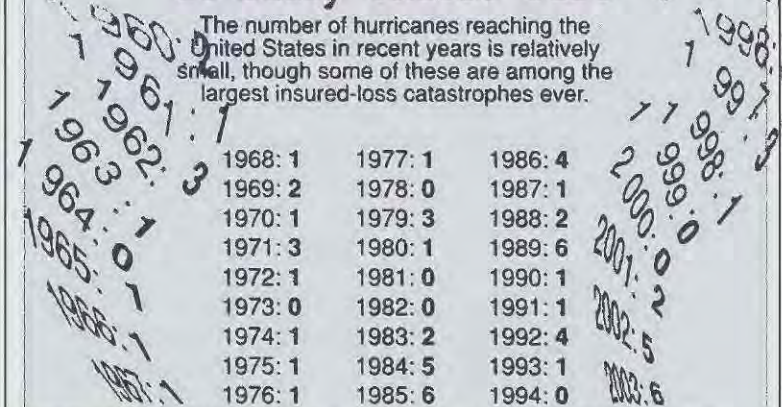
El Niño produces low-level, westerly winds that typically cut up hurricanes in the Atlantic before they take shape. El Niño existed in full force from 1991 to 1994 and reduced hurricane activity, though Hurricane Andrew hit during that period.

Although the scientists note that El Niño largely has vanished, Atlantic Ocean waters have warmed, increasing hurricane potential.

- Upper stratospheric winds, which blow directionally in two-year cycles called quasi-biennial oscillation, have shifted to the west.

## It only takes one

The number of hurricanes reaching the United States in recent years is relatively small, though some of these are among the largest insured-loss catastrophes ever.



Source: Insurance Information Institute

GRAPHIC BY MIKE GARVEY

Historically, hurricane activity has been more forceful in westward periods.

The CSU group predicts that there will be 12 tropical storms this year, eight of which will qualify as hurricanes and three of those will be severe enough to qualify as a Grade 3, 4 or 5 hurricane—meaning winds will exceed 110 mph. However, the scientists do not predict where or when the storms will strike.

In fact, they make no promises that the hurricanes will reach shore at all in the continental United States or in the Caribbean.

Over the last 30 years, "landfalls" have been far less frequent than during the period between 1944 and 1965, Mr. Gray pointed out. "But if we were to

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## Congressman argues for an overhaul of OSHA

The problem with the Occupational Safety and Health Administration, says Rep. Cass Ballenger, R-N.C., is it sees its primary roles as policing and penalizing.

Rep. Ballenger says OSHA's function should be one of educating businesses about workplace safety and considering the individual needs of specific industries.

The congressman, who has represented a northwestern North Carolina district since 1986, is chairman of the Economic and Educational Opportunities Subcommittee on Workforce Protec-

tion. He recently introduced the Safety and Health Improvement Regulatory Reform Act (BI, June 19).

Among other things, the reform legislation would require that at least half of OSHA's budget be spent on consultation and training to help employers operate safe workplaces and comply with regulations, that OSHA be subject to the risk assessment regulations and cost/benefit analysis approved by the House earlier this year, that the penalty structure be changed, that OSHA be merged

with the federal Mine Safety and Health Administration and that OSHA take over some of the functions of the National Institute of Occupational Safety and Health, which would cease to exist.

Rep. Ballenger, who is also the founder and chairman of Plastic Packaging Inc., a manufacturing company in Hickory, N.C., recently discussed his OSHA reform bill with Associate Editor Mark A. Hofmann on Capitol Hill:

Why are you pursuing OSHA reform so vigorously?

You've got to realize that I've



Mr. Ballenger

always tried to put together a bill that was defensive: What would we put on the floor to defend our-

selves against some crazy Democrat bill that was coming up.

The basic idea is OSHA has lost its purpose. Its purpose started off being the health and safety of workers, and now it's been more like a cop on the beat who gets rewarded for the number of tickets he can hand out. And it has become an anti-business operation of the federal government.

Which reforms do you think will be easiest to pass, and which hardest?

See Ballenger on page 6

**Updates**

**Insurer income off in 1994**

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return on net worth to drop to 5.5% from 10.4%.

The industry's combined ratio deteriorated to 108.5% in 1994 from 106.9% in 1993. The biggest culprit for the industry's \$22.4 billion underwriting loss last year was the Northridge earthquake, which caused an estimated \$11.7 billion in insured losses. Total catastrophic losses of \$16.2 billion made 1994 the second-worst catastrophe year after 1992.

Slumping equity and bond markets limited growth in investment income to 1.2%—\$33 billion, up from \$32.6 billion. Realized capital gains fell 72.4% to \$1.7 billion from \$9.8 billion.

ISO also said that industry surplus grew 4.6% to \$190.6 billion from \$182.3 billion at year-end 1993. As a result of the soft market, premium growth also slowed, to 3.4% in 1994 from 6.1%.

**Bronx fire claims settled**

NEW YORK—Scottsdale Insurance Co. will fund the largest portion of a \$15.8 million settlement to the families of 92 people killed or injured in a 1990 fire at an unlicensed Bronx nightclub.

Morris Jaffe and Jay Weiss, who sublet the building containing the Happy Land Social Club from its owner, Alexander DiLorenzo III, bought a primary and excess liability program with limits of \$6 million from the Scottsdale, Ariz.-based insurer. It will pay the full amount of the policies plus \$800,000 in interest.

Contributing a total of more than \$2 million are three other insurers—Landmark Insurance Co., a unit of American International Group Inc.; Transamerica Insurance Co.; and Federal Insurance Co., a unit of Chubb Corp.—which together wrote \$26 million in primary and excess liability coverage for properties owned by Mr. DiLorenzo.

Contributing a total of about \$5 million are 12 companies that manufactured products in the building and their insurers. Alexander & Alexander Services Inc., the broker for Messrs. DiLorenzo and Weiss, also agreed to pay \$200,000; and the City of New York \$250,000.

Several factors made the case hard to pursue: The club owner, who was killed in the fire, sublet from Messrs. Jaffe and Weiss and was uninsured; Mr. DiLorenzo has filed for bankruptcy protection; the building housing the club was not listed as an insured property on Mr. DiLorenzo's policies; and Mr. Weiss became effectively judgment-proof after selling most of his property to his wife, actress Kathleen Turner.

"Getting records was tough," said Michael Lippman, a lawyer with the Bronx County Public Administrator's office, which represented the families of 55 of the 87 people killed in the fire (BI, April 2, 1990).

**CHA pension fraud indictment**

CHICAGO—With the trial of two defendants in a Chicago Housing Authority pension fund fraud case still two months away, federal law enforcement officials haven't ruled out asking a grand jury to add additional charges or defendants to the indictment.

For now, the indictment names only Joseph Polichemi of London and Fort Lauderdale, Fla., and Lyle E. Neal of Hi Hat, Ky., on wire fraud charges in connection with an investment scheme that caused a loss of more than \$13 million from CHA pension funds. But the U.S. Attorney's Office could ask the grand jury to add charges or defendants, said Assistant U.S. Attorney Brian Blanchard.

John D. Lauer, the CHA's former director of risk management and benefits, who placed the authority's funds in the investments (BI, June 27, 1994), has not been indicted.

Messrs. Polichemi and Neal—who allegedly promised to put the funds in investments earning returns of 25% to 75% that did not exist—are set to go to trial Sept. 11 in U.S. District Court in Chicago.

Meanwhile, the CHA has made no claim against its \$1 million public officials liability policy with the Housing Authority Risk Retention Group. When the loss was revealed last year, CHA officials said it was fully insured. Since then, "we advised them that they were not fully insured," said John Salisbury, HARRG's chief executive officer.

**Senate reviewing regulations**

WASHINGTON—The Senate will consider major changes to the federal regulatory system this week as debate begins on a new version of the Comprehensive Regulatory Reform Act of 1995.

The bill, S. 343, would require federal agencies like the Occupational Safety and Health Administration and the Environmental Protection Agency to subject most proposed federal regulations that have an annual economic impact of at least \$50 million to cost/benefit analysis. The bill, sponsored by Senate Majority Leader Robert J. Dole, R-Kan., and Sen. J. Bennett Johnston, D-La., also would allow judicial review to determine whether agencies were obeying that law.

Federal agencies also would be required to publish a list every five years of any existing regulations they intend to review along with a schedule for completing the reviews within the next 11 years. Rules subject to review would include those deemed unnecessary, out of compliance with the cost/benefit requirements, or those that could be revised to save money or enhance benefits.

**College gets endowed chair**

NEW YORK—The College of Insurance plans to appoint a "world-class professor" to a \$1.5 million endowed chair established by X.L. Insurance Co. Ltd., says Ellen Thrower, president of the college.

The endowment honors Michael J. Kevany, the former chairman, president and CEO of the Bermuda-based insurer, who died in May.

The endowment strengthens ties between the college and the Bermuda community, said Gavin Arton, senior vp of X.L.

The professor who is appointed to the post will focus on cutting-edge issues, particularly on risk financing, Ms. Thrower said.

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**OxyChem settlement insured**

By MICHAEL BRADFORD and SARA MARLEY

CORPUS CHRISTI, Texas—Occidental Chemical Corp. has insurance coverage to pay the \$65.7 million settlement of a class-action lawsuit filed by residents who claim they were injured by a chemical released from an OxyChem plant located near their homes.

The Dallas-based subsidiary of Occidental Petroleum Corp. agreed to the settlement in the 105th State District Court in Corpus Christi, Texas, late last

month.

The settlement came several days after a jury awarded small cash payments for actual damages to five of 12 plaintiffs who originally brought the suit on behalf of 8,600 residents of Robstown, Texas.

The plaintiffs claimed health problems caused by the 1992 release of the chemical butadiene at the Corpus Christi plant.

The settlement offer was made before the jury considered a punitive damage award after finding Occidental Chemical acted with gross negligence and malice in the

chemical release.

Occidental Chemical has primary liability coverage written by a subsidiary of American International Group Inc. in New York and excess insurance coverage written by two Lloyd's of London syndicates that is sufficient to fund the settlement, according to Mark Romness, an attorney with Occidental.

State District Court Judge Manuel Banales was scheduled last Friday to hear arguments against the agreement from an attorney who represents plaintiffs outside the class action. **BI**

**HMO aims to boost revenues from medical centers**

**FHP positioned for growth**

By JUDY GREENWALD

FOUNTAIN VALLEY, Calif.—FHP International Corp.'s move to reorganize its 57 medical centers to accept fee-for-service patients and provide services to other health maintenance organizations and preferred provider organizations is a smart strategic move that could increase competition in the market, many health care observers say.

The Fountain Valley, Calif.-based HMO plans to create a physician practice management company, to be called Comprecare

Medical Group, that will encompass FHP's staff model operations in Arizona, California, Nevada, New Mexico, Utah and Guam. At least initially, FHP's HMOs would be its major customer, although the group will operate independently (BI, July 3).

Regulatory approval for the new company, which will include more than 500 doctors and 95 dentists and have more than \$350 million in annual revenue, is expected by Jan. 1. FHP also plans to sell its four hospitals.

FHP, which was founded in 1961, was purely a staff-model

system until about eight years ago, when it started to contract with private practice physicians and hospitals rather than exclusively provide care directly in its own medical centers "and that business took off dramatically," a company spokeswoman said. After the acquisition of TakeCare Inc. last year (BI, Jan. 17, 1994), 80% of its business was in a contract delivery network and only 20% in its staff model or medical center operations.

At the same time, the spokeswoman said, California was going *See FHP on page 9*

**Benefit education making strides**

By CHRISTINE MANY

PHILADELPHIA—Employee benefit educators are constantly adjusting their curricula to reflect changes in the field.

Some of those changes, such as increases in managed care programs and a federal pension reform law, have generated an "increased awareness" of the employee benefit field among students, said Jerry Rosenbloom, a professor of insurance and risk

management at the University of Pennsylvania's Wharton School.

Five years ago, the Philadelphia-based business school recognized the importance of studying employee benefits when it established the nation's first professorship in employee benefits. That professorship was made possible through a \$1 million endowment from the Brookfield, Wis.-based International Foundation of Employee Benefit Plans.

*See Wharton page 20*



Olivia Mitchell holds the benefits professorship at Wharton.

**Dependent care services directory deadline**

*Business Insurance* will publish its second annual directory of firms that provide dependent care resource and referral services in the July 31 issue. Accompanying the directory will be a Spotlight report on trends in work and family benefits.

The directory is published as an editorial service and there is no charge to be listed. However,

to be included in the directory, companies must provide dependent care resource and referral services to corporate and institutional clients in at least three states. Also, a questionnaire provided by BI must be completed and returned by the deadline.

Resource and referral services must be offered on a stand-alone basis. Actual dependent care

and benefit consulting services are not considered to be resource and referral services.

If your company would like to be listed in this directory and you have not yet received a questionnaire, please call Kathy Welyki at 312-649-5279.

The extended deadline for returning completed questionnaires is July 17.

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- Uncertainty at Lloyd's of London is causing some realignment of the market's syndicates. **PAGE 17**
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# Muni bond insurers see slow first half

## Competition increasing in '95

By JUDY GREENWALD

Declining municipal bond issuance caused by higher interest rates and an uncertain political environment is increasing competition among municipal bond insurers.

Although growth in bond issuance was less-than-stellar in the first half of the year, insurer executives predict that volume will pick up in the second half.

Still, volume is highly unlikely to reach the \$291.3 billion level of 1993, when lower interest rates sparked a large volume of refunding. Refundings occur when an existing bond is retired by issuing new securities, generally at a lower interest rate. As interest rates rise, though, refundings make less economic sense.

By 1994, the volume of bonds issued dropped to \$164 million and some observers predict that 1995 volume will decline further to between \$125 billion and \$150 billion.

For the first half of 1995, according to industry figures, new

issue volume was \$69.2 billion, down 25.4% from the same period in 1994. Insured volume dropped an essentially parallel 22.5%, to \$27.1 billion. Thirty-nine percent of the new issues were insured, about the same as in first-half 1994.

"You had such an enormous amount of volume in '92 and '93, particularly with the large amount of refunding, so anything that follows is going to look poorer in comparison," noted Mike Romanowski, vp at Conning & Co. in Hartford, Conn.

Higher interest rates, leading to a drop in refunding, are considered a key factor in the decline. With higher interest rates, even new money issues are down this year, he noted.

Higher rates also may lead issuers to delay new issues, said Brady Tournillon, an analyst with Fitch Investors Service in New York.

Other factors were at work as well, however, including political forces. There were 17 governors, *See Muni bond on page 23*

# Trickle down savings

## Small firms also can reap benefits from risk management programs

By MICHAEL BRADFORD

SAN FRANCISCO—A successful risk management program can provide bottom-line benefits to smaller companies as well as their larger corporate counterparts, according to two corporate executives with experience.

"Positive financial results are possible—even within a small firm—with solid, long-term risk management programs," said Charles A. Martin, treasurer and director of finance and administration at Bommer Industries Inc. in Landrum, S.C.

He was speaking at the Second Annual Liberty Mutual Risk Management Conference in San Francisco, sponsored last month by Boston-based Liberty Mutual Insurance Group.

Also speaking at the conference, Stephen W. Nislick, executive vp of administration at Edison Parking Corp. in Newark, N.J., related

the various exposures the parking garage company has to manage in its efforts to maintain a successful risk management program that has reduced claims in half.

A successful program must be built on principles that "fit the firm" for its particular exposures, said Mr. Martin of Bommer Industries, which is a 119-year-old maker of hinges and apartment mailboxes with annual sales of less than \$25 million.

In designing its own risk management program, Bommer Industries put together a safety plan that caused some of the financial decision-makers in the audience to sit up and take notice.

Earlier this year, the company's 200 employees completed 3 million labor hours without a lost-

time accident. "This represents over eight years without a lost-time accident," Mr. Martin emphasized.

As a result, Bommer Industries has averaged a 34% refund of its workers compensation insurance premiums during the past five years. In 1994, Bommer Industries reported 15 workers comp claims that totaled just \$6,621. From 1990 through 1994, there were 56 claims—none resulting in lost time—amounting to only \$43,809.

The key to such success in controlling workers compensation claims is being committed to establishing a safety program that works and frequently communicating with employees and insurers, Mr. Martin stressed.

A small firm can find its size is an advantage in dealing with employees, Mr. Martin said, allowing the company to understand and "impact its risk better than a

*See Small on page 10*



# Skandia America deja vu

## Dowd returns to old post to reposition reinsurer for growth

By JUDY GREENWALD

NEW YORK—James F. Dowd is back as the chairman and CEO of Skandia America Reinsurance Corp. and is developing a business plan to position the reinsurer to take advantage of opportunities in the market.

Mr. Dowd, who had been chairman and chief executive of New York-based Skandia America, a unit of Stockholm-based Skandia Group, from 1984 to 1992, returned to his old position July 1. From 1993 until last month, he was chairman and CEO of Willis Faber North America, a reinsurance brokerage subsidiary of Wil-

lis Corroon Group P.L.C.

"I left originally because the public offering that we tried to do in 1992 unfortunately had to be withdrawn for reasons that had more to do with the economic conditions in Scandinavia than anything else," said Mr. Dowd. "I was disappointed by that" (*BI*, Oct. 5, 1992).

However, he said, "When I left Skandia, I left under very good terms with my Swedish colleagues. I kept in pretty regular contact with them over time and over the last few months we've had increasing discussions. It became clear we shared a common view with respect to the U.S. mar-

ket, and they thought—and I agreed—it was probably time to reassess their position in the U.S. reinsurance market.

"Since we were so similarly inclined as to where we thought it was going directionally," Mr. Dowd said, he was asked to rejoin the company.

Discussing the market's direction, Mr. Dowd said, "I am generally of the view that in this business, and perhaps in reinsurance, bad news often translates into good news."

Mr. Dowd cited the expected continuing consolidation in the insurance business, as illustrated *See Dowd on page 23*

# Mental health care purchasing group

## Employers, unions form coalition to negotiate high-quality care

By MICHAEL BRADFORD

PHOENIX—A group of mostly self-insured Arizona employers and unions is forming a unique coalition to provide workers mental health and substance abuse benefits in a managed care plan.

The participants—six employers and two labor unions—are developing a plan that will work for a group with diverse working conditions and business interests while satisfying management and labor representatives.

Coalitions often "come together with well-intentioned ideas that can be agreed upon by all the companies," said Louis Giallonardo, vp with The Segal Co. in Phoenix. "But when it comes down to making the final decision, they often struggle and end up taking the route that is least resistant: group purchasing."

However, Mr. Giallonardo, who worked as a consultant to the coalition—dubbed The Arizona Healthcare Evaluation Project—said this group was more concerned with quality of care than in negotiating price discounts.

The project also differs from some other coalitions because it consists of a group of "strange bedfellows" that at first glance wouldn't appear likely to band together to purchase health care coverage.

The members of The Arizona Healthcare Evaluation Project are: Arizona Public Service Co.; grocery store chain ABCO Markets Inc.; Cable Systems Inc.; grocery store chain Bashas'; Fry's Food Stores of Arizona Inc.; Magma Copper Co.; Southwest Teamsters Local 104 Security Fund; and United Food & Clerical Workers Local 99R Health & Welfare Trust Fund.

It's unusual to see a large group with such varying interests come together to agree on health care benefits, said Gary Petersen, managing principal at Buck Consultants in Phoenix. "Self-interest stands in the way of a lot of these groups forming," Mr. Petersen added.

The coalition not only is putting together a managed mental health care/substance abuse program but also will develop programs in the Phoenix area that will establish cardiovascular centers and provide benefits that meet women's health care needs.

The idea for the coalition came from Fry's Food Stores, whose management was interested in banding together with other employers to establish a managed care health plan that would include mental health care benefits and substance abuse benefits.

Fry's was familiar with the benefits of a coalition because of the experience of its parent, The Kroger Co. of Cincinnati, which participated in a successful purchasing coalition.

Mr. Giallonardo said much of the credit for the coalition's development goes to James Nygren, director of labor relations at

*See Arizona on page 10*

# Medicare cuts may shift costs to employers

By JOANNE WOJCIK

SAN DIEGO—Employers that have negotiated deep discounts with health care providers are in for a rude awakening if they expect the savings to survive future Medicare and Medicaid cuts, a health care economist warns.

He also chastised employers for increasingly turning the job of purchasing health care coverage over to their employees.

In addition, employers must redefine their commitment to providing health care benefits if they are to survive in today's competitive world economy, a benefit consultant insists.

Over the past three to four years, Medicare payments to hospitals and health care providers have increased, allowing many private payers to negotiate significant discounts, said Stuart H. Altman, a professor in the Heller Graduate School at Brandeis University in Waltham, Mass., during a session titled "The Future of Employer-Provided Health Care Benefits" at the 45th annual Group Health Institute. The conference, sponsored by the Group Health Assn. of America, was held in San Diego June 18-21.

This trend followed an earlier period during which providers

that received less funding from the federal and state governments simply passed on the cost of uncompensated care to employers, according to Mr. Altman.

"When the payment structure of Medicaid and Medicare faltered during the latter part of the 1980s, the privates were forced to pay more," he said. "This was called the great cost shift."

"But, what has happened over the last couple of years?" Mr. Altman asked.

"Medicare and Medicaid have become much better payers to American hospitals over the last three or four years," he said.

And while employers in recent years have prided themselves with using their bargaining clout to negotiate discounts, "maybe it turns out that you had a hospital system that was willing to give you those discounts" because "Medicare and Medicaid actually became better payers," he suggested.

Acknowledging this correlation, employers today should be asking themselves "what's going to happen in the latter part of this decade as these numbers turn sour?" he asked. "Will the providers have the ability to" shift the cost to the private sector?

"If it is true that you have the market power that you think you have, then the answer will be no, they will not be able to, and cost-shifting will be in trouble," he said.

"But, it may turn out that your job's going to get a lot harder," Mr. Altman asserted.

"When you go to extract those discounts in 1996, you may find a hospital that says, 'I'm sorry, I give it to you then I'll go broke. You'll just have to take my price,'" he said.

But Mr. Altman was highly critical of employers that have given up the health care cost fight either by discontinuing health care benefits or by discouraging employees from enrolling spouses and dependents.

He also criticized employers that offer their employees a flat dollar amount for health care expenditures under flexible benefit plans.

"Look at what's happening to the employer-based system" for providing health care coverage, he said. "Between 1988 and 1991, there was a reduction in employer-sponsored insurance by 2.7%."

And despite improvements in the economy in 1992 and 1993, the number of uninsured increased to 41.3 billion in 1993 from 34.7 billion in 1989, he added.

In 1994, only 61% of Americans were covered by employer-based insurance, down from 67% in 1988, according to statistics gathered by Brandeis University.

At the same time, Medicaid coverage increased to 13% of the population from 9% and the per-

*See Cutbacks on page 16*

# Lack of interest kills purchasing group plan

## Benefit Beat

BROOKFIELD, Wis.—Plans to create a group purchasing cooperative for small employers in southeastern Wisconsin have been grounded due to the lack of interest among area agents, brokers and health insurers.

The Health Care Network of Wisconsin, an employer-sponsored health care purchasing organization that currently provides insurance to more than 247,000 individuals, had attempted to form a purchasing group to provide small businesses better access to more affordable health insurance.

The network had planned to form the Wisconsin Health Insurance Purchasing Program, which would have served as a voluntary regional cooperative offering a range of health insurance options to small

employers (BI, Dec. 12, 1994). The purchasing program's purpose was to achieve small group market reform in southeastern Wisconsin without having to resort to legislation, said Jim Wrocklage, chief executive officer of the network.

In December, the network requested proposals from area brokers, agents and consultants, listing the group's requirements for guaranteed issue, continuity of coverage, modified community rating and comparable premiums for all participants. The program would have offered a standardized set of comprehensive medical services through various accountable health plans, including health maintenance, pre-

ferred provider and point-of-service plans.

However, the response among area health insurers and brokers was so minimal that, according to Mr. Wrocklage, it is "not enough for us to go forward." In fact, he said, the group has no plans to pursue it further until the market demands it or the state requires it.

Consultants who worked on the project noted that the insurers were probably concerned about changes in standard underwriting and rating procedures. And, they pointed out, the absence of state reform legislation probably played a part in insurers' decisions not to participate.

Meanwhile, Mr. Wrocklage reported that the Health Care Network of Wisconsin continues to grow and to control health care

costs for its current larger members.

In 1994, 217 self-insured companies and insurers participated, up from 198 in 1993. The number of people receiving coverage grew 7.7% to 224,305 at year-end 1994 from 208,105 in 1993. Of those covered, 89,722 were employees in 1994, up 7.8% from 83,242 in 1993.

Mr. Wrocklage said the number of inpatient and outpatient claims rose in 1994, but he noted that the number of inpatient days dropped, mirroring a national trend.

"The real value in our collective purchasing program is in real dollar savings," he asserted. "HCN members saved an average of 34.3% on inpatient charges in 1994 and 19.2% on outpatient claims" due to the group's power to negotiate with

health care providers.

—By Christine Woolsey

## Benefit communication

More companies are using sophisticated technology in their benefit communications, but many are unsatisfied with the results of their promotional efforts, according to a new survey.

Although employers are turning to high-tech communications methods like interactive software, voice-response phone systems and video-based training, only about one-third of the companies said they are satisfied with the results.

The survey of more than 1,500 communications and training professionals by Watson Wyatt Worldwide found that the use of interactive software and voice-response systems in benefit communications programs nearly tripled to 25% in 1994 from 9% in 1991.

More than half of those surveyed, 53%, also said they are using electronic mail for strategic communications programs and 39% said they are now communicating with employees through audio-visual presentations, up from 33% in 1991, the last time Wyatt did a similar survey.

"By leveraging advances in technology—ranging from interactive software to multimedia video disks—companies hope to boost corporate communications and training effectiveness," said Paul Sanchez, a consultant with Watson Wyatt.

Still, new technology has put up a rather unimpressive record in benefit communications, the survey points out.

Only 35% of employers said they were "satisfied" or "very satisfied" with the results of their efforts to promote and explain employee benefit changes through communications projects.

Employers cited two primary reasons for poor response:

- Lack of strategic focus. Despite some gains, communications remains a very small part of strategic planning. Only 56% of companies said their benefit communications objectives are directly related to their organizations' business objectives.

- Too much reliance on top-down communications. Employers are devoting too many resources to top-down communications like management memos and newsletters as opposed to upward, two-way communications like open meetings and focus groups.

"Employees do not change their mindsets and behaviors because management says to do so," noted Mr. Sanchez. "To change employee behaviors, organizations need to listen as well as talk."

That obviously isn't happening, at least to judge from the survey results. Only 4% of companies surveyed rated their upward communications programs as "excellent," and just 27% said they were "good."

The survey also made it clear that despite growth of technology, companies are still relying mostly on traditional communications methods. For example, 90% of respondents said they use ongoing employee publications to communicate change; 87% use benefits summary plan descriptions; 82% use bulletin boards and 75% use employee memos.

The survey is available for \$125. For copies, call Barbara Dickens, 202-508-4846.

—By Michael Schachner



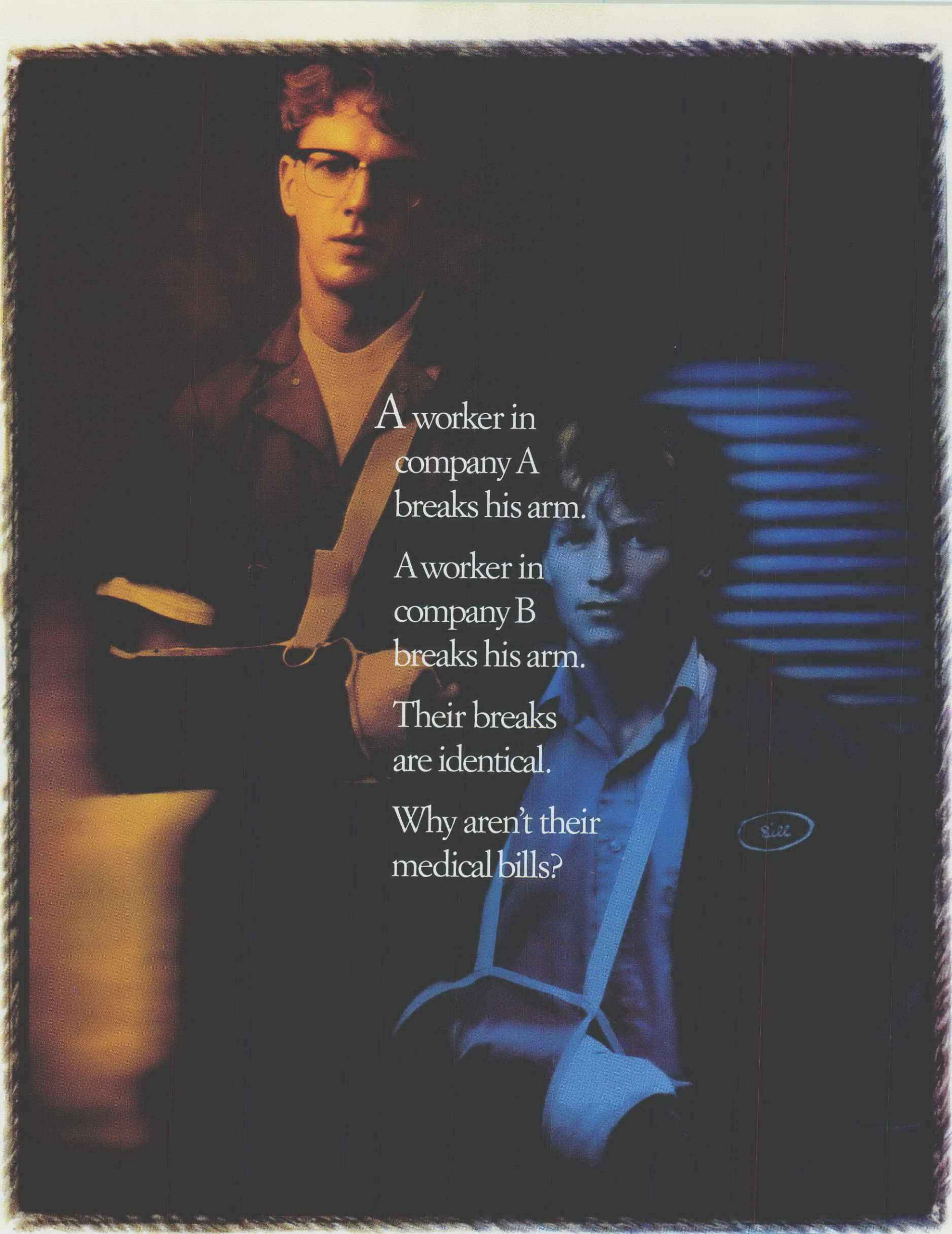
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# PBGC may require more plan data

Proposed regs would require certain employers to provide detailed information

By JERRY GEISEL

WASHINGTON—Employers that have more than \$50 million in unfunded pension liabilities or that have skipped making a required contribution of at least \$1 million will have to disclose new actuarial and financial information directly to the Pension Benefit Guaranty Corp. under proposed regulations.

The regulations, proposed July 6 by the PBGC, also would apply to employers that have received a waiver from the Internal Revenue Service allowing them to temporarily defer contributions of at least \$1 million to their pension plans.

Actuarial information to be filed with the PBGC would include the value of plan liabilities and plan assets, as well as the distribution of participants in five-year age groupings.

Financial information would include audited financial statements, such as balance sheets and cash flow and income statements. If audited statements were not available, unaudited statements could be provided.

If an employer already provides this information to the Securities and Exchange Commission, the company could file a statement to the PBGC indicating when the

statements were made public and where the PBGC can obtain the information.

In cases where a company does not have audited or unaudited financial statements, it could file a copy of its tax return to the PBGC.

Generally, the actuarial and financial information would be due no later than 105 days after the close of the employer's fiscal year. In the case of an employer with a fiscal year ending on Dec. 31, the actuarial and financial information would have to be filed by April 15.

Alternatively, employers could file the required actuarial information no later than 15 days after the dead-

line for filing their pension plan's annual report.

Employers with underfunded plans with fewer than 500 participants would be exempt from filing the actuarial information as long as they do not have any outstanding IRS funding waivers or missed contributions to their plans.

The PBGC has proposed that the rules apply beginning next January. The PBGC estimates that about 100 employers would be affected by the new rules. Employers that fail to provide the information would be subject to a penalty of up to \$1,000 for each day the information is late.

The reporting rules are intended

to give the PBGC more detailed and up-to-date information about the financial condition of employers with underfunded plans and the relative health of their plans. That will allow the agency to move faster to put pressure on companies to step up contributions to underfunded plans, benefit experts say.

But benefit experts do see some potential problems.

They say the rules should be clarified so that privately held companies that submit requests with the IRS for an extension on filing tax returns should be allowed to delay filing financial information with the PBGC.

Still, "overall, the PBGC has tried to be pretty flexible and reasonable in the information they are requesting," says Larry Sher, a partner with Kwasha Lipton in Fort Lee, N.J. **[B]**

## Ballenger

Continued from page 1

The consultation part should be the easiest; I think they're already doing that. In fact, there are several things in the Maine 200 project that are working right now. It's not quite as permissive as mine, it's more mandated. But I think that part of it will be far and away the easiest.

*Editor's note: In the Maine 200 project, OSHA targeted the 200 employers that reported the highest number of workers compensation claims to identify their primary workplace hazards. Companies in the project identified 95,000 hazards and corrected the majority of them within two years, according to OSHA Administrator Joseph Dear (BI, Dec. 12, 1994).*

Most difficult is putting OSHA and the Mine Safety and Health Administration together, though there's good justification for it.

The mine workers think they've got the greatest thing in the world and everybody else recognizes how

bad OSHA is.

**Some people have pointed to the Mine Safety and Health Administration as a more effective and better targeted agency than OSHA. Do you see any possible negative impact on it by combining it with OSHA?**

Well, the gimmick you got is OSHA's budget is \$300 million and MSHA's is about \$240 million, so it's almost as big.

Yet MSHA has only about 14,000 workplaces to take care of, whereas OSHA has 6 million. MSHA has done the job that was there, and it's gotten to the point that every mine always has some inspector in it.

As far as I can tell, if you've got a perfectly safe mine with no history of accidents, you don't need somebody there all the time.

So what our bill does is change the mandate from four inspections a year to one inspection a year. And for a bad mine, you can expect an inspection 10 times a year. But why should you tie up people that way?

OSHA is just completely undermanned and underfunded. Possibly

by putting the two together, you can cut off a lot of the overhead and you can contract out to private contractors. Then you should be able to do a better job with a lesser amount of money.

**Private contractors also would act as consultants and inspectors and be certified through some central authority?**

They'd be certified through OSHA or some training program, but the consulting services would be paid for by the manufacturer. It wouldn't be an expense to the operation of OSHA.

**Given your own experiences as a businessman, if you could enact only one of the changes in your bill, which would it be?**

I don't think there's any one—you have to have about two or three to really make it work.

Subjecting standards to cost/benefit analysis and risk assessment and the consultation provision are the basic things needed for OSHA to actually work with business for the safety and health of workers in

a legitimate, sensible way.

**What impact will the reform bill have on state workplace safety programs, such as the one in North Carolina that came under intense criticism after it was learned that state inspectors never visited a poultry processing plant in Hamlet, N.C., where more than 20 workers died in a 1991 fire?**

**Subjecting standards to cost/benefit analysis and risk assessment are needed for OSHA to work with business in a sensible way.**

I hope it would get state programs to work in the manner in which we're trying to get the federal program to work. I think the states are further along in doing this than the feds are. I know in North Carolina at the present time, they have independent contractors. If you ask North Carolina OSHA: "Do you have anybody who will help me without coming in and penalizing me?" they'll give you the names of some people who will come in, go through your plant and straighten it all up so that you don't have to worry about OSHA when they come. And that's what we'd love to see the federal government do.

**So this bill actually would be taking something from the state experiences and building that into the federal system?**

What we're trying to do is take the good parts that we know exist throughout the country that are not in the federal operation and then put them into the federal program.

**The idea of cost/benefit analysis and industry-specific risk assessment enjoys considerable support from risk managers. Do you see significant opposition to this approach and, if so, where is that opposition likely to come from?**

One thing to be sure that mine owners and mine workers know is that the inspectors they've got now are the ones they're going to continue to have, because they were mine workers and they understand it.

The big argument we had in the past was the fact that OSHA inspectors really didn't know the business they were inspecting.

We have put into the bill that OSHA inspectors should be, if not perfectly industry-specific, at least knowledgeable of what manufacturing is or what construction is. Obviously, one of the worst things

they've got right now is the fall standard. You shouldn't have the same fall standard for a guy climbing a telephone pole as you do for a roofer. They're two completely different things. Yes, there should be some variation along those lines.

**And the cost/benefit analysis is the same trigger as the House regulatory reform bill, \$25 million?**

Yes.

**What's the outlook for the bill? Do you foresee serious difficulties in working out a measure that will be acceptable to both the House and Senate? Has the administration given any indication whether it will accept any reforms?**

I think we're at over 80 co-sponsors now, both Republicans and Democrats. Surprisingly, the difficult part of the thing is, the really anti-bill people in this thing want to do away with OSHA tomorrow.

I'm a businessman, and I realize there are crooks out there and dishonest people, so I think there's a need for OSHA. It just needs to change its direction.

As far as I can tell, we'll get it through the subcommittee, we'll get it through the full committee, I actually think we'll pass it on the floor. Just in discussions I've had with Senate staff, you may find them picking up this bill and having it run in the Senate, too. It would be great if we both ran the same bills.

**There are other bills in the Senate, right?**

Oh, yeah, the Senate's got about three or four bills, where we only have two. One of the House bills does away with OSHA, that's Rep. Joel Hefley's, R-Colo., bill, and there's mine. And, as far as the administration's concerned, surprisingly they have recommended a whole bunch of the stuff that's in this bill. The truth of the matter is the whole attitude of OSHA changed last Nov. 8. And it's a different ball game now.

I'd like to redirect OSHA in such a way that were we to lose control of the House in the next election, they couldn't turn around and run it back the way it was before.

Regulations they can turn around themselves, but if the law is there, at least they'll have to fight to change it. **[B]**

# Carvill

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## Opinions

## Superfund starting point

ALTHOUGH WE have yet to see major Superfund reauthorization legislation this session, one of the lawmakers charged with putting together a bill is providing a road map to reasonable reform.

In fact, the reform "outline" recently released by Sen. Robert Smith, R-N.H., to elicit comments on Superfund goes much farther than many risk managers would have dreamed possible only a year ago.

Sen. Smith, chairman of the Senate Environment and Public Works Subcommittee on Superfund, Waste Control and Risk Assessment, makes clear that he wants a total overhaul of Superfund's liability system (BI, July 3). Not surprisingly, he singles out Superfund's imposition of retroactive liability for cleanups resulting from actions that were legal at the time they occurred as one of Superfund's greatest inequities.

"When Superfund was originally adopted in 1980, its primary purpose was to clean up hazardous waste sites that threatened human health and the environment," wrote Sen. Smith as he explained the principles that guide his Superfund reform plan.

"The adoption of retroactive liability to pay for this program has unfairly penalized a number of individuals and corporations that disposed of hazardous materials in compliance with then-existing federal and state environmental laws," he wrote.

In addition, Sen. Smith notes that the current liability system invites litigation, which has been singled out as one of the major impediments to actual cleanups.

Litigation, he writes, "has resulted in slower cleanups and more money going to lawyers."

Sen. Smith's outline stops short of entirely abolishing retroactive liability, though.

His proposal would repeal retroactive liability for legal dumping that occurred before Dec. 11, 1980, the date the Comprehensive Environmental Response, Compensation and Liability Act that created Superfund was enacted. Many risk managers and insurers would like retroactive liability repealed for legal acts that took place before 1987, when Congress last overhauled Superfund.

For those held liable for cleaning up sites that were fouled after CERCLA's enactment, Sen. Smith advocates replacing the current system of strict, retroactive and joint and several liability with a system of proportionate liability. While this would not be as broad a reform as repealing all pre-1987 liability, we think it would be infinitely fairer than the current system.



- TWO LEAKS TO PLUG -

As the outline puts it, "no person shall be held liable for more than the share of removal, response or natural resource damage costs attributable to that person's conduct." An independent allocator would apportion liability, and those that accepted the allocation would be protected from further assessment. Those who refused could be sued by the federal government.

Sen. Smith, of course, deals with more than liability allocation in his 15-page outline. He also calls for: more flexibility in selecting remedies for polluted sites; limits on the liability of lenders for cleaning up land they've acquired through foreclosure; new limits on how many sites can be added to the National Priorities List of the sites most in need of cleanup; and a greater state role in cleanup administration.

These are all guideposts to Superfund reform. Questions such as exactly when retroactive liability repeal should kick in remain for Congress to decide.

Sen. Smith's counterpart in the House, Rep. Michael Oxley, R-Ohio, has yet to issue a bill or reform outline, though it is not likely that his proposals in general will differ dramatically from Sen. Smith's.

Debate over Superfund should begin in earnest this summer. With the Smith outline serving as the starting point, the road to meaningful reform should be clearer than it has been at any time since Superfund was enacted nearly 15 years ago.

tives—mainly property insurance—in the 1950s and '60s.

Also, the major surge in captive incorporations that took place during the '73-'84 period was to reinsure and fund some portion of the parent's primary casualty program. Perhaps "another evolution" simply means that what goes around comes around.

In the same article, an executive from Aon Captive Management Inc. is quoted as saying "risk managers are pretty smart these days," the implication being that the earlier crop had lower IQs or that risk managers of the '70s and '80s who are still in the profession somehow got brighter.

The remark follows the comment that risk managers are seeking 30% to 40% of their premium from "controlled third-party business" to achieve tax deductions. That was tried before by many captives with universally disastrous results.

Possibly the key word that may make

it different this time around is "controlled." Some examples of what that may be might have been illuminating for your readers. Thirty percent to 40% is a lot of premium for a significant captive insurer. Insuring employee benefits won't do the trick. Where does that premium come from?

Is there really anything particularly new about the part captives may play in a risk management program?

While some captive insurance companies may have bought into finite risk programs, they do seem akin to chronological stabilization plans, which were touted 30 years ago.

I believe most financing techniques—forget derivatives—have been tried, but there is an ebb and flow in their usage depending on insurance market conditions and a natural turnover of financial and risk management executives.

S. Peter Law  
Consultant  
Rowayton, Conn.

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## Letters

## 'Another evolution' that looks awfully familiar

To the editor: The May 29 issue contained an article, "Captives' Appeal to Corporations Remains Strong," about trends in captive insurance company activities.

It characterizes single-parent captive funding of deductible and retention programs as "another evolution" of captive utilization.

I wonder what the risk management executives of many major American and British oil companies thought they were doing when they established their cap-

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# FHP

Continued from page 2

through an economic downturn and many employees who had been using its medical centers were laid off, leading to declines in its revenues. FHP, however, had to continue to pay fixed costs on the centers, which cut into its operating income.

By attracting other HMO and PPO members to its centers under the reorganization, "the end results, we hope, will be a dramatic increase in the revenue that comes in. The fixed costs are going to remain the same, so all that extra revenue will just fall to the bottom line."

Analysts and other observers say it is a good move.

"It seems like an intelligent decision," said Thomas Snow, an analyst with Buckingham Research in New York. Selling off the hospitals will eliminate that drag on earnings, he said. And bringing in non-HMO member patients will keep doctors busier "and hopefully make more money."

"My sense is they're headed in the right direction," said Steve Richter, Los Angeles-based health care practice leader for Watson Wyatt Worldwide in southern California. Staff-model plans generally are not growing and this new approach will make them "much more market driven in terms of flexibility."

"I think it's the right thing for them to do," agreed Randall Huyser, an analyst with Furman Selz in San Francisco. The staff-model operation "has really been a drain not only on profitability but also on management time."

**This new physician company may become an important competitor to doctor-owned chains,' says Thomas Snow.**

Furthermore, he added, "I think they decided that they might be able to create some incremental values for shareholders by separating it out as a separate company because this physician management area has been one of the hottest areas in health care."

FHP has said that Compicare may sell shares to the public to raise capital for future expansion and may spin off a portion of its shares to FHP shareholders.

The move "might make them a little bit more palatable to companies interested in merging or acquiring them," said Glenn Meister, a principal in the Los Angeles office of A. Foster Higgins & Co. Inc.

Compicare could also increase competition in the market.

"I guess longer term, this new physician company may become an important competitor to doctor-owned chains," said Buckingham's Mr. Snow.

"It could create more competition, especially in the Orange County market among the major doctor groups because FHP will no longer be a captive, he said. "But I think it will take time for them to wean away from being closely identified as an FHP affiliate, and the lion's share of their patients will still be FHP patients," said Mr. Snow.

"There's been a tremendous consolidation in the market, so if they can increase competition, that's a real positive for the purchasing community," said Watson Wyatt's Mr. Richter. "I think this is their

best shot at doing so because... I think their staff-model product has not been a highly desirable option for a lot of employers."

However, Michael LeConey, an analyst with RAS Securities in New York, pointed to FHP's recently appointed chairman, Jack Anderson, who had previously been TakeCare's chairman. "I don't think of Jack as a price cutter or taking a disrupting type of an approach."

"My guess would be that frankly he would probably capture more of the untapped market rather than necessarily pull market share away from somebody else. That's not really his style," he said.

"It will make the plan look a lot more similar to other competing HMOs, certainly in this marketplace," said Foster Higgins' Mr. Meister. But he added he is unsure whether this will make it more competitive. **BI**

# BC/BS plan ends claims handling jobs

ALBUQUERQUE, N.M.—New Mexico Blue Cross & Blue Shield is not renewing its contracts to process Medicare Part A claims in New Mexico and Colorado next year.

The Medicare Part A intermediary contract is with the Blue Cross & Blue Shield Assn., so operations will be assumed by another BC/BS plan based on competitive bidding. Medicare Part A covers hospitalization; Part B covers physician services.

Next year, the Albuquerque, N.M.-based company also will give up its contract for processing Medicare home health care and hospice claims in Arkansas, Louisiana, New Mexico, Oklahoma and Texas.

New Mexico BC/BS made the decision because of "performance issues" and business reasons, according to a company statement.

According to a spokeswoman for

New Mexico BC/BS, senior management last winter received an anonymous letter alleging that a 1990 provider audit conducted by the firm was faulty. Management investigated the audit and found "there may have been an overpayment" by Medicare to a Denver hospital that either was not discovered or was covered up, but "nobody knows exactly what the figure is," the spokeswoman said.

New Mexico BC/BS reported its findings to the federal Health Care Financing Administration, fired one employee and disciplined several others, the spokeswoman said.

According to a spokesman for the Blues plans, the investigation of the overpayment also uncovered evidence that performance reports were not correct. The Blues reported this to HCFA, which in conjunction with the inspector general's office of the

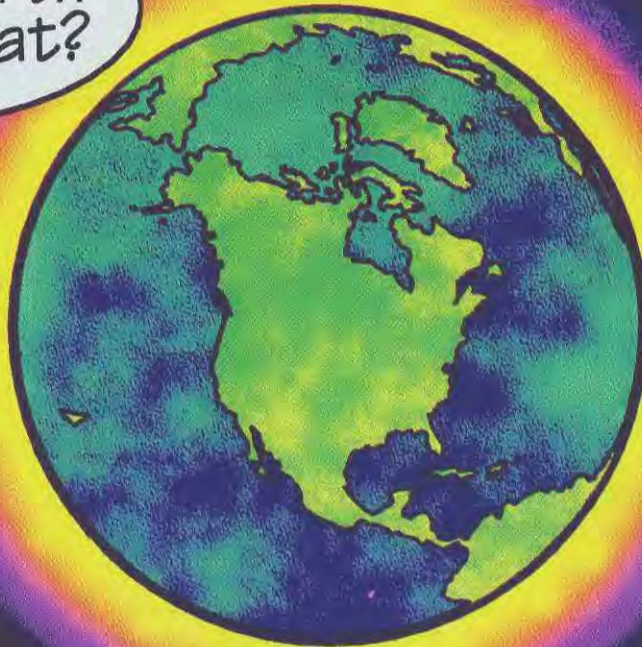
Department of Health and Human Services, began an investigation. The Blues launched a parallel investigation with an independent auditor.

"I believe this will be resolved within the next month or so. As far as we can tell, the problems are limited to those things we told HCFA about in the first place," said the spokesman. He said that the Blues had recovered \$1.9 million in overpayments from the hospital, which was then paid back to the government on June 23.

New Mexico BC/BS processes claims submitted by hospitals, home health agencies, hospices, skilled nursing facilities and certain other service providers. New Mexico BC/BS paid \$3.3 billion in total benefits and processed 4.9 million bills in fiscal 1994.

—By Deborah Shalowitz Cowans

Where on earth can I find that?



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## Study sees no linkage of implants, illnesses

BOSTON—A new study has found no link between silicone breast implants and connective tissue diseases.

Hundreds of thousands of women are seeking restitution from silicone gel breast implant manufacturers, alleging the devices made them sick.

About 400,000 women have registered to participate in a global settlement with implant manufacturers and 11,123 have filed lawsuits on their own.

But, those women may be more inclined to join the global settlement in light of "the mounting evidence of lack of connection," said Dean Hansell, a partner with LeBoeuf Lamb Greene & MacRae in Los Angeles who was involved in an early stage of coverage litigation involving implant manufacturers.

The study will carry particular weight because it comes from well-known researchers and prestigious institutions, added Mr. Hansell.

Doctors from Harvard Medical School and Brigham & Women's Hospital in Boston conducted the study, which was funded by the National Institutes of Health and published in the New England Journal of Medicine.

The study followed 516 women with definitive connective tissue disease identified through a survey of 87,501 nurses. Of the nurses in the study, 1,183 had implants, of which 876 were silicone.

Of the number of women who had connective tissue disease, only three had implants, and only one of these nurses had silicone implants.

Over a 14-year period from 1976 to 1990, the study found no evidence that scleroderma, rheumatoid arthritis, systemic lupus erythematosus or more than 40 symptoms seen in connective tissue diseases occurred more often in women with implants than in those without.

It is the largest epidemiologic study with the longest follow-up period conducted to date, but critics claim the number of women was inadequate and the method flawed because the women reported their own symptoms and were not examined by researchers.

Plaintiffs attorneys maintain that silicone implants cause a still-undefined disease with symptoms that may overlap those of connective tissue disease but not meet all of its diagnostic requirements.

—By Sara Marley

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## Small

Continued from page 3  
large firm because it knows its employees better."

Bommer Industries established incentive programs for its employees, offering free doughnuts, coffee and soft drinks each time workers reach 50,000 hours with no lost-time accidents and setting other benchmarks that rewarded workers with gifts and time off.

"Communicate, communicate," Mr. Martin emphasized. Safety should be stressed at every opportunity, including in memos from the company president that can be read at the end of employee meetings.

Bommer Industries posts a running total of hours without a lost-time accident and sets goals with rewards at increments of 250,000 hours.

The most important benefit of a successful safety program, apart from the financial savings, is high morale, Mr. Martin pointed out. Workers will view the company as a good place to work and will become proud of maintaining their safety record.

But, companies that succeed in improving safety in the workplace can't rest on their accomplishments, Mr. Martin warned.

Risk management decisions must be re-evaluated over time, he said. "Just because a risk management decision is proper for today does not necessarily mean that it always will be. What is a good decision today may change in five years due to the insurance market or factors at your company that would impact it."

Edison Parking Corp. found itself re-evaluating risk management decisions in the face of exposures that had conference attendees wondering why anyone would enter the parking garage business and whether they ever again should park in those facilities.

Edison Parking, which operates 140 garages and 10 mini-storage warehouse facilities nationwide, has 1,400 employees and gross revenues of about \$150 million a year.

Typical exposures Edison Park-

ing faces include slips, trips and falls. Vehicle owners who park in a garage expose the vehicles to weather damage, collision and theft of the vehicle or its contents. Customers are exposed to muggings and assaults, and some have been struck by cars in the garages, Mr. Nislick said.

In one case a few years ago, a car that had accelerator problems was driven down an elevator shaft by an employee.

And, in another, a new Mercedes-Benz was splashed with paint from a can crushed in a garbage truck while parked in an Edison facility. Some Edison employees, trying to be helpful, attempted to remove the paint with steel wool.

Edison Parking Corp. also faces

"We replaced our professional risk manager with one of our operating executives who had prior administrative experience" but no actual risk management experience, said Mr. Nislick.

Then the company developed a reporting system that connected risk management, executive management and operating personnel and reflected claims activity by separate facilities. A loss control committee was formed and chaired by Edison Parking's head of operations.

The operations personnel at each location emphasized to the company's facilities that the loss of a claim dollar equaled the loss of a dollar of revenue and operating personnel became responsible for loss control, Mr. Nislick ex-

## 'Just because a risk management decision is proper for today does not necessarily mean that it always will be,' warns Charles A. Martin of Bommer Industries.

exposures, such as water damage to contents, related to its mini-warehouse storage business, Mr. Nislick added.

About 15 years ago, with losses mounting and insurers retreating from Edison Parking, "we embarked on a program to establish a risk management department."

Two years after hiring a risk manager with a loss control background, loss experience was deteriorating further and efforts at risk management were failing, he said.

"We did not have the right person as a risk manager, we did not have the support of operating personnel and we did not have a reporting system which accurately reflected the cost of these risks to the individual facilities," Mr. Nislick said.

"After all this, we still believed in the effectiveness of loss prevention," he added. To rein in losses, the company decided to rebuild its risk management operation and hand much of the responsibility to its operations personnel.

plained.

Therefore, each facility became responsible for identifying the risks at their own operations.

Although the company now has a handle on controlling losses, like Bommer Industries, it cannot afford to stop being vigilant.

Edison Parking, which self-insures its third-party property and liability exposures, reduced claims to less than 3,000 from about 6,000 over seven to eight years.

The company buys coverage for workers compensation and garage liability and, even though it has more locations and exposures, its coverage costs 10% less now than it did 10 years ago, he said.

Mr. Nislick agreed with Mr. Martin that risks must be re-evaluated because their frequency and severity can change dramatically over time. "The effectiveness of programs and systems for preventing risks on an ongoing basis is the responsibility of the loss control committee" at Edison Parking, he said. **BI**

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in his election as  
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National Risk Retention Association



John H. Howard, Sr. Vice President  
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## Arizona

Continued from page 3

Fry's Foods. Mr. Nygren could not be reached to comment on the project.

"When this group first started meeting, one issue that I had was to make sure they talked about delivery of quality health care and not go on the path of becoming merely a volume-purchasing coalition," said Mr. Giallonardo.

Interviews were held with area hospitals and physicians to gauge the quality of care they could provide and that sparked a lot of interest, said Mr. Giallonardo.

That attention, in turn, put pressure on the group to do more than just beat the bushes. It was "OK to stir up the muck," said Mr. Giallonardo, but with the health care community becoming involved, the group was encouraged to forge ahead.

The coalition ultimately evaluated 16 companies that provide managed mental health networks and employee assistance programs. It focused first on quality of service, then on price, network size and other variables.

The coalition unanimously decided on Personal Performance Consultants of St. Louis, a unit of Medco Behavioral Care Corp.

The program that finally took shape is one that offers EAP services to coalition members, as well as outpatient and inpatient mental health and substance abuse services. Benefits are available on both an in-network and out-of-network basis.

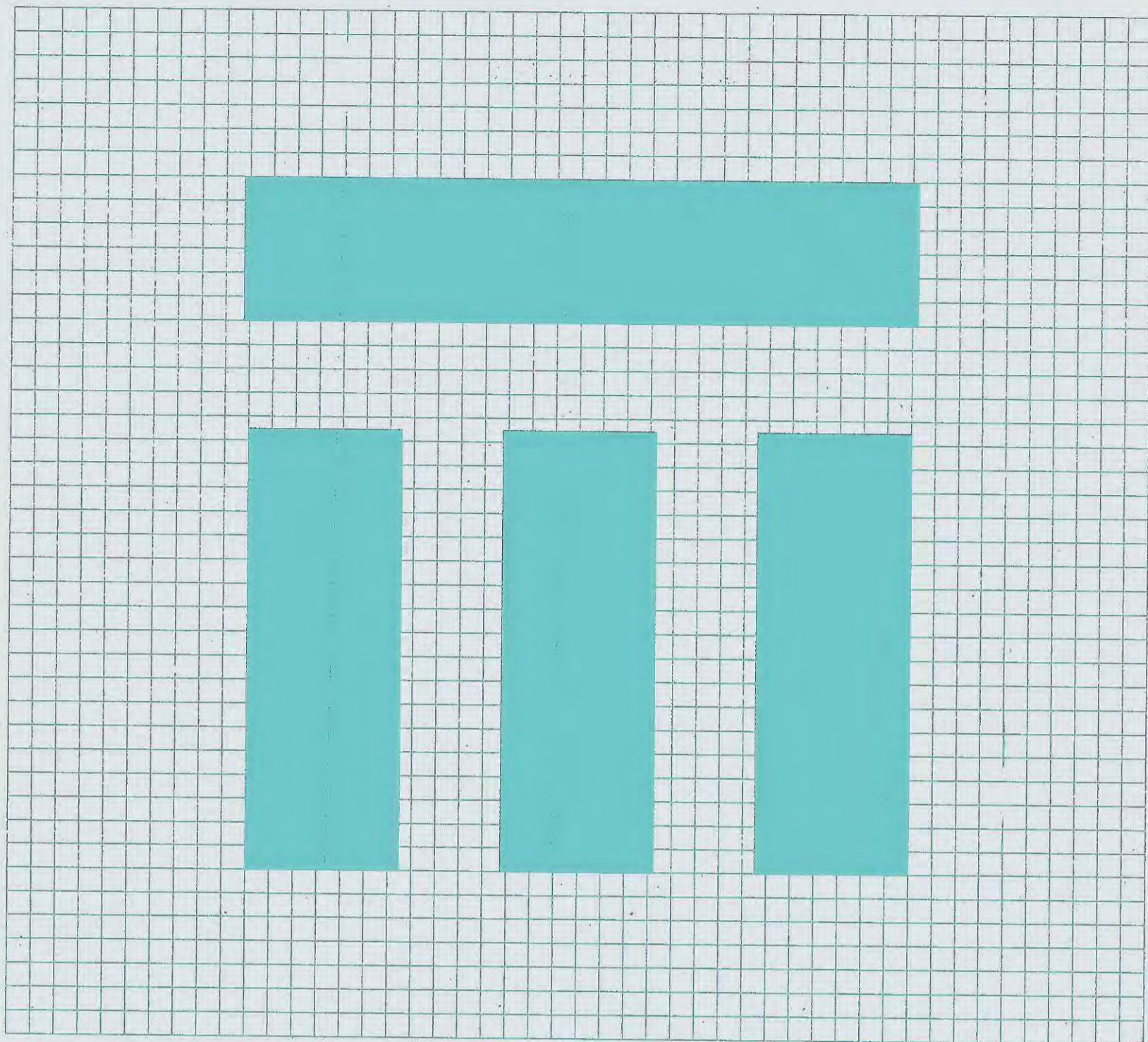
The coalition covers 80,000 people, most of whom will be enrolled in the new program by Jan. 1. Funding for the program will come from assessments to each member based on the number of people covered.

It's not clear whether the coalition's success will lead to the formation of similar groups. "I don't know if we'll see a lot more," said Mr. Petersen. "This is a fairly unique situation."

He said the biggest hurdle in such arrangements often is "developing a cooperative spirit" to agree on things like plan design.

"Coalitions in general continue to be popular," said Mr. Giallonardo. "But I don't know how many more we'll see along the lines of this one."

He said other companies can "look at this and say it's a great idea," but to put a similar coalition together will take "the right leadership and commitment" to keep the group from straying off the path of searching for quality care. **BI**



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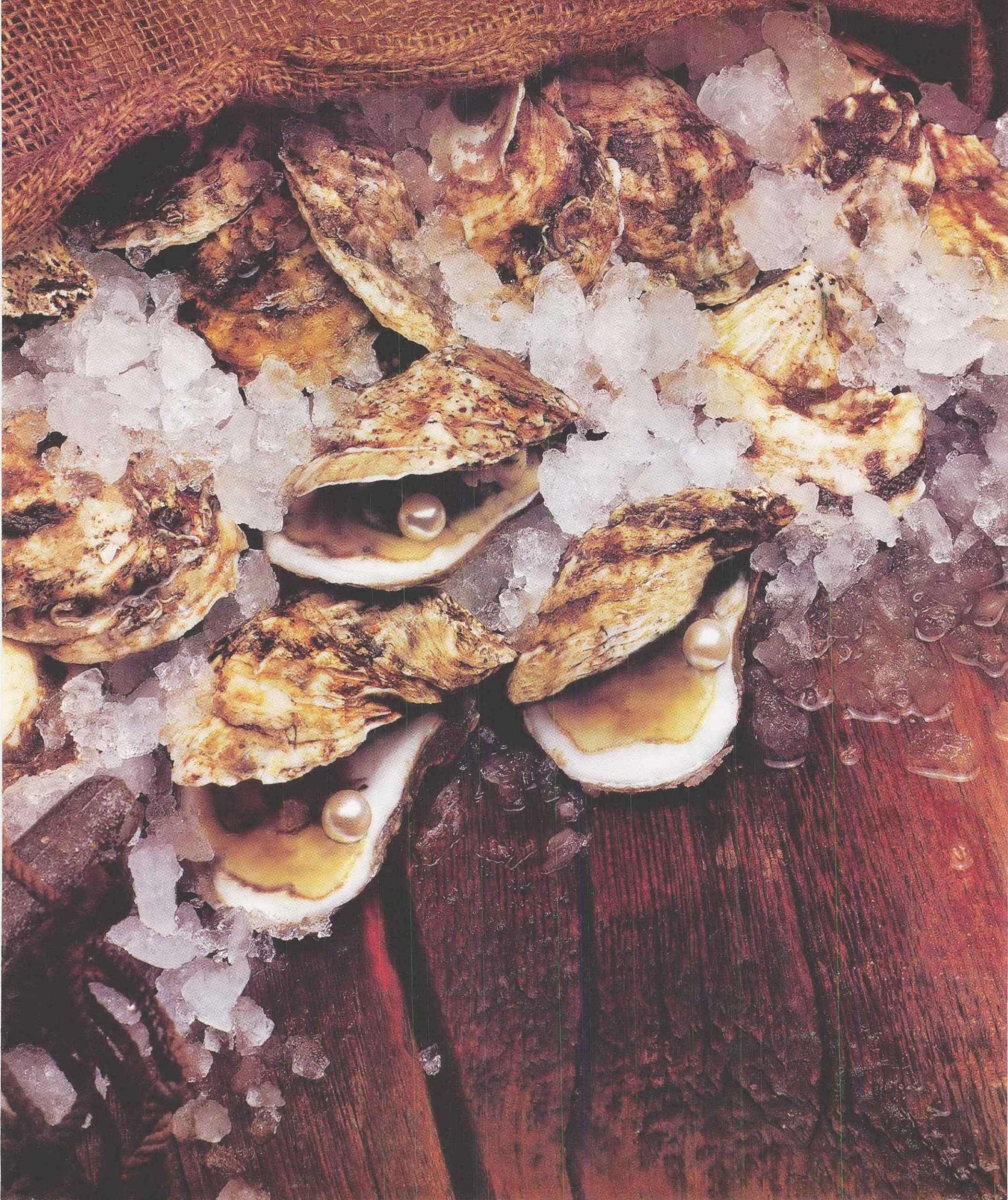
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# Right questions tweak risk programs

By MICHAEL BRADFORD

SAN FRANCISCO—Although each company's risk management program is different, the same questions should be asked by anyone implementing or evaluating a system for controlling losses, two insurance executives say.

In fact, a look at the 10 most frequently asked questions covers many of the basics of creating an effective program, according to J. Michael Ashwood, senior vp-business market sales, and George E. Lepage, vp-business accounts underwriting, at Liberty Mutual Group in Boston.

Their list provided an outline for financial executives who attended the Second Annual Liberty Mutual Risk Management Conference in San Francisco last month.

"There is an organized way to evaluate and select a cost-effective risk management program through a partnership with your insurance carrier," said Mr. Ashwood. And, with no apologies to TV personality David Letterman, the pair presented their Top 10 Questions for Evaluating Risk Management Programs:

1. Are the company's assets adequately protected?

The first step in answering this question is to "thoroughly understand every part, every facet of your operation," Mr. Lepage advised. A risk management program must ensure there are no latent exposures that could appear from sources like asbestos or hidden environmental hazards, he warned.

2. Is there likely to be a "problem" line of business at renewals?

It is vital to keep up with regulatory and legislative changes that could affect coverage availability in some lines, Mr. Ashwood said.

Policyholders also must know whether the insurer offers coverage in every state where the insurance buyer operates. And the buyer

should know the capacity of the underwriter for specific lines and whether it can offer services through joint ventures with other coverage providers like health maintenance organizations.

3. How well does my risk management "partner" understand my business?

The risk manager and insurer should be involved in a company's strategic decision-making because they can provide information that will make decisions easier, Mr. Lepage said.



For example, if a business is considering relocating or expanding into new territories, the risk manager and insurer can provide information related to an area's legal environment, workers compensation insurance costs, building codes and other matters, thereby preventing potential problems that could hinder the move.

4. How does my risk management "partner" measure and reward the performance of its employees?

How an insurer treats its workers can make a difference in the type of service a policyholder receives, Mr. Ashwood noted.

5. Should I consider alternative methods of risk transfer at renewal?

Mr. Ashwood suggested that this decision rests in part on the economic conditions of the business, the markets it serves and the general economy as a whole.

6. Has re-engineering created new exposures for our company?

Mr. Lepage pointed out that many companies have given workers new responsibilities, and those businesses must take a close look at any new exposures that could be created as a result. The company must set some boundaries as to how much power a worker has in making decisions that

could affect the company.

7. How should I measure the financial stability of an insurer?

There are a number of sources for financial and corporate information, noted Mr. Ashwood, who mentioned A.M. Best Co., Standard & Poor's Corp., Moody's Investors Service Inc. and Dun & Bradstreet Corp.

Those sources can provide information like reserve amounts, premium-to-surplus ratios and prior years' performance.

Mr. Ashwood also suggested that prospective policyholders request an annual report from the insurer along with the names of current customers in the same type of business as themselves as a reference.

8. What security requirements do I want at renewal and how can I "sell" them to the insurer?

The policyholder has to forecast losses to show the insurer what it expects to experience in the future as a way to gain favorable terms at renewal.

Forecasting involves such factors as considering changes in the business operation that could reduce certain losses or legislative changes that would accomplish the same thing, said Mr. Lepage.

9. What value-added services do I get or want from my account representative?

An account representative "absolutely has to have a focus on the market" that he or she serves, Mr. Ashwood stressed. "Your account representative must be completely

familiar with your plan and the type of business you're in."

The account representative must have the ability to identify problems that could affect the business and come up with solutions, he said.

10. Do I have the best risk financing program for my business?

Insurers should be willing to provide a range of prospective programs that include features like deductibles and retentions and cover all contingencies, including long-tail risks that may not produce claims for several years from the inception of coverage, Mr. Lepage said. **BI**

## Risk management issues

SAN FRANCISCO—Good risk management means checking the weather report.

The five-year forecast indicated this would be a good time of the year to be in San Francisco, said John F. Ryan, vp of commercial marketing at Liberty Mutual Insurance Group in Boston. The meteorological data proved accurate and Mr. Ryan and his staff drew kudos for planning an event that went off without a hitch under clear skies and mild temperatures in the City by the Bay.

Even the city's trademark fog stayed away for the June 11-13 gathering of the Second Annual Liberty Mutual Risk Management Conference, which was presented in partnership with CFO Publishing Corp. in Boston.

The conference, titled "Facing the Issues that Face Financial Executives," featured a number of sessions aimed at educating chief financial officers and other financial decision-makers on the art of risk management.

Attendees heard from speakers like Charles A. Martin, treasurer and director-finance at Bommer Industries Inc. in Landrum, S.C., who gave testimonials on how to hold down claims costs with effective risk management. Executives from Liberty

Mutual covered the top 10 questions for evaluating a risk management program. Insurance market trends and the future of financial departments were other topics covered at the conference.

The mild weather held on during an evening reception aboard the Balclutha, an 1886 square-rigged ship docked at the Hyde Street Pier.

Details for next year's conference have not been finalized. For more information, contact Liberty Mutual at 617-357-9500.



## Continued lobbying of Congress urged

By MICHAEL BRADFORD

SAN FRANCISCO—Insurers and policyholders have dodged some legislative bullets lately, but now is not the time to let down their guard, an insurance executive warns.

"On the insurance side, we just never seem to run out of major political issues," said Gary R. Gregg, executive vp with Liberty Mutual Insurance Group in Boston. "I don't know whether that's our fault or it's just the fact that we have such enormous fiduciary responsibilities and are in control of so much wealth."

Insurers have watched with some relief as the effort to overhaul the nation's health care system fizzled, but they remain aware that Congress will revisit health care and other issues that will impact insurance companies and their policyholders, he noted.

Speaking at the Second Annual Liberty Mutual Risk Management Conference held last month in San Francisco, Mr. Gregg added that "many of the issues facing the insurance industry are imposing similar challenges on other sectors of the American economy."

He addressed an audience of financial decision-makers at the conference titled "Facing the Issues that Face Financial Executives."

Mr. Gregg said the critical political issues facing insurers and policyholders include:

- Health care reform. "Given my company's business, we have been particularly interested in how health care reform affects workers compensation and automobile insurance," Mr. Gregg said. "But, the issue is of course much bigger than that."

- Financial services deregulation. Legislators are examining how to keep the insurance, banking and securities industries competing fairly while staying ahead of international competition, Mr. Gregg said.

- Superfund reform. This is "crit-

ical to the financial well-being of the insurance industry," he remarked, and "just about anyone else should be concerned about (Superfund) bankrupting much of American industry."

- Product liability and tort reform.

Health care, Superfund and tort reform issues "overwhelm all others in terms of their economic, political and social complexity," he said.

"The obsession with health care reform at the federal level, as a matter of national politics, is over for now and perhaps for the foreseeable future," he noted. "However, the federal government is still extremely concerned about the cost of health care, particularly Medicare's bite out of the federal budget." And, not only in Washington but also in the states, forces against managed care are on the march, said Mr. Gregg.

Rather than basking in the defeat of the "ill-conceived reforms of the Clinton administration, we need to focus on the lessons we learned over the last few years as we look to the future," Mr. Gregg warned.

Tort reform battles also continue to be fought, he said.

"A prime example of how the legal system has run amok is the recent case of a woman who spilled a hot cup of McDonald's coffee on her lap as she was leaving the drive-through, then sued for, and was awarded, a multimillion-dollar judgment," he said (BI, Feb. 6).

While no one wants to eliminate compensation to someone who is harmed negligently or intentionally, "we also don't want people using the courts as the equivalent of a winning lottery ticket," he said.

"Fortunately, the country finally seems ready to curb some of these excesses.

"After years of clamoring for product liability and tort reform by businesses and insurers, Congress stands ready to enact, at minimum, product liability reform and maybe, just maybe, some broader tort reforms."

Republicans rode into Washington this year with tort reform as a prime objective, Mr. Gregg said. "With common-sense legal reform as a key feature of the Contract with America, House Republicans quickly passed a bill containing many changes which until now businesses and insurers could only dream about."

Those changes included limits on punitive damages, establishment of federal product liability standards and elimination of joint liability for non-economic damages. "Many of the reforms applied not just to product liability cases but to all civil lawsuits in any state or federal court," he said.

The House bill met resistance in the Senate, however, and votes to pass the original version never materialized.

The Senate bill was scaled back and, among other changes, would apply only to product liability cases, not all civil lawsuits.

"With different bills in the House and Senate, the likely scenario is that a conference committee will work out the differences," he said.

"The final product will probably look more like the Senate version because... (Republicans) don't have the votes to pass a more sweeping tort reform bill."

Most observers, he added, expect President Clinton to sign a version of the law despite his hints at a veto. "This would be an important step toward getting our nation's legal system back in balance. It would also open the door to getting broader civil justice reforms enacted."

Mr. Gregg urged businesses to "keep the pressure on Congress and on the state legislatures" to enact such reforms. **BI**

### NOTICE

To: The American Policyholders of National Employers' Mutual General Insurance Association Limited (In Liquidation)

Pursuant to the terms of a conservation agreement between Anthony James McMahon and Roger Smith as Liquidators (the "Liquidators") of National Employers' Mutual General Insurance Association Limited, ("NEMGIA") and the Superintendent of Insurance of the State of New York as Conservator (the "Conservator") of NEMGIA, dated March 31, 1995 (the "Agreement"), the Liquidators are required to provide notice to American Policyholders that the Conservator has petitioned the Supreme Court of the State of New York supervising the conservation of NEMGIA for an order approving the Agreement. Accordingly, this is to notify you, as an American Policyholder, as follows:

(a) Pursuant to an order of the Supreme Court of the State of New York dated July 12, 1993, the Conservator is conserving trust funds in the amount of \$1.5 million posted by NEMGIA pursuant to NYCRR Section 27.5 (Regulation 41) for the benefit of American Policyholders as defined in the trust agreement dated December 31, 1985 between NEMGIA and Bankers Trust Company.

(b) The Conservator and Liquidators have entered into the Agreement, for the purpose of avoiding duplication of effort and expense, by which the Conservator will distribute the trust funds to the Liquidators for distribution for the creditors of NEMGIA.

(c) The Agreement provides that the Liquidators will either combine the trust funds with the general assets for distribution to all creditors of NEMGIA, if American Policyholders would receive a greater pro-rata distribution from the general assets than they would receive from the trust funds, or that the Liquidators will distribute the trust funds to American Policyholders (as agent for the Conservator), if American Policyholders will receive a greater pro-rata distribution out of the trust funds than out of the general assets.

(d) The Agreement provides that the Liquidators will determine the value of all claims and that the final adjudication of claims by the Liquidators will be binding on the Conservator.

(e) The Conservation Proceeding will be terminated following distribution of the trust funds to the Liquidators.

(f) A hearing has been scheduled before Hon. Alice Schlesinger of the Supreme Court of the State of New York on the 6th day of September, 1995 at 9:30 a.m. at 80 Centre Street, Room 279 at which time all persons who object to the Agreement may be heard.

(g) American Policyholders who wish to be heard must serve written objections on the Conservator by 23 August 1995. Written objections should be served on the Superintendent of Insurance of the State of New York as Conservator of NEMGIA, 123 William Street, New York, New York 10038-3889 and must be filed in the Supreme Court of the State of New York, County of New York, 60 Centre Street, New York, New York 10007, in the proceeding entitled "In the Matter of the Conservation of NATIONAL EMPLOYERS' MUTUAL GENERAL INSURANCE ASSOCIATION LIMITED, Index No. 403456/93".

Dated: July 3, 1995

EDWARD J. MUHL  
Superintendent of Insurance of the  
State of New York as Conservator of  
NATIONAL EMPLOYERS' MUTUAL GENERAL  
INSURANCE ASSOCIATION LIMITED

# Chasing down lost policies

By David M. Halbreich

When it comes to archiving information—particularly documents relating to insurance—even the best-managed companies often fall short.

Rarely do companies organize their insurance policies by year, or by type of coverage. Rather than finding policies worth millions of dollars stored neatly in plastic sheathes, bound together in the company vault, a request for lost policies often yields the somewhat sheepish admission that the documents were lost or destroyed years ago.

Why keep the information, most managers wonder. What difference does it make once the policies expire? It can mean millions of dollars to a corporation.

Take Fibreboard Corp., for example. The company faced more than 200,000 bodily injury claims that fell under policies dating back to the 1950s and beyond, and through insurance coverage litigation managed to pass almost all of its \$3 billion-plus settlement agreement onto its insurance carriers by referencing expired policies.

## Surprisingly few companies follow the simple maxim 'save your policies' that could provide immediate solace if trouble arose.

Other corporations in a mix of industries have faced major issues and claims—from pollution and subsidence, to electromagnetic fields and tobacco—that have triggered old coverage. Any time it can be shown that there was injury or damage during an older policy, it is sufficient to trigger the older coverage.

Without the policy, what is to stop an insurance company from swearing that it never issued the coverage? And what if other events during the regular course of business worked to exhaust that coverage? Or worse yet, what if your company was among the last to be hit with a certain kind of lawsuit, long after the insurance companies put absolute exclusions for that type of claim into the policies?

Despite the stakes, surprisingly few companies follow the simple maxim "save your policies" that could provide immediate solace if trouble suddenly arose and evidence of past insurance was needed. In fact, companies should do more than just save their policies. Management should save everything associated with the purchase of the policies—the checks, correspondence with the insurer and the broker, promotional material sent by the broker or insurer, accounting documents showing the purchase of the policies, etc.

Assuming the worst, then, what can a company do to find evidence of its coverage? And even if some evidence of coverage is found, will that be sufficient? Here are some issues for management to consider:

### The search begins

The first step is to zero in on the relevant time frame, since certain claims have the potential for triggering 40 years of coverage or more while others may involve events in the more recent past.

Consider what the name of the company was at the time. Have there been mergers or acquisitions during the relevant time period that have resulted in a name change? Also, consider what line of business the company was focused on at the relevant time.

Typically, companies have to provide evidence of insurance to different regulatory entities, which may serve as another lead.

Also look at whether the structure of the company has changed over time. Was there a reorganization? A

purchase of substantially all of the assets of another company? A merger? Was there a parent company? Copies of the policies may reside in the other company's files.

Additionally, try to determine who was responsible for purchasing insurance. Was it a risk manager, the company treasurer or CFO, the general counsel's office? Keep in mind that the company's current reporting lines may in no way match the way in which insurance was purchased in the past. Also, try to determine if brokers were involved. By interviewing those in-house people who were responsible for purchasing the coverage, you may be able to gather more information on outside brokerage houses. All of the brokers should be contacted and the individuals responsible for the account should be interviewed.

### What to look for

It is virtually impossible to catalog all the different kinds of evidence that may reference insurance purchased by a corporation within the confines of this article.

What is important for companies to consider is how secondary evidence can be used as clues that ultimately may lead to finding the actual policy. And in some cases, secondary evidence may even be sufficient to persuade the insurer to drop a defense based on lack of coverage. If that tactic is not successful, secondary evidence can be used to help establish the material terms of the coverage through litigation.

Here is a brief rundown of sources of secondary evidence that a company should track down in its efforts to locate a lost policy:

- Documents—those that contain policy information such as policy number, term limits, name of the insurer or broker.
- Correspondence—documents relating to the policy, such as claim documents, records of premium payment, applications for coverage, solicitations for coverage, insurance requirements for certain contracts.
- Insurer's internal documents—prior reserves established, evidence of reinsurance placed on the policy.
- Document retention programs—may make specific reference to procedures for maintaining coverage.
- Legal department files—may have referred to coverage information in the ordinary course of handling a then-existing claim.
- Corporate indexes/documents—include listings of the contents of the corporate vault, any written guidelines for handling claims against the company or accident reports. These documents may refer to the name of the insurer or provide other useful information.
- Accounting records—accounts payable work papers prepared in the course of audits may indicate the name of the insurer or the policy number.
- Licensing records—governmental permits and the like often require evidence of insurance as part of the permit process. Checking these files may yield these certificates or they may be maintained by the regulatory agency itself.
- Miscellaneous sources—minutes of meetings of the board of directors, minutes of shareholders' meetings, files on easements, construction projects, lines of credit, vendors' files and safety records.

Remember, there is really no limit to the extent of the search. Your company's efforts likely will depend on the size of the claim at issue. In other words, the more dollars at stake, the more exhaustive the search within the company's archives.

### Proving lost coverage

If the insurer is going to force you to litigate the existence of the older coverage—in spite of the strength of the secondary evidence obtained—then a few additional points need to be noted.

First, the corporation (or policyholder) will have to prove that the original policy cannot be found and that it was lost or destroyed without fraudulent intent. All that usually is required to verify this is proof that your company has conducted a reasonably diligent search for the policy in places where it would ordinarily be located.

Once the policyholder meets the "search test," then the company can introduce secondary evidence to the policy's term. How can you introduce evidence of a document that your company does not possess?

There are a myriad of ways, including:

- Employee testimony. People who remember the coverage can testify to its terms. You would be surprised at the intricacy of the details that from time

## Searching for missing insurance policies can involve frustrating and painstaking work. The alternative, however, is usually unacceptable.

to time are recollected, sometimes after more than 20 years from when the policy expired.

- Insurer files. Often, some of the best evidence comes from the insurer's own files, including loss prevention records, old claims files, old marketing files, premium receipts, etc. If your search turns up certificates of insurance, then this can go a long way to proving the coverage bought.

- Industry standards. Evidence of what standard forms of coverage were in use during a given period of time is not difficult to develop and tends to shift the burden to the insurer to prove that something other than the standard form was used.

Similarly, you may have evidence of other coverage placed with the same insurer during different time periods. Testimony then could establish that the type of coverage did not change from year to year. By the same token, you could use another insurer's policies that were purchased from a different period to the same effect.

### Burden of proof

It is important to remember who has the burden of proof in these insurance coverage cases.

Typically, the policyholder must prove by a preponderance of the evidence that the policy was issued and what its material terms are. The insurer typically has the burden of proving restrictions on that coverage, such as exclusions and limits of liability.

Searching for missing policies can involve frustrating and painstaking work. The alternative, however, is usually unacceptable to management. As in the case of Fibreboard or other companies facing "bet the company" litigation, proving the existence and parameters of missing coverage can be absolutely essential to the continued life of the company.

Even for those companies facing more limited threats, the continuous resource drain of paying to defend against claims that should be covered by an older policy is untenable. After all, what were the premiums for, if not the security of knowing the company's insurer would be there years later when a claim materializes out of the blue? **BI**



David M. Halbreich is head of the Southern California Coverage Group and a partner with law firm Brobeck, Phleger & Harrison in Los Angeles. He represents policyholders in disputes with insurance companies.

# Ounce of prevention can cut care costs

## Greater attention to factors causing illness is needed: Expert

By JOANNE WOJCIK

SAN DIEGO—Managed health care systems must treat the mind as well as the body to improve outcomes and reduce health care costs, a health care expert says.

Unfortunately, "there's this funny mismatch between the current orientation of medical care toward providing superb acute care and the growing need of the

population to receive services that help to prevent and manage chronic conditions and thus avoid acute care," according to Jessie C. Gruman, executive director of the Center for the Advancement of Health in Washington.

The center was founded in 1992 by the John D. and Kathryn T. MacArthur Foundation and the Nathan Cummings Foundation to advance an evidence-based view of health that recognizes the contributions of a range of behavioral and psychosocial factors to help outcomes.

"There's a huge gap between what we know and what we do in health care," Ms. Gruman said during a session on "Integrating Mental Health Care and Physical Health Care Therapies" at the recent 45th annual Group Health Institute, sponsored by the Group Health Assn. of America in San Diego June 18-21.

"We need to go beyond the easily measured disease states as the focus of medical intervention," she said. "The old adage, 'When all you have is a hammer, everything looks like a nail,' applies. We need to add tools to medicine if we are to meet the changing needs of our population of patients," she said.

Simply investing in more expensive technology, however, is not the answer, according to Ms. Gruman.

"Ninety-five percent of the \$1 trillion that we spend on health in this country goes for medical treatment, yet we know that medical treatment affects only a tenth of the preventable mortality," she said.

"The focus of medicine on the stark power of high-technology diagnostics and therapeutics can really offer significant gains, par-

ticularly in the area of early detection and screening," she acknowledged.

"But what's lost in the glare of those pyrotechnics is the really mundane reality of individuals and their families who are coping on a daily basis with being chronically ill or disabled," she said.

As a result, these people often become high-cost users of the medical system.

"The recognition and adoption by the medical system of a broader understanding of what factors determine health and well-being does offer strategies for helping to... reduce costs and improve health outcomes," she said.

For example, "we need to consider factors that are broader than disease in planning health care that's both efficient and effective," she said, such as "psychological, social and behavioral ones like stress, like social support, like depression and anxiety."

Unfortunately, this raises significant problems for the medical community, which has been trained primarily to detect and treat organic illnesses, pointed out Dr. Andrew L. Epstein, primary care internist at Harvard Community Health Plan and assistant professor of medicine at Harvard University in Cambridge, Mass.

For example, according to a 1961 study of 1,000 people, only one of 250 people who reported one or more illnesses or injuries in a 30-day period were referred to a university medical center for treatment.

"And that is where physicians are trained," he said.

"Conventional medicine regards things like depression, anxiety and social support as too elusive to measure, let alone to manipulate," Ms. Gruman said. "But this simply isn't true anymore. We have robust, empirically sound and scientifically based evidence that the way we think, the way we feel and the way that we act affect the onset of some diseases, the progression of many and the management of nearly all."

Scientific studies that Ms. Gruman pointed to as evidence included:

- A UNICEF study last October that described a new health crisis in Eastern Europe related to the fall of communism: excess mortal-

ity of more than 800,000 between 1989 and 1993.

Most of the deaths were not due to erosion of the medical system or epidemics of infectious disease, but rather due to increased incidence of cardiovascular disease among young men—those between the ages of 30 and 55.

The study attributed the increased mortality rate among young men to political and economic upheaval, greater poverty, unemployment, divorce, migration, hopelessness and conflicts in work and family.

"This natural experiment shows the influence of social stress on morbidity and mortality, and while we don't have the same general level of social upheaval in this country, among certain social strata we certainly do," Ms. Gruman said.

- The life expectancy for men in central Harlem is less than it is for

men in Bangladesh, according to a recent widely reported study that Ms. Gruman did not identify.

"And, just as in Eastern Europe, cardiovascular disease is primarily responsible for this," she said.

These and other studies all prove that "divorce, unemployment, violence in the neighborhood play a critical role in the health of the population at large," Ms. Gruman said.

Unfortunately, while the U.S. health care system historically has excelled at treating acute illness, it is not equipped to accommodate the types of chronic diseases that now afflict the population, Ms. Gruman asserted.

For example, seven of the 10 leading causes of death in the United States are due to chronic diseases for which there is no cure.

"For these conditions, the focus of medicine must be to provide care. That's long-term management of disease and prevention of

complications and co-morbidity," or related health problems, she said.

And, as the number of people over the age of 65 grows, medical providers increasingly will be called on to treat these individuals' chronic illnesses. With age comes a decrease of functioning, an increase in chronic disease and a loss of independence, Ms. Gruman noted.

Already the number of people over the age of 65 has risen dramatically to 16.4% of the population today from 4.1% at the turn of the century.

At the same time, life expectancy at birth has increased to 75 years from only 47 years in the year 1900.

"Until medicine as we know it comes to cure old age and compress morbidity into a matter of days, this is going to be a continuing challenge for medicine in general and health care in particular," she said. BI

GHA

## 3,197 attend GHAA institute

SAN DIEGO—Even though health care reform legislation was never enacted in Washington, managed care is fast becoming the *de facto* national health care policy, according to Steven A. Schroeder, president of the Robert Wood Johnson Foundation.

"In my more than 45 years" in the health care industry, "I have never seen such incredible change," Dr. Schroeder told the 3,197 attendees of the 45th annual Group Health Institute, sponsored by the Group Health Assn. of America June 18-21 in San Diego.

"It's as if the country voted for it, but it didn't," Dr. Schroeder said. "It's become a default health policy."

But Dr. Schroeder, whose foundation has provided financial support to numerous state-based health reform initiatives, urged the members of the Group Health Assn. of

America, the nation's largest and oldest managed care industry trade group, to be careful with their newfound power.

"We want to do everything we can to make sure the public benefits from the surge" in managed care growth, "to be sure we don't win the battle and then lose the war."

Specifically addressing health maintenance organization executives, Dr. Schroeder admonished: "As you worry about market share, don't destroy your seed corn," referring to the primary care physicians that were used to build their networks.

He also warned that "excessive focus on short-term profit and market share could invite regulatory backlash."

"This is really a critical time

for the GHAA," he said, in keeping with this year's Group Health Institute theme, "Building on a Legacy of Health Care Leadership."

"You can now be the elder statesmen" and "raise our health care system's performance to a new level," Dr. Schroeder urged the audience.

Besides Dr. Schroeder's address, the institute featured a satellite speech from House Speaker Newt Gingrich, R-Ga., and numerous continuing education classes designed to educate leaders of the managed care industry.

Next year's Group Health Institute will be held June 16-19 in New Orleans.

For more information, contact Bonita Nunez at the Group Health Assn. of America, 1129 20th St. N.W., Suite 600, Washington, D.C. 20036; 202-778-8490.

—By Joanne Wojcik

## Ruling frees Lloyd's underwriters from posting bonds in dispute

SAN JOSE, Calif.—Lloyd's of London underwriters need not post a \$475 million bond prior to litigating a pollution coverage dispute with Lockheed Martin Corp., a California superior court judge ruled.

Lockheed tried to use a little-known provision in California and other states' insurance code that requires non-admitted insurers to post a bond prior to a coverage dispute. Lockheed sought a bond from its London insurers—led by the Ariel syndicate managed by Methuen (Lloyd's Underwriting Agents) Ltd. and by British Aviation Insurance Group—in its dispute over environmental damage at 13 California sites.

Several other aerospace manufacturers in California have filed similar cases against their overseas insurers (BI, June 19).

In rejecting the claim, Judge Alden Danner in the Santa Clara Superior Court cited the \$11 billion Lloyd's American Trust Fund and other trust funds held in the United States by Lockheed's other insurers as sufficient to guarantee any future claims.

"This is especially gratifying because large corporate policyholders have been abusing these statutes for improper purposes," said Jim Barber, a partner at Hancock, Rothert & Bunshoft, which represented the London insurers.

But, the judge ruled that insurers may have to post a bond for liabilities arising in 1977, when Lockheed's surplus lines broker, Swett & Crawford, allowed its surplus lines license to lapse in violation of California's insurance statute. A hearing will be held Aug. 4.

—By Gavin Souter

## Cutbacks

Continued from page 3  
centage of uninsured increased to 16% from 15%.

"Employer-based insurance declined across the board," Mr. Altman said.

"And the number of uninsured actually increased," he said, especially among the highest-paid workers.

In contrast, the percentage of those uninsured "actually fell among the poverty group because they were able to get Medicaid coverage," Mr. Altman pointed out.

This shows that the majority of the population that became uninsured were employed, according to Mr. Altman.

And, if this trend continues, more than half of the working population in the United States will be without health care coverage by the end of the decade, he predicted.

Unfortunately, "the concept of collectively purchasing insurance is breaking down," Mr. Altman said.

For example, "more and more employers are now engaged in this legal, but morally questionable

behavior of trying to bribe their employees not to buy insurance," he said.

"They're called cafeteria plans," he said.

Employers that offer flexible benefit programs in which a fixed sum is allocated to each employee for health care expenditures are actually encouraging employees to "go get health care from your spouse's employer" and use those flex dollars to buy other perks, such as additional vacation time, Mr. Altman said.

But U.S. employers must redefine their commitment to providing health care coverage if they are to remain competitive in the world economy, asserted Larry Leisure, a partner with Price Waterhouse in San Francisco.

"In the early 1980s and late 1970s—the good old days—employers were fairly paternalistic," and provided generous health care benefits to employees and retirees, he recalled.

"But many employers discovered that was unsustainable," he said.

Some employers shifted the higher health care costs to employees in the form of copayments and deductibles, he said.

Other employers, though, intro-

duced managed care that restricted employee access to lower cost plans and providers, Mr. Leisure pointed out.

Recent changes in the Federal Accounting Standards for requiring employers to reserve for future retiree health care expenditures also have altered employers' attitude toward health care benefits.

Now employers are seeing health care benefits as a part of employee compensation, and "flexible benefit plans are a way of treating health care benefits like compensation," Mr. Leisure explained.

"I do believe in the future that employers are going to treat health care benefits like compensation and employees and retirees will be given a flat dollar amount that they can apply to any number of choices" of health plans, he predicted.

This approach also puts the health care purchasing decision back into the hands of the actual consumer. And, this serves to dissuade employees from looking to their employer as a third-party "tooth fairy" who will always pick up the tab, no matter how unreasonable that tab might be, Mr. Leisure said. BI

## INTERNATIONAL

## Syndicate realignment seen at Lloyd's

By SARAH GODDARD

LONDON—The number of active Lloyd's of London syndicates is continuing to fall as uncertainties remain about the market's trading base.

In the past few weeks, syndicates have been moving to other managing agencies or merging or both to position themselves for the new-style Lloyd's envisioned in the market's reconstruction plan.

Notable among the recent changes was investment banking company Cater Allen Holdings P.L.C.'s announcement that it will withdraw from the Lloyd's managing agency business at the end of this year.

The company was not confident it could raise enough support for the syndicates for next year, explained David White, deputy chairman. It could not accurately assess the number of members that would be in the market in 1996 or the amount of capital they would provide, he said.

Subsidiary Cater Allen Syndicate Management Ltd. currently manages three active Lloyd's syndicates and eight in runoff. Methuen (Lloyd's Underwriting Agents) Ltd. is in the final stage of talks with Cater Allen about taking over marine syndicate 375, which has capacity this year of £58.2 million (\$91.1 million).

Directors of the two companies have reached an agreement, but it

has not been formalized, said Richard Sumner, manager of special projects at Methuen in London.

Mr. Sumner also confirmed that Methuen was taking a "provisional look" at another Cater Allen syndicate, non-marine syndicate 322. He added that Methuen looked at every Lloyd's syndicate from time to time to keep "abreast of what is going on in the market."

Syndicate 55, the last of Cater Allen's active syndicates, will announce its plans within the next week, said its underwriter, George Lloyd-Roberts.

Discussions about the future of the runoff syndicates also are taking place, said Mr. White, but no decisions have been taken yet.

At the end of last year, Cater Allen transferred management of syndicate 190, which wrote predominantly North American business, to Liberty Syndicate Management Ltd. The syndicate manager is 25%-owned by Liberty Mutual Insurance Co.'s Liberty Europe (Holdings) Ltd. unit.

Under new corporate capital regulations at Lloyd's announced last week, Liberty Europe can take over full ownership of Liberty Syndicate Management in the near future, said Ewen Gilmour, manager of Lloyd's corporate membership unit. The syndicate is 100% capitalized by Liberty Corporate Capital Ltd., a wholly owned subsidiary of Liberty. Rich-

ard Hazell, chairman of Liberty Europe in London, was underwriter for the syndicate from 1967 to 1992.

He said it was a "distinct possibility" that Liberty Syndicate Management will be an agent for more syndicates in the future. "Nobody knows the capital situation for 1996, but...if good opportunities present themselves, Liberty will take them."

Liberty Mutual also has increased its involvement in the London market with the formation of Liberty Reinsurance Co.

Grahame Potter—previously chief executive of Copenhagen Reinsurance Co. (U.K.) Ltd.—was recently named the company's chief operating officer. James Payne, former chairman of reinsurer broker E.W. Payne Cos. Ltd., earlier was appointed chairman of Liberty Re.

Meanwhile, managing agency Murray Lawrence & Partners Ltd., one of the largest in the Lloyd's market, has decided to merge two of its smaller marine syndicates into two larger syndicates next year.

Paul Archard, managing director of Murray Lawrence in London, said the mergers would secure the future of the smaller syndicates in a market that was "moving toward larger business units." Although he didn't foresee any major drop in Lloyd's capacity next year, he thought that smaller syndicates may lose out in favor of the larger ones, partly be-

cause of the lower expense ratios for bigger syndicates.

Other moves in the market include the transfer of aviation syndicate 53 from Marchant & Eliot Underwriting Ltd. to Crowe Syndicate Management Ltd. next year.

Among Crowe's five syndicates currently underwriting is specialist excess-of-loss aviation and catastrophe syndicate 808. Crowe Managing Director Kevin Collins said that the two syndicates will not be merged, partly because they write very different books of business. This leaves Marchant & Eliot with just one syndicate—282—and Mr. Collins said that Crowe was given an opportunity to "look closer" at it but decided not to since the agency does not want to expand any further for 1996.

According to syndicate 282's underwriter, Andrew Elliott, there are no immediate plans to relocate the syndicate outside the Marchant agency. A fall in capacity to £35.5 million (\$55.5 million) for this year from £131.3 million (\$245.5 million) in 1992 has forced the syndicate to review its underwriting strategy, focusing on what Mr. Elliott calls its core accounts.

It continues as a joint lead on the Marchant Space Consortium, alongside syndicate 800, but space business accounts for only 25% of the syndicate's book. The rest is divided between catastrophe, war and politi-

cal risk and marine liability. He says there has been interest in investing in the syndicate from corporate Lloyd's members, particularly those already involved in the industry.

Meanwhile, the Brockbank Group P.L.C. has sold its subsidiary, Sentinel Run-Off Ltd., to runoff experts Market Group Management P.L.C. Ian Martin, previously chairman of Sentinel and investment director of Brockbank in London, said the sale would benefit names on the seven syndicates that were being administered by Sentinel because of the scale of MGM's operation.

"It is becoming increasingly clear that it is in the best interests of names to have their runoff dealt with by larger organizations because these businesses can provide economies of scale," he said.

MGM employs 350 people and the 17 Brockbank employees who worked on the runoff are being brought on board. Mr. Martin said the sale lets Brockbank "concentrate on its core business."

Brockbank syndicate 861 is the second largest in Lloyd's this year, with capacity of £245.3 million (\$383.9 million). It recently recruited professional indemnity underwriter Miriam Goddard—previously with Burnhope syndicate 1212—to expand the syndicate's errors and omissions business, particularly from the United States. **■**

## Store's collapse largely uninsured

By KATE TILLEY

SEOUL, South Korea—The department store building that collapsed in Seoul late last month had only minimal property insurance coverage, according to foreign insurers based in this city of 12 million people.

Although coverage could have been written by a foreign insurer, it was much more likely written by the government-owned insurer, Korean Insurance Co., observers say.

The building collapsed just before closing time on June 29, and the death toll as of last Wednesday was 112 confirmed dead, 381 missing, and between 1,000 and 1,500 injured.

Foreign insurers were uncertain whether Sampoong Co., which built and operated the five-story Sampoong Department Store, had any public liability coverage but expected that coverage also would be minimal, if it had any at all.

"It would be a very modest amount; it probably wouldn't cover even one fatality," said one insurer active in the market.

Because of the rigid tariff structure in the insurance market and the resulting high premiums, it is not unusual for owners of large properties to buy very little insurance, underwriters confirmed.

Some of the dead and injured may have had personal or group sickness

and accident or life insurance policies, as South Korea's life insurance market is the sixth-largest in the world.

But, Gerry Carter, CIGNA Insurance Co.'s general manager in Seoul, said many of those killed and injured were women, and they were less likely to have life or sickness/accident policies than men.

Foreign insurers say the tragedy may highlight problems with the insurance market and prompt the South Korean government to speed its plans for deregulation of the insurance industry.

In 1992, the government released a plan to progressively deregulate the *See Collapse on page 19*



Sampoong Co. may have only minimal property coverage and perhaps no liability coverage to apply to the collapse of its Seoul store.

## Orion paying ILU claims

By SARAH GODDARD

LONDON—Policyholders who bought coverage from the insolvent Orion Insurance Co. P.L.C. through the Institute of London Underwriters are receiving their first claim payments under a special agreement decided upon last October.

Under the agreement, Orion's parent, Internationale Nederlanden N.V., should pay in full all claims under policies that were issued after 1970 by Orion and its subsidiary London & Overseas Insurance Co. P.L.C. through the ILU (*BI*, Oct. 24, 1994).

The first \$11 million was made available last week under this special agreement to policyholders who held proof of claim. Further payments will now be made on a monthly cycle.

The total unaudited liabilities of Orion and London & Overseas are estimated to be \$1.66 billion as of Dec. 31, 1993, and total assets are estimated at \$1.07 billion, according to the provisional liquidators' most recent report. These figures

are expected to be confirmed by audit in the near future and the 1994 year-end position is currently being reviewed, said the provisional liquidator, Paul Evans, a partner at Price Waterhouse in London.

The arrangement with the ILU provides for the payment of claims on policies that were written on or after March 20, 1969, for Orion and Aug. 28, 1970, for London & Overseas.

Currently, the insolvent companies are only paying insurance claims, but cedants who are not retrocessionaires of the companies should soon have their reinsurance claims incorporated into the arrangement, as well.

The ILU plans to establish a further program to cover retrocessionaires' claims, but the program would be very complex and there is no start-up date in sight, said Edward Walker, membership financial director of the ILU.

Mr. Walker said he is confident that all valid claims presented through the current plan will be paid in full, though the total

amount of ILU policyholders' claims has not been estimated. "The ILU has guarantees from a number of parent companies of members," he said, "and where a member fails, that guarantee will be used."

In conjunction with brokers, the ILU has chosen certain policyholders to receive the first payments under the arrangement. Generally, these are the larger claims and the agreement specifies that claims greater than \$50,000 will be made direct to the policyholder. Claims below this threshold will be paid through the broker unless the broker requests direct payment to the policyholder. Mr. Walker said the majority of claims that have been presented are less than \$1,000.

The arrangement is already being reviewed by the ILU and computer systems will be developed to speed up claims payment. "Rather than hold up payments, we manually prepared them for July," said Mr. Walker, "but we are aiming to develop the computer systems to *See Orion on page 19*

## KOKOs' future in doubt after Gerling withdraws

By DON LEWIS KIRK

COLOGNE, Germany—Gerling Konzern Allgemeine Versicherungs A.G. is now the second major insurer to abandon the controversial underwriting consortium that sets property insurance rates for large industrial risks in Germany.

The move by Gerling, one of Germany's leading industrial insurers, comes less than a month after Allianz Versicherungs A.G. announced a similar step (*BI*, June 5).

The consortium—called konsortialkommissionen, or KOKOs—has come under fire from large industrial companies in Germany as it has raised rates across the board to offset sizable industrial property losses in recent years.

Gerling Chief Executive Juergen Zech said the insurer will implement a new rating system for commercial risks—using individual risk assessments rather than a broad tariff—by next month.

The move should help Gerling keep major clients from drifting to

foreign competitors, as has happened with some German companies, said Mr. Zech.

Dieter Nowak, Gerling's property insurance director, said he expects many companies with good loss experience will be able to take larger deductibles or make additional improvements to safety and loss control programs to keep their rates low.

Gerling will take a "harder line" with loss-prone policyholders, he added. "We plan a check-up. Those not willing to change their safety philosophy and management will see their premium rise—or lose us as their insurer."

While the "new orientation" in the German property insurance market will reduce rates for many larger clients, Mr. Nowak said the change could mean rate hikes for middle-size and smaller commercial clients if conditions merit.

Mr. Nowak also believes the move by Gerling and Allianz, as well as the complaints of policyholders, have sealed the fate of the KOKOs. *See Gerling on page 17*

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#### BUSINESS INSURANCE CLASSIFIEDS ASSURE TOP QUALITY RESULTS

### LEGAL NOTICE

#### IN THE HIGH COURT OF JUSTICE CHANCERY DIVISION COMPANIES COURT

No: 007734 of 1994

#### In the matter of SCAN RE INSURANCE COMPANY LIMITED and in the matter of the Companies Act 1985

#### NOTICE IS HEREBY GIVEN THAT:

- On 15 February 1995, the scheme of arrangement between Scan Re Insurance Company Limited (the "Company") and its Scheme Creditors (as defined in the scheme of arrangement) was approved by Scheme Creditors.
- On 15 March 1995, the High Court sanctioned the scheme of arrangement as approved by Scheme Creditors.
- On 27 March 1995, the United States Bankruptcy Court for the Southern District of New York granted a permanent injunction order under section 304 of the United States Bankruptcy Code, providing for the enforcement of the terms of the scheme of arrangement in the United States of America.
- On 29 March 1995, the High Court ordered that the winding-up petition presented against the Company be dismissed and the appointment of provisional liquidators to the Company be terminated.
- On 29 March 1995, the order made in the High Court sanctioning the scheme of arrangement was delivered to the registrar of companies in England for registration and the scheme of arrangement became effective. The "Effective Date" of the scheme of arrangement is therefore 29 March 1995.
- On 29 March 1995 Gareth Howard Hughes and Nigel James Hamilton, partners in Ernst & Young and formerly the joint provisional liquidators of the Company, were appointed "Scheme Administrators".
- On 23 May 1995, the "payment percentage" under the scheme of arrangement was set at 7.5%. Persons with claims should submit them to the company in the normal way at the following address:

For the attention of Geoff Freeman  
Scan Re Insurance Company Limited  
44/46 Old Steine  
Brighton  
BN1 1NH

The members of the creditors committee are:

- ITT New England Management Company Inc.
- Continental Re Management Inc.
- Aachener Ruckversicherungs - Gesellschaft A.G.
- Unionamerica Insurance Company Limited
- Policyholders Protection Board
- Lloyd's Underwriters' Non-Marine Association Limited
- Lloyd's Underwriters' Association
- Transit Casualty Company

Dated: 27 June 1995  
Ashurst Morris Crisp  
Broadwalk House  
5 Appold Street  
London EC2A 2HA  
(Reference NJA)

Solicitors to:

Gareth Howard Hughes and Nigel James Hamilton  
Scheme Administrators

### WANTED

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CEO's, Presidents, and Owners, ..... 2,009  
Vice Presidents, General Managers and Other Administrative Personnel ..... 5,645

**Financial:**  
Chief Financial Officers and Vice Presidents of Finance ..... 3,539  
Secretaries, Treasurers, controllers and other Financial Personnel ..... 3,279

**Risk/Employee Benefits:**  
Vice Presidents, Directors, Managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations ..... 15,529

**Sub-total** ..... **30,001**  
Associations ..... 343  
Government, Unions and Educational Institutions 950

**Commercial Consumers**  
**Sub-total** ..... **31,294**  
Insurance Agents and Brokers ..... 8,285  
Insurance Companies ..... 7,687  
Accountants, Actuaries, Attorneys & Consultants ..... 3,563  
Adjusters, Appraisers, TPA's, Captive Managers & Health Care Providers ..... 1,844  
Others Allied to the Field ..... 1,028

**Total Qualified** ..... **53,701**  
Non-qualified ..... 74  
Single Copy Sales ..... 6

**TOTAL CIRCULATION** .. **53,781**  
★ Source Business/Occupational breakdown of qualified circulation, November 28, 1994 Issue, as submitted to BPA for December 1994 BPA Publisher's Statement

## INTERNATIONAL

# Aviation liability limits to increase in Australia

By KATE TILLEY

CANBERRA, Australia—Australia's Federal Parliament has passed an amendment to its aviation legislation that would lift the minimum liability limit for international airlines to about \$500,000 Australian.

The Transport Legislation Amendment Bill No. 1 has been passed by both chambers of Parliament and was expected to be approved by the Governor General today.

The bill would raise the minimum liability limit for international flights by Qantas Airways Ltd. and Ansett Airlines Ltd., Australia's two international carriers, to 260,000 Special Drawing Rights, or about \$573,000 Australian, per passenger (BI, Jan 2). That would bring the country's international limits in line with the domestic limit, which also was increased to \$500,000 Australian last year (BI, Nov. 28, 1994; Aug. 29, 1994).

The Australian government cannot force other international airlines traveling to Australia to agree to the new limit but wrote to them seeking voluntary compliance. A spokesman for the Department of Transport said "most are in favor," though some airlines were concerned that it would be hard to implement different limits in different countries.

International limits were discussed at the International Air Transport Assn.'s conference in Washington late last month.

Steve Showell, general manager of risk and insurance for Sydney-based Qantas, Australia's major international airline, said the airlines had agreed to establish two committees to examine liability limits.

The airlines have favored a limit of 250,000 SDRs if a country's laws require it or a carrier voluntarily adopts such a limit.

Mr. Showell said Qantas opposes any proposals for unlimited liability but conceded that the previous limits in Australia were too low.

A second amendment bill, which would enforce mandatory, non-voidable insurance for all airlines operating in Australia, also was passed by the Federal Parliament on June 30. That bill would prevent insurers from denying liability coverage, regardless of whether the airline was negligent. The Transport Department spokesman said the bill was likely to apply starting Jan. 1, 1996.

The bill, which also amends the

Civil Aviation (Carriers' Liability) Act, would require the department to set regulations on the minimum level of coverage airlines must buy and would require all Australian states to pass mirror legislation. Those minimums would depend on the number of aircraft in operation and the number of passengers, among other things.

Aviation brokers say the amendments are unlikely to change ticket prices greatly but will mean that insurers will seek strict compliance with safety standards from airlines.

Aviation underwriters say they will raise premiums as soon as the law making insurance non-voidable takes effect. Geoff Butler, director of Australian Aviation Insurance Group (Agency) Pty. Ltd. in Melbourne, said rates rose when the domestic liability limit went up last year (BI, Nov. 28, 1994), and would lift again when the law took effect.

He anticipated rises of at least 200%, but said the increase would depend on the aircraft operator. Some "fringe" charter operators were no longer operating charter flights because of the increased liability limits, Mr. Butler noted.

Underwriters would look more closely at risks and seek audits of airlines unfamiliar to them. Underwriters also would impose more stringent pilot qualifications, he said.

Ruben Alvaro, aviation specialist with the Sydney office of Sedgwick Ltd., also expects underwriters to seek additional premiums once the law making coverage non-voidable goes into effect. But he said it would be hard for underwriters to assess the increase because there is no precedent for non-voidable cover.

"Insurers are being required to cover something outside the contract...the level of increases are going to depend on claims experience," he said. He expects insurers to set a nominal figure and monitor it in light of claims. "The risk for the underwriter is so much greater that no one knows what to charge," he said.

At this year's Aviation Insurance Assn. conference (BI, May 15), airlines were warned to expect steeper liability premiums. And at the International Airline Insurance Conference in London earlier this year (BI, March 20), airline risk managers were told the cost of liability claims, plus the move to larger aircraft, meant current limits were insufficient to cover the perils. **BI**

hold its market position. "Competition has made it difficult to make a profit with normal property insurance business."

Gerling intends to strengthen its profile as the commercial insurer for difficult risks, Mr. Zech said. "I must deal with difficult risks so that they remain insurable," he said.

In 1995, Gerling expects gross premium volume to rise 7%, following an 11.3% increase in 1994, when premium volume totaled 3.8 billion DM (\$2.45 billion). Net premium volume increased 20% to 2.1 billion DM (\$1.36 billion) in 1994 from 1.7 billion DM (\$979 million) in 1993. Net profits rose 54.5% to 23.8 million DM (\$15.3 million) from 15.4 million DM (\$8.9 million).

A higher frequency of large claims last year boosted gross losses by 18.5% to 1.68 billion DM (\$1.08 billion) in 1994 from 1.42 billion DM (\$817.8 million) in 1993. However, because a large portion of business had been reinsured, the insurer's net underwriting losses narrowed to 42.2

## Orion

Continued from page 17  
clear the backlog."

Both Orion and London & Overseas stopped paying claims last October.

Meanwhile, Mr. Evans, Orion and London & Overseas's provisional liquidator, is constructing a scheme of arrangement for business that was not placed through the Institute of London Underwriters. He hopes the scheme of arrangement

## Collapse

Continued from page 17

industry, with the final moves being made in 1998, when the high tariffs would be eliminated and foreign brokers permitted to operate fully in the market. There are no independent brokers in South Korea.

Currently foreign brokers can establish representative offices in South Korea but cannot provide risk management or loss control services.

"It's unfortunate that it takes a tragedy for (faster deregulation) to happen," Mr. Carter said.

Another foreign insurer agrees that deregulation may be hastened by the department store collapse. Already it has hastened the use of foreign inspection services on South Korean construction sites.

Underwriters say once brokers are able to offer risk management services to South Korean companies, the companies will begin to appreciate the need for a range of coverages to limit their exposures.

The chairman of the department store's operating company and several other executives have been arrested and face criminal charges of involuntary manslaughter over the building's collapse. Media reports allege company executives knew the building was unsafe but did not order its evacuation.

The government has announced that it may change the law so that, in the future, company executives in similar circumstances could be charged with second-degree murder.

The building was constructed in 1989, and additions were made last year.

Since the loss, the South Korean government has instigated inspections of residential apartment buildings built during South Korea's construction boom in the

will be in place by the end of this year.

Policyholders not covered by the ILU arrangement will only receive a percentage of their claims, but that level is yet to be decided, he said.

In a recent report to brokers and intermediaries, Mr. Evans said that preparing the audited accounts for 1993 and 1994 had been difficult because of cross-guarantees between Orion and London & Overseas—which had been requested by the U.K.'s Department of Trade and Industry after Orion bought its subsid-

iary in the 1970s.

Also creating difficulties are the existence of third-party liability, pollution and asbestos claims, which are difficult to quantify; the uncertainty of recovery from reinsurance companies; and the fact that some claims have not been reported yet.

Orion had operated a number of aviation and marine insurance pools, mainly since 1977, and agreements are being completed with most of the pool members to resume making claims payments on pool business. **BI**

1980s, and similar checks of office and retail buildings are likely to follow.

And Mr. Carter said his company is likely to review its risk selection process to ensure it writes coverage only for safe buildings.

The department store collapse follows last year's failure of a partly constructed bridge in which 32 people died (BI, Oct. 31, 1994). Poor construction also was blamed for that loss, which was not insured. **BI**

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## Gerling

Continued from page 17

"There will be no more KOKOs as we know them," said Mr. Nowak.

An official death knell was expected July 4 at a meeting of fire insurers in Frankfurt. The Verband der Schadenversicherer, a property insurer group that determines the fate of the KOKO, would not comment on the speculation.

By leaving the tariff system behind, Gerling and Allianz have removed an advantage from smaller insurers, which rely on German Property Insurers Assn. statistics. Data from the two companies will no longer be available to the group.

Mr. Nowak also predicts a change in the competitive environment: "The competitive factor in industrial insurance will be more in technical services than in premiums."

By concentrating on market segments that demand "specific know-how" Mr. Zech believes Gerling can

# Forecast

Continued from page 1

go back to an active landfall period, we will see greater damage than we have ever seen."

"This is the highest forecast to come out in the 11 years Dr. Gray has been doing this," added Christopher Landsea, a researcher with the CSU group. "The forecast might be right, but we don't know for sure whether they will make land or where they'll hit. But, with more hurricane activity out there, the chances increase for landfall."

Predictions for 1995 are very similar to studies performed in 1966, 1971, 1975 and 1980, he said.

Mr. Landsea noted that 1966 and 1980 were two especially severe hurricane seasons. In 1966, there were seven hurricanes, of which three were major storms, and in 1980, there were nine hurricanes, two of which were major storms.

Over the past 11 years that the CSU group has issued a formal hurricane prediction, Mr. Gray said the forecasts have been quite close to correct in all but two years: 1989 and 1993.

Mr. Gray said that if the group's prediction holds up—and it has been amended once already to reflect less severe hurricane activity than originally predicted in April—"it will be one of the busiest hurricane seasons in the past (30) years."

Others in the atmospheric sciences field say that while the CSU group's hurricane prognostications have been closer to accurate more times than they have been inaccurate, it's not a guarantee of what will happen.

Nevertheless, they say the CSU

prediction is something to look at and ponder.

Dean Churchill, an assistant professor of meteorology and oceanographic geography at the University of Miami, said Mr. Gray is respected by peers and is widely considered to be the only person doing this type of prediction.

However, "his predictions cause more excitement in the media than among meteorologists," Mr. Churchill said.

He agreed that atmospheric and climatological signs point to a large number of hurricanes. "But that's not saying where they will hit or whether they will stay at sea."

**'I look at this forecast with great interest. It dictates the acid level in my stomach and how well I sleep until Sept. 15,' says Steve Lilienthal, a senior vp with USF&G Corp.**

The major problem for insurance companies looking at the forecast is that even if the CSU group's prediction is dead-on correct, given the fact that the scientists only finalize their forecast in June, there is nothing insurers can do now to limit their potentially larger exposure.

It's now July, and even though the forecast is grim, regulation and common sense prevent insurers from canceling policies in hurricane-prone areas, one insurer executive said.

"I look at this forecast with great interest. It dictates the acid level in my stomach and how well I sleep

until Sept. 15," said Steve Lilienthal, a senior vp with USF&G Corp. in Baltimore. "But, by the time he predicts this, it's too late for us to change anything. All we can do is hope he's wrong."

Mr. Lilienthal said it takes about three years for a large commercial insurer like USF&G to reduce its exposure in a certain geographic area. Thus, insuring property in storm-prone areas must be done based on mathematical ratios and projected rates of return, not gut feeling and hurricane projections.

"You have to decide how much corporate net worth you'll put up at risk. We need to know our gross and net loss potential and then bal-

jection, Mr. Doyle said.

He also said that the Gray study lacks two key elements that insurers and reinsurers could use to better manage their hurricane risk and exposure: It is not released during renewal season and it does not predict where the storms will hit.

"The direction of the storm has ultimate bearing on loss. If it hits an uninhabited part of Mexico and peters out, who cares if it was a Grade 4?" Mr. Doyle asked.

A spokesman for the National Hurricane Center in Miami also cautioned against reading too much into Mr. Gray's forecast.

"It is often assumed, especially in the insurance industry, that an increased level of activity means more (hurricanes) will make a landfall and do a lot of damage, and no one can tell you that. Besides, what does it matter, anyway? It only takes one," the spokesman said, referring to Hurricane Andrew.

In order to provide comprehensive hurricane forecasts to insurers and all businesses that can be affected by heavy storms, the Bermuda Biological Station for Research has begun a project called the Risk Prediction Initiative, which in theory would "forge a closer connection between science and business," said Tony Michaels, an associate research scientist with the station.

Mr. Michaels said other scientists besides Mr. Gray are doing state-of-the-art climate variability studies, but noted that the information collected by these other researchers is not being processed en masse and put out in one usable form for the public.

"We'd like to format all that in-

formation and then get it out to all businesses affected by climate changes. Now, the question is, if Bill Gray in Colorado says there's going to be six storms, can you use that information or is there more you need?" Mr. Michaels asked.

Business needs input on weather patterns from more meteorologists and scientists than just one group, he contends. "Others are doing the statistical analysis on climate, but they're not going public with it in the same way" as Mr. Gray. "But, surprisingly few are actually working solely on hurricanes."

With most scientists agreeing with the CSU forecast, though, the Insurance Institute for Property Loss Reduction is urging insurers to help policyholders prepare for the worst.

A spokesman for the Boston-based insurer-supported organization said it's important for insurance companies to take catastrophe forecasts seriously and do what they can to mitigate loss.

"For commercial buildings, there may not be that much you can do now besides moving out loose debris, but residential buildings can get shutters ready and put up hurricane clips on the roof," the spokesman said.

Barnett Banks Inc., which has 700 properties in Florida, isn't taking any extra risk management steps based on Mr. Gray's forecast.

"He's just like any other weatherman, so I don't put a lot of weight behind it. We've already done what we're going to do," said James Dineen, risk manager for Jacksonville-based Barnett Banks.

"If I haven't taken proper precautions for hurricanes yet, then I'm in trouble. It's a little late now," he added. **BI**

# Wharton

Continued from page 2

The endowment brought to fruition the school's desire to recognize the field of employee benefits as an academic discipline, said Mr. Rosenbloom.

The school already had considerable experience in benefits education. For 19 years, it has developed the curricula for the Certified Employee Benefits Specialist professional designation. Mr. Rosenbloom is the academic director of the CEBS program.

The IFEBP grant enabled Wharton to also develop courses in employee benefits within the school's insurance and risk management department.

Since the professorship was established, progress in course devel-

opment has been excellent, said Mr. Rosenbloom. "We've developed a few courses and still have more on the drawing board," he said.

Currently, the insurance and risk management department offers about two employee benefits courses per semester.

Offerings have included: employee benefit plan design and financing, employee benefit planning, and social insurance measures such as Social Security and Medicare.

A wide range of students, from traditional undergraduate and graduate students to people already working in employee benefits, have taken the classes.

"There's also been a spin-off effect," said Mr. Rosenbloom. "We try to incorporate employee benefits materials into the broader insurance courses in the undergradu-

ate, MBA and Ph.D. programs."

The changes within the benefits field over the past five years have had a great impact on course material, said Olivia Mitchell, who in 1993 was selected to fill the benefits professorship at Wharton. Previously, she had been a professor of labor economics at Cornell University for 16 years. The position, called the International Foundation of Employee Benefit Plans Professorship of Risk Management and Insurance, was not filled until three years after its establishment because it first had to be partially funded.

Because of the constant changes in the employee benefits field, people spend a lot more time thinking about benefits and their consequences, she said.

"There's been a shifting of responsibility to employees, who

must now learn about their benefits and know what's available to them," said Ms. Mitchell, who teaches both undergraduate and graduate courses in employee benefits.

"People are worried about whether or not they are making the right decisions about their benefits," she said. "They are aware that in some cases, they won't know for years if they made the right decision."

The constant changes create "confusion and discomfort among employees," she said.

"What I have to teach to students is how they must make their employees feel comfortable and help them understand their benefits."

To help her students keep up with the constant changes, Ms. Mitchell tries to strike a balance between conceptual material and current practices.

"We do a lot of case studies and look at what some companies are doing," she said. Guest speakers, including actuaries, benefits managers and chief financial officers frequently talk to Ms. Mitchell's classes about their companies' benefit plans.

"Then we deal with the theoretical issues, such as what benefits do, how they help employees, and what their consequences are," she said.

Some curriculum changes in the employee benefits courses at Wharton also reflect the constantly evolving global workforce.

"We get into the concept of international benefits a lot more now," said Mr. Rosenbloom. A new course, "Employee Benefits for a Global Workforce," examines whether employees working in different parts of the world should receive identical benefits.

Approximately one-third of Wharton students are foreign, which "makes for a good educa-

tion," said Ms. Mitchell.

Foreign students describe their countries' benefit plans in classes so students can compare the United States' and other nations' systems.

"Students begin to realize that what we do in the United States as far as benefits are concerned is not the norm," said Ms. Mitchell.

The changes in the benefits field have led to an increased awareness about employee benefits among students, said Mr. Rosenbloom.

He noted that some students take a personal interest because they are looking for jobs themselves and they realize the importance of knowing their choices.

"People are finally starting to understand that employee benefit plans go way beyond the concept of fringe benefits," Mr. Rosenbloom said. "They're beginning to see that this concerns their financial security and future." **BI**

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# Trigger

Continued from page 1

Although the high courts in four other states have adopted the continuous trigger theory—not all in pollution cases—many attorneys expect the California ruling to be influential.

Policyholder attorneys also say their clients will now find it easier to obtain coverage for pollution claims in California without having to resort to lawsuits.

"The court has opened the door for the spreading of costs among multiple insurance carriers and that should lead ultimately to fewer coverage disputes and fewer lawsuits," said Dorn Bishop, an attorney with Latham & Watkins in San Diego who represented Montrose and drafted the briefs used in the appeal.

However, an attorney for Admiral said the case's impact is not so clear-cut. "The definition of what is 'continuous or progressively deteriorating' must still be settled" in such cases, said Peter Abrahams, a partner in the Encino, Calif., firm of Horvitz & Levy.

In its decision, the state Supreme Court ruled that Admiral could be liable even though the environmental damages in question first happened before its policy went into effect.

"In the case of successive policies, bodily injury and property damage that is continuous or progressively deteriorating throughout several policy periods is potentially covered by all policies in effect during those periods," the state's high court stated in its 60-page opinion.

"Stated in the insurance industry's parlance, we conclude the 'continuous injury' trigger of coverage should be adopted for third-party liability insurance cases involving continuous or progressively deteriorating losses. In this case, because the potential of coverage arose under Admiral's policies, so too did its duty to defend Montrose in the underlying lawsuits," the court said.

While other state high courts have ruled similarly, the California decision is significant because it's often a harbinger state, attorneys say.

"Any decision the California Supreme Court renders is precedentially significant," said Barry Ostrager, a partner at Simpson Thacher & Bartlett in New York.

The court stated that the plain language of the policy supports the continuous theory trigger. And it also examined the decades-old drafting history of CGL policies and concluded that the continuous trigger theory is consistent with the intention of insurers.

"The insurance industry hates that because they have been fighting all over the country to keep this drafting history out of litigation," said David L. Mulliken, national chair of Latham & Watkins environmental department and lead attorney representing Montrose in the case. "They have fought bitterly to keep drafting history out of courts."

Policyholder attorneys were quick to point out that insurers have argued over the years for the "manifestation" trigger, under which only the policy in effect when damage is first manifested could be tapped.

"It's resounding," said Jordan Stanzler, a partner in San Francisco with Anderson Kill Olick & Shinsky, a policyholder firm that filed an amicus brief in the case.

The justices "take everything apart, piece by piece and then put it back together again. They really look on all the arguments. It brings coverage to what had been a murky

area," Mr. Stanzler said.

Another coverage attorney characterized the ruling as a warning to insurers.

The decision increases an insurer's liability because now policies written years ago are at risk for legal defense costs against claims that repeated exposure to hazardous substances caused progressive or deteriorating property damage or bodily injury, said Jeffrey Kaufman, a partner in San Francisco for Kaufman & Logan.

"This decision sends a message to insurers that they'd better get their underwriting houses in order or they will pay for losses they never intended to cover," Mr. Kaufman said.

The California court also rejected the insurer's argument that "the fact that Montrose knew it was more probable than not that it would be sued is not enough to defeat the potential for coverage."

The high court's ruling affirms a 1992 decision in which a state appeals court in Los Angeles ruled that a policyholder facing pollution claims is entitled to CGL coverage from the time pollution first begins

until the time liability is known (BI, March 9, 1992).

The case stems from property damage and bodily injury claims arising from waste dumped at the Stringfellow acid pits near Riverside, Calif.

Montrose manufactured DDT for use in pesticides from 1947 to 1982. The now-defunct company pur-

court ruled in favor of Admiral, which argued that the property damage and injuries stemming from the pollution did not occur during its policy period. The trial court also agreed with Admiral that a manifestation trigger of coverage should apply.

While the case arose out of a defense coverage dispute—and Cali-

## The Montrose decision tells insurers 'they'd better get their underwriting houses in order or they will pay for losses they never intended to cover,' says Jeffrey Kaufman.

chased primary and excess CGL insurance from seven insurers from 1960 to 1986. All but one—Admiral Insurance Co., which sold four CGL policies to Montrose from 1982 to 1986—agreed to provide a defense to property damage and bodily injury claims related to the waste site.

Montrose sued Admiral seeking coverage for defense costs. A trial

California's Supreme Court noted it was only ruling on the duty to defend—the decision's impact is significant because environmental litigation primarily involves defense costs, attorneys say.

"The duty to defend is overwhelming" in environmental cases, said Mr. Abrahams, Admiral's attorney.

# Value Health, J&J enter joint venture

AVON, Conn.—Value Health Inc. and Johnson & Johnson Inc. jointly will develop disease management products and services under a new five-year contract.

Two subsidiaries—Value Health Sciences Inc. of Santa Monica, Calif., and Johnson & Johnson Health Care Systems Inc. of Piscataway, N.J.—will create integrated health management programs to assist managed care organizations and medical providers in delivering high-quality, cost-effective care.

Under the terms of the contract, Value Health Sciences will form a multidisciplinary team of health services researchers and medical professionals dedicated to J&J's work.

Value Health previously had entered into a similar disease management arrangement with Pfizer Inc.

For more information, contact Judith Hyfield-Starr at Value Health at 203-678-3472, or Sarah Colamarino at Johnson & Johnson at 908-562-3132.

## D&O joint venture

NEW YORK—A new joint venture of Chicago-based CNA Insurance Cos., Centre Reinsurance Co. of New York and Zurich-American Specialties, a Zurich-American Insurance Group unit, will focus on writing multiyear finite risk directors and officers liability insurance for financial institutions.

Up to \$30 million of capacity per risk will be underwritten. The venture is set up and ready to go and business will be written "as soon as it comes in the door," said a Centre Re spokeswoman. She would not say how much business the venture is projected to write.

For more information, contact William Jewett, senior vp of underwriting and business development at Centre Reinsurance Co. of New York, at 212-898-5388.

## Large property risks

HARTFORD, Conn.—ITT Hartford Group Inc. is using a new product called "Major Account Cornerstone" to expand from the small to mid-size commercial property market into the large commercial property account market.

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Accounts must have a total insurable value of at least \$10 million and meet minimum requirements of a \$50,000 property premium and a \$5,000 deductible.

The product currently is filed in 49 states and approved in 46. Additional information is available by

## Markets

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## Risk management unit

SCHAUMBURG, Ill.—A new risk management services unit of Roanoke Brokerage Services Inc. will concentrate on marketing to and servicing corporations with complex risk management challenges.

The new unit, located at the company's headquarters in Schaumburg, Ill., will be headed by John W. Elder and Ralph M. Wilson, both vps. For more information, contact Roanoke Brokerage Services at 708-490-9540 or 800-762-6653.

In 1994, parent company The Roanoke Cos. Inc. reorganized its nine individual national insurance brokerage subsidiaries into the single Roanoke Brokerage Services unit, with Robert P. Froese named president and chief operating officer of the new corporation.

## Syndicate reactivated

CHICAGO—The reactivated RCA Syndicate #1 Ltd. on the Illinois Insurance Exchange is interested in underwriting casualty coverages, including professional liability insurance for podiatrists and environmental consultants.

The original syndicate began its IIE affiliation in 1982, though it has been inactive for several years.

RCA was reactivated last month by L&W Holdings Inc. of Las Vegas to take advantage of the syndicate's name recognition and some prior state approvals, among other things, said Steven M. Lademan, president of Principal Management Inc. in Lansing, Mich. He will oversee the syndicate's operations.

He expects the syndicate also will follow in Principal's footsteps and write excess indemnity coverage for Texas employers that are non-subscribers to that state's workers compensation system. It also may provide limousine operators with commercial liability and physical damage coverages.

Mr. Lademan is a director of both L&W and Pegasus Insurance, which is domiciled in the Cayman Islands.

For additional information, call Mr. Lademan at 800-397-1853.

## J&H energy unit

HOUSTON—A new global energy unit at Johnson & Higgins will serve the risk management needs of the oil, gas and petrochemical industries.

The new unit, based in Houston, will be headed by William J. Keckeisen, a managing principal. The unit also will have offices in Dallas, Denver, New Orleans and Tulsa, Okla.

For more information, call 713-651-1900.

## Health care merger

LOS ANGELES—Managed behavioral health care and employee assistance program services providers Managed Health Network Inc. and Health Management Center have merged.

HMC will retain its own name and function as a separate division of MHN to handle trust fund and labor accounts. Terms of the transaction were not disclosed.

With the merger, MHN's individual provider network will increase nearly 50% to 14,850 nationwide while its total contracting facilities will nearly double to almost 900. The new alliance will serve more than 380 clients representing about 2.3 million covered lives.

For more information, contact MHN in Los Angeles at 213-299-0999.

## Voluntary benefits

CHICAGO—Jardine Insurance Brokers Inc. has formed a new voluntary benefits division specializing in the enrollment of voluntary payroll deduction universal life and associated products.

The new voluntary benefits division will perform all marketing, administrative and enrollment functions and is designed to market

Policyholder attorneys contend the California court is certain to also apply the continuous trigger theory to indemnification claims.

"It's just hard to think why this wouldn't apply," Mr. Stanzler said. "It's hard to imagine they would come up with a different rule for indemnity."

Several other attorneys also think that the decision may have some repercussions for indemnity coverage since the contractual language in Montrose's insurance policies is identical to the language used for covering other losses, including product liability and construction defects.

"Under the language of most third-party liability insurance policies, coverage will be triggered if damage occurs during the policy period—not when it is discovered or manifests itself," said Mark Newell, an attorney for Latham & Watkins, one of the Montrose attorneys.

*Montrose Chemical Corp. vs. Admiral Insurance Co.; California Supreme Court, July 3, 1995, SO26013.*

turnkey enrollment services to Jardine clients and independent insurance agencies throughout the country.

Cesar Goldman has been named president of the new Chicago-based division. For more information, call Mr. Goldman at 800-526-6672.

## Operations transfer

HONOLULU—Industrial Indemnity Co. plans to transfer all underwriting functions from Honolulu to Seattle in an effort to reduce the cost of operating in a "difficult workers compensation market."

About 15 workers will make the move. Industrial Indemnity's claims service and marketing will not be affected.

"We've been in Hawaii since 1959," said Jack Miller, the San Francisco-based company's CEO. "But over the last several years, a variety of factors in the workers compensation system have affected our ability to achieve our goals in the state. It is our hope that recent legislation and additional needed reforms will take place to help improve the current situation in workers compensation for all concerned. Unlike other insurers who have exited the market, however, it is our intention to continue to serve the Hawaii employer community."

Hawaii Gov. Benjamin J. Cayetano on June 29 signed a comprehensive workers comp reform package that employers hope will contain runaway costs (BI, May 22).

For more information, contact Industrial Indemnity in Seattle at 206-667-3800.

## Buck opens office

NEW YORK—Buck Consultants Inc. has established a consulting office in Trinidad and Tobago. The practice, named Buck Consultants Ltd., is located in Port of Spain with the staff headed by Kyle Rudden. The new office can be reached by phone at 809-637-6449 or by fax at 809-633-7968.

## Willcox in Seattle

NEW YORK—Willcox Inc. Reinsurance Intermediaries has opened an office in Seattle.

The new office's address is 11 Third Ave., Suite 2500, Seattle, Wash. 98101, and the telephone number is 206-583-8350. New York-based Willcox is a wholly owned subsidiary of Johnson & Higgins.

# Maternity

Continued from page 1  
hospital, down from an average of 3.9 days in 1970. During the same period, the average length of stay for women giving birth by C-section fell to four days, down from an average of 7.8 days.

The decline shows no sign of abating. Managed care organizations, for example, are experimenting with programs in which women and babies are discharged in 12 hours or less.

In the view of some politicians, childbirth has become little more than a "drive through delivery." They believe short hospitalizations are placing at risk the health of both newborns and mothers.

Sen. Bill Bradley, D-N.J., one of the sponsors of the Senate legislation to mandate coverage for a minimum length of stay for a mother and child following birth said a 24-hour stay does not allow health professionals to detect many health problems facing newborns, such as jaundice and dehydration.

In addition, a 24-hour stay, he said, does not give mothers the opportunity to be taught basic infant-care skills, such as breast-feeding.

"This, combined with the fact that many mothers are simply too exhausted to care for their child 24 hours after delivery, often leads to newborns receiving inadequate care and nourishment during their first crucial days of life," Sen. Bradley said.

It is time, Sen. Bradley added, for legislators—by mandating minimum lengths of health care coverage for childbirth—to counteract what he says are the negative effects of premature discharges.

But managed care organizations and others say there is no evidence that earlier discharges are leading to an increase in health care problems for mothers or their infants.

In normal deliveries, "It is medically appropriate for women to go home after 24 hours. It has been shown over the years—with that policy in place—there has been no increase in readmissions or complications," said a spokesman for Prudential Insurance Co. of America in Newark, N.J.

"There is no body of evidence that earlier discharges have led to an increase in adverse health outcomes," adds Mary Case, a principal with Kwasha Lipton L.L.C. in Fort Lee, N.J.

HMO executives say it isn't just efforts to lower costs—the average cost for a vaginal delivery in 1993 was \$6,430 and \$11,000 for a C-section—that have driven them to reduce coverage periods for uncomplicated deliveries. They argue that getting women and their infants out of the hospital faster is better for both, noting the greater likelihood of being exposed to infections in hospitals.

"Going back to the home environment is generally healthier for the mother and the child," says Larry Rambo, president of Prime Care Health Plan Inc. in Milwaukee.

HMO officials and others also say the debate over what should be a minimum length of hospitalization for childbirth obscures what they say is a much more important issue: the type of care an expectant mother receives throughout her pregnancy and after she goes home.

"It is important to view pregnancy and childbirth as a process," says a spokeswoman for the Group Health Assn. of America, a

HMO trade association in Washington.

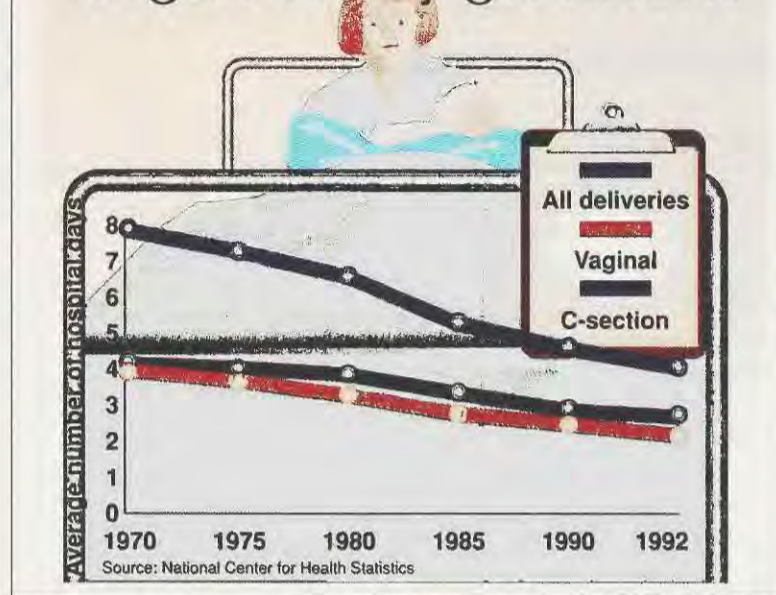
"The real issue is the entire continuum of care from prenatal through followup after the mother goes home," said Suzanne Mercure, benefits administration manager at Southern California Edison Co. in Rosemead, Calif.

Indeed, in birthing centers—where mothers typically go home 12 hours or less after giving birth—the emphasis on prenatal care and education "makes us feel

While average lengths of inpatient hospital stays for childbirth have been falling, some employers, though, have been increasing coverage.

Engineering Research Associates Inc. recently expanded coverage for C-sections to four days from three days because of employee concerns and because research revealed that four-day coverage was the norm, said Nina Falci, benefits manager for the Vienna, Va.-based company.

## Lengths of stay get shorter



GRAPHIC BY MIKE GARVEY

comfortable that the mother will know how to handle and feed their baby when they go home," said Ruth Watson Lubic, general director of Maternity Centers Assn. in New York.

Also lost in the debate over what should be a minimum length of stay, HMO officials say, are their efforts to provide more care to mothers after they leave the hospital.

For example, Prime Care automatically includes coverage for a followup home visit by a health care professional within 48 hours after the woman has been discharged from the hospital.

The mother may have more questions at home because, unlike in the hospital, she now has to take full care of the baby, Prime Care's Mr. Rambo said.

## 'Horseplay' ruling upheld

Injury covered by comp system, court rules

SAN BERNARDINO, Calif.—Injuries caused by horseplay specifically condoned by an employer are compensable under the exclusive remedy of workers compensation, a California state appeals court ruled last month.

The decision stems from a case in which three defendant employees cited the exclusive remedy provision when a co-worker sued them for negligence after she suffered a back injury when they lowered her chair and she abruptly sat in it.

The plaintiff was a part-time cashier for First Federal Credit Union in San Bernardino when the injury occurred in 1986.

She received workers comp benefits for the injury and then sued her three co-workers in San Bernardino County Superior Court.

In a deposition, a supervisor stated that the credit union encouraged practical jokes and pranks as a way to build camaraderie. The court ruled that the co-workers acted within the scope of their employment and granted their motion for summary judgment,

according to their Los Angeles attorney, H. Vincent McNally.

In appealing the lower court's ruling, the plaintiff argued that the trial court erred in part because she believed practical jokes were not common and not condoned by the employer.

But the appeals court disagreed, arguing in part that an injured worker cannot recover damages from a co-employee if the employer would have been liable for the co-employee's tort had the injured person not also been an employee.

The state appellate court also found that the co-workers were within the scope of their employment.

"The injury resulted from a risk created by the employer when it urged its employees to engage in pranks and practical jokes," the judges concurred.

*Susan Oliva et al. vs. Peggy Heath et al.*, California Court of Appeals, 4th Appellate District, No. EO12513; June 9, 1995.

—By Roberto Cenicerros

## Updates

### Some robbery losses covered

BERLIN—A spectacular bank robbery in Berlin recently may cost insurers several million dollars.

On June 27, four robbers vanished into tunnels they had excavated beneath a Commerzbank branch in suburban Berlin with 5 million DM (\$3.6 million) in ransom money and an undetermined amount taken from safety deposit boxes.

The heist baffled police, who had surrounded the building and blocked an apparent getaway van after four armed masked men entered the bank and took more than a dozen hostages.

After nine hours, police delivered 5 million marks (\$3.6 million) in plastic garbage bags to a bank entrance. While the police waited outside, the robbers escaped with the loot through a hole chiseled in the basement floor. The hostages were not harmed.

Commerzbank said its theft insurance would cover damages suffered by bank customers. Under certain circumstances, normal theft and robbery insurance in Germany could cover such a loss.

A spokesman would not say whether the bank had kidnap and ransom coverage. Such policies are voided if the policyholder discloses that it has coverage.

### Lloyd's capital changes

LONDON—Lloyd's of London is moving closer to becoming a market of insurance companies rather than syndicates under several changes in corporate capital regulations announced last week by Chairman David Rowland.

The changes, outlined in a report to be published this week, include permission for corporate members and insurers to fully own Lloyd's managing agents for the first time.

Capacity rules also are being relaxed, allowing corporate investors to fully capitalize individual Lloyd's syndicates. Solvency requirements for these investors will be assessed individually to reflect the spread of business being written.

Meanwhile, Lloyd's for the first time will hold four weekly auctions for 1996 capacity starting Aug. 3, to give 1995 members the opportunity to sell syndicate participations in 1996.

Also, the 12-person names' advisory committee, which will advise the Council of Lloyd's on the allocation of the £2.8 billion settlement offer (\$4.48 billion) in the rescue package presented in May (BI, May 29), was selected last week from all parts of the Lloyd's membership, including prominent action group members.

The committee includes: Michael Deeny, chairman of the Gcoda Walker Action Group; Angela Gillibrand, a Lloyd's name; Richard Hartley, a member of the High Premium Group, an association of big-ticket investors at Lloyd's; Desmond Heyward, a name; Damon de Caszlo, chairman of the Feltrim Names Assn.; John Mays, chairman of the Merrett 418 (1985) Names Assn.; Christopher Messer, chairman of the Janson Green Action Group; Alan Porter, chairman of the Devonshire Names Action Group and Cuthbert Heath Names' Assn.; John Rotson, director of Anton Members Agency Ltd. and a working name; Richard Spooner, chairman of Gresham 321 Action Group and committee member of the Assn. of Lloyd's Members; and Bernhard Steinhart, a name.

Sir Adam Ridley, a committee member of the ALM, is the chairman. Lloyd's Chief Executive Peter Middleton will attend the meetings to act as a facilitator.

### Environmental reporting guide

NEW YORK—All businesses would have to accrue environmental clean-up liabilities under a proposal before the Financial Accounting Standards Board.

Under a draft written by a committee of the American Institute of Certified Public Accountants, the liabilities to be accrued would include: incremental direct costs of remediation; the costs of compensation and benefits for employees' expected time devoted to clean-up tasks; a company's share of the liability for specific sites; and its portion of the amount that other parties or the government will not pay.

In addition, the draft includes guidance on the inclusion of environmental clean-up liabilities in financial statements and on disclosures about environmental cost-related accounting principles, and loss contingencies for clean-ups.

The proposed guidelines "appear redundant" at first glance, said Cheri Hawkins, assistant treasurer and director of insurance for Weyerhaeuser Co. in Tacoma, Wash., and chair of the Risk & Insurance Management Society Inc.'s environmental committee.

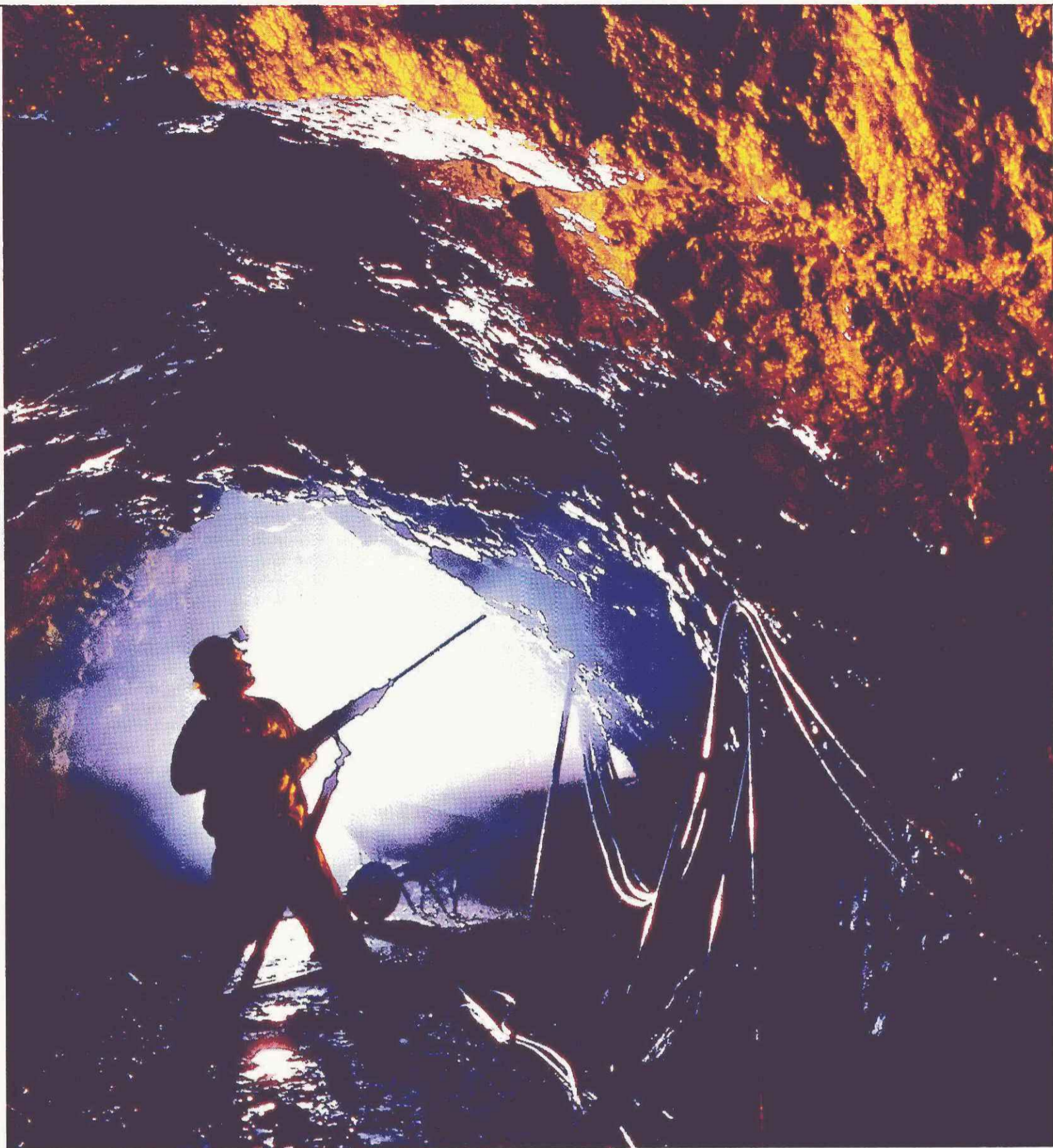
"Internal costs are already built into the company's numbers, so if you accrue them again, you're doubling up," she said. "They're not additional contingent liabilities that need to be dealt with."

If approved by FASB, the guidelines would become generally accepted accounting principles. The AICPA executive committee expects the guidelines to become effective for fiscal years beginning after Dec. 15, 1995. It is soliciting comments on the proposed guidelines from financial statement preparers, auditors, users and other interested parties. The deadline for comments is Oct. 31.

### Briefly noted

The House Appropriations Committee's Subcommittee on Veterans Affairs, HUD and Independent Agencies is expected to vote to slash appropriations for the federal Superfund program when it meets today. . . Burnham, Pa.-based Freedom Forge Corp. reached an agreement with the Pension Benefit Guaranty Corp. to make supplemental contributions to a pension plan through October 1999 to ensure the plan has liquid assets to cover at least three years of benefit payments. The plan has \$12 million in unfunded liabilities, while three other plans provided by the manufacturing firm have \$33 million in unfunded liabilities.





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