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Update

Court upholds random tests for drug use by airline workers

SAN FRANCISCO—Airlines must randomly test employees for drug use, the 9th U.S. Court of Appeals has ruled, upholding a Federal Aviation Administration regulation.

"The court of appeals held that the FAA's interest in promoting air safety through random drug testing outweighed aviation industry employees' Fourth Amendment right to be free from unreasonable search and seizures," a summary of the decision said.

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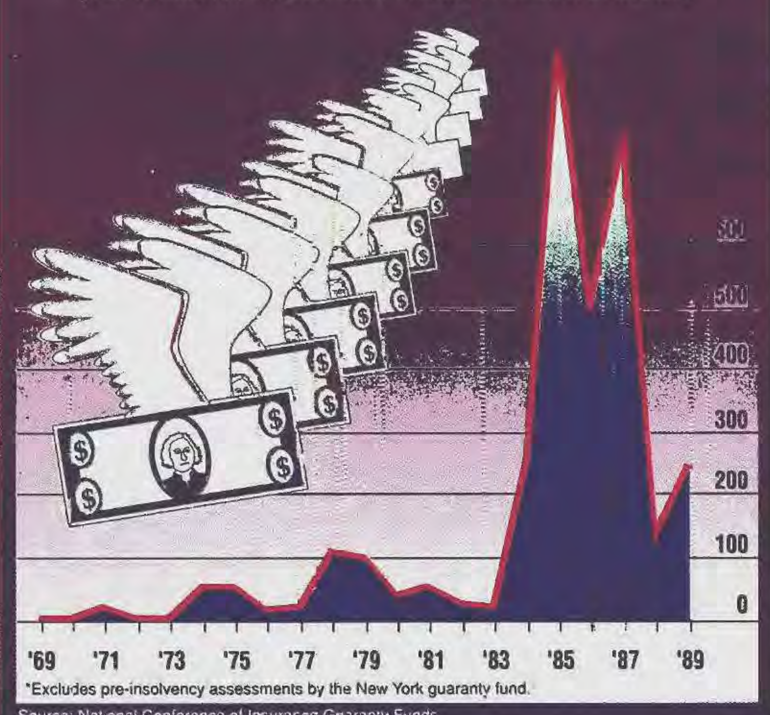

BI/JOHN HALL

Mid-'80s failures hike guaranty fund costs

$2.4 billion assessed for '84 to '87

By JERRY GEISEL

INDIANAPOLIS—Cleaning up the corpses left by savage property/casualty rate wars in the early 1980s already is costing insurers billions of dollars, and the ultimate tab remains uncertain.

State guaranty funds have assessed solvent property/casualty insurers about $2.4 billion to pay for claims against the 72 insurers that failed between 1984 and 1987, according to a new report by the National Conference of Insurance Guaranty Funds, an Indianapolis-based trade group.

Costs of earlier failures are dwarfed by the cost of insolvencies during those four years.

The $2.4 billion needed to pay claims against the insurers that became insolvent during 1984 through 1987 is more than four times the $513.2 million needed to pay claims against insurers that went under in the preceding 15 years.

And the 1984-to-1987 assessments represent nearly 75% of the more than $3.3 billion in assessments for insurers that failed between 1969 and 1989, according to the guaranty fund report.

The $3.3 billion figure excludes assessments made by the pre-insolvency guaranty fund in New York.

Already nearing the $2.5-billion mark, the tab for the 1984-to-1987 insolvencies is sure to rise.

That is because guaranty funds typically only assess insurers as funds are needed to pay claims owed by failed companies. Since claims on long-tail coverages can come in for years after the insurer was declared insolvent, determining the ultimate cost of an insolvent company's claims can take a decade or longer.

"The book is still open on many insolvent insurers," said James Lane, counsel for the guaranty fund trade group.

"There are still a lot of dollars left in the pipeline," agreed Phillip Schwartz, a vp with the American Insurance Assn. in Washington, D.C.

Last year, for example, guaranty funds assessed $10.4 million to cover claims of insurers that failed between 1970 and 1980. And they assessed another $411.3 million in 1989 to pay for insolvencies of

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N.Y. employers blast work comp reforms

By DOUGLAS McLEOD

ALBANY, N.Y.—New York employer groups are blasting a workers compensation bill they say dramatically boosts their costs while providing few cost-cutting reforms.

The bill, passed by the New York Legislature this month and expected to be signed soon by Gov. Mario Cuomo, provides long-delayed increases in the maximum benefits payable to injured workers and makes several other changes in the state workers comp system.

While conceding that New York benefit levels have lagged far behind those of many states, employer groups complain that the measure—which nearly doubles the maximum benefit for partially disabled workers effective immediately—imposes large increases too quickly.

Workers comp premiums could soon rise $486 million for insured employers, with another $210 million in hikes possible as higher benefits are phased in over the next two years, according to the New York Compensation Insurance Rating Board.

Left out of the bill are several reforms employers pushed for, including limitations on stress claims, alcohol- and drug-related claims and elimination of employer liability when injured workers sue third parties.

"We could not be more disappointed in the outcome," lamented Paul Magaril, vp-government affairs with the New York Chamber of Commerce.

"Benefits had to be increased. They were far too low," he conceded. But "this was an opportunity to eliminate some of the abuses and unnecessary costs in the system. It was an opportunity that unfortunately was lost."

"There is not one cost-saving reform or system change contained in that bill," complained Robert Gaines, vp-government affairs with the American Insurance Assn. in Washington, D.C. "I don't think business got anything, and if they did it was window dressing.

"If I were a business in New York I would be disappointed, and if I were labor I would be thrilled," he added.

Labor officials in fact expressed satisfaction with the first increase in New York workers comp benefits in five years.

"In our opinion, it was long overdue," said Ed Donnelly, director of legislative affairs for the AFL-CIO in Albany.

Legislative efforts to increase work comp benefits have failed in each of the last three years, Mr. Donnelly noted.

"Since the benefits are three years late, (employers) are probably enjoying all the

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IIS honors Barlow

Risk manager in hall of fame

By LINDA J. COLLINS and STACY SHAPIRO

PARIS—Douglas Barlow, the first risk manager to be inducted into the Insurance

Hall of Fame, is a described by colleagues and friends as a true "Renaissance man."

Despite his retirement as risk manager of a Canadian multinational in 1972, Mr. Barlow remains a scholar, innovator and educator at the age of 83, they point out.

For his achievements as a risk manager from 1959 to 1972, Mr. Barlow was entered into the Insurance Hall of Fame at an awards ceremony during the International Insurance Society conference in Paris last week. Founded in 1957, the Hall of Fame includes 79 people from 13 nations.

It recognizes "major figures in the history of insurance," according to the IIS, which has been sponsoring the ceremonies since 1984.

"Doug is a futurist and he was a futurist for his whole career. His interest in the risk management profession has never abated: retirement hasn't stopped him at all," said P. Richard Hackenburg, executive vp of Corroon & Black of Massachusetts Inc. in Boston.

Mr. Hackenburg noted that Mr. Barlow "has been a lifelong student of the business and was essentially decades ahead of his time. The things he was doing in the '50s and '60s were avant-garde and set

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House panel hears debate on Risk Retention Act changes Page 2

Attorneys oppose class action against Manville injury fund Page 2

Health insurers share blame for rising costs, public says Page 3

NEWSPAPER

Update

FAA drug testing rule upheld

Continued from previous page

The FAA rule affects 538,000 aviation workers (*BI*, Nov. 28, 1988).

Attorneys for aviation workers have less than two weeks to petition the appeals court for a rehearing and about 90 days to ask the U.S. Supreme Court to hear the case, said Stephen Berzon, a partner with Altshuler, Berzon, Nussbaum, Berzon & Rubin of San Francisco. Mr. Berzon represented the two pilots who originally challenged the FAA rule in December 1988, a month after its adoption.

The pilots' petition to the 9th U.S. Circuit Court of Appeals in San Francisco was later consolidated with lawsuits by major aviation industry unions and other airline workers.

Airline employees are still deciding on their response.

Loss cover adequate: ARCO

NEWTOWN SQUARE, Pa.—ARCO Chemical Co.'s business interruption insurance will cover most—if not all—of the company's losses resulting from an explosion and fire at its Channelview, Texas, plant earlier this month, a spokesman said.

The Newtown Square, Pa.-based chemical company last week invoked contractual provisions that allowed it to place customers on a restricted product allocation schedule after the blast. The plant accounts for up to 83% of ARCO Chemical's domestic production of styrene, the spokesman said.

The spokesman noted that damage to the plant was confined to the utilities area and that production areas were not affected.

"We anticipate it will be several months before we can resume production at full capacity, but as we can recover utilities, sections of the plant will be phased in," the spokesman said.

However, the spokesman could not comment on the extent of damages to the facility because company officials are unable to assess damages while the Occupational Safety and Health Administration is investigating the blast. The blast killed at least 17 workers and injured two others.

The company has at least $300 million in property insurance, as much as $400 million in business interruption coverage and at least $300 million in liability coverage, sources say (*BI*, July 9).

The spokesman would not comment on ARCO's insurance.

An OSHA spokeswoman would not comment on the cause of the blast pending completion of the agency's investigation "within six months."

Safety standard proposed

WASHINGTON—Plants that process hazardous chemicals would have to implement stringent safety management programs to analyze potential processing hazards under a Department of Labor standard proposed last week.

Plant owners would have to assess where problems could occur during chemical processing, take corrective steps and develop backup plans in case a processing system fails.

Plans for the standard were announced in April following the 1989 explosion at a Phillips Petroleum Co. plant in Pasadena, Texas, which killed 23 workers and injured more than 130 others (*BI*, Oct. 30, 1989).

Assistant Secretary of Labor Gerard F. Scannell cited that case and the July 5 ARCO Chemical Co. explosion in Channelview, Texas, as examples of the "tragedies" the proposal is designed to avoid.

About 2.2 million employees in 28,000 companies would be affected by the rule, says the Occupational Safety & Health Administration. OSHA projects annual compliance costs for employers at $233 million, but says companies would save $400 million a year from reduced injuries and accidents.

Reinsurance commutation rule

NEW YORK—Any commutation plan offered by an impaired or insolvent insurer must be offered to every ceding insurer within 90 days after the insurer is declared impaired or insolvent under a new New York regulation.

The new rule setting standards for the commutation of reinsurance agreements by impaired or insolvent insurers and reinsurers is intended to avoid insurers' rehabilitation or liquidation and restore their surplus, New York regulators say.

Reinsurers are expected to be the primary users of Regulation 141, said an Insurance Department spokesman. "I don't expect it will be used that frequently. But I think it's important because it's another tool."

Peter Bickford, an attorney with Bickford, Hahn & Hayes in New York, commented, "I think it's a good regulatory tool and should help us feel more comfortable working with regulators in addressing financial viability before it's too late."

A proposal approved by the state legislature in 1989 gives the superintendent the authority to permit an impaired or insolvent insurer to commute reinsurance agreements.

Regulation 141 will not affect the controversial Constellation Reinsurance Co. liquidation, because it applies only to impaired or insolvent firms, and Constellation Re is already in liquidation (*BI*, March 19).

Malpractice settlement covered

SANTA MONICA, Calif.—A settlement that could reach $6 million between a Los Angeles fertility clinic and the mother of the nation's first set of septuplets will be fully covered by insurance.

One of the seven babies was stillborn, and three others died within 19 days. The surviving children suffer varying degrees of mental retardation and health problems, the suit had alleged.

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Errors & omissions

• A provision of California A.B. 4196 would eliminate coverage waiting periods for new employees in a group plan who had previously been covered by another employer's health plan. This was incorrectly reported in a July 9 article on California's health care legislation.

Judge sets a deadline for Manville trust reform

By STACY ADLER

NEW YORK—Attorneys for asbestos victims staunchly oppose consolidating all their claims against the Manville Personal Injury Trust into a nationwide class-action lawsuit, as suggested last week by a federal judge.

However, some attorneys for asbestos producers say a class action is a viable solution to the cash-flow problems plaguing the trust.

Marianna Smith, director of the Manville trust, said she was "surprised" by U.S. District Judge Jack B. Weinstein's suggestion of a class action to consolidate the more than 100,000 claims pending against the trust.

"Two years ago we looked at all these possibilities and we were advised that a mandatory class action would not be successful," said Ms. Smith.

Severe cash-flow shortages have forced the trust—the centerpiece of the Manville reorganization plan—to defer payment to asbestos bodily injury victims for 10 to 20 years (*BI*, Jan. 22).

The fund has only $100 million in cash in 1990 to pay the more than 100,000 pending claims, although the trust's ultimate value based on future contributions from Manville is estimated at $2.5 billion. The trust has paid claims more quickly and at a higher value than was initially anticipated.

To ensure more timely payments to victims, Judge Weinstein, who is overseeing 500 asbestos cases in New York, is attempting to amend the reorganization plan (*BI*, June 4, May 28).

At a hearing last week, the trust was given until Aug. 6 to restructure itself to solve the problems.

Previously, the judge has suggested structured settlements or increased payments from Manville as solutions to the cash flow problems (*BI*, June 11).

In the meantime, the judge issued a temporary restraining order at last week's hearing barring the trust from paying any settlements, judgments, or plaintiffs' attorneys fees until the changes are made. The trust can pay salaries, operational expenses, trustee fees and retained attorneys fees, said Ms. Smith.

While the judge is urging all parties involved with the trust to consider combining all the asbestos personal injury cases into one na-

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New Risk Retention Act amendments debated

Regulators assail bill

By ADRIENNE C. LOCKE

WASHINGTON—Federal legislation designed to clarify some ambiguities in the Risk Retention Act actually would reduce state regulators' scrutiny of risk retention groups and purchasing groups, opponents told a House panel last week.

Regulators would be reluctant to take any action against questionable groups because the bill designed to clarify the Risk Retention Act, H.R. 4351, subjects their actions to intervention by federal authorities, asserted Zack Stamp, director of the Illinois Department of Insurance.

Mr. Stamp testified at a House Commerce, Consumer Protection and Competitiveness Subcommittee hearing last Wednesday.

In addition, the bill would eliminate fees that regulators can charge both types of groups, which would reduce the money available for stepped up solvency examinations of these groups, Mr. Stamp said.

However, supporters of H.R. 4351, introduced in March by Rep. James Slattery, D-Kan., say the proposed changes to the Risk Retention Act would help ensure the financial stability of risk retention groups and risk purchasing group insurers without stifling the formation and continuation of these alternatives to conventional insurance arrangements.

One of the major issues is the interpretation of the act's provision permitting a purchasing group to buy insurance from only an insurer that is licensed in the state in which the group is located.

Howard Greene, director of governmental affairs at the Risk & Insurance Management Society Inc. in New York, said RIMS interprets this provision to mean the insurer has to be licensed in the home state of the purchasing group, or in the state that the purchasing group declares as its principal

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Record AIDS verdict spurs call for cap on malpractice awards

By MICHAEL BRADFORD and MARK A. HOFMANN

PHOENIX—A physician is seeking a new trial after a state court jury awarded $28.7 million to a 5-year-old boy and his parents in what is believed to be the largest-ever malpractice award in an AIDS case.

Last month the Phoenix doctor was found negligent for allowing the child to receive a transfusion of tainted plasma shortly after his birth in 1985. The boy has since tested positive for acquired immune deficiency syndrome.

Compensatory damages of $26.7 million were awarded to Alex Edwards, while each of his parents was awarded $1 million in compensatory damages.

The award was several times greater than settlement offers made by the parents but rejected by the physician's malpractice insurer.

Meanwhile, the award also has sparked a movement by Arizona doctors to cap malpractice awards.

It is "the largest we've seen" in a malpractice case involving AIDS, said plaintiffs' attorney R. Douglas Dalton of the Phoenix firm Meyer, Hendricks, Victor, Osborn & Maledon. "We've never seen one close to this."

The jury made the award at the conclusion of the second part of a bifurcated trial. In the first part, the jury in May found Dr. Abraham Kuruvilla liable for infecting the child with the human immunodeficiency virus—which causes AIDS—and failing to obtain parental consent to perform the transfusion in which the boy was

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- In Speaking Out, Joseph P. Monteleone of Reliance National Insurance Co. says the prompt advancement of defense costs benefits everyone. **PAGE 19**
- Without a major overhaul of the comp system, cost control efforts will be ineffective, says consultant Jeffrey R. Kreider in Speaking Out. **PAGE 19**
- In International Perspectives, Australian risk manager Kevin D. Mutch reviews some of the issues raised by recent litigation with a captive for coverage. **PAGE 23**

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Who's to blame?

A Blue Cross & Blue Shield survey asked 2,000 Americans to what extent they believe certain groups and factors are responsible for rising health costs.

	Great deal	Some	Very little	None	Don't know
Health insurance companies	56%	34%	6%	2%	2%
Hospitals	55	38	4	1	2
New medical technology	44	43	7	2	4
Doctors	38	50	8	2	2
Federal government	35	46	10	4	5
General economic conditions	30	51	11	3	5
Individuals who use medical services	23	48	17	8	4
Employers	13	44	26	13	4

Source: Blue Cross & Blue Shield

BI/JOHN HEILAND

Health insurers at fault for rising costs: Public

By JERRY GEISEL

WASHINGTON—Health insurance companies are just as responsible for rising health care costs as hospitals, according to a new public survey.

Fifty-six percent of Americans responding to a Blue Cross/Blue Shield Assn. survey place a "great deal" of blame on health insurers for soaring medical care costs, while 55% blame hospitals for health care cost escalation.

Only 13% pin the blame on employers.

The public also believes insurers and hospitals have an equal responsibility to control health care costs.

Forty-six percent of the public said both insurers and hospitals have a great deal of responsibility to try to control health care costs.

The survey, "Second Opinions: America's Voices and Views on Health Care," also found that most of the public believes the federal government should do more to assure that everyone receives needed health care services.

However, the public is sharply divided over whether the government should administer health care programs.

And, while a majority of respondents say they would agree to pay more taxes to assure that all Americans have health care coverage, only 10% said they would be willing to pay as much as $1,000 annually in new taxes for universal health care coverage.

Only a small percentage of the survey respondents believe health care is the most important problem facing the nation, but most believe that rising health care costs are leading to a future crisis.

These findings are contained in a new BC/BS survey that was released last Thursday at a press conference in Washington, D.C.

As a major player in the nation's health care delivery system, BC/BS "felt it was necessary to listen to the American consumer," explained BC/BS President Bernard Tresnowski.

The Gallup Organization conducted the survey in January, obtaining responses to a wide range of health care issues from 2,000 adults.

Fifty-six percent of the respondents had annual household incomes of at least $40,000.

In addition, 20.6% of the respondents were college graduates, 24% had attended but did not complete college, 36.1% were high school graduates and 18.6% did not graduate from high school. Less than 1% did not disclose education information.

Perhaps the most interesting survey result is that the survey respondents blame health care insurers and hospitals nearly equally for rising health care costs.

Mr. Tresnowski said the public is "shooting" just the bearer of bad news.

"When premiums are raised or benefits cut back, which are reflections of rising health care costs, the insurers are the conveyors of bad news," he said.

But, laying of some of the responsibility for rising

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Define pollution as trespass to get coverage

New policyholder tactic

By STACY ADLER

SAN FRANCISCO—Policyholders are opening a new line of attack against insurers to obtain coverage for hazardous waste cleanups by claiming cleanup costs are covered under the personal injury endorsement to the comprehensive general liability policy.

Pollution is a trespass or nuisance covered by that CGL endorsement, policyholders contend.

If courts agree with the argument, it would be a boon to policyholders because the endorsement does not contain a pollution exclusion or language requiring pollution to be unexpected or unintended.

To date, one federal appeals court has allowed a policyholder to recover cleanup costs under a personal injury endorsement.

Kirk Pasich, a prominent policyholder attorney and an early advocate of this argument, outlined the reasoning behind the argument at a program sponsored in San Francisco last month by the Practising Law Institute, the nation's oldest non-profit legal education organization.

The personal injury endorsement to the standard CGL policy provides coverage for trespasses and nuisances, according to Mr. Pasich of Hill, Wynne, Troop & Meidinger of Los Angeles.

Specifically, the exclusion states it provides coverage for "wrongful entry or eviction or other invasion of the right of private occupancy."

Most policyholders are forced to clean polluted property as a result of claims filed by the U.S. Environmental Protection Agency under the Comprehensive Environmental Response, Compensation and Liability Act, better known as the Superfund act.

Because CERCLA is "an extension of the law of trespass and nuisance," government cleanup orders are insured under the personal injury endorsement, Mr. Pasich explained.

However, many policyholders fail to pursue insurance under the personal injury endorsement, leaving millions of dollars of coverage untapped, he said.

Instead, most policyholders, following their insurers' lead, view pollution as "property damage" and assume that the CGL's property damage provisions must respond to CERCLA or other environmental claims, he explained.

But, "in fact, the personal injury provisions of these policies should cover environmental claims, including trespass, nuisance and CERCLA claims," Mr. Pasich asserted.

"The application of the artificially limiting label of 'property damage' to environmental claims only serves to reduce the insurance coverage otherwise available," he said.

Insurer attorney Victor Rabinowitz of Buchalter, Nemer, Fields & Younger in Los Angeles seemed surprised by the personal injury argument, calling it a "very creative idea."

"Probably, if not certainly, it would get a policyholder a defense from most insurers" for pollution claims against the policyholder, Mr. Rabinowitz said.

"However, I don't know how far it goes toward global resolution of this problem since there are very

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Colonial Penn slaps ex-MGA with RICO suit

By DOUGLAS McLEOD

ATLANTA—Colonial Penn Insurance Co. is pressing civil racketeering charges against a former managing general agent and a reinsurance intermediary, accusing them of fraudulently binding Colonial Penn as a fronting insurer on millions of dollars of trucking business.

In a complaint filed in federal court in Atlanta, Philadelphia-based Colonial Penn charges that American Owner/Operator Underwriters Inc., an Atlanta-based MGA headed by Richard D. Slautterback, and Summit Intermediaries Inc. of Morristown, N.J., dumped more than $30 million in trucking business on Colonial Penn in violation of a $12 million premium cap placed on the MGA operation.

AOO—terminated by the insurer as an MGA in 1986—and several agencies from which it accepted business still owe Colonial Penn more than $7 million in premiums, the lawsuit charges.

Summit Intermediaries also collected $430,000 in refunds owed Colonial Penn by some of its reinsurers, but did not forward the money to Colonial Penn, the complaint charges.

The defendants have denied Colonial Penn's charges and filed counterclaims against the insurer.

Mr. Slautterback and AOO charge, for example, that Colonial Penn terminated AOO's agency contract, took over premium collection and claims payments and rescinded the trucking program's reinsurance coverage in an effort to take over a book of business it knew to be profitable.

Colonial Penn's actions breached the agency agreement, according to AOO, which seeks roughly $41 million in compensatory damages.

Summit, meanwhile, has separately filed a claim seeking additional commissions on business produced by AOO.

The Colonial Penn suit involves business that caused Old Republic Insurance Co. to sue Mr. Slautterback and AOO in 1986, according to Colonial Penn. Old Republic charged that AOO breached its MGA contract and fiduciary duties by failing to account for millions of dollars of trucking, general liability and workers compensation premiums.

Mr. Slautterback denied the charges and filed counterclaims against Old Republic, based in Greensburg, Pa., but later settled with the insurer, agreeing to turn over $2.4 million in premiums and to give the insurer access to company records.

Old Republic had terminated AOO's agency agreement in October 1985, and, at Old Republic's insistence, Mr. Slautterback agreed to shift about $30 million in trucking business to Colonial Penn from Old Republic, Colonial Penn charges. This move immediately caused AOO to exceed the $12 million Colonial Penn premium cap, the insurer alleges.

Colonial Penn's complaint, charging violations of the federal Racketeer Influenced and Corrupt Organizations law, was filed in U.S. District Court last December

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Employers fear extra FSA costs

By MICHAEL SCHACHNER

Employers expect to be stuck with unexpected bills for employee health care claims against flexible spending accounts as a result of new Internal Revenue Service regulations, a new survey says.

Seventy percent of the survey respondents anticipate that FSA participants who plan to leave their jobs will file health care claims against their accounts for amounts that exceed their contributions to the FSAs, leaving employers on the hook for the difference.

'This survey shows some severe edginess on the part of employers. . .' Mr. Davidson says.

As a result, employers are looking for ways to escape the liability, according to the survey, "Health Flexible Spending Accounts and Proposed IRS Regulations," conducted by the International Foundation of Employee Benefit Plans of Brookfield, Wis.

Under IRS regulations proposed in March 1989 and effective Jan. 1., employers have to reimburse employees for claims against their health care FSAs, even if the employee has not yet accumulated sufficient funds in an account to cover the claim (*BI*, June 5, 1989; March 6, 1989).

As a result, if a worker leaves a company before making sufficient contributions to fully fund his health care FSA, his employer would be on the hook for picking up the difference between the amount contributed to the FSA and the amount of the claim.

Previously, employers paid claims against FSAs only to the extent of employee contributions.

Only 15% of the respondents to the survey said they did not anticipate such a scenario, while another 15% said they were uncertain how the IRS regulations would affect employers.

Of the 254 firms responding to the survey, 42%, or 107, offered their workers health care FSAs.

"Clearly, this survey shows some severe edginess on the part of employers in regard to liabilities associated with the regulations," said Craig J. Davidson, a research associate with the IFEBP. "Regardless of whether the liabilities stem from abuses or not, it is bad for the employer."

In response, some employers are looking for ways to reduce their potential losses, while others are delaying implementing health care FSAs until they see how the IRS regulations affect employers that already have FSAs.

The only certain way employers can escape the liability is to terminate FSAs, employee benefits consultants say.

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RRA proposals

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place of business.

But some regulators say this provision means that purchasing group members can buy coverage only from insurers licensed in the state in which the group members are located, Mr. Greene said.

That would mean that a national purchasing group would have to use an insurer that meets the licensing requirements of many states, which can be costly and time consuming.

Such an interpretation would defeat the spirit of the Risk Retention Act, which was to facilitate buying insurance on a group basis, supporters of the act argue.

"States have too often interpreted the act in a manner which runs counter to its spirit, purpose, and intent, as RIMS understands them," Mr. Greene said.

The ambiguity about which state may regulate risk purchasing groups operating in several states exists in part because Congress paid more attention to provisions governing risk retention groups, testified attorney Victor Schwartz, a partner with Crowell and Moring in Washington, D.C., on behalf of the National Risk Retention Assn.

Under H.R. 4351:

- States other than the state that licenses a risk retention group or the state in which a purchasing group maintains its principal place of business would be prohibited from imposing any rules or fees.
- Members of risk retention groups and risk purchasing groups no longer would be required to use a licensed insurance agent in transactions with the groups.
- Risk retention and risk purchasing groups would be required to file uniform registration forms in each state where they operate.
- Purchasing group insurers would be required to maintain a minimum capital surplus of $3 million and file annual financial statements that are certified by a certified public accountant.
- States would be required to treat risk retention groups as admitted insurance companies for premium tax purposes.
- Non-domiciliary states would have to recognize a letter of credit as an asset if it has been issued by a member of the federal reserve system and has been approved by the insurance commissioner of the risk retention group's chartered state.
- Purchasing groups would be required to provide the insurance department in each state in which they operate information on the groups' insurers, principal and officers and managing or servicing organizations.
- Purchasing group insurers would be required to file annual financial statements and other information, like coverage limits, deductibles, and rates, with the insurance commissioner of each state in which members of purchasing groups they insure conduct business.

For state regulators, this bill represents an 'ominous threat' of federal action, says Zack Stamp.

Mr. Stamp, who spoke on behalf of the National Assn. of Insurance Commissioners, objected that H.R. 4351 also would allow the U.S. Attorney General or the Department of Commerce to file a civil action against a state regulator thought to be applying any insurance law or regulation in a manner "inconsistent " with the Risk Retention Act or that discriminated against a risk retention or risk purchasing group.

As a result, state regulators would be reluctant to investigate the financial stability or the practices of a risk retention or risk purchasing group operating within their states but licensed in another state for fear of civil suits by the federal government, he said.

And this hesitancy could allow groups with questionable financial standing to continue doing business unchecked in states in which they are not licensed, he said.

"Few insurance regulators can effectively interpret and administer the law when faced with such an ominous threat," Mr. Stamp said.

"Serious consideration should not be given" to a bill that would allow the federal government to intervene against regulators who are only trying to protect insurance consumers, he said.

In addition, the bill would prohibit non-domiciliary states from charging risk retention or risk purchasing groups registration fees, thereby eliminating resources that are needed to help pay for the states' regulation of the groups, he said.

Mr. Stamp also objected to killing a provision of the Risk Retention Act that requires state-licensed agents to act as intermediaries between a risk retention group or risk purchasing group and new members.

Eliminating such a requirement would remove a major tool for regulatory enforcement, Mr. Stamp asserted.

If only licensed agents are allowed to do business with the group within a state, any problem risk retention or risk purchasing group can be prevented from operating in a state by prohibiting their agents from operating in that state, he explained.

However, Mr. Schwartz says that often a purchasing group is knowledgeable enough that it doesn't need the representation of a licensed agent to explain particulars of the coverage.

"In some instances, there is really no need to have agents in the middle" of the process, he said.

And, requiring the use of licensed agent "is one factor that prevents groups from forming" because it is more expensive for purchasing groups to use them, and slows their entry into the marketplace, he said.

Its proponents also say H.R. 4351 would ensure more regulatory authority for the states, while reinforcing the intent of the act itself.

Supporters of the bill note that about 70 risk retention groups and about 400 purchasing groups have been established since 1986. And they say they recognize that the act needs to be amended to clarify some regulatory issues inadequately addressed by 1986 amendments.

The NRRA does not believe the Risk Retention Act has caused or promotes "fraudulent conduct" by risk retention and risk purchasing groups. But the group does recognize that some adjustments to the Risk Retention Act, such as provisions in H.R. 4351 that would toughen reporting requirements and clarify the authority of state insurance regulators, "would be beneficial," said Mr. Schwartz.

Susanne H. Howard, associate undersecretary of economic affairs at the Department of Commerce, agreed that the Risk Retention Act is somewhat ambiguous, but she also chastised some regulators for moving too slowly in taking action against questionable risk retention and risk purchasing groups.

The department's 1989 report on the Risk Retention Act found that state monitoring of risk retention and risk purchasing groups has been "uneven" and that "more effective monitoring and alerting other regulators to problems should enhance the operation of the act," she said (*BI*, Dec. 11, 1989). ■

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1,600 take AT&T's early retirement offer

Benefit beat

By MICHAEL SCHACHNER and ADRIENNE C. LOCKE

Nearly 1,600 new retirees of American Telephone & Telegraph Co. are receiving enhanced pension benefits under an early retirement program offered to workers in the company's long-distance service unit.

Under the program, offered to workers in the company's Network Service unit who agreed to retire between April 1 and May 31, AT&T added five years of age and five years of service to the retirees' pension benefit calculation formula. Then, the New York-based company boosted the retirees' pension benefits by 15%.

Employees retiring early with at least 75 years in combined age and service were eligible for their full defined benefit pension benefits before the early retirement incentives were applied.

The pension benefits of those who retired early and did not meet the 75 years of age and service were discounted before the early retirement incentives were applied.

"That was the primary reason we offered the 15% bonus on top of the five and five," an AT&T spokesman explained.

The program is part of a move by AT&T to reduce its Network Service unit's workforce to 25,000 from 31,000, he said.

Pilot AIDS coverage

A pilot program in Maryland will pay the premium for extended health care coverage under COBRA for 150 state residents with the virus that causes AIDS and who are poor and too ill to work.

Under the AIDS Insurance Assistance program, the state Department of Health and Mental Hygiene will pay the premiums for a group of Maryland residents with the AIDS virus who qualify for coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 instead of paying their health care costs through the state-administered Medicaid program.

Maryland officials estimate they will pay $1,500 in annual health care insurance premiums for each individual in the program.

State legislators approved the pilot program in April and appropriated $225,000 to finance the program through 1992.

Under COBRA, most workers who leave their jobs can remain in their former employer's health plan for 18 months by paying 102% of the group rate.

Former employees who receive Social Security disability benefits can purchase and additional 11 months of COBRA coverage but must pay 150% of the group premium (*BI*, Nov. 27, 1989).

The pilot program is designed to assure that people who have AIDS obtain needed health services and receive continuity of care, according to Adele Wilzack, secretary of the state Department of Health and Mental Hygiene.

Many people who have AIDS often cannot afford health insurance and end up on Medicaid, which often will not cover many of the services or drugs required in treating a person who has AIDS, according to Lester Schumacher, coordinator of Insurance Recovery, a unit of the state Department of Health and Mental Hygiene, and administrator for the pilot project.

The new program also is intended to reduce the level of uncompensated care and the dependency on Medicaid and other public assistance programs, Ms. Wilzack explained.

In Maryland, 39%, or approximately 975, of the more than 2,500 people who have been diagnosed with AIDS are on Medicaid, the state reports.

Officials say Medicaid spends up to $20,000 annually on direct-care costs for each Medicaid program recipient with AIDS.

As a result, the pilot program should save the Department of Health and Mental Hygiene, which administers the Medicaid program, about $2.2 million annually, officials say.

To qualify for the program, an individual must:

- Test positive for the human immunodeficiency virus, which causes AIDS.
- Be too ill to work or will likely have to stop working within three months due to illness.
- Be unable to obtain health insurance through a spouse, parent or legal guardian.
- Have an annual family income that is no greater than 200% of the national poverty level and assets of no more than $10,000.

Hospital pensions

Hospitals generally offer workers defined contribution retirement plans rather than defined benefit pension plans, according to a recent survey conducted by accountant Deloitte & Touche.

Thirty-nine percent of the nearly 600 hospitals that responded to the firm's fourth annual survey on hospital benefit and compensation programs currently provide only defined contribution retirement plans. Thirty-two percent provide defined benefit plans only, and 11% offer both defined contribution and defined benefit plans.

Only 18% of the responding hospitals offer neither type of pension plan.

The majority—59%—of the hospitals that answered the questionnaire were located in urban areas, and the remainder were located in rural areas.

About 49% of the survey participants have fewer than 100 beds, about 20% have between 100 and 400 beds and 31% have more than 400 beds.

The survey found that larger hospitals are more likely to offer some form of pension plan than their smaller counterparts.

While 32% of the hospitals with fewer than 100 beds do not offer any kind of pension plan, only 3% of hospitals with between 300 and 399 beds do not offer any retirement plan.

And, all responding hospitals with more than 400 beds offer some kind of pension plan.

More than 60% of hospitals offering defined contribution plans require employee contributions on either a pre-tax or after-tax basis, the survey reports.

Seventy-two percent of the hospitals that offer a defined benefit plan do not require employee contributions, the survey found.

The survey also found that about 65% of hospitals believe their employees understand their pension plan, compared with about 35% in 1988. ■

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Opinions

The boys of bummer

NOT THAT WE wish names at Lloyd's of London any more misfortune, but we still wish the All-Star Game last Tuesday night would have been called on account of rain.

Heck, paying on the $17.5 million in rain cancellation insurance that underwriters at Lloyd's and London companies issued to Major League Baseball would have been a drop in the bucket compared with the European storm losses they have already paid this year.

And baseball fans sure deserved a better All-Star Game.

If the game were replayed:

- The wind could have been blowing out at Wrigley Field instead of in.
- National League home run leader Ryne Sandberg of the Chicago Cubs could have hit a home run for the hometown fans.
- The Oakland A's Jose Canseco (and countless others) could have connected at least once with the ball for a hit.
- Announcers Tim McCarver and Jack Buck could have had an extra day to pump some life into their commentary (and have had something to comment on).
- New York Met Darryl Strawberry could have improved on his attempted throw to Des Moines, Iowa, from right field.
- Pinch runner Barry Larkin of the Cincinnati Reds —the only National Leaguer to reach second base (by stealing it)—could also have stolen third and home to give his team a run.
- And, if the game had been replayed without a rain interruption, more baseball fans around the country would not have been asleep when Harry Caray led fans in the famous Wrigley Field tradition of singing "Take Me Out to the Ballgame" during the seventh inning stretch.

Since it didn't rain long enough to cancel the game, too bad CBS did not buy coverage against broadcasting the most boring All-Star Game in recent memory.

Of course we realize that underwriters at Lloyd's—avid fans of the snail-paced game of cricket—wouldn't understand what we're complaining about, even if they had seen the game.

Letters

Lloyd's tax pact not so onerous for U.S. names

To the editor: I read with interest the article "U.S., Lloyd's Tax Pact" in your May 7 issue. I do feel your readers would be interested in some additional information on the new U.S. closing agreement concerning taxation of Lloyd's of London names' U.S. income. As U.K. tax adviser to more than 1,000 U.S. names, we have been looking at the agreement very closely.

Although it is true to say that a proportion of U.S. business will be taxed at U.S. tax rates, the higher rates will only apply to a name earning more than $50,000 on this part of his underwriting.

Furthermore, the U.S. name will still pay a tax at personal income tax rates on the whole of his Lloyd's income with a deduction for the corporate tax paid by the syndicate.

Perhaps the most significant advantages of the agreement, neither of which were mentioned in your article, are first that the U.S. name will now only pay tax personally when he *receives* a distribution from Lloyd's and the tax will be based on that distribution. In the past, he has been taxed on investment income as it arose in the syndicates before receipt by the name.

There is, therefore, now a cash-flow advantage. In addition, the name will find it easier to reconcile his distribution with the amount of income returned for tax purposes.

Secondly, the definition of non-U.S. source business has been greatly enhanced, thus allowing a significant improvement in the ability of most U.S. names to obtain full credit for their foreign taxes paid.

There are some adverse features such as the tightening of the passive loss rules and some discounting of reserves, but, on balance, we have had in the main favorable comment from U.S. names to whom we have spoken.

Ian P.H. Roberts
Partner
Neville Russell
London

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Protecting employer from lead 'exposure'

To the editor: I wish to comment on your editorial, "Safety Rule Discriminates," which commented on a ruling that corporate policies prohibiting fertile women from holding certain jobs is discriminatory (*BI*, June 4). At what point is the level of lead exposure low enough to guarantee that there will be no fetal damage? Any trial lawyer can answer. No lead is the answer.

That being the case—and it is the case —suppose we suggest to Johnson Controls Inc. and the Occupational Safety and Health Administration that they remove all lead from the air in which employees work. But that's probably years away. In the meantime, suppose we suggest that Johnson Controls not prohibit fertile female workers from holding certain jobs with exposure to lead, but instead ask them to sign releases for themselves, their spouses and their unborn children.

"Illegal!" you say. "Unenforceable!" you say. Good. Now you have the point.

Robert Alkire
Risk Manager
Knoll International Holdings Inc.
Saddle Brook, N.J.

New York liquidators preparing for worst?

To the editor: Your June 11 editorial "Insurers Following S&Ls?" was right on the mark.

In the June 17 issue of The New York Times, the Liquidation Bureau of the New York State Insurance Department ran a help-wanted ad seeking reinsurance accountants, noting that "challenging opportunities now exist within our growing downtown Manhattan organization for seasoned insurance professionals."

What should we understand about the general state of financial health among insurance companies operating (or that formerly operated) in New York when the Liquidation Bureau advertises that it is a "growing" organization offering "extensive benefits, including free dental and vision, and competitive salary" to prospective accounting staff members?

It certainly sounds like an incipient S&L-type debacle to me.

Ed King
Denville, N.J.

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Firms advised to help with child care

By ADRIENNE C. LOCKE

ARLINGTON, Va.—Employers should help employees work out child care difficulties because, left unresolved, they can hamper productivity, a child care benefits expert says.

Setting up job sharing plans, flexible work hours and child care referral services can demonstrate a willingness to help, said Faith Wohl, director of Work Force Partnering, an employee relations program at E.I. du Pont de Nemours & Co. in Wilmington, Del.

Employers also should develop existing child care resources, she said last month at a benefits conference sponsored by the Manufacturers' Alliance for Productivity, a business-supported research group.

"Employers must acknowledge that work and family issues cannot be solved only at work or at home," but through cooperation, she said.

Ms. Wohl says a 1985 survey by the giant chemical concern found that more than 70% of its Delaware employees with children under the age of 13 used some type of child care. And 25% of those employees had major concerns about child care.

Employees were missing work to care for sick children because they were unable to find child care or because they faced other related problems, she said.

DuPont's response, said Ms. Wohl, was to set up Delaware's first employer-sponsored child care resource and referral service in 1986.

New concerns arose in a follow-up survey conducted in 1988.

According to the larger poll of more than 6,000 workers at 14 locations, child care remained a major concern of DuPont employees. Many employees were passing over certain promotions or new jobs they thought would make their child care responsibilities harder to meet, Ms. Wohl said.

The survey found that many workers felt there was a lack of appropriate child care for children aged 10 to 13, and many respondents were not comfortable leaving these children in their current day care situations, she said.

Elder care also emerged as a prominent concern. Some 37% of workers said they had some responsibilities for, and concerns over, the care of an elderly dependent, and 5% said they were major responsibilities and concerns, she said.

DuPont's response: allowing employees to adjust their work schedules, expanding its referral service to encompass elder care services and extending the program from Delaware to all U.S. employees, Ms. Wohl said.

The company also expanded to six

Continued on next page

Reform of budget 'abuses' urged

By ADRIENNE C. LOCKE

ARLINGTON, Va.—Business leaders should call for reform of the federal budget process that can produce ill-considered employee benefits and pension legislation, says a former congressman.

Last-minute additions to budget reconciliation bills can result in the passage of proposals that have not been clearly thought out and that would not have withstood scrutiny as independent bills, contended John Erlenborn, a partner with the law firm Seyfarth, Shaw, Fairweather & Geraldson in Washington, D.C.

In addition, more public participation in the legislative process has created new outside pressures that can adversely influence voting on certain issues, he said last month at a benefits conference in Arlington, Va., sponsored by the Manufacturers' Alliance for Productivity and Innovation, a business-supported research group.

"Working knowledge of the pressures and process may help you to better understand how Congress goes about making decisions," said Mr. Erlenborn, a former Republican representative from Illinois.

Under the budget process, Congress and the president must approve items in a reconciliation package as a whole, not item by item, he explained.

So, once a hastily considered proposal is in a budget package, time constraints—for getting the budget approved to avoid automatic budget cuts—usually allow it to become enacted, he said.

These proposals are offered as an amendment to a committee's budget package or as an amendment on the floor of the House or Senate, he said.

"This has become a way for people who could not gain support for their legislation to sneak it into law by attaching it onto the budget reconciliation bill," he said.

As an example, he cited an amendment offered by Rep. Peter J. Visclosky, D.-Ind., to the House Education and Labor Committee's budget package that would have required employers to share trusteeship of pension plans with employees. The proposal was adopted, although no hearings had been held.

Only by special permission granted by the House Rules Committee was the Visclosky amendment language removed from the full House budget package, he said.

That proposal was later considered in the House Labor-Management Relations Subcommittee as a bill, H.R. 2664, where it now faces tough opposition from the business community and the Bush administration (*BI*, Jan. 29).

Meanwhile, to further the concept of "government in the sunshine," federal legislators have opened more hearings and committee mark-ups on bills to the public, he said.

Behind closed doors, though, senators and representatives were usually frank and outspoken in their opinions of proposed legislation regardless of its effect on their district, "and made their decision for the greater good of the public," contended Mr. Erlenborn.

The new spotlight has made them more acutely aware of pressure from special interest groups, political action committees and other lobbying groups, he said.

As a result, Congress is more volatile and unpredictable than ever before, said Mr. Erlenborn. ■

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Child care

Continued from previous page

months its program that allows an employee leave or part-time work after the birth or adoption of a child or to care for a sick child or elderly dependent.

"The business community sees child care as one more problem to be managed to ensure that their workforce can get to work on time," Ms. Wohl said. Employers, she adds, need to talk to workers to "get a clear sense of the barriers that people must face just getting to work."

Because worker needs can vary among regions, Ms. Wohl advises employers first to assess specific needs of their workforce.

For example, in the Southwest, in-house child care is plentiful and affordable. In the East, it's expensive and very hard to find.

And for some employers, Ms. Wohl says, investing in the existing child care infrastructure may be more effective or more affordable than creating a new program.

For example, an employer could start a worksite day care program, only to discover that over time worker needs have changed and day care is is not needed as much as some other service, she said.

Developing joint centers—as some DuPont offices do—with other businesses can spread the responsibility and costs, she said.

Another option is setting up flexible spending accounts to help employees pay for child care services, she said. ■

'Play or pay' health plan touted

By ADRIENNE C. LOCKE

ARLINGTON, Va.—If businesses want to retain an employer-sponsored health care system, they will have to take responsibility for offering insurance to workers who currently have none, says a Pepper Commission staff member.

That is the reasoning behind the commission's "play or pay" proposal that would require companies to either provide coverage for their employees or pay a payroll tax toward federal insurance, says Monica McFadden, who served on the staff of the U.S. Bipartisan Commission on Health Care, better known as the Pepper Commission.

A new public program would cover part of the cost of part-time workers and the unemployed under the proposal, but U.S. employers also have a responsibility to offer health insurance coverage to their workers and dependents, said Ms. McFadden.

"We (the government) are doing our part, but you (the business community) have to meet your responsibility," she said at a benefits conference last month sponsored by the Manufacturers' Alliance for Productivity and Innovation, a business-sponsored research group.

The Pepper Commission issued recommendations on requiring employers to provide health insurance and establishing a federally funded long-term health care program in March.

Observers immediately took a close vote—the employer coverage requirements passed 8-7—as a sign that Congress would shy away from the proposals (*BI*, March 12).

Ms. McFadden said the Pepper Commission plan would ensure coverage for all Americans more effectively and at a lower cost to business than either a universal, nationalized insurance program or a program of expanding Medicaid coverage and private-sector subsidies.

Nationalized coverage initially would save businesses an estimated $209 billion a year, Ms. McFadden said. But, it would also require $222 billion in federal expenditures and would likely mean far higher corporate taxes, she pointed out.

And expanding and improving Medicaid coverage, and subsidizing and improving access to private insurance initially would save employers $22 billion, Ms. McFadden said. But it would require $36 billion in federal expenditures, she added.

By commission estimates, such a program would also leave 14.4 million people without health insurance, she noted. Congress would be very hesitant to approve a big-ticket health care bill that left that many people uninsured, Ms. McFadden said.

"What you want is to have everyone connected to the (health care) system," she said.

The Pepper Commission proposal would cost less in federal money than the other two options, with a federal price tag of $23 billion, she said. Everyone would be insured, but more costs would be borne by the private sector.

Employers that provide insurance will save $10.6 billion a year as the need for cost shifting to pay for the uninsured is eliminated. And individuals and families would save $20.6 billion annually in out-of-pocket expenses, the commission reported.

On the other hand, employers that currently don't provide health insurance would spend an additional $27.4 billion a year on coverage, Ms. McFadden noted.

Under the Pepper Commission proposal, all employers with more than 100 workers would have to offer a health care plan meeting federal standards to employees and dependents or pay a new payroll tax.

That as-yet-unspecified tax would be high enough to encourage employers to offer coverage.

The proposal also provides, among other things, for mandating that small employers provide workers with coverage or pay the payroll tax if a sufficient percentage of their workers are not covered within several years after the proposal's enactment (*BI*, March 12). ■

Benefits conference attracts 70

ARLINGTON, Va.—About 70 people attended the Manufacturers' Alliance for Productivity and Innovation's New Trends in Employee Benefits Conference in Arlington, Va., last month.

Membership in the non-profit research organization includes companies from the automotive, oil and gas, telecommunications, chemical and aerospace industries.

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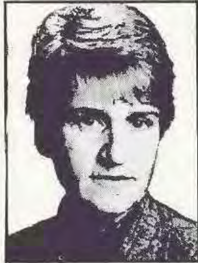
At issue

Have you measured how FASB's retiree health care rules will affect your bottom line?

Lynford E. Gabriel
Manager-pension funding & general insurance
Clark Equipment Co.,
South Bend, Ind.

We had our actuaries evaluate our current health care plan and determine what effect the original FASB rules would have on our earnings. The impact is significant because we have a ratio of retirees to active employees that is 2.5-to-1.



Phyllis Payne
Director-compensation & benefits
Ingersoll Rand Co.,
Woodcliff Lake, N.J.

We are currently recalculating our retiree medical liabilities under FASB, although we do already have some idea of the magnitude of this liability from studies conducted prior to the FASB proposal. In addition, we have already made significant changes to our retiree benefits program in anticipation of FASB's effect on our bottom line.

Donald A. Kissack
Director-benefits
Minnesota Mining & Manufacturing Co.,
St. Paul, Minn.

Yes, we have looked at FASB's impact and we have a good handle on it. We've been pre-funding retiree health insurance in one form or another since the early 1970s. We do have a liability out there that is bigger than what we've been pre-funding for, but the bottom line is we expect to be in a lot better shape because of that past practice.

Dan Borbas
Vp-human resources
Zurich-American Insurance Group
Schaumburg, Ill.

We are in the midst of making that evaluation right now. We are certainly concerned about the implications. At this point, we aren't sure we fall under FASB because we do our accounting on a statutory basis as compared to generally accepted accounting principles. Our sense is, however, that we will have to comply with FASB and we are taking a look now.

Compiled by Christine Woolsey

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Comings & goings: buyers

Greyhound Dial names vp-benefits

Joan F. Ingalls, 40, named vp-compensation and benefits of Greyhound Dial Corp. in Phoenix, Ariz. In this newly created position Ms. Ingalls is responsible for directing the design of the company's employee benefit plans, as well as base, incentive and executive compensation programs. Ms. Ingalls reports to Robert A. Lang, vp-human resources at Greyhound Dial. Ms. Ingalls joined Greyhound Food Management Inc.—a subsidiary of Greyhound Dial—in 1981 as manager of compensation and systems. Most recently she was executive director of compensation and benefits at Greyhound Dial, which is the holding company for airport concessions company Dobbs International Services Inc., money order company Travelers Express and Premier Cruise Lines. Prior to joining Greyhound Dial, she was personnel director of Joy Manufacturing in Philadelphia, a division of Pittsburgh-based Joy Technologies Inc. She also has served as personnel manager at York, Pa.-based Dentsply International Inc., a dental supplies manufacturer, and has served as vice president of personnel for a subsidiary of Mellon Bank Corp. in Harrisburg, Pa. Ms. Ingalls, who holds a bachelor's degree in psychology from Temple University in Philadelphia, is a member of the American Compensation Assn. and of the Human Resources Planning Society. She also is a frequent lecturer on executive compensation issues.

Ms. Ingalls

* * *

Beverly E. Khosh, 34, named manager, employee benefits, of American Restaurant Group Inc. in Newport Beach, Calif. Ms. Khosh, who is responsible for the administration of life insurance as well as medical, dental, 401(k) and disability plans, replaces **Andrea McMahon**, who left the company. Ms. Khosh reports to William J. McCaffrey Jr., vp and chief financial officer. Ms. Khosh, whose most recent title was benefits administrator, joined American Restaurant Group in 1989. American Restaurant Group owns and operates such specialty restaurants as Anderson's Black Angus, Spoons, Velvet Turtle, Spectrum Foods and Grandy's. Prior to joining American Restaurant Group, Ms. Khosh was benefits administrator for the city of Santa Ana, Calif. Also, she has held underwriting and plan administration positions with Western Growers Insurance Co. of Irvine, Calif., and Admar Group Inc., a managed health care firm in Orange, Calif. Ms. Khosh received a bachelor's degree in behavioral sciences from California Polytechnic State University in San Luis Obispo.

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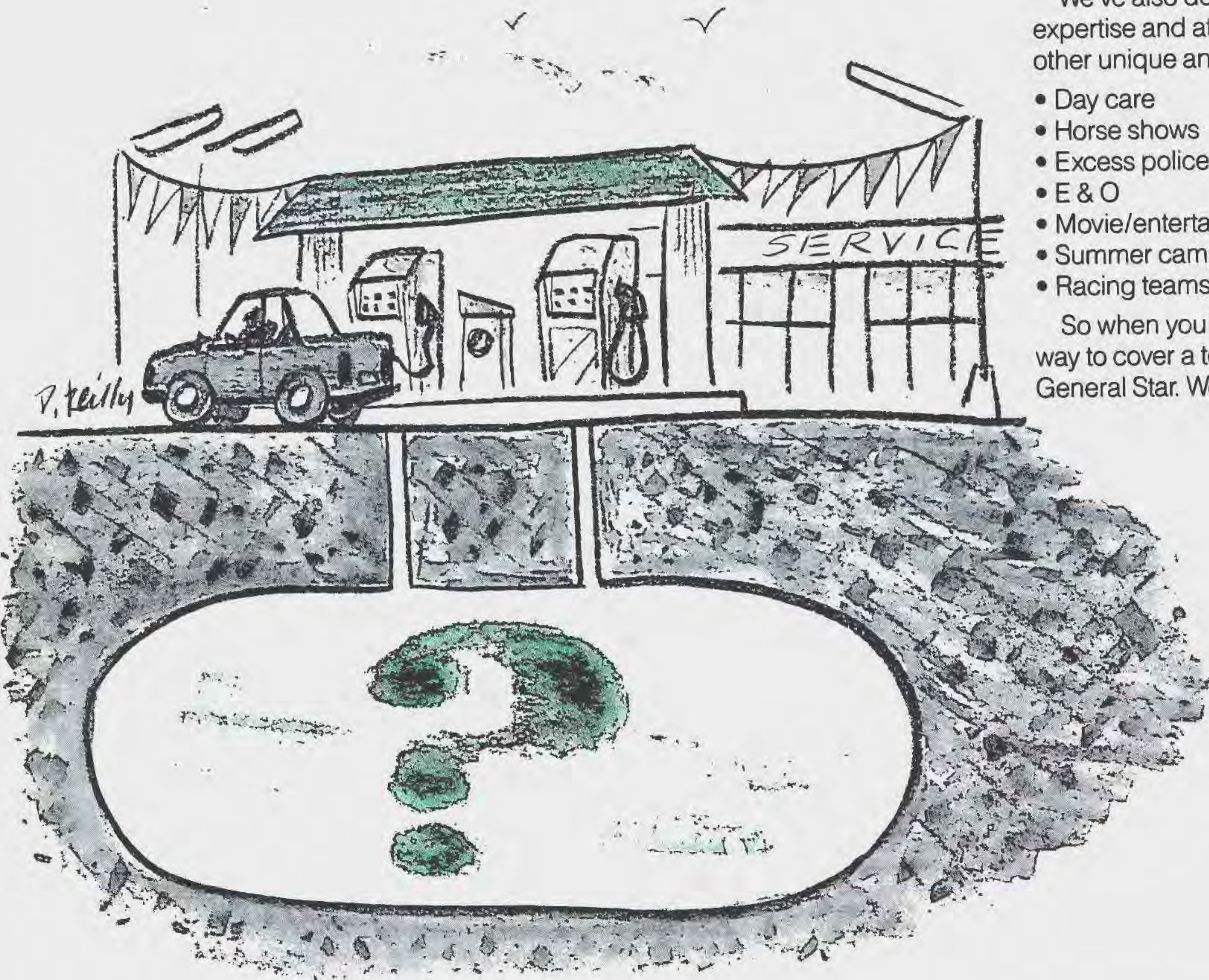

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New strategy

Continued from page 3
low limits" on the personal injury coverage, he said.

"This is a new area," said Richard D. Williams, an insurer attorney with Charlston, Revich & Williams in Los Angeles and chairman of the PLI program. "Ground is being broken."

However, "Mr. Pasich is trying to make the personal injury tail wag the general liability dog," Mr. Williams said.

According to Mr. Pasich, there are several coverage advantages for a policyholder who can obtain environmental claims coverage under the personal injury endorsement:

- Claims for gradual pollution would be covered because the personal injury endorsement does not contain a pollution exclusion that would bar coverage for environmental damage that is not "sudden and accidental."
- Even known pollution could be covered under the personal injury endorsement because it does not contain language stating that pollution must be unexpected and unintended.
- A continuous trespass or nuisance could trigger multiple policies because the personal injury endorsement does not contain language that states coverage responds only to "occurrences" within the policy period.
- Policyholders can expand their recovery under the CGL policy by exhausting both the aggregate CGL limit and the limit under the personal injury endorsement.
- Most insurers do not reserve their rights to deny coverage under the personal injury endorsement. Therefore, some courts will rule that insurance companies have waived their rights to deny coverage for pollution cleanups under this portion of the policy.

So far, only the 1st U.S. Circuit Court of Appeals has ruled that there could be coverage for pollution claims under the personal injury endorsement, according to Mr. Pasich.

The court in March found coverage for pollution claims against a city-owned sewage plant in Keene, N.H., under the personal injury endorsement.

In that case, Jack and Mary Meanen sued the city in 1987 claiming that they "have been continuously bombarded by and exposed to noxious, fetid and putrid odors, gases and particulates, to loud and disturbing noises during the night and to unduly bright night lighting" from the city sewage treatment plan that borders their property.

The Meanens also alleged that the plant has "unreasonably and substantially interfered with (their) quiet enjoyment of the homestead."

The City of Keene sought coverage from two of its liability insurers: Titan Holdings Syndicate Inc., a syndicate on the Illinois Insurance Exchange, and Great Global Assurance Co. of Scottsdale, Ariz., which was placed in receivership and liquidated in 1988.

The insurers wrote liability policies applicable to the time period in which the Meanens claimed damage.

Both policies covered liability for "personal injury," though each policy defined that term somewhat differently.

Titan's policy said personal injury, other than bodily injury, arises out of one or more of a list of offenses including: "wrongful entry into, or eviction of a person from, a room, dwelling or premises that the person occupies."

According to the 1st Circuit, that language precluded coverage for the Meanens' claims.

The court reasoned that the language "wrongful entry" most closely resembled the tort of trespass, which is an intentional act under the law.

As a result, the court held that a prerequisite to coverage under the Titan policy was an allegation that the discharges from the sewage plant were intentional.

But the Great Global policy contained a significant difference in the definition of a personal injury. It said a personal injury arises out of a "wrongful entry or eviction or other invasion of the right of private occupancy."

The 1st Circuit held that because the Meanens alleged that the discharges from the sewage plant have interfered with their right to enjoy their property, the city's Great Global policy must respond to their claim.

"The Meanens' claims of liability for interference with quiet enjoyment and use of their home arising from any means alleged, including pollutants, fall within the personal injury coverage afforded by the Great Global policies and are not excluded by the pollution exclusion," the court ruled.

Mr. Pasich predicted that many courts will follow the 1st Circuit's lead in providing coverage for environmental claims under the personal injury provisions of CGL policies.

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Titan Holdings Syndicate Inc. v. City of Keene, N.H.; 895 F.2d 265 (1st Cir. 1990).

Insurers prove case of pollution plaintiffs by denying coverage

By STACY ADLER

SAN FRANCISCO—Litigation between policyholders and their liability insurers over coverage for third-party pollution claims is a "double-edged sword," according to attorneys.

If a policyholder that is defending such claims is forced to litigate simultaneously with its liability insurers, the policyholder can be put in a very difficult position, said Kirk Pasich of Hill, Wynne, Troop & Meisinger in Los Angeles.

The insurer, in its attempt to avoid coverage, will try to show that the policyholder expected or intended to pollute the environ-

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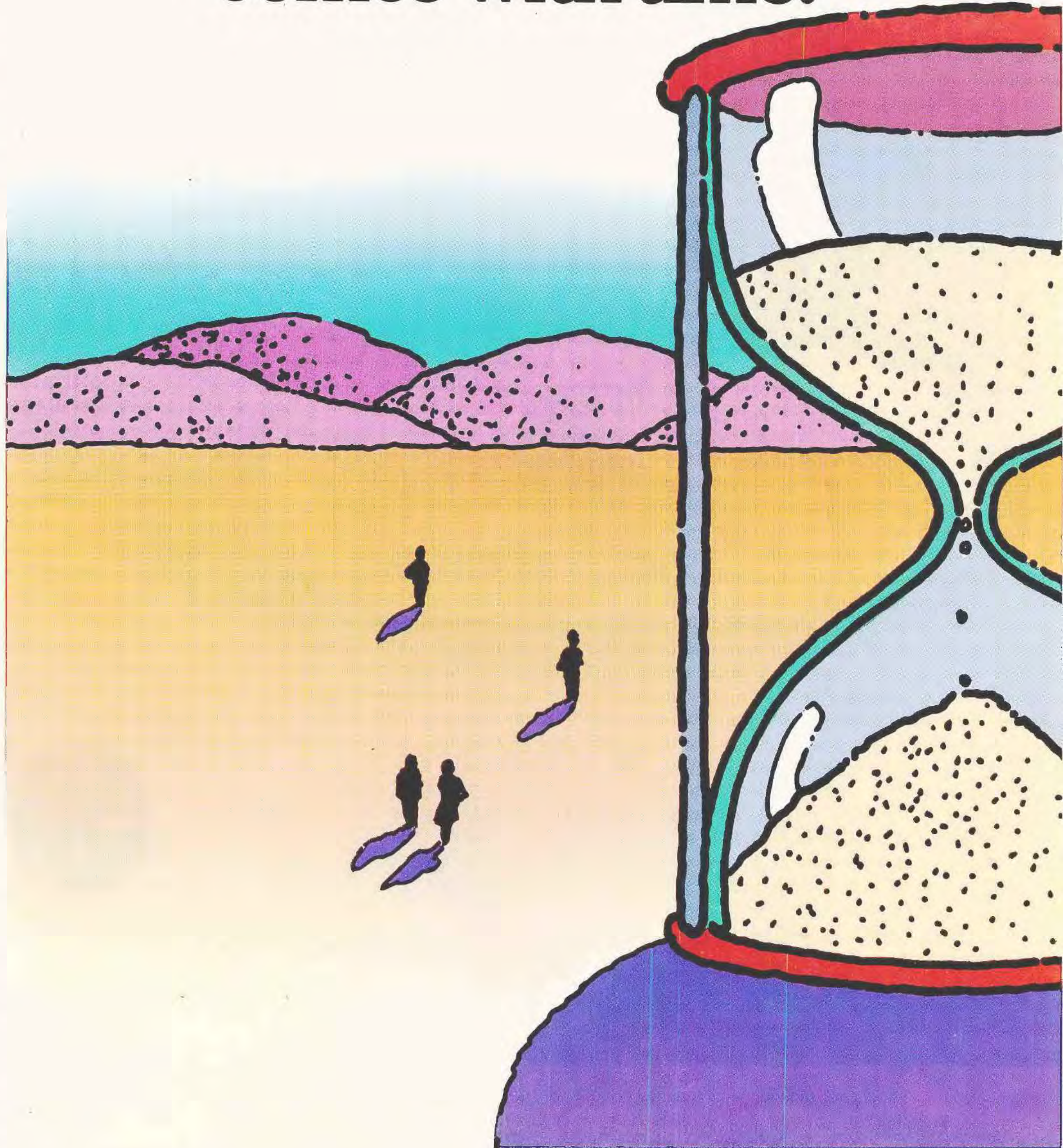


Continued from previous page
ment because the standard comprehensive general liability policy bars coverage in such cases.

An insurer that succeeds with this argument not only avoids coverage, but also proves the claims of the third parties suing the policyholder, explained Mr. Pasich.

The net result: A policyholder is left without coverage and could face enormous liabilities to the third parties, he said.

Mr. Pasich and other attorneys discussed litigation between policyholders and insurers involving environmental claims at a program last month in San Francisco sponsored by the Practising Law Institute, the nation's oldest non-profit legal education organization.

"It simply is not fair for an insurance company to argue 'expected and intended' when the policyholder is attempting to defend against the underlying liability," asserted Mr. Pasich.

Insurer attorney Victor Rabinowitz of Buchalter, Nemer, Fields & Younger in Los Angeles admitted, "If we win on 'expected or intended,' we have proven the plaintiff's case."

However, Mr. Rabinowitz said insurers have no choice but to litigate with policyholders while the policyholders are defending underlying environmental actions.

He said defending these actions is so expensive that insurers must step in as soon as possible, attempting to show why their policy does not provide coverage.

'Insurers will not and cannot afford to take on this liability,' says attorney Richard D. Williams.

Insurer attorney Richard D. Williams agreed: "This is high-stakes litigation. Millions—even billions —of dollars of insurance coverage are at stake.

"Insurers will not and cannot afford to take on this liability," said Mr. Williams of Charlston, Revich & Williams in Los Angeles, who chaired the program.

In addition to arguing that policyholders expected or intended to pollute, insurers claim that coverage is barred by the pollution exclusion, which bars coverage for all pollution that is not "sudden and accidental."

Policyholders counter that the clause should be interpreted to bar coverage only for pollution that is expected or intended. In essence, they argue that the exclusion is a restatement of the language barring coverage for events that are expected or intended.

Insurers, on the other hand, argue the clause should bar coverage for all pollution not occurring quickly.

The latest wrangling over the pollution exclusion has centered on the drafting history of the comprehensive general liability form.

Policyholders are attempting to use drafting history documents to show that insurers never intended to exclude coverage for gradual pollution, explained Mr. Pasich.

For example, Mr. Pasich read a statement made in a 1966 paper written by Gilbert L. Bean of Liberty Mutual Insurance Co. Mr. Gilbert said the 1966 CGL policy was intended to provide "coverage for gradual (bodily injury) or gradual (property damage) resulting over a period of time from exposure to the insured's waste disposal. Examples would be gradual adverse effect of smoke, fumes, air or stream pollution, contamination of water supply or vegetation."

This statement and others like it show "the drafters of the CGL policy intended to provide coverage for gradual pollution," asserted Mr. Pasich. "It is inconsistent for insurers to claim today that they never thought these (cleanup costs) were insured," he maintained.

Mr. Pasich also pointed out that in the early 1970s insurers told state regulators that including the pollution exclusion in the CGL policy would not result in the reduction of coverage.

Policyholders argue that insurers' current attempts to bar coverage for gradual environmental damage claims are inconsistent with these early statements that there would not be a change in coverage.

But Mr. Rabinowitz counters that there is no inconsistency.

"It is probably correct to say that there was no change in coverage" when the pollution exclusion was added to the CGL policy, he said.

"Gradual pollution was always thought to be expected pollution" and therefore not covered, explained Mr. Rabinowitz. "While sudden pollution was always thought to be unexpected" and therefore covered, he said.

However, Mr. Rabinowitz admitted it would be "the height of redundancy" to add an exclusion that said nothing different from what was already in the policy, namely that there is no coverage for expected or intended events.

He said the real change brought about by the pollution exclusion was the test to determine if pollution is insured.

Prior to the exclusion, insurers had to prove a policyholder expected or intended pollution in order to bar coverage, he said. After the exclusion was incorporated the insurer merely had to show the pollution was not sudden or accidental to bar coverage, he said. "No inquiry into intent was required," he said.

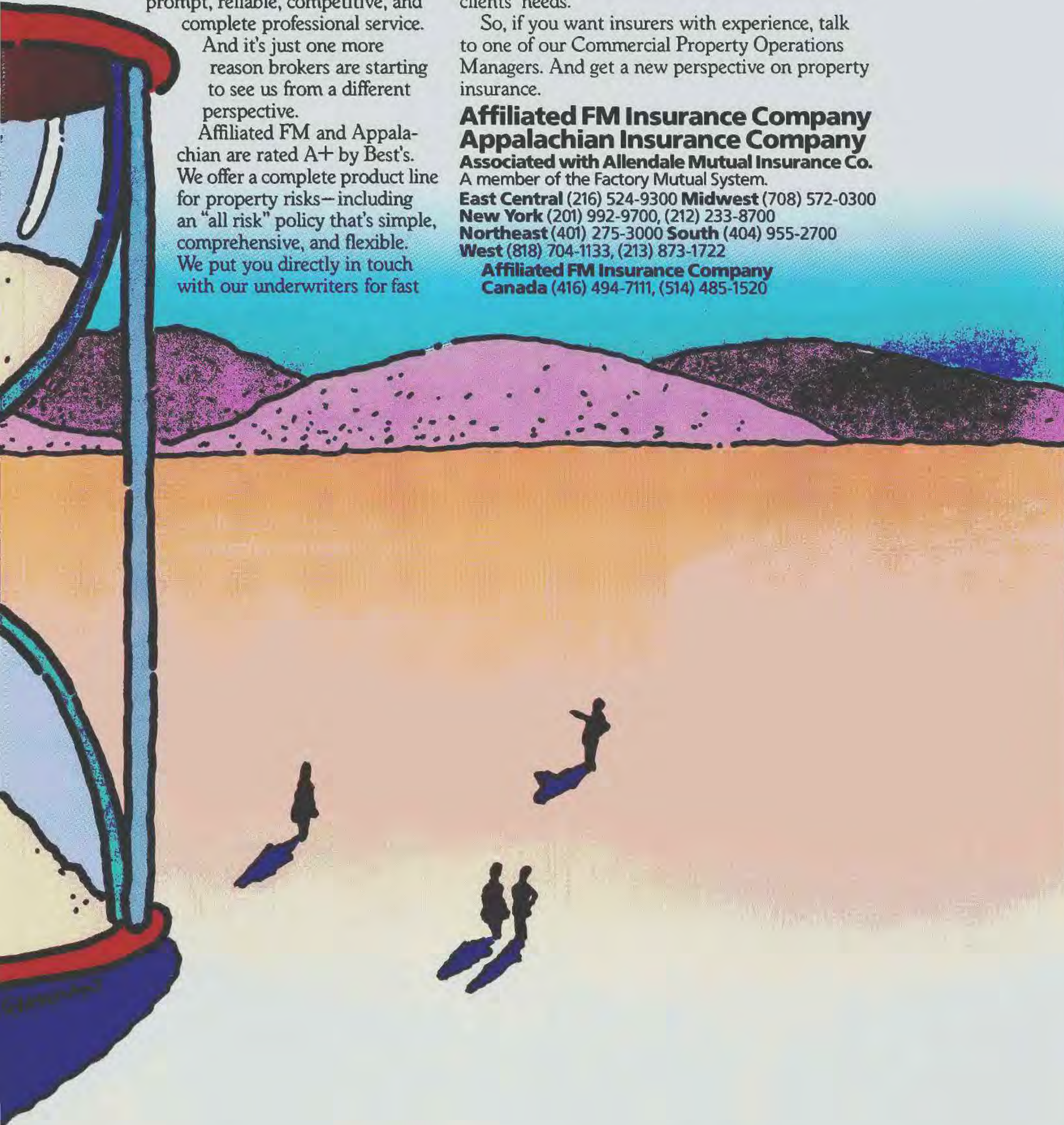
In a new twist on these drafting history arguments, Mr. Pasich argued that the drafting history of the Superfund Act also proves that insurers intended to provide coverage for gradual pollution.

"The American Insurance Assn. wrote a letter to the Senate urging them not to enact CERCLA for fear of liability," said Mr. Pasich. "Crum & Forster sent a similar letter."

In its Sept. 17, 1980, letter, the AIA said: "If the occurrence which results in alleged liability is continual, insurers which provided pollution liability coverage years ago may be subjected to the liability concepts" in CERCLA.

This letter proves that insurers' arguments today that gradual pollution is not insured are inconsistent with their early views, said Mr. Pasich.

The AIA's 1980 letter "is very different from what insurance companies are saying today," said Mr. Pasich. ■



Suits to repair damage to resources expected

By STACY ADLER

SAN FRANCISCO—Environmental pollution lawsuits increasingly will seek to recover the costs of repairing damages to natural resources in addition to cleanup costs, an insurer attorney predicts.

"The private sector is energized, well-equipped and will continue to pursue environmental actions," said Roger L. Carrick of Heller, Ehrman, White & McAuliffe, a San Francisco firm that represents insurers in coverage litigation.

So will government agencies, he said.

And, while insurers deny that comprehensive general liability policies cover the costs of government-mandated cleanups, they do not dispute that claims for damage to natural resources are covered, another insurer attorney says.

"There is no dispute that natural resource claims are insured," said Richard D. Williams of Charlston, Revich & Williams in Los Angeles, who chaired the program.

Mr. Carrick and Mr. Williams made their remarks during a discussion on trends in environmental litigation at a program sponsored by the Practising Law Institute last month in San Francisco.

Most environmental lawsuits are filed under the Comprehensive Environmental Response, Compensation & Liability Act, better known as the Superfund act.

Plaintiffs can sue under Superfund to recover the costs of cleaning polluted property and repairing damage to natural resources.

> **'There is no dispute that natural resource claims are insured,' says attorney Richard D. Williams.**

A vast majority of environmental pollution suits seek coverage for cleanup costs, but more also will seek coverage for damage to natural resources, Mr. Carrick said.

For example, the U.S. Justice Department in June sued eight companies in California under the natural resources provisions of the Superfund act, charging that the companies damaged a marine wildlife habitat off the Southern California coast.

The suit alleges that the companies released chemicals into the Los Angeles sewage system that have caused birth defects in birds and marine life in coastal waters. Among the chemicals allegedly released are the pesticide DDT and polychlorinated biphenyls, or PCBs, a manufacturing byproduct.

The lawsuit seeks the cost of cleaning up the pollution and also the cost of restocking fish and creating artificial reefs.

The eight companies are: Atkemix Thirtyseven Inc., Chris-Craft Industries Inc., ICI American Holdings, Montrose Chemical Corp., Stauffer Management Co., Simpson Paper Co., Potlatch Corp. and Westinghouse Electric Corp.

Mr. Carrick said it is expected that the government will expand the suit to include a total of 200 defendants.

"We will soon see this type of pleading in all CERCLA actions," Mr. Carrick predicted. ■

Maryland Casualty may appeal liability for condo damage

By LOUISE KERTESZ

SAN DIEGO—Maryland Casualty Co. is expected to appeal a state appellate court decision that it is liable for property damage to a condominium complex that was caused by subcontractors working for Maryland Casualty policyholders.

The June 27 decision by the state Court of Appeals' 4th Appellate District reverses an earlier San Diego Superior Court ruling that Baltimore-based Maryland Casualty was not liable for property damage to Roundtree Condominiums of Carlsbad, Calif.

Roundtree and general contractor DMF Construction Inc. of San Diego had filed property damage claims against their comprehensive general liability policy written by Maryland Casualty after they were sued by several homeowners who alleged that their condominiums had been damaged by soil subsidence.

The homeowners alleged their units had "severe cracks" in the walls and floors and that "the roofing system had failed, causing rain water and moisture to penetrate the roofs."

The insurer refused to pay the claims and filed for a declaratory judgment.

The trial court ruled that "coverage was barred by the terms of. . .exclusions" to the CGL policy issued to Roundtree and DMF. One exclusion barred coverage for work performed by subcontractors and another barred coverage "for an insured's product."

However, the appeals court overturned the trial court, noting that Roundtree and DMF paid "an additional 20% of their premium" for a broad-form endorsement that nullified the exclusions.

In addition, while the trial court had found that the homeowners' losses "were not property damage within the meaning of the policy," the appeals court disagreed.

"It's a very important case in California and I anticipate that (Maryland Casualty) will appeal," said Robert Coffin, a partner with Ault, Deuprey, Jones, Danielsen & Gorman of San Diego, which represents Maryland Casualty.

Mr. Coffin explained that California developers and general contractors can be held "strictly liable" for defects in condominium projects.

That means "the projects are looked on as a product, the same as an automobile or a saw," and that the contractor is liable for defects even though it may not be at fault, Mr. Coffin said.

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Insurer Topics

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Hiring temporary help

Insurers find in-house pools, contacts cost-effective

By MARK A. HOFMANN

Insurers are increasingly taking a do-it-yourself approach to lining up temporary personnel and hiring people under contract.

Rather than pay temporary services to supply them with extra help, some insurers have created large, in-house pools of talent for their headquarters. In addition, insurers are tapping a growing population of skilled retirees to meet part-time staffing needs (see story page 16B).

And, when a need arises for temporary professional help, some insurance executives plug into an informal network of personal contacts to fill the slots.

But self-reliance doesn't mean that insurers have turned their collective back on outside contractors when they seek certain types of expertise (see story page 16B). In fact, both insurers and providers of contract services say that changing demographics and profit goals will assure that demand for part-time help and project-oriented special services will keep both in-house and outside contractors busy in the future.

Smaller insurers particularly will continue to rely on outside contractors because their temporary employee needs do not justify the creation of an in-house program.

But, in larger companies with more employees absent on a given day due to illnesses or vacations, an in-house temporary employee program can be cost-effective.

Insurance company human resources professionals generally cite the higher cost of using personnel supplied by temporary employment agencies as the chief reason for forming in-house temporary pools.

Jim Miller, assistant vp with Philadelphia-based CIGNA Corp., pointed out that temporary employee agencies tend to have a markup of 30% to 45% over the hourly wage paid an employee. In contrast, CIGNA's "CIGNA Temp" program has an administrative overhead of 7.3% over the hourly rate, he said.

Jan Hahn, head office employee relations manager for Schaumburg, Ill.-based Zurich American Insurance Co. of Illinois, said that a temporary agency can quickly provide well-trained and high quality personnel but also at a hefty charge.

As a result, Zurich is developing an "alternative staffing network" to fill temporary positions, which is expected to be operating in a few weeks, Ms. Hahn said.

Jodie Figge, an assistant vp responsible for headquarters human resources with Charlotte, N.C.-based Royal Insurance Co. of America, shares Ms. Hahn's sentiments.

"We have a pretty well-worn path to our door from temporary agencies," she said. The temps are well-qualified and well-motivated, she said. But, because the temporary agencies train, screen and check the references of their workers, as well as provide some employee benefits, they charge considerable mark-ups, she said. So, like Zurich, Royal is considering establishing an in-house pool, she said.

"We think we can do it cheaper," said Ms. Figge.

Warren, N.J.-based Chubb Corp. found out just how much more cheaply it could provide temporary services in-house compared with using outside contractors about four years ago, said Helen Maksymiuk, human resources manager with day-to-day responsibility for home office staffing.

The in-house program saved Chubb about $80,000 in the first year, and roughly $90,000 in each of the last three years.

Escalating temporary costs led Chubb human resources professionals to hold an evening "open house," complete with refreshments, to recruit temporary help. About 25 people responded to an advertisement announcing the event. Those who attended were interviewed and given typing tests on the spot, and about half of them had the requisite typing skills, she said.

The attendees who made the grade received follow-up calls. "When we called them, we had positions we had to fill," said Ms. Maksymiuk. The skilled typists who didn't display writing expertise received training and were placed in openings throughout the home office, she said. Some worked three days a week, others five days a week throughout the lifetime of a specific project, she said.

The human resources department monitored the program's performance by having each temp evaluated biweekly by someone within that department. The results were positive, she said, and some of the temporary workers moved into full-time positions.

Ms. Maksymiuk said the Chubb temporary program, which has no formal name, currently has about 60 enrollees.

"These are primarily individuals who have heard about our program," said Jan Tomlinson, national human resources manager for Chubb & Son.

About half of the temporary workers now are on assignment in the home office, said Ms. Maksymiuk.

The system benefits both the part-timers and their employer,

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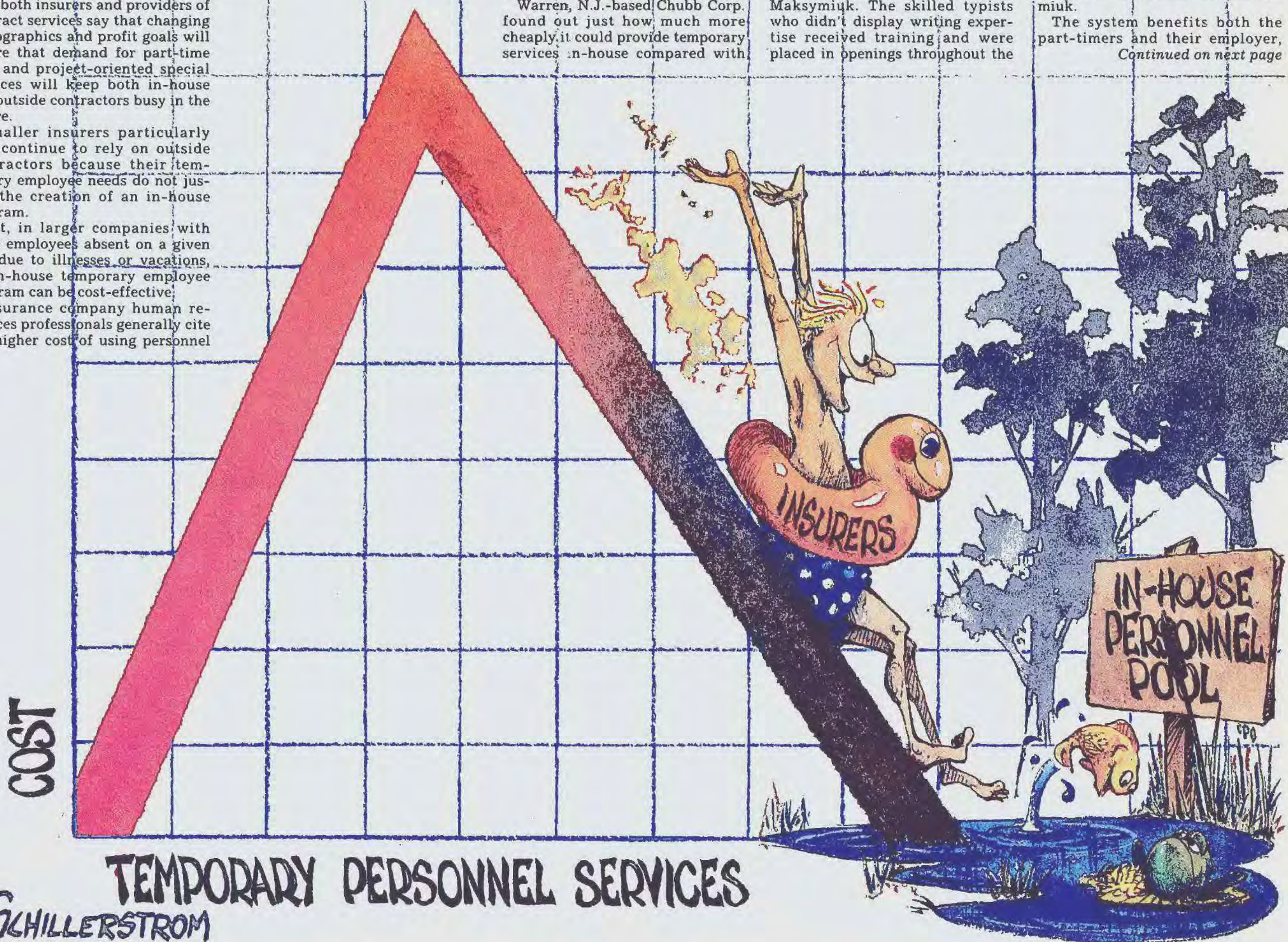

Temporary help

Continued from previous page

Ms. Tomlinson says. "They have all the benefits of temporary employment, but they work for one company. They get to know us," she said. The temporaries also learn of full-time jobs if they want them, she said.

From Chubb's vantage point, the temporaries provide a pool of workers who already know the company's systems and culture, she said. Because of this, the temps' productivity is higher than might be expected if part-timers were drawn from a pool that worked for Chubb one week and another type of industry the next, said Ms. Tomlinson.

Ms. Maksymiuk also noted that because the temps often move into full-time positions, Chubb has reduced its recruiting costs as well.

"The temporary employees are a very substantial source for full-time hiring," agreed John Marks, assistant vp-human resources for the home office of Novato, Calif.-based Fireman's Fund Insurance Co. "We have an in-house temp pool, which we use quite extensively," he said, noting that the pool was drawn upon for about 800 personnel requisitions in 1989.

Fireman's Fund's pool generally has between 100 and 150 enrollees at any given time. "It's quite a cross section" that includes retirees, people who want "to get a foot in the door" and others who simply want to work part-time on a regular basis, he said.

The Fireman's Fund program, called the "Spare Hat Temporary Program" in reference to the company's fire helmet logo, began in the early 1980s, shortly after the company moved its headquarters from downtown San Francisco to its current location about 30 miles away. Like many other insurers, Fireman's Fund wanted an alternative to high-skilled, yet high-priced agency-provided temporaries, Mr. Marks said.

Unlike its counterparts in Philadelphia, Chicago or Hartford, Conn., Fireman's Fund doesn't have a large pool of insurance-oriented workers to draw upon and having an in-house service helps remedy the situation, he said.

And even in an insurance center like Chicago, problems arise. "Let's say I needed a rater. There's no way I could get one from a temp service, or maybe once in 100 calls," said Zurich's Ms. Hahn.

Finding professionals with specific skills willing to work on a temporary basis can mean that insurance executives will get involved in some serious networking.

"We find that in general it's hard to use temporary help. It takes quite a while to bring someone up to speed," said Joe Pratt, vp and actuary responsible for personal lines for Woodland Hills, Calif.-based property/casualty units of Transamerica Corp.

But about a year ago, demands for data required by California's Proposition 103 sent Mr. Pratt looking for additional help.

"We had to gather a tremendous amount of data" quickly, he said.

Requiring actuaries to put in added overtime would not have sufficed, he said, so he called a former colleague who had struck out on his own as an actuarial consultant. The consultant worked on site for six weeks getting the data together, Mr. Pratt said, and then returned to his office.

Jim Vogt, Transamerica's senior vp-commercial claims, found himself a few months later doing what Mr. Pratt had done. The company in January began consolidating its roughly 20 regional claim offices into three centers—in Lehigh, Pa., and Phoenix for commercial lines and Battle Creek, Mich., for personal lines. Some of the regional office personnel began resigning and others were being transferred to the new facilities, leaving Transamerica short of managers.

"We had a tremendous requirement for technicians," said Mr. Vogt, who described the type of people sought as "decision-makers" like adjusters or supervisors who could act as a "bridge" during the shutdown of the regional claim offices.

"We individually used all of our contacts. We ferreted out people who might be able to do these things. We knew what our needs were and then we went out and found people we knew," he said.

Transamerica ultimately found 20 or so "bridge" professionals, some of whom were retirees, others of whom were professionals between jobs willing to accept a short-term assignment.

Mr. Vogt cited two major advantages to the networking approach. "You know what you're getting," he said. These were personal acquaintances with proven track records, he said.

The other advantage went straight to the bottom line. "We didn't have one dollar spent on headhunters," said Mr. Vogt, and "we have not had a problem finding good people."

> **'Let's say I needed a rater. There's no way I could get one from a temp service,' says Jan Hahn.**

CIGNA's Mr. Miller also has a reliable source of professional and managerial part-timers, although he freely admits that luck plays a role in creating the pool. He estimated that about 100 or so of the 385 people in CIGNA Temps available at the company's Philadelphia and Bloomfield, Conn., locations are professionals or managers. Although some are insurance professionals, the background of the professional temps is "predominantly general business—accountants and financial types," he said.

One of the most common reasons that a professional enters CIGNA Temps is demographic, said Mr. Miller. With more and more two-earner professional families, a job transfer for one partner means that the other is going to be looking for suitable employment. CIGNA Temps provides "a place for them to hang their hats while they find a job," he said.

Another source of professionals for CIGNA Temps is in response to advertising placed when departmental managers require a temporary employee with skills currently not available in the temp pool, Mr. Miller said. The system also allows professionals between jobs to become known to CIGNA managers in the event a full-time opening should occur, he said.

Although temporary employees aren't usually entitled to the corporate benefits packages offered to full-time employees, many insurers offer them some benefits in addition to their pay.

The insurance units of Hartford, Conn.-based Travelers Corp., for example, offer a limited package of benefits to part-timers enrolled in the corporation's TRAV Temps program, said Florence Johnson, assistant director-corporate human resources and services. Once a temporary employee has completed 500 hours of work, he or she can participate in medical and dental plans and receives term life insurance coverage. In addition, if the temporary works on the day before and the day after a paid holiday, the part-time employee is paid for the day off.

Temporaries enrolled in CIGNA Temps receive pension credits under CIGNA's pension plan and are eligible to enroll in the company's 401(k) program, said Mr. Miller.

Chubb's Ms. Maksymiuk said that although her company offers no benefits package to temps, they do receive pay for paid holidays if they're working that week.

On occasion, in-house temporary pools can't meet the demands of a specific project, and insurers turn to outside consultants on a project basis.

Andy Jarmel, chief executive officer of the Chicago-based AAM Companies, which consist of Asset Allocation & Management Co., Asset Allocation & Management Group and Polysystems Inc., said his organization often sets up an office on-site with a client to assist with investment strategy.

Smaller companies, whether life or property/casualty, often simply cannot afford a full-fledged investment department, said Mr. Jarmel, whose group caters solely to insurers. Rather than go to general investment advisers who do not necessarily understand insurance companies, the insurers seek out experts in their industry, he said.

"Our clients include companies that have one or two investment people in place. We are not there to eliminate jobs. We're there to supplement," said Mr. Jarmel.

Another consultant who specializes in the insurance industry also reports a demand for specialized insurance temporary employees—those who are willing to start at the top and stay there.

A. Donald Ikle, a partner with New York-based search firm Ward Howell International Inc., said there is a demand for temporary executives, although in the case of high-level officers, "temporary" may mean five years, rather than the week or two it can mean for a worker in a clerical pool.

Occasionally a chief executive officer will step down without having groomed a successor, Mr. Ikle said. But cutbacks and reorganizations have left a pool of executive talent available to fill the gap, he said.

When the need arises, a very senior manager who has either gone into early retirement or who feels frustrated about the chance for advancement within his company will be willing to take the helm of a smaller insurer for a short, specific term, Mr. Ikle said.

Insurers agree that demand for temporary help of all sorts, whether provided by an outside vendor or through a formal internal facility, is unlikely to slack off and is likely to increase as the 1990s progress.

With fewer skilled workers available, more working mothers needing flexible schedules and some states requiring that employers provide parental leave, "the dependency on alternative sources will become greater," said Fireman's Fund's Mr. Marks.

Because there are fewer qualified people to draw upon, jobs remain open longer and thus the requirement for temporary workers grows, he said.

Mr. Marks also pointed out that companies seeking ways to cut costs are staffing for "valleys rather than peaks," keeping a minimum number of people on the payroll. When a crunch time comes, temporaries are used to beef up staffs, he said.

Travelers' Ms. Johnson agreed. "From what I've seen around me, we're trying to maintain a lean workforce," she said. "We're going to be more careful (about staffing) in the future," she added. ■

Returning retirees bring experience and leave savings

By MARK A. HOFMANN

Some insurers look to the past to meet present and future staffing needs.

An increasing number of property/casualty companies say they use retirees, regardless of where they used to work, to meet temporary employment needs.

With skills and motivation often lacking in their younger counterparts, retirees can save firms money, say human resources managers.

Since 1981, Travelers Corp. insurance units in Hartford, Conn., have relied on its Retiree Job Bank for part-time help. Originally restricted to former Travelers employees, the jobs were opened up in 1985 to other retirees. This January, the pool was expanded to include all temporary workers and renamed TRAV Temps, said Florence Johnson, assistant director-corporate human resources and services.

"Responsible, mature and skilled" retirees have been used mostly in administrative support jobs, she said. Some, though, turn up in managerial positions.

After an officer retires, a department will often say " 'We want so-and-so back,' " according to Ms. Johnson. Retired executives, who generally work on short-term projects, can enhance productivity with their knowledge of the company, she said.

The success of the Retiree Job Bank is being replicated with the expanded TRAV Temp program, Ms. Johnson said.

In January, outside agencies supplied 185 people, or about 36% of Travelers' temporary workers. By March, the agencies supplied 79 and by the end of last month the number was down to 14, she said.

Travelers estimates this program will save $400,000 to $500,000 in 1990 and more than $1 million in each subsequent year, compared with what Travelers would have to spend to obtain the same services from an outside temporary agency.

At CIGNA Corp., a similar program now includes 200 retirees, primarily in clerical positions.

But "we've actually had a couple of (former) execs in Encore," the 3-year-old program, said James Miller, an assistant vp with the Philadelphia-based insurer. "More and more older folks want to come back to work, particularly on a part-time basis."

Like their Travelers counterparts, CIGNA retirees generally come back on a project basis, Mr. Miller said. They work a maximum of 10 days a month, he said.

Retirees are also a critical component of Zurich-American Group's in-house staffing strategy.

Through its "Alternative Staffing Network," the company hopes to draw on former employees, former temporary employees, retirees and, in some cases, children of employees, said Jan Hahn, head office employee relations manager for Schaumburg, Ill.-based insurer. The program is slated to begin as early as Aug. 1.

Like Mr. Miller, Ms. Hahn sees nothing surprising about retirees interested in returning to work. "They're living longer and they want to work longer."

And that re-entry of older workers is good for companies, contends Ms. Hahn. "Who has more experience than retirees?" she asked.

"I really do think there's a cost savings" in using retirees, "particularly those with technical skills such as rating," said Helen Maksymiuk, human resources manager with day-to-day responsibility for home office staffing at Warren, N.J.-based Chubb Corp.

By using a "bank of information" on its retirees, Chubb matches them with jobs, often using them to train younger workers, she said.

"Do you know what it's like when you have two or three new raters?" asked Ms. Maksymiuk. Retirees can serve as rating instructors while full-time raters can carry out their jobs, she said.

Ms. Maksymiuk said the retirees in Chubb's program generally have been in retirement for at least one year. She said retirees generally have more than enough to keep themselves busy during their first year of retirement as they take the trips they've always dreamed of or do other things they never seemed to have the time to do. By the second year, some retirees are more than willing to return to work on a part-time basis, both for extra income and to renew acquaintances, she said. "They love coming back," she said. ■

In-house delays prompt insurer to hire data firm

By MARK A. HOFMANN

WEST CHESTER, Pa.—When Howard C. Stevens had to wait too long to get relatively simple data from his in-house electronic data processing department, he took drastic action.

Mr. Stevens, chairman, president and chief executive officer of Penn Mutual Insurance Co., decided the best way to speed up data processing was to turn the company's electronic data processing department over to an outside contractor.

He chose Computer Advisory Group, a seven-year-old company based in Lancaster, Pa.

CAG specializes in insurance, banking, manufacturing, food processing and general industrial companies with $1 million to $350 million in annual sales. It handles data processing for three regional property/casualty companies in eastern Pennsylvania.

Tom Wolf, the chief executive officer of Computer Advisory Group, said he and his brother Ted—the firm's president—began by selling software and hardware as well as consulting services. They soon decided to leave the equipment business to others.

"We decided to focus purely on selling services," because medium-sized companies, which they viewed as an attractive market, were not satisfied with their data processing operations, he said.

According to Ted Wolf, office politics hampered many companies in his target market. "I can't tell you how many MIS (management information systems) directors I talk to who have two years of backlog. When they open up, they

Continued on page 16D

Why Some Reinsurers Still Don't Cut It.

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Data processing

Continued from page 16B

tell you it's politics," he said. "You can look at the backlog, and say that 90% were wish lists, not business requirements."

As consultants rather than employees, Computer Advisory Group can recommend that certain projects aren't a priority, making time for the more important projects.

Mr. Stevens of Penn Mutual said that backlogs were one reason the West Chester, Pa.-based insurer sought outside help.

Changes in an internal program—like altering the way names and addresses of policyholders were printed out on declarations—took months to complete, as did requests for reports, according to Mr. Stephens. "It's hard to manage when you're not getting the necessary reports."

Completing rate changes could take up to six weeks and no employee seemed to have a satisfactory explanation for the delays, he said.

"I wasn't quite sure we were getting the straight story," Mr. Stevens said. "I'd ask for something, they'd say it would take six months. Some of the things seemed like the easiest things to do, and they said it would take six months."

Virtually the entire internal electronic data processing department got pink slips: A single contract employee from Computer Advisory Group replaced the manager, programmer and assistant programmer, said Mr. Stevens.

The change has worked well, he said, noting the company has "not had a moment of downtime" during working hours since the responsibilities were contracted out.

Though he did not give specific figures, Mr. Stevens said efficiency has grown dramatically. For example, rate changes that took six weeks to get into the system now take 24 hours, he said.

Ted Wolf

Ted Wolf said that in general, contract electronic data processing is about 30% more efficient than keeping the service in-house.

Contract personnel generally are better motivated, he said. His brother adds that contractors don't have to deal with internal politics on a daily basis.

"When we go in, our goals are directly in line with our client's goals," said Ted Wolf. The relationship is based on service, instead of politics, he said.

Demand for such contracted services from small and medium-sized insurers will continue to rise, predict the Wolf brothers, whose revenue has grown to $4.2 million last year from $1 million in 1987 and is projected to climb to between $7 million and $8 million this year.

In fact, outsourcing—the complete provision of electronic data processing services rather than simply consultation—should be among the hottest growth areas of the next five years, said Ted Wolf.

Heightened emphasis on holding down costs—which includes personnel cutbacks—will make the words "outsourcing" and "downsizing" synonymous, he said. ■

August

Employee Development & Education

BI editors will examine how insurers are using educational programs to keep their employees' job skills sharpened — are they developing their own programs or turning to outside sources. In addition this section will look at remedial programs — are they effective tools for helping employees who lack basic educational skills.

Issue: August 20
Ad Closing: August 8

September

Conferences & Exhibits

There's no limit to creativity. Trade show exhibit designs can play off a sporting event, game, host city, conference theme or your product and look like your office, your living room or the great out doors; they can draw customers in with your literature or premiums from the ridiculous to the sublime. BI editors examine the fine art of exhibits and the marketing opportunities available through sponsorship events.

Issue: September 17
Ad Closing: September 5

October

Claims Automation & CPCU Report

Today's technology provides claims departments with more than statistics ... now qualitative information — programs that offer value judgements — are also available. From the detection of insurance fraud to artificial intelligence, BI editors will report on how insurers are using advanced automation systems to improve their operations. Also in this section — a report on the Chartered Property & Casualty Underwriters conference.

Issue: October 15
Ad Closing: October 3

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Insurer Topics

New firm designing standard interface

By LAURA MAZZUCA and MARK A. HOFMANN

CHICAGO—Insurers, agents and automation vendors say they are one step closer to adopting a system to standardize interface among firms.

The Alliance for Production Technology, a joint venture of several insurers and system vendors, is developing standardized software designed to eliminate much of the "fragmentation" that has hampered agency/company interface, said Philip L. Engel, vp-corporate services for the property/casualty units of Chicago-based CNA Financial Corp.

Although the industry has been attempting to achieve a single-system, single-entry interface for at least a decade, most insurers still rely on proprietary systems. This forces agents to use different systems for each insurer they represent.

The new, for-profit group will promote the use of standard software that would reduce the need for agents to enter the same data into their systems for different insurance companies, Mr. Engel said.

Standardized software would enable agents to transmit and retrieve information from multiple insurers without having to enter data on a buyer more than once, explained Tom Eustace, chairman and chief executive officer of Applied Systems Inc., an agency automation vendor based in University Park, Ill. Applied Systems is a partner in APT.

Other partners, besides Applied Systems and CNA, include: Agency Management Services Inc., an agency automation vendor based in Dallas; Fireman's Fund Insurance Cos. of Novato, Calif.; New Hampshire Insurance Co., a Manchester, N.H.-based unit of American International Group Inc.; and the insurance units of Hartford, Conn.-based Travelers Corp.

Agency Management Services, in turn, is jointly owned by CNA, Fireman's Fund and New Hampshire Insurance.

Other insurers and software vendors that have been invited to participate in APT include: Redshaw Inc., a Pittsburgh-based vendor; Hartford Insurance Group of Hartford, Conn.; St. Paul, Minn.-based St. Paul Cos. Inc.; Basking Ridge, N.J.-based Crum & Forster Corp.; and Kemper Group's national insurance companies in Long Grove, Ill.

APT products will conform to and build on the standards established by ACORD and the Insurance Value Added Network Services. ACORD, formed in the 1970s by the insurance industry, sets data processing standards for insurer-agency transactions, while IVANS, launched in the early 1980s, is an industry-sponsored data communications network.

As an "alliance of competitors," APT is a first in the agency software vending industry, and stands a good chance of succeeding, said Gregory A. Maciag, vp and treasurer of ACORD, based in White Plains, N.Y.

"Our reaction is very positive because it's just another way to implement ACORD standards," he said.

Continued on page 16F

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THE ASSET MANAGEMENT PROFESSIONALS.

Standard interface

Continued from page 16D

Many in the industry are optimistic that APT may launch a new era of cooperation among vendors, agents and insurers.

"Automation of the exchange of information between insurance company and agency is very important to the future success of our industry," said Giles Madray, senior vp, administrative operations, for Alexander & Alexander Inc. in Owings Mills, Md. "We need to reduce our overhead cost of providing the product to our clients, thereby reducing the price of the product we sell."

"What this does is put a lot of the fragmentation behind us," said CNA's Mr. Engel. "Instead of spending so much time talking about it, we'll be able to have a standard," he added.

With consumer pressure for an improved delivery system increasing, the time seems right to break the "gridlock" of proprietary systems, said David Wroe, president and chief executive officer of Agency Management Systems, one of the APT partners. APT has been on the drawing board for nine months, he noted.

Even some consumer activists say the development of APT is a step in the right direction, although not necessarily for the same reasons cited by the industry.

"In preparation for the inevitable repeal" of the McCarran-Ferguson Act, "companies realize they can't rock along as they used to," said J. Robert Hunter, president of the Alexandria, Va.-based National Insurance Consumers Organization.

As pressure mounts from direct writers and banks entering the business, insurers finally realize that they must offer more automation to successfully compete, Mr. Hunter said. A standardized automation system "could mean a real era of head-to-head competition" between direct writers and independents, "which is good for us," he said.

CNA's Mr. Engel said that one impetus for the development of APT was a desire to hold the line on insurance costs.

"Consumers want somebody to work on cost reduction," he said. Insurers, stung by consumer-driven measures like California's Proposition 103—which among other things required insurers to roll back "charges" 20% (*BI*, Nov. 14, 1988)—need to promote APT-style solutions, he said.

"We think customer service will improve," as a result of standardized interface, said Paul Philp, vp-information services for New Hampshire Insurance. Policy issuance will become more efficient, he said.

CNA's Mr. Engel downplayed the possibility that APT will raise antitrust questions.

"Participation in APT is completely open, and we're not reducing the competition among vendors," he said. "Strategic alliances are fairly common."

Others in the industry are more sanguine about APT's success.

"We all have to be careful not to get drawn into the campaign without looking at the means and bounds," contended John Pottridge, director of industry affairs for the National Assn. of Professional Insurance Agents in Alexandria, Va.

For experts to assess its prospects, they need more information about the consortium, including the cost of a product to agents, "what it will look like when it sits in the agent's office," and how it will affect other software vendors, he said.

"We would certainly support anything that would get us to interface, but we need to receive more specifics," Mr. Pottridge added.

APT's success will depend on a large number of vendors joining and spurring increased involvement by insurers that have long maintained proprietary systems, according to Shirley Lukens, director of automation for the Independent Insurance Agents of America, Alexandria, Va.

"There are always those companies who don't want the playing field to be leveled," said Ms. Lukens. "But it may be detrimental for them not to be a part of this." ■

August September October

Employee Development & Education

What are agencies doing to keep producers and other employees up-to-date on the insurance industry? BI editors will report on the types of in-house programs used for on the job training as well as the outside sources available for continuing employee education. In addition, this section will review the sources agents and brokers use to recruit new employees.

Most Productive Agencies/ Automation

BI editors track the most productive agencies and profile some of the industry's leading firms. This section will also have reports on how companies can pattern their operations after the success of others. In addition, how advances in automation influence productivity in insurance agencies will be reviewed.

Customer Service IIAA Conference Report

Are agents and brokers delivering what their clients are looking for? Editors will focus on how agents and brokers can improve the service they give to clients and look at customer service representatives, their responsibilities and their compensation. Plus, this section will report on happenings at the Independent Insurance Agents of America annual convention.

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Agent/Broker Topics

Oppose expensive local taxes, experts say

By MARK A. HOFMANN

MILWAUKEE—Even though state premium taxes can cost more than federal income taxes, insurers —particularly life insurers—generally don't pay sufficient attention to them, several experts say.

Like comedian Rodney Dangerfield, "premium taxes don't get any respect," said Edward M. Burgh during a panel discussion at the annual meeting of the National Assn. of Life Companies in Milwaukee last month.

Mr. Burgh, an attorney and certified public accountant who founded Los Angeles consulting firm E.M. Burgh & Associates, noted that among the 50 states, the District of Columbia and Puerto Rico, insurers are charged 19 different premium tax rates that range from 0.8% to 4%.

Insurers will pay an estimated $5.5 billion in federal income tax in 1990. But their state tax bill will exceed $6 billion, he said.

However, "many states do not tax domestic and foreign companies in the same manner and, in some cases, domestic companies are not taxed at all," Mr. Burgh said.

For example, in some states, municipalities and counties can add their own premium taxes to state levies, he said.

Mr. Burgh cited a Kentucky law as an example of tax legislation that could make life more difficult for insurers.

In Kentucky, municipalities and counties are allowed to impose premium taxes in addition to a state premium tax, Mr. Burgh said. Insurers can take credit against a county's premium tax, though, for any premium tax paid to a municipality in that county, he added.

The catch is that regulators in other states may be inclined to "retaliate" against this tax by assessing a similar tax on Kentucky-domiciled insurers operating in their state.

However, Kentucky state law then calls for the insurance commissioner to retaliate by imposing an equal tax on insurers domiciled in that other state, he added.

The result may be "circular taxation"—round after round of retaliatory taxes, according to Mr. Burgh.

Continued on page 16H

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State taxation

Continued from page 16F

Conceivably, all premiums written in Kentucky by companies domiciled in another state that retaliated against Kentucky's premium taxes could be eaten up by this retaliatory taxation, Mr. Burgh predicted.

To remedy this and other tax problems, tax issues must be "elevated to top priority," Hugh E. Ray, president of the Florida Assn. of Domestic Insurance Companies in Tallahassee, said at the NALC meeting.

He called on life insurers to "coordinate efforts" to block measures similar to Kentucky's.

"Sanity" on tax issues will have to come from life insurers because property/casualty companies face more pressing problems of their own, according to Mr. Ray. He cited poor combined ratios in the property/casualty insurance industry, problems with workers compensation rates and the continuing impact of California's Proposition 103.

Premium taxes are only one issue that ought to concern insurers, Mr. Ray said, adding that they can ill-afford to ignore measures like the municipal license fees in Florida.

Florida municipalities can charge a license fee for any insurer selling coverage within the town's borders, he explained.

In some cases, at a customer's request, an agent has gone to a neighboring town to sell a single small policy and the neighboring town has requested a licensing fee from the concerned insurer, he said. Fees can be as much as several hundred dollars, according to Mr. Ray.

The problem of municipal license fees is going to increase, Mr. Ray predicted. As federal aid cutbacks continue, municipalities will look for revenue wherever they can, he said, noting that insurers are going to look very attractive.

Mr. Ray advocated making tax issues a "top priority," coordinating insurer lobbying efforts on premium-tax proposals and creating coalitions with community groups like tax watchdog organizations that share some interests with insurers.

Mr. Ray also urged insurance company executives to become politically active on tax issues. "I can't emphasize enough your personal involvement in the legislative process," he said.

Mr. Ray's trade group, the Florida Assn. of Domestic Insurance Companies, is trying to put together a clearinghouse to share municipal licensing fee information with other state insurer groups, he said.

"In such states as Louisiana and Kentucky, municipal licensing fees are so onerous that I would advise a company against doing business there" unless it had a very good reason for doing so, he said. "I think this is the kind of thing that will spread."

Membership in the National Assn. of Life Companies is open to "any corporation, association or society engaged in a life insurance business which is in good standing and qualified to do business in any state or territory of the United States or the District of Columbia," according to the group's bylaws.

'I can't emphasize enough your personal involvement in the legislative process,' Mr. Ray says.

According to a statement of principles adopted upon its inauguration in 1955, the group was founded to give "younger, smaller progressive companies" a united voice in their dealings with regulators, legislators and other insurers.

Forty-three companies signed on as charter members of the National Institute of Life Companies after the 1955 meeting in Atlanta.

Today the Washington, D.C.-based group has more than 600 members.

Some 208 of its members also belong to the American Council of Life Insurance and 103 to the Health Insurance Assn. of America, according to S. Roy Woodall, Jr., the NALC president and a former Kentucky insurance commissioner.

The National Assn. of Life Companies is located at 1455 Pennsylvania Ave. N.W., Suite 1250, Washington, D.C. 20004-0401; 202-783-6252. ■

Document reinsurance: Attorney

By LINDA J. COLLINS

CHICAGO—An insurer's best defense in a reinsurance dispute is full documentation of all negotiations, transactions and conversations with reinsurers, says an insurer attorney.

"In the reinsurance arena, it is all too common to find that reinsurance contracts are drafted on the basis of good faith, fair dealing, handshake deals, custom and practice—things that are not written down anywhere," said John K. Conway, assistant general counsel for Long Grove, Ill.-based Kemper Group's national insurance companies.

But the reinsurance contract should be a "starting off point whenever you're discussing your ability to recover from your reinsurer. Too often, it is one of the last things that people look at," Mr. Conway explained last month at the Illinois CPA Foundation's Reinsurance Update Conference in Chicago.

He cautioned insurers to have not only a detailed, properly documented, signed and executed reinsurance contract, but also records of "all the discussions you have had with your reinsurer over time, all the scraps of paper you have put in the files and every communication that you have given the reinsurer by telephone or otherwise."

Subsequent changes, he warned, must be in writing "because when push comes to shove, people will have different versions of what went on, and unless you've got enough paper in your file to document your position, you are going to lose."

And, Mr. Conway cautioned insurers to make sure that they have complied with all of a reinsurer's requests and requirements so "the reinsurer has no reason to claim that his failure to reimburse you is due to your failure to perform likewise under the contract."

Insurers do not always comply fully with requests for more detailed information, but reinsurers can use that failure to comply as reason for delaying payment, he stressed.

"It's urgent then that you make sure that these files are audited periodically and all requests for information from your reinsurers are complied with in writing," he said.

In addition to the contract itself, all reinsurance claims should be fully documented, including when the reinsurer was first notified of a claim, Mr. Conway said.

In some jurisdictions, late notice may excuse a reinsurance company even if it cannot show harm from the late notice, he said.

Therefore, "the safe practice is to make sure that the reinsurers are put on notice as early as possible within the parameters set forth in the contract and that all of the information is updated as soon as possible," Mr. Conway said.

When insurers do run into claims paying difficulties with a reinsurer, they should confront the reinsurer as soon as possible, he advised.

"If there is a problem and the reinsurer balks at paying, you can't let that matter sit. You have to adopt an aggressive collection effort based upon full knowledge and due diligence and be as persistent as possible. If you don't, there are bad players out there who just won't pay you," he explained.

Mr. Conway said that the insurer should always stress its overall relationship with the reinsurer, including the number of years they have dealt with each other, the amount of money the insurer pays the reinsurer each year and the availability of other reinsurers in the market.

"Let them know that if they respond to you with unsatisfactory claims handling practices you can well take your business elsewhere," he said.

According to Mr. Conway, ceding companies "have every right and obligation to be as tough and consistent as possible to prevent a slow-pay situation from developing into a no-pay situation.

"You have to let the reinsurer know what your expectations are from the start—prompt payment of losses, with no ifs, ands or buts," he said.

In fact, he suggested that ceding companies periodically "make sure letters of credit are in force," and told insurers not to "hesitate to draw down on them if the reinsurer balks on paying."

"Above all, put as much effort, intensity and tenacity into the collection process as possible. At a minimum, apply more effort to collect than the reinsurer does to resist," Mr. Conway said.

And, if all of the insurer's documentation and discussions prove fruitless, an insurer can consider arbitration or litigation.

Mr. Conway noted that "the Supreme Court has upheld the use of mandatory arbitration clauses in contracts, so that if you want to bind someone to arbitration, you have to do so in the contract. Barring that, you cannot compel your assuming company to arbitrate your difference."

So, if the contract does not contain an arbitration clause, an insurer's ability to get the reinsurer to agree to arbitration will "depend on how they view their chances in each scenario," Mr. Conway said.

He observed that arbitration has long been preferred to litigation and in most cases it is probably still more beneficial for both parties.

For example, arbitration is much quicker than litigation from start to settlement, Mr. Conway said.

It is also less expensive because it is not necessary to hire as many attorneys or expert witnesses, or to pay for as much of their time.

Arbitration is also more private because "you don't have to show up in a courtroom that is open to the public," he pointed out.

And it is generally less adversarial and can be considered a conciliatory gesture, he said.

Finally, arbitration panels, unlike juries, are usually composed of people knowledgeable about insurance and reinsurance, Mr. Conway added.

Despite the advantages to arbitration, litigation has become a more common way of resolving reinsurance disputes, he noted.

"Arbitration works well in a reinsurance world that is governed by good faith, handshakes and follow the fortunes. But, when things get down and dirty and people do not see eye to eye, litigation is often sought by both parties to the dispute," Mr. Conway explained.

But, he cautioned that "the decision in the end to litigate or arbitrate should be based upon the facts underlying the claim, the relative positions of the parties, the conditions of the contract and whether or not the parties want to get along in the future."

If the insurer and reinsurer want to work together in the future, they probably want to avoid litigation, which sometimes creates insurmountable rifts in business relationships, Mr. Conway said. ■

Information technology use viewed

ATLANTA—A recently released study undertaken by the Life Office Management Assn. holds that insurers have not effectively tapped the management and planning resources available through information technology.

According to "Information Technology. . .Achieving the Potential," a so-called "opportunity gap" is yawning ever wider between the potential of information technology and the ability of individual insurers to make the most of its potential.

"Today (information technology) can do far more than simply support your company's tactical and operational objectives of efficiency and effectiveness. (It) opens opportunities for massive changes in your organization and opens similarly imposing opportunities for you to achieve strategic advantage. (It) can become integral to your company's new products, services and delivery mechanisms—and it can directly drive your corporate strategy through the business options it enables," says the report.

The report suggests insurers ask themselves 10 questions to determine whether they are making the most of information technology. Those "only batting .500" are said to need remedial action.

The questions include: Are you comfortable with the quality of reports that you receive? If you need new information located in several different automated sources, can you get it quickly and relatively painlessly? Are you satisfied with the return on your information technology investments? Is your senior information technology executive a full-fledged member of your senior management team?

Copies of "Information Technology. . .Achieving the Potential," are available at $15 per copy for LOMA members, $30 for non-members. For information, contact the Life Office Management Assn., 5770 Powers Ferry Road, Atlanta, Ga. 30327, 404-951-1770.

IT briefs

Insurance fraud hotline

WARWICK, R.I.—Metropolitan Property & Casualty Insurance Co. has established a toll-free hotline for reporting insurance fraud.

The Warwick, R.I.-based company, which is a unit of Metropolitan Life Insurance Co. of New York, designed the hotline to encourage consumers to report suspected instances of insurance fraud regardless of whether the fraud involves Metropolitan.

The number of the hotline, which operates 24 hours a day, seven days a week in the 48 mainland states, is 800-922-FRAUD. Inquiries will be turned over to the insurer's special investigation unit, which will contact the proper authorities.

Metropolitan says its SIU uncovered $2.2 million in fraudulent claims in 1989.

Eno new HIAA counsel

WASHINGTON—Woodrow E. Eno has been named general counsel and director of the legal/state affairs division of the Health Insurance Assn. of America. Mr. Eno succeeds Joe W. Peel, who retired on July 1.

Mr. Eno is a graduate of the University of Nebraska law school. Before joining HIAA, he was a senior counsel of the product support area of CNA Financial Corp. in Chicago. ■

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Business Insurance

Curiale succeeds Corcoran as N.Y. insurance chief

By MEG FLETCHER and SAM CRISTY

NEW YORK—Under the direction of a new superintendent, the New York Insurance Department welcomes a legislature-ordered audit of its operations, says a spokesman.

Salvatore R. Curiale, 45, took office early this month as the 34th superintendent after he was both confirmed by the state Senate and sworn in on June 30.

Gov. Mario Cuomo in January nominated the former state workers compensation fund executive for the $87,338-a-year post.

Mr. Curiale succeeds James P. Corcoran, who resigned in January after seven years to become a partner with Wilson, Elser, Moskowitz, Edelman & Dicker, a leading insurance defense firm.

That resignation was upstaged by state Comptroller Edward V. Regan's allegations of ongoing "fraudulent activities" and lax management controls at the state's Liquidation Bureau. Mr. Regan's charges focused on the disappearance of thousands of blank checks and inadequate policies concerning the department's use of outside consultants, which he charged allowed for favoritism and excessive billings (*BI*, Jan. 15).

Mr. Curiale

Mr. Corcoran denied most of the allegations, claiming Mr. Regan, a Republican, had political motivations for attacking the Democratic administration.

However, Mr. Corcoran acknowledged in January that the Liquidation Bureau previously discovered some problems and remedied most of them administratively, although at least one former employee was sued by the state insurance department. That case is still pending.

Any problems were related to particular individuals and were not agency-wide, State Sen. Guy J. Valella, R-Bronx, chairman of the Senate Insurance Committee, said recently.

Sen. Valella said the allegations prompted him to consider proposing the audit, especially since a new superintendent would be taking over the department.

"We're not trying to point fingers and say, 'here's how you didn't do your job.' We're trying to say, 'look—here's how you can do it better," Sen. Valella said.

The legislature budgeted $250,000 for the audit, which will focus on equipment and personnel spending. It will be conducted by an outside consultant, who is to file a report by February 1991.

"We actually look forward to these studies," said Deputy Insurance Superintendent Kevin Foley. "Usually people come away with a better understanding and a more positive attitude" about the department, he said.

Mr. Curiale comes to the superintendent's post after a three-year tenure as executive director of the State Insurance Fund, the competitive state workers compensation fund.

The appointment marks his return to the insurance department, where he had served from 1983 to mid-1987 as deputy superintendent and later as first deputy superintendent.

He began his public service career in 1969 as a law clerk and later as an attorney for the law department for the City of New York's Contract Division. After practicing civil law privately from 1972 to 1977, he counseled the New York State Racing and Wagering Board from 1977 to 1983.

A Brooklyn native, Mr. Curiale earned a bachelor of science degree in economics at Manhattan College in 1966 and received a law degree from Fordham University in 1969.

He resides in Bellerose Village with his wife and three children.

Mr. Curiale declined interview requests, citing work-related demands on his time. ■

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AIDS suit

Continued from page 2

infected. Dr. Kuruvilla had denied that he was negligent.

Mr. Dalton said the family tried twice to settle with Dr. Kuruvilla's malpractice insurer, physician-owned insurer Mutual Insurance Co. of Arizona in Phoenix, but that an agreement with the company was never reached.

He would not discuss details of the settlement talks.

However, Dr. Kuruvilla was willing to settle the case before the trial began, according to one of the defense attorneys, Jeff King with the Phoenix law firm Weyl, Geyer, MacBan & Olson.

The award exceeds the limits of Dr. Kuruvilla's medical malpractice insurance, said Chic Older, executive vp of the Arizona Medical Assn. in Phoenix.

Mr. King, noting that the defense will appeal the award if it is denied a new trial in the case, said no decision could be made about whether Dr. Kuruvilla would sue the insurer for bad faith to recover the full amount of the award until the litigation is concluded.

Scott Diener, risk manager at Mutual Insurance, would neither comment on the case nor on the details of Dr. Kuruvilla's malpractice insurance.

"We think it will be overturned," Mr. Diener said of the award.

The case centers on one of two transfusions Alex Edwards received shortly after his birth in March 1985.

In court papers, the parents say they were asked for their consent to give Alex a transfusion shortly after his birth at Desert Samaritan Hospital and that they expressed concern over transmission of the AIDS virus.

"If a transfusion was necessary, the parents wanted to donate their own blood for use in their child because of their fear of AIDS being transmitted by the transfusion," the documents state.

In addition, "Alex did not need (the transfusions) to save his life," the plaintiffs contend in the court papers. The transfusions were recommended and performed because of respiratory problems the infant was experiencing, the papers say.

However, the papers say that someone at the hospital informed the parents their fears about blood contamination during a transfusion "were groundless since the blood used for neonates had been screened to eliminate the risk of transmitting AIDS."

The documents say that the Edwards, relying on that information, "consented to the transfusion."

However, the papers continue, the Edwards "were not told of the need for future transfusions or given the option of making a directed donation for use if future transfusions became necessary."

Shortly after receiving the initial transfusion, Alex was transferred to Good Samaritan Medical Center in Phoenix, where the boy received the AIDS-tainted plasma in a transfusion that was given without consent, the parents charge.

Dr. Kuruvilla "gave the transfusion without the parents knowledge or consent," Mr. Dalton said. "The parents should have been notified."

Because the parents were unaware of the second transfusion, neither "understood the substantial nature, probable results, or alternatives to defendant's proposed treatment of Alex Edwards with blood or blood products," the suit alleges.

Performing the transfusion without parental consent constitutes battery on the child, the suit charged.

The parents discovered Alex had received the second transfusion only after the child was diagnosed with AIDS in 1988. The parents then contacted Mr. Dalton's law firm, which had represented another child who had contracted AIDS while at Good Samaritan.

After further checking, the parents learned that Alex had received a transfusion while at Good Samaritan.

Good Samaritan and Blood Systems Inc. in Phoenix, which supplied the blood products for the transfusion, originally were named in the suit but settled with the family before the trial began. The settlements contained non-disclosure clauses.

A Good Samaritan spokesman did say that the medical center was self-insured, though legal fees exhausted its retention. The settlement was covered by an excess insurer, but the spokesman would not identify the insurer or provide coverage information.

Blood Systems, a non-profit corporation, was insured for its portion of the settlement, according to attorney Steve Labensky with the Phoenix firm Lewis & Roca. Mr. Labensky also declined to identify the insurer.

Meanwhile, doctors throughout Arizona "were outraged at the award in the Kuruvilla case," said Mr. Older of the Arizona Medical Assn.

About 1,100 doctors and 600 other participants marched on the state capitol last month to call for changes to the way malpractice awards are granted in Arizona.

That march came too late in the legislative session for lawmakers to act on malpractice awards, but lawmakers were served notice that "they have to address it immediately upon returning," said Mr. Older.

The medical association is considering whether to support several reforms, but it "would be premature to discuss (them) at this time," he said.

"We feel that the system is broken and that the entire system needs to be reformed," he said.

In one sense, he said, he was "glad" the award exceeded the doctor's malpractice limits.

Had the insurance covered the whole award, "this would have been just another settled case" instead of one that has focused attention on the state's malpractice award "crisis," Mr. Older said.

Mr. Older acknowledges that capping such awards would not be easy. Arizona's constitution prohibits any limits on liability, so capping damage awards would require amending the state's constitution. ■

pro•file /ˈprō-ˌfīl/*v*,: to provide data portraying significant features.

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Work comp claims handling

Changes needed in how insurers manage claims

Speaking out

By Jeffrey R. Kreider

FOR THE LAST 21 years, I have been involved in the workers compensation system in a good number of states across the United States as a claims supervisor, a provider of case management services or as a health care provider trying to attract workers compensation business.

As a result of being able to view the workers compensation system from virtually all sides, I have become increasingly interested in the multitude of publications talking about the need to control costs in workers compensation claims.

Based on my experience over the past two decades, I feel confident in saying that without a major overhaul within the insurance system, many of the techniques that have worked in the general health insurance arena to control costs will not work in the workers compensation system.

I do not plan to quote statistics on the rise of health care costs as many other articles have. I'm sure readers are convinced of and familiar with the rise in these costs. I would like, however, to ask some questions and provide some thoughts that I hope will spur some insurer into action to make changes that can have a permanent effect on rising workers compensation costs.

The first thing that needs to be dramatically changed is that the original spirit and intent of the workers compensation system must be realized and upheld. All the recent articles have stressed the fact that workers compensation is a "no-fault" and "non-adversarial" system. Unfortunately, in reality it doesn't work that way.

In my experience, I have run into only a handful of claims adjusters and supervisors specializing in workers compensation who treat the injured worker in a non-adversarial way. For the most part, when a worker is injured, a claim is presented and that claim is placed in the claim process, all efforts are exhausted to deny the claim, deny the disability and avoid payment before any effort is made at case management. Unfortunately, by the time the claims department decides to utilize case management techniques that have worked in other health care arenas, it can no longer communicate with the injured worker because he or she no longer trusts the claims department. Or, the injured person has hired an attorney.

In literally thousands of cases I have handled from a case management standpoint, the average time it took for the claims department to decide case management was necessary was 17.5 months after the accident. In looking at all of these cases, virtually 100% belonged in a case management system from the onset.

I have conducted training programs in case management for insurance companies across the nation, at which the audience totally agrees with the procedures I indicate should be invoked from the first day of the claim. Unfortunately, after the training session they return to their desks and continue to handle claims the way they have in the past, and follow procedures that historically have not worked.

The second major change that must occur is in the structure of the claims department itself. The claims person's role must be clearly defined as one that, as quickly as possible, determines compensability. Once compensability is determined and it is decided that the claim must be paid, in my view, there is no longer a significant role for the claims person. Now, every effort must be made to manage the case in a way that promotes wellness and a return to work, and results in cost savings. There are only three ways to accomplish this:

- Medical care coordination.
- Medical cost control.
- Active job placement.

Under our present workers compensation system, invoking the techniques that will work is, at best, difficult and, at worst, impossible. The reason the problem has gotten out of hand is that we continue to have claims people who are experts in the law and investigative techniques trying to determine treatment needs, make judgments on "reasonable and necessary costs," and attempt to coordinate a return-to-work program. These are issues that must be addressed by experts in those fields.

The structure within the insurance industry that will control costs is to have a small number of claims people whose sole function is to determine compensability under the law, and invoke appropriate investigative measures in the complicated cases to decide whether to pay a claim. When it is determined the claim is worthy of payment, immediately the case should be turned over to the "case management" department, which should consist of medical specialists who are medically qualified, and vocational specialists who are vocationally qualified. Their whole function, in

Continued on next page

Defense costs should be paid promptly

Speaking out

By Joseph P. Monteleone

WHEN SHOULD INSURERS pay defense expenses? There have been several court decisions on the timing of payment of defense expenses under the directors and officers liability policy, and some insurers have begun to address the issue in their policy language. But insurers should look at pragmatic considerations that are not always consistent with case law or policy language.

Regardless of what the law of a particular jurisdiction may permit, the advancement of defense expenses benefits both the insurer and the policyholder.

Before discussing reasons for this, it is important to define the concept of "advancing" expenses. It is not the creation of a retainer or fund by the insurer to be drawn down as legal expenses are incurred. Rather, it is the simple notion of paying all reasonable legal defense expenses as they are billed by the appropriate vendors. This is valuable to the insurer *and* the policyholder for several reasons.

First, money has a certain time value. It often takes years for claim matters, particularly in the professional liability area, to be concluded by settlement, dismissal or final adjudication. In cases where defense expenses reach the hundreds of thousands of dollars, and perhaps millions, it puts a tremendous financial strain on a policyholder to pay these expenses and wait for reimbursement from the insurer.

Second, although the insurer loses the benefit of the "float," the ability to make use of money allocated for claims but not yet paid, the insurer and policyholder will be able to address any disagreements they may have on the reasonableness and propriety of defense expenses early in the claim life and hopefully at frequent intervals.

Early discussion would keep these disputes not only smaller in scope but also easier to resolve, since parties are less intransigent when less money is at issue. In addition, the parties can agree to avoid problems in future bills, an ability that is lost if the process is deferred to the conclusion of the claim.

Finally, aside from possible disagreements over the reasonableness of certain expenditures, issues of coverage and allocation of expense between the insurer and non-insured parties may affect the extent of the insurer's obligation to pay defense expenses. Again, it benefits both the insurer and the policyholder to resolve these disputes early, albeit perhaps only on an interim basis, and proceed with a cooperative defense effort.

Too often in the litigious insurance climate that exists today, the insurer and policyholder lose sight of the fact that the plaintiff or claimant is the true adversary. Therefore, any disputes between the insurer and the policyholder should be subordinated to the primary objective of defending the policyholder. Advancement of defense expenses, even though there may be no legal imperative to do so, furthers that mutually shared objective.

While there may be occasions when advancement of defense expenses would not be in the mutual best interests of the insurer and all of its policyholders, and the policy language fully supports a deferral of any payments, those occasions should occur infrequently and such a claim should be handled in an otherwise cooperative climate.

We now have decisions on the issue throughout various state and federal jurisdictions; however, the decisions unfortunately are about evenly split between those holding for contemporaneous payment of defense expenses and those permitting the insurer to defer payments until the conclusion of the claim.

What is even more confusing is the fact that some courts have interpreted virtually identical policy language in an inconsistent fashion. Particularly illustrative of this are two conflicting decisions: *Okada vs. MGIC Indemnity Corp.*, in which the 9th U.S. Circuit Court of Appeals found a contemporaneous duty to pay, and *Zaborac vs. American Casualty Co.*, in which the U.S. District Court for the Northern District of Illinois ruled that a duty to pay does not arise until disposition of the claim.

And, in one jurisdiction, the U.S. District Court for the Southern District of New York, there are arguably inconsistent opinions coming from the same court and even the same judge.

This judicial confusion, however, underscores the need for parties to work out an understanding early in the life of a claim.

Likely results would be a better working relationship between the parties involved, a more effective legal defense and a decreased chance of misunderstandings and litigation between the insurer and policyholder. ■

Joseph P. Monteleone is vp and claims counsel for Reliance National Insurance Co. in New York.

Work comp costs

Continued from previous page

a non-adversarial way, would be to help the injured worker through a very complex health care system and guide that worker from disability to return to work.

Disability is a very complex issue that involves the physical, emotional, financial, vocational and motivational aspects of every injured worker. Because injury and resulting disability stimulates reactions and needs in all of these areas in every injured worker, we need to establish a cost control system that will take into account the predictable human behaviors that result.

The current system does not respond well to these behaviors.

When the claims department is finally modeled in the way I have described, there will be an immediately noticed result of less legal representation for injured workers and, therefore, lower legal costs for the insurer.

There will, in fact, actually be medical care coordination and medical cost control. In a system in which the claimant can view the claims department as an entity that really cares about the claimant's progress and return to health, the claimant will voluntarily call the claims department to ask for help, advice and direction at any time there is confusion about the medical advice he or she is receiving. In a system in which the injured worker can see the claims department as an objective advocate, significant savings will result.

For those readers who doubt such a system will work, I would point out that the system has worked, even when such a system was developed under less than desirable circumstances.

The private sector of rehabilitation that was developed more than 20 years ago has shown the insurance industry significant cost savings on hundreds of cases that did not get into the case management system at an ideal time. If we embrace the case management system as it should be, there is no limit to what can be saved. ■

Jeffrey R. Kreider is president of The J.R. Kreider Co. Inc. in Westlake, Ohio, a health care consulting firm and specialist in disability management issues.

Applying strategic planning

Risk management too complex for 'seat of the pants' approach

By Frederic J. Kakis

OUR ERA IS ONE of the most exciting in the history of human development. The rapid advances of science and technology have irrevocably and irreversibly altered life on this planet by prolonging life, alleviating suffering and providing more creature comforts and more leisure time to enjoy these comforts.

While life has become more complex, the quality of the environment has deteriorated and natural resources have dwindled. In the midst of this society, where such rapid changes in lifestyle are taking place at an ever-increasing pace, the business of risk management has also become extremely complicated.

Today's risk manager must be cognizant of environmental issues, regulations of the Occupational Safety and Health Administration, the Environmental Protection Agency and other government agencies, labor relations, economic trends, workers comp laws and accident prevention and safety, not to mention the entire Pandora's Box called claims evaluation and handling.

It should be obvious from the above that risk managers today face an enormous challenge that would tax even a superman. Consequently, many cannot handle it and risk management in many instances has become crisis management; i.e., risk managers are jumping around putting out fires and neglecting the broader picture.

This "seat of the pants" approach to risk management eventually backfires, leaving the organization exposed.

This article will explore the application of basic strategic planning principles to risk management.

Strategic planning is a systematic means of coping with uncertainty. A strategic plan is the vehicle for implementing the central commitments of the company or the organization.

A well-prepared strategic plan serves as a blueprint for action that allows the transition from a realm that is predominantly verbal to a physical reality that corresponds to the full realization of the goals and objectives of management. Consequently, a necessary prelude to effective strategic planning is a clear articulation, by senior management, of the company's organizational mission. The mission statement must be worded in such a way as to convey in precise terms what needs to be accomplished.

An example of such a mission statement, as it relates to risk management, could be: "This company is committed to providing a safe, healthful and pleasant working environment for all its employees regardless of their position or seniority." Such a statement sets the parameters for the design of a strategic plan. The key words are "safe," "healthful," "pleasant" and "all employees." Thus, definition of these parameters becomes necessary.

Once the analysis of the mission statement is complete, one can proceed with the design of the strategic plan.

An effective strategic plan should contain, at a minimum, the following elements:

- A prioritized outline of the broad objectives of the organization as a whole, as well as the corollary objectives for the various pertinent segments or subsets of the organization. As much as possible, the objectives must be stated in measurable quantitative terms.

Today's risk manager must be aware of safety, labor relations, workers comp law and economic trends. The challenges are so enormous they would tax even a superman.

For example, "to decrease on-the-job injuries by the end of the fiscal year" is a much better objective than "to improve safety in the workplace." There should be only a limited number of broad objectives.

- A study of factors such as: Population trends and demographics, availability of human resources, identification of the competition, capital needs, sources of funding and the possible impact of growing technology and changing trends.
- A breakdown of the total risk management plan into regional subsets to take into account the special needs of each division or department.
- An audit of available resources. This involves a complete analysis of the strengths and weaknesses of the organization. For example, the qualifications and commitment of the staff may be cited as one of the strengths. Similarly, the lack of a training program or the low productivity of a certain sector may be listed as weaknesses.
- A systematic analysis of constraints. Examples may be federal, state and local laws; regulations and guidelines from the EPA, OSHA and other government agencies; lack of adequate budgets; poorly designed facilities; no correlation of responsibility and authority; understaffing and overstaffing.
- A timetable, which should spell out the period covered by the plan. The timetable also should specify how often the plan will be reviewed and possibly revised.
- A description of the review process. Questions to be considered include: What will be the nature of the review? Who should be involved? What are the milestones or critical decision points? What kind of mechanism would be used to monitor the effectiveness of the proposed plan? What are the criteria for evaluation?
- A list of action items. This list should be prioritized so that in the event there aren't enough resources to implement the entire plan, one can eliminate the least crucial elements rather than make an across-the-board cutback, which drains the blood out of all the projects.
- A consideration of alternatives. This should include an analysis of the potential risks, resources and rewards. The analysis should be followed by selection and justification of the best course of action.
- A clear set of strategies that would define an action program for implementing broad goals and objectives.
- Task assignments. Who is going to do what? An integral part of a good strategic plan is the identification of the human resources needed to implement the plan and the specific role that each individual will play.
- Administration. Spell out the chain of command. Who reports to whom? Be sure there is a good correlation of responsibility and authority to make decisions. Set up position descriptions and define the criteria and procedure to be used for performance evaluation.

A strategic plan for risk management that incorporates the 12 points listed above can go a long way toward ensuring that the long-term interests of the organization are protected.

The global view of risk management requires a focus on prevention. The No. 1 priority for a risk manager is to minimize the organization's exposure to potential claims and liabilities rather than the settlement of existing claims. This function frequently is neglected under day-to-day pressures.

The lack of a comprehensive strategic risk management plan aggravates this situation and forces the risk manager for the self-insured entity to function more like the claims manager of an insurance company. However, there are a number of basic differences between regular insurance companies and self-insured organizations.

Insurance companies, when faced with excessive claims, have a number of options available: They can cancel policies, increase premiums or try to underwrite more business to offset losses.

In the case of the self-insured, excessive claims have a direct effect on the bottom line that cannot be offset by the above methods. Thus, it is incumbent upon the risk manager to prevent the loss of income, to the extent possible. This requires good planning. ■

Frederic J. Kakis, Ph.D., is executive vp of Impact General Inc., a forensic science and engineering firm in Orange, Calif.

FSA survey

Continued from page 3

Thirty-one percent of the survey respondents expect employers to terminate FSAs to avoid having to pay the additional health care claims.

But, 51% said they do not expect employers to terminate their FSAs because of the new IRS regulations. The remainder, 18%, said they were uncertain how employers would react.

Terminating health care FSAs may not be the best approach employers can take to avoid paying health care claims against insufficiently funded FSAs, said Linda Nash, a consultant with Buck Consultants Inc. in Secaucus, N.J. "Termination definitely works, but it is perceived by employees as something very negative," she said.

"FSAs are often used as sweeteners. They soften the blow of cost-shifting, and to take that away creates a negative impression when employers push higher deductibles and copayments," Ms. Nash explained.

Instead of terminating FSAs, 57% of survey respondents expect employers to take another approach to at least reduce the amount of health care claims they expect to be stuck with because of the IRS regulations: limiting employees' annual FSA contributions, thus reducing the amount of health care claims against underfunded FSAs employers may have to pay.

And, among the four approaches the survey suggested employers could take to limit their losses resulting from the new IRS regulations, limiting employees' annual FSA contributions would be the most effective, according to 48% of the survey respondents.

Only 12% said this method would be the least effective.

Lance Tane, a partner with Kwasha Lipton in Fort Lee, N.J., said employers should consider reducing the maximum contribution employees can make during the first couple of years of their employment, when turnover is historically at its highest level.

Twenty-one percent of the respondents said restricting the types of eligible expenses for reimbursement would be the most effective method, while 24% said it would be the least effective.

Thirteen percent said imposing accelerated employee contribution schedules would be the most effective measure, while 21% said it would be the least effective.

And, 15% said insuring the risk would be the most effective method, but 35% said this method would not work.

Mr. Davidson said respondents did not find that method viable because no insurer currently offers that kind of coverage. "To my knowledge, there isn't one insurer that has established a market for this. I really think there's a niche here that could be explored."

Mr. Tane and Ms. Nash also suggested that employers deduct from the final paycheck of workers leaving a company prior to completely funding their FSA the amount necessary to fully fund the FSA.

"Because the IRS wants these plans to operate as an annual insurance policy, I see no problem in collecting the amount due if an employee leaves," he said.

The survey also asked what should be done with FSA contributions remaining after claims and administrative fees are paid.

Forty-seven percent said the employer should retain the so-called "experience gains." Twenty-six percent said employee contributions for the next year should be reduced by the amount of the left-over funds. Twenty-two percent favored refunding excess contributions to employees. And, 5% suggested other alternatives or had no answer.

Among the survey respondents that offer health care FSAs:

- 62% said the FSAs are funded through pretax salary reduction.
- 24% said the FSAs are funded through salary reductions and the value of excess credits from comprehensive flexible benefit plans.
- 8% said the FSAs are funded through salary reduction and employer contributions.
- 4% said the FSAs are funded entirely through employer contributions.
- 2% said the FSAs are funded through a combination of flex credits and employee and employer contributions.

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A copy and executive summary of "Health Flexible Spending Accounts and Proposed IRS Regulations" is available for free through the public relations department at the International Foundation of Employee Benefit Plans, P.O. Box 69, Brookfield, Wis. 53008-0069, 414-786-6700.

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Costs survey

Continued from page 3

health care costs on insurers is not unreasonable or unfair, Mr. Tresnowski added.

"It is a fair response. The insurer has a responsibility to contain health care costs," he said, noting consumers and providers share responsibility for cost control.

"Insurers are not the only party in the transaction. The consumer has a responsibility to be better educated and more informed at the point of service, while providers have a responsibility in the judgments they make about the care they provide," he said.

The public agrees that many groups also bear a "great deal" of responsibility for rising health care costs, including consumers. In fact, 23% said individuals using medical care services were greatly to blame for health care cost increases.

However, more respondents believe other groups and factors share a great deal of blame for rising health care costs: For example:

- 44% said new medical technology had a great deal to do with rising health care costs.
- 35% said the federal government bore much of the responsibility.
- 30% blamed general economic conditions.

The survey also found the public clearly wants the government to take a larger role in improving access to health care coverage.

Indeed, 86% of respondents either strongly agreed or somewhat agreed that the federal government should assure that everyone gets needed health care services.

Just 13% either disagreed somewhat or strongly disagreed that the federal government needs to do more to improve access to health care coverage. Only 1% did not express an opinion.

The public, though, is closely divided on whether the federal government is equipped to run health care programs.

For example, 48% of respondents either strongly or somewhat agreed that the federal government is well-suited to run programs that affect the health and welfare of all Americans.

'Our society, in general, would like government to do more financing of social goods. But, the public is not convinced that government is the best administrator of those initiatives,' says BC/BS President Bernard Tresnowski.

However, 49% strongly or somewhat disagreed. Three percent did not express an opinion.

Similarly, 49% said that regardless of cost to the taxpayers, the federal government should provide health care.

But, 43% said expanding the government's role in the health care delivery system would be a costly mistake. Eight percent did not express an opinion.

Mr. Tresnowski of BC/BS believes the public is saying that it wants the federal government to spend more money on health care, but that government should not be administering those programs.

"Our society, in general, would like government to do more financing of social goods. But, the public is not convinced that government is the best administrator of those initiatives," he said.

For example, the survey found that 68% of respondents would like to see increased government spending on health care during the next several years.

However, 22% favor maintaining government spending at current levels.

Just 6% say government spending should be reduced. And, 4% did not express an opinion.

However, 63% of respondents either strongly or somewhat agreed that government-run programs are inefficient and wasteful.

Thirty-five percent disagreed that government programs are wasteful.

And, 2% did not express an opinion.

In addition, a slender majority—53%—of respondents said they would be willing to pay additional taxes to assure universal health care coverage.

But, 42% said they would not be willing to fork over more taxes.

And, 5% did not express an opinion.

Among those willing to pay more in taxes for universal health care coverage, 56% said they would pay at least $500 more annually, while 39% would be unwilling and 5% said they were unsure.

Just 10% of all respondents said they would be willing to pay at least $1,000 a year in additional taxes.

But much of the public is aware that even if overall spending on health care were doubled, it still would not be enough to provide all the care that people want.

Indeed, 76% of the respondents said even if health care spending—which now exceeds $600 billion annually—were doubled, it still would not be enough.

However, 20% disagreed.

And, 4% did not express an opinion.

Few respondents—just 2%—said the quality or cost of health care, or both, is the most important problem the nation faces.

That ranks well below drug abuse, which 44% of the respondents ranked as the nation's most important problem.

Other issues, including poverty/homelessness, the economy and the environment, each were ranked as the nation's most important problem by about 5% of respondents.

But, Americans are concerned about health care issues.

For example, 57% of the respondents said they are "very concerned" about the cost of health care, and 44% said they are very concerned about the quality of health care.

In comparison, 56% said they were very concerned about acquired immune deficiency syndrome; 55% expressed concern about public school education; 51% are concerned about poverty and homelessness; and 48% are concerned about the environment.

Americans, though, still are most concerned about drug abuse: 76% of the respondents said they are very concerned about that issue.

And, most respondents-70%-clearly believe that health care costs could lead to a crisis if they are not checked.

However, 26% disagreed.

And, 4% did not express an opinion.

Meanwhile, 88% of the respondents said they generally are satisfied with the quality of care they receive from their physicians.

Just 10% were dissatisfied with their doctor's care.

And, 2% did not express an opinion.

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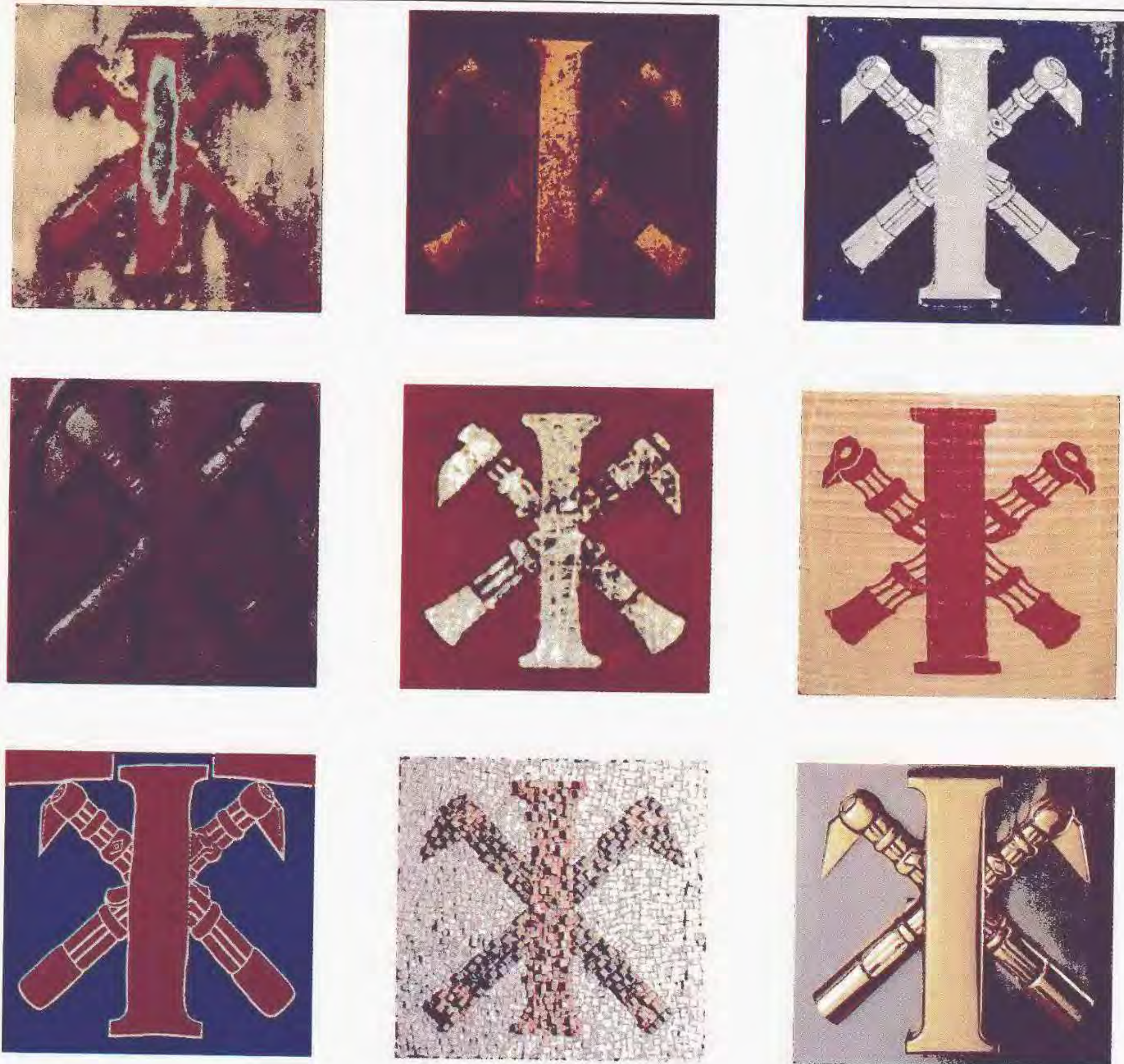
Copies of "Second Opinions: America's Voices and Views on Health Care," are available by contacting the Blue Cross/Blue Shield Assn., P.O. Box 70360, Chicago, Ill. 60673. The cost is $25 for the summary report and $35 for the comprehensive report. Checks should be payable to "BCBSA Second Opinions."



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INTERNATIONAL

New rules may spur growth of EIL market

By KATE McILWAINE

Australian underwriters are working to provide companies with a domestic market for environmental impairment liability insurance in the wake of tough, new environmental protection measures.

So far two Australian underwriters are offering EIL cover, and a broker is working to develop coverage for underground storage tank owners.

These new environmental liability packages are being developed in response to new state legislation imposing stiff fines and penalties for environmental pollution. One state measure also holds directors and officers personally liable for a company's cleanup costs.

Sydney-based Harbor Pacific Liability Underwriting Pty. Ltd., an underwriting agency, launched its policy on March 31, although it has not yet written any business, said Managing Director Peter O'Shea.

The $5 million Australian ($4.04 million) of cover provided by his company would be written on a claims-made basis, Mr. O'Shea said. While the wording was developed in Australia, he noted it was similar to wordings in European EIL policies.

Harbor Pacific moved into the EIL market because "no one else was doing it," he said. "We saw it as a niche market."

Mr. O'Shea said the policy's deductibles were "high, but flexible," depending on the nature of a company's risk. Harbor Pacific's policies are underwritten by a large Austra-

lian insurer, which he declined to name.

Mr. O'Shea said many Australian companies do not purchase EIL coverage because they have some pollution coverage under public liability and industrial special risk policies.

Two companies have approached Harbor Pacific about coverage—one in the chemical industry, the other a waste disposal firm—but Mr. O'Shea said detailed audits to examine the applicants' specific exposures would be needed before he would consider writing the coverage.

Harbor Pacific is "very careful" about assessing the risks it is prepared to insure and is not marketing the policy heavily, he said. "We take a very conservative approach."

Another firm, Melbourne-based Richard Oliver Underwriting Managers Pty. Ltd., a unit of Melbourne-based broker/underwriting agent Richard Oliver Australia Pty. Ltd., has finalized arrangements with underwriters for an EIL policy that was launched earlier this month.

Ian Cummings, a manager of Richard Oliver Underwriting, said he had negotiated with the 10 to 14 insurance companies that would be underwriting portions of the cover.

The lead insurer will be Sydney-based QBE Insurance Group Ltd., he said. Lloyd's of London syndicates managed by Michael Payne & Others Ltd. is another confirmed participant, while Australian Reinsurance Co. Ltd., a Swiss Reinsurance Co. unit in Melbourne, will provide reinsurance, Mr. Cummings said.

The bottom layer of the policy will be $10 million Australian ($8.1 million) and Mr. Cummings is seeking additional capacity to provide up to $25 million Australian ($20.2 million) of coverage.

The Richard Oliver policy has varied deductibles, ranging from $10,000 Australian ($8,079) up to $500,000 Australian ($403,950), depending on the nature of the policyholder's business, he said.

Mr. Cummings said the final deci-

Continued on next page

Aneco downplays impact of Crawley exit

By ROGER SCOTTON

BERMUDA

HAMILTON, Bermuda—Aneco Reinsurance Underwriting Ltd. is conducting "business as usual" in the wake of President Jonathan Crawley's unexpected departure earlier this month, says the firm's senior underwriter.

"It's very much business as usual for us at the moment," said Bruce Jones.

Though Mr. Crawley will not discuss his future, it appears from Mr. Jones' business-as-usual statement that the former president's plans to set up a new reinsurer to buy Aneco's continuing book of business have been scrapped.

Mr. Crawley, who was a driving force behind Aneco and responsible for building its reputation as a key provider of reinsurance for captive insurance companies, had hoped to have $30 million of capital in place for his new company, Ascot Reinsurance Co. Ltd., by the end of June (*BI*, May 21). Although he remained an Aneco employee, Mr. Crawley resigned from the reinsurer's board of directors two months ago in anticipation of forming Ascot.

Aneco, which is owned by Forum Re Group (Bermuda) Ltd., has described Mr. Crawley's departure as the result of a mutual agreement. It has appointed Director David Thirkill, who heads the Forum Re Group unit Forum Reinsurance Co. Ltd., as chairman and interim president.

Mr. Thirkill said last week that it was "sad" that Mr. Crawley's "management buy-out" was not successful. Mr. Thirkill said he will be president of Aneco for "a very short period," adding that Mr. Crawley's replacement will come about as a result of internal promotion.

Last year, Aneco wrote about $20 million in gross premiums (*BI*, April 30), more than half of it from reinsuring captives—an emphasis that Mr. Jones said would not change following Mr. Crawley's resignation.

"Aneco will remain a strong supporter of captive insurers; it's our bread and butter book. This is fantastic business. It is indigenous to Bermuda and we'll be expanding it in the future," he said.

While the names Aneco and Crawley had become synonymous in recent years, Mr. Jones said: "I'm not aware of any adverse reactions toward the changes at Aneco. Having spoken to most of our producers, it appears that we're going to get their continued support."

Mr. Jones added that Aneco now intends to "batten down the hatches" and get on with its business as quietly as possible.

"I don't think we'll be making quite as many headlines as we have in the past," he said.

Cambridge dividend

Cambridge Reinsurance Ltd. is paying creditors a second interim dividend in what is shaping up to be one of the fastest reinsurance liquidations ever.

And Cambridge liquidator David Lines hints that a third cash distribution may be possible before the end of the year.

The second dividend, like the first one announced in March 1989 (*BI*, April 3, 1989), is worth about $5 million and is equivalent to nearly 4% of Cambridge's $130 million in total claims.

According to a letter Mr. Lines sent to creditors, as of April 30 almost $2.9 million of the first dividend had been paid out and a further $2.1 million had been set aside.

This is barely five years after Cambridge, a unit of Nova Scotia-based National Sea Products Ltd., collapsed with nearly $80 million in liabilities.

The funds set aside are intended to be used to pay dividends to creditors whose claims have yet to be agreed upon, the letter said.

The liquidators have completed an actuarial estimation of Cambridge Re's liabilities "which were contingent or for some other reason were unascertained or did not bear a certain value as of May 17, 1985," when the company entered liquidation, the letter said.

Commenting on future developments, Mr. Lines said he is considering a third interim payment that he hopes will be made before year-end.

"We would very much like to distribute more money to our creditors and we are going to do our very best to do this before the end of the year," he said. "It all

Continued on next page

Claim involving captive raises issues

By Kevin D. Mutch

INTERNATIONAL PERSPECTIVE

MAJOR INSURANCE CLAIMS invariably produce new twists and challenges to the norm. Case in point: The actions by disgruntled landowners on Bougainville Island in regard to their allocation from the Papua New Guinea government of royalties and taxes on the Bougainville Copper Ltd. operations on the island resulted in damage to the mine facilities and the subsequent claim.

BCL lodged a claim with its property and business interruption insurers, which included its parent company's captive insurance company subsidiary. The insurers argued that the claim was uninsured and the dispute eventually proceeded to trial in the Supreme Court of Victoria. Three weeks later, the parties agreed to a settlement of $102.5 million Australian ($78.6 million)—one of the largest single material damage and business interruption claims ever in the Southern Hemisphere (*BI*, March 5).

Let's examine some background to the BCL situation. Bougainville is situated in the Solomon Islands approximately 600 miles east of Port Moresby, the capital of Papua New Guinea. The island was a German colony until after World War I, when residents reluctantly became part of an independent Papua New Guinea.

Gold and copper deposits in the Panguna Valley of Bougainville were discovered in 1964. BCL was incorporated in 1967 with 20% of the shares held by the Papua New Guinea government and the majority held by the shareholders of CRA Ltd. The mining company achieved public company status in 1973. The mine operated under a Papua New Guinea Act of Parliament established in 1967 and amended in 1974.

The mine commenced commercial production in 1972 and today is classified as one of the world's largest gold and copper mines, contributing 6% of the world's copper supply. The mine produces 90 million metric tons of material per year and employs a largely indigenous workforce of 3,600.

Among the events that led to BCL's claim:

- Saboteurs initially attacked support facilities Nov. 25-26, 1988, and later a tower supporting power transmission lines from the mine to the island port of Arawa on Dec. 1, 1988, causing production to cease.
- The tower was repaired on Dec. 3, with production resuming only until another tower was felled on Dec. 4. BCL indicated it would not resume production until security was tightened.

On Dec. 10, production recommenced in an environment of conciliatory language between landowners and government officials. Subsequently, 600 Papua New Guinea army personnel were deployed to protect the BCL facilities.

- Further towers were felled May 21-22, 1989, after which production ceased. An attempt to resume production in early September was aborted following attacks on buses transporting mine personnel.

BCL filed a claim for $400 million Australian ($306.6 million) with its insurers, seeking coverage for business interruption and property losses.

BCL's property insurance program was led by CRA's Singapore-based captive Metals & Minerals Insurance Pte. Ltd., which provided 88.5% of the coverage and had a global reinsurance program in place; 10% was placed with GRE Pacific Insurance Pty. Ltd., a unit of Guardian Royal Exchange Insurance Group; 1% was placed with American Home Assurance Co., a unit of American International Group Inc.; and 0.5% was placed with Taisho Marine & Fire Insurance Co. Ltd.

The insurers rejected BCL's claim, arguing that the following precluded coverage:

- The aggregate loss was directly caused by or resulted from insurrection, rebellion, etc.
- The loss arose from more than one event and, hence, a series of deductibles should apply.
- Production was not resumed when technically possible because of concerns for the safety of personnel, which was not provided for in "insensitive" policy conditions.
- Non-disclosure of increased landowner unrest

Continued on page 25

INTERNATIONAL

Australian EIL

Continued from previous page
sion on acceptance or rejection of a risk would lie with the lead underwriter, which will rely heavily on environmental audits of applicants.

Richard Oliver Underwriting Managers moved into the market because it saw a need for the Australian market to provide some EIL capacity so it had some control over the market, he said.

Much of the EIL coverage currently available in Australia is underwritten by Australian units of large overseas insurers, with most of that risk being placed in the United States or London markets.

Mr. Cummings said Richard Oliver's EIL policy was researched for 12 months, and then it took another six months to put the details together after discussions with underwriters. Initially, cover will be offered to companies in the manufacturing sector, though it eventually will be expanded to cover transportation, storage and offshore risks, like oil rigs, he said.

Spurring the development of these policies are environmental liability measures introduced last year in New South Wales and Victoria—Australia's two most populated states.

In New South Wales, the Environmental Offenses and Penalties Act, introduced in November, provides for fines of up to $1 million Australian ($807,900) for companies and $150,000 Australian ($121,185) or a seven-year jail term for individuals found guilty of damaging the environment.

New South Wales also can require large corporations to post a bond with the government that can be used for cleanup costs. Sydney-based chemical firm ICI Australia Ltd. was the first company required to do so, posting a $3.5 million Australian ($2.8 million) bond that it will forfeit if it fails to meet the state's pollution standards in the next three years.

In Victoria, there is a similar law called the Victorian Environment Protection Act which, among other things, makes directors and officers liable for pollution caused by their companies.

Melbourne-based broker Sedgwick James Ltd. warns in a newsletter to clients: "That means if a company breaches the act, each person who is a director or is involved in the management of that company faces a presumption of guilt and may be personally liable."

Although directors could be held liable for cleanup costs under the Victoria measure, their D&O policies are unlikely to cover them because of the potential size of the claims, Sedgwick noted.

Queensland also plans to introduce an anti-pollution law this year.

Pat Comben, the Queensland State Government Environment Minister, said some major companies found it "paid to pollute," even if they were prosecuted, because the existing Queensland laws on environmental damage were not stringent enough. He said the current act would be replaced with an Environment Pollution Control Act that would provide for $1 million Australian ($807,900) fines for polluters.

While pollution control is enforced by the state rather than federal government, the federal government feels there is a need to ensure that environmental liability codes are uniform, rather than drastically different from state to state, said Jim Devine, a research officer with the Australian government.

To address this concern, the states' environment ministers met in March and discussed uniform penalties, standards and cleanup requirements.

Mike Juleff, environmental engineering manager for Richard Oliver Risk Management Pty. Ltd., an affiliate of Richard Oliver Underwriting, said the Australia and New Zealand Environment Council, a government-sponsored body, was setting uniform levels to ensure that on an international basis "the option for pollution havens is reduced."

Mr. Juleff said some Australian states are taking a stronger approach to the polluter-pays principle than exists in the United States.

"Under the legislation, private assets can be seized. While that hasn't happened yet, I know of a couple of cases where it could potentially happen," Mr. Juleff said.

In addition to developing EIL insurance policies, some Australian firms are offering environmental auditing services to companies wishing to assess their pollution exposure.

Andrew G. Marr, managing director of Risk Science International, a wholly owned subsidiary of Frank B. Hall & Co. Australia Pty. Ltd. in Sydney, said his company expects to perform about 50 environmental audits this year, compared with only five last year.

Noting the increasing concern about pollution, he predicted its control, management and elimination in Australia will become technically more difficult, legally more complex and more costly.

Broker Sedgwick James has set up a risk services division that employs a specialist in environmental risk management, according to Andrew Smith, operations manager-Australia.

The broker has placed EIL cover for a variety of Australian clients, he noted. However, Sedgwick had to look to the overseas market for cover because there was no indigenous market for it in Australia, Mr. Smith said.

"It's available, but not widely and freely. There are high deductibles," Mr. Smith said.

Underwriters have always been concerned about the level of environmental protection measures in place at a company, so only companies with good risk management have been able to get the cover, he said.

"There's only a very small percentage of Australian companies who buy (EIL cover) now," Mr. Smith said. Many firms do not perceive a need for the coverage and others consider it is too expensive, he noted.

However, Mr. Smith said EIL cover was likely to become a more popular product during the next decade.

"There'll be an increase in demand, but I don't think Australian insurers will write a lot. They may support it, but we won't become a lead market," he said.

Harbor Pacific's Mr. O'Shea said EIL insurance was likely to remain a "fringe product" until industrial special risks policies excluded pollution cleanup costs or restricted them to first-party coverage.

Many public liability policies indemnify against sudden and accidental pollution, and first- and third-party cleanup costs can be covered under an industrial special risks policy when they result from an insured peril, such as a fire or earthquake. Liability and industrial special risks policies will not indemnify against gradual pollution.

Mike Grossman, regional casualty manager-Australasia, for American International Group Inc. based in Melbourne, said he expected to see EIL policies develop gradually in Australia.

He said AIG, a major provider of pollution liability insurance in the United States, was considering implementation of a pollution liability policy in Australia.

"We have gone down that track with some clients, but generally there's not yet sufficient awareness or concern," he said.

Mr. Grossman said there was no doubt pollution liability insurance would become more readily available in Australia in the next 12 months, but he warned it would be expensive.

Another firm developing pollution-related coverage is Melbourne-based broker OAMPS Ltd. The firm will soon introduce a package to cover leaks from underground fuel tanks, says Chairman Peter R. Claringbold.

OAMPS, which specializes in placing coverage for the oil distribution industry, plans to first market the package in the United States.

Mr. Claringbold said OAMPS would be cautious in the business it accepts. "We will be monitoring tanks to establish which ones are leaking and we will not be insuring them," he said. "We'll be covering site cleanups and third-party costs."

Mr. Claringbold expects it will be several years before the insurance package is marketable in Australia, but he said a major spill or leakage would speed that up.

The UST package would be expensive and deductibles would be high, he said, but it would be less expensive in Australia because of "the liability climate in the United States." ■

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BERMUDA

Continued from previous page
depends on how the collections go over the next six months."

In an accompanying summary of cumulative receipts and payments since the start of the liquidation, Mr. Lines calculates that total receipts topped $22 million as of the end of April, of which $12.5 million represented the collection of outstanding insurance balances.

Cambridge's expenses had reached $7.4 million by April 30, which includes $3.7 million in joint liquidators' fees and nearly $1.4 million in legal fees.

Cambridge's assets include cash holdings of $4.1 million, an investment portfolio of $5.6 million and a sum of just more than $2 million described as a first dividend reserve.

Mr. Lines' letter noted that fellow liquidator Gerry Weiss resigned from the liquidation following his retirement from Cork Gully, a London unit of Coopers & Lybrand.

Mr. Lines said an application has been filed with the Bermuda Supreme Court seeking confirmation of Michael Jordan, chairman of Cork Gully's insolvency practice in London, as Mr. Weiss' successor. Mr. Jordan is also liquidator of River Plate Reinsurance Co. Ltd.

Cambridge Re's joint liquidators have made unprecedented use of provisions of the century-old Bermuda Bankruptcy Act to actuarially determine the reinsurer's contingent liabilities, which they believe will cut the time of liquidation by 15 years (*BI*, March 16, 1987).

Norad creditors paid

Qualifying creditors of Norad Reinsurance Co. Ltd. will receive an interim cash payment instead of final distribution, says the liquidator of the insolvent Bermuda reinsurer.

Liquidator Chris Whittle, who last year announced plans for paying out the entire Norad estate (*BI*, Oct. 10, 1989), said earlier this month that the Norad committee of inspection has instead decided to recommend an interim distribution of almost $5 million, equivalent to about 12 cents for every dollar Norad owes.

However, Mr. Whittle stressed that "even though we've delayed the completion of the winding up, there is still the same basic desire to get this liquidation finished quickly and at minimal expense."

"We're aiming to have the dividend out on or about July 18 to those creditors whose claims have been admitted in the liquidation," he said.

Early estimates, which put the net deficiency at about $50 million, have not changed substantially, he said. "We're still going to be in that area, although on a discounting basis, it will be less than $50 million."

Norad, a captive subsidiary of Philadelphia-based Berwind Corp., was under management by James Bermuda Ltd., now a unit of Sedgwick Group P.L.C., when it stopped underwriting in 1985. It was placed in liquidation on Oct. 5, 1988, following a meeting of creditors.

Its biggest creditor is the insolvent Mutual Fire Marine & Inland Insurance Co. of Philadelphia, whose liquidators are claiming about $25 million from the failed reinsurer. ■

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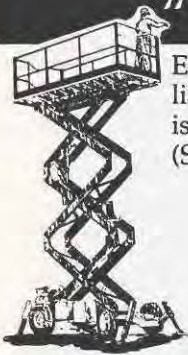

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Business Insurance

Guaranty funds

Continued from page 1

companies that went broke between 1984 and 1987.

Projecting the ultimate costs to solvent insurers of the mid-1980s failures is difficult, but experts agree on the chief culprit: underwriting wars several years earlier.

"Companies were foolishly underpricing coverages to seek market share at the expense of good underwriting practices," said Peter Lefkin, an assistant vp and director of federal relations for Fireman's Fund Insurance Co. in Washington, D.C.

"Insurers competed for premium dollars to invest in high-yield securities in the early 1980s," said the AIA's Mr. Schwartz.

Then, several years later, claims on long-tail lines began to come in and interest rates began to fall, he noted.

"The seeds of insolvencies were sown years before," said Dale Stephenson, president of the NCIGF.

Another contributing factor was that insurers in the early 1980s moved into markets where they lacked underwriting expertise, said Tom O'Day, associate vp of the Alliance of American Insurers in Washington, D.C.

In addition, he notes, adverse court rulings, especially in the environmental and product liability insurance coverage areas, led to losses insurers did not anticipate when they initially set premiums.

Industry experts, referring to a congressional subcommittee report—"Failed Promises: Insurance Company Insolvencies"—issued in February (*BI*, Feb. 26), say mismanagement and fraud also played significant roles in some insurer failures.

"Fraud, mismanagement, underpricing, cash-flow underwriting, changes in the legal system—these were all factors in insolvencies," said Mr. Lane, the counsel for the NCIGF.

A relative handful of the 200 insurers that have failed since 1969 account for most of the billions of dollars in assessments.

Ten failures, for example, account for more than $2 billion, or about two-thirds of the $3.3 billion in assessments for all 200 insolvencies, according to the guaranty fund report.

And unpaid claims for just Mission Insurance Group Inc. and its affiliates have resulted in assessments of $625.5 million—or 20% of the total—since the 1987 insolvency.

"One company can leave behind a big insolvency trail," said Mr. Stephenson, president of the guaranty fund group.

Costs for picking up the promises of failed companies—through guaranty fund assessments—are unprecedented and growing, but assessments understate the true cost of insolvencies. The funds pay claims when insolvent licensed insurers cannot, raising funds by assessing other licensed insurers.

However, guaranty funds cover neither reinsurance nor some lines of insurance. And, they do not cover claims against insurance policies written on a surplus lines basis, except in New Jersey which has created a surplus lines guaranty fund.

Mission, whose insolvency has been pegged at about $2 billion, wrote a huge volume of reinsurance.

In addition, while guaranty funds typically do not limit the amount they will pay toward workers compensation claims, they do impose a cap on payment of any one claim for other lines of coverage. The caps vary by state but generally are $300,000.

Ultimately, insurance companies say, the public pays for insolvencies through higher prices insurers charge to recover the cost of guaranty fund assessments.

"Eventually, costs are passed on," Mr. Stephenson said.

And, in some states, insolvencies mean reduced revenues from insurance premium taxes. More than a dozen states permit insurers to offset, in varying degree, premium taxes they owe by their guaranty fund assessments.

In 1985, 25 insolvencies resulted in guaranty fund assessments, according to the NCIGF report. That was the highest annual total, followed by 22 in 1975 and 17 in 1984. Many of the 1975 failures, though, were under $1 million.

Of the 23 property/casualty insurer failures in 1989, only 13 resulted in assessments last year, said the report.

While guaranty fund assessments involve billions of dollars, they still amount to well under 1% of premiums written by property/casualty insurers, experts note.

"There isn't any question that the above assessments represent a great deal of money. It is, however, important to maintain appropriate perspective in these days when 'viewing with alarm' and 'crisis' talk is rampant," Mr. Lane said in a statement accompanying the report.

Even at more than $3 billion, the guaranty fund assessments are a fraction of the several hundred billion dollars U.S. banking officials estimate it will cost to clean up the federally insured savings and loan associations.

•

Copies of "State Insurance Guaranty Funds and Insurance Company Insolvency Assessment Information: 1969-1989," may be obtained by writing Dale Stephenson, President, National Conference of Insurance Guaranty Funds, 1190 Market Towers, 10 W. Market St., Indianapolis, Ind. 46204. The report is free to state regulators and guaranty funds. For others, the cost is $25.

Most costly insurance company insolvencies

Based on guaranty fund assessments since 1969

Insolvent company	Total assessed	Year of insolvency	Domicile
Mission Insurance Group Inc.[1]	$625.5 million	1987	California
Transit Casualty Co.	326.7 million	1985	Missouri
Ideal Mutual Insurance Co.	250.9 million	1985	New York
Midland Insurance Co.	201.2 million	1986	New York
American Mutual Insurance Cos.[2]	128.5 million	1989	Massachusetts
Carriers Insurance Co.	119.4 million	1986	Iowa
Integrity Insurance Co.	97.1 million	1987	New Jersey
Coastal Insurance Co.	90.0 million	1989	California
Iowa National Mutual Insurance Co.	90.0 million	1985	Iowa
Reserve Insurance Co.[3]	87.5 million	1979	Illinois
Universal Casualty Insurance Co.	70.7 million	1984	Florida
American Excel Insurance Co.	59.1 million	1988	Iowa
Excalibur Insurance Co.	57.3 million	1984	Minnesota
Signal Insurance Co./Imperial Insurance Co.	53.5 million	1978	California
Allied Fidelity Insurance Co.	45.7 million	1986	Indiana
Glacier General Assurance Co.	44.8 million	1985	Montana
Proprietors Insurance Co.	40.3 million	1981	Ohio
Consumers Indemnity Co.	40.0 million	1988	Washington
Great Global Assurance Co.	39.3 million	1986	Arizona
Gateway Insurance Co.	38.7 million	1974	Pennsylvania

[1] Includes Mission Insurance Co.; Mission National Insurance Co.; Enterprise Insurance Co.; Holland-America Insurance Co. [2] Includes American Mutual Liability Insurance Co. and American Mutual Insurance Co. of Boston. [3] Includes American Reserve Insurance Co. of Rhode Island.

Source: National Conference of Insurance Guaranty Funds

BI/HOLLY SEGUINE

INTERNATIONAL

Bougainville claim

Continued from page 23

considered material to the policy.

Although BCL reached a settlement of its claim with the insurers, the dispute certainly provided a comprehensive test of some important elements of not only captive-led insurance programs but also of claim resolution by settlement. Some issues, while satisfactorily addressed in BCL's claim, may not be fully considered by other risk managers.

One such issue is that a captive-led program contains the potential for a group subsidiary to take legal action against the captive to force the settlement of a claim. The action may have a public focus, especially if the subsidiary is only partly owned by the group. Executives should be cognizant of this eventuality. Using a fronting insurer for the captive is the preferred solution.

Another issue is that the directors of a captive may find themselves with a conflict of interest. Invariably, a finance director of the holding company is also a director of the captive, while the risk manager is also invariably referenced in the communications of both the claimant subsidiary and the captive. In the process of discovery, board and executive minutes of the holding company (and others) in relation to the claim may be subpoenaed.

Yet another issue raised by the dispute is that in captive programs, the company's broker has two discrete functions:

- Coordinating group data and renewal strategies for placement with insurance markets, along with the servicing of group subsidiaries.
- Placing reinsurance for the captive.

The reinsurance program for the captive preferably should be established by a separate broker from the retail servicing broker. At the very least, the brokering of reinsurance to the captive should be separated organizationally within the brokerage.

A conflict may arise from the reinsurance broker being a component of the insurer's team in the process of litigation and the retail broker being part of the subsidiary's team.

Another potential source for a conflict of interest is that frequently the captive manager is a subsidiary of the brokerage organization that provides reinsurance and retail brokering services.

A problem that may arise under a settlement of a claim is that the specific issues of the claim are not legally resolved. As a result, the contribution to the settlement itself may pose a problem for co-insurers that, for example, disagree whether the loss was a one-event loss or a multiple-event loss, or disagree on the value of each loss within an event.

The issue of how many events occurred also has implications for excess insurance programs.

When attempting to resolve settlements involving captives it is essential to ensure that all reinsurers—via the binding position of the lead reinsurer—will accept the terms of such a settlement. This is a difficult task for large reinsurance programs given the scarcity of time available for finalizing such settlements with all parties once court proceedings have commenced.

Where a large claim is involved, continual communication on the status of the claim to reinsurers is essential for captives. The implication of an insurer not agreeing with co-insurers to the settlement of a claim—in the absence of a lead insurer clause—is significant for a corporate buyer of insurance. A claim may then be forced into court and to judicial finality by the actions of one co-insurer.

For large organizations, the consideration of all information relating to a specific risk should not be confined to the local insurance officer contact. It is critical for the chief executive of the particular operation to be aware of the content/context of insurance renewal submissions to ensure that issues somewhat outside of core operations are properly considered in the context of not only disclosure but also of the scope of risks covered.

A final issue raised by the BCL dispute is that insurance policies may not provide for business interruption coverage following a loss where a resumption of business activity was delayed for personnel safety reasons. Although a legal interpretation of this issue was prevented by the BCL settlement, it warrants policy wording consideration. ■

Kevin D. Mutch is general manager-risk management of CRA Financial Services Pty. Ltd. in Melbourne, Australia. In addition, he is national director of the Assn. of Risk & Insurance Managers in Australia.

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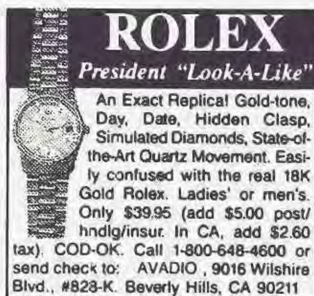

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Colonial Penn

Continued from page 3

and was an amended version of a 1987 suit.

The RICO charge was added after Colonial Penn discovered Mr. Slautterback's October 1985 agreement with Old Republic to transfer the trucking business, according to Paul W. Burke of Drew, Eckl & Farnham, an Atlanta law firm representing Colonial Penn.

In addition to naming Mr. Slautterback, AOO and Summit, the complaint names as defendants several other underwriting operations controlled by Mr. Slautterback.

After reviewing a Colonial Penn statement supporting the RICO allegations, U.S. District Judge Jack T. Camp issued an order March 29 allowing the insurer to pursue the charges.

Colonial Penn—a unit of Miami-based Florida Power & Light Co.—entered into an MGA agreement with AOO in 1985.

Under the agreement, Colonial Penn agreed to front truck physical damage and cargo insurance and related bond business produced by AOO, which also arranged reinsurance coverage, administered claims and performed other management functions.

Colonial Penn assumed 10% of the first $50,000 of each claim, with the remaining 90% of the business reinsured by Mutual Indemnity Ltd., a Bermuda-based rent-a-captive facility, court papers say. AOO was to share in Mutual Indemnity's profits on the business.

The program also included stop-loss reinsurance placed with a pool of reinsurers including Reinsurance Corp. of New York and Prudential Reinsurance Co. of Newark, N.J., according to Mr. Burke.

The $2 million in stop-loss coverage was to attach when the program's loss ratio hit 70% and included a provision for a refund of part of the premium if reinsurers paid no losses, Mr. Burke said.

Within months after entering the MGA agreement, Colonial Penn auditors visited American Owner/Operator Underwriters Inc.'s offices and found its underwriting department in 'chaotic condition,' court papers filed by the insurer say.

Summit acted as a reinsurance intermediary on the Mutual Indemnity and stop-loss placements, according to the complaint.

The suit also says that Summit—which had established a branch at AOO's address—acted as a go-between in Colonial Penn's negotiations with AOO on the MGA agreement.

Within months after entering the MGA agreement, Colonial Penn auditors visited AOO's offices and found its underwriting department in "chaotic condition," court papers filed by the insurer say.

Mr. Slautterback acknowledged administrative problems and promised they would be corrected.

A subsequent March 1986 audit, however, found that AOO may have exceeded the $12 million premium cap on the operation, and Colonial Penn ordered AOO to stop binding policies and provide an accounting of premiums.

Later audits found that AOO could not account for premiums owed to Colonial Penn and that premiums had been deposited into accounts controlled by Mr. Slautterback's companies rather than into premium trust accounts required by the MGA agreement, the complaint charges.

Colonial Penn also found that more than 2,300 policies had not

Continued on next page

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Insurance services guide

Business Insurance

Circulation Breakdown*

Commercial Consumers

Administrative:
CEO's Presidents, and Owners ... 3,291
Vice-Presidents, General Managers and Other Administrative Personnel ... 3,847

Financial:
Chief Financial Officers and Vice-presidents of Finance ... 2,382
Secretaries, Treasurers, contollers and other Financial Personnel ... 3,562

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 ... 11,566
Sub-total ... 24,648

Associations ... 539
Government, Unions and Educational Institutions ... 1,389
Commercial Consumers
Sub-total ... 26,576

Insurance Agents and Brokers ... 10,223
Insurance Companies ... 7,713
Accountants, Actuaries, Attorneys & Consultants ... 3,353
Adjusters, Appraisers, TPA's, Captive Managers & Health Care Providers 1,115
Others Allied to the Field ... 2,149
TOTAL ... 51,129

* Source Business/Occupational breakdown of qualified circulation, November 27, 1989 issue, as submitted to BPA for December 1989 BPA Publisher's Statement.

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Colonial Penn

Continued from previous page

been properly processed, that AOO had made "grossly negligent" clerical errors in posting reserves and that the agency had little or no control over independent appraisers investigating and settling claims, court papers filed by the insurer charge.

Colonial Penn canceled AOO's agency contract on July 16, 1986.

Though AOO continued to handle claims and policy administration for a few months, Colonial Penn also took over these functions in September and November 1986, citing continuing administrative problems at AOO and numerous complaints from state regulators and policyholders, court papers say.

In subsequent audits, Colonial Penn found that AOO had written between $32 million and $35 million in premiums, including the business formerly written by Old Republic. About $7 million is still owed to Colonial Penn by AOO or its agents, the insurer charges.

Colonial Penn later negotiated a cancellation of the Mutual Indemnity reinsurance coverage—which had included a $12 million cap on gross premiums in the AOO program—and took back about $900,000 in funds held by the reinsurer, Mr. Burke said.

The insurer also drew down a $432,000 letter of credit issued to Colonial Penn by Mutual Indemnity, placing the funds in a trust account while losses on the program developed, he said.

Colonial Penn has since canceled all of the business written by AOO.

In its complaint, Colonial Penn charges that AOO and Summit negotiated the agreement with Old Republic knowing that the transfer of business to Colonial Penn would automatically violate the $12 million premium cap on the program.

AOO, Summit and Mr. Slautterback committed fraud—and violated the federal RICO law—by failing to pay and investigate claims or collect and remit premiums, and by executing the agreement with Old Republic, the lawsuit charges.

Colonial Penn also maintains that it was owed a 50% refund on the $1.35 million premium it paid for the stop-loss coverage on the program. Of the $675,000 refund owed, however, Summit collected only $487,500 and improperly kept $430,000 of this to offset money owed to Summit by AOO, the complaint charges.

In addition to the RICO charge, Colonial Penn's complaint accuses AOO and Summit of breach of contract and fiduciary duties and Mr. Slautterback of breach of fiduciary duties. Summit is also charged with negligence.

In a May 15 answer to the complaint, AOO and Mr. Slautterback deny the allegations and raise numerous defenses and counterclaims.

Among other defenses, AOO charges that Colonial Penn authorized additional underwriting above the $12 million limit on the condition that additional reinsurance be placed, but later fraudulently rejected available additional reinsurance.

Mr. Burke, Colonial Penn's lawyer, denied that the insurer ever authorized additional underwriting. He said the insurer considered buying additional reinsurance retroactively after discovering AOO had written more than $30 million in premiums, but decided it would have been too expensive.

AOO also maintains that Colonial Penn can not sue it for outstanding premiums owed by producing agents because Colonial Penn itself took over premium collection efforts, cutting AOO out of the collection process.

In a separate counterclaim, AOO also charges that Colonial Penn intentionally breached the agency agreement—taking over administration, premium collection and claims functions and rescinding the Mutual Indemnity reinsurance—because it knew the business was profitable and wanted to keep profits that otherwise would have reverted to AOO.

Mr. Burke confirmed that business has produced a good loss ratio—which he estimated to be about 60% or slightly higher—but pointed out that Colonial Penn has incurred heavier than normal expenses after being forced to take over administration of the program.

He also denied that Colonial Penn took over the business because it wanted the profits for itself, noting that the insurer subsequently canceled all the policies.

Charging breach of contract, tor-

The litigation between Colonial Penn, AOO and Summit is still in the discovery stage.

tious interference with business relationships and fraud, AOO seeks roughly $41 million in compensatory damages and an unspecified amount of punitive damages.

Summit, meanwhile, has also denied Colonial Penn's charges and raised defenses and a counterclaim of its own.

Among other arguments, Summit maintains that it properly set off amounts refunded by Colonial Penn's stop-loss reinsurers against amounts it was owed by AOO. Summit maintains that the refund from the reinsurers was payable to AOO and that Summit was therefore entitled to the setoff.

In a counterclaim, Summit also argues that it is entitled to share in an unspecified amount of additional commissions owed by Colonial Penn to AOO. Summit collected a fee of 1.5% on commissions paid to AOO on the program.

The litigation between Colonial Penn, AOO and Summit is still in the discovery stage, and a trial date has not yet been set. ■

S E T Y O U R D A T E S

issue:	July 16
closing:	July 3
demographic section:	Insurer Topics: Contracting for Services
issue:	July 23 — Reader Service
closing:	July 10
editorial feature:	Risk Management: Systems & Analysis — Directory: Risk Management Info Systems
issue:	July 30
closing:	July 18
issue:	August 6
closing:	July 25
editorial feature	EBC Award Profiles
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Douglas Barlow

Continued from page 1

a path for the risk managers who have followed him in the '70s and '80s."

Risk management consultant Jim Spivey said that while his "stature, demeanor, bearing and eloquence make him most impressive, his caring and willingness to devote his time to discussing the philosophy and the technical aspects of the business to those of us who are still learning personifies Doug Barlow.

"To me, Doug Barlow is one of the giants of the profession and a founder of several of the basic principles risk managers will still be using 200 years from now," added Mr. Spivey, president of C.J. Spivey & Associates Inc. in Charlotte, N.C.

Mr. Barlow says he was just doing his job.

When he was appointed general risk manager-corporate for Massey-Ferguson Ltd. in Toronto in 1959, "I found that the job required simple insurance buying," Mr. Barlow recalls. "I changed that very fast to form an integral risk management program."

For example, he says, when the agricultural manufacturing concern planned to join a cooperative that owned a hangar for industrial aircraft, he saw a potential liability. Trained as a lawyer, he made sure the aircraft and hangar owners contractually released each other from liability for the property.

"Insurers liked the idea," Mr. Barlow recalls. "We were the first to do this. It was called a 'knock-for-knock agreement.' "

Mr. Barlow is credited with creating the first global insurance and risk management program for all classes of risk for Massey-Ferguson's operations in 1962.

"I held a competition in London among the brokers," he said. Brokers could not just get quotations from the insurers and compete on prices. Instead, they had to come up with ideas for creating a global program, a competition won by Hogg Robinson, now Hogg Group P.L.C., he said.

"What he built was the first true risk management program," said William E. Toyne, director of risk services for Sedgwick James Inc. in Toronto.

Mr. Toyne's former brokerage, Toronto-based Tomenson Saunders Whitehead Ltd., was one of the brokers for Massey-Ferguson's global program. TSW was acquired by Fred S. James & Co. Inc. in March 1984.

"What Doug saw was that Massey—one of the earliest multinational corporations—had a great deal of dependency upon several critical plant locations in various countries around the world and some serious resulting liabilities," Mr. Toyne explained.

He noted that before Mr. Barlow was appointed, the company's insurance/risk management program was "completely decentralized."

After three years of development, Mr. Barlow launched a risk management program "combining pretty dedicated attention to loss prevention with a fairly sophisticated international insurance program," according to Mr. Toyne.

But "the real coup," he adds, was selling the company in 1965 on creating Polygon Insurance Co., a captive insurer which wrote its primary property and liability coverages.

Polygon, one of the earliest captives, is no relation to the captive of the same name now in Guernsey.

Also in the '60s, he created the now-familiar concept of "cost of risk," which to him seemed obvious.

"Like all (corporate) costs, the cost of risk should be reduced," Mr. Barlow said. "Risk can be analyzed in its components."

Mr. Barlow defined the cost of a risk as the sum of insurance premiums, self-funded losses, risk control expenditures and other administrative costs. He united for the first time in one formula all of the factors related to the management of a risk.

Mr. Barlow was also the first Canadian elected president of the American Society of Insurance Management Inc., a position he held in 1971-1972. ASIM is the predecessor of the Risk & Insurance Management Society Inc.

During his presidency, Mr. Barlow was instrumental in expanding ASIM's services to employee benefit managers (*BI*, April 20, 1971).

> **'Doug Barlow is one of the giants of the profession,' says Mr. Spivey of C.J. Spivey & Associates Inc.**

According to RIMS Executive Director Ron Judd, Mr. Barlow was also responsible for adding industry sessions and exhibitors to the RIMS conference.

"He's an innovator—always has been," Mr. Judd said. He added that Mr. Barlow has "probably contributed the most from the risk management ranks to the academic field of risk management," including the translation of several texts.

Since his retirement in 1972, Mr. Barlow has remained active in the risk and insurance field. Recently he translated from French into English a chapter in the "The Ordinance of Marine," a 16th-century marine insurance document drafted by experts under the direction of Jean-Baptiste Colbert, minister of the crown of Louis XIV.

This document "is arguably the most important text in the evolution of insurance and insurance law," he says.

He is currently working on the parameters of risk management and the facts that must be taken into account. His premise is that "every decision taken or consciously not acted upon creates risk," he said. Mr. Barlow said if he can arrive at any conclusions that advance risk management, he will publish them.

The induction of Mr. Barlow into the hall of fame is a tribute to all risk managers, says Cheri J. Hawkins, president of the Risk & Insurance Management Society Inc. and director of insurance for Weyerhaeuser Co. in Tacoma, Wash.

"RIMS is swelling with pride over this first risk management inductee into the Insurance Hall of Fame," she said.

"Doug is a consummate student of risk management and insurance," agreed H. Felix Kloman, vp of Tillinghast, the risk management consulting division of Towers Perrin Forster & Crosby Inc. in Stamford, Conn. Mr. Barlow "is constantly asking the question, 'Why?,' challenging conventional wisdom and finding new approaches to risk management," he added.

"He is a Renaissance man and as well-educated a person I know in all facets of knowledge," said Dr. H. Wayne Snider, professor of insurance and risk management for Temple University in Philadelphia.

Mr. Barlow's previous professional honors include the Donald W. Stuart Award for outstanding contributions to risk management in Canada and the prestigious RIMS Dorothy and Harry Goodell Award in recognition of his contributions to the society.

Those accolades, though, tell only part of the story.

As a teenager, he was a violinist with the Sherbrooke, Quebec, symphony, sometimes acting as concert master. But, convinced that he could not make a career as a soloist, he enrolled in mathematics at Bishop's University in Lennoxville, Quebec, writing his master's thesis on astrophysics.

As a Rhodes Scholar, he went on to earn a degree in common law at Oxford. After returning to Canada, he took a degree in French civil law at McGill University in Montreal.

Mr. Barlow took a job as general counsel for an insurance brokerage in Quebec City. His responsibilities included tracking changes in insurance and insurance law, analyzing and providing advice on insurance contracts and claims and drafting new forms for special risks.

During this time, he designed the first group travel accident policy when he recognized that most group policies excluded death or injuries sustained as a result of airline travel.

From 1950 to 1955, Mr. Barlow was a professor of insurance at Laval University in Quebec, where he wrote a book for his students, "The Elements of Insurance."

He opened his own law office in 1954, but had to leave the practice a year later when he contracted tuberculosis. After recovering, Mr. Barlow joined Massey-Ferguson as risk manager, a position he held until retiring in 1972.

That retirement was short-lived. Before the end of the year, he was appointed corporate secretary for Tomenson Saunders.

Mr. Toyne of Sedgwick James said that the former brokerage sought the legal and insurance-related expertise of Mr. Barlow as it was expanding rapidly throughout Canada.

"Prior to his appointment, no one had really paid a lot of attention to corporate legal/secretarial issues," Mr. Toyne said. In what was to have been a part-time post for 18 months, Mr. Barlow remained with the brokerage for about 10 years.

Yvon Menard, manager of risk & insurance for Marathon Realty Co. Ltd. in Toronto and vp of research for RIMS, said that he joined TSW in 1973 as a trainee in its international department and "learned risk management at the knee of Doug Barlow. I can't think of anyone more deserving of the (Hall of Fame) award." ■

Judge to rule on Prop 103 refund hearings

LOS ANGELES—A Los Angeles Superior Court judge who will rule on insurer challenges to a rate rollback decision by the California insurance commissioner will decide on July 30 whether to allow the Insurance Department in the meantime to conduct hearings on whether five insurers must issue policyholder refunds.

Judge Dzintra Janavs last week stayed the hearings, originally set to begin Wednesday, while she reviews Insurance Commissioner Roxani Gillespie's ruling that insurers that earned more than 11.2% on their combined business from November 1988 to November 1989 must roll back "charges" for most types of property/casualty insurance written during that period to 20% below November 1987 levels (*BI*, June 18).

The insurance "charge" rollback was mandated by Proposition 103.

About 60 property/casualty insurers sought the stay in lawsuits they filed challenging Ms. Gillespie's ruling. The lawsuits charge that the commissioner's ruling was not supported by hearings on a "fair rate of return" for insurers (*BI*, July 9).

In a hearing last week, Judge Janavs "strongly indicated she believed the rollback hearings should be put off" until she can review the commissioner's decision and the decision can "ultimately be reviewed by the California Supreme Court," said Dana Brooks, an attorney with Rubinstein & Perry in Los Angeles, the commissioner's special counsel.

Judge Janavs set a tentative September hearing to issue her ruling on the challenges to Ms. Gillespie's decision, Ms. Brooks said. ■

Update

Malpractice settlement covered

Continued from page 2

Patti Frustaci of Riverside, Calif., gave birth to the septuplets in 1985 after taking Pergonal, a commonly used fertility drug, administered by Dr. Jaroslav Marik, co-owner of the Tyler Medical Clinic.

Ms. Frustaci sued Dr. Marik and the clinic for medical malpractice and wrongful death in October 1985.

Under terms of an agreement between Ms. Frustaci and the Tyler Medical Clinic, approved by the Santa Monica Superior Court last week, the facility's medical malpractice insurer initially will pay $450,000. In addition, the facility's insurer, the Doctors' Co. of Santa Monica, will purchase annuities to provide lifetime monthly income for the three surviving septuplets. The Doctors' Co. is the state's second-largest member-owned medical malpractice pool.

While the settlement could amount to more than $6 million if the surviving children reach a normal life expectancy, the payout in 1990 dollars will be less than $1 million, estimated Craig Dummit of Los Angeles, Dr. Marik's attorney.

Also under the settlement, Dr. Marik was dropped from the suit.

Seat belt requirement mulled

WASHINGTON—Employees driving or riding in company vehicles would be required to wear seat belts under rules proposed last week by the Occupational Safety & Health Administration.

Under the rule, employers would be subject to OSHA fines and penalties if employees failed to use seat belts. OSHA can assess a fine of up to $10,000 for a willful violation of a safety rule, though actual fines usually are much less.

The proposed rules also would require companies to offer driver safety programs for employees who routinely drive company cars. OSHA estimates that the rules would save about 500 lives annually and cost employers about $220 million annually.

The rules were published in the July 12 issue of the Federal Register, with a comment period ending Nov. 9. OSHA is seeking input on how to enforce the proposed rule.

All-Star Game covers the bases

CHICAGO—Major League Baseball nearly had to file a claim on a $17.5 million policy against the cancellation of last week's 61st annual All-Star Game due to rain.

The coverage, led by Lloyd's of London underwriter V.W. Broad of V.W. Broad Underwriting Agencies Ltd., was mainly placed with syndicates at Lloyd's, although other London underwriters participated, London sources say.

A spokesman for Major League Baseball in New York would not comment on the limits nor on the cost of the policy.

"It's the first time we've done it," the spokesman said of the policy, which would cover any "financial loss" that would occur due to cancellation of the game. "We looked at the rainfall in Chicago for the month of July over the last few years," he said.

The July 10 game was delayed in the seventh inning for slightly more than one hour due to rain, but play later resumed.

Arrests in JUA kickback case

TRENTON, N.J.—An employee of one of the largest claims processors for New Jersey's massively insolvent joint underwriting association for high risk drivers has been arrested on charges that he received payments from at least five auto body repair shops in exchange for processing inflated claims.

Following an 18-month investigation by the New Jersey attorney general office's Division of Criminal Justice, William P. Horan, a group director in Piscataway, N.J., for Computer Sciences Corp., and the five shop operators were arrested earlier this month and charged with conspiracy to commit commercial bribery and theft, which are racketeering charges. The El Segundo, Calif.-based company is one of the largest claims processors for the JUA.

State Attorney General Robert J. Del Tufo said the alleged scheme was conducted from February 1989 to June 1990.

Mr. Horan and the five shop operators are free on bail. The case is still before a state grand jury.

A CSC spokesman said the company's regular audits on the JUA contract did not turn up the discrepancy the state attorney general found. "This came as a surprise to us."

Mr. Horan, who has been with CSC about 15 months and who is not considered an executive, is "still technically with the company, though he has been relieved of his duties," the spokesman said.

This case demonstrates "that the high incidence of insurance fraud is what is driving up costs," said a spokeswoman for the New Jersey Insurance News Service, an insurer-sponsored information agency.

Gov. James Florio and state auditors have blamed much of the JUA's $3 billion debt on sloppy claims management and fraud by auto insurers, which are to be assessed $1.4 billion over the next seven years under New Jersey's auto reform law (*BI*, March 12).

Briefly noted

A congressional conference committee hammering out **oil spill liability legislation** agreed last week to require almost all tankers to be equipped with double hulls. The conferees expect to approve a compromise bill shortly. . . .Standard & Poor's Insurance Rating Service has lowered the claims-paying ability rating of **Crum & Forster Inc.** from AA, or excellent, to A+, or strong. The move followed concern about the quality of the company's reinsurance recoverables (*BI*, June 4). . . .Dow Chemical Co. plans to challenge a complaint by two environmental groups that **Proposition 65** requires that the company's K2r Spotlifter carry a cancer warning (*BI*, July 9). Meanwhile, five major retail chains in California are pulling the product from store shelves. . . .Five days of fire in Santa Barbara County, Calif., caused an estimated **$265 million in insured property damage**, reports the Property Claim Services division of the American Insurance Services Group. In addition, a hail storm that hit parts of Minnesota July 7-8 caused an estimated $15 million of insured property damage.

Manville trust

Continued from page 2

tionwide class-action lawsuit, it's not clear whether he will order a class action.

Whether he has the power to order such an action nationwide remains unclear, attorneys say.

Advocates of class actions maintain that consolidated litigation saves tremendous amounts of money and time by having one trial rather than thousands.

Most class actions allow plaintiffs the option of not participating in the consolidated case, but if the defendant is shown to have limited resources, the class can be mandatory for all plaintiffs.

According to Leon Silverman, a special adviser appointed to review problems at the trust, the class action Judge Weinstein is proposing would not allow claimants to opt-out of the consolidated lawsuit.

Ms. Smith said a mandatory nationwide class action "would be a difficult thing to put together."

Mr. Silverman would not comment on the viability of such a class action, but several plaintiffs' attorneys with claims against the trust said a consolidated lawsuit would be "devastating" for victims.

"Class action is not the solution," said Paul Gillenwater, of Gillenwater, Nichol & Ames in Knoxville, Tenn.

"Plaintiffs should have the right to bring a lawsuit where they live," he said. "It is not fair to make a Tennessee plaintiff go to New York."

"It is all too easy for an individual plaintiff to get lost in a class action," added Michael Goldberg of Mandell, Lewis & Goldberg in Vienna, Va., an early critic of the reorganization plan.

And Gene Locks of Greitzer & Locks in Philadelphia, said a class action would be "terrible for plaintiffs."

"It would result in another eight years of delay," predicted Mr. Locks, noting that a class action on behalf of school districts has been dragging on for eight years.

Several attorneys and a trust official questioned whether Judge Weinstein legally has the power to create a mandatory nationwide class action.

"We don't know" if he has that power, said Ms. Smith.

One prerequisite for a class action is that all claims have a certain amount of commonality.

However, Mr. Gillenwater said "commonality is lacking in these cases."

"Each case is different," he said. For example, some victims have fatal illnesses, while others have not experienced any illness.

"This group of cases is not suited for a class action," agreed Mr. Locks.

He pointed out that another prerequisite for a mandatory class action is that the defendant have a limited amount of funds. Since 20% of future Manville profits go to the trust, "there is no limited fund," asserted Mr. Locks.

'One of the essential things that facilitated the reorganization plan was conceding to plaintiffs attorneys demand that their fees not be subject to a limit, agreed Arthur Olick of Anderson, Kill, Olick & Oshinksky in New York.

Mr. Gillenwater suggested that a better solution than a class action would be mandatory mediation in which the mediator has the ability to impose sanctions on parties that fail to negotiate in good faith.

However, defense attorney Arthur Olick of Anderson, Kill, Olick & Oshinksky in New York, goes beyond Judge Weinstein's suggestion. He contends that for a mandatory class action to be a viable solution it must include the more than three dozen asbestos defendants nationwide, not just Manville.

"This is the only fair, equitable, expedient solution," he argued.

But, Mr. Olick, whose firm who represents asbestos producers, pointed out that there may be legal obstacles to the quest for a national class action.

Judge Weinstein's jurisdiction is limited to federal court and he does not have the ability to consolidate state court cases, he said.

However, if New York Supreme Court Justice Helen E. Freedman continues to cooperate with Judge Weinstein, there could be both state and federal jurisdiction nationwide, he said.

Justice Freedman is overseeing with Judge Weinstein the litigation of 500 New York asbestos victims against the Manville trust.

Other federal judges have rejected the idea of a nationwide asbestos class action.

One advantage of a class action is that less money would be spent on attorneys fees and court costs, said Mr. Olick.

Criticism of plaintiffs' attorneys fees has resurfaced in recent reports on the trust fund.

When the trust was created, *Business Insurance* reported that since 25% to 40% of a recovery traditionally goes to lawyers, a small number of attorneys filing a majority of the claims against the $2.5 billion trust stood to collect nearly $1 billion (*BI*, Dec. 16, 1985).

Whether to limit attorneys fees was a strong bone of contention among the creators of the reorganization plan.

Manville stockholders fought hard for some limit. However, plaintiffs' attorneys made it clear that the only way they would consent to the reorganization plan was if their fees were left untouched.

"We were told that if we changed anything, the whole thing would fall through," said an attorney who help orchestrate the plan.

"One of the essential things that facilitated the reorganization plan was conceding to plaintiffs attorneys," agreed Mr. Olick.

Continued on next page

New York Comp reform

Continued from page 1

money they saved," he observed.

Mr. Donnelly also maintains that the New York rating board has overstated the cost of the benefit increases and that the bill does contain significant cost-saving measures.

The reform measure will:

- Increase the maximum benefit paid to partially disabled workers—who represent more than 90% of workers comp cases in the state—to $280 per week from $150, effective July 1. Weekly benefits for totally disabled workers will increase to $340 from $300 as of July 1.

The gap between partial and total disability payments will disappear July 1, 1991, when benefits for both categories increase to a maximum $350 per week.

As of July 1, 1992, partial and total disability payments will be capped at $400 a week.

- Exclude work-related stress claims if they are based on "a lawful personnel decision involving a disciplinary action, work evaluation, job transfer, demotion or termination taken in good faith by the employer."
- Exclude coverage of injuries arising solely from drug or alcohol use.
- Allow workers comp insurers and group self-insurers to offer deductible programs to policyholders, subject to approval by the New York Insurance Department.

The bill sets out a number of requirements for such deductible programs, including that they reduce premiums commensurately with the type and size of the deductible and that the insurer pay claims within the deductible and then seek reimbursement from the employer.

An insurer may treat an employer's failure to reimburse such a claim the same way it would treat non-payment of premium, the bill says.

- Create new procedures intended to speed the handling of some workers comp claims.

For example, the bill provides for pre-hearing conferences on contested claims to settle procedural and other matters before cases are heard by the workers comp board.

The bill also establishes a new conciliation bureau to expedite handling of claims where the expected duration of benefits is eight weeks or less.

In addition, the bill provides that contested claims that have not been resolved within two years will be referred to a special panel for expedited hearings.

- Permit health insurers to request quarterly computer searches of workers compensation claims data to identify injured workers who have filed dual claims with both health and workers comp insurers for the same injury. The workers comp board will then notify the health insurer of duplicate payments. The health insurer is entitled under the law to reimbursement from the workers comp insurer or employer for any claim payments stemming from compensable workplace injuries.
- Establish a temporary state commission to study the workers comp rating process in New York, including the operations of the New York rating board. This provision was included at the behest of the AFL-CIO, Mr. Donnelly said.

Business and labor representatives agree that increased benefits were needed in New York, which has long had some of the lowest maximum benefits in the nation.

The increase in the maximum total disability benefit to $340 a week, however, will still leave New York behind 31 other states with higher benefits, said the Business Council of New York State Inc. in Albany.

Even after total disability benefits rise to $400 a week in 1992, New York is still likely to rank no higher than 21st nationally, the Business Council predicted.

Though employer groups have not objected to the benefit increases contained in the bill, they did fight the bill's two-year phase-in schedule, arguing that it puts too heavy a burden on employers too quickly.

"Our objections have very little to do with benefit levels. . .that's something we never opposed," said Mr. Magaril of the Chamber of Commerce. "We were much more concerned with phase-in dates and reforms."

"It's the rate of implementation that has the impact," AIA's Mr. Gaines concurred.

While not disputing the eventual $400 maximum weekly benefit for partial and total disability, for example, employer groups suggested phasing in the increase over four years instead of two and closing the gap between partial and total disability benefit levels over two years instead of one, Mr. Gaines said.

The new benefit levels effective July 1 could immediately cost employers $486 million in additional work comp premiums. This translates to a 19.2% increase for the average employer if the increases are approved by the Insurance Department, said Jack Piercy, president of the New York rating board.

Added to a 10.2% average premium hike already approved by the New York department for July 1 renewals, the new benefits would create a 29.4% total increase in average workers comp premiums this year, Mr. Piercy said.

The rating board has already submitted data to the New York department supporting proposed premium increases and hopes to have a decision shortly after the bill is signed into law, Mr. Piercy said.

The benefit increase due to take effect in 1991, meanwhile, will cost employers another $108 million in additional premiums and the 1992 benefit increase will cost an additional $102 million, Mr. Piercy projected.

'Our objections have very little to do with benefit levels,' says the Chamber's Mr. Magaril.

Some observers worry that the costs may prove higher than the rating board estimates.

Martin Minkowitz, a lawyer with the New York firm of Stroock & Stroock & Lavan, noted that rising benefit levels often lead to greater utilization, with claims frequency rising and injured workers staying out longer.

"It's suddenly worthwhile to file a claim," Mr. Minkowitz observed, noting that this kind of trend is not included in the rating board cost projections.

The AFL-CIO's Mr. Donnelly, though, maintained the cost projections are overstated and pointed out that the Insurance Department may not approve premium increases as high as those suggested by the rating board.

"I think they are erring on the side of conservatism," he said of the rating board.

While expressing concern about the speed of the benefit increases, employer groups and others say they are even less pleased with what they contend is the bill's lack of meaningful workers comp reforms.

"I think you are going to have real problems down the road when you see the results of these increases in benefits" without a corresponding tightening of claims standards, said Donald DeCarlo, senior vp and general counsel with New York-based Commercial Insurance Resources Inc.

The No. 1 reform on the Chamber of Commerce's list was the elimination of so-called "*Dole vs. Dow*" liabilities, which are not addressed in the bill, Mr. Magaril said.

Named for the New York state court case that established them, these liabilities stem from cases in which an injured worker, barred from suing his or her employer, instead sues a third party such as the manufacturer of a product used in the workplace. The third party then sues the employer to recover any damages awarded.

Though relatively few work comp cases produce *Dole vs. Dow* liabilities, their costs are high, according to Mr. Magaril, who said New York employers will pay about $120 million in additional work comp premiums this year because of these cases.

He added that these costs are expected to rise by about 25% a year.

Debate over how to resolve *Dole vs. Dow* liabilities has been largely responsible for holding up bills to raise workers comp benefits over the last three years, business and labor sources agree.

Employer groups also pushed for limitations on stress-related claims and complain that the limitations in the bill do not go far enough.

For example, while the bill excludes stress claims related to "lawful personnel decisions," this provision only codifies what had already been established in workers comp case law, according to Robert Crandall, legislative analyst for the Business Council.

The Business Council unsuccessfully fought for added limitations, such as excluding stress claims arising from disputes between employees, he said.

"The fix that they came up with is not a complete fix for a problem that has been getting more expensive in New York," Mr. DeCarlo agreed.

Employer groups are also unhappy with the provision excluding claims for drug- or alcohol-related injuries: Where the bill excludes injuries caused "solely" by drug or alcohol use, employers lobbied to insert "predominantly."

"It's almost impossible to meet the 'solely' burden" in arguing the exclusion should apply, Mr. Magaril said.

While complaining they lost out on key provisions of the bill, critics offer lukewarm praise for some other changes it makes in workers comp law, such as allowing employers to take deductibles on work comp policies.

"It's a positive thing. It might encourage safety if you know employers have a stake in the deductible amount," Mr. DeCarlo observed.

"If it's going to provide any savings, it will be among small employers," Mr. Crandall added. "Most of our larger manufacturers are self-insured anyway."

Mr. Minkowitz, however, questioned how much employers will really benefit from the provision.

While large self-insured retentions and deductibles can produce substantial premium savings, the deductibles taken by small employers are unlikely to cut costs much, especially considering the liabilities the employer assumes with the deductible, Mr. Minkowitz said.

"I'm not so sure very many employers are going to take advantage of that," he observed.

Critics are also equivocal about the bill's attempt—through pre-hearing conferences and the new conciliation bureau—to streamline the claim system and cut a backlog of claims estimated at 300,000 cases.

The conciliation bureau may help with less controversial claims, Mr. Crandall conceded, noting that a similar system has worked in Massachusetts. However, he added that the bureau over the long run may simply evolve into another level of bureaucracy in the claims system.

The AFL—CIO's Mr. Donnelly, meanwhile, complained that the bill limits the types of claims the conciliation bureau can handle and does not make agreements reached before the bureau final in all cases.

These provisions "considerably water down the potential effect" of the bureau, he said.

The AFL-CIO is pleased, however, with the bill's provision setting up a temporary state commission to investigate the workers comp rate-setting process.

In statements last month, New York State AFL-CIO President Edward J. Cleary charged that workers comp insurers and the New York rating board have conspired with the Insurance Department to inflate premiums.

The AFL-CIO's study commission proposal was intended to determine the cause of increases in work comp premiums in recent years, especially in light of the fact that benefits have not increased, Mr. Donnelly explained.

Mr. Piercy, the rating board's president, called the allegations of collusion with insurers and the Insurance Department "absurd," but said the board would cooperate with the study commission's inquiries. ■

Continued from previous page

Without the concession that attorneys' fees remain untouched, "there would not have been a reorganization plan and Manville might have been liquidated," said Mr. Olick. "But that might have been better."

In approving the Manville reorganization plan, Bankruptcy Judge Burton R. Lifland said he lacked the power to limit attorneys fees (*BI*, Dec. 29, 1986).

"The objectors here seek to raise a putative controversy between third parties, the merits of which may very well be subject to judicial determination at a later time and place, but which does not affect the administration of the debtor's (Manville's) estate," he wrote.

"The fee arrangement between a claimant and his or her attorney is immaterial to these reorganization proceedings. As such, these objections raise collateral disputes which this court is not empowered to rule upon," the judge said.

Stockholders lost an appeal of that ruling in federal district court and did not pursue more appeals.

Much of the recent criticism of plaintiffs' attorneys fees suggests that their fees have contributed to cash shortfalls at the trust fund.

However, Ms. Smith said: "Even if the attorneys took no fees, we would still have this cash-flow problem." She said settlements are based solely on the plaintiffs' injuries without consideration for how much of the settlements will be paid to attorneys.

Nonetheless, plaintiffs' attorneys have been under attack.

"Initially, contingency fees were justified by a handful of attorneys who developed the theories and facts that led to this litigation," said Mr. Olick. "Today, however, there is no justification for contingency fees."

Mr. Olick added that if a national class action is formed, there "is no question" that attorneys' fees would be controlled by the court.

But plaintiffs' attorneys maintain it is essential their contingency fee structure remain intact.

"But for the contingency fee arrangement that has been accepted by the bar and the courts, untold thousands of people would be deprived of the right to counsel," said Mr. Gillenwater. "Very few of these people can afford an attorney on an hourly basis."

Mr. Gillenwater said his fee is justified, in part, because his law firm was one of the firms that laid the groundwork for the asbestos bodily injury litigation.

"Critics fail to realize the money we lost in the beginning," he said.

In addition, he added that filing a claim with the Manville trust is not as simple as critics charge.

"We must be ready to take every case to trial," he said. "You can't get fair value for a lawsuit unless you are ready to go to trial."

"For eight years nothing was paid to claimants or their attorneys," said Mr. Locks, referring to the early years of litigation against Manville and the period of its reorganization.

He called the criticisms of attorneys fees media "sensationalism."

Ms. Smith agreed: "The press has tried to make a simple story out of a very complex situation."

Mr. Gillenwater also defended the trust against accusations it has failed to fulfill its charge. "People at the trust have done an outstanding job of settling the pre-petition cases. They simply were not given enough money," he said. "I don't think the trust is a failure."

The trust was initially funded with $155 million from Manville and $631 million from its insurers. As of Dec. 31, 1989, the trust had only $253 million in cash and marketable securities to pay claims. In 1990, the trust expects interest income of $13 million. Manville will not begin making payments of $75 million annually until 1991, and the trust will not share in Manville's profits until April 1992. After deducting required reserves and expenses, the trust has only $100 million in cash this year.

"It should be no surprise to anybody that the trust has run out of money. It was designed to run out of money," said one attorney involved in the reorganization, explaining that everyone in the reorganization knew there would be periods of cash flow shortages. ■

Lawyers failing to aid fund

Plaintiffs' attorneys representing asbestos victims have yet to contribute any of their fees to a special fund 21 months after they had promised to do so.

The fund, created under the Manville Corp. reorganization plan, compensates claimants who are unable to collect from the Manville Personal Injury Trust Fund. These claimants include those few who are barred by the statute of limitations from recoveries.

The Asbestos Victims Special Fund Trust was initially financed with $5 million from Manville Corp.

Plaintiffs' attorneys representing asbestos victims pledged during the reorganization hearings to contribute 25% of their fees from handling claims filed after the reorganization plan was consummated.

However, to date, not a single plaintiffs' attorney has contributed to the fund, confirmed Mary Vogel, executive director of the Asbestos Victims Special Fund Trust.

Not even the five plaintiffs' attorneys who act as trustees to the fund have contributed any money.

Trustee Gene Locks said he was unsure whether any of these post-petition claims have been settled.

However, Marianna Smith, director of the Manville Personal Injury Trust Fund, said about 5,000 post-petition cases have been settled.

But, she has no records to show whether any of the five trustees or other plaintiffs' attorneys representing victims at the time of the reorganization handled these post-petition cases.

It is not clear whether plaintiffs' attorneys who did not take part in the reorganization plan are bound by the promise to contribute to the special fund.

From Manville's original $5 million, the fund has dispersed more than $200,000 to 22 victims, according to Ms. Vogel.

In addition, the fund is intended to provide research grants and sponsor public education programs, she said.

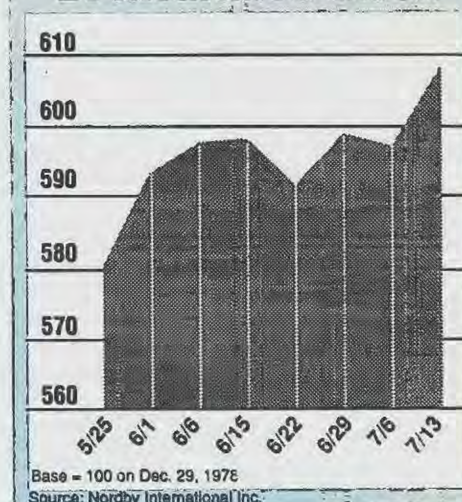
Plaintiffs' attorneys created the special fund, in part, to offset criticism of their contingency fee structure (see related story).

Typically, a plaintiff's attorney receives 25% to 40% of his client's recovery. Since the Manville Personal Injury Trust Fund is expected to have $2.5 billion, the attorneys filing claims with it stand to gain nearly $1 billion.

One attorney, who asked not to be named, said the creation of the special fund is "cosmetic." The plaintiffs' attorneys are simply "putting make-up" on the problem, the attorney charged.

Attorney Arthur Olick agreed: The amount of money plaintiffs' attorneys have pledged to contribute is "insignificant" compared with the total amount of fees they are paid, he said.

—*By Stacy Adler*



Insurance industry stocks shot upward last week, as the *Business Insurance Index* rose 10.4 points to 608.1 on July 13, from 596.7 on July 6. Advancing issues were led by Frontier Insurance Group, up 23.3%; Fremont General Corp., up 14.4%; and HMO America Inc., up 14.0%. Decliners followed American Indemnity Financial, down 9.5%; FHP International, down 8.0%; and Sears, Roebuck & Co. (Allstate) down 5.2%. The most active issue during the week was Sears, Roebuck, 2.7 million shares traded. The *BI* Index gained 1.9% for the period; the Dow Jones 30 Industrials climbed 2.6%; the Standard & Poor's 500 was up 2.4%; and the New York Stock Exchange Composite grew by 2.3%.

British Issues

July 12 Companies	Price pence	P.E	Div. pence	Yield %	1 Week High—Low pence pence
Comml Union	514	23.7	28.7	5.6	514—504
Genl Accident	533	16.3	33.4	6.3	536—527
Gdn Royal Exch	233	20.4	15.3	6.6	233—224
Royal	493	26.5	34.0	6.9	493—491
Sun Alliance	332	12.2	16.7	5.0	332—322
Brokers					
Bradstock	251	17.7	10.0	4.0	252—251
CE Heath	497	14.7	34.5	6.9	497—495
Hogg Group	170	11.2	9.7	5.7	170—170
Lloyd Thompson	314	19.6	9.7	3.1	314—307
PWS Holdings	84	13.1	3.3	3.9	85—84
Sedgwick Grp	239	15.0	16.0	6.7	240—235
Steel Brri Jones	281	17.1	14.7	5.2	284—281
Willis Faber	239	15.0	16.0	6.7	239—235

Source: Philip Olsen, Insurance Industry Specialist London

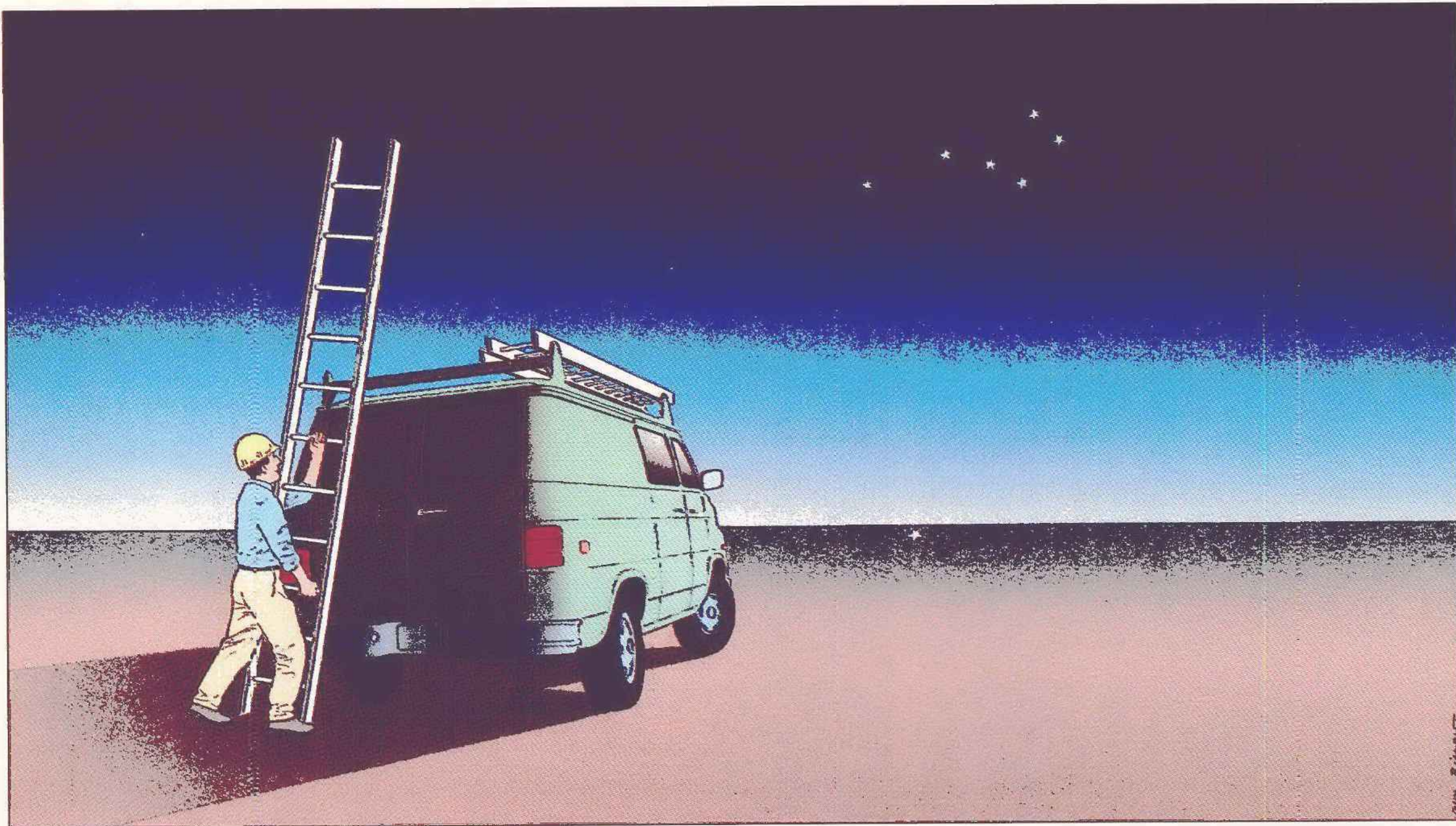
BI Industry Stock Report

JULY 9, 1990 THROUGH JULY 13, 1990

Company	Exch.	Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander	NYS	22.88	-3.68	-27.38	34.00	23.00	251	1.00	4.37	18	9.18	2.49
Corroon & Black	NYS	31.25	0.81	-18.30	41.00	28.50	221	1.36	4.35	17	12.73	2.45
Gallagher Arthur J. & Co.	NYS	22.75	0.55	-8.08	26.50	19.88	27	0.60	2.64	17	5.33	4.27
Frank B. Hall	NYS	3.25	4.00	8.33	4.38	2.50	41	0.00	0.00	-2	-2.80	-1.16
Hilb, Rogal & Hamilton	OTC	14.25	1.79	-23.49	20.63	12.50	79	0.28	1.96	19	4.60	3.10
Marsh & McLennan	NYS	76.50	-1.92	-1.92	89.75	65.63	381	2.60	3.40	18	10.56	7.24
Poe & Associates	OTC	12.00	6.67	-9.43	13.00	8.00	3	0.40	3.33	15	1.93	6.22
BROKERS	AVERAGE		1.2	-11.5					2.9	15		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	42.25	3.05	1.50	46.50	33.00	209	0.44	1.04	9	25.06	1.69
Berkshire Hathaway Inc.	NYS	7300.00	3.55	-15.36	8900.00	5675.00	0	0.00	0.00	-24	2869.00	2.54
ITT (Hartford Group)	NYS	58.63	2.18	-2.09	64.50	51.38	1279	1.60	2.73	8	56.33	1.04
Sears (Allstate)	NYS	34.25	-5.19	-11.61	47.25	34.63	2691	2.00	5.84	9	37.75	0.91
CONGLOMERATES	AVERAGE		0.9	-6.9					2.4	1		
INSURERS/REINSURERS												
Aetna Life & Casualty	NYS	53.38	3.14	-7.97	62.50	45.25	1038	2.76	5.17	9	58.11	0.92
Ambase Corp.	NYS	6.75	-1.82	-46.53	16.38	5.75	387	0.00	0.00	8	29.08	0.23
American General	NYS	47.25	-0.79	44.27	50.63	28.13	1012	3.20	6.77	14	34.68	1.36
American Heritage	NYS	22.00	1.15	-22.81	24.63	19.75	3	1.00	4.55	11	22.60	0.97
American Indemnity/Fin'l	OTC	4.75	-9.52	-40.63	12.75	4.25	6	0.08	1.68	-1	17.38	0.27
American International	NYS	94.63	1.47	-10.31	112.00	84.75	1888	0.52	0.55	11	41.92	2.26
Aon Corp.	NYS	38.88	-2.51	-8.26	43.25	33.38	164	1.52	3.91	11	19.62	1.98
Argonaut Group	OTC	77.00	1.32	11.80	77.25	57.00	33	1.60	2.08	9	36.83	2.09
AVEMCO Corp.	NYS	30.00	0.84	23.08	30.13	20.38	18	0.40	1.33	20	9.52	3.15
Baldwin & Lyons Inc.	OTC	21.25	-1.73	-1.16	24.00	18.88	3	0.28	1.32	7	20.80	1.02
Belvedere Corp.	ASE	3.88	-3.13	-29.55	5.63	3.38	2	0.04	1.03	-5	8.03	0.48
Chandler Insurance	OTC	8.63	-1.43	-26.60	13.25	7.63	82	0.00	0.00	4	9.53	0.91
Chubb Corp.(s)	NYS	46.75	3.03	-51.24	51.38	34.88	867	1.32	2.82	9	55.49	0.84
CIGNA Corp.	NYS	49.88	0.50	-17.22	66.75	45.25	467	3.04	6.10	11	66.64	0.75
CNA Financial Corp.	NYS	76.25	3.21	-23.75	108.75	68.25	166	0.00	0.00	9	54.87	1.39
Continental Corp.	NYS	28.13	-3.02	-10.36	38.63	25.75	510	2.60	9.24	11	41.36	0.68
Durham Corp.	OTC	30.00	1.69	-2.44	34.75	28.00	2	0.92	3.07	14	26.32	1.14
Fund American Corp.	NYS	35.25	6.42	0.00	40.75	29.50	1088	0.68	1.93	53	32.74	1.08
Fremont General Corp.	OTC	16.88	14.41	-16.15	22.50	14.38	261	0.80	4.74	7	19.09	0.88
Frontier Insurance Group	NYS	27.75	23.33	50.00	26.75	14.13	220	0.00	0.00	12	7.29	3.81
General RE Corp.	NYS	85.13	0.29	-5.42	96.25	67.88	857	1.52	1.79	13	29.04	2.93
Hanover Insurance Co.	OTC	25.50	-0.49	-16.39	33.00	22.75	101	0.44	1.73	8	32.03	0.80
Harleysville Group	OTC	27.38	4.29	-0.45	28.75	20.13	63	0.60	2.19	9	18.94	1.45
Hartford Steam Boiler	NYS	58.63	-0.85	8.06	60.75	43.00	77	1.80	3.07	15	18.94	3.10
Kansas City Life Ins.	OTC	36.00	0.00	0.35	36.25	34.50	13	1.12	3.11	10	39.22	0.92
Kemper Corp.	NYS	41.38	0.91	-12.43	51.88	34.00	449	0.92	2.22	10	29.97	1.38
Lawrence Insurance Group	ASE	8.75	-2.78	22.81	9.13	6.50	0	0.36	[illegible]	16	4.40	1.99
Liberty Corp.	NYS	49.88	4.45	17.35	50.25	35.00	10	0.92	1.84	11	31.82	1.57
Lincoln National	NYS	54.75	0.00	-10.25	62.88	51.38	115	2.60	4.75	10	49.19	[illegible]
NAC Re Corp.	OTC	35.25	6.02	-2.76	41.00	28.00	180	0.20	0.57	15	22.81	1.55
Navigators Group	OTC	33.00	-0.75	20.00	33.75	25.25	5	0.00	0.00	12	15.22	2.17
Nobel Insurance LTD.	OTC	3.25	-10.34	62.50	3.75	1.50	8	0.00	0.00	-2	7.76	0.42
NWNL Companies	OTC	29.63	2.60	-25.00	44.13	26.50	365	1.32	4.45	6	37.50	0.79
Ohio Casualty Corp.	OTC	43.63	1.45	-8.64	52.50	34.75	208	2.32	5.32	12	33.30	1.31
Old Republic Int'l	OTC	26.00	1.96	1.46	29.00	21.13	211	0.72	2.77	6	30.70	0.85
Orion Capital Corp.	NYS	21.75	-0.57	-6.45	28.50	18.38	197	0.92	4.23	7	19.72	1.10
Phoenix RE Corp.	OTC	10.75	2.38	-17.31	15.50	8.75	49	0.20	[illegible]	-15	12.99	0.83
Protective Life Corp.	OTC	13.63	-2.68	-4.39	16.00	10.88	45	0.68	4.99	8	14.54	0.94
Provident Life	OTC	23.50	2.17	-9.18	30.13	19.00	87	0.80	3.40	7	23.24	1.01
Re Capital Corp.	ASE	14.13	0.89	-2.59	15.25	11.25	13	0.00	0.00	11	14.43	0.98
RLI Insurance Corp.	NYS	13.50	0.93	52.11	14.75	6.88	26	0.40	2.96	8	12.42	1.09
St. Paul Companies	OTC	60.25	3.43	0.42	63.50	52.50	972	2.40	3.98	7	43.47	1.39
SAFECO Corp.	OTC	36.88	3.51	-7.23	42.38	30.38	636	1.36	3.69	9	24.87	1.48
SCOR U.S. Corp.	NYS	10.25	3.80	-28.07	14.50	8.38	58	0.20	1.95	13	10.61	0.97
Seibels Bruce Group	OTC	9.75	-3.70	-10.34	13.50	8.75	82	0.80	8.21	-2	13.75	0.71
Selective Ins. Group	OTC	15.50	-1.59	-18.95	20.25	15.50	116	1.04	6.71	5	15.72	0.99
Statesman Group Inc.	OTC	1.94	0.00	-29.53	3.38	1.88	92	0.16	8.25	4	4.19	0.46
Tokio Marine & Fire	OTC	46.00	1.66	-38.97	78.13	40.88	19	1.04	2.25	-	70.93	0.65
Torchmark Corp.	NYS	47.50	0.00	-17.03	58.75	41.00	151	1.40	2.95	12	13.23	3.59
Transamerica	NYS	39.38	1.61	-11.76	48.00	33.75	475	1.92	4.88	9	34.63	1.14
Travelers Corp.	NYS	29.00	-2.52	-21.36	45.00	28.38	1458	2.40	8.28	7	44.85	
Trenwick Group Inc.	OTC	25.13	6.91	3.08	26.88	16.75	32	0.48	1.91	12	16.91	1.49
United Fire & Casualty	OTC	35.00	0.72	6.06	35.00	30.50	2	1.20	3.43	10	22.56	1.55
USF&G Corp.	NYS	27.00	1.41	-8.86	33.88	24.75	2083	2.92	10.81	20	22.87	1.18
UNUM Corp.	NYS	55.63	-0.22	16.49	56.63	34.63	591	0.80	1.44	13	31.20	1.78
USLIFE Corp.	NYS	41.00	5.81	-9.39	48.13	34.75	167	1.48	3.61	9	54.34	0.75
Washington National	NYS	21.63	0.58	-23.45	29.13	19.50	19	1.08	4.99	80	32.90	0.66
USLICO Corp.	NYS	21.00	0.00	-11.58	25.38	20.75	68	1.00	4.76	8	27.73	0.76
Zenith National Ins.	NYS	15.00	-0.83	-20.00	21.50	13.50	21	0.88	5.87	8	13.81	1.09
INSURERS/REINSURERS	AVERAGE		1.2	-6.2					3.5	11.0		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	17.25	-8.00	-18.82	26.38	14.00	931	0.00	0.00	14	3.54	4.87
HMO America Inc.	OTC	7.13	14.00	-8.06	10.63	4.38	333	0.00	0.00	8	1.12	6.36
Pacificare Health Sys.	OTC	24.25	-3.00	-6.73	30.38	14.75	124	0.00	0.00	19	6.35	3.82
Safeguard Health Enter.	OTC	7.00	7.69	-17.65	12.50	5.13	251	0.00	0.00	11	2.99	2.34
Sierra Health Services	ASE	7.25	5.45	-18.31	9.63	5.50	86	0.00	0.00	12	0.62	11.69
United Healthcare Corp.	OTC	19.25	10.00	57.14	18.88	7.88	1201	0.00	0.00	24	0.34	56.62
United Medical Corp.	ASE	10.88	-1.14	81.25	11.38	5.75	18	0.20	1.84	19	5.70	1.91
U.S. Healthcare	OTC	22.00	6.67	54.39	21.38	9.63	0	0.36	1.64	30	3.07	7.17
HMOs	AVERAGE		4.0	15.4					[illegible]	17		
ALL COMPANIES	AVERAGE		1.4	-4.3					[illegible]	11		

System design: Nordby International Inc.

Performance Without Consistency Isn't Enough. Any group insurance company can promise fast claims service, but we guarantee it. ◆ We're confident enough about the quality of our claims service to put our high standards in writing, guaranteeing to meet our promised



turnaround time. We're comfortable offering this guarantee because we routinely exceed industry standards in turnaround time of claims processing. Our resources include an advanced cost-management technology in processing systems -- a Personalized Claims Administration system which provides flexible, adaptable administration of any benefits program. ◆ Clients who depend on your advice want to know what group insurance companies promise. Now you can tell them what we *guarantee*. For more information, call Tom McKellar at 1-800-877-1052.

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