

Business Insurance

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Family can sue pesticide makers, says court, citing tobacco case

BROOKLYN, New York—Citing the U.S. Supreme Court's recent decision in a tobacco liability case, a New York federal judge has ruled that federal regulations do not bar a family from suing pesticide manufacturers under state law for marketing a product with an allegedly inadequate warning label.

U.S. District Court Judge Jack B. Weinstein last week ruled the case can go to trial even though the companies complied with federal warning-label regulations.

Continued on next page

Transit threatens proposal to revive Walbrook

By STACY SHAPIRO and DOUGLAS McLEOD

LONDON—One of Walbrook Insurance Co. Ltd.'s largest creditors is trying to unhook a proposed bailout that needs the backing of most of the insurer's 200 major creditors by the end of this week.

Transit Casualty Co. is trying to stop the plan, under which claims would be paid in full but large claimants would bolster Walbrook's capital by buying redeemable preferred stock with 60% of their claims payments.

Transit has asked the House Oversight & Investigations Subcommittee chaired by Rep. John D. Dingell, D-Mich., whether a foreign corporation can solicit U.S. policyholders for a preferred stock plan. Rep. Dingell has asked the chairman of the Securities and Exchange Commission for an answer, which may come today.

Walbrook, a unit of London United Investments P.L.C., was the leading insurer on the U.S. casualty line slip underwritten by sister company H.S. Weavers (Underwriting) Agencies Ltd. until the slip stopped underwriting in March 1990 (BI, April 2, 1990).

The Weavers slip was London's leading U.S. liability insurance market.

Walbrook announced a moratorium on claims payments on May 29 pending provisional approval of the stock plan.

Walbrook is now insolvent.

According to draft copies of Walbrook's 1991 results, Walbrook had a year-end shareholder fund deficit of 169.7 million pounds (\$317.3 million). A year earlier, there had been a surplus of 9.6 million pounds (\$18.5 million).

The deficit is a result of new calculations of loss reserves by Tillinghast, which is performing an actuarial analysis of Walbrook's reserves. The Towers, Perrin unit advised that loss reserves should be 410.2 million pounds (\$767.1 million), an increase from 345 million pounds

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Clinton calls for family leave

Health reform, Medicare tax highlight Democrat platform

By JERRY GEISEL

WASHINGTON—If Arkansas Gov. Bill Clinton wins the presidency, enactment of family leave legislation would be a virtual certainty next year and the drive for health care reform will get a powerful jump-start.

However, Gov. Clinton, who accepted his party's nomination for president at the Democratic National Convention in New York last week, also may push for higher Medicare and Social Security taxes on middle and upper income retirees.

Gov. Clinton has not yet publicly staked out positions on risk management issues. However, the Democratic platform includes an ambiguous provision that says job safety laws should

be reformed "to empower workers with greater rights and to hold employers accountable for dangers on the job."

Gov. Clinton's running mate, Sen. Albert Gore Jr., D-Tenn., was an early supporter of legislation to expand the federal Risk Retention Act.

However, Sen. Gore has been sharply critical of limiting monetary awards in product liability suits (see story, page 29).

If Gov. Clinton is elected and, as expected, the Democrats continue to control Congress, enactment of family leave legislation is just about a done deal.

"It is as close to a slam-dunk as you can imagine," said Stuart J. Brahs, vp-federal government relations in the Washington of-

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Licensing rule could hurt captives

By MARK A. HOFMANN

WASHINGTON—Captive managers and risk managers fear that a Senate subcommittee's recommendation that offshore insurers and reinsurers be federally certified could burden captives with unjustified and possibly fatal financial requirements.

Even domestic insurance company trade groups differ on the recommendation, which was contained in the Senate Permanent Subcommittee on Investigations' recent report, "Problems With the Regulation of the Insurance and Reinsurance Industry" (BI, July 6).

The American Insurance Assn. does not think the recommenda-

tions go far enough, while the Alliance of American Insurers is not certain the requirement is necessary.

But observers are unanimous in their praise for recommendations that would crack down on insurance fraud and make certain types of insurance fraud federal crimes.

The Senate subcommittee

recommended:

- Creating a federal certification program for offshore insurers and reinsurers.
- Swift enactment of the insurance fraud provisions contained in H.R. 3371, the omnibus anti-crime bill (BI, Feb. 3).
- Creating new joint state and federal task forces to combat in-

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Gov. Clinton received a rousing send-off at the Democratic convention. If the momentum continues, his administration would seek health care reform and family leave legislation.

AP/Wide World Photos



Hit hard by the riots, Reed's Music Shop is trying to bounce back. At right, Jerry Bleeker and son Donald in their re-stocked store.

Photo by Louise Kertes

Rebuilding slow in wake of riots

Only music shop's spirit is left unbroken

By LOUISE KERTESZ

LOS ANGELES—Reed's Music Store, a family-owned business with five decades of history in south-central Los Angeles, is one of the few insured stores in the neighborhood that has reopened after the wave of looting and vandalism that followed the Rodney King verdict.

Twisted and charred rubble is all that remains of many retail stores on South Vermont Avenue, a couple of miles from the flashpoint of the riots that erupted in Los Angeles in April. Freshly painted, newly fur-

nished and partially stocked, the musical instrument store is open for business. But many business owners remain undecided about rebuilding in south-central Los Angeles, or they have decided not to rebuild, according to several insurers.

"People are cashing out or seeing what the environment is like before rebuilding" in south-central Los Angeles, said Dorothy Pawloski, general adjuster-Northern California region for CIGNA Property & Casualty Insurance Co. Ms. Pawloski said that among the

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Update

Pesticide makers face tort suit

Continued from previous page

In the case, Mary Ellen and Kevin Burke and other family members are suing Kenco Chemical & Manufacturing Corp., which makes a flea and tick pesticide; parent company Core Markets Inc.; and Dow Chemical Co. DowElanco Inc., a joint venture between Dow Chemical Co. and Eli Lilly & Co., manufactured a chemical used in a pesticide Kenco produced.

The family alleges the manufacturers did not adequately warn consumers of the dangers of its product. The warning label on the pesticide did not say the chemical is hazardous to pregnant women or their unborn children. Ms. Burke and her exterminator used the pesticide while she was pregnant, and as a result, her two children were born with severe brain damage, the suit charges.

Judge Weinstein ruled that in following the high court's decision in *Cipollone vs. Liggett Group Inc., et al.*, (BI, July 6; June 29) the pesticide manufacturers could be sued under state tort law even though their actions fell within federal regulations on warning labels.

Workers comp fraud alleged

SAN FRANCISCO—California's largest workers compensation insurer is suing a group of former policyholders for allegedly defrauding it of millions of dollars.

The complaint, filed July 14 by the State Compensation Insurance Fund in federal court in San Francisco, alleges violations of the Racketeer Influenced and Corrupt Organizations act.

According to the complaint, the defendants, who operated temporary help agencies, misrepresented the number of workers they employed, the amount of annual payroll, the nature and type of work performed, prior workers comp premiums and claims to obtain coverage through the fund at reduced rates.

As one scheme was on the verge of being uncovered, the defendants would shut down that operation and open another under a different name, the complaint says. More than 50 names were used, it says.

Named in the suit are: Vincent M. Marconi; Oralie Tuema Miller; the estate of Everett Wayne Miller; Glenn R. Miller; Shelley J. Walsh; Robin Robinson; Joseph Jenkins; Victor Lugo; West Coast Personnel Inc. and Pacific Payroll Service Inc., both of Anaheim, Calif.; and Budget Payroll Service Inc. of Ontario, Calif.

Both the Federal Bureau of Investigation and the U.S. Attorney's Office in Los Angeles are investigating the insurer's charges.

New York liable in AIDS suit

ALBANY, N.Y.—A New York court has awarded \$5.4 million to a nurse who contracted the AIDS virus after being stuck with a hypodermic needle containing the infected blood of a prison inmate being treated at a hospital.

The award is thought to be the largest-ever pain and suffering award against New York state, said plaintiffs' attorney Robert Julian, a partner in Julian & Pertz in Utica, N.Y.

The nurse was injured during a scuffle with the patient, which ensued after he suffered a seizure while being treated for pneumonia. During trial, witnesses testified that she and other nurses repeatedly called for help to two prison guards standing outside of the patient's room but that the guards failed to respond.

Included in the award by a State Court of Claims judge is \$4.25 million for pain and suffering; lost wages and medical expenses; and \$1 million for her husband's loss of consortium.

The state pays awards from a fund established by the Legislature. The Attorney General has not decided whether to appeal.

\$355 million catastrophe toll

RAHWAY, N.J.—Five natural catastrophes wreaked \$355 million of insured property damage around the country during the past few weeks, according to the Property Claim Services division of the American Insurance Services Group.

Wind, hail, tornadoes and flooding, assigned Catastrophe No. 20, caused an estimated \$220 million of insured damage to portions of Colorado, New Mexico, Oklahoma and Texas June 24-28.

Heavy rain and high winds, assigned Catastrophe No. 21, caused an estimated \$25 million of insured property damage to parts of central and southern Florida June 25-29.

The earthquake near Los Angeles, assigned No. 22, wrought about \$40 million of insured damage June 28-29 (BI, July 6).

Two weather systems marked by wind, hail, tornadoes and flooding struck the Midwest and New York during the first week of July. Catastrophe No. 23 caused an estimated \$30 million of insured property damage to parts of Illinois and Indiana July 2-3.

And, Catastrophe No. 24 resulted in an estimated \$40 million of insured property damage to parts of upstate New York on July 5.

Appeal in huge asbestos suit

BALTIMORE—Six asbestos companies say they will appeal a jury's verdict that they were negligent for failing to warn steelworkers and shipyard employees about the dangers of asbestos.

The July 13 verdict marks the end of the first phase of the nation's largest asbestos personal injury case, which consolidated 8,500 claims. The second phase later this month will determine

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Errors & omissions

• American International Group Inc. holds a 44% stake in Transatlantic Reinsurance Co., not 47% as misstated in a June 22 article.

Royal, agent file suits over canceled policies

By DOUGLAS McLEOD

CHICAGO—Royal Insurance Co. of America and one of its former agents are suing each other over a block of excess liability business on which Royal says it was defrauded.

Quill Marine Insurance Brokers Inc., a Chicago agency, filed suit against Royal earlier this year after Royal terminated Quill's agency agreement and attempted to cancel excess liability

coverage it had placed for dozens of marine and energy risks.

The agency, also known as Quill Marine Insurance Underwriters Inc., has asked a Chicago judge to rule that Royal improperly terminated its contract and wrongfully tried to cancel or not renew its clients' policies.

Royal has filed a counterclaim against Quill; George E. Foundos, the agency's president; and James W. Brower, a Royal marine underwriter who was

fired in February.

Royal charges that Quill, Mr. Foundos and Mr. Brower defrauded the insurer by misrepresenting the excess liability risks, charging policyholders premiums that were "grossly in excess" of those quoted by Royal and issuing insurance documents that contained terms and conditions that differed from those in Royal policies.

Royal's counterclaim seeks *Continued on page 28*

But language in workers comp ruling gives employers hope

Subrogation duty denied

By JOANNE WOJCIK

LOS ANGELES—Employer attorneys are attempting to snatch victory out of the jaws of defeat in a recent California workers compensation decision.

California's 4th District Court of Appeal in Los Angeles ruled late last month that employers cannot sue their workers compensation insurers for failing to exercise subrogation rights.

But the court left employers an opening. In its analysis, the court suggested that had employers alleged negligent claims handling, it might have ruled otherwise.

As a result, attorneys representing employers in similar cases already are citing the decision in *New Plumbing Contractors Inc. vs. Nationwide Mutual Insurance Co.*

"On the narrow issue, it's a

loss," admitted Arthur J. Levine, the Fullerton, Calif., attorney who represented Anaheim-based New Plumbing in the case. "But they raised the suggestion that you can sue for improper claims payment and excessive reserving."

"The decision enforces the insureds' right to sue its insurer for these issues," agreed Esteban G. Gallegos, a partner with Rox-

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Policyholders out of luck

8th Circuit decides three coverage issues in insurers' favor in single cleanup case

By STACY GORDON

ST. LOUIS—Reinforcing its own previous pro-insurer rulings, the 8th U.S. Circuit Court of Appeals has ruled that the comprehensive general liability policy does not cover hazardous waste cleanups.

In a three-pronged ruling, the 8th Circuit held that:

- Cleanup costs are not "damages" as that term is used in the CGL policy.
- The pollution exclusion, which bars coverage for pollution that is not "sudden and accidental," excludes coverage for all pollution that does not occur "abruptly."
- Cleanup demand letters from environmental authorities do not trigger an insurer's duty to defend a policyholder.

"This is a sweeping victory for insurers, deciding in their favor three major coverage issues in a single case," said Thomas Brunner of Wiley, Rein & Fielding in Washington.

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Texas Eastern loses coverage battle over \$750 million PCB cleanup cost

By STACY GORDON

PHILADELPHIA—In a massive victory for insurers, a federal judge has ruled that Texas Eastern Transmission Corp. does not have coverage for an estimated \$750 million pollution cleanup.

The decision is significant because it involves the first time a huge hazardous waste coverage case has been consolidated by the Judicial Panel on Multidistrict Litigation in Chicago.

"Texas Eastern presents one of the largest claims ever for environmental contamination and the court gave insurers a sweeping victory," said Margaret Warner of Carr, Goodson & Lee in Washington, who represents several insurers in the case.

"The insurance carriers have always felt

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Inside

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Cover in place; let the Games begin

By MARIA KIELMAS

BARCELONA, Spain—The rain in Spain has been giving insurers of the XXV Summer Olympic Games some sleepless nights.

If bad weather means some events are canceled, and the TV networks covering the games prove they have suffered a financial loss as a result, they may have a case for claims.

The omens do not look good. The opening ceremony will be held July 25. And for the last two years on July 25, Barcelona has endured torrential rainfall.

"It was like tropical rainfall; it was absolutely incredible," said Patrick Vajda, liability manager at Gras Savoye S.A. of Paris, which helped place much of the coverage for the Games.

"We worry about rain more than terrorism," said Xavier Parrizas, director of risk management at the Comite Organizador Olimpico de Barcelona, the organizing committee for the Summer Olympics.

A record 15,000 athletes and coaches, along with 25,000 organizers and sponsors, will be on hand for the Olympics, which run for 16 days through Aug. 9. The entire budget is about \$2 billion.



AP/Wide World Photo

A comprehensive property/casualty package caps the risk management program for the XXV Summer Games in Barcelona. In addition, Blue Cross & Blue Shield Assn. is again covering the U.S. Olympic Team (see story, page 18).

Five principal types of insurance are in place for the Games: television rights, general liability, electronic property, non-electronic property and athletes and spectators medical.

Of the total 600 million pesetas (\$6.36 million) in premium paid by the organizing committee, 55% is attributed to the TV rights and general liability coverages, said Mr. Parrizas.

La Union y El Fenix Espanol Cia. de Seguros y Reaseguros S.A. of Madrid, Spain, is the exclusive insurer for the Olympics, he said. This is because Banco Espanol de Credito, the sponsoring bank for the Games, had a controlling interest in UFE when these sponsorships were decided. Following an asset swap last year, UFE is now owned by French state-controlled insurer Assurances Generales de France.

The organizing committee's two brokers and advisers are Gras Savoye and Johnson & Higgins Ltd. of London.

J&H Ltd. Chairman Nuno de Brito y Cunha says the two brokers worked together on the Olympic project and in placing the television rights and general liability coverages in the worldwide reinsurance

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Employers profit with family benefits: Expert

By CHRISTINE WOOLSEY

LAS VEGAS, Nev.—Implementing work and family benefits is not just "the right thing to do," but a way for employers to solve real problems, including productivity problems, absenteeism and turnover, says a work and family benefits specialist.

"We all need employees to concentrate on their jobs," said Sandra Barud, president of Barud & Associates Inc., a child care benefits consultant in Pasadena, Calif. But worries and distractions about whether their



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children are being taken care of can hinder employees' job performance, she said.

More employers are becoming aware of the importance of work and family benefits, she said during the annual Society for Human Resource Management conference held here June 28-July 1.

In fact, a SHRM survey re-

leased during the conference found that nearly three times as many employers offer child care benefits today as in 1988. Almost 30% of the 1,004 human resource professionals surveyed said they provide some sort of child care service; only 10% did in 1988.

Many more benefit managers want to offer child care benefits but are waiting for corporate approval, Ms. Barud noted. But, she said, "Oftentimes, we worry too much about getting these programs approved and not about" the programs themselves.

"If you are trying to select the

best work and family benefits for your company, stop thinking of them as employee benefits," Ms. Barud advised. "If you do, there is the inclination to do what the employees want and only do enough to keep them happy."

Instead, think of family benefits as "a management tool," advised Ms. Barud. "People have problems with productivity and performance because of a lack of child care benefits. It affects absenteeism and turnover, and you should think about child care benefits in terms of eliminating these problems."

Employers agree that the need must be addressed: 23% in the SHRM poll say they are "very concerned" and 55% say they are "somewhat concerned" about family-related workplace problems. And, 90% of employers said child care problems cause absenteeism and tardiness, while 80% said workdays are cut short due to child care problems.

Ms. Barud said employers that design child-care benefits aimed at reducing workplace problems will end up "putting in more comprehensive programs, saving

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Workers comp woes spur Disney to draft its own reform legislation

By JOANNE WOJCIK

BURBANK, Calif.—Dissatisfied with lawmakers' proposals to reform the state's beleaguered workers compensation system, The Walt Disney Co. is taking matters into its own hands.

As a last-ditch attempt to cut its workers comp costs, Disney has drafted its own bill. It has been sent to Assembly Insurance Committee Chairman Burt Margolin, D-Los Angeles, and to members of a workers comp task force appointed by Assembly Speaker Willie Brown, D-Los Angeles.

Disney already had implemented cost-control programs like managed care, safety, light-duty programs and administering its own claims. But costs were still out of line.

"We realized that we were doing everything we could internally to address excessive workers compensation costs, but we weren't involved legislatively," said Stephen M. Wilder, Disney's assistant treasurer-risk management.

"It's the biggest expense we have from a risk management standpoint," he said, estimating that benefits and administration of the company's self-insured workers compensation program consume more than 50% of his annual risk management department budget.

In addition, "Every vendor and supplier involved passes on workers compensation costs to us" in the form of higher costs for goods and services, Mr. Wilder said.

Reform proposals offered so far, including one by Gov. Pete Wilson, are inadequate, Mr. Wilder said. "We didn't feel that Wilson's proposal did everything that was needed," he said.

For example, the governor's proposal to limit compensation

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Defense firms under fire

Bill would increase pension obligations for workers let go

By JERRY GEISEL

WASHINGTON—The nation's biggest defense contractors, already reeling from federal cutbacks in military spending, would be saddled with massive new pension liabilities under legislation working its way through Congress.

An amendment attached to a Defense Department spending

bill would require big defense contractors to offer rich, special pension benefits to certain older workers who are laid off or terminated under a defense contract.

The House last month cleared a defense bill, H.R. 5006, containing the amendment, which was proposed by Rep. Martin Frost, D-Texas.

Benefit experts say election year politics is behind the legislation. They note that with the defense industry downsizing because of the end of the Cold War, legislators are trying to ease the burden of layoffs by mandating

special benefits for workers laid off or terminated.

The Senate Armed Services Committee this week is expected to begin action on its defense spending bill, S. 2629. It is not known yet whether an effort will be made to include the Frost amendment in the Senate legislation.

But, even if the Senate does not pass a similar amendment, the Frost amendment still would be alive. Its fate, along with other provisions in the two Defense Department bills, would be decided by a congressional conference.

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Families win jury verdict but Pan Am fight not over

By STACY SHAPIRO

NEW YORK—Determining compensation for the families of victims aboard the Pan American World Airways flight that blew up in 1988 could be a protracted affair following a recent jury verdict lifting the compensation limit set by an international agreement.

With emotions running high among the families, Pan Am and its insurers, the battle in the

courts could continue for years.

It is a battle that should not have to be fought, argues the former claims manager for Pan Am's leading insurer, United States Aircraft Insurance Group. He says he believes these cases should have been settled three months after the bombing.

The families won a major victory July 10 when a federal jury found Pan Am and subsidiary Alert Management Systems Inc. guilty of willful misconduct for

failing to detect an unaccompanied bag carrying a bomb on board Flight 103 (BI, July 13).

After deliberating for 3½ days, the jury also decided that the willful misconduct caused the deaths of all those on board.

Ordinarily, the Warsaw Convention would limit the airline's liability to \$75,000 in compensatory damages per passenger. But the convention does not apply to cases of willful misconduct.

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Risk retention group challenges state law

By JERRY GEISEL

HARRISBURG, Pa.—A suit challenging Pennsylvania requirements that effectively require risk retention groups chartered in other states also to be licensed in Pennsylvania before writing coverage for motor carriers can proceed, a federal judge says.

Financial responsibility requirements issued by the Pennsylvania Public Utility Commission require motor carriers to obtain liability insurance from an insurer authorized and licensed by the state.

Charter Risk Retention Group Insurance Co., a Nebraska-chartered risk retention group that writes coverage for limousine operators, is challenging the requirements, arguing that enforcement of the rules violates the federal Risk Retention Act.

U.S. District Court Judge William Caldwell in Harrisburg, Pa., last month denied a motion by the utility commission to dismiss Charter's suit.

Had Judge Caldwell dismissed Charter's suit, it would have been devastating to risk retention groups, said David Bossman, chairman of the National Risk Retention Assn., a Washington-based trade group representing risk retention and risk purchasing groups.

Dismissal of the suit "would have driven a big hole through the pre-emption provisions of the Risk Retention Act," added Mr. Bossman, who also is presi-

dent of the American Feed Industry Insurance Co. Risk Retention Group, an Iowa-domiciled risk retention group.

Attorneys for Charter and NRRA, pointing to several statements in Judge Caldwell's memorandum, say his opinion paves the way for a future ruling in their favor. Attorneys for the Pennsylvania Utility Commission declined to comment while the case is being litigated.

To give states "unlimited discretion to dictate the means of demonstrating financial responsibility would render meaningless the anti-discrimination provisions of the act," Judge Caldwell wrote in a memorandum handed down last month.

The Risk Retention Act, enacted in 1981 and expanded in 1986, pre-empts state laws that interfere with the ability of risk retention groups—special multiple-owner captive insurers—to operate nationwide. The law also is intended to make it easier for businesses to band together to form risk purchasing groups to buy commercial liability coverages on a group basis with less interference from state regulators. About 75 risk retention groups now write a wide range of liability coverages for policyholder owners.

But disagreement over the extent to which the Risk Retention Act pre-empts state law has triggered a slew of litigation.

Courts generally have supported the view that the federal law broadly pre-empts state laws

that interfere with risk retention groups.

Several courts ruled in the early 1980s that federal—not state—law determines what coverages the groups can write.

For example, a federal court in Delaware ruled in 1983 that the Risk Retention Act's definition of product liability—at the time the only coverage risk retention groups could write—would determine whether a group was, in fact, offering product liability insurance.

Delaware regulators and the National Assn. of Insurance Commissioners had argued that state definitions should determine whether a Delaware-chartered risk retention group was offering product liability coverage. By Delaware's definition, the group was writing surety and property coverages in the state (BI, Oct. 17, 1983).

Congress in 1986 expanded the Risk Retention Act to allow risk retention groups to provide all types of commercial liability coverage except workers compensation (BI, Oct. 20, 1986).

Some courts, though, have supported state regulators' arguments that the act's pre-emption provisions are much narrower for risk purchasing groups.

Federal district and appellate courts have said there is nothing in the Risk Retention Act that bars a state insurance regulator from requiring an insurance company to meet a state's licensing requirements before providing coverage to a purchasing

group member in the state (BI, May 9 1988).

Judge Caldwell's memorandum in the Charter Risk Retention Group case is believed to be the first that deals with the relationship of state financial responsibility requirements and the Risk Retention Act's pre-emption provisions, noted Philip Olsson, a partner with the Washington law firm of Olsson, Frank & Weeda, which filed an amicus curiae brief for the NRRA.

Under the basic pre-emption provisions of the Risk Retention Act, a risk retention group, after being licensed by a state, can operate nationwide without having to meet the licensing requirements of other states in which it provides coverage.

But the Risk Retention Act does not pre-empt the authority of states to specify a means of demonstrating financial responsibility.

In the Charter case, the Nebraska-licensed risk retention group filed suit after the utility commission directed 16 limousine companies insured by Charter to show why they should not be required to obtain coverage from a Pennsylvania-licensed insurer.

Pennsylvania regulators had argued that the Risk Retention Act itself says it does not pre-empt state laws specifying means of demonstrating financial responsibility.

But Judge Caldwell said the Pennsylvania regulators overlooked the introduction to the

federal law's financial responsibility provision, which says that the provision is subject to another section of the law which says states may not discriminate against risk retention groups or their members, Judge Caldwell wrote.

"The two sections must be read together to properly construe the act's meaning," Judge Caldwell added.

"Plaintiff argues that by categorizing risk retention groups as unacceptable for purposes of demonstrating financial responsibility, defendants have indirectly regulated plaintiff's business by effectively compelling its members to obtain insurance elsewhere, in direct violation of the act," according to Judge Caldwell.

Judge Caldwell said he agreed with the defendants that the Risk Retention Act allows states to demand that proof of financial responsibility "include or exclude particular forms of insurance."

However, he said, this only means that should a "particular" risk retention group fail to meet a state's financial responsibility guidelines, it could be excluded as an eligible insurer.

"Any other reading of this provision—such as that states may exclude risk retention groups in general as a means of showing financial responsibility—would allow states to discriminate against all risk retention groups and their members" in violation of the law, he said. ■

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Deere to open health facility for workers

By SALLY ROBERTS

Benefit Beat

Deere & Co. later this year will offer employees, retirees and their dependents in Moline, Ill., a new health care option built around a company-run primary health care facility.

The John Deere Family Health Center will open its doors in October to 35,000 eligible employees, retirees and dependents near the Moline headquarters of Deere, which manufactures agricultural, industrial and consumer equipment.

Employees will have no out-of-pocket expenses under the health center option, which will be structured like a staff model health maintenance organization, in which salaried physicians treat patients. Right now, employees have no copayments or deductibles under Deere's self-insured indemnity plan or under an HMO it offers from Heritage National Healthplan Services Inc.

But the company expects that the health center's lower benefit administration costs and utilization management will generate savings.

The center was developed in conjunction with the Mayo Clinic in Rochester, Minn., and uses Mayo's input at all steps of the process, a Deere spokesman said. Mayo is assisting with the health center's design, specifications for patient flow and the design of a computer administration system. Mayo is also providing guidance on staff levels and recruitment, the spokesman said.

The creation of the health center is part of a labor agreement reached last year with the United Auto Workers, but it will be available to all Deere employees (BI, Oct. 21, 1991).

The health care facility will employ eight family practitioners, as well as a full-time Mayo administrator, a full-time pharmacist and a staff nutritionist, the spokesman said.

Among other primary care services, the center will offer radiological testing, physical therapy, and dietary and nutritional counseling.

Employees that select the

health center option can get primary care only through the center; referrals to other facilities and providers will be made only as needed. Deere is currently contracting with these other providers.

Although there are no financial incentives for workers to select the health center over other health plan options, Deere is hoping that Mayo's reputation for quality care will attract employees and retirees, the spokesman said.

In fact, an in-house survey of employees found that approximately 58% were interested in using the primary care facility.

Additionally, the company is encouraging employees and retirees to choose the center by advertising the center's benefits through a series of mailings and meetings, the spokesman said.

While the center will not be more economical for employees, it does offer quality health care and is centrally located, he said.

Other selling points: short waiting times at the health center and a drive-through prescription drug facility.

"We want to make it as con-

venient as possible," the spokesman said.

Deere also wants to make it cost effective. One of its objectives, the spokesman said, is to effectively manage its health care expenditures, which last year exceeded \$200 million.

Deere officials are confident the new health center will save money, the spokesman said.

Part of the savings will be realized because the center is based on a staff model HMO, which is recognized as providing efficient medical care on a cost-effective basis, said Deere's spokesman.

Savings also are expected to be achieved through reduced patient administration costs and stricter patient management. That management will be possible because the patients will receive all care through the facility, eliminating the potential for conflicting or duplicate services.

This is not the first time a company has opened an on-site primary care facility, the spokesman said. But the John Deere Family Health Center is the first on-site facility developed in conjunction with the Mayo clinic.

The center is a joint effort between Deere, the UAW and Minerservco Inc., a corporate affiliate of the Mayo Clinic.

The UAW represents the largest group of factory workers for John Deere, the spokesman said.

He would not comment on the cost for building the health center.

PPO effectiveness

Milliman & Robertson Inc. is trying to determine which factors distinguish cost-effective preferred provider organizations from other PPOs.

In a study, commissioned by the American Assn. of Preferred Provider Organizations, the actuarial consulting firm aims to identify PPO characteristics to be used as guidelines for evaluating the ability of a PPO to deliver health care services cost-effectively and efficiently, said Richard Kipp, a senior consultant in Philadelphia.

The study will be divided into three phases:

- A discovery process, which will entail identifying significant PPO characteristics and their value as indicators of cost savings and effectiveness.

These may include the size of a network, types of providers, level of cost savings and utilization controls, Mr. Kipp said.

- A survey of PPOs identified with these characteristics, collection of survey data and analysis of results.

- Presentation of the study's results to the AAPPO, which is scheduled for 1993, he said.

Health reform study

Despite deep frustration with rising health benefit costs, large U.S. employers are still unwilling to support a complete revamp of the nation's health care system, a new study finds.

William M. Mercer Inc. surveyed more than 400 top human resource executives directly responsible for health care benefits to identify the necessary compromises that might lead to a workable health care system in the next century.

Of these, 77% think that with only incremental improvements, the current health care system is

workable.

These respondents, named Revampers by the survey authors, do not agree on the type of changes they would make, although they strongly concur on the need to keep government involvement in the health care system to a minimum.

The remaining 23% of respondents, dubbed Overhaulers, are in favor of a complete redesign of the current system, but also do not unanimously agree on recommendations for a new system.

Stephen C. Caulfield, a managing director at Mercer in Boston, said he was surprised at the 77% majority who think the health care system needs just incremental changes.

"There seems to be a real disconnect" between the perceived dissatisfaction with rising costs and efficiency of health care and "the lack of political will to engage in fundamental societal change," he said.

The major difference between the Revampers and the Overhaulers is in their opinions on how the health care system should be financed, Mr. Caulfield said. All the other differences in opinion are subtle.

According to the survey, the Revampers strongly favor the current system of financing health care and reject any alternatives involving added taxation. The Overhaulers, on the other hand, overwhelmingly prefer financing health care through higher individual income taxes or additional taxes on employers and reject the current use of employer-sponsored group insurance.

The greatest unanimity between the two groups is found in their views on how much consumers should pay for medical services. Both strongly favor copayments because they create an incentive to be cost-conscious while also eliminating inappropriate use of health care services, the survey said.

Of all surveyed companies, 82% have already taken action to shift medical costs to their employees. Nine percent plan to do so in the next 12 months, while 9% have no such plans.

Another significant finding was in the degree of support from both groups as to who should have access to health care.

A small majority of Revampers and Overhaulers think all citizens should be covered for routine and catastrophic medical costs, but access to specialists and high-tech medical services should be rationed according to a set policy.

The Revampers and the Overhaulers are divided over who they think should manage the health care system to ensure quality services. The Revampers slightly favor the current system, which includes some government involvement, while the Overhaulers slightly favor the private sector only.

Compensation for providers is the only factor in which both groups equally reject the current system in favor of a controlled fee-for-service system, in which physicians and hospitals are paid on a fixed, regulated schedule for all services.

For a free copy of "In The Cards: A Survey on the Future of the U.S. Health Care System," call Mercer's public relations department, 212-345-7584. ■

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Mickey's rallying cry

IF EMPLOYERS with operations in California join with The Walt Disney Co., we believe they can obtain badly needed reforms to the state's ailing workers compensation system.

And the benefits of this employer-driven reform effort could spread across the country.

Thoroughly frustrated with its inability to control rising workers compensation costs—despite implementing all the best programs to prevent injuries to workers, to obtain quality and cost-effective medical care and to promptly return people to work—Disney has drafted proposals that it believes target the biggest problems in the state's workers comp system (see story, page 3).

And because it's fair, Disney is calling for increasing disability benefits for injured workers.

The proposed reforms are the product of Disney's risk management department under the leadership of Stephen M. Wilder.

This effort to tell lawmakers what practical changes employers need in a workers compensation system is the kind of risk management activism that is needed around the country where workers compensation costs are crushing companies' ability to stay in business, let alone expand.

Disney, to be fair, is not the first employer to lobby for changes in workers compensation laws. Indeed, the most successful reform efforts have been led by employers in Colorado and Texas.

But Disney is using its powerful name to demand change from a state legislature that is among the toughest in the country to budge on business issues.

Any company with employees in California that doesn't join this effort has no right to complain



"HE ROARED, I TELL YA! I HEARD HIM ROAR!!"

about rising workers compensation costs in California. Not even the usually anti-business California Legislature will be able to resist when Mickey and a few hundred thousand of his friends descend on Sacramento.

And, a successful employer-driven reform effort in California would inspire employers elsewhere to try the same.

Just as Disney figured out, all the best internal workers comp programs can't control costs if they are stymied by workers comp laws that encourage overpayment of doctors and lawyers and don't encourage workers to go back to work.

Letters

Why wait for the regulators on 24-hour coverage?

To the editor: Roger J. Thompson's June 29 article, "Time to Put Up or Shut Up," suggests that the 24-hour coverage concept, at least for medical benefits, is well within our grasp.

It is bewildering to hear a major workers compensation insurer claim that it needs detailed guidelines from the regulatory authorities before it can proceed to offer a policy that covers both occupational and non-occupational injuries and illnesses. What a credit it is to Mr. Thompson that he clearly defines the issue by its sub-issues: medical benefits; income replacement benefits; benefits administration; and funding. In so doing, achieving the goal of an integrated benefit program, if only for medical benefits, appears to be very real now. In time, the other sub-issues can be resolved.

The financial reason to focus on the integration of medical benefits is large. Medical payments in workers compensation are rapidly approaching 50% of total claims costs. The rate of increase in health care costs in workers compensation and health plans is well into the double digits. The commonality that exists in medical claims strongly suggests that an integrated claim sys-

tem can be constructed very easily. With the adoption of managed care techniques and direct provider contracting, there is no doubt that the health care component of workers compensation and group health care can be dramatically reduced.

It is unfortunate that Mr. Thompson and The Travelers Insurance Co. believe that the regulatory agencies must provide the incentive for the development of new ways of doing business. I

hope that Mr. Thompson really isn't saying that Travelers cannot develop a 24-hour policy without the approval and endorsement of a regulatory agency.

I blanch at what his shareholders and his clients would say upon learning that the clearly evident savings of an integrated benefit program will not be taken.

Ralph N. Galascione
La Jolla, Calif.

Fairness vs. family benefits

To the editor: I agree that education and the quality of our schools is very important. I disagree strongly that parents in the workplace should receive a package of benefits (which has significant value) not available to those who are not parents.

A March 2 Benefit Beat article, "Family Benefits," implies that unpaid leaves of absence would help children start school ready to learn. Where's the proof? Who knows what parents would really do with their leave?

Any extra effort and money spent on parental benefits could be used to expand or improve benefits for the employees themselves. Other employees' children should not come before me as the employee! All employees should receive a relatively equal package of benefits, whether parents or not.

In addition, the proposal seems to want to place a lot of responsibility on employers for educating and caring for children. But the primary responsibility should not have to come from employers. The majority of such an important responsibility needs to

originate from the federal, state and local governments—and our governments could find the money if they wanted to!

Our children are important, but they are not the responsibility of our employers. It is much fairer for everyone to pay for this through taxes rather than through our jobs.

Carol L. Lloyd
Lake Ridge, Va.

The Sam Walton of insurer ratings?

To the editor: Your description of Martin Weiss in the July 6 article, "Weiss Ratings Called Simplistic By Firm's Critics," makes him sound like the "Ross Perot" or the "Sam Walton" of insurer ratings: criticized and vilified by competitors, the media and other special interests, but acclaimed by customers.

James C. Wilson
Consulting Actuary
Winston-Salem, N.C.

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Work and family

Continued from page 3

more money for the company and making employees happier."

Employers should consider a number of factors when designing child care benefits.

The first step is to define the company's overall corporate goals and philosophy and relate them to the benefits plan. "Don't just think of dependent-care goals; think of the overall goals of the company, like productivity, accuracy, creativity," explained Ms. Barud.

If the company's goal is employee creativity—which is central to advertising agencies or toy manufacturers, for example—a company may want to put in a child-care program so employees are not distracted by family-care worries, she said.

Employers also should keep in mind human resource department goals and whether the company is centralized or decentralized.

"There is an issue of equity across worksites," she said. "That doesn't mean you have to do the same thing at each site; you should make programs site-specific." But the programs should be available to all employees who need them, and they should be designed so that as many employees as possible use them, she said.

"Don't design an on-site day care facility for 30 children if you employ 7,000 workers," Ms. Barud said. "Don't make the benefits program so expensive that you exclude lower-income employees."

Another consideration is whether to include employees in the planning and implementation of child-care benefit programs, Ms. Barud pointed out. If they are to be included, "don't just ask them what they want, because they don't know what they want, and they don't know what is available or what works," she said.

Instead, the consultant suggested, "Look at the kinds of problems they have with dependent care. Find out how dependent care problems interfere with work. Then ask them about their preferences and about what programs they think they would use."

Many employees will cite cost problems as a significant barrier to child care. "It costs about \$10,000 per year to pay for decent child care, but most care doesn't cost that much because it's not decent. There is a real quality problem, and parents can't afford to pay, so they get low-quality services," said Ms. Barud.

Even the costs for marginal child care can be prohibitive. "The average cost for marginal child care is about \$4,000 per year for a preschool-age child and about \$7,000 per year for infant care in a center," Ms. Barud said.

Low-income individuals spend about 23% of their salary on child care—that's why many of them don't use it, she added. "There are a lot of kids out there left home alone. I can't tell you how many kids under five are left alone."

Lack of time is another frequently cited complaint of working parents, according to Ms. Barud. "It takes time to raise kids, and it takes even more time and emotional energy for the difficult tasks like teaching values."

And time, she pointed out, is

in short supply these days. The average work week has increased to 48 hours from 41 hours for most employees; for professionals, the average work week is 52 hours.

Surveying employees about their problems is a good way to guarantee child-care benefits will meet their needs, Ms. Barud said.

Employers should survey all employees—not just current parents—to find out who plans on having children in the future. Also, surveying the entire workforce will give insight on how some employees' child-care problems affect their co-workers, she said.

Employees should be asked what their child-care problems are and how those problems affect them at work. Employers that instead ask employees what types of programs they would like may inadvertently raise their expectations, Ms. Barud explained.

"If you just let people talk... you'll get some amazing data," Ms. Barud said. For example, in focus meetings with branch managers, a bank recently found out that employees had been leaving keys and cash out in the open when they hurried to leave work and pick their children up at day care, the consultant said.

"The parents were concerned about being late to pick up their children, because they knew if they were late too many times their kid would be kicked out of the program," Ms. Barud said.

Employers also should look beyond data in absentee records as a way to find out who is missing work because of dependent-care problems, she said, because "people tend to hide why they are absent."

Employers that ask employees about their child-care problems will find out more than those that just check records.

Employers can offer workers with children a variety of different programs, Ms. Barud said. Each employer should study the availability of community child-care resources, the company's resources and limitations, and employee preferences before choosing a plan.

The least expensive programs include distributing information about community resources and support groups, she said. Some employers have established a "care-giving network"—a personal computer-based system that lets parents share information about child-care providers in the community.

Growth continues in more traditional forms of employer assistance like on-site child-care centers, dependent-care spending accounts and reimbursement. But less conventional programs also are emerging.

To save time, some employers have put dry cleaners, photo developers and even grocery stores on-site. "Time is such a big problem—especially for women in management," noted Ms. Barud.

Other employers have established on-site emergency child-care centers. "These programs are particularly popular with law firms, because they don't want to lose billable hours," Ms. Barud explained.

And, employers are looking into providing "quality of life improvements," like time off or flexible work schedules, rather than salary increases or promotions for working parents, she added. ■

Shake, rattle and human resources

LAS VEGAS, Nev.—Braving strong tremors from two nearby earthquakes, nearly 4,000 human resource professionals packed the Las Vegas Convention Center for the Society for Human Resource Management's 44th annual conference held June 28-July 1.

More than 100 speakers—including benefit consultants, labor and management attorneys and human resource professionals—discussed health and child care benefits, the Americans with Disabilities Act and other employment-related legislation, workplace privacy issues and

human resource strategies.

At the exhibition hall, some 350 companies offered information about insurance products, employee benefit management services and health care cost containment programs.

SHRM, founded in 1948 as the American Society for Personnel Administration, has more than 435 chapters representing roughly 80,000 human resource professionals worldwide. The group offers educational programs, seminars and conferences throughout the year.

Next year's national conference will be held in Washington May 23-26. For more information, contact the Society for Human Resource Management, 606 N. Washington St., Alexandria, Va. 22314-3440; 800-255-2772.

—By Christine Woolsey

Job descriptions in writing: Required? No. Useful? Yes.

By CHRISTINE WOOLSEY

LAS VEGAS, Nev.—Whenever a new federal law requires workplace compliance, employers are sought out by vendors willing to assist them in meeting the law's requirements. The Americans with Disabilities Act is no exception.

A flurry of software programs are now available to help employers comply with the law, which takes effect for most companies on July 26.

Some firms, though, are making sales by erroneously implying that their services are needed to comply with the ADA, warns a management consultant specializing in the ADA and affirmative action.

For example, marketing material from a few software firms erroneously states that the ADA requires employers to provide written job descriptions, said Ellen Shong Bergman, president of Ellen Shong & Associates in Winston-Salem, N.C.

Those companies are selling software programs designed to help employers write the job descriptions, she said.

But the ADA requires no such descriptions, Ms. Bergman explained during a session at the annual conference of the Society for Human Resource Management, which was held here June 28-July 1.

Written job descriptions can help an employer define what is and is not an essential function of a particular job.

But they are not required by the Equal Employment Opportunity Commission, which is providing technical assistance to employers and is in charge of enforcing the employment provisions of the law, explained Ms. Bergman.

"I am in favor of written position descriptions," she said. "But whether or not you ought to write them (should not) depend on the fact that someone is trying to sell you a product to help you write them."

All employers must read the disabilities law and regulations themselves, Ms. Bergman said. "That's a necessary part of your preparation."

After reading the law's re-

quirements, some employers may decide to write job descriptions, she noted.

Employers can benefit from written job descriptions if a dispute about the essential functions of a particular job arises between a job applicant and an employer, according to the consultant.

Disputes could arise if a job applicant claimed he or she was not offered a job because of his or her disability, rather than because the applicant could not perform one or more of the essential job functions.

The EEOC would probably side with the company if it maintained written job descriptions

Chemical companies, therefore, should include information about the presence of any chemicals in the air that may bother sensitive individuals, said Ms. Bergman.

"Don't think this is (the human resource manager's) job alone," Ms. Bergman stressed. "Involve line management and incumbent employees" in drafting job descriptions, she suggested.

Job descriptions also should include information about how employee absenteeism will affect the job, Ms. Bergman said. "It's important to document what will happen (to business) if an employee doesn't show up for a certain number of days."

Written job descriptions should include both the physical and mental requirements, says Ms. Bergman. 'The way in which a job is performed and where it's performed is very much a part of the description of the job.'

for advertised job openings, Ms. Bergman said.

However, "I think if a job function is essential, that will be a defense, regardless of whether it is written before or after the position has been advertised," explained the consultant. "Certain job functions are obviously essential regardless of whether they are written in a position description."

Written job descriptions should include both the physical and mental requirements, explained Ms. Bergman. "The way in which a job is performed and where it's performed is very much a part of the description of the job."

Descriptions should be detailed.

For example, said Ms. Bergman, if a job requires a person to lift 25 pounds, the job description should detail how high and how often the person is required to lift the weight.

And, job descriptions should include information about "the environmental issues of employment," she said.

When working for the Equal Employment Opportunity Commission, Ms. Bergman found that many employees' complaints about job discrimination had to do with their inability to work in certain workplaces because of the quality of the air or the level of noise.

Disputes may arise when employees who have to receive regular or periodic medical treatments argue that they are being unlawfully discriminated against because of a disability, not because of excessive absence from work, she explained.

To prevent future disputes involving absenteeism, employers "may not ask a job applicant how much time he or she may need away from work for physical therapy or other medical treatment," Ms. Bergman pointed out.

But, she said, "You may tell him what your attendance requirements are and ask him whether he can meet them or not."

Employers also can ask for attendance information from previous employers, she noted, so long as that request is made of all job applicants—not just people with disabilities.

Position descriptions that include the phrase, "and other duties as assigned," may also help mitigate ADA-related disputes, the consultant added.

"It's not practical to revise a position description immediately, as the requirements of the position change," she noted.

Using the phrase, "and other duties as assigned," will give employers more flexibility when adding duties to a particular job, she said. ■

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Casting a vote for privacy

Survey says off-duty behavior is off limits to human resources

By CHRISTINE WOOLSEY

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LAS VEGAS, Nev.—While smokers should pay more for health insurance, other off-the-job activities that put employees at risk for higher health care costs should not be an employment issue, human resource professionals agree.

Employee privacy—one of the most highly charged issues in the workplace—was the subject of a lively and stirring debate at the

Society for Human Resource Management's annual conference in Las Vegas.

Led by Harvard law professor Arthur R. Miller, a panel including attorneys, a union representative and human resource professionals discussed controversial topics like charging higher health insurance premiums for smokers.

Some of the thousands of human resource and employee benefit professionals attending the session were able to participate in the debate by recording their views on hand-held "audience response monitors." The electronic monitors were placed randomly among the crowd and "voters" were asked to register a "majority" opinion, voting for themselves and the people

sitting to their left and right. The results were immediately tabulated and displayed on a large screen.

Mr. Miller presented the panel with a variety of situations pitting employee privacy against employers' rights. For example, he asked whether or not it is acceptable to prohibit employees from smoking both on and off the job. Most agreed that on-the-job smoking could be prohibited, but the lines began to blur when off-the-job behavior was involved.

"It's an employee relations issue," said panelist Jonathan Segal, a management attorney with Wolf, Block, Schorr & Solis-Cohen in Philadelphia. "Employers can prohibit smoking at work and can charge employees more in health insurance, but they can't really tell them what to do at home."

Panel member Arte Nathan, vp-

human resources at the Mirage Hotel & Casino in Las Vegas, said employers do not have the right to monitor employees' off-work behavior in the name of health care cost control. "Costs should not be an excuse for an invasion of privacy," he said.

Others were concerned about where employers' "Big Brother" behavior would end.

"What if the employee is a skier or eats at McDonald's?" asked Lewis Maltby, director of the American Civil Liberties Union task force on civil liberties in the workplace in Washington. "Just about everything you do in private life has some impact on your health and health care costs."

"The lesson in this situation is this: If you have community rating and you break out the smokers or the cancer victims or those with the human immunodeficiency virus, you break up the group and you lose the advantage of spreading the risk," offered panel member Amitai Etzioni, a sociologist at George Washington University.

"The first step should be to appeal to people's moral judgments. Coercion is the last resort."

Panelist Barbara Easterling, secretary and treasurer for the Communications Workers of America union in Washington, suggested that the employer ought to have the smoker enter a program so he or she could stop smoking.

Sixty-four percent of the voting audience agreed that smokers should pay more for health insurance. But, 93% said other off-the-job activities that put employees at risk for higher health care costs should not be an employment issue.

Mr. Nathan's comment seemed to sum up the discussion: "There are no issues outside the gray zone in human resources—that's why it's a lousy job."

Other panelists were Lynn Outwater, a management attorney with Jackson, Lewis, Schnitzler & Krupman in Pittsburgh; and Jack Raiser, a labor attorney with Lan-kenau, Kovner & Bickford in New York. ■

Consultant outlines steps to top flex plan

By CHRISTINE WOOLSEY

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LAS VEGAS, Nev.—There are eight key steps in making a flexible benefits program successful, an employee benefits consultant maintains.

Benefit managers and human resource executives first should "develop a human resource strategy that ties back to the company's overall vision and values," said Richard Johnson, managing director and consultant with William M. Mercer Inc. in Chicago.

Support for flexible benefits has to come from the highest levels, he said at the Society for Human Resource Management conference held here June 28-July 1.

Next, benefit managers should "get out of the renewal-to-renewal mindset." Many employers do not actively manage their plans until insurance or provider contracts, for example, are up for renewal.

Employers instead should think about benefit programs with a longer-term view, he said.

"A renewal mindset is totally reactive—you are behind and can never get ahead," he explained.

Instead, employers "need to decide where (they) want to be as a plan sponsor in 1995. Then you can discuss what needs to be done in 1994 and 1993."

Employers implementing flexible benefits also should use the program to manage the costs and other aspects of their health benefits, as well as their disability and workers compensation plans.

"Employers have health care, dental, workers comp, sick leave and disability benefits, among other things," he said. "All of them involve health issues, and you should manage them simultaneously."

It also is important to "empower employees to become more prudent consumers of health care," Mr. Johnson said.

"Instead of talking to employees about employee benefits as an entitlement, try to get them into a lifestyles mindset. Then relate the flexible benefits program to their individual needs and requirements," he advised.

Meanwhile, employers should be

sure they can measure the success of flexible benefit programs, he said. For example, if the program offers preventive care to employees and dependents, employers should know how many are using those services and whether they are working.

"If you change the plan design, change it in a way that can be measured and understood."

Mr. Johnson also recommends that employers measure more than just health care claims costs within a benefits program.

"Look at all of your vendors and the programs and services they offer," he said. "Put in an audit format, so you can measure how much money (the company) is spending on all of this vending and advice."

Employers can save money by streamlining some of these services, he noted.

Mr. Johnson also noted that data collection and information access is becoming more important to employers. But, with so many vendors, sometimes access to that data is not easily obtained, he said.

He recommends that employers consolidate the number of vendors providing information and try where they can to eliminate the middleman from the communication process. Then, it may be easier to create an information access system that allows employees, dependents, retirees and even providers to access information instantly, without all of "the filters."

Employers also should set realistic goals and objectives when implementing flexible benefits, Mr. Johnson said. Many employers think flex plans will automatically save money, but that may not happen unless programs are carefully managed.

"Flexible benefits by itself will cost you money. It's what you do with it that is important," he explained. "If you are thinking about putting in a flex plan, you should think about whether it is appropriate for your company—not just whether it's feasible. If you have a checkbook, anything is feasible. But, flexible benefits are not appropriate for all employers."

When following these principles, employers should keep in mind that flexible benefits are not a quick fix, Mr. Johnson said. "From the time you implement a flex plan, you probably won't realize a return for 12 to 18 months or longer," he said. ■

Pan Am verdict

Continued from page 3

And the families may still not be able to collect punitive damages. The U.S. Supreme Court last year let stand an appellate court ruling striking down a punitive damages award against another airline found guilty of willful misconduct (*BI*, Dec. 9, 1991).

The recent verdict means Pan Am's aviation liability underwriters could end up paying \$250 million to \$300 million, according to some estimates. USAIG, the leading underwriter, had set a reserve of only \$90 million (see story, page 14).

But Robert L. Alpert, former senior vp and director of claims for USAIG, predicts underwriters will eventually pay as much as \$500 million because the cases continue to be tried in the courts.

Mr. Alpert says that in February 1989 he recommended that the Pan Am cases be settled for sums higher than the Warsaw Convention limits.

"I strongly disagreed with the philosophy of the chairman of USAIG on defending the cases," he said last week. "There was simply no rationalization for USAIG to take the position that a U.S. carrier could not be responsible for its security."

After 16 years with USAIG, Mr. Alpert left in October 1989. "A very significant part for leaving the company was because of the way they were handling this case," said Mr. Alpert, who is now president of International Claims & Litigation Management Group, a consulting firm in Albertson, N.Y.

It was USAIG's chairman, John Brennan, who decided to continue defending the cases based on the Warsaw Convention limits, according to Mr. Alpert and other parties involved. USAIG did not return calls.

"How can you not attribute responsibility to Pan Am in this case?" asked Mr. Alpert rhetorically.

Pan Am says it will appeal the recent verdict. But it will be some time before the presiding judge, U.S. District Judge Thomas C. Platt, will consider that request.

This week, the jury in the case is scheduled to begin hearing 135 damage cases—one by one—to determine how much each family should receive. Judge Platt will not decide whether Pan Am can

appeal until all of the cases are heard.

If each case lasts three days, as expected, hearing them all would take more than a year.

In addition to the 135 cases before Judge Platt, there are 100 others pending. Altogether, the 235 complaints ask for damages totaling \$14 billion.

Listening to each damage case separately is "drip-feed pain," which means that "the judge is holding Pan Am's nose to the grindstone" to encourage the airline to settle with the families, said an aviation lawyer not involved in the case.

This procedural move "will make it hard to keep one's resolve to appeal," the lawyer speculated.

But aviation underwriters believe Pan Am's insurers should continue to fight in the courts for reasons of principle, as well as for monetary reasons.

The underwriters believe there was a political motive behind the terrorist explosion on board Flight 103 and that various governments—not underwriters—should compensate victims.

Pan Am tried to bring in the U.S. government as a third party to the current case, but Judge Platt dismissed that action before the trial started. That dismissal, though, was on the condition that if any evidence during the trial supported Pan Am's claim, the judge would reinstate the action against the government.

The U.S. government is now seeking a final order dismissing the action following the decision on willful misconduct. The U.S. government also is seeking sanctions against Pan Am's lawyers for filing frivolous litigation.

Underwriters also question whether federal aviation authorities in Frankfurt, Germany, and London should be held partially responsible. The flight originated in Frankfurt and continued after planes were changed following a stopover in London. The unaccompanied baggage containing the bomb was first loaded on the flight in Frankfurt and was transferred in London.

"There are questions of principles involved, but also, if willful misconduct is proved, then the Warsaw limits are set aside," summed up a London aviation reinsurer. "There are big principles at stake, but there is also big money." ■

Pan Am's security may have been lax because of instructions the airline took from German or British aviation authorities, which should be held responsible, the reinsurer said.

Attorneys for both the families and Pan Am are barred from discussing the evidence in the case.

Plaintiffs' attorney Lee S. Kreindler, a partner with Kreindler & Kreindler in New York, spelled out in court at the end of the 10-week trial Pan Am's alleged "fraud," "deceit," and security violations that caused the Flight 103 disaster.

Pan Am was guilty of willful misconduct by violating security regulations under the U.S. Federal Aviation Act of 1958, known as the Air Carrier Standard Security Program, Mr. Kreindler said in court.

After two years of investigation, evidence shows that the bomb was hidden in an unaccompanied bag that was transferred in Frankfurt from an Air Malta flight to a Pan Am Boeing 727, which was the first leg of Flight 103.

The bag was transferred to a Pan Am Boeing 747 in London for the last leg of Flight 103 to New York.

Under the aviation regulations, all baggage must be matched with passengers, Mr. Kreindler said. Yet positive matches of bags and passengers were not made either in Frankfurt or in London, he said.

In fact, there were seven bags on board Flight 103 that did not match claim tickets held by passengers on board, Mr. Kreindler said.

Each and every element of the airline's security system "was sick, because management determined it was going to cut back on funds, it was going to save money. It was going to be a money-grubbing operation at the expense of the passengers, at the expense of the families, at the expense of the decedents of the families that we represent," Mr. Kreindler said.

Pan Am also did not have properly trained staff in Frankfurt or in London, Mr. Kreindler said.

And, during the months before the Lockerbie disaster, there were numerous warnings that security had to be tightened in the wake of the shooting down of an Iranian airbus by a U.S. Navy

Continued on next page

Pan Am verdict

Continued from previous page ship, according to the lawyer.

In particular, three months before the Pan Am bombing, a terrorist cell was discovered in Neuss, near Frankfurt, where 16 members of the Popular Front for the Liberation of Palestine general command were making bombs, Mr. Kreindler said. The police found one bomb "clearly intended for an airplane in a Toshiba radio cassette recorder," he said.

In addition, the U.S. embassy in Helsinki two weeks before the Flight 103 disaster received a call that a flight from Frankfurt to the United States was going to be bombed. The U.S. government distributed this information to airlines, including Pan Am.

Evidence showed that the day after the explosion, a Pan Am executive found in a pile of papers in his office a warning from the U.S. government "for the benefit of the screeners, the X-ray screeners, the people at the main counter, the people guarding the airplane," Mr. Kreindler said.

Experts testified that it would have been impossible to detect the plastic explosive used inside the Toshiba radio cassette that was planted in the unaccompanied Air Malta bag.

In ads, Pan Am touted 'one of the most far-reaching security programs,' says Mr. Kreindler.

It would have been easy, though, to detect a radio cassette by X-ray, Mr. Kreindler said.

Pan Am at this time was including a surcharge on fares for a security system it installed in 1986 and advertised as "one of the most far-reaching security programs in our industry," Mr. Kreindler.

The security surcharge for each passenger was \$5 for a one-way fare and \$10 for a round trip, which 97 deceased passengers paid on Flight 103, Mr. Kreindler said.

Pan Am earned \$18 million annually from this surcharge, which evidence showed was not allocated for security, he said.

"That is just awful," Mr. Kreindler said.

The Pan Am case is one of the few involving the Warsaw Convention in which willful misconduct has been proved.

Jetliner crashes often involve passengers covered under the convention because they have been ticketed in a foreign country and are traveling internationally.

However, "there are few cases where willful misconduct has been proved, and those that have are almost exclusively in the United States," said attorney Sean Gates, a partner with Beaumont & Son in London.

The most recent case in which an airline has been found guilty of willful misconduct involved Korean Air Lines Flight 007. Soviet fighter jets shot down the flight after it strayed into Soviet air space in 1983.

All 269 passengers were killed, but the airline already had settled with the families of 162 of them by the time the case reached the Supreme Court at the end of 1991.

The Supreme Court refused to

reinstate a \$50 million punitive damage award against KAL. A federal appeals court had overturned the award by a lower court, ruling that the Warsaw Convention bars punitive damage awards against airlines.

By refusing to review the case, the high court let stand a trial jury finding that the airline was guilty of willful misconduct.

In the past few weeks—nine years after the plane was shot down—10 more plaintiffs have settled their claims against KAL, Mr. Kreindler said. And, six more plaintiffs whom his law firm represents are waiting to settle.

"But we didn't start settling any of them until a few weeks ago," he said.

New York Bureau Chief Stacy Gordon contributed to this article.

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USAIG expected Warsaw limit to apply to Pan Am

Since shortly after Pan Am World Airways Flight 103 blew up, the airline's lead liability insurer has operated on the assumption that the Warsaw Convention limitations would apply.

Therefore, United States Aircraft Insurance Group—which wrote 30% of Pan Am's liability coverage—set the original reserve at \$60 million.

About \$30 million of the reserve was to cover compensation to the relatives of the 243 passengers; \$10 million was for ground-related claims, including the deaths of 11 Lockerbie residents; and \$20 million was for crash-related expenses.

The reserve did not include compensation for the families of Flight 103's 16 crew members, whose claims are still outstanding. The Warsaw Convention does not deal with compensation for crew.

USAIG, though, may have since increased the reserve for the Lockerbie crash.

Fearing that the Warsaw liability limit may be lifted, many of the other underwriters involved in Pan Am's coverage set reserves based on a \$250 million to \$300 million loss (*BI*, Jan. 16, 1989).

"Reserves on this accident depends on which underwriter you talk to," an aviation expert said.

Others involved in Pan Am's \$750 million liability coverage include Lloyd's of London's Ariel syndicate; La Reunion Aerienne in France; Associated Aviation Underwriters of Short Hills, N.J.; and CAMAT in France.

USAIG quickly settled the ground-related claims. The company also offered the families of the passengers \$100,000 per decedent, said plaintiffs' attorney Lee S. Kreindler, a partner with Kreindler & Kreindler in New York, in previous interviews.

As of last week, nearly \$56 million in liability claims had been paid by USAIG, London underwriters said.

USAIG did not return calls.

The amount settled includes compensation for ground victims and physical damage in Lockerbie; claims by the families of 30 passengers; and legal expenses, including the cost for private investigators.

—By Stacy Shapiro

Ailing airlines face security questions after Pan Am ruling

By JUDY GREENWALD

NEW YORK—Airlines will be torn between beefing up security and conserving their limited financial resources following a jury's finding that Pan American World Airways mishandled security for a flight destroyed by a terrorist's bomb.

While the verdict may encourage airlines to improve security measures, even the relatively few financially healthy airlines face increasing financial pressures these days

But, some observers note that airline security has been tightened since the onset of the Persian Gulf War.

A federal court jury on July 10 ruled that Pan Am was guilty of "willful misconduct" in its handling of security for Flight 103, which a terrorist's bomb blew up over Lockerbie, Scotland, in December 1988. The Warsaw Convention, which generally would limit an airline's liability to \$75,000 per person, does not apply in cases of willful misconduct.

Continued on next page

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Continued from previous page
duct (BI, July 13).

A second phase of the trial will determine the amount of damages to be paid to the families of 135 of 243 passengers killed on the flight. The plaintiffs are seeking \$350 million in damages.

Representatives of airlines either would not comment on their security or said it is adequate.

"We feel we have the best international security system in the world," said an American Airlines spokeswoman.

"We're confident that the airport security in all cases is effective," said an Alaska Airlines spokesman.

Observers point out that airlines' financial woes discourage further spending on security.

"I don't think the airline industry's response is going to be to step up spending," because even the apparently healthy air-

lines are having trouble just meeting their operating costs, said an airline securities analyst.

"I think the airlines' position is they comply with minimum standards set by the government," the analyst said.

Besides, she said, airlines "don't compete on security. If it's not really a factor they compete with each other in, they're a lot less likely to spend money to improve on it."

The verdict "serves notice to the airlines that they will be held accountable and responsible" and should beef up security, said Mitch Baumeister of Baumeister & Samuels in New York, one of the lawyers for the families of the Flight 103 victims.

However, "Economics tend to take a front seat, unfortunately," he said.

"The safety of the passengers should be first and foremost with

'During the Gulf War, there was a considerable increase in security,' notes S&P's Mr. Baggaley.

any airline, but the economics of the matter is another thing," agreed Ron Civello, vp with Southern Marine & Aviation Underwriters Inc. in New Orleans.

Yet airlines also should consider the potential damage to their business if a terrorist incident occurs. It could cost more "if they don't do something than if they did," Mr. Civello said.

Airlines must review their security in light of the verdict, said Roy W. Krieger, a lawyer who frequently represents airlines.

Airlines' insurers also will look closely at the issue, said Mr. Krieger, who is with Adler, Kaplan & Begy in Chicago.

Insurers may raise rates for those airlines that are "not looking up to par, so to speak. That's a given," he said.

While it is no secret that airlines are financially strapped, "I think they would find the money to beef up their security," Mr. Krieger said. "It seems to me common sense."

Other observers say airlines' security already has been strengthened.

"I think the security tightening has gone on for a long period of time" even before the verdict, said attorney Carroll Dubuq of Graham & James in Washington, who represents airlines in litigation.

"I think the security's already there," Mr. Dubuq said.

"During the Gulf War, there was a considerable increase in security, which has already been pretty significant," said Phillip Baggaley, an analyst with Standard & Poor's Corp. in New York.

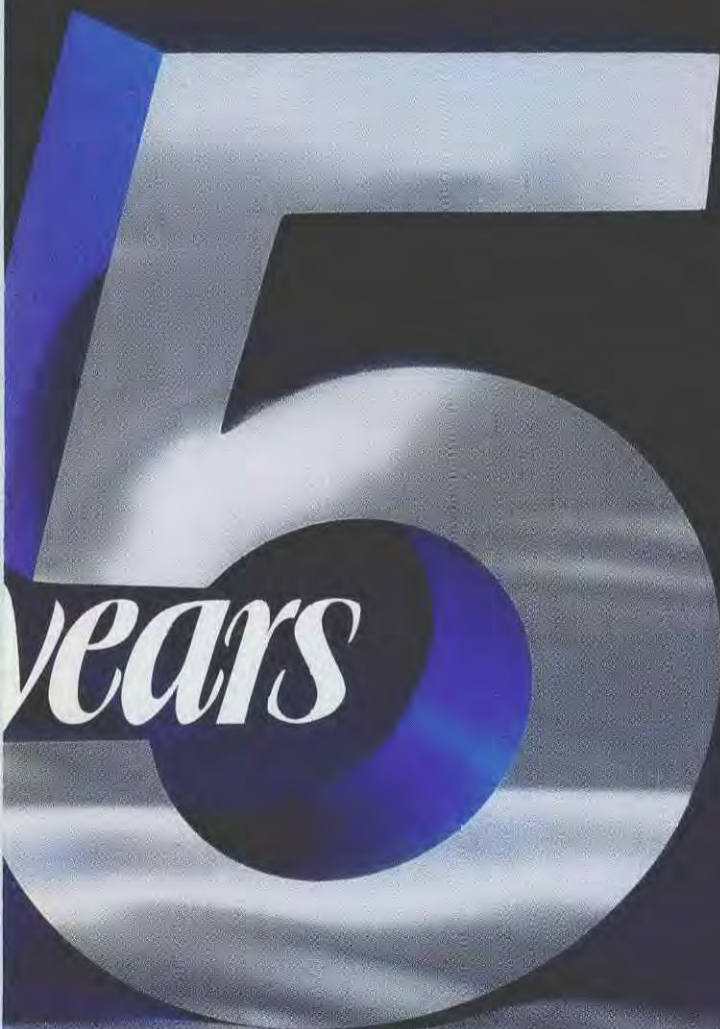
"I think the general trend has been increasing spending there," he added.

Robert Pannabecker, a consultant with Honolulu-based Risk Consultants, a unit of Frank B. Hall & Co. Inc., concurs.

At the time of the Gulf War, airlines beefed up security substantially. While it has been relaxed to a degree since, it is still tighter than it was previously, said Mr. Pannabecker.

Airlines generally now carefully match luggage with passengers traveling from Europe and X-ray the pieces before the passengers are permitted to check in, observers noted. ■

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Rebuilding

Continued from page 1

several losses she adjusted after the riots, only Reed's Music has begun to rebuild.

Transamerica Insurance Co. reports that of its 35 policyholders whose businesses were completely destroyed in the riots, only seven will definitely rebuild in the south-central area. The other 28 are undecided, a spokesman said.

A Farmers Group Inc. spokesman said that of its policyholders whose businesses were destroyed, 35% are undecided about whether to rebuild in south-central Los Angeles, about 30% will definitely rebuild there, about 25% will probably rebuild there and about 10% will not rebuild there.

A spokesman for Aetna Life & Casualty Co. said that of the fewer than 10 claims it has settled as of last week, one-third will not rebuild in south-central Los Angeles, one-third will rebuild there and one-third are undecided. "It's a mixed bag," he noted, adding that about 30 policyholders' businesses were destroyed in the riot.

But Reed's Music Store is a unique situation.

"Our roots are here," said 80-year-old Jerry Bleeker, president and owner of Reed's, one of the oldest stores selling musical instruments in the city. Before purchasing Reed's in the mid-1940s, he had been a musician at the former Republic Pictures movie studio.

"We have three generations of customers," he added. "But many older customers who have moved out of the area are afraid to come back to the store."

"I understand," Mr. Bleeker said with a shrug.

Beginning on April 29, rioters took or destroyed virtually everything in Reed's showroom and repair shop and at a separate storage facility, including 132 pianos, several of them grand pianos. They took priceless items like the antique organ used in the film "Beethoven" and burned an heirloom piano being refinished for a leading television writer.

Looters descended on the store "50 at a time" while Reed's employees were still there, said Mr. Bleeker. They overturned cabinets containing thousands of intricate piano parts and painted graffiti on the walls.

Even the Christmas decorations were taken from a storage area.

"If they couldn't take it, they destroyed it," said Reed's manager, Donald Bleeker, who is Jerry's son.

Reed's was not equipped with sprinklers, which prevented total fire losses elsewhere in the community (see related story). But

neighbors with garden hoses extinguished several fires in the showroom.

Although it now has only a few pianos in its showroom, Reed's reopened early this month, with the help of a \$250,000 advance from its insurer, CIGNA.

A CIGNA policyholder for three years and a policyholder of several other insurance companies since the 1940s, Reed's had never made an insurance claim before the April riot, according to Jerry Bleeker.

Though "hit and run" thefts have been common through the years, the Bleekers did not make claims because they wanted to keep their premiums down, he said. Reed's property coverage from CIGNA carries an annual premium of \$10,000.

The policy provides \$387,300 in coverage for property damage to the showroom and \$178,000 for property damage to the storage facility. It also provides \$347,100 in coverage for the contents—or inventory—of the showroom and \$57,800 for the contents of the storage facility.

The policy also includes one year's business interruption coverage—with a 30-day extension "if the business isn't back up to speed after a year," said Ms. Pawloski.

Coverage for accounts receivables totals \$650,000.

The \$250,000 advance from CIGNA is the first installment on payment of a claim that will include about \$100,000 for property damage—which the policy will completely cover—and about \$300,000 in business interruption, which the policy also will completely cover, said Ms. Pawloski.

The actual amount the Bleekers will receive for business interruption will depend on how much income the store actually loses during a one-year period following the loss. The actual amount will be based on a "model" of what the business was doing before the loss and where it was trending, she said.

"We owe you the difference" between what the store takes in during the year after the loss and what it was expected to take in, she told the Bleekers at a meeting in late May that *Business Insurance* attended. "We put in your cash register what your customers don't," she said.

Business interruption coverage also reimburses Reed's for all continuing expenses—like salaries of key employees that the company cannot afford to lose. Among these are technicians who are experts in piano refinishing and repair.

Reed's policy also provides up to \$10,000 to advertise the fact that the store is again open for business.

"There's so much down, you have to let them know you're up," Ms. Pawloski said.

In fact, after the music trade press reported that Reed's was destroyed, Jerry Bleeker wrote them a letter to say the reports were wrong.

The Bleekers plan to issue flyers in the neighborhood, asking for the return of their merchandise, no questions asked.

Insurance will likely not cover all of Reed's contents—or inventory—loss, which the Bleekers estimate will run over \$500,000.

The gap exists partly because Donald Bleeker, who purchased the insurance, did not realize that when he calculated the cost of replacing his inventory, he should have included his office equipment and tools.

"I've talked to about 100 agents through the years" in shopping for insurance, "and none of them" made it clear that office equipment and tools should have been included with merchandise in his inventory calculation, he said.

"I've always bought more (coverage) than I needed," said Donald Bleeker, adding that he would have factored in the cost of his office equipment if he had realized that it was not covered.

A loss that the insurance policy likely will completely cover is

Reed's accounts receivable.

"At the time of the loss, they had outstanding just over \$600,000 in accounts receivable," said Ms. Pawloski. "We won't settle that until we see which (bills) they cannot collect."

"We do know we will be paying something," she added, because looters took Reed's computer and discs containing all of the billing records. But ironically, one woman came in during the riots to pay her monthly installment on a piano, Jerry Bleeker told Ms. Pawloski.

"You're obviously valued as a business," she remarked.

The store's renovation included the installation of a steel door at the back of the showroom. The Bleekers also installed bullet-resistant glass and "bumper bars" at the front of the showroom. The bars would discourage someone from driving a car through the showroom window, Jerry Bleeker explained.

"They are putting in added protection at their own cost," Ms. Pawloski explained, "which will favorably affect Reed's next premium when CIGNA loss control specialists inspect the store, she said.

Reed's rebuilding has gone fairly smoothly with one major exception. Though Reed's has been a customer at a Bank of America

branch since the mid-1950s, the bank would not cash CIGNA's \$250,000 check immediately, the Bleekers said.

The bank released \$4,000 and suggested the Bleekers take out a loan, they said. Only after "fighting" with the bank did it release \$50,000, but it held the balance for a total of 11 business days, which amounted to about 20 days, Donald Bleeker said.

A spokesman for the branch said that it was bank policy to hold for 10 days any check that was not a cashier's check, that was over \$5,000 and that was drawn on an out-of-state bank. "We've known Don a long time," which is why the bank released \$50,000 before the hold period elapsed, the spokesman said.

Even a check from a company like CIGNA could present "potential problems" if it were not held, he said. For example, CIGNA might not honor the check because of "some irregularity," such as an improper signature, or because an "adjuster acted outside his authority," the branch spokesman said.

"This is the first I hear of a bank doing that," said Ms. Pawloski, who said she gave out millions of dollars in insurance checks following the fire in Oakland, Calif., earlier this year. ■

Buildings saved by sprinklers

By JOANNE WOJCIK

LOS ANGELES—All but two of 55 commercial buildings equipped with overhead sprinkler systems survived the recent rioting here, a new study shows.

And the only reason that one sprinkler-equipped building still burned was because the system was disengaged after the first night of rioting, leaving it vulnerable to arsonists on the second night, according to the study's author.

Another burned when fire from an adjacent building spread across the roof line, according to Steve Hart, director of the Fire Sprinkler Advisory Board of Southern California in Cerritos, a promotional group that did the study. The group is funded by the local sprinkler fitters union.

"That's one of the pitfalls," he said. "We have unsprinklered buildings attached by roof lines to sprinklered buildings."

The study confirmed what property loss control experts have been saying all along: That automatic sprinklers can substantially reduce the severity of fire loss.

While sprinklers alone are not

an adequate fire suppression system, they were about all the defense some Los Angeles property owners had during the riots that erupted April 29 (*BI*, May 4).

Angry mobs blocked firefighters from reaching many of the more than 1,000 commercial structures set ablaze by Molotov cocktails hurtled through broken windows.

By the time the rioting was over, insured property losses had reached \$775 million, making the civil disturbance the costliest in U.S. history.

A total of 60 people died, 2,283 were injured, between 600 and 700 buildings were totally destroyed and another 759 were damaged.

A city study found that about 1,300 separate addresses suffered some type of riot damage. And some 5.8 million square feet of commercial property burned to the ground.

Of the 55 buildings known to be sprinkler-equipped, the Fire Sprinkler Advisory Board found that all but two survived the riot-triggered fires. Since the study was completed, several more buildings in the riot-scarred areas were found to be equipped with sprinklers.

Mr. Hart attributed one of the failures to "individuals who shut down the automatic fire sprinkler systems after they activated and extinguished the preliminary fires."

This left buildings vulnerable when a second wave of looters came through. Mr. Hart added that it is not yet known why the sprinklers were not reactivated.

Automatic sprinklers will spray until they have been shut off manually, explained Bruce Pitzer, chief engineer in the Los Angeles district office of Factory Mutual Engineering & Research Corp., a division of the Factory Mutual System.

A FEDCO Inc. department store, which is insured by Factory Mutual, is cited in the study as an example of how well overhead sprinklers work.

A total of 22 sprinklers extinguished nine fires set by rioters in the 116,000-square-foot store at the corner of La Cienega Boule-

vard and Rodeo Road in the Baldwin Hills section of Los Angeles, the study found.

Only three weeks after the riots, the store reopened.

"There's no question in my mind that we have a store today because of the overhead sprinkler system. It was money well spent," said Nathaniel Lord, risk manager for the Santa Fe Springs, Calif.-based department store chain.

FEDCO's adjacent tire center, which was not equipped with sprinklers, was not spared. The 8,400-square-foot structure succumbed to rioters' torches.

Sprinklers were not required when the building was built, Mr. Lord explained, and it had not been retrofitted due to cost.

"But I'm not sure that we would have had the same dramatically positive result," since the tire center was filled with highly flammable substances, he said.

Factory Mutual's Mr. Pitzer disagreed: "While it may not have been as dramatic, it would still show how well sprinklers work" to mitigate fire damage, even in buildings containing highly combustible materials.

In fact, Mr. Pitzer said, water-powered overhead sprinklers can be very effective in fighting such fires, provided that there are enough of them and that they are positioned correctly.

FEDCO's riot-related losses, including damage caused by water and looters, totaled just under \$14 million—far less than what it would have been had the sprinklers not been activated by the heat of the flames.

"It could have been a \$35 million loss," Mr. Lord estimated. "The sprinklers saved us \$15 million to \$25 million."

This proves that fear of water damage should not deter risk managers from considering installing overhead sprinkler systems, Mr. Pitzer said. Putting sprinklers in during construction costs only about \$1 per square foot, and retrofitting costs only about \$2 per square foot. "That's why I'm having them installed in my home," he quipped. ■

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Insurer Topics

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Recessionary marketing tactics

By SARA MARLEY

As the recession continues with only sporadic signs of improvement, insurers are looking for ways to make their marketing dollar go further.

For Chubb Corp., the most cost-effective way to tout its wares is through exhibitions at trade shows.

This year, Chubb began attending trade shows and annual association meetings

for industries it has targeted.

"We want to go where the customers are," said Mary Lu Korkuch, manager of promotion and public relations for the Warren, N.J.-based insurer. "It's unique, and it's been very profitable for us at a time when the economy is sluggish."

Ms. Korkuch said Chubb spends \$20,000 to \$25,000 per show. This includes costs to ship its booth and materials, plus costs to staff the booth with three to eight underwriters in a specific field. But the insurer attributes \$3 million in new business so far this year directly to its presence at six trade shows.

"The policyholder walks around the corner at a convention, and his (or her) insurer is there. What better way to show them that we are interested in their ind-

Insurers find ways to stretch thin budgets

ustry?" Ms. Korkuch said.

The insurer also found that trade show crowds are interested in its personal insurance products.

However, the recession is also having an impact on conference attendance, so Chubb has designed a way to bring the show to them.

In the past year, the insurer has sponsored one-day seminars for agents and brokers in its offices around the country, complete with Chubb's trade show exhibit.

For example, the San Francisco office sponsored a mini-show for brokers last year and is now working on one for buyers. The Minneapolis office held an international insurance seminar and a products fair in the Boston office last month attracted agents and brokers from four states, Ms. Korkuch said.

Care is taken to make the seminars educational, not just promotional, Ms. Korkuch said. "We talk about what's going on in the market, not just what Chubb can do for them."

The recession and soft market conditions also have taken a toll on other insurers' marketing plans.

The condition of the market and the economy deals a double blow to insurers, said James B. Rugh, manager of advertising and sales promotion for Hanover Insurance Co. in Worcester, Mass.

"Budgets get slim, and companies try to save some money, including in the marketing and communications area," Mr. Rugh said.

"Clearly, the last few years have been difficult business years for insurance companies. The result is that they tend to cut back with marketing expenditures," said J. Robb McPherson, senior vp of advertising agency

BBDO Chicago Inc.

Despite those constraints, "they have a greater desire than ever to talk to, know and serve their customers," said Mr. McPherson.

One result of the current business climate is that many insurance companies have cut back their advertising in trade publications.

"That tends to be one of the first things that they do," Mr. McPherson said. However, he added, "they won't give up direct communications with the consumer."

"It's a reflection of the hard times. There is a lot of scratching and scrambling going on," he said.

Despite across-the-board budget tightening, some insurers find the recession is a good time to maintain or step up marketing efforts.

"Our marketing practices are designed to serve us well over the long term," said a spokesman for CNA Insurance Cos. in Chicago. CNA's marketing efforts focus on print and radio advertising, he said.

"We do not change our marketing practices in response to short-term adversities, such as economic downturns," the spokesman explained.

"It's the best strategic time to push your story. It's not too crowded," agreed Richard Calderhead, president of advertising agency Calderhead & Phin in New York.

But most insurers are simply trying to maintain marketing efforts and market share.

"In this economy, the current mindset is 'more of the same,'" according to Kimberly Paterson, president of Creative Insurance Marketing in Red Bank, N.J.

"Insurance companies view money spent on marketing and advertising as discretionary. Budgets have really taken a hit. Every single expense has to be justified," she said.

Public relations and image advertising have been cut back the most, she said. The reduction in image advertising is felt across the industry, she noted.

"The public is so cynical and skeptical about insurance. Companies are the victims of negative press generated by the industry as a whole," Ms. Paterson said.

Insurers "read popularity polls. They know where they stand with the public. They can't let this go on anymore, but they don't have the budgets" to change the industry's image, she said.

"What money is left is spent specifically on product promotion," Ms. Paterson added.

Several insurers' marketing efforts bear out that view.

"We're doing more remarketing of products than new product development," said Frederick W. Baker, assistant vp and director of communications at Harleysville Mutual Insurance Co. in Harleysville, Pa.

The insurer is repackaging and enhancing coverages, including raising limits and deductibles, Mr. Baker explained. "We're adding more bells and whistles."

While insurers like Harleysville are refocusing existing products, Arkwright Mutual Insurance Co. is trying to let consumers know that it can develop a "total property/casualty solution," according to William Moriarty, a vp and staff officer of marketing.

In conjunction with its retail brokerage subsidiary Hobbs Group Inc., Arkwright can tailor a full insurance program for clients. Marketing coverage this way actually saves the insurer money, because clients get only the products and services they need, Mr. Moriarty said.

Although Arkwright has offered casualty insurance through the Hobbs Group since 1985, Mr. Moriarty said the insurer is currently working on improving internal understanding of the tailored program's possibilities before beginning new external marketing efforts.

At Liberty Mutual Insurance Co., marketing strategies are now planned for each profit center rather than companywide. This allows for a broader range of advertising and promotional activities, said Whitney C. Lancaster, assistant vp and manager of marketing and public relations.

The new approach to marketing and communications has been coupled with a commitment to get "back to basics," he said.

"We have to know what's really important to the buyer. That's the most powerful creativity," he added. ■



PHIL WITTE

Insurer advertising experts: Get creative. It pays.

By SARA MARLEY

SANTA FE, N.M.—Only good advertising will break through the flood of information consumers receive daily, insurance marketing specialists agree.

"The world is not waiting for the message you have to deliver," said Stavros Cosmopoulos, a Boston-based independent advertising and marketing specialist.

Consumers receive between 4,000 and 7,000 messages daily, he observed.

"Most publications are purchased for their editorial or en-

tertainment content," Mr. Cosmopoulos said. "Readers have other things to do besides respond to ads. All activities are competition."

"There's too much of everything," agreed Richard W. Calderhead, president of New York advertising agency Calderhead & Phin. "There's too much insurance. The property/casualty cycle won't quit. The market won't turn around."

Therefore, in addition to cutting through the clutter, insurer advertising must also distinguish a company from the competition, Mr. Calderhead said.

Both Mr. Calderhead and Mr.

Cosmopoulos spoke at the Insurance Marketing & Communications Assn.'s annual meeting



Companies must avoid 'boastful, empty promises. They are either too narrow or too broad,' says Richard W. Calderhead of Calderhead & Phin.

here last month.

Ads should draw the reader's attention, deliver a message and lead the consumer to buy your

product rather than a competitor's, Mr. Calderhead said.

In addition, consistency in advertising helps to set an insurance company apart. For example, Metropolitan Life Insurance Co.'s campaign featuring the Peanuts cartoon characters provides both consistency and diversity, Mr. Calderhead said.

Its slogan, "Get Met. It pays," also is effective because it "describes what the company does, promises a benefit and does it with flair," he said.

On the other hand, companies must avoid "boastful, empty promises. They are either too narrow or too broad," he said.

Advertisers should distill their message to a single point, which can penetrate the consumer's attention much easier than several messages, Mr. Cosmopoulos said.

"You must arrest the attention of the reader. There is no requirement to read any message. A fraction of a second later, you must pique his interest."

Another effective advertising tool is using corporate symbols, like the Prudential rock or the Transamerica tower, he said.

However, Mr. Cosmopoulos said, although "a logo has an appropriate place, it shouldn't upstage the rest of the ad. If it does, skip the ad and just run the logo."

Celebrities also can be used to support a creative idea, but not to replace it, said Bob Garfield, a columnist in Washington for Advertising Age, which is a sister publication of *Business Insurance*. The best celebrity spokespeople are those who come to represent the product, like

Bob Garfield, a columnist for Advertising Age, praises ads that possess the 'I-factor': ingenuity, involvement and intelligence.



athletic shoe hawkers Bo Jackson and Michael Jordan, Mr. Garfield explained at the IMCA meeting.

Humor also can be an effective method of communicating the advertising message.

"The world has a natural resistance to advertising. Humor releases that for a moment," Mr. Cosmopoulos suggested.

"Humor can be effective in an ad," Mr. Garfield agreed. "But be sure to make it funny."

Mr. Garfield also praised advertising that possesses the "I-factor": ingenuity, involvement and intelligence.

The design of an ad controls the way it is read, according to Mr. Cosmopoulos. It must be organized logically and read sequentially, he said.

Type must be large and "read easily by someone who should be wearing glasses but isn't," he commented.

"If it's a challenge for the public to read your ad, don't bother," Mr. Cosmopoulos said.

A good relationship with the advertising agency is the key to producing an effective campaign, according to Mr. Calderhead. He offered the following rules for a productive agency relationship:

- Principals of ad agencies must be involved.

- The ad agency must have access to the insurer's top management.

- The agency should know important media in your field, including trade and consumer business publications.

- The ad agency should produce the kind of creative product the insurer needs now, conduct a periodic review of the campaign and make any necessary adjustments.

- A good ad agency will help train the insurer's marketing staff, which is taking the message to buyers, and even accompany them on sales calls. ■

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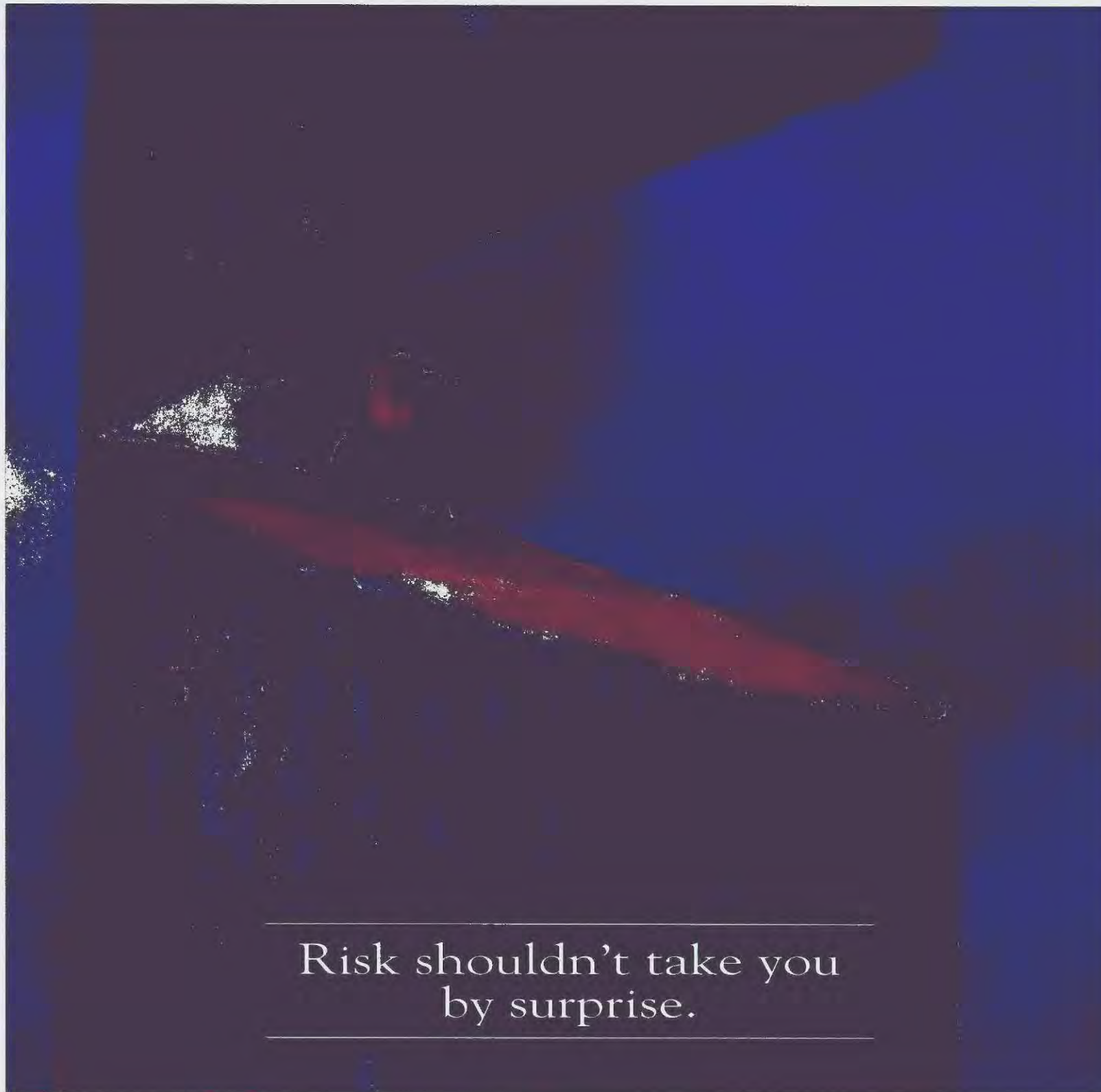
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Marketing efforts derailed by myths: Clancy

By SARA MARLEY

SANTA FE, N.M.—Marketing myths are hurting American business, says a marketing expert.

"American business is in trouble—and the problem is not Japan," said Kevin Clancy, former chairman of Yankelovich Clancy Shulman in Boston. "Marketing, in practice, doesn't work nearly as well as it should."

Problems in American marketing are due in part to the reliance on myths, Mr. Clancy said last month at the annual meeting of

the Insurance Marketing & Communications Assn.

One myth, he said, is that high-volume buyers are the best prospects. In reality, the largest consumers tend to be price conscious and disloyal because they are constantly courted by competitors, Mr. Clancy contends.

A related marketing myth is that the middle market is



Mr. Clancy

shrinking, he said.

"The middle market is thriving," Mr. Clancy countered. Those consumers tend to be practical and look for value and quality. They avoid status symbols and are open to new products, he said.

Another myth is that whether or not consumers like a company's advertising is irrelevant, so long as the advertising is memorable.

"The attitude toward advertising is the best predictor of success," Mr. Clancy said.

Advertising helps shape a company's reputation. "Buying decisions are based on the reputation

of a corporation," Mr. Clancy said. "A well-done corporate reputation has a payoff."

'Marketing efforts are rarely successful,' says Mr. Clancy, noting that 80% of new products fail.

A company's compelling, attention-grabbing message also must be backed up with enough media exposure to break through

the clutter of information the consumer receives, Mr. Clancy noted.

In addition, marketing campaigns must be monitored after they are introduced.

"Marketing and advertising are more science than art," Mr. Clancy said. "You don't have to rely on mythology."

Because of reliance on these myths, "entire industries are failing. Product categories are overcrowded. Once-dominant players are slipping," Mr. Clancy said.

Companies also are not cultivating the growth of their core products. The 1980s were more about shuffling assets than a true business boom, Mr. Clancy said. Many losses, including losses in the insurance industry, were "hidden within consolidated business reports," Mr. Clancy claimed.

"For the average company, take away the mergers and acquisitions, and the core business is limping along. There was no organic growth" in the '80s, he said.

Like other aspects of a business, marketing and advertising should show a "reasonable return on investment," he said.

But, according to Mr. Clancy, "Marketing efforts are rarely successful."

In fact, 80% of new products fail, mainly because they are not distinguished from competitors, he said. And a poorly executed marketing effort can ruin even an established product, he added.

"Most promotion is unsuccessful. You see a one-time increase in sales," but that usually occurs because the product's price is lowered as part of the total marketing effort, according to Mr. Clancy. ■

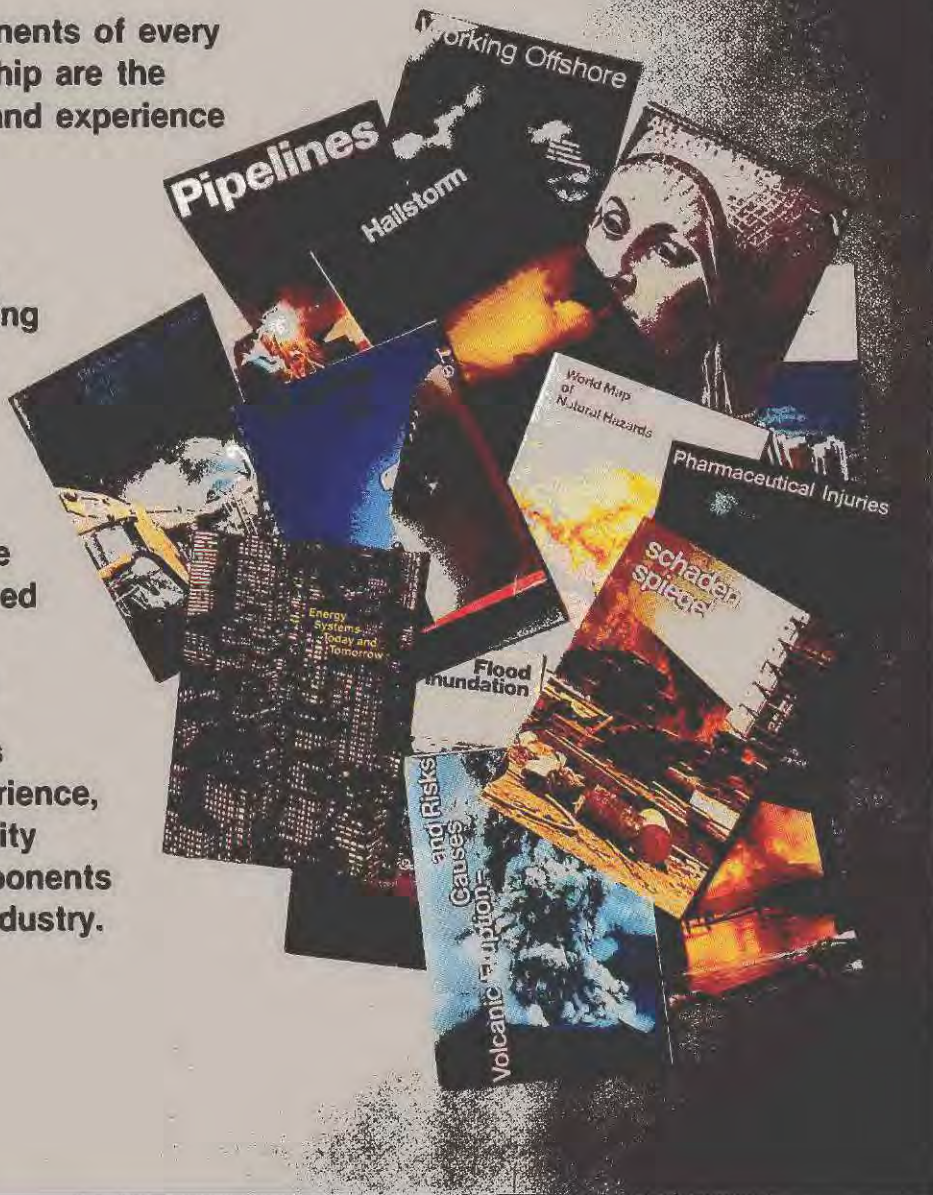
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IMCA meeting draws about 200 to New Mexico

SANTA FE, N.M.—Nearly 200 people attended the annual meeting of the Insurance Marketing & Communications Assn. last month in Santa Fe, N.M.

Boston-based IMCA is a professional association for U.S. and Canadian property/casualty insurer advertising specialists; public relations personnel; and marketing, communications, sales promotion and research professionals.

Among the experts who conducted presentations on advertising and marketing were advertising consultant Stavros Cosmopoulos; Kevin Clancy, former chairman of Yankelovich, Clancy, Shulman; and Richard Calderhead, president of the New York-based Calderhead & Phin advertising agency.

IMCA's winter meeting will be held Jan. 16-19, 1993, in Jacksonville, Fla. For more information, contact Executive Director William T. Hadley at 148 State St., Suite 305, Boston, Mass. 02109; 617-266-8400; fax: 617-236-1177.



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Insurer Topics

Interactive media

Continued from previous page
 Instead, they will make greater use of interactive television, which can respond 24 hours a day to viewers' service and information requests, Mr. Emerick predicted.

Robert N. Paltos, national sales manager for Prodigy Service Co. of White Plains, N.Y., explained how electronic interactive media works and what it means to marketers.

Prodigy, which operates an online information service marketed largely to home computer users, is a joint venture of International Business Machines Corp. and Sears, Roebuck & Co.

Home computers are "starting to dominate" the affluent households that financial products marketers wish to reach, he said.

Households that subscribe to the Prodigy service, for instance, have an average annual income of \$74,000, he said. The average user is 38 to 39 years old and much better educated than the public as a whole: 96% of users have college degrees, he said.

Though they don't have much time, these people are "constantly bombarded" with information, he said. Illustrating the overwhelming proportion of that bombardment, Mr. Paltos said that a single weekday edition of The New York Times contains as much information as the average 17th century Englishman had to absorb in a lifetime.

Interactive media can make life easier for the type of people Prodigy seeks as customers, he said. If time-crunched professionals can avoid lines by shopping or banking by home computer, they will.

At the same time, interactive electronic media allows them to pick and choose what they want to do or read, he said. If they want to read news headlines or access an electronic encyclopedia, if they want to play a game or exchange messages with other subscribers, they can do that.

Mr. Paltos pointed out that

Volkswagen of America Inc. currently allows Prodigy users to schedule maintenance or to request information about new car models through their computer terminals. "What is to prevent the possibility of insurance companies and agents doing what Volkswagen is doing on the system today?"

For marketers, interactive media is not just another approach to advertising.

Interactive media also can generate sales leads by tracking subscribers who electronically request information on a product and can also provide next-day research results, Mr. Paltos said.

He said these functions will become increasingly valuable as the size of Prodigy's subscriber base increases to an estimated 2 million by the end of this year and to an estimated 10 million within the next few years.

"You're looking at a subscription base larger than the Sunday editions of The New York Times and Los Angeles Times," said Mr. Paltos. "Interactive technology is going to allow you a great deal of opportunity to target and choose your customer base."

He predicted that other communications companies, such as American Telephone & Telegraph Co., will soon enter the interactive marketing marketplace.

However, as interactive marketing becomes more commonplace, some people will rebel against it as an invasion of privacy, predicted Taurus' Mr. Emerick. They will see Orwellian overtones in having their personal buying decisions monitored.

"I think we'll have a privacy backlash," said Mr. Emerick.

However, that backlash will probably be short-lived, he said.

People want individualized information, Mr. Emerick observed. Otherwise, they get overwhelmed with demands that they don't need.

"I think people will give up information to get information," he said.

The art of public relations

Homework pays off when firm wins rights for its client to use Ansel Adams photo

By MARK A. HOFMANN

BRIDGEPORT, Conn.—Some pictures are worth more than a thousand words.

And more than a thousand words often are required for a public relations firm to get the rights to use certain pictures to illustrate clients' promotional materials.

But for Mary Lee Cato and client Environmental Services Corp., the words—and cash—necessary for the right to use an Ansel Adams photograph on a corporate brochure represent time and money well spent. Mr. Adams, who died in 1984, was an internationally acclaimed photographer and environmentalist.

ESC, a Reston, Va.-based environmental consulting firm that provides risk management services both to insurers and to policyholders, became the first corporation to receive the right to use an Ansel Adams photograph in its material, according to Ms. Cato, president of Cato & Newby Inc., a Bridgeport, Conn.-based public relations firm. The Ansel Adams Publishing Rights Trust is "extremely protective" of the late Mr. Adams' work, Ms. Cato said.

Ms. Cato said that after reviewing other possibilities, she and ESC officials decided to pursue permission to use an Adams photo.

"Frankly, we had no idea it could be done," according to Ms. Cato.

Ms. Cato said she thoroughly researched Mr. Adams' life and times. "We read every book by Mr. Adams—and he was a prolific writer. We studied his philosophies, his life, his family and his friends. We even knew he had a cat named Tommy when he was 9 years old," she said.

Ms. Adams said she also discussed the matter with art museum officials she knew and even printers who had worked with Mr. Adams in the 1970s.

"Still believing that Mr. Adams' work was off limits to the business community, we wrote a letter to the Ansel Adams Publishing Rights Trust requesting permission," Ms. Cato said.

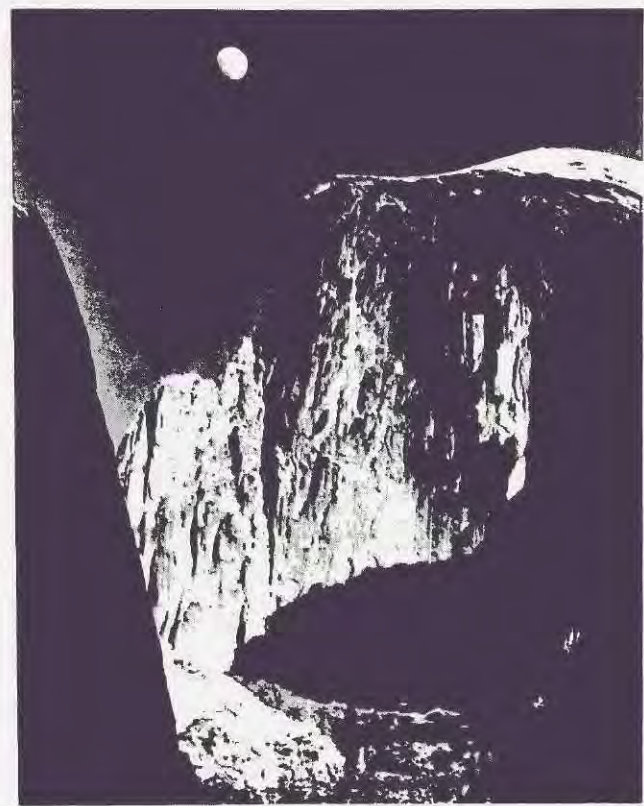
The letter explained what ESC does and why the corporation thought it was appropriate to use an Adams photograph.

To her surprise, Ms. Cato heard from the Adams trust within a day. ESC could select any photo it wished—for a fee. Ms. Cato would not disclose how much ECS had to pay for the rights to use the photo.

ESC chose a photo titled "Moon and Half Dome, Yosemite Valley, 1960" for the brochure cover. The brochure appeared last November.

The Adams cover has generated a considerable amount of positive comment, according to Ms. Cato.

"They've gotten a lot of feedback. It was well-received even in Japan," she said. One Japa-



ESC

Cato & Newby won approval for a client to use this Ansel Adams photo.

nese insurer ordered several hundred of the brochures, she noted.

Ms. Cato said that her client and the Adams photographs were a good mesh, given the nature of ESC's work and Mr. Adams' commitment to environmental protection. She said that use of the Adams photograph emphasized the "perfection" that both the photographer and the consultant bring to their endeavors.

"Was it a matter of being in the right place, at the right time, representing the right client?" asked Ms. Cato. Although those factors obviously played a role in getting permission to use the Adams photograph, Ms. Cato believes that had the public relations firm not done its homework, or if the firm had not been able to show that ESC works to improve the quality of the environment, the request would have been denied.

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Business Insurance

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Moon and Half Dome, Yosemite Valley, 1960, by Ansel Adams. © 1991 by the Trustees of The Ansel Adams Publishing Rights Trust. All rights reserved.

Defense firms

Continued from page 3
ference committee.

The House defense spending bill amendment would apply to employers that had \$100 million in defense contracts on average between 1989 and 1991. These contractors would have to provide two new special early retirement benefits to workers with at least 10 years of service at the time of layoff or termination and either were 55 years old or would be 55 by Dec. 31 of the year following termination.

Those benefits would include a full pension benefit without any actuarial reduction for early retirement and a \$500 supplemental benefit payable each month until the worker reaches age 62.

No one knows exactly how many employers and employees would be affected by the legislation, but the number could be substantial.

The Defense Department reports that the 100 largest defense contractors in fiscal 1991 each had well in excess of \$100 million in defense contracts, ranging from a high of \$8 billion to a low of \$142 million. These 100 firms held a total of about \$85 billion out of a total of \$136 billion in defense contracts in 1991.

No congressional estimates have been made of the cost to defense contractors of having to offer enriched early retirement benefits to laid-off or terminated older workers.

But benefit lobbyists and consultants say the cost to defense contractors would easily run in the tens of millions of dollars and perhaps exceed hundreds of millions of dollars.

"It would be extraordinarily expensive," said Mark Ugoretz, president of the ERISA Industry Committee in Washington.

"It will cost the defense industry mega-bucks. It would be a new, big cost coming at a time when a company could least afford it," agreed Michael Johnston, a consultant in the Cleveland office of Hewitt Associates.

For example, a worker entitled

to the special \$500 monthly supplement beginning at age 55 would receive up to \$42,000 in new benefits by the time he or she reaches age 62.

And that would come on top of a pension benefit that will not be reduced for early retirement. This could cost employers tens of thousands of dollars per terminated employee, benefit consultants estimate.

"A full subsidy down to age 55 costs a fortune," said Henry Saveth, a principal with A. Foster Higgins & Co. Inc. in New York.

The potentially huge cost of the early retirement amendment poses other problems for employers.

For example, because the amendment does not cover contractors with less than \$100 million in defense contracts, big contractors would be at a competitive disadvantage compared to smaller contractors.

At the same time, adding these pension liabilities could increase the premiums a defense contractor pays to the Pension Benefit Guaranty Corp., the agency that guarantees workers' and retirees' basic pension benefits.

Employers with fully or overfunded pension plans now pay an annual PBGC premium of \$19 per plan participant. But employers with underfunded plans pay as much as \$72 per plan participant. The exact amount depends on a plan's funding level.

Taking on this new pension liability could cause a plan to drop down to an underfunded position, thus increasing its PBGC premiums, said Henry Anderson, a consulting actuary at Buck Consultants Inc. in New York.

Correspondingly, the PBGC, already staggering under a \$2.5 billion deficit, would face the risk of being hit with even larger losses if a defense contractor with an underfunded plan collapsed.

Benefit lobbyists also note that enactment of the legislation would be yet another disincentive for an employer—at least big defense contractors—to offer a defined benefit pension plan.

that cleanup payments may ultimately exceed \$1.1 billion.

"The Pentagon has ignored a massive liability and is allowing its contractors to charge the American taxpayers for the cost of cleaning up environmental messes at defense plants across the country," said Rep. Conyers, who is chairman of the House Government Operations Committee.

"The Department of Defense is not a welfare agency. If these contractors can make billions in profits while polluting, they should also pay for the cleanup," he said.

Contractors are getting a "sweetheart deal," said Rep. Boxer.

The Defense Department currently has no system for identifying past and future environmental cleanup costs for which contractors may seek reimbursement. Both representatives called on Defense Secretary Richard Cheney to begin collecting data on these costs.

The GAO report did note that the Defense Department already has begun working on "more effective oversight" of costs, including cleanup costs, charged to the government.

—By Mark A. Hofmann

While all defense contractors covered by the legislation would have to offer the \$500 monthly supplemental benefit to eligible workers, it only would apply to defined benefit plans.

"This sends another signal to employers that they should not sponsor defined benefit plans,"

'There is a real question of equity here,' says Manuel Castells of Kwasha Lipton.

said Mr. Ugoretz of the ERISA Industry Committee.

Benefit lobbyists also say the legislation could cause morale problems at companies that employ workers on projects under defense contracts and employees not working on defense projects.

"How does an employer communicate that some workers—because they work in one unit—will be eligible for a windfall? It will cause enormous resentment," said Lynn Dudley, senior legislative analyst at the Washington-based Assn. of Private Pension & Welfare Plans.

"There is a real question of eq-

uity here," said Manuel Castells, a partner at benefit consultant Kwasha Lipton in Fort Lee, N.J.

As often is the case with measures affecting employee benefits, legislators approved the Frost amendment without committee hearings and with virtually no discussion on the House floor.

The provision—buried at the tail end of the 628-page Defense Authorization bill—escaped the scrutiny of employer benefit lobbying organizations until earlier this month.

Benefit lobbyists say defense contractors should not be the ones who have to pick up the social welfare costs of the reduction in defense spending.

"The government's inability to prepare properly for the impact of the peace dividend is resulting in cost shifting onto a very narrow group of employers. Costs are being passed onto defense contractors who had no control over government policy to wind down defense spending," ERIC's Mr. Ugoretz said.

Benefit lobbying groups are sending out special legislative alerts urging their members to lobby against the proposal. Among those groups are the ERISA Industry Committee and the APPWP.

"It is another example of gov-

ernment shifting more benefit costs to employers," said the APPWP's Ms. Dudley.

Defense contractors also would face higher health care continuation costs under legislation introduced in the Senate.

The legislation, S. 2906, introduced by Sen. Claiborne Pell, D-R.I., would require defense contractors with more than \$15 million in defense contracts annually to pay at least 50% of COBRA health care continuation premiums for up to one year for workers who are laid off.

Under the health care continuation provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, employers can require COBRA beneficiaries to pay 102% of the health care premium.

But, employers complain that the premium beneficiaries pay for coverage does not come close to covering its cost. That is because those individuals who are most likely to opt for coverage are those who anticipate using medical services.

For example, in a National Assn. of Manufacturers survey, 50% of respondents said they paid out \$1.90 in claims for every \$1 they collected in premiums from COBRA beneficiaries during the first half of 1990, up from \$1.67 in 1989.

Pension tax affects hardship withdrawals

WASHINGTON—A new federal law that imposes a 20% federal withholding tax on certain pension distributions will have an even greater impact than initially thought.

As earlier reported, the law, which expands unemployment benefits, will require employers, at the request of a terminating employee, to directly transfer pension distributions, like those from profit-sharing plans, to an Individual Retirement Account or to a defined contribution plan offered by the individual's new employer (BI, July 13).

While terminated employees would have to request these transfers, employers would have to inform employees of their options.

Unless the distributions are transferred to an IRA or a new employer's plan, a 20% withholding tax will be imposed.

Benefit experts now say that the withholding tax will not be restricted to termination of employment situations. The law clearly also applies to active employees who want to make hardship withdrawals from their 401(k) plans.

Internal Revenue Service hardship rules let employees make in-service 401(k) plan withdrawals for certain specific reasons: to make a down payment on a house; to cover uninsured medical expenses; or to pay for a child's educational expenses.

It isn't uncommon for 5% to 10% of 401(k) plan participants to request such withdrawals each year, benefit consultants say.

With a 20% withholding tax in effect, employees will have to request larger withdrawals to meet financial needs, noted Frank Roque, a consultant with Hewitt Associates in Lincolnshire, Ill.

"Employees will have to withdraw more to get the same amount of money" as they now would receive without the withholding tax, Mr. Roque said. The withholding tax will apply to distributions made after Dec. 31.

Hardship withdrawals are taxed now, including a 10% special tax on distributions to employees under age 59½. But the taxes aren't due until an employee files an income tax return.

That gives employees the ad-

vantage of the "float"—the time between when the funds are received and when the taxes are due—notes Marjorie Martin, vp and director of Noble Lowndes' information center in Roseland, N.J.

There may be one way for employees—with the cooperation of their employers—to avoid the 20% withholding tax on in-service hardship 401(k) distributions, benefit consultants say.

An employer could transfer the hardship distribution to an employee's IRA, and the employee could then withdraw the funds, they say.

But other benefit consultants question whether such a technique would pass muster with the IRS.

"It doesn't seem to pass a 'smell' test," said Henry Saveth, a principal with A. Foster Higgins & Co. Inc. in New York.

The IRS could say the distribution was to avoid the withholding tax, not to meet financial hardships for which in-service withdrawals are allowed, Mr. Saveth said, adding that the IRS needs to clarify the issue.

—By Jerry Geisel

GAO finds defense contractors billed U.S. for cleanup obligations

WASHINGTON—Two representatives are calling on the secretary of defense to gather data on defense contractors' past and estimated future pollution cleanup costs.

This action follows a report indicating that the federal government will reimburse the companies for more than \$1 billion in cleanup costs.

The Department of Defense has already paid four defense contractors a total of \$59 million for waste site cleanup since 1984, the General Accounting Office found.

The actual reimbursements ranged from \$500,000 to \$51.8 million, according to the GAO report, which was prepared at the request of Reps. John Conyers Jr., D-Mich., and Barbara Boxer, D-Calif.

According to the GAO, defense contractors have billed Superfund cleanup work to the government, because federal contracting rules do not deal with such charges. The Superfund law is formally known as the Comprehensive Environmental Response, Compensation & Liability Act of 1980.

So far the payments have covered only a handful of Superfund sites. But the GAO projects

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Olympic cover

Continued from page 3
market. About 60% of the coverage was placed in the London market and 40% elsewhere in Europe.

Gras Savoye and J&H also will be brokers for the XVII Winter Olympic Games in Lillehammer, Norway, in 1994, and are bidding for a role in the 1996 Summer Games in Atlanta.

The TV rights insurance—which has limits of 15 billion pesetas, or about \$150 million—has three layers: a \$50 million primary layer, a \$50 million layer excess of \$50 million; and \$50 million excess of \$100 million.

It covers loss of revenues from broadcasters due to both the cancellation of the entire Olympics and cancellation of particular events. However, the \$150 million in limits is much less than the \$500 million value of the TV contracts.

"Everybody thinks total cancellation is crazy," said Mr. Vajda, explaining why the sum insured is less than the contracts' worth.

Those include a contract for about \$400 million with General Electric Corp.'s National Broadcasting Co. unit. The organizing committee's other TV contracts are with NHK International of Japan, the European Broadcasting Union and television networks in Canada, Australia and New Zealand.

"We placed the TV insurance policy five days before the outbreak of the Gulf War, so we got lower rates," said Mr. Parrizas.

The general liability coverage has a limit of \$100 million or about 11 billion pesetas. It covers claims against third parties—including spectators, coaches, sponsors and subcontractors—and product liability claims for souvenirs sold by the Olympic committee.

This coverage was placed three years ago, said Mr. Parrizas.

The property coverage, he said, comes in two varieties: electronic equipment, which has a limit of 5 billion pesetas (\$53 million); and non-electronic equipment, which has a limit of 2.5 billion pesetas (\$26.5 million).

Accident and medical insurance has a limit of 5 million pesetas (\$53,000) per person for the so-called Olympic family—athletes, coaches, organizers and sponsors—and 2.5 million pesetas (\$26,500) per person for spectators.

"If you are a member of the Olympic family and you have an accident in Barcelona, all your medical and hospitalization expenses will be paid for by the organizing committee," said Mr. Vajda. In case of emergency, everyone will receive free medical treatment. If need be, members of the Olympic family will be transported home at the expense of the organizing committee.

Mr. Vajda said the most important innovation in these Olympics has been the protection of the computer system. "It is top secret, but if the computer system does not function, nothing can proceed."

Electronic technology develops as rapidly as the knowledge of anyone who might want to sabotage the system, he said. "So every four years, you have to reinvent the

protection."

Protection also will be a top priority in and around the Olympic village.

According to Spanish press reports, some 1,000 security plans for the Summer Games will be coordinated from a specially constructed, windowless center near the Olympic village. Guarded inside and out, it has been dubbed the "Olympic bunker." A hotline puts the center in instant communication with Spain's Prime Minister Felipe Gonzalez.

Overall Olympic security is headed by Spain's secretary of state for security, Rafael Vera.

Throughout the Games, all of the Spanish security services will be on duty. The National Police will deploy 18,000 officers around the village and nearby sports centers; 6,000 members of the Civil Guard will work further afield. Four Civil Guard submarines will patrol coastal waters within 12 nautical miles of shore; as many as 1,000 members of the Mossos D'Esquadra, the autonomous Catalanian

police force, will guard particular individuals and buildings within the province; 4,500 agents of the Urban Guard of Barcelona will be used for traffic duty and coping with crime in the streets and against tourists; and 3,500 specially sworn-in guards will act in a support function for the National Police at entrances to the Olympic stadiums.

In addition, the Spanish press reports that the army will patrol railway lines and passes through the Pyrenees Mountains and the French border, as well as strategic centers like dams, electrical installations, telecommunications centers and railway stations.

The air force will be coordinated from its base at Zaragoza and will run air traffic control for the El Prat airport. Two planes will be kept on permanent standby in the event of a terrorist attack. Sixteen naval vessels will patrol the coast from 12 to 200 nautical miles offshore and, in case of emergency, will be authorized to intervene farther out at sea.

U.S. team covered by Blues

By SALLY ROBERTS

BARCELONA, Spain—Members of the U.S. Olympic Team who sustain injuries in this summer's XXV Olympiad will once again be covered by Chicago-based Blue Cross & Blue Shield Assn.

More than 850 athletes, coaches, physicians and trainers participating in the 1992 games will be covered under BC/BS's Olympic sponsorship agreement.

A fund-raising campaign launched by BC/BS last year will raise \$1.5 million to help cover the costs of the participants' insurance. In addition to covering the participants in the Summer Games, the campaign helped fund health insurance for the approximately 320 U.S. participants in the 1992 Winter Games in Albertville, France (BI, Feb. 3).

The effort also raises money for BC/BS sponsorship programs for Olympic athletes.

BC/BS became an official sponsor of the U.S. Olympic Games in 1985. The BC/BS contract with the U.S. Olympic Committee provides each delegate with first-dollar health coverage with a \$1.5 million maximum benefit, a BC/BS spokesman said.

The 1992 Summer Games run from July 25 through Aug. 9. Coverage for the team members begins when they sign in at the Olympic Village in Barcelona and will stop when they sign out.

The coverage is underwritten by Denver-based Rocky Mountain Life Insurance Co., a unit of BC/BS of Colorado, which jointly administers the coverage with BC/BS of South Carolina.

The BC/BS plan also will act as a secondary health plan for those team members who have their own health insurance through an individual plan or an employer-sponsored plan, the spokesman added.

In addition to covering the Olympic delegation, BC/BS also covers the staff of the U.S. Olympic Committee in Colorado Springs, Colo., he said. Under the coverage, employees pay no deductible or copayment if they use providers in the BC/BS pre-

ferred provider organization. Otherwise, there is an annual deductible of \$100 per person and \$300 per family. Above that deductible, employees pay 20% of all health care received outside the PPO up to \$2,000, he said. The coverage has a lifetime maximum of \$1.5 million.

BC/BS's plan does not include dental coverage or accidental death and dismemberment coverage, he added.

The 1988 Winter and Summer Games resulted in claims for six injuries, he said, but he could not comment on the nature or size of those claims.

In addition to providing insurance, BC/BS also supports young athletes who need financial help through the "Adopt an Athlete" program. While the athletes, in return, make appearances for BC/BS plans, the main reason for the program is to support the Olympic Games, the spokesman said. "It's more than merely money; there's personal involvement."

About 50 athletes from both the Winter and Summer Games are involved in the "adoption" program, the spokesman said.

To avoid jeopardizing the athletes' amateur status, BC/BS coordinates athletes' appearances and sponsorships through the national governing bodies of the sports in which they compete, he added. Athletes are required to have amateur status to compete in the Games.

The \$1.5 million to be raised is \$1 million short of the BC/BS 1988 Olympic fund-raising effort that brought in \$2.5 million.

"This is the way negotiations came out," said a BC/BS spokesman. "We are still very much involved with the Olympics," he added, "but it's not the formalized event fund-raising we did" in 1988. Instead, BC/BS participated more in the fund-raising efforts of the Olympic Committee itself.

According to the U.S. Olympic Committee, the winter and summer teams brought home 94 medals in 1988, including 36 gold, 31 silver and 27 bronze.

Reliance National and FHP offer managed 24-hour cover

FHP Inc. and the Risk Management Services division of Reliance National Insurance Co. have teamed up to offer a 24-hour managed care program.

The program will integrate workers compensation and group health coverage to provide continuous, coordinated health care for employees.

FHP, a health maintenance organization based in Fountain Valley, Calif., and its subsidiaries will underwrite the benefit coverages and Reliance National will underwrite the workers compensation coverages. FHP will administer and manage the program.

The program will focus on managing the medical costs associated with workers comp claims much like they are managed for group health claims, an FHP spokeswoman explained. FHP will provide occupational nurses who, much like primary gatekeeper physicians in a traditional HMO, will make sure injured workers follow a doctor's prescribed recuperation plan and return to work as quickly as possible, she explained.

FHP decided to team up with New York-based Reliance National following the success of its 24-hour managed care program in California. Because FHP wanted to introduce 24-hour coverage in other states, it sought a national insurer as a partner, the spokeswoman said.

Insurance Co. of the West, a San Diego-based insurer, will continue to underwrite workers comp coverages for FHP's 24-hour program in California.

New business in other states will be handled by Reliance National, she said.

Baxter spinoff

Baxter International Inc.'s board of directors has agreed in principle to spin off its alternative-site health care services divisions.

Caremark Inc., the orthopedic services division and the prescription service division will operate under the Caremark name as a free-standing company with publicly traded stock.

Baxter plans to complete the separation by the end of the year.

Markets

Caremark will provide products and services for home health care, AIDS care, women's health care, physical therapy and prescription services. Sales for these businesses exceeded \$1 billion in 1991 and have been growing more than 20% a year for four years, according to Baxter.

Baxter's renal therapy business is not included in the spin-off.

The new company will be headed by C.A. Piccolo, executive vp of Deerfield, Ill.-based Baxter.

Stop-loss insurance

The Travelers Cos. has begun marketing stop-loss insurance for small to medium-sized self-funded employers through VASA Brougner Inc.

The Indianapolis-based stop-loss reinsurance underwriting agent is wholly owned by VASA North America, a U.S. subsidiary of WASA Insurance Group of Sweden.

Travelers hopes to increase its share in the market for small- to midsize-employers. Travelers stop-loss business currently is limited to groups of 100 lives or more.

The coverage limit is \$1 million, over various retentions.

Travelers has received approval to write coverage through VASA Brougner in 35 states. Approval for the remaining states is expected within 60 to 90 days, a Travelers spokesman said.

As part of the deal, VASA Brougner clients will gain access to ConServCo, a utilization management firm owned by Travelers.

Boiler reinsurance

Hartford Steam Boiler Inspection & Insurance Co. has entered into an agreement with Home Insurance Co. of New York to provide boiler and machinery reinsurance and engineering services to The Home's policyholders.

Effective July 1, Hartford Steam Boiler reinsured Home's existing portfolio of boiler and machinery business.

JULY CLOSINGS

issue: July 20
closing: July 8
demographic section: Insurer Topics: Marketing/Advertising & Sales Promotion

issue: July 27 — Reader Service
closing: July 14
editorial feature: Risk Management: Systems & Analysis
Directory: Risk Management Information Systems

issue: August 3
closing: July 22
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Business Insurance
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Protecting buyers' needs

State regulators must give policy form changes greater scrutiny

By Jon Harkavy

I WAS REMINDED of Yogi Berra's line, "It's deja vu all over again," after reading the Feb. 10 article, "Defense Cost Wording Triggers CGL Dispute."

As a former general counsel to the Risk & Insurance Management Society Inc. who has had numerous tiffs with the Insurance Services Office Inc. on policy form modifications, I've seen this process play out in an utterly predictable fashion.

Should a controversy over this latest modification develop, look for these renditions of "ISOspeak":

• "Such coverage was never afforded by the CGL."

Isn't it incredible that an organization totally funded by its insurer members is given serious credence as a legitimate arbiter to what coverages are excluded or included within the CGL? A more suspicious person than myself might think that an organization would rewrite drafting history or intent in a manner beneficial to the cause of its own members. What is a language clarification to ISO invariably represents a loss of coverage to the policyholder.

• "ISO never intended to offer such coverage under the CGL."

Translated into Realspeak, this bit of ISOspeak would go something like: "We didn't draft the original policy language as tightly as we should have and the courts are actually construing all the ambiguities against the insurer. Let's blame the courts for social engineering, promulgate exclusionary modifications which will get our members off the hook, and magnanimously draft endorsements which our insurers can either ignore or charge additional premiums for."

The process of promulgating common policy forms, which is supposed to be safeguarded... through adequate state supervision, in reality often has no state oversight at all.

• "The public will be better served if policyholders that need such coverage can obtain it through separate endorsements."

This is ISO's variation of "Let's kill the patient to cure the disease." ISO will maintain that insurers could not continue to provide a particular coverage without raising the premiums for those policyholders that may not need or want such coverage.

There are numerous problems with this facile argument. About the only time a policyholder knows that he or she needs or wants the coverage in dispute is after a loss occurs. Moreover, when ISO is asked what reductions in advisory rates will result from eliminating a coverage afforded under the CGL policy, the ISO representative will opine in indecipherable "actuarialese" as to why such a determination cannot be made for at least 10 years.

If ISO has no firm quantitative idea as to potential losses attributable under old CGL policy language, how can it assert that the cost of providing such coverage cannot or should not be borne by all policyholders?

Furthermore, how then can ISO's members be expected realistically to price an endorsement which provides the deleted coverage? In short, about the only moment of candor I've seen in this process is when ISO changed the title of its "comprehensive general liability" policy to "commercial general liability" in the mid-1980s.

This is a process run by insurers for insurers with

Speaking out

ISO as the illusory buffer. Unfortunately, the institutional safeguards built into the system to protect consumer interests often have to be kicked out of hibernation.

Let's face it, except for a brief stint during the insurance crisis of the mid-1980s, the commercial insurance consumer is little more than an afterthought to a state regulator being pilloried by the general public for high auto insurance and health care premiums.

Other than as a lucrative source of premium tax, it would seem that the only regulatory concern for commercial policyholders is to restrict their access to alternative/non-admitted markets and to deny them guaranty fund coverage.

Thus the process of promulgating common policy forms, which is supposed to be safeguarded against anti-consumer abuse through adequate state supervision, in reality often has no state oversight at all. The process of determining which changes are made to the CGL policy inevitably reflects insurance company input, but not that of the policyholder, regulator or general public.

Once the modifications are promulgated by ISO, they generally sail by state insurance departments either through "file and use" or through the most perfunctory review process. On occasion, the National Assn. of Insurance Commissioners can be galvanized into action, but rarely on its own initiative, since it takes a wakeup call from the producer and buyer communities to get the NAIC to undertake a critical review of proposed CGL modifications.

I find it astounding that Congress, within the scope of McCarran-Ferguson Act reform efforts, has so singularly focused its efforts on the red herring of advisory rates rather than on the more substantive issue of policy forms. ISO's advisory rates have about as much impact as the sticker price on a U.S. automobile; they provide a benchmark, but no one pays that price.

On the other hand, the impact of policy coverage goes on long after the premium terms have been negotiated. What good are low premiums if the coverage is less than adequate? Premium rates go up and down; coverage, once it is lost within the corpus of the CGL, is seldom made available to policyholders again.

Even in the alternative insurance market, changes in policy forms have a significant impact, due to the need to "follow form" in excess and reinsurance transactions. In short, the insurance buying public faces a far greater danger of collusion from the current system of policy from promulgation than it does from the setting of advisory rates.

It was not coincidental that the federal antitrust suit filed against ISO and other members of the insurance industry by state attorneys general, as well as state suit by the Texas attorney general, revolved not around rate setting, but rather policy form promulgation.

Let me make it clear at the outset that the process of developing standardized policy forms is vital to the insurance industry and general public; indeed, that is why I am so determined that the integrity of the process be strengthened.

Without standardized policies, policyholders would be faced with bewildering confusion as to what coverage they were actually securing, making it most difficult to shop insurers. Gaps in excess/umbrella coverage for policyholders would increase without policy form standardization; reinsurance placements affecting insurer solvency could be affected as well.

While policy form standardization must be

maintained, the level of consumer-oriented oversight must be raised considerably. The NAIC does not appear to have any institutionalized mechanisms to review proposed ISO policy form changes; instead it has to be dragged into the fray by the buyer or producer communities.

Perhaps even more important, the NAIC rarely exercises its input as to where ISO's energies should be devoted as to future CGL modifications. As a result, the proposed changes invariably reflect only the concerns of insurance companies rather than the needs of consumers.

Except for a brief stint during the insurance crisis of the mid-1980s, the commercial insurance consumer is little more than an afterthought to a state regulator.

For instance, in an all-too-rare example of regulatory resolve, ISO has been rebuffed several times during the past several years in its call to put defense costs within policy limits. Not surprisingly, in its latest CGL modification, ISO would put third-party contractual liability defense costs within policy limits, through use of an optional endorsement.

Could this be a back door attempt to secure eventual regulatory acceptance of defense costs within policy limits through a piecemeal approach? If you control the process and the agenda, you eventually get your way. Expressed a different way, even a .175 hitter will get a hit if given enough swings.

The NAIC must therefore do more than increase its scrutiny of ISO proposals; it must seek also to guide and direct ISO's efforts so that future proposed CGL modifications reflect policyholder as well as insurer needs.

ISO must make a concomitant effort to reform itself internally. As a former association person, I realize that the first instinct of survival is to satisfy your members. However, ISO, operating under a general exemption from antitrust laws, must serve the general public as well as its insurance company members.

Pressured by antitrust suits against it, ISO has made an effort to add several "public interest" members to its board.

The two directors added were safe choices; well known inside the Beltway and respected in their fields, but with little or no insurance background. As a result, there is no ombudsman within ISO to effectively counterbalance the expected institutional bias in favor of insurers. One can be knowledgeable about insurance without being tied to insurers; there are many individuals in the risk management and producer communities who would become viable consumer advocates without fear of incurring the wrath of insurers.

My guess, however, is that ISO is afraid to have an informed critic, much less consumer advocate, in its midst. Such short-term thinking is counterproductive, for ISO's credibility would be greatly strengthened if it truly recognized its obligation to the insurance buying public as well as to its insurer members. ■

Jon Harkavy is vp and general counsel of Vermont Insurance Management Inc., an independent captive management firm in Arlington, Va. He served as the general counsel and director of governmental affairs at the Risk and Insurance Management Society Inc. from 1982 to 1989.

Self-insurer claims handling

By Alan Jay Kaufman and Mary K. Kator

IN AN EFFORT TO LOWER insurance costs and maintain more control over litigation decisions, an increasing number of corporations are choosing to become self-insured. These corporations are taking over the claims handling role of primary insurers and are learning that one aspect of this role is dealing directly with excess insurers. In this new relationship, the rights and duties of self-insurers increasingly are the subject of debate and, inevitably, litigation.

The courts have not yet established the roles and responsibilities of self-insurers in their relationship with excess insurers. One of the key questions is: Are self-insured corporations held to the same responsibilities as primary insurers? The verdict is still out.

Two of the biggest controversies that have arisen with self-insurers are the duty to notify excess insurers of litigation, especially of potentially large claims, before an excess verdict is rendered, and the duty to settle cases that result in excess verdicts.

The courts have ruled that primary insurance companies must inform excess insurers of lawsuits in which the excess underwriter may end up paying damages and must settle cases if they could result in excess liability. However, they have not decided whether self-insurers have the same responsibilities to excess insurers.

This is an important issue, because a self-insured corporation's interests may be very different from those of an insurer. A corporation may decide to pursue litigation and risk potentially large damages in an effort to nip similar lawsuits in the bud. An insurer, however, may prefer to settle a case and keep costs to a minimum. As a result, excess insurers are more often at risk when a self-insured company is involved and a large verdict could result in a coverage dispute.

The key to resolving these issues is better communication between the self-insurer, its defense counsel and its excess insurers.

The seeds of these differences were planted in the late '70s and early '80s when many large companies self-insured the first layer of coverage to gain more control over claims defense. By using a combination of in-house and outside counsel, self-insurers gained direct control over the claims handling process, from deciding on litigation strategy to authorizing settlement.

As the market softened and experience with self-insurance increased, excess insurers became more willing to underwrite coverage above a new self-insured layer. This arrangement has not been without its share of problems, largely because some policyholders may not be aware of the expectations of excess insurers, particularly the duty to give timely notice of potentially large claims and the duty to settle those claims in good faith.

The purpose of notice to excess insurers is threefold:

- To give the excess insurer an opportunity to investigate the facts and circumstances affecting the question of liability and the extent of such liability.
- To give the insurer the opportunity to evaluate claims and to defend against fraudulent, invalid or excessive claims.
- To give the insurer the opportunity to explore settlement possibilities to reduce or eliminate its exposure.

Late notification of claims is the main problem excess insurers face with self-insurers. Unlike primary policies, excess liability policies do not require that the policyholder give notice of every case. Instead, the obligation to give notice is often triggered by the policyholder's knowledge that injuries or damages are "likely" to involve excess liability.

For example, some excess policies provide a "notice of occurrence" clause. This clause states that whenever the policyholder has information from which it may reasonably conclude that an occurrence involves injuries or damages for which it could be held liable and are likely to involve the excess policy, immediate notice shall be sent to the insurer.

Good faith advised when dealing with excess insurers

Problems often arise from the phrase "may reasonably conclude," which seems to give the policyholder the discretion to decide when notice should be given. As a result, some policyholders failed to give excess insurers notice of cases involving serious injuries because they did not believe they were likely to be found liable, only later to "get hit" at trial. These companies can get "hit" again when the excess insurer denies the claim based on late notice.

It appears that the courts will decide whether a policyholder has breached its duty to give notice based on an objective view of the facts, not the policyholder's subjective view of the merits of the case. To make this decision, the courts often will look to the evaluation of the case given by the policyholder's counsel, particularly the counsel's estimation of the policyholder's potential exposure.

A delay in notifying an excess insurer can result in no coverage, especially if the amount of potential liability was apparent at the outset. For example, in the 1989 case *Campagne Des Bauxites vs. Argonaut-Midwest Insurance Co.*, the U.S. Court of Appeals in Pennsylvania found that a policyholder's eight-year delay in giving notice of a \$23 million claim—because the policyholder had doubts about its excess coverage—warranted judgment for the insurer, which was held to have properly denied coverage.

In most cases, the amount of potential liability is not apparent at the outset, and self-insurers must decide whether the facts of the case warrant notice to the excess underwriter. When deciding whether a particular claim should be reported, a self-insurer should ask: If we lose, could the award be 25% or more of the self-insured layer?

If the answer is yes, you should inform the excess insurer. Some excess policies use 25% as the threshold for requiring notice. The threshold could be even lower in cases involving punitive damages, which can result in a verdict much higher than predicted.

For example, if a company is self-insured for \$500,000 per occurrence, and the plaintiff's injuries are unspecified back problems, the defense attorney would probably not estimate the potential exposure to exceed \$100,000. In this case, notice would not be necessary. However, if discovery reveals that the back condition has worsened to the point of total disability, or if a punitive damages claim is made, the potential exposure might increase to \$250,000 or more, and prompt notice should be given.

In most jurisdictions, a policyholder's breach of a liability policy's notice provision does not relieve an insurer of the obligation to provide coverage unless the insurer has been "materially prejudiced" by the breach.

Material prejudice occurs if the policyholder's failure to give notice to the excess insurer prevents the insurer from minimizing its exposure. For example, prejudice may occur if the late notice precludes the excess insurer from exploring the possibility of a reasonable settlement, perhaps involving a contribution from the excess layer. When the lack of timely notice prevents the insurer from making any investigation of the alleged injuries or possible defenses to liability, prejudice will be found.

A common myth among self-insurers is that excess insurers do not want notice and would not do anything if notice were given. While this is sometimes true, it is hard to prove later when coverage is denied. The best rule is: When in doubt, give notice.

Another sensitive area between self-insurers and excess insurers is whether self-insurers must settle a case that is likely to involve excess liability. Many self-insurers believe they should have the discretion

to take a case "all the way." Excess insurers, however, disagree because they may have more at stake.

Many cases have held that primary insurers have a duty to excess underwriters to settle cases in good faith to avoid excess liability. This good faith duty is usually based on the doctrine of "equitable subrogation." It allows the excess underwriter to step into the shoes of the policyholder and assert the policyholder's rights against the primary insurer for failing to settle in good faith to protect the policyholder from excess liability. Because a self-insurer acts as its own primary insurer and cannot assert a claim against itself, it appears that the equitable subrogation theory doesn't apply. Some states have used other theories to allow excess insurers to sue primary insurers, but these theories have not yet been applied to self-insurers.

There is little authority on whether a self-insurer has the same duty as a primary insurer to act in good faith toward an excess insurer. The better view is that a self-insurer has a duty to its excess insurer to settle in good faith due to their direct contractual relationship, based on the implied covenant of good faith and fair dealing, which exists in all contracts according to common law.

Despite the fairness of charging a self-insurer with the same duties as a primary insurer, one court has held that while a self-insurer has a duty to act in good faith, the duty does not extend to settling claims to protect the excess underwriter from a potential exposure. The logic of this decision is questionable, because in such a case the self-insurer acts as a primary insurer, which almost all courts agree has a duty to excess insurers to settle in good faith. Furthermore, this view would result in an excess underwriter having no basis for denying coverage regardless of how badly the case was handled.

Not every failure to settle, followed by a high verdict, means the policyholder acted in bad faith. But there are cases in which the failure to settle goes beyond bad judgment or negligence. The law in this area is still developing, and excess insurers will continue to fight for the right to deny coverage where the self-insurer has acted in bad faith by refusing to settle.

One key to avoiding potential problems is good communication between the defense attorneys and the self-insurer. The self-insurer must be aware of its potential exposure and request a thorough evaluation as early as possible and on a continuing basis up to trial. It should also request that its counsel pursue a reasonable settlement when the damages are likely to exceed the limits of self-insurance and the self-insured could be found liable.

Self-insurers must resist the temptation to approach litigation subjectively, such as by refusing to compromise "on principle" or because the company would rather "go all the way to the Supreme Court before giving the plaintiff a dime." Excess insurers have a right to expect that self-insurers will defend claims in a businesslike manner, which includes negotiating a reasonable settlement if it makes good sense to do so.

In order to avoid costly coverage disputes, self-insurers should give notice to excess underwriters whenever the plaintiff's damages might exceed 25% of the self-insured layer, or less if the excess policy notice provision requires otherwise. For notice purposes, the focus should be on the "worst case" potential exposure, not the chances of being held liable.

Self-insurers should act in good faith toward excess insurers, including attempting to negotiate a reasonable settlement in cases in which excess damages are likely if the self-insurer is found liable.

While these suggestions will not resolve all of the disputes that arise between self-insurers and excess insurers, they might help smooth the path to a better working relationship. ■

Alan Jay Kaufman is the founder and senior partner of the Detroit law firm Kaufman & Payton. Mary K. Kator is an associate with the firm.

For the Record

Workers comp rates are falling in Texas

AUSTIN, Texas—Workers compensation insurers in Texas are re-evaluating and some are lowering recent rate hike requests at the Texas State Board of Insurance's urging.

Boston-based Liberty Mutual Insurance Group, the state's largest workers comp underwriter, and Frontier Insurance Co. of New York have responded with new filings that will spare some employers higher rates.

The State Board urged workers comp insurers in a bulletin late last month to review their latest rate request after state lawmakers criticized board members for not rejecting rate increases in the wake of reforms that have reduced workers comp losses.

Insurance regulators asked insurers to reassess their rate hike requests after determining that workers comp claims costs were down 25.7% during 1991, the first full year that reforms passed in 1989 were in effect (*BI*, Dec. 18, 1989).

Liberty Insurance Co. has refiled a rate that is 15% below last year's level. The insurer's original filing sought no change.

Liberty Mutual Fire Insurance Co., another Liberty Mutual company, is asking for rates 5% higher than last year, rather than a 10% increase originally sought.

Liberty Mutual Insurance Co. did not change its original filing, which seeks a 15% increase.

Frontier has decided to leave rates at last year's level rather than seeking a 15% increase.

Kaiser to raise rates 7.1% for large HMO

PASADENA, Calif.—Kaiser Permanente last week announced that it will raise rates next year an average of 7.1% for its health maintenance organization in Southern California.

That increase for Kaiser Foundation Health Plan, which has more than 2.3 million members in Southern California, is below both the 10.6% increase Kaiser levied in 1992, and national health care inflation.

Rates for specific employers will vary depending on benefits, demographics and plan history.

A Kaiser spokeswoman attributed the smaller rate hike in 1993 to Kaiser successfully absorbing many new members in recent years. In addition, she said, many new Kaiser facilities are now up and running, which will allow the HMO network to service its own members rather than referring them elsewhere.

Mutual Benefit bailout hinges on creditor law

NEWARK, N.J.—Major life insurers and state guaranty funds have agreed to bail out Mutual Benefit Life Insurance Co., but only if New Jersey gives policyholders priority over the insurer's other creditors.

The State Senate has already passed such a measure, but the Assembly has not (*BI*, June 22).

Under the tentative plan, state guaranty funds would cover the full amount of death, disability and retirement benefits, and full account values for individual life insurance policies and tax-deferred annuities.

For other contracts, for which

coverage varies depending on state guaranty laws, a consortium of about 20 major life and health insurers would provide 100% of all credited payments, plus interest.

During the seven years the plan would be in effect, withdrawals, except in certain cases, would be severely penalized.

New Jersey Insurance Commissioner Samuel Fortunato said the plan would be filed for court approval once the Assembly passes the priority creditor bill.

The agreement is also subject to final approval by the industry consortium and the state guaranty funds it would affect. The New Jersey Assembly is due to reconvene today.

Intracorp now offering health services plan

BERWYN, Pa.—Health care cost containment company Intracorp is offering its utilization review clients a new service to help employees better manage their personal health.

The Berwyn, Pa.-based unit of CIGNA Corp. will offer employers a Personal Health Management program as an add-on to existing Intracorp UR services. The program is designed to help employers better control health care costs by giving employees the information and support they need to become more responsible health care consumers.

Under the program, which begins Jan. 1, employers can add many new services, including educational materials like health-related literature and videos and self-care guides.

Employees and dependents also can receive individual telephone counseling and referral service information from professional nurses. Employees can reach the nurses by dialing the same toll-free number they use for Intracorp's UR program.

The program also includes services designed to identify individuals who are potentially at risk for illness. Intracorp has contracted with StayWell Health Management Systems, a national wellness program vendor based in Minneapolis, to administer the health risk assessment services and to provide employee health surveys.

In addition, employers can receive group analysis of the overall health risk trends within their employee populations. The data can help employers evaluate their employees' current and future health needs.

The cost of the program varies from 25 cents to about \$1 per employee per month, with some components available on a fee-for-service basis.

Measure would cover D.C. workers' partners

WASHINGTON—A measure that would allow employees of the District of Columbia to obtain coverage under the city's group health care plan for a domestic partner of either sex survived fiery debate in the House of Representatives and now must win Senate approval.

The measure was part of a \$3.9 billion District budget package that won House approval by a 231-to-181 vote July 8.

Under the domestic partner legislation, any couple regardless of sex could register with the city as domestic partners (*BI*, March

16). District employees would be able to add domestic partners to their health insurance as a dependent.

Opponents of the measure in the House, led by Rep. Clyde Holloway, R-La., held that the measure promoted homosexuality. The measure is backed by the city's politically powerful gay community.

The measure now goes to the Senate, which was in recess until this week because of the Democratic Convention. However, even if the Senate approves the domestic partner portion of the budget, President Bush is likely to veto the whole package because of an unrelated provision providing public funds for abortions.

Budget now screens for 'high risk' drivers

LISLE, Ill.—Budget Rent A Car Corp. now requires rental applicants to complete a questionnaire designed to help screen out and reject "high risk" drivers, and thus hold down its liability risks and settlement costs.

Lisle, Ill.-based Budget's questionnaire asks applicants if they have incurred serious driving violations such as suspended licenses, convictions for driving while intoxicated, or responsibility for two or more accidents within the past three years.

According to data from the questionnaire, combined with Budget's insurance actuarial data, only 2% to 5% of car renters would fall into this "high risk" group, a spokesman said.

The company could not estimate insurance savings that may result from this program, which began July 13.

Congress passes bill to broaden Connie Lee

WASHINGTON—President Bush is expected to sign into law the Higher Education Act, which includes provisions that would permit the government-supported College Construction Loan Insurance Assn. to guarantee higher education issues rated A- or higher.

Until now, the triple-A rated Connie Lee, which is half-owned by the Student Loan Marketing Assn. with the U.S. Dept. of Education and half by private investors, was restricted to insuring higher education debt rated triple-B or lower (*BI*, Oct. 21, 1991). The Higher Education Act would allow it to only write A-rated debt if all five private monoline financial guarantee insurers first declined to write the business. It also could guarantee only up to \$600 million for higher-rated schools within a five-year period.

Connie Lee President Oliver Sockwell said the legislation will permit Connie Lee to insure the issues of A-rated higher education institutions that have been in a "never never land" because they could get neither private financial guarantee insurance nor insurance from Connie Lee because it has been restricted to lower-rated issues.

Connie Lee had originally sought to insure the higher-rated issues after they had been rejected by only one insurance company.

But this was changed following a lobbying effort led by Financial Guaranty Insurance Co., a private financial guarantee insurer, that had argued in part that Connie Lee's government

backing gave it an unfair competitive advantage.

The measure also includes a Congressional request for a study by the Government Accounting Office as to how effectively Connie Lee and private insurers meet higher education institutions' needs.

Study finds 15% rise in life insurer capital

HARTFORD, Conn.—The capital and surplus of 65 major U.S. and six Canadian life insurance companies increased nearly 15% in 1991, a new survey shows.

In addition, the "capital adequacy ratio"—or ratio of reported capital to required capital—for those companies rose nearly 11% last year, according to the "Life Solvency Monitor" published by consulting and investment firm Conning & Co.

The improvement was due to "a shift in asset classes, as insurers moved out of more capital-intensive, higher-risk classes, perhaps in response to regulatory pressure," the report said.

Industry problems in 1991 "may be beneficial over the long term" as insurers refocus on the "protection features" of their products, Conning said.

Property owner owes duty of care: Court

SAN FRANCISCO—A property owner who leases his property owes a "general duty of care" to those who will use it, a California appellate court says.

The June 18 ruling came in a wrongful death suit filed by the family of construction worker Pete Krongos, who was employed by a company that leased property from Dana L. Whitaker. Mr. Krongos was electrocuted on Mr. Whitaker's property in 1988 while holding a boom cable when the boom touched an overhead 12,000-volt power line. The power line was strung about 29 feet over where the accident occurred.

Mr. Krongos' family sued both Mr. Whitaker and Pacific Gas & Electric Co. of San Francisco, charging the defendants had negligently strung the power lines. A Superior Court judge granted both defendants summary judgment and dismissed the case.

But, on appeal, a three-judge appellate panel ruled that Mr. Whitaker had a general duty to use due care to protect people "from an obvious electrocution hazard on the property." The case was returned to Superior Court to determine whether Mr. Whitaker breached this duty.

The court, though, affirmed the summary judgment in PG&E's favor.

For landlords, the decision means that to avoid potential liability, they must determine how their property will be used before leasing it, said John Walovich, a partner with San Francisco-based Vogl & Meredith in San Francisco.

Du Pont to phase out sales of Halon 1301

WILMINGTON, Del.—E.I. du Pont de Nemours & Co. will stop selling Halon 1301, a fire suppressant with a high ozone depletion potential, at the end of 1993.

And, sales of Halon 1301, will be cut in half in 1993 from 1992 levels.

Under the Clean Air Act, fire

suppressants must have an ozone depletion level of 0.2 or lower by the year 2000. Halon's level is 10.

Halon 1301 is "particularly notorious" for contributing to destroying the atmospheric ozone layer, noted Donald Dunn, market manager-fire extinguishants for Du Pont. Because of this, Du Pont has received "continued pressure from environmental groups... stockholders and employees" to reduce the firm's Halon production, he said.

Du Pont had decided several years ago that as soon as alternatives to Halon became available, "we would make definitive attempts to withdraw from the marketplace," Mr. Dunn added.

Du Pont has developed an alternative to Halon 1301, FE 13, that has an ozone depletion potential of zero. FE 13 has passed toxicity testing and is commercially available (*BI*, May 18).

Winston Hill must stop writing health cover

MONTPELIER, Vt.—The Winston Hill Assurance Co. Ltd. has been ordered by Vermont insurance regulators to stop renewing and writing new group health insurance in the state.

During an investigation after a consumer complaint, the Department of Banking, Insurance and Securities determined that Winston Hill sold insurance in Vermont through the Eastern Retail Hardware Assn. and third-party administrator Comprehensive Group Benefits without being licensed by the state.

Winston Hill also failed to file rates and forms and may be unable to meet its obligations to honor claims, state regulators said.

11th Circuit overturns air quality standards

WASHINGTON—The Occupational Safety and Health Administration is deciding whether to appeal a federal appeals court ruling that overturns workplace air quality standards.

The 11th U.S. Circuit Court of Appeals in Atlanta ruled recently that OSHA issued its 1989 air quality standards with "such inadequate explanation that it is virtually impossible for a reviewing court to determine if evidence supports (its) conclusions."

The rules, proposed in 1988, covered 428 substances.

OSHA set more stringent standards for 212 substances; established exposure limits for 164 substances not previously regulated; and reaffirmed existing standards for 52 substances (*BI*, Jan. 23, 1989; June 13, 1988). Industries had until Dec. 31, 1992, to comply.

Both labor and industry groups challenged the standards. Unions called them too weak; manufacturers claimed adequate technology did not exist to meet the standards for some substances.

In a unanimous decision, the three-judge panel said OSHA had not made a sufficient case for the limits it set for individual substances.

The panel also agreed with an AFL-CIO charge that OSHA gave insufficient reasons for its decision to delay implementation of the rules from 1989 until 1992.

Hazardous waste

Continued from page 2

"This court has again given short shrift to the efforts of major industrial polluters like General Dynamics to make the words of the contracts say what the polluters—after the fact—wish them to say," said Mr. Brunner, who represents the Insurance Environmental Litigation Assn., a consortium of 20 insurance companies, in this type of litigation.

The July 6 ruling stemmed from a claim by St. Louis-based General Dynamics Corp. against its liability insurer, Aetna Casualty & Surety Co. of Hartford, Conn., for the cost of cleaning up 16 hazardous waste sites located in eight states. General Dynamics sent its waste to the 16 sites.

Aetna wrote primary liability coverage for General Dynamics from 1975 to 1978.

As a result of the 8th Circuit's ruling, Aetna does not have to defend General Dynamics against, nor indemnify it for, pollution cleanup claims filed by federal and state environmental

authorities.

The court held that pollution cleanup claims are not "damages" as that term is used in the CGL policy.

The CGL policy states that the insurer will pay "sums which the insured shall become legally obligated to pay as damages because of . . . bodily injury or property damage."

Applying its now-famous 1988 decision in *Continental Insurance Co. vs. Northeastern Pharmaceutical & Chemical Co.*, the court ruled that cleanup costs are equitable in nature and that the CGL policy covers only legal damages awarded by a court (*BI*, March 7, 1988).

To date, only the 4th U.S. Circuit Court of Appeals has agreed with the 8th Circuit that cleanup costs are not "damages" as that term is used in the CGL policy (*BI*, July 27, 1987).

Four other federal appellate courts have ruled in favor of policyholders on this critical issue: the 9th Circuit (*BI*, Nov. 25, 1991); the District of Columbia Circuit (*BI*, Sept. 23, 1991); the 3rd Circuit (*BI*, May 6, 1991);

and the 2nd Circuit (*BI*, Oct. 23, 1989).

The 8th Circuit also ruled that the pollution exclusion bars coverage for General Dynamic's pollution cleanup claims.

The pollution exclusion bars coverage for all pollution that is not "sudden and accidental."

This marks the first time the 8th Circuit has addressed the so-called 'suit' issue, says Ms. Foggan.

General Dynamics argued that the exclusion should be construed to bar coverage only for pollution that is expected by the policyholder.

But the 8th Circuit did not agree. Reversing the trial court, the 8th Circuit held that the term "sudden" has a temporal element.

"Because 'accidental' includes the unexpected, 'sudden' must

mean abrupt," the court said. "To hold otherwise would render the word 'sudden' superfluous."

Currently, the numerous federal and state court decisions regarding the pollution exclusion issue are split.

The 8th Circuit's ruling is significant because it marks the first time the 8th Circuit has ruled on the pollution exclusion, said insurer attorney Laura Foggan of Wiley, Rein & Fielding in Washington.

The 8th Circuit also ruled that letters from state and federal environmental authorities do not trigger an insurer's duty to defend.

The CGL policy says the insurer has a duty to "defend any suit . . . seeking damages."

The court ruled that the cleanup demand letters from environmental authorities are not the equivalent of a lawsuit.

"The demand letters in this case did not seek damages; rather, they sought to have General Dynamics participate in and negotiate the cleanup of the various sites," the court said.

This decision also marks the

first time the 8th Circuit has addressed this so-called "suit" issue, Ms. Foggan said.

Indeed, very few courts have addressed this issue, she said.

Attorneys for General Dynamics say no decision on whether to seek reconsideration or reargument has been made.

"It is hard to predict whether this decision will be influential," said General Dynamics attorney James Price of Spencer, Fane, Britt & Browne in Kansas City, Mo.

"The 8th Circuit in the past has indicated it does not believe there is insurance coverage for environmental claims," Mr. Price commented.

Mr. Price would not disclose the amount of cleanup costs that General Dynamics faces. But, "In terms of absolute dollars, this decision is not all that significant," he said.

Attorneys for Aetna could not be reached for comment.

Aetna Casualty & Surety Co. vs. General Dynamics Corp., U.S. Court of Appeals for the 8th Circuit, No. 91-2252.

Texas Eastern pollution verdict

Continued from page 2

This was a situation of no coverage," she said. "This was a case of long-term pollution committed intentionally in the normal course of running a pipeline."

A spokesman for Houston-based Texas Eastern said the company has not decided whether it will appeal the July 9 ruling.

But the spokesman said the court's decision barring insurance coverage will not have an adverse financial impact on the company. Texas Eastern has been accounting for the cleanup costs on a pay-as-you-go basis, reporting cleanup costs in its annual reports as part of operating expenses.

In addition, the company has worked out a cost-sharing arrangement with its customers, which are utilities and other pipeline companies. Under the agreement, customers will pay 57.5% of all cleanup costs and Texas Eastern will pay 42.5%.

The decision stems from the consolidation of three separate coverage lawsuits pitting Texas Eastern against 21 of the liability insurers that provided the company coverage from 1958 to the present.

All three lawsuits followed a claim filed by Texas Eastern seeking coverage for the costs to remove PCBs—polychlorinated biphenyls—from its 10,000-mile

natural gas pipeline that stretches through 14 states.

The first suit was filed by Texas Eastern's primary insurer, Fidelity & Casualty Co. in federal court in Dallas on Dec. 11, 1987.

The second lawsuit was filed by excess insurer Associated Electric & Gas Insurance Services Ltd. in federal court in Philadelphia on March 11, 1988.

And, the third lawsuit was filed by Texas Eastern in state court in Houston on March 21, 1988, against all of its liability insurers. This lawsuit was then removed to federal court.

In May 1988, the Judicial Panel on Multidistrict Litigation in Chicago ruled that all three lawsuits should be consolidated and heard in federal court in Philadelphia (*BI*, June 13, 1988).

And, on July 9, the U.S. District Court for the Eastern District of Pennsylvania in Philadelphia issued a sweeping ruling in favor of the insurers. No other coverage litigation is pending.

The court found that the comprehensive general liability policy's pollution exclusion clause, which bars coverage for all pollution that is not "sudden and accidental," precludes coverage in this case because Texas Eastern released PCBs as part of its ongoing business operations.

In addition, the court found that Texas Eastern had failed to

provide all of its insurers with timely notice of its pollution-related problems.

The facts of the coverage dispute begin with Texas Eastern's purchase of the War Emergency Pipeline from the U.S. government in 1947. Texas Eastern converted the pipeline to transport natural gas.

In late 1957 and early 1958 Texas Eastern began using a lubricant containing PCBs along

The insurers 'have always felt this was a situation of no coverage,' says attorney Ms. Warner.

the entire 10,000-mile pipeline. The lubricant was added to prevent fires along the pipeline.

Pollution problems arose when the PCB-containing lubricant leaked into the ground and groundwater in numerous areas along the length of the pipeline. Exposure to PCBs is suspected of causing cancer.

The court found that between 1958 and 1976, Texas Eastern was aware that pipeline liquids were escaping onto Texas Eastern's property and neighboring properties.

On Aug. 19, 1987, Texas Eastern gave formal notice of its PCB pollution problems to insurers.

By June of 1988, Texas Eastern had entered into a consent decree with the U.S. Environmental Protection Agency in which the company agreed to spend \$400 million to clean up property in 14 states that had been contaminated with PCBs. Texas Eastern also paid \$15 million in civil penalties for violating federal environmental laws (*BI*, June 13, 1988; Nov. 16 1987).

And in May of 1991, Texas Eastern agreed to pay \$200 million to remove PCBs from 19 sites in Pennsylvania and pay a record \$18.6 million in civil penalties for violating state environmental laws (*BI*, May 27, 1991).

Current estimates of the total cost of the cleanup are currently in excess of \$730 million. This includes an estimated \$480 million for on-site cleanups and \$250 million for off-site and groundwater cleanups.

Finally, as many as 13 third-party lawsuits were filed against Texas Eastern alleging bodily injury and property damage as a result of the PCB contamination.

U.S. District Court Judge Donald W. VanArtsdalen, interpreting Texas law, said the 1987 notification to insurers constituted late notice.

In a 183-page opinion, Judge VanArtsdalen commented: "Texas Eastern provided carriers with late notice of all the claims for which Texas Eastern seeks insurance coverage."

The court also determined that the insurers were prejudiced by Texas Eastern's late notice and, therefore, relieved of their obligations under the policies.

"This decision shows that policyholders are not free to negotiate over years and reach agreements in which they are obligated to spend hundreds of millions of dollars without having first notified their insurers of their intent to do so, as Texas Eastern did," said insurer attorney John Rivkin of Rivkin, Radler & Kremer in Uniondale, N.Y.

Judge VanArtsdalen also concluded that Texas Eastern's claims were not covered under the policy because the company's polluting activity could not be deemed to be "sudden and ac-

cidental."

The insurance companies in the case are: Fidelity & Casualty, which is the only primary insurer, and the following excess insurers: AEGIS, Aetna Casualty & Surety Co., American Home Assurance Co., Boston Old Colony Insurance Co., Continental Casualty Co., First State Insurance Co., Highlands Insurance Co., The Home Insurance Co., The Insurance Co. of North America, Insurance Co. of the State of Pennsylvania, Lexington Insurance Co., Midland Insurance Co. (in receivership), National Surety Corp., Prudential Reinsurance Co., Stonewall Insurance Co., United States Fire Insurance Co., and four underwriters at Lloyd's of London and London market insurance companies.

In re Texas Eastern Transmission Corp. PCB Contamination Insurance Coverage Litigation, U.S. District Court for the Eastern District of Pennsylvania, MDL Docket No. 764.

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Business Insurance

INTERNATIONAL

U.K. regulators blast pension oversight

By GAVIN SOUTER

LONDON—The body that oversees British pension fund investment managers has been insufficiently critical and too "mechanistic" in its approach, charges a report issued in the wake of the Maxwell pension fund scandal.

Much stronger regulation is needed from the Investment Management Regulatory Organization to prevent the misappropriation of pension funds by IMRO members, according to a report by the Securities and Investments Board, which regulates London's financial district.

And the SIB itself needs to ex-

amine its own shortcomings, which were made apparent in the Maxwell scandal, says the British Chancellor of the Exchequer.

Media baron Robert Maxwell allegedly took 426 million pounds (\$817.9 million at current exchange rates) from his companies' pension funds prior to his death last year (*BI*, Dec. 16, 1991).

Earlier this month, George Nissen resigned as IMRO chairman amid widespread criticism of the self-regulatory organization (*BI*, July 6).

IMRO was responsible for oversight of the two Maxwell companies that managed the pension funds: Bishopsgate In-

vestment Management and London & Bishopsgate International Investment Management.

"The fact that such a massive fraud could be carried out reflects badly on the U.K. corporate and financial system as a whole," said Andrew Large, chairman of the SIB.

The lessons of the Maxwell affair should be learned quickly and thoroughly, he said.

"We've got to have a regulatory system which makes it hugely difficult for a rogue elephant to operate within it, however hard it may be to stop determined people with criminal intent," Mr. Large said.

IMRO itself says its monitoring

of member companies' pension management activities was conducted conscientiously but without "flair or imagination." That assessment came in the agency's own report on its handling of the Maxwell affair.

"There appears to have been insufficient senior control and review, and the planning and timing of visits (to member companies) was in the hands of the relevant team rather than conducted according to a coordinated overall plan," the IMRO report says.

In its report, the agency assesses its performance as "not good enough."

To shore up regulation, the

agency is: creating a new post of assistant director to review its ability to keep a watch on the pension funds of "risky" member companies; increase its number of monitoring staff to 36 from 32; introduce a "watchlist" of higher-risk members; and give more training to monitoring staff, particularly in the field of crisis management.

The Securities and Investments Board takes a more critical view.

"The (IMRO) report reveals serious weaknesses in IMRO, and SIB draws certain more severe conclusions from the report than does IMRO," the SIB report says.

"SIB believes that IMRO's
Continued on next page



AP/Wide World Photo

The explosion at the Nevcin Polymers plant near Amsterdam killed three people, injured 11 and damaged a wide area.

Dutch plant insured for explosion losses

UITHOORN, Netherlands—Insurers and reinsurers in the Dutch, London and continental European markets expect to pay 100 million guilders (\$58.7 million) in property and business interruption claims stemming from a chemical plant explosion about six miles south of Amsterdam earlier this month.

Three people were killed and 11 were injured in the explosion at a plant owned by Nevcin Polymers. Nevcin is 50% owned by Cindu International in the Netherlands and 50% owned by Pittsburgh-based Neville Chemical Co., a Cindu spokesman said.

The plant was producing hydrocarbon resins. The explosion took place in a polymerization vessel, the spokesman said.

The damaged area was around 120 square yards, a spokesman for the Uithoorn municipal authorities said.

Nevcin's property coverage was led by Hanover International Insurance in Rotterdam. "We have been advised that the estimated loss for property and business interruption is likely to be 100 million guilders," said Cees Hakvoort, a Hanover director. Hanover has extensive reinsurance in the London and continental European reinsurance markets, he said.

The risk was placed by Beakouw Mendes, a wholly owned subsidiary of Alexander & Alexander Services Inc.

All of the primary insurance was placed in the Dutch market, an A&A spokesman said.

—By Gavin Souter

Directive to harmonize E.C. insurer accounting

BRUSSELS, Belgium—Discrepancies among many European insurance and reinsurance companies' accounting practices should be a thing of the past after 1995, thanks to a European Community directive recently submitted to U.K. insurers for comment.

The Council Directive on the Annual Accounts and Consolidated Accounts of Insurance Undertakings is designed to enable common accounting standards to be applied to the balance sheets of insurers based in different E.C. member nations. It should make it easier to compare the fi-

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financial strength of insurers.

Until now, important accounting procedures, like the valuation of assets, have varied widely from country to country. For example, British insurers value assets like real estate conservatively on a historic-cost basis. Elsewhere in the European Community, insurers employ current-cost accounting.

The directive, which must be implemented into national law by 1994 to apply to accounts

drawn up from 1995 on, also harmonizes the calculation of technical reserves. Such uniformity is essential if non-life insurers are to be able to sell insurance across borders, relying only on their home state regulation from 1994 on, as is envisaged by other E.C. legislation.

A special section of the directive governs Lloyd's of London syndicates. This section generally formalizes Lloyd's current practices, including reinsuring a syndicate's liabilities into the next year and producing aggregate accounts for all syndicates.

Continued on page 25

Lloyd's looking ahead

Market leaders put 1989 behind, see profits by '92

By STACY SHAPIRO

LONDON—There is light at the end of a very long, dark tunnel for Lloyd's of London, its leaders believe.

Despite a record 2.06 billion pound (\$3.85 billion at applicable exchange rate) global loss in 1989 and expectations of poor results in 1990 and 1991, profits might return in 1992, they say.

"We can look forward to much better trading conditions; a leaner, fitter market; and a generation of underwriters chastened by the searing experience of recent years" said Chairman David Coleridge in the official Lloyd's global results and market report published last week.

In the marine market, "there are real grounds for optimism," added Stephen Merrett, chairman of Lloyd's Underwriters' Assn. "This year, the market has seen material improvements in general levels of rating for the traditional areas of our account. . . . The dramatic contrac-

tion in (the reinsurance) market will reinforce the resolve of many underwriters to return to profit."

George Lloyd-Roberts, chairman of Lloyd's Underwriters' Non-Marine Assn. Ltd., also finds encouragement in some U.S. court rulings reducing the long-tail pollution claims hurting Lloyd's syndicates.

"Whilst the (non-marine) underwriting climate continues to be difficult, rates are hardening," he added. "If the incidence of catastrophes reverts to a normal pattern and if un-

Continued on next page

Coleridge lobbies for support

LONDON

Council Now."

He explained that six resolutions will be heard at the meeting, four of which are "based on an expression of no confidence in the Council of Lloyd's" and two that are in favor of the current council.

Mr. Coleridge suggested, among other things, that members:

- Vote in favor of an Assn. of Lloyd's Members' resolution, which states that the membership has confidence in the council.

The ALM resolution also

stresses that the council should "without further delay" implement essential task force recommendations in regard to market governance and should encourage the "working community" to make a substantial financial contribution to a fund for distressed names.

"The Council of Lloyd's welcomes the expression of confidence contained within the resolution and the support that it gives for two major current initiatives" that the council is already pursuing, said Mr. Coleridge.

- Vote against several resolutions put forward by a group of disgruntled members stating that

Continued on page 25

Lloyd's results

Continued from previous page
derwriters receive a more reasonable hearing from the U.S. courts, the market should make a substantial profit."

At the annual general meeting last month, Lloyd's reported the loss for the 1989 underwriting year, which closed Dec. 31, 1991, under three-year accounting (*BI*, June 29).

But the official accounts were only published last week. This was due to the late reporting of seven loss-riddled syndicates formerly managed by Gooda Walker Ltd. To date, members have been asked to pay 682.2 million pounds (\$1.3 billion) in cash calls for the 1983 to

1990 years (*BI*, July 6).

Even now, the results from the Gooda syndicates—now managed by G.W. Run-off Ltd.—“are subject to some uncertainty,” says a note in the global results. But because G.W. Run-off believes that the outstanding liability reserve represents “a best estimate,” Lloyd's Council decided to include the results in the globals, says the note.

The 1989 global figures represent the aggregated results of the 436 syndicates in the market that year. Only 146 of those produced a profit after members' personal expenses, though another 132 produced losses of 20% or less.

Many syndicates should show “some improvement” in 1990, but

will still lose money, said Mr. Coleridge. Gains in 1991 should be “more marked,” he added.

Major catastrophes in 1989 pushed overall marine losses up 59% to 875.1 million pounds (\$1.64 billion) from 551.13 million pounds (\$1.06 billion) in 1988.

Disasters like Hurricane Hugo, combined with “totally inadequate” rates, produced “one of the worst years on record,” said Mr. Merrett. In 1989, the marine market's net premiums grew 5% to 1.33 billion pounds (\$2.49 billion) from 1.26 billion pounds (\$2.43 billion) in 1988. Underwriting losses before investment and members' personal expenses, however, jumped 35% to 820.6 million pounds (\$1.5 billion)

from 609.4 million pounds (\$1.18 billion) in 1988.

The marine market's 1990 results “will be poor” though better than 1989's, said Mr. Merrett. “Fortunately... some marine syndicates (are) forecasting reasonable profits (in 1991).”

The “fundamental problem” has been that marine underwriters have been accepting business “at woefully inadequate rates for many years and are now suffering the consequences,” said Mr. Merrett. “Despite the severity of the losses that have been suffered by ourselves and our foreign competitors, individual underwriters have not found it possible to take effective remedial actions as quickly as they might have hoped.”

Losses in the non-marine market for 1989 are the worst in all of Lloyd's—982 million pounds (\$1.84 billion). It turned a \$149.3 million profit (\$288.1 million) in 1988. Total underwriting loss before investment income and members' personal expenses soared some 650% to 1.15 billion pounds (\$2.15 billion) from 154 million pounds (\$297.2 million).

The non-marine market wrote 1.76 billion pounds (\$3.29 billion) in net premiums in 1989, up 11% from 1.58 billion pounds (\$3.05 billion) in 1988.

“Worldwide overcapacity led to fierce competition and in turn to inadequate rates in non-marine insurance” in 1989, said Mr. Lloyd-Roberts. “This testing environment coincided with a succession of very large losses.”

Nevertheless, 74 out of a total of 175 syndicates in the non-marine sector showed a profit, said

Mr. Lloyd-Roberts.

In the meantime, “it is difficult to view 1990 with much optimism,” he said, because the January-February 1990 windstorms in Europe together produced Europe's largest-ever loss. In 1991, rates started to rise “but with no consistency” and the typhoons in Japan produced the Far East's largest insured loss. “It may be, however, that 1991 will prove to have been the turning point,” said Mr. Lloyd-Roberts.

Only the two smallest markets—aviation and motor—made a profit in 1989.

Lloyd's aviation market reported profits of 38.6 million pounds (\$72.2 million) in 1989, off 75% from 154.2 million pounds (\$297.6 million) in 1988. International overcapacity caused the aviation market to drop its net premiums to 281 million pounds (\$525.5 million) in 1989 from 320.9 million pounds (\$619.3 million) in 1988.

Overall, aviation insurers paid claims of more than \$1.5 billion from 28 jetliner disasters, but took in only \$500 million in premiums in 1989, said John Westcott, chairman of Lloyd's Aviation Underwriters' Assn.

Rates continued downward in 1990 despite the airline losses, and Lloyd's aviation market is likely to produce an overall loss, said Mr. Westcott. Few syndicates will also see any profit in 1991 following 23 jetliner crashes, he said.

October 1991 saw efforts to raise rates, but capacity grew in anticipation of higher premiums when it needed to contract more, he said.

Motor market profits fell 53% to 47.2 million pounds (\$88.3 million) in 1989. ■

Pension regulation

Continued from previous page
monitoring failures in this case reveal a more general lack of market awareness and skepticism in dealing with information about transactions and in monitoring returns,” the report says.

This is of particular concern because such alertness is the key to the British regulatory system, SIB says.

For its part, the SIB says it must consider whether to intervene more in its own regulatory agencies.

Rather than withdraw IMRO's status as a regulatory body, the SIB is instead directing the agency to make improvements in three areas.

First, IMRO should employ more experienced monitoring staff with a greater mix of skills. It should also strengthen its arrangements for dealing with areas of potential and actual risk for investors and review its rules on its own board

members' interests.

The agency should also review its admissions procedure and its approach to monitoring its members.

Third, IMRO should re-examine itself to pick up any shortfalls which neither it nor the SIB has identified so far.

But the SIB itself was tainted by the Maxwell scandal, said Norman Lamont, the Chancellor of the Exchequer.

“IMRO's performance also raises questions about the SIB's monitoring of IMRO and its general oversight of the self-regulatory organizations under the Financial Services Act,” he said in a written reply to a parliamentary question.

Consequently, Mr. Lamont said he has instructed the SIB to review how it carries out its own responsibilities.

Meanwhile, a unit of Willis Cor-

roon P.L.C. has launched a fidelity and crime insurance policy to protect pension fund beneficiaries from dishonest actions by trustees of occupational pension plans.

The policy was developed by the financial institution and specie division of Willis Faber & Dumas in conjunction with Chubb Insurance Co. of Europe.

The policy covers: fraudulent or dishonest acts committed by any trustee or employee; loss of valuable property such as currency, securities, and precious metals while the property is in transit; and loss resulting from computer theft by any person.

There is around 150 million pounds (\$288 million) of insurance capacity available in the market to cover financial crime risks, said Oliver Prior, chairman of the Willis division. ■

What others may overlook...



Verrazano-Narrows Bridge · Triborough Bridge and Tunnel Authority

INTERNATIONAL

GLOBAL BRIEFS

Continued from page 23

Last year, the European Parliament also proposed that each individual Lloyd's member should be regulated under the directive, but the European Commission rejected this idea as impractical.

Another directive likely to impact heavily on the emerging single European insurance market is the third life insurance directive. This was approved by E.C. finance ministers when they met in Luxembourg on June 29. It is expected to be implemented into the national law of member states by 1994.

Sir Leon Brittan, vp of the European Commission, hailed the directive as a crucial step toward a "true single insurance market."

The directive enables life insurers in any one E.C. member state to

sell insurance in any other E.C. member state via brokers. No longer will an insurer have to set up an office in the target market.

Life insurance has proved harder to liberalize than non-life insurance, because E.C. members were concerned about protection for policyholders who might have their entire life savings invested in life policies.

—By William Pitt

French AIDS fund

PARIS—France's insurance industry is uniquely responding to the needs of people with acquired immune deficiency syndrome.

French non-life insurers have contributed 1.2 billion francs (\$241.2 million) to a fund to compensate people who contract AIDS through blood transfusions.

These people currently number between 6,000 and 8,000, of whom

1,200 are hemophiliacs, according to a spokesman for the Federation Francaise des Societes d'Assurances, a French insurer association.

In addition, French life insurers are issuing policies to people infected with the virus that causes AIDS to make help them secure home loans.

Last year, the French government and non-life insurers agreed to create the fund to compensate people who contracted AIDS through blood transfusions. The fund would be financed by a levy on non-life insurance premiums (*BI*, Nov. 25, 1991).

Insurers later abandoned the levy plan and instead agreed to make one-time contributions to the fund according to their proportion of the French non-life insurance market.

Under the agreement, the French government is responsible for making up the difference between what the insurers pay and the total cost to the fund.

French press reports have suggested the final charge to the fund over several years may be 8 billion francs (\$1.61 billion) or more.

The cost to individual insurers is beginning to emerge in the companies' 1991 results.

Union des Assurances de Paris S.A., France's biggest insurer, contributed 109 million francs (\$21.9 million); Assurances Generales de France, the second-largest state-owned insurer, paid 68 million francs (\$13.7 million); AXA Midi Assurances S.A., a private sector insurer, contributed 85 million francs (\$17.1 million).

People who have contracted AIDS through contaminated blood transfusions and obtained compensation from the fund do not have to waive their legal rights, said a spokesman for FFSA.

But the existence of the fund may help stem what for insurers was a worrying trend in 1991: The in-

crease in medical malpractice suits against hospitals and clinics.

The FFSA's 1991 annual report, published last month, describes a growing tendency among French courts to award medical malpractice damages on a no-fault basis; previously, people who had contracted AIDS through a blood transfusion had to prove fault on the part of the hospital or clinic.

"Such leeway in interpreting medical liability, if it is confirmed, would create problems in insurability of the risks in question," said the FFSA.

Meanwhile, French life insurers are selling coverage to mortgage applicants who have the human immunodeficiency virus and need a life policy to obtain a loan. Such coverage, which is offered for five to 10 years with limits of up to 1 million francs (\$201,000), is unique in the world, according to the FFSA.

—By William Pitt

LONDON

Continued from page 23

the council has "failed in its duty" to manage and regulate the affairs of Lloyd's and calls for a vote of no confidence for the members of the current council.

Mr. Coleridge says that the council thinks the resolutions' allegations are "wholly unjustified."

Mr. Coleridge says another resolution members should vote against calls for rescinding a levy imposed on members that is equal to 1.66% of their allocated capacity. Lloyd's introduced the levy earlier this year to boost its Central Fund to 1 billion

pounds (\$1.92 billion at current exchange rates) to meet solvency requirements (*BI*, June 29).

The levy "was judged to be necessary and sufficient to cover potential solvency deficiencies and cash calls that individual names would be unable to meet, without reducing the Central Fund to such a level that would damage policyholders' confidence in Lloyd's," he said.

—By Stacy Shapiro

Sphere Drake boost

Sphere Drake Insurance P.L.C. is increasing its paid-up capital by 14 million pounds (\$27 million at current exchange rates) to take advan-

tage of rising insurance rates in the London market, says Chairman Ian Dean.

The additional capital, which is being contributed by the company's principal shareholders, will raise Sphere Drake's paid-up capital to 67 million pounds (\$129.3 million) from 53 million pounds (\$102.3 million).

"We will use the extra capital to expand the existing areas of the company which are experiencing significant rate increases," Mr. Dean said.

Those key areas include marine and non-marine excess-of-loss reinsurance, for which rates have been rising during the past 18

months, he said.

Marine insurance rates also are increasing, according to Mr. Dean.

"We are now seeing real movement in the marine account, with hull rates increasing in excess of 30% and cargo rates up by around 15%," he said.

The shareholders subscribing to the new capital are: The Dai-Tokyo Fire & Marine Insurance Co. Ltd.; Electra Investment Trust P.L.C., a British investment company; Centre Capital Investors, a British investment partnership; and affiliates of John Head & Partners, a New York investment bank.

—By Gavin Souter

New M&G executive

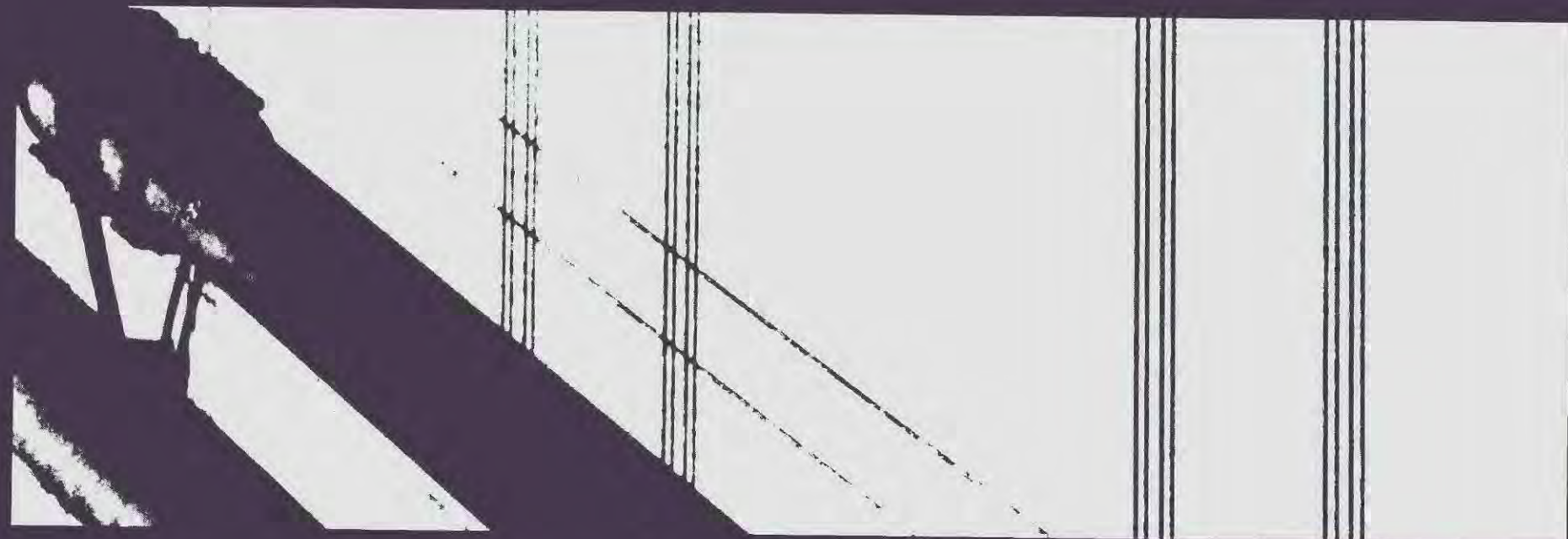
Mercantile & General Reinsurance Co. P.L.C. has named John Engstrom chief executive, replacing John Lock, who retired at the end of June.

Mr. Engstrom previously was worldwide head of reinsurance operations for Sweden's Skandia Group, a post he had held since July 1991. He joined Skandia in 1976 as a product development manager in Stockholm.

Marie-Louise Wenander succeeds Mr. Engstrom as head of Skandia's reinsurance operations outside North America.

—By Maria Kielmas

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**Business
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Senate report

Continued from page 1
insurance fraud.

- That the U.S. State Department begin negotiations with other countries over sharing information on insurance fraud.

- Developing a national intelligence data base on individuals and businesses involved in insurance fraud.

- Reviewing how unscrupulous individuals are taking advantage of the Risk Retention Act of 1986 and the insurance industry's surplus lines authority.

- Reviewing financial privacy laws and current Government National Mortgage Assn. recording procedures "as they pertain to law enforcement's need for disclosure of beneficial owners of government securities."

U.S. Senate investigators have found that financially troubled insurers are falling prey to "shady operators" offering questionable government-backed securities to bolster the insurers' capital (BI, Oct. 21, 1991).

"At a time of increasing insolvencies and abuse within this industry, the implications of the subcommittee's report are sobering," said Subcommittee Chairman Sam Nunn, D-Ga.

"Unless definitive and forceful action is taken by both federal and state governments, the fraud and abuse uncovered by our investigation will only continue to grow, leaving our nation to reap a bitter harvest of defrauded victims left with little more than worthless insurance policies," Sen. Nunn said.

"I hope in particular that the report's recommendations calling for increased international cooperation and information sharing between U.S. insurance regulators and their foreign counterparts will be heeded," said Sen. William Roth, R-Del., the subcommittee's ranking minority member.

But, a captive manager executive wondered whether the situation with offshore insurers and reinsurers has reached the point at which a federal solution is necessary.

Referring to the financial problems of domestic insurers, Alan Cossar, executive director of Hamilton, Bermuda-based Alexander Insurance Managers Ltd., a unit of New York-based Alexander & Alexander Services Inc., said: "I do think the offshore companies are getting blamed for a lot of things they're just not responsible for."

Mr. Cossar expressed concern that legislation drafted to enact the Senate subcommittee's recommendations might treat offshore, pure captive insurers as if they were traditional insurers.

"To subject pure captive insurance companies to additional regulation is only to increase the cost of using the captive as a risk management tool," he said.

"I'm very frightened, particularly if you're regulating for solvency," said Jon Harkavy, vp and general counsel for Vermont Insurance Management Inc. in Arlington, Va.

"There's always the danger of one-size-fits-all" federal regulation or certification, he said.

For example, an offshore captive may find it impossible to meet the capital and surplus requirements justifiably imposed on a traditional insurer, he said.

This could be "a boon to on-shore domiciles," he added.

Mr. Harkavy also said he "really would dislike" stripping

state insurance commissioners of their power to approve reinsurance credit, he said. Individual commissioners could have a better assessment of a reinsurer's stability than a centralized bureau and should not be robbed of their discretionary powers, he said.

The New York-based Risk & Insurance Management Society Inc. also is concerned that legislation aimed at regulating offshore insurers and reinsurers could be brought to bear against captives, said Paul Brown, director of government and public affairs and general counsel.

However, "I don't think I'd go so far as to say RIMS disagrees" with the idea of the federal government assuming some role in the regulation of offshore insurers, Mr. Brown said.

In fact, "The feds are in a better position to regulate this" than state officials, he said.

RIMS also has voiced its support of the federal government regulating the solvency of property/casualty insurers writing coverage for large commercial policyholders, though it has not offered a specific proposal (BI, April 6).

But Mr. Brown also is concerned that the certification process also might be used to regulate captive insurers, possibly subjecting them to unrealistic financial requirements. "Captives could be regulated out of business," he said.

RIMS would like to work with Congress on any legislation that would enact the subcommittee's recommendations, he said.

RIMS wants to make Congress "aware that captives are a different breed" from traditional insurers, he said.

"I can't imagine this would work to the detriment of captives," said Franklin W. Nutter, president of the Reinsurance Assn. of America in Washington.

However, he stopped short of endorsing a federal rather than state role in regulating offshore insurers.

"We do think improved solvency surveillance involves some greater scrutiny of the international insurance and reinsurance market, either at the state or federal level," he said.

Mr. Nutter pointed out that an RAA report issued earlier this year found that 1,776 alien reinsurers—not affiliated with any U.S. company—from 78 countries and an additional 171 alien reinsurers—affiliated with U.S. companies—from 30 countries wrote business in the United States in 1990.

"The point in these numbers is that there are so many companies from so many countries doing business in the United States that it's nearly impossible to track them," Mr. Nutter said.

The National Assn. of Insurance Commissioners, while saying, "There is much in this report to commend," also took issue with the recommendation of federal oversight of offshore insurers and reinsurers.

"State regulators recognize that there are weaknesses in the regulation of offshore reinsurance companies," said William H. McCartney, president of the Kansas City, Mo.-based NAIC and insurance commissioner of Nebraska.

"That is why we have included the Model Credit for Reinsurance Act and the Reinsurance Intermediaries Act in the Financial Regulation Standards and why we are exploring the question of whether further action is needed

to improve regulation of non-U.S. insurers," he said.

The Alliance of American Insurers also does not endorse a federal role in regulating offshore insurers and reinsurers.

The current system of state oversight, under which regulators can assign or deny credit for reinsurance, should promote purchasing quality reinsurance, said David M. Farmer, vp-federal affairs in the Alliance's Washington office.

Mr. Farmer also pointed out that reinsurance buyers have a duty to themselves to exercise "some measure of caution" in their purchasing practices.

"It's certainly incumbent upon policyholders to be cautious when dealing with offshore reinsurers that are not household names and to be sure to check on their securities," he said.

He added that the Alliance is ready to work with Sen. Nunn and others in solving the problems involved with offshore reinsurers.

However, the American Insurance Assn. in Washington sup-

ports federal oversight of offshore insurers and reinsurers.

"We like very much the recommendation that Congress establish certification for offshore insurers and reinsurers," said Melissa Wolford, director-federal affairs for the AIA.

But, "We'd like to see things go a little further," she said.

The AIA supports legislation that would allow insurers to choose whether they will be regulated for solvency by state regulators or by a new federal agency. Rep. John Dingell, D-Mich., introduced the bill, H.R. 4900, that would establish this two-tiered regulatory approach in April (BI, April 20; April 13).

Offshore insurers and reinsurers currently operate in "a totally unregulated area," Ms. Wolford said. "The state commissioners have no jurisdiction over it, and it's an area where there's been a lot of abuse."

She made clear that the AIA has nothing against foreign insurers and reinsurers in general. "We need foreign reinsurers," she said. "But it protects every-

one to weed out the bad ones."

All segments of the insurance industry, though, concur that stronger sanctions for insurance fraud are necessary.

"It's hard to argue against any of the provisions combatting insurance fraud," said Mr. Brown of RIMS. Regarding H.R. 3371's anti-fraud sanctions, Mr. Brown said, "We've been endorsing that since Day 1."

"We strongly support" the call to make insurance fraud a federal crime, the AIA's Ms. Wolford said.

Insurance groups have been consistent in their support for the insurance provisions of H.R. 3371, which would establish four federal insurance fraud offenses, including:

- Knowingly filing with a regulator false financial statements about an insurer.

- Embezzling insurance company funds.

- Falsifying records with the intention of defrauding an insurer or a policyholder.

- Criminally obstructing proceedings before a regulator. ■

Royal, Quill dispute

Continued from page 2

more than \$1 million in compensatory damages and \$10 million in punitive damages.

Following complaints by Mr. Foundos to regulators in several states, Royal has agreed to reinstate coverage for many policyholders through affiliate Royal Surplus Lines Insurance Co.

The Royal dispute is not the first such trouble for Mr. Foundos, whose Illinois agent's license expired May 1 and was not renewed. St. Paul Fire & Marine Insurance Co. in 1983 sued Mr. Foundos and Deerfield Organization Inc., a Chicago agency he then headed, in Cook County Circuit Court (BI, Dec. 12, 1983; April 11, 1983).

St. Paul charged that Mr. Foundos fraudulently issued marine policies after the insurer canceled Deerfield's limited binding authority in 1981. The policies generated nearly \$600,000 in premiums that St. Paul never received and \$132,758 in losses St. Paul paid, the suit alleged.

Mr. Foundos filed a counterclaim charging that St. Paul improperly canceled Deerfield's agency contract. The counterclaim sought \$15 million in damages for lost business and goodwill and \$20 million in punitive damages.

St. Paul withdrew its complaint in 1986, and Mr. Foundos separately filed suit in U.S. District Court in Chicago charging St. Paul with malicious prosecution. This suit was settled in 1986 "to my satisfaction," Mr. Foundos said, refusing to provide details.

A St. Paul spokeswoman declined to comment.

The dispute between Mr. Foundos and Royal began earlier this year when Royal notified Quill that its agency contract was being canceled.

Quill's latest complaint against Royal was filed in Cook County Circuit Court April 30.

The agency's suit notes that the agreement Quill signed with Royal in April 1991 to produce marine insurance for the insurer gave Royal the responsibility to accept or reject individual risks the agency submitted.

Royal accepted 102 risks submitted by Quill under cover notes that barred cancellation before the expiration date for

any reason other than non-payment of premium, the suit says.

The business consisted mainly of marine hull, protection and indemnity, and umbrella liability coverage for marine and oil and gas risks. Umbrella liability limits varied from \$1 million to \$10 million per occurrence, according to copies of cover notes filed in court.

But, Royal officials in January ordered the insurer's marine underwriter, Mr. Brower, to stop accepting new or renewal business from Quill. The next month the officials notified Quill that its agency contract would be terminated as of Aug. 8.

In March, Royal also sent out non-renewal notices to Quill clients whose coverage renewed before June 1 and cancellation notices to those renewing after June 1, the suit says.

Quill's complaint argues that Royal's cancellation of its contract was improper and that the contract requires Royal to work with Quill to resolve problems and avoid cancellation.

Royal's attempts to cancel or not renew Quill business also were improper, the suit says.

A state judge rejected Quill's request for an injunction barring the policy cancellations and non-renewals. However, Quill still seeks a declaratory judgment that Royal wrongfully terminated the agency agreement and violated its terms by canceling or refusing to renew coverage for its clients.

Royal has denied Quill's allegations, and last month it filed an amended counterclaim charging Quill, Mr. Foundos and Mr. Brower with fraud.

The insurer charges that the three defendants developed a scheme to induce Royal to insure various pieces of business by misrepresenting the nature, size and location of the risks.

Royal charges that it was induced to write business that did not meet its underwriting guidelines, including risks that:

- Were less than 70% marine in nature.

- Included product liability and pollution exposures.

- Provided excess coverage to large industrial corporations with "long-term catastrophic" exposures.

Quill and Mr. Foundos issued insurance documents to policy-

holders that contained terms and conditions that differed from those in Royal's policies, the insurer charges.

Quill and Mr. Foundos also billed policyholders for premiums that were "grossly in excess" of those charged by Royal without informing either Royal or the policyholders of the changes, the insurer alleges.

Mr. Brower aided the alleged scheme by helping Quill and Mr. Foundos conceal it from other Royal officials, the insurer's counterclaim charges.

Mr. Brower maintained the Quill records by himself in Royal's Chicago office and delayed processing policies for up to several months to stall discovery of the alleged scheme, Royal alleges.

Underwriting information was "skewed" to conceal the nature of policyholders' business, and Mr. Brower did not keep information—like policyholders' addresses—that would allow Royal to contact policyholders directly, the insurer charges.

In addition, 60 risks Mr. Brower had bound were not discovered by Royal until after he was fired earlier this year, the counterclaim says.

Mr. Brower has not answered the counterclaim, but his Chicago-based lawyer, Robert Habib, denied the charges.

"They are just trying to humiliate a guy they have already kicked in the stomach," Mr. Habib said, calling Royal's charges "unethical."

Mr. Foundos also denied wrongdoing and said Royal, despite its damage claim, has suffered no losses on any of the business he produced.

"They have made nothing but money" on the business, he said.

Mr. Foundos also confirmed that he let his Illinois agent's license expire May 1 but said he plans to renew it.

Meanwhile, he said he has turned over certain business to his son, George A. Foundos, who is licensed.

This business includes operation of the American Pet Care Assn., a group offering its members various services, including pet health care insurance, underwritten by Assicurazioni Generali S.p.A. of Italy, according to Mr. Foundos and APC promotional brochures. ■

Clinton plans

Continued from page 1

of The Principal Financial Group, a diversified financial services company.

"One can expect quick enactment of parental leave legislation" possibly within the first few months, said Frank McArdle, a consultant in Hewitt Associates' Washington office.

During the last congressional session, both the House and Senate approved legislation that would give employees unpaid leave—with continued health insurance—to take care of family situations like illness and the birth or adoption of children.

President Bush vetoed the legislation, arguing that it was an unwarranted government benefit mandate.

Congress did not override the veto (*BI*, Nov. 18, 1991; July 9, 1990).

In his acceptance speech last week, Gov. Clinton, directly criticizing President Bush's veto, said he would lead the charge for parental leave.

"He won't give mothers and fathers a chance to take some time off when a baby's born or a parent is sick. But I will," Gov. Clinton said.

A position paper Gov. Clinton released last month also made clear that he would not waste any time approving parental leave legislation.

"Parents should not have to choose between the job they need and the family they love. I will immediately sign into law the Family and Medical Leave Act. This bill will give American workers the right to take 12 weeks of unpaid leave in order to care for a newborn child or sick family members—a right enjoyed by workers in every other advanced industrial nation," he said in the paper.

Gov. Clinton also left no doubt last week that his vision of the nation's future—in which he sees a "New Covenant" between government and Americans—includes affordable universal health care.

He said he sees "an America in which health care is a right, not a privilege; in which we say to all of our people: 'Your government has the courage, finally, to take on the health care profiteers and make health care affordable for every American.'"

President Bush "won't take on the big insurance companies to

lower costs and provide health care to all Americans. I will," Gov. Clinton said.

In his position paper, Gov. Clinton details how he would expand health care and restrain costs. Elements of the Clinton plan include:

- Requiring employers to either offer health care "or opt to buy into a high-quality public program."

Essentially, this would be a "play-or-pay" approach.

Gov. Clinton, though, has not made clear whether an employer not offering a health care plan would pay a payroll tax to the federal government to support a public plan for the uninsured, or if the employer would actually pay a health insurance premium to the government.

- Setting a national health care spending cap.

Gov. Clinton said he would scrap the Health Care Financing Administration, which now runs the federal Medicare program, and replace it with a board charged with establishing national health care spending targets.

The board would consist of consumers, providers, employers, labor and government officials.

- Reforming health insurance underwriting.

Insurers would be prohibited from denying coverage to individuals with pre-existing medical conditions. And, insurers would have to use community rating in setting premiums and a common claims form.

- Creating a core benefits package.

All Americans would be guaranteed a basic benefit package that would include physician care, inpatient hospitalization care and prescription drug benefits.

A national board would outline the basic benefits package.

Gov. Clinton also said he favors an expansion of managed care networks, which would receive a fixed amount of money for each participant. That, he said, would give networks the necessary incentive to control costs.

But, while no American would go without health care, "Everyone who can must share in the

costs," Gov. Clinton said.

The Democratic Party provisions on health care, which were outlined by California Insurance Commissioner John Garamendi during the convention last week, also call for universal coverage, cost controls and banning exclusions for pre-existing medical conditions.

The platform rejects the notion of adopting a national health insurance system from another country, emphasizing that health care reform must be "uniquely American."

Washington benefit lobbyists have no doubt that health care reform would be a top priority in a Clinton administration.

"Gov. Clinton will aggressively push for health care reform," said Principal's Mr. Brahs. "And his election would provide tremendous momentum for members of Congress to advance health care reform legislation."

If Gov. Clinton takes the White House, "there will be a big difference in will and enthusiasm for health care reform," said Mary Nell Lehnhard, senior vp in the federal affairs office of Blue

Cross & Blue Shield Assn. in Washington. "There will be a much greater focus on health care."

By contrast, congressional Democrats until now have not made much of an effort to move major health care reform forward this session knowing that President Bush—who opposes health care cost controls and a play-or-pay or a single-payer system—would veto their proposals.

Still, electing a Democrat who favors major health care reform does not guarantee enactment of such a measure.

The biggest challenge a Clinton administration might face in trying to win passage of reform legislation might be rounding up enough support from fellow Democrats, whose support for reform is splintered among various approaches.

"The Democrats are in disarray. They can't agree among themselves," observed Ellen Goldstein, director of health care policy at the Assn. of Private Pension & Welfare Plans in Washington.

"His big challenge will be to get Democrats to agree among themselves," she said.

Jimmy Carter, the last Democratic president, favored significant health care reform but could not win support from Democratic liberals or conservatives when he tried to develop a health care reform package in the late 1970s.

Others say that regardless of who is in the White House, it still will be years—in the absence of a national consensus—before significant health care reform legislation is passed.

Meanwhile, Gov. Clinton says he favors higher Medicare taxes on middle- and upper-income retirees.

For example, Gov. Clinton's position paper calls for boosting Medicare Part B premiums—which help fund coverage for physician charges—for retirees earning more than \$125,000.

Currently, retirees pay a flat monthly rate of \$31.80 for Part B, regardless of income.

Gov. Clinton also has said he favors raising the portion of Social Security benefits on which middle and upper income retirees pay taxes. Currently, 50% of benefits paid to individuals with incomes exceeding \$25,000 and couples with incomes exceeding \$32,000 are taxed. ■

Insurers dislike Gore's stance on some issues

WASHINGTON—Sen. Albert Gore Jr., D-Tenn., is Bill Clinton's pick for the No. 2 spot on the ticket, but he's not No. 1 on any list prepared by insurance lobbyists and tort reformers.

Although Sen. Gore won the admiration of risk managers for his support of expanding the Risk Retention Act six years ago (*BI*, March, 10, 1986), positions he has taken since on matters like tort reform and funding pollution cleanup are unlikely to endear him to any segment of the property/casualty industry.

Sen. Gore "certainly doesn't have Vp (Dan) Quayle's zeal for tort reform," said Peter Lefkin, vp-federal affairs in Washington for Fireman's Fund Insurance Co.

In fact, Sen. Gore appears to oppose product liability reform.

When the Senate Commerce Committee debated a uniform product liability bill in 1986, Sen. Gore was outspoken in his opposition to monetary caps on non-economic damage awards (*BI*, June 30, 1986). He is not among the co-sponsors of a more moderate reform bill, S. 640, that is scheduled for Senate debate in September.

"He has consistently opposed product liability reform and other tort reforms," said Leslie Cheek, senior vp-federal affairs in the Washington office of Crum & Forster Inc.

"He has strong ties to the personal injury trial bar," Mr. Cheek said.

"Al Gore has been a consistent opponent of product liability reform," agreed Victor

Schwartz, an attorney with the Washington law firm Crowell & Moring and a lobbyist for the Product Liability Coordinating Committee, a business lobbying group which supports S. 640.

Like Mr. Cheek, Mr. Schwartz said that Sen. Gore has taken the plaintiff bar's position on product liability reform, which is that reform proponents have established no case for change.

Sen. Gore is also a defender of the Superfund law, formally known as the Comprehensive Environmental Response, Compensation and Liability Act.

"Based on his record so far, he would appear to be inimical to our interests in reforming" Superfund liability, said Mr. Cheek.

Sen. Gore "was a strong supporter of reauthorization in 1986," said Mr. Lefkin of Fireman's Fund. "Our task is to try to prove to him that the law is not working as intended."

Tom O'Day, associate vp in the Washington office of the Alliance of American Insurers, said the insurer group was disappointed with Sen. Gore after he moved from the House of Representatives to the Senate.

"We felt when he was in the House, he was a moderate Democrat. When he went to the Senate, he became less moderate," said Mr. O'Day.

But the lobbyist takes some comfort in Mr. Gore's position on the ticket.

"Just as Dan Quayle doesn't lead the Bush administration, Al Gore wouldn't lead a Clinton administration," he said.

—By Mark A. Hofmann

Walbrook rescue plan

Continued from page 1

(\$665.9 million) in 1990.

The reserves are net of reinsurance recoveries and discounted.

The increase in reserves is attributed to increased losses on hospital professional liability and accountants and attorneys errors and omissions insurance.

In addition, another 73.9 million pounds (\$142 million) has been estimated for unrecoverable reinsurance, run-off costs and the drawing down on letters of credit, bringing total reserves to 484.1 million pounds (\$930 million).

Walbrook directors are recommending the preferred stock plan to re-establish the solvency of the company. They have been discussing the plan with major North American insurance and reinsurance policyholders since April (*BI*, June 8).

The plan was officially unveiled at formal meetings in Chicago and London during the past few weeks. The 200 major credi-

tors are supposed to provisionally approve it by July 24.

Walbrook officials described policyholder reaction to the proposal as "good" and "positive."

The 200 major creditors, each expected to be owed more than \$1 million, could redeem their shares in Walbrook in 2012, or earlier at Walbrook's discretion. Transfers would be allowed only in very limited cases.

No dividend would be paid, but shareholders would receive additional funds when the shares are redeemed.

The preferred shares would add capital of 270 million pounds (\$518.7 million at current exchange rates)—enough to cover the company's 170 million pound deficit at the end of 1991 and boost capital by another 100 million pounds (\$192.1 million).

If Walbrook remains solvent, the directors believe that it will be able to recover fully on its reinsurance contracts. But they warn that if the plan is rejected

and the company goes into a scheme of arrangement whereby a schedule of dividend payments are made to policyholders, full recovery would be unlikely.

With a few exceptions, reinsurers have not paid claims to Weavers stamp companies, including Walbrook, since late 1990.

"The directors unanimously recommend support for the proposals, because they believe they are in policyholders' best interest," said the preferred stock documents. The directors do caution that because policyholders have varying interests, "it is essential that in considering these proposals, policyholders take their own advice."

Transit seems strongly opposed to the preferred stock plan, although it hasn't said so officially. Transit claims to account for between 7% and 10% of Walbrook's total indebtedness, though Walbrook officials contend that this is "wildly ex-

aggerated."

Transit has applied in the High Court of England and Wales for provisional liquidators to be appointed to oversee Walbrook's affairs. Its request is to be heard Aug. 4.

Transit also has filed a petition with the court to wind up Walbrook, which may not be heard until October.

Transit would prefer that Walbrook be run off together with four insolvent sister insurance companies known as the KELM companies, which also wrote on the Weavers slip: Kingscroft Insurance Co. Ltd., El Paso Insurance Co. Ltd., Lime Street Insurance Co. Ltd. and Mutual Reinsurance Co. Ltd.

Provisional liquidators at accounting firm Cork Gully were appointed to the KELM companies earlier this year.

"Transit considers that the interests of all creditors of Walbrook would be best served if Walbrook were treated the same

way as the KELM companies and that it would be cheaper, quicker and more efficient if the same persons developed schemes (of arrangement) for both the KELM companies and Walbrook," Transit stated last week.

In the preferred stock plan documents, Walbrook directors replied: "Walbrook opposes the appointment of provisional liquidators."

Last week, Transit also distributed a six-page circular to policyholders as they were walking out of the London meeting. The circular explained why Transit "may not support" the preferred stock plan.

In particular, Transit notes that the directors of Walbrook failed to cease paying claims at an earlier date when it was clear that the company was insolvent.

"Developing Walbrook's plan would be extremely costly and time-consuming," says the Transit circular. "There is no guaran-

Continued on next page

Walbrook rescue

Continued from previous page
tee that it would work. Transit believes that it would not.

"Creditors of Walbrook should not permit Walbrook's directors to spend a vast amount of time and money on developing their own plan without being sure that there is no alternative," the Transit circular says.

On July 7, Burleigh Arnold, special deputy receiver for Transit, sent a letter to the Dingell subcommittee with copies of Walbrook's preferred stock plan.

Mr. Arnold questioned whether a "foreign corporation" can offer a preferred stock plan to U.S. policyholders without first filing the plan with the Securities and Exchange Commission. "Is there no protection for such actions?" Mr. Arnold asked.

Rep. Dingell sent a letter to Richard C. Breeden, chairman of the SEC, on July 9.

"The foreign operators of Walbrook and Weavers are apparently seeking to avoid their cash obligations in the United States by substituting payment

of claims with an offering of preferred stock in Walbrook, whose rehabilitation prospects and worth are uncertain, to say the least," Rep. Dingell wrote.

"The Transit receiver has raised a valid question regarding the legality of such a preferred stock offering under the federal securities law," he continued.

Mr. Dingell asked the SEC chairman:

- Whether there are requirements for Walbrook to register the preferred stock plan under federal securities laws.

- Whether the SEC has reviewed the "propriety" of Walbrook's stock offering.

- Whether the "directors of Walbrook (can) successfully disclaim legal liability for this stock offering in the United States."

- Whether the SEC plans to enforce the federal securities laws in regard to Walbrook's preferred stock plan.

Rep. Dingell says he hopes to have a reply by today.

U.S. lawyers for Walbrook are now contacting the SEC. Before the Chicago and London policyholder meetings, Walbrook

directors were advised by lawyers that the preferred stock plan complies with SEC regulations.

Transit's Mr. Arnold said last week that Transit will not say yes or no to the Walbrook plan until a provisional liquidator is appointed for Walbrook who gives an "independent" opinion on the merits of the plan.

Mr. Arnold said his reservations about the plan include that it would effectively create two classes of creditors—major creditors who would buy preferred stock and only get 40% of their claims paid in cash; and those who wouldn't have to buy the stock and would be paid 100% of their claims in cash.

"It sets one class against the other," he said.

Also, the plan could have important U.S. tax implications, said Mr. Arnold. The Internal Revenue Service could impose taxes based on 100% claims recovery, even though 60% are paid back in preferred stock. Transit has not asked for an opinion from the IRS yet, he said.

Walbrook's plan "has so many holes in it," said Mr. Arnold. ■

Update

Appeal in huge asbestos suit

Continued from page 2

damages, which could total hundreds of millions of dollars.

The six named defendants in the case are GAF Corp., Keene Corp. and Pittsburgh Corning Corp., which made products containing asbestos; and AC&S Inc., MCIC Inc. and Porter-Hayden Co., which installed products containing asbestos.

The companies cannot appeal the negligence verdict until both phases of the trial have been completed.

Eight other defendants settled earlier with the plaintiffs.

Maine work comp withdrawal

AUGUSTA, Maine—Commercial Union Insurance Co. wants to withdraw effective Dec. 31 from Maine's troubled workers-compensation market.

The Boston-based insurer is one of the few remaining insurers servicing the state's residual market, where most workers comp policies are written.

CU filed its withdrawal request with Maine Insurance Superintendent Brian Atchinson because residual market deficits have climbed to a total of about \$500 million since 1988, said Robert C. Gowdy, CU executive vp and senior insurance officer. Unlike other states, though, Maine requires insurers to share that burden with employers.

FASB investment reporting rule

NORWALK, Conn.—The Financial Accounting Standards Board is considering a proposal that would require companies—including insurers—to report more of their investments at market value on their balance sheets rather than at their amortized cost.

The effects of the proposal could create volatility in the value of insurers' assets because of their bond investments. The market value of bonds—which are now reported at their amortized cost—rises when interest rates are low and falls when rates rise.

Under the proposal, investments would be classified under one of three groups: debt securities held for investment, which are investments like bonds that management has a "positive intent and ability" to hold to maturity; investments that are available for sale; and those held for trading, said Robert C. Wilkins, FASB project manager in Norwalk, Conn.

Investments in the first category would continue to be reported at amortized cost, but those in the other two would be reported at market value. Unrealized gains and losses on investments in the third category also would be reflected in the earnings statement.

Union health plans targeted

NEW YORK—Two states have issued cease and desist orders against several companies marketing unauthorized group health coverage through two purported union locals.

Missouri has ordered Royal Guardian Mutual Benefit Assn. Inc. and the United Labor Council Local 615 Welfare Fund, both of Tempe, Ariz., to stop selling health insurance without a license.

Separately, Secure Marketing Co. of America Inc., a St. Charles, Mo.-based producer for the Local 615 plan, agreed to pay \$15,000 to cover claims incurred by plan enrollees, Missouri regulators say.

New Hampshire regulators last month issued a cease and desist order against National Benefit Consultants Inc. of Cherry Hill, N.J.

Regulators say the firm solicited business for Physicians Benefit Plan of Simi Valley, Calif., an allegedly fraudulent health program sponsored by the National Council of Allied Employees Local 444.

Regulators in several other states have charged that the NCAE, its local affiliates and United Labor Council Local 615 act as fronts for unauthorized insurance sales (BI, May 18).

Briefly noted

The State of California is seeking damages from Southern Pacific Transportation Co. and others to cover the costs of responding to and cleaning up a **toxic herbicide spill in the upper Sacramento River** after a 1991 train derailment. Southern Pacific may have at least \$200 million to pay liability claims excess of a \$10 million self-insured retention (BI, July 29, 1991). . . . The California Supreme Court has refused to reinstate the nation's first negligence award against a blood bank for providing AIDS-tainted blood (BI, Dec. 12, 1988). An appeals court overturned a judgment against **Irwin Memorial Blood Bank** in April. . . . A New York state court judge has approved a reorganization plan for **Constellation Reinsurance Corp.** under which Centre Reinsurance Co. will assume Constellation's assets and liabilities and cover its obligations up to \$305 million (BI, May 11). . . . In an effort to raise more than \$360 million in capital, the **Equitable Life Assurance Society of the United States** on Tuesday will place 43.5 million shares of common stock up for sale at \$9 per share. . . . **Skandia America Corp.** has filed a registration with the Securities and Exchange Commission for an initial public offering of 7.5 million shares of common stock, or about 30% of the stock now held by Skandia U.S. Holding Corp. . . . A London High Court judge last week denied a petition by members of syndicates formerly managed by Gooda Walker Ltd. to obtain a **judicial review of the Corporation of Lloyd's**. . . . Marion Merrell Dow Inc. Shareholders have filed four lawsuits in federal court in Kansas City charging that the company concealed that its **Seldane antihistamine drug** has been associated with heart problems in some users taking other medications. . . . A National Assn. of Insurance Commissioners panel last week affirmed its support for a 1986 model law that limits insurers' ability to grant **extraordinary dividends**, defined as those exceeding the lesser of 10% of surplus or net income (BI, June 15).

California workers comp case

Continued from page 2

borough & Associates in Los Angeles who represents employers in disputes with workers compensation insurers.

The decision suggests that "a bad faith claim closely related to misconduct by the carrier in the claims handling context would be permissible," said Steven Paine, an attorney with Cotkin, Collins & Franscell in Los Angeles who has represented both employers and insurers in coverage cases.

That conclusion is rejected by lawyers for insurance companies.

"It's really reaching to come to that conclusion. If anything, it may have some ramifications favorable to insurers," said Ralph LaMontagne of Bronson, Bronson & McKinnon of Los Angeles, who represented Nationwide in the case.

For example, he said, the court's decision stressed that subrogation is an insurer's right and not its duty.

Insurer attorney Andre Cronthall, of Sheppard, Mullin, Richter & Hampton in Los Angeles, concurred: "The ruling is consistent with earlier cases that found the insured should not be permitted to interfere with an insurer's administration or adjustment of a claim."

The June 29 decision is believed to be the first California appellate court ruling on the issue of whether employers may sue a workers compensation insurer for breaching the covenant of good faith and fair dealing when they fail to subrogate.

The case involved a workers compensation claim paid by New Plumbing's insurer, Nationwide, during the 1985-86 policy year for an injury sustained by employee Peter Legro. Because the injury was the result of a third party's negligence, Mr. Legro in May 1987 also sued the third party, not identified in court papers.

But Nationwide, New Plumbing charged, did not "properly investigate or pursue its subrogation rights on the Legro complaint. It also failed to file a timely intervention, facilitate settlement or move the case toward trial."

As a result of Nationwide's failure to subrogate, New

Plumbing asserted that its experience modification factor increased, affecting its workers compensation premiums for policy years 1987 through 1990.

New Plumbing's suit also argued that Nationwide breached its fiduciary duty to protect the policyholder's interests by not diligently pursuing its subrogation rights.

But the Los Angeles Superior Court ruled that New Plumbing did not have a cause of action to sue and dismissed the case.

New Plumbing appealed, but the appellate court sided with the lower court.

"We conclude that because the workers compensation law does not impose a duty on the carrier to pursue its subrogation rights in any particular manner, New

'The bottom line is, this case. . . raises some intriguing questions,' says Mr. Levine.

Plumbing cannot state a cause of action for negligent performance of that duty," the Court of Appeal said.

"Furthermore, because subrogation is a right, not an obligation, the insurer presumably has the option of not pursuing subrogation recovery at all," the court added.

The Court of Appeal also concluded that while "California courts have never squarely held that the relationship between the insurer and the insured is fiduciary. . . even assuming a fiduciary-type relationship exists, neither the duty nor the covenant of good faith and fair dealing extend beyond the terms of the insurance contract in force between the parties."

"The contract said that the insured is entitled to have its claim paid and be defended. When you go beyond that, it becomes a marketplace issue," explained Mr. Cronthall, who represents State Fund Insurance Co. in workers comp coverage cases.

"If the insured doesn't think the premium is fair, it shouldn't sue its insurer. It should work in

a positive manner with the insurer or go to another carrier," he said.

"The plaintiff was trying to extend the covenant of good faith and fair dealing not only to this policy, but to future policies," maintained Nationwide's attorney, Mr. LaMontagne. "This is an extremely strict fiduciary responsibility."

However, the Court of Appeal suggested three times in its written opinion that employers can sue their workers compensation insurers for improper claims payments, pointed out plaintiffs' attorney Mr. Levine.

The court also cited other cases requiring insurers to investigate claims thoroughly, to refrain from applying standards known to be improper and to avoid unreasonable delay in processing or paying claims—three areas in which employers often complain of insurer abuses, he added.

In oral arguments during the appeal, Mr. Levine had asserted that the case should be broadly viewed as an improper claims handling case rather than simply as a technical subrogation matter. He also argued that Nationwide's claims reserves were excessive because they were not reduced for likely subrogation recovery.

The court said it disregarded this argument only because "new issues cannot generally be raised for the first time in oral argument," not because the issue lacked merit. Mr. Levine and other employer attorneys are taking that as a cue that they may pursue this cause of action in other cases.

In fact, Mr. Gallegos said he is including it in an appellate brief he is preparing in a case involving excessive reserving.

The court suggested that it may have ruled otherwise "had New Plumbing brought these issues up before," he said.

"The bottom line is, this case doesn't resolve the issue of whether employers can sue for improper claims payment or excessive reserving," said Mr. Levine. "But it raises some intriguing questions."

New Plumbing Contractors Inc. vs. Nationwide Mutual Insurance Co. Fourth Appellate District Division Three. No.G010671.

Pricing front disquiets brokers

By LEONARD M. WILSON
Special to Business Insurance

THIS IS THE SUMMER OF OUR discontent, as Shakespeare might have said if he were a participant in the commercial property/casualty scene, or perhaps a member a Lloyd's of London.

There is not much good news for the insurance broker or underwriter on the pricing front. And we seem to be surrounded by reminders that all is not well with the insurance industry.

A few weeks ago, we were riveted by a doleful headline in the May 25 issue of *Business Insurance*: "Drastic Brokerage Contraction Forecast." This prognosis, valid or not, is not a source of jolliness for a financial person who roots for the prosperity of all brokers, especially the public insurance brokers.

No doubt the diminished profitability of insurance brokers as a rule fosters the prospect of new alliances. Soft markets and structural changes in brokerage over the past 10 or 15 years have had their telling effects.

Consolidation, though, has been the name of the game in the 20 years that we have followed the insurance brokerage industry as an analyst. Regional brokers became national, national brokers became international, and all the while mergers and acquisitions thinned the ranks of brokers.

We have watched as former publicly owned stalwarts of the industry Fred S. James & Co. Inc., Rollins Burdick Hunter Co., and, more recently, Corroon & Black Corp. joined the ranks of the merged, with Frank B. Hall & Co. an announced candidate for a future amalgamation.

In the past, the driving forces for consolidation emanated from the need to serve the client through wide geographic representation and from the virtues of greater critical mass. Financial considerations were largely secondary. Now, the driver of brokerage consolidation seems to be reduced profitability, and a hoped-for profit improvement through economies of scale.

In the investment business, the term

cross-current is often used as a euphemism to peg an unpleasant industry influence. We encountered one such cross-current at a recent visit to the offices of a major corporation. We struck up an informal conversation with the company's risk manager. When we asked him about his views on pricing in commercial markets, he replied that he was not really in touch with insurance pricing. It seems that he was placing the lion's share of his corporation's property and liability insurance with a seasoned, well-capitalized industry captive.

The risk manager liked the captive a lot. Its pricing was stable, and coverages were available under accommodating terms. He didn't think that his company would be returning to the conventional markets anytime soon. And the industry captive was now handling a large chunk of the insurance needs of other companies within the same industry.

As for his insurance broker, a long-standing relationship was intact and still highly valued, but the broker had less to do, and therefore the broker's total compensation had declined. Here is a case study in the dynamics of the alternative market, another cross-current, with clearly negative implications for brokers and underwriters alike.

From time to time, we take a random poll of insurance and investment professionals about prospects for premium rates. One group of respondents thinks prices won't firm up before 1993. They are not sure that rates will turn in 1993, but they are certain they won't turn before the end of the year—a kind of guarded optimism.

Others expect premium rates to firm in 1994 but not before, and maybe not then. That is as big a hedge as one can find, and reflects an underlying fear that excess capacity in commercial insurance is not going to disappear. From the viewpoint of investors looking at insurance brokerage stocks, a problematic turn in premium rates in 1994 is just about an eternity away.

One of our contacts pointed out that paid claims for commercial insurance were not rising very much. This stability

after six years of rate competition suggests that underwriters are perhaps not so badly off. Maybe reserves are stronger, and maybe there is less ammunition for the position that reserve deficiencies will turn insurance markets.

With a principal focus on commercial lines, we have remained largely detached from the carnage in personal lines for a number of years. But the steady procession of underwriters curtailing premium volume in personal lines is disquieting. Where will all this liberated capacity find a home? Commercial insurance would appear to be the logical direction, making more capacity where it is not needed. This is another cross-current.

Roughly a month ago, a group of insurance analysts visited London and heard first-hand about the difficulties of the London market. Interestingly, about the time that they returned to New York, property and casualty stocks began to advance, although insurance brokerage stocks seem to be locked in a fairly tight trading range.

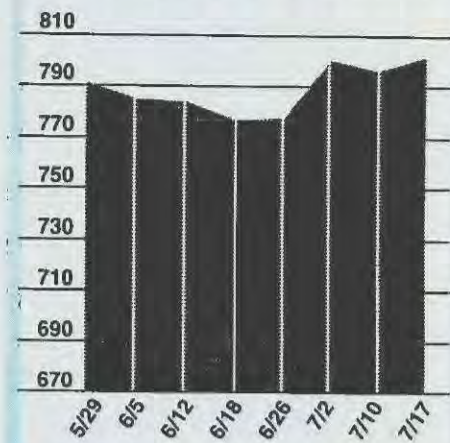
Some investors, we believe, hearing the analysts' account of the tightening London market, which is not exactly news, may have jumped to the conclusion that the U.S. primary market would be pulled up by the London market. This cause-and-effect link is conjecture on our part, but given the industry environment other explanations for the stock price advance are hard to come by.

Now that the second quarter has closed, it will be only a matter of days before brokerage earnings results will appear. We will be looking for straws in the wind that suggest a change for the better.



Leonard M. Wilson is a senior vp with Lazard Asset Management Inc. He is a member of the New York Society of Security Analysts.

BI Insurance Index



Base = 100 on Dec. 29, 1978
Source: Nordby International Inc.

Insurance industry stocks advanced last week, as the *Business Insurance Index* climbed 5.0 points to 800.7 on July 17 from 795.7 on July 10. Advancing issues were led by Lawrence Insurance Group, up 15.8%; Markel Corp., up 14.1%; and Fremont General Corp., up 12.9%. Declining issues followed Safeguard Health Enterprise, down 15.0%; Chandler Insurance Group, down 13.8%; and AVEMCO Corp., down 8.1%. The most active issue was U.S. Healthcare, 5.1 million shares traded. The *BI Index* was up 0.6%; the NYSE Composite was up 0.3%; the Standard & Poor's 500 was up 0.2%; and the Dow Jones 30 Industrials remained flat.

British Issues

July 16 Companies	Price pence	P/E	Div. pence	Yield %	1 Week	
					High	Low
Comm'l Union	453	N/M	31.5	7.6	458	453
Gen'l Accident	415	N/M	35.7	8.6	418	413
Gdn Royal Exch	144	N/M	10.0	6.9	144	133
Royal	200	N/M	15.0	7.5	203	200
Sun Alliance	270	N/M	19.0	7.0	270	266

Brokers	Price pence	P/E	Div. pence	Yield %	1 Week High	1 Week Low
Bradstock	128	14.4	6.3	4.9	128	128
CE Health	338	19.5	34.5	10.2	338	329
Hogg Group	149	9.0	10.9	7.3	152	149
JIB Group	155	11.4	10.0	6.5	157	155
Lloyd Thompson	205	20.5	6.0	2.9	205	201
Lowndes Lmbrt	289	11.2	6.8	5.8	289	289
PWS Holdings	42	4.6	5.3	12.6	42	42
Sedgwick Grp	178	13.9	16.0	9.0	178	174
Steel Brl Jones	226	11.3	17.7	7.8	228	225
Willis Corroon	212	13.4	17.6	8.3	213	203

Source: Philip Olsen, Insurance Industry Analyst, London

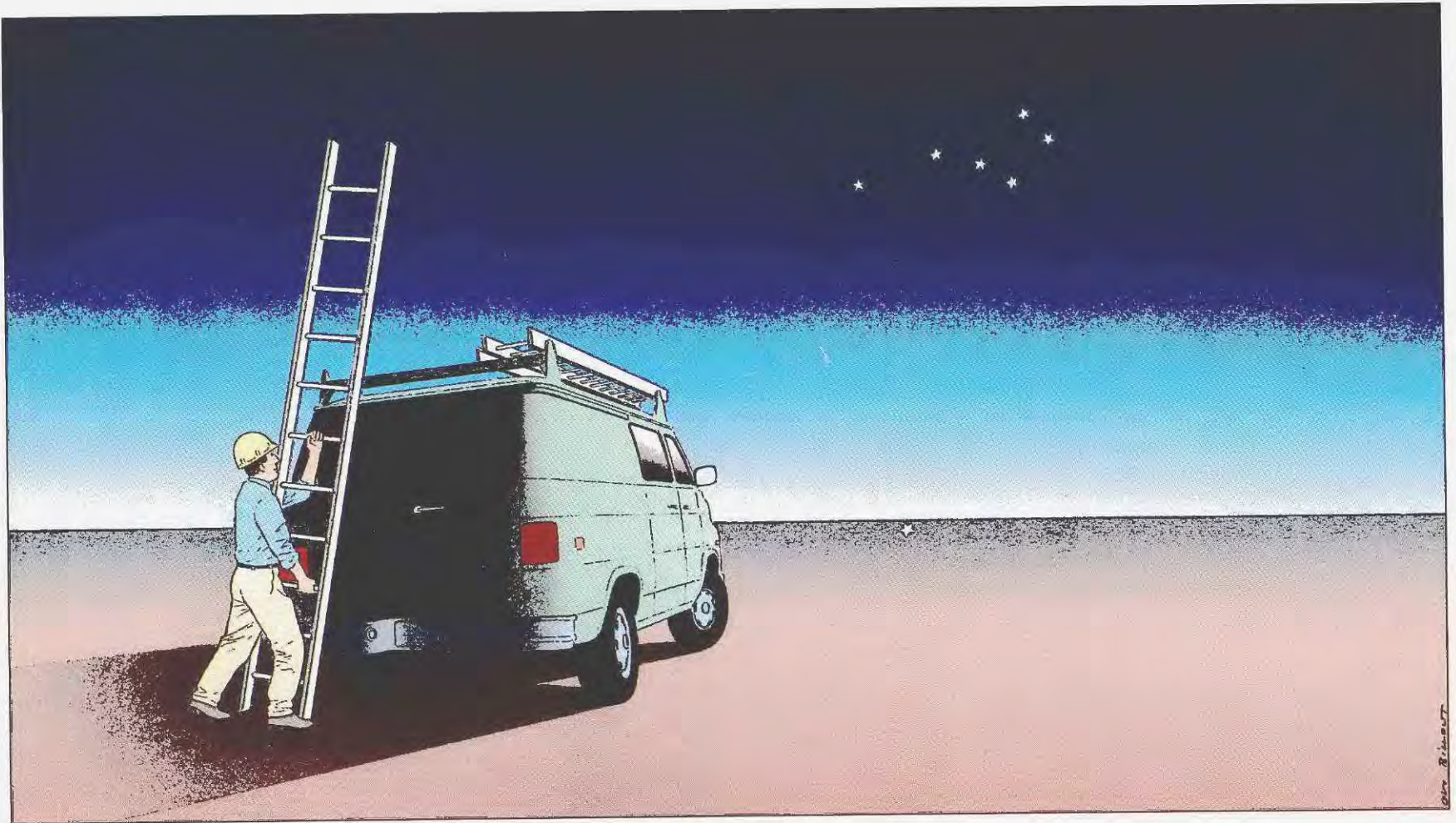
BI Industry Stock Report

JULY 13, 1992 THROUGH JULY 17, 1992

BROKERS	Price	Weekly		Year to Date % change	Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value	Price	Weekly		Year to Date % change	Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value	
		% change	% change		High	Low								High	Low		% change	% change							
Alexander & Alexander	NYS	23.00	0.55	12.20	23.38	18.00	98	1.00	4.35	144	13.10	1.76	Mutual Risk Mgmt. Ltd.	NYS	28.63	1.78	-18.51	37.75	21.13	15	0.12	0.42	19		
Gallagher Arthur J. & Co.	NYS	25.00	2.04	11.73	25.25	19.00	122	0.64	2.56	20	5.88	4.25	NAC Re Corp.	OTC	27.50	0.92	-12.70	33.00	21.75	65	0.16	0.58	12	18.90	1.46
Frank B. Hall	NYS	3.75	0.00	-11.76	5.50	3.13	223	0.00	0.00	-3	1.95	1.92	National Re Holdings Corp.	NYS	18.00	0.00	N/A	23.63	17.00	87	0.12	0.67	9	N/A	N/A
Hib. Rogal & Hamilton	NYS	12.88	11.96	-2.83	15.50	11.00	53	0.40	3.11	21	3.56	3.62	Navigator's Group	OTC	34.00	3.03	-17.07	48.25	29.50	70	0.00	0.00	20	13.52	2.51
Marsh & McLennan	NYS	78.88	2.27	-3.07	83.75	70.00	277	2.68	3.40	16	28.00	2.82	Nobel Insurance LTD.	OTC	4.94	1.29	23.45	6.00	3.38	63	0.00	0.00	3	7.76	0.64
Poe & Associates	OTC	12.75	-7.27	6.25	16.00	11.00	83	0.40	3.14	16	2.82	4.52	NWNL Companies	NYS	41.25	5.43	32.53	41.75	18.63	421	1.48	3.59	12	62.65	0.66
BROKERS AVERAGE			1.6	2.1					2.4	31			Ohio Casualty Corp.	OTC	56.00	0.00	13.13	58.25	43.50	146	2.68	4.79	9	18.00	3.11
													Old Republic Int'l	NYS	20.00	-6.98	12.68	22.50	14.63	298	0.40	2.00	8	33.09	0.60
													Orion Capital Corp.	NYS	36.13	-1.03	14.23	36.88	27.25	123	0.92	2.55	6	43.50	0.83
													Phoenix RE Corp.	OTC	11.63	-1.06	10.71	12.00	8.50	21	0.20	1.72	28	13.30	0.87
													Provident Life	OTC	23.88	0.53	2.69	24.25	17.75	379	1.00	4.19	10	39.50	0.60
													Re Capital Corp.	ASE	12.88	1.98	-10.43	17.50	12.50	4	0.24	1.86	13	15.05	0.86
													Reliance Group Holdings	NYS	4.75	0.00	15.15	5.88	3.50	42	0.32	6.74	3	6.40	0.74
													RLI Insurance Corp.	NYS	20.63	6.45	25.00	21.25	11.88	18	0.48	2.33	9	14.41	1.43
													St. Paul Companies	NYS	76.38	-0.85	4.80	80.75	57.13	470	2.72	3.56	8	86.60	0.88
													SAFECO Corp.	OTC	49.63	-1.49	1.79	52.50	35.50	709	1.64	3.30	12	51.65	0.95
													SCOR U.S. Corp.	NYS	16.75	3.08	8.94	18.88	12.75	6	0.28	1.67	9	11.19	1.50
													Seibels Bruce Group	OTC	5.88	0.00	6.82	8.75	4.00	15	0.36	6.13	-3	10.60	0.55
													Selective Ins. Group	OTC	21.75	4.82	29.85	21.75	14.75	69	1.12	5.15	9	30.75	0.71
													Statesman Group Inc.	OTC	7.50	7.14	30.43	7.50	4.13	1291	0.00	0.00	4	2.48	3.02
													Tokio Marine & Fire	OTC	41.75	3.73	-18.93	55.25	32.25	1	0.00	0.00	-	70.93	0.59
													Torchmark Corp.	NYS	69.50	2.39	20.09	69.50	47.75	590	1.60	2.30	14	40.95	1.70
													Transamerica	NYS	44.50	-0.28	11.60	46.75	32.00	413	2.00	4.49	30	55.00	0.81
													Transatlantic Holdings	NYS	33.38	4.71	-14.15	39.63	29.00	97	2.04	0.72	10	18.38	1.82
													Travelers Corp.	NYS	22.00	-3.53	1.73	23.75	17.25	1340	1.60	7.27	8	59.00	0.37
													Trenwick Group Inc.	OTC	29.75	4.39	4.39	30.75	23.00	60	0.72	2.42	11	21.71	1.37
													United Fire & Casualty	OTC	38.75	0.00	29.17	41.34	28.00	0	1.00	2.58	11	35.39	1.09
													Union Ind. Corp.	OTC	35.63	2.52	-0.35	38.50	31.00	1004	1.00	2.81	13	37.23	0.96
													UNUM Corp.	NYS	41.50	0.91	2.47	44.00	28.81	632	0.64	1.54	13	37.70	1.10
													U.S. Facilities	OTC	10.13	-1.22	-31.93	19.00	8.63	48	0.00	0.00	7		
													USF&G Corp.	NYS	13.88	0.91	91.38	14.75	5.63	2645	0.20	1.44	-9	12.30	1.13
													USLIC Corp.	NYS	18.25	4.29	-1.35	21.00	17.00	49	1.00	5.48	-15	33.15	0.55
													USLIFF Corp.	NYS	50.75	-2.64	6.01	52.50	38.50	179	1.68	3.31	10	84.55	0.60
													Washington National	NYS	21.63	4.85	36.22	21.63	13.50	186	1.08	4.99	-37	33.50	0.65
													Zenith National Ins.	NYS	18.00	-2.04	6.67	19.50	13.75	2	1.00	5.56	8	13.14	1.37
													INSURERS/REINSURERS AVERAGE			1.5	10.5				3.2	12.6			
													HEALTH MAINTENANCE ORGANIZATIONS												
													FHP International	OTC	16.50	1.54	15.79	27.00	9.88	536	0.00	0.00	16	15.50	1.06
													HMO America Inc.	OTC	12.88	5.10	-23.13	24.88	9.63	381	0.00	0.00	14	0.61	21.11
													Pacificare Health Sys.	OTC	27.25	-3.54	-31.01	31.25	10.75	198	0.00	0.00	19	28.25	0.96
													Safeguard Health Enter.	OTC	14.75	-15.00	-9.33	14.75	5.38	128	0.00	0.00	13	3.53	2.41
													Sierra Health Services	ASE	19.75	3.27	6.76	27.50	12.38	78	0.00	0.00	10	1.78	11.10
													United Healthcare Corp.	NYS	89.00	2.89	19.46	93.00	40.25	951	0.03	0.03	34	43.60	2.04
													United Medical Corp.	ASE	7.75	6.90	10.71	9.75	5.88	5	0.20	2.58	30	8.79	0.88
													U.S. Healthcare	OTC	54.50	0.00	31.33	57.75							

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