

Business Insurance

Health care bills would increase employer-provided coverage

WASHINGTON—Legislation that would mandate employer-provided health care coverage and would remove state benefit mandates for coverage offered by groups of small employers has been introduced in Congress.

Sen. John D. Rockefeller IV, D-W.Va., last week introduced a reform proposal modeled on the recommendations of the Pepper Commission, which he chaired. Under the bill, S. 1177, employers with more than 100 employees would be re-

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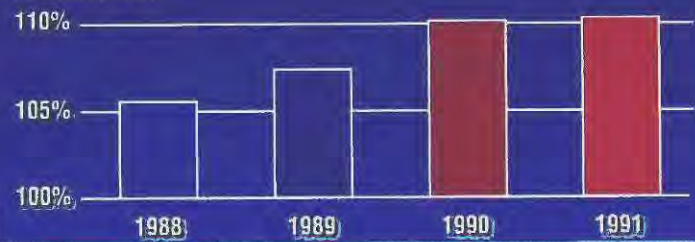
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Is no news good news?

Major U.S. property/casualty insurers are still bumping along at the bottom of the cycle, with a first-quarter combined ratio virtually unchanged from a year ago. However, insurers lost premium volume in this year's first quarter.

Combined ratio



Change in premium volume



Source: BI survey

GRAPHIC BY JOHN SMITHER

First-quarter results prolong insurer gloom

By JUDY GREENWALD

Insurers hoping to see some signs of a turn in the market are again disappointed and there are no indications that their spirits are likely to rise any time soon.

The lackluster results that haunted the commercial property/casualty insurance industry in 1990 did not improve in the first quarter of 1991, analysts and insurer executives agree.

And, aside from the market forces pinching insurers' bottom lines, the industry's problems are exacerbated by a \$1.4 billion assessment on workers compensation insurers to boost the reserves of the National Workers Compensation Reinsurance Pool, which reinsures residual markets in 31 states.

The assessment will further drain insurers' earnings without hastening a turn in the overall marketplace, observers say (BI, April 15).

The 30 major commercial insurers surveyed by *Business Insurance* posted a 110.6% combined ratio for the first quarter, a deterioration from the 110.1% combined ratio

posted in the first quarter of 1990.

However, the first-quarter 1991 combined ratio was a slight improvement over the 110.7% combined ratio the insurers reported at year-end 1990 (BI, April 1).

Still, market observers say there is little cause for optimism.

"The market continues to be very soft and there's just no sign that it's going to change any time soon," said Barbara Stewart, president of Stewart Economics in Chapel Hill, N.C.

"I imagine we're in for a very long period of soft pricing and disappointing results," she said. "My gut feeling is that this is going to be a long, drawn-out and excruciating affair."

Bernard C. Hlavac, vp and treasurer at Sentry Insurance Cos. in Stevens Point, Wis., commented: "Our results in the first quarter are close to what we did last year, and I think we were hoping for a slightly better year, but I think it's going to be a struggle to get there."

Sentry's net income nudged ahead 1.5% to \$12.2 million in the first three months of this year.

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NAIC's oversight lacks muscle: GAO

State officials defend system before Dingell

By DOUGLAS McLEOD

WASHINGTON—The National Assn. of Insurance Commissioners is incapable of establishing a uniform insurance solvency regulatory system because it can't compel states to follow its standards, a report by the General Accounting Office concludes.

While crediting the "good intentions" of the NAIC's widely publicized solvency policing agenda, the GAO found that fundamental barriers in the state regulatory system—along with NAIC's lack of enforcement powers—will prevent the program from ever achieving its goals.

A key element of the NAIC agenda, for example, is a program for the accreditation of state insurance departments that meet minimum NAIC financial reg-



Rep. Dingell

ulation standards.

The GAO, however, questioned the thoroughness of NAIC's accreditation reviews and concluded that the standards on which accreditation is based are vague and provide "little more than an appearance of uniformity" among states.

Richard L. Fogel, assistant comptroller general, stopped short of recommending federal insurance regulation in his testimony before the House Oversight & Investiga-

tions Subcommittee last week. The subcommittee, chaired by Rep. John D. Dingell, D-Mich., ordered the GAO study.

However, Mr. Fogel cast doubt on one idea discussed in earlier subcommittee hearings: state or federal empowerment of the NAIC to enforce compliance with its standards.

For various reasons, neither state nor federal empowerment is likely to work, Mr. Fogel said.

NAIC officials, meanwhile, criticized the GAO report and defended state regulation in testimony before the subcommittee last week.

"The GAO would scrap a system that has provided solid protection for consumers to replace it with what?" asked Earl R. Pomeroy, North Dakota insurance commissioner and a former NAIC president.

"A blend of federal and state regulation of the sort that brought us problems in banking and thrifts? Or complete transfer of authority to federal regulators whose own record of regulation is spotty

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Workers sue employers over potential GIC losses

By JERRY GEISEL

Employees enrolled in 401(k) plans sponsored by two companies that purchased guaranteed investment contracts from Executive Life Insurance Co. are demanding their employers cover any benefit losses resulting from the insurer's collapse.

These suits may be only the tip of the iceberg of litigation from First Executive GIC investment losses, benefit experts warn.

And more employers are expected to try to protect their 401(k) plan participants from losses from the Executive Life debacle.

Employees of Unisys Corp. and Honeywell Inc. filed separate suits in federal court this month. Both suits charge that the companies violated the fiduciary and disclosure standards laid down by the Employee Retirement Income Se-

curity Act of 1974 by purchasing GICs from Executive Life, which was seized last month by California regulators.

By investing a sizeable portion of its fixed income fund in Executive Life GICs, Honeywell failed to adequately diversify the fund's GIC assets, according to a suit filed in U.S. District Court for the District of Minnesota.

Meanwhile, plaintiffs' attorneys say eight suits have been filed against Unisys in connection with the purchase of Executive Life GICs. The suits charge that the Blue Bell, Pa.-based computer manufacturer, among other things, failed to adequately take steps to eliminate those contracts from fund portfolios.

All the suits seek recovery of any participant losses related to the purchase of Executive Life GICs. The suits also seek unspecified pu-

nitive damages as well as attorneys' fees.

At Honeywell, 16%, or \$72 million, of its fixed income fund, is invested in Executive Life GICs. At Unisys, \$134 million, or 30% of a fixed income fund that is being phased out is invested in Executive Life GICs, while \$44 million, or 7%, of an insurance contract fund is invested in Executive Life GICs.

These suits are the latest fallout following the April 11 seizure by California regulators of the junk bond-laden insurer, which sold more than \$1 billion of contracts to 401(k) and other pension plans. Many of the GICs were purchased between 1986 and early 1988, when Executive Life offered highly attractive rates and was rated AAA by Standard & Poor's Corp. and A+ by A.M. Best Co.

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Health care bills introduced

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quired to provide a minimum health care benefits package or pay a new payroll tax to fund a public program that would provide coverage. Employers with 100 or fewer workers would have five years to offer health coverage to the workers before they would be subject to the tax.

Identical legislation, sponsored by Rep. Henry A. Waxman, D-Calif., is expected to be introduced in the House this week.

The U.S. Bipartisan Commission on Comprehensive Health Care—known as the Pepper Commission—announced its recommendations last year (*BI*, March 12, 1990; March 5, 1990).

Meanwhile, Rep. Rod Chandler, R-Wash., last week introduced legislation that would void state benefit requirements for health insurance policies sold to small employers that band together to buy coverage on a group basis.

Insurers also would not have to pay state premium taxes on health insurance policies sold to these groups under the bill.

To qualify, the small employer group would have to have at least 100 employer members, with no individual company having more than 100 employees. These groups would have to be controlled by their members and not by an insurer.

All small employer groups would have to be certified by the Health and Human Services Department.

"Significant steps must be taken today to improve access and control costs. This legislation puts affordable health insurance within the grasp of small employers and provides them with the incentives to reach out and take hold," Rep. Chandler said.

C&F to spin off Constitution Re

BASKING RIDGE, N.J.—Crum & Forster Inc. filed a registration statement with the Securities and Exchange Commission last week for an initial public offering to sell more than 50% of Constitution Re Corp., a newly formed holding company for Constitution Reinsurance Corp.

No price has been set for the offering of 10.6 million shares, nor has a date been set for the sale, said a C&F spokeswoman. Proceeds of the offering, which is contingent on regulatory approvals and market conditions, will be used to bolster C&F's commercial property and casualty insurance operations.

Constitution Re, the 11th-largest U.S. reinsurer, wrote \$318.4 million in net premiums in 1990 (*BI*, April 22).

Separately, C&F said it has signed a letter of intent to sell its Toronto-based Canadian business to General Accident Assurance Co. of Canada for an undisclosed amount.

Insurer must be notified: Court

BOSTON—A manufacturer that enters into a consent decree with the government to clean up polluted property without notifying its insurer forfeits coverage, the Massachusetts Supreme Court ruled.

The court held that Liberty Mutual Insurance Co. does not have to indemnify Mansfield, Mass.-based Augat Inc. and wholly owned subsidiary Reliable Electronic Finishing Co. Inc. for more than \$4 million of cleanup costs stemming from a consent decree with the Massachusetts Department of Environmental Quality Engineering. Augat operated a water treatment system that discharged contaminated water into the sewer system and soil at a plant in Canton, Mass.

Liberty Mutual wrote primary CGL coverage for Augat from 1970 to 1986 with annual limits of \$500,000. The policy stated: "The insured shall not, except at his own cost, voluntarily make any payment, assume any obligations or incur any expenses other than for first aid to others at the time of the accident."

"The purpose of the policy provision was to give the insurer an opportunity to protect its interests," the court said. "After Augat agreed to a settlement, entered into a consent judgment, assumed the obligation to pay the entire cost of the cleanup and in fact paid a portion of that cost, it was too late for the insurer to act to protect its interests. There was nothing left for the insurer to do but issue a check."

The court denied Augat's arguments that the consent decree was not "voluntary" and that Liberty Mutual must show it was prejudiced by the policyholder's action before it can deny coverage.

Huge satellite losses feared

LONDON—Satellite insurers have been put on notice of two potential claims totaling about \$235 million.

By far the largest single risk is the Telesat Anic E2, owned by Telesat Canada, which has an insured value of \$220 million and is feared to be a total loss (*BI*, April 22). The coverage is placed in world markets by Leslie & Godwin Ltd. in London and Richards Mellington Inc. in Montreal.

The other potential loss is for an ASC2 satellite, which was launched in March and is owned by the American Satellite Corp. Three of the satellite's transponders—or radar devices—have power problems.

Underwriters have been informed that a maximum \$15 million partial claim may be filed. The satellite's total insured value is \$107 million. The coverage is placed in world markets by Leslie & Godwin and Frank B. Hall & Co. Inc. in New York.

Reinsurers' results improve

WASHINGTON—U.S. reinsurers posted a 105.8% combined ratio for the first quarter, an improvement from the 107% posted by a comparable group of reinsurers for the same period a year ago, according to the Reinsurance Assn. of America.

The 62 reinsurers participating in the latest survey, which reported \$432.7 million in net income in the first quarter, wrote \$2.7 billion of net premiums, up 7% from \$2.5 billion in 1990's first quarter (*BI*, June 4, 1990).

First-quarter 1991 premiums earned totaled \$2.7 billion, while there were \$2 billion in loss and loss adjustment expenses and \$818.5 million in underwriting expenses. The reinsurers reported \$167 million in underwriting losses. Policyholder surplus totaled \$12.6 billion.

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Court finds that asbestos causes property damage

By MICHAEL SCHACHNER

SPRINGFIELD, Ill.—An Illinois Supreme Court ruling that asbestos in buildings constitutes property damage and that an asbestos installer facing litigation from building owners is entitled to a defense from its liability insurers will influence courts nationwide, attorneys say.

In unanimously affirming an appellate court decision, Illinois' highest court becomes the first state supreme court to rule that asbestos fibers in buildings constitutes physical damage to tangible property under comprehensive general liability insurance policies.

As a result, the court ruled, an installer that purchased CGL coverage over a 21-year period is entitled to a defense.

Both policyholder and insurer attorneys call the May 20 decision a landmark ruling.

Policyholder attorneys laud the decision, saying it confirms what many trial and intermediate courts have already ruled: Asbestos in buildings constitutes property damage as defined by the comprehensive general liability insurance policy.

"This is a very significant ruling because you have the first high court in any state ruling on the issue of whether asbestos in buildings constitutes property damage caused by an occurrence," noted attorney William Skinner of Covington & Burling in Washington, D.C., which represents Armstrong World Industries Inc. in asbestos lawsuits.

"The trend is clearly emerging—

and I think all new cases will fall in line—that asbestos contamination is physical damage to property as defined under a CGL policy," Mr. Skinner said.

Insurer attorneys agree that courts nationwide will be influenced by the Illinois Supreme Court's ruling on insurers' duty to defend.

However, they add that the scope of the ruling is limited because it did not address several other major issues at the center of hundreds of asbestos property damage cases. Those issues include whether insurers must indemnify policyholders for court awards to building owners to cover the cost of identifying and removing asbestos and, if so, which liability policies must respond.

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Safeway claims dispute

Coverage for settlement of warehouse fire claims at issue

By JOANNE WOJCIK

OAKLAND, Calif.—Safeway Stores Inc. is embroiled in litigation with its primary liability insurers over coverage for a \$59 million settlement of claims arising from a 1988 warehouse fire.

The Oakland, Calif.-based grocery store chain announced last week that it would pay \$59 million to settle 11,800 claims brought by residents living near the facility in Richmond, Calif. In return, the residents signed release forms waiving their rights to sue.

An additional 2,400 claims are still being negotiated.

Plaintiffs' attorneys representing the claimants had alleged that the fire contributed to the deaths of

more than 18 nearby residents who were already suffering from various diseases. In addition, the fire was blamed for personal injuries like smoke inhalation and damage to automobiles, homes and personal property.

Safeway's liability insurers already have paid out \$39 million in third-party bodily injury and property damage claims stemming from the fire, *Business Insurance* learned.

However, the insurers contend that the most recent \$59 million settlement is not covered, prompting Safeway to file suit in San Francisco Superior Court to recover the cost of the settlement.

Documents related to the litigation have been sealed by the court,

said Robert Zeavins, an attorney with Buchalter, Nemer, Fields & Younger in Los Angeles, who represents National Union Fire Insurance Co. of Pittsburgh, Pa., in the case.

The insurers, led by National Union, a unit of American International Group Inc., maintain that Safeway's liability policy excludes coverage for third-party damage resulting from smoke and fumes released from the warehouse fire.

The pollution exclusion clause added to the commercial general liability policy in 1986 excludes coverage for smoke damage from a hostile fire, according to a spokesman for the Insurance Services Office Inc. in New York.

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Texas Eastern litigates over PCB cleanup cover

By STACY ADLER

HOUSTON—Texas Eastern Transmission Corp. will pay \$200 million to remove PCBs from 19 sites in Pennsylvania and a record \$18.6 million in civil penalties for violating state environmental laws.

The cleanup costs were "included in the company's previously announced cleanup estimate" of \$400 million to remove polychlorinated biphenyls from 90 sites in 16 states, said a Texas Eastern spokesman (*BI*, June 13, 1988; Nov. 16, 1987).

However, the company says it

now expects to spend \$480 million for on-site cleanups and \$250 million for off-site and groundwater cleanups nationwide.

And, the \$480 million cleanup estimate does not include governmental fines or penalties.

The Houston-based company said it expects the Pennsylvania agreement to be merged into a larger agreement it has reached with the U.S. Environmental Protection Agency to clean up the company's compressor station sites along its 10,000-mile long natural gas pipeline.

Texas Eastern, which owns and

operates a pipeline that stretches from Texas and Louisiana to the Northeast, used PCBs—which are suspected of causing cancer—as a fire-retardant in the pipeline beginning in 1968. The company is currently litigating with its 29 general liability insurers over coverage for the cleanup costs. There are lawsuits pending in state court in Texas and federal courts in Dallas and Philadelphia.

There have been no judgments on the availability of insurance to cover the cleanup costs.

The company is accounting for

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Public entity risk managers need a renewed commitment to enforcing police officer training in the constitutional use of force, says this week's editorial. **PAGE 8**

Two Crum & Forster Inc. units have been fined \$250,000 each by the New York Insurance Department in connection with various violations. **PAGE 10**

Despite E.C. efforts to harmonize laws, local traditions will present obstacles to an open insurance market for years to come, says R. Patrick Thomas of Alexander & Alexander International Inc. in Perspectives. **PAGE 27**

AMBAC Indemnity Corp. says Citibank's plans to sell a majority interest in the municipal bond insurer to the public will have no impact on its operations. **PAGE 29**

Japan's Ministry of Finance is considering broad changes to the nation's insurance law in an effort to spur competition in the market. **PAGE 31**

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CEOs to make next cost cuts in health plans?

By JOANNE WOJCIK

SAN JOSE, Calif.—Concern over rising health care costs will move from the employee benefits department into the corporate boardroom during the next decade, predicts a health care consultant.

And when that happens, the onus will be on employee benefit managers to educate corporate financial officers about quality and cost-effectiveness of certain types of employee benefits to prevent top management from using a meat-ax approach to cost containment, the consultant warns.

While health benefit decisions are not made by the top decision maker at 99% of U.S. corporations, "for the first time, the CEOs are going to have to deal with health care," asserted Peter Boland, president of Boland Healthcare Consultants in Berkeley, Calif., at the recent annual meeting of the Na-

tional Assn. of Employers for Health Care Action.

The meeting, titled "Managed Health Care: Strategies for the '90s," was held May 16-17 in San Jose, Calif.

Mr. Boland said three factors will work together to bring health care costs to the attention of chief executive officers:

- Continuously rising health care costs, despite benefit managers' past efforts to curb them.

"In general, I don't believe that managed care, per se, has saved money," Mr. Boland said. "It shifted costs, it shifted risks, it's done a lot of things. But aggregate health care costs and the unit costs have not been appreciably affected by the intervention of managed care."

- New Financial Accounting Standards Board rules that will require employers to account for fu-

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Concerted effort needed to reform system

Interactive panel views comp crisis

By MEG FLETCHER

CHICAGO—A workable solution to the problems in the workers compensation system requires the participation of all those with a stake in the system, despite their divergent interests, experts say.

Eleven "stakeholders"—including employers, employees, insurers, lawyers, doctors and state workers comp administrators—discussed "Workers Compensation: Crisis Resolution" during a nationwide "videoconference" last week sponsored by The Society of Chartered Property & Casualty Underwriters.

The 2¼-hour program was broadcast to more than 1,600 people at 40 sites around the nation. In addition, people viewed the program at five companies that paid a special fee to receive the broadcast, a Society of CPCU spokesman said.

The interactive program allowed viewers to telephone panelists with questions.

The 80-year-old workers compensation system is being plagued by "a growing crisis," said Stephen J. Paris, president of the Society of CPCU and managing partner of the Boston-based law firm Morrison, Mahoney & Miller.

Panelists collectively rated the health of the workers comp system as a "7" on a scale ranging from a high of 1 to a low of 10. However, individual panelists' ratings ranged from a "5" by a state workers compensation administrator to a "14" by William Hager, president of the National Council on Compensation Insurance in Boca Raton, Fla., which collects statistics and proposes rates on behalf of insurers and manages residual market programs nationwide.

The disparity in the assessments of the health of the workers comp system was indicative of the different points of view of panel members.

From insurers' perspective, the

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Governmental risk management

Risk managers need to assess air quality problems

By SARA J. HARTY

ATLANTA—Risk managers can help prevent prolonged, expensive investigations into indoor air quality problems by doing their homework before a problem develops or at least before outside specialists are called in, two risk managers suggest.



The American Society of Heating, Refrigerating & Air Conditioning Engineers in Atlanta sets fresh air standards with which all risk managers should be familiar, said Sharon E. Floistad, risk manager of the Douglas County School District in Castle Rock, Colo.

Risk managers need to get "more involved in the design phase of buildings—especially remodels and renovations," Ms. Floistad advised.

They should also make sure that contractors are very familiar with the ASHRAE standards, Ms. Floistad said in an interview after her presentation at 12th annual Public Risk Management Assn. conference, held May 13-15 in Atlanta.

Contractors "typically want to go with the system that gives the most energy-efficient building and that can sometimes compromise fresh air standards," she said.



Ms. Floistad and another public entity risk manager shared the tips they learned when they faced

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Written policies best defense against police liability exposures

By MICHAEL SCHACHNER

ATLANTA—Police departments can best manage potential liability by implementing written policies and procedures and then training officers to adhere to them, according to a liability management consultant.

Police chiefs and municipal risk managers also must make a greater effort to supervise and guide subordinates to control police liability exposures, he said.

In light of recent highly publicized cases of police brutality, like the Rodney King case in Los Angeles (BI, March 25), law enforcement officers now are under a tremendous amount of scrutiny regarding the use of force, observed G. Patrick Gallagher, director of the Institute for Liability Management in Leesburg, Va.

"Jury sensitivity toward police violence is way up, while police credibility is down. Supervisors

must do more to look over their subordinates—not overlook their actions," Mr. Gallagher said during a session at the 12th annual Public Risk Management Assn. conference in Atlanta earlier this month.

"The police chief and risk manager can't manage liability if they can't manage their people. The greatest exposure to liability exists when the police chief knows what's going on but doesn't do anything," he explained.

Mr. Gallagher said that while police work is a "tough line of business where the adrenaline gets pumping," supervisors of line officers must implement a systematic approach to instructing officers about the proper use of force, one which addresses liability and increases effectiveness. Any approach also must detail disciplinary measures the department will take against officers who violate policy.

"As a leader, you need to guide with a plan and vision," Mr. Gallagher said.

That plan should include:

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Proposals target safety of blood, tissues

By CHRISTINE WOOLSEY

The risk of medical providers using contaminated blood and human tissue when treating patients would be mitigated under a new American Red Cross program and a proposal by some tissue banks to provide safer products.

In an effort to allay the public's fears about the safety of the nation's blood supply, the Red Cross is overhauling the way it collects, processes and distributes blood.

At an estimated cost of \$120 million, the Red Cross will temporarily shut down every Red Cross regional blood center in the country during the overhaul, which is expected to take 2½ years to complete.

Meanwhile, some of the nation's 700 to 800 tissue banks and organ procurement agencies believe that internal risk management and voluntary quality controls may not be

enough to guarantee the safety of the human tissues and organs those facilities process.

As a result, some tissue banks and a consultant on federal regulation of medical devices are calling for the Food and Drug Administration to implement regulations that would require tissue banks and other centers that handle skin, bone or ligaments to follow a standardized set of operational procedures during processing.

That consistency would help guarantee the safety and effectiveness of these medical "products," they say.

And, some independent tissue banks are calling for the government to form a national computer registry that could track the path of tissues from donor to recipient.

Some of those facilities pointed to an incident last month in which the Colorado Department of Public Health raised concerns that a tis-

sue bank may have processed and dispensed tissue infected with the virus that causes acquired immune deficiency syndrome, despite conducting proper screening procedures.

The Red Cross says that next January it will begin a program of closing each of its 53 blood centers for eight weeks at a time to install a single national computer system designed to facilitate record keeping and retrieve information on blood donors.

In addition, the Red Cross is re-vamping its donor referral registry. All Red Cross centers will be able to tap into this archive through the national computer system to obtain any health history data or test results that have categorized a blood donor as unsuitable.

The new system will replace the 10 independent operating systems the Red Cross currently uses.

The Red Cross at the same time

will implement new standard operating procedures and improve staff training.

"The procedures will be uniform—that's really the key risk management technique going on here," said Christopher Mandel, director of risk management for the American Red Cross. "Because of the decentralized nature of our current structure, centers were basically able to do whatever they wanted and needed to do in terms of automation. Now there will be one system everyone can understand and tap into."

The use of one central computer system is "particularly important with donor referral—health histories and lifestyle histories are a key part of the system" and will help the Red Cross keep track of unsuitable donors, Mr. Mandel said.

The reforms also limit blood

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Photo by Michael A. Marcotte

American Red Cross regional blood centers will be shut down during a procedural overhaul.

Workers comp

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system is "a monster" that is doomed to fail in many states unless regulators allow insurers to charge adequate rates and control costs, Mr. Hager said.

The NCCI says the "key cost drivers" in the system are: increased medical costs; increased indemnity costs; the burden posed by the residual market; and fraudulent practices, like employee leasing schemes designed to avoid payment of workers comp premiums.

Insurers also are frustrated by many states' prohibitions against using managed care techniques like limiting an employee's choice of subsequent treating physicians, said Gary Countryman, president of Liberty Mutual Insurance Co. in Boston, the nation's largest workers comp insurer.

In addition, medical costs are excessively high in too many states due to provider cost shifting, while litiga-

tion involving both claimants and defense lawyers—as well as the doctors both sides find to support their cases—is increasing, several panelists said.

Litigation added \$1 billion to California workers comp costs in 1988, or an amount equal to one-sixth of all California workers comp costs, Mr. Hager said.

Mr. Hager and Mr. Countryman also faulted employers for not educating employees about the workers comp system before an injury occurs.

In addition, it can mean "big bucks" in workers comp cost savings if an employer shows an injured employee that it cares about him and his recovery, Mr. Countryman said.

However, other panelists said insurers are the cause of workers comp problems.

For example, panelists engaged in a heated exchange over whether insurers of residual market risks provide adequate loss control services.

"Loss control is almost non-exis-

tent in the residual market," said Allyn C. Tatum, a commissioner with the Arkansas Workers Compensation Commission and president-elect of the International Assn. of Industrial Accident Boards & Commissions.

The NCCI's Mr. Hager responded that Mr. Tatum's allegation was "ir-accurate."

"It's simply not being done," quickly retorted Richard L. Katten, vice chairman and chief operating officer of The Ferd. Marks Insurance Agency Ltd. in New Orleans and immediate past president of the Society of CPCU.

Other panelists faulted insurers for sloppy claims handling and failing to keep employers informed about the status of contested claims.

The two employer representatives on the panel—both self-insurers—focused on not exaggerating the crisis and on ways to control health care costs and help employees return to work.

Alan Strohmaier, director of un-

employment and workers compensation issues for General Motors Corp. in Detroit, emphasized that some states' workers comp systems work well and he urged panelists to "build on these strengths."

"Once we label something a crisis, the tendency is to go to work with a meat ax, rather than a scalpel. History is full of examples which demonstrate that this doesn't work," he said.

In addition, Lucille Gallagher, vp-risk management for Monfort Inc. in Greeley, Colo., and vp-governmental affairs for the Risk & Insurance Management Society Inc., urged all employers to follow the lead of self-insurers that have lowered their workers compensation costs. These companies have done so by demonstrating their concern about employees' health through education and loss control programs, active management of claims, and emphasis on return-to-work and wellness programs, she said.

Labor spokesman James Ellenberger, assistant director of the AFL-

CIO's Department of Occupational Safety and Health in Washington, D.C., expressed his frustration with inadequate loss control and inadequate benefit levels in some states.

In addition, he noted labor's opposition to efforts by employers and insurers to limit employees' choice of physician or a Florida program that allows employers to combine workers compensation and group health care coverage into a "24-hour" coverage program. Under that program, injured employees could be required to make copayments for medical care (BI, March 18).

A government representative—William E. O'Neill, chairman of the Industrial Commission of Virginia—said that more states should adopt alternative dispute resolution procedures, which have proved effective in his state.

Arkansas's Mr. Tatum joined several panelists in expressing concern about unnecessary litigation, adding that he personally is "really concerned" that employers and insurers are litigating admittedly compensable claims.

However, a defense and a claimants' counsel strongly advocated their roles in the system.

Employers need lawyers to represent their interests because of the increasing complexity of claims for problems like stress and toxic exposures, as well as questions about whether claims filed by an aging workforce are indeed work-related, said Paul Goodrich, a defense attorney with Morrison, Mahoney & Miller.

"Lawyers are not interlopers;" they are "inherent in the system" and should be "invited to the feast," said Peter Macdonald, a claimant attorney with Macdonald & Wallace in Quincy, Mass. "Creative lawyering" is a boon to injured employees because it requires employers to be "a little more humanitarian," he said.

Doctors were criticized by many panelists for overcharging workers compensation claimants through cost shifting and sometimes subjecting injured workers to excessive and unnecessary treatment.

Besides voicing problems, the panelists also outlined potential solutions for the ills that plague the workers compensation system.

The "ultimate solution" is controlling cost through utilization review, managed care, alternative dispute resolution and a renewed commitment to safety, Mr. Countryman said.

Reaching that solution requires reforms that can only be achieved through coalition building, communication among stakeholders—preferably before a crisis develops—and lobbying with the help of employees, he said.

An effective coalition must have leaders "that can stand up to vested interests," Mr. Hager warned.

In addition, they must be able to hammer out an effective compromise in which each party wins more than it loses, GM's Mr. Strohmaier said.

But such a movement should not lose sight of the fact that the "principal parties" are employees and employers, the AFL-CIO's Mr. Ellenberger emphasized.

Certifying lawyers as being capable of handling workers comp cases may help, suggested Mr. Macdonald, the claimant attorney.

In addition, states should consider adopting a program like one in California designed to establish standards for medical providers who evaluate uncontested workers compensation cases, said Dr. Ira H. Monosson, president of the State of California Industrial Medical Council in Santa Monica. That should help reduce "doctor shopping" as well as the influence of "medical mills," where patients receive multiple specialty exams and treatment whether or not they are needed, he said.

If the existing system cannot be fixed, there will be increased interest in alternatives like state workers compensation funds—which labor supports—and 24-hour coverage programs, other panelists said.

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EPO, flex plan keep health costs in check

By MICHAEL SCHACHNER

Benefit beat

A recently implemented flexible benefits plan with an exclusive provider organization feature is helping one of the largest private hospitals in Phoenix rein in rising health care costs by keeping more than 85% of medical expenditures within its own control.

Due to unexpected high enrollment in the EPO, St. Joseph's Hospital and Medical Center now estimates that about \$7 million of an estimated \$8 million in medical claims this year will be paid to the hospital itself or to network doctors affiliated with St. Joseph's, said A.J. Lindemann, vp-human resources.

"Now we're redirecting most of our employees to our hospital and exclusive providers with whom we have discounts," according to Mr.

Lindemann. "The program will also allow us to build an extensive data base which can give us information to become more competitive," he said.

The EPO, which is one of many features in the hospital's new self-funded flexible benefits plan, has attracted about 87% of eligible St. Joseph's employees.

Mr. Lindemann estimates that 3,000 of the hospital's 3,500 benefit-eligible employees and 2,300 of their dependents have enrolled in the EPO, which the hospital began offering as part of the flex plan on Jan. 1.

"Enrollment far exceeded our expectations and wildest dreams," Mr. Lindemann said.

"We would have been very excited with 70% enrollment," he added.

Only 250 of the hospital's benefit-eligible employees and 187 of their dependents have opted for traditional indemnity coverage.

The remaining 250 eligible employees have opted not to obtain health coverage through the hospital.

St. Joseph's, a division of Catholic Healthcare West, believes it is one of the first health care facilities in the country to implement a flexible benefits plan with an EPO feature under which the hospital acts as the plan purchaser and provider.

EPO enrollees must seek care through a network of 700 Phoenix-area physicians, all of whom are affiliated with the hospital.

EPO enrollees pay only a \$15 of-

face visit copayment.

Additional tests and major radiology must be conducted at St. Joseph's and are fully covered by the plan.

EPO enrollees in need of hospitalization must be admitted to St. Joseph's. The hospital, in essence, reimburses itself using Medicare diagnostic-related group rates.

The health care costs incurred by EPO enrollees who obtain care from providers outside of the network are not covered.

"Everyone wins here," Mr. Lindemann said.

"Employees pay much less" than they would through the indemnity option, and they "work in partnership with the hospital to absorb cost increases. The hospital works in partnership with physicians to expand their patient volume. And, the hospital reduces benefit expen-

ditures because we pay doctors off a fee schedule instead of retail rates, and hospital costs are paid to ourselves based on DRGs."

The EPO also requires no claim forms or hospital registration.

"It's simple and paperless, which is exactly what we wanted," Mr. Lindemann said.

EPO enrollees are not subject to any deductibles or copayments.

An employee's monthly contribution toward the cost of coverage is based on several factors, including length of service; lifestyle habits, like whether the employee smokes; and the number of individuals covered.

Mr. Lindemann said that the EPO is a drastic departure from the hospital's only previous health care program—a traditional indemnity plan.

"Employee reaction to the indemnity plan was dismal, and \$5.6 million of about \$8 million in annual costs were being paid to facilities outside our universe of influence," Mr. Lindemann explained.

Under the self-funded indemnity plan, most enrollees are subject to a \$500 or \$1,000 per person deductible. The monthly contribution toward the cost of coverage is based on the deductible and other factors.

However, enrollees who live outside of the EPO area can select a \$200 deductible.

A traditional indemnity plan enrollee also is subject to a 20% copayment requirement. The annual out-of-pocket maximum, including deductibles, is \$5,000.

St. Joseph's claims administrator is ALTA Health Strategies Inc. of Salt Lake City.

In addition to the EPO, the flex plan also offers St. Joseph's employees:

- Dental and vision benefits.
- The option of one of three levels of long-term disability coverage: 40%, 50% or 67%.
- Six levels of life insurance, written by Northwestern National Life Insurance Co. The coverage also is available to spouses on an after-tax basis. Available limits are \$10,000; \$50,000; limits equal to an employee's base salary and two, three or four times base salary.
- The option of buying or selling 40 hours of vacation and sick days.

Mr. Lindemann said this option is one of the most appreciated benefits in the flex plan.

"Employees get what they ask for, and we get happier employees. It's a great benefit for single parents who may want to buy orthodontia benefits or something. Also, employees who don't use all their vacation can sell them back at the end of the year for cash. There's no use-it-or-lose it," Mr. Lindemann said.

- The option of placing up to \$3,000 in a pretax health care spending account. The money can be used to pay copayments in the EPO or deductibles and copayments in the indemnity plan.

The hospital committed itself to flexible benefits in 1989 but did not begin creating the EPO until last July, according to Mr. Lindemann.

"We didn't want an off-the-shelf flex plan," he said.

"We wanted to find a way to reel in costs that was automated and not people-intensive. This program only requires one full-time medical director and a part-time assistant."

"Everyone has been amazed at how quickly and cheaply we set this up," he said. Initial start-up costs were only about \$100,000, including legal and consulting fees. "We did a lot of the work ourselves," Mr. Lindemann explained.

The Wyatt Co. in San Diego was St. Joseph's consultant. ■

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Opinions

Minimizing police liability

PUBLIC RISK MANAGERS, who have long recognized the potential liability for excessive use of force by their police departments, have powerful new arguments for a renewed commitment to adopting and enforcing police officer training in the constitutional use of force.

The videotaped beating of Rodney King by Los Angeles police officers in March has heightened public awareness and scrutiny of police activities, greatly increasing a municipality's exposure to accusations and findings of police brutality.

Juries, with the horrific scenes of that beating engraved in their memories, are likely to be much more sympathetic to plaintiffs alleging police brutality.

Two sessions at the Public Risk Management Assn.'s recent annual meeting dealt with this important issue, offering public risk managers excellent advice (see story, page 3).

Supervisors of line officers must implement a systematic approach to instructing officers about the proper use of force and detail disciplinary measures the department will take against officers who violate policy, it was pointed out.

All public risk managers with a police force in their jurisdiction, even those with the highest confidence in their department's training and use-of-force policies, should meet with their police chiefs to review those policies and procedures. Reinforcement of their importance and effectiveness is the least that needs to be done, while some jurisdictions may find their policies and procedures in need of improvement. Any risk



manager whose relationship with the police chief is too weak to accomplish this is not doing his or her job.

Public risk managers must capitalize on this new public awareness to implement effective police training policies to ensure that what happened in Los Angeles will not happen in their jurisdictions.

More than a municipality's finances are at stake. The lives and constitutional rights of its citizens and respect for the police force are at risk, too.

Letters

State funds meet most tank coverage needs

To the editor: As a major producer of pollution liability insurance for petroleum storage facilities, I would like to comment on Robert R. Harrigan's letter on this subject (*BI*, April 29).

Mr. Harrigan makes comparisons between state underground storage tank funds and pollution liability insurance with a pronounced bias toward insurance.

Mr. Harrigan indicates that since many state tank funds are structured on a reimbursement basis, a tank owner/operator may experience a substantial delay in obtaining money from the fund. First, most state funds provide for partial reimbursement, so the tank owner/operator should not have to wait for reimbursement until cleanup is complete. Second, payment delays are endemic with insurance companies on this line of business, to a great extent caused by the necessity of going back and forth with the policyholder regarding what costs are covered.

For example, a petroleum official involved with the administration of the Ohio fund indicates that tank owners/operators are submitting expenses for everything, including the kitchen sink. I am not surprised; we have been experiencing this since our involvement with this coverage in 1982.

Mr. Harrigan is correct that "participation in a state fund does not necessarily meet the EPA financial tests." This is true where the state fund clearly intends to satisfy only a part of Environmental Protection Agency requirements; for example, when a fund only provides coverage for cleanup and not third-party liability. In such instances, insurance, or another acceptable mechanism, can be used to cover that portion not covered by the fund. However, a UST

owner/operator can use state funds that have been submitted to, or approved by, the EPA to satisfy all or part of EPA requirements.

Mr. Harrigan's contention that some state funds are underfunded is valid, but most state funds are moving toward funding through taxes, as opposed to fees, and this should solve most funding problems.

Conversely, Mr. Harrigan does not address certain major problems that relate to pollution insurance policies as compared to state funds. For example:

- Nearly all state funds are entitlement programs, which means that no underwriting requirements other than tank registration have to be met. This has obvious appeal to the tank owner/operator when compared to the lengthy and costly underwriting requirements usually necessary to obtain insurance.

- Many insurance policies have a retroactive exclusion that negates coverage for leaks occurring prior to the policy effective date. Since gradual leaks are responsible for at least 85% of all UST losses, a retroactive provision has the effect of eliminating coverage for most losses discovered during the first three or four years that the insurance is in force. Most state tank funds not only do not have a retroactive restriction, many even provide reimbursement for losses cleaned up within a certain time period prior to the establishment of the fund.

Costs of carving out drug benefits

To the editor: You reported that many employers are considering carving out their prescription drug programs from their current major medical plan designs in order to capture data and effect savings (*BI*, May 6).

In reality, the opposite is likely correct.

A state in the far Northwest carved out a portion of its prescription drugs from its major medical coverage and offered a mail order benefit to capture the maintenance drug savings. Although there may have been some savings of ingredient costs, by carving out the benefit and allowing employees immediate access to this coverage with inappropriate front-end deductibles and coinsurance levels (flat copayments and no deductibles were used in the plan design), the employer's contribution to the benefit went from 68% of the balance of its major medical coverage to 92% of the prescription drug program. If mail service can offer up to a 20% savings on ingredient costs, then this plan cost the state more than 10% (after cost sharing), assuming it was able to capture the full ingredient savings suggested.

Another example is a utility in New En-

gland with two benefit plans. One for certain bargained active employees has a carved-out prescription drug pharmacy reimbursement program along with mail order service. The employer is paying 93% of the benefits under this program. Under its salaried and retiree groups, which are still totally subject to the medical deductible and coinsurance levels, the employer pays 67%.

Therefore, the very act of carving the benefit out may incur the greatest cost increase for the employer. Nowadays, the latest in technology allows us to capture all of the data, effectively manage the benefit, yet still require the employee to pay for the drugs in full prior to submission of the claim. This allows the cost containing aspects of major medical to work, while capturing the savings opportunities from effective claims processing and retail network development—but without the high utilization or aberrant cost sharing percentage seen with carved-out benefits.

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SUBSTANCE ABUSE IN THE WORKPLACE — THE VOICE OF EXPERIENCE.

Part of an ongoing series of conversations between Argonaut Insurance Company, our clients and their brokers, dealing with issues important to their business. The intent is to keep the lines of communication open. We invite your participation.

THE PARTICIPANTS: **MARK A. MARIANI**, Owner and President of Mariani Packing Company, a leading processor and distributor of dried fruits. **BOB APPLEBY**, Woodruff Sawyer & Co., Mariani Packing Company's broker. **STEVE LA SHIER**, Senior VP Safety Management, Argonaut Insurance Company. **JOE SILVA**, Executive Safety Management Consultant, Argonaut Insurance Company.

MODERATOR: First of all, how many employees do you have?

MM: About 225. Approximately 40 are salaried and the balance hourly.

MODERATOR: And how many facilities do you have?

MM: We have three full time facilities, primarily processing plants. San Jose is the final packaging facility.

MODERATOR: You've had a substance abuse program in place for about 18 months. Tell us about it.

MM: Our program is very simple. Every new employee is to be tested. Part of the program is the knowledge that if someone wants to work here, they will be tested. Upon the completion of those tests they either will or will not be eligible to work here.

MODERATOR: What motivated the program? Did you have an internal problem, or was it just the realization that substance abuse is a growing problem in general?

MM: We didn't have a problem. I think there was an awareness at the management level within the company that we can't put our heads in the sand and think that we're not

affected by drugs in the workplace. The other issue was that we found it was the newly hired employees that were being hurt on the job. They would come on for ten days, two weeks, then get hurt and go on workers' comp or disability. Pre-testing was one component of an overall effort to identify and correct the causes of injuries in the workplace.

MODERATOR: What kind of reaction did you get from the employees when you told them you were going to initiate the program?

MM: There wasn't any negative response.

JS: The program wasn't just thrown at them. There was a lot of publicity, a lot of talking about it before it began.

MM: We let people know through our bi-monthly newsletter. We also have what we call "toolbox meetings," department meetings, on a regular basis.

JS: Also, this program didn't affect existing employees.

MODERATOR: Do you bring up substance abuse as part of those "toolbox" meetings?

BA: Substance abuse is just one of many factors in the overall safety program that we talk about.

MM: I don't think the substance abuse issue can be handled successfully if that's the only issue. I think you have to go to the employees and say "How can we make this a safer workplace as a whole?" And substance abuse, along with being ill-prepared in the mornings, or not understanding regulations and a lot of other factors, are all part of a program to insure a healthier workplace. I think what's really important is that you

have to deal with the well-being of the workplace as a whole.

SL: That's exactly how you should approach it. The successful substance abuse programs are the ones that have dealt with it just as you have—as a safety and health issue.

MM: I think it's interesting that while an abuse program has to be orchestrated by management, it also has to have the support of employees. We just finished tabulating a questionnaire we passed out among our employees. One of the questions was how they felt about drug testing. Over 98.6% of them said "We want drug testing."

SL: 98.6%. That's an impressive figure.

MM: We don't feel we're here to be the police. We're here to provide a safe environment for our working community. We're 225 people who spend nearly 1/2 of our lives together, and we'd better work as a community for the safety and well-being of all of us.

MODERATOR: Why did you put out the questionnaire?

MM: We wanted to ask them "Do you think drugs should be in our workplace? Do you think our equipment operators and drivers of our vehicles should be drug tested to provide a safer work environment for all the community members?"

And 98.6% said yes, we want testing. I intend to take that response and implement a program for random drug testing.

SL: What you're doing now is not random. You're talking about a specific class of employees—equipment operators, forklift drivers—people that have the capability of doing serious damage to your plant, to themselves or other employees. Courts have upheld that testing an entire class of employees, because of their job function, is legal. Especially if it's demonstrated that their job is safety

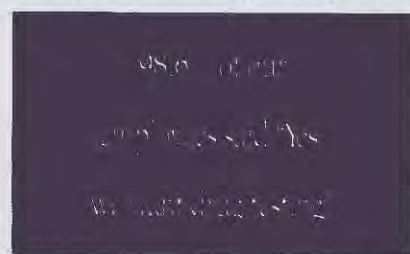
related. And if you structure your program properly, you'll find that as long as you test every single person in that class, you won't be labeled discriminatory. Now, I always

recommend that customers pass their programs through a labor attorney.

JS: They're testing a specific group for safety related reasons.

SL: Right. That's not random. You're specifically testing all the workers in a clearly defined group. What you're doing is called "periodic and intermittent" or "routine" testing of that job class.

MM: I was ahead of myself when I said random. I should have said that we are classifying 'safety-sensitive job descriptions' and that we will be having unscheduled testing of workers in those classifications. Again, the process as we see it is first having the mandate by our community, developing the



criteria, and rewriting our policy handbook. Then we'll have everyone tested in those classifications. And we'll tell them that if they're going to continue to be a forklift driver for us, we'll be routinely testing them.

JS: If I could interject something here; the questionnaire that Mark is talking about addressed much more than just substance abuse. It covered a wide variety of issues. Substance abuse is not being singled out, it's being incorporated into the overall management concerns.

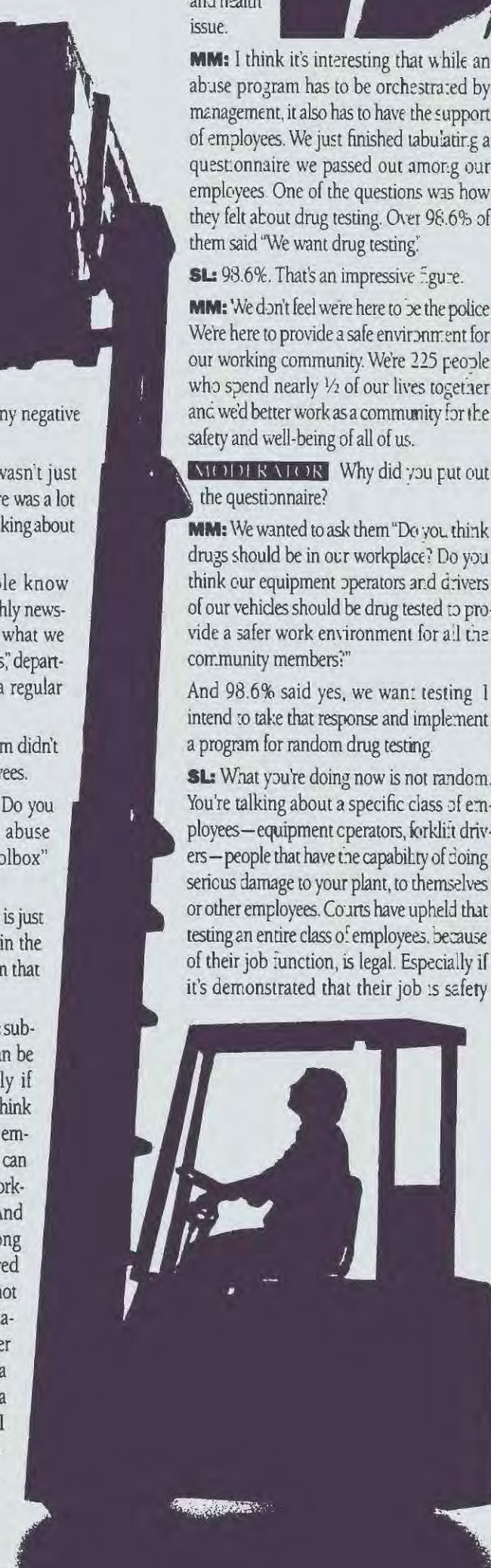
BA: What Joe's saying is important. If other companies are going to follow our example, I think it's very important that they look at substance abuse as a component of any safety program and not make it the only issue.

Continued next week

We'd like to hear what you have to say about substance abuse in the workplace, and about our discussions on topics that concern your business. Send your comments to Mike Crall, President, Argonaut Insurance Company, 250 Middlefield Road, Menlo Park, CA 94025.

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New York fines Crum & Forster units

NEW YORK—Two Crum & Forster Inc. units have been fined \$250,000 each by the New York Insurance Department in connection with violations involving inaccurate schedules in 1987 and 1988 financial reports, reinsurance and managing agency agreements and establishing inadequate reserves.

According to a stipulation agreement signed by both New York regulators and company officials, Basking Ridge, N.J.-based United States Fire Insurance Co. and Westchester Fire Insurance Co. filed inaccurate schedules in their 1987 annual and March 1988 quarterly statements that "did not allow for proper evaluation" of their reserve adequacy.

In addition, from 1978 to 1987, through their participation in a reinsurance pooling arrangement, the units participated in several reinsurance agreements and managing general agency agreements with affiliated Crum & Forster insurers without submitting the agreements for prior approval by the superintendent, as required by New York statutes.

In addition, according to the department, in 1986 the units also became aware they were liable for a loss in connection with a financial guarantee policy involving four \$30 million notes issued by a partnership.

In violation of the insurance law, however, they did not establish

Around the states

adequate reserves until shortly before a \$120 million loss payment was paid in October, 1988. Because of an estimated \$30 million salvage recovery on the property, there was a net loss of \$90 million reported as of September 1988, according to a department report.

A Crum & Forster spokeswoman noted that "there were procedural errors that the two companies got themselves involved with." She added, "Most, if not all, of these violations have been corrected."

The stipulation agreement states the violations "were not the result of any conscious company policy or practice to evade the requirements of the insurance law" and that the units will "take all additional steps necessary to prevent the recurrence of similar violations."

—By Judy Greenwald

EPA limits liability

TACOMA, Wash.—The U.S. Environmental Protection Agency agreed to limit the liability of a bank that wants to foreclose on polluted property.

Under the agreement, the Seafirst Bank of San Francisco will pay about \$250,000 to clean up property on Commencement Bay near Tacoma, Wash. and contrib-

ute \$350,000 to clean the bay. The total cost of cleaning the bay is expected to reach \$32 million.

The EPA is seeking the balance of the cleanup costs from more than 200 companies that own property on the bay or sent their wastes to the area.

The owner of the property went bankrupt five years ago. The mortgage on the property was held by American Savings Financial Corp. of Tacoma, which was purchased by Seafirst.

The agreement reflects a 1989 policy instituted by the EPA to work out agreements that limit the liability of innocent prospective purchasers of polluted property, explained Allan Balkalian, assistant regional counsel for the EPA in Seattle.

Although this is the first so-called Prospective Purchaser Agreement the EPA has entered into solely with a bank, the agreement is unrelated to the agency's proposed lender liability rules, which make lenders that take part in the management of a company jointly and severally liable for cleanup costs, explained Mr. Balkalian (*BI*, Sept. 3, 1990).

"This is not a lender liability settlement; it is a prospective purchaser settlement," explained Mr.

Balkalian.

By freeing future purchasers of the property from liability for cleanup costs, the agreement allows the property to be put to a beneficial use, explained Michele Corash, an attorney with Morrison & Foerster in San Francisco, who represented Seafirst Bank, a unit of BankAmerica Corp.

—By Stacy Adler

Comp deductible

INDIANAPOLIS—Beginning July 1, employers in Indiana will have the option of obtaining workers compensation insurance with a deductible, under a new law signed recently by Gov. Evan Bayh.

House Act No. 1517 says that insurers may offer deductibles in multiples of \$500, up to a maximum of \$5,000 per compensable claim, or offer coinsurance for each compensable claim. The co-insurance must require the insurer to pay 80% of the benefits due to an employee, and an employer may not be required to pay more than \$4,200 in coinsurance for each claim.

An employer is not permitted to require an employee to pay a deductible or coinsurance for workers compensation benefits, the law says.

The law also states that in most cases an employer must notify an employee of its intention to termi-

nate temporary total disability benefits. If the employee objects, he or she must make a written complaint within seven days of receiving the notice.

If the state workers compensation board is unable to resolve the disagreement within 10 days of receiving the employee's objection, it must arrange for the employee to be examined by an independent doctor. If the doctor determines the employee can return to work or the employee does not appear for the examination, the benefits may be terminated.

If either side disagrees with the doctor's decision, the matter can be referred to the workers compensation board for a hearing. The employer is not required to continue the benefits for more than 14 days after the proposed termination date unless the independent doctor says the employee is unable to return to work.

The law also sets a schedule of benefits for temporary total disability and permanent partial impairment, which increase annually until July 1, 1994. The benefits, which vary according to the severity of the injury, are generally based on the idea the injured worker should receive a benefit equal to about two-thirds of his or her wages, said Roy Dominguez, chairman of the Workers Compensation Board of Indiana.

—By Colleen Johnson

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AIG makes several management changes

American International Group Inc. has announced several top management changes.

Thomas R. Tizzio has been elected president of AIG with responsibilities for worldwide general insurance operations (BI, May 20). Mr. Tizzio, who joined AIG in 1967, had been vice chairman-domestic general insurance.

Among other duties, Mr. Tizzio was elected president of AIG's Domestic Brokerage Division in 1985 and executive vp of AIG in 1986.

Jeffrey W. Greenberg, formerly president of National Union Fire Insurance Co. of Pittsburgh, Pa., has been named executive vp in charge of domestic brokerage at AIG. As head of the brokerage group, Mr. Greenberg—who joined AIG in 1978—succeeds Mr. Tizzio.

Before being appointed president of National Union in 1987, Mr. Greenberg served as president of the North American division of American International Underwriters, AIG's overseas general insurance marketing division.

Succeeding Mr. Greenberg at National Union is **William D. Smith**, who had been president of the insurer's management liability division. Before joining AIG in 1990, Mr. Smith served as corporate director of risk management for Sears, Roebuck & Co.

Kevin H. Kelley, president of AIG's Lexington Insurance Co. unit, was named senior vp of the

Comings & goings: Industry

parent company. Mr. Kelley, who joined Lexington in 1975, will also become chairman of Commerce & Industry Insurance Co.

Edmund Tse was named an executive vp-life insurance with executive responsibility for coordin-



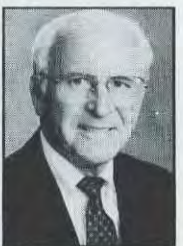
Mr. Friedewald



Mr. Puntney



Mr. Liggett



Mr. Clark



Ms. Brierre



Mr. White

ating AIG's life insurance operations in southeast Asia, the Philippines and Taiwan. He will continue as president of American International Assurance Co. Ltd., AIG's southeast Asian life insurance unit based in Hong Kong. Mr. Tse has been with AIG for 30 years.

R. Kendall Nottingham, currently chairman of American Life Insurance Co., will also become a senior vp of AIG. He has been with AIG for more than 20 years.

In other insurer changes:

Metropolitan Life Insurance Co.

of New York announced three promotions to senior vp: **James A. Valentino**, in the pension division; **Judy E. Weiss**, in charge of pensions, corporate accounts; and **Dr. William T. Friedewald**, who remains the company's chief medical

director.

Eric Puntney named vp and director of marketing/underwriting effective Aug. 1 for Economy Fire & Casualty Co., a Kemper Group unit. He replaces **George Liggett**, who is retiring after 25 years with the company.

Jim Clark named vp of Group Insurance Services Inc. of Chattanooga, Tenn, a unit of Blue Cross & Blue Shield of Tennessee.

Agent/Broker

Linda K. Brierre named senior

vp at Frank B. Hall & Co. of Illinois in Chicago.

Richard N. White elected vp and regional manager for the metro region of Hobbs Group Inc. in Greenwich, Conn. Hobbs Group is a brokerage subsidiary of Arkwright Mutual Insurance Co.

Paul R. Wankle named area president in Oakland, Calif., with Gallagher Heffernan Insurance

Conn.; and **Kurt G. Steinhauer** in New York.

James R. Cody joined Reinsurance Alternatives Inc., an intermediary in Minneapolis, as senior vp.

Scott D. Moore will join Skandia American Reinsurance Corp. of New York as senior vp and chief financial officer. He currently is partner with Coopers & Lybrand.

Other suppliers

Michael R. Touhy named managing director of the Tillinghast division of Towers, Perrin, Forster & Crosby Inc. Since 1989, Mr. Touhy had been head of the Tillinghast life insurance consulting practice nationally.

Martin E. Segal Inc. of New York announced five promotions to senior vp: **Julian K. Byron**; **Glen E. Cline**; **Matthias F. Erieg**; **Thomas R. Harter**; and **Lawrence M. Singer**. The consulting firm also announced these promotions to vp: **Peter Bernstein**; **John J. Coyle**; **Roderick B. Crane**; **Bonnie S. Gellas**; **Marvin B. Gibbons**; **James Green**; **Jean S. Kuhl**; **Virginia McGlinley**; **William F. Robinson Jr.**; **B. Shana Saichek**.

ABBIE Home Healthcare, a provider of medical equipment and services for home health care, named **Timothy M. Aitken** president of the Costa Mesa, Calif.-based firm. ■

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Reinsurance

Mark Rosen, deputy general counsel with the Federal Deposit Insurance Corp., will on June 3 become managing director of Executive Re Inc. of Simsbury, Conn. Executive Re, a directors and officers liability reinsurer, is a unit of Aetna Casualty & Surety Co.

General Reinsurance Corp. announced two promotions to vp: **J. Frederick Coon** in Hartford,

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Indoor air quality

Continued from page 3
indoor air quality problems.

Poor indoor air quality may present a problem for up to an estimated 30% of all new and remodeled buildings, according to Ms. Floistad.

Poor indoor air quality can cause sick building syndrome or building-related illnesses, both of which may be caused by poor ventilation, pollutants emitted inside the building, contamination from outside sources and biological contamination, according to an Environmental Protection Agency fact sheet distributed to risk managers at the session.

According to the EPA, symptoms of building-related illness include coughing, tightness in the chest, fever, chills and muscle aches that are believed to be caused by exposure to indoor pollutants. Those suffering from BRI do not always feel immediate relief after leaving

the building.

With sick building syndrome, however, occupants generally complain of things like headaches, eye, nose or throat irritation, itchy skin, dizziness, nausea and difficulty concentrating, according to the EPA. The cause of the symptoms is unknown and complainants report relief upon leaving the building.

"That was the big thing I heard: 'As soon as I leave the building I'm OK,'" Ms. Floistad said, recalling a first-hand experience with sick building syndrome.

The Douglas County School District opened its new administrative building, converted from an old high school, in April 1990. The building had been completely gutted and rehabbed; only the wood floors and stone walls remained from the high school.

However, employees working in the remodeled building soon began to complain of burning lungs, eye irritation, inability to wear contact

Poor indoor air quality can cause sick building syndrome or building-related illnesses.

lenses and fatigue, she said.

The county Health Department ran tests that showed a negative reading for carbon monoxide but high levels of carbon dioxide.

An investigation was begun to find the source of the problem. In the meantime, Ms. Floistad said, employees were required to take a five-minute break every hour outside the building and a one-hour lunch break outside the building, which alleviated symptoms of illness.

The building's air quality problems were eventually found to stem from a combination of circum-

stances. Exhaust stacks that were too short allowed air that was leaving the building to be sucked back in and recirculated, Ms. Floistad said.

"We raised those stacks, and that cost about \$50. That cured a lot of our problem," she said.

Furthermore, workers had installed a belt on the air intake fan that was too large and slipped off. As a result, fresh air was not coming into the building, she said.

The last contributing factor was environmental. Ms. Floistad showed the audience a picture of the administration building, behind which loomed a large rock structure that gives the city of Castle Rock its name.

Between the rock and the administration building are train tracks that carry as many as 100 trains a day, Ms. Floistad said. The exhaust fumes from the locomotives are unable to dissipate because of the huge rock wall, which compounded the building's venti-

lation problems.

While the causes of the air quality problem were eventually discovered, the school district faced 19 worker compensation claims and \$6,500 in investigation costs.

"We have been reimbursed by our general contractor for part of our investigation costs," Ms. Floistad said.

While the Douglas County School District's problem "was a regular everyday ventilation problem," according to Ms. Floistad, the city of Westminster, Colo., faced a more exotic problem.

After opening a new swimming pool complex, lifeguards began to exhibit signs of building-related illness, explained Pierrette E. Ray, the city's risk manager.

Whereas the Douglas County school employees reported almost immediate relief upon leaving the administration building, the lifeguards only found relief after two or three days away from the pool.

Westminster had constructed the pool facility because it had "wanted to do something that would set us apart from other cities in Colorado," Ms. Ray said, who was not risk manager at the time.

The facility is based on "leisure pools" common in Europe and Canada. The pool area is completely enclosed with permanent glass windows.

The complex includes a deep pool with rope swing and diving platform, a large recreational pool and a play pool. There are also two large saunas and a sun deck outside for sunbathers, Ms. Ray said. Special features include a 72-foot water slide in the recreational pool; a smaller slide in the play pool; several water falls that connect the three pools and are part of the pool complex's water circulation system; and fan and mushroom sprays set in the pools.

These "water features made the pool unique but were also part of our problem," Ms. Ray said. "The pool was a huge success with all kinds of utilization; therein was also part of the problem."

From the beginning, the air in the building was "thick, heavy and smelled like chlorine," Ms. Ray said.

Soon the lifeguards began to complain of congestion, difficulty breathing and aching muscles. The city's workers compensation doctors could find nothing wrong with the guards.

After several days away from the pool, though, the symptoms would disappear.

Finally the ailing lifeguards were diagnosed with hypersensitivity pneumonitis, a rare allergic reaction, Ms. Ray said. In fact, the condition is often referred to as farmer's lung, since farmers who have inhaled moldy hay dust are the most common patients, she said.

The pool had to be closed. "This was a multimillion-dollar facility that had been paying its way. We closed it, and our income dropped right away," Ms. Ray said.

The pool area subsequently was found to have ventilation problems that were repaired at a cost of almost \$400,000.

However, two months after the pool reopened, 17 lifeguards—15 of them new employees—began to complain of the same symptoms.

"Clearly our problems were not just related to air," said Ms. Ray.

All 17 employees were diagnosed as having contracted or being likely to contract hypersensitivity pneumonitis.

Finally, experts concluded that the pool's filtration system was "grossly undersized," allowing bacteria and cell bodies free to float in the water and into the water falls, slides and sprays.

"The drops from the sprays were just the size for inhalation into the lungs," Ms. Ray said.

Continued on page 14

A Global Perspective...



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Indoor air quality

Continued from page 12

Now the city plans to install a new filtering system that should solve the problem.

However, in the meantime, it has faced 82 pool-related workers compensation claims, \$153,369 in costs to investigate the problem and \$500,000 in remediation costs. The pool is still not open.

When all is said and done, the city expects the combination of inadequate ventilation and filtration to cost \$2.5 million to \$3 million, she said.

The project's contractors have been notified of the city's intent to file suit for damages.

PRIMA names new directors at conference

ATLANTA—About 1,400 people attended the 12th annual Public Risk Management Assn. conference, held May 12-15 in Atlanta.

Attendance was up slightly from 1,300 last year, according to PRIMA. Also, 112 exhibitors displayed their wares in the exhibit hall at the Atlanta Hilton & Towers Hotel, up from 98 exhibitors a year ago.

During the conference, PRIMA announced its 1991-93 board of directors.

Michael Burch, risk manager of Larimer County, Colo., was elected president, succeeding Tom Phillips, risk manager for the city of Santa Monica, Calif. (see story, page 23).

Larry Weston, executive director with the Water & Sewer Insurance Pool in Issaquah, Wash., will take over as PRIMA's vp of Region 2, the Northwestern states. He replaces Mr. Burch.

Annese Ashton, risk manager for Genesee County, Mich., will take over as vp for Region 3, the Midwestern states. She replaces Stanley Fayne, director of safety and risk management for Oakland County, Mich.

Elizabeth Puddington, executive director of the New Hampshire School Boards Insurance Trust, takes over as vp of Region 4, the Northeastern states. She replaces Corey Stein, risk manager for the city of Harrisburg, Pa.

Piper Price, assistant director with School District R-12 in Springfield, Mo., takes over as the at-large vp. She replaces Rita Constantino, business manager for the Oxford Public School District in Oxford, Conn.

Remaining on the board as vps are: Jim Garrison, risk management administrator for the city of Phoenix, representing Region 1; Fred Marshall, risk administrator for the city of Winston-Salem, N.C., representing Region 5; and Mary Wheeler, risk manager for the Albuquerque, N.M., public school district, representing Region 6.

Richard Maddalena, administrator of the Special District Risk Management Authority in Sacramento, Calif., was named the new president of the PRIMA pooling section. He replaces Dubravka Romano, associate executive director of the Texas School Services Foundation in Austin.

Next year's PRIMA conference is scheduled for May 17-20 at the Disneyland Hotel in Anaheim, Calif.

For more information, contact Lynne Armstrong, Manager of Meetings and Conferences, PRIMA, 1117 N. 19th St., Suite 900, Arlington, Va. 22209; 703-528-7701.

—By Michael Schachner

From a workers compensation standpoint, indoor air quality problems are becoming more significant, Ms. Floistad said. "Risk managers need to educate themselves. Knowledge is the best defense," she said.

Risk managers should be "extremely specific in contract language about what you're looking for in specifications," said Ms. Ray.

Definitions of terms should be very clear as well, she added.

For instance, "what does six air changes per hour mean? To me it means a complete change of outside clean air with inside air. To a contractor, it may mean a complete shift of air from the top of the room with air at the bottom of the room," Ms. Ray explained.

The session was moderated by Eunice Brown, risk manager for the Cuyahoga County Board of Mental Retardation and Developmental Disabilities in Cleveland. ■

Information on air quality problems

By SARA J. HARTY



ATLANTA—A rash of unexplained headaches, coughing, muscle aches or nausea affecting occupants of a single building should be a tip-off to a possible air quality problem, say two risk managers.

Pierrette E. Ray, risk manager of the city of Westminster, Colo., and Sharon E. Floistad, risk manager of the Douglas County School District in Castle Rock, Colo., spoke of their personal experiences with "sick" buildings at the Public Risk Managers Assn. conference earlier this month (see story, page 3).

Risk managers who believe they have an indoor air quality problem or would like more information on the subject may wish to consult the following sources:

- The Environmental Protection Agency, Public Information Center, Mail Code PM-211B, 401 M St. S.W., Washington, D.C. 20460.

The EPA has published a variety of fact sheets on sick building syndrome and indoor air quality.

- The National Institute for Occupational Safety and Health, 4676 Columbia Parkway, Cincinnati, Ohio 45226.

NIOSH publishes a step-by-step guide for indoor air quality investigations.

- The American Society of Heating, Refrigerating & Air Conditioning Engineers, 1791 Tullie Circle N.E., Atlanta, Ga. 30329.

ASHRAE has published voluntary standards for indoor air quality.

- Solar Energy Research Institute, 1617 Cole Blvd., Golden, Colo. 80401-3393; 303-398-1520.

- National Jewish Center for Immunology and Respiratory Medicine, Dr. Cecile Rose or Dr. John Martyny, 1400 Jackson St., Denver, Colo. 80206; 303-398-1526.

Dr. Rose was the physician who finally diagnosed the hypersensitivity pneumonitis of the city of Westminster lifeguards.



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Playground safety tips

Knowing how kids play enhances loss prevention: Expert

By SARA J. HARTY

ATLANTA—Understanding that children don't always play the way adults intend them to can go a long way toward making playgrounds safer.

For example, one child will sit on a playground swing seat while, at the same time, another will stand on the same seat. To an adult, this is an example of "misuse," but the thing to remember is that "kids don't play exactly in the fashion we would like them to," said Frances Wallach, president of Total Recreation Management Services Inc. of New York.

Ms. Wallach spoke on playground

safety at the 12th annual Public Risk Management Assn. conference earlier this month in Atlanta.

Playground safety guidelines should virtually eliminate this particular problem by calling for soft belt swings that serve the dual purpose of making it nearly impossible for two children to ride on the same swing. In addition, a soft seat will cushion the blow if a child is hit in the head by a swing.

Another problem in "all playground settings is that we are seeing children younger than the designated age playing on that equipment," Ms. Wallach said.

Good equipment can become a hazard when it is used by children too young or too old for it, she said.

The idea that "parents make good supervisors" is one that requires

some thought as well, Ms. Wallach said. She said that often parents can be seen encouraging their children to misuse the equipment. For example, Ms. Wallach projected a photographic slide that pictured an adult helping a toddler to climb up a slide instead of sliding down it.

"Repair, replace or remove" damaged equipment, Ms. Wallach stressed. Otherwise, children will find a way to enhance their play with the damaged equipment.

She told of a child who seriously injured himself on a damaged piece of play equipment. Instead of repairing the equipment, sawhorses were placed around it. Ms. Wallach noted that for adults, a sawhorse may mean to stay away, but for children they are simply additional pieces of equipment on which to play.

Another child was seriously injured by the same piece of equipment within the week, she noted.

Another slide projected by Ms. Wallach depicted a playground slide that had not been completely removed, leaving the ladder still standing. To prevent play on the freestanding ladder, trash cans had been tied to the top of the ladder.

Ms. Wallach observed dryly that the play possibilities for children were rather obvious.

Besides proper care of equipment, Ms. Wallach said that other playground safety problems that risk managers must address include:

- Surfacing. Hard surfaces are a major reason for serious injury, she said. However, the American with Disabilities Act requires access for disabled children and many soft surfaces are difficult to traverse in a wheelchair or on crutches.

- Remembering that any modifications in playground equipment can lift responsibility from the manufacturer.

- Trees located on or at the edge of a playground should be pruned up to a height of seven feet. Ms. Wallach showed a picture of tree that had branches all the way to the ground. A little boy lost an eye when he ran into one of the branches.

Risk managers do not have to be told that attitudes toward responsibility for accidents have changed, Ms. Wallach said.

She noted that after she had broken an elbow at a local playground as a child, "the first thing my mother did was hit me because at that time, the attitude was, 'if you're playing on the playground, you should certainly be able to take care of yourself.'"

That is no longer so. Now if a child breaks an elbow at a playground, there is no doubt that he would have been a major league pitcher and a lawsuit will follow, she said.

However, risk managers can take several steps to guard against such litigation. For example, recreation departments should unflinchingly use waivers or hold harmless agreements when sponsoring potentially hazardous activities, advised Robert K. Bush, an attorney with Ancel, Glink, Diamond & Cope, a firm in Chicago that specializes in public entity defense.

Mr. Bush spoke at another session at the PRIMA conference.

Besides serving to make sure that the participant or his parent is aware of the potential hazards, these contracts can shield against liability for an accident, he explained.

Adult participants without a mental handicap can sign their own waivers, while parents should sign for minors, he said.

Waivers of liability that are sometimes printed on the back of tickets to an event are not likely to be enforced by the courts. Such a waiver, though, "helps in negotiating" a settlement, he said.

As to how long a signed waiver should be kept after the activity concludes, "forever is a good time," Mr. Bush said, half-jokingly. He added that the waivers must be kept for at least a year or two after the statute of limitations has run.

Warning signs are another tool that can be used as a first line of defense should an accident occur, he said. Not generally needed for open bodies of water or other obvious hazards, warnings are needed for hazards that may be unknown.

Signs must be reasonably detailed with warnings of particular risks, Mr. Bush said. For example, "A 'no diving' sign is not sufficient if there are hazards underneath the surface that you know about," he said. That sign should also include the fact that submerged rocks or undertows are present.

Keven O. Marks, loss control manager for the Park District Risk Management Agency in Wheaton, Ill., said a good warning sign should:

- Include the word DANGER prominently printed across the sign.

- State the unacceptable activity. A sign that says "No sledding" clearly states what is prohibited.

- Contain an explanation of conditions making the activity unacceptable. Sledding may be banned because there are "too many trees."

- Include a list of potential consequences. For example, someone on a sled could hit a tree and break his or her neck or arm.

- A graphic example of an accident occurring. In this case, a person on a sled can be shown hitting a tree head-first.

The session was moderated by Annesse Ashton, risk manager for Genesee County, Mich.

Arthur H. Mittelstaedt Jr., a safety consultant with Ward Associates in Ronkonkoma, N.Y., and Kenneth Kutska, superintendent of parks and planning for the Wheaton Park District in Wheaton, Ill., also spoke at the session featuring Ms. Wallach. That session was moderated by Betsy R. Kutska, executive director of the Park District Risk Management Agency in Wheaton.



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Police liability

Continued from page 3

• A complete program of policies and procedures. "You have to have these. There are no short cuts," Mr. Gallagher asserted.

Policies are usually formal written rules. They are formal when issued by the police chief, but they become informal when modified by supervisors, he noted.

"You need policies for every little thing you do," agreed Richard Shaffer, police chief for the city of Harrisburg, Pa., in another session during the PRIMA conference. "Whether it be in the use of firearms, foot pursuit or vehicle operation, you must have written policies governing the procedures."

• Training. "You have to train your people in departmental policies. Officers do go through the academy, but they don't come out with an understanding of your department's policies," Mr. Gallagher said.

"For example, a shooting case can

become a problem—not because the officers lacked the skills to fire their weapons properly, but because they weren't trained as to when to shoot," he explained.

"You can't have police on the street with a gun or performing a high-speed chase when they haven't completed proper training courses. We wouldn't have pilots flying airplanes under the promise that they'll soon be attending flight school," Mr. Gallagher said.

• Supervision and discipline. Officers who commit egregious acts do not feel that they will be held personally responsible, Mr. Gallagher said.

"Often, the police department doesn't feel pain or loss in a lawsuit. Change your policy so that the officers know that they'll be held directly responsible for what they do on the street," he advised.

Supervision and discipline, "combined with policy and training, is your defense in court," Mr. Gallagher said.

"If you have clearly written policies, training and supervision, you can control a case. You can't control a robbery or a high-speed car chase at 2 a.m., but if you have done everything else, it forces the plaintiff to fight you based on the incident only, rather than on five fronts."

"If you have policies and training, the chief, the department and the city are much better protected," Mr. Shaffer agreed.

• Review and revision. Risk managers and police department heads must pay close attention to police liability lawsuits filed locally or nationally, court decisions and any new state or local statutes that affect law enforcement and adjust their policies and procedures accordingly, Mr. Gallagher urged.

• A legal adviser, who does not necessarily have to be the city attorney.

Mr. Gallagher recommended that the public entity responsible for a law enforcement body employ a full-time specialist knowledgeable about police work who would advise the chief and city attorney after an incident, handle post-incident press relations and be a liaison between the department and a plaintiff.

"This specialist should be able to offer advice, but not necessarily legal counsel. Many city attorneys just don't understand police work," Mr. Gallagher said.

A problem in implementing the program often develops, though, because many risk managers cannot establish a partnership with the police chief and the department's other ranking officers, according to Mr. Gallagher.

"Hopefully, the relationship between the police department and the risk manager is good," Mr. Shaffer said. "But if the chief is not open to communication, then the risk manager should go straight to the mayor, who is likely the only one who'll be able to change the police chief's mind," he said.

"But don't start out by trying to stuff your risk management program down the throat of the police chief," Mr. Shaffer warned. "You have to remember that cops aren't risk managers—they're police officers, and they don't know your lingo and speech."

In developing a liability management program, departments should study the programs in place at similar police departments around the country and use them as models, Mr. Gallagher advised.

"Try to identify five departments that you would call leaders. Examine their leadership, training courses and values and employ them for yourself. There are plenty of very good police departments out there—they just have to be identified," Mr. Gallagher said.

Mark Wilson, risk manager for the city of Plano, Texas, moderated the session at which Mr. Gallagher spoke.

Valerie Harrington, risk manager of the city of Etobicoke, Ontario, moderated the session at which Mr. Shaffer spoke. ■

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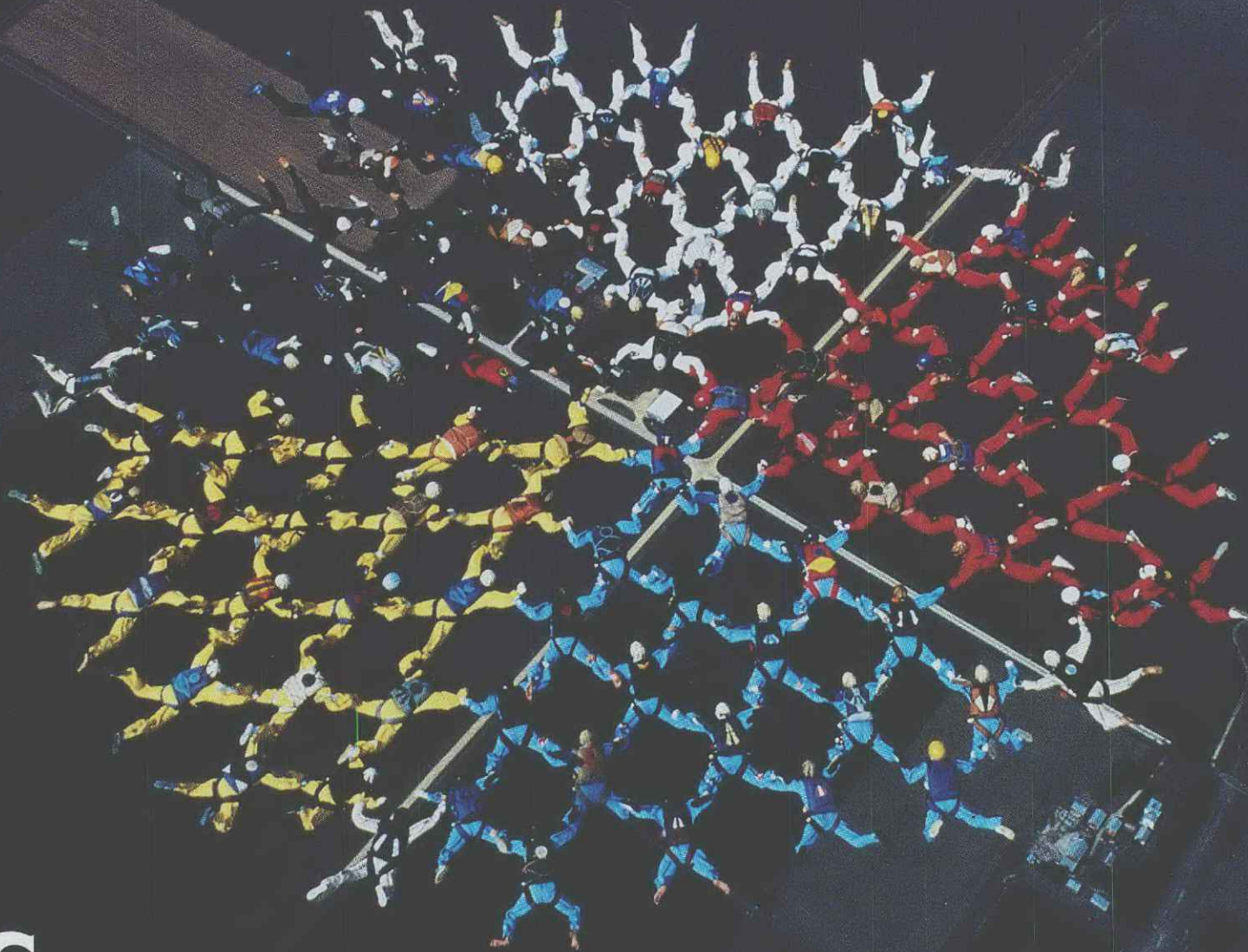
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**Business
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Fire departments urged to adopt safety rules

By MICHAEL SCHACHNER

ATLANTA—Fire departments looking to develop a formal safety program should look to a National Fire Protection Assn. model for guidance, a loss prevention specialist recommends.

"All fire departments should keep a safety and health plan up to date based on NFPA 1500," asserted Jonathan Kipp, loss prevention manager with the Compensation Funds of New Hampshire in Bow, N.H.

Mr. Kipp, speaking earlier this month at the 12th annual Public Risk Management Assn. conference

in Atlanta, emphasized that the Quincy, Mass.-based NFPA's Code 1500 is probably the best written foundation for creating a fire department safety program. Drafted in 1987, the code is currently being revised.

Using these guidelines as a framework, fire departments can set their own individual safety agendas, depending on characteristics like size and location, Mr. Kipp said.

"NFPA 1500 is good because it's not a canned safety program. It's a framework for establishing what you ought to do, and you really need a safety program. So much of our focus has been on how to protect the citizens, and the firemen are put second."

"Firefighters mostly get hurt like (workers in) any other industry. Only 20% of their injuries come from battling fires. The remainder come from contact with objects, slip and fall instances, and other things," he noted.

Mr. Kipp outlined some key elements of NFPA 1500's fire department safety program:

- Departmental administration must develop a safety policy statement.

"This is top management's commitment to the program. Without it you're doomed to fail," said Mr. Kipp.

- When training and educating firefighters, department safety managers must make certain that all live fire training sessions are safe.

"For example, in a breathing apparatus drill, you don't want smoke-generating devices putting out toxic smoke," he said.

- Safety must be taken into account when operating all vehicles and equipment.

"This sounds general, but it means a lot," Mr. Kipp said. "In all situations, riders on fire trucks must be seated and belted. And in many states, the drivers of those trucks are exempted from having to obtain a commercial operators' license, so it's imperative that they at least get proper training in operating the vehicles."

In the area of protective clothing and equipment, "this is your last line of defense so everything must fit securely and be issued individually. You don't want generic gear like some departments had for quite a while," said Mr. Kipp.

- During emergencies, it's important to have a formal "incident management system" as well as a "personnel accountability system."

"You certainly don't want to be walking away from a fire thinking all is well only to find out that one of your men is unaccounted for," Mr. Kipp said.

- All firefighters should be in good physical condition.

To ensure firefighters are in good shape, pre-placement physical screenings and follow-up evaluations are a good idea, he said.

"This is a hard-sell to the unions, but we're moving forward. You don't need a set timetable for evaluations because it depends on age and physical condition. You can even have a staff doctor doing the evaluations, especially if the doctor knows the firefighters and their lifestyles and work-related hazards," Mr. Kipp pointed out.

"You would think that fire departments have had safety programs forever, but in most cases that's not true," he said. "Always remember that the best way to get a firefighter's name into the newspaper is to have him get hurt or killed. We have to quit that."

Thomas LoPizzo, director of group services with the Vermont League of Cities & Towns in Montpelier, moderated the session. ■

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Doctors debate future of health care

By SARA J. HARTY



ATLANTA—The public and physicians would be better served by a "massively restructured" health care system, says a proponent of nationalized health care.

Under the current system, costs are out of control and many people do not have access to health care, said Dr. Henry S. Kahn, associate professor at Emory University School of Medicine in Atlanta and chairman of the Georgia Chapter of Physicians for a National Health Program.

However, a Canadian-type, single-payer system is "undesirable and, more importantly, not feasible," said Dr. Alan R. Nelson, the immediate past president of the American Medical Assn. in Chicago.

"One of my Canadian colleagues says, 'Fast, good, cheap. You can have any two of the three but not all three,'" Dr. Nelson said.

In Canada, "they have good and cheap, but often not fast," he said.

But, Americans "have different expectations and certainly have a different relationship with their government," Dr. Nelson observed.

"Americans don't like to stand in line. They'll sue before they'll queue," he joked.

The two doctors debated the pros and cons of a national health care system earlier this month at the 12th annual Public Risk Management Assn. conference in Atlanta.

Dr. Kahn noted that there are 37 million people without health insurance in the United States and that 20 million to 40 million more Americans are so underinsured that they risk poverty if they were to suffer a serious illness.

Still, health care represents 12% of the U.S. gross national product, he said. "We are seeing rationing in the presence of abundance, not rationing in the presence of scarcity."

Dr. Kahn said a national health care system should:

- Provide universal and comprehensive coverage.
- Preclude hospitals from charging patients admission fees. Hospitals would be compensated on a lump sum basis for their operating expenses.
- Preclude all out-of-pocket expenses for health care recipients.
- Provide for system adminis-

tration by a public or quasi-public institution.

- Guarantee accountability to the public.

However, Dr. Kahn conceded that the Canadian system is not perfect: Canada has the second most costly health care system in the world, at 8% of GNP.

Dr. Nelson said that, "at its best, the U.S. health care system is unsurpassed."

"Few Americans would choose to have a serious illness treated elsewhere," he said.

However, Dr. Nelson acknowledged that he is "starting with the assumption that the status quo is not desirable."

To have more than 30 million uninsured Americans is a disgrace for a country as wealthy as the United States, he said. No woman should go through pregnancy without prenatal care, and no child should be without necessary immunizations, he said.

In addition, health care costs are unacceptable and must be lowered, Dr. Nelson said. "Cost contain-

ment dominates our thinking, and it should," he said.

However, in the country's media-driven society, "miracles are heralded but never with a fiscal note," Dr. Nelson said.

People who can pay for health care should pay, said Dr. Nelson, who supports keeping—but improving—the current health care system.

"Significant change, not just tinkering, is not only necessary but it is desirable," Dr. Nelson said.

Among other reforms, the AMA

supports:

- Expansion and improvement of Medicare.
- Increased employer-provided insurance.

Tax credits should be given to small employers so they can afford to offer health insurance to their employees, said Dr. Nelson, adding that two-thirds of uninsured Americans are employed.

- Tax law changes that would allow individuals to establish individual retirement accounts for

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National health

Continued from previous page
health care.

Dr. Kahn and Dr. Nelson also agreed that hospital and physician administration costs are driving up overall health care costs.

In the United States, there may be two clerks handling one physician's administrative work at an average of one hour per transaction, Dr. Kahn said.

In Canada, with its single-payer national health system, one clerk can handle the administrative work for eight physicians at an average of three minutes per transaction, he said.

Dr. Nelson suggested that one way to ease administrative costs under the current U.S. health system would be to develop a standard claim form.

The session was moderated by Mary Lou Emmert, risk and benefits manager for Monterey County, Calif. ■

Not all public entities need TPAs

But other entities can benefit from administrator's expertise, data analysis

By MICHAEL SCHACHNER

ATLANTA—Public entities that manage their own liability and workers compensation claims have more control over their claims dollars and can be more flexible than if they use a third-party administrator, according to a municipal administrative specialist.

However, quality TPAs can provide specialized expertise in the areas of state regulation and claims data analysis that many self-administered entities do not have, counters an executive with a large third-party administrator.

"You self-insure to better con-

trol your dollars," said Sherry R. Rynders, administrative services director with the city of Fort Myers, Fla., during a session on how self-insured public entities should manage their claims at the 12th annual Public Risk Management Assn. conference in Atlanta.

"So why not also manage the claims yourself? It allows you to accurately set your loss reserves, and if you want to change anything in-house, you can do it without having to make any contract changes with a TPA," Ms. Rynders said.

But Ollie L. Darmon, assistant vice president with Sedgwick James of Georgia Inc. in Atlanta, insisted that most TPAs are flexible and can work to the advantage of the public entity because they offer per-

It projects a better image if a city, not a TPA, is in control of taxpayers' money, says Ms. Rynders.

formance guarantees and access to comprehensive data bases.

In advocating self-administration of claims, Ms. Rynders said this method allows a public entity to save TPA fees and use the savings to bolster its internal claims staff.

In addition, she said self-administration eliminates common conflicts that arise between the self-

insured public entity and its outside administrator.

"How often do you disagree with your TPA?" she asked the audience at the session. "There are cases when you want to fight the claim and the TPA just wants to settle it. If you pay it just to avoid a battle with the TPA, the word gets out that your town rolls over on claims," Ms. Rynders said.

"This is the taxpayers' money you're sending out the door, and it projects a better image if you, and not a TPA, are in control of it," she said.

Ms. Rynders also maintained that TPAs occasionally can be the cause of image and communications problems within a municipal entity.

"It's so much easier to get a report going with your attorney if there is no TPA interference. And, without the TPA you get a straight answer," she noted. "Also, you have to pay attorneys' fees every time the TPA talks with a lawyer."

Employees also seem to be more open with internal claims personnel than with TPA employees, Ms. Rynders said. "They report a lot more because they know the information is not leaving the house."

Accountability is another advantage to self-administration, Ms. Rynders said. "With internal claims management, you have nobody but yourself to blame if something goes wrong."

But Sedgwick James' Mr. Darmon countered that most large TPAs must purchase errors and omissions coverage as part of their contract with the self-insured client. "If the TPA messes up, you're covered, so I don't know why you'd want to take the blame for a mistake," he said. "If you're not getting this coverage as part of your contract, you should—or you should consider switching TPAs."

And Mr. Darmon said TPAs have an incentive to do the best job possible. That incentive, he said, is profit.

"We want a long-term relationship with the client," Mr. Darmon said. "That's why we're continually training our people and offering performance standards where we are accountable for our work," he said.

In addition, Mr. Darmon questioned the self-administered entity's ability to deal with regulators and the courts.

"Compare our experience in processing and managing claims to that of a town that handles only a few hundred claims per year. If you handle 15,000 workers compensation claims per year like we do, you get to know the judges, attorneys and doctors. You know the lawyers that are good as well as the ones that are bad. You know which attorneys want to settle claims and which ones don't," Mr. Darmon said.

Mr. Darmon also said TPAs are equipped with the technological ability to help their clients control costs better.

"We shoot to provide the holistic package, where you're not charged for every little thing we do. We have the computer system necessary to analyze claims data. It's not a static system. It's constantly being updated to meet various client needs. If the data fields are there, you can do with it what you like," he said.

Mr. Darmon acknowledged, however, that hiring a TPA is not the correct choice for all public entities. "If you're a small town or (a member of a pool) of some sort, you may not need our expertise."

William Knickerbocker, risk manager for the Kansas City, Mo., city school district, moderated the session. ■

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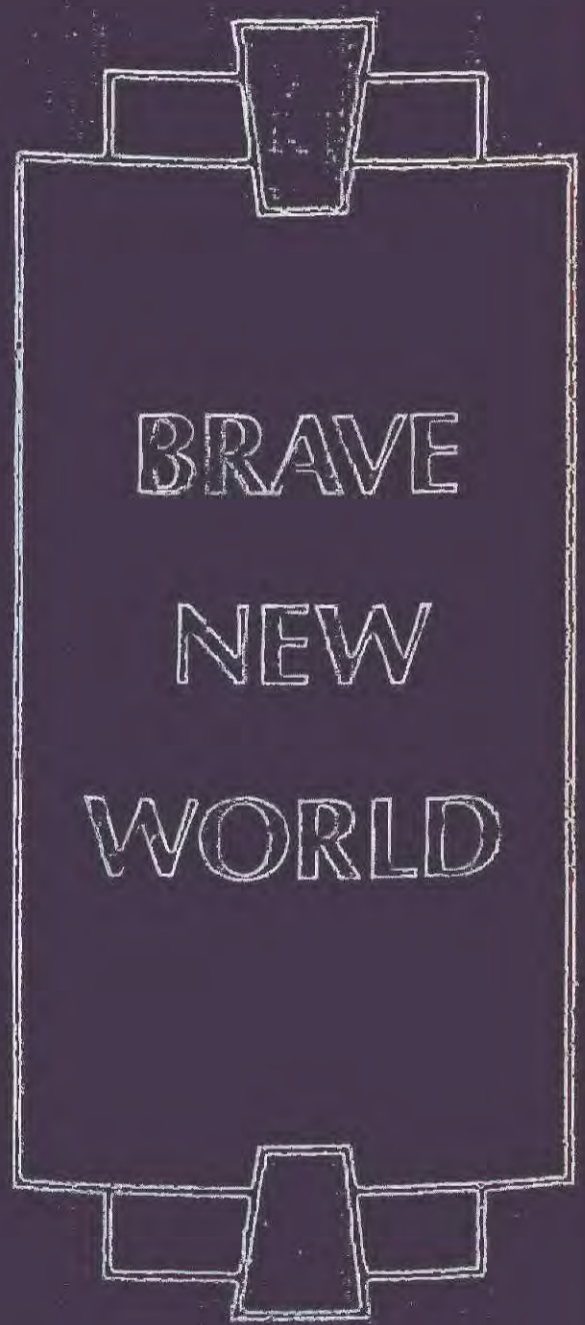
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Risk managers or party poopers?

Special event planners often overlook hazards

By SARA J. HARTY

ATLANTA—Analyzing the risks posed by municipal special events can be made more difficult by the nature of the event, but risk managers can mitigate the potential for accidents and liability with careful planning, a special events consultant says.

"There are a lot of people involved in special events who don't have a clue about risk management. On the other hand, many risk managers don't know much about special events. Somehow the two must be integrated," said Alexander Berlonghi, president of Event Risk Management in Dana Point, Calif.

Marketers and planners of special events sponsored by public entities—like concerts, art fairs and fireworks displays—are often enthusiastic, yet uneducated, about potential problems, making risk managers "the party poopers of events," said Mr. Berlonghi during the 12th annual Public Risk Management Assn. conference, held May 13-15 in Atlanta.

Special events are characterized by generally tight budgets—many don't actually receive any revenue until the day of the event—and they are time- and deadline-oriented, Mr. Berlonghi said.

This makes accidents more likely to occur in the frenzied hours just prior to the start of the event, he said.

Analyzing the risks posed by these events is complicated by the fact that six months prior to an event there typically are only two or three planners involved but, as the event approaches, the number of people involved grows rapidly, he explained.

Many of these people working on the event—like ushers, maintenance personnel and security guards—don't show up until the day of the event and "may know about as much (about the risks of the event) as the people attending," Mr. Berlonghi said.

Risk analysis prior to the event is also made more difficult by the lack of structures or equipment on the premises prior to the day of the event.

"You don't see the fences and scaffolding," and you may not even know all the equipment and types of vehicles that will be present on the day of the event, Mr. Berlonghi said.

One way to keep on top of unseen risk factors is to use "countdown meetings," he said.

All persons in charge of different aspects of the event—be it security, scaffolding or stages—are gathered together. Each one is given three to five minutes to report on what has been done, what needs to be done and what each group is waiting for to complete its assignment. There is no discussion, just a report of the facts.

By scheduling the meeting for at least half an hour longer than it should take and ending it early, the organizer can then tell the committee members, "We've got a few minutes; why don't you work out some of the loose ends with each other," he said.

"This is an excellent way of finding out the risk factors," Mr. Berlonghi said. He suggested holding at least two regularly scheduled countdown meetings prior to an event.

Mr. Berlonghi cautioned against making generalizations about risks at certain types of events. "There

have been riots at art fairs and hundreds of rap concerts where nothing happened," he said.

"Security for an event is more like security for a war. As people move from one area to another, the police must also," he said. "You want to manage crowds so they have a good time."

Ushers, maintenance people, parking, traffic control, lost-and-found stations and sanitation faci-

lities are all aspects of crowd management, he explained.

On the other hand, when security says, "I'm sorry, that goes beyond what you can do at our event; either stop or leave"—that's crowd control, he said.

"Volunteers are terrific at events because they save money, but they are also a liability," Mr. Berlonghi said.

It is important to not let volun-

teer ushers or maintenance people take on the job of crowd control, he said, because their lack of training could lead to disputes with attendees and liability for organizers or sponsors. Ushers' duties should be restricted solely to crowd management, he said.

Mr. Berlonghi noted that some cities give ushers hats to wear. If an usher takes his hat off, that can be a sign to the security staff that assistance is needed, he said.

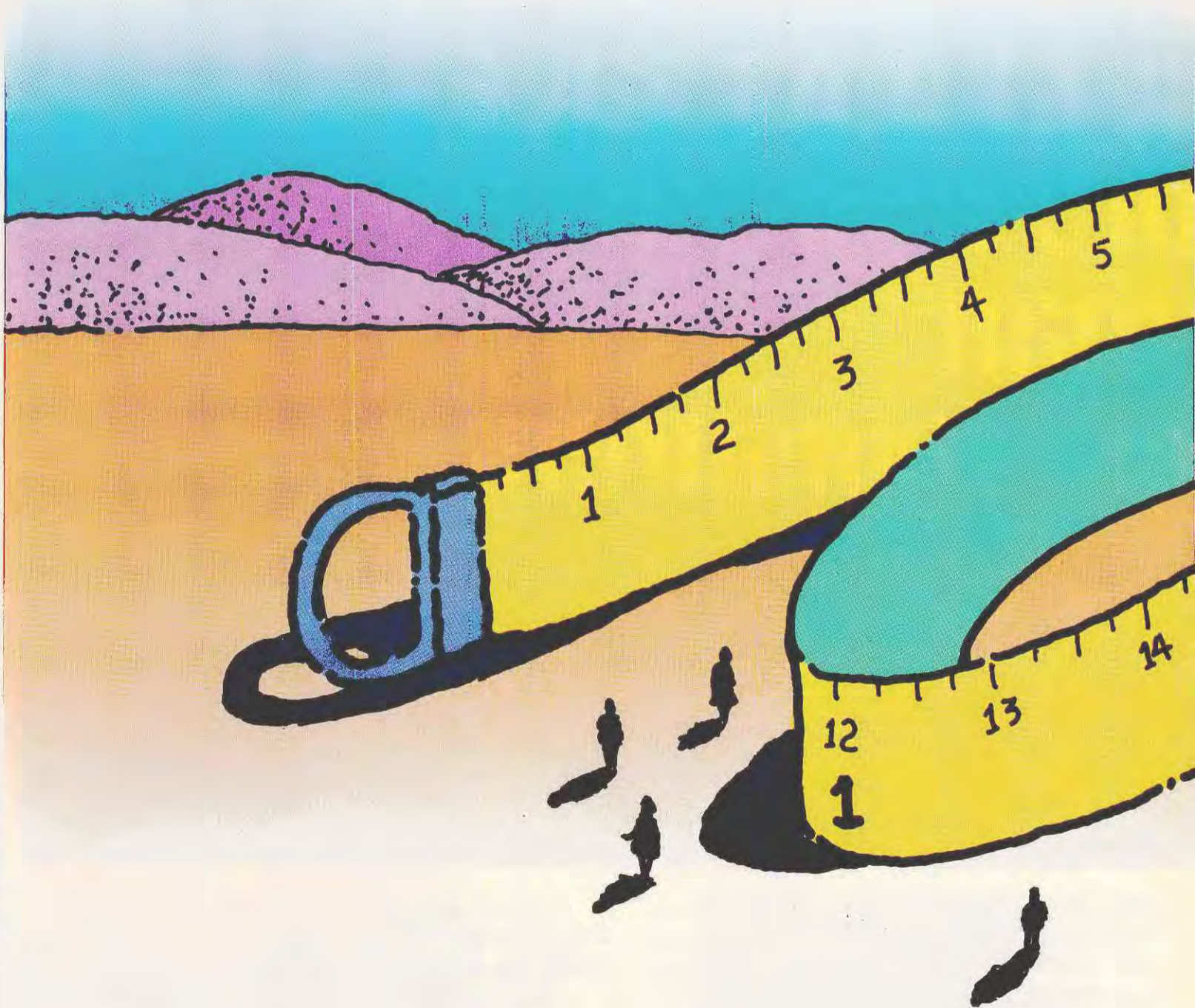
An example of good events planning is evident in Santa Monica,

Calif., where the 4th of July fireworks celebration is actually held by "The Dawn's Early Light," Mr. Berlonghi said.

Since the fireworks display is held so early in the morning, the event is "more family-oriented, and crime is less of a problem. Also, traffic is less of a problem that early in the morning," he explained.

The session was moderated by Ken Horner, director-risk services for Cities & Villages Mutual Insurance Co. in Brookfield, Wis. ■

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Communication fuels benefits program

By MICHAEL SCHACHNER

ATLANTA—Because employee benefits will continue to be one of the biggest and most costly workplace issues of the 1990s, effective benefit communication is becoming more and more important.

"Employee benefits are a bigger issue in the 1990s than they were in

the 1980s, but that doesn't mean the challenge of providing and communicating cost-effective benefits is less difficult," said Mary Garneau, director of benefit communications with Buck Consultants Inc. in Atlanta.

Ms. Garneau, speaking earlier this month at the 12th annual Public Risk Management Assn. conference in Atlanta, said that it is prime time to let employees know exactly what benefits they're entitled to and how those benefits fit into a public entity's overall

operating plan.

"In the 1980s we talked in a vacuum with only a few people within a company understanding the benefit plans. Now, it's time to let it sink into the general population."

When communicating employee benefit programs to workers, employers have to use common sense and be aware of the balance between employee expectations and reality, Ms. Garneau said.

"The expectation most employees have is that benefits are an entitlement that come alongside a

paycheck. If you fool with benefits, you have a problem because employees feel they never have enough," she said.

However, the reality surrounding employee benefits is that employers are facing shrinking budgets and, as a result, benefit cutbacks may be necessary, according to Ms. Garneau.

In addition, the ability to communicate those changes may be hindered by sagging corporate earnings, she added.

"Companies are going through a

lot of downsizing, and when this happens public relations and corporate communications are usually the first to go. You still have to try to communicate to employees because no communication is a form of communication in itself.

"No news tells employees that they're not up to hearing difficult truths. What then occurs is the rumor mill gets cranked up and rumors are often worse than reality," Ms. Garneau said.

She urged employers to break through common barriers to benefit communication. Those walls include cost, time, the belief that communications materials are ignored and the assumption that an insurer or plan administrator will do the communicating.

Instead, employers should embark on a formal communications campaign that establishes a clear benefits philosophy.

"This shows you where you have been and in what direction you're going. Simply put, it tells you how the organization feels about benefits and what it is willing to insure," she said.

A planned approach saves time and money, and should include employee surveys, focus groups and other ways of finding out what employees are thinking, Ms. Garneau said.

"It's a very good thing to ask people what they think. Employers often think they know what's on the employees' minds but they really don't," she said.

Also, the entire communications project should not be rushed.

"Doing a communications program on a shoestring leads to some initial savings, but you'll have to go back again and again, especially if you're trying to tell workers about a flexible benefits plan, which takes some coaching and hand-holding," Ms. Garneau said.

In addition, if employers don't communicate to employees the nuances of a flex plan, they'll likely experience the same adverse selection they were experiencing in indemnity options before the implementation of flex, according to Ms. Garneau.

"If you have spent the time and money to get an HMO, a PPO and other special benefits, you can't afford to not explain them," she said.

The key to keeping the cost of a benefits communications plan to a minimum is by taking ample time to develop the plan, she said.

"The longer you have to develop the plan the less it will cost," Ms. Garneau said. "But, for example, if you decide in January that you want a flex plan up and running in July, it's going to be very expensive to let everyone know what is happening. The longer the time frame, the more you can accomplish in-house."

A benefits communications plan should always convey three key messages, she said. They are: Use benefits wisely; rising costs are a fact of life; and everyone is in it together.

Lastly, benefits communications materials should be kept short and simple so as not to lose their messages.

"Clear, simple and interesting materials help reinforce your key messages," Ms. Garneau said.

"And, as Daniel Webster said, 'There is nothing so powerful as the truth,' and while employees may not like it, at least they know where they stand," she said.

Debbie Slappey and Amy Asher, both assistant communications consultants with Buck Consultants in Atlanta, also spoke at the session. Abigail Hudgens, risk and benefit manager with the city of Knoxville, Tenn., moderated the session.

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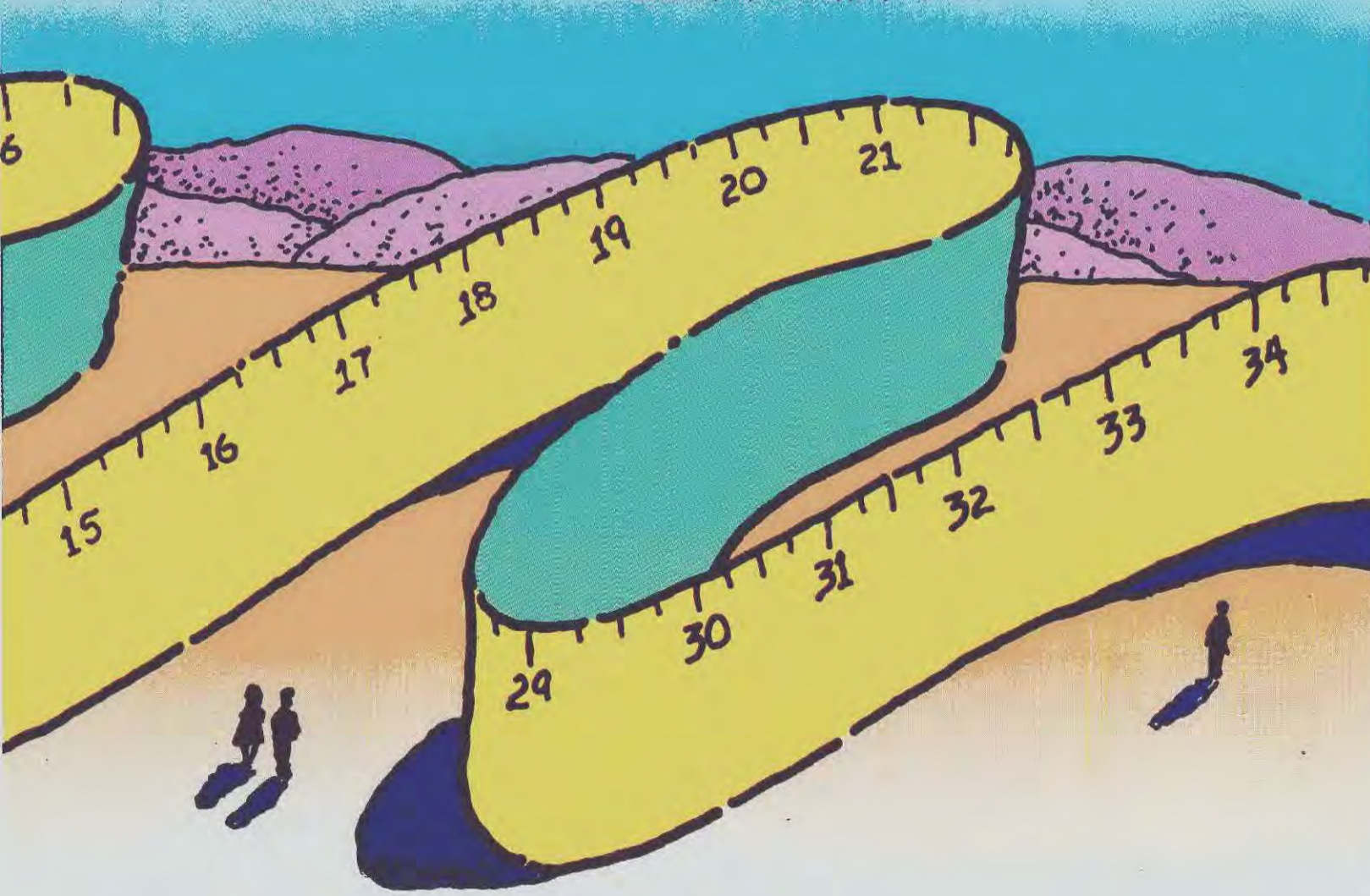
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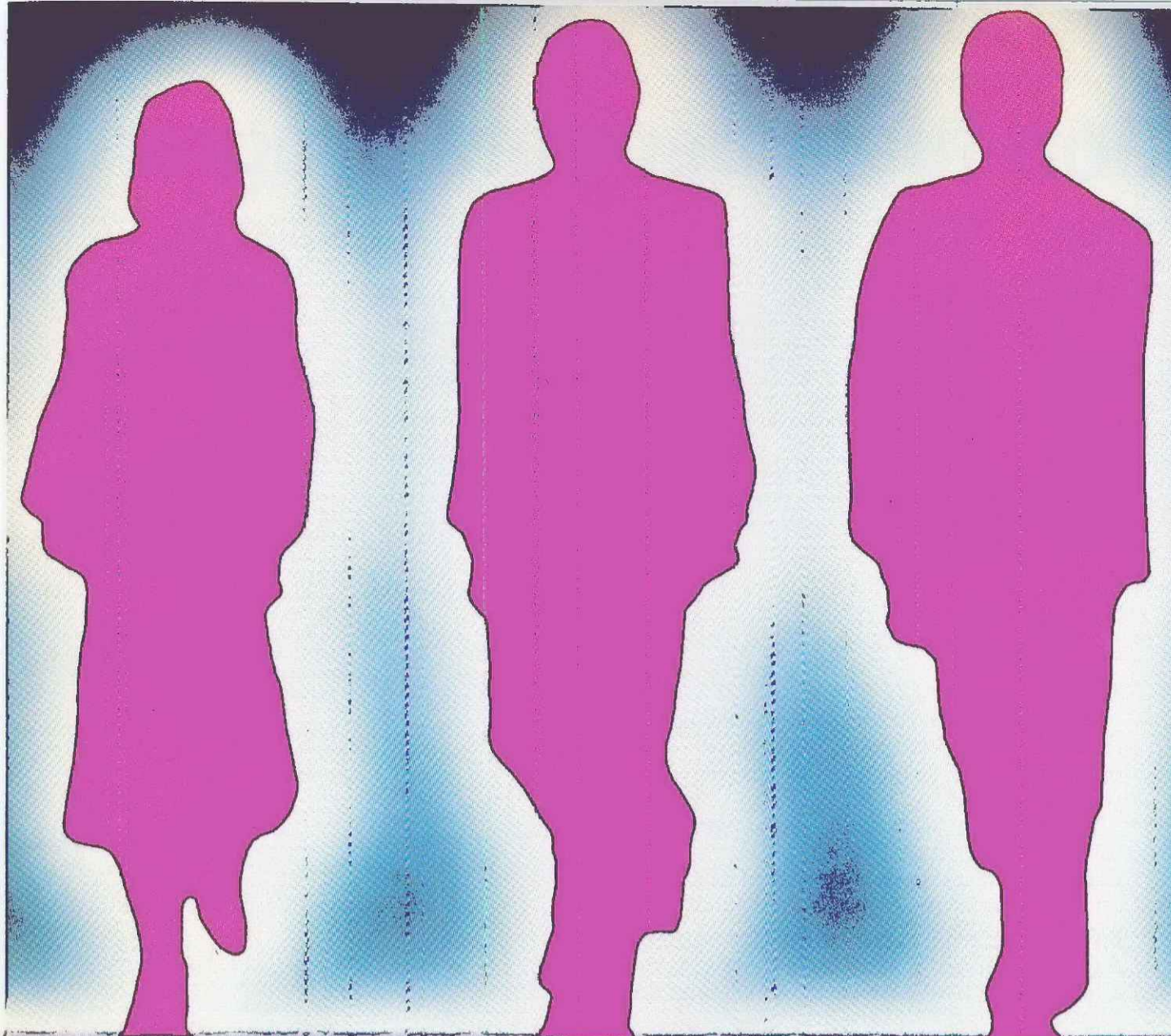
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'New' Europe is years away

By R. Patrick Thomas

WE HAVE HEARD MUCH about the European Community's directives, in particular the product liability directive, the proposed product safety directive and the harmonization of technical standards (*BI*, April 2, 1990). However, these are relatively minor byways along the main highway of economic integration. The free flow of capital and goods, common banking standards and monopoly and merger issues are still the European Community's main focus.

Insurance and risk management are not regarded as major factors in the creation of Europe's single market. Moreover, insurance and risk management are not uniform or even comparable in most European countries. There are four distinct insurance traditions in Europe. In Great Britain and the Netherlands, the insurance market was built on a maritime trading empire. In Belgium, Luxembourg and France, the Napoleonic Code applies, and insurance regulations and practices have incorporated major aspects of the code. A third group of countries, including Germany, Austria and Switzerland, developed as federations of principalities with a myriad of different laws and customs. In Greece, Italy, Spain and Portugal, political and religious customs have been major influences in shaping present-day commerce.

In addition to differences in economic and political history, Europe is made up of different cultural traditions that will not change overnight. It remains a diverse society, and many more aspects of life remain untouched than have been altered in recent years. Despite the European Commission's efforts to harmonize the laws of the individual countries, local traditions will present obstacles for at least the next 20 years.

The pharmaceutical industry has most often been in the spotlight for product-related as well as environmental issues. A December 1989 study by

Despite the European Commission's efforts to harmonize the laws of the individual countries, local traditions in Europe will present obstacles for at least the next 20 years.

Tillinghast, a division of Towers, Perrin, Forster & Crosby Inc., analyzed a major German company. The study found that the company has two-thirds of its \$1.5 billion sales in Europe and one third in the United States and that it has no adverse claims experience in either continent. In Europe it could purchase full occurrence-based general liability cover including sudden and accidental pollution, with no deductible, for a premium of approximately \$1 million. In the United States, the company was unable to buy occurrence cover. In addition, it had to accept a \$2 million deductible and a pollution exclusion for a premium of \$2.5 million. The premium alone is five times more per dollar of sales in the United States than in Europe. This example is representative of some of the problems in obtaining product liability cover in general, not just those affecting product liability cover for pharmaceutical companies.

One reason for the apparent lack of concern in Europe regarding liability insurance is the social security systems in most European countries. Those who fall ill or are injured by a product at work or in a car accident generally have all their medical bills paid and a large portion of their wages or salary continued. Lawsuits are not always considered a necessary measure for an injured individual to obtain compensation for the injury suffered. In addition, the legal remedy in Europe has, since Roman times, been an expensive business.

Cultural traditions, not E.C. directives, shape risk functions

As a result, very few individuals can afford this form of recourse. Even with legal aid, many people shy away from bringing a lawsuit. In most countries, the losing party can end up having to pay its legal costs and those of the prevailing party as well.

However, changes in Europe as well as the merger and acquisition activity prior to 1992 may lead to new challenges for risk managers.

The expected improvement in infrastructure—perhaps even the opening of the Channel Tunnel—will probably lead to a greater concentration of commerce with more sophisticated distribution patterns. Goods from a single source are more likely to be spread across a greater area, resulting in potentially larger claims from a single faulty product source. Therefore, the need to devise labels and warnings may become more acute, and the exposure to recall claims could be expanded.

Who is to respond to these challenges?

So far, true risk managers as they are known in the United States are few and far between in Europe. So who does "manage risk" in Europe? In Great Britain, the insurance function is usually in the hands of the company secretary—a combination of administrative director, legal counsel and bookkeeper. In Germany, the responsibility generally falls on the legal department, with consequent emphasis on policy wordings and contracts. In Belgium, it is often the shipping manager who takes on the task; in the Netherlands, usually the purchasing manager; in France, the accountant one step down from the chief financial officer; in Spain, the personnel manager; and in Italy it is often the general manager's secretary. All in all, it is a mixed group and generally one without any specific training in risk management.

The claims and legal climate in Europe has not had the effect of improving risk management practices as it has in the United States. On the other hand, contact with the United States can affect risk management, even though it is often only regarding exports. One example is a tire manufacturer that started exporting to the United States. The owner was told early on by distributors, brokers and attorneys that his company should incorporate proper warnings on the tires. It took over a year to persuade the tire manufacturer's legal department that such warnings were necessary. The company's European tires still do not have the warnings.

However, a more immediate impetus for product safety for major European corporations is not the proposed products safety directive but internal standards imposed by major manufacturers. One demanding company in Europe requires an absolute commitment to quality from all suppliers. The firm tests dozens of batches of products and is stringent in excluding those that do not meet their standards.

The higher unit labor costs in Europe have fostered increased mechanization, the use of robots and automated warehouses. This, in turn, has made it imperative to be able to trace and identify products quickly through machine reading. Bar codes are used extensively and, by linking the infrared reader to a computer, it is relatively simple to pinpoint any batch of components or products. This procedure was invented for reasons other than safety, but a resulting advantage is the ability to remove faulty products from circulation quickly and unobtrusively.

Most European executives involved in risk management have not had specific training in this

area because companies usually leave the design and manufacture of products to plant or product managers. They will need to set up more safety committees within companies to gather information from all people concerned with design, manufacture, storage and distribution. However, it is unlikely for the near future that such committees will be the norm, or that they will be headed up by qualified risk managers.

Turning to the insurance aspect of the changes in European legislation, it is traditional for insurance industry experts to issue warnings of increased claims activity. This, they say, will necessitate the increase of product liability insurance rates, a move to claims-made forms and more restrictive policy wordings, which could lead to higher costs. However, at this time, there appears to be no foreseeable crisis in European liability insurance, no explosion of claims activity, no deterioration in product claims experience and no need for a wholesale re-examination of policy cover.

It took over a year to persuade one European tire maker to put the necessary warnings on tires exported to the United States. Its European tires still don't have the warnings.

It is interesting to note that when several U.S. insurers imposed restrictive clauses on overseas liability contracts, U.S. risk managers sought out European casualty insurers for their overseas risks.

There is a large liability insurance capacity in Europe. The products directive, which is not generally an exclusive remedy, imposes a ceiling on strict liability of 70 million European Currency Units (\$85.4 million at current exchange rates). Many major corporations already purchase amounts well in excess of this—as high as \$500 million in some cases. In addition, they can offer generous excess capacity, notwithstanding restricted wordings. The legislative changes based on the product liability directive do not appear to significantly affect the availability or essential cost of product liability insurance.

However, pollution coverage is a more sensitive issue. There has been much talk about the "greening" of Europe, and Germany is the first major country to have to confront a significant Green political party. The European Community has probably issued the greatest number of all its edicts in connection with the environment, and there is no doubt that this issue is beginning to develop the same sort of interest as has existed in the United States for the past 10 or 12 years. It seems likely that an omnibus E.C. directive eventually will be passed that will hold strictly liable the entity responsible for the pollution.

For years, it has been standard in Europe for general liability insurers to provide certain pollution cover in their policies. Coverage is generally written on an occurrence basis, and the typical clause covers property damage, bodily injury and direct financial loss as a result of sudden, unexpected and intended events. The concept of "accidental" is often included.

While these terms have been the subject of extensive litigation in the United States, they continue to be used and interpreted in their traditional sense throughout Europe. European general liability policies do not normally extend to cover cleanup costs to prevent a loss. The German water pollution policy does not specifically include this, and in France, Italy and the Netherlands, special policies may be purchased to provide this extension.

The demand for these specialized pollution
Continued on next page

European risks

Continued from previous page

policies has been small. The initial French pool, known as Garpol, was only able to attract about 200 clients, of whom 60% were operators of waste dumps. The low level of Garpol capacity was assumed to be a deterrent, so a new pool, Assurpol, was set up with a capacity of close to \$20 million. In the Netherlands, there is a reinsurance pool known as MAS offering some gradual pollution cover, and ANIA in Italy does the same. We will probably see continued use of pools, and the interest level will likely stay low.

It is possible to obtain environmental impairment liability policies, but often this cover is only available after extensive surveys have been carried out by independent consultants. This is likely to lead to a vicious cycle: A corporation may approach an insurer seeking cover and will be told that only after surveys, risk management programs and monitoring have been set up can insurance protection be considered. Even then the insurer may only be willing to offer cover of perhaps \$5 million. Many corporations may tend to self-insure instead or carry the risk in a captive, where they may be able to find some excess cover in the reinsurance market. When insurers price themselves out of the risk transfer market, potential premiums can be lost to the conventional market.

There are many political issues that may affect implementation of strict liability. In spite of all the statutes and injunctions relating to pollution, in some cases there is a reluctance by authorities to prevent pollution or punish polluters because they are often major employers, sometimes in areas in which employment opportunities are limited. A

shutdown because of pollution-related offenses could lead to job losses and the diversion of new investment to countries that are not so stringent in monitoring those offenses. In Europe, the desire to avoid confrontation is still strong.

Risk management professionals in the "new Europe" will probably witness a growth in the number of captives. Tax legislation in certain countries has tended to inhibit this, but recent moves, such as the special tax concessions in

Capacity for product liability insurance and broad wordings will probably remain available in Europe. Insurance is not expected to be a major element in dealing with pollution problems.

Dublin, may make onshore funding vehicles more attractive. Likewise, the increased size of European corporations will result in large overall premium volume, which is more likely to provide the financial basis for the decision to self-insure. Neither legislative developments nor pollution issues are likely to be critical components in this trend. Once formed, captives probably will be used to provide coverages not available in the conventional insurance market.

Other professions may benefit from these developments. There has already been an unprecedented boom in legal advisers moving into Brussels to keep up with all the different aspects of E.C. law. The complex web of E.C., national and local law will pose many problems for cross-border business. Insurers themselves are striving for new

groupings and alliances. Many of them are increasing their staffs to provide increased engineering and loss prevention services, which up to now generally have been soft-pedalled. Environmental consultants and engineers are moving to set up business in Europe, particularly in the United Kingdom. Insurance brokers are strengthening their European networks and emphasizing risk management services.

Neither the new product liability rules nor environmental policy directives are expected to have a major impact on the risk management profession or on the European insurance industry. In all likelihood, capacity for product liability insurance and broad wordings will remain available. Insurance solutions are not expected to be a major element in dealing with pollution problems. The trend toward self-insurance and captives will probably accelerate as a result of larger economic groupings within Europe. The necessity to provide insurance cover will not be an important factor in the development of the captive sector. Although risk managers will continue to gain more expertise, particularly in the financial and contractual areas, technical issues will probably be the responsibility of designated safety engineers. Those who anticipate any radical change may be disappointed. ■



R. Patrick Thomas is director of Alexander & Alexander International Inc.'s global business development group in New York.

Risk financing techniques

Losses, premiums affect company's income tax treatment

By The Insurance Institute of America

The following question and answer are drawn from the curriculum for the Associate in Risk Management designation awarded by the Insurance Institute of America. They represent the type of question asked—and the possible answers—in one of the three examinations for the A.R.M. designation.

This month's question and answer, taken from a recent national examination in ARM 56—Essentials of Risk Financing—deals with how a differing income tax treatment of various risk financing techniques can influence an organization's risk financing decisions.

Q: Gamma Corp. treated each of the following losses or liabilities arising out of 1990 events as a current expense paid out of current revenues.

Explain how each loss or liability will affect the company's 1990 federal income tax return, and describe any likely differences in the company's 1990 federal income tax liability if each loss or liability had been fully covered by insurance purchased by the company in 1990.

A: Gamma Corp.'s losses and liabilities are as follows:

- One of the company's trucks, with a book value of \$20,000 and an actual cash value of \$50,000, was destroyed in a highway accident. The company paid \$80,000 for a new replacement

A.R.M. exercises

truck.

- The company paid \$16,000 to a passerby injured through the negligence of one of its employees and set up an unfunded reserve of \$60,000 for estimated future payments to the claimant.

In general, a casualty loss—and the tax treatment of that loss—affects an organization's tax deductions for casualty losses, for depreciation expenses and for incurred insurance expenses. And, in certain cases, insurance proceeds may generate taxable income for an insured organization.

To what extent should Gamma Corp.'s management be influenced by any difference in federal income tax treatment of these losses when deciding whether to insure or retain such losses?

Justify your position.

In general, a casualty loss—and the tax treatment of that loss—affects an organization's tax deductions for casualty losses, for depreciation expenses and for incurred insurance expenses.

In addition, under certain circumstances, insurance proceeds may generate taxable income for an insured organization.

If Gamma Corp. retains the loss on the truck, the two 1990 tax effects are a \$20,000 casualty deduction for the book value of the truck and a change

in truck depreciation expense for the portion of the year the company owned the new (rather than the old) truck.

If the company receives a \$50,000 insurance recovery for the lost truck, it can't recognize a 1990 casualty loss

for the vehicle.

However, it can take an insurance expense tax deduction for the truck insurance premiums attributable to 1990, and can choose whether to treat the \$30,000 gain from the insurance recovery (the \$50,000 of insurance proceeds minus the \$20,000 book value of the lost truck) as either a long-term capital gain in 1990 or as a reduction in the depreciable value of the new truck (so that its tax-deductible depreciation expense for trucks is reduced in future years).

The tax treatment of retained or insured payments for liability losses largely parallel those for property losses, except that no depreciation expense or potential capital gain is possible for the organization found to be liable.

If Gamma Corp. retains the liability loss on the injured passerby, the \$16,000 paid in 1990 is deductible as an ordinary business expense for that year. However, establishing an unfunded reserve for future years' payments has no tax consequences. In future years, the company can deduct from its taxable income only the payments made in those future years.

If Gamma has liability insurance for this claim, it suffers no casualty loss for tax purposes. However, the 1990 premium for the liability insurance is a tax-deductible business expense for the company.

All management—including risk management—decisions should be made on the basis of aftertax, rather than pretax, revenues and costs. (For a tax-exempt organization, aftertax costs and revenues equal pretax costs and revenues.) Both insuring and retaining losses have tax consequences for taxable organizations.

In general, insurance costs are tax-deductible before losses occur, but the costs of retained losses are deductible only after those losses have occurred and their amounts can be known with reasonable certainty. ■

The sample questions and answers used in this column are taken from the Associate in Risk Management designation curriculum of the IIA. For more information on the content of the A.R.M. program, write Dr. G.L. Head, Vp, Insurance Institute of America, P.O. Box 314, Malvern, Pa. 19355.

Citibank plans AMBAC divestiture

Public share offering to raise \$567 million

By JUDY GREENWALD

NEW YORK—An AMBAC Indemnity Corp. official says Citibank's plans to sell a majority interest in the municipal bond insurer to the public will have no impact on its operations.

Robert J. Genader, senior executive vp of AMBAC, says it will continue to be "business as usual" at the 20-year old insurer following Citibank's planned divestiture of about 50.3% of AMBAC Inc., AMBAC Indemnity's holding company.

Citibank, the main operating subsidiary of New York-based Citicorp, has filed a registration statement with the Securities and Exchange Commission seeking permission for a public offering of 17.6 million shares, with a possible over-allotment of an additional 2.64 million shares.

Citibank is seeking to sell the stock for \$28 per share, or \$566.7 million.

In addition, AMBAC has filed a registration statement with the SEC proposing to sell \$150 million of debt securities.

The \$150 million will be used to repay a loan AMBAC plans to take to pay a dividend to Citibank.

Because AMBAC has never promoted its relationship with Citibank, the divestiture is not expected to have an impact on the company, Mr. Genader said. "We've always been such a distinctly separate business," he said.

"I don't think we'll be hurt or helped" by the stock sale, Mr. Genader said. "We never pushed on the market our ownership. We have always stood on our own strength," he said.

"I think customers are not even going to be aware the ownership has changed," Mr. Genader added.

Mr. Genader also noted that Citibank has been trying to sell AMBAC since March 1990 (*BI*, March 12, 1990).

Citibank said at the time that proceeds from the sale would be used to rebuild capital depleted in connection with a \$1 billion provision involving loans to underdeveloped countries.

Citibank also has said more recently that the equity sale will improve Citibank's capital position.

"It's been a consistent objective that they have been trying to achieve," said Mr. Genader, who would not comment on what interest has been generated by Citibank's offer.

But, Richard Smith, vp for rating agency Standard & Poor's Corp. in New York, said in regard to Citibank's attempted sale of AMBAC: "Either nobody wanted it or nobody was willing to pay the price that Citibank wanted."

Both the equity and the debenture sales are contingent on AMBAC retaining its Triple-A rating from S&P and Moody's Investors Service.

The Triple-A ratings conferred by the rating agencies enable AMBAC—which accounts for about one-third of the municipal bond insurance market—to confer its top rating in turn on the lower-rated municipal bonds it insures.

Both rating agencies have already affirmed the ratings.

"Moody's has known for some time of Citibank's plan to divest itself of AMBAC Inc. and, based upon these plans and the capital structure expected to result from this move, we believe that no rating action is warranted at this time," the rating agency said in a statement.

S&P's Mr. Smith said the equity offering is not expected to have

any impact on AMBAC's creditworthiness. "That didn't create any problems for us," he said.

AMBAC reported \$112.2 million in net premiums written in 1990, a 30.3% increase from \$86.1 million in 1989.

Mr. Smith said the equity sale holds advantages for both Citibank and AMBAC. He pointed to federal risk-based capital guidelines that Citibank must abide by, which became effective this year (*BI*, Feb. 20, 1990).

Under the 1988 Basel Accord, an international agreement in which the United States is participating, banks had to maintain a minimum ratio of total capital to total risk-weighted assets of 7.25% by year-end 1990. Bank have to maintain a minimum 8% ratio by year-end 1992.

In determining total risk-weighted assets, off-balance sheet items—or contingent liability items, including financial guaranty insurance obligations—are taken into account, along with on-balance sheet items such as loans.

"AMBAC's liabilities all needed to be included in Citibank's calculations, and that's the problem," said Mr. Smith, noting that bond insurers were not considered when the regulation was devised. As a result, AMBAC's higher-quality

'I don't think we'll be hurt or helped' by the stock sale, says Mr. Genader, AMBAC's senior executive vp.

insurance business is treated the same as lower-quality letters of credit or direct lending operations, he said.

Citibank never put additional money into AMBAC because of the regulation and would not have had to do so, but the capital would nevertheless have had to be somewhere within the Citibank organization, Mr. Smith said.

This is why Citibank was willing to sell the operation, he said. It frees up capital for other businesses.

At the same time, one could view Citibank as a somewhat "less than ideal" owner because of the onerous regulation, Mr. Smith observed.

In addition, the access to the public AMBAC will now have could be viewed as positive, he said.

However, the public is not a "particularly reliable source of capital," Mr. Smith said.

He pointed to S&P's statement affirming AMBAC's triple-A rating, which states in part that public ownership will require AMBAC management to "place even greater emphasis on strategic capital formation issues."

AMBAC will have to structure its operations so that it can obtain money when it is available, not just when it needs it, Mr. Smith commented.

It cannot always assume it will have access to the public markets, he said.

For example, Mr. Smith pointed to the negative impact on the stock of municipal bond insurer MBIA Inc. when there were reports that the city of Philadelphia was experiencing financial difficulties (*BI*, Oct. 8, 1990).

"We just don't view the equity markets as a continuing source of capital," Mr. Smith said.

AMBAC's Mr. Genader re-

sponded to the S&P statement on strategic capital formation issues: "We always have been concerned that we generate adequate capital internally to fund our growth."

"I think S&P is recognizing that this is a much more mature, solid industry today than it was in 1985," when there was a big spurt in the growth of financial guarantee insurers.

Mark H.S. Cohen, managing director of the financial guarantee group at Fitch Investors Service, which does not rate AMBAC, said he believes the sale could be positive for the insurer.

"The business of financial guarantee insurance essentially is a perception one," he said. "You have to create the perception—and the reality, actually—that you're pristine."

Referring to Citibank's financial difficulties, Mr. Cohen said it has

been difficult over the past two years for AMBAC to have a "sick parent."

However, AMBAC has done a good job of dealing with the negative perception that policyholders may have had in connection with its ownership by Citibank, Mr. Cohen commented.

But, "on the flip side," AMBAC no longer will have a rich parent to "step up to the plate" in the event it needs additional capital, Mr. Cohen observed.

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INTERNATIONAL

London will review war risk policies

By GAVIN SOUTER

LONDON—Aviation underwriters will review the wording of war risk policies in the aftermath of the Persian Gulf War and a recent arbitration decision on the payment of claims following a Chinese hijacking incident.

London market aviation underwriters and war risk underwriters will set up a body "within the next few weeks" to review war risk coverages and will publish their findings, "hopefully within months," said Peter Hubert, chairman of Lloyd's Aviation Underwriters Assn.

The war risk coverage review body, which is yet to be estab-

lished, will consist of war risk underwriters, aviation hull underwriters and aviation liability underwriters from Lloyd's of London and the London insurance company market, Mr. Hubert said.

Its main task will be to establish a satisfactory method of dealing with coverage following a nuclear detonation, he added.

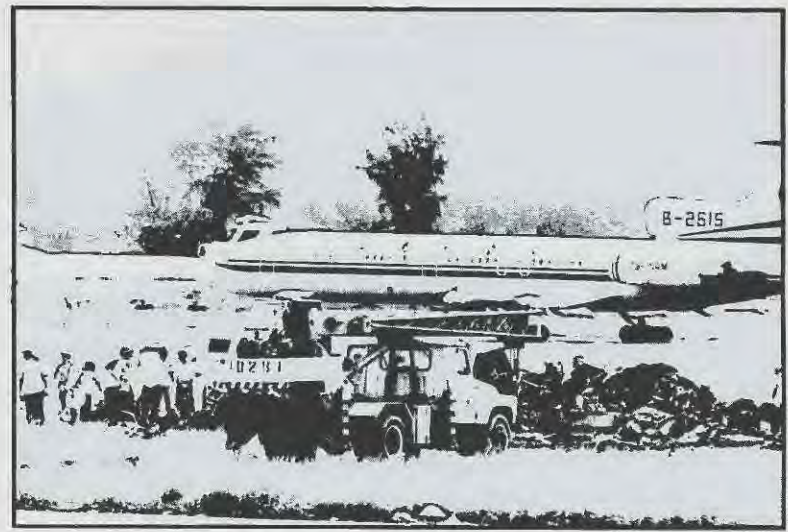
The review body will focus on a clause in the policies that calls for the automatic termination of war risk coverage if a nuclear weapon is detonated. Underwriters and brokers had worried about the effect on the marketplace if nuclear weapons had been used in the Persian Gulf War, forcing the automatic cancellation of war risk

policies (BI, Jan. 28).

Problems with the coverage as now written were highlighted by the Persian Gulf War when brokers had to set up automatic reinstatement line slips to allow war risk coverages to continue after a nuclear explosion.

"This was not satisfactory, because the limits" available through the replacement line slips "were much less than the original coverage purchased. We must review whether automatic termination should take place and if so under what circumstances," Mr. Hubert said.

The review body also will consider the ramifications of the arbitration ruling that all-risk aviation



A coverage ruling in a Chinese aviation loss may affect war risk cover.

underwriters should pay a claim for two aircraft destroyed after a hijacked aircraft crashed into them, Mr. Hubert said.

The arbitration concerned a claim from October 1990 that was

provisionally settled jointly by all-risk and war risk underwriters pending an arbitration.

The two aircraft, a Boeing 757 and a Boeing 707, were destroyed
Continued on page 34

Lloyd's losses to grow: Analyst

By GAVIN SOUTER

LONDON—Overall market losses at Lloyd's of London will increase following Lloyd's first marketwide loss in more than two decades, market analyst Chatset Ltd. says.

Chatset predicts that Lloyd's will announce a 278 million pound (\$536.5 million at appropriate exchange rates) loss for 1988 when it reports its global results next month (BI, May 20).

The loss will double the number of members fleeing the market this year, Chatset said, predicting that 5,000 members will resign from Lloyd's effective at year-end.

However, even worse results are yet to come, Chatset said. When Lloyd's 1989 results are released in June 1992, the overall market loss could be as much as 10% of the market capacity, or 1 billion pounds (\$1.74 billion at current exchange rates), Chatset cautiously predicted.

"I am very nervous about predicting so far in advance, but I think we would be lucky to escape with a market loss of less than 1 billion pounds" for the 1989 underwriting year, said Charles Sturge, joint editor of Chatset's Lloyd's League Tables.

This will cause even more members to resign from Lloyd's and could cause capacity in 1992 to shrink to 8 billion pounds (\$13.9 billion) from the current 11 billion pounds (\$19.1 billion), Mr. Sturge said.

However, a reduction in capacity "will be very healthy for the market and it will tighten it up," he added.

Besides the resignation of members, Lloyd's capacity also will be reduced by members that choose to decrease their underwriting capacity, Mr. Sturge said.

Lloyd's last posted a marketwide loss in 1967 in the wake of Hurricane Betsy.

The 1988 loss will come entirely from the marine market, according to Chatset.

The marine market will post a loss equaling 14% of premium capacity, while the non-marine market will show a 5% profit, the aviation market will report a 10% profit and the motor market will post a 12% profit, Chatset said (BI, May 20).

When losses from syndicates that have not closed their accounts
Continued on page 34

Libya builds two 'rivers'

Brunt of coverage for project ceded to European markets

By MARIA KIELMAS

LONDON—London-based United Insurance Brokers Ltd. will place facultative reinsurance for the \$5.3 billion second phase of Libya's Great Man-made River project, the broker confirms.

The 2,600-mile long \$25 billion pipeline is designed to collect fossil water from aquifers in southern Libya and transport it hundreds of miles north to Mediterranean coastal areas to be used as drinking water and to irrigate 72,900 acres of coastal farmland.

About 80% of Libya's 4 million population lives on the coast. Over the years, local aquifers there have been seriously depleted. Water supplies are supplemented by 14 desalination plants.

The \$3 billion initial phase of the multiple phase project, which was started in 1983, is designed to pump water from aquifers in Sarir and Tazarbo north to the cities of Benghazi and Sirte.

The first water was scheduled to arrive by August this year, but United Insurance Brokers Chairman Jad Kabban says the project is running about one year behind schedule. All phase one work is now expected to be completed in 1992.

The second phase of the project, which is expected to cost \$5.3 billion, will connect Tripoli, Libya's capital, with aquifers in west central Libya. This phase is scheduled to be completed in 2002.



The Libyan state insurance and reinsurance monopoly, Libya Insurance Co., is underwriting the entire project.

For the second phase of the project, LIC retains 6% of the business and cedes 34% to its treaty reinsurers—predominantly London market companies, though Arab and European reinsurers also participate, said an LIC spokesman in Tripoli.

The remaining 60% of the reinsurance for the second phase, all facultative, is being placed by United Insurance Brokers.

Mr. Kabban says the lead underwriter on the facultative placement is Skandia Insurance Co. Ltd.

Other leading reinsurance companies on the project include Munich-based Munich Reinsurance Co., Cologne-based Gerling-Konzern, Globale Ruckversicherungs-A.G. and Bahrain-based Arab Insurance Group B.S.C.

Mr. Kabban declined to reveal

the gross premium for the project.

United Insurance Brokers also placed 10% of the reinsurance for the first phase of the project, Mr. Kabban said. He said that the risk so far had been "profitable to the market."

U.S. insurers and reinsurers have been banned from doing business in Libya since the U.S. government imposed economic sanctions on the country in 1986. These sanctions were renewed in January this year.

Mr. Kabban said U.S. capacity has not been missed because the world market has ample capacity.

"I would think (U.S. insurers) are missing good business," Mr. Kabban said.

The Libyan property/casualty and life/health insurance market's total premium volume is about 60 million dinars annually (\$17.4 million).

This figure includes premiums from large-scale risks, like the water project, and from state oil company National Oil Corp. LIC reinsures more than 90% of these large-scale risks abroad, but it retained 50% to 60% of other business in its 1990/1991 fiscal year the LIC spokesman said. "We retain almost 100% on our marine account, and on fire we retain 1.5 million dinars (\$435,000) on each and every risk. We probably have one of the highest retentions in the Middle East. Over the years, Libya has developed a firm policy regarding retentions," the spokesman said.

Japan considers insurance reforms

By JUDITH RAWNSLEY

TOKYO—Japan's insurance industry is poised for its first shake-up in 50 years.

Japan



A draft report on reform of the insurance industry, released last month by an advisory body to Finance Minister Ryutaro Hashimoto, has called for:

- Removal of barriers between life and non-life insurance.
- A partial lifting of restrictions on insurers entering the banking

and securities businesses.

• Reforms of the way insurance companies manage their assets, including raising ceilings on investment in stocks and real estate.

The report, which was drawn up by the advisory Insurance Council, will now be acted upon by the Ministry of Finance, which oversees the country's insurance industry. The Ministry of Finance is expected to reshape the structure of the industry by 1994 at the earliest.

The Insurance Council's report comes as part of the Ministry of Finance's overall financial reform

program, which also includes a review of the separation of banking and securities brokerages in Japan.

"We expect discussions about insurance industry reform to be finished by the end of the year, so the technical discussion as to how to actually introduce the system is likely to begin next year," according to Atsushi Mimura, an official of the First Insurance Division in the Ministry of Finance.

Discussions about the overhaul of Japan's insurance law began in April 1989, when the Insurance Council launched a study of the law.

The council placed priority on the promotion of competition between life and non-life insurers, as well as interaction with other financial sectors.

"We have been discussing reform of the insurance business law since the spring of 1989, as part of the overall program of financial deregulation and in order to promote greater competition among the insurance companies," said Mr. Mimura.

Under the proposal now being considered, life insurers would be allowed to more freely invest about 10 trillion yen (\$72.8 billion) of their total assets of more than 100

trillion yen (\$728.3 billion), while continuing to hold about 90% of their assets in reserve for the needs of policyholders.

Under current law, insurers are restricted as to how they can invest their assets.

For example, not more than 30% of assets can be invested in equities or in foreign currencies, while the limit on real estate investments is 20% of assets.

Deregulation is also expected to force life insurers to compete more actively, resulting in lower premiums and higher dividends on investment-type policies.

Continued on page 35

INTERNATIONAL

Citicorp divests London-based brokerage

By GAVIN SOUTER

LONDON

LONDON—The management-led buyout of Citicorp Insurance Brokers Ltd. was completed last week as the company changed its name to Nelson Hurst Group Ltd.

The purchase was led by the Chief Executive David Woodward who, along with CIB's 11 other board directors, received financial backing from three institutional investors: National Westminster Bank P.L.C., Bank of Scotland P.L.C. and Advent International, a fund manager. The purchase price was not disclosed.

CIB reported 34 million pounds (\$65.6 million at year-end exchange rates) in revenues in 1990 and expects to generate revenues of 35 million to 40 million pounds

(\$60.9 million to \$69.2 million at current exchange rates) in 1991, Mr. Woodward said.

The new company will continue to concentrate on CIB's traditional markets, Mr. Woodward said. These include professional liability, marine and aviation insurance and international non-marine facultative reinsurance, he said.

Nelson Hurst also will continue to place "a significant amount" of Citicorp's own insurance needs, Mr. Woodward said.

The brokerage is represented in 18 countries and has about 750 employees, Mr. Woodward said.

Nelson Hurst units in South

America and Asia will operate as Citicorp Nelson Hurst, though Citicorp does not have an equity stake in the company, he said.

He would not disclose the breakdown of ownership in Nelson Hurst other than to say that all shares had been bought from Citicorp, all of the directors have an ownership stake in the company and no one individual has more than 50% of the shares.

CIB was formed in 1984 from the insurance division of another Citicorp company, Grindlay Brandts Bank. The company doubled in size in 1989 when it bought professional liability broker Nelson Hurst & Marsh (Holdings) Ltd.

The new company has reverted to the Nelson Hurst name because "the name goes back to 1919 and it

is a well-respected and well-known name in Lloyd's and the London market," Mr. Woodward said.

A spokesman for Citicorp said: "The sale of Citicorp Insurance Brokers to its management is in the best interests of both parties. Citicorp has consistently stated that it will de-emphasize involvement in non-core activities. The sale is in line with this" (see story, page 29).

Capacity exceeded

Lloyd's of London has told three excess-of-loss reinsurance syndicates to cease underwriting because they have exceeded their stamp capacity.

However, two of the syndicates will appeal the ruling.

The three syndicates are marine syndicate 575, managed by J.H. Chappell (Underwriting Agencies) Ltd., and marine syndicate 321 and aviation syndicate 1122, both managed by Gresham Underwriting Agencies Ltd.

Problems arose for the syndicates after they had to write automatic reinstatement coverages following the chain of catastrophes that blighted the 1987, 1988, and 1989 underwriting years.

Under many excess-of-loss reinsurance contracts, coverage is automatically reinstated one or more times after limits are exhausted. An additional premium is paid upon reinstatement.

During the three years when the syndicates exceeded their underwriting capacity, the market suffered an extraordinary number of catastrophe losses, including the European windstorms of 1987, the explosions of the Enchova and Piper Alpha oil platforms in 1988 and the San Francisco earthquake and Hurricane Hugo in 1989.

On top of this, the aviation insurance market suffered eight major losses in 1989.

"Our aviation underwriter stopped underwriting any more risks after three of the losses, but he then had to face another five and nobody could have predicted that," said John Goodger, managing director of Gresham.

Syndicate 1122 is forecast to exceed its 1989 capacity of 2.8 million pounds (\$5.1 million at applicable exchange rates) by 30%, Mr. Goodger said.

Gresham is appealing the suspension order on the grounds that the syndicate has written only 48% of its 1991 capacity and, unless it obtains more premium income, it will be unable to meet its reinsurance costs and expenses, forcing it to recoup these costs from its members, Mr. Goodger said.

Gresham also will appeal the suspension of syndicate 321, he said.

Syndicate 321 exceeded its 1987 capacity of 25 million pounds (\$37.1 million) by 6%, exceeded its 1988 capacity of 39 million (\$73.6 million) by 48% and exceeded its 1989 capacity of 40 million (\$72.3 million) by 14%, Mr. Goodger said.

The syndicate probably would have not written any more business this year, he said, since most of its business renews on Jan. 1.

However, it will appeal the decision because of the uncertainty the suspension would place on the syndicate, he said. Mr. Goodger explained that there is no set date for the ban on underwriting to be lifted and the syndicate would have to begin negotiating renewals in October.

J.H. Chappell will not dispute the ruling affecting syndicate 575, said John Heynes, chairman of J.H. Chappell.

Syndicate 575 exceeded its 1988 capacity of 23 million pounds

(\$43.4 million) by 44%, and it is forecast to exceed its 1989 capacity of 33 million pounds (\$59.7 million) by 18%. While the syndicate is not expected to exceed its capacity in 1990, Lloyd's forecasts that it exceeded its 1991 capacity by 2%, Mr. Heynes said.

Sedgwick results

First-quarter results remained static at Sedgwick Group P.L.C. as insurance premium rates remained depressed.

Sedgwick reported unaudited pretax profit for the first quarter totaling 42.6 million pounds (\$74.6 million at March 31 exchange rates), compared with 42.5 million pounds (\$69.7 million at March 30, 1990, exchange rates) for the first quarter of 1990.

Revenues increased by 1% to 183.2 million pounds (\$320.6 million, and expenses were reduced by 2% to 138.9 million pounds (\$243.1 million).

"The market continues to be very flat, so any revenue gain is a good thing," said Sedgwick Chairman David Rowland. Only specialized areas in the London market have seen significant premium increases, he added.

However, the sharp contraction in capacity in the London non-marine reinsurance market, which followed the January and February 1990 European storms, has resulted in lower revenues for Sedgwick's London reinsurance broker, E.W. Payne Cos.

But, Sedgwick James in the United States showed a moderate increase in revenue, Mr. Rowland said, noting there was "good profit improvement in the U.S."

Kuwaiti rates

Aviation cargo war risk premiums for flights in and out of Kuwait have been standardized.

The Lloyd's of London/Institute of London Underwriters war risk ratings committee on May 13 set aviation cargo rates for Kuwait at 0.05% per \$100 of insured value as the threat of damage to cargo subsides in the aftermath of the Persian Gulf War.

Previously, rates for aviation cargo insurance for flights to and from Kuwait had been set on a "held cover" basis, which meant that individual underwriters could set their own rates.

Marine cargo rates for ships calling on Kuwaiti ports remain on a "held cover" basis.

New Royal unit

Royal Insurance Holdings P.L.C., the parent company of Charlotte, N.C.-based Royal Group Inc., is forming a new company to underwrite worldwide property and casualty risks for multinational corporations.

Royal Insurance Global Ltd., headquartered in London, will focus on providing services for multinational clients, a focus in which the insurance company expects great potential for growth, pointed out Ian Rushton, group chief executive of Royal Insurance Holdings.

Thomas J. Brown, currently managing director of Royal Insurance Holdings, will serve as chief executive of worldwide operations for Royal Global. The new company also will have locations in New York, The Netherlands and Australia.

For more information, contact Claude Adams, Vp of North American Operations, Royal Insurance U.S.A., 150 Williams St., New York, N.Y. 10038; 212-553-3398.

Continued on next page

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Acordia

INTERNATIONAL

LONDON

Continued from previous page Legionnaires' disease

A former cab driver who claimed to have nearly died from Legionnaires' disease was awarded 26,400 pounds (\$45,936) in British High Court last week in the first court-enforced compensation award for victims of the disease.

Peter Lower, 50, of north London, contracted the virus in April 1988 after it spread from a cooling tower of the British Broadcasting Corp.'s radio headquarters in central London.

He was one of 89 people who contracted the disease, which has symptoms similar to viral pneumonia. Three of those people died.

Mr. Lower suffered cardiac arrest and nearly died as a result of the disease, said his lawyer, William O'Brien, a partner at Russell Jones & Walker in Manchester.

The BBC and its liability insurer, Commercial Union P.L.C., offered Mr. Lower 18,000 pounds (\$31,320) in damages and compensation for loss of earnings. He rejected the offer, claiming he is still suffering fatigue. "The judge made the award on the basis that Mr. Lower was still suffering from the disease," Mr. O'Brien said.

Sixty-seven other claims against the BBC, including awards to relatives of the three people who died, have been settled already.

Mr. Lower's award is the largest yet, said a BBC spokesman, who would not reveal the total paid so far.

Twenty-two other claims are pending, though the spokesman

ing. "None of the remaining cases are controversial."

Another outbreak of Legionnaire's disease in 1989 affected about 30 people in the Piccadilly area of central London, but the source of the virus was not identified at the time.

However, Mr. O'Brien has been approached by a victim who says he can identify the source and that he wishes to file a claim against that party. He said he will assess the case over the next few weeks.

Jardine purchase

London-based Jardine Insurance Brokers International Ltd. has acquired the majority interest in specialist North American casualty broker J. Besso & Co. Ltd. for an unspecified sum.

Jardine acquired Besso from London United Investments P.L.C., which held 25%, and other institutional investors, said a Jardine spokeswoman. Colin Bird—not to be mistaken with LUI's administrator of the same name—will remain chairman of Besso.

Soccer star covered

Underwriters of permanent disability coverage as well as British soccer fans are wishing English star Paul "Gazza" Gascoigne a speedy recovery from the knee injury that may keep him off the field until the end of the year.

The underwriters wrote 5.5 million pounds (\$9.6 million) of disability coverage for Mr. Gascoigne. Windsor Insurance Brokers placed the coverage on behalf of Mr. Gascoigne for his team, the Tottenham Hotspur, market sources say.

The coverage is led at Lloyd's of London by David Sear, un-

derwriter for a syndicate managed by Gooda Walker Ltd., the agency confirmed.

A payment will be made only if the injury forces Mr. Gascoigne to permanently quit soccer.

Mr. Gascoigne tore his knee ligaments making a tackle during English soccer's premier event, the F.A. Cup final, on May 18. He was carried off the field on a stretcher and was rushed into surgery.

Calling the operation a success, a Spurs spokeswoman said he was expected to be playing again by Christmas.

The Spurs went on to beat Nottingham Forest, 2-1.

After shooting to fame as the star of the England World Cup squad last year, Mr. Gascoigne has expanded his activities outside soc-

cer, including recording a hit record.

The injury could not have come at a worse time for the Spurs, which were rumored to have considered selling Mr. Gascoigne's contract to help reduce its 11 million pound (\$19.3 million) bank overdraft.

It was widely rumored that Mr. Gascoigne would be dealt to Rome's Lazio team for 7.9 million pounds (\$13.8 million) last week, but the deal was postponed because of the injury.

The deal would have alleviated the pressure on the Spurs, whose shares are quoted on the London Stock Exchange. Lazio is still in negotiations with the Spurs.

But, if Mr. Gascoigne's contract is sold, his disability coverage

could be invalidated.

"When a transfer goes through, any outstanding disability claims die with the transfer," said Brian Cook, a director at Windsor. He would not confirm that Windsor placed the coverage.

However, Windsor does place coverage for the Football League, which makes "nominal" payments for loss of earnings to injured players, Mr. Cook said.

The coverage is underwritten by Colin Owen, underwriter for Lloyd's syndicate 718, which is managed by Oxford Syndicate Management Ltd., he said.

The Spurs say they will continue paying Mr. Gascoigne's salary—rumored to be more than 3,000 pounds (\$5,250) per week—while he recovers.

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INTERNATIONAL

Lloyd's losses

Continued from page 31

are added to known losses, the loss for 1988 could be as much as 550 million pounds (\$957 million), Chatset said.

"Added to this, advance cash calls on the 1989 year are thought to be about 300 million pounds (\$522 million), plus a few calls on the 1990 year, so, in total, names may (have) to write out checks this year for 800 million pounds (\$1.39 billion) or just under 8% of their stamp allocation," Chatset reported.

"Pre-1986 names will be hardest hit as continuing losses on the open years make their impact," the analyst said.

Although the marine market was hit by the \$1.3 billion Piper Alpha loss in 1988, much of the 1988 loss was produced by marine syndicates that write incidental non-marine accounts, including U.S. liability expo-

sures stretching back over 50 years, Chatset said. Many major syndicates have had to "dramatically increase their reserves on the old years," said Mr. Sturge explained.

Syndicate 406, managed by Wellington Underwriting Agencies Ltd., gives a good example of the problems that the marine market faced on its 1988 year of account, Chatset said.

Syndicate 406 wrote net premiums of only 34.2 million pounds (\$66 million at appropriate exchange rates) on gross capacity of 115.6 million pounds (\$223.1 million), or just less than 30% of its capacity.

Losses after an allowance for incurred-but-not-reported losses totaled 51.9 million pounds (\$100.2 million), which produces an ultimate loss ratio of 152%, Chatset said.

"Thus the only good thing about 1988, from a name's point of view, was the gross overcapacity of the market. Otherwise, losses on the pure 1988 year could have been three

times as great on stamp allocation. Quite clearly, premium rates were ludicrously low," the analyst said.

The main losses for the syndicate arose from prior years of account, which now need an additional 89.8 million pounds (\$173.3 million) of reserves, Chatset said.

The reserves are made up as follows: 49 million pounds (\$94.6 million) for pollution losses, 15.7 million pounds (\$30.3 million) for asbestos losses, 16.3 million pounds (\$31.5 million) for other liability losses and 8.8 million pounds (\$17 million) for other non-liability losses, Chatset said.

The syndicate's prior year losses were cut to 54 million pounds (\$104.2 million) through payments from time and distance reinsurance.

The reserve restrictions imposed on Lloyd's by the British Inland Revenue puts the market at an unfair disadvantage to its European competitors, Chatset said. These restrictions

require that British insurers justify their reserves, while the same is not required of European insurers, Chatset said. Also, the Inland Revenue usually requires there to be a historical precedent for the occurrence of claims in a particular year and does not accept the argument that IBNR claims are generally increasing, Chatset added.

And recent developments like the U.S. Environmental Protection Agency's decision to regard drilling rig mud as a toxic waste will increase the need for additional reserve increases to account for as-yet unknown long-tail liability losses, Mr. Sturge said.

"The drilling rig market is very worried that the mud used to block oil wells will be regarded as a pollutant. . . . Professional reinsurers, such as Swiss Re and Munich Re, have been able to build up reserves to pay losses like this, but in Lloyd's, the (Inland Revenue) only allows

syndicates to put aside a relatively small amount," he added.

In the non-marine market, profits will drop to just less than 6% of capacity in 1988 from 10% of capacity in 1987, Chatset predicts.

However, Hurricane Hugo losses, which Lloyd's says may hit \$4.2 billion, will mean that the non-marine market will join the marine market in the red in 1989, pushing the overall loss up to 1 billion pounds (\$1.74 billion), Chatset said.

Motor and aviation syndicates will do little to stem the 1989 losses, since they will both produce lower profits for the year, Chatset said.

And, with retrocessional reinsurance scarce, all syndicates will have to bear more of their future losses, Mr. Sturge said. "It looks like Lloyd's is becoming more and more of a net market—that is, syndicates will have to retain much more of what they write rather than send it around the rest of the market." ■

War risk coverage

Continued from page 31

on the ground at Guangzhou airport in China on Oct. 2 after a hijacked Boeing 737 exploded on landing and crashed into the two stationary aircraft, killing 127 people (BI, Oct. 8, 1990).

All three aircraft, which were valued at around \$80 million, were owned by the Civil Aviation Administration of China and were insured by the People's Insurance Co. of China.

However, more than 60% of the hull, hull war risk, and liability coverage was reinsured in the London market.

The reinsurance was placed by C.T. Bowring & Co. Ltd. and Willis Faber P.L.C.

The war risk underwriters, led by Lloyd's syndicates managed by Janson Green Ltd., fully paid for the loss of the 737, but all-risk underwriters, led by underwriter Barry Coleman on a syndicate managed by Murray Lawrence & Partners, provisionally paid 50% of the claims for the 707 and 757.

Following arbitration proceedings held in March, Lord Roskill, a retired House of Lords judge, ruled that the all-risk insurers should pay 100% of the claims for the 707 and 757 that were parked.

The all-risk underwriters have subsequently repaid the war risk underwriters the 50% of the claims for the two aircraft that they had paid, Mr. Coleman said.

In his ruling, Lord Roskill said that although the destruction of the two aircraft on the ground was caused by the hijacking, the wording of the hijacking exclusion clause in the all-risk policies did not exclude coverage for aircraft that were not hijacked, said Jonathan Barrett of Clyde & Co., the war risk underwriters' lawyer.

The arbitration could be precedent-setting, said Grant Whytock, a director at Nicholson Chamberlain Colls BankAssure Ltd.

However, due to the unique circumstances of the crash, the ruling may not be enough to change policy wordings, Mr. Whytock said last week.

"All three of the aircraft were owned by the same company and were directly insured by the same insurer. However, there are now moves in China to split up all of the state airlines, so perhaps a similar loss could not happen again," he said.

"There is a possibility that the policy wordings could be adjusted to exclude similar losses, but nothing has yet been discussed in the market," Mr. Coleman said.

If all hijack-related losses were excluded from all-risk policies, underwriters would have to secure an agreement from war risk underwriters to assume the additional liability, added Mr. Coleman. ■



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INTERNATIONAL

Japanese market

Continued from page 31

The Insurance Council hopes that intensified competition will lead to a greater number of insurance products to cover the country's growing number of senior citizens.

The reform plan also will include discussion as to how life and non-life insurers can move into each other's areas of business.

Insurers are likely to be allowed to compete directly in the three specific areas of medical, old age and personal accident insurance.

According to analysts, there is already some overlap in this area; changes in the law will just make such business official.

Entry for the life insurers into key non-life insurance areas like fire insurance, however, will be permitted only through subsidiaries, according to the Ministry of Finance.

In addition, overall reform of the industry would allow life and non-life insurers to enter other financial businesses now only handled by banks and securities firms. These businesses would include foreign exchange and the un-

derwriting of privately placed bonds.

The Ministry of Finance also intends to approve entry for banks and securities firms into the insurance business via subsidiaries. However, the proposed reform, which is expected from the ministry next month, largely depends on the result of discussions about the removal of barriers currently separating the banking and securities businesses.

The draft also recommends that insurers limit their capital-to-assets ratio similar to the level required for banks and securities houses by international banking agreements.

The Ministry of Finance decision to review the insurance industry comes at a time when insurers are keen to diversify their sources of funds.

The companies have been badly hit by declines in stock prices, which reduced the value of their investment portfolios, and by a decline in the influx of new funds after the deregulation of interest rates, which has diverted funds to bank deposits from insurance investment products.

Sales of high-return, single-pre-

mium annuity-type policies, very popular during the 1980s in particular, have declined, plunging 60% in the six months ending Sept. 30, 1990. Both the life and non-life insurers are in favor of reforms that would allow them to enter

business if it were allowed to do so, analysts say.

"The life insurers are so much more powerful than the non-life that if the barriers between their business areas came down—though I don't think that this will happen

Nippon Life Insurance Co. of Osaka alone is as big as the entire non-life insurance industry in Japan and could easily swallow up a big chunk of the nation's non-life business if it were allowed to do so, analysts say.

new areas of business and, thus, create more competition and revenues.

However, although reform of the insurance industry would undoubtedly stimulate competition, analysts say major life insurers have a lot more to gain from liberalization of the laws than the smaller non-life companies.

Nippon Life Insurance Co. of Osaka alone is as big as the entire non-life industry in Japan and could easily swallow up a big chunk of the nation's non-life busi-

ness completely—the non-lives would have a lot to lose," said Linda Daquil, financial analyst at UBS Phillips & Drew in Tokyo.

For example, savings-type casualty insurance—which offers the policyholder a return on the invested premium upon the policy's maturity (BI, May 13)—provides up to 40% of non-life insurers' premium income, so small to medium-sized non-life companies could be hurt by competition from life companies in this area.

Another crucial area of business

for the non-life industry is fire insurance underwriting.

"If the Ministry of Finance lets the life insurers into fire underwriting, it would be very bad for the non-lives, as this is their most predictable business area after marine insurance," Ms. Daquil observed.

Non-life insurers, however, at the same time have been applying for licenses to engage in pension fund management, which life insurance companies view as their own domain. Reforms in this area could provide a suitable compromise.

"The quid pro quo would be allowing non-lives into the pension fund market," said Ms. Daquil.

The Ministry of Finance's reforms are expected to encourage reorganization within Japan's banking, securities and insurance sectors.

The ministry, which has been eyeing the possibility of reform in the U.S. banking and insurance sectors, has already decided to approve entry of banks and securities firms into each other's businesses through the use of wholly owned subsidiaries.

Japan may reform insurance laws for foreign firms

TOKYO—The Ministry of Finance's Insurance Council, an advisory body, is considering a proposal to abolish a separate law regulating the operation of foreign insurance companies in Japan.



The law has been criticized as unfair and currently is viewed as a source of trade friction with other nations, insurance industry sources say.

If the law is abolished, the government would unify rules regulating both foreign and domestic insurance companies.

"There currently are two different laws for domestic and foreign insurance firms," said Atsushi Mimura, an official with the Ministry of Finance's

First Insurance Division. "The subcommittee has been discussing the problems the current Insurance Business Law has been creating for foreign firms. The same two laws are likely to be harmonized."

Under the current law, foreign insurance companies are required to set up a 10 million yen (\$72,830) trust deposit with the Ministry of Finance prior to writing any business in Japan.

Foreign insurers also must obtain approval from the ministry for each contract involving foreign currency.

"This issue will be discussed at the General Assembly of the Insurance Council," Mr. Mimura said. "And, the Insurance Council is likely to make a final decision whether to abolish these restrictions by the end of the year," he said.

Meanwhile, the United Kingdom recently asked Japan to liberalize its insurance market. U.K. negotiators at recent financial talks between the two countries in Tokyo requested that their Japanese counterparts allow Lloyd's of London to operate in Japan, among other things.

—By Judith Rawnsley

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First Executive

Continued from page 1

Other Executive Life developments last week include:

- California Insurance Commissioner John Garamendi released a "rehabilitation blueprint" for Executive Life that will give policyholders two choices.

Policyholders could either cash out policies for a reduced value or could swap Executive Life policies for new policies from a newly organized company. Those taking the second option would be required to hold policies for a minimum "lock-in" period, probably between three and five years. But those who exchange policies would later have a chance of receiving higher benefits than those who cash in now.

Mr. Garamendi, though, warns that the proposal could collapse if a \$643 million Internal Revenue Service lien against Executive Life is upheld.

In addition, Mr. Garamendi said at a congressional hearing in Washington last week that the "spirit" of ERISA suggests that the federal Pension Benefit Guaranty Corp. should, if necessary, guarantee benefits to Executive Life annuitants who had been covered by pension plans that later were terminated to recover surplus assets.

Mr. Garamendi also said that employers that purchased annuities from Executive Life to replace benefits of overfunded pension plans they

terminated should be required to make up any benefit shortfalls resulting from the insurer's collapse. Executive Life annuitants now are receiving only 70% of promised benefits (see story, page 37).

- Two more employers—Ralston Purina Co. in St. Louis and Promus Cos. Inc. in Memphis, Tenn.—are promising employees that they will bear potential losses connected to the purchase of Executive Life GICs by their 401(k) plans.

Ralston Purina says it will make up any losses of principal and interest, both accumulated and future, on the \$14 million invested in Executive Life GICs in its plan's fixed income fund. Those contracts represent about 13% of the \$107 million fixed income fund.

"Management has agreed to ensure that the necessary funds are available to keep the plan running smoothly and to protect your account balance in the fixed income fund from losses with respect to Executive Life investments," Ralston Purina told its employees.

However, the company noted that its intervention is a "one-time event" and that it would not intervene if other "investment situations" arise in the future.

In addition, Promus—which operates the Embassy Suites, Homewood Suites and Hampton Inns hotel chains—says it will guarantee principal and interest accumulated through March 31 on \$12.8 million in Execu-

tive Life GICs held by its 401(k) plan.

"We felt this was the right thing to do. We want our employees to have every confidence that their 401(k) plan is a good way to save," a Promus spokeswoman said.

Ralston Purina and Promus' action follows the decision of Holiday Inn Worldwide, the Memphis-based hotel chain, to protect employees from losses on \$12.8 million in its plan's so-called Stable Income Fund that is invested in Executive Life GICs (BI, May 13). Holiday Inn said it will guarantee principal and interest accumulated through April 11 on Executive Life GICs. Principal, but not interest, would be guaranteed after April 11.

- The Alaska Legislature last week gave final approval to a measure that sets up a \$45 million fund to protect more than 22,000 participants in a state-sponsored savings plan that purchased Executive Life GICs and annuities. The legislation also would allow an additional \$95 million to be used in the future, if necessary.

In all, the Alaska savings plan purchased about \$132 million in Executive Life GICs—about 20% of the plan's assets—and \$5 million to \$6 million in Executive Life annuities to provide benefits to employees when they retired.

- Labor Department officials said they have received a flood of phone calls from employers interested in purchasing Executive Life GICs from their 401(k) plans. Such purchases

would make employers, not 401(k) plans, Executive Life creditors.

Such a sale—normally barred by ERISA—would have to be approved by the Labor Department through an individual exemption.

Speaking last week before the annual Washington meeting of the Assn. of Private Pension & Welfare Plans, Deputy Assistant Secretary of Labor Ann Combs pledged quick action on individual employer requests for exemptions so they can purchase Executive Life GICs from their 401(k) plans.

Earlier this year, Georgia-Pacific Corp. received Labor Department permission to purchase an Executive Life GIC held by a subsidiary's savings plan.

It was "the simplest, cleanest way to remove an investment that fell below our credit standards," said John Stettler, director of benefit investments and risk management for the Atlanta-based company.

Also at the APPWP meeting, Michele Varnhagen, an aide to Sen. Howard Metzenbaum, D-Ohio, and counsel to the Senate Labor and Human Resources Committee, said the committee will investigate whether employer purchases of Executive Life annuities satisfied all fiduciary obligations under ERISA.

- A group of major employers whose savings plans purchased Executive Life GICs is forming to protect the interests of plan participants as well as to keep companies informed of the latest Executive Life developments, said Mark Lipscomb, manager of investor and public relations at Unisys, which belongs to the group.

Benefit experts expect more companies to take action to protect their 401(k) plan participants from investment losses resulting from the Executive Life debacle.

"There are some employers who believe that since employees didn't make investment decisions as to which GIC insurers were selected, the employees should not be hurt" if one of the insurers fails, said Kim McCarrel, a consultant with Wyatt Asset Services Inc. in Portland, Ore.

More litigation, though, likely is in store for employers that do not make their employees whole.

"I would not be surprised if there was more litigation. Whenever there is money involved, there is litigation, even when the employer has done everything it could to ensure that a GIC insurer it selected was highly rated," said Henry Saveth, a princi-

pal with A. Foster Higgins & Co. Inc. in New York.

Indeed, Karl Cambronne, a partner with the Minneapolis law firm of Chestnut & Brooks, which has filed suits against Honeywell and Unisys, said he has been contacted by other plaintiffs' attorneys seeking additional information about the litigation.

The suit against Honeywell charges that Honeywell, its retirement committee and 401(k) plan trustee did not disclose to participants that a significant portion of their "risk-free" investment in the fixed income fund had become very risky.

"Defendants totally failed to inform plaintiffs and the members of the class that a staggering 16% of the fund was in serious jeopardy as a result of the shaky financial condition of Executive Life," the suit says.

"This loss is even more unpalatable when it is remembered that contributors to the fund reasonably believed that they had selected an extremely safe, virtually risk-free retirement investment. Many good, faithful Honeywell employees will suffer sleepless nights as a result of defendants' unconscionable dereliction of duty," according to the suit.

The suit also says that the 16% of fixed income investments in Executive Life GICs "is far in excess of what prudence would dictate appropriate for a pension plan. Prudence would indicate that a well-diversified portfolio of GICs would be far more likely to minimize the risk of loss to plan participants," the suit said.

Citing company policy, a Honeywell spokeswoman declined to comment on the suits.

In one of the suits against Unisys, plaintiffs charge that the company failed to provide information to plan participants that was "sufficiently accurate and comprehensive" that their investments were "in dire jeopardy" because of the investments in Executive Life GICs.

In addition, because Unisys failed to "adequately monitor the status of Executive Life and to take steps to eliminate the Executive Life GICs from the funds' portfolios, the defendant breached its fiduciary obligations," the suit charges.

Unisys also declined to comment on the litigation. However, Mr. Lipscomb, the manager of investor and public relations, noted that at the time the Executive Life GICs were purchased, the insurer had the highest ratings available. ■

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Texas Eastern

Continued from page 2

the cleanup costs on a pay-as-you-go basis, reporting cleanup costs in its annual report as part of operating expenses, the spokesman said.

Texas Eastern already has spent \$50 million for investigative cleanup efforts in Pennsylvania. And, under the Pennsylvania agreement, the company will spend \$150 million more in cleanup costs.

Unlike the U.S. EPA agreement, Texas Eastern has agreed to clean up off-site soils, streams and groundwater in Pennsylvania.

Specifically, Texas Eastern has agreed to clean up all contaminated stream sediments and off-site soils to attain essentially undetectable levels of PCBs of less than 2 parts per million. The company also has agreed to clean up its own property to about 5 parts per million, which will make the soil safe for human contact.

In addition, the company will conduct continuing studies to evaluate the environmental impact and the effectiveness of the technology used in the cleanups.

"Our efforts in this case have resulted in a much better deal for Pennsylvania than if we would have simply accepted those agreed to by the U.S. EPA," said Pennsylvania Gov. Robert P. Casey. "We've gone the extra mile to protect our people, our law and our water." ■

In addition to the \$200 million in cleanup costs, Texas Eastern will:

- Pay \$5.35 million in civil penalties to the state Department of Environmental Resources to settle charges that the company violated Pennsylvania's Clean Streams Law and Solid Waste Management Act. This is a state record for civil penalties.

- Pay \$3.55 million over the next 10 years to the Department of Environmental Resources for the agency's future costs associated with overseeing the cleanup of the contaminated sites.

- Post a \$3 million letter of credit with the Department of Environmental Resources necessary to guaranty payment for cleanup activities at the sites.

- Pay \$1.55 million to the Department of Environmental Resources for past oversight costs, dating back to 1987.

- Spend \$3 million to develop and evaluate new types of technology for cleaning up groundwater contaminated with PCBs.

- Pay \$1.55 million to the Pennsylvania Fish Commission to assess the impact of PCBs and other contaminants on aquatic life. This payment includes a \$300,000 donation to the Fish Fund.

- Pay \$650,000 to the Pennsylvania Game Commission to evaluate the effect of PCBs and other contaminants on wildlife. ■

Annuity guarantees urged

By JERRY GEISEL

WASHINGTON—The Pension Benefit Guaranty Corp. should guarantee retirement benefits for employees and retirees whose companies terminated pension plans and subsequently purchased annuities from life insurers, including Executive Life Insurance Co., argues California Insurance Commissioner John Garamendi.

Executive Life, which among other things wrote annuities for participants in terminated pension plans, was placed in conservation by the California Insurance Department last month (see story, page 1).

The PBGC maintains that its benefit guarantees only extend to defined benefit pension plan participants and not to individuals who receive annuities purchased from insurance companies by employers that have terminated their pension plans.

However, Mr. Garamendi said the PBGC's position is "bad news" to the millions of retirees and employees whose companies terminated their pension plans and funded their pension benefits with insurance company annuities.

"It also is inconsistent with the spirit of the landmark ERISA legislation of the 1970s, which would lead any layman to believe that it was the pension benefits that were guaranteed by the Pension Benefit Guaranty Corp.," Mr. Garamendi told the House Subcommittee on Select Revenue Measures last week.

To fail to guarantee annuities would invite "public ridicule" of the pension benefit guarantee program, he said.

"I invite you to imagine having to explain to the widow of a retired pensioner that she is out of luck because the elaborate pension benefit guarantee system we set up for her does not in fact guarantee her pension because her pension is not the exact kind of pension we guarantee," the California regulator said.

But the committee members said they were concerned about extending PBGC guarantees to annuities.

Rep. Rod Chandler, R-Wash., worried that broadening PBGC guarantees to cover annuities could send PBGC termination insurance premiums—which are paid by employers—spiraling.

New premium hikes could lead more employers to terminate their defined benefit pension plans, Rep. Chandler warned.

Rep. Charles Rangel, D-N.Y., also was troubled by Mr. Garamendi's suggestion that the PBGC guarantee annuities.

"It never entered my mind that PBGC should be exposed to that kind of liability," Rep. Rangel said.

Mr. Garamendi also said employers that terminated overfunded pension plans and then purchased Executive Life annuities to replace pension benefits have an obligation to make up any benefit shortfalls to workers and retirees. Currently, under the California Insurance Department's conservation plan, individuals covered by Executive Life-issued annuities are receiving 70% of promised benefits.

"Surely companies that did (pension) reversion raids in the '80s should be held accountable" and cover any shortfalls to annuitants caused by Executive Life's collapse, Mr. Garamendi said.

But, Rep. Don Sundquist, R-Tenn., pointed out that while asset reversions may have been "raids," such actions were not against the law.

Angered subcommittee members wanted to know how it was possible for Executive Life to hold a

high percentage of its assets—more than two-thirds—in junk bonds.

"To allow 67% of assets in junk bonds is pure incompetence," fumed Rep. Byron Dorgan, D-N.D.

Mr. Garamendi agreed that a cap, possibly 20%, is needed on the maximum percentage of insurer assets that could consist of non-investment grade or junk bonds.

He also said he is investigating the California Insurance Department's regulation of Executive Life.

Mr. Garamendi also repeated to the subcommittee earlier warnings that a \$643 million Internal Revenue Service lien on Executive Life for back taxes and penalties and interest "guarantees failure to rehabilitate the company and conserve for the people as much as we possibly can" (BI, April 29).

But even if the IRS lien is lifted, policyholders will not receive all promised benefits under the most optimistic of rehabilitation plans, he said. ■

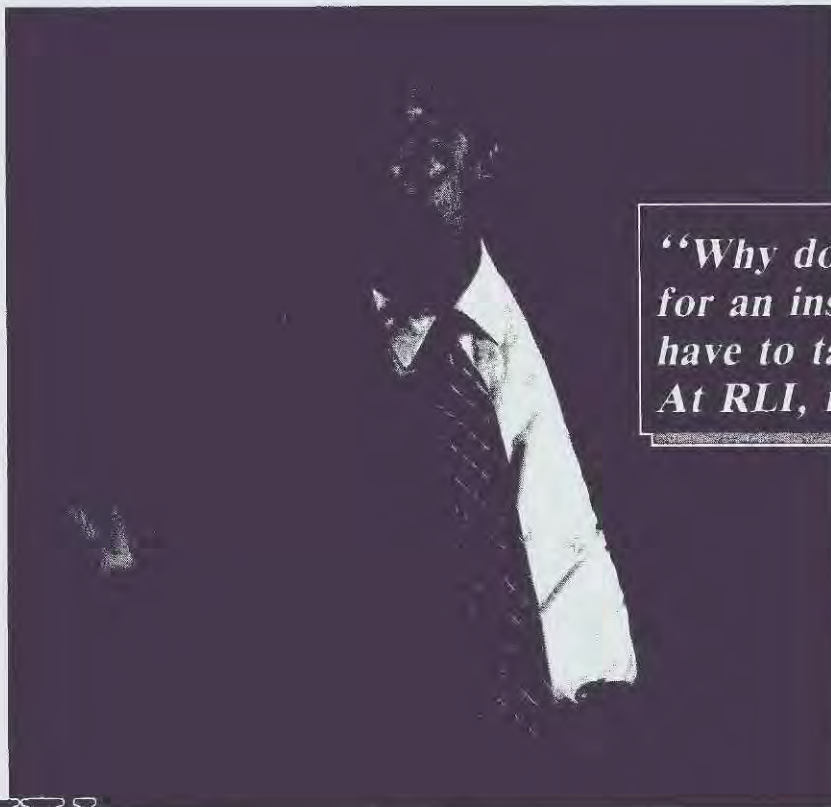
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Chief executives

Continued from page 3

ture retiree health care costs on their current financial statements.

Once it factors in these liabilities, "a \$500 million company will become a \$400 million company," Mr. Boland said (BI, April 1).

However, FASB is considering a rule that would reduce the liabilities employers must recognize on their balance sheets—and the resulting charge on their income statements—by more than a third in many cases.

The proposed rule change still must go through the accounting board's lengthy review and approval process, but is expected to become final by early next year (BI, May 20).

• The new Medicare physician payment schedule included in last year's budget law.

Among other changes, physicians will now be paid according to the relative value of their services, not the market levels that they generally charge. The new approach, which will be phased in during 1991 and 1992, is intended to slow the growth of Medicare physician payments, which rose as much as 15% per year during the 1980s.

However, costs not paid by the Medicare program are likely to be shifted to the private sector, similar to the cost shifting that occurred after Medicare changed the way it reimbursed hospitals for inpatient charges in 1983. While that system, based on diagnosis-related groups, did cut the government's health care costs somewhat, hospitals shifted those costs onto other patients.

The new Medicare payment rates for physicians will have a "tremendous impact on cost shifting in the next 18 to 24 months," Mr. Boland stressed. "There's going to be more cost shifting in the next two years than we could have imagined in the last two years," he warned. As a result, "any employer that does not have almost all of its employee population sheltered in a fixed capitation program or a fixed performance-based kind of contract is going to get killed."

Several problems will result when CEOs take control of the fight against rising health care costs, according to Mr. Boland.

First, "when CEOs are put in the hot seat, what will they do?" he asked. "Call in the cost cutters."

Unfortunately, the cost cutters likely to be selected by corporate financial officers are not likely to be familiar with employee benefits, Mr. Boland pointed out.

"These are not human resources people," he said. "They look at one thing: Where is the bleeding?"

"Our concern is that these cost cutters, as smart as they may be, may not be long-term visionaries. Our concern is they're going to use a meat ax not a scalpel."

The second problem that could result from top executives taking over benefit cost containment decisions is the areas in which they make the cuts, he said.

Mental health and substance abuse benefits will be "the single most obvious area for cuts," he predicted. "They don't like to deal with it, they don't understand it, it affects fewer people and it's less bread-and-butter than acute care."

It will be benefit managers' job

to educate CEOs and CFOs about the role that mental health care and substance abuse benefits—including employee assistance plans—can play in reducing overall health care costs, Mr. Boland asserted.

Top executives also would probably cut the number of health care plans offered to employees, according to Mr. Bowland.

Already, many large U.S. corporations are consolidating their health care plans. BankAmerica Corp., for instance, last year pared its health maintenance organization offerings to six from 15 (BI, Oct. 1, 1990).

Several other employers are replacing multiple health care plans with a single point-of-service plan. Examples include Allied-Signal Inc.'s Health Care Connection and the CustomCare plans at Southwestern Bell Corp. (BI, Feb. 18).

While many of the recent plan consolidations may have benefitted both employers and their employees, Mr. Boland expressed concern that the criteria used to make the cuts were too superficial because they focused solely on which plans covered the most employees.

"It doesn't take a genius to figure out where to make cuts based on that," he quipped.

Enrollment should be the first concern in such a decision, according to Mr. Bowland, but quality of care also should be taken into consideration because "there is no cost containment without quality assurance."

"We've been so over-focused on cost containment that we haven't realized that we can't manage cost without managing the care," he said. ■

Resist urge to cut mental benefits, psychiatrist says

By JOANNE WOJCIK

SAN JOSE, Calif.—Self-insured employers should offer behavioral health benefits to their workforce in order to reduce overall health care costs and be more competitive in the global marketplace, a psychiatrist says.

"We need to preserve and enhance the physical fitness and the mental health and productivity of our workforce in order to be competitive in this global marketplace," said Michael A. Freeman, president of the San Francisco-based Institute for Behavioral Healthcare.

Unfortunately, many employers that are faced with increases in their mental health care spending usually eliminate or reduce mental health care benefits, Mr. Freeman told benefit managers attending the annual meeting of the National Assn. of Employers for Health Care Action, held May 16-17 in San Jose, Calif.

In fact, "fully 15% of American employers impose benefit limitations, benefit restrictions or some form of benefit reductions," Mr. Freeman said.

But mental health care "benefit elimination is not the right solution," according to Mr. Freeman, especially since one out of five people has a diagnosable psychiatric condition, and one out of four women will have a major depressive episode in the course of their lifetimes. Depression's mortality rate is 15%, Mr. Freeman added.

Employees with psychiatric conditions, especially those suffering from chemical dependency, will generate five times more medical claims than those who are psychologically healthy, Mr. Freeman said.

Behavioral health problems also produce numerous indirect costs, like excess medical plan utilization, absenteeism, workers compensation stress claims, lower productivity, accidents and injuries, wasted management time and unnecessary employee turnover, recruitment and training, according to Mr. Freeman.

"That's just the tip of the iceberg," he said. "Every once in a while you have something like Exxon, which gets in trouble with the Valdez oil spill. Disasters of that nature are not isolated."

The captain of the Exxon Valdez was intoxicated under Coast Guard blood alcohol content limits and not at the ship's helm when the Exxon Corp.-owned tanker ran aground in March 1989, triggering a huge oil spill that fouled Alaska's Prince William Sound (BI, April 3, 1989).

Mr. Freeman said he knows of a situation in which marijuana-impaired employees who failed to keep the computerized records of stolen credit cards cost one financial services company \$20 million overnight.

"The bigger the company, the bigger the problem," he said.

Higher overall health care costs are a secondary phenomenon of behavioral health problems, according to Mr. Freeman.

"It's kind of like if you look at the surface of a pond and see ripples, you know there was a stone dropping someplace else a while back. It's the same way with costs of benefits expenditures. When you see utilization profiles and expen-

diture profiles, it's a reflection of something that happened earlier in the employee's behavior," he explained.

While self-insured employers have a variety of options to manage behavioral health and control health care costs, they must realize there's no off-the-shelf product that will respond to their employees' behavioral health care needs, Mr. Freeman stressed.

For example, such programs as behavioral health prevention, promotion, management and consumer education that prevent unnecessary utilization in the first place cannot be purchased on the open market, according to Mr. Freeman.

"It's not like you want a car, so you go to the automobile dealer to see what's for sale this year," he said.

Instead, behavioral health care benefits must be customized to meet the needs of each employer's workforce in order for them to be effective.

Mr. Freeman cited the advantages and disadvantages of several behavioral health management options for self-insured employers:

- Benefit redesign, including limitations, restrictions, exclusions and incentives.

Benefit redesign is relatively easy to accomplish and produces direct cost savings, but it can increase the indirect costs of behavioral health problems or negatively affect quality of care, according to Mr. Freeman.

- Stand-alone utilization review programs, including inpatient UR, outpatient UR and retrospective review.

While UR is simple to administer and can reduce costs without affecting the original benefit design, the UR process can be adversarial, Mr. Freeman pointed out.

In addition, UR vendors can be unreliable, since there are no universally accepted UR standards or criteria, he added.

- Carving out mental health benefits from a company's health care plan and contracting with an alternative delivery system, such as a specialized behavioral managed care vendor, to deliver these services.

Carve-outs are the most cost-effective approach to behavioral health management and have great potential for quality assurance and quality improvement, according to Mr. Freeman. In addition, contract designs can be flexible.

However, employees lose freedom of choice of providers, and these benefits usually are not integrated with a company's employee assistance program, he pointed out.

- EAP-driven managed behavioral health care systems in which EAP case managers act as gatekeepers, determining the need for referrals as well as providing follow-up care.

Such programs produce significant cost savings and positive outcomes while securing good employee relations, according to Mr. Freeman.

However, some EAP case managers may not be qualified to make referrals, and the programs can be costly since they require employers to fund start-up costs.

In addition, such EAP programs can increase employer liability if the EAP is developed in-house rather than provided by an outside contractor, according to Mr. Freeman. ■

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SAN JOSE, Calif.—Gary Yeaw, director of group insurance at Allied-Signal Inc. of Morristown, N.J., was elected chairman of the National Assn. of Employers for Health Care Action during the group's 1991 annual meeting.

In addition, Stan Benson, vp of health care operations at Pfizer Pharmaceuticals Inc. in New York, was re-elected vice chairman, and Elmer Kindt, manager of compensation analysis at Dow Chemical Co. in Midland, Mich., was elected treasurer.

Ruth H. Stack will continue to serve as president of the Key Biscayne, Fla.-based organization.

NAEHCA members elected to the board of directors were: Thomas E. Burns, manager of employee benefits at General Electric Co.; Michael R. Herman, director of national accounts management at Merck, Sharp & Dohme, a pharmaceutical manufacturer in West Point, Pa.; Joe Johnson, operations manager-benefits at Bell South Corp. in Atlanta; William R. Johnson, director of corporate employee benefits at International Multifoods Corp. in Minneapolis; and Joyce Johnston, manager of patient care services at Southern California Edison Co. in Rosemead, Calif.

A total of 150 members and exhibitors attended the meeting, titled "Managed Health Care: Strategies for the '90s," which was held at the Fairmont Hotel in downtown San Jose.

Next year's meeting is scheduled for April 30-May 1 at the Marriott Hotel in Minneapolis.

For more information, contact Ms. Stack at NAEHCA, P.O. Box 220, Key Biscayne, Fla. 33149; 305-361-2810.

—By Joanne Wojcik

Firms detail cost savings success

By JOANNE WOJCIK

SAN JOSE, Calif.—Point-of-service plans offer the most effective method for maximizing managed health care networks while minimizing employee relations difficulties, a benefit manager says.

"Point-of-service is the most pragmatic way of extending managed care," said Gary Yeaw, director of group insurance at Allied-Signal Inc. in Morristown, N.J., one of the pioneers in the development and use of point-of-service managed care plans.

However, employers should know that they will not realize savings until several years into a plan's operation because of the cost of building a point-of-service network, Mr. Yeaw told benefit managers attending the annual meeting of the National Assn. of Employers for Health Care Action, held May 16-17 in San Jose, Calif.

After three years of offering its point-of-service product, dubbed the Health Care Connection, Allied-Signal's projected per-capita costs for health care are 23% lower than they would have been if its previous indemnity arrangement had been continued, according to Mr. Yeaw.

The projected plan costs for 1991 are \$2,902 per employee, compared with a projected \$3,569 per worker that would have been paid in indemnity plan premiums for the current plan year, he said.

In addition to lower premium costs, the Health Care Connection also resulted in fewer hospital admissions and shorter lengths of stay (BI, Feb. 18).

The program placed greater emphasis on outpatient treatment, with employees having an average of 4.4 physician encounters per year compared with the indemnity plan average of just two office visits annually.

These results show that "the gatekeeper system is the most effective method for managing care, and the primary care physician is in the best position to act as the care manager," said Mr. Yeaw.

Other, less tangible findings of Allied-Signal's experiment with point-of-service plans, he said, included:

- A point-of-service network must be integrated vertically, with all types of hospitals and outpatient treatment facilities, as well as hori-

zontally, with all types of providers.

- Discounted fee arrangements should be avoided. The chosen payment system should address both the price and the volume of services.

- Providers should participate in the financial outcome of the program at reasonable levels.

- The insurer or administrator should share in the financial success or failure of the plan.

"Try to establish a system where everybody has a stake," Mr. Yeaw advised employers considering a point-of-service plan.

Under Allied-Signal's program, plan administrator CIGNA Health Plans Inc. agreed to absorb cost increases that exceeded a stipulated amount in each of the program's three years (BI, Feb. 22, 1988).

While neither CIGNA nor Allied-Signal will disclose the specific percentage for the first two years of the program, CIGNA guaranteed that Allied-Signal's costs would not increase more than 6% to 7% in the third year (BI, March 19, 1990).

Allied-Signal recently negotiated an extension to its three-year contract with CIGNA, the terms of which were not released.

- Point-of-service networks should address quality of care in addition to financial arrangements.

- Health care can be delivered most effectively using a mix of in-house services, staff models, group models, independent practice associations and non-network providers, depending on the circumstances.

Sharon Diehl, manager of benefits operations for Xerox Corp. in Stamford, Conn., described her company's strategy for managing health care. She said Xerox decided to consolidate its HMO management under a single program called HealthLink (BI, June 25, 1990).

To select the HMO companies that would serve as HealthLink "managers," Xerox used a competitive bidding process, according to Ms. Diehl.

"As a result of the competitive bidding process, in 1991 our program includes six HealthLink managers with a total of 151 (local) network plans," she said. The program will add 10 more local plans in 1992.

In addition to the HealthLink HMOs, Xerox also has a self-insured indemnity plan and a choice of 36 non-HealthLink HMOs, a reduction from 50 the year before.

In order to reduce its non-HealthLink HMO offerings, Xerox will no longer permit employees to enroll in those plans for the first time. However, those that were enrolled prior to the introduction of HealthLink are permitted to continue.

Xerox plans to offer only 27 non-HealthLink HMOs in 1992.

While 98% of Xerox employees are eligible to participate in HealthLink, approximately 52% do so, according to Ms. Diehl. While this number may appear small, it is up 13% from last year, she pointed out.

While Ms. Diehl did not provide cost savings figures for the plan, she said Xerox will monitor the plan's performance through oversight activities and reports conducted by the national HealthLink managers.

"Xerox and its national HealthLink partners will collaborate to address additional member needs and requirements for program enhancements," she said.

Because Hewlett-Packard Co.'s business philosophy places heavy emphasis on profit-sharing—approximately 22% of its profits are shared with employees—the company also stresses cost-sharing in its benefit program, according to Arthur J. Young, corporate benefits manager for the Palo Alto, Calif.-based company.

After studying the types of diagnoses that generated the most health care expenditures in 1989, the company in 1990 limited some benefits—like physical therapy, chiropractic treatment and mental health care benefits—while encouraging employees to use preferred providers.

For example, employees who use PPO providers receive 90% coverage, while those who use non-network providers receive only 70% coverage.

The changes resulted in a net savings of \$3.5 million last year, according to Mr. Young.

In addition, by increasing employee cost-sharing in the indemnity plan, HMO participation grew to 56% in 1990 from 21.7% in 1985.

Like Xerox, Hewlett-Packard is paring down its HMO offerings, he said. Using selection criteria that focus on federal qualification, financial stability and rates, Hewlett-Packard reduced its HMO contracts to 78 in 1991 from 84 the year before.

The panel was moderated by Stan Benson, vp of health care operations at Pfizer Inc. in New York. ■

Preserve relationships: Expert

SAN JOSE, Calif.—Employers should select a managed care plan on the basis of how well it supports the patient-doctor relationship, a health care expert says.

"The nature of that relationship, the nature of that bond," is critical to "what happens in terms of patient outcome," said David McKinnon Lawrence, vice chairman of Kaiser Foundation Health Plan Inc. in Oakland, Calif.

"When we see it working at its best... there is greater likelihood of appropriate technical output. But more importantly, there is greater likelihood of appropriate clinical or patient care-oriented outcome," Mr. Lawrence said during his keynote speech at the recent National Assn. of Employers for Health Care Action meeting in San Jose, Calif.

In selecting a managed care plan, employers also should examine the plans' commitment to quality, systems organization and integration, and accountability and responsibility programs, according to Mr. Lawrence.

"Each of these criteria has the potential of helping to enhance the

quality and efficiency, and thereby moderate the cost," he said.

When determining a plan's commitment to quality, the employer should ask where quality fits into the organization's priorities and how it screens its participating physicians.

"Is it merely a matter of price or efficiency? Or does the plan apply an ongoing test of a physician's credentials and clinical decisions?" Mr. Lawrence asked.

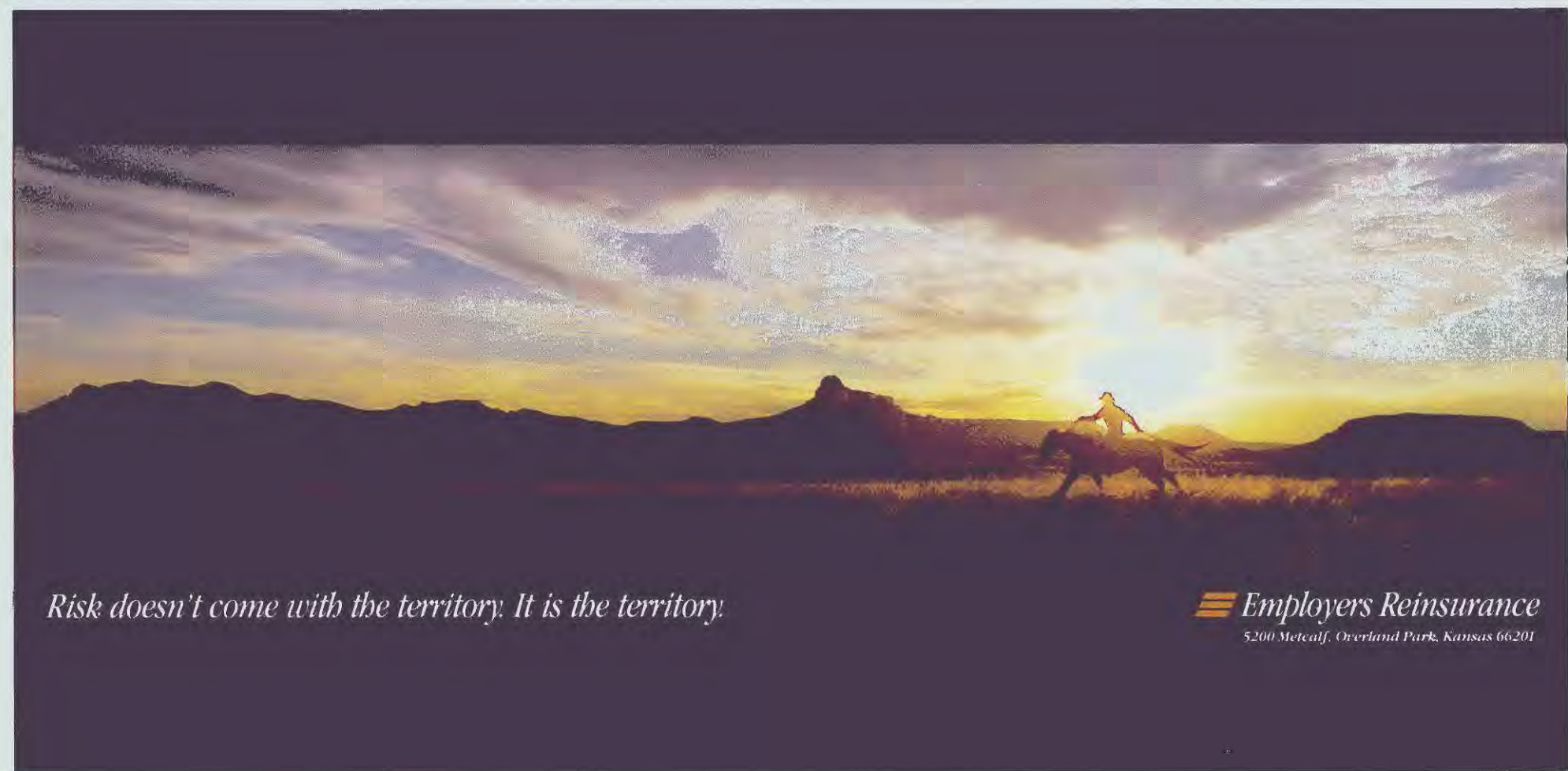
In addition, employers should make sure the plan has a quality assurance program in place that provides incentives for physicians to act in the best interest of patients.

Systems organization and integration also are essential to forming a commitment to quality, according to Mr. Lawrence.

"Look at the relationships and linkages among the insurance element, the business management and the providers," he said.

A good system will not only identify the good quality physicians and hospitals but also will keep track of patients' records, making sure they precede them when they receive treatment.

—By Joanne Wojcik



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Blood supply

Continued from page 3
testing—currently conducted at 53 blood centers—to fewer than 10 regional laboratories and beef up internal inspections at those labs.

Red Cross officials hope that limiting the number of testing labs will alleviate safety concerns about the quality control of blood testing procedures.

However, customized patient services—like special blood typing, tissue services and holding a person's blood for use during surgery—will now be provided by all Red Cross blood centers.

Other Red Cross centers will provide blood to areas whose center has been temporarily closed. At the end of each regional transformation, normal donor recruitment, blood collections and blood component production will resume at each of the centers.

As the Red Cross implements these operating reforms, it also plans to appoint a biomedical board of directors at each local center to oversee only the center's blood services. Currently, there is no separate oversight of a center's blood services and social services.

Red Cross officials say the governance changes are needed because the organization's blood services and social services operate with different missions and separate budgets.

The AIDS epidemic and many recent FDA citations charging

**'The reorganization
was needed to
restore public
confidence,' says
Mr. Mandel.**

some Red Cross blood centers with unsafe practices spurred the Red Cross into action.

"The reorganization was needed to restore public confidence in the nation's blood supply and to reach a more effective level of regulatory compliance," Mr. Mandel said.

"We had been going through some changes of these types since last summer," Mr. Mandel said. But, "the missing element was the centralization of the testing process." Red Cross senior management felt an overhaul—rather than a piecemeal approach—was necessary to ensure all blood would be safe, he said.

"By and large, the performance of most Red Cross centers has been good" and the problems generally "are not direct threats to public health," an FDA spokesman said.

However, he said that "there have been a small number of cases of serious and chronic problems. The strict procedures we insist upon were not being followed, leading us to believe that the nation's blood supply was not as safe as it could be."

The most serious problems have been limited to a Red Cross blood center in Albany, N.Y., and a center in Portland, Ore., the FDA spokesman said.

The FDA threatened to revoke the Albany center's license because of severe problems in record keeping, blood testing, and training for personnel and supervisors. The center eventually withdrew its license voluntarily.

The FDA ordered the Portland center closed after hitting it with more than 50 citations, including poor record keeping and distribution of infected blood.

In a speech given last week dur-

ing the organization's annual national meeting, Red Cross President Elizabeth H. Dole said that "more than one-third of the FDA citations in the past year stem from errors reported or the lack of proper procedures in the blood testing process."

Quality control of testing procedures is "difficult to maintain with absolute integrity when 53 different laboratories are involved," she said.

The Red Cross performs seven tests on blood to ensure its safety.

Red Cross labs performed 100 million more tests from 1985 through 1990 than they did in the previous five years, Ms. Dole explained. "With fewer testing labs we will have greater control over quality at this stage."

While new capacity is trickling into the liability insurance market for blood banks, the Red Cross does not look to the traditional market for coverage. The Red Cross in 1988 set up a captive to underwrite the first \$1 million of general liability and association liability coverage, among other coverages (*BI*, Dec. 24, 1990; April 18, 1988).

Mr. Mandel said the Red Cross is uncertain about how it will fund the sweeping reforms. "The financing is still being worked on. It's likely it will be financed through loans, fund raising and expense reductions that result from the reforms," he said.

Unlike the Red Cross, the tissue bank industry is fragmented and some banks are looking to the government to help them initiate reforms.

Some tissue banks are calling on the FDA to standardize the way human tissue products are regulated, much like the way mechanical medical devices are already regulated, said Ed Ransom, a consultant with Rantran Inc., an independent medical device manufacturing consulting firm in Ashland, Va.

"The tissue industry has never been under specific enforced regulation," he noted. But, the industry

Continued on next page

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**Business
Insurance**

Continued from previous page should be regulated in the same manner that the medical device industry is regulated by the FDA, he said.

"Tissues are products. When you go in and make a bone product, you do a lot to it. You trim it to size, make it different shapes—in essence, it's a manufacturing process," Mr. Ransom explained.

"We want consistency of process and consistency of regulation so that the consumer and medical profession has consistency of product. We are trying to assure a safe and effective product so that if a medical facility gets tissue from one tissue bank, they will know it's as high quality as from another bank."

However, another group of six tissue banks that process heart valves are submitting a proposal to the FDA calling for specific regulation but want separate treatment from manufacturers of mechanical medical devices.

"We feel there is a need for regulation, but we feel we need different set of regulations because tissues aren't strictly mechanical—they have biological aspects," said Mike Strong, scientific director of Northwest Tissue Center in Seattle.

"We'd like to see some legislative activity that would classify us in a category of our own" with regulations based on the tissue banking industry's particular characteristics, Mr. Strong said.

Some tissue banks also are calling for the government to create a national computer registry that would serve as a registry of donors, much like the system the Red Cross intends to implement.

Mr. Strong said he would support a national registry that would collect data on tissue donors and recipients.

That registry could ensure that information about subsequent problems experienced by recipients is sent to the tissue banks or organ procurement agencies for their review, Mr. Ransom explained.

Timely notification of potential quality problems would enable tissue banks and other processing centers to examine their internal processes for flaws that may have led to a defect, he said.

New laws regulating the medical device industry "mandate that distributors and hospitals report back any serious problems that happen in the field," Mr. Ransom pointed out. Similar laws should be developed for the tissue banking industry, he suggested.

This notification could eliminate the possibility of tissue banks releasing additional infected tissues to other recipients, said Tim Hubbard, president of medical research group and law firm Chatham-Borough Research Group in Pittsboro, N.C.

Mr. Hubbard pointed out that tissue banks and organ procurement agencies request that doctors who implant these materials fill out and return a card that gives information about the recipient. However, because physicians are not obligated to return the cards, the return rate on such cards is only 30% to 40%, he said.

Confidentiality concerns and a lack of funding are the major roadblocks to setting up a national registry of donors, processing centers, implanting facilities and recipients, Mr. Ransom said.

"There is a lot of concern about costs," Mr. Strong agreed. "We don't have the funding to get it going."

But, because of budget and staff cuts at the FDA, it may be unlikely that the agency will be given the authority to oversee the tissue banking industry, the FDA spokesman and other sources say.

Still, some tissue banks point to an incident earlier this month that they say underscores the need for a

computerized registry of tissue and organ recipients.

The FDA says that tissue bank LifeNet Transplant Services of Virginia Beach, Va., processed and dispensed to medical providers tissue contaminated with the AIDS virus.

In the incident, a Virginia hospital harvested five organs, 54 tissue grafts, two corneas and several vials of bone marrow from a gunshot victim who apparently contracted AIDS shortly before he was killed during a robbery in 1985, FDA officials say.

The tissues were supplied to LifeNet, which then supplied many of the tissues to more than 30 hospitals.

In April, the Colorado Department of Public Health notified LifeNet that one of the tissue recipients of an unprocessed, fresh frozen graft was infected with the human immunodeficiency virus, which causes AIDS. The department suspected the tissue may have been contaminated because the recipient—an elderly woman—had no other AIDS risk factors.

A LifeNet investigation found that three recipients of organs from the gunshot victim had died from AIDS-related illnesses within a few years of the transplants. LifeNet, though, did not process those organs.

LifeNet then asked the FDA and the federal Centers for Disease

Control in Atlanta to help notify 53 other recipients of the man's tissue.

Mr. Hubbard of Chatham-Borough, which represents LifeNet, said that tracking the recipients would be much easier if a central registry existed.

LifeNet officials would not return phone calls.

However, Mr. Hubbard asserted that the facility is not at fault for releasing the infected tissues because LifeNet conducted further tests when the tissues were being processed. "Tissues are processed to make them safe for transplantation, but there is really no way to make them safe from HIV," he said.

HIV testing is conducted using blood samples, which are tested for the presence of HIV antibodies. However, the virus may not have been detected in this particular donor's tissue because a window exists from the time a person is infected with HIV and the time the body produces HIV antibodies, Mr. Hubbard explained.

FDA officials also say there is no evidence to suggest that any improper procedures were followed in the recovery or distribution of the donor's tissues and organs. Prior to the surgical removal of the organs and tissues, the donor's blood was screened twice and tested negative for signs of HIV infection, they said.

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Insurer results

Continued from page 1

"We haven't seen anything that's given us any encouragement," said Alan Levin, senior vp at rating agency Standard & Poor's Corp. in New York.

"The results were somewhat poorer than expected," said Michael Lewis, first vp for Dean Witter Reynolds in New York. "Things went wrong" in some areas, like continued inadequate rate structures, bad weather that triggered catastrophe losses and slowing investment income growth, Mr. Lewis said.

The other major trend illustrated by first-quarter results, said Mr. Lewis, is the "tremendous gap between the commodity property/casualty and the specialty writers," like Chubb Corp. and General Re Corp., which "continue to see decent results."

Chubb reported a 98.8% combined ratio for the quarter, down from 102.1% a year earlier, while General Re's first-quarter combined ratio stood at 99.7%, up from 99.0%.

"Generally, it was a disappointing quarter" for a number of reasons, said David Seifer, vp at Donaldson, Lufkin & Jenrette

Insurers' poor first-quarter results are due to factors like continued inadequate rate structures, bad weather that triggered catastrophe losses and slowing investment income growth, says Michael Lewis of Dean Witter Reynolds.

Securities Corp. in New York. There were no real changes in pricing or underwriting practices, investment income growth was minimal, the upswing in the group health insurance cycle appears to be topping out and, finally, "no one really seems to be concerned" about lackluster results, he said.

"The threats to earnings in '91 and '92 are more severe than I had thought going into the quarter," Mr. Seifer said.

However, some observers point out that insurers' results could have been a lot worse.

While Thomas D. Sargent, vp at Conning & Co. in Hartford, Conn., noted that "the major trends evident for a while are still very apparent," he added that first-quarter results were "pretty close to expectations and were not bad, with a few exceptions."

"Results were certainly not that

brilliant, but they were not that bad," agreed Dennis Busti, president of Reliance National Insurance Co. in New York. He noted, though, that his conclusion is based on companies' published results and added that he suspects that insurer's actual results—after reserve deficiencies are addressed—are worse.

Besides the slight deterioration in the combined ratio, other first-quarter results posted by the insurers surveyed by *Business Insurance* show that:

- Underwriting losses again rose, increasing 4.6% during the quarter to \$2.6 billion. This compares with a 2.7% increase in all of 1990 and a 31.9% increase in 1990's first quarter (*BI*, May 28, 1990).

- Net written premium volume actually fell 1.7% to \$23.5 billion. This compares with a 1.8% increase in all of 1990 and a 2.4% increase

in the first quarter of last year.

- With cash flows still declining, investment income growth continues to be nominal, increasing only 4.6% to \$3.9 billion. This compares with a 4.8% increase in investment income in all of 1990 and a 7.2% rise in 1990's first quarter.

- Policyholder surplus for the companies reporting that data increased 5.5% to \$41.2 billion. This compares with a 4.1% increase in 1990 and a 5.5% increase in the first quarter of last year.

- Net income increased 5.7% to \$1.6 billion. For 1990, insurers posted a 27.4% decline in net income, while net income declined 15.3% in last year's first quarter.

Individual insurers' results varied dramatically from last year. For instance, Home Insurance Co., which reported a \$200 million loss last year stemming from significant losses in its junk bond portfolio, reported a \$28 million profit in the first quarter.

However, Reliance Group Holdings Inc., which had reported a 513.7% increase in net income in 1990 to \$133.4 million, posted an 81.4% decline to \$1.8 million for the first quarter. Reliance's 1990 results reflected a \$245.5 million aftertax gain from the sale of its General Casualty Insurance Co.

subsidiary in April (*BI*, April 1, 1990). Reliance's results were down in the first quarter because of the continued softness in the property/casualty market as well as some pressure on its title insurance business caused by the sluggishness in the real estate market, a spokesman said.

Meanwhile, insurers vary on how they will reflect the workers compensation residual market assessment in their results, with many insurer officials noting that they do not yet know precisely how much they will be charged.

For instance:

- Transamerica Insurance Co.'s first-quarter results reflect its original \$2.1 million estimate of its share of the pool's reserve deficiency, said Ed Santos, chief financial officer for the Woodland Hills, Calif.-based insurer. Transamerica now estimates, however, that the assessment could cost it another \$4 million, which would be reflected in future earnings.

- Philadelphia-based CIGNA Corp.'s first-quarter results reflect its estimate of a total assessment of \$23 million after taxes, though it has not yet received a final bill, said a company spokesman.

- Baltimore-based USF&G

Continued on next page

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West Coast Reinsurance Intermediary is seeking a reinsurance Accounting Manager. Responsibilities include management of all reinsurance accounting staff, functions and accounting systems. Strong experience in reinsurance accounting, management and industry knowledge is required. Send resume to:
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Summary of major property/casualty insurers' first-quarter results

Ranked by change in net income. All amounts in thousands of dollars.

Rank 1991	Corporate				Property/casualty operations									
	Consolidated revenues 1991	Net income 1991	Percent increase (decline) 1990-1991	Combined ¹ ratio 1991	Combined ¹ ratio 1990	Net premiums written 1991	Percent increase (decrease) 1990-1991	Pretax underwriting income (loss) 1991	Percent increase (decline) 1990-1991	Pretax investment income 1991	Percent increase (decrease) 1990-1991	Policyholders surplus 1991	Percent increase (decrease) 1990-1991	
1	Home Insurance Co.	580,000	28,000	315.4	111.6 ²	108.4 ²	455,000	(19.6)	(55,000)	(1.9)	74,000	(14.0)	761,000	(3.8)
2	Royal Group (U.S. subs.) ²	N/A	9,600	174.4	126.4	123.0	383,000	(28.2)	(97,600)	21.4	84,000	0.4	861,200	15.4
3	Hartford Insurance Group	2,292,000	136,000	100.0	107.3	107.5	1,590,000	3.2	(131,000)	7.7	273,000	21.3	2,786,000	1.4
4	Lincoln National Corp.	2,128,800	39,400	50.4	112.3 ²	107.8 ²	571,100	(7.7)	(61,300)	(24.6)	68,300	(17.1)	1,306,500	(12.0)
5	Crum & Forster Inc.	950,600	48,400	29.8	115.1	115.1	641,200	(19.2)	(96,800)	22.9	148,400	(1.6)	1,402,600	5.4
6	CNA Financial Corp.	2,680,000	117,600	24.8	114.4 ²	114.0 ²	1,760,000 ²	6.7	(263,400) ²	(5.6)	298,900 ²	12.2	3,390,000	8.0
7	Argonaut Insurance Co.	129,293	21,877	21.2	106.1 ²	103.2 ²	109,085 ²	(0.3)	(8,554) ²	(42.5)	29,794 ²	(2.0)	419,584	5.1
8	Continental Corp.	1,328,200	38,700	20.2	115.0 ²	114.9 ²	1,024,100 ²	(8.5)	(150,100)	7.0	180,300	(2.2)	2,042,200	1.1
9	Chubb Corp.	1,089,400	128,300	15.5	98.8 ²	102.1 ²	737,700	11.9	8,100	158.7	120,400	4.2	1,475,800	11.9
10	CIGNA Corp.	4,711,000	48,000	14.3	117.8	117.4	1,332,000	(4.5)	(238,000)	1.3	218,000	1.4	2,005,000	1.7
11	Old Republic Int'l	298,337	24,883	12.4	107.3 ²	104.8 ²	169,736	(4.8)	(14,825)	5.7	41,438	12.5	796,294	17.2
12	The St. Paul Cos. Inc.	1,021,167	84,171	9.4	105.1	105.6	748,088	3.1	(41,150)	(3.0)	160,331	2.2	1,542,473	3.8
13	Ohio Casualty Corp.	405,311	17,832	8.9	103.2 ²	106.8 ²	370,246 ²	(1.2)	(10,329)	62.0	46,508	1.5	537,372	6.5
14	American International Group	4,077,083	375,404	5.6	99.7 ²	99.3 ²	2,239,804	0.2	24,872	13.3	283,032	13.1	N/A	N/A
15	General Re Corp.	804,100	150,400	2.2	99.7 ²	99.0 ²	572,900	7.7	(4,600)	43.2	187,100	9.2	3,120,000	16.4
16	Travelers Corp.	2,989,600	93,100	1.6	112.6	113.9	1,123,900	(9.5)	(149,800)	15.7	189,800	1.2	1,948,600	(8.0)
17	Sentry Insurance Cos. ²	376,904	12,247	1.5	105.9	104.9	325,295	10.6	(22,144)	(20.0)	39,227	8.0	688,078	11.6
18	Hartford Steam Boiler	154,100	20,633	1.3	88.2	84.4	84,610	14.6	9,456	(16.7)	10,108	10.5	380,088	13.3
19	SAFECO Corp.	822,824	55,308	(1.7)	110.2	106.1	426,330	3.4	(43,408)	(75.0)	72,015	4.0	1,113,929	9.8
20	Fremont General Corp.	148,615	6,445	(2.2)	105.4	105.0	114,950	1.8	(5,902)	(12.4)	15,214	(19.0)	188,816	(0.5)
21	Berkshire Hathaway Group	175,470	57,062	(4.1)	138.2	113.9	162,700	74.7	(32,181)	(149.8)	91,282	15.8	N/A	N/A
22	Transamerica Ins. Group	547,751	11,530	(15.3)	113.1	111.2	469,212	-	(63,593)	(22.0)	63,834	4.8	796,601	1.2
23	Aetna Life & Casualty Co.	4,695,700	137,400	(23.6)	116.5	113.8	1,502,400	(6.0)	(236,300)	(7.1)	266,600	2.0	2,594,800	4.8
24	Reliance Ins. Co. & subs.	846,555	1,789	(81.4)	107.7 ²	108.1 ²	444,790	(7.6)	(30,600)	(16.8)	56,867	3.3	N/A	N/A
25	USF&G Corp.	1,092,000	(55,000)	(207.8)	116.3 ²	109.3 ²	885,000 ²	(17.3)	(144,000)	(9.1)	115,000	(23.8)	1,307,000	(1.8)
	— Fireman's Fund Ins. Cos. ²	N/A	N/A	N/A	121.1	117.5	711,706	(2.4)	(138,660)	(7.8)	146,970	18.0	1,435,566	27.9
	— Commercial Union Ins. (U.S.) ²	N/A	N/A	N/A	112.7 ³	110.3 ³	356,300	(1.7)	(53,300)	(13.4)	42,100	(5.8)	577,800	1.1
	— Kemper National P/C Cos. ²	N/A	N/A	N/A	102.9	112.8	915,572	10.3	(158,833)	(33.0)	86,447	12.6	1,572,591	(3.5)
	— Nationwide Mutual Ins. Co. ²	N/A	N/A	N/A	107.1	109.9	1,488,902	4.1	(106,597)	5.6	194,947	11.6	3,534,614	20.7
	— Liberty Mutual Ins. Co. ²	N/A	N/A	N/A	115.9	112.3	1,781,938	6.5	(254,034)	(65.0)	279,956	5.7	2,636,020	8.1
	Cumulative	34,344,810	1,609,081	5.7	110.6	110.1	23,497,564	(1.7)	(2,569,582)	(4.6)	3,883,870	4.6	41,220,526	5.5

¹ After dividends

² Statutory

³ Before dividends

N/A—Company did not provide data

Continued from previous page
Corp.'s \$20 million estimate of its share of the assessment also is reflected in the first quarter, said a company spokesman.

• Hartford-based Travelers Corp.'s results included an aftertax charge of \$7 million, said a spokesman. However, a major portion of its share of the assessment was provided for in previous quarters.

"We believe we've taken care of this. We don't anticipate any more changes," he said.

• SAFECO Corp. of Seattle already has established a supplementary reserve for the workers comp pool reserve shortfall, said George Yonker, assistant controller.

However, the assessment will cost an additional \$2 million, which will be reflected in second-quarter results, he said.

• A total of \$2 million was reflected in Sentry's first-quarter results, said Mr. Hlavac, with an additional estimated \$8 million to be layered into the insurer's results throughout the year.

• Reliance's estimated \$4 million contribution is being split between the first and the second quarters, Mr. Busti said. "We just wanted to get rid of it as quickly as possible," he said.

The impact of the workers compensation market assessment on insurers "ran the gamut," commented Charles Ronson, an analyst with Baird, Patrick & Co. in New York.

"It depends how cautious the companies had been" in setting their reserves, Mr. Ronson pointed out.

"Most of it could have been anticipated," added Mr. Ronson. "It did not take a rocket scientist to realize you've got serious problems there," he said, referring to the workers compensation residual market.

Insurers also reported varying impacts of catastrophes on their first-quarter results.

For instance, weather-related losses reduced Lincoln National Corp.'s earnings by \$22 million on an aftertax basis, stemming in part from tornados and wind damage in the Midwest during the last week in March.

But, CIGNA's results reflected pretax catastrophe losses of just \$5 million, compared with \$57 million in the first quarter of 1990, which included \$52 million for the massive European windstorms (BI, Feb. 5, 1990).

"Some companies got hit pretty badly," commented Gloria Vogel, associate director at Bear Stearns

'Some companies got hit pretty badly' by disaster losses, says Ms. Vogel. Others 'got off scot-free.'

& Co. in New York. "Other companies seemingly got off scot-free."

Storms in the Midwest and the carryover from the California freeze in December were among the biggest weather-related problems, she said. "It depended on where your book of business was going as to whether you were going to be affected or not."

Meanwhile, although USF&G plans to raise up to \$300 million in additional capital through a stock sale, observers generally agree that others are unlikely to follow USF&G to market.

USF&G has filed a registration statement with the Securities and Exchange Commission for a public offering of up to 3 million shares of a convertible preferred stock offering at \$50 per share, with a possible over-allotment of an additional 450,000 shares.

It also plans a separate proposed private placement of another series

of preferred stock. The company said last week that it had received commitments to purchase an aggregate of \$130 million in preferred stock as part of the private placement.

A.M. Best Co. has assigned the insurer an A-minus rating on the basis of its plan to raise the equity and to continue to implement a cost containment and capital preservation strategy, USF&G also said.

The insurer announced an additional 1,900 layoffs last month, to bring total cuts to 25% of its workforce (BI, April 8).

Most observers identify USF&G, which reported a \$569 million loss in 1990 and a \$55 million loss for the first quarter, as in a unique situation in the property/casualty insurance industry.

"In all honesty, most companies don't really need the money, and when they will need the money, in a pinch, I'm sure, they can borrow it," said Baird Patrick's Mr. Ronson, commenting on USF&G's stock offerings.

"I think the industry overall is overcapitalized," said David Wells, an analyst with rating agency Fitch Investors Service in New York.

USF&G needs the capital, said Mr. Wells. But, "I don't see other commercial property/casualty insurers running in any numbers to the market. I don't see why they would want to. For the most part, I don't think they need the capital to write business."

USF&G's capital needs put it in a unique situation, agreed Conning's Mr. Sargent. "The average property/casualty company is not going to be in the market looking for stock unless there's a special situation," such as the case with financial guarantee insurer AMBAC Indemnity Corp., which Citicorp is selling to the public (see story, page 29).

However, "in general, because of attractive rates in the capital mar-

kets, more companies may be issuing more debt," said Marvin Shulman, an analyst with rating agency Moody's Investors Service, who noted that USF&G's convertible preferred issue has the option to be converted into common stock.

These other insurers will be replacing short-term debt with intermediate-term debt, thus locking in relatively low interest rates for the next five to six years, said Mr. Shulman.

USF&G's success in raising the capital could actually prolong the underwriting cycle, said a CIGNA official. "I think it's an interesting test, because if they can raise capi-

tal easily, it will allow other companies, rather than raise prices, to go to the capital market."

Meanwhile, most observers say it will be late this year before the market turns—at the very earliest.

"We just don't see it for this year," said Reliance's Mr. Busti.

"My own view is it's going to be turning in late '91 or early '92," said Baird, Patrick's Mr. Ronson.

The CIGNA official also said he would be surprised if there were any signs of a change before the January 1992 renewals. "And, it could be longer," he said. "We're simply not seeing any signs of reversal at this point."

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PruCare acquires John Hopkins HMO

Prudential Insurance Co. of America will expand its managed care offerings in Baltimore and Washington, D.C., through its acquisition last week of The John Hopkins Health Plan.

The Newark, N.J.-based insurer's Prudential Health Care Plan Inc. unit acquired the HMO, which has approximately 113,000 members in Maryland and Washington, D.C. Formerly a subsidiary of the Johns Hopkins Health System, the Baltimore-based HMO includes more than 70 primary care physician offices, more than 1,500 specialists and 26 hospitals.

Johns Hopkins owns and operates 11 medical offices. Those offices will remain with the Hopkins Health System, but PruCare members will be able to receive health care services through them. Because the company will contract with the same hospitals and physicians that are currently part of the Hopkins network, HMO members' services should not be disrupted.

PruCare acquired all of the Hopkins network's employer and subscriber contracts, as well as its marketing, enrollment, claims processing and client service operations.

The Hopkins network will become part of PruCare. A new name for the HMO has not been determined. No building closings or layoffs are planned. Hopkins network officers, management and staff will continue to perform their current functions.

Prudential's PruCare HMO is the seventh-largest general service health maintenance organization in the country, with more than 800,000 members (BI, December 1990).

TPA audits

Self-insured employers interested in conducting an independent audit of their third-party claims administrator can engage the services of a newly formed company.

Cleveland-based Cristovin Inc. will perform a quality assurance review that examines the accuracy and efficiency of claims administration services.

Cristovin also will perform audits for self-administered em-

Markets

ployers, said Anthony J. Marley, president of the newly formed company. And, he said, the firm offers its services in all states.

Cristovin's audit examines how claim eligibility is verified and makes assessments of the TPA's reporting, billing, collections and adjudication processes. The audit also checks whether the TPA is complying with relevant federal regulations regarding plan administration.

Within two weeks after the audit is completed, a report of Cristovin's findings is sent to the client, detailing the results of the audit and recommending solutions to any inefficiencies in the administration process.

In addition to improving TPA services, employers also can use the results of the performance reports to negotiate the prices of administrative services only contracts. For example, if the audit finds an administrator isn't performing up to par, an employer may be able to negotiate a price reduction until service improves.

For more information, contact Anthony Manley, President, Cristovin Inc., 6902 Pearl Road, Suite 500, Cleveland, Ohio 44130; 216-884-5454.

New consulting actuary

A newly formed actuarial and benefit consulting firm in Chicago is challenging the notion that major employers can only be serviced by one of the nation's largest benefit consulting firms.

Chicago Consulting Actuaries Inc. will operate as a "boutique" consultant—providing specialized financial advice to sponsors of retirement plans and other employee benefit programs.

"With today's computer technology, we have research, analysis and reporting capabilities matching those of the largest consulting ventures," said Thomas S. Terry, president of CCA. But, he said, "our smaller size means we're attentive and responsive to client needs the way only a smaller, more client-focused firm can be."

The company will provide basic pension actuarial and plan design consulting services and will focus on the design and financing of retiree medical benefits and non-qualified pension benefits.

CCA will target Chicago area employers but offers its services to employers located elsewhere.

In addition to Mr. Terry, CCA's professional staff includes Harold S. Cooper, Lina E. Flores and James G. Peard, all formerly with TPF&C, the employee benefits division of Towers, Perrin, Forster & Crosby Inc.

For more information, contact Thomas S. Terry, President, Chicago Consulting Actuaries Inc., 216 S. Jefferson, Suite 600, Chicago, Ill. 60666; 312-454-3222.

Specialty brokerage

A new minority-owned specialty insurance broker has been formed to provide insurance products to financial institutions, as well as to other businesses.

Mumbly Green Insurance Services Inc.'s focus is on creative specialty products that will provide clients with a competitive edge, noted President Kim M. Green. In addition, MGIS will provide risk management and consulting services for insurance buyers without their own risk management operations, said Executive Vp Lily Han.

Both Ms. Green and Ms. Han have extensive experience in underwriting and brokering insurance programs for Fortune 1,000 companies.

For more information, contact Kim M. Green, President, Mumbly Green Insurance Services Inc., 30 Wall St., Sixth Floor, New York, N.Y. 10005; 212-509-0303.

Name change

Prescot Management Ltd., a unit of Minet Holdings P.L.C., will now operate as **Minet Risk Services Ltd.** in all locations worldwide. The division provides risk consulting and advice on alternative risk financing services.

Mergers/acquisitions

Minneapolis-based **United HealthCare Corp.**, a managed

care services company, acquired the **Institute for Human Resources**, a Rockville, Md.-based provider of employee assistance program services. Terms were not disclosed. IHR serves approximately 250 organizations covering more than 750,000 employees and dependents. The combined organization will do business under the IHR name.

Noble Lowndes U.S.A., a benefit consulting firm based in East Orange, N.J., recently acquired **Cowan Actuarial Co.**, a Cincinnati-based consulting group that provides actuarial and consulting services for retirement plans. The new entity will be known as Noble Lowndes/Cowan Actuarial. The acquisition will beef up the consultant's presence in the Midwest, noted John Malpass, managing director.

Republic Hogg Robinson of Pennsylvania Inc., a Wynnwood, Pa.-based unit of broker Republic Hogg Robinson Inc., acquired **Barry R. Milberg & Associates Inc.**, a Bala-Cynwyd, Pa., pension actuarial/administration and record-keeping firm. The firm specializes in the design and installation of qualified retirement plans and currently operates as a division of RHR of Pennsylvania in Wynnwood.

Stockton, Calif.-based **Health Care Evaluation Inc.**, a managed care utilization review firm, merged with **Pacific Peer Review Inc.** of Oakland, Calif. HCE specializes in managed health care programs, and PPR focuses on hospital utilization review. The company will conduct business as Health Care Evaluation Inc. and will be headquartered at 6602 N. Inglewood Ave., Suite G, Stockton, Calif. 95207; 209-951-6711.

New offices

Applied Risk Insurance Services Inc. has moved its offices to 25251 Paseo de Alicia, Suite 108, Laguna Hills, Calif. 92653; 714-770-8867.

Medical care cost containment firm **Value Health Sciences Inc.**, moved to 2400 Broadway, Suite 100, Santa Monica, Calif. 90404; 213-315-7400.

St. Louis-based **Paragon Life**

Insurance Co. moved its headquarters to 100 S. Brentwood, St. Louis, Mo. 63105; 314-862-2211.

The **National Assn. of Casualty & Surety Agents** moved its headquarters to 316 Pennsylvania Ave. S.E., Suite 400, Washington, D.C. 20003; 202-547-6616.

The **National Assn. of Surety Bond Producers** moved its offices from Bethesda, Md., to 5301 Wisconsin Ave. N.W., Suite 450, Washington, D.C. 20015; 202-686-3700.

Medco Containment Services Inc., a health care cost containment company, moved its headquarters from Fair Lawn, N.J., to 100 Summit Ave., Montvale, N.J. 07645; 201-358-5482.

Benefit consultant **William M. Mercer Inc.** consolidated its two Chicago area offices. The firm will relocate 175 consulting and support staff from Deerfield, Ill. to the Chicago office at 10 S. Wacker Drive, Chicago, Ill. 60606-7485; 312-902-7500.

Frank B. Hall & Co. of Arizona, a unit of Frank B. Hall & Co. Inc., opened a new office in Phoenix. The address is 3030 N. Central Ave., Suite 609, Phoenix, Ariz. 85012; 602-274-4477.

Princeton, N.J.-based **American Re-Insurance Co.** relocated its Los Angeles offices to 333 City Blvd. West, Suite 1900, Orange, Calif. 92668-2924; 714-634-2233.

Benefit consultant **Yaffe & Co. Inc.** moved its main offices from Baltimore to Towson, Md. The address is Mercantile-Towson Building, 409 Washington Ave., Suite 700, Towson, Md. 21204; 301-494-4100.

American Royal Reinsurance Co. moved its offices to 1 Liberty Plaza, 29th Floor, New York, N.Y. 10006; 212-225-7500.

Pasadena, Calif.-based employee benefit consultant **Garner Consulting** and its insurance agency division, **Garner Insurance Services**, have relocated. The new address is 199 S. Los Robles Ave., Suite 560, Pasadena, Calif. 91101; 818-440-0399.

American Re-Insurance Co. Ltd.'s Chicago office moved to 10 S. Wacker Drive, 12th Floor, Chicago, Ill. 60606; 312-993-8600; 800-621-2106.

Genesis Underwriting Management Co. moved its offices to 75 Wall St., 25th Floor, New York, N.Y., 10005; 212-908-2500.

Clayton Environmental Consultants Inc., a subsidiary of Marsh & McLennan Cos. Inc., moved its offices to 5785 Corporate Ave., Suite 150, Cypress, Calif. 90630; 714-229-4806.

Integrated Run-off Insurance Services Corp., formerly Aon Risk Consultants, moved from Old Bridge, N.J., to 8 Centre Drive, Jamesburg, N.J. 08831; 609-655-8383.

Kernan Associates Inc., an insurance and reinsurance consulting firm, relocated to 560 Lexington Ave., 16 Floor, New York, N.Y. 10022; 212-888-5639.

Conger's Inc., a risk management and insurance consulting firm, is relocating to Glacier Building, 111 N. Higgins, Suite 109, Missoula, Mont. 59802.

Spectrum Underwriting Managers Inc., a group medical stop-loss placement facility, opened a new office at 2780 Waterfront Parkway, East Drive, Suite 325, Indianapolis, Ind. 46214; 317-328-0279.

Community Care Network, a managed care company, moved its Los Angeles office to Warner Center Plaza, 21700 Oxnard St., Suite 1050, Woodland Hills, Calif. 91367; 818-594-0811; 213-477-4420; 800-222-7771.

Travelers Corp. opened an Atlanta office at 400 Perimeter Center Terraces, Suite 800, Atlanta, Ga. 30346; 404-393-7517. ■

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The pristine beaches of Manzanillo Bay, deep sea fishing, championship golf, and the exotic resort of Las Hadas on Mexico's Gold Coast. They're all part of Transamerica Insurance Finance Corporation's first annual Leadership Council Meeting to be held October 15 to 20, 1991 to address the policies, procedures and operations that will shape the future of the premium financing industry.

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Update

Life/health insurer's rating cut

NEW YORK—Standard & Poor's Corp. has lowered the claims paying ability rating of Mutual Benefit Life Insurance Co. to A from AA+, citing capital losses of more than \$200 million last year as mortgage and real estate losses exceeded expectations.

The lower rating also affects about \$1.5 billion of industrial revenue bonds and collateralized mortgage obligations guaranteed by the insurer, according to Mark Puccia, who is in charge of S&P's life and health insurance ratings. S&P also lowered the insurer's commercial paper rating to A1 from A1+.

Mutual Benefit Life said in a statement that it plans to take several steps to reposition itself in the marketplace, including creating a separate stock company for its group business, which will create access to capital markets. Mutual Benefit Life reported \$3.2 billion in written net premiums last year, including \$605 million in group accident and health insurance premiums and \$224 million in group life insurance premiums, according to S&P. S&P noted in its report that the company's group business continues to perform well.

Eastern retiree health care pact

MIAMI—Some 14,000 retirees of bankrupt Eastern Air Lines Inc. have negotiated an interim agreement that extends their health care benefits for six months while they litigate their standing in Eastern's bankruptcy proceedings. Eastern, which filed for bankruptcy under Chapter 11 of the Federal Bankruptcy Act in 1989, claims it can no longer afford to pay for retiree health care (BI, May 6).

Under the agreement, the retirees will contribute \$75 monthly and Eastern will contribute \$145 monthly per retiree toward the cost of individual health care coverage until Dec. 30. The retirees previously did not have to contribute toward the cost of coverage.

The settlement, which originally was to apply only to 7,000 non-union workers and pilots, was extended by the bankruptcy judge late last week to include all Eastern retirees, said William G. Bell, an attorney who represents many of the retirees.

Meanwhile, retirees will continue to litigate their priority in the bankruptcy proceedings, Mr. Bell said. If that issue is not resolved by Dec. 30, there will be additional hearings before the bankruptcy court on the retiree health care issue.

EXEL applies for stock offering

HAMILTON, Bermuda—EXEL Ltd., the parent of excess liability insurer X.L. Insurance Co. of Bermuda, has applied to have its common stock quoted by NASDAQ for the over-the-counter market.

Caymans-based EXEL said it filed a registration statement with the Securities and Exchange Commission last week for an initial public offering of 10.1 million shares. About 8.1 million of those shares would be offered in the United States and about 2 million would be made available in what the company calls "a concurrent international offering outside the United States."

The offering, which represents about one-fourth of EXEL's 43 million shares, is being made by 25 of its 108 corporate shareholders.

Following a 10-for-one stock split on May 3 that reduced the book value of EXEL shares to \$20 from \$220, the company expects the shares to be traded in the low- to mid-20s.

EXEL pointed out that it will not receive any of the proceeds from the offering, which was announced last month after 75% of its shareholders at the company's annual meeting approved going public (BI, April 8).

Chief Financial Officer Brian Walford said it is too early to say which market will be used for the international offering.

ACLI reviews McCarran stance

WASHINGTON—The board of directors of the American Council of Life Insurance will vote this week on whether to reverse its earlier support for a legislative alternative to the McCarran-Ferguson Act.

The ACLI board in March voted to support a measure that would leave the insurance industry fully subject to two federal antitrust laws: the Sherman Act of 1890 and the Clayton Act of 1914. However, the ACLI proposal would exempt insurers from oversight by the Federal Trade Commission (BI, April 1).

The board also authorized discussions with other insurer trade groups to develop an alternative to McCarran-Ferguson.

But earlier this month, the ACLI's legislative committee voted 8-7 that the group should not endorse a McCarran-Ferguson alternative.

"There were some member companies who felt more time should be spent examining the issue, and the board felt they should be accommodated," an ACLI spokesman said in explaining the board's decision to take another vote.

The American Insurance Assn. already has proposed a McCarran-Ferguson alternative (BI, May 20), while the Alliance of American Insurers says it will work with trade groups and congressional staffers on alternatives. The National Assn. of Independent Insurers opposes any changes to the 1945 law.

Briefly noted

Peter Christie has been named group managing director and chief operating officer of London-based broker **Minet Holdings P.L.C.** Mr. Christie, currently deputy group chairman responsible for North American operations, will direct all of Minet's worldwide operations in his new position. . . . Wind, hail, tornados and flooding caused an estimated **\$50 million of insured property damage** to six states May 10-13, reports the Property Claim Services division of the American Insurance Services Group. The severe weather, assigned Catastrophe No. 74, hit portions of Kansas, Missouri, Nebraska, North Dakota, South Dakota and Texas. . . . The Alaska Legislature approved a resolution last week authorizing Gov. Walter J. Hickel to settle the state's claims against Exxon Corp. arising from the 1989 **Exxon Valdez oil spill**. Exxon earlier this month terminated the \$1 billion civil agreement it reached with the state in March as part of a larger settlement that included a plea bargain on federal criminal charges after a federal judge rejected the plea bargain (BI, May 13).

Asbestos ruling

Continued from page 2

As a result of the ruling, Wilkin Insulation Co. of Mount Prospect, Ill., which installed spray-on fireproofing materials containing asbestos in hundreds of public buildings in Illinois and Indiana between 1958 and 1970, is entitled to a defense in nine pending asbestos-related lawsuits filed by schools and public entities.

The five insurers wrote a total of \$9 million of primary CGL limits for the installer from 1964 through 1984. Wilkin could trace its CGL policies only as far back as 1964, explained Wilkin co-counsel Craig Mielke of Murphy Hupp Foote Mielke & Kinnally in Aurora, Ill.

The duty-to-defend litigation ensued when Baltimore-based United States Fidelity & Guaranty Co. in 1984 refused to defend Wilkin in the nine underlying lawsuits. USF&G claimed asbestos fibers only constitute a health hazard to humans and are not destructive to property.

The insurer, which wrote \$500,000 of primary CGL limits for Wilkin from Jan. 1, 1984, to Jan. 1, 1985, filed a lawsuit seeking a summary judgment on the issue of whether it had to defend the installer.

Wilkin then filed suit against USF&G as well as its other CGL insurers between 1964 and 1985 seeking a summary judgment requiring the insurers to pay defense costs. The other liability insurers, though, have provided the installer a defense under a reservation of rights.

The other insurers are:

- Argonaut Insurance Co. of Menlo Park, Calif. Wilkin purchased \$300,000 in primary CGL limits annually from Argonaut and one of Argonaut's subsidiaries between April 1, 1964, and April 1, 1973.

- Commercial Union Insurance Co. of Boston. From April 1, 1973, through April 1, 1977, Wilkin purchased \$500,000 in primary limits annually from Commercial Union and one of its units.

- Aetna Casualty & Surety Co. of Hartford, Conn. Wilkin purchased \$500,000 of limits annually from Aetna between April 1, 1977, through Jan. 1, 1982.

- A Zurich Insurance Co. unit. Wilkin purchased \$500,000 of CGL limits from Zurich between Jan. 1, 1982, through Jan. 1, 1984.

Defense costs are not included within Wilkin's CGL limits, said Wilkin co-counsel Stephen C. Neal of Kirkland & Ellis in Chicago, who represented Wilkin before the appellate and Supreme Court.

Wilkin also purchased excess liability coverage each year from various insurers, with limits ranging from \$1 million to \$5 million excess of primary limits, Mr. Mielke said.

A trial court granted summary judgment for the insurers in August 1987.

But, Wilkin appealed, and an appellate court reversed the decision in December 1989, finding that the nine underlying complaints "sufficiently alleged property damage caused by an occurrence to bring the cases within coverage by plaintiff's insurance policies," court papers say.

Because no determination had been made about Wilkin's liability in the underlying cases, any determination of the insurers' duty to indemnify Wilkin would be premature, the appellate court ruled.

The Illinois Supreme Court, in an opinion written by Justice Michael Bilandic, a former Chicago mayor, affirmed the appellate court's decision.

The insurers had argued that there was no "event or accident" resulting in property damage.

However, the court ruled that an occurrence, defined as "an accident including continuous or re-

peated exposure to conditions that result in property damage, neither expected nor intended by the insured," is covered by a CGL policy.

"By virtue of the continuous or repeated exposure to the condition of asbestos fiber release, the buildings and contents became contaminated. It is the continuous exposure. . . that constitutes the accident," Justice Bilandic wrote.

"The underlying complaints" against Wilkin "allege that the buildings and the contents therein were contaminated by toxic asbestos fibers. Therefore, the underlying complaints allege physical injury to tangible property. Thus, we find that the underlying complaints allege potentially covered property damage," Justice Bilandic wrote.

The court also rejected insurers' argument that they should not have to provide a defense to Wilkin because there were several coverage exclusions in the policies written for Wilkin.

The Supreme Court ruled that a pollution exclusion, a sistership exclusion, a business risk exclusion and miscellaneous exclusions in the policies were all inapplicable.

In addition, any ambiguity about a policyholder's right to a defense must be construed in favor of the policyholder, the court found.

As a result of the ruling, Wilkin is entitled to unlimited defense costs. Wilkin has accumulated at least \$200,000 in defense costs to date, primarily from defending itself in suits brought by the Chicago Public Schools and two suburban Chicago school districts, as well as a national class-action suit pending in Philadelphia, Mr. Mielke said.

The insurers have until June 10 to petition for a rehearing, said Robert Kiesler of Kiesler & Beran in Chicago, USF&G's attorney and the lead insurer attorney in the case.

The insurers have not decided whether they will file for a retrial or abide by the ruling and pay Wilkin's legal expenses, he said.

"The Supreme Court ruling is a total affirmation of the appeals court ruling and is the most comprehensive ruling to date on the defense issue," said Mr. Neal, Wilkin's co-counsel.

"The court ruled against the insurers on all issues of their appeal. It is clear that they have a duty to defend," he said.

"The court rejected all of the defenses that insurers have been trying to use. That's why this case is so important," agreed Covington & Burling's Mr. Skinner.

"This is a good decision for building owners because it establishes the property damage issue, and it's also good for asbestos manufacturers and installers because it establishes the duty to defend issue," observed Marilyn Kueper, assistant chief of asbestos litigation for the Illinois attorney general's office, which filed a brief in the case in support of Wilkin.

Tom Freeman of Brobeck, Phleger & Harrison in San Francisco, which represented asbestos manufacturers in the coordinated asbestos litigation in California in 1988 (BI, Sept. 12, 1988), believes that insurers' "first line of defense" in asbestos property damage coverage disputes—that asbestos does not constitute property damage—is crumbling.

"Nearly every court to date has ruled that asbestos in buildings constitutes property damage for the purpose of insurance. Now, there is a supportive state supreme court ruling, too," Mr. Freeman explained.

But Mr. Freeman stopped short of saying the Illinois decision will influence courts nationwide presiding over similar cases.

"We all believed the California case was comprehensive enough to

resolve everything. But you still have the hard-liners challenging the coverage issue. So, I'm a little skeptical about predicting that the Illinois case will affect anything but Wilkin Insulation."

Mr. Kiesler, USF&G's attorney, said that because this decision was returned by Illinois' highest court, "other courts will look to it for guidance."

But, Mr. Kiesler said the court overlooked key elements in USF&G's case.

"Our whole case centered around whether asbestos fibers released into a building damages property. Asbestos fibers, although harmful to human beings, are not destructive to tangible property."

"If the fibers shorted out a motor, that's property damage. But all we have here is perceived bodily injury. As a matter of law and contract, we feel the court erred in its ruling" Mr. Kiesler said.

David C. McLauchlan, an attorney with Lord, Bissel & Brook in Chicago, which represents Lloyd's of London underwriters in asbestos cases, also called the decision "an important statement on the duty to defend."

But he predicted that the case will have limited impact on other asbestos litigation because it involved an asbestos installer, which he labeled an "aberrational insured," rather than an asbestos manufacturer.

Mr. McLauchlan also said he was "surprised" that "the decision says insurers have a duty to defend but doesn't say which insurers." It would be "unfair" to interpret the opinion to mean all of Wilkin's insurers have a duty to defend if an insurer can show its policy would not have to respond to any court awards in the underlying litigation, he said.

However, Mr. Neal, Wilkin's attorney, said he believes all of the insurers are "jointly and severally on the hook for defense costs."

Mr. McLauchlan also pointed out that the decision does not reach the "critical" issue of whether insurers owe a duty to indemnify policyholders for the costs of removing asbestos from buildings. This "devalues the opinion and its precedent value," Mr. McLauchlan said. "It is not a comprehensive decision."

Jerry S. Sallee of Dinsmore & Shohl in Cincinnati, which represents Liberty Mutual Insurance Co. in asbestos-related cases, agreed.

The high court "only said a carrier has the duty to defend if potential liability exists. That's the broadest reading a policyholder can draw from this," Mr. Sallee pointed out.

The case also may have limited influence outside of Illinois because it was not based on facts developed in a lengthy trial but rather on a stipulated record, Mr. McLauchlan observed.

Mr. Sallee also questioned the method the court used to make its judgment.

"This decision is set apart from the others, especially the recent U.S. Gypsum case, because no records were used. This was a simple granting of summary judgment. There was no extensive discovery nor were there near the number of depositions and documents taken. I don't think the court aired out the underlying cases well enough," Mr. Sallee said.

In the seven-month-long case involving U.S. Gypsum Co., a Cook County, Ill., judge ruled that asbestos in buildings constitutes property damage but that only the producer's liability coverage in force when the building owner discovers the asbestos is triggered. That ruling is being appealed (BI, Jan. 21).

Associate Editor Stacy Adler in New York contributed to this report.

NAIC oversight

Continued from page 1

at best, and who face unimaginable budget deficits year in and year out?"

While the subcommittee staff has floated a proposal calling for a federal role in insurance regulation, subcommittee members last week appeared divided on the idea (BI, March 25).

Rep. Norman Lent, R-N.Y., for example, repeatedly pointed to the savings and loan debacle in questioning the superiority of federal regulation, while Rep. J. Roy Rowland, D-Ga., questioned the need for creating "a new federal bureaucracy" to regulate insurance.

Other subcommittee members, though, appeared to be in favor of some form of federal action.

"The pretense of protection is probably worse than no protection at all," said Rep. Dennis E. Eckart, D-Ohio, referring to the current state regulatory system.

"Federal minimum standards may be necessary," observed Rep. Gerry Sikorski, D-Minn.

'Federal minimum standards may be necessary,' says Rep. Gerry Sikorski, D-Minn.

Last Wednesday's packed subcommittee hearing—attended by several more subcommittee members than previous hearings by the panel on insurance matters—centered on the GAO's report on the operations of the NAIC.

The report was one of two studies on insurance regulation released by the GAO last week: a second study submitted to Rep. Cardiss Collins, D-Ill., found that states have typically been late in taking formal action against troubled insurers (see related story).

The GAO's examination of NAIC operations was requested by the House subcommittee in January, and GAO officials worked between January and May at NAIC's headquarters in Kansas City, Mo. (BI, Jan. 28).

In presenting the report last week, Mr. Fogel credited the NAIC's efforts to develop its solvency policing agenda, intended to create a uniform national regulatory system.

However, "we do not believe that NAIC can successfully attain that goal," Mr. Fogel testified.

To create a national system, Mr. Fogel testified, a regulatory body like the NAIC would need the power to:

- Establish uniform requirements for accounting and timely financial reporting by insurers and set uniform rules defining safe and sound operations of insurers.
- Establish minimum capital standards that reflect the risks inherent in an insurer's operations.
- Set minimum standards for effective solvency regulation by state insurance departments.
- Monitor the states' regulatory functions and compel state regulators to enforce solvency rules and take action against troubled companies.

Noting that the NAIC has no power to compel states to adopt its model solvency laws, Mr. Fogel expressed doubts about the NAIC's ability to enforce state-by-state compliance with the models through its insurance department accreditation program.

He also questioned the quality of the accreditation process, under which the NAIC accredits insurance departments in states that have adopted certain model laws and that pass a review of their regulatory procedures.

Reports by the NAIC recom-

mending accreditation for the New York and Florida departments—the only two states accredited so far—were only a half-page in length, Mr. Fogel told Mr. Dingell, the subcommittee's chairman.

Accreditation files for the two states included copies of the states' laws and regulations but no work papers or discussion by the NAIC accreditation team, Mr. Fogel said.

In a review of the Illinois Insurance Department, an NAIC accreditation team was denied access to corrective orders against specific companies, the GAO found.

"So without these documents, they could not determine if there was proper implementation" of NAIC standards? Mr. Dingell asked.

"That's absolutely correct," Mr. Fogel said.

In later testimony, NAIC officials maintained that there were work papers supporting the accreditation teams' recommendations on New York and Florida, and that half-page documents simply represented "yes or no" recommendations on accreditation.

However, even if widely implemented, the standards would still "provide little more than an appearance of uniformity," because most are vague and subject to widely varying interpretations, Mr. Fogel testified.

One of the NAIC's standards, for example, requires states to set minimum capital and surplus requirements for insurers but does not say what the minimum requirements should be.

The NAIC has said, though, that it will define this standard more clearly when it completes new risk-based capital requirements.

The investment regulation standard, meanwhile, requires insurers to maintain "diversified" investment portfolios, but does not define what "diversified" means, Mr. Fogel noted.

The NAIC's fundamental problem, though, is that it lacks the authority to compel states to adopt its standards or perform any other regulatory function, he said.

The "NAIC is dependent on consensus—indeed unanimity—among state insurance commissioners and legislatures to enact and implement its policy recommendations," he testified.

While the regulatory group has made progress in its reform efforts lately, "given NAIC's historical lack of success in securing state adoption of its model policies, it is highly questionable whether such progress will be sustained over the long run," Mr. Vogel testified.

This quandary probably could not be resolved either by the states or by the federal government granting enforcement powers to the NAIC, he added.

Empowerment by the states would require each state legislature to cede part of its authority to the NAIC, he noted. This authority could always be revoked, leaving the NAIC in a weak position as a regulator.

Empowerment by the federal government would create an "irreconcilable conflict of interest" for insurance commissioners, who would be accountable to both state and federal authorities, he said.

Several NAIC officials took issue with the GAO's conclusions in testimony last Wednesday.

"I will stack the record of state insurance regulation against the record of any regulation, state or federal, of any other financial institution," said James E. Long, North Carolina insurance commissioner and NAIC president.

Mr. Long said 44 states have considered laws or regulations included in the NAIC's solvency standards and 20 of those states have adopted legislation enacting the standards this year.

"Look at the record of the last three months and find another time in American history when so

Regulators slow to act: GAO

By DOUGLAS McLEOD

WASHINGTON—State insurance regulators generally have delayed taking formal action against financially weak property/casualty insurers, hampered in part by the lack of a clear standard defining when a company is in trouble, the General Accounting Office concludes.

In a review of state actions in insurer failures since 1980, the GAO found that regulators in most cases took no formal action until after insurers were statutorily insolvent and in many cases allowed insurers to continue writing even after they were identified as financially troubled.

The investigative arm of Congress submitted the report last week to Rep. Cardiss Collins, D-Ill., chairwoman of the House Subcommittee on Commerce, Consumer Protection and Competitiveness.

A second GAO report on the operations of the National Assn. of Insurance Commissioners was submitted last week to the House Oversight and Investigations Subcommittee (see story, page 1).

In its survey on state responses to insolvencies, the GAO compiled data on the actual insolvency dates for 140 of 215 property/casualty insurers that regulators reported taking over in the 1980s.

That information was compared with the dates regulators reported they first took action against 122 of the 140 companies.

In 87 of the 122 cases—or 71%—state insurance departments did not take formal regulatory action or seek rehabilitation orders until after the insurers were insolvent, the GAO found.

In 83% of those 87 cases, regulators took no action until one month or more after the insolvencies, and in 39% of the cases took no action for more than six months after the insolvencies. In one case, more than two years went by before the insurance department acted, the GAO found.

Troubled companies also were often allowed to continue writing business, according to the study: Of 65 troubled insurers whose premium writings GAO analyzed, 47 increased net written premium volume between 1984 and 1988. And, 36 of these increased their writings after regulators identified them as financially troubled.

Thus, the GAO concluded, insurance department delays in acting against weak companies have increased the ultimate cost of insurer insolvencies.

For example, the report said Transit Casualty Co. could have been taken over a year before it actually was in 1985. Up to \$1 billion in post-liquidation claims could have been prevented if Transit's underwriting had been restricted in 1984, the GAO said.

Delays in obtaining liquidation orders against failed insurers have also delayed claim payments to policyholders for extended periods, the GAO said. In many cases, state regulators suspended payments while keeping companies in rehabilitation, the GAO said.

Of 127 companies in liquidation for which the GAO determined the actual date of insolvency, 56% were insolvent for seven months or more before liquidation orders were issued, either because regulators were not aware of the insolvency or because decisions were made to delay liquidation.

The GAO cited several possible reasons for insurance department delays in acting against troubled

companies. These include:

- Reliance by the states on outdated or unverified financial data.

The initial indicator of financial trouble is often the insurer's annual statement, though these statements are not submitted until two or three months after the end of the year and can take six weeks to three months for regulators to review, the report says.

In several cases, failed insurers also submitted inaccurate, incomplete or misleading financial data, the report added.

The GAO noted that the NAIC now requires independent audits and actuarial certification of loss reserves with each annual statement, beginning with the 1990 annual statement (BI, June 18, 1990).

Insurance department field exams are another source of information about troubled companies, though regular exams are required only every three to five years and can take months and sometimes years to complete.

- States often do not have statutory or regulatory standards for identifying troubled companies.

Of five insurance departments visited by GAO examiners—California, Illinois, New York, Oklahoma and Washington—only Illinois had written criteria for identifying troubled insurers, while the others relied on the case-by-case judgment of department officials.

While the case-by-case approach allows flexibility, it can also create uncertainty and internal disagreement about whether a given insurer is troubled, the GAO concluded.

For example, the Texas Insurance Board had information indicating the possible insolvency of National County Mutual Fire Insurance Co. in August 1987, but disagreement among top department officials over the company's condition delayed action against the insurer until October 1988, the GAO said.

The report also quotes an unidentified Midwestern regulator and a guaranty fund official who say the Massachusetts Insurance Department should have taken over American Mutual Insurance Co. of Boston a year or more before it did in 1989.

- Statutory definitions of insolvency may be too vague.

While the NAIC's model law on rehabilitation and liquidation contains a definition of insolvency, it deals "only tangentially" with the question of loss reserve adequacy, the GAO concluded.

The model law's definition of liabilities includes reserves, but does not specify what constitutes an adequate level of reserves, leaving the issue open to dispute between an insurer and its state regulator.

The GAO recommended a variety of steps that could be taken to address the shortcomings it cites in the report, including more frequent submission of insurer financial data to regulators, a uniform standard for determining when an insurer is financially troubled and a more detailed definition of insolvency.

The study also notes that insurer solvency regulation and monitoring of troubled companies is the responsibility of the states only because it was delegated from the federal level under the 1945 McCarran-Ferguson Act.

Although the report makes no recommendation about where regulatory authority should rest, it notes that "overriding federal legislative authority still exists" to reassume insurance regulatory duties.

much solvency-related legislation was enacted by so many states in so short a time," Mr. Long said.

William H. McCartney, Nebraska insurance commissioner and the NAIC's vp, asserted that the GAO report "is the product of a strong bias against state government."

Mr. McCartney maintained that while national minimum solvency standards are needed, there should not be complete uniformity in regulation.

"The ability of the states to experiment with new forms of solvency regulation is one of the strengths of the system," he argued.

Mr. McCartney also complained that the GAO wrongly measured state regulation against "an artificial standard of perfection."

The GAO "tells us that only perfect regulatory systems can regulate effectively and since state insurance regulation is imperfect, it cannot regulate effectively," he said.

After reading their prepared testimony, the NAIC officials faced a withering barrage of questions from Mr. Dingell on the NAIC's response to the deterioration and ultimate collapse of Executive Life Insurance Co. in Los Angeles (see

story, page 1).

Mr. Dingell produced a December 1990 NAIC resolution condemning the New Jersey Insurance Department for demanding a special \$500 million deposit by Executive Life to protect the state's policyholders. The resolution—adopted four months before Executive Life's failure—stated among other things that "it is the expert opinion of the special committee that the Executive Life companies are in no imminent financial danger based upon the information, data and reports it has reviewed over the last several months."

Mr. Dingell also produced a December 1990 Illinois Insurance Department memo sent to all other insurance commissioners reporting the resolution and urging individual states not to take "unnecessary and precipitous regulatory action."

"What it does is testify to the splendid good health of Executive Life Insurance Co.," Mr. Dingell said of the resolution. "Anyone reading this would have been impelled to run out and buy some Executive Life stock."

Mr. McCartney explained that an NAIC working group had been monitoring Executive Life since

January 1990 and was concerned in late 1990 that actions like New Jersey's could trigger massive policy surrenders.

He added that regulators did not have financial data showing that the company was insolvent until the first quarter of 1991.

Asked why they didn't take action on their own to protect Executive Life policyholders in their states, Mr. Pomeroy, Mr. Long and Mr. McCartney said they largely relied on the California department as Executive Life's primary regulator.

"You had the authority, but you didn't do anything," Mr. Dingell charged. "There is nobody in your state that is protected by you. You all ceded your authority to California."

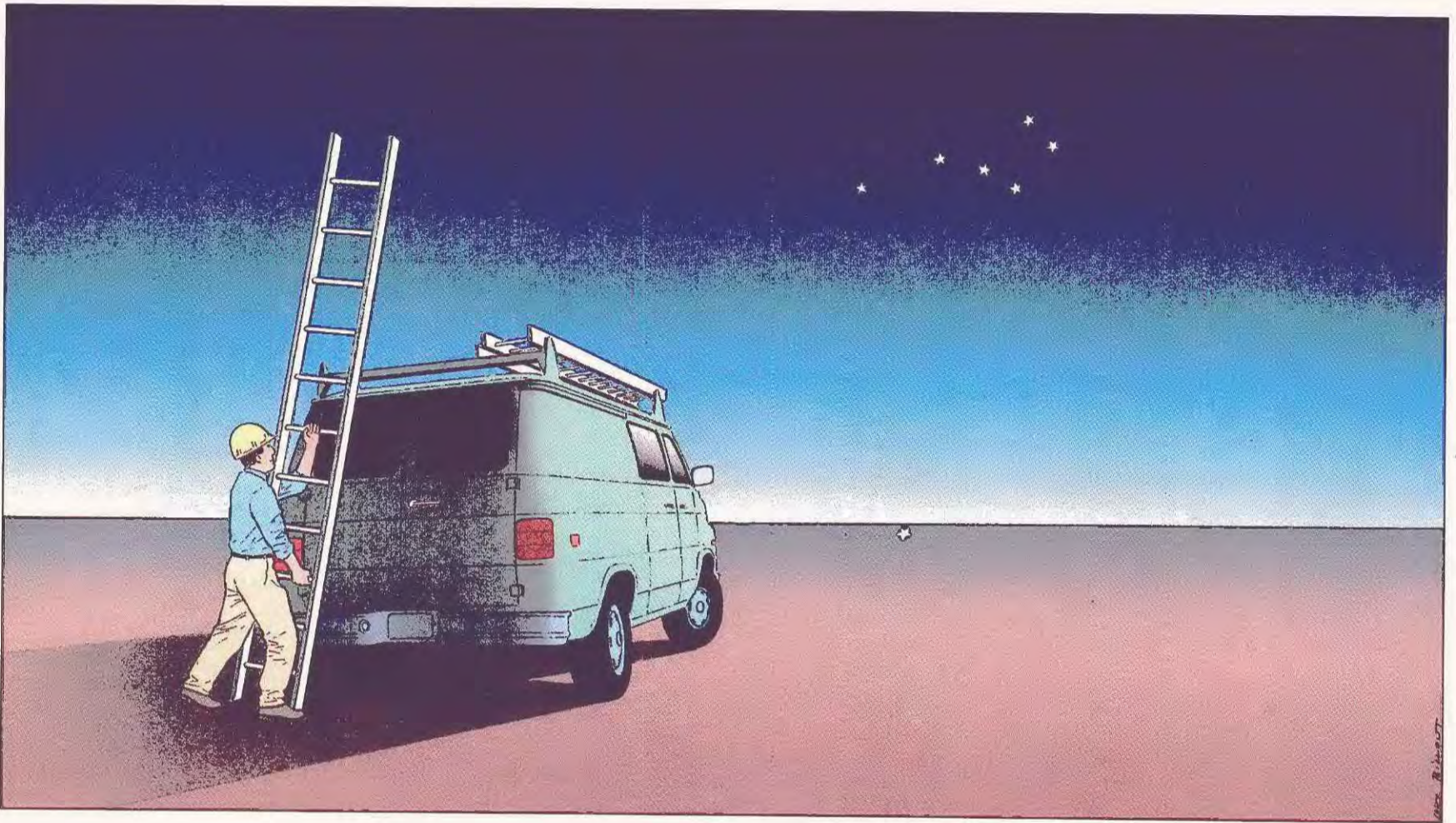
Rep. Thomas J. Bliley Jr., R-Va., asked why regulators allowed Executive Life to accumulate a massive portfolio of junk bonds over several years.

"If you are supposed to be the watchdog, obviously the watchdog was asleep," he said.

Mr. Pomeroy noted that state insurance regulators were not the only regulators who failed to recognize the danger of large investments in junk bonds. ■

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