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Update

Employers face new FASB rule on post-employment benefits

NORWALK, Conn.—A new Financial Accounting Standards Board rule requiring employers to account for certain post-employment benefits for non-retirees could cost major companies billions of dollars in profits, some benefit consultants say.

FASB plans to release the rule, FAS 112, later this week. It will take effect in fiscal years after Dec. 15, 1993, said Kim Petrone, FASB staff member. An exposure draft was released in May (*BI*, May 25).

The rule will apply to workers compensa-

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Congress may act on AIDS benefits

By MARK A. HOFMANN

WASHINGTON—The Supreme Court's refusal to review a discrimination suit by a man whose health benefits were cut after he told his employer he had AIDS could bring swift congressional action.

In fact, the emotions aroused by that case—*Greenberg vs. H&H Music Co.*—could lead to what benefits lawyers and consultants call an overreaction that would unfairly penalize all employers.

Some of these experts say that no remedial laws are needed because the Americans with Disabilities Act, which took effect in July, bars companies from cutting group health benefits for a particular illness after claims have already been filed.

Soon a bill will be reintroduced in the House to accomplish much the same thing by amending the Employee Retirement Income Security Act of 1974.

"There's going to be a hue and cry because this is truly a tragic situation," said Ellen Goldstein, director of health care policy for the Assn. of Private Pension and Welfare Plans in Washington. "It would be unfortunate to draw the conclusion from *H&H Music* that employers are out to cut back on promised benefits or that this is a license to cut back benefits."

John McGann, who worked for the Houston music store, brought his suit in 1988. A few months earlier, Mr. McGann had told the company he had AIDS. At that time, H&H had an insured plan that provided up to $1 million in

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Union Indemnity reinsurers can rescind cover

By MARK A. HOFMANN

NEW YORK—The liquidator of Union Indemnity Insurance Co. may appeal a state trial court's second ruling in three years that some of the failed insurer's reinsurers can rescind their contracts.

Voiding those contracts could more than double the size of the defunct insurer's insolvency to $300 million, noted Judge Ira J. Gammerman. He ruled for the reinsurers after finding that Union's financial status was fraudulently misrepresented to them.

Prohibiting defrauded reinsurers from rescinding their contracts could cause more trouble in the marketplace than increasing the size of one insolvency would, Judge Gammerman wrote in a 15-page decision that mirrored his 1989 ruling in the case.

"If fraud on reinsurers is permitted to go unsanctioned, more insurance companies may be victimized—resulting in increased company insolvencies—and reinsurers will be reluctant to underwrite risks within the state," he wrote.

"We are considering an appeal right now," said a spokesman for the New York Insurance Department, which is overseeing Union's liquidation. The spokesman could not provide a current estimate of Union's insolvency, which stood at $138.5 million

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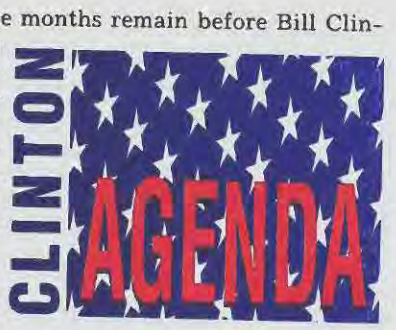
Groups try to help guide Clinton's benefit policy

By SALLY ROBERTS



While two more months remain before Bill Clinton takes the reins of power, lobbying groups already are trying to influence the incoming administration on employee benefit issues.

Last week, some employers, insurers and other health care interest groups said they were banding together to announce their support for a fundamental overhaul of the health care delivery system and their opposition to any "quick fixes."

Those groups—which include the Washington Business Group on Health, Blue Cross & Blue Shield Assn., the American Hospital Assn., the Catholic Health Assn., and the American Nurses Assn.—are wasting no time in telling the president-elect how to fix the system.

"We hope you and the Congress will make a strong commitment to comprehensive and fundamental changes in the way health care is both delivered and paid for in America. We urge to avoid any 'quick fix' approach that merely alters a severely flawed system," the trade groups said in a letter delivered last week to Gov. Bill Clinton.

However, the groups endorsed no specific proposals.

Other business groups—including the U.S. Chamber of Commerce, the National Assn. of Manufacturers and the National Federation of Independent

Pension reform vies for Clinton's attention. Page 35

Businesses—also are making their positions known to Gov. Clinton and his transition team.

Meanwhile, a group of state and local government officials, including the National Governors Assn., last week were preparing to write to Gov. Clinton to urge that he make health care cost control a top priority.

Lobbying normally slows down during a presidential transition, but business groups are speaking out on benefit issues because the stakes are high: Gov. Clinton has said that he will unveil compre-

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Cigarette litigation continues

Lawyers do not view Cipollone dismissal as obstacle in future

By MICHAEL SCHACHNER

Lawyers whose clients are suing tobacco companies insist that the recent dismissal of the most prominent cigarette liability case in history will not hurt future cases.

These attorneys lament the fact that the landmark liability suit brought by Rose Cipollone against three cigarette makers was dismissed with prejudice earlier this month at the request of the Cipollones' lawyer, Marc Z. Edell. Such a dismissal means the Cipollone family cannot continue to pursue the claims.

Some even say that the tobacco industry deserves a feather in its cap for outlasting the lawyer and law firm that invested nine years and more than $1 million in pursuing cases against tobacco companies.

Plaintiffs' attorneys say Mark Z. Edell's efforts helped to smooth their way—in terms of precedent and discovery—in litigation against tobacco companies.

Mr. Edell's efforts were not fruitless, though. Attorneys say he made significant gains, both in terms of precedent and discovery, before his firm dropped the Cipollone case on Nov. 4, citing excessive costs (*BI*, Nov. 9).

Specifically, the U.S. Supreme Court ruling in the case helps all current and future cases, lawyers say. In June, the high court ruled that federal law does not bar smokers from bringing certain damage claims against cigarette makers (*BI*, June 29).

"The tie the Cipollone case had to other cases is that all benefitted from the Supreme Court's decision to allow these cases to be brought. Other than that, every case stands or stumbles on its own," said Richard Daynard, chairman of the Tobacco Products Liability Project, an anti-smoking group affiliated with Northeastern University in Boston.

Tobacco company lawyers were encouraged by Mr. Edell's move.

By dropping the Cipollone case—and four others—after nearly a decade of work, Mr. Edell and his Short Hills,

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AP/Wide World Photo

Highly hazardous cargo

Workers in France load 1.7 tons of plutonium aboard Japanese freighter Akatsaku Maru on Nov. 7. The controversial shipment will take two months to reach Japan. See story, page 4.

Update

New benefit accounting rule

Continued from previous page

tion, disability benefits, salary continuation, COBRA health coverage continuation and "any other post-employment benefits," she said. Employers will be required to account for the value of the benefits during an employee's active service if, for example, the payment of benefits is probable and the amount can be reasonably estimated.

Some benefit consultants project that complying with FAS 112 may cost U.S. employers as much as $30 billion. This is one-tenth of the $300 billion estimated cost of FAS 106, the retiree health care accounting rule effective in 1990.

But, the $30 billion estimate is a one-time charge and is probably overestimated, because it is "not scientifically derived," said Diana Scott, a consultant with Towers Perrin, who was project manager for FAS 106.

Because FAS 112 deals with inactive employees, smokestack industries in the throes of layoffs and downscaling may be the first to feel the impact of the rule, said Alan Glickstein, a consultant with Kwasha Lipton in Fort Lee, N.J. But, "It's way too early to jump to conclusions" on how much FAS 112 will cost, he said.

Many employers already account for some of these benefits, so FAS 112's impact is "not nearly as complex or important as FAS 106," said Dan Klein, a principal with William M. Mercer Inc. in Chicago.

Philadelphia cuts health costs

PHILADELPHIA—About 15,000 City of Philadelphia employees have approved a four-year contract that will lower the city's group health plan costs by about $14 million annually.

Under the contract, members of Local District Council 33 and Council 47 still may choose among several managed care plans or the city's self-insured indemnity plan. But, employees will be subject to a higher coinsurance requirement under the indemnity plan.

The bulk of the group medical plan's cost savings will result from reduced premiums the city has negotiated with health maintenance organizations and the city's reduced indemnity plan costs. HMO premiums and indemnity plan costs will be cut to about $360 per employee per month from a range of $437 to $482. The unions in the new contract gave up the right to negotiate coverage costs with HMOs. But, they maintained the right to administer the group plans.

The city reported $175 million in medical plan costs for fiscal year ending June 30.

City workers, who also agreed to a 33-month wage freeze, still do not have to make premium contributions to their medical plans, unless they want richer indemnity plan coverage, said Peggy Van Bell, assistant budget bureau director for the city.

The agreement also guarantees retiree medical benefits at no cost.

City workers walked off the job in October when Mayor Edward G. Rendell proposed cutting retiree benefits and taking over the administration of the employee health plans (*BI*, Oct. 12).

About 8,500 other union employees, including the police and fire departments, are still in arbitration.

Seibels forced to trim business

COLUMBIA, S.C.—Seibels Bruce Group Inc., an insurance holding company hard hit by losses from Hurricane Andrew, last week ceased writing all new business in Alabama, Florida, Mississippi and Virginia. It will, however, continue as a servicing carrier for the National Flood Insurance Plan in those states.

Seibels Bruce also increased its net Andrew loss estimate to $26.7 million from $10.6 million. Claims before reinsurance are now estimated at $88 million, up from $61.5 million, "well beyond" the limits of its catastrophe reinsurance, the insurer said.

The day after Andrew hit Florida, Lincoln National Corp. called off a planned merger of subsidiary American States Insurance Co. with Seibels (*BI*, Aug. 31).

The new loss estimates also mean that Seibels Bruce is in default on a $23 million loan that required the insurer to maintain a $47 million surplus. Seibels Bruce's policyholders surplus stood at $50.6 million at year-end 1991.

"The company is in discussions with the South Carolina Department of Insurance and the term loan lender concerning alternatives to deal with the additional reduction of surplus," Chairman Sterling E. Beale said. "Essentially, each alternative requires an internal restructuring and a substantial downsizing."

The insurer will continue to write business in Georgia, Kentucky, North Carolina, South Carolina and Tennessee.

N.J. proposal for the uninsured

TRENTON, N.J.—Gov. Jim Florio is proposing a managed care plan to provide health insurance for about half of the 950,000 uninsured people in New Jersey.

The State Health Insurance Enrollment and Local Care Delivery plan, or SHIELD, would provide coverage to about 450,000 working uninsured and temporarily unemployed citizens. For a family of four, the annual cost of coverage would be about $1,250 plus "modest" deductibles and copayments for certain care.

The plan aims to drive working uninsureds toward affordable preventive and primary care, rather than emergency care in hospitals. There would be no copayments for preventive care from a primary

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Errors & omissions

• The Home Insurance Co. was inadvertently omitted from the Sept. 9 directory of global property/casualty insurers. The company's listing appears on page 38.

Wisconsin comp system a good role model: Study

By MEG FLETCHER

CAMBRIDGE, Mass.—States that want to improve their workers compensation systems could learn a lot—and maybe save a lot—by studying Wisconsin's system, a researcher contends.

However, at least one observer of the Wisconsin workers comp system questions whether key elements of its success are readily transferable to other states.

"Wisconsin has one of the best workers compensation systems in the nation," contends Duncan S. Ballantyne, a senior analyst with the Workers Compensation Research Institute in Cambridge.

The Worker's Compensation Division of the Wisconsin Department of Industry, Labor and Human Resources provides affordable, stable costs for employers while doing a good job of delivering reasonable benefits to injured employees, Mr. Ballantyne said in a 118-page study that will be available from the WCRI later this month.

"Compared to other jurisdictions, the cost of workers compensation insurance to Wisconsin employers is well below average," Mr. Ballantyne said.

Comparing weekly workers comp insurance premiums per employee, the study shows that

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Lower captive tax eyed

Vermont may lower premium tax to keep edge over Hawaii

By JERRY GEISEL

MONTPELIER, Vt.—Gov. Howard Dean is expected to propose legislation in January that would reduce premium taxes paid by captives domiciled in Vermont.

While Gov. Dean has not finalized the new premium tax structure he will propose, he has said that lower premium taxes are needed to keep Vermont competitive with other domiciles.

Initially, Gov. Dean suggested that premium taxes first be reduced on so-called "mega" captives—roughly the largest 10 to 20 captives—with premium taxes cut later for others.

Vermont captive managers say Gov. Dean's position is flexible and that his decision is not final.

"At this point, I think the governor has an open mind," said Edward Meehan, executive vp at Vermont Insurance Management Inc. in Montpelier.

While Gov. Dean is working out the final details, a special subcommittee of the state Department of Banking, Insurance and Securities' captive advisory board is proposing premium tax cuts for all captives to be phased

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Union to receive $28 million settlement of pension litigation

Fund mismanagement alleged

By JOANNE WOJCIK

NEW YORK—Insurers will pay the bulk of a $28 million settlement for one of the largest pension fund mismanagement suits ever filed under ERISA.

Members of the International Organization of Masters, Mates & Pilots union have agreed to drop their class-action suit against the former union officials who were trustees for the plans and the plans' administrator, Tower Asset Management Inc. of New York.

Mismanagement caused account balances in two pension funds to fall 28% in 1986, the suit charged.

Plan participants charged that the trustees failed to properly investigate Tower Asset before appointing it, failed to properly monitor its performance and failed to promptly terminate the company once its potentially improper and imprudent investments became known.

Tower Asset, according to the suit, put virtually all of the assets it managed for the plans in

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Results of benefit manager study are now available

Four out of five employee benefit managers report that their companies review their health insurers' performance at least once a year, according to a new study.

And more than a quarter of mid-size and large companies review their health insurers quarterly or semi-annually.

In addition, 87% of employee benefit managers agree that the trend away from traditional indemnity insurance will accelerate in the near future.

These are among the findings of the "Employee Benefits Manager Viewpoint," a joint venture study by *Business Insurance* and Yankelovich Clancy Shulman.

The study is based on in-depth interviews with nearly 300 executives responsible for employee benefits in their companies. Interviews covered critical group health care issues, growth areas, key factors that motivate the selection of group health care providers and advisers and sources of information about group health insurers and advisers that employee benefit managers consider more useful.

The study results were released to sponsors last month.

Now, the study is available to others, at a cost of $6,500 until Dec. 1. After Dec. 1, the cost increases to $7,500.

"Readers will gain valuable insights about the decision-makers responsible for benefit plans and packages—what are the key factors in the decision, how to reach these decision-makers, and what marketing messages and strategies are most effective with them," according to Jason Sheftell, an account executive with Yankelovich.

Purchasers of the "Employee Benefits Manager Viewpoint" will receive two copies of Volume I: Management Overview and Detailed Findings, and two copies of Volume II: Computer Tabulations. The latter is the complete compilation of all interview data reported by region, industry, company size and type of respondent—services versus manufacturing.

For additional information on the study, please contact Mr. Sheftell at Yankelovich Clancy Shulman, 8 Wright St., Westport, Conn. 06880; 203-227-2700. BI

Inside

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- The sun may be setting on Texas' unique insurance regulatory structure. **PAGE 21**
- The Americans with Disabilities Act—millstone or milestone? Two different perspectives on **PAGE 23**
- Australia's major insurance law is working against insurers and policyholders alike, observers say. **PAGE 29**
- A reinsurer's refusal to pay runoff policy claims is on trial in London's high court. **PAGE 29**
- Canada's changing benefits climate demands that risk managers get involved, an expert says at the Canadian Risk & Insurance Management Society meeting. Conference copy begins on **PAGE 33**

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Non-compete disagreement

Willis Corroon suing several former executives

By JUDY GREENWALD

SAN FRANCISCO—Willis Corroon Corp. is locked in a bitter dispute with its former president and chief operating officer, John Lamberson, and six other former Willis employees over Mr. Lamberson's formation of a competing brokerage.

Willis Corroon charges Mr. Lamberson and other former employees who have joined Lamberson, Koster & Co. in San Francisco with, among other things, breach of contract for allegedly violating non-compete agreements, misappropriating trade secrets and engaging in unfair competition.

In its suit, filed in Superior Court in San Francisco, the world's fourth-largest insurance brokerage is seeking $10 million plus costs.

Lamberson, Koster, which specializes in the construction industry, is expected to generate $2 million to $3 million in commissions and fees this year.

Mr. Lamberson and the other defendants deny the charges, and are countersuing Willis Corroon for slander and unfair business practices, among other things. They allege that Willis Corroon has told prospective clients it is willing to spend $20 million to put Lamberson, Koster out of business in an effort to discourage them from doing business with the firm.

Lamberson, Koster won an initial victory in October when San Francisco Superior Court Judge Lucy Kelly McCabe lifted an Aug. 4 temporary restraining order against the defendants, refused to issue a preliminary injunction and also denied a motion to hold Mr. Lamberson and the brokerage in contempt of court.

A status conference is expected to be held in February. Unless the suit is settled, a trial could

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AP/Wide World Photo

The La Mede refinery, owned by state-controlled Total S.A., burns after it was rocked by a series of explosions last week.

French refinery blast may cost $400 million

By ALINE SULLIVAN

MARSEILLES, France—Insured damages from the explosion and fire last week at the La Mede oil refinery near Marseilles could reach $400 million.

Observers say the fire could cause property insurance rates for energy companies to harden at renewals.

The refinery, which is owned by the state oil company TOTAL S.A., was rocked by a series of pre-dawn explosions on Nov. 9. The refinery's catalytic cracker and control room were destroyed before the fires were extinguished in the evening. Other parts of the refinery and nearby residences were also damaged. Six workers were killed and two were injured.

A spokesman for TOTAL in Paris said last week it was too early to gauge the extent of the damage and the cost of a disruption in the refinery's operation. However, the catalytic cracker alone will cost between 1 billion and 2 billion francs ($185 million and $370 million) to replace, he said.

A broker with Paris-based Societe Generale de Courtage d'Assurances S.A., which placed TOTAL's direct insurance program, said the insured loss could total about $400 million.

"We have insurance to pay the (killed) workers' families and to cover the cost of the damage," the TOTAL spokesman said. "We also have insurance to cover us for loss of business up to three years." He declined to comment further on TOTAL's insurance program.

The refinery's direct property coverage was placed in the French market by SGCA, which is a unit of Alexander & Alexander Services Inc. State-controlled insurer Groupe des Assurances Nationales was the lead underwriter.

TOTAL's reinsurance program is placed with the company's offshore captive and is then retroceded worldwide, according to the broker. SGCA's Canadian affiliate, Reed Stenhouse Cos. Ltd., another unit of A&A, placed the reinsurance cover, the broker said.

The first $150 million of retrocession claims will be paid by Oil Insurance Ltd., the Bermuda-based petroleum industry mutual insurer.

The SGCA broker said TOTAL's captive retained a "moderate" layer of the reinsurance program above OIL's coverage.

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Employers urged to focus on work comp loss control

By MICHAEL BRADFORD

NEW ORLEANS—Employers must demand that insurers help them control losses if they expect any relief from rising workers compensation costs, according to one insurance executive.

The future of workers compensation, as far as insurers and employers are concerned, "is in the area of loss containment," said Caleb L. Fowler, executive vp at CIGNA Corp. in Philadelphia. "And the ability to contain loss is done through capability and expertise."

Employers are realizing that insurers and intermediaries are not all equally qualified to help contain workers comp losses, he said. "If I were a buyer today, I would focus almost exclusively upon the kind of capability that my insurance company has to directly reduce my workers compensation losses."

Speaking earlier this month at the 12th annual Construction Insurance Conference, Mr. Fowler said that focusing on program costs is wrong.

"What you ought to do is focus on what goes to your bottom line and what you can impact," he said.

Employers that can "abate the rate of increase of workers comp losses" can end up saving more than the total cost of administering the program, he stressed. "It is there where the game is going to be won or lost."

Claims are unquestionably "the biggest piece of the pie," agreed Quill O. Healey, chairman and chief executive officer of Sedgwick James Inc. in New

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Health reform road map

Group sets goals for health in 2010; reforms to follow

By SARA J. HARTY

ARLINGTON, Va.—When planning a special family vacation, the first step is deciding where the family would like to go. Later, decisions are made about whether to fly or drive, and which routes would be most appropriate.

In the same way, the first step to health care reform is deciding where health care should be in 20 years, according to a group of health care experts.

The actual map that should be followed to get there can be determined after everyone has agreed on a vision of health care and how it should be delivered, concluded 18 national health care experts. Representing the health care and insurance industries, government and academia, the 18 collaborated on a project called the Belmont Vision.

The project was launched to recommend general health care goals for the year 2010.

"The essential problem is that the current system no longer works," observed Walter J. McNerney in an introduction to a white paper the project released. Mr. McNerney is chairman of the Belmont Vision and a professor of health policy at the J.L. Kellogg Graduate School of Management at Northwestern University in Evanston, Ill.

The group calls for a definition of "health" that is "sufficiently broad to encompass strategies directed at our major causes of illness: namely poverty and lack of education," Mr. McNerney wrote.

The group envisions a social contract that provides all individuals with a high-quality,

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Managed care savings less than expected: Study

By CHRISTINE WOOLSEY

Premium increases for managed care programs like health maintenance organizations and preferred provider networks were only slightly lower than those for insured indemnity plans for some employers in 1990, a new survey shows.

Premium increases for point-of-service plans were lower than those for other managed care plans or indemnity plans, but many employers were still unconvinced of POS plans' cost-effectiveness and did not offer them in 1990.

However, the survey found that some managed mental health and prescription drug programs do save money.

The survey, scheduled to be released by Hewitt Associates next month, provides information on the managed care initiatives taken by 372 employers.

While their popularity is on the upswing, managed care programs had premium increases of about the same levels as indemnity plans, the survey indicates.

Premiums for indemnity plans increased 15% on average in 1990, compared with 14% for PPO premiums and 13% for HMO premiums, the survey found.

Premiums for point-of-service HMOs rose just 10%.

"The percentages are close, and that's significant because it reflects how little you are able to affect health care costs by putting in managed care," said Kenneth Sperling, a Hewitt consultant in Rowayton, Conn.

'Employers are almost a little jaded now. They know managed care isn't a magic solution—it's just an incremental strategy to control costs over the long term. Most employers put managed care programs in with that objective,' says Mr. Sperling.

"If you think managed care is a silver bullet, you're wrong," he said.

"Employers are almost a little jaded now. They know managed care isn't a magic solution—it's just an incremental strategy to control costs over the long term. Most employers put managed care programs in with that objective."

Cutting costs more substantially would require major changes in health plans, like raising deductibles or copayments or cutting benefits, Mr. Sperling noted.

Employers with managed care programs can generally expect their annual premium increases to average about three percentage points below the average increase in indemnity plan premiums, according to William Danish, health and welfare practice leader for Alexander Consulting Group Inc. in Lyndhurst, N.J.

Data on indemnity plan premium increases may be distorted in the Hewitt survey, he said.

"The indemnity plans reflected in the survey might be located in (smaller) areas where there isn't a lot of managed care. Those areas might not have managed care plans because health care costs aren't so high, inflation is lower and claims experience is better," he suggested.

Hewitt's Mr. Sperling agreed. For example, in smaller cities, where indemnity plans are probably more prevalent than managed care plans, "We aren't see-

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Japanese nuclear risk

Pools reinsure liability exposure on plutonium transport

By ALINE SULLIVAN

CHERBOURG, France—Nuclear insurance pools worldwide are believed to be reinsuring the liability coverage for one of the most hazardous shipments of radioactive material ever.

The Japanese freighter Akatsuki Maru set sail Nov. 7 from Cherbourg, France, on a two-month ocean journey to Japan, carrying 1.7 tons of plutonium.

The shipment's cargo, hull and liability exposure is covered by the Japan Atomic Energy Insurance Pool. The pool, which is composed of 22 Japanese insurers and 11 foreign insurers operating in Japan, is the sole underwriter of nuclear insurance in Japan. The pool's exposure is likely to be reinsured with several of the other 27 national nuclear energy insurance pools worldwide, insurers say.

They also say the coverage for the shipment likely does not exceed the liability limits set by international shipping conventions for nuclear risks. Liability is capped at about $300 million, most of which is borne by the government of a shipper's home country.

The voyage has become controversial because of the risk of environmental disaster and the freighter's vulnerability to terrorist attack. Plutonium is the most toxic radioactive element known and is used in nuclear weapons.

A spokesman for the environmental group Greenpeace said one gram of plutonium released into the atmosphere could give hundreds of thousands of people cancer. And the amount being shipped is enough to make 120 nuclear bombs, he said.

The Akatsuki Maru's route is shrouded in secrecy. Countries along three possible routes to Japan have said they will not permit the ship to enter their territorial waters. Panama's objection will prevent the ship from passing through the Panama Canal, which leaves the Cape of Good Hope or Cape Horn passages as the most likely routes. Although South Africa and Argentina have also objected to the shipment, the ship could pass the capes and still remain outside the 200-mile territorial limits of these countries.

The ship and its cargo are owned by the Japanese Power Reactor & Nuclear Fuel Development Corp., according to officials at the Japanese Embassy in Paris. "The transport is insured for material damage and liability in the Japanese pool and is probably reinsured by pools in other countries," said an underwriter in the London office of a leading Japanese insurer.

Geoff Warren, general manager of the British Insurance Atomic Energy Committee, said national nuclear energy insurance pools reinsure the exposure of other pools "if the risk is large enough." Almost all of this reinsurance is arranged on a facultative basis, he said.

Mr. Warren said he was unaware of any attempt to reinsure the risk in the London market.

Tom Aldridge, an underwriter with Lloyd's of London managing agency Jansen Green Ltd., said to his knowledge, the ship was not insured or reinsured in the Lloyd's market. Jansen Green syndicate 79 is the leading underwriter of nuclear risks at Lloyd's.

Liability for nuclear shipments is capped by the so-called Paris and Vienna conventions.

According to a spokeswoman for France's state-owned nuclear fuel company, Cie. Generale des Matieres Nucleaires, the Paris convention requires that transporters of nuclear substances have strict liability to any injured third parties of 150 million francs ($27.8 million). Beyond that, the transporter's home country must provide up to 1.5 billion francs ($277.5 million) to indemnify third parties.

The Paris convention, first agreed to in 1960, is currently in the process of also fixing a limit on operators' liability of about 120 million pounds ($181.7 million), Mr. Warren said.

"Japan is not a signatory to those conventions, but it does have legislation in force that embodies the same principles," he said.

Commercial insurance is not normally available for the transportation of nuclear materials, said a London marine insurance broker.

"The insurance industry decided long ago that this was not the type of risk that it could cover," said the broker. "The number of shipments like this are so small and any loss would be so huge that there just isn't the spread needed for commercial coverage."

A spokesman for the International Maritime Organization in London said insurance coverage "would be a matter for the company concerned."

"As long as the ship and cargo meet the regulations of the International Atomic Energy Agency, then it is OK," he said. "There are a lot of international agreements covering liability and compensation, but they are not mandatory."

The Vienna, Austria-based International Atomic Energy Agency oversees the loading and unloading of plutonium shipments worldwide. The actual transportation is governed only by the country or countries involved.

Japanese officials said the plutonium on board the Akatsuki Maru will be used as fuel for experimental civilian reactors. The plutonium is manufactured in European reprocessing plants from Japanese nuclear waste that was sent to Britain and France in the 1980s as part of a $4 billion contract.

Japan plans to ship about 28 more tons of plutonium from Britain and France during the next 20 years. However, Japanese government officials last week reportedly were reconsidering Japan's future use of nuclear fuels.

The only previous shipment of plutonium on the high seas was from France to Japan in 1984, the Greenpeace spokesman said. That shipment was about one-eighth the size of the current shipment.

The spokeswoman for France's nuclear energy company, COGEMA, said that hundreds of voyages transporting Japanese uranium to Europe have already taken place without noteworthy accidents. Uranium is a less toxic radioactive substance than plutonium and is not as readily convertible into nuclear weapons.

On board the Akatsuki, the plutonium is wrapped in a series of cylinders—enclosed in one another like Russian dolls—that can resist considerable temperatures and depths, the COGEMA spokeswoman said.

The Akatsuki Mar is escorted by the Shikishima, a lightly armed Japanese coast guard vessel. A Greenpeace ship carrying salvage equipment is following the ship and the U.S. Defense Department is monitoring the Japanese ship. BI

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Daycare center flies in airport terminal

Employees of both Milwaukee's Mitchell International Airport and the airlines that fly in and out of the airport now have an on-site child care center that's open every day before the sun even comes up.

The 2,800-square foot daycare center was opened recently in the airport's main terminal building. About 2,500 airport employees, airline employees and those employed by a local post office, airport service companies and the local bureau of the Federal Aviation Administration are eligible to use the facility.

Known as "Airport Learning Years," the facility is run by the The Learning Years Inc., a Milwaukee child care firm that runs another daycare center in the city. The center is open every day from 4:30 a.m. to 7 p.m.

Airport Learning Years can accommodate up to 50 children between six months and 6 years old. At full capacity, the center employs nine counselors who, on a daily basis, lead children in walks through the airport, trips to a nearby frozen yogurt stand and to a viewing area of the airport runways.

"It's the best facility you could ask for. It's incredibly stimulating for the kids," said Laura Gilbert, president of The Learning Years. "Kids really love watching planes take off and land, and they are fascinated by all the people shuttling through the airport. It's just a fun atmosphere for kids."

The center opened Oct. 30 after almost four years of planning by airport and airline management.

Beth Foy, management analyst to the airport, said the airport paid about $150,000 to remodel the area that now houses the daycare center. However, it was the airline companies that use Mitchell International that paid for the facility through rent and landing fees, she noted.

Fees for the child care center are based on age. Weekly fees range from about $75 for children age 3 and older, to $115 per week for infants.

"Child care isn't really that profitable. We're just trying to cover costs and provide our employees with a good facility where they feel comfortable leaving their kids," Ms. Foy explained.

Only America West Airlines directly subsidizes employee use of the daycare center. Several other airlines offer pre-tax vouchers to defray some of the cost.

Ms. Foy said airport employees do not currently receive subsidies from the airport.

—By Michael Schachner

GM early retirement

To further trim its payroll, ailing General Motors Corp. is offering salaried employees 52 or older a six-week window during which they can retire with full retirement benefits.

Starting earlier this month and continuing through year end, salaried employees with at least 10 years of service are eligible to receive "unreduced" benefits upon retirement. The vehicle manufacturer does not add age or years of service in the calculation of retiree benefits.

Normally, GM freezes pension benefits earned by vested employees who leave the company before age 62 until they reach age 65.

The company would not say how many people are eligible for the plan.

The new offering comes only months after GM concluded an early retirement program for salaried employees age 53 or older (*BI*, Feb. 10).

Designed to cut the payroll by about 9,000, that offer was accepted by 10,000 employees in Canada and the United States.

The company still wants to cut its 81,000-member white-collar workforce by another 10,000 by the end of 1993.

—By Michael Schachner

Benefit Beat

Managed care on campus

Nearly three-quarters of U.S. colleges and universities now offer some type of managed care health plan, according to a recent survey.

Seventy-two percent offer managed care plans to their employees, said Hewitt Associates, which surveyed about 260 educational institutions.

Most colleges—60%—offer employees a health maintenance organization, although few actively encourage enrollment, the survey reported.

Almost three-quarters of colleges and universities offering HMOs neither encourage nor discourage enrollment. Of those that do encourage enrollment, 15% do so by competitively pricing HMO contributions, the survey noted.

A median of about 40% of eligible employees now opt for coverage through an HMO, Hewitt found.

Only 6% of the colleges and universities surveyed offer point-of-service plans. However, 10% plan to offer the option within the next two years, while the remainder said they are not considering the option.

Most schools don't offer a point-of-service plan because it is not offered by insurers or managed care companies in their area, said Mark Nelson, a Hewitt consultant.

Of the schools offering point-of-service plans, most said administrative costs did not increase. Annual administrative costs ranged from $264 to $480 per employee.

"I was surprised there was no change in their administrative costs" because point-of-service plans are usually more expensive than other types of health benefit plans, Mr. Nelson said.

Meanwhile, the study found that only 31% of colleges and universities surveyed offer preferred provider organizations. Sixty-nine percent said they did not offer a PPO, and just 4% said they are considering offering the plan option within the next two years.

Of the schools offering a PPO, 92% offer only one, the survey

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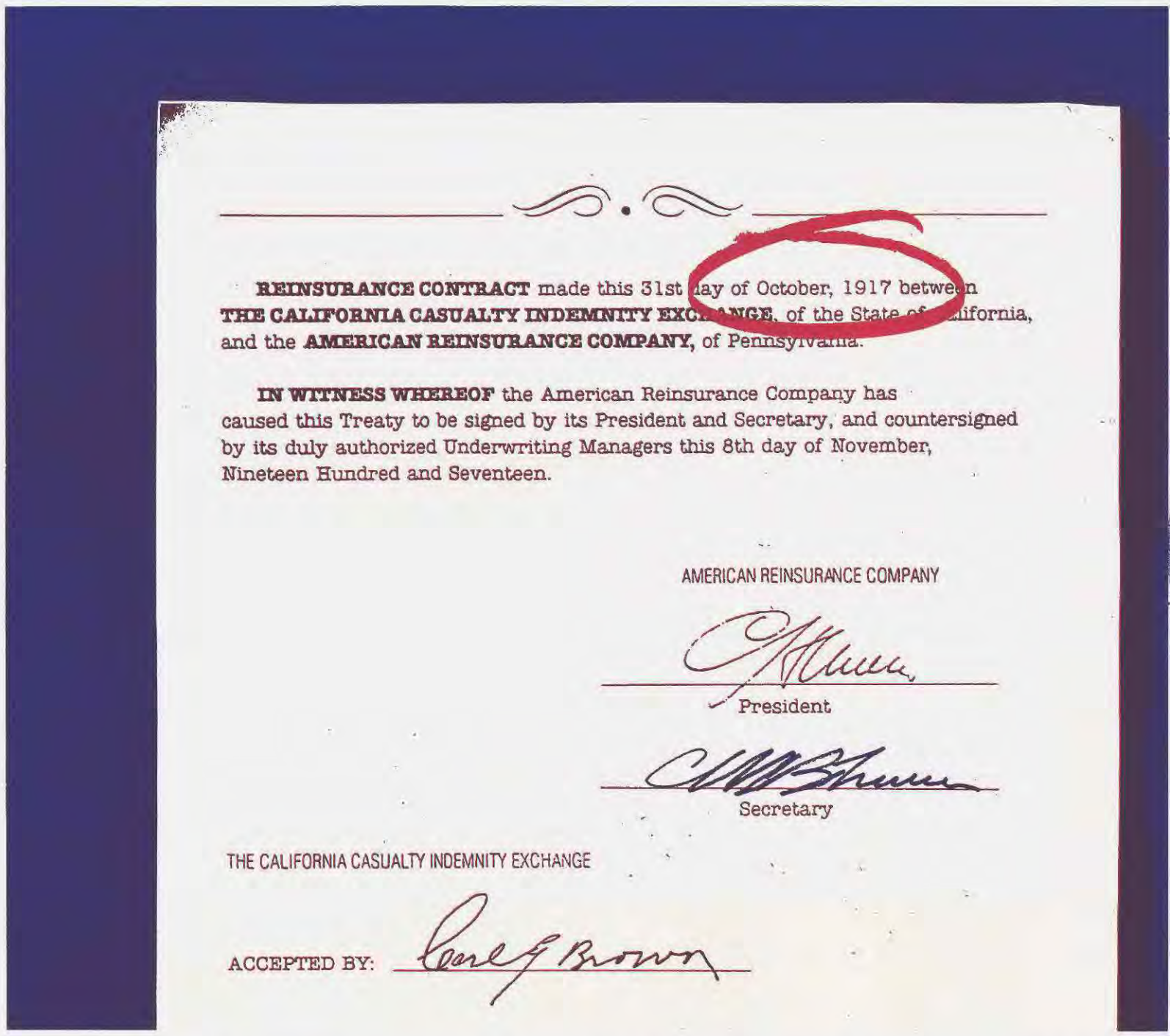

REINSURANCE CONTRACT made this 31st day of October, 1917 between **THE CALIFORNIA CASUALTY INDEMNITY EXCHANGE**, of the State of California, and the **AMERICAN REINSURANCE COMPANY**, of Pennsylvania.

IN WITNESS WHEREOF the American Reinsurance Company has caused this Treaty to be signed by its President and Secretary, and countersigned by its duly authorized Underwriting Managers this 8th day of November, Nineteen Hundred and Seventeen.

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President

Secretary

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In 1917, we first put our pen to this treaty. In 1992, after seventy-five years of a mutually beneficial relationship, they've renewed with us again. In fact, over half of our clients have been with us 20 years or longer. Formed to underwrite Workers' Comp for coal miners in Central Pennsylvania, we are now a multi-line, multi-national corporation with assets over $ 3.8 billion.

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Continued from previous page
found. The median participation rate for such plans is about 50%.

Most of the 38 schools responding to a question on PPO savings said adding a PPO did not produce savings—42% said costs were unchanged and 18% said their costs actually increased. Only 40% of respondents said health costs decreased, while the average decrease was 6%.

Hewitt also found that more colleges and universities are offering managed mental health and managed prescription drug programs.

Forty-four percent of schools offer some type of managed mental health service, including employee assistance programs, psychiatric utilization review and managed mental health networks.

Most schools could not say how much money, if any, these programs saved.

However, 37% of the schools with mental health utilization review programs did say they experienced savings, while 19% said they saved money through an employee assistance program, and 18% reported that they cut costs with their mental health network.

Average per capita health care costs and health plan cost increases closely mirror those of employers in general, the survey found. The average annual cost per employee increased 12% to $3,169 for 1992 from $2,825 in 1991.

Copies of the study, "College and University Experience in Managed Care 1992," are available for $75 by calling Diane Schuett at Hewitt Associates, 708-295-5000.

—By Christine Woolsey

For the Record

SAFR Reinsurance receives capital boost

NEW YORK—SAFR Reinsurance Corp. of the U.S. has received a capital contribution of $27.5 million from its parent, SAFR North America Corp.

The contribution boosts the reinsurer's capital and surplus to $86 million as of Sept. 30, 1992, according to the company.

The New York-based reinsurer ultimately is owned by Societe Anonyme Francaise de Reassurances in Paris.

Insurers to settle poultry plant claims

RALEIGH, N.C.—Three insurers have tentatively agreed to pay $16.1 million to settle general liability claims stemming from a 1991 fire that killed 25 workers at a processing plant in Hamlet, N.C.

Under an "agreement in principle," Crum & Forster Inc. unit U.S. Fire Insurance Co. will pay $15 million, American International Group Inc. will pay $1 million and Liberty Mutual Insurance Co. will pay $100,000 to settle the claims, said an attorney representing the victims' families. The three companies insured now-defunct Imperial Food Products Inc. of Atlanta, which operated the plant.

North Carolina law permits workers to sue their employers outside of the workers compensation system if the employers permit conditions "substantially certain " to injure workers. Investigators determined that locked exits and other safety violations prevented workers from escaping (*BI*, Sept. 9, 1991).

Insurer seeks to limit drawbridge liability

CHICAGO—After advancing $2.5 million to fix a downtown drawbridge after a freak accident, an insurer is now seeking a court order that could limit its liability.

In a lawsuit filed in state court last week, Northbrook Property & Casualty Insurance Co. seeks a judgment that the policy it wrote for a contractor doing repair work at the time of the accident covers only "betterments and improvements," not routine repairs. Northbrook is asking the court to order a refund of any of the $2.5 million not used for those purposes.

Both the City of Chicago and the contractor—a joint venture of F.H. Paschen Group/Meccor Industries—claim that the full repair costs should be covered under the policy.

One leaf to the drawbridge has been raised since the freak accident in September (*BI*, Sept. 28).

Northbrook also contends that if its policy does indeed cover the entire project, the city and contractors are underinsured, which would violate a "need for adequate insurance" provision in the policy and therefore limit Northbrook's responsibility.

Drexel coverage suit dismissed by court

NEW YORK—Fidelity insurers do not have to pay hundreds of millions of dollars in claims stemming from illegal acts by Drexel Burnham Lambert Group Inc. or former employees Michael Milken and Dennis R. Levine after a suit by the fallen securities powerhouse was dismissed last week.

Drexel could still re-plead some counts unrelated to the Milken and Levine claims, said New York Supreme Court Judge Edward J. Greenfield.

The firm was trying to recover $140 million to $475 million to pay losses related to the two high-profile securities felons, said Robert B. Budelman Jr. of Sedgwick, Detert, Moran & Arnold in New York. He represented Vigilant Insurance Co.

Mr. Milken is now in a federal prison for six securities-related felonies (*BI*, Feb. 24). Mr. Levine was recently released from prison.

Insurers successfully argued that Drexel knowingly violated securities laws before any of the fidelity bonds were issued. They also said it would be against public policy to allow Drexel to recover the fines and penalties it was required to pay the government, Mr. Budelman said.

A lawyer for Drexel would not comment.

Some other insurers involved were: Aetna Casualty & Surety Co.; Home Insurance Co.; National Union Fire Insurance Co. of Pittsburgh, Pa.; North River Insurance Co.; Reliance Insurance Co.; and underwriters at Lloyd's of London.

OSHA seeks comments on safe crane operation

WASHINGTON—Federal labor authorities are seeking public input on their plans to upgrade safety standards for crane operators.

Send comments, in quadruplicate, by Feb. 12, 1993, to the Occupational Safety and Health Administration Docket Officer, Docket No. S-400, Room N2634, 200 Constitution Ave. N.W., Washington, D.C. 20210.

Attached to and forming part of Reinsurance Agreement No. 620-0056 made and entered into by and between the AMERICAN RE-INSURANCE COMPANY, Princeton, New Jersey (hereinafter and thereinafter called the "Reinsurer") and THE CALIFORNIA CASUALTY INDEMNITY EXCHANGE, the CALIFORNIA CASUALTY INSURANCE COMPANY, CALIFORNIA CASUALTY & FIRE INSURANCE COMPANY and CALIFORNIA CASUALTY GENERAL INSURANCE COMPANY, all of San Mateo, California.

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Opinions

Pension issues a priority too

WHILE THE INCOMING Clinton administration has promised to make health care reform a top priority, we hope the new administration also will provide strong leadership to solve a slew of pension problems.

One of the first things the new administration can do on the pension front is endorse and press for speedy passage of a pension simplification package approved twice by Congress but vetoed on both occasions by President Bush because of objections to other parts of the legislation.

The simplification provisions are modest, such as making it easier for employers to run Internal Revenue Service non-discrimination tests on their 401(k) plans and slightly easing the administrative burden of complying with a new 20% withholding tax on many pension distributions.

While the simplification provisions may make only a small dent in the mass of complex pension rules and regulations that have accumulated over the years, enactment of the provisions will at least deliver a message to employers that government is serious about easing, not adding, to employers' compliance burden.

Similarly, we hope the Clinton administration takes a long look at the package of pension nondiscrimination rules that the IRS now is redrafting. Howls of protest, rightly so, came from employers when an earlier package—far too complex and poorly drafted to boot—was released last year.

Since then, the IRS has proposed certain modifications to make those rules somewhat less obtuse, but further improvements are needed.

President-elect Clinton also will inherit a problem that the Bush administration made little progress in resolving: shoring up the financial base

of the Pension Benefit Guaranty Corp.

To be fair to the outgoing administration, it did develop legislation to better protect the agency from being hit with big losses from terminations of underfunded pension plans.

But the administration was unable to generate much interest in Congress in the legislation or to line up a significant number of powerful congressional allies to back and push for passage of the legislation.

We hope the new administration proves more skilled than its predecessor in working with Congress to develop the bipartisan support that is necessary to get PBGC reform legislation passed.

Letters

Family leave would ultimately hurt employees

To the editor: In response to your Oct. 5 editorial regarding the president's veto of family leave legislation, perhaps Congress made a well-intentioned effort to ease the pressures between families and careers by passing the family leave bill. However, what most workers don't realize is that the legislation would have hurt a vast majority of American workers, including some of those it aims to benefit.

Employers and employees currently negotiate benefit packages that ideally benefit both parties. Federal law does not interfere in these employer-employee negotiations; instead, it lets each business decide which benefits best suit its workplace.

In 1989, benefits comprised about 30% of employee compensation. Oddly enough, increased benefits, rather than wage increases, have been responsible for most of the growth in total compensation since 1987. If mandated family leave legislation were passed, it would change the process of employer-employee negotiating. Instead, the government would step in and insist that business offer a specific benefit to all workers. Employees would ultimately pay for this policy through the loss of jobs, lower wages or even the loss of other types of benefits.

The editorial suggests that family leave programs build morale and loyalty to the company. However, if a business has so much to gain, it would introduce a leave policy on its own.

Most advocates will cite Western Europe, where family leave benefits exist in almost every nation, as an example of how a national leave policy would work. However, between 1975 and 1985, only 2 million jobs were created in Western Europe, compared with 26 million in the United States. The numbers indicate the European market's problems with juggling too many labor costs and trying to meet the challenges of a changing workforce. This is not the time for Congress to stifle the American market with such regulations. Given the condition of the economy, I believe the public is more concerned with creating and maintaining jobs than comparing how we stack up with other countries on family leave policies.

Allowing flexibility in the workplace is the best way to address workers' needs and evaluate employers' ability to provide those needs. Mandating costly benefits, as Congress attempted to do with the family leave legislation, would simply strain the economy and add to recessionary pressures already burdening American businesses. Instead of assisting families, the bill passed by Congress would reduce parents' options, narrow the range of available benefits, reduce job creation and increase discrimination. We commend President Bush for making the right decision.

Jay Dee Shattuck
Chief Operating Officer
The Management Assn. of Illinois
Springfield, Ill.

Business Insurance welcomes letters from its readers. Please keep your comments as brief as possible. We reserve the right to edit letters for clarity or space. We will not publish unsigned letters. Send your comments to Letters to the Editor, Business Insurance, 740 N. Rush St., Chicago, Ill., 60611-2590.

Society cannot afford 'ridiculous' rulings

To the editor: Insurance legal decisions affect every aspect of social and economic activity in the United States.

There are well-established precepts of fundamental insurance law that must be followed if insurance is to fulfill its purpose of insuring. Society cannot tolerate nor can it afford the ridiculous findings that are being foisted on an unknowing populace; to wit, the 6th U.S. Circuit Court of Appeals' ruling in *Park-Ohio Industries vs. The Home Insurance Co.* (*BI*, Oct. 5).

The U.S. courts refuse to acknowledge that pollution is something totally separate and apart from an unintentional tort. Pollution, as excluded from general liability insurance, is and has been from Day 1 precisely the act of polluting the land, air or waterways with the intentional or expected release or discharge of pollutants or contaminants.

For the 6th Circuit, or any court, to disembowel the well-established precepts of insurance law is unconscionable.

If a product causes injury or damage after it enters the stream of commerce, then the manufacturer and all vendors are entitled to defense and indemnity under product liability coverage.

Richard K. Fox
Senior Consultant
R.K. Fox & Associates
Noblesville, Ind.

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Work comp costs

Continued from page 3

York.

Mr. Healey pointed out that while insurance buyers have concentrated on finding savings in risk financing and risk control, "generally speaking, we have abandoned the claims portion to the insurance companies or TPAs. The employer has not gotten involved in trying to manage workers compensation claims."

And intermediaries aren't much help. In most cases, they "don't have a clue about the claims process," he said. "Most employers don't have a clue. That's unfortunate because that's where all the money is."

Employers have to become "proactive in managing claims" in a workers comp environment that has become a "plaintiffs' system," Mr. Healey stressed. "Plaintiffs' attorneys are making a living off the workers comp system."

He advised employers to carefully choose a good intermediary and then to lean heavily on it.

"The broker's role has changed dramatically," he said. "He is now a very, very valuable part of your advisory team," and has to be knowledgeable about the complex financial aspects of a workers comp program.

Mr. Fowler of CIGNA said there has to be a proactive spirit of cooperation among insurance buyers, brokers and underwriters if workers comp costs are going to be brought under control.

Insurance buyers have to be "willing to intervene in the workers compensation loss process or medical care management process in order to bring costs under greater control," said Mr. Fowler. "I see no other alternative."

The tools at their disposal, he suggested, include things as simple as checking for "double-dipping," in which a claimant receives both group medical benefits and workers comp medical payments for a single injury.

Insurance buyers have to be 'willing to intervene in the workers compensation loss process or medical care management process in order to bring costs under greater control. I see no other alternative,' Mr. Fowler says.

Ultimately, Mr. Fowler speculated, something as radical as a single workers comp insurance product that covers all lost-time injuries may replace today's statutory system. Obviously, he noted, such a product is "some years away."

But as the system continues to deteriorate, such a one-product solution may be the kind of "radical reform that we have to move toward," he remarked. Despite his call for working together, Mr. Fowler was not optimistic that the workers comp system would see much improvement in the near term.

Coverage rates are inadequate in most states, Mr. Fowler said, because regulators have limited them.

"In my home state of Pennsylvania, the degree of rate inadequacy is now estimated at 52%. How do you reform a system that now charges half of what is estimated that the costs are?" he asked.

Workers comp losses account for approximately 40% of all the losses in the property/casualty insurance market, and the total underwriting loss has amounted to about $7 billion since 1989, according to Mr. Fowler.

"In the vast majority of states, workers compensation is a loser (for insurers)," he declared. And for insurers and employers, the worst is yet to come.

"I don't think you have seen anything yet in terms of what the ultimate cost and deterioration of this system will be.

"If costs continue to increase like they have so far for another five years—which is not at all improbable—your workers compensation costs could just about double from what they are today.

"So if you think it's bad now, I would tell you that it's going to get a lot worse," Mr. Fowler warned.

Regulatory changes on a state-by-state basis have done little to solve workers comp problems nationwide, he said. That means "you are forced into an arena to talk about more aggressive and fundamental reforms."

Some states are showing foresight in discussing such reforms, he noted. Florida and California are discussing 24-hour coverage, and "other states increasingly talk about it."

While 24-hour coverage means a lot of different things to different people, he remarked, "I would define it as a proactive partnership between employers and insurers to effectively contain workers compensation costs."

Construction contractors facing an "almost suicidally competitive marketplace," are looking to several areas to reduce workplace accidents and their related costs, according to Thomas M. O'Leary, senior vp and general counsel with The Pepper Cos. in Chicago.

One way The Pepper Cos. has targeted losses is with a post-accident drug and alcohol testing program, he said. When the program was started in 1986, approximately 30% of injured employees tested positive for drug or alcohol use after an accident, Mr. O'Leary pointed out.

"Now it's down to about 10%," he said.

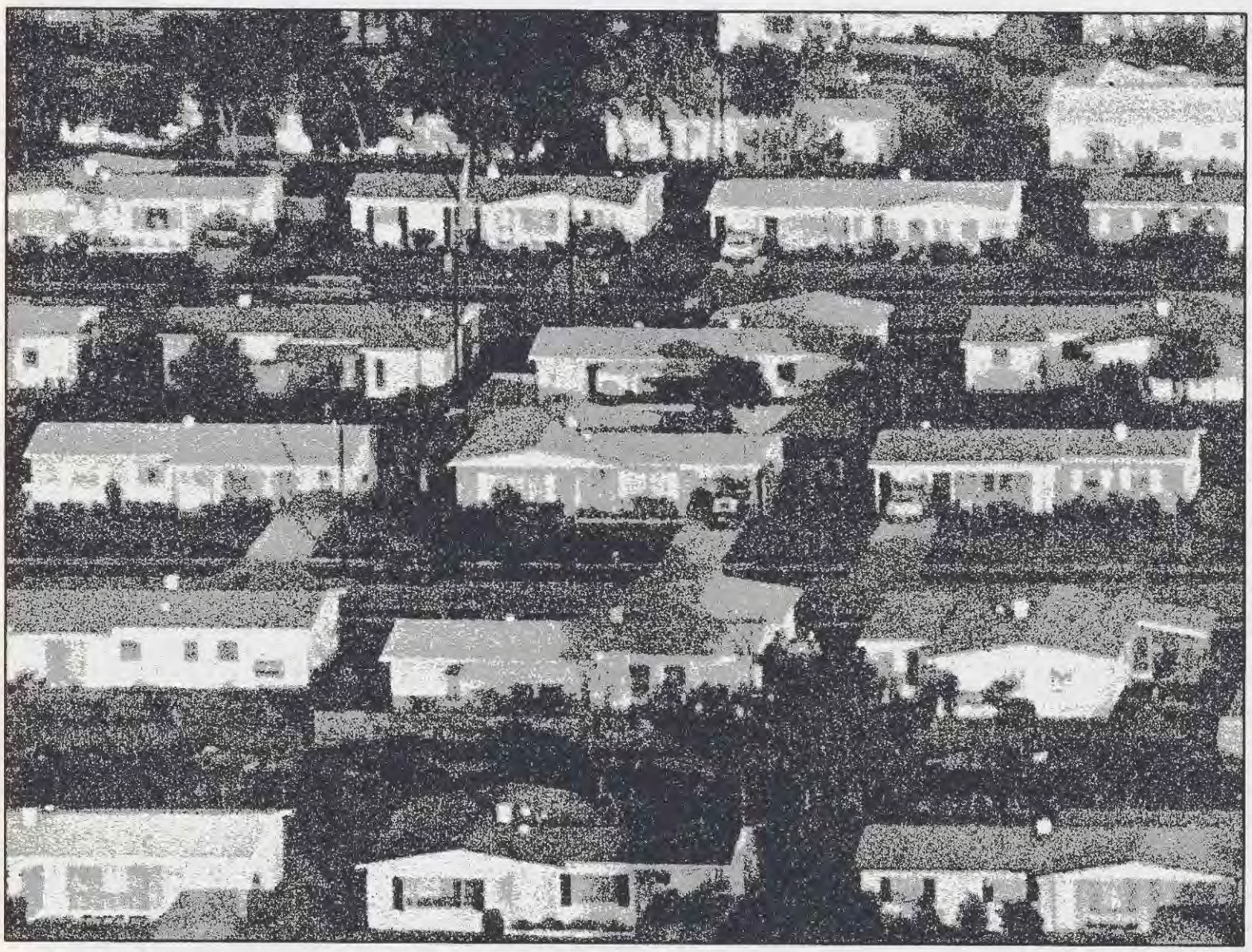
The contractor has a safety program written by its foremen for use in the field and holds an annual safety seminar for tradesmen that work more than 1,500 hours per year.

The company also is improving its awards program that is used as an incentive for employees to avoid accidents. Initially, an employee qualified for a gift after a certain number of injury-free hours.

But coffee mugs and down coats awarded in the summer were not being well-received, according to Mr. O'Leary. So now the company is implementing a U.S. savings bond incentive program that "I think is going to be much better-received," he said.

The panel discussion was moderated by William S. McIntyre, president of American Contractors Insurance Group Inc. in Dallas.

BI



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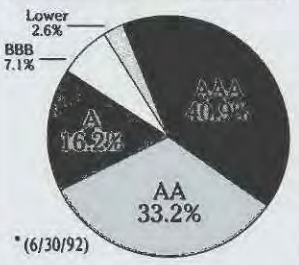

*(6/30/92)

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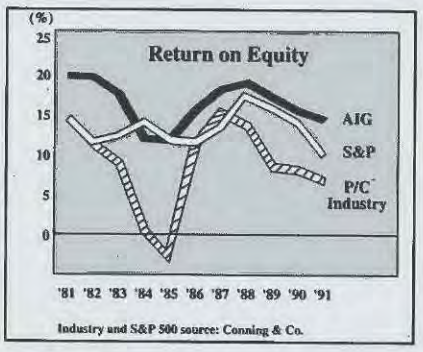

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The EPA under Clinton

Compliance dates may be accelerated

By MICHAEL BRADFORD

NEW ORLEANS—Under the Clinton administration, the Environmental Protection Agency is likely to tighten some regulations and could accelerate some compliance deadlines, an expert predicts.

"We will have a difference in what happens with respect to environmental matters," said Rodney J. Taylor, U.S. director of Sedgwick James Environmental Services in Nashville, Tenn.

Speaking this month at the annual Construction Insurance Conference, Mr. Taylor reminded his audience that vice president-elect Al Gore "has been declared an expert in the environmental area, and I expect that he will have a fair share in shaping the policies of the EPA."

Mr. Taylor said he expects "a bit tighter regulation than we've seen under the Bush administration" along with "a little more active enforcement of the regulations already on the books and perhaps some acceleration of deadlines that are already in place."

Many of those deadlines are related to "regulations which were stalled" by the President's Council on Competitiveness, said Mr. Taylor. That group tried to curtail regulations it believed would harm the economy.

Although the Clinton administration will somewhat affect EPA regulations, the agency's day-to-day operations probably will not change, Mr. Taylor predicted.

"The EPA was founded in 1970. It's gone through several administrators and several changes," but a lot of staffers have been there for a number of years, he pointed out. "There are people in staff functions in that organization that will probably stay in place despite the changes in the administration."

And legislation regarding environmental matters "is not that easy to change," Mr. Taylor emphasized. "It's not going to change overnight in spite of what anybody thinks ought to be done or what the mandate of the public seems to be in this election."

Regardless of who is in the White House or EPA offices, environmental liability issues will grow more complex, Mr. Taylor said.

Ten years ago, the major environmental issue for policyholders and insurers was determining what was covered under commercial general liability policies "with various forms of pollution exclusions," he said.

"Well, a lot has changed in the intervening years," he said. "We've had 10 years of activity under (the Comprehensive Environmental Response & Liability Act). We've had billions of dollars spent by both the government and private industry" to identify and clean up polluted sites.

He said the 1,500 sites on the Superfund priority list for cleanup are only the beginning. "There are probably as many as 220,000 sites at which hazardous materials may have to be cleaned up at some point in time."

Those cleanups are projected to cost $752 billion over 30 years. That is a "monumental number," said Mr. Taylor, "and one that will have a dramatic impact on all of us in the United States if we have to share that cost, which we obviously do."

Insuring such complex risks is difficult, he acknowledged, but there is no shortage of coverage.

"More insurance is available today than has been available in the last 10 years," Mr. Taylor said. "Insurance products are being developed at a rate that is truly encouraging. There are new products virtually every month and some of them have tremendous possibilities."

He mentioned a form of environmental directors and officers liability insurance as a new entrant in the market. The coverage provides protection to directors and officers against pollution-related claims and limits of up to $10 million.

Mr. Taylor listed other types of liability insurance available to cover environmental exposures for contractors, engineers and other businesses, including:

- Pollution legal liability, which provides coverage for third-party claims for bodily injury and property damage arising from a specified site. Limits of up to $40 million are available, with minimum premiums of $25,000 and minimum retentions of $25,000
- Pollution liability for contractors involved in remediation work. Limits of $10 million are available, with minimum premiums of $15,000 and retentions of $25,000.
- Errors and omissions insurance, which is purchased by engineering firms conducting studies or gathering data related to remediation efforts. The policy covers damages related to negligence, and limits of $10 million are available. Minimum premiums are $15,000, with minimum retentions of $25,000 required.
- Environmental remediation coverage for mandated cleanup of a polluted site. The policy pays for cleanup and remediation up to limits of $5 million. The minimum premium is $10,000 and the minimum retention is $25,000.

At least 18 underwriters provide coverage for pollution related to underground storage tanks, Mr. Taylor pointed out. Limits as high as $5 million are available, and the insurance covers cleanups required by law.

"(Don't) throw away your old CGL policies," he told policyholders. "They are still paying for claims as a result of cleanups, including claims for Superfund," advised Mr. Taylor. BI

Meeting draws 600 attendees to chilly Crescent City

NEW ORLEANS—Late fall weather turned crisp and wet as around 600 people gathered for the 12th annual Construction Insurance Conference.

The annual gathering of risk managers, insurers, brokers and others involved in the construction industry was centered at the Sheraton New Orleans, a stone's throw from the city's famed French Quarter.

Those who strolled into the Vieux Carre were dressed for rain as a cold front rolled into the Crescent City. But the weather didn't dampen their enthusiasm.

The 2½-day conference, presented by the International Risk Management Institute Inc., featured more than 25 different presentations on topics including workers compensation, environmental liability, the Americans with Disabilities Act, safety and loss control, bonding joint ventures and advanced risk financing techniques.

Speakers—including Quill O. Healey, chairman and chief executive officer of Sedgwick James Inc. and Caleb L. Fowler, executive vp of CIGNA Corp.—discussed the workers compensation insurance crisis.

Rodney J. Taylor, director of Sedgwick James Environmental Services, reviewed the market for environmental liability insurance and discussed changes that could result from a Democratic administration.

Next year's conference will be Nov. 8-11 in Nashville, Tenn. For more information, contact the International Risk Management Institute at 12222 Merit Drive, Suite 1660, Dallas, Texas 75251-2217; 214-960-7693.

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Wisconsin comp

Continued from page 2

Wisconsin ranked 30th out of 47 jurisdictions in 1989. In addition, Wisconsin employers' average premium per employee is 13% below the average premium in Georgia, which was the median of all jurisdictions, and 27% below the national average, the study finds.

"Wisconsin achieves this low cost to employers despite paying average benefits," Mr. Ballantyne said. For example, it is one of 23 states that pays 100% of the statewide average weekly wage as the maximum benefit for temporary total disability.

The system also is satisfactory from an injured employee's perspective because benefits are considered reasonable, according to Mr. Ballantyne. For example, average wage-loss benefits for a permanent partial disability claim ranked 10th highest in a survey of 50 states in 1991.

Wisconsin's basic, permanent partial disability benefit of $144 a week is "relatively low," compared to other states, he said. However, for some types of injuries, like some back injuries, Wisconsin's system pays benefits for up to 1,000 weeks, instead of the typical 420-week duration of benefits in many states, he said.

Mr. Ballantyne said Wisconsin has four secrets to its success:

• The system encourages employers and employees to focus on returning injured employees to work.

The system encourages employers to make timely offers of jobs paying at least 85% of pre-injury wages to employees with some types of permanent partial disabilities, like some back injuries. Employers that don't make such an offer within a prespecified time period must pay the worker benefits according to a higher benefit schedule.

And, the system encourages employees to accept such offers because permanent partial disability benefits are relatively low for those whose injuries do not take a long time to heal, he said. In addition, the system does not pay lump sum benefits under compromise and release agreements.

"Other reinforcing features include: unilateral termination of temporary total disability benefits by employers when employees reach maximum medical improvement; and the existence of disability evaluation guidelines, which reduce the number of minor permanent partial disability awards," Mr. Ballantyne said.

To be effective, these features should be implemented as a group, rather than individually, he added.

• Active involvement by the state workers comp agency reduces litigation and attorney involvement.

The state workers compensation division actively monitors and enforces the law, which often results in employers and insurers paying permanent partial disability benefits promptly, Mr. Ballantyne said.

The state division also strives to inform and protect unrepresented employees, which reduces litigation, he said.

"Despite its active posture, the Wisconsin agency's budget is quite low compared to many other states," Mr. Ballantyne said. "This suggests that the extra expenditure up front on dispute prevention more than pays for itself by saving resources that would later have to be spent on dispute resolution," he added.

• A system for assessing the extent of disability and resolving disputes about permanent partial disability benefits also reduces litigation.

For example, the system uses mandatory minimum impairment ratings. There also is "heavy" reliance on the treating physician to issue an impairment rating at the end of an employee's healing period, he said.

In an impairment dispute, the system essentially requires a judge to choose between the low impairment rating that is typically proposed by an employer and the high rating proposed by the employee. This approach prevents a judge from merely splitting the difference, as is often done in other states. It also limits the range of disagreement, Mr. Ballantyne said.

• Lower system costs and an orderly process for initiating change are more likely because management and labor representatives control the system.

The state's Worker's Compensation Advisory Council negotiates system changes and then recommends legislation to achieve those changes. Voting members of the council consist of five management and five labor representatives, each appointed to five-year terms.

Other interested parties—including insurers, attorneys, rehabilitation specialists and physicians—are allowed to air their views, but act only as advisers to the council.

Wisconsin's Legislature "reinforces this control by enacting labor and management agreements and shunning other proposals," such as reforms proposed by attorneys or physicians, Mr. Ballantyne said.

This continuous process results in evolutionary change, rather than letting problems fester until massive changes are needed.

Most employees in Wisconsin are generally satisfied with the system, observed Robert Glaser, assistant director of District 32 of the United Steelworkers of America in Brookfield, Wis., and an advisory council member. But labor would like to see changes, he said, including higher benefits and cost of living increases for permanent total benefits.

Most employers, too, are satisfied with the system, said John Metcalf, director of human resource policy for Madison-based Wisconsin Manufacturers & Commerce, a manufacturer trade group that serves as a de facto state chamber of commerce.

While states can learn a lot from Wisconsin, their ability to adopt its approach may be limited, one observer says.

"One of the main obstacles for replicating the Wisconsin experience in other states is the willingness of the Legislature to give up policymaking authority in this area and accept only recommendations of the advisory council," added Mr. Metcalf, an advisory council member.

"While the Wisconsin Legislature's deference to the labor/management group is unusual, it is not impossible for other states to adopt," said the WCRI's Mr. Ballantyne.

•

"Workers Compensation in Wisconsin: Administrative Inventory" will be available for $25, plus 5% tax for Mass. residents, in late November from the Workers Compensation Research Institute, 101 Main St., Cambridge, Mass. 02142, 617-494-1240.

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Pension suit

Continued from page 2

speculative, venture-capital investments or in maritime-related businesses that could create jobs for union members.

"Tower Asset had no experience with pension fund management," said participants' attorney David S. Preminger of Rosen, Szegda, Preminger & Bloom in New York.

The settlement, which was approved Nov. 2 by U.S. District Court Judge Vincent L. Broderick, is expected to restore approximately two-thirds of plan participants' losses.

Judge Broderick also issued an injunction greatly restricting the union pension plans for 10 years. For the next five years, they must be run by independent fiduciaries. After that, trustees for the two plans must follow guidelines and procedures detailed in the settlement agreement.

Also as part of the settlement, plan trustees Robert Lowen and Lloyd Martin, former president and vp of MM&P, have agreed to resign as trustees or service providers of the plans and not to serve in those capacities with any plans governed by the Employee Retirement Income Security Act in the future.

Former union Secretary/Treasurer Allen Scott also has agreed never to serve as a trustee or service provider to the plans, and other trustee defendants have agreed to comply with the fiduciary standards of ERISA for the next 10 years.

"It's a good representative case to illustrate the broad reach of ERISA in both imposing and enforcing fiduciary duties," observed John Berringer, a lawyer specializing in ERISA.

"And, to the extent that the settlement is funded by insurance proceeds, it's just another reminder to plan trustees involved in similar situations to study their insurance policies," said Mr. Berringer, who is with Anderson, Kill, Olick & Oshinsky in New York.

"Pension plan officials must pay attention when hiring and monitoring investment managers or risk serious consequences," said David George Ball, assistant secretary of the Labor Department's Pension and Welfare Benefits Administration. The Labor Department had also sued the pension plan trustees and administrators.

Tower Asset Management, which was terminated as a manager in November 1985, is contributing $250,000 to the settlement.

Insurers for the plan trustees are paying a total of $12.75 million. Aetna Casualty & Surety Co., which provided fiduciary liability coverage in 1983-1984, will pay $7.5 million, and Republic Insurance Co., the fiduciary liability insurer in 1985, will contribute $5.3 million. Both figures were provided by Mr. Preminger, the plan participants' attorney.

Meanwhile, Federal Insurance Co., a unit of Chubb Corp., will pay $2 million on behalf of American President Lines, one of the companies contributing to the pension plans.

Attorneys for the plan, who were trustees and allegedly violated their fiduciary duties, and their insurers will pay $5.3 million. The defendant lawyers' counsel declined to comment on insurance.

Other parties to the settlement include: Marine Midland Bank, which was custodian for one of the plans and will pay $2 million; and the former auditor for both plans, Waldbaum Rockewer & Co. of Philadelphia, which will pay $1.6 million.

Waldbaum, which has since dissolved, was insured by First State Insurance Co.

At the center of the case is the appointment of Tower Asset to manage $15 million in assets of the Individual Retirement Account Plan, one of the two union retirement plans.

Another $9.5 million in IRA plan assets was entrusted to Tower Asset in 1984. That same year, trustees for the Pension Plan, a defined benefit plan, put $6.5 million under the firm's management.

Eventually, one-half of the two plans' assets was under Tower Asset management, according to Mr. Preminger.

The IRA plan, a defined contribution plan, suffered the bulk of the losses and will receive $24 million of the settlement money, according to Jeffrey Lewis of Sigman & Lewis in Oakland, another lawyer for the plan participants.

The Pension Plan, which was not so seriously hurt by the mismanagement, will get the remainder of the money.

Before the out-of-court settlement, Judge Broderick ruled that Tower Asset Management had violated ERISA by receiving stock or investment banking fees from companies in which it had invested plan assets.

In 1987, the court entered a judgment requiring Tower Asset Management and its principals, Andrew Levy, Samuel Kovnat and W. Randolph Wheeler, to repay the plans $1.1 million in fees and other property they received in this manner.

That ruling was affirmed by the 2nd U.S. Circuit Court of Appeals.

Also in 1987, a federal magistrate, Naomi Reice Buchwald, ruled that the plans had lost approximately $28 million in principal and income as of 1985-1986 due to the poor performance of investments made by Tower Asset.

In 1991, the court entered an injunction against Tower Asset Management and its former principals barring them from ever serving as investment managers for providing services to any pension plans covered by ERISA.

Two plan participants—Andrew Cullen and Peter McGuire—brought a class-action suit in April 1986, charging that the plan trustees and administrator had violated ERISA requirements to act prudently and solely in the interests of plan participants. Several months later another suit made similar claims. The two suits were later consolidated.

Soon after, in April 1987, the Labor Department filed a suit that made similar charges.

Additional lawsuits were filed against the former auditor of the plans, charging that it was negligent in its review of the Tower Asset Management portfolio, and against Marine Midland Bank, the former custodian bank to the IRA plan, charging that the bank failed to inform the plans about irregularities in the Tower Asset portfolio.

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In re Masters, Mates & Pilots IRAP Litigation, U.S. District Court for the Southern District of New York, No. 85-CIV-9445 (VLB).

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HEALTH CARE MANAGEMENT CONFERENCE AGENDA

WEDNESDAY, JANUARY 13

6:00 p.m.–7:30 p.m. *Early Registration and Cocktail Reception*
Hosted by The Upjohn Company

THURSDAY, JANUARY 14

7:45 a.m. *Continental Breakfast & Registration*

9:00 a.m. OPENING REMARKS BY CONFERENCE CHAIRMEN

Kathryn J. McIntyre
Publisher/Editorial Director
Business Insurance

James M. Burcke
Editor
Business Insurance

9:15 a.m. LATEST DEVELOPMENTS IN HEALTH MAINTENANCE AND PREFERRED PROVIDER ORGANIZATIONS

This panel discussion, moderated by James Burcke of Business Insurance, will focus primarily on the impact managed care has had on the delivery and financing of health care and on the range of options now available to employers. The panel will analyze the following models in terms of their ability to deliver affordable quality care:

- ▶ *Exclusive Provider Organizations*
- ▶ *Point-of-service plans*
- ▶ *Managed fee-for-service*
- ▶ *Utilization review*
- ▶ *Specialty networks*

Moderator:
James M. Burcke
Editor
Business Insurance

Larry Goelman
President & Chief Executive Officer
Cost Care, Inc.

Chip Sharkey
Senior Vice President,
National Marketing
Cigna Corporation

Ed Zalta
Chairman of the Board
& Chief Executive Officer
CAPP CARE, INC.

10:30 a.m. *Mid-morning Refreshments & Table-Top Exhibits*

11:00 a.m. SPECIAL PRESENTATIONS ON THE NEXT GENERATION OF MANAGED CARE

New models are in the making as managed care continues to evolve and establish itself as the preferred approach in delivering quality care at an affordable cost. Two distinguished experts in the health care field will share their perspectives and insights on the future direction of managed care and what the implications are for purchasers in the health care marketplace.

Joseph W. Duva
Partner
Ernst & Young

Jacque J. Sokolov, M.D.
President
Sokolov Strategic Alliance

12:15 p.m. *Luncheon for Speakers and Attendees*
Hosted by John Hancock Financial Services

1:00 p.m. KEYNOTE LUNCHEON SPEAKER

Stephen M. Wilder
Assistant Treasurer, Risk Management
Walt Disney Company

1:45 p.m. *Break*

2:00 p.m. ***Concurrent Session A:***
DIRECT CONTRACTING: SELECTING AND STRIKING A DEAL WITH A HOSPITAL

- ▶ *Selection criteria*
- ▶ *Negotiating and cutting the deal*
- ▶ *Case Studies: State of Utah and Safeway, Inc.*

Linn J. Baker
Director – Public Employees
Health Program
State of Utah

Nancy Hughes
Group Insurance Manager
Safeway, Inc.

Dr. Arnold S. Milstein
Managing Director
William M. Mercer, Inc.

2:00 p.m. ***Concurrent Session B:***
WORKERS COMPENSATION WORKSHOP: APPLYING MANAGED CARE TECHNIQUES TO CONTAIN WORKERS COMPENSATION COSTS

- ▶ *The range of services required*
  - • *Specialized networks*
  - • *Case management*
  - • *Practice guidelines*

HEALTH CARE MANAGEMENT CONFERENCE AGENDA

▶ *Fraudulent claims: Who is the culprit?*
- *Closing the loopholes*
- *Implementing a prevention program*

▶ *The working model*

Charles Jacobs
President
InterQual, Inc.

Jerry A. Miccolis
Vice President & Workers Compensation
Practice Leader
Towers Perrin

Ed Zutler
President
FHP Insurance Group

3:30 p.m. *Mid-afternoon Refreshments & Table-Top Exhibits*

4:00 p.m. **HEALTH CARE COALITION UPDATE**

As organizations committed to purchasing quality health care for their members and as lobbyists for health care reform, coalitions have spearheaded research projects that have been at the forefront in exploring creative solutions to the health care crisis. Ms. Hubers of The Alliance will discuss how employers can purchase health care based on value. Ms. Powers of the Bay Area Business Group on Health will outline current projects, with special emphasis on the coalition's preventive care initiatives.

Debra Hubers
Director of Marketing
The Alliance

Patricia E. Powers
Executive Director
Bay Area Business Group on Health

5:00 p.m. **COCKTAIL RECEPTION**

FRIDAY, JANUARY 15

7:45 a.m. *Continental Breakfast & Table-Top Exhibits*

9:00 a.m. **REMARKS FROM THE CHAIR**

9:15 a.m. **THE AIDS/HIV CRISIS: ONE EMPLOYER'S RESPONSE**

With no cure in sight, AIDS has challenged employers to respond to a worldwide epidemic that is affecting all aspects of corporate life and the bottom line. Digital Equipment Corporation has established and implemented a coordinated, integrated strategy on behalf of all employees and their families. Worldwide in scope, Digital's HIV/AIDS program encompasses education and outreach that has increased productivity, maintained excellent employee relations and contained health care costs.

Paul A. Ross, Ed.D.
Corporate Manager,
HIV/AIDS Programs
Digital Equipment Corporation

10:00 a.m. *Mid-morning Refreshments & Table-Top Exhibits*

10:30 a.m. **PREVENTIVE CARE: INTEGRATING PREVENTIVE CARE INTO BENEFIT PROGRAMS**

▶ *Financial incentives to promote healthy behavior*

▶ *The ingredients of a successful wellness program*

▶ *Effective employee communication*

Michael Fox
Managing Consultant
A. Foster Higgins & Co.

Lynn Gilfillan
Community Wellness Development
Coordinator
Coors Brewing Company

Allen Iampaglia
Risk Manager
City of Glendale, Arizona

11:30 a.m. ***Concurrent Session A:***
NEW DIRECTIONS IN FLEXIBLE BENEFITS

▶ *New ways to manage flexible benefits administration*

▶ *Flexible benefits for retirees*

Larry Atkins
Manager, HR Systems
Barnett Banks, Inc.

Sally Gottlieb
Manager of Benefits Administration
Apple Computer, Inc.

11:30 a.m. ***Concurrent Session B:***
BALANCING QUALITY AND COST IN PRESCRIPTION DRUG BENEFIT PLAN DESIGN

▶ *Critical factors in plan design*
- *Quality versus cost in prescription drug benefits*
- *Appropriate drug utilization review*
- *Patient-focused pharmaceutical care*

▶ *Coordinating a full service pharmaceutical benefit*

▶ *Utilizing mail-service in combination with pharmacy networks*

James Heenan
Director, Corporate Accounts Sales
The Upjohn Company

12:30 p.m. *Luncheon for Speakers and Attendees* ***Hosted by FHP, Inc.***

1:15 p.m. **KEYNOTE LUNCHEON SPEAKER**

Frank McArdle
Partner
Hewitt Associates

1:45 p.m. *Break*

2:00 p.m. **AN IN-DEPTH LOOK AT THE CANADIAN HEALTH CARE DELIVERY SYSTEM**

With the health care crisis continuing unabated, the United States has looked with increasing interest to other nations' health care delivery systems. The Canadian health care system has received considerable attention for its ability to deliver universal health care.

Dr. Robert M. MacMillan
Executive Director
Health Insurance Division
Ministry of Health, Ontario

2:45 p.m. **DEBATE ON THE CANADIAN SYSTEM**

Dr. Anthony R. Masso
Vice President, Managed Care and
Insurance Products
Health Insurance Association of America

Howard Weizmann
Vice President
Aetna Benefits Consulting Practices
Aetna Life & Casualty

3:30 p.m. **END OF CONFERENCE**

▶ **HOW TO REGISTER:** Register for The *Business Insurance* Winter Health Care Management & Cost Containment Conference in one of three easy ways:

1. Telephone IBF Conferences at (516) 229-2375, or
2. Fax your registration to us at (516) 229-2386, or
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▶ **VENUE:** Hotel del Coronado
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IBF CONFERENCES

Health care vision

Continued from page 3

comprehensive health care system. In turn, society will assume the financial cost of the system "and recognize that the equal participation of some requires subsidization by others," according to the paper.

In addition, the group would like to see an emphasis on educating young people about their responsibility for personal health so they will make more appropriate choices with regard to personal behaviors, health care providers and therapies.

With health rights ensured by the system, individuals would be required to assume additional responsibilities for their own health habits and how they impact others and the system itself.

Government will be "a major source of financing and the principal vehicle for subsidies for care," the group says.

In addition, government will monitor "the health care system to detect deficiencies and institute corrective action."

The Belmont Vision is "based on the principle of wiser use of funds, rather than increased total funding."

By eliminating the many "perverse incentives" that currently exist, like defensive medical practices, unregulated fees-for-service and cost shifting, newly available funds can be reallocated.

The Belmont Vision may help businesses shift their focus from health care to health, said Lawrence S. Lewin, chairman of Lewin/ICF Health and Income Group, a public policy and health care consulting firm in Fairfax, Va.

Employers with employee assistance programs that have emphasized "overall worker productivity have found that this is a good investment," he said.

Just as important, the vision calls for a nation that pools risks rather than segments them, Mr. Lewin said.

"The underlying premise of competition" between insurance companies "is now considered inappropriate," Mr. Lewin said.

In the past, insurance companies have been encouraged to compete in a system where success was measured by covering "the most people with the fewest health care cost expenditures."

If risk avoidance is taken away from insurers, "what's left for them to do is to build systems and structure payment incentives so that care is managed," Mr. Lewin said.

Insurers will be "far more skilled at managing risk rather than avoiding it," he said.

The health maintenance organization that operates on a capitated basis is one model "embracing managed care control technologies" that more traditional insurers should examine, Mr. Lewin said.

The project was sponsored by a group of pharmaceutical companies that commissioned the Institute for Alternative Futures, a non-profit think tank, to direct the project. The Belmont Vision was named for the conference center in Baltimore where the experts met for two days to organize their thoughts.

Members of the project, in addition to Messrs. McNerney and Lewin, include Rick J. Carlson, president of the Health Strategies Group in Washington; Paul M. Ellwood, founder and president of Interstudy, a managed care research firm, and clinical professor of Neurology, Pediatrics, and Physical Medicine and Rehabilitation at the University of Minnesota in Minneapolis; Amitai Etzioni, professor at George Washington University in Washington; Willis B. Goldbeck, founder of the Washington Business Group on Health and a consultant to the European Regional Office of the World Health Organization and other health care organizations; Rep. Bill Gradison, R-Ohio; Kathryn E. Johnson, president and chief executive officer of The Healthcare Forum in San Francisco; Dr. John Kitzhaber, president of the Oregon Senate; Dr. C. Everett Koop, a professor at Dartmouth College in Hanover, N.H., and former U.S. Surgeon General; Donald R. Lee, vp of professional affairs for Proctor & Gamble Pharmaceuticals and chairman of the National Pharmaceutical Council.

Other members are Robert D. Ray, president and chief executive officer of Blue Cross & Blue Shield of Iowa and former Iowa governor; Trish Riley, executive director of the National Academy for State Health Policy in Portland, Maine; Baltimore Mayor Kurt L. Schmoke; Dr. Samuel O. Thier, a physician and president of Brandeis University in Waltham, Mass.; Dr. Hugh H. Tilson, director of the division of Epidemiology, Surveillance an Pharmoeconomics at Burroughs Wellcome Co. in Research Triangle Park, N.C.; Dr. Reed V. Tuckson, a physician and president of Charles R. Drew University of Medicine and Science in Los Angeles; and Gail L. Warden, president and chief executive officer of Henry Ford Health System in Detroit.

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Single copies of "Healthy People in a Healthy World: The Belmont Vision for Health Care in America" are available at no charge. Contact the Institute for Alternative Futures, 108 N. Alfred St., Alexandria, Va. 22314; 703-684-0640.

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On a warm afternoon in August, Jeremy Masters came home.

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InsurerTopics

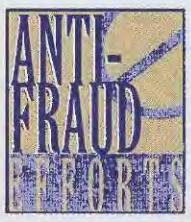
A special editorial section sent exclusively to insurers and reinsurers

Curbing a costly problem

Insurers and government rev up efforts to stop auto theft-related fraud

By SALLY ROBERTS

Every 19 seconds, somewhere in the United States, there is a car theft.



About 1.7 million car thefts were reported last year alone. But, the National Insurance Crime Bureau says 15% of vehicle theft claims are fraudulent. That would mean 255,000 of the 1991 claims were bogus.

Fraud involving auto theft is in part responsible for many insurers' underwriting losses, said Frank Hall, senior claims consultant for State Farm Insurance Co. in Bloomington, Ill. Insurers shift these losses to consumers in the form of higher comprehensive automobile insurance premiums, he said.

Such fraud "has a very significant impact on the insurance industry and on consumers," agreed Gary Mellini, auto director in the claims department at Allstate Insurance Co. in Northbrook, Ill.

"It's a drain on society," he added.

Insurers recognize that fraud stemming from auto thefts is a big problem and have implemented anti-fraud efforts.

Still, total reported thefts keep rising. For example, 1991's reported 1.7 million auto thefts was a 1.6% increase from 1990 and a 6.2% increase from 1989, according to the NICB.

And, while the NICB does not estimate the financial impact of auto theft on insurers, it does estimate the total value of motor vehicles stolen in 1991 at nearly $8.3 billion.

Car theft is "big business," said Timothy Goggin, superintendent-special investigations unit at Nationwide Mutual Insurance Cos. in Columbus, Ohio.

"There is lots of money out there that's being siphoned illegally by criminals," he added.

Despite continuously rising auto thefts, recent developments—both legislative and technological—have given many insurers hope that auto theft will soon decrease.

More people are becoming aware of the problem and the government is "finally waking up and doing something" about it, Mr. Goggin said.

Some companies have decided to take action. Eight insurance companies and numerous other companies and associations formed a coalition to lobby for an anti-car theft act. The insurers are GEICO Corp., ITT Hartford Group Inc.; Kemper National Insurance Cos., Liberty Mutual Insurance Co., Nationwide Mutual Insurance Cos., Progressive Insurance Group, State Farm Insurance Co. and Travelers Corp.

Their effort was a success: President Bush signed the Anti-Car Theft Act into law on Oct. 26. Among other things, the act requires new passenger vehicles' vehicle identification number to be permanently marked on its engine, frame, transmission and other major parts.

Currently, the VIN is generally only marked on the dashboard and the body.

According to a summary of the bill, removing or altering such markings is also a federal crime.

"The VIN marking is a tremendous help to the industry," Mr. Goggin said.

One common form of auto theft fraud is stealing a car, stripping its parts and then selling the parts on the open market, Mr. Mellini explained.

"The sum of the parts is two to three times the value of the whole car," he said.

The law aims to reduce the number of stolen parts. Parts with a VIN engraved are now considered contraband, and anyone selling them is committing a felony, he said.

The new Anti-Car Theft Act will also discourage export fraud, another popular form of auto fraud, according to the NICB.

In this type of operation, scam artists first obtain a bank loan, then purchase a vehicle, insure it to the fullest extent and export it. They then report the vehicle stolen to police and to the insurer and later receive the proceeds from conspirators who sell the vehicle overseas, the NICB said.

The new law directs Customs officials to conduct spot checks of cars and containers leaving the country.

These checks, though, are imperfect. Thieves buy cargo boxes, put two stolen cars inside and label it as household goods. Officials usually do not check the box, explained the NICB spokesman.

But under the new bill, U.S. Customs is directed to conduct a pilot study to explore X-raying outgoing containers for stolen vehicles.

Simply weighing the boxes could curtail some illegal exporting, the spokesman added.

One way the law aims to curb fraud is tougher penalties. It doubles the maximum sentence to 10 years for the export or import of, transportation of, and sale or receipt of stolen vehicles.

Another vehicle theft-related fraud is the "owner give-up" method in which an owner uses a middleman to have his vehicle "stolen" and disposed of.

Once the owner has waited a discreet amount of time, he or she collects the insurance money while the "stolen" car's parts are sold to salvage yards and auto shops.

In another type of owner give-up scam, a person abandons the vehicle on the street, expecting that it will be stripped for parts, stolen, or taken to the pound and destroyed. Shortly after abandoning the vehicle, the owner reports the auto as missing to the police and to the insurance company and collects on the claim.

"The only thing that can be done about this is joint undercover operations," the NICB spokesman said.

And many insurance companies take part in the undercover or sting operations.

For example, State Farm Insurance Cos. takes part by furnishing cars to undercover detectives in local law enforcement agencies, Mr. Hall said.

Allstate's Mr. Mellini said his company also donates cars in sting operations, while Nationwide Insurance Co. goes as far as providing undercover claimants. "We use as many tools as we can to meet the challenge put forth by those individuals wanting to defraud the insurers," Mr. Goggin said.

Automobile title fraud is another popular fraudulent activity.

A classic example of title fraud

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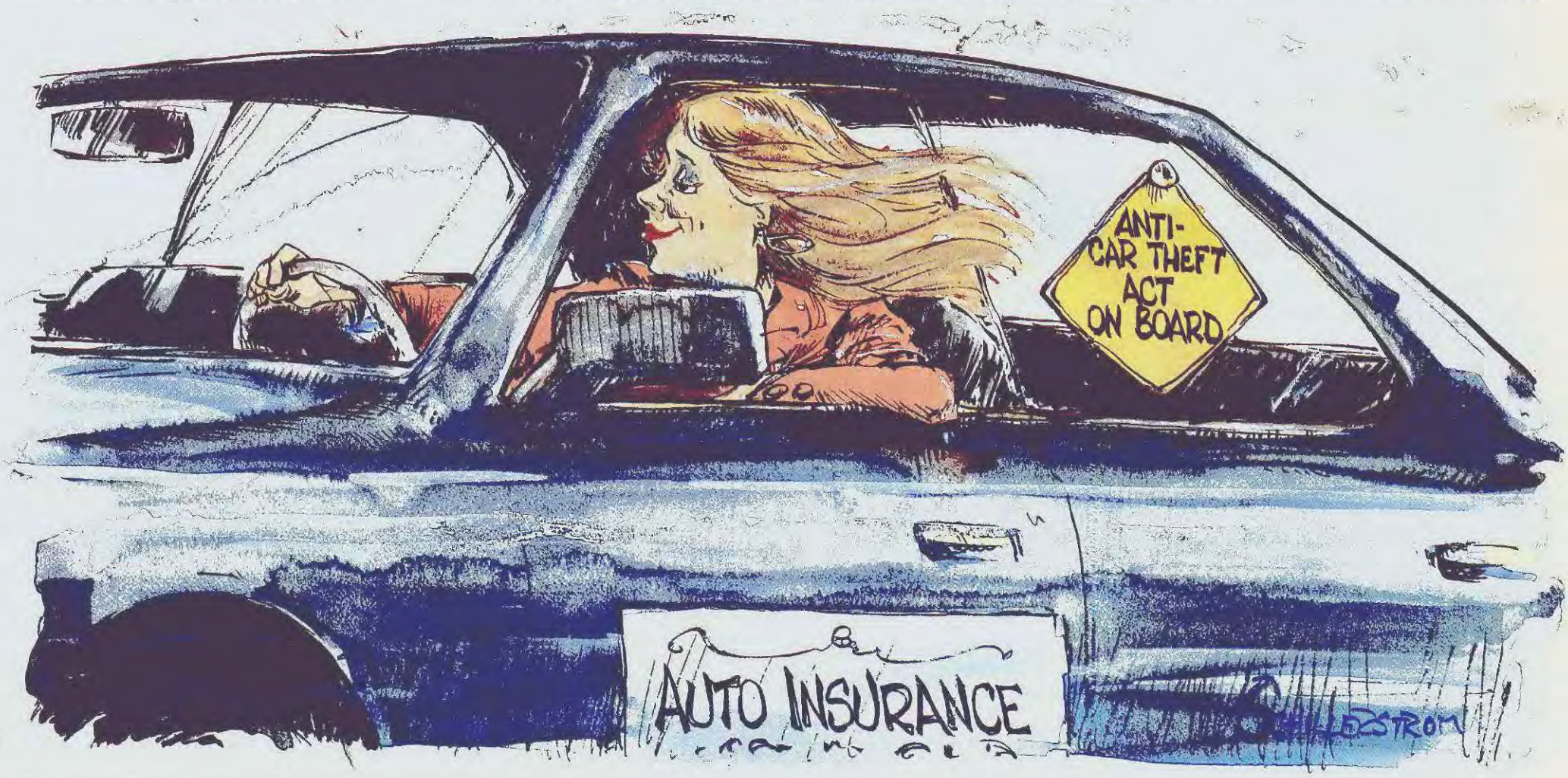


Insurer Topics

Auto theft fraud

Continued from previous page
is stealing a car, stripping its parts and leaving the shell of the car for the police to pick up. The stripped car, after going through the insurance company, eventually winds up in a salvage yard where the thief then buys the car back, thus obtaining a salvage title. After putting the stripped parts back into the car, the thief then takes the car to a different state and exchanges the salvage title to a good title, even though the car is not inspected, Mr. Goggin explained.

Once the thief has a good title, the car can be sold on the open market, he said.

"We need to tighten up on titling laws," Mr. Goggin said. Title fraud should be a felony in every state, he said, but some still consider it a misdemeanor.

A start in the battle against title fraud is again found in the Anti-Car Theft Act. The act requires that a state Department of Motor Vehicles check with the state of origin to verify that the title is legitimate before it issues a title to an owner presenting an out-of-state title.

The law also grants start-up funding to link state motor vehicle departments' computers so that each state will have access to other state's lists of valid titles.

This computer link is just one example of how technology is taking part in tackling auto theft fraud.

On Oct. 1, the NICB opened its Data Base Systems program to roughly 800 insurance companies to instantaneously report every stolen car that comes through the company.

The computer also allows users to track questionable auto claims by reviewing manufacturers' records of assembly and shipping, theft, recovery, salvage, impound and export information.

Every special investigative unit, claims personnel or other designated insurance company representative can gain access to and receive almost instantaneous results for any suspect claim, according to the NICB.

Insurance companies have always been able to manually send auto theft claims to NICB, but the new access allows instantaneous information, Mr. Hall said.

In addition to the NICB data base system, many insurers have their own computer systems that track suspicious auto claims.

State Farm's internal system is capable of indicating possible fraudulent claims, Mr. Hall said. For example, any person filing an auto claim who has filed a previous claim will come up on the computer, he explained. In addition, any recurring doctors' or lawyers' names on a policyholder's claim will serve as a red flag for potential fraudulent claims, Mr. Hall said.

Special fraud investigators then take the lists and determine which claims need further investigating, he said.

In the future, technology will make it even harder for criminals to get away with stealing a car, Mr. Goggin predicts. Twenty years from now, he said, stolen cars will be tracked by satellite. BI

System puts a fast focus on auto fraud

By SALLY ROBERTS

SOMERSET, N.J.—Security firm D.B. Kelly Associates Inc. and International Business Machines Corp. have developed a computer system that makes photos and complete documentation of suspected stolen vehicles instantly available to insurance companies.

The IBM ImagePlus system was developed in response to the New Jersey Fair Automobile Insurance Reform Act, effective in 1991.

Under the act, the state must photograph all cars with more than 300 miles on the odometer before owners can buy insurance.

The act aims to prevent fraud by eliminating bogus theft claims and to document any existing damage at the start of a policy, said Theresa Begnoche, image marketing specialist for IBM in Parsippany, N.J.

Before the act, a person could buy a totaled car at a junk yard, get a title for it, fully insure it, dispose of it, report it stolen and "get a $10,000 check in the mail," Ms. Begnoche said. Additionally, before the law was passed, a person could file an insurance claim after an accident and claim pre—existing damage along with the damage incurred from the wreck, she said.

The new system allows insurers to "have virtually instantaneous access to the photos and documents that they need to settle a claim or investigate a potential fraudulent claim," said Dennis M. Kelly, chief executive officer of D.B. Kelly Associates in Somerset, N.J.

"Without this computer automation, claims adjusters and fraud investigators would have to rely on manual retrieval of photos and documents," he said. And the computer-generated photos are better quality than the previously used Polaroid shots that tend to fade.

Thirty insurance companies have access to the data base system, which began operating simultaneously with the Fair Act.

D.B. Kelly provides the computer workstations and software to the insurers, who in turn send their policyholders to the firm's inspection sites.

Although there is little information on the act's effectiveness, there was a 2% drop in the New Jersey auto theft rate from June 1991 to December 1991, said Tom Mulvey, senior consultant-special investigations for Hannover Insurance Co. Inc. in Piscataway, N.J.

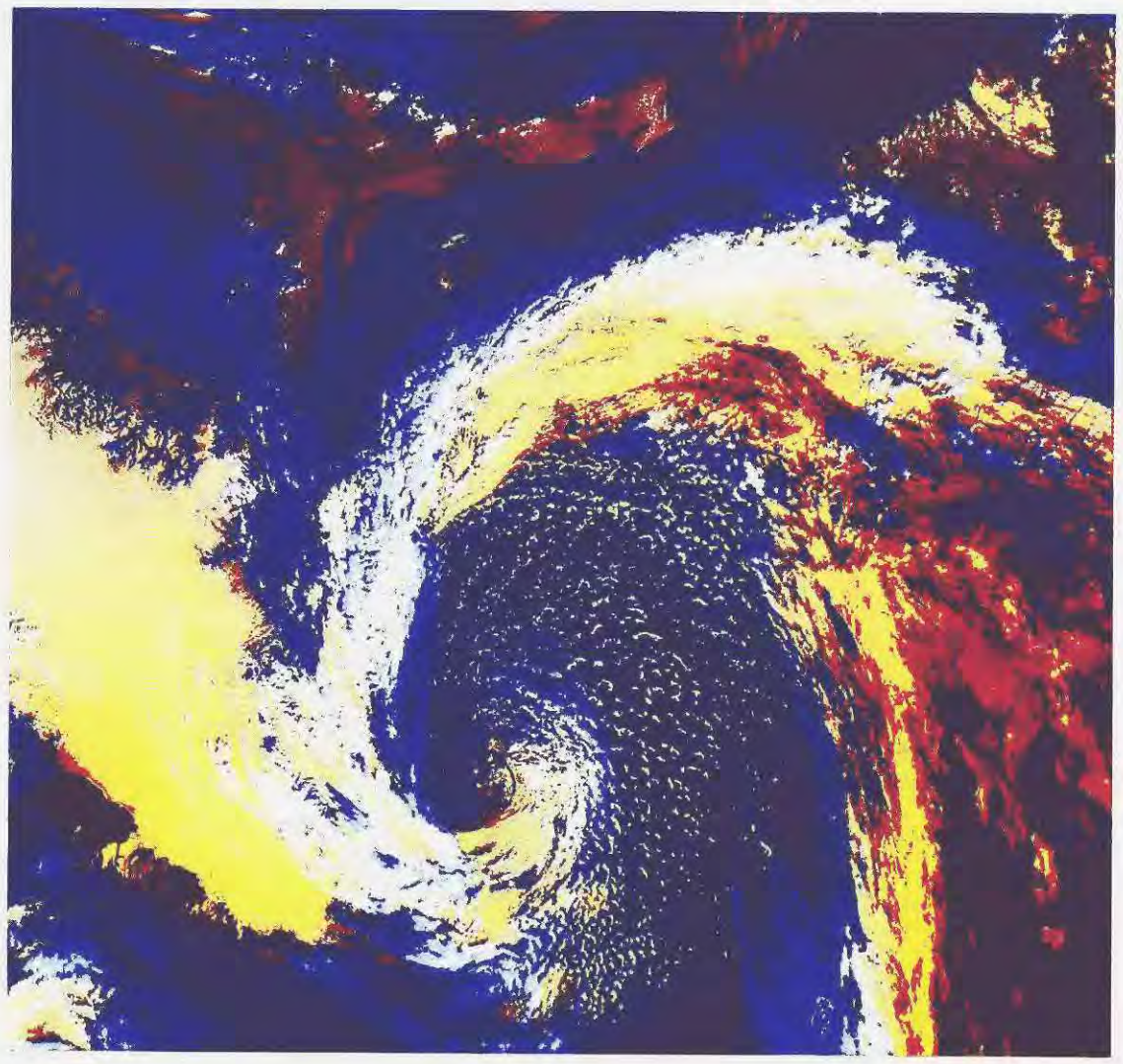
Similar laws exist in New York, California and Massachusetts. Many other states are considering them, Ms. Begnoche said.

In tandem with the law, the IBM-designed system works like this:

People seeking car insurance must have their cars inspected and photographed at state-approved inspection sites before receiving coverage.

The inspectors use a hand-held camera that records a complete four-sided color image of a car and its identification number. The information is stored on a two-inch diskette which is then entered into the main data base at D.B. Kelly.

When an insurer needs to access a customer's file in the event of a stolen vehicle claim or potential fraudulent claim, the insurer dials directly into the system and the vehicle information and color-image photos are displayed on the terminal within minutes. BI



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Insurer Topics

Hot on the trail of insurance fraud

Investigator recalls suspicious claims

By EILEEN P. GUNN

NEW YORK—A wedding guest claims he chipped his teeth when he slipped doing the conga on faulty steps outside an American Legion Hall, but the bride's mother has him on videotape dancing two hours after the alleged accident.

ANTI-FRAUD EFFORTS

A Molotov cocktail shatters a pizza parlor window and the month-old business burns to the ground. Did a nervous competitor throw the bomb, or was the owner trying to cash in on a doomed venture?

With a 35mm camera, a back seat full of files, a sharp eye and chatty demeanor, James Coen covers Long Island, N.Y., in a black Plymouth, piecing together the facts of scenarios like these.

As an agent of Fireman's Fund Insurance Cos.'s special investigations unit, his job is to uncover insurance fraud wherever it lurks.

Theoretically, it is easier to train an adjuster in investigation than to teach a police officer about the insurance industry. However, most SIU agents are former police detectives because corroboration with local authorities is essential to the job.

It is difficult to convince district attorneys to prosecute claim fraud because they consider it a "victimless crime, but culprits can often be brought in on connected charges of filing false police reports, causing arson on their own property and mail fraud, according to Mr. Coen.

Mr. Coen, an exception to the former-police officer rule, came to Fireman's Fund as an adjuster eight years ago. A list of friends and relations in local police and fire departments gave him the connections he needed to go out in the field and investigate the questionable claims he now trains adjusters to spot.

In one instance in August, an adjuster received a routine letter from an attorney claiming his client fell at a wedding reception at an American Legion Hall, which is covered by a commercial group property policy from Fireman's Fund. The attorney said his client fell as a result of the property owner's negligence.

After a routine check that the man was at the wedding and he did fall, the adjuster expected to pay about $6,000 for soft tissue injuries and chipped front teeth.

James Coen says leads can come from chats with the right people.

The adjuster phoned the bride's mother, who remembered asking the claimant about a rip in the back of his shirt a few hours into the reception. He told her he fell outside on stairs that were marked off with yellow danger ribbons.

She also told the adjuster she was annoyed by an offhand comment the victim's wife made to her a few days after the wedding that "at least we'll get his teeth fixed out of this."

To the adjuster this offhand comment was a "red flag"—a tip-off of a possible attempt to receive coverage for pre-existing injuries.

The list of "red flags" includes a claim on a brand new policy or on one about to expire; and claims filed by a financially unstable company, a recently divorced person, or a policyholder who walks into a broker's or agent's office out of nowhere.

"The single most important thing any SIU can do is to teach the adjusters who sit behind a desk and see mostly legitimate claims how to pick out the ones that are potentially fraudulent," Mr. Coen said.

Ten out of every 100 claims that come through Fireman's Fund are red flagged, and eight of those will be fraudulent. But Mr. Coen suspects fraudulent claims number three or four times that.

"Honestly, we only catch the stupid people," he said. "If they sit down and think it all through carefully, I won't catch them."

Many of his coups are chance discoveries because he happened to chat with the right person while on the trail.

After flagging the wedding claim, the adjuster sent the file to Mr. Coen, who had to find out if the victim really fell and if he had chipped teeth before the accident.

He began his investigation at the American Legion Hall where he did not find any yellow danger ribbons or evidence of repair on any of the stairs. So he headed to the home of the family that threw the wedding and had offered to show him a videotape.

"Rarely do you get a break like this," Mr. Coen said about the videotape.

He sat in the living room watching a videotape and chatting leisurely with the parents of the bride about weddings and the wonders of video technology.

The work is not always the stuff of a "Dragnet" episode, but

Continued on page 20F

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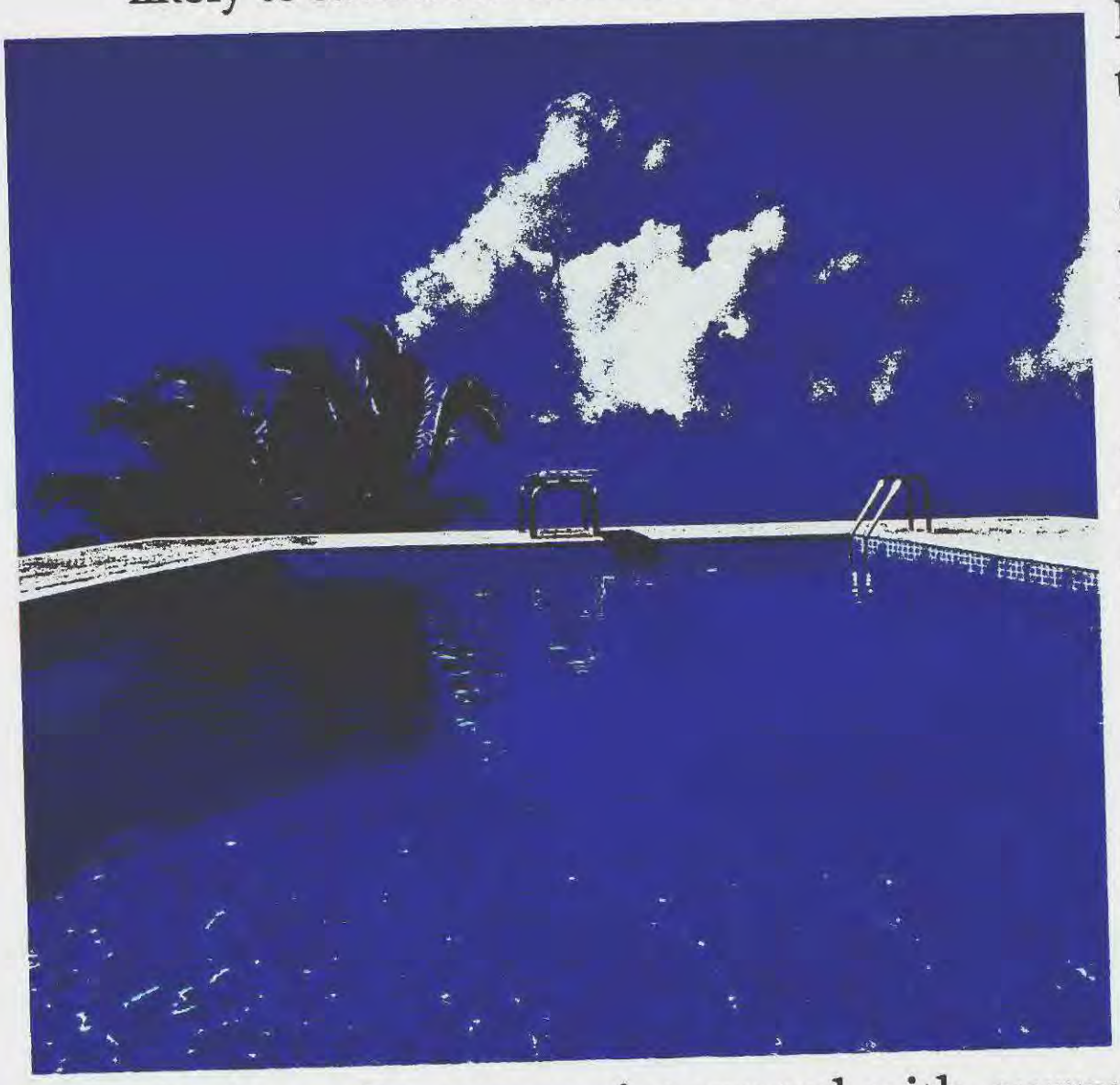

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Investigator

Continued from page 20D

for this SIU agent it all pans out.

From the videotape, he learned that the claimant hopped onto a conga line that wound its way out a side door of the reception hall, around the building and in a back entrance Mr. Coen hadn't noticed before. A few minutes later the claimant was at the bar with a visible rip in the back of his shirt.

But several frames after that he back on the dance floor, grinning, doing an energetic hokey-pokey.

So Mr. Coen borrowed a copy of the tape and headed back to the American Legion Hall, where he ran into the man who tended bar at the wedding.

Mr. Coen confirmed that the steps the conga line danced upon were the same steps where the claimant allegedly fell, and he found out there had been yellow tape setting off a loose railing on the staircase the day of the wedding.

Moreover, the tape was there because a loss control consultant from Fireman's Fund had inspected the building a few weeks before the wedding and had sighted the loose railing, which was consequently under repair and marked off the night of the accident.

"We could get hung on this," Mr. Coen said as he headed back to his office. "Not only do I believe he fell, but we had notice of the condition of the area where he fell."

But that still did not settle the question of the chipped teeth.

Some claims are blatantly fabricated, and others are exaggerated and opportunistic but basically legitimate. "It's not clear where the line is drawn," the investigator said.

Next he called the claimant's attorney for permission to look at dental records. At the end of October, he was still waiting for them.

The attorney "dropped out of sight" for a few weeks in September, and has since been "sitting" on the case, according to the investigator. Although lawyers are often the perpetrators of fraud schemes acting alone or in conspiracies with doctors, Coen suspects in this case the attorney was a victim.

"I don't think this was a crooked attorney saying 'Hey, let's see if I can get those teeth fixed for you,' " said Coen. "I think this guy is hoping the case will just go away."

If the claim is still alive at this point, and if Mr. Coen cannot gain access to prior dental records, his next step will be to contact the New York State Fraud Bureau, one of 13 nationwide, which has the power to subpoena records and examine people under oath, among other police powers.

The investigation will cost Fireman's Fund about $9,000, which is $3,000 more than it would have cost to settle. And they may still have to settle the legitimate portion of the claim. But to Fireman's Fund it is money well spent.

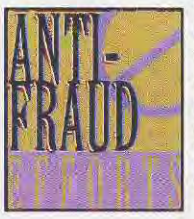
"It was worth it because all the claimant's neighbors and everyone in that American Legion Hall knows we investigated this, and down the line one of them will slip and fall and they won't try" to get coverage for pre-existing injuries, Mr. Coen explained. "That savings is intangible, but you have to believe it's there." BI

Anti-fraud momentum is growing

States, insurers put more into the fight, a new study finds

By EILEEN P. GUNN

The battle against insurance fraud is gaining momentum with increasing efforts by individual insurance companies and state fraud bureaus, according to a recent survey by the Insurance Research Council.



The property/casualty insurance industry allocates more than $200 million a year specifically to fraud deterrence efforts, according to the survey released last month by the Oak Brook, Ill.-based group. But this is only a fraction of the total amount insurers actually spend fighting fraud, the IRC adds.

Only 66 of the 128 insurers that returned the IRC survey could provide specific information about the money they spend on anti-fraud efforts, because these expenses are often allocated to different budget areas rather than listed under a separate fraud budget.

Individual companies earmark from as little as $5,000 to as much as $10 million on anti-fraud efforts, the survey shows. These efforts include forming special investigations units, training personnel to identify suspicious claims, connecting with claims information networks and hiring outside investigators. The median total amount spent on fraud-fighting efforts this year by the 66 companies that provided figures is $394,251.

"It's a never-ending cycle," said Elizabeth Sprinkel, assistant director of the IRC, who wrote the survey with IRC staff member Julie Banks. "If you don't fight it, people will continue to think it's OK to pad insurance claims and engage in other fraudulent behavior."

Among the responding insurers, 61.7% have special investigation units—the teams that investigate fraudulent claims—in 1992, up from about half in 1983. Moreover, whether they have an SIU or not, nearly all—98.4%—of the insurance companies surveyed said they investigate potentially fraudulent claims.

Those companies without SIUs use private investigators, local law enforcement or state fraud bureaus instead.

One insurer explained in the survey: "(Our) fraud control program is based on a decentralized group of specialists who provide training in awareness and investigation. . . .While not composed of the elements of a true SIU operation, many of the same functions are performed."

Among the insurers with SIUs, 51.9% had a centralized organizational structure, while 48.1% had a decentralized SIU with

Continued on page 20H

1992 1993

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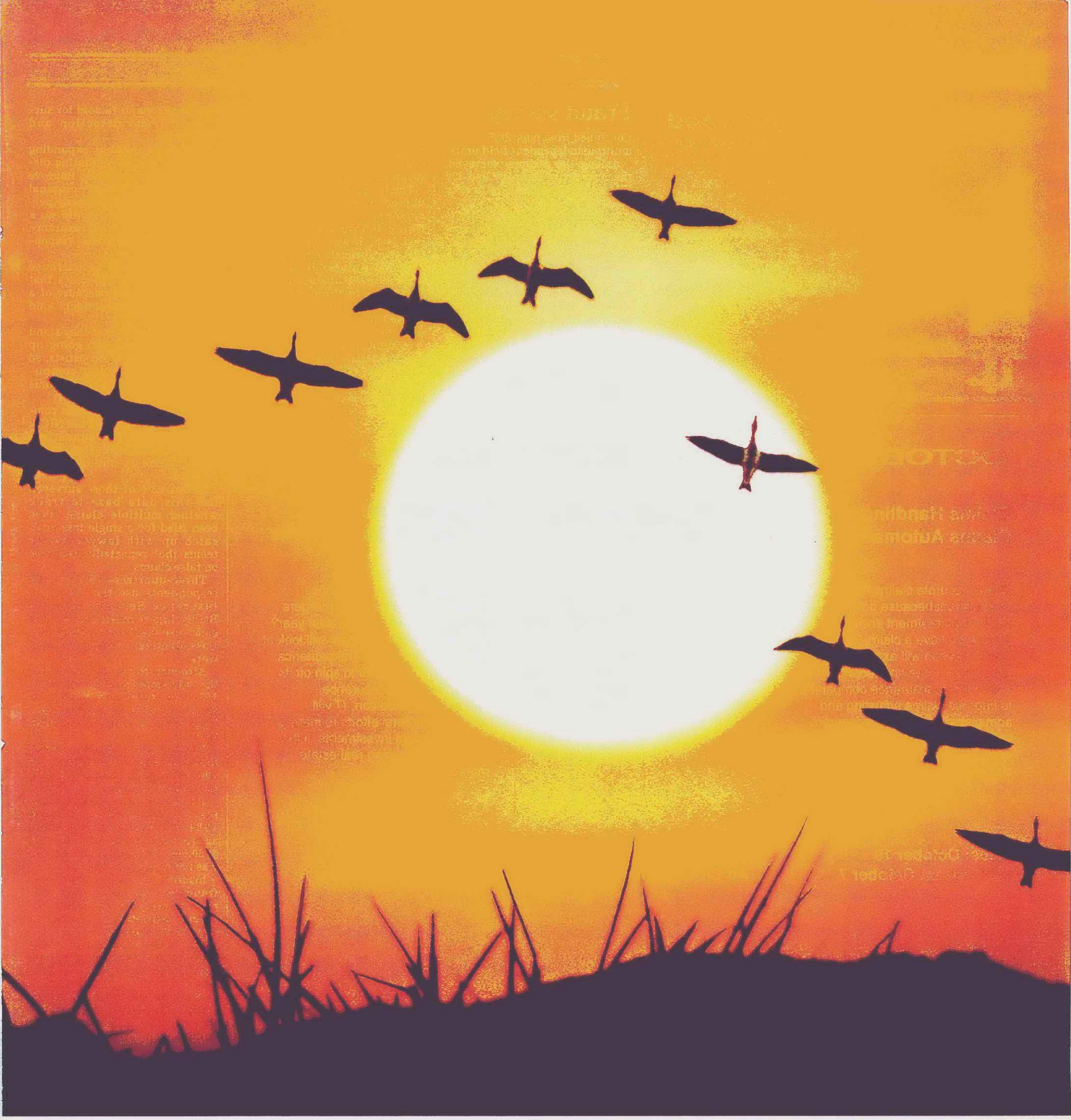

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Fraud survey

Continued from page 20F

multiple independent field units.

Among the insurers surveyed, the most active company had 326 SIU investigators in 47 offices in 1992.

In a 1984 survey by the IRC's predecessor, the most active company had 37 investigators in 20 offices.

Although the number and size of SIUs have expanded significantly, the median number of claims handled per investigator has remained at 15 per month since 1982.

Ms. Sprinkel would not comment on whether this indicates the number of incidents of insurance fraud are rising.

After investigation, training is the most common aspect of a fraud control program, the survey shows. More than 95% of the insurers train adjusters and other employees to recognize suspicious claims.

The training is most often conducted by home office claims personnel or SIU agents. The National Insurance Crime Bureau, which was formed earlier this year through a merger of the National Automobile Theft Bureau and the Insurance Crime Prevention Institute (*IT*, Jan. 20), also has a training program that is used by 18% of the insurers surveyed.

In addition to training and investigations, insurers ranked support of claims management, centralized data bases, and public awareness and media attention as the major factors for success in fraud detection and deterrence.

Increasing training, expanding SIU units and consolidating disparate data bases would improve detection, while tougher criminal and civil penalties and more persistent prosecution would go a long way in deterring insurance fraud, according to the respondents.

"There is no way to determine the number of fraud cases that will not take place because of a single denial (of coverage)," said one respondent.

Insurers realize that they stand or fall together when going up against insurance con artists, so cooperation through computerized data bases has become standard procedure.

More than 800 insurance companies are members of the NICB, which provides a computerized network of information about false claims as one of its key services.

About 63% of those surveyed use this data base to track whether multiple claims have been filed for a single loss or to catch up with lawyer-doctor teams that repeatedly conspire on false claims.

Three-quarters—75%—of the respondents use the American Insurance Services Group's Bodily Injury Index Bureau and 65.5% use the Property Insurance Loss Register, two other networks.

Although North Carolina's was the only state fraud bureau until 1976, 14 states now have such agencies and several others have legislation pending to establish them.

New Jersey's bureau, established in 1983, is the largest with 100 investigators and a $4.6 million annual budget.

The Idaho and Arkansas bureaus, established in 1982 and 1984 respectively, have two agents each. Arkansas' budget is $156,000. Data on Idaho's bureau was not released to the IRC.

Insurers are required to report fraudulent claims to these bureaus in every state but Ohio, although legislation is pending in Ohio to change that.

The main function of these state fraud bureaus is to investigate claims reported as fraudulent.

The state agents are more powerful than SIU agents because they have the authority to issue subpoenas, call in witnesses, carry out search warrants, assess fines, make arrests and carry firearms, though their jurisdiction is limited by each state's borders.

State fraud bureaus also seek to educate the public, the industry and local law enforcement on the extent of insurance fraud, and attain visibility for the fight against it.

For example, one of the key objectives of the New York Insurance Department Fraud Bureau is to convince the public insurance fraud is not a victimless crime.

"The victims are everyone," said Ms. Sprinkel: "The insurance companies, the insureds, even the uninsured who can't get insurance because fraud drives rates up."

•

Copies of the survey are available for $5 from the Insurance Research Council, 1200 Harger Road, Suite 310, Oak Brook, Ill. 60521; 708-572-1177.

OCTOBER

Claims Handling/ Claims Automation

Quick, accurate claims handling is so important because policyholders expect top treatment and service when they have a claim. *BI's Insurer Topics* section will examine the latest techniques and technologies employed by insurance companies to improve claims adjusting and administration. And, are insurers being pressured by some state insurance regulators to improve their claims handling records?

Issue: October 19
Ad Closing: October 7

NOVEMBER

Anti-Fraud Efforts/CPCU Conference Report

Fraud costs insurers hundreds of millions of dollars each year. And, as insurers become more sophisticated in detecting fraud, the fraud artists themselves become more sophisticated too. *BI's Insurer Topics* section will look at the most common techniques used to defraud insurers and how individual insurance companies can work by themselves and with law enforcement agencies to detect fraud.

Issue: November 16
Ad Closing: November 4

DECEMBER

Mergers/Acquisitions/ Divestitures & Investments

How active has the insurance industry been in pursuing mergers and acquisitions over the past year? *BI's Insurer Topics* section will look at this activity including Transamerica Corporation's attempt to spin off its property/casualty insurance operations. In addition, *IT* will examine insurers' efforts to manage their real estate investments in the face of the slumping real estate market.

Issue: December 21
Ad Closing: December 8

Insurer Topics

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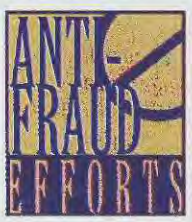
Insurer Topics

More teamwork, less talk

Insurers must engage the public in the campaign against fraud

By LOUISE KERTESZ

SAN FRANCISCO—Although insurers and state regulators are taking steps to combat fraud, some believe that not nearly enough is being done.



"We've talked these things to death," asserted Frank E. Doolittle, director of the insurance fraud division at the Florida Department of Insurance in Tallahassee.

At industry meetings about fraud, "You folks are all very polite. We exchange niceties, and I feel we go out of here saying, 'It's the damned lawyers' fault,' " he said.

"We've got to stop talking the problem to death and join hands and get some work done," said Mr. Doolittle at a recent conference here sponsored by the Society of Chartered Property & Casualty Underwriters.

"I think insurance companies should be in the law enforcement business," he added. "Companies should have a moral responsibility to (fight fraud) in well-investigated cases." Otherwise they risk losing credibility, Mr. Doolittle said.

"I second that," said Edward Feldman, an assistant head deputy district attorney in Los Angeles. "There is no way the problem is going to solve itself."

One problem for prosecutors is that they "get garbage" from insurers in terms of documenting suspected cases of fraud, he added.

"We haven't done enough," conceded Kenneth M. Goodnight, claim security executive at Royal Insurance Co. in Charlotte, N.C.

Insurers, though, have come a long way, Mr. Goodnight said. In the past 10 years, insurers have become better at training claims staff to detect fraud and many have developed fraud investigation units.

Realizing that the savings are potentially large, many insurers are adding staff to their investigative units even as they cut back elsewhere, Mr. Goodnight said.

State regulators are also taking steps to combat fraud. Since its 1990 inception, the workers compensation fraud bureau in Florida, for instance, has made 250 felony arrests, Mr. Doolittle said.

"But we're tremendously underfunded and understaffed," he asserted, adding that the bureau has 42 investigators, but could use 300.

The department plans to sponsor legislation to fund state prosecutions of workers comp fraud. California recently passed such a measure (*BI*, Aug. 5, 1991).

"To get a handle on insurance fraud requires a team effort," agreed Arnold Schlossberg Jr., president and chief executive officer of the National Insurance Crime Bureau in Palos Hills, Ill. That effort requires changing the public's attitude toward insurance fraud, he said.

In a recent poll, 23% of the people surveyed said it was acceptable to defraud an insurer to recoup a deductible, Mr. Schlossberg noted.

One questioner asked those on the panel why so many people consider padding claims acceptable and whether the attitude was "endemic" to the fact that policyholders often "pay and pay premiums" without seeing a return.

"It's a matter of public education," said Mr. Schlossberg. "We've got to have more personal contact out there. The public does not understand the insurance mechanism."

This attitude is "a societal problem," said Mr. Doolittle. "Let's be very visible to the public and inform them what fraud is doing to their pocketbook."

"Rampant claimant fraud is born out of the philosophy that every gray cloud has a silver lining," and that if a policyholder is injured or suffers a loss he or she can make some money by exaggerating a claim," said Mr. Feldman. "The system rewards low-level injuries."

"We have to fundamentally change our system to eliminate that kind of fraud," he asserted.

"In California, you know you're going to make $6,000 if you're hit from behind in a car. The industry has communicated it won't fight (such a small claim)," Mr. Schlossberg said.

Royal, though, says it will fight such claims if it believes the claims are fraudulent. "We must portray that we have zero tolerance for fraud—zero," said Mr. Goodnight.

"Get out into the community. . . face to face as much as we can," Mr. Goodnight urged insurers. "It's a matter of education, both of the carrier and the public, that in the long term it's costing them."

More insurance companies need to take a stand against fraud, those on the panel agreed.

"I don't think any one of us is doing as much as we need to do to tackle the problem," said Mr. Feldman. Some insurers have been "very supportive" of efforts to prosecute fraud, but "others are not so responsive," he said.

Fear of bad-faith judgments prompts many insurers to settle even suspect claims, pointed out Royal's Mr. Goodnight. But insurers with good investigative units should not fear bad-faith suits. "A very professional, prompt fraud investigation is the key," he said.

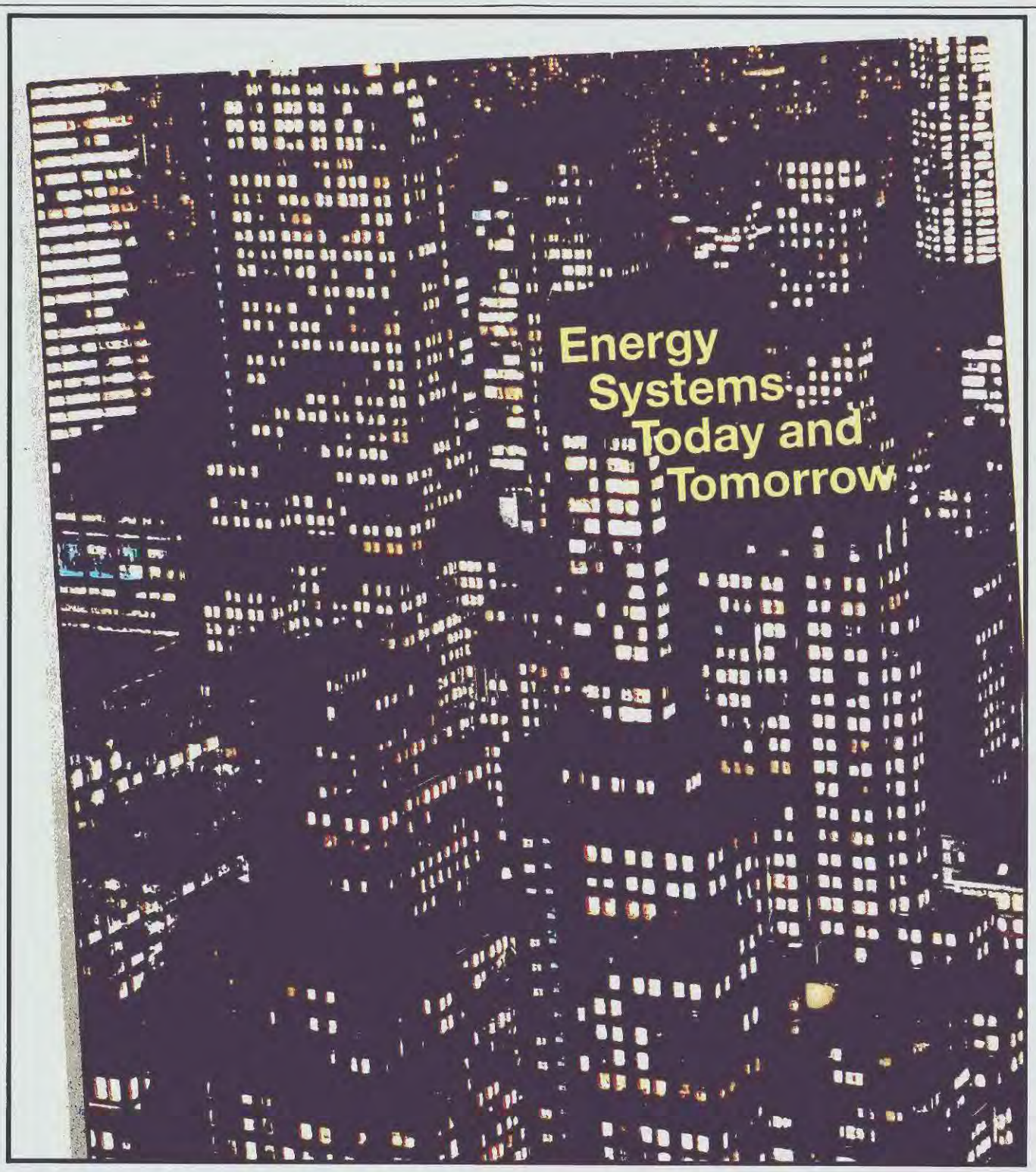
Some insurers might question if it is worth spending $200,000 in defense of a bad-faith suit, Mr. Goodnight said. "Yes, because we have to take a stand," he asserted.

He conceded, though, that there was an "outside possibility" of being hit with a bad-faith judgment when challenging claims.

Small insurers especially fear bad-faith liability. But the unacceptable alternative is to reward fraud, said Mr. Schlossberg. He urged insurers to lobby for laws like one in California that makes insurance fraud a specific felony.

Insurers that do not fight fraud vigorously help propagate an image of the industry as "a pass-through mechanism that passes on the cost of fraud to the public," he said.

The panel was moderated by Patricia A. Lombard, executive director of the Western Insurance Information Service in Los Angeles. BI



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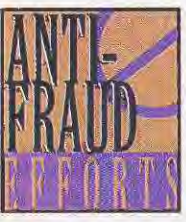
Insurer Topics

200-mph winds difficult to plan against

By LOUISE KERTESZ

SAN FRANCISCO—Though agents and insurers in Florida are "generally well prepared" to deal with hurricanes, Andrew was far more than they bargained for.



"I don't think there was a way to be prepared" for the effects of 200 mph winds, said Thomas R. Jones Jr., president of the T.R. Jones Co. agency in Homestead, Fla.

"Our agents had a disaster plan based on Hugo. . .and it was a disaster," said Mr. Jones. His agents' reliance on cellular phones, for instance, was foiled by downed transmission towers.

"Communication was a large problem initially" for State Farm Fire & Casualty Co. agents, who had also counted on being able to use cellular phones, said Frank R. Haines, a claims vp at State Farm in Bloomington, Ill.

Both men spoke at a session on Hurricane Andrew at a recent conference in San Francisco sponsored by the Society of Chartered Property & Casualty Underwriters.

Another problem with the Jones agency's disaster plan was that it "didn't contemplate damage to the office," said Mr. Jones, who noted that the agency suffered water damage.

"But the biggest thing our plan did not contemplate was the human impact," Mr. Jones said. The Jones family at one point housed 15 people, including members of the agency staff who found themselves homeless.

Despite extensive planning, State Farm encountered similar problems. With hotels destroyed, there was no place to put its claims adjusters. At one point, some adjusters promised a hotel a power generator in exchange for being allowed to book into the hotel, said Mr. Haines.

Business will probably not return to normal in Florida "for at least a year," Mr. Jones said. The agency is now writing new business "with caution."

"We've had to do some things in this disaster that we've never done before," Mr. Haines said, including hiring security guards. "We had safety concerns for our adjusters," when some policyholders were observed with guns.

Asked to assess insurer response to Andrew, Mr. Jones said said that each of the 15 insurers his agency represents responded differently. "By and large we're pleased, though I wish they had got there slightly sooner."

Asked about the regulatory climate in Florida following the disaster, Mr. Haines responded that state agencies "have a very difficult job. . .they're doing it effectively. We don't agree with every order. But they are accessible. . .(and) they are interested in working with the industry. I give them high grades so far."

Following any loss, "there is some good," said Alice B. Fielding, president of Jacksonville agency Heston Fielding & Associates Inc.

There was a tremendous response to help hurricane victims. "Ask anyone—do we care about each other in this country? You better believe we do," said Ms. Fielding, panel moderator. BI

OCTOBER — **IIAA Conference Report**

Issue: October 5
Ad Closing: September 22

Is there a merger in the works between the Independent Insurance Agents of America and the other large agent trade group, the National Association of Professional Insurance Agents? *BI's Agent/Broker Topics* section will assess the state of the IIAA and analyze the potential for such a union and the impact on independent agents. What's more, *BI* will cover the IIAA conference in New Orleans and report the big stories emerging from that meeting.

NOVEMBER — **Relations With Direct Writers**

Issue: November 2
Ad Closing: October 21

Are direct-writing insurers friend or foe? Independent agents have long feared direct-writing insurers because of their growing market share. However, some independents are now acting as agents for direct writers. *BI's Agent/Broker Topics* section will look at what independent agents can learn from direct writers ... how they can promote customer loyalty and improve efficiency.

DECEMBER — **PIA Conference Report**

Issue: December 7
Ad Closing: November 23

What big stories will emerge from the National Association of Professional Insurance Agents convention to be held in Orlando? *BI's Agent/Broker Topics* section will report on the last major gathering of agents in 1992. Reports will focus on the major issues agents faced during this year and the challenges they will encounter in 1993.

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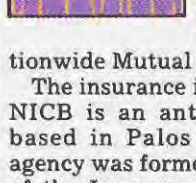
Fighting insurance criminals

New national bureau leads fraud battle

By MARK A. HOFMANN

BALTIMORE—Insurers are not alone in their battle against fraud, an insurance executive says.



"This is a war and we have an ally in this war—the National Insurance Crime Bureau," said Eldon Ziegler, vp-claims for Nationwide Mutual Insurance Co.

The insurance industry-backed NICB is an anti-fraud agency based in Palos Hills, Ill. The agency was formed by the merger of the Insurance Crime Prevention Institute and the National Automobile Theft Bureau (*IT*, Jan. 20).

Mr. Ziegler, who is chairman of the NICB's board of governors, made his observation during an insurance fraud seminar sponsored by the International Assn. of Special Investigative Units, which represents about 870 special investigators from about 130 property/casualty insurers.

One contributing factor to the creation of the NICB was industry concern about the effectiveness of having fraud-fighting efforts split between two organizations, said Mr. Ziegler.

"Until last year, we had two organizations investigating insurance crime. These two organizations had separate agendas, separate data bases and separate investigative staffs. People like you were frustrated because of the lack of coordination in investigations and information access," he said.

"Divided efforts and fragmentation are the enemies of an effective fraud-fighting program."

According to Mr. Ziegler, polling by the Insurance Information Institute indicates that a plurality of the public believes that insurance companies—not state regulators or law enforcement agencies—should be responsible for dealing with car theft.

By forming the NICB, the in-

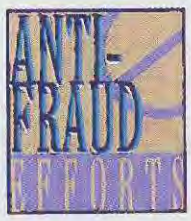
Continued on next page

Insurer Topics

Fraud: Insurers up against a tough adversary

By LAURA MAZZUCA

CHICAGO—Insurers concerned with losses from catastrophes like Hurricane Andrew are often unaware of an even bigger drain on their profits: fraud.



Fraud, including auto theft, costs insurers more than $24 billion per year—as much as several Hurricane Andrews—said Arnold Schlossberg Jr., president and chief executive officer of the National Insurance Crime Bureau in Palos Hills, Ill.

Of all claims paid, about 10% are "highly inflated or fraudulent," he added. Assuming that the industry pays about $170 billion in claims each year, that's $17 billion a year.

According to the Federal Bureau of Investigation, more than $8 billion in stolen cars alone was reported in 1991. With the economy continuing to worsen, auto theft will continue to be a "huge problem," Mr. Schlossberg said.

And there's only so much law enforcement can do. The insurance industry must join forces with the authorities in sharing data and reporting suspicious claims, he said.

Mr. Schlossberg recently moderated a panel on "Beating the Cheating" at the annual CCC Information Services Inc. claims conference for insurance and auto repair industry executives. Chicago-based CCC Information Services provides automated claims services to property/casualty insurers.

Law enforcement agencies need the help of the insurance industry to track and prosecute fraud perpetrators, agreed John O'Neill, assistant special FBI agent in Chicago.

Since the 1970s, the FBI has focused only on auto theft rings, not individual thefts, Mr. O'Neill said. This focus meant they were tracking less data—a big mistake for the FBI, since auto theft today not only is on the rise, but is even taking more violent forms such as carjacking, he said.

The FBI is now redoubling its efforts to track car theft cases, and Mr. O'Neill encouraged insurers with databases and claims information to report suspicious claims to the FBI.

Through insurer databases, the industry can create a "seamless web" of shared information to spot fraud and set up a source of "one-stop shopping" for claims processors to call for information on questionable claims, Mr. Schlossberg said.

To that end, CCC and the NICB have entered an agreement in which NICB would gain direct on-line access to CCC's vehicle identification number database, both to use the information and to add its own. Included are U.S. and Canadian vehicles involved in total losses, reported stolen or processed as salvage. CCC-member claims processors can then have access to suspicious vehicles, Mr. Schlossberg said.

The NICB's merged database

Continued on next page

NICB's mission

Continued from previous page

dustry began "shouldering its responsibilities for what the public expects," said Mr. Ziegler.

Public education about the costs of insurance crime is one major challenge for the group. "The NICB understands that the most important battle is taking place in the minds of consumers," he said. "At the most basic level, consumers don't understand that they're footing the bill for insurance crime, so we need to use all kinds of media to get the message out."

So far, the group has used media contacts and has distributed brochures to law enforcement agencies and claims staffs. Other efforts have been aimed specifically at lawmakers and special investigators, he said.

Although the NICB is not a lobbying organization, its members have been working with insurance trade groups and individual companies to draft model antifraud legislation for consideration by state legislatures, Mr. Ziegler said.

He also noted that NICB President Arnold Schlossberg recently testified before the House Subcommittee on Crime and Criminal Justice in support of tougher penalties for automobile theft.

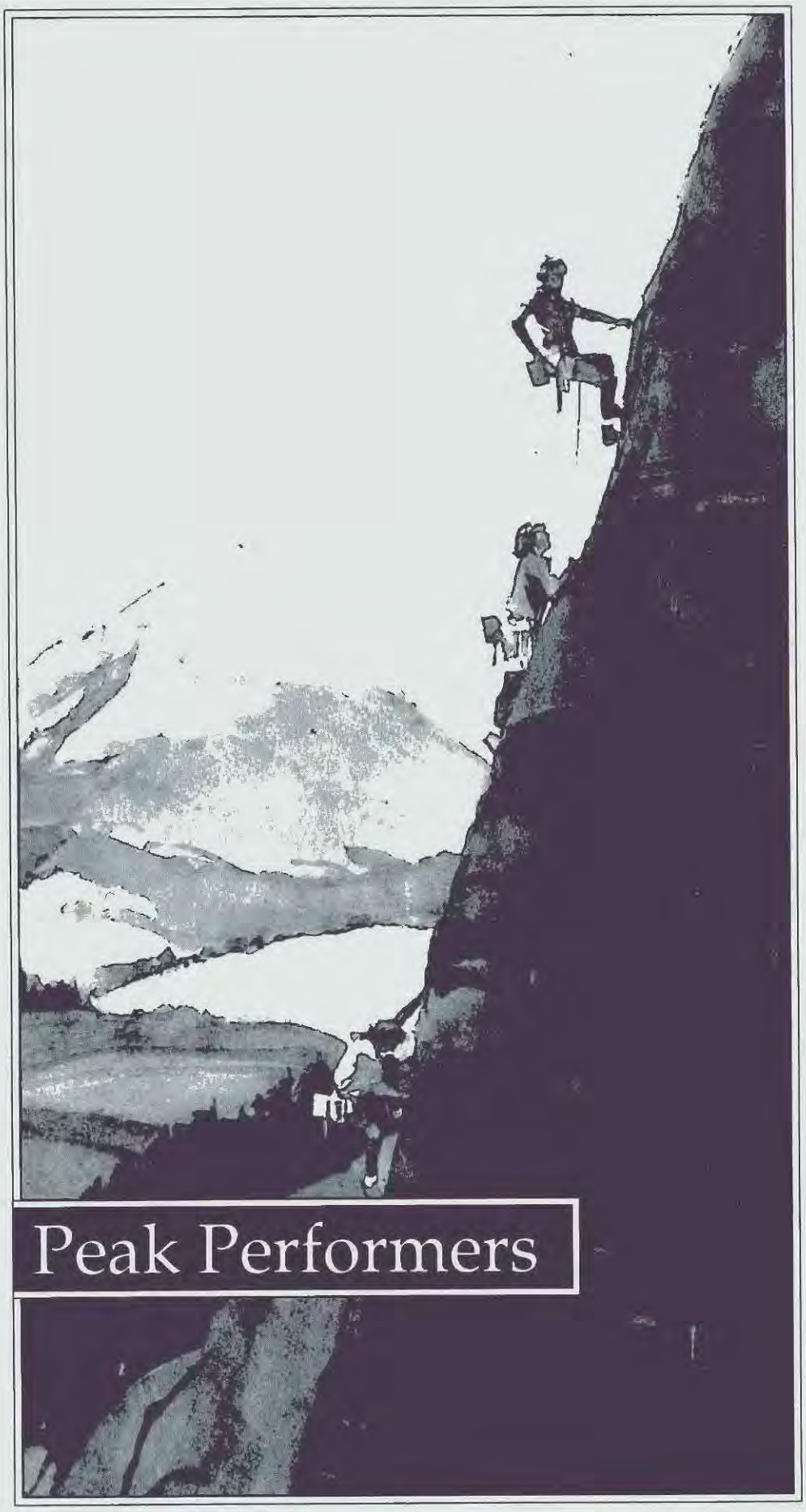
"We need to send a message that claims crime doesn't pay, and prosecution is at the heart of that message," said Mr. Zeigler. "It offers the opportunity for greater public education and proves the insurance industry and law enforcement are serious about this effort."

Mr. Ziegler also called for more vigorous attempts to pursue restitution. "To help this effort, NICB is coordinating a file of civil actions taken by insurance companies on behalf of policyholders," he said.

"This includes the use of RICO—the Racketeer Influenced Corrupt Organizations Act—to attach personal property. Civil actions could be especially effective with professional people. Such suits would send the message that people who engage in insurance crime will lose their home, cars and even their underwear," said Mr. Ziegler.

Mr. Ziegler reminded his audience once again that NICB, IASIU and the other agencies battling fraud have a common enemy—"the insurance criminal."

"To everyone engaged in this war—whether in the public or private sector—I urge that we not fight among ourselves. When we do, it distracts us from the real enemy. We must have a unified effort from insurance companies, claims departments, SIUs, industry agencies, trade associations, legislators, regulators, prosecutors and law enforcement," he said. BI



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Insurer Topics

Tough adversary

Continued from previous page
of its 803 member insurers allows cross-checking of fraudulent claims.

Most insurers are simply "managing" fraud rather than eliminating it, said Gilbert Palmer, special product manager for Allstate Insurance Co. of Northbrook, Ill.

Insurers sharing their claims data with information companies like CCC will enlarge the database for fraud elimination. Allstate supports any anti-fraud initiatives, and will cooperate with the rest of the industry, Mr. Palmer added.

But even the best database is useless unless claims processors are made "fraud-aware," are encouraged to spot suspicious claims before the risk is accepted and are taught to look at fraud as something the insurer must "manage," he added. Without this, "we're data-rich but information-poor," Mr. Palmer said.

Auto repair shops see another side of attempted fraud, said Lou Di Lisio, owner of Lou Di Lisio's Auto Body Shop.

For example, unscrupulous people—both inside and outside the insurance industry—find ways to rip off insurers by misusing direct repair programs, Mr. Di Lisio said.

Third parties such as tow truck operators hit up body shops for 10% to 20% kickbacks from repair costs; customers try to get body shops to save them the deductible by increasing the work estimate; adjusters try to build "special" relationships with the shop to get kickbacks of their own; and some insurers' mandate for shops to use salvage parts "creates a marketplace for fraud and theft," Mr. Di Lisio said.

Worst of all, even though body shop representatives inform an insurer's local office management about such fraud, they are still "uninformed or uncaring" about the situation, and frequently choose to ignore it, he added.

However, the 1990s can be dubbed the "decade of insurance fraud awareness" since the "sleeping giant" of the insurance industry is finally becoming aware of what a serious problem fraud is, said Timothy Goggin, superintendent-special investigating unit of Nationwide Insurance Co.

Nationwide launched its corporate fraud control program with a staff of 25 in 1988. By 1992, it quadrupled the size of its fraud investigation unit to 85 employees—including Pyra, the insurance industry's first fire accelerant-sniffing dog, "the newest tool in our arsenal to fight claim fraud," he said.

Units like this must help claims processors, giving them information "to make an informed decision on a claim," Mr. Goggin said. "If we act, the sleeping giant is going to wake up." BI

Combatting workers comp fraud

BALTIMORE—Insurers must include employers for a campaign against workers compensation fraud to be successful, according to an insurance fraud specialist.

Employers should be educated about the impact of workers comp fraud, said Sherri Miller, assistant vp of Transamerica Insurance Co.'s special investigation unit. Investigators also should work to build goodwill with employers during investigations, she said.

An ambitious workers comp antifraud effort has saved Woodland Hills, Calif.-based Transamerica an estimated $1 million per month in California, said Ms. Miller during a panel discussion at the recent annual seminar of the International Assn. of Special Investigation Units.

Ms. Miller also noted that Transamerica has been offering rewards of $5,000 for tips that lead to felony insurance fraud convictions. The company maintains a toll-free telephone line to field reports of suspected fraud.

Another speaker said that despite popular belief, psychological workers comp claims may be the easiest to investigate for possible fraud, particularly in what he called "Ozzie and Harriet" cases.

Rene Folse, of the Thousand Oaks, Calif.-based law firm Miller & Folse, said that so-called Ozzie and Harriet cases are those where a worker with a work-related psychological injury claims to have had a perfect home life before the alleged injury.

The truth, according to Mr. Folse, is far different. Most people's psychological problems stem from earlier trauma that they haven't outgrown. These early problems aren't hard to uncover, he added.

Another area of workers comp fraud that demands attention is premium fraud, said Joseph Callahan, a former Scotland Yard official who heads Aetna Life & Casualty Co.'s premium fraud control unit in Hartford, Conn.

Mr. Callahan cited several strategies used by employers with poor claims records to get around paying higher premiums. These strategies include leasing the company to a relative with a clean claims history; moving to another state and changing the company's name; and being less-than-truthful about the nature of the company's work, the number of employees or working conditions.

Mr. Callahan said that a key way to prevent workers comp premium fraud is to encourage better relations between claims and underwriting personnel.

"They don't talk" to each other at some companies, he noted.

Aging population

NEW YORK—The U.S. and European insurance markets face similar challenges stemming from an aging population, speakers noted recently at the Eighth International Insurance Symposium.

"The U.S. has a rapidly growing older population that requires an ever-larger share of health care," said Stanley Peck, vp of the Health Insurance Assn. of America in Washington. "Half of Medicaid funding is used up in nursing homes."

Employers increasingly will sponsor programs to help defray the costs of elderly care, predicted Mr. Peck at the symposium, which was sponsored by the International Insurance Council. He also predicted that all Americans would be covered by some form of health insurance by the turn of the century.

Herbert Schimetschek, president of the board of directors of the Austria Insurance Group in Vienna, said European insurers are beginning to see potential in the aging population at a time when they face increased competition. Products will become more sophisticated as insurers seek to tap this market, he predicted.

This aging will also impact the group pension market, said John O'Dea, general manager of Equitable International, a division of the Equitable Cos. Inc. in New York.

"The 40 to 60 age group will increase by 18% by the year 2000. People are living longer and retiring earlier. As a result, the need for more complex products will be greater than ever," said Mr. O'Dea.

IT Briefs

Pride in profession

NEW YORK—Insurance professionals are hearing what's right, rather than what's wrong, with their chosen calling in new brochures written and distributed by the Insurance Information Institute.

The series, called "Be Proud," began earlier this fall. Each message begins with a sentence containing the phrase "be proud" and then details how the property/casualty insurance industry has improved society and safety.

For example, the recently issued fifth "Be Proud" message detailed industry efforts to ease suffering in the wake of Hurricane Andrew. It tells how an adjuster literally gave the shirt off his back—as well as his tie and shoes—to a policyholder who needed to attend an important business meeting.

After three more inspirational vignettes, readers are exhorted, "Insurance employees: Stand up and take a bow!"

Previous messages involved how insurers worked to promote air bags and child safety seats as well as the industry's efforts to combat drunk driving. Future messages will involve insurers' role in motorcycle safety and safer workplaces. The messages are aimed at insurance company and agency employees.

To receive a complete set of existing messages or to get on the list for future messages, send a request to Ronn Mullins, editor of the III Insurance Daily at the Insurance Information Institute, 110 William St., New York, N.Y. 10038.

Arbitration guide

WASHINGTON—The Reinsurance Assn. of America has published a free directory of insurer/reinsurer arbitrators. The "RAA Arbitrators Directory" includes industry experience for arbitrators and the date of their last arbitration. Contact Ellen Kirkpatrick, 1819 L St. N.W., Suite 700, Washington, D.C. 20036; 202-293-3335. BI

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Business Insurance

Change on horizon for regulatory board in Lone Star state

By MICHAEL BRADFORD

DALLAS—The next session of the Texas Legislature could drop the curtain on the state's unique insurance regulatory structure.

Texas is the only state with a State Board of Insurance and a board-appointed commissioner who enforces its rules and handles day-to-day administrative affairs.

The three-member board, appointed by the governor, retains the authority to establish rules and set policy. The governor also appoints the chairperson, who holds no statutory authority over the other two members but does have the power to call and preside over meetings.

The insurance board is set for a sunset review during next year's legislative session, at which time lawmakers could revise the board's structure or decide to eliminate it.

"I think it's likely that the makeup and responsibilities of the board will be altered significantly," said Thomas J. Bond, a partner with the law firm of Akin, Gump, Hauer & Feld in Austin.

'I think it's likely that the makeup and responsibilities of the board will be altered,' says Mr. Bond.

Speaking at the annual meeting of the Dallas-Fort Worth Chapter of the Risk & Insurance Management Society Inc. last month, Mr. Bond pointed out that the term of board member Richard F. Reynolds will expire in January, and members Claire Korioth and Allene D. Evans have been discussing possible changes to board members' duties.

He said those discussions have ranged from making the board members' jobs part-time supervisory positions or doing away with the board altogether.

Mr. Bond said the board was made up of part-time members until the 1960s, and "their major function was to appoint the commissioner and the commissioner ran the agency."

An alternative to the current method of choosing a commissioner would be to make it a gubernatorial appointment. That would guarantee the office would be filled with someone who held strong qualifications for the job, he said.

"I think that's important for the future of regulation in Texas," Mr. Bond observed, "primarily because we have too many people stirring the soup down there."

Counting board members, their staff and other personnel, "on any given day there are probably 20 people trying to run the department," Mr. Bond said.

"The board does support a change in the current structure," said Caroline Scott, director of the insurance fraud unit at the Texas Department of Insurance, who also spoke at the Dallas-Fort Worth RIMS meeting.

The structure "does present certain problems in terms of the number of people in the process and the ability to react and respond quickly," she agreed.

But having an elected commissioner would be "very problematic for me," Ms. Scott said.

She said there is a "need to have a professional who is responsible for administering and regulating this very complex industry. The examples I have seen of elected officials have not been overwhelming to me." BI

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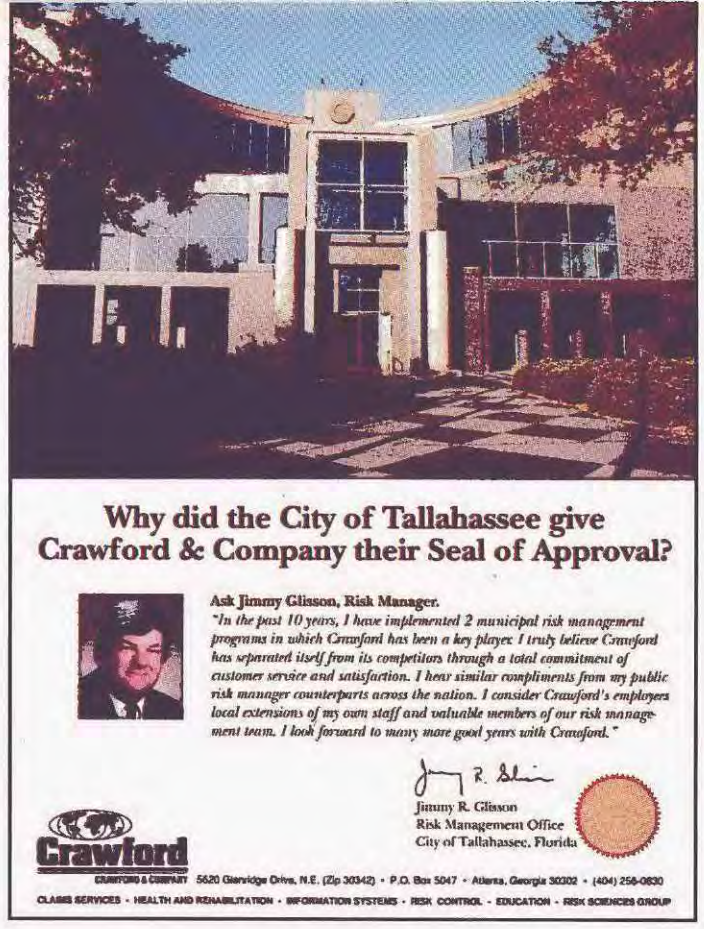

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A second look at the ADA

Recent events may indicate costly threat to health plans

By Linda M. Laarman

THE AMERICANS With Disabilities Act, while intended as an anti-discrimination and equal employment opportunity law, could become a costly mandated benefits statute. Until recently, this possibility was generally ignored in the volumes written and spoken about the ADA. But now the Supreme Court has decided not to review *Greenberg vs. H&H Music* and reinforced the principle that, under the Employee Retirement Income Security Act of 1974, employers have broad discretion to limit health plan coverage. The result is an enhanced focus on the ADA.

Indeed, the Bush administration gave the go-ahead to use the ADA to attack employer changes to health plans. It told the Supreme Court recently in a memorandum on *H&H Music* that while ERISA does not provide a remedy for the type of employer action taken in the case, the ADA may. Earlier, the administration disapproved Oregon's proposed universal health plan, contending that the state's Medicaid health services rationing plan violated the ADA (*BI*, Aug. 10).

The ADA also threatens numerous cost containment and managed care practices. To cite just one of many possible examples, employers' ability to limit what they will pay for treatments for psychiatric counseling and for alcohol or drug dependency treatments may be severely curtailed.

This might not be so difficult for employers to swallow if one of the stated purposes of the ADA was to reform health care plans, if health plans had been the subject of full discussion when the ADA was going through Congress, and if the resulting law reflected reasonable conclusions drawn from those deliberations.

Clearly, however, health care reform was not a purpose. And the ADA and its legislative history provide strong evidence that the lawmakers did not even understand the fundamental workings of employer health plans, much less how the ADA provisions they wrote potentially could affect them. Now, employers may have to bear the cost of that misunderstanding.

It is helpful to review what the ADA does with respect to health plans. Although most of the changes reflect worthwhile social objectives, the combined effect could be that employers, and their employees, will now be forced to incur still greater health costs, or reduce or even eliminate their health benefits, at a time when health care costs are out of control and the country—finally—is engaged in a serious debate about the future health care system and employers' role in that system.

First, the ADA prevents employers from rejecting disabled job applicants on the grounds that hiring such applicants may drive up health costs. This also holds true where a job applicant has a disabled spouse, child or other dependent, regardless of whether the applicant is disabled. A closely related requirement is that an employer may not in fact exclude disabled employees and dependents from its health plan on the grounds that such coverage will increase costs. There may be a limited exception, most relevant to smaller employers, if an individual's health is so poor that an insurance company would refuse to insure him.

There may or may not be a correlation between having a disability and incurring greater than average medical expenses, depending on the nature of the disability. There is no question, however, that because of these new requirements, employers will now have to provide health benefits to individuals whose disabilities may generate greater than average expenses.

Smaller employers will find these new requirements particularly burdensome and, as a result, some will be compelled to cut back overall benefits in their health plans or further increase employee costs. Nevertheless, these changes were clearly intended by Congress, and employers cannot now legitimately claim to be surprised.

The bombshell is what the ADA says about coverage and cost rules within health plans, such as exclusions or dollar caps on benefits for certain diseases, second opinion requirements and differences in employee costs depending on whether an employee satisfies certain wellness criteria. What Congress seems to have intended, and what the ADA actually does, seem to be two different things.

In considering the ADA, the various congressional committees involved repeatedly expressed their intent that the ADA generally not disturb existing health care practices. In fact, the ADA's health care rules are cast in the form of an exception to the general anti-discrimination provisions of the statute. However, these rules appear to say that existing practices are good only if they can be justified on the basis of risk classification standards, defined as "actuarial principles or actual or reasonably anticipated experience."

To further explain, it appears that Congress thought that insurance companies and employers possessed something resembling huge data banks containing lists of medical conditions, types of treatment, and various wellness criteria, and the linking of those items to the risk of medical costs. Health plan practices that limit

Continued on next page

ADA should be seen as ally in improving productivity

By Eric Reisenwitz

SOME EMPLOYERS RUN THE risk of viewing the Americans with Disabilities Act in the same vein as they may have seen the people it covers. Instead of seeing the new law's ability to help reduce benefit costs and improve workplace productivity, they may focus on the limitations it places on business.

Risk managers and benefits managers who are familiar with disability management and who are accustomed to managing people with disabilities are more likely to see the new law in a positive light. These professionals will recognize the ADA can be an ally in managing the workplace of the future.

Before exploring how the ADA can help, let's begin by reviewing how the law affects employers. The law itself counts some 43 million Americans with disabilities. That number includes nearly 13 million of working age, between ages 16 and 64. Clearly, the ADA is intended to open doors for a greater number of those Americans with disabilities.

Employers often overlook the fact, though, that 4 million of the 13 million people with work disabilities are already in the workforce. Another 1.4 million employees each year will become disabled for some time, based on statistics from the National Institute of Disability & Rehabilitation Research.

These numbers mean employers must consider how the ADA applies to millions of current employees who have disabilities or will become disabled, as well as people with disabilities entering the workforce.

Employers familiar with the concept of disability management programs will find it easier to comply with the ADA. They may already have strategies in place that help them accommodate current employees who become disabled. And these strategies also will help to accommodate new employees with disabilities.

Disability management and the ADA share a common outlook: a willingness to focus on the abilities of people, rather than their disabilities. Employers who see this relationship will find three opportunities in the new law. One, it will make management more aware of the benefits of disability management services—especially back-to-work programs with proven success. Two, by encouraging managers to take a more active role in the rehabilitation process, the law has the potential to help lower disability insurance claim costs, and therefore, the premiums employers pay for disability insurance. And three, the law encourages managers to better match people's abilities with job responsibilities, which will help protect the employer against discrimination claims and will lead to a more productive use of people's talents.

Let's look at each of these opportunities:

- **Awareness.** The ADA will encourage employers without formal disability management programs to add programs that will help them accommodate and encourage rehabilitation of employees who become disabled. As employers use disability management services, they will see that these strategies do more than help meet the requirements of the ADA. Disability management programs also help control costs and preserve labor in a shrinking labor force.

Disability expenses average more than 8% of employers' total payroll, according to statistics from the Washington Business Group on Health. Half the tab goes for direct costs of disability—sick pay, short-term disability, long-term disability, disability pensions, workers compensation and miscellaneous accident insurance. The balance represents indirect costs, such as lost productivity, customer satisfaction, recruitment, as well as lost business costs.

As the ADA heightens awareness of disabilities and their costs to businesses, more managers will want a crash course in the basics of disability management. They should look at programs that not only help control costs but monitor the quality of service their employees receive. The best disability management programs incorporate four elements: prevention, integration, cost reduction and management information. Before addressing cost reduction, let's quickly review the other three:

- Prevention includes wellness, safety and employee assistance programs that can help reduce the impact of disability on businesses by preventing disabilities before they occur. Many employers already use these programs as part of their health care and workers compensation programs; they simply need to understand that these programs play a role in reducing work loss as well.
- Integration, or seeing the links between disability programs and other benefits, is the second element of disability management. When an employee becomes disabled, the event should not be viewed simply as short-term disability or a long-term disability, but instead, it must be seen as a singular event that ripples across an employer's operation.
- Management information strategies help tie together information about disability benefits so employers can identify opportunities to prevent disabilities,

Continued on next page

ADA: A costly threat

Continued from previous page
benefits for specified medical conditions or types of treatment, or that increase employee costs for failure to satisfy specified wellness criteria, could be analyzed—and apparently, in all but the most egregious of cases, justified—using this data, it was believed.

In reality, no such data currently is used and probably does not even exist. Although decisions about health plan coverage and cost practices are not totally arbitrary, they clearly involve imprecise information, opinions and value judgments.

The ADA also provides that a health plan practice may not be a "subterfuge" to evade the purposes of the act but does not define the term. This has resulted in considerable debate in legal circles regarding the ADA's effect on health plans. In fact, lawyers at the Equal Employment Opportunity Commission and in private practice, as well as the courts, probably will be debating the meaning of "subterfuge," "risk classification" and other ADA terms and rules for years to come.

Unfortunately, however, most employers do not have the luxury of waiting for the law to settle before making decisions about their increasingly expensive health plans. The mere fact that there is significant legal uncertainty, coupled with the threat of no-win employment litigation (especially when it is remembered that jury trials are available in ADA litigation), could have a chilling effect on both traditional and innovative cost containment and managed care.

Finally, the problems are compounded by the fact that the ADA potentially treats as "disabilities" a host of conditions that, prior to the ADA, typically would not have been considered as such. Employees not obtaining the health plan coverage they want for dependencies, for stress, for depression and for infertility treatment are potential claimants.

Here are a few examples of typical plan designs and how they may fare under the ADA:

- Blanket exclusions or dollar caps applicable to entire diseases are likely to become highly questionable. Employers probably will not be able to justify them on the basis of risk. Even if they can be so justified, they could be attacked as "subterfuges."
- Coverage limitations on drugs, devices, procedures and other treatments probably will continue to be acceptable, without regard to whether they can be justified on the basis of risk, so long as they are "neutral" and uniformly applied. This is true even though such limitations may have a harsher effect on the disabled than on others.

Few would quibble if all the ADA did was stop discrimination, without any cost attached. But there is a clear cost.

Thus, for example, an annual limitation on the amount reimbursable for physical therapy will be acceptable, even though certain disabled individuals may be more harshly affected by the limitation than other individuals. Similarly, exclusions or caps on "experimental treatments" and lifetime or annual dollar maximums on reimbursements applicable to treatments of all types will be acceptable.

- Many other types of limitations, however, either will have to be reformulated to be neutral, justified by an insurance expert on the basis of as-yet-to-be-developed risk classification principles, or dropped from the plan.

For example, limitations on coverage for treatments related to alcohol and drug dependencies and to mental and nervous conditions may pose particular problems. It is common for health plans to impose special dollar caps or limitations on the number of reimbursable in-patient days applicable to these types of treatments but not others. Although Congress may have expected that these types of limitations would fall into the neutral category, it is not difficult to imagine an alcoholic, for example, arguing that these types of limitations unfairly single out him and his disability.

- Many managed care practices may be challenged. For example, suspect practices may include making full reimbursement contingent on obtaining a second opinion or on working with a "patient advocate," particularly where those conditions are imposed for some but not all types of diseases or treatments.
- Certain wellness-based health incentives may be challenged. An illustration is the increasingly common practice of requiring employees to pay higher health premiums if they fail to satisfy certain wellness criteria, such as cholesterol and blood pressure levels.

Of course, if the basic anti-discrimination purpose of the ADA is accepted, then it may follow that some current health practices should not pass muster. For example, why should it be acceptable to cap expenditures for AIDS if there is no cap for other catastrophic diseases such as cancer, and there has been no cost comparison? Isn't an employer that has imposed such a cap really making a judgment about the value of one disability (or worse, type of individual) over another? And isn't that discrimination, plain and simple?

And few would quibble if all the ADA did with respect to health plans was stop discrimination, without any cost attached. But there is a clear cost, given the ADA's prohibitions on taking an individual's medical status into account in hiring and in deciding who will be covered under its health plans, the many types of conditions that may be treated as disabilities, and the apparent need to change many existing coverage and cost practices. The cost of restructuring and administering plans to meet the ADA also should not be overlooked.

The ADA can now be added to a long list of statutes, including at the federal level the COBRA health care continuation rules and the Medicare secondary payer rules, in which Congress and state mandated benefit laws have shifted to employers the medical costs of a group that they deem worthy of protection. The politicians get credit for reaching out to the less advantaged, while employers are stuck with the bill.

We are now engaged in a great national health care reform debate. One of the central realizations fueling the debate is that the United States cannot afford to pay for unlimited health services. One of the central questions is whether perpetual cost-shifting to employers is the most effective and fair way to extend and pay for that coverage we need to provide.

The fact that the ADA health plan rules become effective in the midst of this debate, requiring expanded health plan coverage and yet again shifting the cost of the expansion to employers—especially when the ADA was not intended by Congress as a health reform law—is a truly unfortunate irony. BI

Linda M. Laarman is an attorney and principal at the Washington Resource Group of William M. Mercer Inc.

ADA: A valuable ally

Continued from previous page
reduce costs and improve benefits. This same information can help employers as they plan ways to comply with the ADA. For instance, data on rehabilitation cases will show employers the type of accommodations they should consider for employers with disabilities.

- **Cost Reduction**. Controlling disability costs is a major part of a disability management program. It also represents the second great opportunity offered by the ADA. The law encourages employers to accommodate employees returning from disability leave, which will help reduce the incidence and duration of disability claims. Those savings will help control the costs employers pay for disability insurance programs.

The potential premium savings—the direct cost of disability—is only part of the equation. Effective cost-control programs also help reduce the indirect costs of disability, the 4% of payroll that often gets overlooked. Consider what it costs to recruit new staff, advertise, read cover letters and resumes, screen and interview applicants, and review references. On average, hiring a new employee costs more than $2,800. Hiring a senior level manager or executive costs nearly $6,600. Just to hire a non-exempt employee costs $1,150, says the Saratoga Institute, a Silicon Valley research and consulting firm.

Compare those figures with the costs to make a reasonable accommodation for an employee returning from disability leave. The President's Committee on Employment of People with Disabilities reports that in 88% of cases employers can accommodate people with disabilities for less than $1,000 with quick fixes, such as adding voice amplifiers to phones, making minor furniture moves or installing flashlight signals for the hearing-impaired.

Yet, some employees—roughly 6% of all long-term disability cases—will require rehabilitation services to return to work. In these cases, which usually involve more complex disabilities, the disability insurer takes the lead for the employer by identifying employees who need rehabilitation services and working with the employer to help these employees return to work. In many cases, a disability insurance program pays for the rehabilitation services, so the costs do not increase the employer's costs of accommodating employees returning from disabilities.

- **Productivity**. If reducing costs isn't reason enough to see the potential benefits of the ADA, consider how the law can help employers preserve talented employees in a labor shortage. Restructuring a job for a person with a disability may be easier than competing for qualified applicants in a tighter labor market. By encouraging more rehabilitation, the ADA and disability management will help employers retain talented, and more productive workers.

Value employees for what they can do, not what they can't do. Understand what the ADA offers, rather than what it limits.

The ADA also will lead employers to better define the essential job responsibilities to help protect against a discrimination claim. That process will help match employees' abilities with job responsibilities, leading to a more productive use of talents.

Clearly, the ADA will present challenges to employers. It is a complex law that will generate much discussion in the years ahead. Yet, these three opportunities—a greater awareness of disability management, cost savings from the increased use of rehabilitation, and a more productive use of people's talents—are real and should not be overlooked.

To realize these opportunities, employers need only adopt the outlook that disability management and the ADA share: Value employees for what they can do, rather than for what they can't do. Understand what the ADA offers, rather than how it limits business.

That outlook will benefit employees and employers alike. BI

Eric Reisenwitz is vp-disability with the CIGNA Special Benefits Companies in Philadelphia.

Union Indemnity

Continued from page 1
eight years ago.

Union was a subsidiary of Frank B. Hall & Co. Inc., although the insolvent unit's assets and liabilities were retained by Reliance Group Holdings Inc. when Hall was sold to Aon Corp. (*BI*, July 27).

"From our perspective, it's a wonderful decision," said Lawrence I. Brandes, a lawyer who represented 11 of the 13 reinsurers in the case.

This was the first court to consider whether, "as a matter of public policy, a reinsurance contract can be rescinded after the company goes into liquidation. And it held that it can be," said Mr. Brandes, a partner with Miller, Singer, Raives & Brandes in New York.

"What the court did was to affirm the principle that a liquidator does not have 'super rights.' It makes clear for New York (that) the liquidator is not going to be able to avoid the sins of the company he is liquidating," said Stuart Cotton, a reinsurance lawyer with Mound, Cotton & Wollan in New York. He was not involved in the Union Indemnity case.

Had the decision gone the other way, the impact could have been "scary," said Mr. Brandes. "If liquidation would have prevented you from presenting a fraud defense, would it also prohibit you from asserting any other defense, such as coverage?"

Union was found insolvent at year-end 1984 and ordered into liquidation in 1985. It had allegedly used gross misrepresentations to secure reinsurance contracts. Union's liquidator sued, claiming that Hall was responsible for the collapse, and in 1989 the broker paid $48.5 million to settle that suit (*BI*, June 5, 1989).

Later that year, Judge Gammerman ruled that the reinsurers could void their contracts with Union (*BI*, Oct. 30, 1989).

The judge found that Union had made material omissions, as well as misrepresentations, and that its officers and directors were aware of Union's true financial condition. He also ruled that "had a reinsurer been aware of insolvency, it certainly would not have underwritten the sum encompassed by reinsuring the bankrupt company."

The liquidator asked Judge Gammerman to reconsider the case.

In his Oct. 28 decision, Judge Gammerman wrote that he agreed to re-examine the case because "recision of the reinsurance treaties would have a significant impact" on the Union Indemnity estate and could "more than double the size of the insolvency."

This "cataclysmic result" and the "serious public issues raised" required further examination, wrote the judge.

The liquidators fared no better this time around, though.

First, the liquidator argued that the reinsurers had the right to examine Union books, and thus could have detected the fraud.

But this right was severely limited, Judge Gammerman ruled. The reinsurers could not examine the books until after the treaties had been signed and effective, he wrote.

"Moreover, the right of inspection was limited to the records pertaining to the reinsurance provided, which, in turn, was limited to fidelity and surety business, so that the general financial condition of Union was not necessarily open to inspection," wrote Judge Gammerman.

Next, the judge turned the liquidator's arguments concerning accessibility of Union's financial records against the Insurance Department itself.

"It is not at all clear that reasonable inspection by the reinsurers would necessarily have uncovered the insolvency at an earlier time. Indeed, the superintendent's regular audits of Union did not reveal the fraud, and the Department of Insurance permitted Union to stay in business for several years after the actual insolvency occurred," he wrote. "That Union was permitted to continue to operate as before was some indication of its solvency that could have been relied on by the reinsurers."

Judge Gammerman also cited a 1991 New York appellate court decision that allowed reinsurers to offset amounts owed to an insolvent insurer by amounts the insolvent company owed them (*BI*, May 20, 1991).

'If liquidation would have prevented you from presenting a fraud defense, would it also prohibit you from asserting any other defense, such as coverage?' asked Mr. Brandes, who represented 11 reinsurers in the case.

In that case, *In the Matter of Midland Ins. Co.*, the Insurance Department had argued that while the insolvent insurer might have a duty to allow offsets, the liquidator is a different party altogether and had no such duty. Judge Gammerman quoted the appellate court's rejection of that argument, holding that "liquidation cannot place the liquidator in a better position than the insolvent company he takes over, authorizing him to demand that which the company would not have been entitled to prior to liquidation."

Mr. Brandes said the reinsurers affected by the ruling are Allianz Syndicate of the defunct New York Insurance Exchange; American Centennial Insurance Co.; Atlas Assurance Co. of America; First Horizon Insurance Co. Ltd.; GTE Insurance Co.; Hannover Reinsurance A.G.

Other affected reinsurers are: KCC New York Syndicate Corp., another NYIE syndicate; Kansa Reinsurance Co.; Philan Insurance Ltd. and Benodet Insurance Ltd., two Cayman Islands captives with a common parent that ceased writing business in 1987; The 1792 Co., also of the late NYIE; Puritan Insurance Co.; Republic Insurance Co.; and Simcoe & Erie General Insurance Co.

•

In the Matter of the Liquidation of Union Indemnity Insurance Co. of New York; Liquidator vs. American Centennial Insurance Co. et al.; Michigan National Bank-Oakland vs. American Centennial Insurance Co., et al., Supreme Court of New York, New York County, No. 41292-85, No. 23453-85.

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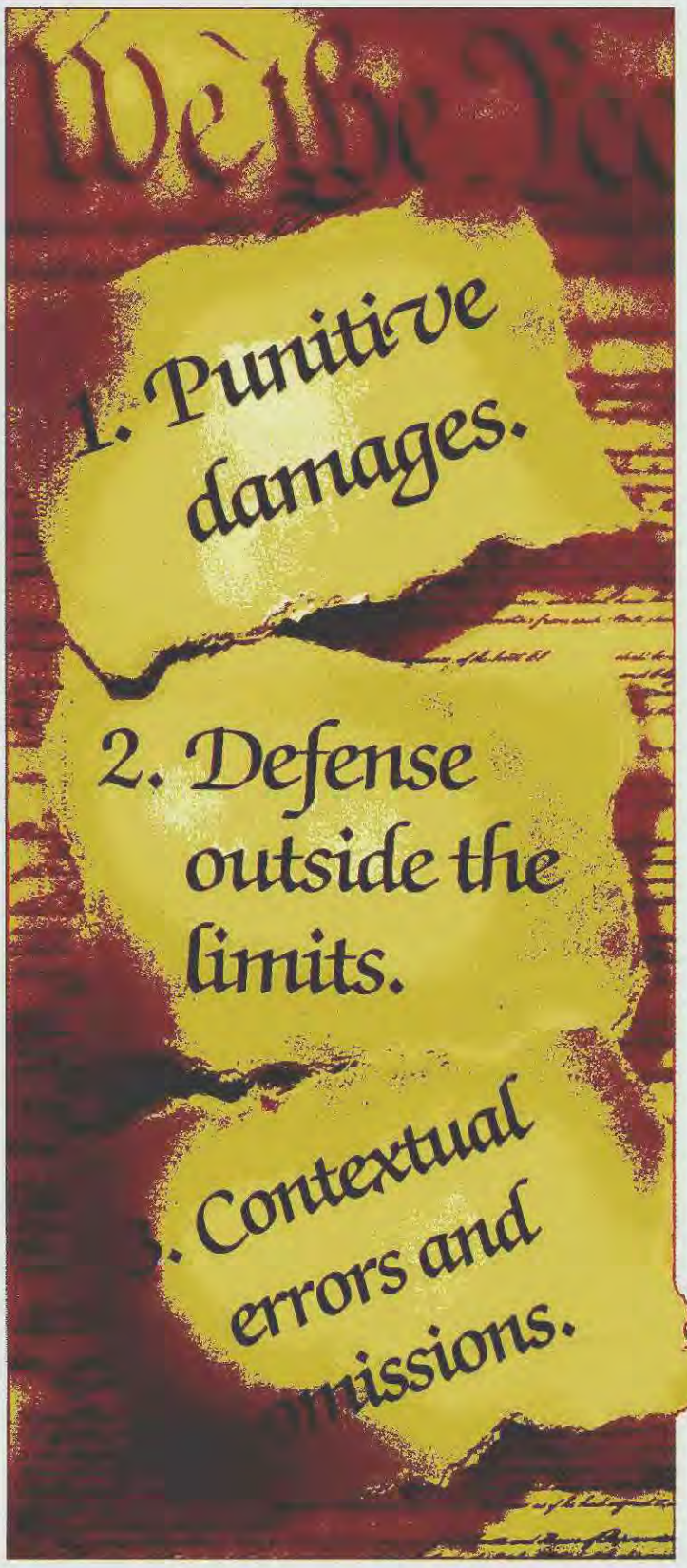

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Cigarette liability

Continued from page 1

N.J., law firm may be indicating that there is no pot of gold at the end of the litigation rainbow, said Charles Wall of Phillip Morris Cos. Inc.

The New York-based company is a defendant in many of the 50 or so cigarette liability suits still pending in various state and federal courts.

"When the leading case is dropped, one could say that it might impact the other cases. Presumably, Mr. Edell realized that there would be no payout. One would assume that other lawyers would take a lead from this," said Mr. Wall.

But this doesn't appear to be happening.

Instead of backing off, lawyers for smokers are prepared to capitalize on the strides Mr. Edell made during his lengthy battle with the tobacco companies.

"He settled the question of federal pre-emption. We won that ruling and now know exactly what we can do," said Don Barrett, an independent attorney in Lexington, Miss., who has three cases pending against cigarette companies.

"It was also his work that disclosed the history of the tobacco industry's efforts to systematically mislead the public about the ills of smoking," Mr. Barrett said.

It was this argument that persuaded a federal court jury in New Jersey to award Ms. Cipollone's family $400,000 in 1988. That ruling was later overturned by a three-judge panel of the 3rd U.S. Circuit Court of Appeals because certain defense evidence had been improperly barred (*BI*, Jan. 15, 1990).

A retrial of the Cipollone case against Phillip Morris, Lorillard Corp. and Brooke Group Ltd.'s Liggett Group unit was due to begin this spring.

"Marc obviously accomplished a lot and it hurts a little to see such an important player bow out. I imagine the tobacco industry is quite pleased that they succeeded in grinding down a good attorney," said Dan Childs of Johnson & Childs in Philadelphia, which is suing Loews Corp. unit Lorillard over the use of a cigarette filter that was proved to contain asbestos.

But he said the dismissal of the Cipollone case will have no bearing on his cases involving the Kent Micronite filter. "Our claims are based on asbestos in cigarette filters in the 1950s. It's a completely different premise than Marc pursued."

While Mr. Edell's firm, Budd Larner Gross Picillo Rosenbaum Greenberg & Sade, said costs were its sole reason for dropping the Cipollone case, other attorneys report that they are not encountering equally burdensome costs.

"Hard out-of-pocket costs are not that great. It's the time these cases take to come to trial that's concerning us," said George Covert of Covert & Braud, a Baton Rouge, La., law firm that has nine suits pending against cigarette companies.

Mr. Barrett also said that he is not running up costs similar to the $1 million at Mr. Edell's firm.

"It's the work that Mr. Edell did that allows lawyers like myself to step in and spend much less. I don't think these cases are as expensive to win now that we have the Supreme Court on our side. These cases can be won for less than $50,000 because they're basic products liability cases. I'm sure that bothers the cigarette industry," he said.

But whether such cases really are "basic" is open for dispute.

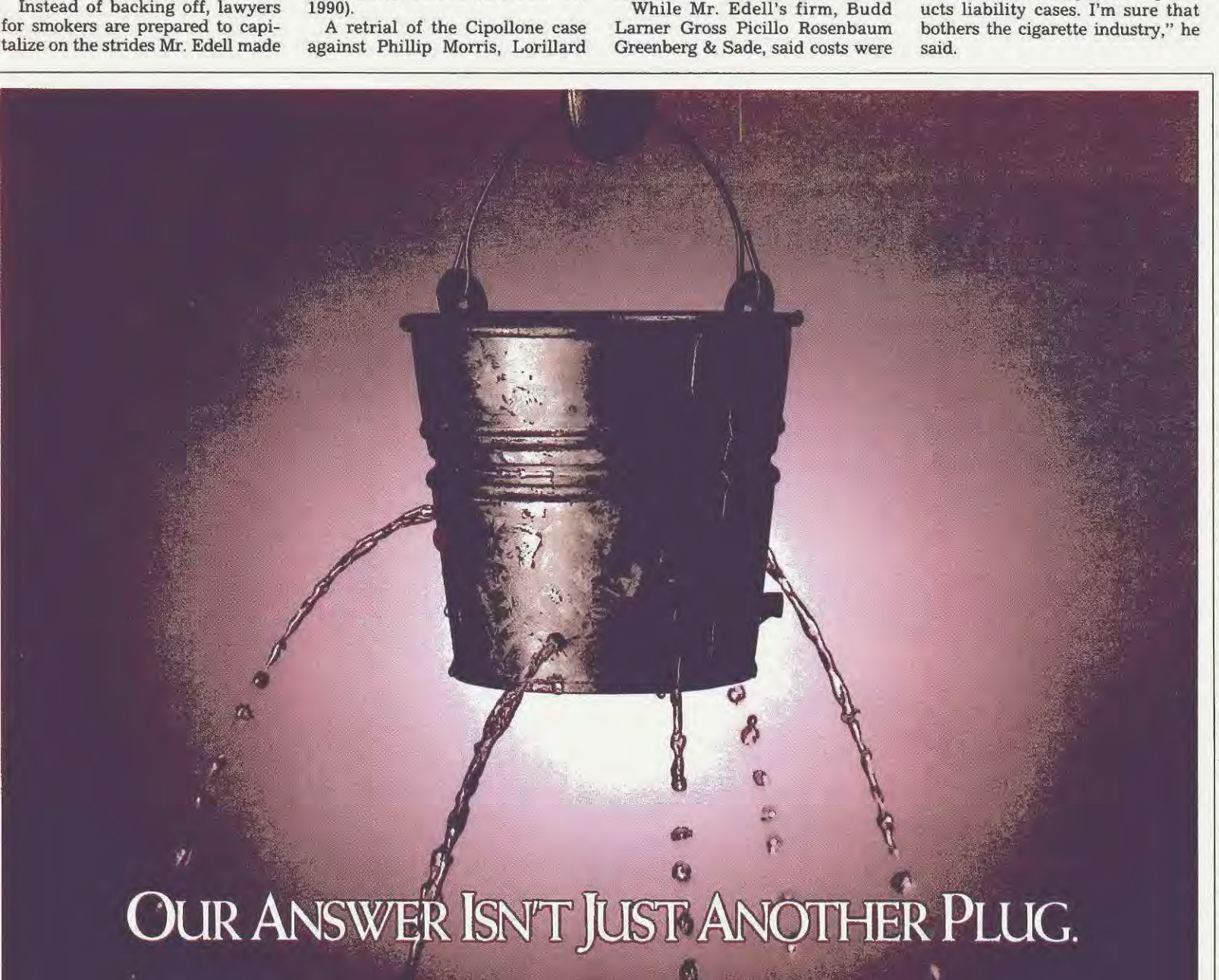
Even Mr. Edell said there is no such thing as a sure thing, especially when long-time smokers are pitted against the powerful tobacco industry.

"All cases like these have difficulty in terms of jury appeal. It isn't particularly easy to get a jury to appreciate addiction and how the tobacco industry has played on this dependence," Mr. Edell explained. "But at the same time, almost all cases have some favorable facts."

Mr. Daynard of the Tobacco Products Liability Project said many of the pending cases are actually stronger than the Cipollone case. "Rose Cipollone never tried to quit smoking and there were some questions about whether smoking really caused her cancer."

But Mr. Wall of Phillip Morris said the dismissal of the Cipollone could dissuade other lawyers from taking similar cases.

"When a plaintiffs' lawyer sees this, he may decide not to file. Other cases may not be as costly as Edell's, but they'll still take time. . .lots of time," he said. BI



Today's employee health care system is shot full of holes. Unnecessary surgical procedures, extended hospital stays, inappropriate diagnostic testing, over-utilization of psychiatric and substance abuse benefits, code gaming and the rubber stamping of claim payments can seriously drain a company's profits.

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Oil refinery blast

Continued from page 3

Although he declined to specify the exact amount, he said the captive is "well protected."

James Edwards, a broker with Reed Stenhouse in Toronto, confirmed TOTAL is a client of the firm's Calgary, Alberta, office but would not comment further.

Work has been halted at the La Mede refinery and is not expected to resume for at least a month, said the TOTAL spokesman. The refinery won't operate at full capacity for several months, he added. Prior to the explosion, La Mede was refining 134,000 barrels of oil a day.

The SGCA broker said liability claims will probably be less than 15 million francs ($2.8 million) because the refinery is in a sparsely populated area and because the families of workers killed in the blast will be covered by a government compensation scheme.

"But for property and business interruption, it is a disaster," he said.

"The disaster may have come too late to affect Jan. 1 renewals in general, but it will definitely have some impact on oil and gas rates next year," the broker said.

Guy Cowan, an energy broker with Sedgwick Energy Ltd. in London, said claims from the La Mede refinery may be large enough to help boost rates.

"Rates have been rising over the past 12 months and are continuing to rise," he said. "There is a general correction in the market worldwide."

The La Mede loss will have a "substantial" impact on TOTAL's reinsurance renewals in January, predicted the SGCA broker.

At mid-year renewals, energy rates were already rising, particularly in the London market where capacity is tight (*BI*, July 13).

Investigations into the cause of the explosions will take several weeks and will be hampered by the loss of the control room, the TOTAL spokesman said. Preliminary reports by firefighters indicated the explosions were caused by a gas leak in one of the refinery's gas treatment units.

La Mede is the second largest of TOTAL's three refineries in France. The spokesman said the other refineries will be able to make up some of the lost production. Outside France, TOTAL has four other refineries in Europe and four in the United States. BI

Vermont tax

Continued from page 2
in over three years.

Under that proposal, the current 0.7% tax on the first $20 million of direct written premiums would be reduced—starting next year—by 0.1% each year for three years until the tax is 0.4%.

Above the $20 million mark, all premiums would be taxed at 0.1%. Currently, the rates are: 0.5% for $20 million to $40 million; 0.3% for $40 million to $60 million; and 0.1% on premiums above $60 million.

Although no final tax package has been agreed to, state officials and captive managers and attorneys say there is a consensus that premium taxes will be reduced.

"We are very serious about premium tax reduction. We want and will maintain our competitive position," said Len Crouse, director of the captive division at the state Department of Banking, Insurance and Securities.

"Everyone—the governor, the Legislature and the captive industry—is committed to keeping Vermont competitive," said Malcolm Cutts-Watson, a vp with Johnson & Higgins Services Inc. in Burlington.

While no one mentions it by name, Hawaii is the domestic domicile that stands to gain, it is feared, if Vermont doesn't reduce its premium taxes.

Depending on the type of captive, the premium tax in Hawaii can be as low as 0.25%.

Vermont now has about 225 captives (*BI*, March 30) and will license more than 20 new ones this year, predicts Mr. Crouse.

If the premium tax is lowered, Vermont should be well positioned to capture the lion's share of the surge of new captives that are expected to be formed when the market tightens, said Jeffrey Johnson, a partner with the law firm of Primmer & Piper in Montpelier. BI

Willis Corroon

Continued from page 3
begin early next fall, said William McInerney Sr. of McInerney & Dillon in Oakland, who represents Mr. Lamberson and the other defendants.

In its suit filed in August, Willis Corroon describes the defendants' conduct as "willful, intentional, malicious, oppressive" and "despicable."

The brokerage states Mr. Lamberson formed Lamberson, Koster after his retirement in June, and was joined by John Koster, formerly the chairman and director of Willis Corroon in California. They then recruited other Willis Corroon employees to the new brokerage.

Access to Willis Corroon's trade secrets gives Lamberson, Koster a "tremendous, unfair" advantage, the suit charged. Mr. Lamberson's high-level positions, it states, gave him "direct access to plaintiffs' most confidential client information and most vital trade secrets."

Willis Corroon's charges are denied by the defendants.

They also say Mr. Lamberson, 59, left Willis Corroon and formed Lamberson, Koster only after being told by CEO Richard Miller that there was no longer a job for him at the firm. In effect, they say, Mr. Lamberson was forced into early retirement.

Mr. Lamberson joined Corroon & Black following the 1968 purchase of Miller & Ames, which specialized in insurance and surety bonding for the construction industry. He became Corroon & Black's president and chief operating officer in 1989, and retained that position after its merger with Willis Faber the following year. In March 1991,

'There's probably a lot of internal reasons' why Willis is pursuing the case, says Mr. Lamberson.

he was named co-head of the brokerage's worldwide retail strategic business unit.

Mr. Koster, 62, left the company after being stripped of much of his responsibility and being told someone younger was wanted to fill his post, according to the defendants' court papers.

In its countersuit, the defendants ask for a preliminary and permanent injunction forbidding Willis Corroon from discouraging clients from doing business with the firm, and unspecified compensatory damages, interest on lost revenues, punitive damages and costs.

"We obviously think we're right on this," Mr. Lamberson said in an interview. For 31 years, he says, he was a dedicated and loyal employee. "I'm very disappointed I was put in a position where I decided to start this little business here."

Willis Corroon, he noted, generates more than $1 billion in annual revenues while "if we do $2 million to $3 million we'll be very happy."

"I think there's probably a lot of internal reasons" why Willis is pursuing the case despite its disproportionately greater size, said Mr. Lamberson.

A Willis Corroon official said, "Our basic position is (that) the matter is in litigation, and for that reason, we think it's inappropriate to discuss it." BI

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INTERNATIONAL

Trial opens on Eagle Star runoff claims

By STACY SHAPIRO

LONDON—Trial is set to begin today of a lawsuit filed by a Lloyd's of London underwriter over a reinsurer's refusal to pay claims under an unlimited runoff policy.

The case is unusual because the reinsurer, Eagle Star Insurance Co. Ltd., allegedly had honored the runoff policy for at least 18 years and paid a total of $29 million in claims before it halted payments in June 1991.

The suit, filed by Lloyd's underwriter Paul Toomey, is one of at least two disputes in which Eagle Star is being sued after it stopped paying claims on runoff reinsurance policies. The other, involving Lloyd's underwriter Michael Meacock, is planned for arbitration.

Eagle Star would not comment on the two cases.

The case also draws attention to a controversial 1991 London High Court decision that effectively limited reinsurers' liability for some asbestos liability claims paid by ceding companies under the Wellington Agreement.

Mr. Toomey contends that decision prompted Eagle Star to stop paying claims.

In that case, the High Court ruled that a Lloyd's syndicate must prove the extent and validity of each asbestos-related claim it paid under the Wellington Agreement before those claims were paid under runoff reinsurance contracts (*BI*, July 22, 1991). The syndicate there was managed by Roberts & Hiscox Ltd.; Richard Outhwaite wrote the runoff policies.

The ruling said that a reinsurer could refuse to pay claims settled through the now-defunct Asbestos Claims Facility, which was formed by the Wellington Agreement, if a ceding underwriter had not obtained the consent of the reinsurer before joining the facility.

The court also ruled that reinsurers have the right to refuse claims by ceding underwriters when the cedant had no legal obligation to make the underlying payment, despite a "follow-the-settlement" clause in the reinsurance contract.

Following the ruling, the Center for Claims Resolution—the ACF's successor—changed its claims sharing formula (*BI*, Nov. 11, 1991).

Messrs. Hiscox and Outhwaite earlier this year settled their differences on the runoff policy, quashing a legal challenge of the

Continued on page 32

AMB-Credit Lyonnais strike deal at last

PARIS—The future of Europe's biggest cross-border insurance alliance was resolved Nov. 10 after months of negotiations between German insurer AMB Aachener-Munchener Beteiligungs and French state-owned bank Credit Lyonnais.

Credit Lyonnais agreed to buy a 50.1% stake in AMB's loss-ridden banking subsidiary, Bank fuer Gemeinwirtschaft, for 1.42 billion German marks ($890 million at the current exchange rate).

The deal paves the way for AMB's management to register a 25% stake that French insurance company Assurances Generales de France acquired in AMB last year.

AMB told AGF early this year that it would register the shares —giving AGF full voting rights and a seat on AMB's board—provided the French insurer was able to help it find a buyer for BfG. AGF suggested Credit Lyonnais, which holds about 2.5% of the French insurance company.

GLOBAL BRIEFS

A Credit Lyonnais spokesman said last week that the acquisition of BfG shares would be carried out through "exchanges of various securities in which AGF will be involved."

There is speculation that Credit Lyonnais may be able to increase its stake in AGF as part of the deal.

The decision followed months of meetings between AMB chairman Wolfgang Kaske and Credit Lyonnais Chairman Jean-Yves Haberer.

Also present at the meetings was Hans Matthofer, chairman of the BGAG German trades union holding company that originally wholly owned BfG, but now holds 49.9% of the bank.

AMB bought a 50%-plus one share stake in BfG in 1987 to develop a banking base in Germany and expand its cross-selling opportunities. But restructuring the bank has cost AMB dearly, and a further capital injection will be required next year.

The proposal is not without its twists, however. A Frankfurt lawyer, Nicolaus-Jurgen Weickart, plans to lead AMB's small independent shareholders in an effort to contest the AMB/AGF deal. He represents an unidentified client who owns 1% of AMB and has secured the support of shareholders holding another 9% of the company's capital.

According to Mr. Weickart, AGF is planning to take control of AMB by stealth without making a formal offer to shareholders. He hopes to force AGF into making a full bid for the German insurer.

Shareholders will vote on the sale of BfG and the plan to register AGF's holding at an extraordinary meeting later this year, probably near Christmas, according to an AMB spokesman.

Italian insurer Fondiaria S.p.A., which owns 20% of AMB, will play a key role in the struggle. Analysts expect Fondiaria to oppose AGF's ambitions, favoring instead development of Fondiaria's tripartite alliance with AMB and Britain's Royal Insurance P.L.C. (*BI*, Nov. 25, 1991).

However, the French insurer should be able to count on the support of Dresdner Bank and Munich Reinsurance Co., said Michael Huttner, an insurance analyst at stockbroker BNP Securities in London. These two companies each own 10% of AMB.

AGF is not the only French state-owned insurance company to have difficulty establishing a foothold in the German insurance market.

Union des Assurances de Paris, France's biggest insurer, is also struggling to convert a 34% stake in French insurer Groupe Victoire into a 50% stake in Victoire's German subsidiary, Colonia Group A.G.

Colonia management has indicated it is perfectly happy with the status quo and is not eager to be controlled by UAP.

—*By Aline Sullivan*

Global briefs continued on page 32

AP/Wide World Photo

Italian flood claims small

FLORENCE, Italy—Total insured and uninsured damage from flooding in Florence earlier this month may reach 500 billion lire ($365.5 million), a spokeswoman for Florence-based insurer Fondiaria S.p.A. said last week.

But claims are likely to be small because mainly cars, rather than houses or businesses, are covered for flooding under property policies, she said. The insurer's total car-related claims are expected to reach 50 million lire ($36,550), she said.

The floods were the worst Florence has experienced since the autumn of 1966, when the Arno River burst its banks and badly damaged the city center. The banks of the Arno contained the torrent this time, but some of the river's tributaries overflowed, flooding parts of the city's suburbs.

—*By Aline Sullivan*

Members want role in syndicate runoff

By GAVIN SOUTER and STACY SHAPIRO

LONDON

LONDON—Members of Lloyd's of London's oldest nonmarine syndicate are forming an action group to press for member supervision of the runoff of the loss-riddled syndicate.

The group says it may also go to court alleging negligent underwriting at syndicate 404, managed by Cuthbert Heath Underwriting Ltd.

"We want to exert some influence over the runoff of the syndicate and put the names in the driving seat," said Alan Porter, chairman of the action group and also of Devonshire Action Group. He said the members would employ outside runoff specialists.

Syndicate 404—the first nonmarine syndicate at Lloyd's—stopped accepting new business in September when it became clear that it would not receive sufficient support from members to enable it to operate in 1993 (*BI*, Sept. 28).

Syndicate 404's 1989 account remains open. Estimates are that it lost 58 million pounds ($94.4 million at year-end exchange rates) on a capacity of 77.3 million pounds ($124.4 million).

Plans to buy Cuthbert Heath, which also manages several other syndicates, were announced by A.J. Archer Holdings P.L.C. in August (*BI*, Sept. 7).

The members' action group would also review the possibility of starting a negligence action against members agents and managing agents over syndicate 404 losses, Mr. Porter said.

The losses are largely due to long-tail U.S. liability claims for asbestosis and pollution, he said.

"There is still a big question mark over how much was known and how much was revealed by market practitioners in the early 1980s about asbestosis risks in Lloyd's," Mr. Porter said.

M&M buys U.K. broker

Marsh & McLennan Cos. Inc. is beefing up its insurance program management operation by acquiring the bulk of privately owned U.K. broker Frizzell Group Ltd. for 107 million pounds ($162.1 million).

Last week, M&M Chairman A.J.C. Smith announced the merger of insurance program

Continued on page 31

Clearer laws, fewer rules, sought for Australian marketplace

By KATE McILWAINE

CANBERRA, Australia—Cost-effectiveness in the Australian insurance market is being undermined by two pressing problems: ambiguity in the country's main insurance law and escalating rates for professional liability coverage, according to government officials and legal experts.

These challenges have prompted some to call for less government regulation and better industry self-regulation, according to speakers at the sixth annual conference of the Australian Insurance Law Assn. last month in Canberra.

The Insurance Contracts Act 1984 imposes excessive costs on policyholders and insurers because it is poorly worded, contends David Kelly, chairman of the Law Reform Commission of Victoria, which reviews legal reforms for the state government.

Mr. Kelly said the act, currently under a routine review by the Insurance and Superannuation Commission, Australia's regulatory authority, is in need of a "plain English rewrite."

Attorney Nancy Milne agreed that the act imposes extra costs on insurers, citing as an example a recent court decision that observers say makes effective claims-made liability policies impossible in Australia.

In the case of *East End Real Estate Pty. Ltd. vs. C.E. Heath Casualty & General Insurance Ltd.*, a third party filed a claim against the real estate company while it was covered under a claims-made general liability policy written by C.E. Heath Casualty & General Insurance. However, East End Real Estate did not file a claim with the insurer until after its policy period expired.

Nevertheless, when interpreting the language of the Insurance Contracts Act, the

Continued on next page

AILA conference

Continued from previous page

Court of Appeals for New South Wales found the insurer liable for the claim, although the size of the claim was reduced by the extent of prejudice the insurer suffered because of the late notification. The insurer was not granted an appeal.

While the court had to interpret the act as written, one justice said he believed the ruling does not reflect legislators' intent.

Mr. Kelly quoted Justice Cole, who said of the decision: "It must be seriously doubted whether the legislature intended to deny insurers the right to agree with the insured that there be a claims-made and notified policy."

The East End decision could lead to decreased insurance availability and higher premiums to compensate insurers for the greater possibility of claims, Justice Cole noted.

Ms. Milne, a partner in the Sydney law firm Phillips Fox, said the act must be amended in order for insurers to be able to offer claims-made policies in Australia. She said insurers' costs as a result of the decision could be "substantial."

Meanwhile, the increasing cost of professional indemnity insurance in Australia is reaching crisis proportions, according to speakers at another AILA session.

In fact, some professionals are going without the coverage rather than pay the high premiums, the speakers said.

Many professionals who choose not to insure their liability exposures are divesting assets to make them less attractive to litigants, according to Sydney barrister John Dowd.

Mr. Dowd, a former attorney general in the New South Wales Parliament, introduced legislation that would limit professionals' liability in that state. The legislation has been temporarily shelved.

He said increases in claims and premiums have resulted in "defensive professionalism," which has lowered service quality. And in some cases, services have been dropped because of "prohibitively expensive and sometimes unobtainable insurance," he said.

Ian Bowden, managing director of Solicitors' Mutual Indemnity Pty. Ltd. in Sydney, said professional indemnity coverage is the third-largest expense for most solicitors and, if the trend of rising premiums continues, it could take second place, surpassing office rental costs.

Mr. Bowden called for comprehensive, industrywide data collection on professional indemnity claims experiences and problem areas so risk-management procedures could be developed and implemented for various professions.

Proposals for a national scheme to limit professional liability were considered by a July meeting of the Standing Committee of Attorneys General, which decided to set up a working party to prepare a paper on any potential conflicts with Australia's Corporations Law. No date has been set for the paper's completion.

Terry J. Paradine, chairman and chief executive of Marsh & McLennan Pty. Ltd. in Sydney, told the conference that litigation against troubled financial institutions, much of it involving claims under professional indemnity policies, has contributed to a contraction in the professional indemnity insurance market.

Amid the challenges facing the insurance industry, some observers are calling for increased self-regulation.

Richard Smith, deputy commissioner for non-life insurance at the Insurance and Superannuation Commission in Canberra, warned that over-regulation can stifle the insurance industry.

Delivering a paper at the AILA meeting on behalf of the former Insurance Commissioner Richard Beetham, who unexpectedly left office when his contract expired Sept. 30, Mr. Smith said insurers —not regulators—are ultimately responsible for their performance. Regulators cannot be blamed for corporate failures, he said.

Although the government has a responsibility to establish minimum standards of financial prudence and proper marketplace behavior, that does not mean commercial organizations are "absolved in any way from their responsibilities," Mr. Smith said.

"Nor should consumers of insurance be led to believe that caveat emptor no longer applies," he stressed.

Mr. Smith said if there were sufficient regulation to guarantee that no company would ever fail and no policyholder would ever be disadvantaged, the end result would be "inordinately stringent regulations and an excessively interventionist regulator. . .all of which would stifle competition, enterprise and efficiency."

The challenge is to achieve a balance between government regulation, self-regulation and caveat emptor, he said.

John Button, Australia's minister for industry, technology and commerce, told conference attendees there is no point in government acceding to consumer or bureaucratic demands for regulation if those demands threaten an industry's growth or viability.

"But that does not mean government should abandon the field in favor of the untrammeled play of market forces," he said.

Bruce Howe, general manager of Sydney-based Mercantile Mutual Insurance (Australia) Ltd., said while there is a need for regulation, shareholders "must be penalized for the poor decisions of management."

In addition, policyholders should "not escape at least some financial penalty for making. . .poor choices," he said.

Mr. Howe cited Municipal Mutual Insurance Ltd. as an example. The U.K. insurer, which specializes in writing property/casualty coverages for public entities, entered the Australian market in 1989 and wrote coverage at prices between 40% and 60% less than its competitors, according to Mr. Howe.

Local insurers could not compete and left the market. But this year, losses forced Municipal Mutual to leave the Australian market and, ultimately, to stop accepting new business (*BI*, Oct. 5).

Mr. Howe said shareholders must "pay the price of inappropriate behavior and, to some degree, the policyholders also bear some responsibility for accepting insurance from an insurer which adopts what is a clearly unsustainable commercial strategy."

Mr. Howe said he rejects the idea of guaranty funds or assessing levies on solvent insurers to bail out insolvent companies.

Shareholders 'must be penalized for the poor decisions of management,' says Mr. Howe.

Such provisions are "anathema to well-managed insurers" as they "cop it in the neck both ways," he said.

Irresponsible players affect the health of prudent insurers by charging inadequate prices, then leave the genuine insurers to pay the bills, he said.

Mr. Kelly of the Law Reform Commission of Victoria said insurer self-regulation would produce "acceptable results" only if it is done in collaboration with the country's regulatory bodies: the Insurance and Superannuation Commission and the Trade Practices Commission. It also requires consultation with client groups, he said.

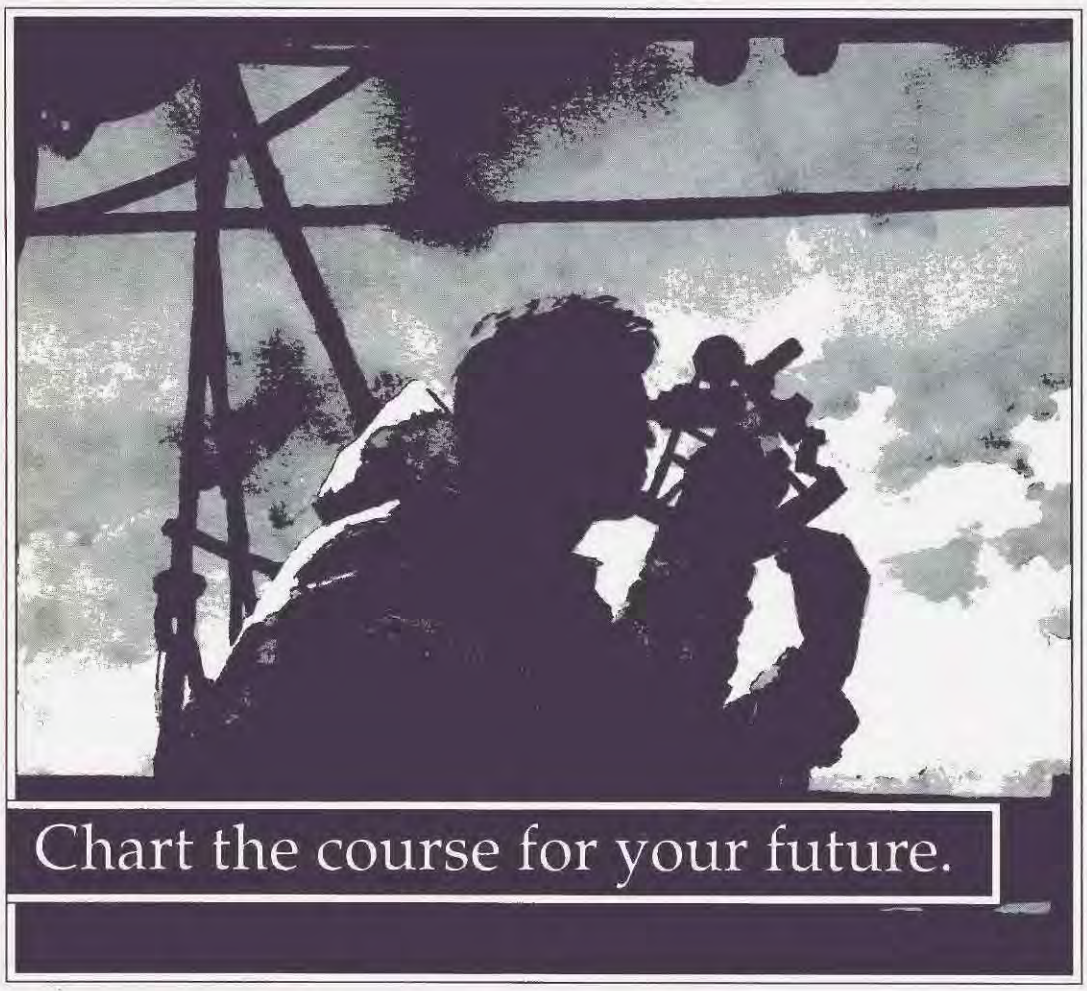
Professor Allen Fels, chairman of the Trade Practices Commission in Canberra, said effective self-regulation of the insurance industry is desirable, but the industry has not yet met all the criteria he considers necessary for a "truly effective scheme" of self-regulation.

"The TPC takes a non-interventionist approach. . .We want the industry to fix its problems, rather than have the regulators intervene," he said.

Helen Conway, general counsel and group secretary of Sydney-based NRMA Insurance Ltd., said the industry has to move to self-regulation "positively and urgently."

She also argued that sufficient remedies are now available under insurers' duty of utmost good faith, without the need for more stringent regulation under the Trade Practices Act.

But M&M's Mr. Paradine contends the insurance industry has had "a poor track record" on self-regulation, and that is why government intervention had been needed. BI



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INTERNATIONAL

LONDON

Continued from page 29

management unit Seabury & Smith with Frizzell Financial Services Ltd., one of two units in the Frizzell Group. The financial services unit constituted 85% of the group's 1991 revenues.

The transaction will double the size of M&M's insurance program management operations, which specialize in coverage for affinity groups. Combined, Seabury & Smith and Frizzell Financial had $262.8 million in revenues and 1,950 employees in 1991.

It is the first time Seabury & Smith has acquired an operation outside the United States and Canada, said President Claude Mercier.

There are no plans to create a global network in insurance program management, said Mr. Smith. But if opportunities arise, M&M will look at them, he said.

The 40% ownership of The Frizzell Group belonging to the Frizzell family has been up for sale since earlier this year, but it was decided to sell 100% of Frizzell Financial in the interests of clients, said Mr. Frizzell, who owns 5% of the company personally with his wife. Another 40% is owned by "3i" (formerly Investors in Industry), and the rest is owned by directors, staff and a profit sharing program.

The other unit, Frizzell Insurance Brokers, will continue to exist independently with the same investors, though Mr. Frizzell will step down as chairman and be a director.

Mr. Frizzell will continue to be the chairman of Frizzell Financial—which will maintain its name—for four years.

ILU to vote on move

The Institute of London Underwriters is expected this week to ask its membership if they want to move into the London Underwriting Center with members of the London Insurance and Reinsurance Market Assn.

The ILU could make a presentation as early as this week to its membership about the pros and cons of moving when the new market is scheduled to open next year, said ILU Chairman Peter Evans.

The ILU and members of LIRMA have had discussions since February about moving into the London Underwriting Center together when it opens next August.

The ILU consists of marine underwriters of London-based insurance companies and LIRMA consists of non-marine underwriters of the same companies, so it makes sense for these departments to someday be housed together, said Victor Blake, chairman of CNA Reinsurance of London Ltd. and LUC organizer.

Some people think the ILU, LIRMA and Lloyd's of London should all be housed in one building, but that is impossible because the market would need 300,000 square feet of office space, Mr. Blake said.

Meanwhile, the ILU and LIRMA continue to examine the merger of their policy signing, accounting and claims administration bureaus. "There is as yet no merger," Mr. Evans said last week. "It's an event that might happen and might not."

M&G U.K. layoffs

Mercantile & General Reinsurance Co. P.L.C. has laid off 15% of its U.K. non-life staff following grim undisclosed third-quarter results.

M&G announced earlier this year that it would look at its non-life business to find out what streamlining should be done and what classes should be written.

An M&G spokesman says that the announced layoffs are a result of this examination. He would not say how many people have been let go or how many of the 1,500 employees worldwide were U.K. non-life employees.

Among those laid off, he confirmed, was Richard Elliott, a senior executive who was at one time in charge of M&G's aviation and marine operations and most recently was manager-general division. Mr. Elliott was given one week's notice after 24 years with M&G.

The decision to lay off non-life staff went "hand in hand" with the bad third-quarter results, confirmed an M&G spokesman. The results are reported internally to parent Prudential Corp. P.L.C., but not publicly. The poor results are a result of "deterioration in Hurricane Andrew (claims) and other classes of business over the last few years," he said. BI

NHL ordered to return surplus pension assets

By FRED WILLIAMS

Crain News Service

TORONTO—An Ontario court has ordered the National Hockey League to return surplus pension assets it claimed were misused by the league and that could eventually total more than $50 million.

The ruling last month followed a lawsuit filed against the NHL on behalf of seven former NHL stars, including Gordie Howe and Bobby Hull.

NHL officials said they will appeal the decision.

Justice George Adams of the Ontario Court of Justice General Division ordered 21 NHL clubs, the NHL Pension Society and Manufacturers' Life Insurance Co. of Toronto, to return about $25 million plus interest in surplus pension funds to players who retired before 1982.

Justice Adams ruled that provisions of the pension plan stated any surpluses would be used for the benefit of those retired players and no one else.

The former players argued in court that the clubs used surplus funds to reduce plan contributions after 1982 and to pay for additional benefits for players who retired after 1986.

NHL President Gil Stein issued a brief statement saying the league will appeal the decision. NHL officials did not respond to repeated telephone calls seeking information about the case and current NHL pension policies.

"We've been advised that the Ontario Court of Justice has ruled in favor of the former NHL players," Mr. Stein said in the statement. "Counsel representing the league has been advised to file an appeal."

Justice Adams delivered the 150-page ruling Oct. 22 in favor of the seven retired stars. In addition to Messrs. Howe and Hull, other former players who filed the suit were Allan Stanley, Andy Bathgate, Eddie Shack, Leo Reise and Carl Brewer. The decision could affect

Continued on next page

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GLOBAL BRIEFS

Hemophiliacs may sue

BONN, Germany—German hemophiliacs who contracted HIV through contaminated blood transfusions may be prompted to sue their physicians for pain and suffering damages if a test case is successful.

In the last five years, about 1,300 German hemophiliacs with HIV or AIDS have been compensated under a settlement negotiated between plaintiffs' attorneys and pharmaceutical manufacturers' insurers. The settlements excluded compensation for pain and suffering.

Under the German Pharmaceutical Act of 1976, pain and suffering awards are excluded in strict liability settlements, said Karl Hermann Schulte-Hillen, a leading plaintiffs lawyer based in Siegen, Germany.

The pharmaceutical law covers compensation for medical care resulting from the injury, lost earnings, special costs or expenses incurred, burial costs and compensation for surviving dependents.

However, the hemophiliac victims could claim pain and suffering damages if they sued their doctors under German tort law, according to Mr. Schulte-Hillen. He said if one such lawsuit that he is aware of—filed by an HIV-infected hemophiliac in Bonn—is successful, it could open the door for many similar cases.

"There are approaches to address further claims against doctors," agreed insurance lawyer Friedrich Gras von Westphalen, a partner in Cologne-based law firm Gras von Westphalen & Modest. However, the question of joint and several liability between the pharmaceutical companies and the doctors must be decided, he said.

So far, physicians' malpractice insurers are resisting the claims, the lawyers agreed. But "if the wall is broken," it could lead to further large settlements, said Mr. Gras von Westphalen.

—By Carolyn Aldred

EC maternity directive

BRUSSELS, Belgium—Employers in the European Community beginning in 1994 will be liable for protecting pregnant employees from physical or mental risks to themselves or their unborn children.

A directive passed last month by the European Commission will give employers two years to assess any physical, chemical or biological risk facing pregnant employees. They must also follow E.C. guidelines regarding exposure to mental and physical fatigue.

If the employer's assessment reveals a safety or health hazard, working conditions must be adjusted accordingly. Otherwise, the employee should be moved to other work or given time off.

The directive will make it easier for women in the European Community to file liability suits against their employers, said Denise Kingsmill, an attorney specializing in employment law at Clyde & Co. in London.

"Women suffering injury at work previously needed to establish that the injury was reasonably foreseeable by the management," said Ms. Kingsmill. "Now there is a positive obligation on employers to ensure that working conditions are appropriate for pregnant employees."

Making employers responsible for risk assessment could increase liability claims, European employment lawyers said.

"It isn't clear yet how the risk assessments are going to be supervised," said a Paris-based lawyer who asked not to be identified. "But certainly employers may be held to have carried them out negligently or inappropriately."

The directive also entitles employees to at least 14 uninterrupted weeks of maternity leave, with no service requirement. Women will receive 90% of their normal pay for six weeks and statutory sick leave pay for subsequent weeks.

The directive makes no allowance for paternity leave.

Earlier this year the British government objected to the commission's original plans to require full pay for 14 weeks.

A spokesman for the Assn. of British Insurers said the organization's liability committee will meet in December to discuss the possible impact of the directive.

The directive would prohibit countries that now require more than 14 weeks of leave from reducing that level. Only Portugal, which currently requires 90 days of leave, will need to lengthen its minimum allotment.

Britain, which has the lowest level of paid maternity benefit in the European Community, will be particularly affected by the directive. Under current law, women in Britain must work for the same company for two years before they are entitled to maternity leave. The directive will remove this stipulation.

The directive also reinforces national legislation in the E.C. nations that bars employers from dismissing pregnant women for reasons connected with their pregnancy. Pregnant employees are also entitled to prenatal medical exams during work hours without loss of pay.

Further legislation governing maternity leave in the European Community is likely when the directive is reviewed in five years.

The European Commission said earlier this month that it views the directive "merely as a first step," toward more comprehensive protection. It plans to lengthen the maternity leave and increase the level of workers' benefits and the rules limiting night work.

The directive must be implemented by all member countries by October 1994.

—By Aline Sullivan

Munich Re results

MUNICH—Munich Reinsurance Co., the world's largest reinsurer, said group net profit for the year ended June 30 rose to 177.6 million deutsche marks ($116.5 million at the applicable exchange rate), up 69% from 104.9 million marks ($57.9 million) in the previous fiscal year.

Group premium income rose 11.3% during the fiscal year to 15.8 billion marks ($10.37 billion).

—By Don Lewis Kirk

Singapore reinsurers

SINGAPORE—Two defunct Singapore reinsurers plan to propose schemes of arrangements to pay dividends to their creditors.

ICS Reinsurance Private Ltd. and RMCA Reinsurance Ltd., a subsidiary of Reinsurance Management Corp. of Asia, are both in "financial difficulty and will be unable to meet in full all liabilities," their London-based financial advisor Cork Gully said in statements to creditors.

Both companies, which ceased writing coverage in 1991, accepted property reinsurance business from brokers representing insurers worldwide. Both suffered losses from Hurricane Hugo and the 1990 European windstorms.

As of June, ICS Re's assets totaled $113 million Singapore ($69.9 million at the applicable exchange rate) while its liabilities totaled $191 million Singapore ($118.1 million).

RMCA Re's assets as of June totaled $127 million Singapore ($78.5 million) while its liabilities totaled $199 million Singapore ($123 million).

Cork Gully told creditors that the choice now is "liquidation or some form of arrangement with the company's creditors." The specialist insolvency practitioner suggests a scheme of arrangement which will offer a schedule of agreed payments to creditors.

The plans should be sent to creditors by year end and approved by courts in Singapore and England in 1993.

—By Stacy Shapiro

NHL pension ruling

Continued from previous page

several hundred players, according to Mark Zigler, a Toronto lawyer with Koskie & Minsky who represented the players.

Mr. Zigler said the surplus arose in the NHL's defined benefit plan—a participating group annuity program through Manufacturers Life—resulting in a "dispute about whether to use the surplus on behalf of the players or by the NHL for current pension costs."

The surplus, generated from higher than anticipated interest rates, was accrued from the time the NHL's pension program began in the 1940s.

Mr. Zigler said he did not know the final amount that could be returned to retired players, nor the number of retirees that could benefit from the action. Some sources believe the total could reach upwards of $50 million, but the exact amount will be determined by the court.

An NHL background paper released in 1991 states that the league instituted a defined contribution plan in 1986 to replace the group annuity programs that had been in place in some form since 1947. (In 1982, the league instituted a new participating group annuity, also with Manufacturers Life, to cover players who retired after 1982.)

The league contributes $5,000 per year per player into the defined contribution plan.

"The court has ruled the pension money was to be used exclusively for the players involved," Mr. Zigler said. "To the extent that it hasn't been, the clubs and Pension Society are responsible for any shortfalls, plus interest."

Earl Cherniak, lawyer for the NHL clubs and Pension Society, had argued in court the league-controlled Pension Society was within its rights to use the surplus to reduce club payments into the pension plan and fund the pensions of current players.

But Mr. Zigler argued the Pension Society was a trust and its directors were bound to act in the best interests of the members. By using the surplus to reduce payments by the league's clubs, Mr. Zigler argued, the Pension Society abandoned the players to benefit the league.

"It's all to be paid back and allocated to the guys who played before 1982," Mr. Zigler said. BI

Eagle Star trial

Continued from page 29

ruling.

The *Hiscox vs. Outhwaite* decision was the first reason why Eagle Star stopped paying claims on the 19-year old policy, Mr. Toomey said.

Eagle Star now also claims it is not paying claims due to the policy wording, added Mr. Toomey, who did not elaborate.

The runoff policy was taken out by Mr. Toomey's father Leonard Toomey for syndicate 640 in 1973, before the market knew that long-tail business would create the flood of claims that it has, said Mr. Toomey. "He was farsighted for those days."

The unlimited runoff policy, placed with Eagle Star by J.S. Pincham & Co. Ltd., reinsures all the business for 1965 and prior underwriting years.

The premium was about 1.5 million pounds ($2.27 million at the current exchange rate).

From 1973 until June 1991, Eagle Star received monthly debit notes from syndicate 640 and over the years paid a total of $29 million in claims, said Mr. Toomey.

'This litigation started cash flow problems,' Mr. Toomey said. Closing the syndicate was 'a great shame.'

Then the payments stopped and the allegations began.

The syndicate, which started in 1919, had to leave its 1989 account open because Eagle Star stopped paying claims under the runoff policy, according to Mr. Toomey. "This litigation started cash flow problems," he said.

The syndicate had a cash call on its 273 members totaling 2.9 million pounds for 1989 ($4.68 million at the applicable exchange rate). Three-quarters of that total was to pay claims that Eagle Star was refusing to pay, he said.

This year, the syndicate shut down and Mr. Toomey is now working as general manager for Lloyd's runoff company Syndicate Underwriting Management Ltd. Closing the syndicate was "a great shame," he said.

Mr. Toomey wants the High Court to declare that the runoff policy with Eagle Star is still valid.

Toomey vs. Eagle Star and similar cases are generating discussion in the London market, especially because they again bring *Hiscox vs. Outhwaite* to the forefront.

"There still seems to be a lot of hot air and nonsense circulating about (asbestos reinsurance recoveries), with certain organizations still questioning claims following the Hiscox/Outhwaite decision," Robin A.G. Jackson, chairman of the Asbestos Working Party in London, wrote to underwriters in late September.

The Asbestos Working Party had asked for a legal opinion from London law firm Barlow Lyde & Gilbert on reinsurance recoveries in asbestos-related claims in light of *Hiscox vs. Outhwaite*, according to Mr. Jackson's memo.

The law firm noted, among other things, that the Center for Claims Resolution has been billing only those producers named as defendants in the suits which the CCR is handling on their behalf.

This "should further reduce —if not eliminate entirely—any remaining discrepancies so far as future claims are concerned," the law firm stated.

Also, "the judgment in the Hiscox vs. Outhwaite case does not, in our view, apply to pure LMX (i.e. retrocessional) business at all," said the law firm, referring to London market excess-of-loss retrocessions. "Retrocedants whose inward liabilities are governed by U.S. law must pay asbestos-related claims which arise out of the Wellington Agreement just as much as they must pay claims for which they would have been liable in the absence of that agreement."

In the meantime, "Intap", the International Alliance of Asbestos & Pollution Reinsurers, has not yet addressed the effect of *Hiscox vs. Outhwaite* on claims payments, said Wilhelm Zeller, member of the board of Cologne Reinsurance Co., which founded Intap in 1991.

Separately, as the Toomey trial begins, Eagle Star is fighting another battle in the British courts.

Litigation began last month between Eagle Star and Banque Bruxelles Lambert S.A. to determine who is liable for huge differences in the purchase and sale price of six commercial properties.

BBL is seeking a declaration in the English Commercial Court that mortgage indemnity guarantee policies it bought from Eagle Star are valid and will cover the bank's claims arising from losses on the property deals, which are likely to exceed 100 million pounds ($151.5 million).

Eagle Star counters that the coverage is invalid because the original valuations of the properties were overstated, said Michael Heath, a director of Eagle Star.

The trial is expected to last 13 weeks. BI

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Business Insurance

Assessing benefit plans

Changes in employee benefits pose new risk exposures

By SARA J. HARTY

OTTAWA—Risk managers need to re-examine their role—or lack thereof—in company benefits departments, suggested two benefit consultants.

A plethora of benefits issues can expose a company to liability, which a risk manager is best suited to address, they say.

"The benefits waterfront is changing very rapidly. From a risk perspective, you need to be on top" of those changes, said Joe Timmins, a consultant with The Wyatt Co. in Ottawa.

Traditionally, the risk manager has had little involvement in the employee benefits department, observed Mr. Timmins, who spoke at a session at the Canadian Risk & Insurance Management Society conference last month.

In the past, benefits have not been perceived as presenting any significant risks—certainly not on the same scale as property/casualty losses, he said.

But the idea that benefits are "fringe issues" is rapidly changing as the costs become significant—generally equaling 30% to 35% of payroll in Canada, Mr. Timmins said.

Benefits and human resource issues do present liability risks, he stressed. Canada is "becoming a more litigious society, like our neighbors to the south," Mr. Timmins noted.

"You as risk manager do have opportunities to assess, measure and manage risks. There are some applications for risk management skills and techniques to help control bottom line costs" in the benefits department, agreed Renate M. Rodgers, also a Wyatt consultant in Ottawa.

Assessing, measuring and managing benefits-related risks "sounds like a job for the risk manager," Mr. Timmins said.

While the benefit manager may focus on benefits first and costs second, the risk manager is likely to reverse the emphasis, providing needed balance in the benefits department, he said.

Retiree benefits also are beginning to manifest risks worth managing, Mr. Timmins said.

In the past, a limited retiree population in Canada meant a limited cost exposure from retiree benefits, he said.

"Changing demographics and a higher incidence of early retirement" is altering that view, he observed.

Risk managers can help limit their company's financial exposure to growing retiree benefit costs through stop-loss insurance, advice on plan design and proper communications, Mr. Timmins said.

For employers that seek to reduce or alter retiree benefits, there is not much in terms of Canadian litigation, he observed. "From the U.S. perspective, a promise is a promise unless you do things to protect yourself," Mr. Timmins noted.

Don't break promises that the company already made, he suggested. Instead, stress to active employees that "this is the benefit as of today and it is subject to change."

Human rights issues provide another area for risk management.

While it is not law in Canada, the Ontario Human Rights Commission has set a precedent that benefits—including pensions—must be the same for same-sex couples as for heterosexual married couples.

This presents a problem since regulations enforced by Revenue Canada, the nation's tax authority, do not permit the extension of pension benefits to same-sex couples, Mr. Timmins said.

However, risk and benefit managers need to be aware of this precedent and that human rights commissions in other provinces have indicated that they will take a similar stance, Mr. Timmins said.

"From an actuarial standpoint, there does not appear to be any significant difference in experience" between same- and opposite-sex couples, Mr. Timmins said.

New areas that risk managers should watch include:

- Employee assistance programs, which are one of the fastest growing benefits in Canada, Mr. Timmins said.

If an employer decides to implement an EAP, it should decide whether administration will be contracted out or done internally, Mr. Timmins said. The risks of doing it internally should be considered carefully, he said.

For instance, what kind of liability does the company take on if an EAP counselor who works for the company refers an employee to a counselor who sexually harasses or abuses the employee? he asked.

- Electronic drug card systems, which promise to deliver pharmaceuticals to employees within 24 hours of an order and at a reduced expense.

These systems "sound good, but there are risks," he said. For instance, a drug could be dispensed improperly, again raising liability issues for the employer.

Barbara E. Hardy, chief of risk management for the Canada Mortgage & Housing Corp. in Ottawa moderated the session. BI

Loss prevention program can avert costly losses

OTTAWA—Planning and preparation won't stop every loss, but risk managers can stack the odds in their favor by developing and implementing a loss prevention program, according to two experts.

From a lawyer's perspective, good practical advice for risk managers is to "first, minimize the foreseeable, and second, prepare for the unforeseeable," said Douglas L. Talley, vp and counsel with Risk International in Akron, Ohio.

For example, Tylenol performed a great job of damage control after its capsules were laced with cyanide. "That was totally unforeseeable, but the manufacturer did a great job of minimizing the damage," Mr. Talley noted.

One way to step up a company's preparation level is to implement a loss control policy statement, similar to a mission statement, Mr. Talley suggested.

And, preparing for the foreseeable can be made easier by adopting a policy of "exposure avoidance," suggested Moreno Fiore, account executive with Allendale Insurance in Montreal.

For instance, an employer might "discontinue a problematic product line or modify a manufacturing process to minimize the use of problem fluids," he suggested.

Both men were speaking at a session at the 1992 Canadian Risk and Insurance Management Society conference, held Oct. 4-7 in Ottawa.

"Preventing a loss from occurring is much less costly than addressing it afterward," Mr. Fiore noted.

Mr. Fiore made several suggestions for preventing specific types of losses:

- Arson fires. Automatic sprinklers should be locked so that they cannot be disabled. Access should be tightly controlled and placed in non-public building areas.

And new employees, especially security guards or others with access to private areas after hours, should be carefully evaluated.

- Smoking-related fires. The company smoking policy must be well communicated. It is important to set up realistic smoking rules—for providing adequate breaks that can be taken in a designated smoking area.
- Exposure protection. "Know your neighbors, the processes they are using and the controls they have in place."

Review the availability of water for the fire department to use he suggested. If water is inadequate, build a pond or reservoir for that purpose.

- Occupancy arrangement. For instance, establish control by making sure that the "manufacturing operations are separate from the storage areas."

In addition, make sure that barriers and fire walls are well-placed with regard to company operations and their locations, he said.

Alex Shevchenko, president of Alex Shevchenko & Associates, moderated the session.

—By Sara J. Harty

Using 20/20 hindsight

Communication would have helped

By SARA J. HARTY

OTTAWA—It is impossible to overemphasize the importance of clear policy wording before a loss occurs—and good communications between policyholders and insurers afterward, contends one risk manager.

With the added benefit of hindsight, Diane Wolfson, director of risk and insurance at Domtar Inc., shared some of the lessons she learned after her company suffered two large losses.

Both losses at the Montreal-based pulp and paper company involved the same piece of machinery, a large boiler critical to production, Ms. Wolfson told risk managers last month at the Canadian Risk & Insurance Society's annual meeting in Ottawa.

Construction of the boiler was not even complete in October 1987 when the first loss occurred. A small explosion ultimately caused nearly $15 million worth of damage: $5 million in property damage; $5.5 million in extra expense; and $4.4 million in business interruption. All the damages were readily apparent, though the claim with insurers was not resolved until December 1989.

The second loss involved the inappropriate seepage of acid into the same boiler, damaging various boiler components.

Damages from the acid did not become apparent until April 1990, although the company later determined that the acid had been leaking gradually for five months.

Property damage this time was $1.6 million, with extra expenses of $5.2 million. This claim is yet to be resolved with insurers.

Because the actual losses were so different in nature it is difficult to compare the resolution efforts with insurers.

However, Ms. Wolfson said that in retrospect, Domtar should have taken into account certain factors within the company.

For instance, employee morale had declined considerably between the 1987 and 1990 accidents, she said. By 1990, Domtar, which had made $1.29 per share in 1987, was losing $2.85 per share and there was open talk of a restructuring.

Employees were concerned about their jobs and that may may have contributed to communication problems in 1990, she observed.

Evidence that may have been present was not forthcoming from workers and, in general, workers were more concerned with protecting their jobs than with cooperating with company efforts to resolve the loss.

Also contributing to problems was short-staffing in the risk management department. Staff members were not always available for meetings with insurers and company representatives. And letting those employees fall out of the loop contributed to Domtar's problems in trying to settle its claim, she said.

Although questions about the intent of policy language was the last problem Domtar expected to encounter, coverage issues were raised in both losses, Ms. Wolfson said.

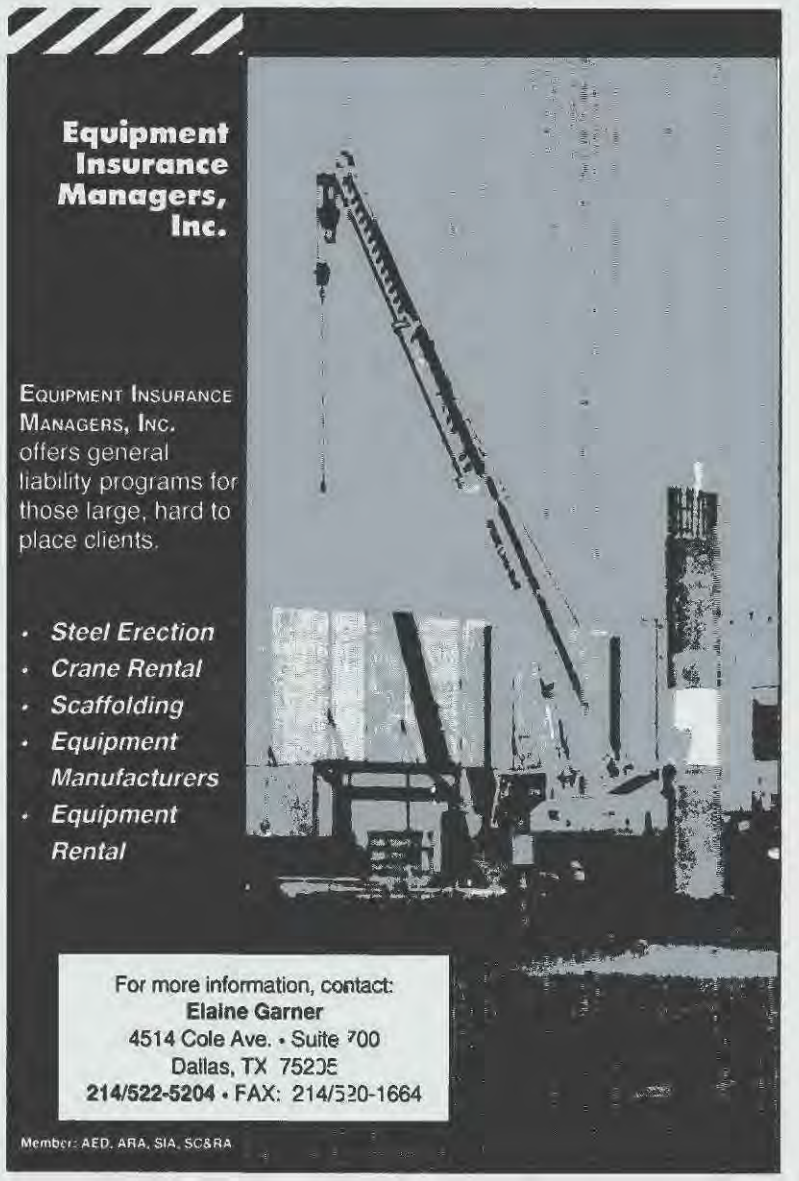
In both instances, insurers denied coverage at some point during their investigation, and the actual intent of the policy wording was called into question.This was resolved in the first accident, but is still an issue in the second, she said.

After years of trying to resolve these losses, certain lessons have emerged, she said. For instance, "our broker had good boiler machinery expertise and we didn't make use of it soon enough."

- Face-to-face meetings with the insurer are important, she said. These meetings help persuade the insurer that a policyholder is making a good faith effort to reach an equitable decision, she said.
- Any and all possible insurers should immediately be notified of a loss and should receive on-going status reports. These reports should also be sent to a company's senior management.

Suzan L. Ness, director of risk management at UNIVA Corp. in Montreal and Daniel Desjardins, manager of risk management and insurance at Bombardier Inc. in Montreal, also spoke at the session.

The session was moderated by Glen Frederick, manager of insurance and risk for the Canada Post Corp. in Ottawa. BI



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What will he write on clean pension slate?

New issues, old standards to vie for new president's attention

By JERRY GEISEL

WASHINGTON—Some old pension issues—like simplification, control of pension assets and reform of the Pension Benefit Guaranty Corp.—are likely to resurface after Bill Clinton takes office.

New issues, like faster vesting and pension changes that may be of particular interest to women, could also emerge next year.

At the same time, pension experts are divided on whether a new administration will mean a slowdown or speedup in finishing long-delayed Internal Revenue Service non-discrimination rules for pension plans.

They add that if the Clinton administration is preoccupied with the economy and health care reform, it could be up to Congress to take the lead on pension issues.

Unlike, say, health care reform —the subject of many Clinton speeches and position papers— pension issues went largely unaddressed during the campaign. Gov. Clinton has yet to make known his views on how, if at all, the nation's pension system should be changed.

"There is largely a clean slate on pension issues," said James Klein, executive director of the Assn. of Private Pension & Welfare Plans in Washington.

"The new administration has yet to define itself on pension issues," agreed Frank McArdle, a consultant with Hewitt Associates in Washington.

Although there is more speculation than certainty, some needed changes in the pension system seem obvious.

Take simplification, for example. Twice this year, President Bush vetoed tax bills that would have, among other things, simplified 401(k) non-discrimination testing and reduced the administrative requirements of a new 20% pension withholding tax. Those and similar provisions are expected to resurface in a new tax bill now being drafted by House Ways and Means Committee staffers.

"The simplification provisions have become so non-controversial that they clearly will be in a new tax bill," said Stuart J. Brahs, vp-federal government relations in the Washington office of The Principal Financial Group.

But the Clinton administration may not give its blessings to all of the simplification provisions.

For example, the tax bills passed by Congress would have created two new safe harbors for 401(k) plans. Plans that qualified could have avoided the non-discrimination tests, which are designed to ensure that contributions by high-paid employees do not exceed those from low-paid employees by more than a certain amount.

These safe harbors would allow many high-paid employees in plans that qualify for the safe harbors to contribute hundreds of dollars a year more than they otherwise could under current rules.

And that may not fly with the Clinton administration. "There may be an even greater commitment to ensuring that benefits are delivered in a broad, nondiscriminatory way," said Harry Conaway, a William M. Mercer Inc. principal in Washington.

An old issue, control of pension assets, may also resurface.

In 1989, Rep. Peter J. Visclosky, D-Ind., proposed legislation that would have required employers to share control of pension assets through joint employer/employee boards.

Vigorous business lobbying ultimately killed the proposal. Corporations threatened to terminate pension plans if they had to share control of assets but remain liable for investment losses (*BI*, Oct. 2, 1989).

But such a proposal could find support in a Clinton administration. "Joint trusteeship of pension assets is a big issue for labor and Gov. Clinton received strong support from labor," notes the APPWP's Mr. Klein.

Others, though, doubt that Gov. Clinton would risk a confrontation with business. "My sense is that Bill Clinton is a middle-of-the-road, pro-business Democrat. I doubt if he would support an issue—a Visclosky-type proposal—that employers have so vigorously opposed," said Mercer's Mr. Conaway.

One of the few pension issues that Gov. Clinton did address

during the campaign—albeit only vaguely—was improving pension plan funding and thus reducing the PBGC's exposure to big claims.

During the second presidential debate, Gov. Clinton said the government has to "strengthen the (funding) requirements on private retirement plans."

Pension observers note that support for shoring up the PBGC has tended to be bipartisan and that should continue with a new administration.

In the late 1970s, the Carter administration worked closely with Congress to improve funding of multiemployer pension plans to protect the pension agency from large claims.

Similarly, the Reagan administration and Congress collaborated in the mid-1980s to raise PBGC premiums and make it more difficult to terminate underfunded pension plans.

New pension issues could crop up with the lead for action coming from Congress. Record numbers of women in Congress, for instance, could increase interest in amending laws or regulations that are perceived as unfair to women.

One example is the Employee Retirement Income Security Act, which permits employers to not recognize service of less than 1,000 hours per year for pension vesting purposes. This rule disproportionately affects women, who are more likely than men to work part time.

"This, the 'Year of the Woman,' could spill over into benefit issues, like pension coverage for part-timers," said Hewitt's Mr. McArdle.

Women's rights groups also cite as unfair rules permitting employers to require five years of work before employees are first and fully vested in pension plans. Because of family responsibilities, women are more likely than men to leave a job within five years.

Other pension-related issues that could emerge include raising taxes on Social Security benefits. During the campaign, Gov. Clinton suggested raising taxes on Social Security benefits for retirees with incomes well over $100,000 per year.

The Clinton administration also will face an issue left over from the Bush administration: non-discrimination rules for pension plans.

Currently, the IRS is drafting new rules after an early set of rules was sharply criticized as overly complex and sloppily drafted.

Over the past year, the IRS had taken some steps to make compliance easier for employers. Rather than require 401(k) non-discrimination tests to be run annually, for example, tests once every three years would be permitted.

But final rules have not yet been drafted and some say the IRS may push to get the rules out now and end what has been a major embarrassment for the agency.

Others, though, say the regulatory process may slow during the transition period. And once a new administration takes charge, it may want to review all pending rules, leading to yet more delays. BI

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Speculation on Garamendi's plans

SACRAMENTO, Calif.—It hasn't taken long after Gov. Bill Clinton's victory for rumors to start flying concerning California Insurance Commissioner John Garamendi's future plans.

Mr. Garamendi, who served as state chairman of Gov. Clinton's successful presidential bid, shared his ideas for reforming the nation's health care system with the Democratic candidate during the campaign.

In addition, the commissioner has proposed establishing a commission to study the concept of a 24-hour health plan that would integrate health insurance, workers compensation insurance and the medical coverage component of automobile liability insurance. The proposal was contained in S.B. 6, which passed the state Legislature but was vetoed by Republican Gov. Pete Wilson.

Fueling the rumors that Mr. Garamendi may be moving to Washington was the fact that his wife, Patti, ran for a seat in the U.S. House of Representatives.

However, after counting absentee ballots last week, Ms. Garamendi narrowly lost the race to Republican Richard Pombo for the seat representing the state's 11th Congressional District.

Despite the rumors, an Insurance Department spokeswoman said, "Commissioner Garamendi has every intention of serving out his term."

But he may influence the nation's health care policy from a distance.

"He's very interested in working closely with the Clinton administration on health care reform and universal access to health care," she said.

—By Joanne Wojcik

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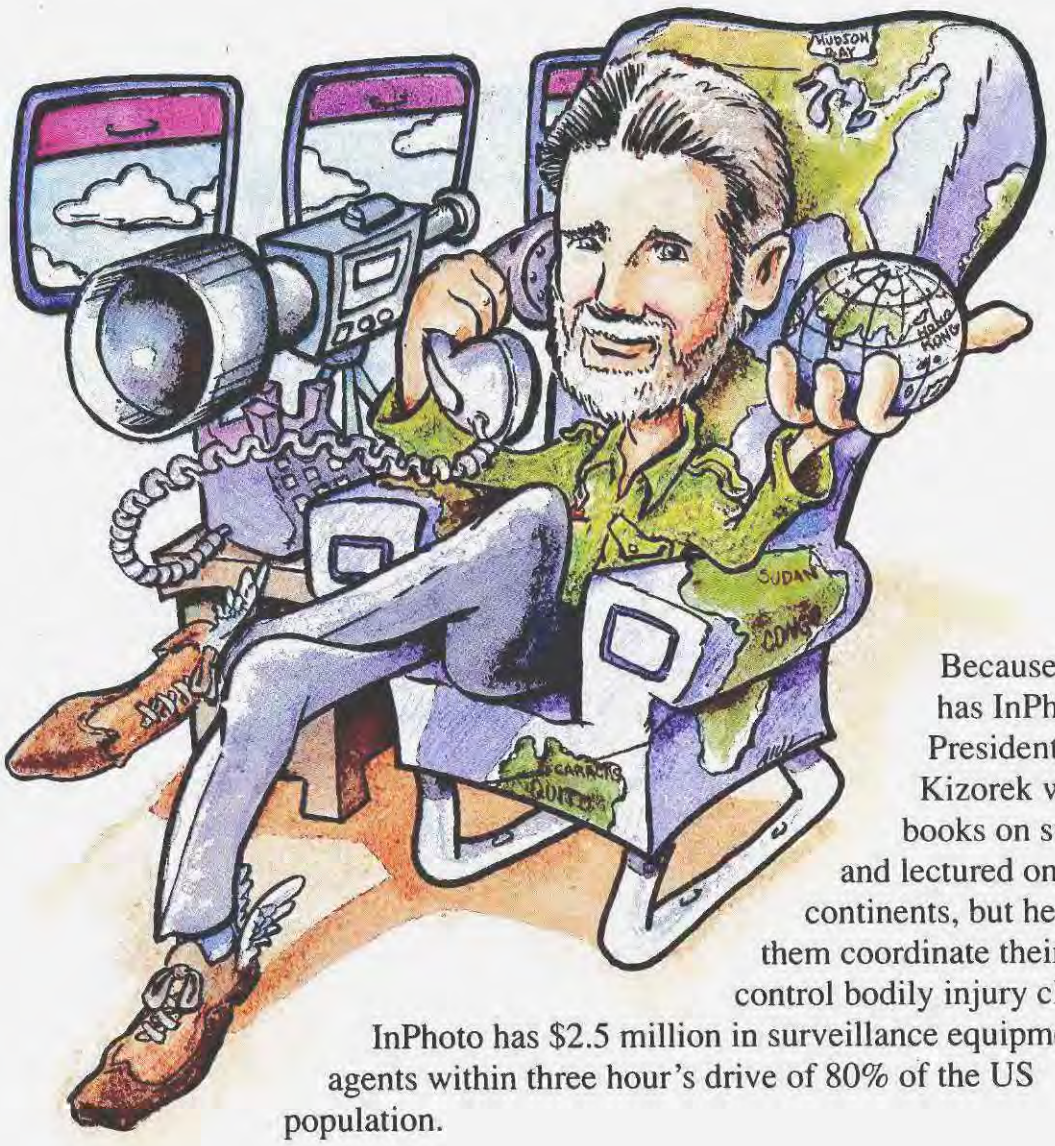

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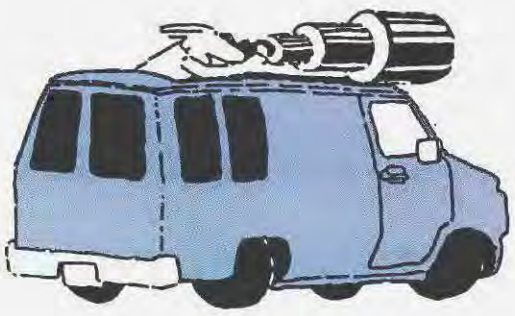

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Insurer assets sold to help cover claims

BATON ROUGE, La.—The sale of railroad equipment, tracks and train cars has netted $815,000 that will be used to help pay claims of failed North American Indemnity Co.

The Louisiana Insurance Department sold the equipment belonging to Dardanelle & Russellville Railroad to Ouachita Railroad Inc. Ouachita had an option to purchase the equipment in a leasing arrangement.

Dardanelle & Russellville Railroad was owned by a subsidiary of Baton Rouge-based North American Indemnity, which was placed into liquidation in May.

The money will be turned over to the Louisiana Insurance Guaranty Assn. to help pay the claims and obligations of the failed insurer. North American Indemnity wrote liability and workers compensation coverage.

—By Michael Bradford

Barry Keene to head California tort group

SACRAMENTO, Calif.—State Sen. Barry Keene will head a group attempting to change a state civil justice system that business groups consider the nation's most notorious.

Sen. Keene, D-Ukiah, will resign his seat and become president of the Sacramento-based Assn. for California Tort Reform on Dec. 9.

"We must address the enormous costs of business-as-usual in California's judicial system," he said. "With California's economy and business climate in so weakened a state, the need for tort reform has never been greater."

A recent state-financed study blamed the state's liberal legal system for some of its economic problems (*BI*, May 4).

Sen. Keene said the current civil justice system "produces a product equivalent to the Model T. It was very good for its time, but it needs updating to meet today's demands. It is also critical that we advance the development of alternative avenues for dispute resolution less costly than the courts."

Sen. Keene, who announced earlier this month he is quitting the Legislature after 20 years, has served as Senate majority leader and as chairman of the Senate Judiciary Committee.

—By Joanne Wojcik

Lobbying plans

Continued from page 1
hensive health care reform legislation within the first 100 days of his administration.

Last week, he made initial moves to achieve that goal with two health policy appointments to his transition team. Those new staffers are: Judith Feder, the former staff director of the Pepper Commission, which proposed the "play-or-pay" approach to expanding health care coverage; and Atul Gawande, a former aide to Vice President-elect Al Gore, who helped develop a "managed competition" bill introduced earlier this year by Rep. Jim Cooper, D-Tenn.

Gov. Clinton has promised a complete overhaul of the health care system, including requiring employers to either offer a health plan meeting specified federal standards or pay a premium to help fund coverage for workers in publicly sponsored plans.

Similarly, some observers think that Gov. Clinton and Congress may move to allow states to regulate employer health plans. That could be done by changing the Employee Retirement Income Security Act, which now bars state laws or rules that "relate" to employer-sponsored benefit plans.

And Congress, with strong support from Gov. Clinton, is certain to pass family and medical leave legislation. Some in Congress may also press for a law that would affect more employers than the two measures previously passed by Congress but vetoed by President Bush.

Employers can play a role in shaping the administration's precise policy on these and other benefit issues.

"There are lots of opportunities for employers to influence the outcome. Employers definitely want to get involved," said Frank McArdle, a consultant with Hewitt Associates in Washington.

The Washington-based Employers Council on Flexible Compensation already has begun meeting with transition and congressional staffers to explain how flexible benefit plans work and to be sure that health care reform will not disrupt them.

"We're telling our story. We're educating. We know many people on Capitol Hill and the executive branch don't have real world experience with benefit plans and don't always understand the ramifications of proposals," said ECFC Executive Director Ken Feltman.

"We are trying to avoid another Section 89," Mr. Feltman added, referring to complex non-discrimination rules for health plans that were abandoned in the late-1980s.

Other groups have started to lobby Clinton staffers and Congress on their opposition to one of the centerpieces of the Clinton agenda: requiring employers to offer health plans or pay premiums to a publicly sponsored health plan.

The NAM, with 12,000 employer members, has already sent a letter to Clinton advisers stating its opposition to such requirements, said NAM Assistant Vp Sharon Canner.

The Chamber is "positioning" itself to persuade Gov. Clinton and his advisers to adopt a managed competition approach to reform rather than requiring employers to provide coverage, said Kristin Bass, manager of human resources policy for the Chamber in Washington.

The NFIB, the nation's largest small-business advocacy group, is warning Congress that a health care mandate, like the one proposed by Gov. Clinton, would be "very fatal to small business owners," said Kelleen Jackson, a health care analyst at the NFIB.

Many small employers would have to lay off workers and others could be forced out of business if they had to offer benefits or pay premiums, Ms. Jackson said.

Small-business owners are contacting members of Congress and voicing their disapproval with the proposal, Ms. Jackson said.

The NFIB also is readying its lobbying forces against a possible congressional drive to pass expanded family and medical legislation.

During the last two sessions, Congress approved similar bills that would have required employers with more than 50 workers to offer up to 12 weeks of job-protected leave to employees who have to take time off for family-related situations, like the birth of a child or to care for an ill parent. During the leave, the employer would have to continue the employee's health coverage.

With promised support from Gov. Clinton, passage of the family and medical leave legislation is certain. But small employers worry that the legislation could be expanded to cover firms with fewer than 50 employees or that employers would have to offer paid leaves of absence.

There "will be no economic recovery" if the exemption for businesses with 50 or fewer workers is dropped, said Tracy Wurzel, the NFIB's director of House legislative affairs.

Small employers are lobbying newly elected members of Congress and are "strongly advising them not to drop the (exemption) provision," she said.

Employer groups also are warning Clinton and congressional staffers not to interfere with ERISA's pre-emption provision.

Under that provision, states cannot enforce rules or laws that "relate" to benefit plans. ERISA pre-emption, though, does not apply to state laws that regulate insurers. As a result, states can require insurers to pay premium taxes on policies they sell and can require insurers to offer certain benefits in policies they sell to employers.

But states cannot, for example, tax self-funded health plans offered by employers or require self-funded plans to offer specific benefits.

Congress, though, can give states' waivers from ERISA pre-emption. In 1982, Congress approved a waiver for Hawaii's universal health care law so that Hawaii could regulate all health plans.

And as other states look for ways to expand access to health care coverage, they will seek waivers from ERISA pre-emption. That would allow states, for example, to tax self-funded plans to finance state-run plans for the uninsured.

Some observers note that, as a governor, Mr. Clinton would be sensitive to state demands and would likely support state efforts to win waivers from ERISA pre-emption or even eliminate it.

The ERISA Industry Committee, a Washington-based benefits lobbying group representing about 125 big companies, says it is talking to Clinton and congressional staffers to argue that approval of ERISA waivers would be inconsistent with health care system reform efforts.

"We can't go back to a state-based system. It is too expensive. . .and socially regressive. It simply does not work," said Mark Ugoretz, the group's president.

Approving ERISA pre-emption waivers would be "counter to national health care reform," argues Karen Milgate, a senior associate with the Washington Business Group on Health.

The NAM is preparing letters to the Clinton administration urging it to make any waivers part of a national health care reform strategy rather than individual state experiments, Ms. Canner said. BI

AIDS benefits

Continued from page 1
lifetime benefits.

Several months after learning Mr. McGann had AIDS, H&H dropped its commercial insurance, set up a self-insurance plan and capped lifetime benefits for AIDS—though not other illnesses—at $5,000.

Mr. McGann sued, claiming the company had discriminated against him in violation of ERISA. His suit was dismissed by a trial court and that ruling was upheld by the 5th U.S. Circuit Court of Appeals (*BI*, Aug. 6, 1990).

After Mr. McGann died in 1991, his estate continued the legal battle, seeking review by the U.S. Supreme Court.

The Bush administration urged the justices not to hear the case (*BI*, Oct. 26).

"(The) case is really about discrimination against people with AIDS, and not discrimination against people exercising ERISA-protected rights," Solicitor General Kenneth W. Starr wrote in a brief to the court.

"Because Congress directly addressed the subject of AIDS discrimination in employee benefit plans under the ADA, claims such as that in issue will likely turn on the requirements imposed on employers under that law," the solicitor general wrote. "The need for review in this case is therefore further diminished."

A majority of the justices declined to review the case.

That decision will further "galvanize" congressional attention predicted Frank McArdle, a consultant with Hewitt Associates in Washington.

By refusing to review the case, the Supreme Court increased the chances of benefit discrimination suits under the ADA, said Mr. McArdle.

But even review of *H&H Music* by the high court would not resolve how such actions should be treated under the ADA. Benefits lawyers do not completely agree on how the disabilities law would have applied to the actions by H&H Music.

"This problem is adequately covered under the ADA. If this were to arise today, the employee would have a cause of action under the ADA," said George Pantos of Vedder Price Kaufman Kammholz & Day in Washington. He is also counsel to the Self-Insurance Institute of America.

"I think the ADA will play a role in cases that came after the effective date, because the act does prohibit discrimination as to benefits as well as in the workplace," said Norman Newman, a partner with Winston & Strawn in New York.

Mr. Pantos added, however, that the "law would have to be tested" in court to see exactly how it applies in such cases.

Those legal tests are forthcoming.

"These kinds of policies will be hotly litigated under the ADA. A company would be extremely unwise to impose this type of policy," said Mike Isbell, a staff attorney with the Lambda Legal Defense and Education Fund, a gay rights group based in New York.

"The question is whether an amendment to ERISA is the best route" or whether the question of discrimination against AIDS patients should be part of a larger package of health care reforms, said Mr. Isbell. "I think it's important to move on both issues."

Making the first move in Congress were Reps. William Hughes, D-N.J., and Sherwood Boehlert, R-N.Y. They recently introduced a bill to amend ERISA to prohibit retroactive reduction of benefits and to allow state courts to award consequential and exemplary damages in such cases.

"This bill addresses the most egregious aspect of *H&H Music*—the retroactive reduction in benefits to employees who have relied on benefit coverage promised by their employer," said Rep. Hughes.

"Under this legislation, changes made to eliminate or reduce benefits for employees, who at the time of the change were in a course of treatment that was medically necessary, are now deemed a form of discrimination under ERISA," he said. "An exception has been provided to employers who can demonstrate that, but for the adoption of the change, the plan would have to be terminated."

That bill—H.R. 6147, the Group Health Plan Non-discrimination Plan of 1992—was introduced only a few days before the 102nd Congress adjourned. It will be reintroduced during the 103rd Congress, said Elaina Goldstein, counsel to the House Subcommittee on Retirement Income and Employment, which Rep. Hughes chairs. "We're working to get additional support for the bill," said Ms. Goldstein.

That prospect makes benefit consultants uneasy.

"It's a matter of some concern because this type of situation is relatively rare. There's concern that the congressional reaction will be overreaction," said Henry Saveth, a principal with A. Foster Higgins & Co. Inc., in New York.

"I think it is a rather limited phenomenon and at this point restricted to AIDS," said John Hickey, a partner with Kwasha Lipton in Fort Lee, N.J. The Hughes approach would add "unnecessary bureaucracy," he said.

Were Congress to restrict the ERISA pre—emption of state laws—like antidiscrimination statutes—it would create chaos for national companies, he said. BI

Supreme Court declines review of damage cases

WASHINGTON—The Supreme Court last week refused to hear two constitutional challenges concerning damages—one involving punitive damages and the other involving a cap on compensatory damages.

In the punitive damages case, two former asbestos manufacturers claimed that their 14th Amendment right to "due process" was violated when two juries that heard the same evidence and were given similar instructions returned significantly different awards.

Two juries in West Virginia heard joint testimony in 1991 trials against Keene Corp. of New York. One jury awarded punitive damages of $105,000 while the other jury awarded none. Also in 1991, two West Virginia juries heard joint testimony and instructions in suits against Owens-Illinois Inc. of Toledo, Ohio. One jury awarded punitive damages—in this case, $30,000—and the other awarded none.

"We were devastated that the Supreme Court did not take the case," said Stuart Rickerson, vp-general counsel of Keene. "We think it was an excellent opportunity to review the utterly arbitrary, multiple awards of punitive damages in asbestos cases."

"It's unfair to permit more than one award for the same course of conduct that took place 33 years ago," said Jim Miller, a lawyer with King & Spalding in Washington, which represented Owens-Illinois in its appeal.

By refusing to hear the case, the high court was not necessarily saying it has no merit. In the court session ending in July, the justices accepted only 127 of 6,700 cases.

"The court surely must take the question some day, otherwise liability is limitless," Mr. Rickerson said. "These companies have been punished enough for actions that took place in the 1930s, '40s, '50s and '60s."

Punitive damages are designed in part to deter future conduct, but Keene's former subsidiary stopped manufacturing products containing asbestos in 1972, Mr. Rickerson said.

Keene has spent $422 million defending and paying damages in asbestos suits related to Baldwin-Ehret-Hill, a now-defunct company it bought in 1968 for $8 million, he said.

Keene has outstanding awards of $63 million, including $13 million in punitive damages, and expects to exhaust its product liability coverage for personal injury by year end, it announced in its third-quarter report to shareholders.

Keene has proposed a $250 million-per-year fund to pay claims without tort suits or punitive damages (*BI*, Oct. 19).

The second case challenged the constitutionality of a Colorado law that caps liability damages against the state.

Without comment, the court declined to review the Colorado Governmental Immunity Act, which limits the state's liability for an accident at $150,000 per person and $400,000 per incident.

Lawyers for several victims of a major bus accident involving a state highway crew had challenged the statute on the grounds that it obstructed the victims' constitutional right to due process. In 1987, a state highway crew working on a mountainside dropped a massive boulder on a tour bus, killing nine passengers and injuring 19 others.

Because total claims are capped at $400,000 per accident, individual damages in the case can not exceed $14,285 per person. Lawyers for the victims' families had been seeking millions of dollars in damages from the state.

—By Sara Marley and Michael Schachner

Upjohn challenges Halcion liability verdict

DALLAS—The Upjohn Co. is challenging a Texas state court verdict that it is liable to the family of a former police officer who claimed taking the sleeping pill Halcion caused him to kill his best friend.

Upjohn is asking state district Judge John Marshall to set aside the jury's recommendation that William Freeman's family receive $1.6 million in compensatory and $200,000 in punitive damages.

The Kalamazoo, Mich.-based drug company argues that it should not have to pay the damages when both Mr. Freeman and his doctor were found more liable than the company. Upjohn also cites a recent Food & Drug Administration finding that the drug is safe when used as directed.

The jury found Mr. Freeman 50% liable for the 1987 shooting. His doctor was found 30% liable for writing the prescription, and Upjohn 20% liable for marketing a defective product. Judge Marshall must now decide whether Upjohn must pay all or any of the damages.

Upjohn has insurance to cover the award.

—By Michael Schachner

Managed care

Continued from page 3

ing the same types of cost factors—like doctors increasing fees 20% and hospitals raising rates to make up for cost-shifting from public programs."

Other consultants point out that any survey on health plan costs reflects only the experience of those employers studied and not necessarily of all employers.

"If you look at employers on a broad base, premium increases are probably all over the board," said Bill Gibson, senior consultant with Noble Lowndes in Newtown, Pa.

"Employers should take a balanced approach when comparing their health plan costs to employers in a survey. They should look at their own claims experience so far this year to get a feel for next year's premium increases," said Tim Garmager, a principal with Deloitte & Touche Inc. in Chicago.

The Hewitt report found that managed care is increasingly popular among employers. Eighty-two percent of those surveyed offer some type of managed care plan.

HMOs are the most popular: 70% of those surveyed offer one or more, and 45% offer a PPO.

Point-of-service plans are far less popular, despite evidence that they help slow down premium increases.

Only 9% of surveyed employers currently offer a point-of-service HMO, also referred to as an open-ended HMO. These plans allow enrollees to make a choice at the time they seek services to stay within the network of providers or go to outside doctors but at reduced benefit levels.

While 19% of the respondents indicated they were either considering or planning to offer this option within the next two years, 72% said they would not offer such a plan.

This group of employers listed several reasons, with many employers citing more than one reason.

Thirty-eight percent said they remained unconvinced that the plans were cost effective. "There is not a whole lot of data about how much these plans save," Mr. Sperling explained.

"Allied-Signal put in one of the first point-of-service plans in 1987, and its data is only anecdotal," he said. "The history we do have shows that, by-and-large, HMOs control costs better than indemnity plans. And, since point-of-service is a combination of HMOs and indemnity plans, it's only reasonable to assume it will be more effective than indemnity and slightly less effective than an HMO."

Employers that do offer the plans report that 88% of participating employees' benefit claim dollars are paid to network providers, the survey reported.

"That proves point-of-service plans are more effective at keeping claims dollars in the network" than PPOs are, Mr. Sperling observed. "Employers with PPOs said less than 60% of claims flow through the network—so what they've really got is an indemnity plan."

Twenty-seven percent of the respondents said they do not offer point-of-service plans because they are not available in their area. That complaint may become less significant as insurers invest more in this product line, Mr. Sperling said.

Nearly a quarter of employers surveyed said they avoided point-of-service plans out of concern for the cost and complexity of administering them.

Yet half the employers who offer the plans reported that their administrative costs did not change when a point-of-service HMO was implemented.

The survey also showed that some managed mental health and prescription drug programs help employers contain costs.

Among employers that could measure the success of these programs:

- 86% reported medical plan savings by using a mental health/chemical dependency network.
- 80% reported reduced mental health inpatient days as a result of mental health/chemical dependency utilization review.
- Employers with mail-order prescription drug programs reported an 11% decrease in costs on average.
- Employers with a preferred pharmacy network reported a 21% decrease in drug costs on average.

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Copies of "Employer Experience in Managed Care 1992" are available for $75 from Diane Schuett at Hewitt Associates, 100 Half Day Road, Lincolnshire, Ill. 60069; 708-295-5000.

List should have included Home

The following company was inadvertently omitted from Nov. 9 directory of global property/casualty insurers.

THe Home Insurance Co.
59 Maiden Lane, New York, N.Y. 10038; 212-530-7373;
fax: 212-530-3004

	1991	1990
Int'l premiums	$25,000,000	NA
Offices: Claims	50	NA
Underwriting	50	NA
Employees	15	NA
Foreign countries	50	NA
Owned offices	3	NA

International operations began: 1991.
Parent: Trygg-Hansa SPP.
Specialties: Industrial, commercial property/casualty and specialty lines.
Services: Captive programs, loss control services for all written lines, retrospectively rated programs, statistics in support of international programs.
Affiliates: Australia, Austria, Argentina, Bahamas, Bahrain, Belgium, Brazil, Canada, Chile, Columbia, Cyprus, Denmark, Egypt, Estonia, Finland, France, Germany, Greece, Guam, Hong Kong, Ireland, Israel, Italy, Japan, Jordan, Korea, Kuwait, Lebanon, Malaysia, Mexico, Netherlands, New Zealand, Norway, Oman, Philippines, Poland, Portugal, Russia, Saudi Arabia, Singapore, Spain, Sweden, Switzerland, Taiwan, Thailand, Turkey, United Arab Emirates, United Kingdom, United States, Venezuela, Yemen.
Officers: Peter O' Conner, senior vp-international; John Malloy, vp-international casualty; Bengt Lindemalm, vp-Nordic business; Patrick Gallagher, vp-international operations; Gerald Kraut, assistant vp-international property; John Burke, assistant vp-international marketing; Frank Amodeo, vp-Canada; John Follansbee, vp-Pacific Rim.
U.S. contact: Peter O'Conner.

Scandinavian Re to get capital boost

HAMILTON, Bermuda—Sirius International Group plans to inject $50 million into its Scandinavian Reinsurance Co. Ltd. unit, nearly doubling the finite risk reinsurer's capital and surplus.

In a transaction slated for completion Dec. 31, Sirius plans to buy $50 million of preferred capital stock from Scandinavian Re. The move is an effort to enhance the Bermuda unit's credibility and security. Both companies are units of Asea Brown Boveri A.B. of Sweden.

Equity capital is "becoming significantly more important as a competitive factor," said Scandinavian Re President Jens Juul. But the "increase does not mean that we are going to double our volume overnight, nor that we are going to dramatically change our risk exposures," he added.

Scandinavian Re projects that its 1992 premium volume will be about one-third of its capital and surplus and says its "under-leveraged" balance sheet should comfort brokers and clients. At year-end 1991, its capital and surplus was $61.5 million—including $25 million of paid-up capital and $25 million of contributed surplus.

—By Roger Scotton

Skandia rejects sweetened offer

NEW YORK—Skandia Group has rejected a $550 million offer from a group led by John Head III for Skandia America Reinsurance Corp. after rejecting the group's earlier offer of $500 million (*BI*, Nov. 9).

Skandia said it objected to retaining $125 million of preferred stock in the U.S. operation as part of the deal.

Skandia says it will restructure the unit, cutting its annual net written premium volume to about $100 million from about $450 million and concentrating on casualty facultative and treaty business.

Standard & Poor's Corp. lowered the claims-paying ability ratings of Skandia America and two affiliates to BBB from A. A.M. Best Co. also placed the A rating of Skandia America and three affiliates under review.

—By Douglas McLeod

Judge dismisses some flood claims

CHICAGO—A judge has dismissed economic damage claims filed against the City of Chicago by businesses that did not sustain property damage during the April underground flood.

The claims, contained in consolidated litigation against the city, represented the bulk of claims against Chicago.

In a written order on the city's motion to dismiss the claims, Cook County Circuit Court Judge Donald J. O'Brien ruled that businesses that did not suffer physical damage cannot collect from the city: "Defendants should not be held liable for damages of unlimited and unknown scope where there is no damage to person or property."

But, the judge did not dismiss allegations that the city failed to warn businesses about the potential of a flood in the underground tunnel system and that the city failed to repair the tunnel immediately after it learned earlier in the year that a tunnel wall holding back the Chicago River was collapsing.

The judge also refused to dismiss economic damage claims filed by businesses that suffered damage to perishable goods, like food, merchandise or files. But, he said he would revisit the issue later if discovery showed that those plaintiffs suffered only economic losses.

Plaintiffs' attorneys are not discouraged. "He didn't dismiss the entire complaint," said Bruce Goodhart of Holstein, Mack & Klein in Chicago. The ruling was not a surprise in light of case law, he said.

The plaintiffs are considering whether to appeal.

Judge O'Brien is expected to rule within a few weeks whether to grant the plaintiffs class-action status, Mr. Goodhart said.

—By Sara Marley

Update

N.J. proposal for the uninsured

Continued from page 2

physician or community health clinic. But there would be a $200 deductible plus 20% copayment for hospitalization coverage.

Absent from the plan is a way to cover costs beyond what the fees will cover and a way to provide care for 500,000 other uninsured residents.

Care for the uninsured is now financed by a 19% surcharge on all hospital bills. Self-funded employers have challenged the surcharges in court (*BI*, June 1).

Berwind settles Mutual Fire suit

PHILADELPHIA—Berwind Corp. has agreed to pay $11.25 million to the rehabilitator of Mutual Fire, Marine & Inland Insurance Co. to settle litigation over reinsurance claims left unpaid by Berwind's defunct captive subsidiary.

The Pennsylvania Insurance Department, Mutual Fire's rehabilitator, sued Philadelphia-based Berwind in 1989, seeking to "pierce the corporate veil" and hold Berwind liable for Mutual Fire claims against Norad Reinsurance Co. Ltd., Berwind's Bermuda captive.

Norad was ordered liquidated in Bermuda in 1988 and was estimated last year to be insolvent by $34.6 million (*BI*, Nov. 4, 1991).

Mutual Fire, Norad's largest creditor, has separately filed about $28 million in claims against the Norad estate. Mutual Fire has received about $4 million from the estate so far and will receive another $800,000 to $1 million when Norad's liquidators make a final distribution in December, said Alexander Bratic, Mutual Fire's special deputy rehabilitator.

BIC liable for children's burns

BRISTOW, Okla.—BIC Corp. is appealing a $22 million award by an Oklahoma state court jury to three children who were badly burned while playing with a disposable BIC lighter in 1988.

The children dropped the lighter while it was lit, starting a fire that caused the lighter to explode, said their lawyer, E. Terrill Corley of Tulsa, Okla. All three children—5-year-old twins and their 2-year-old brother—were badly burned. Their medical bills totaled $547,000.

The family filed suit in state court in 1990. The family charged that "BIC lighters have a history of failing to extinguish," Mr. Corley said.

BIC said that on appeal it will blame the injuries on inadequate supervision. The Milford, Conn.-based company says its insurance and reserves would cover the award.

Briefly noted

Berkshire Hathaway Inc. reported Friday that it will pay out $125 million in Hurricane Andrew claims stemming from its "super-cat polices." Berkshire Chairman Warren Buffett told shareholders that if no other major catastrophes occur during 1992, Berkshire would lose only about $4 million on its super-cat business. Overall, Berkshire's insurance operations generated operating earnings of $4.3 million in the third quarter, down from $55.8 million a year earlier. . . .**Blue Cross & Blue Shield of Illinois** has agreed to pay Cook County, Ill., $2.4 million to settle a nearly nine-year battle over refunds of administrative fees the county has paid. The county sued the Blues plan in 1984, alleging it breached its contract by not passing along savings the Blues realized through negotiated fee arrangements with local hospitals. . . .A National Assn. of Insurance Commissioners task force has reaffirmed that all life/health insurers must report **risk-based capital** calculation results in annual statements (*BI*, Sept. 28). Some insurers' continue to oppose such public scrutiny. . . .The 6th U.S. Circuit Court of Appeals will not reconsider a ruling that the **CGL absolute pollution exclusion bars product liability coverage** under Ohio law when damage is caused by a product's release of pollutants (*BI*, Oct. 5). This is believed to be the first time a federal court has dealt with the impact of the pollution exclusion in the post-1986 CGL policy on product liability coverage. . . .The Chicago Board of Trade on Dec. 11 will begin trading **insurance futures contracts** based on catastrophe losses nationwide and in the East (*BI*, Nov. 2). No date has been set for trading West and Midwest catastrophe contracts. . . .Tennessee Gov. Ned McWherter has approved an **8% workers compensation rate increase** effective Jan. 1. . . .A Colorado state court judge has let stand an $8.2 million jury award against a New Mexico blood bank that provided **HIV-contaminated blood** used in a 1983 transfusion that led to the AIDS-related death of the plaintiff earlier this year (*BI*, Aug. 10). The plaintiff died before the jury reached a decision. . . .The St. Paul Cos. Inc. expects to take a "material" write-down on the value of the **goodwill associated with The Minet Group P.L.C.**, which it acquired in 1988. As of Sept. 30, Minet's book value was $783 million, $482 million of which was attributable to goodwill, a St. Paul spokesman said. The write-down will result in a loss for the fourth quarter and year. . . .A **record $120 million legal malpractice award** delivered by an Oklahoma state court jury last month has been settled for substantially less (*BI*, Nov. 2). The parties are prohibited by the terms of the settlement from disclosing the amount. . . .**Brian M. O'Hara**, president and chief operating officer of Bermuda-based X.L. Insurance Co. Ltd., assumes the additional position of chief executive officer Dec. 1. He succeeds Michael J. Kevany, who becomes CEO of its parent, EXEL Ltd. . . . **Trenwick Group Inc.** filed a registration statement with the Securities and Exchange Commission for the public offering of $75 million of convertible subordinated debentures. . . .Regulators halted two unauthorized **multiple employer welfare arrangements**—Atlantic Healthcare Benefits Trust of Virginia Beach, Va. and Western Businessmen's Assn. of Phoenix—from doing business in Illinois. . . .**LTV Corp.** told the Pension Benefit Guaranty Corp. last week that it does not intend to terminate any of its three underfunded pension plans.

Brokers' potential in a hard market

By LEONARD M. WILSON

SPECULATION IS NOW RIFE among investors as to the direction of premium rates on commercial lines. The evidence of a hardening market, so far, is spotty. But insurance stocks, brokers and underwriters have already begun to act as if the turn were a foregone conclusion.

Our most recent industry contact on the subject of rates presented a tantalizing contrast. First, the hopeful scenario. Underwriters are concerned now about having underestimated the exposure level in property coverages. Reinsurance is tight, and primary retentions are rising. Prices on property risks need to increase. The time seems ripe to attempt modest price advances on the liability side as well.

What about the less hopeful scenario? Underwriters are shaving capacity in the property market. Ergo, to compensate for lower premium volume there, insurers could plausibly adopt a more aggressive pricing posture in commercial liability to bolster written premiums.

Rather than dwell on the "will it or won't it," we have tried to posit the effect of a moderately firm market on broker earnings.

There is no denying that five years of soft commercial prices have taken a toll on brokers' profitability. Most brokers have experience a substantial decline in profit spreads.

So there is plenty of room for upside profit leverage in an improved backdrop. The leverage comes from the spread between the rate of growth in revenues and the growth in expenses. In soft markets, that spread turns negative as revenues gain at an anemic pace; while expenses, even on an austerity basis, advance faster than the top line. The result: squeezed profit margins.

In a hard market, revenue growth accelerates, and brokerage expenses rise more rapidly as budget restraints are lifted and needs are deferred. Also, staff additions and catch-up compensation are fulfilled. Typically, though, the rate of increase in revenues outstrips the markup in costs, which results in widening profit margins, thereby generating a pronounced acceleration in earnings growth.

Using this as a departure point, we created several models that quantify the potential jump in earnings in a better environment. Hypotheticals are used, not actual operating results.

In the first model, pretax profit margins start out at only 6% of revenues, quite a depressed level. Here are our assumptions for revenue growth in a moderately firming insurance market. Premium rates contribute three percentage points to commissions. The economy continues to recover fitfully and provides 2% of underlying growth to the existing book of business.

Finally, net new business, still the single most important driver of the top line, adds 7%. In the real world of a market genuinely tightening across the board, these assumptions could prove conservative.

Most analysts perceive that a change is in the making, but too many disappointments over the long, dry spell argue for caution.

In the aggregate, commissions rise 12% per year. Other categories of the top line, investment income and benefits consulting, are assumed to rise in line with commissions. Since non-U.S. markets are hardening, it is reasonable to expect similar overall growth in international brokerage.

Forecasting expenses is touchier. We have used a one-year increase in expenses of 9%, based on: general inflation, 3%; headcount increases, up 3%; and compensation rising roughly 5% above inflation.

These assumptions for revenues and expenses provide a positive operating spread of 3%: Revenues advance at 12%, while expenses rise at 9% per year.

In the first year of a harder market, our insurance broker with the depressed margins experiences earnings growth of about 70%. If we put together two years running of a hard market, and a consequent positive operating spread, earnings almost triple.

For example, if earnings were $1 per share in the base year, after two years of firm rates—and incorporating our other assumptions—earnings would rise to $2.60 per share. This degree of leverage intrigues investors when they contemplate the effect of better pricing on commercial lines.

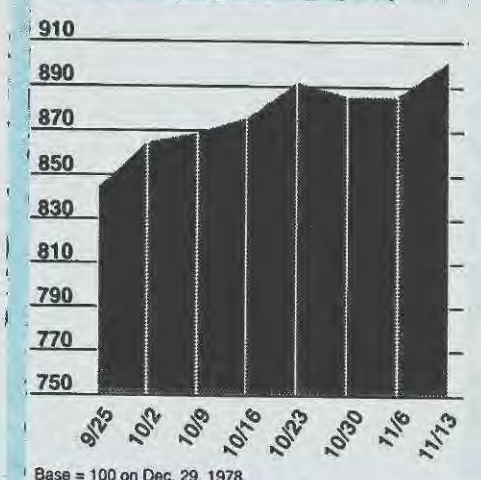
The earnings leverage is a great deal less dramatic for a brokerage with considerably wider profit margins. Take a broker with pretax margins of 20%. Plugging our assumptions into a model income statement, earnings increase roughly 25%, still a pleasing improvement compared with the past five years of earnings stagnation. Earnings of $1 per share would then rise to $1.55 after two straight years of firming prices.

Investors perform this kind of arithmetic when assessing the potential impact of a brightening market. Earnings growth for the main body of common stocks should approximate 8% to 10% over the next several years, allowing for a fairly brisk economy. Operating gains for the public brokers could markedly outstrip the earnings progress of corporate America with the advent of a harder market. Faster earnings growth equals greater stock price appreciation.

For now, there is uncertainty—and not only about rates. Most analysts perceive that a change is in the making, but too many disappointments over the long, dry spell argue for caution. BI

Leonard M. Wilson is a senior vp with Lazard Asset Management Inc. He is a member of the New York Society of Security Analysts.

BI Insurance Index



Base = 100 on Dec. 29, 1978
Source: Nordby International Inc.

Insurance industry stocks climbed last week, as the *Business Insurance* Index gained 4.1 points to 900.6 on Nov. 13, from 886.5 on Nov. 6. Advancing issues for the week were led by Statesman Group Inc., up 14.1%; Kemper Corp., up 11.4%; and Gainsco Inc., up 8.2%. Decliners followed Seibels Bruce Group, down 50%; American Indemnity Financial Corp., down 8%; and Chandler Insurance Co., down 7.5%. The most active issue was U.S. Healthcare, 5 million shares traded. The *BI* Index was up 1.6%; the Standard & Poor's 500 was up 1.2%; the NYSE Composite was up 1.1%; and the Dow Jones 30 Industrials fell 0.2%.

British Issues

Nov. 12 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	568	N/M	31.5	5.5	578—	566
Genl Accident	568	N/M	35.7	6.3	568—	536
Gdn Royal Exch	173	N/M	10.0	5.8	173—	165
Royal	247	N/M	7.0*	2.8	247—	226
Sun Alliance	331	N/M	19.0	5.7	331—	314
Brokers						
Bradstock	119	13.3	6.3	5.3	119—	119
CE Heath	301	17.5	34.5	11.5	301—	289
Hogg Group	155	14.6	10.9	7.0	155—	155
JIB Group	155	11.9	10.0	6.5	160—	155
Lloyd Thompson	231	18.7	7.5	3.2	231—	231
Lowndes Lmbrt	282	11.0	16.8	6.0	282—	280
PWS Holdings	40	4.6	5.3	13.3	40—	40
Sedgwick Grp	159	12.7	8.0*	5.0	159—	150
Steel Brrl Jones	199	9.8	17.7	8.9	199—	199
Willis Corroon	197	12.4	17.6	8.9	205—	197

Source: Philip Olsen, London * Estimated

BI Industry Stock Report

NOVEMBER 9, 1992 THROUGH NOVEMBER 13, 1992

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander	NYS	27.00	2.37	31.71	27.38	18.00	330	1.00	3.70	96	13.10	2.06
Gallagher Arthur J. & Co.	NYS	29.00	3.11	29.61	29.00	20.00	373	0.64	2.21	19	5.88	4.93
Frank B. Hall	NYS	2.88	0.00	-32.35	5.50	2.63	0	0.00	0.00	-3	1.95	1.47
Hilb, Rogal & Hamilton	NYS	14.50	-0.85	9.43	15.63	11.00	72	0.44	3.03	22	3.56	4.07
Marsh & McLennan	NYS	92.75	-1.07	13.98	94.50	70.00	575	2.68	2.89	22	28.00	3.31
Poe & Associates	OTC	14.50	5.45	20.83	16.00	11.25	0	0.40	2.76	18	3.05	4.75
BROKERS	AVERAGE		1.5	12.2				2.1	25			
CONGLOMERATES & HOLDING COMPANIES												
Berkley W R. Corp.	OTC	46.38	-0.80	52.05	47.75	26.75	322	0.36	0.78	17	36.95	1.26
Berkshire Hathaway Inc.	NYS	9800.00	4.26	8.29	9800.00	254.69	0	0.00	0.00	33	7270.00	1.35
ITT (Hartford Group)	NYS	68.38	3.21	18.40	70.63	50.00	1275	1.84	2.69	16	112.05	0.61
Sears (Allstate)	NYS	43.13	0.88	13.86	48.00	32.50	3774	2.00	4.64	42	34.50	1.25
CONGLOMERATES	AVERAGE		1.9	23.1					2.0	27		
INSURERS/REINSURERS												
AEGON N.V.	NYS	41.75	1.21	19.29	42.75	32.25	85	2.68	6.42	7	N/A	N/A
Aetna Life & Casualty	NYS	43.00	2.08	-2.27	47.00	36.50	605	2.76	6.42	14	87.60	0.49
Allied Group Inc.	OTC	28.75	0.00	69.12	31.13	16.25	74	0.64	2.23	9	19.85	1.45
American General	NYS	51.88	-0.24	16.57	52.75	39.00	661	2.08	4.01	11	60.00	0.86
American Heritage Life Ins.	NYS	29.75	-3.25	-2.86	32.50	22.03	62	0.84	2.82	14	N/A	N/A
American Indemnity/Fin'l	OTC	5.75	-8.00	21.05	9.25	4.63	3	0.08	1.39	3	12.93	0.44
American International	NYS	115.38	3.94	17.28	115.38	82.00	2025	0.56	0.49	16	99.30	1.16
Aon Corp.	NYS	49.50	1.80	24.92	51.13	35.50	312	1.68	3.39	13	39.70	1.25
Argonaut Group	OTC	27.75	-1.77	16.84	30.00	21.75	23	0.84	3.03	8	20.96	1.32
AVEMCO Corp	NYS	23.63	5.00	-5.50	28.00	21.50	24	0.40	1.69	26	9.55	2.47
Baldwin & Lyons Inc.	OTC	34.25	-2.14	33.01	35.00	25.00	7	0.48	1.40	8	24.29	1.41
Chandler Insurance	OTC	4.63	-7.50	42.31	7.63	3.13	5	0.00	0.00	42	5.95	0.78
Chubb Corp.	NYS	87.75	2.63	13.96	88.38	62.38	769	1.60	1.82	14	42.67	2.06
CIGNA Corp.	NYS	52.63	2.43	-13.91	61.75	47.13	753	3.04	5.78	11	117.15	0.45
CNA Financial Corp.	NYS	94.38	1.75	-3.70	104.50	78.50	62	0.00	0.00	12	70.23	1.34
Continental Corp	NYS	27.88	3.24	0.90	34.75	20.00	489	2.60	9.33	20	40.00	0.70
EXEL Ltd.	NYS	45.75	0.83	22.00	46.00	30.00	305	0.92	2.01	9	N/A	N/A
Fund American Corp.	NYS	71.13	-1.22	1.79	73.50	62.50	7	0.68	0.96	17	36.11	1.97
Fremont General Corp.	OTC	26.50	0.95	8.72	27.25	17.00	104	1.00	3.77	6	45.55	0.58
Frontier Insurance Group	NYS	37.00	-4.21	37.04	40.50	21.91	50	0.60	1.62	13	26.65	1.39
Gainsco Inc.	ASE	14.88	8.18	59.38	14.88	7.47	415	0.04	0.27	20	3.37	4.41
General RE Corp.	NYS	113.38	1.57	11.29	117.00	77.50	1008	1.80	1.59	16	78.65	1.44
Guaranty National Corp.	NYS	17.63	0.00	21.55	20.38	12.63	103	0.48	2.72	11	N/A	N/A
Hanover Insurance Co.	OTC	48.88	1.03	36.71	49.25	33.00	108	0.44	0.90	8	37.44	1.31
Harleysville Group	OTC	26.13	-4.13	22.94	28.25	16.75	208	0.64	2.45	11	22.99	1.14
Hartford Steam Boiler	NYS	55.00	-0.45	-4.35	59.25	45.13	76	2.12	3.85	21	35.50	1.55
Kemper Corp.	NYS	26.88	11.40	-29.51	46.13	20.75	1168	0.92	3.42	19	50.00	0.54
Lawrence Insurance Group	ASE	8.00	0.00	-28.09	11.13	7.00	1	0.48	6.00	18	4.71	1.70
Liberty Corp.	NYS	25.75	-2.37	16.38	32.88	20.13	109	0.48	1.86	10	29.35	0.88
Lincoln National	NYS	69.88	4.10	27.63	69.88	49.38	382	2.92	4.18	11	81.00	0.86
Markel Corp.	OTC	28.00	-2.61	27.27	29.25	18.00	23	0.00	0.00	7	15.59	1.80
Mutual Risk Mgmt. Ltd.	NYS	37.38	-0.99	6.41	40.00	25.75	10	0.24	0.64	22	-	-
NAC Re Corp.	OTC	40.13	3.55	27.38	42.00	21.75	104	0.16	0.40	36	18.90	2.12
National Re Corp.	NYS	29.38	3.98	N/A	31.00	17.00	188	0.12	0.41	14	N/A	N/A
Navigators Group	OTC	35.00	6.87	-14.63	48.25	28.50	6	0.00	0.00	19	13.52	2.59
Nobel Insurance LTD.	OTC	5.13	7.89	28.13	6.00	3.75	256	0.00	0.00	3	7.76	0.66
NWNL Companies	NYS	41.63	6.05	33.73	43.75	26.00	369	1.48	3.56	11	62.65	0.66
Ohio Casualty Corp.	OTC	61.00	0.00	23.23	66.63	44.00	36	2.68	4.39	12	18.00	3.39
Old Republic Int'l	NYS	24.88	-4.33	40.14	26.50	16.00	158	0.40	1.61	8	33.09	0.75
Orion Capital Corp.	NYS	38.25	-0.33	20.95	41.00	29.00	108	1.00	2.61	6	43.50	0.88
Phoenix RE Corp.	OTC	13.38	-0.93	27.38	13.75	8.75	19	0.20	1.50	-19	13.30	1.01
Provident Life	NYS	26.00	4.00	11.83	28.00	19.75	296	1.00	3.85	11	39.50	0.66
Re Capital Corp.	ASE	15.75	-2.33	9.57	16.38	12.25	2	0.24	1.52	28	16.07	0.98
Reliance Group Holdings	NYS	5.75	2.22	39.39	5.88	3.50	213	0.32	5.57	3	6.40	0.90
RLI Corp.	NYS	22.88	0.55	38.64	23.25	15.50	17	0.52	2.27	10	17.92	1.28
St. Paul Companies	NYS	70.38	0.90	-3.43	80.75	65.13	836	2.72	3.87	10	86.60	0.81
SAFECO Corp.	OTC	56.63	1.34	16.15	57.00	40.63	737	1.64	2.90	14	51.65	1.10
SCOR U.S. Corp.	NYS	18.63	0.68	21.14	19.13	13.13	25	0.28	1.50	18	11.19	1.66
Seibels Bruce Group	OTC	1.13	-50.00	-79.55	6.50	1.13	434	0.36	32.00	-1	10.60	0.11
Selective Ins. Group	OTC	21.38	1.79	27.61	23.50	16.00	237	1.12	5.24	9	30.75	0.70
Statesman Group Inc.	OTC	10.13	14.08	76.09	10.13	5.00	603	0.00	0.00	5	2.48	4.08
Tokio Marine & Fire	OTC	43.25	-3.62	-16.02	55.25	32.25	0	0.00	0.00	87	70.93	0.61
Torchmark Corp.	NYS	53.63	1.90	38.98	54.38	34.00	425	1.04	1.94	15	40.95	1.31
Transamerica	NYS	43.38	0.87	8.78	46.75	35.63	316	2.00	4.61	20	55.00	0.79
Transatlantic Holdings	NYS	51.88	2.98	33.44	52.38	29.38	123	0.24	0.46	18	18.38	2.82
Travelers Corp.	NYS	23.00	0.55	6.36	23.75	17.13	1353	1.60	6.96	-13	59.00	0.39
Trenwick Group Inc.	OTC	39.50	-1.25	38.60	42.00	25.00	131	0.80	2.03	16	21.71	1.82
United Fire & Casualty	OTC	39.00	-4.88	30.00	42.50	29.16	1	1.00	2.56	8	35.39	1.10
Unitrin	OTC	37.00	-4.52	3.50	39.50	31.00	162	1.20	3.24	11	37.23	0.99
UNUM Corp.	NYS	49.25	2.60	21.60	49.63	32.00	400	0.64	1.30	14	37.70	1.31
US Facilities Corp.	OTC	9.38	-7.41	-36.97	19.00	7.00	1291	0.00	0.00	7	9.58	0.98
USF&G Corp.	NYS	13.75	2.80	89.66	15.00	5.63	1400	0.20	1.45	-26	12.30	1.12
USLICO Corp.	NYS	17.63	3.68	-4.73	20.38	16.75	17	1.00	5.67	25	33.15	0.53
USLIFE Corp.	NYS	48.63	2.10	1.57	52.50	39.00	54	1.80	3.70	9	84.55	0.58
Washington National	NYS	22.63	-0.55	42.52	23.63	14.00	39	1.08	4.77	18	33.50	0.68
Zenith National Ins.	NYS	16.88	-1.46	0.00	19.50	13.75	49	1.00	5.93	12	13.14	1.28
INSURERS/REINSURERS	AVERAGE		0.0	16.4					3.6	15.2		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	20.00	3.90	40.35	21.25	10.00	655	0.00	0.00	20	15.50	1.29
Pacificare Health Sys.	OTC	45.25	4.62	14.56	45.75	11.13	244	0.00	0.00	27	28.25	1.60
Safeguard Health Enter.	OTC	9.25	0.00	-1.33	14.75	6.75	52	0.00	0.00	11	3.53	2.62
Sierra Health Services	ASE	36.00	7.87	289.19	36.00	13.38	125	0.00	0.00	17	1.78	20.22
United Healthcare Corp.	NYS	52.25	2.45	-29.87	54.75	29.06	785	0.01	0.02	34	43.60	1.20
United Medical Corp.	ASE	6.63	1.92	-5.36	8.75	6.50	7	0.20	3.02	60	8.79	0.75
U S Healthcare	OTC	45.25	4.02	63.55	51.25	21.66	4986	0.36	0.80	27	20.55	2.20
HMOs	AVERAGE		3.5	53.0					0.5	25		
ALL COMPANIES	AVERAGE		1.7	26.2				3.0	17			

System design: Nordby International Inc.

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