

Business Insurance

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

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Eagle Star to become part of Employers Reinsurance Corp.

STAMFORD, Conn.—GE Capital Corp. will acquire Eagle Star Reinsurance Co. Ltd., U.K., from Zurich Financial Services, with the London-based reinsurer becoming part of GE Capital's Employers Reinsurance Corp.

Eagle Star Re primarily provides property, casualty and marine reinsurance to clients around the world. According to Sarah Hibler, a vp and senior analyst at Moody's Investors Service Inc., the acquisition enhances the position of Overland Park, Kan.-based Employers Re in the U.K. broker market, while further

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Wausau to keep its independence in affiliation with Liberty Mutual

By SALLY ROBERTS

BOSTON—Clients of Employers Insurance of Wausau can expect to maintain the same relationships and receive the same products and services from the same brand name despite Wausau's new affiliation with competitor Liberty Mutual Group.

Other than pooling financial results and possible joint initiatives in the future, the two venerable workers compensation insurers will continue to operate as independent mutuals. While the insurers have different distribution systems, they both say they will compete against each other in the commercial insurance marketplace.

Last week, the two companies jointly announced that the Wausau, Wis.-based mutual insurer was joining the Boston-based Liberty Mutual Group, ending Wausau's 13-year affiliation with Columbus, Ohio-based Nationwide Group, which has decided to focus on growing its core personal lines and financial services business.

Terms of the deal, expected to close by year end, were not disclosed pending required regulatory review. As part of Nationwide's affiliation agreement, however, \$400 million in surplus notes that Nationwide invested in Wausau will have to be paid back.

"We are really viewing this as a big win for Wausau," said Wausau's president and chief operating officer, Dwight Davis. "The Wausau brand will continue; the services we are known for will continue; and our producer relationships will continue. So what we gain is being associated with a partner that wants to invest and grow the Wausau brand," he explained.

Whereas Nationwide is more committed to personal lines property/casualty and financial service business, Liberty Mutual is more committed to the commercial lines market, Mr. Davis said.

Mr. Davis said he expects the completed transaction will make Wausau stronger financially than it has ever been.

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A mutual partnership

	Liberty Mutual Group	Employers Insurance of Wausau	Combined
1997 net premiums written	\$5.92 billion	\$1.33 billion	\$7.25 billion
1997 workers comp direct premiums	\$1.96 billion	\$710 million	\$2.66 billion
Assets	\$25.6 billion	\$3.6 billion	\$29.2 billion
Policyholder surplus	\$7.2 billion	\$600 million	\$7.8 billion

Source: Company reports, A.M. Best Co., Moody's Investors Service Inc.

GRAPHIC BY ADAM DOI

Personal injury part of CGL policies can cover pollution: Court

By DAVE LENCKUS

OLYMPIA, Wash.—For the first time, a state supreme court has ruled that personal injury liability provisions of general liability insurance policies cover environmental liabilities.

If followed by other courts nationwide, the unanimous decision by the influential Washington Supreme Court on Oct. 1 could help policyholders skirt the pollution exclusions in their general liability policies and allow them to tap their insurance to cover the cost of government-ordered cleanups, some

policyholder attorneys said.

The decision will help policyholders with general liability policies that contain either sudden and accidental or absolute pollution exclusions, policyholder attorneys said.

While acknowledging the ruling's significance, insurer attorneys contend the decision's impact would be limited to private-party claims against policyholders. Those claims typically are far less costly to resolve than are coverage disputes over government-mandated cleanups, they said.

See Pollution on page 24

NationsBank's innovative pension plan in question

By JERRY GEISEL

CHARLOTTE, N.C.—New legal questions are dogging NationsBank Corp.'s innovative participant-directed cash balance pension plan.

Employee benefit and legal experts are questioning how the company's new approach fits with certain Internal Revenue Service rules governing the transfer of funds between defined contribution and defined benefit plans. Charlotte, N.C.-based NationsBank, which now operates under the name Bank of America following its merger with BankAmerica Corp., has refused to discuss the plan (BI, Oct. 5).

"Legal issues have to be addressed in such arrangements," said Fred Rumack, director of taxes and legal services at Buck Consultants Inc. in New York.

The NationsBank plan allows employees to direct the investment of company-provided cash balance plan pay credits. Employees can choose among 11 investment options, including fixed income and various equity funds. Employees' cash balance plan accounts then are credited with the actual returns of the funds they select.

In addition, employees had a one-time opportunity—available through June 28—to transfer to the cash balance plan any pretax

contributions they previously had made to the 401(k) plan and to allocate those 401(k) monies among the 11 investment options.

Regardless of the investment options selected, NationsBank guarantees employees' cash balance pay credits, the funds they transferred from their 401(k) plans and the gains earned by the funds into which they directed their pay credits.

Even if the investment funds an employee selects have negative investment returns, the value of an employee's account balance will not be reduced below the level before investments were made.

Employees' account balances, See Pension on page 26

New treatment for plan quality

Coalition examining health care by community's diseases

By JOANNE WOJCIK

TAMPA, Fla.—While most employer coalitions are giving their health plans report cards, one group of employers is trying a disease-specific approach to measure the quality of health care in its community.

Rather than asking employees, "How do you like your health plan?" the Healthy People/Productive Community Survey asked: "What diseases do you have?" and, "How would you rate the quality of the treatment you've been receiving for them?" explained Frank Brocato, president and chief executive officer of the Tampa, Fla.-based Employers Health Coalition.

The findings will be used to de-

velop best-practice guidelines for health plans as well as to improve existing disease management and return-to-work programs, Mr. Brocato said.

"We can actually break it down by plan and look at it and say, 'This one plan scored very high and does not seem to have the problems that the other two plans have,'" so that "we can find out what somebody is doing better and pass it on" to other plans, Mr. Brocato said.

Employers also can compare the survey findings with their own claims data, which often overlooks secondary medical conditions triggered by primary illnesses, Mr. Brocato explained.

For example, an employer might identify from claims data breast

cancer or heart surgery, but "the employer doesn't see the ongoing depression or hypertension that the patient is going through," he pointed out.

By identifying such secondary disorders and the burden they place on patients' lives, providers can treat patients on a more holistic basis, thus improving the overall quality of health care, he suggested.

Survey respondents reported an average of 2.15 diseases per household.

The survey is the third phase of a continuing quality improvement effort by the coalition, which has been collecting claims data since its formation in 1984. It collected clinical outcomes data between

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Updates

GE Capital to buy Eagle Star

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diversifying its book of business and broadening its customer base.

Donald S. Watson, a director in the reinsurance group at Standard & Poor's Corp. in New York, called the acquisition an "opportunistic" one for GE Capital and said, "It really solidifies their presence in the U.K., and it certainly puts them up there in terms of premium volume."

"GE Capital is a company that can afford to make a transaction in the market when prices are low, and they don't need to use their stock to do it, because they can pay cash," Mr. Watson said.

Terms of the transaction, which is subject to regulatory approval and is expected to be completed by year's end, were not disclosed. Under generally accepted accounting principles, Eagle Star Re had net assets of £232.8 million (\$384.3 million) at the end of 1997.

For Zurich, the transaction was one of the final moves in the strategic reorganization of its London market reinsurance companies. That effort also included linking the specialty insurance business currently written by Zurich Re (London) Ltd. with the company's New York-based Zurich American Specialties operation into a unit to be named Zurich Specialties (London) Ltd. Meanwhile, the reinsurance business written by Zurich Re London will be transferred to Zurich Financial Services underwriting operations in Zurich, Switzerland; New York; or Cologne, Germany.

M&M extends Sedgwick offer

NEW YORK—Marsh & McLennan Cos. Inc. last week extended until Oct. 20 the acceptance period for its roughly \$2 billion tender offer to acquire Sedgwick Group P.L.C.

The offer, announced in August, was expected to be declared unconditional last Monday, but relevant regulatory and other conditions have not been satisfied. Both the European Commission and the Federal Trade Commission must approve the deal. The European Commission has until Oct. 23 to make its ruling.

An M&M spokeswoman confirmed that the FTC recently made a second request for more information, but she discounted a recent published report that the request was to help determine if the acquisition would violate federal antitrust laws.

"It's normal procedure," she said of the FTC's second request.

M&M reserves the right to extend the offer further beyond the Oct. 20 closing date but is not obligated to do so.

M&M still anticipates completing the deal in the fourth quarter, the spokeswoman said.

Pilots flock to early retirement

FORT WORTH, Texas—Thanks to a lucrative retirement option, more pilots than anticipated are bailing out at American Airlines.

Under their contract, American's 9,000 pilots, when reaching the mandatory retirement age of 60—or upon early retirement—are entitled to collect lump-sum retirement payments consisting of mutual fund assets. How much the pilots receive is tied to the stock value of the parent company, Fort Worth, Texas-based AMR Corp. The stock price has dropped significantly since July. Because pilots have a three-month window in which to choose the retirement offer, many are taking early retirement in the summer or fall and are receiving parting sums based on the July stock price, an American spokeswoman said.

About 65 pilots were expected to leave the airline this month, and a similar number left last month, the spokeswoman said. Sixty-five more could retire next month. Pilots on administrative duty were being contacted to fill in for retirees, and a small number of flights, mostly to Latin America, were being canceled due to pilot shortages, she said.

"The bottom line is, we'll deal with the cancellations and we'll deal with the pilots we lose," the spokeswoman said.

Medicare HMO exits continue

The exodus of HMOs from the Medicare market is continuing, with the latest withdrawals pushing to more than 400,000 the number of beneficiaries in HMOs that have announced they are ending their contracts with Medicare.

Amid the turmoil, the Clinton administration says it will cut red tape for HMOs that want to enter markets where there is no other Medicare HMO.

However, American Assn. of Health Plans President Karen Ignagni warned that the exodus of risk HMOs from Medicare will worsen next year unless the administration and Congress work to address certain structural problems in the program.

The latest withdrawals include:

- Woodland Hills, Calif.-based Foundation Health Systems Inc., which is withdrawing risk HMOs in additional counties in four Western states.
- About 7,100 members are affected, according to a Foundation spokesperson.
- These pullouts follow earlier announcements of withdrawals.
- After all the withdrawals, Foundation health plans will serve more than 292,000 Medicare beneficiaries in 96 counties in 10 states.
- Norwalk, Conn.-based Oxford Health Plans Inc., which will exit the market in four New York counties, nine New Jersey counties, six Connecticut counties and five Pennsylvania counties. These plans cover 26,500 retirees, or 17% of Oxford's Medicare risk HMO enrollees.
- Anthem Blue Cross & Blue Shield, which announced in May that it would exit the market in 19 mostly rural Ohio counties and parts of three other Ohio counties, has decided to stay in six of those counties, where no other Medicare risk HMO operates, and in parts of three other Ohio counties where it originally announced it would not offer the product.
- Between 12,000 and 13,000 beneficiaries will be affected by the counties Anthem is exiting. After the withdrawals, Anthem will serve roughly 45,000 Medicare beneficiaries.
- Currently, about 6 million of Medicare's 38 million beneficiaries receive coverage through risk HMOs.

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Insurer execs indicted

Duo conspired in offshore fraud, court papers charge

By DOUGLAS McLEOD

MIAMI—Insurance executive James E. Charge is being held without bail in a Miami jail after his arrest on federal charges that he used an offshore insurance company to bilk California policyholders of \$22 million between 1991 and 1993.

A federal grand jury has indicted Mr. Charge and an associate, John H. Nellmapius, on multiple conspiracy and fraud counts related to their operation of the now-defunct West Point Insurance Co. of Antigua.

The indictment alleges that the

two men conspired to submit a series of bogus West Point financial statements to California insurance regulators, reporting millions of dollars of assets that were essentially worthless.

Mr. Charge also made fraudulent Securities and Exchange Commission filings for Indemity Holdings Inc., a company West Point controlled, prosecutors allege.

West Point continued to collect premiums from California policyholders for six months after it had agreed with state insurance regulators in 1993 to stop writing business in the state. The insurer

later collapsed, leaving about \$6.9 million in unpaid California claims, the indictment says.

Mr. Charge, an Australian national residing in the United Kingdom, was arrested Aug. 8 at John F. Kennedy International Airport in New York. He was later transferred to Miami, where a federal magistrate on Sept. 30 ordered him held without bond, citing a risk he might flee.

At a hearing last Wednesday, Mr. Charge pleaded not guilty to the allegations, and a federal public defender was appointed to represent him. He continues to be

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AIG sued over denial of claim

Bad-faith suit says ad contradicts coverage position

By ROBERTO CENICEROS

MARTINEZ, Calif.—As far as AMERICAN International Group Inc.'s coverage is concerned, the rubber isn't meeting the road, a policyholder's lawsuit claims.

The insurer's advertising isn't all it's stacked up to be either, Walnut Creek, Calif.-based Owens Financial Group Inc. alleges in a bad faith and false advertising lawsuit filed earlier this month in Contra Costa Superior Court in Martinez, Calif.

Owens claims AIG improperly denied it coverage for a lessor's tire recycling site shut down by

California pollution prevention authorities.

Owens is also claiming false advertising over the insurer's magazine advertisements that tout solutions for environmental risks. The specific advertisement is a stark, black-and-white photograph depicting a mountain of discarded tires stacked so high it easily dwarfs three men walking along a road cutting through the dump where millions of tires are stacked.

"Dump them, you break the law. Recycle improperly, you break the law. Meanwhile, more tires just came in," reads part of

the advertisement, which ran for months in several magazines, including *Business Insurance*.

AIG, in a written statement responding to the lawsuit's allegations, said it denied Owens' insurance claims because the mortgage loan company is not entitled to coverage under the terms of the AIG policies, originally issued to Wenbury Environmental Ltd., a now-insolvent tire recycling operation that leased property from Owens.

Owens and its attorneys view the advertisement as proof that AIG specifically targeted tire re-

See AIG on page 23

ADA among cases on high court docket

By MARK A. HOFMANN

WASHINGTON—Defining the scope of the Americans With Disabilities Act could prove to be one of the central themes of the Supreme Court's 1998-99 term.

The justices opened their new term last week by agreeing to decide if employers can be sued for alleged violations of the Americans With Disabilities Act by former employees even though the claimants already sought full disability benefits under Social Security.

The justices also asked the U.S. solicitor general to comment on two other ADA cases they had yet to accept for review.

In addition, the justices last week denied certiorari, or review, to a class-action case from Illinois that employers and insurers had hoped could restrict how some class-actions are composed. The high court already had agreed to deal with another class-action case, as well as cases involving expert testimony, pension plan administration and the pre-emptive powers of the McCarran-Ferguson Act (BI, Sept. 28).

The addition of the ADA case, *Cleveland vs. Policy Management Systems Corp.*, to the docket bears considerable significance for employers.

See Court on page 23

Deadline near for EBC listing

Business Insurance will publish its annual Directory of Employee Benefit Communication Systems in the Nov. 23 issue. This issue also will contain a Spotlight report on effective benefit communication and a feature on the winners of the BI Employee Benefit Communications Awards.

The directory is published as an editorial service, and there is no charge to be included. To be included in the directory, companies must provide proprietary interactive benefit communication software products that allow employees direct access to their personal benefit information, and this software must be available on a direct, unbundled basis.

If your company qualifies and has not received a questionnaire, please request one immediately by calling Assistant Directory Editor Matt Scroggins at 312-649-5483.

Completed questionnaires must be submitted by the extended deadline of Oct. 23.

Inside

- A new participant-directed cash balance plan has considerable risk for both employers and employees, one of this week's editorials says. **PAGE 8**
- The latest financial results for Equitas Holdings Ltd. indicate an improved solvency margin, but the Lloyd's names still express concern about the future. **PAGE 19**
- Health care, agriculture, food processing and public entities are the sectors most likely to experience system failures due to Year 2000 computer problems. **PAGE 27**

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AP/WIDE WORLD PHOTOS

Vehicles are strewn on the Missouri side of State Line Road last week in Kansas City, Mo., after a night of flash floods.

Midwest suffers weather losses

By MICHAEL BRADFORD

PRAGUE, Okla.—Insurers trying to catch their breath from Hurricane Georges claims are facing additional storm-related losses far from the coast.

Several tornadoes ripped through central Oklahoma earlier this month, injuring at least 12 people and destroying homes and businesses in several cities. Insured damage in Oklahoma is expected to reach as much as \$20 million, according to the Southwestern Insurance Information Service in Austin, Texas.

Meanwhile, heavy rain storms killed at least seven in the Kansas City area in Missouri and swamped homes and businesses. Rains also hit neighboring Kansas City, Kan., but the bulk of the damage was on the Missouri side. Much of the insurance to cover flooding of homes is written by the National Flood Insurance Program.

The tornadoes and high winds in Oklahoma destroyed 20 homes and six businesses and damaged more than 250 others, according to the state's Office of Emergency Management.

A spokeswoman for the Oklahoma Insurance Department said commercial losses for the most part were limited to damage to roofs, signs and windows. A high school gymnasium in Pawnee, Okla., suffered extensive damage when a twister blew its roof off. "It's now an outdoor amphitheater," the spokeswoman said.

The spokeswoman said Farmers Insurance Group, State Farm Group and Allstate Corp. will pay the bulk of personal lines claims in the state, as those insurers cover more than half of Oklahoma's homeowners and automobile policyholders.

While tornadoes lashed Oklahoma, heavy rains caused creeks to spill over their banks in Missouri and Kansas. Public facilities were hard hit in Kansas City. The city's American Royal Building, which hosts rodeos

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Some employers using contracts to cut romance risks

By ROBERTO CENICEROS

Just as Anita Hill heightened awareness about sexual harassment in the workplace, the current White House scandal is drawing attention to the appropriateness of romance in the workplace.

That recently became evident when the Los Angeles Times, The New York Times and other media reported on the use of workplace "love contracts" that proponents say can help companies thwart lawsuits resulting from relationships turned bad.

Because soured office romances between employees can spawn sexual harassment lawsuits, some attorneys are recommending that employers consider protecting themselves by asking love-smitten employees to voluntarily sign statements acknowledging that their relationships are consensual.

But other attorneys and risk management experts dismiss the need for such documents. They argue that a strong company policy against sexual harassment and a well-communicated prohibition against workplace dating should be adequate to protect employers.

Those measures, however, are not enough to protect employers in all cases, particularly when the relationship is between bosses and employees they directly supervise, according to proponents of the signed statements.

"The reality is that, unless you fall in love and decide to marry

See Contracts on next page

Employers must lead quality drive: Ellwood

By MICHAEL PRINCE

NASHVILLE, Tenn.—Employers, and employer coalitions in particular, must take the lead in demanding higher-quality medical care, a pioneer in managed care says.

Higher-quality care will then lead to lower costs, said Dr. Paul Ellwood.

"The problem is quality, stupid," said Dr. Ellwood, president and chief executive officer of the Jackson Hole Group, an informal health care policy think tank based in Jackson Hole, Wyo., that became famous for its earlier managed health care proposals. "Solving the quality problem will solve the cost problem," he said.

Dr. Ellwood was the keynote speaker at the third annual conference of the National Business Coalition on Health. The conference was held in Nashville, Tenn.,

earlier this month.

Overall, Dr. Ellwood said managed care has not lived up to its promise. A few large players dominate many markets, reducing



Dr. Ellwood

competition. Also, managed care has had little impact on specific care and medical procedures, he said.

Managed care is "off course and running out of fuel to steer it," he said.

Critics of managed care say it has simply wrung one-time savings out of the system, allowing

costs to once again rise. "If we continue to focus on managing costs and not managing health," these critics will be right, Dr. Ellwood said.

Another problem he noted is that health plans have too many specialists. "There is no way a health plan can feed all those specialists' mouths," he said.

Many managed care plans also lack financial health, he pointed out. Many plans have cut their premiums to maintain market share and now are losing money, Dr. Ellwood noted. Increasing rates to correct this trend won't significantly help, as employers balk at higher rates and cannot easily pass increases along to employees in a tight labor market.

Despite its woes, managed care has scored some successes, he said. Most significantly, the

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SECOND ANNUAL CONFERENCE OF THE NATIONAL BUSINESS COALITION ON HEALTH

Borrowing from managed care

Multiemployer plans slowly adopting managed features: Study

By ROBERT KAZEL

Multiemployer health plans negotiated by labor unions continue to offer workers a degree of insulation from the managed care revolution, a survey says.

But the study, conducted by the Brookfield, Wis.-based International Foundation of Employee Benefit Plans, also found that unions' indemnity or preferred provider organization plans have borrowed numerous administrative features from managed care to increase efficiency and save money.

The study examined 712 multiemployer plans that responded to a mail survey of 1,510 plans last spring. These plans are unique among health plans because they are governed by at least one, and often several, collective bargaining agreements negotiated by unions. The plans are governed by boards of trustees with balanced representation from management and labor and are most common in the construction trades.

The survey found that managed care has not affected these benefit plans as rapidly as has been seen in the single-employer realm.

Sixty-seven percent of multiemployer plans offered a preferred provider organization as a benefit option, yet 58% offered a traditional fee-for-service plan, the study found. If only one type of health plan

See Plans on page 26

Multiple choice

Types of health plans offered by multiemployer plans



Source: International Foundation of Employee Benefit Plans

GRAPHIC BY MIKE GARVEY

Lloyd's 'reinventing' itself

Striking balance between tradition, change a challenge: Taylor

By PAUL D. WINSTON

WHITE SULPHUR SPRINGS, W.Va.—Predictions on whether the commercial insurance market could see a turn in pricing next year are about as varied as the colors of the forests of West Virginia.

At the 85th Insurance Leadership Forum, the annual joint meeting of

the Council of Insurance Agents & Brokers and the Council of Insurance Company Executives, held last week at The Greenbrier resort in White Sulphur Springs, W.Va., talk among some executives turned to whether the market would see firmer pricing in 1999.

Some insurance company executives predict that depressed stock and

bond markets will force higher pricing next year, while other executives see such change as unlikely or likely only in isolated pockets.

Although there was no consensus on when or how the extended soft market might end, there was plenty of discussion of change in the market.

A leading topic of discussion by speakers and attendees alike was technological change and what it means for the insurance industry (see story, page 10).

Change also was a theme of speaker Max Taylor, chairman of Lloyd's of London, who provided an overview of changes occurring at Lloyd's and proposals for the future.

"As we face these times of great change, we at Lloyd's are genuinely reinventing ourselves," Mr. Taylor said. "We've been through a revolution in regulation, we're going through a revolution in our capital base, and have yet to go through a revolution in our distribution."

See Taylor on page 10



PHOTO: PAUL D. WINSTON

Contracts

Continued from previous page
tions," said Garry Mathiason, a senior partner in the San Francisco office of Littler Mendelson, a nationwide firm specializing exclusively in employment law.

Mr. Mathiason equates the contracts to metal detectors at the entrance of public buildings. It's sad they are necessary, he said, but with the boom in employment-related lawsuits, companies need to consider the idea. None of the employees who have signed contracts overseen by Mr. Mathiason has challenged the documents' validity in court, he said, nor has anyone who has signed the documents sued the employer for sexual harassment related to his or her interoffice relationship.

It is common enough, particularly in clandestine office liaisons, for

one party to end a relationship only to have the other person claim, perhaps out of spite, that he or she was forced into the situation, said Beth A. Schroeder, head of the employment law practice at Silver & Freedman in Los Angeles. At that point, a spurned lover has plenty of damning evidence to back his or her allegations, she said.

"They have all the cards and gifts and everything else the alleged harasser gave them, and the harasser says, 'Oh, no, it was consensual,'" she said. "Unfortunately, what I see is in the 'consensual relationship,' somebody later claims it is not consensual."

The agreements that Mr. Mathiason and Ms. Schroeder provide for employees to sign acknowledge that a relationship exists and that neither party was coerced into the affair. The statements also affirm that the company has zero tolerance for sexual harassment and

that if the relationship should ever change or end and one of the parties then feels harassed, that party can then bring it to the employer's attention.

If a problem develops, employers want the parties stepping forward to say they no longer are comfortable working together, rather than quitting and suing for sexual harassment, Ms. Schroeder said. Getting them to step forward empowers employers. "Once they have sued, it is out of your hands and you can do nothing about it but pay money," she said.

The agreements also state that if there is a dispute, the parties will solve the matter through arbitration. Ms. Schroeder refers to the forms as "memos" rather than contracts because they tend to be free of legalese and threatening language. They also state that public displays of affection are not appropriate in the workplace.

But some employer liability experts are skeptical about the need for the agreements.

The signed forms may be worthless as contracts because the employer is not giving up anything in consideration for an employee signing, said Frances J. Skinner-Lewis, a partner specializing in employment law at Schuyler Roche & Zwirner in Chicago.

There is a movement afoot to recognize how employers can protect themselves from workplace relationships, Ms. Skinner-Lewis said. But the best employer protections already are available through strong policies against sexual harassment and well-communicated prohibitions against office relationships, she said.

"If that is well stated, then you save yourself from being a victim of a harassment claim when a relationship goes sour," Ms. Skinner-Lewis said.

Others agree. From a risk control perspective, companies are well advised to maintain policies stating that one spouse cannot supervise another and that a manager should not supervise anyone with whom he or she is involved in a social relationship, said Gary Salmans, vp and manager of risk control services for Sedgwick of Colorado Inc. in Denver.

But asking an employee to sign a statement may not be good advice, said Mr. Salmans. He cites a pair of landmark U.S. Supreme Court cases handed down this summer. In *Beth Ann Faragher vs. City of Boca Raton* and *Burlington Industries Inc. vs. Kimberly B. Ellerth*, the high court said employers have a two-part affirmative defense against sexual harassment lawsuits if they exercise reasonable care to prevent and correct sexually harassing behavior, and if the plaintiff employee unreasonably fails to take advantage of corrective opportunities.

That means if employers present all employees policies on sexual harassment and have a method for reporting occurrences, they are protected, Mr. Salmans said. But the second part of an employer's affirmative defense, as outlined in the second part of the court's decision, could be lost when an employee who signed a contract does step forward and give notice the relationship has ended.

"Why would you want to start another paper trail of something that you are going to have to defend when the federal courts have already set the guidelines for you to follow?" Mr. Salmans wonders.

But proponents said the court decisions make their strategy all the more crucial. The more times you can have an employee's signature saying he or she has been advised of a sexual harassment policy, the better, they said.

It is better for couples to sign the memo because then, if need be, the employer is in a better position to prove that the plaintiffs knew of the sexual harassment policy but did not take advantage of it.

"Even if you have a sexual-harassment policy, people still quit and sue," Ms. Schroeder said. Especially if the activity involves someone of senior status, "People can say, 'I thought I would get fired if I brought it up,' so it is extra protection."

The contracts should be used only for very specific cases and with the advice of counsel, Mr. Mathiason advised. So far, only a "handful" of employers have used the documents in cases involving very senior executives, he said.

Neither Mr. Mathiason nor Ms. Schroeder recommend the contracts be applied on a blanket basis. They are not for employees of equal rank. While workplace romances can turn ugly and disruptive, many marriages also result from employees mating, Mr. Mathiason noted.

Still, one risk manager for a major corporation based in New York said she continues to believe the old advice that workplace involvements are fraught with danger and potential disruptions, though her company does not have a formal prohibition against it.

But today, employees are traveling more and working longer hours the risk manager said. They are more likely to form romances through work rather than through family connections or through outside social gatherings.

"Somebody comes in from Kansas City to work in New York and who do they know?" the risk manager asked. "Usually your workmates are the people who become your friends, or you think they are your friends." **[E]**

NEW traditions For alternative RISK

FRONTIER INSURANCE GROUP, INC.

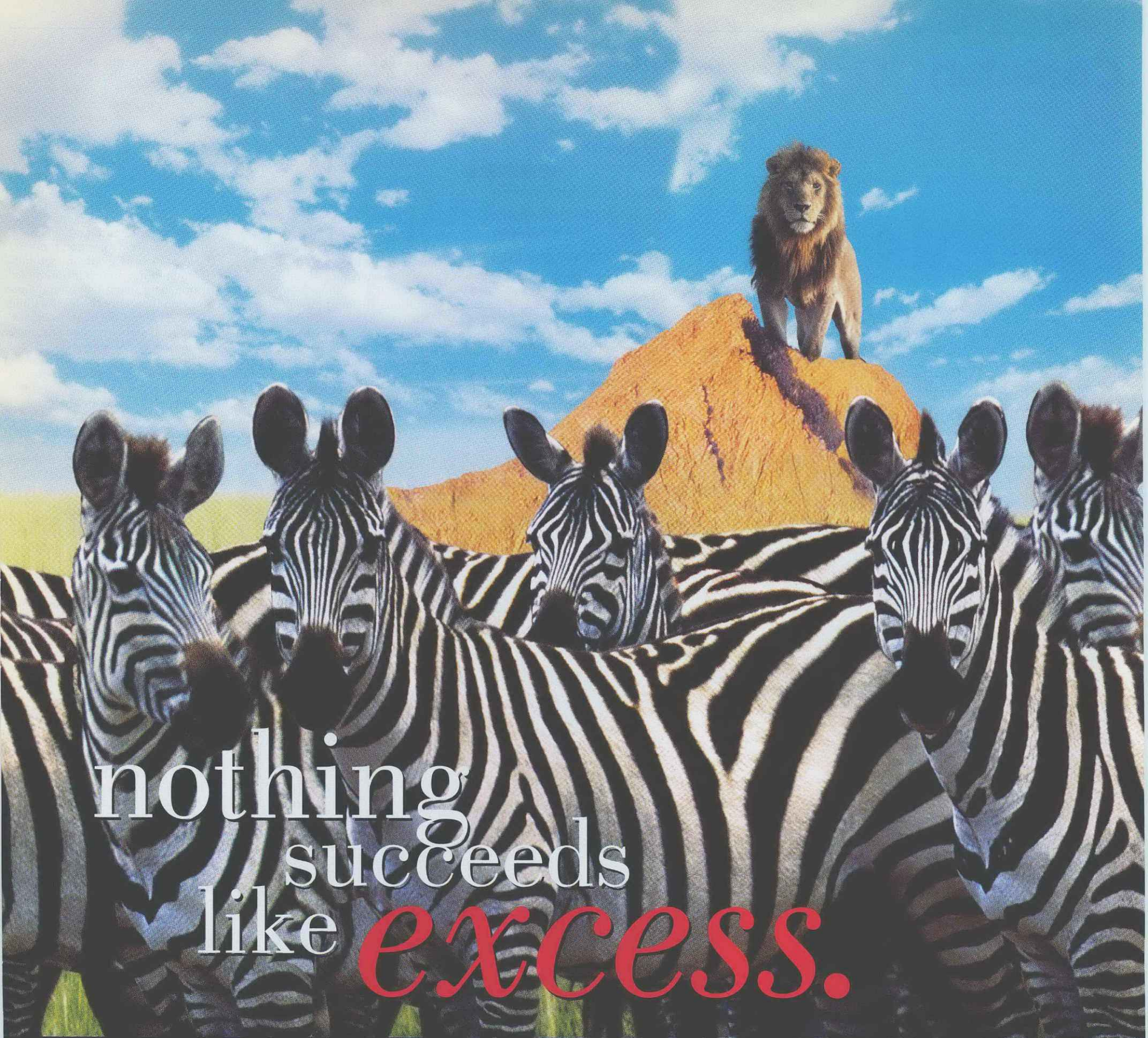
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ZURICH

Coalition

Continued from page 1

1992 and 1997. After completing a three-year trend analysis last year, "we formed an oversight committee to determine where we wanted to go from here," Mr. Brocato recounted.

At first, the coalition considered doing report cards, "but we said, 'NCQA is doing that.'...What we really wanted to know was what the population thinks," he said. Furthermore, "we need to have them look at what they consider to be the impact or the burden of the disease in both the workplace and the home," he added.

The survey findings were released at a recent press conference in Tampa and later presented at the National Business Coalition on Health meeting last week in Nashville, Tenn. The results will be outlined again at the National Managed

Health Care Congress workshop Oct. 27-28 in Atlanta.

The survey was conducted by mail, sent to the homes of 20,000 employees of eight area employers that represent small, medium and large organizations in both the public and private sector. Participating employers included Cargill Fertilizer, Florida Blood Services, GTE, Honeywell Space Systems, Pasco County government, Pasco County schools, Pinellas County government and TECO Energy. The coalition, with eight employees, participated as the small employer in the survey.

The survey, administered by the University of Iowa, was conducted in two waves. First, a general survey that focused on 31 health conditions asked questions pertaining to general health and wellness; return-to-work status; and productivity, both at home and work; as well as patients' satisfaction with physicians,

health plans and benefit programs. First-wave respondents also were asked to list what disorders they had of the 31 listed.

A second survey was sent to the homes of employees who reported that either they or someone in their

'It's exciting that they're making links between chronic and co-morbid conditions,' says Camille Haltom of Hewitt Associates.

household had one or more of the top 10 disorders from the list of 31 conditions.

The response rate for the first wave of the survey was 32%. Of the 6,215 people who responded, 4,707 reported that they or someone in

their household had one or more of the top 10 conditions. The remainder reported not having any of the top 10 conditions.

The second wave of the survey was sent to the 4,707 who responded positively to the first survey. Of those, 40% responded to the second survey.

So far, only the first-wave survey results have been made public. The second-wave results will be released next month.

The most prevalent conditions reported of the top 10 were allergies, 28%; hypertension, 16%; and depression, 9%. Among the other 21 conditions, the most prevalent were arthritis, 21%; neck/back/spine problems, 20%; migraine, 13%; and sciatica and back problems, 13%.

When respondents suffering from the top 10 conditions were asked to rate the quality of the overall health care process, those who had breast cancer rated it the highest, while

those with hepatitis, depression and diabetes rated it the lowest. Mr. Brocato attributed the positive response of breast cancer patients to the large amount of attention and education the disease has been getting in recent years.

By contrast, those suffering from less-publicized diseases reported less satisfaction with care, he pointed out. For example, those suffering from hepatitis criticized access, management of care and coverage; and those with depression reported the least favorable outcomes, quality, communication, plan administration, and overall plan satisfaction, and they were the least willing to recommend their plan to others. Those with diabetes rated customer service low.

The survey also asked employees to rate the "burden" their health conditions created, both in their personal lives and in their social and/or work lives.

"For example, heart problems and breast cancer were two of the top 10 that seemed to impose the greatest burden on the individual, but when you look across the entire strata of the population, hypertension seemed to be a greater burden" on their community life, including family and coworkers, Mr. Brocato explained.

Participants identified depression and allergies as two of the top 10 disease disorders that had the greatest impact on their work lives, while depression and heart problems had the greatest impact on their personal lives, he said.

When all 31 conditions were taken into consideration, loss of motion, sciatica/back and neck/back/spine had the greatest burden both at work and at home.

For the most part, benefit managers and health care consultants praised the coalition's disease-specific approach to measuring health care quality in the community.

"This will affect systemically the practice in the marketplace by providers and how health plans support consumers, so that there will be a much broader impact than just for these employers. They are to be commended for the initiative they've taken," observed Suzanne Mercure, formerly the benefits manager for Rosemead, Calif.-based Edison International and now a principal at Barrington & Chappell, a health care consulting firm in Falls Church, Va.

"A lot of the coalition work (usually) looks at financial indicators or proxies for quality of care, but they don't get right down to this detail of a needs assessment," observed Camille Haltom, a health care consultant with Hewitt Associates L.L.C. in Lincolnshire, Ill. "So it is kind of exciting that they're making some links between chronic conditions and co-morbid conditions."

"This is an excellent start. The Tampa employers are to be commended for taking the initiative," said Robert Brown, president of the Mid-American Coalition on Health Care in Kansas City, Mo. "The Tampa experience shows that we're turning a corner and trying to start making a difference and not just talking about cost."

But Ray Brusca, vp-benefits at Black & Decker Corp. and a member of the Washington Business Group on Health's board of directors, doubted the coalition's effort will have much impact on improving the quality of health care on a communitywide basis.

"It's an interesting survey, but given the small number of participants and the size of the Tampa area, I question whether the organization will be able to achieve any demonstrable changes in health outcomes in the community as a whole," he said.

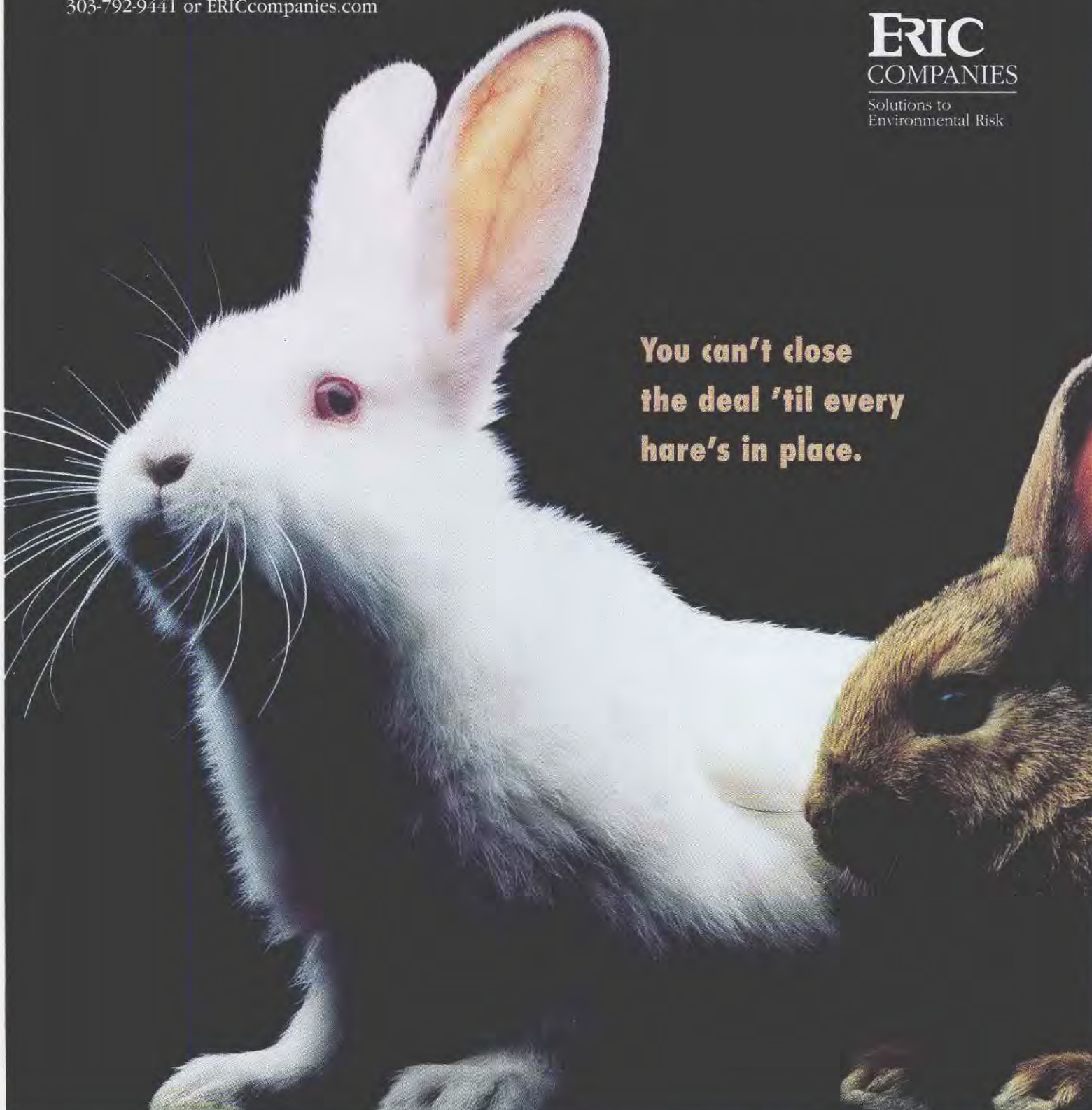
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Case not changing awards

Law professor sees 'no evidence' of larger punitive verdicts

By GEORG SZALAI

Contrary to popular belief, the landmark Supreme Court decision in *BMW of North America Inc. vs. Gore* has had no real effect on the correlation between compensatory and punitive damages awards or the frequency of court orders reducing such awards, a recent study says.

"It may take a while for it to take effect and trickle down, but right now, there is no evidence" for any significant influence by *BMW*, said Theodore Eisenberg, the Henry Allen Mark Professor of Law at Cornell Law School and co-author of the study of published court opinions.

The 1996 *BMW* decision by the Supreme Court was the first to strike down a punitive award on constitutional grounds (*BI*, May 27, 1996). In that case, Dr. Ira Gore Jr., an Alabama physician, sued *BMW* for failing to disclose that a new \$40,000 sedan had been given a touch-up paint job after being damaged in transit. The jury, urged by Dr. Gore's attorney to teach *BMW* a lesson for touching up about 1,000 cars nationwide without disclosure, awarded Dr. Gore \$4,000 in compensatory damages and \$4 million in punitive damages. The Alabama Supreme Court then cut the punitive award in half.

In a 5-4 decision, however, the U.S. Supreme Court struck down the \$2 million damage award as unconstitutionally excessive. The high court ruled that the award violated the 14th Amendment's due process clause, which prohibits a state from imposing "grossly excessive" punishment.

In their study, Mr. Eisenberg and Martin T. Wells, associate professor at Cornell's Department of Social Statistics, analyzed 254 state court and federal cases involving compensatory and punitive awards before and after *BMW*. All cases were considered by a court at least partly for the relation between the two awards.

"We find no significant difference in the pattern of awards before and after *BMW* and no significant difference in the rate at which courts order a reduction in punitive damages awards," the authors say in the study.

This goes contrary to popular belief, Mr. Eisenberg said. "People prematurely said *BMW* had a big effect," he explained.

Earlier studies by the same authors since 1996 showed that juries rarely awarded punitive damages (*BI*, June 24, 1996), especially in product liability and medical malpractice cases. "The available data suggest that businesses, insurance companies and defense lawyers cannot support the claim that punitive awards are frequent, or that they follow a crazy pattern with little or no relation to compensatory awards," Messrs. Eisenberg and Wells said in a study published earlier this year in the *Wisconsin Law Review*.

The new study confirmed these findings. "The message is that punitive damages depend" on the type of case being tried, Mr. Eisenberg said. In fraud, insurer misconduct and employment-related cases such as discrimination and wrongful discharge, punitive damages were awarded most frequently and at a higher cost, according to the study. In other cases, awards were rare, Mr. Eisenberg said.

"I don't claim that there are no crazy awards out there, but the risk has been exaggerated," Mr. Eisenberg said. In a 1996 study, Messrs. Eisenberg and Wells and three other authors analyzed one year of jury trial outcomes from 45 of the nation's most populous counties. Mr. Eisenberg and his colleagues found that ju-

ries awarded punitive damages to 6% of all victorious plaintiffs. Because plaintiffs win about half of all verdicts, approximately 3% of all jury verdicts awarded punitive damages.

The relatively small number of high punitive damage awards could be one of the reasons that courts rarely strike such awards. "Most punitive awards are not reduced because they are not extremely high," the authors say in the study. The study shows that the average punitive damages award is \$6.7 million, and the median award is \$187,500.

Some of the recent research that concluded there were serious problems in the tort system was funded by Exxon Corp., which is appealing a \$5 billion judgment after the 1989

Exxon Valdez oil tanker accident in Alaska, Mr. Eisenberg pointed out. He was not sure that the methodology used in these studies was appropriate, he said.

In the study, the authors also reject the existence of another often-reported phenomenon. There was little evidence for substantial regional differences in the punitive/compensatory awards ratio, they found.

Draft copies of the most recent study by Messrs. Eisenberg and Wells and copies of the two earlier academic articles on punitive damages are available by calling Karen Wilson, 607-255-9653; or by sending an e-mail request to eisenberg@law.mail.cornell.edu.

A&E losses fall again

OLDWICK, N.J.—Asbestos and environmental liabilities fell for a second consecutive year in 1997, according to a new analysis by the A.M. Best Co.

A.M. Best, in a recent special report, said asbestos and environmental incurred losses accounted for only 0.7 points of the property/casualty industry's overall combined ratio of 101.6% last year, compared with 4.1 points of the 1995 combined ratio of 106.5%.

The industry's net incurred asbestos and environmental losses fell to \$1.9 billion last year, compared with \$10.3 billion in 1995.

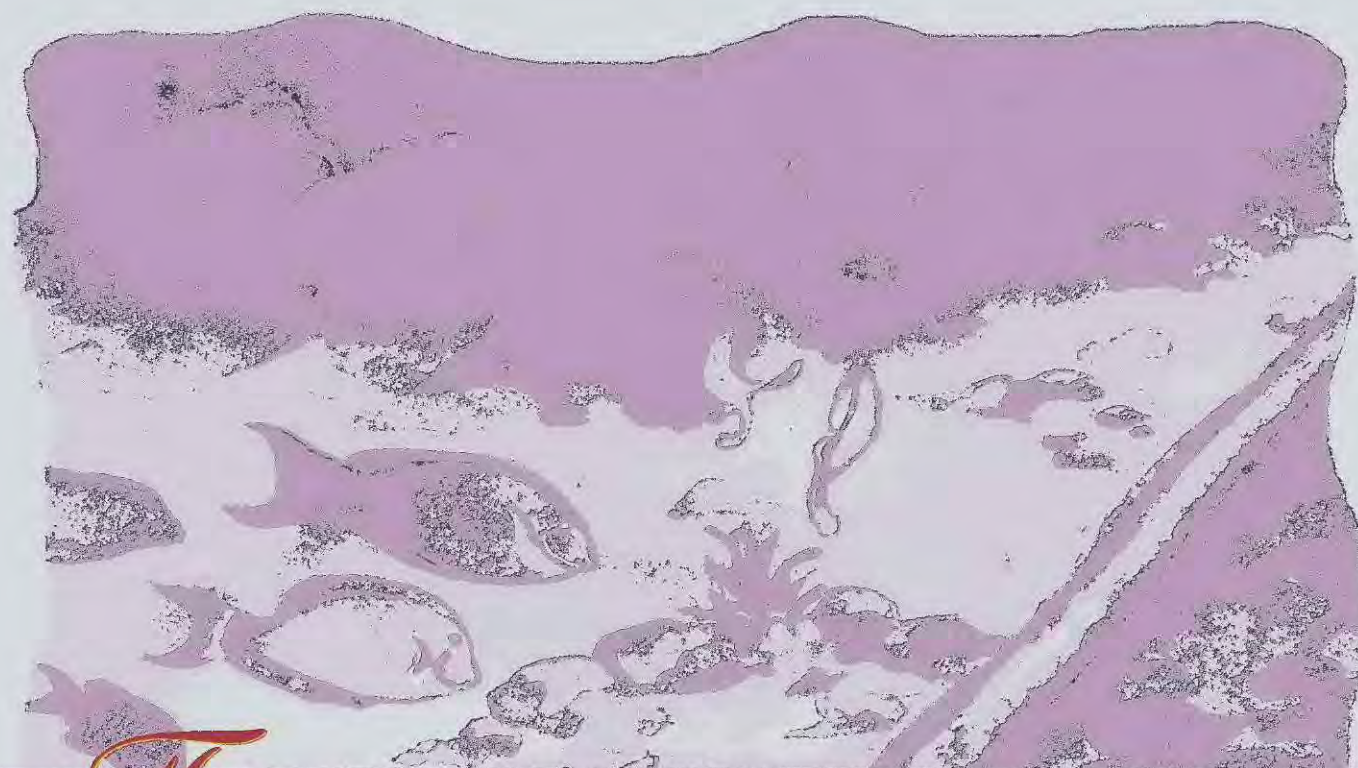
"A.M. Best believes the sharp decline in A&E insured losses

over the past two years reflects larger companies reverting to pay-as-you-go funding after growing comfortable with their reserves based on ground-up exposure analysis.

In addition, soft market conditions in most commercial segments and earnings pressures have discouraged large A&E reserve additions," according to the Best special report.

But the report cautioned, "while unfunded A&E liabilities are no longer the industry concern they were several years ago, they remain a significant financial concern for insurers that have not yet taken appropriate funding actions."

—By Mark A. Hofmann



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Opinions

Don't bank on this plan

IN LOOKING AT A NEW participant-directed cash balance pension plan sponsored by NationsBank Corp.—now known as Bank of America—we're reminded of the old saying, "You can't have something for nothing."

It is, to be sure, an intriguing plan. As we've reported, the plan allows participants to direct cash balance pay credits to as many as 11 investment options. An employee's cash balance plan account will then be credited with the rate of return earned by the funds he or she has chosen. If the funds have negative returns, employees still will receive their pay credits.

Similarly, employees had a one-time opportunity through June 28 to transfer to the cash balance plan pre-tax contributions they made to NationsBank's 401(k) plan. As will the pay credits, an employee's 401(k) monies will be credited with the rate of return of the investment options that employee selected. The company guarantees that employees never will end up with less than the amount they transferred from the 401(k) plan.

Sounds good, doesn't it? Potentially, employees can earn a much higher rate of return on pay credits compared with traditional cash balance plans, where the interest rate credit is fixed but also is typically very low, such as the one-year Treasury bill rate plus 1 or 2 percentage points.

Similarly, the 401(k) transfer feature also sounds like a good deal for employees. Employees' principal is guaranteed, and they need not worry about the downside of investments with above-average risk.

All these transactions, though, are just on paper. In fact, NationsBank doesn't have to invest cash balance pay credits or the transferred 401(k) account balances to the investment options selected by employees.

Because the cash balance plan is a defined benefit plan, NationsBank has the right to invest those contributions as it sees fit.

While NationsBank won't discuss the matter, those who have studied the plan and plan documents say NationsBank believes its actual investments will earn a higher rate of return than the options selected by employees. And that, in turn, will mean lower future pension contributions by NationsBank.

That is perfectly proper and legal. Indeed, employers, through their professional advisers, want to maximize—so long as it is done prudently—pension plan investments so that sufficient assets are available to pay for future benefits.

But while NationsBank's pension arrangement may be legal, that doesn't mean it is right for other employers and their employees.



The conventional wisdom is that defined benefit and defined contribution plans are very different programs, the former providing a secure, predictable benefit and the latter allowing employees to earn—if they are willing to assume the risk—above-average returns.

Is it good retirement policy to have risk in both types of plans? While perhaps not advertised as such, the participant-directed pension plan does transfer risk to employees.

Those employees who select riskier investment options could end up—depending on the results of those options—with just their cash balance pay credits and their transferred 401(k) funds. That may not be enough for employees nearing retirement, especially because NationsBank's pay credit schedule currently appears to be on the low side.

Similarly, a low pay credit schedule means employees choosing fixed-income investment options also may not fare as well compared with participation in traditional cash balance plans with more generous pay credit schedules.

And there is risk for NationsBank as well. With the downturn in the equities market, the benefit guarantees it is providing employees could prove more costly than expected.

Given the pros and cons of this pension program, other employers should look at this approach very carefully and consider the risk to themselves and their employees before deciding to emulate NationsBank.

Medicare HMO program a good choice

WHEN LOOKING AT WHY so many health maintenance organizations are dropping out of the Medicare market, it is important to separate fact from fantasy.

Factually, the move out of this market has been large: HMOs leaving the market now provide coverage to more than 400,000 beneficiaries, or about 6.5% of all retirees enrolled in Medicare risk HMOs.

It would be a mistake, though, as seems to be the pattern now, to blame the HMOs' pullout exclusively on low government payments. HMOs leaving Medicare cite a variety of reasons, including inability to negotiate favorable rates with providers as well as tough competition.

Having said this, there is no question, as we previously have noted, that Congress next year has to take another look at this program—now called Medicare + Choice.

The biggest problem with the Medicare + Choice program is the flawed methodology for setting government payment rates for managed care plans that take over from Medicare the responsibility of providing coverage to retirees. Right now, rate increases are essentially held to 2% a year, while managed care plans are facing much higher costs, such as the rising price of prescription drugs. Clearly, that methodology has to be changed.

Medicare + Choice is one of those rare government programs in which everyone can benefit: Retirees can get better benefits compared with the traditional Medicare program, Medicare can save money when more cost-efficient managed care plans provide coverage, and employers have less demand for health care plans to supplement Medicare.

Now it is up to Congress to make this program work.

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Taylor

Continued from page 3
bution system and product focus," he said.

One of Lloyd's biggest challenges in managing change is striking a balance between adopting new ways of doing things and keeping the best of its traditional methods, Mr. Taylor noted. For example, the market is embracing new forms of capital while it continues to rely on traditional unlimited liability names, Mr. Taylor said.

The market currently is examining whether to change its annual venture system, whereby capital is committed to syndicates for only 12 months at a time. "It has served us well. But going forward, we think fully paid-up permanent capital will be the way to go," Mr. Taylor said.

In addition to seeking longer-term capital commitments, the market's source of capital has changed dramatically. Corporate capital accounts for about 60% of the market's total 1998 capital of £10.13 billion (\$17.01 billion), he



'Lloyd's culture of change and flexibility is the key to our success.'

— Max Taylor

said. By next year, that percentage is expected to grow to 70% to 75%.

Lloyd's increasingly is moving to a dedicated capital model, in which corporate investors provide

capacity to specific syndicates and agencies, which is generally regarded as more efficient than its historic method of allocating capacity to syndicates, said Mr. Taylor.

Investment in Lloyd's by corporate entities, such as insurance and reinsurance companies, is expected to continue. Indeed, that trend could be accelerated by the A- rating for the market that was provided by Standard & Poor's Corp., which forecasts long-term earnings capacity, noted Mr. Taylor.

Lloyd's is also seeking to manage change in its distribution model.

"Our objective for change in distribution is to find a balance" between the existing system of Lloyd's brokers and access by brokers outside the market, Mr. Taylor said.

Lloyd's expects that large so-

phisticated risks will continue to work within the current distribution system, as they have done in the past, Mr. Taylor said. But as the market seeks to expand, Lloyd's underwriters also want ease of access to business in overseas markets, Mr. Taylor observed.

Geographic expansion is another driver of change.

Lloyd's holds licenses around the world, noted Mr. Taylor. It has a longstanding presence as an underwriter of primary business in most English-speaking countries, while in most other countries it also has long provided reinsurance.

Lloyd's is seeking to expand its presence in Latin America and the Far East, Mr. Taylor said.

One form of change has been a constant at Lloyd's since its inception: product innovation. "We are a risk-taking market, not a

risk-avoiding market," the chairman said.

Lloyd's recently has introduced new products in such areas as coverage for liability from contaminated products, losses caused by rogue traders, the costs of failed merger or acquisition bids, and political risk coverage for service companies, Mr. Taylor commented.

In addition, Lloyd's is likely to be at the forefront of developing alternative risk transfer products, once "structural constraints" are overcome, he said.

Ultimately, Lloyd's strength lies in its ability to change, according to Mr. Taylor. "Lloyd's culture of change and flexibility is the key to our success," he said. But amid all the changes it undertakes to remain competitive, "Lloyd's underwriting skills and culture will be retained above all else," he stressed. **BI**

Computers a frequent topic at forum

By PAUL D. WINSTON

WHITE SULPHUR SPRINGS, W.Va.—The changes and opportunities wrought by technology was a common theme among speakers at the 85th annual Insurance Leadership Forum at The Greenbrier.

The Insurance Leadership Forum, sponsored by the Council of Insurance Agents & Brokers and the Council of

Insurance Company Executives, is held each year at The Greenbrier resort in White Sulphur Springs, W.Va.

"Children are growing up digitally wired but have analog

parents and grandparents," remarked Gen. Colin L. Powell, former chairman of the joint chiefs of staff under presidents Bush and Clinton. Gen. Powell touched on technology during a stirring presentation on his life in public service, the challenges of his transition to civilian life, and his leadership of a national campaign to equip disadvantaged youth with the skills to succeed.

Other speakers who addressed the role of technology in transforming their industries included Edward D. Crutchfield, chairman and chief executive officer of First Union Corp. (see story, page 12), Max Taylor, chairman of Lloyd's of London (see story, page 13), and Scott D. Cook, chairman of Intuit Inc.

Technology was a direct theme of "Moving Your Organization Into an Online Future," a panel discussion held during the meeting.

Insurance agents and brokers shouldn't go online simply because the technology exists to do so, said panelist Chip Lawson, senior product manager at IVANS in Tampa, Fla. The best reason to go online is to gain a competitive edge, he said. This is achieved by using technology to provide better customer service, to lower costs and to cater to an increasingly computer-savvy customer base.

But moving online also can expose a business to a variety of risks, Mr. Lawson noted. Those include making a commodity of your product or service, spending lots of dollars for lit-

See Online on page 12

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ZURICH

Financial services roles blurring: CEO

WHITE SULPHUR SPRINGS, W.Va.—The blurring of the lines among banks, insurers and other financial services providers will accelerate in coming years, a bank executive says.

Regulatory reforms, such as financial services modernization legislation in Congress, are one driver of this change, he says.

An even more important factor, however, will be technological innovation, provided that companies avoid substituting human contact and relationships with computers, he contends.

The changes the financial services industry has experienced to date will pale in comparison with what will occur in coming years, predicted Edward E. Crutchfield, chairman and chief executive officer of First Union Corp. in Charlotte, N.C. Mr. Crutchfield addressed attendees of the 85th annual Insurance Leadership Forum, sponsored by the Council of Insurance Agents & Brokers and the Council of Insurance Company Executives and held at The Greenbrier resort in White Sulphur Springs, W.Va.

"The explosion of information technology has broken down the borders of the past," he said.

With computer technology, a company's location becomes less relevant as it is able to access information and provide services worldwide. Money, products and services are easily traded and obtained via computers, he said.

In addition, information technology increasingly will enable companies to learn more about

their customers than ever before, Mr. Crutchfield said.

The bank executive predicted that in two to five years, a handful of financial services firms will control about 60% to 70% of all business.

These companies will offer nearly all relevant financial services, he said, ranging from banking and insurance services to mutual funds and stock brokerage services.

First Union has become one of the largest bank providers of annuities, Mr. Crutchfield said. Annuities have been a far more profitable line of insurance for the bank than small commercial lines products, he noted.

"We haven't broken that code," he said, referring to success in commercial insurance sales. One reason, he said, is that insurance is still a personal, face-to-face business and insurance agents and brokers have better relationships with their customers.

But Mr. Crutchfield warned his audience not to rest on those laurels in light of financial services competition.

"There are so many companies competing for our business that it's unrealistic to think it won't happen to you," he said.

A member of the audience asked Mr. Crutchfield why more banks don't seek to partner with insurance agents, rather than attempting to replace them in a market where they don't perform as well.

"Well, there are dumb bankers, just like everywhere else," quipped Mr. Crutchfield.

—By Paul D. Winston



Council elects leaders

Kilbride, Collins new co-chairmen, reflecting merger with NAIB

WHITE SULPHUR SPRINGS, W.Va.—The Council of Insurance Agents & Brokers elected new officers during its joint annual meeting at The Greenbrier.

James J. Kilbride, chairman and chief executive officer of Morse, Payson & Noyes Insurance of Portland, Maine, and Christopher M. Collins, managing director of J&H Marsh & McLennan Inc. of New York, were elected co-chairmen of the Council.

Both had previously served as co-vice chairmen of the organization following the July 1 merger of the Council with the National Assn. of Insurance Brokers.

Messrs. Kilbride and Collins succeed John C. Adams Jr., executive vp of Hilb, Rogal & Hamilton Co. and CEO of its Florida operations in Daytona, Fla.; and Jane Hill Fleming, senior vp of Sedgwick Inc. of Nashville, Tenn.

Other key Council elections made at last week's meeting included:

- Robert A. Gleason Jr., chairman and CEO of The Gleason Agency in Johnstown, Pa., elected vice chairman.

- Thomas J. Rodell, chairman-Central Region for Aon Risk Services Inc. in Chicago, elected treasurer.

- John Van Osdall, senior vp of USI Insurance Services Corp. in Houston, elected assistant treasurer.

- William R. Wilkerson III, chairman and CEO of Haas & Wilkerson Inc. of Shawnee Mission, Kan., elected secretary.

- Frederick J. deGrosz, presi-

dent and CEO of Alburger Basso deGrosz Inc. of Belmont, Calif., elected assistant secretary.

Ken A. Crerar continues to serve as Council president.

The Council's board of directors for 1998/1999 are:

- Nancy J. Ayers, senior vp of Mesirov Insurance Services Inc. in Chicago.

- Bruce Basso, chairman of Alburger Basso deGrosz Inc. of Belmont, Calif.

- Anthony P. Campisi, executive vp and treasurer of Early, Cassidy & Schilling Inc. of Bethesda, Md.

- Robert F. Denny, chairman and CEO of Cook, Hall & Hyde of East Hampton, N.Y.

- Philip J. Edmundson, president and CEO of William Gallagher Associates of Boston.

- Hugh D. Gorney, managing director of Corporate Broking for Coyle Hamilton Ltd. of Dublin, Ireland.

- Gary R. Griffith, chairman and CEO of Summit Global Partners Inc. of Dallas.

- Markham McKnight, president and chief operating officer of Wright & Percy Insurance of Baton Rouge, La.

- Kenneth M. Padgett, managing director of J&H Marsh & McLennan Inc. of New York.

- Bonnie M. Randall-Molaschi, executive vp and general manager of The Cal-Surance Cos. of Orange, Calif.

- Robert S. Seltzer, president of Cohen-Seltzer Inc. of Fort Washington, Pa.

In addition to a new slate of elected officers, the Council also recently reorganized and made several staff appointments reflecting its July merger with the NAIB.

Barbara S. Haugen was named senior vp and will assume senior management and operational responsibilities with the Council. Ms. Haugen most recently was director of federal affairs for the NAIB.

Joel Wood was promoted to senior vp-government affairs, from vp-government affairs of the Council. He remains the Council's chief federal lobbyist.

Coletta I. Kemper was promoted to vp-industry affairs, from director-industry affairs of the Council.

Anne Flanagan was named director of state affairs. Ms. Flanagan previously held the same position with the NAIB.

—By Paul D. Winston



Online

Continued from page 10

tle revenue gain, reducing the personal service provided to customers, making mistakes or poor service highly visible, and exposing data to security threats.

Another panelist expressed concern that businesses are not using the power of the Internet wisely.

Too many companies focus on attaining the capability to access the Internet, such as through newer and better hardware, rather than on the skills needed to maximize the information obtained online, according to Russ Haynal, head of Internet Navigators, an Ashburn, Va., Internet trainer and consultant.

Many companies give their employees the tools to access the Internet, he said, but do not provide them with the training on how to search the Internet, proper "netiquette," or how to minimize risks to their organizations.

These untrained users waste company time by browsing irrelevant or personal sites, or by failing to find useful information, he said.

In addition to requiring basic Internet training before giving employees access to the Internet, Mr. Haynal also advised that companies encourage employees to have such access at home. Not only does that enable them to practice surfing the Web on their own time but it also assures that unproductive searches are done on personal rather than company time, he said.

Making sure employees know their Internet use is monitored is another way to assure that online time during work is productive, he added.

Another technological development during the meeting was the

unveiling of an overhaul of the Council's home page.

The site, www.ciab.com, offers information on the Council, its services and benefits, membership guidelines, information on leaders and officers, press releases and news on regulatory and legislative fronts. The site also features a locator that visitors can use to identify and obtain information on Council members by state.

The Council also plans to develop a private Web site, www.ciab.org, that will carry the same public information as its primary site but will also offer secure information available only to members.

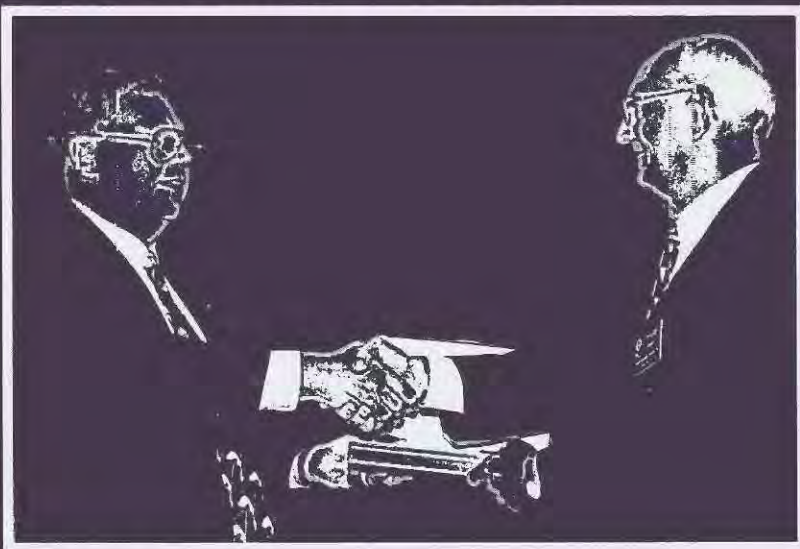
The Council also announced several technology initiatives, including its endorsement of IVANS Inc.'s NetConnect service, which will provide an information pipeline linking agents and brokers with insurance companies, as well as providing Internet access and e-mail.

In addition to several presentations on technology, the Insurance Leadership Forum featured a "CyberCafe" throughout the week to expose agency and company executives attending the meeting to the latest in information technology initiatives, such as voice recognition technology.

"We are committed to delivering the finest electronic commerce capability and functionality to assist our leading agents and brokers in communicating online with their peers and with their clients," Ken A. Crerar, president of the Council, said in a statement.

Next year's Insurance Leadership Forum will be held Oct. 2-6. For information, contact the CIAB, 701 Pennsylvania Ave. N.W., Suite 750, Washington, D.C. 20004-2608; 202-783-4400; fax: 202-783-4410; Internet: www.ciab.com

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Mutuals urged to evaluate options

Panel cites other structures as capital enhancement avenues

By RODD ZOLKOS

ORLANDO, Fla.—Structural options such as demutualization won't spell the end of mutual insurers, but they are alternatives many mutuals should consider, consultants and attorneys say.

A panel at the National Assn. of Mutual Insurance Cos.' 103rd annual convention last month in Orlando gave a glimpse into the findings of a NAMIC task force on mutual company structures and a new monograph the association commissioned that outlines possible capital enhancement strategies.

Steven C. Elliott, NAMIC's vp for regulatory affairs, noted that the task force's findings "do not conclude that mutuality is obsolete."

In studying demutualization, the perspective the task force has sought to achieve "is that of mutual property/casualty executives considering the best interests of their policyholders," according to Mr. Elliott.

In addition, a changing environment makes it essential that mutual companies consider all options, said James W. Schacht, national director of insurance regulatory practice for PricewaterhouseCoopers L.L.P. in Chicago. At the meeting, Mr. Schacht discussed some of the contents of the upcoming monograph, prepared for NAMIC by PricewaterhouseCoopers and the LeBoeuf, Lamb, Green & MacRae law firm.

"Not only is the financial services industry, of which you are a part, changing, the world is changing," Mr. Schacht said. And, in the process, insurance customers are changing, he said. "They're buying smarter; they're buying less; in some cases, they're not buying at



NAMIC

all."

"Certainly, another factor that's going on in the insurance industry is how mature the U.S. insurance industry and insurance markets are," Mr. Schacht said, suggesting the growth that U.S. insurers experienced in the post-World War II and Cold War eras won't be repeated.

In that kind of environment, the various capital enhancement options before mutual insurance companies, such as demutualization, surplus notes, affiliation and the formation of downstream holding companies, "are really tools to establish a business strategy or plan."

"The market that you're in is in-

The market that you're in is intensely competitive. It's changing radically, and it's changing overnight,' says Peter K. Demmerle.

tensely competitive. It's changing radically, and it's changing overnight," agreed Peter K. Demmerle, head of the property/casualty practice for LeBoeuf, Lamb in New York.

Mr. Demmerle noted that options such as joint ventures or the creation of downstream holding companies can be undertaken with less expense or effort than such steps as merging with other companies or demutualizing.

Whatever the option selected, Mr. Schacht emphasized that any capital enhancement technique should be part of a broader strategic plan for the company.

Such a plan, he said, must begin with an evaluation of the company and its attributes, a determination of exactly what the company seeks to accomplish, and an identification of what changes might be needed in distribution systems, product offerings or operations.

"All of these various factors and options need to be evaluated," he said. And the process should include an evaluation of competitors' abilities and characteristics.

Further, a strategic plan should be a dynamic instrument, Mr. Schacht said, continually subject to updating and review.

Another critical element in coping with the changing business environment is ensuring that the mutual company's board is prepared to address those changes, said Karen Balaban, special counsel at the Saul, Ewing, Remick & Saul L.L.P. law firm in Harrisburg, Pa.

"In order to get a culture and a mentality that will look to the future, you have to start with your directors," she said.

That includes taking a hard look at directors' competencies. "I think you'll want to look for some strong business attributes," Ms. Balaban said.

"I'm not saying, 'Dump your board of directors,'" she said, but mutual company executives do have a responsibility to educate their directors so they can deal with the current business environment.

"How can you make a change if you don't truly understand what the options are, what it would mean to you?" Ms. Balaban asked.

Mutual executives also should use their regulators as resources in developing capital enhancement strategies, Ms. Balaban suggested.

"Talk to your regulator. Many times they'll allow you to sit down and discuss on an informal basis some of the options that are before you," she said.

Mr. Demmerle agreed on the value of building relationships with regulators and discussing options with them. "I don't think you should ever be in a position where you're going to your regulator with a plan out of the blue," he said.

He added that mutual executives considering a capital enhancement strategy should be prepared to make a case for just why the additional capital is needed. **BI**

Small companies face challenges

By RODD ZOLKOS

ORLANDO, Fla.—The competition between small insurance companies and their larger counterparts is truly a David vs. Goliath story, and on many fronts, Goliath is clearly winning.

Smaller companies typically face relatively higher expenses and generate less in investment returns than the large insurers, according to James E. Bachman, vp at General Re-New England Asset Management Inc. in Farmington, Conn.

Speaking last month at the 103rd annual convention of the National Assn. of Mutual Insurance Cos. in Orlando, Fla., Mr. Bachman said expense ratio is "where things start to get a little rocky for the smaller compa-

nies."

He noted that, from 1993 to 1997, companies with less than \$25 million in assets had average expense ratios of 35.7%, considerably higher than the industry average of 25.7%.

The "great news" is that smaller companies "tend to have vastly superior loss ratios," than larger ones, Mr. Bachman said.

"However, the price for that looks to be increased volatility in the loss ratio," he said. "So, on the one hand, we have a tremendously wonderful loss ratio for the smaller company, but it's unpredictable."

And smaller companies' investment yields trail those of their larger counterparts significantly, averaging 5.1% for

See Small on page 16



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WHO SHOULD ATTEND

Risk managers, loss prevention and safety managers, workers compensation and benefit managers, plus insurers, brokers, consultants and representatives from HMOs, PPOs and state and local governments.

PROGRAM AGENDA

MONDAY, OCTOBER 26

9:30 AM
GOLF TOURNAMENT
 Hosted by: Deloitte & Touche LLP and SAC³

3:00 PM
EARLY REGISTRATION

4:00 PM
**EMPLOYER'S PRIVATE
 ROUNDTABLE**
 Moderator:
Kathryn J. McIntyre
 Vice President, Publisher and Editorial Director
 Business Insurance

5:30 PM
WELCOME RECEPTION
 Hosted by: Integra Group

TUESDAY, OCTOBER 27

7:45 AM
**REGISTRATION AND
 CONTINENTAL BREAKFAST**
 Hosted by: Bayne Consulting Group, Ltd.

9:00 AM
OPENING REMARKS
Alexandra Scott
 President & CEO
 International Business Forum

9:05 AM
KEYNOTE
Bruce G. Sundquist
 Vice President
 American Re-Insurance Company

**CHALLENGING TRADITIONAL
 WORKERS COMPENSATION
 PARADIGMS**

9:45 AM
**THE NEW WORLD OF
 WORKERS COMPENSATION**

Moderator:
Maddy E. Bowling
 Independent Consultant

William Granahan
 Senior Consultant
 Milliman & Robertson Inc.

Barry E. Thompson
 National Practice Co-Leader
 Workers Compensation and
 Disability Management Services
 Deloitte & Touche LLP

Daniel J. McVey
 President
 Missouri AFL-CIO

Greg Owen
 Manager, Claims Administration
 Risk Management
 Harrah's Entertainment Inc.

Scott Lund
 Vice President, Marketing
 SAC³

10:30 AM
**TABLE-TOP EXHIBITS
 REFRESHMENTS**
 Hosted by: Paradigm Health Corporation

11:00 AM
**THE DECISION WHETHER TO
 IMPLEMENT AN INTEGRATED
 DISABILITY MANAGEMENT
 PROGRAM**

Moderator:
Terry R. Bolz
 Vice President, Casualty Managed Care
 Wausau Insurance Companies

Tom Parry
 President
 Integrated Benefits Institute

Victor Paganucci
 Director, Integrated Disability Systems
 Champion International Corp.

Joanne L. Pomerleau, B.S., RN
 Workers Compensation Coordinator
 Maine Employee Health and Benefits

Arthur Wilcox
 Director, Public Employee Division
 New York State AFL-CIO

12:00 PM
**MEETING THE CHALLENGES
 CREATED BY THE AMERICANS
 WITH DISABILITIES ACT AND
 FAMILY MEDICAL LEAVE ACT**

Moderator:
Betsy Robinson
 Vice President
 Product Development and Management
 GENEX Services Inc.

Robert B. Steggert
 Vice President, Casualty Claims
 Marriott Corporation

Ken Mitchell
 Vice President, Return-to-Work Programs
 Provident Insurance Company

Marylou Kinlen
 Manager of Disability Plans
 Norwest Bank Corp.

Sharon Kaleta
 Director of Risk and Benefits
 Paragon Steak House Restaurants Inc.

12:45 PM
LUNCHEON
 Hosted by: Intracorp

1:45 PM
LUNCHEON SPEAKER
Susan K. Moreland
 Director of Risk Management
 San Francisco Newspaper Agency

**A CASE STUDY ON REDUCING
 WORKERS COMPENSATION
 LIABILITIES**

2:15 PM
BREAK

Presented by Business Insurance and IBF • International Business Forum

2:30 PM
CONCURRENT SESSIONS: A OR B

Session A: **ALTERNATIVE DISPUTE RESOLUTION**

Moderator:
Duncan Ballantyne
Senior Analyst
Workers Compensation Research Institute

Ed Zutler
Vice President, Integrated Benefits
AIG

Pat McGinn
Senior Business Representative
Regional Council of Carpenters

Mike Massey
Assistant Executive Director
Piping Industry Progress and
Education Trust Fund

Session B: **ARE YOU USING THE RIGHT REPORT CARD?**

Moderator:
Peter F. Rousmaniere
President
Rousmaniere Designs

Nicholas J. Lannutti
Senior Vice President, Corporate Actuary
National Council on Compensation
Insurance Inc.

Alex Swedlow
Research Consultant
California Workers Compensation Institute

Eloise Lincicum
International Workers Compensation/
Employers' Liability Manager
Apple Computer Inc.

Fred Scardellette
Vice President, Information Management Services
Intracorp

3:30 PM
**TABLE-TOP EXHIBITS
REFRESHMENTS**
Hosted by: Wausau Insurance Companies

4:00 PM
CONCURRENT SESSIONS: C OR D

Session C: **FUNDING MECHANISMS**

Moderator:
Jeffrey W. Pettegrew
Vice President
Insurance and Risk Management
Western Staff Services

Robert B. Hill
President
Professional Underwriters

Darin R. Haines
Manager, COSE Workers Compensation Program
Greater Cleveland Growth Association

John R. Keenan
Chief Executive Officer
Keenan & Associates

Session D: **EVALUATING ERGONOMICS PROGRAMS**

Moderator:
Alexandra R. Charish
President
Charish Ergonomics Inc.

Soha Sadek, Ph.D.
Ergonomist Consultant
Applied Risk Management Inc.

Sam Fulginiti
Risk Manager
Godiva Chocolatier

5:00 PM
COCKTAIL RECEPTION
Hosted by: GENEX Services Inc.

WEDNESDAY, OCTOBER 28

7:45 AM
CONTINENTAL BREAKFAST
Hosted by: TravelersPropertyCasualty/
Constitution State Services

9:00 AM
**KEYS TO RESPONSIVE
RETURN-TO-WORK PROGRAMS**

Moderator:
Dr. Thorv Hesselund
Director of Vocational Programs
Paradigm Health Corporation
Jean M. Long, RN, COHN, CCM
Manager, Loss Control
Fireman's Fund Insurance Company

Clifton Matsuno
Administrator for Rehabilitation Services
Protect Physical Therapy

Marshall Sherman
Director, Risk Management
Aramark Corporation

Soraya M. Wright
Corporate Risk Manager
The Clorox Company

John J. Larkin Jr., M.D.
Vice President, Clinical Affairs
Integra Group

10:00 AM
**TABLE-TOP EXHIBITS
REFRESHMENTS**
Hosted by:
Specialty Risk Services/The Hartford

10:30 AM
**DOING WHAT'S BEST FOR THE
WORKER: CAUGHT BETWEEN THE
EMPLOYER, THE TPA, INSURANCE
COMPANY AND THE OCCUPATIONAL
HEALTH PROVIDER**

Moderator:
Stephen M. Holcomb
Senior Vice President
Specialty Risk Services/The Hartford

Panelists:
Leo Costantino
Workers Compensation Manager
UCLA

Jerry L. Thomas
Managing Director, Workers Compensation
American Airlines/AMR Corp.

Maria Bayne
President
Bayne Consulting Group Ltd.

11:30 AM
**WORKERS COMPENSATION
INSURANCE FRAUD: SPECIFIC
STEPS AND SOLUTIONS TO
COMBATING FRAUD**

Moderator:
Dominic Dugo
San Diego County District Attorney

William Kizorek
President
InPhoto Surveillance

Jeff Nale, Esq.
Bello, Tade & Nale

Kevin Saucier, R.S.A., REA
Director of Environmental, Health and Safety
Guess? Inc.

12:30 PM
LUNCHEON
Hosted by: AIG American Home Assurance/
Specialty Workers Compensation

1:30 PM
LUNCHEON SPEAKER
Jerry L. Thomas
Managing Director, Workers Compensation
American Airlines/AMR Corp.

**THE AMERICAN AIRLINES
SUCCESS STORY: BEST PRACTICES
AND LESSONS LEARNED**

2:00 PM
BREAK

2:15 PM
LOW BACK TREATMENT GUIDELINES

Moderator:
Edward C. Woodward
President
California Workers Compensation Institute

Nancy Geedey, RNC, CCM
Director, Case Management
Managed Care USA Services

Michael D. Roback, M.D.
Diplomate, American Board of
Orthopaedic Surgery
Industrial Medical Council of California

3:15 PM
CONFERENCE ADJOURNS

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Leo Costantino • Workers Compensation Manager • UCLA

"Everything you included on the agenda was interesting and informative."

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BIWCFPS

Small

Continued from page 13

companies with less than \$25 million in assets vs. an industry average of 5.9%.

Among the factors affecting smaller companies' investment returns are the heightened impact that certain regulations have on them, Mr. Bachman suggested.

"There are rules that all of us have to live by in the investment of money that is generated in the insurance industry," he said. "As you look at the situation, this is one of the obstacles that is confronting the smaller companies more than the larger organizations."

Among those regulations are the "per name" limits that typically restrict investments, except in U.S. government securities, to no more than 5% of an insurer's admitted assets in a given entities' securities.

For small insurers, that restriction means they are often executing their trades in "odd lots," rather than the "round lots" that typically trade in \$1 million increments. Trading in odd lots raises the costs of those transactions.

There are no simple solutions to the problem, Mr. Bachman said, in large part because of external factors such as regulations and the higher execution costs of the small companies' trades.

Small insurance companies can seek to change some internal factors however, that could improve their picture. One is to look for ways to improve operating results, Mr. Bachman said.

Another is to change their investment asset allocation. Smaller companies typically have a greater percentage of their portfolios in U.S. government securities and other securities with higher ratings and shorter maturities than do large companies. Moving some of those investments to higher-yielding securities could be one way to improve investment results.

Changes in management practices and relationships also could potentially help smaller companies improve their competitive position in comparison with the large company "Goliaths," Mr. Bachman suggested. Again, modifying long-held relationships could be difficult "but might be something you want to look at," he said. **BI**

FEMA touts loss mitigation efforts

Programs focus on flood risks and disaster-prone areas

By RODD ZOLKOS

ORLANDO, Fla.—Because pre-disaster loss mitigation efforts have proved their worth in reducing the costs of natural disasters, federal disaster officials hope to join with the insurance industry in promoting loss mitigation.

"While we can't control Mother Nature, we can affect human nature," Michael Armstrong, associate director of the Federal Emergency Management Agency, said during a panel discussion at last month's 103rd annual convention of the National Assn. of Mutual Insurance Cos. in Orlando, Fla.

Mr. Armstrong ticked off facts that he suggested build the case for why not only the insurance industry but other businesses should be interested in promoting disaster loss mitigation efforts.

Small businesses hit by natural disaster have a subsequent 30% failure rate, he said. Meanwhile, he suggested that \$12.8 million in mitigation work to the Des Moines, Iowa, water treatment facility prior to 1993's floods could have prevented \$200 million in flood-related business losses there.

FEMA currently has two mitigation-oriented programs, one geared specifically to flood risks and another aimed at changing behaviors in connection with how and where people build in disaster-prone areas, Mr. Armstrong said.

As part of that latter effort, "Project Impact" focuses on "the idea of building a disaster-resistant community." The program initially is offering grants of \$500,000 per community to use as seed money to develop a locally driven public-private partnership aimed at meeting that goal.

Last year the project tapped a diverse group of seven pilot communities across the country. "I would say,

at this point, that we've been very successful," Mr. Armstrong said, noting that the federal seed money has generated roughly a two-to-one

private-sector match in the pilot communities.

This June, FEMA Director James Lee Witt announced

that the agency would expand the program to one community in each state.

FEMA also is embarking on a new strategy to deal with the issue of repetitive losses, Mr. Armstrong said.

"We know that we have to revisit our disaster declaration criteria," he said. The agency has to "turn the faucet off" in areas where there have been multiple disasters and local property owners and government officials have done nothing to deal with the problem or to mitigate losses, the FEMA official said.

"We're also excited about our growing partnership with the insurance industry," Mr. Armstrong said. "In the communities we have designated as Project Impact communities, I would like to see insurance companies come to the table as local partners."

One way insurance companies have become involved in the mitigation effort is through the Institute for Business & Home Safety, an industry initiative aimed at reducing deaths, injuries and losses caused by natural disasters.

"We exist for only one reason: natural disaster mitigation," said Harvey G. Ryland, president and chief executive officer of the Boston-based IBHS, adding that natural disaster losses are associated with only two factors: where you build and how you build.

One of the primary goals of the IBHS is "to establish natural disas-

ter mitigation as a public value," Mr. Ryland said. "When we reach that day, we won't have to be here talking about natural disaster mitigation, because people will demand it."

Mr. Ryland suggested that, at some point in the future, there will be an IBHS seal of approval, similar to the Underwriters Laboratories seal, designating structures that meet minimum standards for disaster protection. And, in fact, Mr. Ryland said, the first such IBHS-approved home already has been built in Evansville, Ind.

The IBHS is working with FEMA and others to develop incentives for seeking such approval on new construction, Mr. Ryland said.

While such incentives could take the form of price reductions on insurance premiums, other incentives must be provided as well, the IBHS president said. "We are saying that there must be up to 30 different sources of incentives to really encourage people to take action."

And just designing and building new structures to disaster-resistant guidelines also isn't adequate, Mr. Ryland said. "We must be concerned about retrofitting existing structures," he said.

As one step in that effort, working through the IBHS, the insurance industry is making a commitment to perform non-structural disaster protection retrofitting of all 93,000 non-profit child care centers in the United States, Mr. Ryland said.

"It's a fairly easy thing to do on a Saturday morning with four or five employees," he said. "It takes four or five work hours. The materials we're generally able to get donated."

As another step in the retrofitting direction, the organization has created a "10 most-wanted list" of the top 10 sources of insured loss in natural disasters.

That list includes such things as window damage and roof sheathing torn loose in windstorms. The IBHS is exploring ways of significantly reducing the costs and complexity of retrofitting existing structures to mitigate those sorts of losses. **BI**

NAMIC convention draws 2,000 attendees

ORLANDO, Fla.—This year's 103rd annual convention of the National Assn. of Mutual Insurance Cos. drew approximately 2,000 attendees to Marriott's Orlando World Center Sept. 20-23.

During the convention, Robert E. H. Rabold, chairman, president and chief executive officer of Motorists Mutual-American Hardware Insurance Group, was elected NAMIC chairman for the coming year. He replaces outgoing

Chairman Dwight Shore, manager of Marshall Mutual Insurance Co. in Marshall, Ill.

Next year's NAMIC convention is scheduled for Sept. 19-22 at the Marriott Rivercenter/Marriott Riverwalk Hotels in San Antonio.

For more information on next year's conference, call 317-875-5250 or visit NAMIC's World Wide Web site at www.namic.org.

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Storms

Continued from page 3

and livestock shows, was left with water damage and an accumulation of mud. Repairs are expected to cost about \$3.5 million, according to the city manager's office.

Kansas City's property insurance covers flooding, according to Mark Haskin, risk manager for the city. Chubb Corp. and Reliance National Insurance Co. write the first \$10 million of the coverage on a quota share arrangement, and Hartford writes a \$40 million excess layer. The coverage carries a \$500,000 deductible.

A spokesman for the Federal Emergency Management Agency, which administers the National Flood Insurance Program, said 1,435 NFIP policies are in force in Clay County, Mo., which includes Kansas City. Those policies represent \$231 million in coverage. In Wyandotte County, where Kansas City, Kan., is located, 351 policies are in force, representing \$61.6 million in coverage.

The spokesman did not have an estimate of how much in claims the NFIP would pay.

As cleanup continues in Oklahoma and Kansas City, insurers continue to pay claims from Hurricane Georges. The storm caused widespread damage in the Caribbean and United States.

The Insurance Service Office Inc.'s Property Claim Services unit reported that the hurricane caused an estimated \$2.5 billion in insured property damage, more than half of which was sustained in Puerto Rico.

However, that estimate does not include damages from non-U.S. territories in the Caribbean, such as the Dominican Republic, which sustained widespread damage.

According to PCS, Puerto Rico suffered \$1.7 billion in insured property damage. Florida sustained \$325 million in insured property damage; Mississippi sustained \$310 million, and Alabama suffered \$100 million. The U.S. Virgin Islands sustained an estimated \$50 million and Louisiana about \$15 million in insured property damage.

PCS estimates that the hurricane will generate approximately 685,000 claims.

Hurricane Georges was the costliest hurricane this year and the first catastrophe to cause more than \$1 billion in insured property damage since Hurricane Fran ripped through portions of the Southeast, Midwest and Mid-Atlantic states in 1996, causing an estimated \$1.6 billion in insured property damage (*BI*, Sept. 16, 1996).

Mark A. Hofmann contributed to this report.

Care management an effective new tool

By Dr. Victor Villagra

EMPLOYERS ARE DEMANDING a lot from their health plans these days. Chief among these demands are improving the quality of care, keeping costs affordable, supporting employers' workplace health initiatives and educating employees to take a greater role in their own health care. How is the managed care industry responding?

Managed care has long emphasized the twin goals of preventive medicine and appropriate care. Through a variety of strategies—ranging from utilization review and case management to funneling specialty care through primary care gatekeepers—health plans have sought to provide quality care to large populations of members.

While reducing unnecessary medical procedures and hospital admissions, these quality initiatives also brought cost-effectiveness to the fore, a concept long missing from the fee-for-service health care delivery system.

Managed care is entering a new phase. Like other industries in the competitive 1990s, managed care companies are using innovation to meet the needs of their customers.

One result is a new approach to delivering care known as "medical care management." Going beyond traditional utilization management, medical care management is driven by the wealth of detailed clinical information now available at health plans' fingertips thanks to recent advances in information technology.

The care management approach seeks to provide physicians with information that will help them identify patients at risk for disease and provide the most appropriate care.

Medical care management, as its name suggests, is a critical change in emphasis from managed care. Cost efficiency is not at the root of the process but occurs as the result of focused prevention, early detection of disease, coordinated treatment processes and the collection and analysis of vast amounts of claims data converted into clinical information.

Recall that the traditional indemnity insurance model centered on waiting for a sick employee to contact a doctor or visit the hospital emergency room. Medical resources were typically focused on managing episodes of acute illness and hospitalization.

Under medical care management, however, promoting wellness and preventing disease is elevated to the same plane as treating illness. Care management seeks to manage care globally—from prevention through treatment and recovery. It aims to meet both employer and employee needs by improving the overall health status of populations, one individual at a time.

The care management approach also seeks to provide physicians with information that will help them identify patients at risk for disease and that will help them provide the most appropriate level of care for their patients. The goal is to work with physicians to achieve quality outcomes, not to look over their shoulders and second-guess them.

Care management also supports employers' workplace health initiatives to foster employee health—such as wellness programs—which reduce absences from work; increase productivity; and, ultimately, help the bottom line.

What kind of cost impact can this have? Unhealthy lifestyles cost America \$188 billion in health care expenses annually.

The savings in insurance premiums from just one employee quitting smoking average \$1,100 per year,

according to studies by Johnson & Johnson and the University of Michigan.

Care management differs from disease management. Care management targets those employees with high-cost chronic conditions, such as asthma, diabetes, cardiovascular diseases and hypertension. These cases are the major cost drivers in the medical delivery system.

That may sound very much like what's commonly called "disease management," which is partially right. Both care management and disease management seek to effectively identify and treat chronic conditions, thereby promoting quality outcomes and controlling costs. But while disease management stops there, care management focuses on the entire spectrum of health status among enrollees—from the healthy to the sick.

For example, a care management program might identify a population of healthy women within the fertile age range and ask them, on a confidential basis, whether they are planning a pregnancy within the next year. For those who are, records will be checked to ensure that immunizations are current. Additionally, they will get advice about the benefits of folic acid supplementation and the dangers of smoking and drinking alcohol.

Under a care management approach, all employees—healthy or otherwise—may be asked to fill out health risk assessment questionnaires to help identify those at risk for disease.

With the employees' consent, the results of the assessment would be provided to their primary care physicians, who can use that information to counsel them on taking preventive steps and making lifestyle changes.

Those employees suffering from chronic disease would be trained in self-management and treated based on the best medical practices currently available—the disease management component of care management. Thus, disease management is just a part—albeit an important part—of care management's broader approach to health care delivery.

Care management differs in a fundamental way from disease management because it is based not on a particular drug protocol or therapy but on managing the care of all enrollees. In its initial stages, disease management programs were designed primarily by pharmaceutical companies to encourage early drug intervention with the twin goals of controlling employers' costs and promoting products.

Not surprisingly, as these programs evolved, they came to rely heavily on drug therapies to control symptoms and head off complications. Hence, the disease states targeted most frequently by disease management programs, such as asthma and diabetes, are those most responsive to drug-based treatments.

Without question, many asthma and diabetes management programs have demonstrated they can improve quality while reducing costs. Harvard Pilgrim Health Care's pediatric asthma program, for instance, cut inpatient admissions by 86% and emergency room visits by 79%. And CIGNA's Lovelace Health Systems has experienced an 83% decline in lost school, day care and work days among children with asthma and their parents.

But what about musculoskeletal and other high-cost conditions that respond minimally, if at all, to drug therapy? Care management can make a difference.

Low-back pain, for instance, is potentially a highly preventable and controllable affliction that affects millions of people each year.

The combined cost of the medical resources used to treat this condition plus the lost work and productivity stemming from it total several billion dollars annually.

A large chunk of those dollars is spent on surgery and X-rays that, according to the low-back pain

guidelines of the federal Agency for Health Care Policy and Research, have no proven value in producing better outcomes.

Now consider how a care management program for managing low-back pain performs. A care management program for low-back pain starts by identifying who is eligible by using information

Care management differs in a fundamental way from disease management because it is based not on a particular drug protocol or therapy but on managing the care of all enrollees.

technology.

Multiple data sources are pooled and analyzed, including claims and pharmacy data, diagnostic and procedure codes, lab reports and demographic information. Health risk assessments and 24-hour telephonic health information lines are other potential sources for patient identification.

Once identified, patients receive the appropriate intervention from their care manager, based on the severity of their condition.

Primarily, patients are educated on how to avoid further episodes of low-back pain. For uncomplicated back pain, they may be advised to take pain medication, see a chiropractor briefly and maintain normal activities as tolerated. Resources include educational materials and health information lines in which employees can speak in person with nurses or listen to audio tapes about back pain.

On the physician side of the equation, the goal is to better educate providers about low-back pain, ensure effective care and reduce wide variations in practice patterns.

Physicians are provided with clinical practice guidelines from respected scientific sources such as the AHCPR and brief recommendations from peer-reviewed clinical literature about effective ways to treat back pain.

Additionally, data is fed back to physicians on their clinical performance and whether they are following the guidelines. Physicians can use this important information to gauge and improve treatment of their low-back pain patients and to see at a glance how their practices compare with other physicians.

Although still in its infancy, care management shows great promise for improved prevention and patient self-care, reduced variations in practice patterns among providers and lower costs resulting from a decreased need for tertiary-level care.

As a model for delivering health care, care management is being used by health plans to treat an expanding range of conditions. Among the conditions that offer significant opportunities for improved outcomes and cost-effective care are diabetes, asthma, low-back pain, high-risk pregnancies, depression, breast cancer, HIV/AIDS, pneumonia, strokes, congestive heart failure and allergies.

BI



Dr. Villagra

Dr. Victor Villagra is vp-quality and care management for CIGNA HealthCare in Bloomfield, Conn.

D&O policy language leaves room for uncertainty

By Martin R. Pollner
and Brian R. Socolow

ONE OF THE PURPOSES of directors and officers liability insurance is to protect corporate decision-makers from personal liability for claims arising out of the good-faith performance of their duties. Since the mid-1980s, the coverage afforded by D&O insurance has become uncertain, especially in the bankruptcy context, because of conflicting case law interpreting the so-called "insured vs. insured" exclusion clause.

Generally, the insured vs. insured exclusion bars coverage of claims against directors and officers brought "by the company or on behalf of the company."

A typical exclusion clause reads as follows:

"The insurer shall not be liable to make any payment for loss that is based upon or attributable to any claim made against any director or officer by any director or officer or by the institution defined in the policy except for a shareholder derivative action brought by a shareholder of the institution other than the insured."

The underlying rationale of this exclusion is to prevent collusive suits between a corporation and its directors and officers that would effectively compel the insurer to underwrite the company's losses.

This exclusion was created only after a number of corporations successfully litigated and recovered against their own directors and officers under broad D&O policies. As a result, insurers have sought to limit coverage in those circumstances and designed policies denying coverage to directors and officers who were being sued by the corporations that they served.

The language of the typical exclusion, however, has generated uncertainty as to whether claims against directors and officers brought by third parties—such as trustees; statutory receivers, such as the Federal Deposit Insurance Corp.; and debtors-in-possession—are excluded from coverage because the claims are considered to be brought by an "insured," i.e., the company, against another insured. The issue comes into sharp focus in the case of failed companies, where a third-party trustee or a litigation trustee attempts to hold former directors and officers liable for their wrongs to the corporation.

A litigation trustee is usually appointed after a plan of reorganization has been confirmed by the bankruptcy court to pursue various claims against third parties, including former directors and officers. Generally, the appointment occurs in a large Chapter 11 bankruptcy by recommendation of the creditors' committee. Litigation trustees have been appointed in a handful of recent bankruptcy cases, including *In re County of Orange* (Bankr. C.D. Cal.), *In re Resorts International, Inc.* (Bankr. D.N.J.), and *In re Gulf USA Corp.* (Bankr. D. Idaho).

Several courts have considered whether the exclusion applies in an action where a statutory receiver, such as the FDIC, brings suit against former officers and

directors. Most courts have held that the exclusion is not applicable, reasoning that the receiver, in essence, represents third-party creditors and, therefore, the purpose of the exclusion—to prevent collusive suits—is not furthered by excluding coverage.

However, reported cases are few and in sharp conflict as to whether the exclusion applies to claims where the plaintiff is a bankruptcy trustee or other third party in a bankruptcy situation. In *Reliance Insurance Co. vs. Weis*, 148 B.R. 575 (E.D. Mo. 1992), *aff'd*, 5 F.3d 532 (8th Cir. 1993), *cert. denied*, 510 U.S. 1117 (1994), where a creditors' committee in a Chapter 11 bankruptcy sued former directors and officers, the court held that the exclusion applied and denied coverage. The court reasoned that the claims were necessarily brought on behalf of the company because they originally belonged to the company. According to the court, the committee was simply an assignee of the company's claims by reason of the Chapter 11 reorganization plan; since the company itself could not obtain the benefit of the D&O coverage, its assignee stood in no better position.

By contrast, in *Pintlar Corp. vs. Fidelity & Casualty Co. of N.Y.*, 205 B.R. 945 (Bankr. D. Idaho 1997), *aff'd*, Case No. CV 97-250-N-EJL (D. Idaho Sept. 11, 1997), *appeal docketed*, No. 98-35007 (9th Cir. Dec. 31, 1997), the court reached a different result where the plaintiff was a litigation trustee. The court ruled that the exclusion did not apply—thereby upholding coverage—for a litigation trustee's claims against former directors and officers. The court reasoned that the litigation trustee, in pursuing such claims, was acting on behalf of the creditors, not the company. Accordingly, there was no possibility of the suit being collusive. Such reasoning, in the authors' view, was correct and may represent a trend toward finding the exclusion inapplicable in similar circumstances.

The reasons that claims brought by litigation trustees should fall outside of the exclusion are similar to those in cases involving receivers. First, recoveries are generally distributed to the company's creditors, not to the company—which may be an "insured" under a policy. Second, collusive suits between a corporation and its officers and directors are not a threat if, as is the case where a litigation trustee is involved, creditors are the ultimate beneficiaries of the recovery.

The exclusion typically precludes coverage for claims brought "on behalf of the company." This language does not specifically address the nature of claims asserted in bankruptcy or insolvency contexts, where claims that belonged to the company prior to its bankruptcy now exist for the benefit of other members of the bankruptcy "estate"—the creditors. For example, a litigation trustee appointed by a bankruptcy court is typically the assignee of the claims of the bankrupt corporation and, therefore, does not pursue the assigned claims "on behalf of" the insured company. Rather, such a trustee asserts claims on behalf of the trust and its respective beneficiaries. Those beneficiaries are usually creditors and/or shareholders of the debtor. Because creditors of a corporation are not the

corporation itself—i.e., the insured—the exclusion is inapplicable. Indeed, the recognition that creditors are the real parties in interest may underlie the trend toward finding coverage.

Another factor that may prompt the courts to find coverage is the legitimate expectations of corporate directors and officers. After all, D&O insurance typically is bought to protect directors and officers against lawsuits arising from their good-faith mistakes. Such lawsuits are likely to be most numerous—and the need for coverage most acute—in an insolvency or bankruptcy meltdown.

Any uncertainties as to coverage can be resolved by the marketplace. A modification in the policy's language, such as a specific exclusion of all claims "brought by the company, receiver, litigation trustee,..." would eliminate the confusion and create certainty in litigation. Of course, such a product might have limited appeal even if it were priced lower to reflect its decreased coverage.

Some insurance companies, recognizing the need for a product providing better-defined coverage, have begun offering a D&O liability policy that explicitly provides coverage for claims brought by trustees or examiners against directors and officers in bankruptcy situations. Presumably, the pricing of the policy reflects the greater certainty of coverage for directors and officers.

Policy language should be carefully reviewed by both insurers and potential insureds. For example, even expanded coverage for claims of "trustees" or "examiners" might not cover claims brought by litigation trustees, debtors-in-possession, or creditors' committees.

Tightening up the draftsmanship on new policies should have a positive effect in the marketplace. The legitimate expectations of directors and officers can be more effectively met, and all sides should be relieved of unnecessary legal costs when the parties' rights and obligations are more clearly defined.

BI



Mr. Pollner



Mr. Socolow

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No need to send benefit checks behind bars

The Workers' Compensation Act mandated that a claimant's benefits be suspended during his incarceration, according to the Supreme Court of Pennsylvania.

In April 1992, David J. Banic injured his back while in the course of his employment with Trans-Bridge Lines Inc. As a result of his injury, Mr. Banic began receiving weekly workers compensation benefits. On July 12, 1993, Mr. Banic pled guilty in federal court to four counts of a federal offense and was sentenced to 27 months' imprisonment. He began serving his sentence on Sept. 1, 1993.

On Aug. 31, 1993, the Workers Compensation Act in Pennsylvania was amended to provide that nothing in the act shall require payment of compensation for any period during which an employee is incarcerated after a conviction. Mr. Banic reported to federal prison one day

Legal Briefs

after the amendment became effective. On that same date, his employer ceased paying workers comp benefits because of the amendment. The Commonwealth Court of Pennsylvania affirmed the suspension of benefits.

On appeal, Mr. Banic argued that the application of the amendment to him constituted an impermissible retroactive application of the law adversely affecting his compensation benefits to which he was entitled before the amendment. The appellate court concluded that the issue of the amendment's retroactivity was immaterial because there was other basis for denying Mr. Banic's continued benefits. According to the court, when he was incarcerated his loss of earning power was no longer causally related to his back injury. Rather, the court said

it was caused by his incarceration, which necessarily set his earnings level at zero. Because of this change of circumstances, the court said, Mr. Banic's injury was no longer the cause of his decreased earning power such that compensation under the act was warranted in order to provide him compensation for a work-related injury. Thus, the court said the employer was entitled to seek a suspension of his benefits.

Banic vs. W.C.A.B. (Trans-Bridge Lines), Supreme Court of Pennsylvania, Dec. 24, 1997. (BI/02/Jy.-\$10) BI

This abstract was prepared by Mayo H. Stiegler. Copies of this decision are available by sending a \$10 check, payable to Mayo H. Stiegler, to Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590. Please list the number for each opinion.

INTERNATIONAL

Global Briefs

Zurich-based **Swiss Mobiliar Insurance Co.** is the latest insurance company to join **Eureko B.V.**, a European insurance and financial services network based in Amsterdam. As part of the agreement, Swiss Mobiliar has taken a 10% stake in Eureko and Eureko is taking a 22.27% stake in Providentia, Swiss Mobiliar's life insurance subsidiary. The move makes the Eureko network one of the largest insurance groups in Europe, with assets of 262 billion guilders (\$144.13 billion). . . . Munich Reinsurance Co. and Zurich Financial Services Group have joined the British Aviation Insurance Group insurance pool. Both companies will become members of **BAIG Underwriting Services Ltd.** from the beginning of next year, along with founding members **CGU P.L.C.**, **Royal & Sun Alliance P.L.C.** and **British Aviation Insurance Co. Ltd.**, as well as the **Tokio Marine & Fire Insurance Co. Ltd.** and **Mitsui Marine & Fire Insurance Co. Ltd.**, which joined this year. BAIG's pool capacity will stay at the 1998 level, however, because it is assessed on market conditions rather than funds available. . . . The number of ransom demands has hit its highest level ever, according to a survey by **Hiscox Group P.L.C.** Of 1,407 kidnappings for ransom worldwide last year, 887 incidents took place in Colombia. Mexico proved the second most dangerous country, with 237 recorded kidnappings, according to the **Hiscox Kidnap Monitor**. The first half of this year has seen 784 reported kidnappings, indicating that it may be another record year. Hiscox, a kidnap & ransom insurance specialist, warned there could be a further increase in kidnap rates as economic instability around the world increases. . . . **Two paintings stolen** from the **Cheriet Musee des Beaux Arts** in Nice, France, last month (*BI*, Sept. 28) have been recovered by police, and three men have been arrested in connection with the theft. . . . Lloyd's of London has delayed the opening of its **Lloyd's Asia venture** until July of next year. The operation was due to launch in January 1999 but has been put back because of the volume of work still to be completed, said a Lloyd's spokesman. . . . U.K. professional services group **Fishers Group Ltd.** has revamped its operating structure and changed its name to **Miller Fisher Group Ltd.** The Sutton, England-based company is now organized into four main areas: loss adjusting; claims management and administration; investigation services; and inspection services. . . . U.K. Prime Minister **Tony Blair** last week opened **Royal & Sun Alliance Insurance Group P.L.C.'s** first Chinese branch office, after Chinese Premier **Jiang Zemin** had said the insurer would be the first to be granted a license in a visit to the United Kingdom earlier this year. The new Shanghai office of **Royal & Sun Alliance** will provide commercial insurance coverages to foreign-funded joint ventures. . . . **Standard & Poor's Corp.** has assigned an AA- rating to **Gerling Credit Insurance Group**. The rating encompasses **Gerling-Konzern Spezial Kreditversicherungs A.G.** in Germany, **Gerling Namur Assurances du Credit S.A.** in Belgium, **Namur Re S.A.** in Luxembourg and **Gerling Nordisk Kreditforsikring** in Norway. The rating is based on Gerling Credit's strong market position in Germany, diversified book of business, very good underwriting performance and strong capitalization, according to S&P. . . . Lloyd's of London agency **Cox Insurance Holdings P.L.C.** has completed its acquisition of **Anthony Kidd Agencies Ltd.** for £13 million (\$22.2 million). . . . The **HM Treasury**, the regulator for the U.K. insurance industry, will appoint new members of the **Insurance Brokers' Registration Council** when the existing members leave at the end of this month. The IBRC will remain the regulator for U.K. insurance brokers until the Insurance Brokers' Registration Act is repealed as part of a new regime that will turn regulation over to brokers.

Equitas reports higher surplus

Lloyd's names temper positive reaction to results with concern for future

By EDWIN UNSWORTH

LONDON—Lloyd's of London officials are more upbeat than Lloyd's names about the latest financial results for Equitas Holdings Ltd.

"Reinsured names, the Lloyd's market and its clients can be reassured by the report, which shows a continuation of favorable trends in the Equitas accounts," Lloyd's Chief Executive Officer Ron Sandler said.

Lloyd's names welcome the gains in Equitas' surplus, but are sounding a note of caution about what the distant future may hold.

Equitas, the company created to reinsure names' pre-1993 liabilities, reported a surplus for the year ended March 31, 1998, of £718 million (\$1.20 billion).

Apart from being better than had been anticipated two years ago, the surplus was 16% higher than £617 million (\$1.04 billion) as of March 31, 1997, and 22% better than Equitas' opening surplus of £588 million (\$1 billion) on Sept. 4, 1996.

Gross claims paid were £2.2 billion (\$3.68 billion) as of March 31, bringing to £4.76 billion (\$8.01 billion) the total claims Equitas has paid since it was launched.

Chief Executive Officer Michael Crall said this was "significantly less than had been originally projected" at the reinsurer's outset and reflected the fact that claims have been coming in more slowly than anticipated.

Equitas recovered £660 million (\$1.10 billion) last year from reinsurers. Investment returns totaled £932 million (\$1.56 billion).

See Equitas on page 21

EQUITAS

Fiscal year results

	March 31, 1998	March 31, 1997*
Surplus	£718 million	£588 million
Reinsurance recoveries	£660 million	£840 million
Claims paid	£2.2 billion	£2.5 billion

* Seven-month period from Equitas' launch Sept. 4, 1996
Source: Equitas Ltd.

GRAPHIC BY JOHN HALL

Adoption of euro will force new approach by insurers in United Kingdom, exec says

By MATTHEW MacDERMOTT

LONDON—U.K. insurers must develop a strategic vision of the new European insurance market—including new products, distribution and customer needs—that will arise from the introduction of the euro, an insurer executive said.

Ian Bates, group internal control manager for the United Kingdom's largest commercial insurer, London-based **Royal & Sun Alliance P.L.C.**, said there are no set answers to how U.K. insurers should approach the single European currency.

Ultimately, it is up to individual insurers to make their own decisions on the euro, but "there are things you should be thinking about," he said.



tical
Implica-
tions of
the Euro
for the
Insur-
ance In-
dustry,"
held in
London last month.

Starting Jan. 1, 1999, 11 European coun-

"The time for complacency has passed, and the time for commercial reality is here," Mr. Bates said at a conference on "The Prac-

tries will give customers the option of doing business in euros, he pointed out.

"Even though it will be a foreign currency until the United Kingdom joins, if the customer wants to do business in it, are you going to refuse?" Mr. Bates asked. The customer may find another insurer that will accept the euro, he added.

Mr. Bates said commercial reality also suggests it is "probable" the United Kingdom will join European Monetary Union in the "not-too-distant future."

The U.K. government so far has not committed to joining the European Monetary Union but will consider it in the future.

He said insurers can take either a reactive or a strategic approach to the United King-

See Euro on next page

Broker grows in merger debis to place Chrysler coverage

By DON LEWIS KIRK

BERLIN—German automotive giant **Daimler Benz Corp.** plans to expand U.S. insurance brokerage services following its merger with **Chrysler Corp.**

The automaker's Berlin-based subsidiary, **debis A.G.**, which includes an insurance brokerage division, will use the union with Chrysler to place coverage for both the **DaimlerChrysler** group and to other commercial clients. **Debis** will change its name to **DaimlerChrysler Services (debis) A.G.** and handle commercial and personal lines insurance business, according to Executive Director **Klaus Mangold**.

debis will place coverage on behalf of Chrysler but would not comment on how much of the U.S. automaker's insurance needs it will handle.

In Germany, **debis** also provides mobile telecommunications and information technology services to **Daimler Benz** and other companies. By its own report, the insurance brokerage division—**debis Assekuranz Makler**—is Germany's third-largest commercial insurance brokerage, behind **Marsh & McLennan Cos. Inc.** unit **Gradmann & Holler GmbH** and **Aon Jauch & Huebener**, with a premium volume of 1.03 billion deutsche marks (\$572.9 million). Revenues rose 16% last year, reaching 119 million

deutsche marks (\$66.2 million). **Debis** derives 60% of its business from industrial clients, 20% from **Daimler's** own insurance business and 20% from private clients.

Daimler Benz's insurance brokerage has expanded worldwide since its launch in 1990. Beginning as a captive broker for **Daimler**, **debis Assekuranz Makler** expanded services to outside companies, offering coverage placement and consulting services. Clients include companies in the petroleum industry, automobile dealers and public entities.

Previous expansion has focused on Western Europe. In France, **debis** last year acquired majority holdings in the industrial insurer **Theoreme S.A.**, in which it has had a stake since 1994. In Switzerland, it has a cooperative agreement with **GWP Insurance Brokers** in Lucerne. In Germany, **debis** acquired two specialty brokers, **Muenster-based Hans Silkenbaeumer OhG & Industrie** and **Handelsassekuranz GmbH** in Koblenz.

Deutsche Bank is **Daimler Benz's** largest shareholder, with a 21.8% stake in the company. After the merger, **Deutsche Bank's** holdings in **DaimlerChrysler** will fall under 13%.

In its recent business report, **debis A.G.** attributes most of its brokerage growth to commercial and industrial clients.

Britain solicits employer input on work health

By CAROLYN ALDRED

LONDON—Employers in Britain have until Dec. 11 to make their voices heard in setting the occupational health agenda for the next 10 years.

A discussion document published by the government-funded **Health and Safety Executive** urges employers and other interested parties to submit comments and suggestions on how to help the agency develop a 10-year occupational health strategy that "will make a real impact on preventing work-related ill health."

The strategy will link with government plans to boost the public health in general in the United Kingdom. Green papers, or consultative documents, published earlier this year included one titled "Our Healthier Nation," which looks at all aspects of public health, including health in the workplace. A pre-legislative white paper on public health is expected to be published later this year.

The HSE says its discussion document, "Developing an Occupational Health Strategy for Great Britain," is "about preparing a 10-year occupational health strategy that will help all those involved in preventing ill health caused by work to work together toward common aims and targets."

Although employers and the HSE have made considerable strides in improving health and safety at work during the last two decades, "many people are still made ill at work. A recent HSE survey suggests that over 2 million people (in the United Kingdom) are suffering from illness they thought was caused by work," the discussion document points out.

See Health on page 21

Euro

Continued from previous page

dom's position on the euro. The "knee jerk" approach is limited, Mr. Bates said. "It is based on waiting 'til it happens, then fixing it," he said. "There is no strategy involved."

The strategic approach is based on building a broad business strategy that incorporates the euro, Mr. Bates said.

U.K. insurers must "move away from a euro solution to a euro strategy" by developing some kind of vision for the future after U.K. entry into the euro, he said.

The first step will be for the insurance industry to develop internal systems to handle euro-denominated business, but Mr. Bates pointed out that the ultimate effects of the euro are unknown. The new currency may lead insurers to develop new products, distribution channels and information systems.

"What will the market be?" he asked. "What products, distribution and customers are likely after U.K. entry?"

Mr. Bates said there are no correct answers to these questions, except that there is likely to be more commonality and transparency across all European markets.

The answers depend on the structure of individual companies and how they want to be placed in certain markets, he said.

Royal & Sun Alliance is combining a reactive and strategic approach to the euro.

"We need to operate from Jan. 1, but that hasn't stopped us (from) thinking longer-term," Mr. Bates said.

He said RSA has initiated reactive work for Jan. 1 and will have the processes to transact in euros for European customers.

But the company also has initiated research into what effort will be required to convert existing U.K. systems to handle the United Kingdom joining the euro. RSA also has started "the visionary process to identify

where we want to be after U.K. entry," Mr. Bates said.

He said details of RSA's euro programs are commercially sensitive, and he did not disclose them.

"Our approach is to try and stay ahead of the game," Mr. Bates said. "We are taking steps along the way now to get there, rather than lots of little steps later."

Lloyd's of London also is taking a proactive approach to the introduction of the euro. "Lloyd's will be ready," said Andrew Stalker, Lloyd's euro program manager.

He said Lloyd's is making "planning assumptions" based on the Unit-

'We need to operate from Jan. 1, but that hasn't stopped us from thinking longer term,' says Ian Bates.

ed Kingdom eventually joining the euro. That would mean all U.K. insurance contracts and accounting would be done in the new single currency.

However, the current focus is on the impact arising from the euro's initial introduction Jan. 1, 1999.

Lloyd's has adopted the euro as only its fourth claims payment currency. The others are sterling, U.S. dollars and Canadian dollars.

Mr. Stalker expects a switch to euro-denominated policies from two main areas: Eastern European policies, which now are mostly denominated in U.S. dollars; and multinationals such as Japanese exporters, which currently insure exports into Europe in U.S. dollars.

Mr. Stalker said Lloyd's adoption of the euro is a "signal to the market that we are serious about doing business in Europe."

He said that the euro's impact on the insurance industry will be client-driven. "If (buyers) come to us and our brokers and want to convert (to euros), we will be there to provide the service." **BI**

Euro likely to influence insurers even if U.K. doesn't participate

By MATTHEW MacDERMOTT

LONDON—Whether or not the United Kingdom decides to participate in the single European currency, the U.K. insurance industry will be affected and must start preparing for the buyer-driven changes that will follow its introduction.

That was the clear message from a one-day conference—The Practical Implications of the euro for the Insurance Industry—held in London last month.

Eleven European Union countries—Austria, Belgium, Finland, France, Germany, Ireland, Italy, Luxembourg, the Netherlands, Portugal and Spain—are committed to introducing a single European currency, the euro.

On Jan. 1, 1999, the conversion rates between the participating countries and the euro will be locked irrevocably.

The euro then will operate as an accounting unit for commercial contracts and transactions, in parallel with the 11 countries' existing currencies.

Beginning next year, insurance contracts may be denominated in euros rather than national currencies, if buyers so choose, even though the euro itself will not be available until 2001.

The final changeover to the euro, including the introduction of euro notes and coins, will take place Jan. 1, 2002.

The United Kingdom has not joined the euro but can join in the future if it wishes.

John Greenway, chairman of the U.K. government's All Parliamentary Group on Insurance and Financial Services, admitted there is a lot of uncertainty in the U.K. insurance industry regarding U.K. participation in the euro.

In the conference's keynote address, he summarized the U.K. government's position as follows:

"We are not committed to joining, but we can do so later if it is in our interests. ... We are keeping our options open."

Mr. Greenway said it follows that if the U.K. government is "hedging its bets" on joining the euro, U.K. insurers must do the same.

He said he believes potential U.K. entry into the euro is "still some way off" but that "the more pressing need is to position U.K.-based insurance business so as to take best advantage of the euro's introduction."

He predicted four main effects—driven by European insurance buyers—on U.K. insurers resulting from the euro's introduction.

• Dismantling of national currencies will lead to the opening up of insurance markets. Subsequently, insurance contracts across Europe will become more transparent, creating greater pres-

neutralize the impact of whether or not Britain decides to join."

Mr. Greenway said it is important for U.K. insurers to plan their business strategy—whether the U.K. is in or out of the euro—so they have the right structure that is in their best economic interests.

Janette Weir, head of political and economic research at the Assn. of British Insurers, agreed the euro will impact heavily on U.K. insurers' commercial business and investments in Europe. "There will be a big impact on commercial lines if European buyers want to do business in euros from day one," she said.

'We are not committed to joining (the euro), but we can do so later if it is in our interests.... We are keeping our options open,' says John Greenway.

sure on price and service levels.

• Premium, claim and benefit transactions will become euro-based for many European policyholders. Again, the increased transparency should increase competition and drive down prices.

• The euro's introduction will accelerate the process of insurance industry mergers, acquisitions and takeovers in Europe. There also will be big advances in cross-border electronic trading.

• There will be demand for new commercial insurance products and pensions denominated in euros.

Mr. Greenway suggested U.K. insurers adopt a three-point strategy for the introduction of the euro:

First, exploit the significant opportunities for new business that the euro's introduction presents.

Second, protect U.K. market share from any potential advantage that membership of the euro provides to competitor European insurers.

Third, and most difficult, pursue organizational structures that "make sense either way so as to

Therefore, U.K. insurers that want to compete seriously in Europe must be able to provide and transact euro-based products and services, Ms. Weir said. She also agreed that the euro's introduction will create more transparency in European insurance transactions and said U.K. insurers must be prepared to meet the competitive challenges.

As far as the United Kingdom joining the euro, it is difficult to say where the U.K. insurance industry should be, Ms. Weir said.

"It is a strategic issue, and insurers are considering their options about what needs to be done," she said. "Some insurers are doing detailed impact assessments, while some are keeping a strategic watching brief on the issue."

Ms. Weir said U.K. insurers must assume that the United Kingdom will join the euro at some time in the future. However, she concedes that insurers find it difficult to get money from their boards to plan for a changeover to the euro for a "U.K. in" scenario. "There is a lot of competition for board money, especially with Y2K, and there is no certainty with **BI**

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London market, Lloyd's collaborate on wording of euro-related clause

LONDON—The impending introduction of the euro has been the catalyst for the first joint contract wording clause for the London international insurance market.

The EMU (European Economic and Monetary Union) Continuity of Contract Clause, is the first time the London company market and Lloyd's of London have worked together on a contract clause wording.

Representatives of the London International Insurance & Reinsurance Market Assn. and the Lloyd's Non-Marine Assn. developed the wording.

The clause, which will be distributed to Lloyd's and company market underwriters under the

reference LMW 0001, reads:

"The introduction of the euro shall not have the effect of altering any term of this insurance contract or of discharging or excusing performance under this contract, nor give a party the right unilaterally to alter or terminate this insurance contract."

Pam Byrnes, LIRMA clauses subcommittee secretary, said the clause aims to resolve uncertainty regarding new insurance contracts that come into force after Jan. 1, 1999—the launch date of the euro.

In a circular distributed to LIRMA members, Ms. Byrnes said European Union legislation states the introduction of the euro shall neither affect contractual obliga-

tions nor give a party the right to terminate a contract.

This legislation is part of the law of all E.U. member states, whether they participate in the euro or not.

However, Ms. Byrnes said uncertainty exists for contracts governed by the law of non-E.U. members.

"Generally, it is accepted that continuity of contract will not be affected by the introduction of a new currency," Ms. Byrnes said. "However, there can be no absolute certainty that all jurisdictions will apply this principle."

Ms. Byrnes said the clause should be used at the "underwriters' discretion."

—By Matthew MacDermott

INTERNATIONAL

Equitas

Continued from page 19

However, Lloyd's Names expressed mixed feelings about the results.

The Lloyd's Names Assn., many of whose members suffered large losses during the years reinsured by Equitas, said it welcomed the improvement in Equitas' solvency margin in the latest accounts.

However, the LNA also warned of its fear that future claims could reach the point where Equitas might be forced to pay them on a proportional basis.

The LNA also said "it is surprising that the increase is not larger, given the surplus that was expected to arise from the unwinding of the double count."

Double counting arises out of the complex nature of some of the claims, causing them to be accounted for more than once in some syndicates' accounts.

The LNA said Equitas' surplus appears to be offset by a recognition that provisions for claims had been too

heavily discounted when the reinsurer was created. "Falling interest rates will continue to erode discounting and hence solvency margins," the LNA warned.

It was referring to a comment in Equitas' annual report that as a result of the fall in bond yields, the rate at which its claims liabilities are discounted to reflect anticipated yields on investments has been revised to 5.25% from 6.00% per year.

The LNA also said that with potential increases in asbestos and pollution claims, which make up about 50% of Equitas' claims portfolio, and the threat of the U.S. tobacco settlement unwinding, "Equitas will be likely to trigger proportional insolvency clauses early next century."

However, Mr. Crall said the group's solvency margin—the ratio of surplus to net outstanding liabilities—has improved and leaves Equitas in a position to meet obligations to stakeholders, including reinsured names.

He said the real message of the results is that "while at the outset one could have considered it a satisfactory result to hold our own and watch

the liabilities come down, the fact is that we've increased the surplus by 22%, and the solvency margin has improved from an initial 5.6% to 8.5%."

Commenting on suggestions that Equitas could someday be forced to pay claims on a proportional basis, Mr. Crall said: "As far as assurance that it will never happen, I don't think that we can do that any more than we could pick a date where we might pay a return premium. . . I would suggest that the fact that we have been in business for two years, the fact that the balance sheet is improving in strength and the fact that we have in that period of time gained both experience and confidence in handling the book of business is as reassuring to policyholders as it is to reinsured names."

Equitas Chairman David Newbigging also says in the annual report that further progress has been made in the current financial year and that "we have not encountered any major surprises nor have we identified any external event, trend or emerging issue that we believe would endanger the financial stability of Equitas."

Finance Director Jane Barker pointed out a declaration by directors in the Equitas annual report that they "believe that the assets should be sufficient to meet all liabilities in full." She said this statement, which Equitas is required to make each year, applies not just to the following year but to the foreseeable future. "If we believed, as the auditors have pointed out, that there were insufficient means, we could have to take action now," she added.

As anticipated, auditor Coopers & Lybrand again has qualified the accounts because of uncertainties as to the accuracy of provision for claims outstanding of £11.5 billion (\$19.35 billion at a current exchange rate), reinsurers' share of claims outstanding of £3.0 billion (\$5.05 billion at a current exchange rate) and reinsurance recoveries of £1.5 billion (\$2.52 billion at a current exchange rate).

Coopers & Lybrand said, "Further experience may show material adjustments are required to these amounts."

Ms. Barker gave two reasons she believes it is impossible to say when

the auditors will be able to approve Equitas' accounts without such a qualification. First, there is the fundamental uncertainty regarding the asbestos, pollution and health hazard claims, which make up some 50% of the reinsurer's claims portfolio.

"I can't tell you, only because I don't know, when we will get to the stage where we really think that fundamental uncertainty has been removed from Equitas," said Ms. Barker.

The second uncertainty arises out of the quality of data inherited by Equitas when it took over the liabilities of some 300 Lloyd's syndicates. From the start, it was acknowledged that Equitas faced difficulties reconciling the syndicates' different ways of accounting and thus of making sense of its liabilities. Ms. Barker said with time and money, this problem can be lessened.

Both Mr. Crall and Ms. Barker said there was no substance to rumors that circulated during the summer that Equitas was in talks that could lead to it being acquired. No such talks have taken place, they said. **BI**

Fund may allow lawyers to opt out of indemnity pool

By CAROLYN ALDRED

LONDON—British law firms soon may be allowed to take greater control of their professional liability risk financing.

The Law Society of England & Wales is exploring the option of allowing law firms to directly purchase their primary professional liability insurance from the commercial insurance market.

Currently, all law firms operating in England and Wales must purchase coverage of £1 million (\$1.7 million) per loss from the Solicitors Indemnity Fund, a mutual fund set up by the society in 1987. However, huge losses and rate increases in recent years have led to steep increases in premiums paid to the fund.

Law firms with effective risk management and few claims have argued they are subsidizing companies with poor track records. Many law firms, particularly larger ones, have sought to have the choice of directly accessing the commercial market or self-insuring (*BI*, Jan. 19).

A poll among the Law Society's members found that, while the majority of law firms would prefer to

stay with the SIF, a "significant and important minority, especially larger firms, opted for the commercial market option," a Law Society spokesman noted.

As a result, members of the Law Society's Council intend to appoint a committee, composed of senior lawyers and insurance experts, to examine whether the SIF could remain a viable pool if large members

'What the whole (legal) profession needs is realistic risk management,' says Trevor Moss.

were allowed to leave and seek coverage elsewhere, the spokesman said. A final decision will be made in January.

Whatever the outcome, the Council has agreed to a strategy to introduce "far tougher controls to deal with those firms which have poor claims records. This will range from

helping firms to develop better management systems to withdrawing indemnity cover altogether if no improvement is made within a specified timescale," according to a statement released by the Law Society after the Council meeting.

Better risk management is a crucial factor underpinning the legal profession's future insurance arrangements, the Law Society spokesman noted.

Currently, the SIF has no authority to deny coverage for firms that are poor risks. As a result, there "are some firms with appalling claims records that can still get cover," the spokesman said. However, he noted that, whatever the final decision about allowing firms to exit the pool, the SIF will be given the authority to refuse coverage if firms do not improve their risk management in the same way that commercial insurers can refuse to underwrite poor risks.

Meanwhile, Elizabeth Mullins, the SIF's managing director, pointed out that while the idea of the SIF operating alongside commercial insurers appears an attractive option, several obstacles stand in the way.

For example, because the SIF sets

its premiums in advance, "it would be very easy for insurers, once they know the SIF rates, to offer more attractive premiums to those firms who present the better risks," she said.

As a result, "attractive risks would transfer to the market, and there would be a danger of SIF being the dumping ground for the firms which were far less attractive to insurers," said Ms. Mullins.

"Even the prospect of SIF being allowed to remove cover from the very worst risks and a requirement being imposed on the market to share equitably the funding of any assigned risk pool would not eliminate the problem for SIF of losing the balancing effect of the very best risks. It is this that would damage the SIF's cost-effectiveness, even for the average firms," she explained.

Despite those concerns, SIF Chairman Peter Williamson recognizes that a significant number of law firms remain in favor of the open market.

"We must continue to seek ways in which a reformed SIF can be more attractive to the entire profession. Over the coming months, we will

work with groups opposed to SIF to find out to what extent their concerns can be overcome," said Mr. Williamson.

Professional indemnity broker Trevor Moss, a director of Nelson Hurst & Marsh Ltd., called the Council's decision a "step in the right direction."

Mr. Moss, who co-authored a report earlier this year calling for law firms to be given the right to buy primary coverage from the commercial market (*BI*, March 30), believes that the largest law firms will increasingly turn to self-insurance, captives and alternative risk transfer mechanisms, as well as the traditional market, if no longer required to buy primary insurance from SIF.

He also agrees that law firms must beef up their risk management.

"What the whole profession needs is realistic risk management," he said, adding that this likely will increase if law firms are able to use commercial insurers or self-insurance.

"The history of the SIF and risk management is not good," said Mr. Moss, pointing out that, for example, commercial insurers writing excess insurance for law firms have taken "a lot of time and effort scrutinizing firms' exposure to the Year 2000, which SIF has not done." **BI**

Health

Continued from page 19

The main categories of illness reported were musculoskeletal conditions—with an estimated 1.2 million people affected—and stress, with an estimated 500,000 people affected.

Among the factors identified by the HSE contributing to people still being made ill by work was a lack of management accountability. "Although there is a clear focus on prevention of risk via management, real progress will only be achieved if managers are held accountable," the document said. It notes that small employers, in particular, do not recognize their role in managing health and safety and controlling health risks.

Meanwhile, occupational health issues such as back pain and stress often lack the immediacy of safety issues because the illnesses have long latency periods and often have no agreed-upon diagnostic criteria, as well as possible additional causes related to home or leisure.

And where employers do make risk assessments, many "still fail to identify important health risks and expend energy on lesser issues," the

document says, adding that "employers spread their efforts too thinly without really resolving any particular issue."

The HSE proposes seven goals to improve occupational health in the next decade. The goals, designed for the HSE, employers, insurers and any other parties that have an interest in health and safety, aim to:

- Put in place suitable procedures, systems and campaigns to address occupational health issues both now and in the future. For employers, this would mean ensuring that occupational health is recognized as an integral part of management and that managers are held accountable for preventing ill health caused by work.

- Decide which occupational health issues should be targeted for action.

- Develop relevant advice on occupational health to help employers control the targeted health risks.

- Collect and make available essential occupational health information, which may involve employers, insurers and other organizations sharing data and working together.

- Raise awareness of occupational health and make training and education on occupational health avail-

able to everyone.

- Provide systems to assess the effectiveness of actions taken.

- Gain commitment from all interested parties. This could be done, for example, by providing financial or other incentives to companies that showed improved occupational health.

Setting a 10-year strategy also must take into account changes that will inevitably occur in the workplace and that will affect occupational health, the document notes.

For example, in the last two decades, there "has been a large decrease in the number of people employed in manufacturing, and in the future the number of manufacturing jobs is likely to continue falling," the HSE predicts.

Also, "considerable downsizing in some organizations" may lead to an increase in uncertainty and longer working hours for the remaining employees, it notes.

The number of people in part-time work and in self-employment is likely to continue to increase in the next 10 years, along with the number of small companies. The HSE's data suggests that "the self-employed are more likely to have accidents than employees (and) the risk

of fatal or serious injury is greater in small workplaces"; this could mean that these are high-risk groups if a similar trend exists for work-related ill health, according to the document.

Labor market changes, such as an older workforce; more women, including more pregnant women and mothers; and "multiskilling," with people changing jobs more often, also will affect occupational health, the HSE points out.

The rate at which new technologies reach the market also could affect whether health risks can be identified early enough.

Meanwhile, public concern and expectations of health and safety standards will continue to grow, while increasing litigation likely will raise the profile of many occupational health risks, the HSE observes.

Copies of the discussion document, which includes a questionnaire for employers and other interested parties to complete, can be obtained from Dr. Elizabeth Gibby, Health and Safety Executive, Room 717 Rose Court, 2 Southwark Bridge, London SE1 9HS. Comments should be returned by Dec. 11.

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SOUTHERN DISTRICT OF NEW YORK
IN RE PETITION OF DAN YORAM SCHWARZMANN AND
COLIN GRAHAM BIRD, AS JOINT PROVISIONAL LIQUIDATORS OF
BLACK SEA AND BALTIC GENERAL INSURANCE COMPANY LIMITED,
CASE NO. 98-B-46759 (CB)

NOTICE IS HEREBY GIVEN THAT IN CONNECTION WITH THE PETITION FILED PURSUANT TO SECTION 304 OF THE BANKRUPTCY CODE WITH RESPECT TO BLACK SEA AND BALTIC GENERAL INSURANCE COMPANY LIMITED (THE "COMPANY"), THE UNITED STATES BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK (THE "BANKRUPTCY COURT") HAS ENTERED A PRELIMINARY INJUNCTION ORDER DATED OCTOBER 5, 1998 (THE "ORDER"):

(1) ENJOINING ALL PERSONS AND ENTITIES FROM: (A) TRANSFERRING, RELINQUISHING OR DISPOSING OF ANY PROPERTY OF THE COMPANY IN THE UNITED STATES, OR THE PROCEEDS OF SUCH PROPERTY, TO THIRD PARTIES; (B) COMMENCING OR CONTINUING ANY ACTION OR OTHER LEGAL PROCEEDING (INCLUDING, WITHOUT LIMITATION, ARBITRATION OR ANY JUDICIAL, QUASI-JUDICIAL, ADMINISTRATIVE OR REGULATORY ACTION, PROCEEDING OR PROCESS WHATSOEVER) AGAINST THE COMPANY, OR ANY PROPERTY IN THE UNITED STATES THAT IS INVOLVED IN THE FOREIGN PROCEEDING, OR ANY PROCEEDS THEREOF, AND SEEKING DISCOVERY OF ANY NATURE AGAINST THE COMPANY; (C) ENFORCING ANY JUDICIAL, QUASI-JUDICIAL, ADMINISTRATIVE OR REGULATORY JUDGMENT, ASSESSMENT OR ORDER OR ARBITRATION AWARD AGAINST THE COMPANY, AND COMMENCING OR CONTINUING ANY ACT OR ACTION OR OTHER LEGAL PROCEEDING (INCLUDING, WITHOUT LIMITATION, ARBITRATION OR ANY JUDICIAL, QUASI-JUDICIAL, ADMINISTRATIVE OR REGULATORY ACTION, PROCEEDING OR PROCESS WHATSOEVER) TO CREATE, PERFECT OR ENFORCE ANY LIEN, SETOFF OR OTHER CLAIM AGAINST THE COMPANY, OR ANY OF ITS PROPERTY IN THE UNITED STATES, OR ANY PROCEEDS THEREOF, INCLUDING, WITHOUT LIMITATION, RIGHTS UNDER REINSURANCE OR RETROCESSION CONTRACTS; AND (D) DRAWING DOWN ANY LETTER OF CREDIT ESTABLISHED BY, ON BEHALF OR AT THE REQUEST OF, THE COMPANY, OR WITHDRAWING FROM, SETTING OFF AGAINST, OR OTHERWISE APPLYING PROPERTY THAT IS THE SUBJECT OF ANY TRUST OR ESCROW AGREEMENT OR SIMILAR ARRANGEMENT IN EXCESS OF AMOUNTS EXPRESSLY AUTHORIZED BY THE TERMS OF THE CONTRACT AND ANY RELATED TRUST OR OTHER AGREEMENT PURSUANT TO WHICH SUCH LETTER OF CREDIT, TRUST, ESCROW, OR SIMILAR ARRANGEMENT HAS BEEN ESTABLISHED, EXCEPT, HOWEVER, NO DRAWING AGAINST ANY LETTER OF CREDIT SHALL BE MADE IN CONNECTION WITH ANY COMMUTATION UNLESS THE AMOUNT HAS BEEN AGREED IN WRITING WITH THE PETITIONERS OR PERMITTED BY FURTHER ORDER OF THE COURT;

(2) REQUIRING ALL PERSONS AND ENTITIES IN THE POSSESSION, CUSTODY OR CONTROL OF PROPERTY OF THE COMPANY IN THE UNITED STATES, OR THE PROCEEDS THEREOF, TO TURN OVER AND ACCOUNT FOR SUCH PROPERTY OR ITS PROCEEDS TO THE PETITIONERS;

(3) REQUIRING ALL PERSONS AND ENTITIES THAT ARE BENEFICIARIES OF LETTERS OF CREDIT ESTABLISHED BY, ON BEHALF OR AT THE REQUEST OF, THE COMPANY OR PARTIES TO ANY TRUST, ESCROW OR SIMILAR AGREEMENT IN WHICH THE COMPANY HAS AN INTEREST, TO: (A) PROVIDE NOTICE TO PETITIONERS' UNITED STATES COUNSEL OF ANY DRAWDOWN ON ANY LETTER OF CREDIT ESTABLISHED BY, ON BEHALF OR AT THE REQUEST OF, THE COMPANY, OR ANY WITHDRAWAL FROM, SETOFF AGAINST, OR OTHER APPLICATION OF PROPERTY THAT IS THE SUBJECT OF ANY TRUST OR ESCROW AGREEMENT OR SIMILAR ARRANGEMENT IN WHICH THE COMPANY HAS AN INTEREST, TOGETHER WITH INFORMATION SUFFICIENT TO PERMIT THE PETITIONERS TO ASSESS THE PROPRIETY OF SUCH DRAWDOWN, WITHDRAWAL, SETOFF OR OTHER APPLICATION, INCLUDING, WITHOUT LIMITATION, THE DATE AND AMOUNT OF SUCH DRAWDOWN, WITHDRAWAL, SETOFF OR OTHER APPLICATION AND A COPY OF ANY CONTRACT, RELATED TRUST OR OTHER AGREEMENT PURSUANT TO WHICH SUCH DRAWDOWN, WITHDRAWAL, SETOFF OR OTHER APPLICATION WAS MADE, AND PROVIDE SUCH NOTICE AND OTHER INFORMATION CONTEMPORANEOUSLY THEREWITH; AND, (B) TURN OVER AND ACCOUNT TO THE PETITIONERS FOR ALL FUNDS RESULTING FROM SUCH DRAWDOWN, WITHDRAWAL, SETOFF, OR OTHER APPLICATION, IN EXCESS OF AMOUNTS EXPRESSLY AUTHORIZED BY THE TERMS OF THE CONTRACT, ANY RELATED TRUST OR OTHER AGREEMENT PURSUANT TO WHICH SUCH LETTER OF CREDIT, TRUST, ESCROW OR SIMILAR ARRANGEMENT HAS BEEN ESTABLISHED;

(4) REQUIRING EVERY PERSON AND ENTITY THAT HAS A CLAIM OF ANY NATURE OR SOURCE AGAINST THE COMPANY AND THAT IS A PARTY TO ANY ACTION OR OTHER LEGAL PROCEEDING (INCLUDING, WITHOUT LIMITATION, ARBITRATION OR ANY JUDICIAL, QUASI-JUDICIAL, ADMINISTRATIVE OR REGULATORY ACTION, PROCEEDING OR PROCESS WHATSOEVER) IN WHICH THE COMPANY IS OR WAS NAMED AS A PARTY, OR AS A RESULT OF WHICH A LIABILITY OF THE COMPANY MAY BE ESTABLISHED, TO PLACE THE PETITIONERS' UNITED STATES COUNSEL ON THE MASTER SERVICE LIST OF ANY SUCH ACTION OR OTHER LEGAL PROCEEDING, AND TO TAKE SUCH OTHER STEPS AS MAY BE NECESSARY TO ENSURE THAT SUCH COUNSEL RECEIVES (A) COPIES OF ANY AND ALL DOCUMENTS SERVED BY THE PARTIES TO SUCH ACTION OR OTHER LEGAL PROCEEDING OR ISSUED BY THE COURT, ARBITRATOR, ADMINISTRATOR, REGULATOR OR SIMILAR OFFICIAL HAVING JURISDICTION OVER SUCH ACTION OR LEGAL PROCEEDING, AND (B) ANY AND ALL CORRESPONDENCE, OR OTHER DOCUMENTS CIRCULATED TO PARTIES LISTED ON THE MASTER SERVICE LIST;

(5) PROVIDING, WITH RESPECT TO ANY CLAIM, ACTION, ARBITRATION OR OTHER PROCEEDING WHICH MAY BE COMMENCED OR BECOME KNOWN TO PETITIONERS IN THE FUTURE, OR THE ENTITLEMENT OR ALLEGED ENTITLEMENT OF ANY BENEFICIARY OF ANY LETTER OF CREDIT ESTABLISHED BY, ON BEHALF OR AT THE REQUEST OF, THE COMPANY, OR OF ANY PARTY TO ANY TRUST OR ESCROW AGREEMENT OR SIMILAR ARRANGEMENT IN WHICH THE COMPANY HAS AN INTEREST THAT IS IDENTIFIED BY THE PETITIONERS IN THE FUTURE (EACH A "SUBSEQUENT CLAIM"), THAT:

(A) WHEN INFORMED OF A SUBSEQUENT CLAIM, COUNSEL FOR PETITIONERS SHALL SERVE UPON THE HOLDER OF SUCH CLAIM A COPY OF THE SUMMONS, PETITION, AND THE MOST RECENT INJUNCTION ORDER ENTERED BY THE COURT;

(B) THE HOLDER OF A SUBSEQUENT CLAIM WILL HAVE TWENTY (20) DAYS FROM SERVICE OF THE SUMMONS IN WHICH TO FILE AN ANSWER OR MOTION WITH RESPECT TO THE PETITION; AND

(C) ON NOT LESS THAN TWO (2) DAYS NOTICE TO COUNSEL FOR THE PETITIONERS, THE HOLDER OF A SUBSEQUENT CLAIM MAY FILE A MOTION SEEKING AN ORDER OF THE COURT VACATING OR MODIFYING WITH RESPECT TO SUCH SUBSEQUENT CLAIM THE INJUNCTION ENTERED IN THIS PROCEEDING. SUCH REQUEST SHALL BE THE SUBJECT MATTER OF A HEARING AS SCHEDULED BY THE COURT. OTHERWISE, THE HOLDER OF A SUBSEQUENT CLAIM MAY FILE OBJECTIONS AND BE HEARD BY THE COURT IN ACCORDANCE WITH THE TERMS OF ANY ORDER OF THE COURT PROVIDING FOR A HEARING IN THE FUTURE ON THE RELIEF SOUGHT BY PETITIONERS IN THIS PROCEEDING; AND

(6) PROVIDING THAT NOTHING IN THE ORDER SHALL IN ANY RESPECT PREVENT THE COMMENCEMENT OR CONTINUATION OF PROCEEDINGS AGAINST ANY PERSON OR ENTITY OTHER THAN THE COMPANY; PROVIDED, HOWEVER, THAT IF ANY THIRD PARTY SHALL REACH A SETTLEMENT WITH, OR OBTAIN A JUDGMENT AGAINST, ANY PERSON OR ENTITY OTHER THAN THE COMPANY, SUCH SETTLEMENT OR JUDGMENT SHALL NOT BE BINDING ON OR ENFORCEABLE AGAINST THE COMPANY OR ITS PROPERTY.

THE ORDER SHALL REMAIN IN EFFECT PENDING A HEARING SCHEDULED TO BE HELD ON APRIL 21, 1999 AT 2:00 P.M. (THE "RETURN DATE") BEFORE THE HONORABLE CORNELIUS BLACKSHEAR, UNITED STATES BANKRUPTCY JUDGE, IN ROOM 601 OF THE ALEXANDER HAMILTON CUSTOM HOUSE, ONE BOWLING GREEN, NEW YORK, NEW YORK. ALL PAPERS SUBMITTED FOR THE PURPOSE OF OBJECTING TO CONTINUATION OF THE ORDER AFTER THE RETURN DATE SHALL BE FILED WITH THE BANKRUPTCY COURT, WITH A COPY TO THE CHAMBERS OF THE HONORABLE CORNELIUS BLACKSHEAR AND SERVED ON CHADBOURNE & PARKE LLP (ATTN: HOWARD SEIFE, ESQ.), SO AS TO BE RECEIVED AT LEAST FOURTEEN (14) DAYS PRIOR TO THE RETURN DATE.

ANY PARTY-IN-INTEREST THAT HAS NOT RECEIVED A COPY OF THE PETITION, SUPPORTING PAPERS AND/OR THE ORDER SHOULD CONTACT COUNSEL FOR THE PETITIONERS AT THE ADDRESS BELOW:

CHADBOURNE & PARKE LLP
ATTORNEYS FOR THE PETITIONERS
30 ROCKEFELLER PLAZA
NEW YORK, NEW YORK 10112
(212) 408-5100

ATTN: HOWARD SEIFE, ESQ.
LISA DORR, ESQ.

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BPA Publisher's Statement

Charged

Continued from page 2
held without bail, according to the court clerk's office.

Mr. Charge's court-appointed lawyer could not be reached.

Mr. Nellmapius, who operated London-based companies in the early 1990s, has not been arrested and has no lawyer representing him. He could not be reached.

Mr. Charge is no stranger to controversy: He was identified in 1991 Senate subcommittee hearings on insurance fraud as one of two men who tried to obtain a Delaware license for the now-defunct Victoria Insurance Co. Victoria was later licensed in Georgia and was managed by the late insurance swindler Alan Teale.

At the time of his arrest, Mr. Charge was operating Colonnade Insurance Co. A.V.V. of Aruba, which wrote stop-loss coverage for a California health plan that the U.S. Department of Labor shut down in August (BI, Aug. 17). The Labor Department

charged that Colonnade is "not financially secure."

Federal prosecutors obtained their indictment of Mr. Charge and Mr. Nellmapius last year, but the indictment remained under seal until Mr. Charge's arrest.

Prosecutors accuse the two men of conspiring to manufacture a series of bogus West Point financial statements over a two-year period during which the insurer defrauded commercial trucking and automobile policyholders of \$22 million.

When regulators questioned a particular financial statement's valueless assets, the two men would produce a revised statement showing new assets that likewise proved worthless, the indictment says.

Mr. Charge obtained a number of these assets from Buckingham Gardner Management Ltd., a London-based company that owned holdings in several purported Africa-based businesses, according to the indictment.

Buckingham Gardner's main holding was in African Resources P.L.C., a

U.K. corporation of which Mr. Nellmapius was chief executive officer, documents show. African Resources in turn owned interests in other companies, including Luxembourg Estates Co. and Sierra Leone Resources P.L.C.

None of Buckingham Gardner's holdings had any market value, the indictment alleges. Sierra Leone Resources, for example, owned rights to mine an undeveloped bauxite deposit at Port Loko, Sierra Leone, a project that would have required at least \$100 million in start-up capital, the indictment notes.

Between July 1991 and February 1993, West Point paid Buckingham Gardner about \$1.4 million for the use of these assets, prosecutors say.

In an initial fraudulent financial statement in 1991, Messrs. Charge and Nellmapius falsely reported that West Point owned a Florida Keys resort property worth more than \$15 million, prosecutors charge.

Within six months, they had produced two more phony financials in which the resort property was re-

placed by purported holdings in African Resources, Luxembourg Estates and Sierra Leone Resources, according to the indictment. West Point also claimed to own a stake in Continental American Industries Inc., a company the insurer had unsuccessfully negotiated to buy and did not in fact own, the indictment charges.

James E. Charge and John L. Nellmapius are charged with conspiring to manufacture a series of bogus financial statements.

West Point went on to generate two more false financial reports in 1992, one of which listed stock in a company called Anglo Resource & Technology Corp. that was purportedly worth \$20.3 million but actually was worthless; and the other of which falsely reported a \$21.4 million holding in

stock of a company called Intercell Corp., according to the indictment.

As part of the fraud, Messrs. Charge and Nellmapius conspired to pay an accountant "to subvert his professional judgment by falsely certifying four of the financial statements that West Point would submit to California," according to the indictment.

The indictment does not identify the accountant.

It also alleges that Mr. Charge made a series of false financial filings with the SEC for Indemnity Holdings, a company West Point had acquired. One of these filings reported that Indemnity Holdings owned stock in Luxembourg Estates and Sierra Leone Resources worth \$30 million, the indictment says.

Messrs. Charge and Nellmapius are charged in the indictment with one count of conspiracy and 19 counts of wire fraud. Mr. Charge is also named in 30 counts of money laundering, most of them based on West Point payments to Buckingham Gardner bank accounts for use of Buckingham Gardner's "assets." **BI**

Court

Continued from page 2

The question before the justices in the case is whether workers who claim to be disabled in order to collect Social Security disability payments can also pursue claims against employers under the Americans with Disabilities Act.

"It's a very important question and one that's coming up more and more frequently. It's very important to the employer community to get this issue resolved," said Carol Connor Flowe, a partner at the Washington law firm of Arent Fox Kintner Plotkin & Kahn.

Henry Saveth, an attorney with William M. Mercer Inc. in Washington, said: "If the Supreme Court knocks out the ADA protection for those people who are on disability, that would seem to go a long way toward resolving the question of whether the person is protected by the ADA. If they're not protected by the ADA, presumably they cannot sue."

The plaintiff, Carolyn Cleveland, suffered a stroke and applied for Social Security benefits. When her doctor told her she could return to work, she notified the Social Security Administration that she no longer needed the disability benefits.

She returned to work but had trou-

ble dealing with her job responsibilities and was fired. She refiled for Social Security disability benefits and, shortly before she received them, sued her former employer under the ADA.

A three-judge panel of the 5th U.S. Circuit Court of Appeals ruled against Ms. Cleveland in 1997, and the full appellate court refused to review that ruling, so Ms. Cleveland appealed.

"This case is very significant because the circuit courts are split on this issue. What's at stake is whether an employee or former employee who has applied for or who has received Social Security benefits can pursue an action against their employer or former employer under the ADA," said Elisabeth Snyder, legal consultant with Hewitt Associates L.L.C. in Lincolnshire, Ill.

"Employees can't have it both ways... In order to bring a claim under the ADA, employees must be qualified individuals with a disability, which means they are able to perform the essential functions of their job with or without accommodation. If they're a qualified individual, then they can't at the same time represent that they're disabled for purposes of Social Security benefits," said Sue Mahallati Kysela, labor and employment counsel with the National Chamber Litigation Center Inc. in Washington.

Hewitt's Ms. Snyder noted that some courts have held that someone who is permanently disabled under Social Security cannot perform a job, while others have held that the two definitions of disability under Social Security and ADA are different, so different standards apply, she said. "There isn't a set standard, and the lower courts have split on the issue."

The justices would provide some guidance for employers no matter

'It's very important to the employer community to get this issue resolved,' says Carol Connor Flowe.

which way they rule, Ms. Snyder said.

"These are difficult situations for people to be in, because to claim benefits under one statute, they may be reducing the likelihood of receiving benefits under the other. That's appropriate in most cases to prevent double dipping," said Quentin Riegel, deputy general counsel with the National Assn. of Manufacturers in Washington.

Ms. Flowe noted that the justices' decision in *Cleveland* may not be

their final word on the ADA during the current term. In an unusual move, the Supreme Court asked the U.S. solicitor general for comments on two ADA cases that the justices have neither accepted nor rejected, she said.

Both cases involve exactly how the ADA applies to individuals who—though suffering from a condition that constitute a disability—can be treated for that disability so it no longer interferes with their ability to perform a job. One case involves a would-be pilot who wears corrective lenses, the other a would-be delivery man with treatable hypertension. Both had been denied the jobs they sought because their untreated conditions did not meet company guidelines, though when treated, both fell within the guidelines for employment.

Ms. Flowe said the fact that the justices asked for the solicitor general's comments is significant because "it seems to me that more often than not, they end up taking them after asking," she said.

Employers and insurers that hoped the high court would use *State Farm Mutual Automobile Insurance Co. vs. the Honorable John Speroni, Tammy Snider and Michael Avery* to rein in class-action suits had their hopes dashed when the court declined to review the case.

The case stemmed from a provision

in personal automobile insurance policies that allows the insurer to require the use of parts made by non-original equipment manufacturers when adjusting damage claims. Two Illinois citizens sued in state court, holding that the provision violated the state's consumer anti-fraud law. They sought to maintain the suit as a class action on behalf of 5 million State Farm policyholders, even though the majority of those policyholders were not covered by Illinois law. An Illinois judge agreed to apply his state's law to the entire class.

"The denial of the cert. petition is a bit dangerous. It's dangerous for all businesses, because here you have a state court that has basically certified a class of claimants that include millions of claimants from out of state, so you have a state court that is going to render a decision under one particular state law that will impact policyholders around the country. The danger is that you're going to have a state trial court judge who will basically dictate what will happen across the nation," said Stef Zielezienski, senior counsel of the Washington-based American Insurance Assn.

"The denial of cert. in this case is significant to business to the extent that state courts will continue to certify class actions without regard to the laws of other states," said Ms. Kysela. **BI**

AIG

Continued from page 2

cycling operations with the potential for environmental problems, the lawsuit indicates.

But in its lawsuit, the plaintiff alleges AIG is denying it coverage under a pollution legal liability policy by claiming that tires are not pollutants, said Jordan Stanzler, a partner in the San Francisco office of Anderson Kill & Olic P.C. Mr. Stanzler represents Owens.

"I have not seen anything like this in terms of the specificity of the advertising and the irony of the tires," he said. "And they say tires are not a pollutant."

On the other hand, AIG also denied Owens coverage under a commercial general liability policy because the insurer claims tires are a pollutant, Mr. Stanzler said. The two policies were purchased simultaneously, as required by AIG, Mr. Stanzler added.

American International Specialty Lines Insurance Co. wrote the Pollution Legal Liability Select policy for Wenbury with limits of

\$1 million per incident and a \$1 million coverage section aggregate. Commerce & Industry Insurance Co. provided the CGL policy, with limits of \$2 million per occurrence and \$2 million aggregate, the lawsuit states. Both companies are units of AIG. AIG Technical

'An advertisement is an advertisement, while a policy is a contract between the insurer and the insured,' AIG says.

Services Inc., which provides claims services, also is named in the suit.

Further compounding the irony, tens of thousands of the very tires that ended up in the recycling site at which the insurer is denying cleanup coverage came from the dump photographed for AIG's advertisement, Mr. Stanzler said. The site pictured in the ad is not the site involved in the suit.

AIG, in its statement, said the

tire advertisement does not target tire recycling companies and that it does not address specific coverage provisions.

"An advertisement is an advertisement, while a policy is a contract between the insurer and the insured," AIG said in a statement. "The terms of the policy, not statements in an advertisement, determine coverage."

Owens tendered a claim under a CGL policy issued to Wenbury, and Owens was not a named policyholder and it "was not entitled to coverage," according to AIG. Additionally, the policy does not cover claims for injunctive relief and civil penalties, which were the basis for the tender, AIG says.

Owens' and Wenbury's claims under the pollution liability policy were denied for several reasons, according to AIG. Tires are not considered a pollutant, according to policy language. The policy is a claims-made form, and the claim was not reported until after the policy period's expiration, AIG says. Furthermore, the existence or moving of stored tires is not a pollution condition, and the policy is for a pollution condition.

The plaintiff disagrees. The CGL policy was issued with Wenbury as the policyholder, but Owens is listed as an additional insured, according to the lawsuit.

Owens' and Wenbury's relationship dates to January 1997, when Owens leased property in Merced, Calif., to Wenbury on the condition that Wenbury purchase insurance for the tire recycling operation it planned to operate there.

But Wenbury stopped operations not long after starting up when the California Integrated Waste Management Board in June 1997 issued a cleanup and abatement order for the Merced site. Orders were issued to Wenbury and Owens. Wenbury went out of business and thus abandoned the property, leaving Owens strapped with what it initially estimates as \$900,000 in cleanup and landfill fees for disposing of the tires.

Owens eventually was given until October to clean up the property, and it began notifying AIG last summer that it was seeking coverage. Owens claims in its lawsuit that AIG specifically promised that there was coverage for cleanup and removal of the tires in

the event that Wenbury abandoned the property.

Owens also sought coverage from United Capitol Insurance Co. United is named in the lawsuit and denied Owens coverage for several reasons. Those include that there is no claim for bodily injury or property damage and that the conditions cited by California authorities are not "pollution conditions," the lawsuit states.

United Capitol officials could not be reached.

United Capitol's specialized pollution policy was purchased by Wenbury after AIG declined to renew its policy for the Merced site, Mr. Stanzler said. The United policy has limits of \$1 million per occurrence and \$2 million aggregate.

Another defendant named in the lawsuit is W. Robert Stoker, a principal at Davis-Stoker Associates Insurance Services in Thousand Oaks, Calif. He placed Wenbury's coverage, according to the suit.

Mr. Stoker declined comment, saying he first would have to get approval from his errors and omissions insurer. **BI**

Pollution

Continued from page 1

Although Washington's Supreme Court is the first state high court that has found environmental liability claims may be covered by personal injury liability provisions in CGL policies, the 1st and 7th U.S. Circuit Courts of Appeal ruled similarly in the early 1990s.

The New York Court of Appeals, the only other state high court that has considered this coverage question in an environmental liability case, decided in 1994 that personal injury endorsements do not cover pollution-related property damage claims.

The Minnesota Supreme Court in January 1998 and the Nebraska Supreme Court in May 1995 also rejected policyholders' attempts to trigger the personal injury provisions of their CGL policies to cover third-party claims of trespassing. But, those cases did not involve third-party environmental liability claims.

Several lower courts have ruled that personal injury provisions cannot apply to environmental contamination claims, the defendant insurers also argued. But, the Washington Supreme Court refused to consider those decisions. The court observed that many of the personal injury provisions at issue in those cases were far more restrictive than the provisions in the policies in the case the court reviewed.

The case before Washington's high court centered on whether the pollution-related trespassing and nuisance claims that property owners filed against Kitsap County, Wash., amounted to covered personal injuries under the primary and excess general liability policies that 19 insurers wrote for the county over 30 years.

Washington's high court equated the property owners' trespassing and nuisance claims to covered acts of "wrongful entry" and "other invasion of the right of private occupancy" that were enumerated in some of the county's insurance policies.

The decision does not mean, however, that Kitsap County's insurers now must indemnify the county under the personal injury provisions of its CGL policies. Insurers at a later coverage trial could raise other defenses to coverage.

For nearly two years, U.S. District Court Judge Rothstein has stayed a trial in the case for various reasons. Among those was to give the county and its insurers an opportunity to settle their dispute.

The decision is "obviously a big disappointment" for insurers, but there are bright spots, said insurer attorney Laura Foggan, who filed an amicus brief in the case on be-

half of the insurer-sponsored Insurance Environmental Litigation Assn. Among those bright spots is that the insurers in the case still can argue other defenses at trial, said Ms. Foggan, a partner with Wiley Rein & Fielding in Washington, D.C.

Ms. Foggan also said that other courts nationwide likely would not be influenced by a decision from a court with what she called extreme pro-policyholder leanings.

In addition, many lower courts nationwide have recognized that attempts to tap CGL policy limits under personal injury provisions are "a back-door effort" to trigger policies that insurers never in-

surance concepts, explained policyholder attorney William Greaney, a partner with Covington & Burling in Washington, D.C.

Therefore, in cases that involve either offsite migration of pollution or the contamination of landfills not owned by the policyholder, policyholders could argue that cleanup orders issued under federal and equivalent state cleanup laws amount to claims for trespass and nuisance, he said.

If the cleanup orders are worded broadly, "I'd make that argument," said policyholder attorney Edward M. Joyce, a partner with Anderson, Kill & Olick P.C. in New York.

The decision also will be helpful

Washington's high court equated the property owners' trespassing and nuisance claims to covered acts of 'wrongful entry' and 'other invasions of the right of private occupancy.'

tended to respond, she said.

Insurer attorney Curt Feig, who represented Home Indemnity Co. in the case, agreed that the Washington high court's influence on other courts will be limited because the decision "is out on the fringe." Insurers never intended to cover environmental liabilities under personal injury provisions, said Mr. Feig, a partner with Cozen & O'Connor P.C. in Seattle.

But, insurer attorney Michael J. Bond, who represents Transamerica Insurance Co. in the litigation, predicted the court's decision would have "a broad impact across the country." He, as well as policyholder attorneys, said the court "is seen as a leader on these issues."

He predicted, though, that the decision's impact would be limited to private-party lawsuits against polluters. "Any municipality sued by people who live next to a landfill will be very encouraged by this decision," said Mr. Bond, a partner with Gardner Bond Trabolsi McDonald & Clement P.L.L.C. in Seattle.

Some policyholder attorneys disagreed. They said the decision could be helpful to policyholders seeking indemnification for the cost of government-ordered cleanups in jurisdictions where courts have ruled either that those costs are not covered damages or that pollution exclusions bar recovery for those costs.

That is because the federal Comprehensive Environmental Response, Compensation and Liability Act, also known as the Superfund Act, is rooted to an extent in common-law trespass and nuisance

concepts, explained policyholder attorney William Greaney, a partner with Covington & Burling in Washington, D.C.

Until 1996, CGL policies did not explicitly apply the absolute pollution exclusion to personal injury coverage—a deliberate decision by the Insurance Services Office Inc., Mr. Horkovich said. That is important in light of an observation on pollution exclusions that Washington's high court included in its decision, he said. The court noted that insurers could have avoided the pollution exclusion dispute by explicitly applying the exclusion to personal injury coverage.

Mr. Horkovich also disagreed with the notion that the court's decision is "on the fringe" and therefore other courts would not follow it. He pointed out that the court has not been nearly as critical of insurers as the high courts in New Jersey and Georgia have been. Those courts have accused the industry of duping regulators when obtaining approval of the sudden and accidental pollution exclusion, he pointed out.

The Washington case stems from three lawsuits filed against Kitsap County in 1993. Two lawsuits were filed by current and former residents of a mobile home park that was built partially on a waste disposal site the county formerly owned. Also near the park was a landfill where the county had dumped hazardous waste. The mobile home park's owner and other commercial building owners also sued.

The plaintiffs sought to recover

bodily injury and property damages caused by environmental problems that they argued the county created.

But, importantly, the causes of action the plaintiffs argued were for trespass and nuisance.

Kitsap County eventually settled with the plaintiffs and then sought third-party property damage coverage from its insurers. The insurers denied coverage, and the county sued.

After U.S. District Judge Barbara Jacobs Rothstein in Seattle ruled for the insurers in a summary judgment, the county sued the insurers for coverage under the personal injury provisions of the county's policies.

The insurers wrote 23 primary and excess policies for the county from the late 1950s through 1985, according to court documents and Mr. Bond, one of the insurer attorneys involved in the case. The policies provided the county more than \$90 million in coverage over that period, Mr. Bond said. But, not all of the policies contained personal injury liability provisions, and some restricted such coverage to wrongful eviction, he said.

The federal district court asked the state high court for a ruling on whether the property owners' claims against Kitsap County constituted personal injuries.

In a decision written by Justice Gerry L. Alexander, the Washington Supreme Court noted that it squarely disagreed with the New York high court's 1994 decision in favor of insurers.

The Washington high court first rejected the insurers' argument that coverage is barred under Kitsap County's policies because "the essential character" of the property owners' claims against the county governs coverage.

The insurers argued that the property owners essentially sought damages for bodily injuries and property damage caused by their exposure to pollution but that many of the policies exclude such coverage.

The court instead found that coverage is governed by the nature of the offense that the property owners alleged against the county. If those alleged offenses are analogous to covered acts under the personal injury provisions, then the provisions provide coverage, subject to other policy exclusions, the court ruled.

The court then equated the property owners' claims of trespass and nuisance with the covered acts of wrongful entry and other invasion of the right of privacy. That finding was significant, because Kitsap County's policies do not specifically identify trespassing and the other claims as covered acts under the personal injury liability provisions.

The high court also rejected the insurers' argument that the wrongful entry and other invasion coverage is triggered only when a policyholder acted in its role as a landlord to withhold possession of property from another party. The court said such a relationship is unnecessary.

In addition, the court rejected the insurers' argument that the personal injury provisions cover only intentional acts or offenses.

Moreover, the court found that some of the insurers may have provided the county overlapping coverage. The court's finding means that all of the limits of even policies with sublimits for personal injury claims may have to respond to the claims against Kitsap County, according to Mr. Bond.

The court, though, did side with insurers in ruling that the property owners' claims against the county did not constitute wrongful eviction, another act covered by some of the county's personal injury provisions.

However, most personal injury provisions cover wrongful entry of property, which means there is environmental liability coverage under most policies, said Mr. Horkovich, the policyholder attorney with Anderson Kill.

The court did not rule on whether the pollution exclusions in some of Kitsap County's policies barred coverage for personal injury claims. But, the court telegraphed it does not support insurers' argument that the exclusions bar coverage for all environmental liability claims, many attorneys agreed.

For example, the court noted that the fact that only some insurers explicitly made their pollution exclusions applicable to personal injury claims "furnishes a strong argument for the point that this issue could easily have been removed from the case by all of the insurers had they chosen to do so."

The court also noted an opposing view to the insurers' argument that their pollution exclusions would be "read out" of the CGL policies if a court finds there is environmental liability coverage under personal injury liability provisions. The court said that argument "could be viewed as an undertaking by the insurers to read the personal injury provision out of the policies."

Mr. Feig, Home Indemnity's attorney, said that language, while not precedential, has "got to" send a message to the trial court.

But, Mr. Bond, Transamerica's attorney, said the court's language did not trouble him because the court ultimately did not rule on the issue.

Kitsap County vs. Allstate Insurance Co. et al., Washington State Supreme Court; No. 65601-1.

For the Record

Judge tosses suit based on tester program

CHICAGO—A controversial Equal Employment Opportunity Commission program using different job applicants with similar backgrounds as decoys to detect hiring discrimination is under attack on two fronts.

A federal court judge in Chicago last month dismissed a discrimination lawsuit against Guardian Security Services Inc. of Blue Island, Ill., because the lawsuit was based on that investigative technique. The judge ruled that the two African-American college students acting as "testers" in seeking a receptionist job did not have

sufficient standing for the Legal Assistance Foundation of Chicago to sue on their behalf for racial discrimination.

However, the foundation as of late last week had not decided whether to appeal, said attorney Timothy Huizenga.

The testing program also is under attack in Washington. Criticism from Republicans in Congress was one reason the EEOC recently decided to cut funding for the testing program in its coming fiscal year's budget, an EEOC spokesman in Washington said.

The EEOC late last year announced the program, in which testers differ only with regard to the characteristic being tested: race, gender, national origin, age or disability. Tester pairs apply for entry-level jobs, and their treatment by the prospective employ-

er is compared. In cases of unequal treatment, other pairs may be sent in to determine if there is a pattern of discriminatory conduct, according to the EEOC.

California city covered for damage from burst

WESTMINSTER, Calif.—The City of Westminster has insurance coverage for damage to a condominium complex that resulted last month when 5 million gallons of water burst out of a municipal storage tank.

The total damage amount still was not known last week, but it is expected to run into the millions of dollars, a city spokeswoman said. Several people were left homeless and six were injured when a 6-foot wave

of water slammed into the condominiums, destroying 10 of them. Other units were damaged along with cars.

The city has a \$350,000 self-insured retention for property and liability damage, the city's spokeswoman said. Above the SIR, the city has coverage provided through a municipalities pool, Orange County Cities Risk Management Authority. OCCRMA provides coverage up to \$5 million per incident with a \$10 million annual aggregate limit.

Chairman has resigned at Crawford & Co.

ATLANTA—Dennis A. Smith has resigned as chairman of risk and insurance claims management services provider Crawford & Co.

The company announced that his duties would be split between two other Crawford executives.

Mr. Smith, who joined Atlanta-based Crawford in 1972, rose to become president and chief operating officer in 1994 and subsequently was given the additional duties of chairman and CEO. He submitted his resignation "unexpectedly" Sept. 28 to pursue other opportunities, a company spokesman said. No further information was available from Crawford.

Emerging from retirement to take the position of chairman and CEO was Forrest L. Minix, the company's chairman and CEO from 1988 through 1995. Another veteran of the company, Archie L. Meyers Jr., has become president and COO. There had been no COO under Mr. Smith.

Commentary

A voice of praise for telephone mail

I love voice mail systems, provided they are working properly, programmed efficiently and give callers the option of speaking to someone directly during normal business hours.

I found out last week, however, that I am in the minority, at least among those attending the 85th annual meeting at The Greenbrier of leaders of the commercial property/casualty insurance business.

Only about 30% of the audience raised their hands when asked by a speaker, First Union Corp. Chairman and Chief Executive Officer Edward E. Crutchfield, if they liked voice mail. He doesn't, and he made the point that "computers should not replace human contact."

Certainly, I must agree with that assertion in general, but there are circumstances under which I and, I suspect, many customers, prefer computers to human contact.

As an occasional movie-goer, for example, I find the voice mail system for purchasing movie tickets very efficient. It quickly tells me where the movie I want to see is playing. Or, if I prefer, I can punch in my ZIP code and learn what movies are available in my neighborhood when the daily paper isn't handy. And I can purchase the tickets early in the day that I want to go to the movies instead of having to arrive at the theater far in advance of show time to be sure of getting a seat. I happily pay the surcharge for this service.

I also was able to renew my Illinois drivers license this year by simply keying in answers as directed by a new automated telephone renewal system available to qualified drivers. I do not need the human contact of making a trip to a driver services office and standing in long lines.

When I am calling someone, whether for business or social reasons, I am not offended to hear a voice mail message, and I always say "yes" if I am asked if I would like the voice mail of someone who otherwise is

not available. I feel comfortable that the person I am trying to reach will receive my entire message, in my own words.

I also like the convenience of returning phone calls after business hours to people who need only a quick answer to a simple question.

But I think I know why so few people responded positively to Mr. Crutchfield's question. Too often, the systems are not working properly, they are programmed inefficiently and, worst of all, people are hiding behind them.

In my own office a few weeks ago, I was horrified to receive an e-mail when I logged on to my computer in the morning from someone who said she had tried to leave me a voice mail message but the system said the mailbox was full. I had only six saved messages at the time. It turns out that the voice mail system for the company that publishes *BI* was full at the time because employees had overloaded the system with too many saved messages. That will have been remedied by a system change by the time you read this.

I was also a bit miffed recently when I called to activate my new American Express card and had to hold for a customer representative when my Social Security number, as keyed into my telephone pad, was not accepted by the system. It wasn't too long a wait, but more than I had bargained for.

Some instructions on using an automated system are too complicated, such as when they offer too many options to callers. When I hear a message to the effect of, "We have upgraded our voice mail system to better serve you," I know this is going to be a case when I would prefer human contact.

Some people record long-winded voice mail greetings. A friend of mine opens her greeting by saying, "To skip this message, press the pound sign." I'm going to follow her good example when I record a new message this evening.

Worst of all, I think, is when a caller is bounced around from one voice mail greeting to another in a company during regular business hours. Are all those people really busy, or are some of them programming their phones to voice mail so they don't have to answer their phones? The ideal voice mail system would allow forwarding to voice mail only after regular business hours.

But given the choice between conducting simple transactions over the phone with an automated system or standing in lines, or the choice between dictating a truncated message to a harried assistant or leaving a complete voice mail, I'll take the computer over human contact.

Publisher and Editorial Director Kathryn J. McIntyre and Editor Paul D. Winston publish columns on alternate weeks.



Kathryn J. McIntyre

Quality

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growth of managed care has lowered health care costs well below projections made ten years ago.

Dr. Ellwood said that in 1988, health care costs rose 15% over the previous year, and in 1996, costs did not rise. Overall, managed care last year cut \$1 trillion, or about half, from a projection of \$2 trillion in 1997 health care costs, he said.

But how managed care accomplished this concerns him. The lower costs are not the result of better or more efficient medical practices but rather from forcing lower fees on doctors and limiting hospital visits.

The real challenge for today, Dr. Ellwood said, is to improve the quality of health care. Quality problems include too much care, too little care, and inappropriate care. For example, he cited studies showing that 10% of hysterectomies are unnecessary, as well as 20% of pacemakers. In addition, numerous cheap and effective treatments are not used, such as providing aspirin and beta blocker drugs for heart attack victims that could prevent 18,000 deaths each year, he said.

Added to this are the public's

dislike of managed care and doctors' hostility toward HMOs that limit their freedom while drawing out payment schedules for claims. Also, because most physicians belong to more than one managed care plan's network, there is no physician loyalty to plans.

Who can resolve the quality of care issue is of paramount importance, Dr. Ellwood said.

Employers in the past have not matched demands for lower prices with demands for higher quality, says Dr. Paul Ellwood.

Managed care plans won't do anything, he said, as they don't see a market advantage in offering the better-quality plan. Providers, to Dr. Ellwood's disappointment, also won't change the system, as there is no ground swell for tracking patients over a long time period to look at treatment outcomes.

Individuals also can't change the system. "You, as individuals, are powerless in this environment," he said, recounting his own experience as a patient in the health care system that left him feeling unable

to control his own treatment. The government also won't tackle the problem of quality, he said. This leads to employers to change the system. "I still think you're the best bet," he said.

To accomplish this, employers must change their ways, Dr. Ellwood said. In the past, employers haven't matched demands for lower prices with demands for higher quality, he said.

To address this, Dr. Ellwood recommends employers use the Foundation for Accountability system of health quality measures that arose out of the work of the Jackson Hole Group. FACCT, a group of private and public health care purchasers, consumers and community organizations, puts quality measures in a format that consumers can understand, allowing them to evaluate plans and choose. This creates competition among plans to demonstrate their quality or face losing enrollees. FACCT covers five areas that concern consumers: satisfaction with care, staying healthy, getting people healthy, living with illness, and caring for people when abilities change.

Filling in data for these areas is the next challenge, he said, noting that the best way is to ask patients directly to supply the data, as health plans often cannot provide the necessary information. **BI**

Health buyers must use power

Inaction might allow other interests to steer system: Speaker

By MICHAEL PRINCE

NASHVILLE, Tenn.—The U.S. health care system has undergone a revolution in which newly empowered employers must demand medical excellence, a consultant says.

The health care crisis today is not in rising costs but in limited resources, and employers must

address the question of "how to get the most value for your money," said Michael Millenson, a health care consultant and author.

In a speech challenging employers and employer coalitions to use their newfound power in the health care system, Mr. Millenson said health care purchasing can no longer be done on the basis of "cheap, cheap, cheap."

Mr. Millenson, a principal in the Chicago office of William M. Mercer Inc., spoke at the third annual conference of the National Business Coalition on Health. The conference was held in Nashville, Tenn., earlier this month.

The recent growth of managed care represents not a reform of the U.S. health care system, but a revolution. Power has shifted from health care providers to purchasers, he said.

Doing nothing with this power, however, is not an option, he said. The government, as the largest health care purchaser, cannot stand still and allow Medicare costs to skyrocket, as the public won't tolerate higher taxes or a return to budget deficits, he said. And businesses cannot allow health care costs to rise, driving them to drop coverage, squeeze their profits or move operations overseas.

"So, we can't give in," he summed up.

Also, employer inaction might allow other groups to jump in and

direct the health care system. These could include state and federal governments passing more laws covering health care quality, such as mandates. Lawyers also will step into the void with suits against both health plans and employers, allowing judges and juries to control the system, he cautioned.

"If we don't act, other people will," he said.

Mr. Millenson outlined three ways to control costs for any service: pay less, do less, or do things better. Paying less has been used to date to squeeze health care providers, but that can't continue forever, he said.

Doing less, such as through utilization review, has also been used with some success. But it has limits, as people have objected to reduced services and politicians have responded with mandates. Allocation of resources by managed care companies is more visible than it was in the past under traditional plans, and that has led to the current anger toward managed care, he said.

The only solution, he concludes, is to do things better. "This means making purchasing decisions based on quality and costs," he said.

Riding in to demand quality must be employers, he said. Doctors won't be the ones pushing quality and value, because that is not their tradition. But benefit managers, whom Mr. Millenson calls "bureaucrats as heroes," are trained for this approach. "In God we trust... all others bring data," is their motto, he said.

To date, however, most benefit managers have not looked to buy health care based on quality, focusing instead on costs.

Although many purchasers often say they buy based on the quality of health care, in reality, quality too often is defined as customer service and whether the chief executive officer's doctor is in the network.

But in the new health care crisis, this definition no longer

works, he said. Benefit managers are "not putting money where your mouth is," he said.

To truly purchase based on quality and value, employers need to reward providers that are "doing the right thing and doing it right," he said. This means rewarding through pay and/or bonuses those providers that successfully use preventive care to maintain people's health and keep them out of the doctor's office. Too often, he pointed out, those providers that accomplish this receive less money because they perform fewer services. But a system that financially rewards health maintenance and prevention will align providers' incentives with patients and buyers.

"Grab doctors by their wallets and their hearts and minds will follow," he explained.

One reason employers have yet to fully apply these ideas and transform the health care system is that senior executives don't see the reason to change their purchasing ways.

Mr. Millenson said benefit managers can do a better job at convincing senior management of the importance of a quality health plan. For example, benefit managers can demonstrate that prevention programs not only reduce illness but lower absenteeism, saving the company money.

A lot can be done to push the medical community toward better treatment, he said. For example, only half of doctors perform the test to detect ulcer-causing bacteria and thereby provide the proper treatment, he noted. And lost work days because of asthma among workers and their children could be reduced through proper treatment. So, an employer should push health plans to adopt preventive programs in these areas, which despite a higher initial cost might save money in the long run by reducing both long-term illness and sick days.

"Private-sector employers can do well by doing good," Mr. Millenson said. **BI**



SECOND ANNUAL CONFERENCE OF THE NATIONAL BUSINESS COALITION ON HEALTH

Pension

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though, exist only on paper. Legally, cash balance plans are defined benefit plans in which NationsBank and its professional advisers decide how to invest plan assets. The bank is not required to direct pension plan investments to match employees' selections or to credit employees' account balances with the actual returns NationsBank achieves.

While NationsBank's plan is undoubtedly innovative, some benefit experts aren't sure how the design—specifically the transfer of 401(k) monies to the cash balance plan—complies with certain IRS regulations.

Those regulations involve Section 411(d)(6) of the Internal Revenue Code. Among other things, the regulations say that when funds are moved from defined benefit plans to defined contribution plans, or vice versa, certain rights and features of the plan from which funds are moved are "protected" and cannot be taken away.

Among other things, the regulations stipulate that the separate employee account feature of a defined contribution plan, like a 401(k) plan, is a protected feature and must be preserved.

However, funds can be transferred between defined contribution and defined benefit plans—without violating Section 411(d)(6)—if the funds are available for distribution to employees. For example, an employee who retires and wants to transfer a 401(k) account balance to his or her employer's defined benefit plan could do so without violating the IRS regulation, because the employee would have a right to take the entire 401(k) account balance.

However, in a situation where an employee continues to work for the same employer, full distributions of 401(k) account balances are not allowed.

Given the IRS requirements—protection of separate defined

contribution plan account balances for each employee—some benefit experts are puzzled that NationsBank's approach, in which employees could transfer funds to the cash balance plan from their 401(k) accounts, passed IRS muster. That's because cash balance plans have hypothetical account balances but in fact do not have the actual individual account feature of 401(k) plans.

"A cash balance plan account may look like a separate" defined contribution plan account, but it is not, Mr. Rumack said. In a defined contribution plan, like a 401(k) plan, investment earnings must be distributed to employees' accounts. In a cash balance plan, investment earnings belong to the actual plan, he noted.

Some benefit experts say the IRS may have approved the plan because, while it possibly does not fit the exact letter of regulations, in spirit it may be close.

"Can NationsBank say, 'We have not taken away a right... as long as employees have the same opportunity to choose investment options, we have not taken something away.' Perhaps that is a logical argument," said Paul Strella, an attorney with William M. Mercer Inc. in Washington.

Others note that regulations—drafted a decade ago and intended to interpret legislation Congress passed—cannot possibly address all plan designs that have since evolved. That can lead IRS staffers to take positions on which there is little background.

"Legally, this plan raises novel questions. There are no open-and-shut answers," said Richard Shea, a partner with Covington & Burling in Washington.

Mr. Shea noted that it is neither possible nor desirable for Congress to write detailed rules for every new pension plan design. "Regulators exercise discretion to interpret law. The trick to doing a good job is to interpret the law in a way that makes sense and is true to its spirit," he said.

"Do you automatically say 'no' to a new plan design merely be-

cause it was not around when Congress last visited this subject?" Mr. Shea asked.

"Personally, I think, it is possible for a cash balance plan to preserve the separate account feature of a defined contribution plan and add desirable features to it, like investment protection," Mr. Shea said.

Others, though, say that without having access to all details of the transaction, it is impossible to know precisely what legal mechanism NationsBank used to implement the program.

But a benefit consultant who asked not to be identified questioned if the IRS agent understood all the 411(d)(6) issues involved before approving the plan.

"This is a cutting-edge design. It is possible these issues went right by the agent," the consultant said, adding that he wouldn't be surprised if the publicity generated by the plan leads the IRS National Office to intervene and review the plan.

"This plan did not receive the scrutiny it should have," another consultant added.

The IRS declined to comment.

While the design is generating controversy, some benefit experts say that, from an employee perspective, NationsBank's approach combines the best features of defined contribution and defined benefit plans.

"I think it is a great idea. Participants have investment choices, and they have protections against a down market," Mr. Shea said.

"This is a striking example of plan flexibility," added Dave Wolfe, a partner with Gardner, Carton & Douglas in Chicago.

Other benefit experts, though, have noted that the benefit guarantees could cost NationsBank dearly if employees choose investment options that decrease sharply in value.

"The theory is that an employer will earn more than participants' investment choices. I think that will be difficult," said Bob Howley, a Buck Consultants actuary in New York. **BI**

Plans

Continued from page 3

was offered, 51% offered a preferred provider organization, while 34% offered a traditional plan.

Only rarely did a multiemployer plan require a worker to join a health maintenance organization. For all multiemployer plans responding, 29% offered an HMO; if just one option was offered, only 9% of the time was it an HMO.

Half of all multiemployer plans responding offered employees just one plan type, the survey found. Thirty-four percent offered two plan types; 12% offered three plan types, and four out of 100 offered four types.

The study also found that the kinds of plan types offered differed substantially depending on these variables:

- **Geography.** The plans in the western United States (Alaska, California, Hawaii, Nevada, Oregon and Washington) were much more likely to offer HMOs as an option to employees. About seven out of 10 of the Western plans offered HMO plans, compared with just 29% of all plans responding. It is in these states where HMOs got their early footing and where they continue to be most popular.

- **Size of plan.** Large multiemployer plans with thousands of workers are more likely to offer managed care. For plans with 5,000 or more members, 40% of

plans offered an HMO as a choice.

- **Type of industry.** Construction trade unions tended not to offer HMOs. Just over two in 10 were offering HMOs, the survey found, compared with 39% of non-construction plans.

The survey found that, in most cases, multiemployer plans offer workers so-called ancillary benefits of prescription drugs, dental coverage, mental health benefits and vision plans. These benefits were offered by more than three-quarters of plans, with prescription drugs leading the way. Just under nine out of 10 multiemployer plans had prescription benefits, said Peter Alles, the senior research associate who conducted the study. Slightly more than 80% of the responding plans offered dental benefits.

The prescription drug benefit used a prescription card service 82% of the time and mail order services 63% of the time. Some employers offered more than one prescription drug option. Less than one-third of the multiemployer plans said they used a prescription benefits management company to handle drug claims.

Multiemployer plans that are not, strictly speaking, examples of managed care nevertheless have taken on many aspects of HMOs in order to manage costs, Mr. Alles said.

Two-thirds of plans said they have used case management and hospital precertification as stan-

dard tools, with more than half performing concurrent review, which is the review of patients' treatment while they are in the hospital, Mr. Alles said.

In addition, 46% of the multiemployer plans suggest a voluntary surgical second opinion. Seventeen percent require one.

Nearly three-quarters of plans with traditional plans or PPOs used more than one cost-management tool, and almost half used four or more. Only 13% used none of the techniques, the survey said.

More multiemployer plans have not formally adopted managed care structures because of the basic nature of labor negotiation, Mr. Alles said.

In a single-employer setting, human resources professionals can often follow their own preferences in determining health care options. In collective bargaining situations, however, employers may be willing to temper managed care objectives when other contract considerations, such as wages, are more pressing.

"(In contract talks), a group of people have to agree on change," he said. "It's a bargain- and-consensus-based process."

To receive a free copy of the survey, "Managing Multiemployer Health Fund Benefits," contact the public relations office of the International Foundation of Employee Benefit Plans, 414-786-6710, ext. 8219.

Updates

Surcharge exemption ended

BOSTON—Massachusetts regulators have eliminated an exemption that now allows "infrequent payers" to escape—by paying a small fee—a state law that imposes a 5.06% surcharge on hospital bills.

Currently, a health care payer, such as third-party administrator located outside the state, whose Massachusetts hospital bills totaled less than \$300,000 in 1996, is able to escape the surcharge if it registered with the state's Division of Health Care Finance and Policy as an infrequent payer by Jan. 15 and paid a \$2,400 fee.

If, in any calendar year, an infrequent payer were to make at least \$300,000 in payments to Massachusetts hospitals, though, it would be liable for the surcharge in the next year.

The infrequent payer exception will be eliminated beginning next year. State officials earlier said they wanted to eliminate the exemption because of low demand—just 250 payers applied for infrequent-payer status—and to ensure the surcharge system would be more equitable.

Drug mandate suits combined

BOSTON—A federal court in Boston will hold a hearing Oct. 30 and possibly decide then whether HMOs in Massachusetts have the right to scale back prescription drug benefits to retirees eligible for Medicare.

Earlier, the Division of Insurance sued one of the HMOs—Harvard Pilgrim Health Care—charging that its plan to cap prescription drug benefits at \$800 a year runs afoul of a state law and regulation that says Medicare HMOs must offer either unlimited or no prescription drug benefits.

At the same time, the Massachusetts Assn. of Health Maintenance Organizations sued the Division of Insurance, contending that a 1997 federal budget law pre-empts the state law and gives HMOs the authority to cut benefits (BI, Sept. 28).

The two suits were joined last week into one case in U.S. District Court in Boston.

FDA to change proposed rules

WASHINGTON—The Food and Drug Administration is overhauling a set of proposed guidelines that would have held drug companies responsible for the advertising and marketing campaigns of prescription benefit management companies.

As a step to rein in the marketing statements of PBMs and other health care companies either owned by drug manufacturers or closely allied with them, the FDA issued draft guidance early this year (BI, Jan. 12). The proposal resulted in fierce opposition from PBMs, which argued that the rules would interfere with the drug discounting process and send drug prices soaring.

The FDA extended the public comment period in July. In August, however, the administration announced it was planning on a wholly revamped approach to marketing regulation and would eventually issue rules that were "more tightly written, so the intention of the guidance (would be) clearer," an FDA spokesman said.

Guarantee insurers forming

HAMILTON, Bermuda—EXEL Ltd. and financial guarantee insurer Financial Security Assurance Holdings are entering into a joint venture to form two new Bermuda-based financial guaranty insurers that each will be capitalized with a minimum of \$100 million.

Financial Security Assurance International Ltd., a subsidiary of FSA that will be 20% owned by EXEL, is expected to carry FSA's AAA rating. It will reinsure FSA domestic business and may write primary business on international risks, said Robert P. Cochran, FSA chairman and chief executive officer.

X.L. Financial Assurance Ltd., a subsidiary of X.L. Insurance Co. Ltd. that will be 20% owned by FSA, is expected to carry X.L.'s AA rating and will write business that has a "slightly higher risk profile," Mr. Cochran said. It also will reinsure FSA business on a selected basis.

In conjunction with the venture, which is subject to regulatory approval, FSA and EXEL will swap \$80 million of each other's shares.

The insurers are expected to start writing business almost immediately after they are formed, which will be in several weeks, said Mr. Cochran. There are no premium volume estimates.

Briefly noted

Swissair has paid out 4.35 million Swiss francs (\$3.3 million) to 145 families of victims of the fatal crash last month of a Boeing MD-11 off Nova Scotia, said SAirGroup Chief Executive Officer Philippe Bruggisser. By the end of this month, Swissair aims to have contacted all the victims' families to offer them a further payment of up to 100,000 Special Drawing Rights (\$142,840), less any payments made so far. . . . A Bermuda Supreme Court judge on Friday ordered Belvedere Insurance Co. Ltd. into liquidation and appointed two partners of KPMG Peat Marwick LLP as joint provisional liquidators. The move followed a Sept. 22 arbitration settlement between GTE Corp. and a Belvedere subsidiary that effectively rendered Belvedere insolvent, KPMG announced. . . . Zurich, Switzerland-based Swiss Reinsurance Co. is expanding in Latin America with the completion last week of its purchase of Mexican reinsurer Reasegueros Alianza S.A. The deal had been announced in May. . . . California Gov. Pete Wilson has vetoed several workers comp bills. S.B. 324, which was joined with S.B. 557, and A.B. 332, targeted HMO utilization review practices and were considered anti-managed care bills. Also vetoed was S.B. 924, which related to penalties against employers who do not have workers comp insurance. . . . Citigroup Inc., the new company formed in the merger between Citicorp and Travelers Group Inc. (BI, April 13), began trading on the New York Stock Exchange last week. The deal was consummated with the expectation that Congress would lift the current ban on combinations between banks and insurers. Under current law, Citigroup now has a two-year grace period on that ban; the grace period could be extended to five years with the permission of the Federal Reserve Board.

Mutuals

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or Liberty Mutual, the addition of Wausau to its family of companies further strengthens its position as the leading provider of workers comp insurance.

In 1997, Liberty Mutual generated \$1.96 billion in direct workers comp premiums, according to A.M. Best Co. Last year, Wausau generated \$710 million, a company spokesman said.

Combined, Liberty Mutual and Wausau will represent 10.1% of the total workers comp market, with nearly \$2.7 billion in direct premiums, according to Best.

Overall, Liberty Mutual and Wausau wrote \$7.25 billion in net premium in 1997, of which Liberty Mutual accounted for \$5.92 billion and Wausau \$1.33 billion.

As of June 1998, Liberty Mutual reported assets of \$25.6 billion and policyholders' surplus of \$7.2 billion; Wausau reported assets of \$3.6 billion and policyholders' surplus of approximately \$600 million.

The deal is about "growth opportunity," not an opportunity to squeeze expenses, said Ted Kelly, chairman and chief executive officer of Liberty Mutual in Boston.

When the deal is complete, "the Liberty Group will be either No. 1 or No. 2 in market share in 22 states and by far the largest provider of workers compensation," he said.

Moreover, Wausau brings to Liberty Mutual a different distribution channel. Whereas Liberty Mutual is a direct writer on a majority of its accounts, 65% of Wausau's premium is distributed through brokers and large regional agencies.

Liberty Mutual is a direct writer in the "all-important middle market"—those accounts generating between \$75,000 and \$2.5 million in annual premium, Mr. Kelly said. While he

believes strongly in direct business, he said Liberty Mutual recognizes a large market segment prefers to purchase insurance through brokers. "With Wausau as part of our family, we now have someone operating through brokerage distribution," he said.

"Managing multiple channels of distribution and channel conflict is an integral part of financial services," Mr. Kelly continued. "Successful companies have to have the ability to manage multiple channels under conflict."

Market observers say the deal makes sense.

Wausau typically serves larger accounts, and Liberty Mutual has a significant presence in the large national account arena, said Matthew Coyle, a director at Standard & Poor's Corp. in New York who tracks both Liberty Mutual and Wausau. Because Nationwide focuses mainly on personal lines and some small commercial accounts, Wausau "fits more with Liberty's profile than it did in the past with Nationwide," Mr. Coyle said.

Richard S. Betterley, president of Betterley Risk Consultants Inc. in Sterling, Mass., agrees.

"The deal makes a lot of sense," he said. "It makes sense for Liberty to get bigger, and it makes sense for Wausau to be bought by a similar company."

"It's truly a win-win," said John Wicher, managing director of Russell Miller Inc. in San Francisco. The deal allows Liberty Mutual to diversify its distribution and complement its existing business; Nationwide is dis-affiliating with a non-core business; and risk managers get to continue to have a strong Wausau with Liberty Mutual as the ultimate parent supporting the company, Mr. Wicher said.

"To me, it's a natural. It's great," said Ronald Komar, vp-risk management at Kohl's Department Stores Inc. in Menomonee Falls, Wis. Kohl's has a longstanding relationship with Liberty Mutual, which underwrites its workers comp and general liability programs,

and it recently switched its group health business to Wausau.

"Down the road (the affiliation) will be very, very positive," Mr. Komar predicts. "I think it's a natural, long-term, for the possibility of 24-hour coverage."

Indeed, while executives from both companies say product collaboration was not the driving force behind the affiliation, the two insurers may jointly develop products in the future.

One of the areas they highlight is 24-hour coverage, better known today as integrated disability management.

"We've put lots of emphasis on (integrated disability management) and have built a book of business over the last year," said Mr. Davis of Wausau. While Wausau has invested more in this area than Liberty Mutual, there are other areas in disability management and managed care in which Liberty Mutual has more strength, he said.

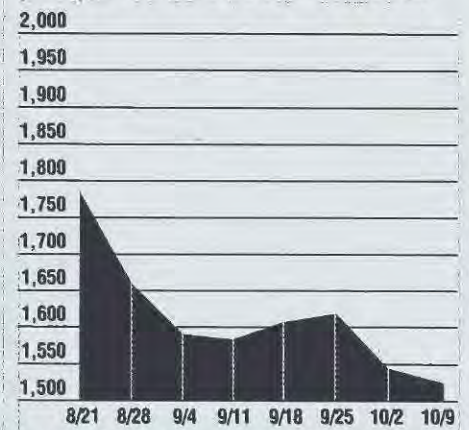
By joining forces, "we have a broader base of experience to share results of a very much emerging market," Liberty Mutual's Mr. Kelly said of integrated disability programs. "Shared experience will speed up development of a product."

A.M. Best's A+ rating of Liberty Mutual's 12-member pool will be unchanged by the addition of Wausau, the rating agency said. Upon completion of the deal, Wausau and its three subsidiaries will be assigned the A+ rating.

S&P said its AA rating of Liberty Mutual also will be unaffected by the Wausau addition.

Moody's Investors Service Inc. affirmed its Aa3 insurance financial strength ratings of members of the Liberty Mutual Group following the announcement. The rating affirmation is based largely on the compatibility of Wausau's business with that of Liberty Mutual, Moody's said.

BI Insurance Index



Base=100 on Dec. 29, 1978

Source: Nordby International Inc. (nordby.com) Boulder, Colo.

PCS catastrophe options

As of Oct. 9	Call spread	Price bid/ask	Call spread	Price bid/ask
National Annual 1998			National Annual 1998	
80/100	1.6/—		10/20	—
150C	—		20/40	0.5/—
National Annual 1999			Eastern September 1999	
40/60	9.2/—		40/60	—/4.5
60/80	4.0/—		Western Annual 1999	
100/120	2.0/6.5		40/60	1.4/—
150C	6.0/—		80/100	1.0/2.0
Southeastern September 1999			Midwest June 1999	
40/60	—/4.3		10/20	1.0/1.4

Total volume: 2 Total open interest: 16,293

For information on PCS cat options, call the Chicago Board of Trade at 312-435-3674.

Source: Chicago Board of Trade

British Issues

Companies	Price pence	P/E	Div. pence	Yield %	52-week high-low
Gdn Royal Exch	239	3.7	13.4	5.7	495-227
Legal & Gen	547	15.6	13.3	3.1	796-400
Royal & Sun	480	11.7	23.6	5.1	825-437

Brokers

Lmbt Fenchurch	104	8.1	5.7	6.9	138-100
Lloyd Thompson	173	10.3	10.5	7.7	213-151
Sedgwick Grp	197	—	7.0	3.5	220-119
Willis Corroon	199	23.1	6.9	4.3	210-116

Note: Prices are Oct. 9 closings; other numbers from Oct. 8.

Source: Nordby International Inc. (nordby.com) Boulder, Colo.

Financial sector called more prepared for Y2K

WASHINGTON—Health care, agriculture, food processing and public entities stand the greatest chance of experiencing "mission critical" system failures because of the Year 2000 computer problem.

In contrast, insurance, banking, investment services, pharmaceuticals and computer manufacturing lead industries in dealing with the problem, with only 15% of the companies in the best-prepared group expected to experience a mission-critical system failure, Lou Marcoccio, research director of GartnerGroup, a Stamford, Conn.-based consultant, told members of the Senate Special Commit-

tee on the Year 2000 Technology Problem last week.

Fully 66% of the companies in the least-prepared group are expected to experience a mission-critical system failure. GartnerGroup defines "mission critical" as any "business dependency" that, if it failed, would result in a shutdown of business, production or product delivery operations; health hazard to individuals; considerable revenue loss; significant litigation expense or loss; or significant loss of customers or revenue.

GartnerGroup also estimated the cost of recovering from a single failure after it occurs

could range from \$20,000 to \$3.5 million.

To help meet the challenges of the Year 2000 problem, the GartnerGroup recommended that, among other things, the Senate require the Securities and Exchange Commission to conduct random audits of publicly held companies as part of Year 2000 disclosure and reporting requirements; charge one existing federal agency with managing and coordinating efforts to deal with the global impact of the problem on the United States; and launch a nationwide program to coordinate readiness efforts with state and local governments.

—By Mark A. Hofmann

BI Industry Stock Report OCT. 5, 1998, THROUGH OCT. 9, 1998

BROKERS

	Price	Weekly % change	Year to date % change	52-week High	Low	Vol.(000)
Aon Corp.	NYS	53.81	-12.50	-8.21	75.56	48.25 3915
E.W. Blanch Holdings Inc.	NYS	36.50	-10.57	5.99	41.13	29.38 213
Gallagher Arthur J. & Co.	NYS	37.56	-6.24	9.07	46.56	33.56 133
Hibb, Rogel & Hamilton	NYS	16.19	-11.00	-16.18	19.50	15.38 64
Kaye Group Inc.	NDQ	6.25	-5.66	-5.66	9.00	5.88 36
Marsh & McLennan	NYS	49.50	10.00	-0.42	64.31	43.38 3456
Poe & Brown	NYS	33.38	-9.18	12.18	42.50	26.50 23
Sedgwick Group PLC	NYS	17.25	2.60	40.10	17.75	9.94 42
Willis Corroon Corp.	NYS	16.81	-1.47	36.55	17.25	10.06 8
BROKERS AVERAGE		-3.94	10.20			

INSURERS/REINSURERS

	Price	Weekly % change	Year to date % change	52-week High	Low	Vol.(000)
ACE Ltd.	NYS	27.75	-4.52	-13.73	43.00	24.38 5746
Acceptance Insurance Cos.	NYS	19.31	-3.44	-20.16	28.63	17.44 137
AEGON N.V.	NYS	72.25	-3.59	61.23	111.31	37.56 430
Aetna Life & Casualty	NYS	65.81	-0.28	-6.73	89.38	60.19 2513
AFLAC Inc.	NYS	32.56	19.50	27.38	38.25	22.13 3730
Allied Group Inc.	NYS	47.88	0.13	67.25	48.38	25.00 116
Allmerica Financial Corp.	NYS	39.94	-22.17	-20.03	75.25	36.38 2090
Allstate Corp.	NYS	41.06	-5.74	-9.25	52.38	36.06 10675
AMBAC Indemnity Corp.	NYS	43.19	-11.86	-6.11	65.94	40.00 1412
American Bankers Ins.	NDQ	34.88	-13.62	-24.08	66.06	30.13 2673
American Financial Group	NYS	32.13	-2.65	-20.31	45.75	30.50 254
American General	NYS	61.19	-3.83	13.18	75.69	46.56 4657
American Heritage Life Ins.	NYS	19.81	-12.67	10.07	26.06	17.06 116
American Indemnity/Fin'l	NDQ	11.50	0.00	-17.12	15.38	9.50 4
American International	NYS	69.69	-5.83	-3.88	102.38	64.75 19939
American Safety Insurance	NDQ	6.75	-14.29	-45.18	15.06	6.75 137
Argonaut Group	NDQ	23.75	-7.54	-29.89	37.50	21.25 169
AXA-UAP Group	NYS	44.94	7.15	15.22	71.25	31.88 422
Baldwin & Lyons Inc.	NDQ	21.00	-7.69	-12.95	28.75	19.69 12
Berkley W.R. Corp.	NDQ	29.25	-2.90	-33.33	49.88	28.50 402
Berkshire Hathaway Inc.	NYS	61605.00	3.54	33.92	84000.00	42500.00 3
Capital RE Corporation	NYS	15.88	-37.44	-48.84	38.69	14.75 1195
Capital Transamerica Corp.	NAS	15.75	-13.70	-26.10	28.00	15.75 65
Centris Group Inc.	NYS	9.69	-2.52	-13.17	14.61	8.63 120
Chartwell Re	NYS	23.94	-13.74	-29.07	35.69	23.94 81
Chubb Corp.	NYS	60.88	0.41	-19.50	88.81	55.38 2705
CIGNA Corp.	NYS	64.00	-1.16	11.39	74.50	45.63 3296
Cincinnati Financial Corp.	NAS	33.00	-7.85	-29.66	47.13	27.81 1797

	Price	Weekly % change	Year to date % change	52-week High	Low	Vol.(000)
Citigroup	NYS	35.44	-8.10	-34.22	73.50	31.06 69866
CNA Financial Corp.	NYS	36.44	-0.85	-14.43	53.25	35.13 1059
CNA Surety	NYS	13.81	-1.34	-10.53	16.75	12.56 220
EMC Insurance Group Inc.	NDQ	10.75	-10.88	-18.87	15.88	10.75 36
ESG Re Limited	NDQ	14.38	-4.17	-38.83	28.88	12.75 514
Enhance Financial Services	NYS	21.00	-25.66	-29.41	37.56	17.31 2328
Everest Reinsurance	NYS	30.56	-13.30	-25.91	45.25	28.75 1173
Executive Risk Inc.	NYS	41.50	-6.08	-40.56	75.75	35.50 294
EXEL Ltd.	NYS	67.19	3.27	6.02	83.25	61.56 874
Fremont General Corp.	NYS	40.13	-16.32	-26.71	62.13	36.00 549
Frontier Insurance Group	NYS	13.06	1.95	-42.90	33.50	12.19 907
Gainsco Inc.	NYS	6.00	-15.79	-29.41	10.19	5.75 236
General RE Corp.	NYS	210.50	3.50	-0.71	275.00	191.00 1376
Gryphon Holdings	NDQ	16.00	0.00	-4.48	19.38	11.38 201
Harleysville Group	NDQ	19.25	-7.78	-19.79	28.50	17.25 183
Hartford Steam Boiler	NYS	37.25	-3.87	1.25	59.56	33.25 502
HCC Insurance Holdings	NYS	17.50	-2.44	-17.65	29.38	15.63 410
ING Groep N.V.	NYS	40.88	2.19	-3.40	76.75	36.06 1145
IPC Holdings Ltd.	NDQ	19.06	-18.01	-40.78	33.25	19.00 156
Hartford Financial Services	NYS	41.56	-10.86	-11.16	60.00	37.63 3772
LaSalle Re Holdings Ltd.	NYS	19.50	-20.81	-44.88	42.94	19.50 133
Life Re Corp.	NYS	91.31	-0.07	40.08	92.94	52.06 885
Lincoln National	NYS	71.06	-11.45	-9.04	98.88	64.63 1973
MAIC Holdings Inc.	NYS	25.75	-3.51	-3.87	30.38	23.94 92
Market Corp.	NYS	138.50	-7.67	-11.29	187.00	132.00 38
MBIA Insurance Group	NYS	49.94	-2.68	-25.26	80.94	46.06 2088
Meadowbrook Insur. Group	NYS	22.56	-9.07	-13.43	35.00	22.56 40
MMI Cos. Inc.	NYS	16.94	-4.91	-32.59	26.88	15.25 71
Mutual Risk Mgmt. Ltd.	NYS	27.50	-20.58	-8.14	39.94	25.38 800
NAC Re Corp.	NYS	49.88	-0.13	2.18	55.88	43.50 232
Navigator Group	NDQ	14.25	-2.56	-24.13	22.38	14.00 19
Nobel Insurance Ltd.	NDQ	0.72	4.55	-94.52	1.00	0.40 45
Nymagic Inc.	NYS	23.13	-7.04	-16.10	34.25	21.75 11
Ohio Casualty Corp.	NDQ	34.63	-6.42	-22.41	51.75	33.81 281
Old Republic Int'l	NYS	19.69	-8.70	-20.59	32.25	17.94 1782
Orion Capital Corp.	NYS	32.00	-8.57	-31.09	59.25	28.00 1454
Partner Re Ltd.	NYS	35.94	-7.56	-22.51	52.50	33.63 342
Penn-America Group Inc.	NYS	8.63	-11.54	-57.93	23.00	8.13 75
Pennsylvania Manufacturer's Co	NDQ	17.50	-7.89	4.48	23.75	16.25 21
Philadelphia Cons. Holding	NDQ	20.75	-1.19	16.90	24.38	15.50 82

		Price	Weekly % change	Year to date % change	52-week High	Low	Vol.(000)
PXRE Corp.	NYS	23.88	-6.60	-28.06	35.25	23.75	280
Reliance Group Holdings	NYS	12.44	-11.95	-11.95	19.81	10.75	1305
Reliastar Financial Corp.	NYS	34.00	-7.48	-17.45	52.44	29.00	3094
RenaissanceRe Holdings Ltd.	NYS	39.50	-7.06	-10.48	50.75	38.00	562
Risk Capital Holdings	NDQ	20.50	-2.09	-7.87	25.50	19.00	74
RLI Corp.	NYS	33.31	-9.97	-16.41	45.63	31.56	33
St. Paul Companies	NYS	32.56	2.56	-20.64	47.19	28.06	3877
SCOR	NYS	58.63	1.96	22.77	72.75	40.75	28
SAFECO Corp.	NDQ	40.38	-0.77	-17.18	56.00	38.25	2745
SCPIE Holdings Inc.	NYS	28.13	-12.11	-2.81	38.38	26.50	NA
Seibels Bruce Group	NDQ	4.13	0.00	-45.00	6.38	3.72	49
Selective Ins. Group	NDQ	17.59	-7.40	-34.84	29.25	17.19	369
Terra Nova Insurance Co. Ltd.	NYS	25.38	-3.56	-3.33	35.00	23.50	142
TIG Holdings	NYS	12.38	-11.61	-62.71	36.56	11.63	1184
Tokio Marine & Fire	NDQ	49.88	10.22	-13.64	60.63	39.00	235
Torchmark Corp.	NYS	34.63	-1.77	-17.93	49.81	31.81	1274
Transatlantic Holdings	NYS	77.81	-4.16	8.83	94.50	67.44	80
Travelers Property Casualty	NYS	27.56	-8.32	-37.36	46.06	24.13	2037
Trenwick Group Inc.	NDQ	31.38	7.96	-16.61	41.75	27.00	39
Unico American Corp.	NDQ	10.50	-7.69	-14.29	18.13	8.88	56
United Fire & Casualty	NDQ	32.63	-10.62	-26.27	47.00	32.13	17
Unitrin	NDQ	68.75	7.21	6.38	74.13	55.56	392
UNUM Corp.	NYS	44.56	-9.17	-18.05	59.63	43.13	1760
Vesta Insurance Co.	NYS	5.50	-27.87	-90.74	64.75	5.19	581
Zenith National Ins.	NYS	23.81	-0.78	-7.52	30.50	23.00	50
INSURERS/REINSURERS			AVERAGE	-6.11	-14.77		

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