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Updates

Medicare bill passed by panel would repeal data bank law

WASHINGTON—The much-criticized Medicare data bank law would be repealed under a provision tucked into legislation to shore up the Medicare program that was passed last week by the House Ways and Means Committee.

The data bank law was enacted in 1993, but Congress—under employer pressure—delayed implementing it until later this year. The law requires companies to file annual coverage reports with the federal Health Care Financing Administration.

See **Updates** *on next page*

Court gives mixed signals

Business, consumer lawyers argue punitive damage case

By MARK A. HOFMANN

WASHINGTON—An unusual case before the U.S. Supreme Court could result in a constitutional standard on punitive damages, but the justices so far have given little indication as to how they will rule.

It is not clear whether the unique nature of *BMW of North America Inc. vs. Ira Gore Jr.* is a better case for businesses, which long have sought constitutional limits on what they regard as runaway punitive awards, or for consumer groups and others who argue that jury freedom to levy large awards is needed to rein in corporate misconduct.

But in oral arguments last week, two justices—Sandra Day O'Connor and Ruth Bader Ginsburg—pointed out the rarity of the situation in the case before the court.

An Alabama jury awarded $4 million in punitive damages to a man who was not told that the BMW he was buying had been damaged and refinished (*BI*, Oct. 9). Jurors arrived at the punitive figure by multiplying $4,000 in compensatory damages by 1,000, which was the approximate number of cars BMW had refinished and sold as new over 10 years throughout the country. BMW appealed to the Alabama Supreme Court, which halved the punitive award but otherwise let the decision stand.

Later, to protect automakers from similar fraud suits, the Alabama Legislature passed a law that refinishing jobs worth less than 3% of a vehicle's value did not have to be disclosed.

Because of this legal change, Justice Ginsburg said the case was a "quirky" one that would never occur in Alabama again. Justice O'Connor, noting the odd use of the multiplier in determining the punitive damage award, wondered whether the case didn't simply "boil down to some kind of a fluke."

But the court's newest member—Justice Stephen Breyer—asked a question that tort reform proponents have been raising for

See **Punitive** *on page 4*



GRAPHIC BY JOHN HALL

Lawmakers return to drawing board

Leaders urge Superfund bill revisions

By MARK A. HOFMANN

WASHINGTON—Superfund reform advocates are hopeful they may get broader liability reform as a result of an unexpected stall in the progress of legislation to reform the controversial environmental law.

The delay came about because Republican leaders of both the House and Senate want the reauthorization legislation to contain broader liability reform than currently offered by the bills' authors.

"We're looking at it as positive development because you're seeing tension between people who want to do more and people who are saying you can't. The delay would appear to indicate that the people who are saying to do more are winning," said Julie A. Rochman, assistant vp of the Alliance of American Insurers in Washington.

In the Senate, Sen. Robert Smith, R-N.H., had initially proposed repealing retroactive liability for legal dumping that took place before Superfund's initial Dec. 11, 1980, enactment. The bill he introduced late last month, though, failed to contain that provision.

Instead, the Smith bill relied on a tax credit mechanism to reimburse potentially responsible parties for 50% of their clean-up costs associated with pre-enactment dumping (*BI*, Oct. 2).

Senate Majority Leader Robert J. Dole, R-Kan., sent Sen. Smith

See **Superfund** *on page 34*

Restriction on leave refused

Specific request for FMLA leave not required, court says

By JERRY GEISEL

NEW ORLEANS—Employees do not have to ask their employers specifically for leave under the Family and Medical Leave Act to take leave under the federal law, a federal appeals court says.

However, the court said, employees do have to tell employers, when "practicable," that it is necessary for them to take leave, while employers have the right to require employees to prove that they are entitled to leave under the FMLA—the 1993 law that allows employees to take up to 12 weeks a year of job-protected leave because of medical problems or certain family needs.

In a case involving an employee who took time off to recuperate from complications following the removal of an ingrown toenail, the 5th U.S. Circuit Court of Appeals said earlier this month that nothing in the FMLA requires employees who give notice of the need for unpaid leave to assert their rights under the FMLA.

"Requiring employees unable to foresee their need for leave to expressly invoke the FMLA's protection would significantly burden the employees. . . .Even more than employees who can foresee their need for leave, those who cannot foresee such need are ill-equipped to identify the statutory source of their right," said the appeals court in reversing a lower court ruling.

Benefit experts caution that the decision does not sweep away employees' obligations to advise employers that they need to take leave.

"The decision tells us what you don't have to ask for. You don't have to say, 'I want family or medical leave' to invoke the protection of the FMLA. You do have to tell your employer something, though what you have to tell the employer isn't sufficiently spelled out in the decision," said Henry Saveth, a principal with benefit consulting firm A. Foster Higgins & Co. Inc. in New York.

See **Leave** *on page 25*

Business as usual in Bermuda

By GAVIN SOUTER

HAMILTON, Bermuda—*August was a tumultuous time for Bermuda.*

The British colony was whipped by the edges of Hurricane Felix; its citizens roundly rejected independence from Britain; and, as a result of that referendum, Sir John Swan, the longstanding premier and a supporter of independence, resigned.

In his stead came another pro-business premier, David Saul, who had been minister of finance under Sir John.

But all might not be as calm as it seems for this international insurance and reinsurance capital.

The departure of U.S., Canadian, and British forces from the island this year has raised the possibility that the government might look to international businesses on the island to replace the lost revenue from those bases.

The island's strict immigration policies have also come under the spotlight as the insurance and reinsurance industry in Bermuda and the need for outside experts to run the businesses continues to grow.

And still lurking is the question of independence. Has the issue disappeared or will lingering concerns over independence and the political instability it might bring deter captives and insurance and reinsurance companies from coming to Bermuda?

Those were among the questions put to the new premier and members of his cabinet during in a discussion earlier this month with Business Insurance *Associate Editor Gavin Souter and Editorial Director and Publisher Kathryn McIntyre.*

Around the table were: Mr. Saul; C. Jerome Dill, deputy premier and minister of education and human affairs; E. Grant Gibbons, minister of finance; Quinton Edness, minister of labor, home affairs and public safety; Lynda Milligan-Whyte, minister of legislative affairs and women's issues; and A. David Dodwell, minister of tourism and marine services.

Q: One of the reasons why this government is here is because of the independence vote. Why did independence come up as an issue this year and is it still an issue?

Mr. Saul: The independence issue is not a new thing in Bermuda,

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Leslie Todd

The new Bermuda cabinet is striving to expand the island's business horizons. From left, Quinton Edness, Grant Gibbons, Premier David Saul, Lynda Milligan-Whyte, C. Jerome Dill, and A. David Dodwell.

Updates

Data bank repeal in bill

Continued from previous page

Those reports would include the names and Social Security numbers of employees and dependents as well as the specific plans in which those individuals are enrolled during the year.

The information is supposed to be used by HCFA to help the agency spot claims, chiefly those of older workers who stay on the job after 65, that should have been paid by employers rather than Medicare.

But many employers say the information has been difficult and costly to compile, especially dependents' Social Security numbers. They also say much of the data will be useless to the government.

Other provisions in the Ways and Means bill would make employer plans the primary payer for 24 months of health care claims for employees with end-stage renal disease, up from 18 months.

The measure also would make clear that HCFA has three years from the time a service is performed to seek recovery against employers, insurers and third-party claims administrators for medical claims that group health plans and not Medicare should have paid.

Other provisions in the legislation, which the full House could vote on as early as this week, would give Medicare beneficiaries new options to enroll in managed care plans and establish tax-favored medical savings accounts.

Highlands expansion planned

DALLAS—New management at Highlands Insurance Group Inc. plans to make the regional workers compensation insurer the cornerstone of a larger national insurer that would be built partially through acquisitions after Highlands' spinoff from giant energy firm Halliburton Co.

The insurer also would be strengthened by adding more lines of coverage, according to Richard M. Haverland, a 25-year industry executive who would become Highlands' chairman and chief executive officer. Mr. Haverland is part of the investment group that could hold a large stake in Highlands after the spinoff is completed, which is expected by year's end.

Under the plan, Halliburton shareholders—in a non-taxable deal—would receive one share of Highlands common stock for every 10 shares of Halliburton common stock they hold. Highlands management and investment group Insurance Partners L.P. then would invest $60 million in Highlands in exchange for debentures and warrants. If the warrants are fully exercised, Insurance Partners' total commitment would approach $130 million, representing a 43% stake in Highlands.

Highlands plans to make a $125 million pretax addition to reserves primarily for environmental and asbestos claims in its third quarter. Highlands, which Halliburton first tried to unload in 1992, has been plagued for years by environmental and asbestos losses from discontinued casualty business.

A.M. Best Co. affirmed its A- rating for Highlands and said its outlook is positive for the company.

Pension asset proposal drafted

WASHINGTON—Employers would be able to withdraw surplus assets from their overfunded pension plans to pay for employee benefit plan costs under a tax legislation proposal floated last week by Republican staffers on the Senate Finance Committee.

Under the staff discussion draft, surplus assets could be withdrawn from an ongoing plan to pay for group health, disability, child care and educational assistance benefits. In addition, assets could be shifted from an overfunded to an underfunded plan. The proposal doesn't define underfunded, though, and doesn't say what taxes, if any, would be owed on such asset transfers.

While a big change from current law, which generally doesn't allow employers to withdraw surplus assets from an ongoing plan, the staff proposal doesn't go as far as a tax bill passed by the House Ways and Means Committee. That bill would allow employers to remove surplus assets—for any reason—as long as the plan was at least 125% funded after the transfer (*BI*, Sept. 18).

The staff discussion draft also would give favorable tax treatment to long-term care insurance and medical savings accounts, as well as expand opportunities to contribute to individual retirement accounts.

The proposal would bar tax deductions for interest on loans taken out after Dec. 31, 1995, on corporate-owned life insurance programs. Deductions would be phased out over five years on COLI loans taken before Jan. 1, 1996.

The staff discussion paper was expected to be considered by Finance Committee members over the weekend, and the committee will begin formal consideration of tax legislation this week.

Ruling favors E.W. Blanch

CINCINNATI—Reinsurance intermediary E.W. Blanch Co. was not negligent in failing to predict the insolvency of three reinsurers with which it earlier had placed coverage for a ceding company, the 6th U.S. Circuit Court of Appeals has ruled.

The court on Sept. 26 affirmed a district court ruling because Blanch evaluated the reinsurers' financial strength during the early 1980s using methods that were standard for intermediaries at the time. It also noted that Blanch could not have been expected to detect the reinsurers' false reports or other fraudulent activity that regulators and an insurer rating agency missed.

The ceding insurer, Cherokee Insurance Co., sued Blanch to recover its nearly $1.4 million of unrecoverable reinsurance from Mission Insurance Co., Mutual Fire, Marine & Inland Insurance Co. and Transit Casualty Co., all of which failed during the mid-1980s. Cherokee failed in 1984 for other reasons—mainly related to its selection of offshore retrocessionaires that did not meet their obligations on reinsurance

See **Updates** *on page 34*

Train derailment insured

Rail risk management picks up steam after Amtrak incident

By ROSEANNE WHITE

HYDER, Ariz.—Railroads are stepping up safety precautions and track inspection in the wake of last week's Amtrak train derailment in Arizona.

Today's expected reopening of track where a 12-car Amtrak passenger train derailed Oct. 9 could help Amtrak and Southern Pacific Rail Corp., which owns the rails, assess equipment and property damage.

As of May 1994, Amtrak had more than $75 million in liability coverage above a $25 million self-insured retention. A spokesman could not confirm that that program was still in place.

The coverage came from two

See **Amtrak** *on page 33*



AP/WIDE WORLD

Amtrak has coverage above a $25 million retention for any liability losses arising from last week's crash of its Sunset Limited near Hyder, Ariz., which has been linked to sabotage.

In defense of derivatives

By DAVE LENCKUS

FAIRBORN, Ohio—Derivatives don't cause poor investment returns—unschooled investors cause poor returns, according to alternative risk-financing experts.

Investors who recently have run into problems with their derivative investments did not understand how to match the design of the derivatives they chose with their organization's business strategy and risk appetite, those experts said at the North Central Regional Risk & Insurance Management Society Inc. Conference in Fairborn, Ohio, last month. The Dayton/Miami Valley, Ohio, RIMS chapter hosted the conference.

The instruments can be useful if management takes time to understand what various derivative products are designed to accomplish and develop procedures to ensure that derivatives do not introduce risk to the organization rather than hedge risk, they said.

"They can protect the bottom line rather than betting the company's bottom line," said Robert C. Cox, a vp with Chubb & Son Inc. of Warren, N.J.

"The problems have more recently come in speculation, or assuming risk, in attempting to profit from changes," said Paul E. Raybin, a senior vp with Rollins Hudig Hall Co. of Chicago.

Mr. Cox likened the potential benefits and risks of using derivatives to those associated with turning over power tools to skilled or unskilled workers.

A derivative is a contract with a value that depends on, or is de-

See **Derivatives** *on page 20*

HIV coverage rules set

By MARK A. HOFMANN

TRENTON, N.J.—A proposed New Jersey regulation on HIV testing for people covered by certain group health policies would allow some health insurers to deny coverage for those individuals.

Under the proposal, commercial health insurers—not health maintenance organizations or self-insured companies—would be permitted to test new applicants for group policies covering 50 or more people for the human immunodeficiency virus, which is believed to cause AIDS.

Coverage could be denied for people who refuse to be tested or for those who test positive in a Food and Drug Administration-approved test and then have those results confirmed by other government-approved tests.

The proposal probably will have a minimal impact on most employers, say consultants and the state Department of Insurance.

Group health insurers would be allowed to ask applicants directly whether they have tested positive for HIV or have experienced symptoms of HIV. But they would be barred from asking subjective questions or those concerning lifestyle. Also, insurers could not single out only HIV for query and may ask HIV-related questions only if they also ask similar questions for other diseases.

The proposal appeared in the Oct. 2 New Jersey Register and can go into effect without legislative approval after a 30-day comment period.

The new proposal is an attempt

See **AIDS** *on page 25*

Quakes shake Mexico

By MARIA KIELMAS

Insured losses are expected to be relatively low in the wake of two strong earthquakes that shook Mexico last week.

The first quake occurred Oct. 9, registering 7.6 on the Richter scale and causing at least 36 deaths. The quake affected Mexico's Pacific coast, particularly the states of Colima and Jalisco. Mexican authorities have not estimated the damage, though the brunt of the quakes was felt by uninsured homeowners. The epicenter was 10 miles off the Pacific Coast and about 200 miles west of Mexico City.

The worst damage was felt in the port city of Manzanillo, in the state of Colima, where the Costa Real hotel collapsed.

A second earthquake, thought to be an aftershock, occurred early Thursday. The epicenter of the quake, which measured 6.1 on the Richter scale, was initially calculated to be in western Mexico, either in the state of Colima or Michoacan. The earthquake shook buildings in Mexico City, causing people to flee their homes and offices, but so far no deaths or damage have

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Insured losses are growing from Hurricane Opal .. Page 34

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- Risk managers should expect to see fewer but larger D&O claims in the future, an attorney says. **PAGE 21**
- Legal advisers are the latest target of litigating Lloyd's of London names. **PAGE 27**

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State oversight failings cited by insurance execs

Limited federal regulation among topics addressed by panel

By PAUL D. WINSTON

WHITE SULPHUR SPRINGS, W.Va.—Amid shortcomings in state regulation, some form of federal oversight may be a better option for the commercial insurance industry, several executives contend.

Among their complaints with the state system are: what they consider excessive and unnecessary regulation, particularly for large commercial risks; approval of deals that allow companies to distance themselves from their past liabilities; and an inability to keep up with today's fast-changing business environment.

The executives also are concerned about Superfund reauthorization and ongoing consolidation in the industry, they said during a panel discussion last week at the 82nd joint annual conference of the Council of Insurance Agents & Brokers and the National Assn. of Casualty & Surety Executives at The Greenbrier.

The panel discussion was one of the more talked about events in an otherwise relatively quiet gathering of agents, brokers, insurers and reinsurers. Other sessions reflected producers' and underwriters' efforts to improve business performance, including working together to improve the quality of service to policyholders.

At the panel discussion, talk focused on whether the industry can keep pace with change.

Several insurer and brokerage executives expressed concern over the implications of regulatory approval for CIGNA Corp.'s plan to restructure its business to place long-tail liability risks into a newly formed runoff operation (*BI*, Oct. 9), and Zurich Insurance Co.'s plan to run off some of the risks of Home Holdings Inc. (*BI*, May 22).

Restructuring is inevitable in an industry that has had some good companies and some bad companies, said Maurice R. Greenberg, chairman and chief executive officer of American International Group Inc. in New York.

However, restructuring must be done with the public interest in mind. "You must stand behind the company, not cut it loose to be a burden on others," he said.

One way to promote the public interest, he suggested, would be to remove guaranty fund protection from liabilities being voluntarily run off by an insurer. That would offer an incentive to keep those liabilities with the parent.

If the insurance industry is to escape over regulation and move more toward self-regulation, "it can't escape its obligations," Mr. Greenberg said.

"The guaranty funds should not be in a position where they pay for runoff companies. That is just plain ludicrous. If we let that happen, we are really an industry that is on its way out," added Dean R. O'Hare, chairman and CEO of Chubb Corp. in Warren, N.J.

"Maybe we're coming up with

See **Regulation** *on page 10*



Kathryn J. McIntyre

Getting out of the sand was as problematical for some as the thorny industry issues discussed at The Greenbrier resort last week.

Comp systems urged to drop crisis mode

By MEG FLETCHER

ALBUQUERQUE, N.M.—Recent market improvements are creating a window of opportunity for state workers compensation systems to move away from crisis-oriented change toward a process of continuous improvement.

But it remains to be seen whether comp system participants—system administrators, legislators, insurers, employers and workers—will overcome past habits and begin solving problems before they reach crisis proportions.

Three speakers at the recent meeting of the International Assn. of Industrial Accident Boards & Commissions touched on this theme.

After an "astounding" turnaround, the state-based workers comp insurance system is "more stable today than it has been in years," said William D. Hager, president of the National Council on Compensation Insurance in Boca Raton, Fla.

For example, the combined ratio of workers comp insurers after policyholder dividends has improved significantly in recent years, with 1994 estimates of 97% by A.M. Best Co. and 101% by the NCCI from 109.1% the year before (*BI*, April 17).

See **Crisis** *on page 14*

Market is hardening for copter coverage

Fleet safety takes on new importance

By ROBERTO CENICEROS

Police helicopters in Los Angeles circle and dart overhead almost nonstop. Day and night their rotors churn over skyscrapers, homes, school yards and busy intersections.

And when a newsworthy police incident occurs, the potential for accidents shoots up as media helicopters swarm in close for film.

Despite those risks and a tightening liability market for helicopters, the Los Angeles city risk manager this month was able to renew hull and liability coverage for the city's helicopter fleet with only a net 10% increase in rates. The city's insurer increased actual rates by nearly 20%, but also credited the account 10% for a good loss record on the retrospectively rated policy.

A 20% increase in rates for $40 million of helicopter liability coverage is not bad, given that nationwide, even the best accounts are seeing rates rise far higher than that. Some commercial helicopter operators with bad loss experience could see rates spiral up to 200%, observers say.

Nationwide helicopter operators' loss record, coupled with the potential for big liability awards, has caused capacity problems, especially above $20 million.

One of the largest insurers of helicopter operators, British Aviation Insurance Group, announced a year ago it would leave the U.S. helicopter market.

Industrywide, premium volume is too small to cover potential claims and build reserves, brokers and insurers say.

"It's just very difficult to ignore two or three or four or five significant losses because there is not enough premium in the overall base of all accounts," said Bill Behan, president of AirSure Ltd., an aviation insurance broker in Golden, Colo. "It's just too small a universe with respect to that class of business."

Liability limits and rates for commercial helicopters reflect a couple of factors:

- Helicopters are more prone to mechanical failure than fixed-wing aircraft, according to an aviation underwriter who asked not to be identified by name.
- Many commercial operators perform high-risk services, such as landing offshore, landing in a field for emergency medical rescues, stringing power lines or moving external loads.

Some risk managers report that formal safety programs and long-term relations with their underwriters are helping them control costs at renewal.

See **Helicopters** *on page 24*



IMAGE BANK

Helicopter rates are spiraling upwards as limited premiums fail to keep pace with losses and growing exposures.

Showdown on hull clauses

Angry shipowners may shift coverage out of London market

By STACY SHAPIRO

LONDON—Shipowners are threatening to pull their business out of the London marine insurance market if new, restrictive hull and machinery insurance clauses are introduced as planned on Nov. 1.

Some are expected to move their fleets' hull coverages to the U.S. market, because U.S. hull insurers are unlikely to change their clauses at the moment.

London underwriters and other non-U.S. marine underwriters also have urged U.S. hull insurers to change their coverage wording along the same lines.

But, London underwriters are unmoved. Not only do they plan to introduce the so-called "institute time clauses," which update hull coverage conditions, on Nov. 1, but they and other non-U.S. marine underwriters also have urged U.S. hull insurers to change their coverage wording along the same lines.

Three years ago, the Joint Hull Committee in London—representing the Institute of London Underwriters and Lloyd's of London marine underwriters—set up a working party to update the 1983 ILU clauses in the hull and machinery insurance policy.

In 1994, the hull committee published a draft of proposed new coverage clauses, but brokers rejected the changes as ill-timed. Following consultation with brokers, another draft was produced earlier this year. This time, shipowners immediately balked at the changes.

During the review process, London underwriters never contacted shipowners directly for input, according to the International Chamber of Shipping in London.

That group, along with other shipowner associations from Greece, Hong Kong and Asia, objected in writing to the joint committee about the lack of consultation and also to four main aspects of the new clauses:

- The duty of the ship's policyholder, owners and managers to ensure that each vessel is surveyed for safety and seaworthiness by a surveyor approved by the underwriters.

Shipowners argue that they, rather than underwriters, should select the surveyors.

Also, the wording of the clause creates uncertainty, the shipowners maintain. For example, shipowners are supposed to report to underwriters whether the surveyor has issued any requirements or restrictions to maintain a ship's seaworthiness. Shipowners say it is unclear exactly what they would have to notify underwriters about, so they may end up filing "unnecessary and unwarranted" defensive notifications to underwriters to make sure this condition is met, shipowners say.

- The extension of a requirement to carry out duties under the policy with "due diligence"—which now applies only to shipowners—to also include the "managers or superintendents or any of their onshore management."

This "pushes the responsibility (of a ship) right down the management scale," said Colin Gilchrist, director of Sedgwick Marine, a division of Sedgwick Marine & Cargo Ltd.

Shipowners contend that "onshore management" is far too sweeping a phrase.

By contrast, the Joint Hull Committee said that the change re-

See **Hull** *on page 22*

Punitive

Continued from page 1

years.

"Is a jury free to transfer the entire gross national product, or any significant portion thereof, under a standard that has no limits?" he asked.

BMW's attorney, Andrew L. Frey, a partner with Mayer, Brown & Platt in Washington, offered the justice no mathematical formula in response, but said that punitive damage awards must take into account "the reprehensibility of conduct."

Justice Breyer's question pleased reform advocates.

"I think the greatest concern was brought up by Justice Breyer, which was that wealth was being redistributed without any pretense of complying with the due process procedural requirement that judgment be supported by an articulated rationale," said Lori Nugent, a partner in Chicago law firm Blatt, Hammesfahr & Eaton. Ms. Nugent and two other partners in the firm filed a brief in the case supporting BMW's position.



AP/WIDE WORLD

'Is a jury free to transfer the entire gross national product. . .under a standard that has no limits?'

Justice Breyer

BMW's attorney, Mr. Frey, had argued that a punitive award of $2 million for $4,000 in compensatory damage was unconstitutional because violated the due process clause of the 14th Amendment.

The court long has held that the clause has a "substantive" component of due process that requires all laws be fair and reasonable in their application.

The U.S. Supreme Court in the past has hinted that there might be some point at which punitive damages violate the doctrine of substantive due process, but has never indicated what that might be. Once, the court indicated the threshold might be in the vicinity of four times compensatory damages, but in another case it let stand a punitive award of more than 526 times compensatory damages (*BI*, June 28, 1993; March 11, 1991).

Mr. Frey also argued that it was wrong for an Alabama court to levy punitive damages for acts that took place in other states for conduct that was legal in those states.

"Alabama law was applied to conduct that Alabama had no business regulating," he said.

The case highlights what is being "submerged" in some similar cases, that people are being punished for actions that took place beyond a court's jurisdiction, Mr. Frey added.

Justice Ginsburg noted that in his summation at trial, the attorney for the plaintiff, Dr. Ira Gore, had urged the jury to multiply the compensatory award by the number of refinished vehicles and BMW did not object. The Alabama Supreme Court said that considering out-of-state refinishing was improper because no evidence had been presented "showing in which states the conduct was wrongful."

The court then cut the punitive award to $2 million, which it called "constitutionally reasonable."

Michael H. Gottesman of the Georgetown University Law Center told the justices that such awards were needed to "jolt" corporations into treating consumers fairly.

This argument was echoed by another of Dr. Gore's attorneys outside the court. Absent the fear of large punitive damage awards, businesses could perpetrate small fraud after small fraud without fear of a large penalty, said A.W. Bolt of Lucas, Alvis & Wash in Birmingham.

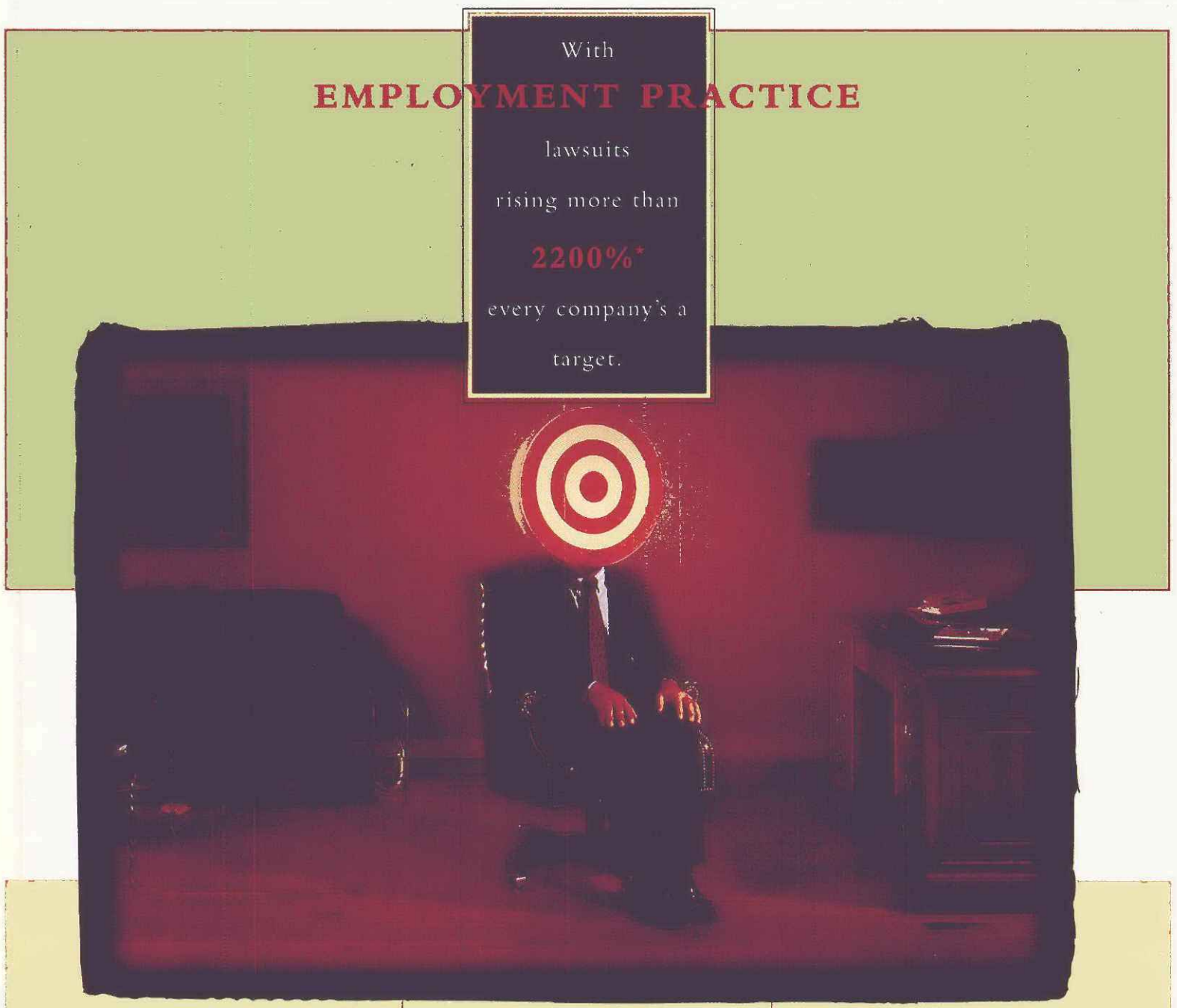
Dr. Gore "paid for a brand-new car" and "he didn't get what he paid for," Mr. Bolt said. "Society ought to stop a practice like that."

In other recent action, the court refused to hear several appeals.

In one case, the court let stand a 5th U.S. Circuit Court of Appeals ruling earlier this year that AIU Insurance Co. of New York was bound by an asbestos-related settlement agreement with W.R. Grace & Co. of Boca Raton, Fla. The American International Group Inc. unit and the former asbestos producer had reached an agreement in principle, but the insurer had not signed the final agreement. As much as $419 million is at issue.

The court also let stand a ruling last year by the 9th U.S. Circuit Court of Appeals that companies cannot take tax deductions for their non-qualified deferred compensation plans until the benefits are paid out. The ruling involved a deferred compensation program offered by J. Albertson's Inc., a Boise, Idaho-based grocer, to its top executives and other employees (*BI*, Dec. 12, 1994).

In the other case, the court let stand a 1992 2nd U.S. Circuit Court of Appeals ruling holding LTV Corp. of Cleveland liable to pay up to $140 million in benefits over 40 years to retired miners. BI



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*"Over the past two decades": source, Inc. Magazine article, "Law and Disorder".

** Insurance coverages are subject to the detailed provisions of the actual policy of insurance.

*** Labor law consultation service for TRIO™ insureds is provided by the law firm of Baker & Daniels (Indiana). Neither Alexander Howden Facility Managers, nor the TIG Insurance Companies are providing legal service or advice.

2 *BI* directory deadlines near

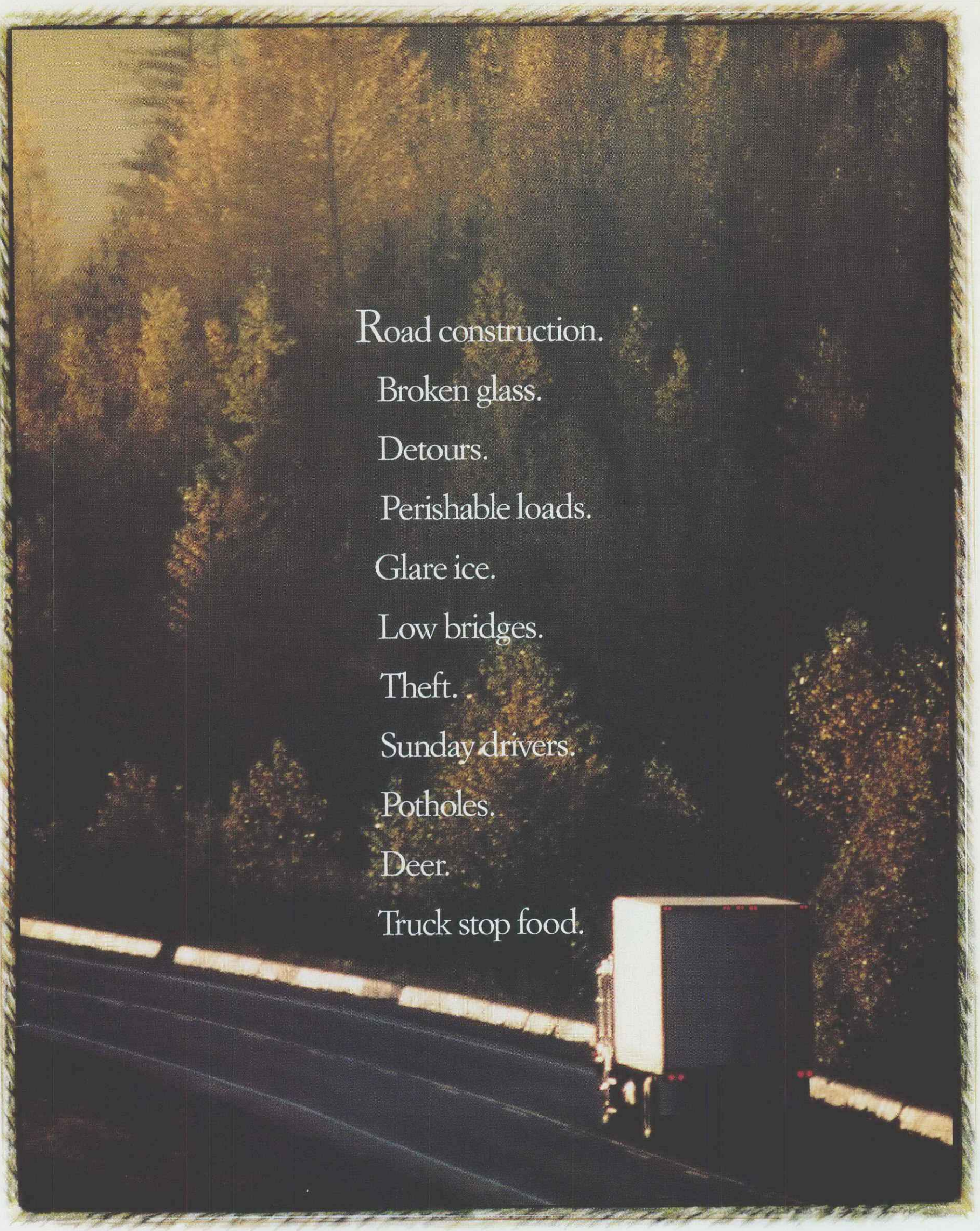
Deadlines are approaching for two *Business Insurance* directories.

The directory of global property/casualty insurers and international employee benefit networks will appear in the Nov. 6 issue. The extended deadline for returning completed questionnaires is Oct. 20. If your company is a property/casualty insurer or an employee benefit network that does business in countries other than the one in which you are based and have not yet received a questionnaire, please call Assistant Directory Editor Rich Trout at 312-649-5483.

In December, *BI* will publish its ninth annual directory of health maintenance organizations, preferred provider organizations and point-of-service plans.

In addition to addresses and phone numbers, the directory will provide information on individual HMOs, PPOs and POS plans, including: model type; number of participating physicians, hospitals and pharmacies; service areas; services offered and rating options; and the number of employers contracting with the organizations.

There is no charge to be included, but HMOs, PPOs and POS plans must complete and return a questionnaire by the deadline of Oct. 31. For a questionnaire, contact Directory Editor Sandra Budde at 312-649-5279.



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Wellness efforts using broader range of tools

Benefit Beat

Employers increasingly are relying on a greater breadth of activities to encourage employees to live healthier lifestyles, according to a new survey.

While health promotion education and training still is the most prevalent health promotion initiative among major employers, fewer employers are relying on this tool than two years ago, a Hewitt Associates L.L.C. survey found.

The survey of 1,035 major U.S. employers found that 78% offered health promotion education and training in 1994, down from 80% in 1993 and 83% in 1992. Education and training activities include classes, newsletters and self-paced kits.

However, health risk assessments, appraisals, financial incentives and disincentives, and other initiatives are growing in popularity, according to the survey.

For example, three-quarters of the surveyed firms said they offered health risk assessments last year, up from 74% the previous year and 66% in 1992. Health risk assessments are actual medical tests, such as cholesterol or blood pressure checks, that usually are given free to employees at a health fair, by a company physician or through a employer-sponsored medical plan.

The use of financial incentives and disincentives showed the most dramatic growth in popularity in the last few years.

According to the survey, last year 35% of employers used financial incentives, disincentives or both to encourage healthy behavior among employees. In 1993, only 18% of surveyed employers used financial incentives or disincentives, and only 14% did so in 1992.

Examples of incentives include monetary rewards for demonstrating health behaviors or for participation in a risk reduction program, such as a smoking cessation program.

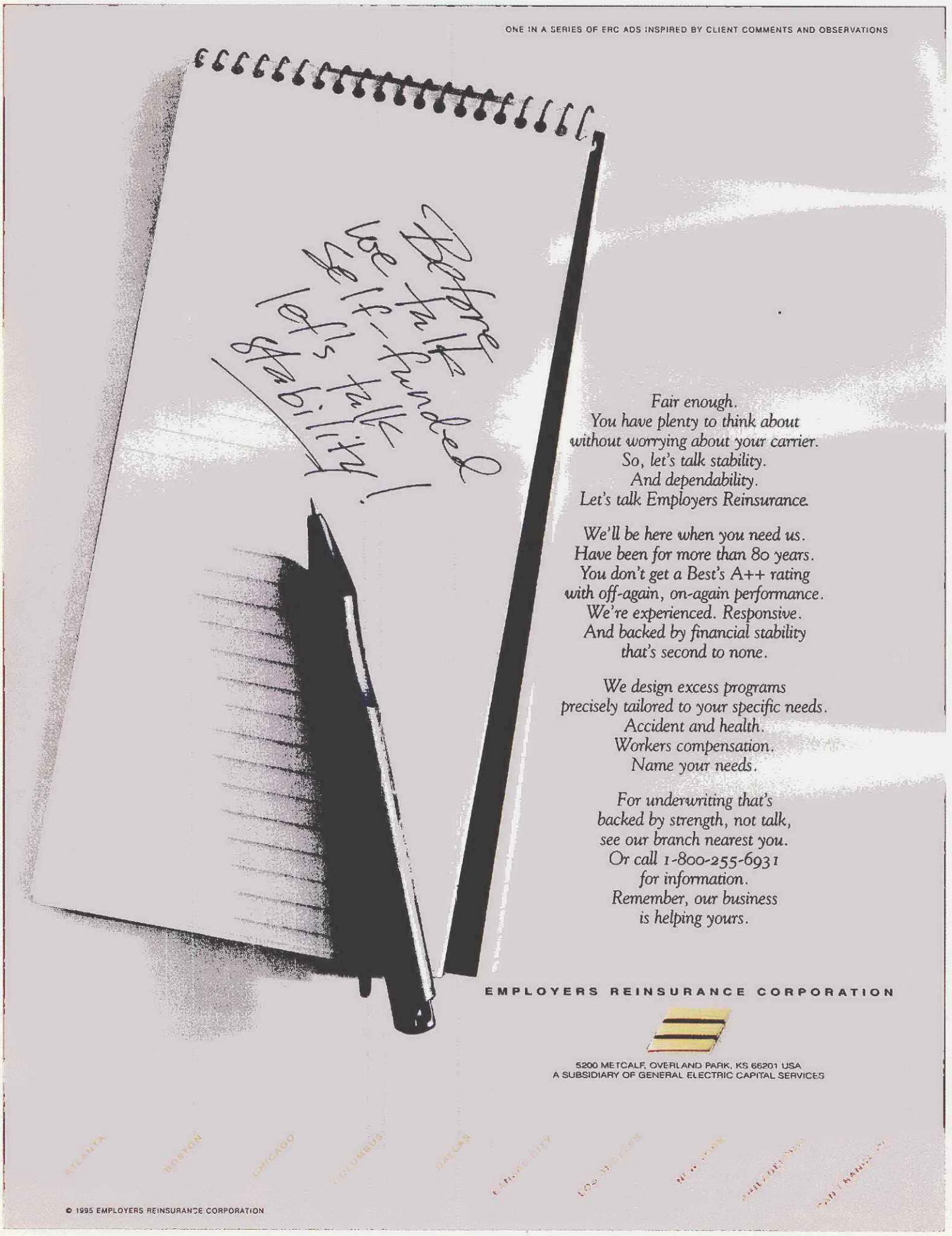
Examples of disincentives include requiring higher medical or life insurance premiums from employees who smoke, or paying lower medical benefits for injuries sustained in an automobile accident where safety belts were not worn or the driver was under the influence of alcohol.

Health risk appraisals—written questionnaires about health and lifestyle—grew slightly in popularity. In 1994 some 32% of employers used health risk appraisals, up from 30% in 1993 and 29% in 1992.

More than half of the responding employers, 52%, said last year they offered a variety of other health promotion initiatives, including prenatal care, on-site or employer-owned fitness facilities, subsidized health club memberships, and employer-paid physicals or well child exams. Only 44% of the employers said they offered these activities in 1993, up from 38% in 1992.

Copies of the survey, "Health Promotion Initiatives/Managed Health Provided by Major U.S. Employers in 1994," are available for $35 from Diane Schuett, Hewitt Associates, 100 Half Day Rd., Lincolnshire, Ill. 60069; (708) 295-5000.

—By Deborah Shalowitz Cowans



401(k) loan survey

More than 80% of employers with 401(k) plans allow employees to borrow from the savings plans, and employees borrow an average of $3,438, according to a new survey.

The survey of 377 401(k) and other defined contribution plans by the Chicago-based Profit Sharing/401(k) Council of America, also found that most plans—73.9%—tie the interest charged on loans to the prime rate. They may charge the prime rate itself or the prime rate plus one percentage point.

While slightly more than 11% of plans allow plan participants to borrow less than $500, most plans—63.1%—set the minimum loan amount at $1,000 to $1,500.

Most employers charge fees when employees borrow from their 401(k) and other defined contribution plans. For example, 40.5% of plans charge an origination fee, while 10.8% impose an annual fee and 6.1% charge other types of fees.

However, 42.7% of employers do not charge employees fees when they take a loan from their savings plan.

The survey also found that nearly all 401(k) plans—93.5%—permit participants to take hardship withdrawals. The most common situations in which hardship withdrawals are permitted include purchase of a primary residence and educational and medical expenses.

Copies of the "38th Annual Survey of Profit Sharing and 401(k) Plans" are available from the Profit Sharing/401(k) Council of America, 10 S. Riverside Plaza, Suite 1610, Chicago, Ill. 60606-3802; 312-441-8550. The cost is $95.

—By Jerry Geisel

Disney partner benefits

BURBANK, Calif.—The Walt Disney Co. will begin offering health care, dental and vision benefits to the live-in partners of its gay and lesbian employees beginning Jan. 1.

The move is in keeping with a corporate non-discrimination policy that applies to sexual orientation, among other factors, a spokesman said.

To claim the benefits, a Disney employee must sign an affidavit that he or she and the partner "essentially are life partners," the spokesman said, including that the couple has lived together for at least a year and are financially interdependent.

The company wiil not extend benefits to unmarried heterosexual partners.

Disney could not provide an estimate of how many of its 65,000 employees nationwide might take advantage of its new benefit.

—By Sara Marley

Your reputation is on the line when your client files a claim. Who comes through without fail?



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Opinions

Health plan, heal thyself

WHO COULD BE AGAINST care for mothers and their newborn infants?

Certainly not the handful of state legislatures that have passed or considered measures this year requiring insurers and health maintenance organizations to provide minimum levels of coverage for hospital stays after childbirth, typically two days following a normal birth and four days for Caesarean section deliveries.

Several members of Congress also want to mandate minimum coverage periods for childbirth. The federal proposals mirror those that have passed state legislatures, except for the fact that any changes made by Congress also would apply to self-insured group health plans.

We understand the motivation and interest of legislators in this area, but we are concerned about the implications of benefit mandates. Once that Pandora's Box is opened, where would lawmakers draw the line?

Instead, we would prefer to see the market address the problem itself, much as it has responded to pressure to relax pre-existing condition exclusions. If it doesn't, the market risks inviting federal intervention.

Lawmakers' interest has been triggered by consumer and physician complaints about the pressure that some insurers and HMOs have been putting on hospitals and doctors to discharge mothers and their infants as soon as possible after uncomplicated deliveries—in some cases, less than a day after the birth—in order to keep costs down.

While some mothers want to go home as soon as possible, others may not be ready for such an early discharge and should not be booted out of the hospital until they and their children are physically and emotionally prepared to go home.

While the motivation is understandable, we question if mandating minimum coverage periods is the right approach.

The practice of medicine is—by its very nature—a changing one. Only a few decades ago, for example, physicians routinely recommended a week of hospitalization for women after childbirth. Such lengthy hospitalizations for normal childbirth are unheard of today.

Improvements in medical care and a widespread recognition that recovery from surgery can often occur faster at home than in the hospital have reduced average



lengths of stays not just for childbirth, but also for virtually all procedures.

It is also worth noting that some women want more natural childbirths with minimal medical intervention, including no hospital stay.

Just as no one could have known years ago how advances in medical science would make unnecessary those once-common weeklong hospitalizations for childbirth, legislators can't possibly know today what will be appropriate lengths of stay for childbirth or other medical procedure in the future. Mandated lengths of stay could quickly become obsolete.

Mandated lengths of stay for childbirth are ill-advised for another reason, as well: they focus exclusively on one aspect of maternity—delivery of the baby in the hospital—and fail to recognize that maternity truly is a nine-month episode.

For all those reasons, we hope legislators drop their well-intentioned but unnecessary and possibly counterproductive efforts to micromanage benefit plan design.

Instead, we urge health care plans to police themselves and ensure that they remain flexible in covering a reasonable longer period of stay after childbirths when needed.

Letters

Proposal can't see the forest for the trees

To the editor: In his Oct. 9 letter to the editor, "Zurich Urged to Preserve Pristine Sterling Forest," Donald C. Pachner suggests that Zurich Insurance Co. should be "forward-thinking" by "donating" Sterling Forest to New York state.

Zurich prides itself on its generosity and is a major contributor to a wide range of philanthropic activities on a worldwide basis.

However, for the record, your readers should be aware that Zurich owns less than 12% of the common stock of Home Holdings Inc., which remains majority owned by Trygg-Hansa A.B.

A subsidiary of Zurich, Risk Enterprise Management, has entered into a contract with The Home Insurance Co. to run off its liabilities and manage its assets.

Sterling Forest is a subsidiary of The Home Insurance Co. As insurance companies do with all their assets, The Home invested in Sterling Forest for the purpose of realizing a return on its investment to eventually help pay its insurance obligations.

The Home has thousands of policyholders throughout the United States and the world. We believe that those policyholders would not be pleased to see Home Holdings donate Sterling Forest to the detriment of the asset base available to pay claims.

The Home's mandate as enunciated by the insurance regulators as part of their approval of the recapitalization is to manage its assets in such a way as to be able to meet all of its financial obligations to policyholders and other creditors.

Sterling Forest has a substantial book value that is important to The Home if it is to meet its goal of paying all policyholders' claims and other debts in full.

With regard to Mr. Pachner's suggestion that the land be sold to New York state or other government entities, Sterling Forest Corp. has always been and continues to be amenable to such a sale of all or part of its lands on a fair and reasonable basis.

This is not the forum to refute Mr. Pachner's erroneous statements about the Sterling Forest land-use proposal, but he and others should be aware that Sterling Forest Corp. shares his concerns about the environment and has made a proposal that, among other things, would permanently preserve over 13,000 of the 17,500 total acres as park land.

We hope that groups like the Sierra Club will be open-minded when reviewing the proposal.

Cooperation among all interested parties—including environmental groups, local municipalities, local residents, the states of New York and New Jersey and Sterling Forest Corp.—can lead to enormous benefits for all concerned.

Steven D. Germain
General Counsel
Home Holdings Inc.
New York

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Regulation

Continued from page 3

arguments for a two-tiered regulatory system," said John F. O'Sullivan, managing director of Marsh & McLennan Inc. in New York. "Quite frankly, I think the guaranty fund should be available for the small policyholder, personal lines. But when it comes to sophisticated buyers, perhaps that should be done on a national basis and they would not have—should not have—access to the guaranty fund."

It does seem "silly" that a guaranty fund should cover a runoff company, agreed Dennis H. Chookaszian, chairman and CEO of CNA Insurance Cos. in Chicago. At the same time, he added, "If you were a policyholder, you wouldn't be very happy about the fact that if 20 or 30 years after you bought the policy, someone said, 'Oh yeah, guaranty funds covered that policy when it was issued, but we changed our mind.' "

This problem arises not because of a single company, nor is it something that will change in the next several months, he said. "It is a fundamental part of restructuring that's going to take place in the casualty insurance business over the next five years."

An industry that traditionally raised capital from individual shareholders is turning more to venture capital firms, Mr. Chookaszian said, and this change is prompting a variety of methods for restructuring liabilities.

"The question becomes: Which of those are responsible transactions and which aren't? The difficulty is that the regulatory process is not adequately prepared to deal with that today," he said. "There need to be some sort of standards to be brought to bear before this becomes a problem."

Regulators must fix the problem and decide what kind of transaction is "legitimate public policy," he advised.

However, Mr. Greenberg suggested that most regulators are not equipped to decide such issues.

"The problem with regulators is shown in one case, quite recently, when a foreign company cherry-picked the business of a company in the United States," according to Mr. Greenberg, referring to the New Hampshire Insurance Department's approval of the Zurich/Home deal.

"The state that had jurisdiction had about three people and thought they couldn't supervise the rehabilitation of the company itself and, hence, they sought the easiest way out. Regulation, in dealing with different states, is not the way to solve the problem if the state with jurisdiction is a state with a small insurance department," he said.

Panel moderator Robert E. Vagley, president of the American Insurance Assn. in Washington, posed the question of whether it is time to rekindle a discussion of proposals for a less-regulated industry under the purview of the federal government.

"The regulatory system causes us a tremendous amount of burden and raises the cost to consumers," said Mr. Chookaszian.

"The burden of state regulation has become so unbearable and so inefficient that many companies are thinking that a federal system might be better," he said.

Mr. Chookaszian said he is encouraged, though, by the efforts of New York Superintendent of Insurance Edward J. Muhl, who is restructuring and eliminating layers of regulation in the state.

"It's essential that we look very closely at the regulatory system," said Mr. O'Sullivan. There are essentially two classes of insurance, he said: personal lines, which requires regulation at the local level, and commercial lines, which should be regulated on a national basis.

"I'm very much in favor of federal regulation, because it reduces costs," said Mr. O'Hare.

"I believe the system we have now is protectionist, for foreign companies in particular that have to contend with 50 different licensing processes" he said. "Yet, we complain about not being able to compete in foreign markets. Until we do something at home, it's very difficult to throw stones."

Ultimately, the industry must come up with proposals for regulating itself if it is to shed the burden of external regulation, said Mr. Greenberg.

The panelists also discussed the need for solutions to the nation's environmental problems and changes in federal Superfund regulations.

"Any sane or thoughtful person wants to see our environment cleaned up. But we ought to do so in the most efficient manner, not the most costly manner," Mr. Greenberg said.

"I think progress has been made in both the House's and Senate's initial bills in the last couple weeks," he said, adding, though, that they are flawed in that they leave retroactive liability intact.

The leaders of the committees are essentially holding insurers over a barrel: They might eliminate retroactive liability if insurers agree to pay some amount toward cleanups, he said.

'The burden of state regulation has become so unbearable and so inefficient that many companies are thinking that a federal system might be better,' says Dennis H. Chookaszian.

Although Mr. Greenberg said he is hopeful that Superfund reform legislation will be enacted, he said that it currently is being overshadowed by budget and Medicare legislation.

"I think our industry needs to continue to take a strong position that we need retroactive liability reform as part of these proposals," said Mr. Chookaszian.

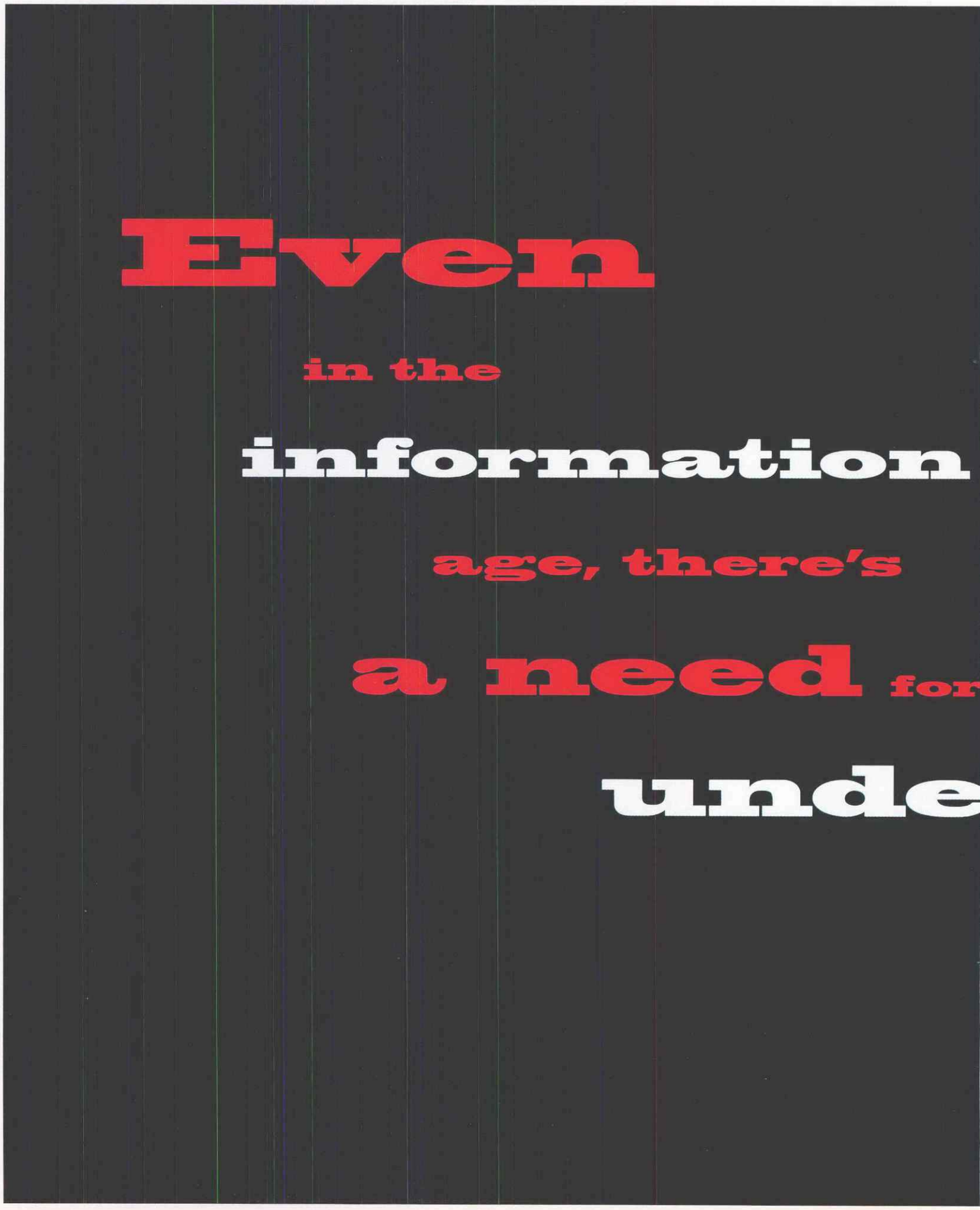
All the executives agreed that the insurance industry currently is much more unified on Superfund that it was a year ago.

"The industry is united under this issue. Retroactive and joint and several liability should be eliminated. When you think of the fact that more money is spent on litigation than actually cleaning up these sites, the situation is ludicrous," said Mr. O'Sullivan.

Mr. Greenberg also deplored the appropriation of billions of dollars in Superfund trust funds to reduce the deficit.

"There was, up until now, about a $3 billion trust fund for Superfund—monies that were set aside, prior to this Congress, to be used as part of the cleanup process. In addition, there was $1.5 billion a

Continued on next page



Regulation

Continued from previous page

year being collected under various taxes for cleanup," he noted. "This Congress has taken away the $3 billion some time ago. There is nothing there but an accounting entry. And the $1.5 billion was taken, and they're now looking for new money. The process is bizarre."

"These funds are being used to reduce the deficit? That's appalling," said Mr. O'Hare.

The executives also discussed the impact of consolidation in the insurance industry

The key concern in consolidations is solvency; whether a company will be around in 20 years or so to pay claims after a consolidation, Mr. Chookaszian said.

Hidden liabilities are another concern, said Mr. O'Hare. "When you look at the kind of liabilities that you may acquire, this tends to be a little scary," he said. "Dennis (Chookaszian) and I lived through something called Fibreboard, where together we paid out over $3 billion. In our case, that evolved from the acquisition of Pacific Indemnity in 1967, where a liability was created in 1957. So mergers and acquisitions can come with surprises and be extremely expensive."

Richard S. Rohde, a partner with San Diego brokerage Barney & Barney, quipped that clients are enthusiastic about consolidation because it means fewer brokers calling on them prospecting for new business.

Mr. Greenberg said the consolidation is simply one facet of ongoing changes in the industry, which will also include new ways of selling insurance.

"I think that change is inevitable. Every industry that I know of has been engaged in recognizing the benefits of change and our industry is no exception. Those who resist change simply won't be around," said Mr. Greenberg.

On large commercial risks, the broker is the key today. But I think that is changing, says Maurice Greenberg.

In the future, he predicted, a lot of personal lines business will be sold on a direct basis.

Mr. O'Hare agreed, noting that the United States is one of the only markets where insurance companies sell through a single distribution system, whereas companies in Europe and Asia employ multiple options.

However, Mr. O'Sullivan said that the broker is still a critical part of the transaction for large commercial risks. He cited Boston-based Liberty Mutual Insurance Co., traditionally a direct writer, which increasingly has used brokers for complex commercial risks in recent years.

"So I think you can try to access the ultimate buyer through any number of distribution systems, but if you are dealing with a sophisticated buyer with complex insurance needs, you need professional insurance broker," he said.

"On large commercial risks, yes, the broker is the key today. But I think that is changing, too," said Mr. Greenberg. "The broker is going to have to become far more sophisticated in balance sheet asset management, not just procurement. If you're the CEO of an industrial company doing business worldwide, you have risks in many different areas, not only insurance risk. What does he care, this CEO, if he has a plant blow up in India, or if he has an interest rate loss or currency loss. . . .he's interested in the bottom line."

Mr. O'Sullivan agreed that brokers have to be able to respond to a wide variety of risks and more sophisticated buyers coming to brokers for help in dealing with financial risks. "Maybe the broker of today has to do more than simply access the traditional pools of risk transfer capital and has to look elsewhere," he said.

The panelists see banks continuing to make inroads into the insurance distribution business, but not insurance underwriting.

Agents should be partnering with banks and negotiating to become their insurance sales arms, rather than focusing on blocking their entry, said Mr. Chookaszian.

Banks have extensive customer lists and the trust of their clients, which agents can use to expand their opportunities, he noted.

"I don't know what the fuss is about," said Mr. Greenberg, noting that in some states with grandfathered laws, banks have owned agencies for years. A larger bank role in distribution is inevitable, he said, though underwriting is unlikely.

"Should they underwrite automobile insurance? No, unless you want another banking crisis," Mr. Greenberg said.

Concluding the discussion, the panelists were asked to list their company's top concerns, as well as what they saw as the leading issue for the industry.

Mr. Chookaszian said: "Our top three concerns are: Merge with Continental. Merge with Continental. Merge with Continental." The industry's largest concerns, he said, are Superfund and mass torts.

Mr. O'Sullivan said M&M's biggest challenge is developing a global brokering system that should be online next year. Industry-wise, his main concern is the need for a two-tiered regulatory system.

Mr. O'Hare said Chubb's primary focus is on becoming a more customer-focused organization. For the industry, he sees Superfund as the top issue.

Mr. Rohde said his firm's top concern is improving quality of contacts with its customers, while a larger concern is the state of California's workers comp market.

Mr. Greenberg said opening new foreign markets and keeping others open is AIG's top concern. He sees the industry's top challenge as maintaining underwriting profit discipline. BI

Having good data is important. But frequently, what a business really needs is timely, useful information to fully understand its situation. Until recently, Leiner Health Products, headquartered in Garden Grove, California, had multiple policies for workers' compensation coverage — one for each state in which the company did business. Collecting and entering current losses and ratings onto spread sheets was slow. The company also had to deal with multiple loss control programs and their representatives, a process the Leiner home office described as frustrating. After determining Leiner's needs, agent Lloyd Ross, along with

rstanding.

SAFECO's commercial lines team, was able to write just one policy. SAFECO's multi-state capabilities now save Leiner time and office expense, and result in fewer loss control visits. Just as important, by putting all locations on a single policy, SAFECO was able to provide Leiner with premium discounts of $100,000. If this is the kind of information you're interested in, let's talk.

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Commercial Lines

Joint conference draws over 1,000

WHITE SULPHUR SPRINGS, W.Va.—The 82nd joint annual conference of the Council of Insurance Agents & Brokers and the National Assn. of Casualty & Surety Executives attracted more than 1,100 registrants and guests to The Greenbrier resort here last week.

The Oct. 8-11 meeting featured several continuing education courses, seminars, panel discussions and speeches, mixed with a healthy dose of golf, tennis and other recreational activities.

Next year's meeting will take place Oct. 6-9 at The Greenbrier. For additional information, contact the Council/NACSE, 316 Pennsylvania Ave. S.E., Suite 400, Washington, D.C. 20003-1146; 202-547-6616.

Improving insurers' image

Public must be educated about industry's role in society

By PAUL D. WINSTON

WHITE SULPHUR SPRINGS, W.Va.—The industry must do a better job of educating the public about insurance and positioning its products if it is to improve its image, a reinsurer executive contends.

Insurance plays a critical role in society but is too often blamed for problems that really constitute a shift in society's acceptance of risks, he says.

"It seems pretty obvious that insurance is the only way that we can achieve personal security for our families and do the kinds of things we want to do. It seems equally obvious that insurance is the lubricant for the wheels of commerce," Ronald E. Ferguson, chairman and chief executive officer of General Re Corp., said at last week's joint meeting of the Council of Insurance Agents & Brokers and the National Assn. of Casualty & Surety Executives at The Greenbrier.

"We can take pride that in our underwriting and risk management activities, we pave the way for the private market to make rational economic and risk management decisions," said Mr. Ferguson, who also is president of NACSE.

Nevertheless, it is an industry whose participants and products generally are held in low esteem.

One reason for this, Mr. Ferguson suggested, may be a case of confusing the message with the messenger.

"We are a scorecard or mirror for society. As society goes through the throes of changing its notions about risk, about reparation systems, about subsidization and about redistribution of wealth, society looks at the insurance industry as the mirror or scorekeeper for all that and sometimes society doesn't like what it sees," he said.

It becomes an "insurance problem rather than a fundamental issue society needs to grapple with," he said.

The solution—albeit a challenging one—is educating the public about insurance's actual role and getting more involved in the political process, Mr. Ferguson said.

As one example of the kind of efforts that are needed, he cited a teacher in Missouri, Ben Stewart, who teaches fourth-, fifth- and sixth-grade students about safety and risk management.

A second reason insurance is unpopular is that the industry has not properly positioned its products and services to consumers, Mr. Ferguson said.

Insurance is not an item whose purchase is immediately appreciated by consumers, unlike such things as food, a movie ticket or a car. Having to buy car insurance may even be seen as a sort of tax, he said.

"The root of the problem—how do we make (buying insurance) a pleasant, pleasurable experience—is found back 50 years ago when the competitive model for business in the United States was developed," Mr. Ferguson said. After World War II, the U.S. economy accounted for 75% of the world's economy, he explained.

The competitive model that emerged in that environment was that business was focused on local markets, advertising and brand loyalty were important, and there was a "product orientation," as opposed to a customer orientation, he explained.

The reality today, Mr. Ferguson told attendees, is that the U.S. economy now makes up only about 22% to 27% of the world economy.

"The U.S. is no longer king of the commercial world. We have moved to an era where the customer or client is king," he said.

If the insurance industry is to meet the challenge of providing a product that is appreciated by the client, it needs to develop a new competitive model, according to Mr. Ferguson.

The key to obtaining a "sustainable competitive advantage," while enhancing the experience of buying insurance, is to focus on five C's:

- Core competency. The industry's core competency is underwriting and risk management, he said. However, for more than 30 years the industry has relied on improving investment returns to buoy results, rather than focus on underwriting profitably. Mr. Ferguson noted that several companies are starting to refocus on those core competencies.
- Compress time. The industry has to use technology and knowledge to re-engineer and reduce "cycle times," such as the time it takes to deliver policies or pay claims, he said.
- Continuous improvement. Citing a former CEO of Xerox Corp., Mr. Ferguson said: "Quality is a journey, not a destination."
- Continuous learning. Time and money is being devoted to training insurance industry personnel over their entire careers, rather than several years at the start of their careers.
- Client relationships. Insurance organizations must be made "flatter, faster and more collaborative" to deliver a valued product or service to the customer, he said.

"If we are able to take these concepts. . .and drive them into the structure and behavior of our companies, we can achieve a sustainable competitive advantage and I think we will then be in a position to not just serve the client but to actually try to delight the client. That should really be our goal," Mr. Ferguson said. BI

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Caution urged on distribution

By PAUL D. WINSTON

WHITE SULPHUR SPRINGS, W.Va.—As it strives to keep up with a changing marketplace, the insurance industry must be careful not to throw the baby out with the bath water, an agent says.

To respond to new customer demands, some in the industry are seeking to create new systems of distribution, rather than improve the current system, he says.

However, there is room for improvement in the service provided by both agents and insurers, he said.

"As we move into another era, let's preserve what works in the old system and make changes where the old system no longer works," said Erland P. Stevens Jr., senior vp of The Putnam Agency in Ashland, Ky., and outgoing president of the Council of Insurance Agents & Brokers.

He spoke to agents, brokers and insurers at the joint annual meeting of the council and the National Assn. of Casualty & Surety Executives last week at The Greenbrier.

Mr. Stevens noted that many insurers are exploring alternative means of selling their products.

"I'm not suggesting that apparent opportunities should be passed by, but I can't help thinking that existing relationships could meet the same needs if the best new products and automation and staff were dedicated to our existing distribution system," he said. "We need to ask ourselves what we could accomplish if we put the resources and creativity that are spent on new projects—some of which are bound to fail—to improve our current system."

In talks with insurers to discuss this and other issues, it has become clear that the industry needs to squeeze costs out of the system and improve customer service, he said.

However, some cost-cutting moves work against improving quality.

"One day we centralize services for efficiency and the next day we decentralize to locate our services closer to the point of sale. Companies suddenly withdraw from markets and dismantle their service teams only to re-enter the business soon afterwards. . . I also fail to see how cutting commissions alone makes the system more efficient," Mr. Stevens said.

But the problem is not only on the company side.

"Many agents and brokers are making short-sighted decisions to save the bottom line. We automate, but automation is one of the first expenses we cut or delay. Banks are far ahead of us in automation and, given the chance, will utilize their distribution network to compete with us. We also have yet to see whether the latest wave of mergers and acquisitions among agents and brokers will truly pay off," he said.

In talks with insurers, the agent and broker group has considered several areas ripe for eliminating inefficiency. Examples include:

- Premium collection. "Direct billing makes sense, but it has to be efficient with timely delivery of policies, logical payment plans and responsive to customer inquiries."
- Endorsements and audits. Mr. Stevens said he questions whether the income justifies the expense.
- Outsourcing. A number of insurers are outsourcing claims, audits and other services, he noted.

It is a good idea, but companies should consider "keeping the revenue in the 'family' " by going to agents and brokers first before an outside provider, he said.

- Personnel. "Too often, the lowest-paid and least experienced (insurer) personnel are the ones making the decisions. We regularly talk with individuals who have a 1% authority to say 'Yes' and 100% authority to say 'No,' " he said.
- Personal lines. "I don't think we should concede defeat in personal lines. If we work together to lower our costs and streamline expenses, we can compete (with direct writers). Once we abandon markets, they are lost to us. How many markets can we afford to abandon?"

"There are great opportunities for us all but, like other industries, we face dramatic challenges that will change the nature of our business," Mr. Stevens said. "The first step is to restore two-way channels of communication and trust." BI

Council picks new officers

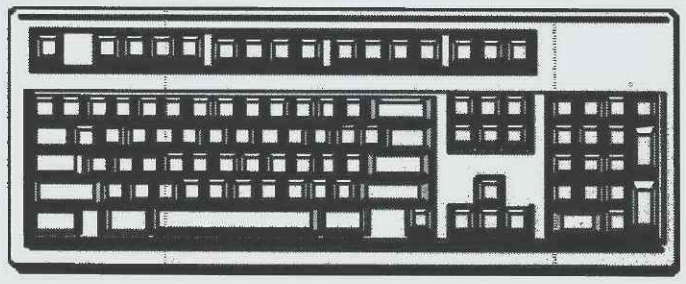
WHITE SULPHUR SPRINGS, W.Va.—The Council of Insurance Agents & Brokers elected new officers for 1995-1996 during last week's annual meeting at The Greenbrier resort.

Harry A. Koch, president and chief executive officer of The Harry A. Koch Co. of Omaha, Neb., was elected president. He succeeds Erland P. Stevens, senior vp of The Putnam Agency of Ashland, Ky.

Other newly elected officers included: Albert R. Counselman, president and CEO of Riggs, Counselman, Michaels & Downes Inc. of Baltimore, elected vp; John C. Adams Jr., executive vp of Hilb, Rogal & Hamilton Co. of Glen Allen, Va., elected treasurer; and James J. Kolbride, president of Morse, Payson & Noyes Insurance of Portland, Maine, elected treasurer.

In addition, the council elected several new directors: Robert F. Denny, chairman of Edward F. Cook Agency Inc. of East Hampton, N.Y.; Philip J. Edmundson, president of Minet Gallagher Associates in Boston; Robert J. Murphy, senior vp and managing director of Alexander & Alexander Inc. in New York; and Ronald S. Pavlik, senior vp of Mesirow Financial Services in Elgin, Ill.

Several directors were also re-elected to another term: Andrew G. Cassidy, senior vp of Early, Cassidy & Schilling Inc. of Bethesda, Md.; James F. Cuff Jr., vp and secretary of Byerly Insurance Agents & Brokers Inc. of Lemoyne, Pa.; Charles R. Daniels III, president of The Daniels Agency in Pawling, N.Y.; Stephen F. Dunlap, chairman and CEO of The Dunlap Co., of Auburn, Maine; Gary R. Griffith, chairman and CEO of Summit Global Partners Inc. of Dallas; John F. O'Sullivan, managing director of Marsh & McLennan Inc. in New York; William T. Platt Jr., who is senior vp of CoreSource Inc. in Mount Clements, Mich.; and Robert J. Sutter, who is vp and sales manager of Pritchard & Jerden Inc. of Atlanta. BI



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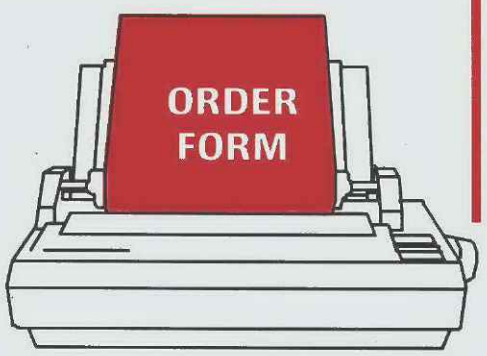
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Crisis

Continued from page 3

"We've made a lot of progress to get it back to a system that is more understandable to the employee and the employer, but I don't think the job is done yet," said Richard L. Thomas, senior vp with American Home Assurance Co. in New York, a unit of American International Group Inc.

Instead of relying on the traditional cycle of crisis, reform, crisis, participants need to overcome their "inertia" and establish a process of data gathering, assessment and mid-term corrections that can lead to continuous improvement, said Richard Victor, executive director of the Workers' Compensation Research Institute in Cambridge, Mass.

The quality of workers compensation data now is so poor overall that the system can be likened "to driving a $70 billion truck down the road at night with no headlights, no instruments and a foggy windshield," Mr. Victor quoted a colleague as saying.

Improving the data and using it to benchmark and compare state operations could help policymakers make corrections that will keep the truck from going off the cliff, he said.

Mr. Victor said the IAIABC could be "a catalyst" for fostering improved data collection with quarterly reviews in individual states.

For example, the IAIABC has already made significant progress in recent years in speeding the electronic transfer of workers comp data through computerized first and subsequent reports of injuries. A new manual on the program was released at the meeting.

But, there is more to be done.

NCCI's Mr. Hager identified five key obstacles to sustaining stability:

- Insist that worker safety becomes a permanent and unyielding focus.

"In recent years, we've seen great employer attention paid to safety," he said. For example, injuries resulting in time losses dropped 18% between 1990 and 1993, even in traditionally dangerous industries like mining, construction and manufacturing. In addition, fatalities have dropped by 50% or more between 1992 and 1995 in 13 states and the District of Columbia.

- Insist that the system deliver medical care and payments to workers with computer-aided speed.

An NCCI study of high-cost injuries in 15 states found that it took, on average, seven to 13 days after an accident for employers to report it to their insurers, and another seven to 16 days for the insurers to make the first benefit payment to an injured worker.

A recent study demonstrates the cost of delays, he said. The medical care and wage-loss payments for an employee injury reported within 10 days costs an average of $5,800, compared with $8,600 for one reported 31 days or later.

- Finish the statutory reforms, particularly in a handful of states that need reform.

The NCCI predicts legislative reforms, including limiting compensability for claims such as stress-induced illnesses, will have removed more than $1.3 billion in costs from the workers comp systems in NCCI states from 1991 through 1995, Mr. Hager said.

Special interest groups must be prevented from eroding the legislative gains that have been made, he said. In addition, reforms must be implemented in Alabama, Georgia, Hawaii, Illinois, Missouri, New York, Pennsylvania and Tennessee.

- Ensure that adequate loss costs are the rule, not the exception.
- Continue to move the residual markets to self-funding status so they no longer are a source of large deficits, as they have been.

American Home's Mr. Thomas said workers comp systems also are challenged by the need to simplify the system to make it easier for workers to understand. In addition, state workers comp systems need to provide "equity" so workers with similar injuries receive comparable benefits, regardless of the state in which they are employed.

"The workers compensation system is a very dynamic system and it is constantly changing," he said. "If we. . .become complacent, as we were 15 years ago, it will spin back out of control." BI

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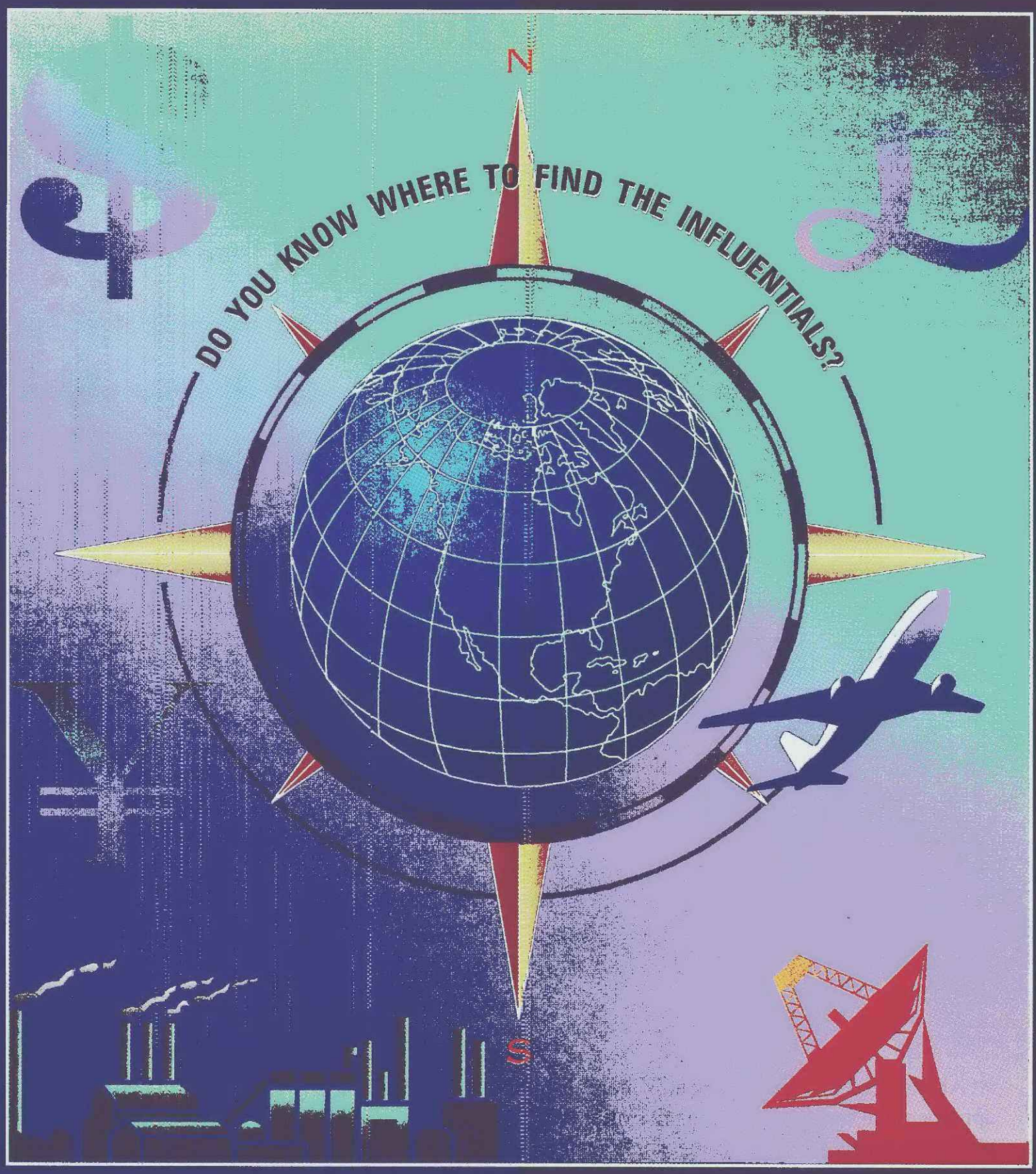
Comp meeting attended by 400

ALBUQUERQUE, N.M.—About 400 delegates, 150 guests and 100 exhibitors attended the 81st annual International Assn. of Industrial Accident Boards and Commissions convention Oct. 3-7.

New officers were elected to one-year terms: President Michael Clingman, CEO of the Arkansas Workers Compensation Commission, who had been acting president; President-elect Ann Clayton, director of the Florida Division of Workers' Compensation; Vp Robert F. Arrigan, chief judge of the Rhode Island Workers Compensation Court; and Secretary Michael LeFever, executive director of the South Carolina Workers Compensation Commission.

The IAIABC recently restructured its operations. George Gomez was hired as executive director of main operations, which recently relocated to Shawnee, Kan., from Daytona Beach, Fla. Robert Collyer, the former executive director, will continue as executive director of the IAIABC's International Workers Compensation Foundation, which remains in Daytona Beach.

The 1996 convention will be Sept. 11-Oct. 2 in Chicago.



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Managed care laws test mettle

Comp programs have to keep abreast of state variations

By MEG FLETCHER

ALBUQUERQUE, N.M.—Keeping up with the latest state options for using managed care for work-related injuries is difficult for even the savviest risk managers.

Thus far, about 30 states have created new requirements and opportunities for allowing employers to use managed care approaches, including testing 24-hour pilot programs, according to the National Council on Compensation Insurance.

"There are a lot of evolving techniques and methods to approach managed care," said Robert Steggert, vp-casualty claims for Bethesda, Md.-based Marriott International Inc.

He spoke at a recent National Council of Self-Insurers meeting held during the annual convention of the International Assn. of Industrial Accident Boards and Commissions.

Workers compensation laws regulating the programs vary significantly state to state, Mr. Steggert said.

One of the simplest is in Colorado. Employers there, or their insurance companies, are required to offer at least managed care or medical case management in 11 designated counties, according to the NCCI.

Florida has one of the most complex. In April, insurance companies first were allowed to offer managed care arrangements, the NCCI said. Beginning Jan. 1, 1997, work-related injuries and illnesses will have to be treated only through managed care arrangements.

Meeting those kind of intensive requirements creates concerns for a large company such as Marriott, which has 10,000 employees in 27 counties in that state, Mr. Steggert said.

It also creates large "hidden" costs for self-insuring employers like Marriott, which may not be reflected in workers compensation data reported to state authorities, Mr. Steggert said.

Marriott is exploring several options for meeting the requirements.

It wants to ensure that the health care providers it uses are committed to an intensive, "sports medicine" approach so workers can return to work as quickly as possible, he said.

For now, Marriott plans to meet many of the new law's requirements through existing in-house programs, including case management, utilization review and grievance procedures.

However, meeting the state's new quality assurance requirements may require purchasing new software or asking an outside vendor that pays the company's claims to monitor Marriott's performance, he said.

State managed care programs feature a range of components, including: certification; coverage and treatment; in-network and out-of-network providers; applications and fees; geographic service areas; reporting requirements; quality assurance programs; dispute resolution; case management; and peer review.

"I think there is room for some standardization of these things," Mr. Steggert said.

States increasingly are turning to managed care approaches, though there is little data to support the cost savings supporters hope such programs will bring to workers compensation, according to other speakers at the IAIABC conference.

Experts say there is little data to support the idea that managed care will generate big workers comp savings.

"We have had a revolution in managed care in the past five years, with almost no evidence," said John F. Burton Jr., dean of the Institute of Labor and Management Relations at Rutgers University in New Brunswick, N.J.

"Hopefully, we have a reform here that is based more on fact than fad," he said.

Studies of medical outcomes are needed to determine the most medically appropriate and necessary patterns of treatment, said Dr. Alfred Taricco, president of Casualty Cost Containment in New York.

"The biggest problems is ignorance and inefficiency," said Dr. Richard D. Rehm, chairman of OccuSystems Inc. in Dallas.

Making managed care work in an occupational setting requires rapid entry into the health care system and expedient decision making, he said.

In addition, physicians need to provide high quality medicine on an efficient basis, which will lead to a rapid resolution of a case and keep a lid on indemnity costs, Dr. Rehm said.

"We don't need to change the laws. We need to use the laws we have efficiently," according to Dr. Rehm. BI

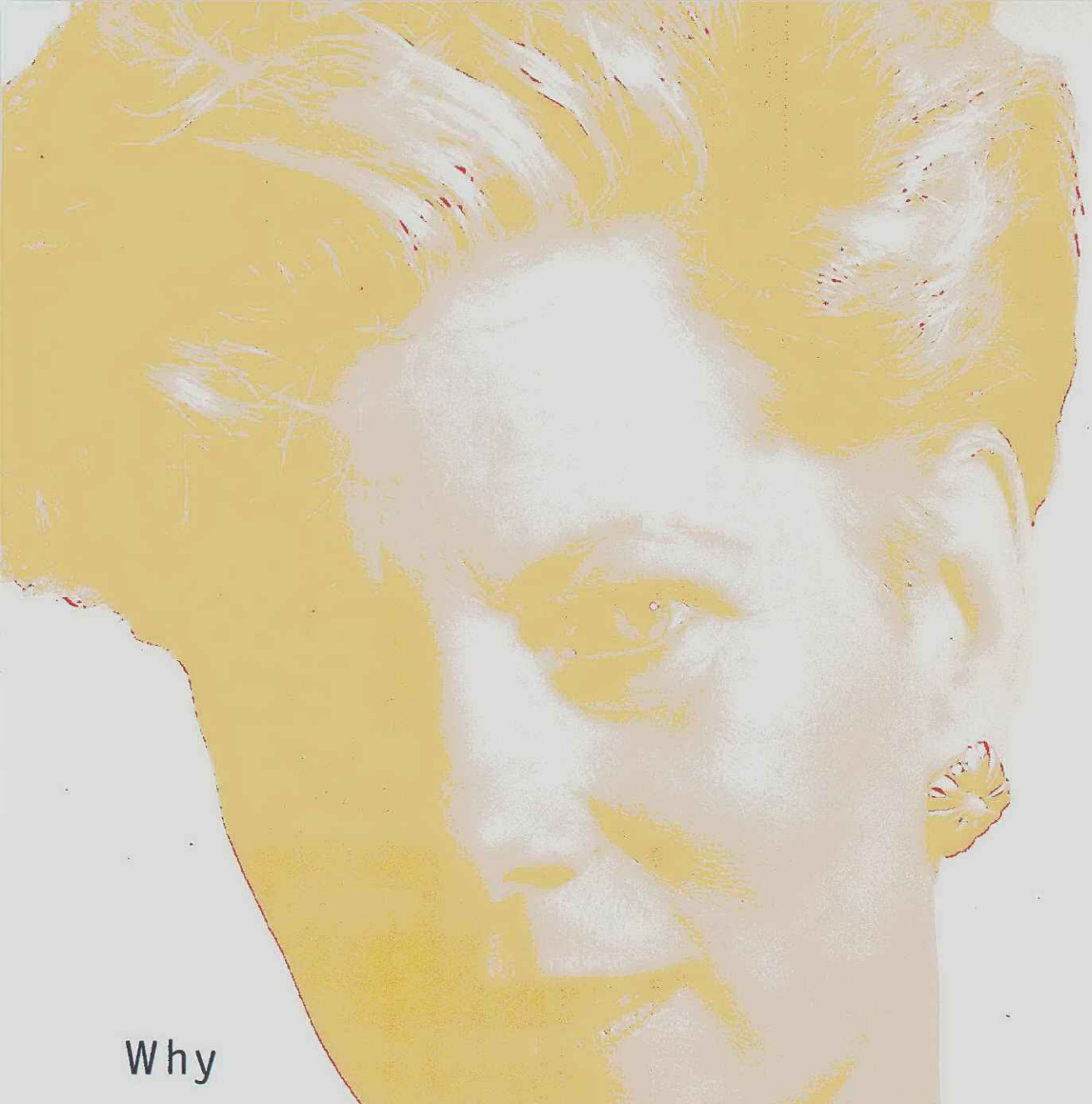
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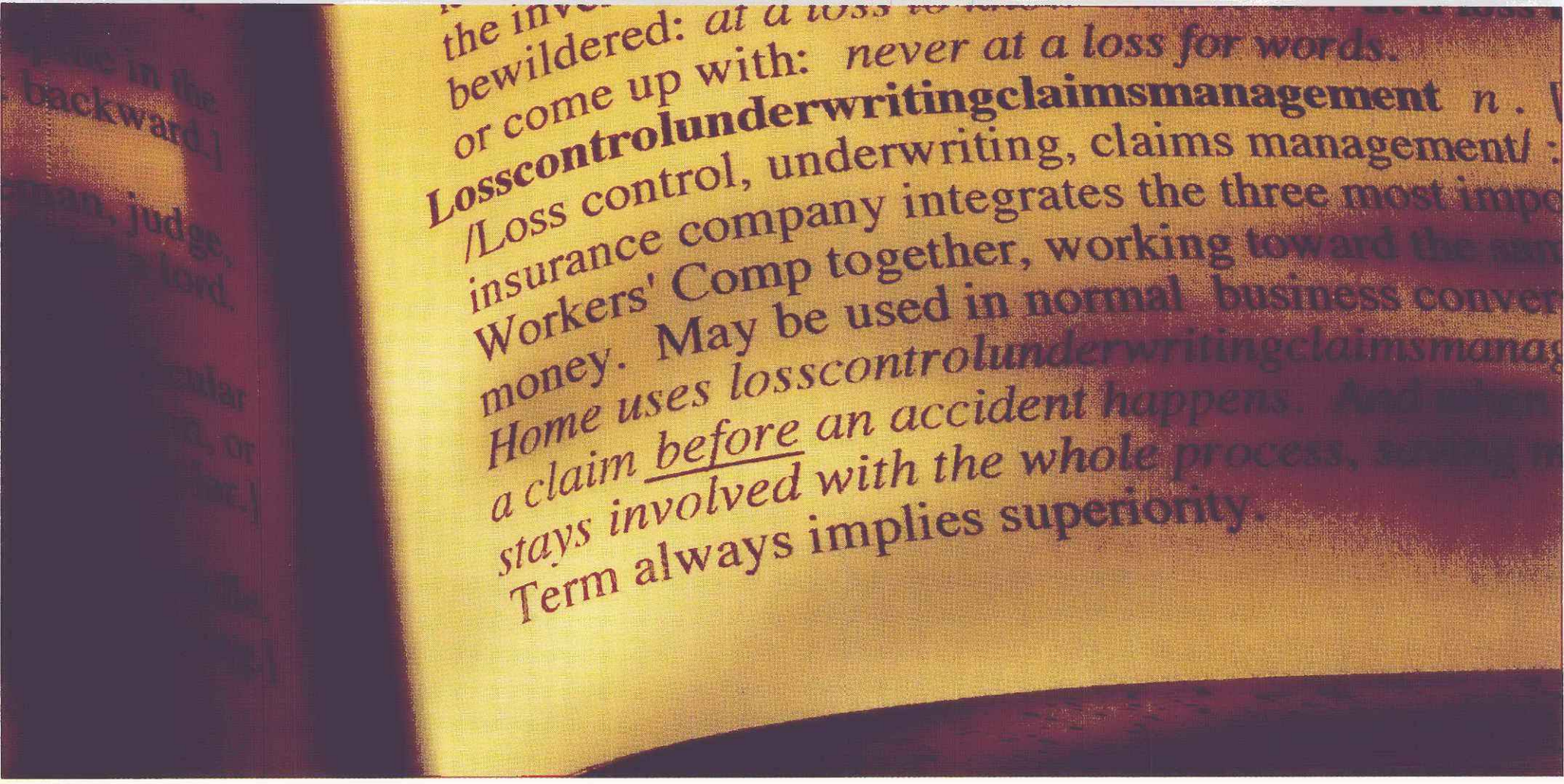
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Tool magnifies insurers' ability to detect fraudulent claims

NICB's national database helping industry in combating fraud

By MICHAEL BRADFORD

Insurers are traveling no farther than their desktops to access a massive and effective insurance fraud-fighting tool.

Since April, insurers and law enforcement agencies have been tapping into NICB Online, the National Insurance Crime Bureau's database of 300 million records that can be used to identify fraudulent claims and help nab those who file the bogus paperwork.

NICB Online pulls together information from a number of sources.

Insurers supply the system with data on fraudulent claims they have received and records on criminals and their crimes are gathered by the NICB from the Federal Bureau of Investigation. Records from agencies like the U.S. Customs Service can tip off investigators if a vehicle reported stolen was actually shipped overseas.

Neither insurers nor the NICB are able to put a dollar amount on how much has been saved by catching fraudulent claims before they are paid by insurers.

But the bureau and the insurance industry agree the database is an effective weapon in the battle against property/casualty insurance fraud that the NICB estimates costs $20 billion annually through higher insurance premiums, higher taxes and inflated prices for goods and services.

"It is an enormous amount of money that they save us, I'm sure," said Gary Turner, material damage claim officer at Kemper National Insurance Cos. in Long Grove, Ill. The insurer uses the database primarily to identify fraudulent workers comp and vehicle claims.

"It's a valuable tool to have in the fight against crime," said a spokesman for Bloomington, Ill.-based State Farm Insurance Co., which frequently taps the database when vehicle fraud is suspected.

The NICB is a 3-year-old organization supported by about 1,000 property/casualty insurers. Based in Palos Hills, Ill., the NICB was established with the mission of fighting insurance fraud.

Its efforts have included development of the database that is particularly well-suited to identifying fraudulent vehicle claims but also is helping insurers check out any type of suspected fraud, from fishy workers compensation reports to homeowners' claims that smell of arson.

NICB Online was unveiled in April and in June officially became the more user-friendly replacement for its predecessor, NICB Data Base Services, which contained similar, though not nearly as extensive, information. NICB Online is available for free to NICB members, law enforcement organizations and state fraud agencies.

NICB Online allows its about 10,000 current users to submit via computer modem questionable claims information or to mail in the information that the NICB will feed into the system.

Users with online access can tap into the database's NICB EyeQ, one of four basic services in the database, which permits cross-referencing and matching of various data. Here, an insurer can input information and check it against millions of other similar pieces of information that have been used on fraudulent claims.

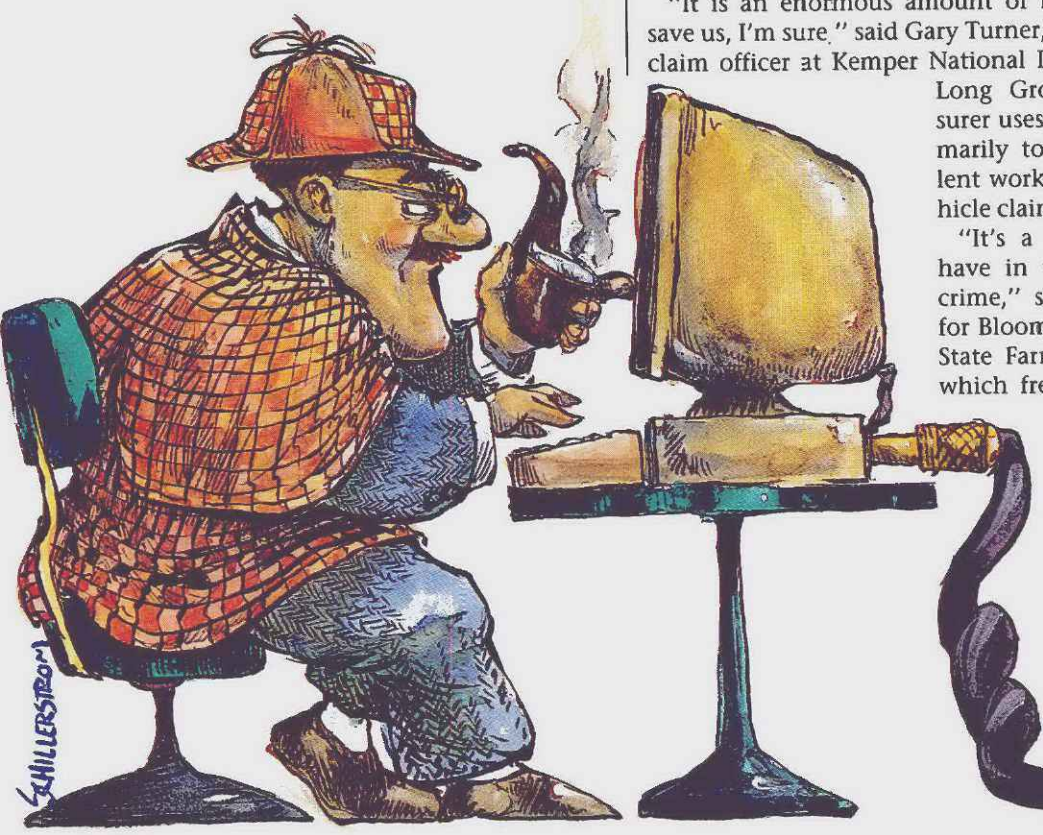
For example, an insurer can search for a name, address, phone number, social security number or driver's license number that may have been used in multiple claims or in previous fraud cases. Matches are compiled and the data can be printed, downloaded, faxed or mailed electronically to another user.

Once an insurance company determines that a claim may be fraudulent, it can decide to pursue an investigation. NICB itself does not bring any actions against people suspected of committing insurance fraud, but the organization does assist investigators and law enforcement with information.

The database's ability to verify information is "one of the most exciting things about the system," said John Damore, applications manager at the NICB.

A search on a Social Security number, for example,

See **Online** *on next page*



Online

Continued from previous page

will reveal whether it was actually issued and if so, in which state it was used, Mr. Damore said. "It can tell you if it was issued to a decedent."

The system also will identify addresses that are actually mail drop services, or businesses that lend out their addresses, a red flag on a homeowner's claim.

Telephone numbers that belong to answering services instead of residences or businesses also are highlighted by the system.

NICB Online's ClaimXchange feature lets users submit multiple claims electronically to the system. Any matches in claims information are reported to identify those previously filed, and the claims that were submitted become part of the system's growing database.

Requests from insurers and law enforcement agencies have been rising since NICB Online became available earlier this year. In August, EyeQ received 145,000 requests for data, up from 112,000 in July.

Mr. Turner of Kemper said his company turns to NICB Online to help spot fraudulent workers comp and vehicle claims.

Every insurer has a list of red flags that will raise eyebrows; a vehicle theft days after the policy is written, theft of a car that was purchased from a friend, a car stolen after a series of mechanical problems. Mr. Turner said those kinds of reports can send the insurer to the NICB database.

The system can quickly relay information on the claimant or the vehicle, telling the user whether the owner has filed a claim with another insurer, if the owner has filed previous collision claims on the vehicle and other information that can prompt an investigation.

State Farm uses the database "to look for patterns of fraud," said the spokesman for the insurer. "We look for indications that someone we suspect has also hit other members of the NICB."

Users also rely on an NICB Online feature called VINassist, which works like a spell-checking program to decode fraudulent vehicle identification numbers or complete partial numbers. With only a few correct numbers of an altered 17-character VIN, the system can piece together the correct number that will reveal a vehicle's history.

VINassist software that was a part of NICB Online's predecessor system was a key that helped unlock the mystery of the 1993 World Trade Center bombing.

When eight characters from a piece of metal found in the debris were fed into the NICB database, a reconstructed VIN matched the 1990 Ford van that belonged to a Ryder truck rental agency in Jersey City, N.J. The renter had reported the van stolen, which is why its identification number was in the NICB system.

The van's renter was arrested when he returned to the rental agency to reclaim a deposit.

In conjunction with the database, NICB members can rely on 200 NICB special agents to help with investigations. The agents work with law enforcement officials and special investigators from the insurance industry to crack fraud cases.

"We refer assignments to the NICB via electronic transmission," said Kemper's Mr. Turner. "These are cases that they work on for us."

NICB members are tied together through the system's NICB InfoCenter, an electronic mail service that lets users swap information. Electronic bulletin boards provide information on NICB events, legislative developments, insurance crime trends and other topics.

Mr. Damore said NICB Online is planning enhancements that will give it an even greater capacity to identify fraudulent claims.

"We want EyeQ to be more powerful by giving it more information," he said. "There are a lot of providers that may have public records" that could become a part of the system, Mr. Damore said. Credit bureaus, for example, have information that could be useful for insurers to use in fraud investigations.

He said ultimately the system would like to give insurers access to any type of public information.

Insurers are involved in plans to include all property/casualty claims, suspicious or not, into the database. "There has been a pilot project for the last three or four months that is testing whether or not we can get a system up," said Paul Cheek, vp-home office claims at GEICO in Washington.

Mr. Cheek explained that including all claims in the database would, among other things, provide "a repository for claims frequency. We ought to have available all of that."

Mr. Damore of NICB said, "We want to have access to all claims, whether they are questionable or not." That way, he noted, claims not marked as fraudulent by insurers will make it into the system and fraudulent claims previously not reported to the NICB will be included.

NICB members that want to access NICB Online generally don't need to make a large investment in computer equipment or software.

Most insurers already have personal computers connected to a mainframe or computers with modems for dial-in access.

Member companies wanting access "need to go through a couple of steps," allowing the NICB to examine applicants' backgrounds to ensure the companies are not fly-by-night or potentially fraudulent organizations, a NICB spokesman said. "It's all pretty simple."

Information on accessing NICB Online is available from the NICB at 800-447-2682, ext. 498. BI

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Health insurers play catch-up

Fraud schemes growing more sophisticated, subtle and severe

By ROBERT KAZEL

Controlling health care fraud can seem like stomping out forest fires that constitute a constant, raging blaze—and yet which are nearly invisible to the eye, the head of a national anti-fraud association says.

Much more difficult to detect than only a few years ago, fraud is burning into insurers' bottom lines despite increased efforts by insurers and federal investigators to find solutions.

William J. Mahon, the executive director of the Washington-based National Health Care Anti-Fraud Assn., might marvel at the variety and ingenuity of health fraud if it weren't costing the nation an estimated $100 billion a year.

"The bigger the potential of health care money grows, the more it attracts a purely criminal, entrepreneurial class," said Mr. Mahon, whose non-profit organization tries to educate insurers on fraud prevention and detection and circulates warnings on suspected schemes. "Ever since there has been insurance there's been insurance fraud, and health care fraud is no exception."

Fighting Fraud

What is new, however, is the speed at which fraud is occurring and the inability of health insurers to track and evaluate claims adequately to be sure they are valid. Only recently have health insurers begun to develop defensive software to detect subtle cheating that may be taking place over a long period. Most small and medium-size insurance companies barely have begun looking at ways to use computers to detect providers who "stay below the radar," learning how to file just enough fraudulent claims to avoid arousing suspicions, Mr. Mahon said.

Health insurance fraud is estimated to account for 3% to 5% of annual national health care spending, but the General Accounting Office has put that figure closer to 10%.

Specific cases often tell the story better. Among the particular examples Mr. Mahon has seen cross his desk in the past few months:

• A former airplane pilot for Brunswick, Ga.-based First American Health Care Inc., a leading home health care company, pleaded guilty last month in Savannah, Ga., to conspiring to defraud Medicare by charging the government for transporting patients when in fact those flights were excursions to college football games, vacations by a top executive and his family and trips to school reunions.

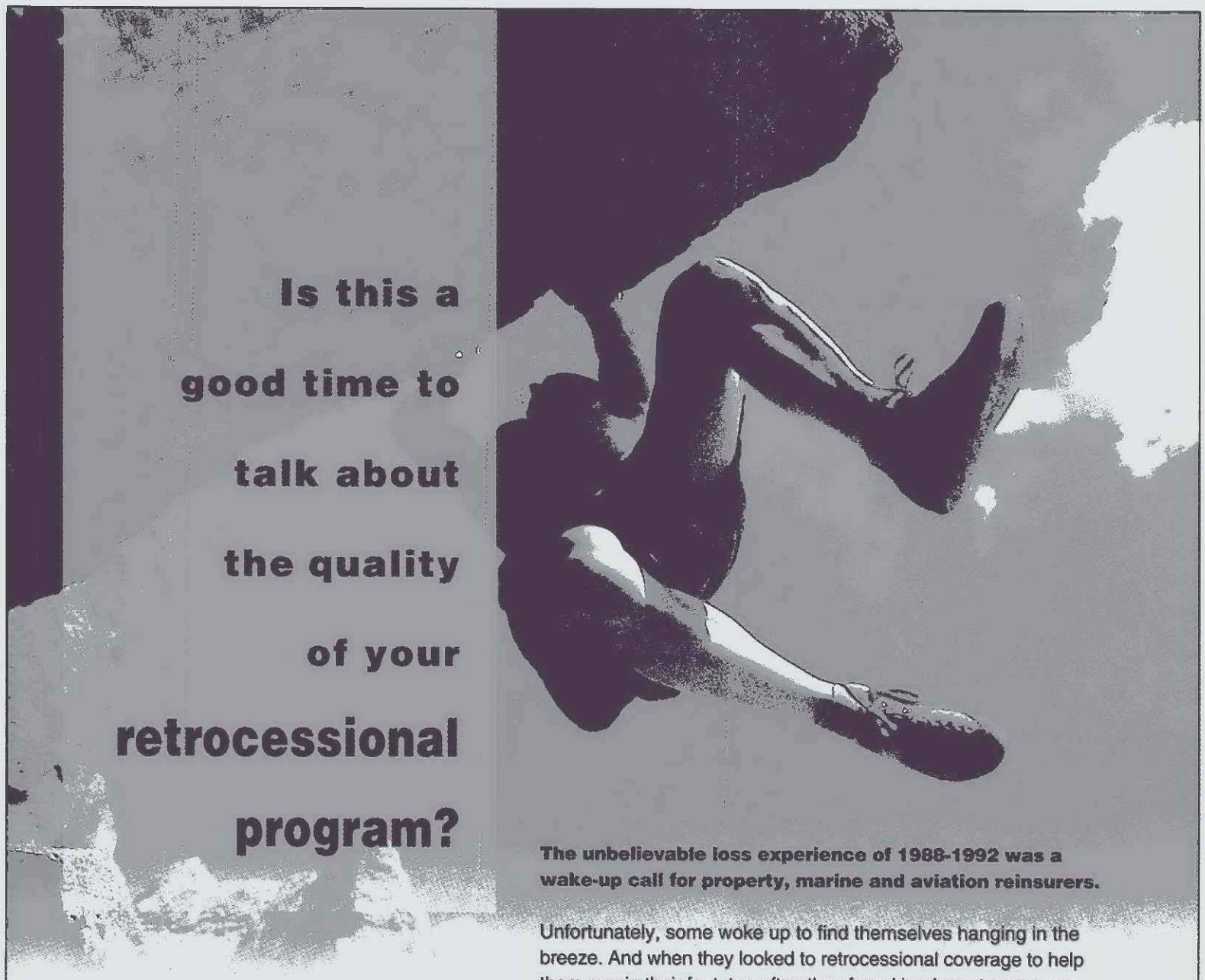
• An Atlanta man was sentenced to 70 months in prison and fined more than $600,000 after transporting convalescent patients in his Corvette instead of using an ambulance and for billing Medicare for transporting patients who actually were dead.

• A chiropractor in Woodland Hills, Calif., was charged in late August with staging traffic accidents on freeways and blind alleys, in cooperation with a Beverly Hills lawyer who allegedly received kickbacks, and billing private insurance companies for treatment not given. The activities took place over the course of a decade, prosecutors allege.

• Officials in the Florida Attorney General's Office in May filed fraud charges against an Orlando mental health center that allegedly billed Medicaid for $75,000 in bogus claims, mostly related to patients' supposed chemical dependencies. Among them were claims for marijuana rehabilitation for small children, including an 18-month-old.

Such schemes have become so immune to industry safeguards that insurance companies have no hope of detecting them unless they develop more sophisticated mechanisms, said Joyce Hansen, chairwoman of the NHCAA and assistant vp of Northwestern National Life Insurance Co. in Minneapolis. Ms. Hansen founded the insurer's fraud investigation unit.

See **Anti-fraud** *on next page*



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Insurer Topics

Anti-fraud

Continued from previous page

Although some of the larger insurers have built impressive anti-fraud investigative units, she said, "the majority of them (insurers) are still doing less than they should."

A common misconception, she said, is that the proliferation of health maintenance organizations has made fraud less profitable.

Actually, physicians and others who have HMO patients are finding other ways to cheat the system by providing minimal care, often by referring the patient too speedily to a specialist instead of doing their own treatment, she said. Also, because most HMOs include some element of fee-for-service coverage, conventional health care fraud—such as bill inflation, fabrication of bills and unnecessary lab tests—remains common and profitable.

Fraud may include acts by both providers and patients, although organizations like the NHCAA, as well as most law enforcement agencies, usually focus on providers almost exclusively. Types of fraud most often include billing for services or supplies that were not provided, misrepresenting the nature of service, the condition, charges or reimbursement, or performing a unnecessary act to make money.

NHCAA members are primarily insurers, managed care organizations and government agencies.

But, most U.S. insurance companies are hardly monitoring for fraud, when they should be contracting with an outside health fraud investigative firm or forming an in-house unit, Ms. Hansen said.

Several Blue Cross & Blue Shield plans have become more active recently in setting up just such investigative divisions. Nationwide, Blues plans in 1994 recovered $68.3 million lost through fraud, a 32.1% increase over 1993.

Part of that increase can be attributed to several large fraud cases that were resolved in 1994, but it also reflects more intense fraud investigations and follow-ups by Blues units all over the country, said John M. Travis, director of financial and information services for the Blue Cross & Blue Shield Assn. in Chicago.

Physicians are those most likely to commit insurance fraud, the BC/BS Assn. says, followed by patients, hospital employees, podiatrists, equipment suppliers, chiropractors, dentists and laboratories.

Last year, Blues plans investigated more than 14,000 fraud cases.

"Quite a few of the fraud schemes are much more sophisticated than they used to be," said Mr. Travis, who coordinates anti-fraud activity for independent BC/BS plans.

Insurance companies are realizing that to fight fraud, they must transmit information to insurers and government agencies more quickly.

Although the NHCAA has set up a database that is intended to link insurers in an up-to-the-minute crime-fighting network, results have been disappointing because many insurers are afraid of being sued if they reveal suspected fraud perpetrators from their own files.

Although 38 states provide some level of immunity if an insurer reports suspected fraud to a law enforcement agency, in 12 states no protection exists and insurance companies can be sued for such civil offenses as malicious prosecution or defamation if they share anti-fraud data.

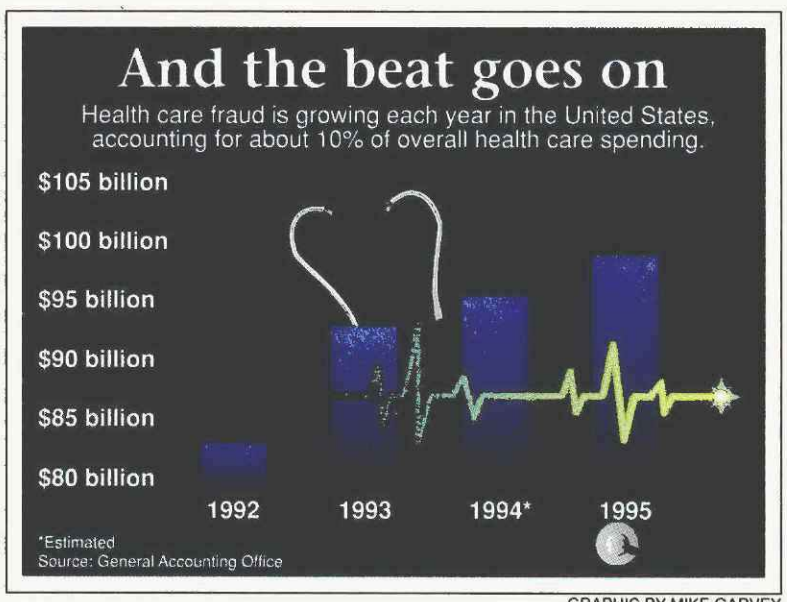
"To what extent is that deterring companies from making cases in the first place? We don't know," Mr. Mahon said. Insurers must be "reasonably protected for the actions they are being asked to engage in."

The NHCAA is supporting new federal laws that would provide a uniform degree of immunity for insurers in all states in fraud cases.

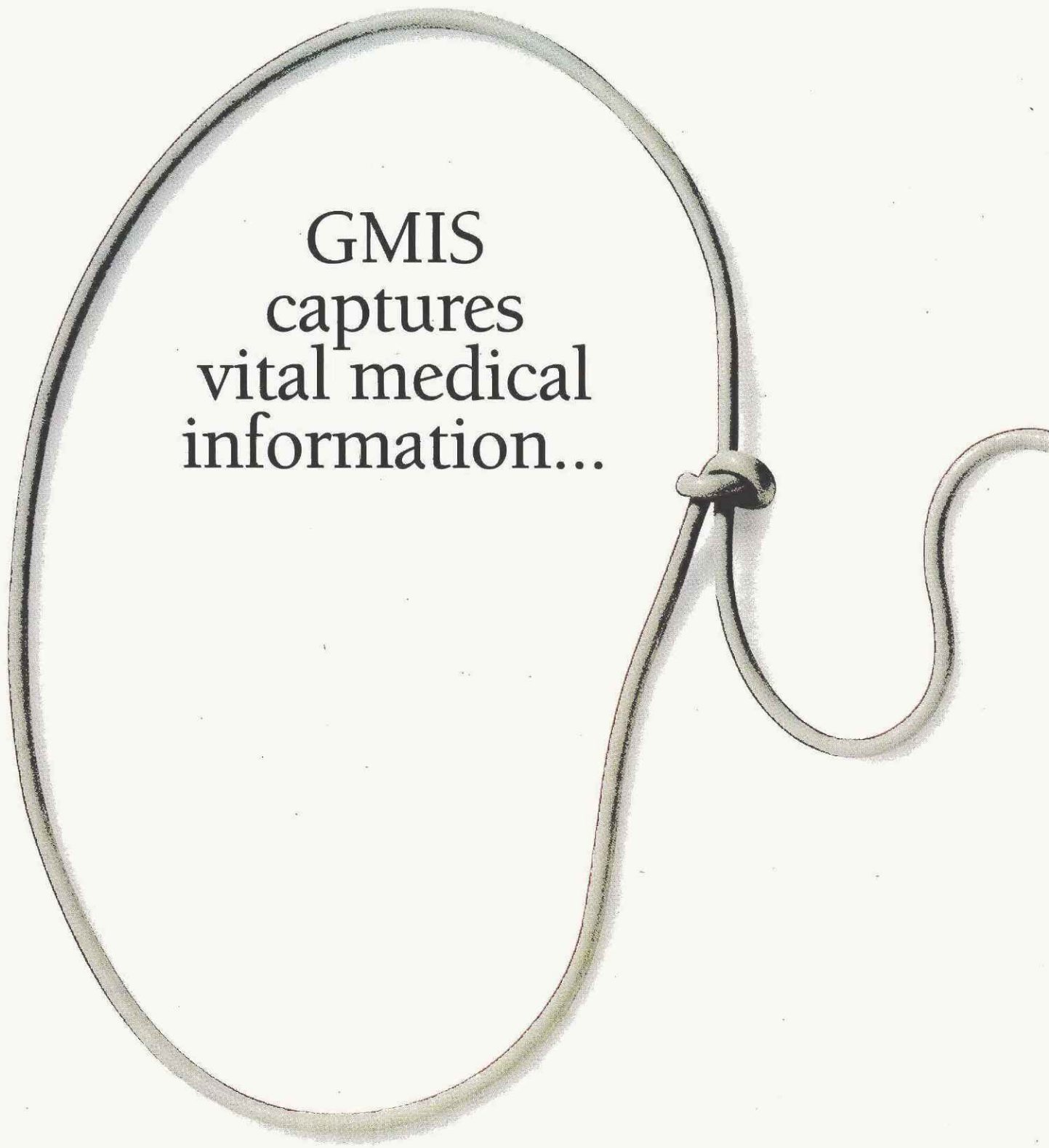
While a 1994 law makes insurance fraud a federal crime, there currently are no specific federal laws on health care fraud (*BI*, Aug. 29, 1994; July 18, 1994).

The association is calling for a comprehensive, specific federal legislative approach to health care fraud that would make it illegal to cheat private insurers in the same way that it is presently illegal to cheat Medicare and Medicaid.

Such a comprehensive approach makes sense, Mr. Mahon said, because providers who cheat public health insurance programs usually also commit fraud against private insurers. BI



GRAPHIC BY MIKE GARVEY



On the frontlines at Fremont

Ranney Pageler's special investigation unit successfully fights fraud

Ranney P. Pageler is vp of fraud investigation for Fremont Compensation Insurance Co. in Glendale, Calif., and for Casualty Insurance Co. in Chicago. He joined Fremont in 1991 and helped develop one of the most dynamic special investigation units in the nation. He also helped develop Fremont's advertisement program, which includes billboards depicting jail scenes and the warning that workers compensation fraud results in jail time. Fremont purchased Casualty in February and quickly commenced the campaign there.

Prior to joining Fremont, Mr. Pageler, 46, was a sheriff's deputy in Los Angeles and Colorado. He also worked as an investigator for the Los Angeles coroner and the Medical Board of California. Later he went to Blue Cross of California in Woodland Hills as a senior fraud investigator. In all, 10 years of his law enforcement career have been focused on claimant and provider fraud.

He was an investigator for the Los Angeles coroner when a woman stole a body and attempted to pass it off as herself. She had the body cremated, and filed for Social Security for her children with the death certificate.

"I was 38 or 39 when I found out fraud is really neat," Mr. Pageler said. "I found my niche."

Mr. Pageler discussed his job recently in an interview with Associate Editor Roberto Ceniceros.

How important are special investigation units in fighting fraud?

They are very important, because everything starts with claimant fraud. All the evidence of claimant fraud is here in the company or with the employer. If companies don't bring that evidence to the surface you can't prosecute those cases. That is number one.

As you start seeing patterns in claimant abuse you identify the provider abuse. That's our secondary step. We have everything we need to prosecute a claimant. But when we get claimants who say, 'I was never treated at that clinic' or 'I have never been there,' and we get four or five of them who say that, or we get video evidence that the person was only in a clinic for five minutes and we are billed for an hour of services, those type of things become probable cause for law enforcement.

That is the information we can turn over to the Department of Insurance or to the local police departments to be able to go in and do search warrants and get the records that you actually make the large providers cases with. If you don't have basic SIUs in the industry, that information never gets to law enforcement.

Do SIUs help control costs?

We're keeping it down. If we can stop a fraudulent claim before it ever comes through the door it's cheaper than handling it once it's inside. So again, when you look at the deterrence side it's very high. I think that is a lot of the value. If you were to sit down and see the dollars that we recover from these people for our insureds, no it's not anywhere near what we pay to do it. But when you look at a 30 or 40 percent reduction in claims over all, that's a hell of difference.


Mr. Pageler

But, industry-wide, do SIUs make a difference?

People that were participating in these schemes over the last few years to rip off the system are just sitting there waiting for a chance to slip back in. We're starting to see it now. We are seeing a rise in return of what we consider to be fraudulent mills. We will keep them away from our door as best as we can. But the industry is going to have to put up with them coming back unless they continue to put up a solid effort fighting these.

Can you stop fraud?

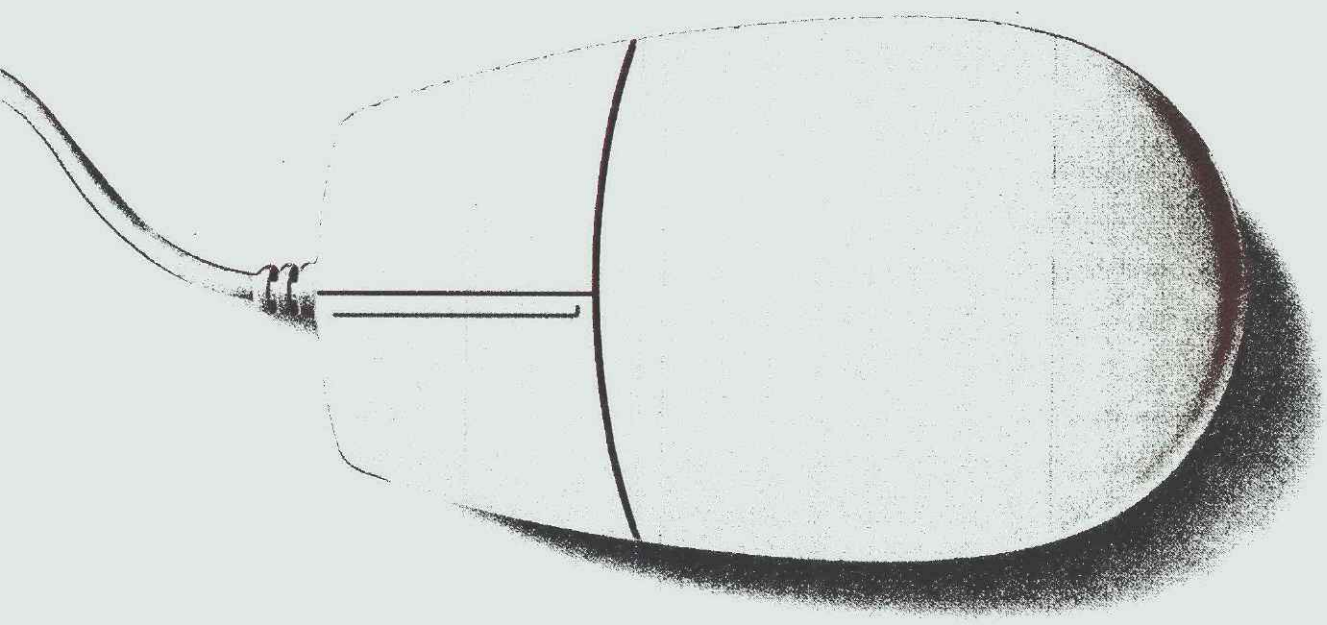
You watch, in the area of provider fraud these people move to the areas where there is the least problem getting their fraudulent money. I can think of several doctors; the first time I saw them cross my desk it was in the auto arena. Then they passed the auto fraud statutes. They moved from auto over into Medical, over into workers comp or into personal injury. Then as we got the workers comp going and started prosecuting there, you're seeing much more on the health-insurance side.

The areas where you don't have specific statutes and specific resources start to heat up.

The feds are working very strongly on health insurance fraud right now. If we start to back off—and we see it in the states where we don't have good,

Continued on next page

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Insurer Topics

Q&A

Continued from previous page

strong anti-fraud statutes in work comp—we see (fraudulent providers moving into those areas and saying) 'Let's get the money out of that area before people start looking at it.' So again, if you back off the pressure you will see those crooks move back into the workers comp arena. I think it's happening. I definitely think a lot of them are moving back in more sophisticated this time.

What does it take to have an effective SIU?

It has to be a real investment. You can't start off and say, 'I'm going to put one person in charge of fraud and get some incredible savings from them.' You're not.

What was behind Fremont's billboard warnings?

The idea was to be very basic. What we came up with was we're here to deter fraud. Those that we can't deter we're going to put in jail. It's that simple. Get that message out. From a claims standpoint it is: 'Let's pay what we owe and resist what we don't owe. If we get the evidence we will put you in jail.' It's no more: 'Oops, I didn't get my claim. I'll walk away and file another one.' No, you're going to do some time in jail and you're going to pay back the money.

Did success in California inspire you to use the ads in Chicago?

Absolutely. Casualty (Insurance Co.) is fun for us because we know what we are doing now. We have four years experience doing this. Now we walk in and we pull together the claims people and we show them what we saw in California). Do we have anything like that in Illinois? 'Oh absolutely not. Not a thing like that. This is a very honest system. Workers get $700 a week. Nobody is ripping it off.'

So after that meeting I took our San Francisco investigator and I asked him to go downstairs and grab 25 examiners just ask them this: 'Do you have any claims where the guy says he can't go back to work, but you have video of him doing things he says he can't do?' And the little lights went on over their heads. In six hours we had 19 cases. Two of those 19 are already in jail. It isn't like these 19 were just cases they pulled out and didn't develop. Two of them are in jail. One in Cook County; one in Rock Island County. There are several others of these cases that are being considered right now and arrests are imminent. When we saw that, and then when they saw that the light went on. There is a problem.

We're not going to walk into Chicago and say you have a provider fraud issue. We don't know if they do. Of the first claimant cases we have now seen mill operations that are every bit as intensive as what we have in Los Angeles and we are working on that. We are ahead of the curve this time. There hasn't been the workers comp reform or fraud attention in Illinois that we had in 1992 here. We came into California after we had the statutes in place.

You seem to enjoy your job. What aspect is most fun?

We seem to stand up with employers and that is really rewarding. When we go into the legislature and testify you are there with employers. We are there with self insureds. We are doing what is right. That's what is fun. The fun part is seeing an employer who has been

One man who claimed to be injured bicycled 43 miles in a negligee to win concert tickets in a radio station contest.

ripped off, who has had a tough time surviving for a couple of years because of the abuse of the system, because it is very expensive once you are abused. (It is rewarding) to be able to hand them back past premiums that they paid and dividends they didn't get to the tune of $20,000 once you take care of that fraudulent claim and get that guy put in jail. Seeing the smile on that employer's face—that is exciting. That is a local issue.

What is the most difficult aspect of SIU work?

I can't think of a hard thing. This is the most wonderful job in the world. You don't know what it's like to call an employer and say, 'By the way, I just called to tell you that gentleman who has been ripping you off, you were so upset about, he is in jail.' There isn't a sad side.

We have been able to use this program to solve a lot of other problems within the system; to focus on some of the absurd decisions that occur at the Industrial Commission or the Workers Compensation Appeals Board.

We had a situation where the state of California said there was a certain standard for licensing of professionals. We had 100-year-old case law and we had a section that said, if you weren't licensed you had no standing in any court of law in this state to collect on a bill. Yet we had unlicensed people coming in to the workers comp arena and having the workers comp appeals board judges ordering us to pay them. It was absurd. Why should the injured worker in this state get less than what the general public is required to get in professional services. It doesn't make sense. We were able to take that issue and fight it. We have been able to use this to fight a lot of issues. I haven't seen a down side in what we are doing.

You see a lot of interesting cases. What is the most bizarre?

In San Diego we had a gentleman named Kelly Strain. We'll be going to trial on him shortly. Mr. Strain supposedly couldn't return to work because of a back injury affecting his legs, his back, unable to stoop and do anything. Totally, temporarily disabled.

He calls into a rock 'n' roll radio station and says, 'I want those rock 'n' roll tickets so badly that I will put on a woman's negligee and I will get on my mountain bike and I will ride 43 miles from Vista to San Diego to your studios to get my tickets. Bright red teddy, panties and a black boa.' Well, the treating doctor's office heard this on the radio and the doctor called us. So we went ahead and dispatched a surveillance van and we followed this guy for 2½ hours up and down the hills along the coast in a woman's negligee riding to the station. Well, it was a slow news day and the radio station was owned by the ABC affiliate in San Diego. So they went out and they filmed it. They put him on TV that night as a funny story. We called the station and said hold on to the video and we took it to the district attorney's office. About three weeks later he was arrested, charged with two felony counts of insurance fraud, workers comp fraud.

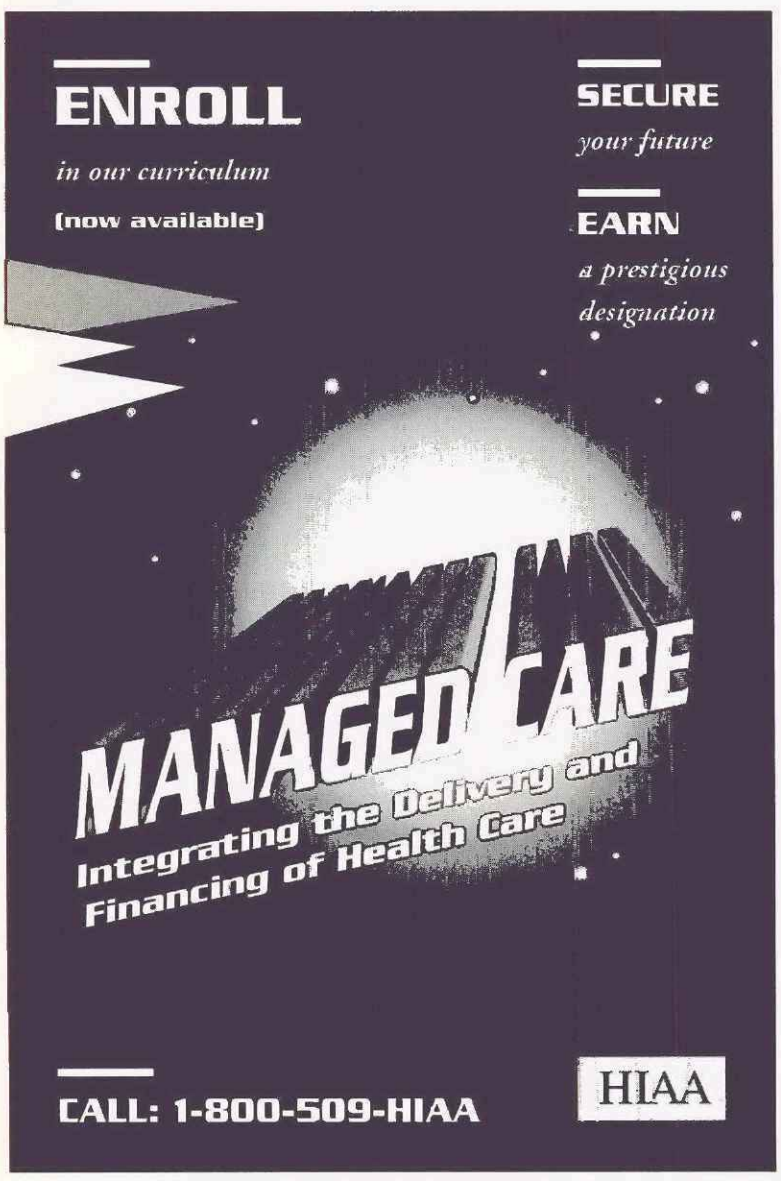
Does it take someone with a law enforcement background?

There is a difference in opinions on that.

But let me tell you who we hired to manage our program in Chicago, Bill Raines. Bill was a Chicago police officer and came out to Oakland, Calif., as a police officer, was shot, retired out and went to law school here in California, passed the bar, went back to his home state, Illinois, passed the bar and went to work for the Cook County Attorney's Office, where he was a prosecutor.

He likes doing police work. That was his first love, more than being an attorney. We just brought him over four months ago to manage our fraud investigations and our compensatory investigations, all of our outside investigations for four states. So we have a guy sitting there who has again, prosecuted these cases, who has arrested these kind of people as a police officer. That is our leader in Chicago. The fraud investigator who works for him came out of the Department of Justice here in California where he supervised investigators in the medical program, Medicaid. He worked the provider side. So we have him back there working fraud cases.

We just added three more compensability investigators; a North Park police officer, two Chicago police officers and one FBI agent. We're bringing them in as compensability investigators so they can learn comp. These are people who know how to investigate. They don't know comp. They will know it and start turning up suspicious claims. BI



IT Briefs

Investigator honored

NAPLES, Fla.—The International Assn. of Special Investigation Units has named Robert Croce its 1995 Investigator of the Year.

Mr. Croce, a special investigator at San Antonio-based USAA Group, was nominated by Steve Brite, regional investigations manager at USAA, for his role in uncovering a fraudulent claim.

In early 1991, a USAA policyholder submitted a burglary claim that Mr. Croce found to be fraudulent and the insurer denied the claim. The policyholder later sued USAA. Mr. Croce's investigative efforts resulted in a $2 million judgment in favor of the insurer.

"The final result of this case can be attributed to the teamwork and talent of a number of professionals," Mr. Croce said in accepting the award last month at the IASIU's 10th annual insurance fraud seminar in Naples, Fla. "To those who might share our insured's penchant for larceny, it was a warning that there are serious consequences for insurance criminals."

Also at the seminar, Larry G. Henning was elected president of the IASIU. Mr. Henning is the SIU corporate manager for Nationwide Mutual Insurance Co. in Columbus, Ohio. Officers elected at the meeting were: John J. McHale, superintendent-SIU at CIGNA Property & Casualty Co., as vp; Timothy J. Goggin, superintendent-SIU at Nationwide Mutual Insurance Co., secretary; and Dale Cordy, director-SIU at Warwick, R.I.-based Metropolitan Property & Casualty Insurance Co., treasurer.

IASIU members also approved a motion to extend membership to agents of the Insurance Crime Prevention Bureau.

The IASIU, the members of which are about 2,700 investigators from about 450 insurers and self-insurers, was founded in 1984 to promote anti-fraud education and communication.

Anti-fraud videos

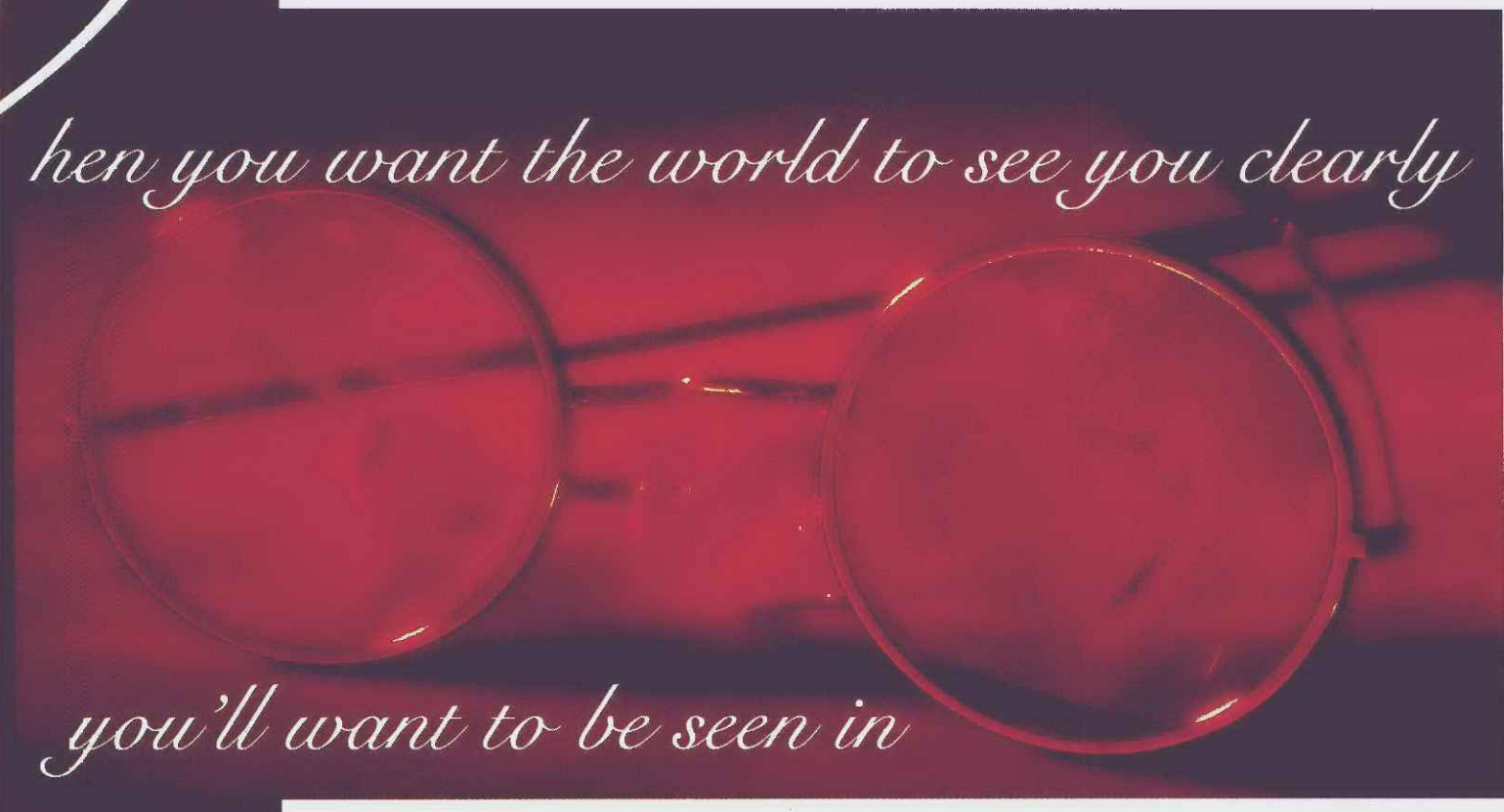
INDIANAPOLIS—A new video series designed to help insurance companies identify fraud is available from the National Assn. of Mutual Insurance Cos.

The series comprises two videotapes. "Fraud I: An Industry Perspective," is intended to help companies counter fraudulent activity in daily operations. The video provides resources that may help insurers detect and investigate suspicious claims. "Fraud II: An Adjuster's Perspective" is designed to help insurers train claims adjusters and shows how to spot common types of fraud associated with applications, padded claims and bogus losses.

Both videos in the series feature interviews with special investigators, legal consultants and a representative of the National Insurance Crime Bureau, a data-gathering organization based in Palos Hills, Ill.

Videos are available for $45 each for NAMIC members and $65 for non-members from NAMIC, 3601 Vincennes Road, P.O. Box 68700, Indianapolis, Ind. 46268. BI

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Fraud law is trap for unwary insurers

Policies need updating now to be certain felons are not on payroll

By W. Neil Eggleston and Dimitri J. Nionakis

PICTURE THIS SCENARIO: An agent from the Federal Bureau of Investigation has just called the general counsel of a large insurance company and informed him that the FBI was investigating violations of federal criminal law relating to the company's employment practices.

Both the director of human resources and the general counsel had held their jobs for a long time and did their best to follow the typical issues and new developments in employment law. But, what they did not know is that the Violent Crime Control and Law Enforcement Act of 1994 enacted new provisions that make insurance-related matters federal offenses for the first time.

These laws affect both the insurance company and its individual employees, from the entry-level secretary to the general counsel and the chief executive officer. Most importantly, the legislation all but mandates that any company engaged in the business of insurance or reinsurance implement a compliance program in its employment practices to ensure that it is not exposed to federal criminal liability.

This legislation resulted from Congress' conclusion that there is a need for federal law addressing the insurance industry. For more than three years, the House Energy and Commerce Subcommittee on Oversight and Investigations conducted hearings on this subject. The panel concluded that the patchwork of state enforcement of insurance laws and regulations was ineffective (*BI*, Feb. 29, 1990).

First, the subcommittee examined the failures of four major insurers: Mission Insurance Co., Integrity Insurance Co., Transit Casualty Co. and Anglo-American Insurance Co. The subcommittee also studied the near-failures of Omaha Indemnity Co. and the Insurance Co. of Ireland. The panel concluded that the states were inadequate in investigating and taking legal action against insurance fraud. The subcommittee also concluded that the existing state statutory penalties and remedies were not in accord with "the realities of today's insurance market and the interstate and international nature of the business of insurance in today's marketplace." In particular, the subcommittee found that individuals involved in insurance fraud often escape investigation and even continue their unlawful behavior in the insurance industry.

Second, the subcommittee found that federal criminal enforcement of insurance fraud had been restricted for two reasons: defrauding or embezzling from an insurance company was not a federal crime; and even though the federal government could prosecute insurance fraud by enforcing mail and wire fraud laws, the provisions have only a five-year statute of limitations, which often expired before criminal investigations could be completed.

Congress rectified the latter by extending the statute of limitations for prosecuting mail or wire fraud to 10 years.

The new legislation appears in the U.S. Code in Sections 1033 and 1034 of Title 18. Section 1033 applies to persons "engaged in the business of insurance whose activities affect interstate commerce." The law defines the "business of insurance" as "the writing of insurance, or the reinsuring of risks by an insurance company, including all acts necessary or incidental to such writing or reinsuring and the activities of persons who act as, or are, officers, directors, agents or employees of insurers or who are other persons authorized to act on behalf of such persons." Under the statute's definition, most insurance companies conduct business that unquestionably affects interstate commerce.

Section 1033 punishes any person who: "knowingly, with the intent to deceive, files a false statement with or willfully and materially overvalues any land to an insurance regulator for the purpose of influencing the actions of that insurance regulator; willfully embezzles or misappropriates funds of an insurance company; knowingly makes false entries or statements regarding the financial solvency of an insurance company with the intent to deceive any individual or regulator regarding the financial solvency of that company; and obstructs the investigations of insurance regulators."

The maximum punishments for these offenses include substantial fines and/or imprisonment ranging from 10 to 15 years.

Section 1033 also criminalizes one aspect of an insurer's employment practices. Section 1033(e)(1) has reciprocal provisions that: bar certain types of felons from the insurance industry and, more significantly for the companies, bar insurers from employing such felons. These requirements will have immediate impact on all insurers and essentially require that companies react immediately to the new requirements to avoid any sanctions against their employees.

The new section prohibits any individual who has been "convicted of any criminal felony involving dishonesty or a breach of trust, or who has been convicted of an offense under (Section 1033)" from willfully engaging in the business of insurance or participating in such business, unless he or she obtains the written consent of any insurance regulator authorized to regulate the insurer. The maximum punishment for this violation is a fine and/or imprisonment for a maximum of five years.

The reciprocal section imposes a restriction on an insurance company's employment practices. Subsection 1033(e)(1)(B) prohibits an

IT Perspective

individual engaged in the business of insurance from "willfully permitting" an individual convicted of the crimes described in subsection 1033(e)(1)(A) to engage in the business of insurance. Under the federal criminal code, an "individual" is a human being. Thus, the statute does not impose direct criminal liability on the company. The statutory limitation to individuals, however, may or may not preclude the possibility of an insurance company being accused of aiding and abetting the commission of this offense. The maximum punishment on an individual for this offense is a fine and/or imprisonment for up to five years.

Finally, Section 1034 authorizes the U.S. attorney general to bring a civil action for monetary damages and injunctive relief against any "person" who has violated Section 1033. "Person" in this context usually includes a company. Consequently, this section may directly affect an insurance company because it permits the attorney general to seek monetary damages in addition to the fines imposed under Section 1033. Any monetary damages awarded under this section for a violation that contributed to the insurer's being placed in receivership will be sent back to the appropriate state regulator for the benefit of that insurer's policyholders, claimants and creditors. More importantly, Section 1034 lets the attorney general seek an injunction against the insurer, which could be as drastic as enjoining the company from further engaging in insurance.

For any insurer, Subsection 1033(e)(1)(B) is likely the most important provision and requires immediate attention. The apparent purpose of this provision is to prevent the recurrence of these types of white-collar crimes by the same individuals. Notably, the provision does not forever bar convicted felons from participating in the insurance business. Rather, such an individual may return to the insurance industry if he or she obtains written consent from an authorized regulator.

A careful reader may have noticed that Subsection 1033(e)(1)(B) punishes only "willful" violations of the employment restrictions. This generally means that to impose liability, the government must show that the individual knew the particular employee had a qualifying prior felony. Reliance on this loophole—without any compliance program—would be perilous. The government may well conclude that a company's failure to determine whether its employees had a disqualifying felony was evidence of willful blindness to the possibility that its employees could have such a felony.

Therefore, any company involved in the business of insurance must ensure that it and its employees are not employing individuals who have prior convictions for violating Section 1033 or who have been convicted of a felony involving dishonesty or a breach of trust. While the direct criminal liability of the company for such a violation may be debatable, the company may still be subject to monetary penalties and injunctions under Section 1034.

How should an insurer begin thinking about a compliance program that will help it avoid liability under the new statute? First, it must determine which positions within the company entail engaging or participating in the business of insurance. There are generally two ways of interpreting this language. The insurer could narrowly view the statute as applying only to individuals who directly engage in writing insurance or reinsuring risks by an insurer. For example, this would include underwriters and real estate appraisers.

But, this approach is probably insufficient for two reasons. First, though the definition of "business of insurance" describes two broad but well-defined categories, it also includes "all acts necessary and incidental to such writing or reinsuring and the activities of persons who act as, or are, officers, directors, agents or employees of insurers or who are other persons authorized to act on behalf of such persons." This language, especially the term "employees of insurers," seemingly broadens the definition. Second, Subsection 1033(e)(1)(A)'s use of the word "participating" may mean it applies to individuals other than those directly engaged in the insurance business as defined by the statute.

Therefore, the safer approach is to include even those individuals who are indirectly involved in the business of insurance but could still engage in the type of unlawful behavior the statute is designed to prevent. This would include individuals who hold supervisory, support or advisory positions, e.g., officers, directors, accountants, advisers and secretaries. Insurers also should consider including clerical support staff and administration personnel.

The next problem is identifying which discrete entities or subsidiaries of the insurance company must comply with this statute.

This can become a difficult question, especially for insurers that have several units but not all of them specifically engaged in the insurance business as defined in the statute.

It is insufficient simply to check the entity's business purpose because some employees may participate in the insurance business even though an entire entity does not. Insurers need to determine which entities employ individuals in positions that the insurer has concluded fall within the definition of the "business of insurance." Then, entities that employ such individuals can apply necessary compliance procedures.

It is worth noting the law does not apply just to new hires. A longtime, perhaps highly trusted, employee might have a conviction that falls within the provisions of Section 1033. Companies must ensure they identify all employees, regardless of length of employment, who have a disqualifying felony.

To be safe, insurers should institute regular procedures to remain in compliance with Section 1033. BI

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Self-insurers calling for relief from some comp regulations

By MEG FLETCHER

ALBUQUERQUE, N.M.—The National Council of Self-Insurers wants state workers compensation administrators to help it overturn some "excessive" regulations and "inordinate" administrative and financial requirements imposed by some states.

The leading organization of companies that self-insure their workers compensation liabilities is challenging only some states' particular rules, not the concept of state regulation itself, emphasized Lawrence Holt, president of the Chicago-based NCSI.

Mr. Holt spoke before the International Assn. of Industrial Accident Boards & Commissions' 81st annual convention held Oct. 3-7.

From the NCSI's perspective, the problems in some states—which were not specifically identified—involve reserving, actuarial studies, manual premium classifications, third-party administrators, security deposits and reciprocity.

Such measures create unnecessary costs for companies that self-insure their workers comp risks, said Mr. Holt, who is also manager-benefit administration at AT&T Corp.'s AT&T Network Systems division in Newark, N.J.

They "only lead to more legal expenses, court delays, increased workloads as well as time-consuming trials and appeals."

They also are an obstacle to the prompt payment of income and medical benefits to employees with work-related injuries, Mr. Holt added

Both the NCSI and the IAIABC should want to avoid those negative consequences, he said.

The NCSI's specific complaints include:

• Reserving practices developed for insurance companies that are inappropriate for self-insurers.

An insurer is encouraged to "guess" when establishing a reserve on each workers comp case, because it is an income tax deduction.

A self-insuring company, which receives no such tax deduction, often may prefer to annually budget a lump sum for all reserves rather than establish them on a case-by-case basis.

"We believe that each employer should be permitted to handle the matter of reserving as it believes best for its business, while simultaneously satisfying concerns of government," Mr. Holt said. "Paid losses or indemnity payments are more solid figures on which to base judgments of ultimate losses and, in turn, reasonable security requirements."

• Requiring that reserves be supported by an actuarial study.

"Actuarial studies are expensive," he said. "One of our members had only four active claims in a state which required an actuarial study of losses from every self-insurer. These were four minor cases, representing a potential total liability of less than $8,000. But the lowest bid the self-insurer could obtain by an actuarial firm for the required study was $18,000."

In addition, such studies are rarely audited to determine if the projected data was correct.

"Perhaps actuarial studies should be limited to situations where there is other evidence that a company or group is at financial risk," Mr. Holt suggested. An alternative for companies with an "excellent" history of paying all claims would be for state authorities to examine those companies' corporate annual statements and 10-K forms.

Certain states' regulations create unnecessary costs for companies that self-insure their workers comp risks, says NCSI's Lawrence Holt.

• Mandating the use of third-party administrators. Some self-insurers prefer to self-administer their claims. Companies that self-administer say it provides the most clear and complete perspective on the case and improves employee relations.

• Increasing demands for higher, advance security deposits, even in the 31 states with self-insurance guaranty funds that assure payment of workers' claims.

• Applying manual premium classifications to self-insurers means those companies are paying unfairly high assessments.

Essentially, an insured employer's manual premium is derived by multiplying a manual rate—which represents the average cost of workers compensation coverage for each of about 600 employer classifications—by each $100 of an employer's payroll.

Many state workers compensation officials use employer classifications as the basis for state-specific assessments to second-injury funds as well as contributions to administrative expenses.

However, manual premium classifications cover all insurance expenses and profits, including agent commissions, lobbying costs and other kinds of overhead expenses—which self-insuring companies do not have. Those increase the size of the base.

In addition, self-insuring companies' workers comp experience has never been part of the data bank that the industry uses, Mr. Holt said.

"Maybe to be fair to both self-insurers and insurance companies, all such assessments should be on the amount of compensation paid out," he suggested.

• Allowing workers who are considered temporarily totally disabled to decide by themselves whether to return to work.

The only recourse for an employer that disagrees with an employee's decision not to return to work is to file for a hearing to suspend benefits, while continuing to make payments.

• Requiring that an employee's compensation rate be calculated on the highest quarter of the four earning quarters prior to the injury.

This often allows an employee, especially a seasonal one, to net a higher annual income than the employee can earn while actually working.

• Limiting an employer to only one independent medical examiner, like an orthopedist, though the employee may subsequently claim a psychological problem, too.

• Requiring each state where an employer wants to self-insure to conduct its own review of the employer's financial worthiness.

The NCSI thinks there should be reciprocity among states concerning the acceptance of a self-insurer that goes through a full qualification process in one state, Mr. Holt said.

The IAIABC's Self-Insurance Committee is now studying whether such a policy is feasible.

Despite these complaints, the NCSI complimented the state workers comp administrators for adopting effective controls on health care costs, including managed care networks and the American Medical Assn.'s guidelines as a basis for worker impairment ratings.

The NSCI sees itself as "a partner" of the IAIABC.

"The partnership is based on the responsibilities we share, the relationship we have developed through the years and the austere as well as very disciplined work setting that we both find ourselves in today," Mr. Holt said. BI

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Malingering often undetected

Diagnosing the condition tests doctors attitudes and skills

O, what a tangled web we weave,
When first we practice to deceive!

Sir Walter Scott

But when we've practiced quite a while
How vastly we improve our style!

J.R. Pope

By MEG FLETCHER

ALBUQUERQUE, N.M.—Malingering is an under-diagnosed problem that can extend the duration of workers compensation claims.

It is also almost as difficult to identify as to reduce, a psychiatrist says.

While most patients tell the truth, the small minority who do not may include some malingerers, said Brian Grant, medical director and president of Medical Consultants Northwest Inc. in Seattle.

Malingering is "the voluntary fabrication or exaggeration of physical or psychological symptoms in order to achieve a tangible goal distinct from the gain of being in a patient role," Dr. Grant said at the recent International Assn. of Industrial Accident Boards & Commissions conference. "It is willful and goal-directed."

It is "not actually a diagnosis, but rather a 'condition' not attributable to a mental disorder that is a focus of attention or treatment," he said.

Forms of malingering include staged events, data tampering, symptom invention and, most commonly in workers compensation cases, opportunistic malingering.

Malingering is likely under-diagnosed for a variety of reasons, Dr. Grant said.

Sometimes it is hard to tell whether a patient's motivation is conscious or subconscious and it is also considered "impolite or slanderous" to suggest that a patient may be malingering, he said.

Physicians are generally selected and trained to be helpers and to believe patients, so they are "deeply disturbed" by the idea, he said. Some also may be inadequately trained to detect the condition. Also, patients may not be monitored closely enough to detect malingering.

Any detection of malingering has to first rule out other related conditions or situations, including defensiveness, deception or unreliability.

It must also rule out many conditions that look like malingering but are not.

These include "factitious disorders" like Munchausen Syndrome, in which a patient intentionally produces physical or psychological symptoms with a psychological need to assume the role of a sick person, he said.

Estimates about the frequency of malingering vary significantly, Dr. Grant said.

Lawyers estimate between 1% and 50% of all patients may be malingerers, while one study found seven true malingerers among 2,500 people injured in industrial accidents.

The General Accounting Office has reported that 40% of people considered totally disabled showed no disability whatsoever one year after their disability determinations.

Tips Dr. Grant offered for reducing malingering include:

- Forthright medical management "in a manner that is empathic yet puts forth the message that the clinician is alert, thorough and competent."
- Thorough claims management and investigation.
- Prevention or careful hiring through the use of screening tests.
- Confronting the malingerer.
- Pursuit of sanctions and prosecutions for perjury and conscious deception.
- Addressing human needs in a way that reduces the need that some perceive to engage in such

This Claims Expert Invested $30,000 in Surveillance. Guess What He Got In Return.



Photograph by Paul Jaques.

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Derivatives

Continued from page 2

rived from, the value of an underlying asset, rate or index. Derivatives are designed to provide protection against risks associated with rate and price movements and to unbundle and transfer risks from entities less willing or able to manage them.

As part of a financial IQ test Mr. Raybin conducted at the outset of his presentation, he asked how many risk managers never used a derivative concept in their risk management programs.

Noting that a derivative is a bilateral contract creating a payment exchange, Mr. Raybin said, "That sounds a lot like insurance."

Insurance is a hedge against the destruction of property, he said. "Realistically, insurance is just a form of a derivative." The insurance company is stopping a risk at a certain point and is spreading it to others, he explained.

Derivatives can be used for various purposes, Mr. Raybin pointed out. They include:

- Hedging against adverse changes in values of assets or liabilities.
- Altering the nature of asset or liability cash flows—that is, exchanging fixed payments for floating payments.
- Speculating in an attempt to profit from anticipated changes in market rates or prices.

"Derivatives are not rocket science," Mr. Raybin said. "They just involve some terms we're not used to."

But, "it's one thing to understand the language and another thing to understand the concepts," Mr. Cox said.

He said the extent to which derivatives are being used by companies is not new.

For example, a business that has to deal with foreign currency or that relies on commodities for its finished goods is a good candidate to invest in derivatives, he said. The instrument could help that business hedge its potential losses from a large fluctuation in the value of that currency or from an interruption in the supply of those commodities.

"Companies that are getting in trouble started off using them to manage risk or to hedge, but the strategies led to introducing risk," Mr. Cox said. That happens when investors use derivatives to speculate on assets, interest and exchange rates or stock and bond indices that are not a vital factor in the company's financial success, he said.

That is why top management must understand the benefits and risks of derivatives and implement controls on their usage, he said.

After all, "the only perfect hedge is in an English garden," Mr. Cox said, quoting a member of the Financial Accounting Standards Board.

Derivatives pose five main risks, Messrs. Cox and Raybin noted:

- Market risk—the value of the underlying assets in a derivatives instrument moves in the opposite direction from what the contract holder predicted upon entering into the transaction.

The huge losses on derivative investments that pushed Orange County, Calif., into bankruptcy last year is an example, Mr. Cox said.

"The derivative operated as it was supposed to. The problem was with the assumption" that interest rates would not rise, he said (*BI*, Dec. 12, 1994).

Indeed, most of the heaviest losses attributed to derivatives "involved bets on interest rates when they were at 10- to 12-year lows and people bet they'd stay there or drop," he said.

- Credit risk—the other party to the derivatives contract defaults. That is rarely a problem, Mr. Cox said.
- Operational risk—human or technology-based errors that prevent a company from truly understanding its financial position.
- Systemic risk—a huge loss in one part of the world affects the rest of the world.

Some financial experts expected a worldwide fallout from the huge derivatives-related losses that Orange County suffered and the collapse of British bank Barings P.L.C. because of securities trading losses, but "that hasn't been borne out," Mr. Cox said.

- Legal risk—the contracts are not legally enforceable.

Short of financial ruin, other implications of heavy derivatives-related losses include lawsuits by shareholders, regulators and counterparties to the derivatives transaction.

'Derivatives are not rocket science. They just involve some terms we're not used to,' says Paul E. Raybin.

Top managers do not have to sign off on every derivative contract to control the risks those financial instruments pose, Mr. Cox said.

"No one expects the board or chief executive to be up to speed on every contract," he said. Instead, their role is to put in the oversight protection mechanism for the company.

The first step in a risk management program is to identify the risks that company is in business to take, Mr. Cox said.

Top management then must establish guidelines on:

- Whom is authorized to trade.
- Which financial instruments can be used and for what purposes.
- The amount of assets that can be committed.
- The responsibilities of all involved, including internal and external auditors and risk management, for evaluating, accounting for and reporting derivative activities.
- Management information systems to measure, manage and report the risks of derivatives activities in a timely and precise manner.
- The minimum credit strength of a counterparty.
- The trigger for early warning systems on expense growth.
- Disclosing the scope and risks of derivatives transactions to shareholders and regulators. BI

Fewer, but bigger, D&O claims foreseen

Securities bill would up ante in remaining suits, expert says

By DAVE LENCKUS

FAIRBORN, Ohio—Federal legislation designed to curtail frivolous securities-related litigation will only minimally reduce directors and officers liability claims but could increase the magnitude of judgments and settlements of claims, a D&O expert predicts.

"Plaintiffs lawyers will need more money out of those cases that remain," said D&O insurer attorney Dan A. Bailey, a partner with Arter & Hadden in Columbus, Ohio. "I think they will succeed in getting that higher number."

Even the short-term impact of the legislation is driving up the number and value of settlements, as plaintiffs attorneys try to resolve their clients' claims before having to deal with any relief the legislation may provide corporate executives, Mr. Bailey said last month at the North Central Regional Risk & Insurance Management Society Inc. Conference. The Dayton/Miami Valley, Ohio, RIMS chapter hosted the conference.

But, the legislation has been diluted since it was introduced, Mr. Bailey said.

"If it were enacted in its original form, there would have been sweeping changes in how directors and officers were prosecuted for security laws violations," he said.

By veto-resistant margins, the House passed its version of the legislation, H.R. 1058, and the Senate passed its version, S. 240, in March. Differences in the bills still must be worked out in a conference committee.

Initially, the legislation in the House would have required the losing party in a case that ultimately is resolved by a judgment or dismissal to pay the other party's attorneys fees.

However, the bill now would grant courts broad discretion in imposing that punishment, and the Senate bill does not contain such a provision.

Courts historically have been reluctant to punish losing parties by imposing the so-called "loser-pays" rule on them, so the impact of that provision probably will not be significant, according to Mr. Bailey.

The House and Senate also took different approaches in an effort to make sure that investors are controlling securities litigation.

Currently, many plaintiffs attorneys track the investments of their longstanding clients so they are ready with a lead plaintiff when a company's stock drops significantly and unexpectedly, for however short a period, Mr. Bailey said.

Under the House bill, a court would appoint a plaintiffs steering committee to retain and dismiss legal counsel. Membership on the steering committee would be limited to class members who cumulatively held the lesser of 5% of the securities involved in the case or securities with a market value of $10 million.

The Senate, though, would require courts to presume that the largest shareholder is the most appropriate lead plaintiff.

Even the short-term impact of the legislation now before Congress is driving up the number and value of settlements, according to attorney Dan Bailey.

"That likely will result in institutional investors being in charge of these cases," Mr. Bailey noted.

Some may think that large institutional investors would be more sympathetic to the plight of companies facing D&O suits, "but I don't think that'll be the case at all," Mr. Bailey said.

Indeed, he would expect the opposite effect. "They lost a lot of money and want to recover it," Mr. Bailey said.

He also believes that institutional investors would be less inclined than individual investors to settle D&O cases for 10% to 15% of their losses.

That kind of recovery probably would not be meaningful for institutional investors, he said. "But if I roll the dice right, hey, I could recover almost all of my loss," he expects them to reason.

Therefore, the Senate provision "would have an ironic effect" of causing more D&O claims to be litigated rather than settled, Mr. Bailey predicted.

Another provision of both bills "may result in back-door legislative reversal" of D&O policyholder victories in three recent allocation disputes, Mr. Bailey said. That provision would eliminate joint and several liability and hold defendants responsible for only their share of liability.

Federal appellate courts this year have greatly limited instances when D&O insurers may reduce indemnification of covered executives based on the liability of uninsured company employees or the corporate entity for the loss.

The courts ruled that D&O insurers could limit indemnification only under two conditions: the actions of uninsured parties led to a larger settlement in the underlying lawsuit against the insured executives, and the uninsured corporation's liability is not concurrent with the insured executives' (*BI*, Sept. 4, Aug. 21, April 24).

A couple of provisions in the legislation would help corporate executives fend off some D&O claims, though, according to Mr. Bailey.

One "very helpful" provision would provide executives a safe harbor against D&O claims that are based on projections of corporate financial results and other forward-looking statements that prove to be incorrect. However, executives and the company would have to qualify those statements by including a notice that the information is a projection and that actual results may be materially different.

Another less beneficial provision would tighten up the pleading requirements for plaintiffs in an effort to encourage the dismissal of meritless cases.

According to Mr. Bailey, many plaintiff attorneys currently allege wrongdoings that "they've taken from the newspapers" and then engage in a "fishing expedition" to uncover information that supports their loosely worded pleadings.

The provision would require specific allegations of wrongful acts.

However, the provision would be more useful in federal circuits in the West than in the East, where pleading requirements already are tight, he said.

In addition, courts typically allow plaintiffs to re-plead their claims after their original complaints are dismissed, according to Mr. Bailey. BI

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Hull

Continued from page 3

flects "the changes in the practice of ship operations since 1983 (which) have been more dramatic."

• The exclusion of pollution coverage, including costs to prevent pollution during a salvage operation.

Hull policies were never intended to cover pollution, said Stephen D. Redmond, chairman of the Joint Hull Committee and marine manager of Eagle Star Reinsurance Co. Ltd. "Now we're making sure there's no uncertainty."

In response to shipowner gripes about the exclusion, the committee introduced pollution expenses protection, which can be purchased in conjunction with the new clauses, said Mr. Gilchrist.

• Owners must notify underwriters of claims within 12 months of the time they became aware of, or "should have become aware of," a loss.

Shipowners would like this requirement deleted from the clauses, since it puts a strict time limit on them and could give rise to legal disputes. There is no time limit in current policies.

In September, shipowners were invited to a meeting with London marine underwriters, a meeting the owners thought was designed to discuss their objections.

Instead, said Linda Howlett, legal adviser to the International Chamber of Shipping, "It was a lecture." The underwriters presented the 16th draft of the clauses as a *fait accompli*, the shipowners said. They are due to become effective Nov. 1.

Far more people were consulted this time than in 1983, when the committee introduced clauses with no consultation, said Mr. Redmond.

The new clauses "reflect the determination of the Joint Hull Committee to provide modern insuring conditions which reflect changes since 1983 in international maritime law and ship operation and management," the committee stated in explanatory notes that accompany the draft clauses.

"There are a lot of unhappy shipowners out there," said Ms. Howlett. "It is now up to shipowners and their brokers at renewal to make a better deal for themselves" by selecting the hull clauses that are best for them.

At renewals, individual shipowners and their brokers will resist elements in the new clauses "they may find objectionable," the International Chamber of Shipping wrote angrily to the Joint Hull Committee after the September meeting.

Though the current draft of the clauses is a "considerable improvement" over what came out 12 months ago, "they're still not as favorable as the old clauses," added Sedgwick's Mr. Gilchrist. "London underwriters clearly will try to make sure that the new clauses are used at renewal. But some shipowners will say, 'Over my dead body.' "

Some shipowners will have nothing to do with the new clauses and will move their fleets to other markets or negotiate with London underwriters to delete some of the contentious clauses, Mr. Gilchrist agreed. In the U.S. and other markets, other clauses are used.

'Underwriters clearly will try to make sure the new clauses are used at renewal. But some shipowners will say, "Over my dead body," ' says Colin Gilchrist.

"Someone whose business is desirable will get what he wants" because it is a soft hull market, he said. But those shipowners whose business is not so desirable will have difficulty finding an alternative to the Institute clauses.

Some marine underwriters are already urging insurers in those other markets to follow the London lead.

"The (London) approach is very timely and the correct approach," said Nicolas Wilmot, marine underwriter for Vesta General Insurance Co. in Bergen, Norway, at the recent International Union of Marine Insurance conference.

Despite "unjustified criticism" from brokers, he said, "the truth of the matter is that the new clauses look at a new situation and the way in which (ship) management is done today which is completely different than it was 10 years ago."

The London and Norwegian approaches are "very similar," and shipowners would be no worse off under the new clauses than under the Norwegian hull clauses which were updated a few years ago, said Mr. Wilmot.

"What I want to know is, when is the American market going to (change) the American clauses to address the problem?" Mr. Wilmot asked.

When are U.S. underwriters "going to look at the problem and give us a sense of their views?" he asked.

One U.S. executive replied that any changes would be slow in coming.

"Since the American market doesn't write substandard tonnage, they don't need the London clauses," said John A. Hickey, president of the American Hull Insurance Syndicate in New York.

American underwriters will change their clauses "someday, but not tomorrow," he said. "But we do try to find out who are the good shipowners, and we do try not to write the ones that aren't so good. We can live with that for a while."

David Davies, marine underwriter for Royal Insurance (Global) Ltd. in London, was disappointed by Mr. Hickey's response.

"The hull market is entering a fairly difficult phase. We rarely if ever march in tune together and that's not what is being asked," said Mr. Davies. "I really, really urge the American market to look closely and professionally at the wording of their coverage in light of the industry that they support today."

Other U.S. underwriters confirmed that the AIMU has had discussions to change its standardized hull clauses.

However, "the reality is that we made a ton of money in 1992, 1993 and 1994 with the old clauses," said one American marine underwriter. "Changes in clauses can help. The reality is quality of risk selection, pricing and appropriate deductibles" make money. The Norwegian, London and U.S. markets were using old forms in 1992 when the hull market hardened. "It was price, not form that brought us back to profitability," he said.

There is some market tension now because when prices start to soften, "we like to point fingers" at someone or something else causing the problem, said the underwriter.

"We never choose to see ourselves as the villain, so it's easier to say, 'it's market A, it's market B or market C.' When you focus on what you're doing wrong, that requires reflection and discipline," he said.

One of the functions of the AIMU is for technical committees to review standard clauses and policy forms periodically, said William Mack, chairman of the AIMU and chairman of American International Marine Agency of New York Inc.

But these are only "suggested clauses" intended to be used voluntarily by underwriters, Mr. Mack added. The AIMU also is considering major changes to its cargo clauses. BI



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Three JUA execs suing over firings

SARASOTA, Fla.—Three of the four executives of a Florida joint underwriting association servicing company fired in August are suing for wrongful termination.

The top officers of Shared Market Information Services Inc. were fired amid allegations of mismanagement and dummy corporations in the nonprofit company's contracts to handle claims in the state's JUAs (*BI*, Sept. 4).

All of the ousted officers except for John H. Kummer, the former president of SMISI, are participating in the lawsuit filed last month in circuit court in Manatee County.

"We want to make sure that every dollar of policyholder money is used appropriately," Insurance Commissioner Bill Nelson said in announcing the dismissals. "Unfortunately, the golden parachutes and other management perks appear to be part of a broader pattern of unacceptable business practices sanctioned or allowed by SMISI's previous leadership."

The absence of an operational budget for SMISI, the apparent lack of financial controls, sloppy and inadequate record-keeping, questionable contractual relationships and loose purchasing practices were also cited by the state insurance commissioner.

Mr. Nelson also made public an interim status report from his investigators looking into SMISI, which Mr. Nelson disbanded shortly after the firings.

The report states that new documents have been uncovered in SMISI's computer system, some of which "have been turned over to the Florida Department of Law Enforcement for deciphering."

"Most of these newly collected records concern plans by top SMISI managers to set up for their own gain and provide a private SMISI-like insurance services company, called Hemisphere Services Group Inc.," the report states.

A business plan, drafts of contracts, sales proposals and correspondence for this for-profit company were prepared or revised on SMISI time and stored in SMISI computers.

Many of these documents were received and stored at SMISI via a sophisticated facsimile gateway system.

Other records show that computer equipment valued at approximately $8,600 is missing from SMISI's inventory.

—By Sara Marley

Metropolitan Life's Reali named vp in department of risk management

Joseph A. Reali has been named vp of the corporate risk management department at Metropolitan Life Insurance Co.

Mr. Reali, 43, is responsible for reviewing, monitoring, measuring and reporting on all the corporation's and its subsidiaries' risks.

He reports to Stewart G. Nagler, senior executive vp and chief financial officer, in the newly created position.

Mr. Reali was previously vp & secretary and vp of tax planning and administration at Met Life.

Mr. Reali earned bachelor's and law degrees from Fordham University and an L.L.M. in taxation from New York University. He is a member of the American Bar Assn. and holds the Associate Life Insurance Counsel designation.

* * *

Rodger A. Cochran has been named director of risk management and employee benefits at Titan Wheel International Inc.

The wheel rim and tire manufacturer is headquartered in Quincy, Ill.

Mr. Cochran, 53, will administer corporate risk management, group insurance benefits, pensions, claims and safety and loss control programs.

He reports to Chief Operating Officer Mike Samide in the newly created position.

Mr. Cochran was previously risk manager at Owen Steel Co. Inc. in Columbia, S.C.

He earned his certificate in general insurance from the Insurance Institute of America and is a deputy member of the Risk & Insurance Management Society Inc.

* * *

Carol A. Fox has been promoted to the new position of director of risk management at Gibson Greetings Inc. in Cincinnati.

In this position she is responsible for all property/casualty insurance programs, as well as all safety, occupational health and environmental issues for the greeting card manufacturer.

Ms. Fox reports to Gibson CFO William L. Flaherty.

She joined Gibson in 1986 as treasury services coordinator and was promoted to corporate risk manager in 1988.

Ms. Fox holds a bachelor's degree in education from Miami University in Oxford, Ohio, and the Associate in Risk Management designation. She is the society director of the Cincinnati chapter of the Risk and Insurance Management Society Inc.

* * *

Drew J. Talley is the new director of insurance and risk management at Witco Corp., a Greenwich, Conn., manufacturer of speciality chemical and petroleum products.



Mr. Talley

Mr. Talley manages all aspects of the company's insurance and risk exposure as well as policy negotiations, claims and relationships with brokers and insurers.

Mr. Talley replaces Tim Bunt, who left the company. He reports to Treasurer James Rutledge.

Mr. Talley was most recently vp and manager of global business with Alexander & Alexander Services Inc.

Mr. Talley holds an M.B.A. in finance and international business from New York University's Stern School of Business and a bachelor's degree in business administration from the University of Washington in Seattle. He is a deputy member of RIMS.

* * *

Patrick F. O'Connor has been promoted to vp of human resources and administrative services for Blue Cross & Blue Shield of Illinois.

Mr. O'Connor, 42, will oversee compensation and benefit programs, and labor relations, workforce diversity, office services, purchasing, graphics and security.

Mr. O'Connor was previously director of human resources. He replaces Charles A. Meyers, former vp of human resources, who left the company, and Larry Hough, former vp of administrative services, who retired.



Mr. O'Connor

Mr. O'Connor reports to Theodore E. Desch, senior vp of law and corporate affairs.

Mr. O'Connor holds a bachelor's degree in philosophy and education from Tolentine College in Olympia Fields, Ill., and a master's in human resources and industrial relations from Loyola University in Chicago.

He is a member of the American Compensation Assn., Society of Human Resource Management and Human Resources Management of Chicago.

* * *

Richard A. Swan has been named vp-health, environment and safety at Occidental Petroleum Corp. in Los Angeles.

Mr. Swan succeeds Catharine deLacy, who resigned. He reports to Donald P. deBrier, executive vp, general counsel and corporate secretary.

Mr. Swan, 48, joined Los Angeles-based Occidental in 1982 when the company acquired Cities Service Co. where he had worked for 12 years. Mr. Swan was named director-investor relations of Occidental in 1991.

A graduate of Drexel University in Philadelphia with a bachelor of science degree in commerce and engineering sciences, he also holds an M.B.A. from Seton Hall University in South Orange, N.J.

* * *

Nicholas A. Parillo has been named vp of risk management at Columbia Gas System Service Corp.

He succeeds Joseph P. Yandoli, who retired after 46 years with the company.

Mr. Parillo joined the Wilmington, Del., energy company last year as director of risk management for Columbia Gas System Service Corp. in Wilmington, Del. (*BI*, Jan. 2).

Mr. Parillo, 46, reports to Peter M. Schwolsky, senior vp and chief legal officer.

Prior to joining Columbia Gas, Mr. Parillo was manager of corporate insurance for Sun Co. in Philadelphia. He has also worked for Reliance Insurance Co. and served on the board of directors of Oil Casualty Insurance Ltd. of Hamilton, Bermuda.

Mr. Parillo holds a bachelor's degree in political philosophy from St. John's University in New York. He is an associate member of RIMS.

Mr. Yandoli will continue working for Columbia as a consultant. He joined the company's service department in 1949 and was named director of insurance in 1979 and vp-risk management in 1989.

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We'd like to report on staff changes in your company's risk management, safety and employee benefits departments. Contact Sara Marley, Associate Editor, Business Insurance, 740 Rush St., Chicago, Ill., 60611-2590, or call 312-649-5313. Please send a photograph, too. BI

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Helicopters

Continued from page 3

"Rates are going up and we're holding our own, said Bob Cummiskey, risk manager in New Orleans for Petroleum Helicopters Inc. "We think we're doing better than the industry. We didn't take a hit like others."

PHI has one of the most respected safety programs in the commercial helicopter industry, according to other risk managers, brokers and aviation underwriters.

PHI has a fleet of about 260 helicopters, Mr. Cummiskey said. Many of the ships service offshore oil rigs. Others, despite the company name, actually are used for emergency medical services.

In 1992, under orders from the chairman to improve safety, the company introduced a program of financial incentives.

"I had no idea we would see such a drastic turnaround. I mean just an instantaneous elimination of accidents, employee injuries, damage to aircraft caused by acts of individuals," Mr. Cummiskey said.

The program was developed by Bruce Gillaspie, PHI's director of safety in Lafayette, La. All company job functions are placed into three categories of risk exposure, Mr. Gillaspie explained. Pilots and lathe operators are in the high category, clerks the low category.

Each year, pilots who do not generate hull or workers compensation losses receive $200 awards. Medium-exposure employees receive $150, and low-exposure workers receive $100. Every fifth year, employees receive 50% of their annual award multiplied by the number of years they have worked safely.

Workers are disqualified from awards if they are involved in OSHA recordable accidents and those that cause property damage in excess of $250, Mr. Gillaspie said. Supervisors and work teams also are eligible for awards, so that employees watch out for each other's safety.

"We have a complete training department for our employees," Mr. Cummiskey said. "There is a flight safety department teaching pilots cockpit risk management. Telling them, 'Don't push the envelop. Don't take chances. Ask questions.' "

As a result, hull damage and workers comp accidents dropped 50% the first year the program was instituted, according to Mr. Gillaspie. During each of the next two years, accidents dropped another 50% from the preceding year.

"We were paying money to the underwriters. We figured, 'Hey, it's just the cost of doing business.' But why give money to the underwriters when we can give it back to our employees, and at the same time encourage them (to practice safety) and eliminate injury to themselves. It's phenomenal the success we had last year," Mr. Cummiskey said.

Instilling safety into the corporate culture makes renewals easier, Mr. Cummiskey said. He is still at the mercy of the market when it comes to rate increases, but they are milder than they would be without the attention to loss prevention.

Not all commercial helicopter operators are in such a good position.

"There have been instances out there where some commercial operators have not been able to buy insurance even when they want to, certainly not on the basis in which they approached it," said John A. Horner, managing director in North America for Sedgwick Aviation Ltd. in Roseland N.J. "And in the end they are forced to pay higher rates for less coverage than they originally intended," he said. "There have been a few instances where because they were trying to negotiate with the marketplace, they didn't have insurance. That is a sign of how difficult it is if you are a commercial operator. Just to find anybody to write it in the first place is difficult; then to find one who will write it at a price you are willing to pay is even more difficult."

Some rates are up 50% to 200% at renewals, some brokers say.

Others say the top-end percentage increases have been limited to smaller accounts, where a $10,000 jump might mean a doubling of premium. But large accounts will also see increases.

"Right now aviation liability in excess of $20 million to $50 million has become very expensive because of reinsurance capacity in the marketplace," Mr. Behan explained. "Especially once you hit $50 million. We are in the process of renewing a large corporate account that is up about 30% overall, and liability is most of it. It's all in the liability."

'Some commercial operators have not been able to buy insurance even when they want to,' says Sedgwick Aviation Ltd.'s John A. Horner.

Rates vary with the specific use of helicopters, and many of those sectors are trying to improve their high-risk status.

Several observers say helicopter tour operators are working hard through their associations to enhance their safety practices because recent losses make them among the hardest hit commercial operators.

Even tour operators with good histories could see 20% to 40% increases, Mr. Behan said. Increases of 40% to 50% are more likely, and Mr. Behan said he knows of two large tour operators with premiums in the hundreds of thousands of dollars that have seen jumps of more than 200%. "They are in that class of business that has been very expensive for underwriters during the last two or three years," he added. "Losses have occurred in that sector of the business. In Hawaii, there have been some significant losses. There was a significant loss a few years ago in the Niagara Falls area, and the Grand Canyon has had its turn in the barrel."

As for helicopters used for logging, construction, fire fighting and other heavy-lift operations, said Mr. Behan, "Those aircraft at the end of the year will average between 35% and 50%."

Tim Harper, risk manager for Erickson Air-Crane Co. in Central Point, Ore., said his company will see increases, but they will be smaller than other companies.

Erickson operates 12 air cranes that are used worldwide for construction, logging and fire fighting. The company's helicopter insurance is placed in the London market.

Erickson keeps rate increases to a minimum by relying on a very "formal approach" to safety, Mr. Harper said. That includes training the employees of other companies on construction projects, so they will understand how to avoid potential risk while they work with a helicopter overhead.

"We provide our clients up front with a contractor's check list," he said. "We provide them up front with information on the aircraft, and then on the day of the job we take their crews, bring them right up to the aircraft when they are sitting on the ground and give very extensive reviews. We have very formal programs. All of our people have radio contact with the cockpit. It's highly orchestrated. It has to be. It's the only safe way to do it."

Pilot procedures and maintenance are key issues, Mr. Harper said. Even experienced pilots are given heavy doses of training. Contracts with clients stipulate that pilots have ultimate authority to cancel an operation.

Mr. Harper and other risk managers say the tight market and the versatility of helicopters makes it crucial to not only cultivate good relations and communication with clients, but with underwriters as well.

Any planned changes in use warrants an immediate call to the underwriters. Those telephone calls keep them feeling "warm and fuzzy" about your operation, which helps at renewal time, risk managers said.

The "first-dollar underwriters come over here and go through the operations and take a look at our jobs," Mr. Harper says. "I just had one of my major underwriters, not too long ago, on a roof top with me."

"Don't market shop," advises PHI's Mr. Cummiskey. "Underwriters are due to make a profit. And if you can exhibit to them that you believe in a safe operation, that you believe in partnering with them, in the long run, it's going to prove beneficial." PHI's coverage has been written by United States Aviation Underwriters Inc. in New York since 1981, Mr. Cummiskey said.

City of Los Angeles Risk Manager Art Cupples agreed that long-term relationships with underwriters are valuable. "I think the whole key to dealing with them is just being up front and telling them what you are doing, Mr. Cupples said. "Nobody likes surprises. If we are going to do some sort of off beat operation, I call and let them know."

The city's helicopters have been insured by Associated Aviation Underwriters for 10 years. The city fleet includes 16 police ships used largely for patrol, six fire department ships used for rescues and fire fighting and six general services helicopters owned by the Department of Water and Power.

With the city's helicopters divided among three departments, pilot training and safety are separated, but responsibility for mechanical maintenance falls under one roof. Mr. Cupples does not oversee those operations, but he does monitor the safety programs, dispenses advice on what underwriters look for and schedules underwriter safety inspections as well as negotiates renewals.

For Mr. Cupples, there is some added incentive to be first to apprise his underwriters of any new use of the helicopters. Los Angeles is home to a very competitive news market.

"We're very visible," Mr. Cupples says. "I don't want them to see it on the news before I tell them."

Media organizations employ their own helicopters, which can present additional hazards to police pilots.

"The biggest problem is the air traffic during an incident," said Mr. Cupples. "It's like a feeding frenzy of sharks. Every little TV station has one."

That is an added consideration for the underwriters, Mr. Cupples said.

"They expect with a fleet our size, we would have at least one accident a year," he said. "It's been a couple of years, But I mean it's just an actuarial or probability thing. With a fleet that size, it's a high probability so they factor that into the rates. That's why the rates are so high on helicopters. There are a lot of incidents. We've had a few. There is only one that has had fatalities."

In the last eight years, the city has lost three helicopters to accidents.

The most serious involved fatalities in June 1992, when a police ship attempted an emergency landing at an intersection. It clipped power lines, crashed and killed a pedestrian and the two officers on board.

The task afterward included sifting through numerous bogus claims that typically follow large incidents involving city equipment, Mr. Cupples said. For example, one man fraudulently claimed the crash knocked him off his motorcycle.

The city's insurer quickly paid the city's claim for the loss of the hull and settled related property damage, such as to cars and a small house that burned. Wrongful death claims filed by the families of the pilots and the pedestrian were subrogated to a helicopter engine manufacturer, which settled with the families.

A product liability lawsuit filed by the insurer is still outstanding against the engine manufacturer, Mr. Cupples said. The city, through the insurer's lawsuit, is trying to recoup losses such as its deductible and the cost of training pilots.

The insurer is trying to recoup legal fees and the cost of the hull, estimated to be worth $1.1 million.

"It could have just as well hit a schoolyard," Mr. Cupples said. "Talk about liabilities. Those things are flying over heavily populated areas. They are always in the air. There are always one or two (police) helicopters somewhere. The potential is ongoing. The only time they don't fly is real early in the morning."

Still, the city's premium will only jump about 10% this year. Last year the city paid $570,000. Hull deductibles range from 5% to 25% of hull value, and liability coverage is written on a first-dollar basis. The values of the helicopters range from $900,000 to $3.5 million.

While other observers say liability coverage above $20 million can be hard to find, Mr. Cupples said he did not experience a problem. Associated Aviation Underwriters writes the first $20 million of the city's liability coverage, with excess layers of coverage placed in the London market, he said. BI

Carvill

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Leave

Continued from page 1

"The court recognizes that notice is required, though what is required will vary by facts and circumstances. Clearly, though, an employee does not have to say 'I want leave under FMLA,'" said John Hoos, an attorney with Hewitt Associates L.L.C. in Lincolnshire, Ill.

The decision marks the first time that a federal appeals court has ruled in a case involving the FMLA, said Donna Lenhoff, general counsel with the Women's Legal Defense Fund in Washington.

The appeals court decision involves June Manuel, who worked in the Lake Charles, La., plant of Houston-based Westlake Polymers Corp. and was later fired because of excessive absenteeism.

According to court papers, Ms. Manuel had missed a substantial number of days of work since she was hired in 1986.

In 1987, for example, she was absent 17 days and was warned that her employment could be in jeopardy if her attendance did not improve. In 1988, though, she missed 49 days, and in 1990, 30 days. In 1991, she was informed her attendance record was unacceptable.

In 1992, Westlake adopted a new four-step system of warnings and disciplinary measures directed at employees with attendance problems. First came an oral reprimand, then a written warning, a one-week suspension and, finally, termination.

Ms. Manuel received several warnings in 1992 about attendance problems, including one in September that alluded to "severe disciplinary action, up to and including termination." Ms. Manuel received another letter in December informing her that in the three months since her last warning she had missed about 14 days. Continued absenteeism, the letter explained, could result in suspension or termination.

In October 1993, Ms. Manuel sought medical treatment for an ingrown toenail. She notified her supervisor, who gave her permission to take the day off.

After the procedure, complications developed, including infection. Ms. Manuel was unable to walk without crutches. Again, she told her supervisor of the problem and stayed in touch with the company during her absence in October and November.

At the end of November, Ms. Manuel was examined by a company physician who said she was able to return to work. She returned to work the next day, but was suspended for four days and issued a final warning letter that her employment would be terminated if she didn't report to work regularly.

In January 1994, she became ill at work and went home. She returned to work after three days but was fired because of her attendance problem.

Last year, Ms. Manuel sued the company in district court, alleging the company violated the FMLA by counting her October-November absence as an "additional step" in its "no-fault" policy.

The district court ruled in favor of Westlake, noting that Ms. Manuel did not "expressly invoke" the FMLA when requesting leave.

The appeals court, though, ruled that nothing in the FMLA mentions the content of the notice an employee must give an employer in order to receive family and medical leave.

The FMLA, the appeals court noted, is one of many federal laws that set minimum employment standards. None of those laws requires employees to refer to the specific statute to receive benefits under those statutes, the court said.

"We do not believe Congress intended to depart from this practice and require employees to consult attorneys before notifying their employer of their need for FMLA leave," the appeals court said.

While employees do not have to cite the FMLA specifically to receive benefits under the law, the law protects employers from potential abuse, the court said, noting that employers have the right to require an employee to obtain certification from a physician verifying that the worker has a serious health condition.

"In short, the FMLA provides safeguards from delinquent employees, but express notice by an employee that she takes leave pursuant to the FMLA is not one of those safeguards," the court ruled.

The case was remanded to district court to determine whether Ms. Manuel gave sufficient notice for leave. The appeals court also gave no opinion on whether the complications from Ms. Manuel's surgery for her ingrown toenail constitute a "serious health condition," one of the qualifying events covered under the FMLA.

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Manuel vs. Westlake Polymers Corp., 5th U.S. Circuit Court of Appeals; No. 95-30050, Oct. 3.

AIDS

Continued from page 2

to update earlier bulletins on AIDS that the department issued nearly a decade ago, a department spokeswoman said. Those bulletins, which forbade HIV testing for health insurance, had no legal force and were outdated anyway, she said.

Acknowledging that the state cannot forbid insurers from using medical underwriting, the department is instead trying to regulate it to protect consumers. "Since they can do underwriting based on health status, we would want them to do it in a uniform and non-discriminatory way," the spokeswoman said. But, there is "practically no" medical underwriting anyway, she added.

Even under the proposed rules, individuals and groups of fewer than 50 people could not be tested. Large employers tend to self-insure their health programs and cannot use HIV testing, and the state's largest health insurer, Newark-based Blue Cross & Blue Shield of New Jersey, doesn't use medical underwriting.

"From a practical standpoint, it may be much ado about nothing," said Paul Sullivan, senior research consultant with Alexander Consulting Group in Newburyport, Mass. He questioned whether many insurers would even bother medically underwriting groups of more than 50 people.

"I don't think it has a big impact," agreed Harvey Sobel, principal and consulting actuary with Buck Consultants Inc. in Secaucus, N.J. Because it excludes small groups and individuals and then limits the right to test new applicants, the proposal covers only a "very small universe," he said.

"I don't feel that the proposal has any importance, primarily because it is targeted to the larger employer, and in that marketplace employers do not ask medical questions of the employees when they put them on the group insurance program," said Allison Kalban-Gernett, a principal with Princeton, N.J.-based health care actuarial and managed care consulting firm Apex Management Group.

Even under the proposed rules, individuals and groups of fewer than 50 people could not be tested.

"My initial reaction would be that no employer in its right mind would try to screen out employees knowing how many (Americans with Disabilities Act) cases are out there," she added.

Insurers aren't rushing to judgment on the proposal, either. The Health Insurance Assn. of America, for example, "has just started to take a look at it but, based on recent reports, it would seem to have little potential impact inasmuch as most group coverage is not (medically) underwritten," a spokesman for the Washington-based group said.

In a newspaper report, an unidentified New Jersey official was quoted as saying that the new rules were designed to force people who engage in behavior that could lead to AIDS infection to confront the consequences of their actions.

The department spokeswoman said that was untrue. BI

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OCT. 22-24. Ninth Annual National Disability Management Conference in Washington, co-sponsored by the Washington Business Group on Health and UNUM Life Insurance Co. of America; $675 for members, $750 for non-members. Sandra Lehner, WBGH, 777 N. Capitol St. N.E., Suite 800, Washington, D.C. 20002; 202-408-9320.

OCT. 23-27. Practical Workplace Ergonomics: Controlling Your Most Costly and Frequent Accidents and Injuries Seminar in Buffalo, N.Y., sponsored by Safety Excellence Resources; $99. **Also Oct. 25** in Syracuse, N.Y. and **Oct. 27** in Albany, N.Y. Susan Hunter, 300 Erie Blvd. West, Syracuse, N.Y. 13202; 315-460-1286.

OCT. 23-24. Fifth Annual Managed Care Conference in Sarasota, Fla., sponsored by the Florida West Coast Healthcare Coalition Inc.; $295. Florida West Coast Healthcare Coalition Inc., 6637 Superior Ave., Suite C, Sarasota, Fla. 34231; 941-923-1697.

OCT. 23-26. 15th Annual Construction Insurance Conference in San Antonio, sponsored by the International Risk Management Institute Inc.; $798. International Risk Management Institute, 12222 Merit Drive, Suite 1660, Dallas, Texas 75251-2217; 214-960-7693.

OCT 23-27. Fundamentals of International Employee Benefits Management conference in Brookfield, Wis., sponsored by the International Foundation of Employee Benefit Plans; $1,175 for IFEBP members, $1,325 for non-members. IFEBP, Registrations Department, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6710 ext. 257

OCT. 24-28. 15th Annual National Educational Conference in Lake Buena Vista, Fla., sponsored by the Self-Insurance Institute of America Inc.; $695 for SIIA members, $895 for non-members. SIIA, P.O. Box 15466, Santa Ana, Calif. 92735; 800-851-7789.

OCT. 25-27. Pension Basics seminar in Atlanta, sponsored by Corbel; $595. Corbel, 1660 Prudential Drive, Jacksonville, Fla. 32207-8917; 904-399-5888.

OCT. 26-27. Employer Behavioral Healthcare Summit in Salt Lake City, sponsored by the Institute for Behavioral Healthcare; $1,195. CentraLink, 1110 Mar West St., Suite E, Tiburon, Calif. 94920; 415-435-9821.

OCT. 27-28. Cents and Sense of Risk Management: Risk Financing, Workers Compensation and Safety and Security seminar in Miami Beach, Fla., sponsored by the American Society for Healthcare Risk Management and the American Hospital Assn.; $325 for ASHRM members, $425 for non-members. Marilyn Geary, ASHRM, 1 N. Franklin, Chicago, Ill. 60606; 312-422-3986.

OCT. 29-NOV. 1. 17th Annual Meeting, Educational Conference and Exhibition in Miami Beach, Fla., sponsored by the American Society for Healthcare Risk Management and the American Hospital Assn.; $450 for ASHRM members, $550 for non-members. Marilyn Geary, ASHRM, 1 N. Franklin, Chicago, Ill. 60606; 312-422-3986.

OCT. 30-NOV. 1. Multiple Chemical Sensitivities: State of the Science symposium in Baltimore, co-sponsored by the International Society of Regulatory Toxicology & Pharmacology, Johns Hopkins University and National Medical Advisory Service Inc.; $450 for ISRPT members, $450 for government/academic, $625 for all others. MCS: State of the Science Symposium, P.O. Box 2307, Rockville, Md. 20847; 301-230-6552.

OCT. 31. Reinsurance Accounting and Auditing seminar in New York, sponsored by the College of Insurance; $325, with a 10% discount for College of Insurance employees and sponsors. The College of Insurance Center for Professional Education, 101 Murray St., Room 426, New York, N.Y. 10007; 212-815-9201.

NOVEMBER

NOV. 1. Personal Umbrella Coverage seminar/workshop in New York, sponsored by the College of Insurance; $95. The College of Insurance Center for Professional Education, 101 Murray St., Room 426, New York, N.Y. 10007; 212-815-9201.

NOV. 1-2. Advanced Business Interruption course in Sevenoaks, England, sponsored by the Chartered Insurance Institute College of Insurance; £540 ($858). The Course Advisor, The CII College of Insurance, Churchill Court, 90 Kippington Road, Sevenoaks, Kent, TN13 2LL, England.

NOV. 1-4. Climate Prediction and Insurance Risk Conference in Bermuda, sponsored by Centre Cat and the Atlantic Global Change Institute; $600. Suzie McKeegan, Project Co-Ordinator, Climate Prediction & Insurance Risk Conference, The Whitfield Building, 61 Front St., Penthouse, P.O. Box 2550 Hamilton HM KX, Bermuda; 809-292-6386.

NOV. 2. Pension & Retirement Savings Plan Fundamental Program in New York, sponsored by New York Metropolitan Area Chapter of ISCEBS; $175. Judith Besse, P.O. Box 307, Grand Central Station, New York, NY 10017; 212-466-4100.

NOV. 2-3. Asbestos Personal Injury Litigation seminar in Scottsdale, Ariz., sponsored by the Defense Research Institute Inc.; $495 for DRI members, $545 for non-members. DRI, 750 N. Lake Shore Drive, Suite 500, Chicago, Ill. 60611; 312-944-0575.

NOV. 5-8. The Risk Management Forum in Monte Carlo, Monaco, co-sponsored by the European Assn. of Risk Managers and the Risk & Insurance Management Inc.; 6,250 French francs ($1,259) for risk managers, 8,900 francs ($1,793) for others. Risk Management Forum, SOCFI-14, rue Mandar-75002, Paris, France; 33-1-42-33-89-94.

NOV. 7. Fifth Annual Insurance Executive Forum in Chicago, sponsored by *Business Insurance*, the Illinois Insurance Exchange and the Katie Insurance School; $125. Illinois State University, Katie Insurance School, Campus Box 5490, Normal, Ill. 61790-5490; 309-438-7785.

NOV. 7. 401(k) Plans From A to Z seminar in San Francisco, sponsored by Corbel; $225. **Also Nov. 9** in Dallas, **Nov. 14** in New York, **Nov. 16** in Boston. Corbel, 1660 Prudential Drive, Jacksonville, Fla. 32207-8917; 904-399-5888.

Nov. 7-8. Disaster Planning & Preparedness seminar in Birmingham, Ala., sponsored by Factory Mutual Engineering & Research; $495. Seminar open to policyholders of Allendale Insurance, Arkwright and Protection Mutual Insurance only. **Also Nov. 9-10** in Charlotte, N.C. FME&R's Insured Education., 1151 Boston-Providence Turnpike, P.O. Box 9102, Norwood, Mass. 02062; 617-255-4606.

NOV. 7-8. Midwest Regional Workshop in Chicago, which is sponsored by the Chicago, Wisconsin and Northeast Illinois Chapters of the Risk & Insurance Management Society Inc.; $225. Liz Fryen, Sherwood Group Inc., 60 Revere Drive, Suite 500, Northbrook, Ill. 60062; 708-480-9080 ext. 230.

NOV. 7-8. Safety & Health Program Management—The Principles course in Long Grove, Ill., sponsored by NATLSCO, a Kemper Risk Management Services company; $300. NATLSCO, 1 Kemper Drive, Long Grove, Ill. 60049-0075; 800-323-9585, ext. 4901.

NOV. 7-8. REBEX '95 conference and exhibition in Chicago, sponsored by the Risk & Insurance Management Society Inc.; $225. Deb Pederson, REBEX '95, 60 Revere Drive, Suite 500, Northbrook, Ill. 60062; 708-480-9712.

NOV. 8-10. Crisis Management Planning course in Atlanta, sponsored by the Risk & Insurance Management Society Inc.; $700 for RIMS members, $800 for non-members. RIMS Professional Development Department, 655 Third Ave., New York, N.Y. 10017; 212-286-9292.

NOV. 9. OSHA Compliance in the 90s course in Long Grove, Ill., sponsored by NATLSCO, a Kemper Risk Management Services company; $195. NATLSCO, 1 Kemper Drive, Long Grove, Ill. 60049-0075; 800-323-9585, ext. 4901.

NOV. 9-10. Meeting the Challenge of a Changing Insurance Environment in Charleston, S.C., sponsored by National Conference of Insurance Guaranty Funds; $250 for the first registrant, $200 for additional registrants, $40 for spouse/guest. NCIGF, The Market Tower Building, 10 W. Market St., Suite 1190, Indianapolis, Ind. 46204; 317-464-8199.

NOV. 9-10. Developing Outcomes Measures and Return-to-Work Guidelines seminar in Boston, co-sponsored by International Business Communications and William M. Mercer Inc.; $1,195. IBC USA Conferences Inc., 225 Turnpike Road, Southborough, Mass. 01772-1749; 508-481-6400.

NOV. 9-10. Charting New Directions: Trends and Changes in Managed Care Purchasing in Washington, sponsored by the Managed Health Care Assn.; $450 for MHCA members, $550 for non-members. MHCA, 1225 Eye St. N.W., Suite 300, Washington, D.C. 20005; 202-371-8232.

NOV. 9-10. Winning Strategies in Patent Litigation seminar in Chicago, sponsored by the Practising Law Institute; $995. **Also Nov. 16-17** in New York, **Dec. 7-8** in Los Angeles. Practising Law Institute, 810 Seventh Ave., New York, N.Y. 10019; 800-260-4754.

NOV. 9-11. ERISA Litigation National Institute in Chicago, sponsored by the American Bar Assn.; $650 for ABA members, $800 for non-members. American Bar Assn., Financial Services N1804, P.O. Box 109078, Chicago, Ill. 60610-9078; 312-988-5314.

NOV. 10-15. 41st Annual Employee Benefits Conference in Honolulu, sponsored by the International Foundation of Employee Benefit Plans; $705. Registrations Department, IFEBP, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6710 ext. 257.

NOV. 12-17. Managing Operations: The College of Insurance Management Program in New York, sponsored by the College of Insurance; $3,295, includes accommodations. The College of Insurance Center for Professional Education, 101 Murray St., Room 426, New York, N.Y. 10007; 212-815-9201.

NOV. 13-15. Managed Health Care Congress Northeast in New York, co-sponsored by the National Managed Health Care Congress and the New York Business Group on Health; $1,195, $795 for government officials. NMHCC, 70 Blanchard Road, Suite 4000, Burlington, Mass. 01803; 617-720-6000.

NOV. 13-17. Fundamentals of IH Monitoring course in Long Grove, Ill., sponsored by NATLSCO, a Kemper Risk Management Services company; $850. NATLSCO, 1 Kemper Drive, Long Grove, Ill. 60049-0075; 800-323-9585, ext. 4901.

NOV. 13-17. Intensive Workers Compensation Course in Glastonbury, Conn., sponsored by Aon Management Institute; $3,900. Aon Management Institute, 628 Hebron Ave., Corporate Center II, Glastonbury, Conn. 06033; 203-659-6780.

NOV. 14. Washington Update Program: Qualified and Non-Qualified Plans: A Briefing from the Department of the Treasury and the Internal Revenue Service in Boston, sponsored by the New England Employee Benefits Council; $175 for NEEBC members, $210 for non-members. NEEBC, 62 Walnut St., Wellesley, Mass. 02181; 617-239-1767.

NOV. 16-17. Posttraumatic Stress Disorder conference in New Orleans, sponsored by the Defense Research Institute Inc.; $475 for DRI member, $525 for non-members. Defense Research Institute, 750 N. Lake Shore Drive, Suite 500, Chicago, Ill. 60611; 312-944-0575.

NOV. 15-17. Fourth Annual National Workers' Compensation & Disability Conference and Exhibit in Chicago, sponsored by the Axon Group, LRP Publications, Jury Verdict Research and the LRP Conference Group; $525 for government and non-profit organizations, $625 for others. LRP Conference Group, 1555 King St. Suite 200, Alexandria, Va. 22314; 800-727-1227 or 703-684-0510.

NOV. 17. New York No-Fault Insurance seminar/workshop in New York, sponsored by the College of Insurance; $95. The College of Insurance Center for Professional Education, 101 Murray St., Room 426, New York, N.Y. 10007; 212-815-9201.

NOV. 17-18. Non-Profit Risk Management Institutes in Arlington, Va., sponsored by the American Red Cross; $250. Non-Profit Risk Management Center, 202-785-3891.

NOV. 28-29. Emergency Response Planning seminar in Princeton, N.J., sponsored by the Factory Mutual Engineering & Research; $495. Seminar open to policyholders of Allendale Insurance, Arkwright and Protection Mutual Insurance only. **Also Dec. 5-6** in Norwood, Mass. FME&R's Insured Education, 1151 Boston-Providence Turnpike, P.O. Box 9102, Norwood, Mass. 02062; 617-255-4606.

NOV. 29. Workers Compensation Insurance seminar/workshop in New York, sponsored by the College of Insurance; $95. The College of Insurance Center for Professional Education, 101 Murray St., Room 426, New York, N.Y. 10007; 212-815-9201.

NOV. 29. ErgoPrime Interactive Ergonomics Training Program in Parsippany, N.J., sponsored by ErgoPrime Group; $249. **Also Dec. 7.** James Golden, ErgoPrime Group, 15 Orchard St., Madison, N.J. 07940; 201-402-4968.

NOV. 30-DEC. 1. Health Care Sponsored Captives seminar in Grand Cayman, sponsored by International Business Communications; $1,095. IBC USA Conferences Inc., 225 Turnpike Road, Southborough, Mass. 01772-1749; 508-481-6400.

DECEMBER

DEC. 4-5. Risk Management Institute in New York, sponsored by American Conference Institute; $1,095. Registrations Department, American Conference Institute, 175 Fifth Ave., New York, N.Y. 10010; 416-927-7936.

DEC. 6. Lloyd's and the London Insurance Market: How Recent Developments will Affect Your Clients conference in New York, sponsored by the Practising Law Institute; $995. PLI, 810 Seventh Ave., New York, N.Y. 10019; 800-260-4754.

DEC. 6-8. Behavioral Healthcare Delivery System Integration conference in Palm Springs, Calif., sponsored by the National Community Mental Healthcare Council and the Managed Care Technical Assistance Group; $1,195. **Also Jan. 24-26** in Washington. CentraLink-I, 4370 Alpine Road, Suite 108, Portola Valley, CA 94028; 415-851-8411.

DEC. 6-8. Second Annual Tri-State Workers Compensation Educational Conference in Memphis, Tenn., sponsored by the International Workers Compensation Foundation, the Arkansas Workers Compensation Commission, the Mississippi Workers Compensation Commission and the Tennessee Department of Labor-Division of Workers Compensation; $175; $200 at the door. International Workers Compensation Foundation, 1575 Aviation Center Parkway, Suite 512, Daytona Beach, Fla. 232114; 904-252-2915.

DEC. 7-8. Negotiating Environmental Agreements executive program in Cambridge, Mass., sponsored by Massachusetts Institute of Technology; $1,175. Carol Sloane, Center for Management Research, MIT, 55 William St., Wellesley, Mass. 02181; 617-239-1111.

DEC. 15. Commercial Building/Personal Property Form seminar/workshop in New York, $95. The College of Insurance Center for Professional Education, 101 Murray St., Room 426, New York, N.Y. 10007; 212-815-9201.

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The Datebook column is compiled from notices sent to Business Insurance. *Notices should be sent at least eight weeks in advance to Datebook,* Business Insurance, *740 N. Rush St., Chicago, Ill. 60611-2590. Please include the cost, if any, to attend the meeting and information on registration for interested readers.* Business Insurance *reserves the right to select meetings of most interest to its readers and cannot guarantee that notices will be printed.*



INTERNATIONAL

First law firm is named in Lloyd's member suit

Clyde & Co. joins auditors as defendant in actions on losses

By SARAH GODDARD

LONDON—Litigation continues at Lloyd's of London, despite management promises that names will know by the end of this month how much money will be available for a proposed settlement.

And there seems to be little chance of the loss-making names easing the legal pressure on the troubled insurance market.

Last week, the Sturge Names Action Group issued a writ against top London law firm Clyde & Co. for its role in the commutation of two unlimited retrocessional policies providing coverage for asbestos and pollution to syndicate 210. This is the first writ to be issued by an action group against a law firm. The action group would not elaborate on the charges.

Clyde & Co. acted as adviser to Sturge Non-Marine Syndicate Management Ltd., the managing agency that oversaw the running of syndicate 210, at the time of commutation in 1991.

The retrocessional policies were placed with Fireman's Fund Insurance Co. and Kemper Reinsurance Co. Fireman's Fund and Kemper Re each covered 50% of the total liability of the policies. The policies offered unlimited protection for asbestos and pollution risks up to 1969.

As claims mounted, Fireman's Fund and Kemper Re commuted both policies for $80 million. The syndicates' asbestos liabilities from Sept. 30, 1991, and pollution liabilities until Jan. 1, 2000, are exempt from coverage in exchange for the commutation payment.

Sturge Names Action Group Chairman John Rew estimates that £135 million ($212.9 million) of syndicate 210's losses—currently £350 million ($551.9 million) for underwriting years 1990 to 1993—is due to pollution and asbestos claims. But he declined to give a figure on possible future losses.

However, he did acknowledge that a successful case against Clyde & Co. could bring in another party to help fund the Lloyd's settlement.

Third parties like syndicate auditors have already been targeted by names' groups. Currently, a decision in such an action is pending in the *Merrett 418 (1985) Names Assn. vs. Ernst & Young* case, which could be handed down before the end of this month (*BI*, July 31; April 10).

Clyde & Co. has declined to comment on the situation, saying that since they have not seen the writ, they cannot make any judgment on its contents.

However, a spokeswoman did say that the law firm was aware of the Sturge Names Action Group's general allegations, "which are without foundation. The action will be contested."

The writ was served on Linklaters & Paines, another London law firm that is acting on Clyde & Co.'s behalf.

The Sturge Names Action Group issued writs against holding company Sturge Holdings P.L.C., the Sturge managing agency, a number of members agents and syndicate accounting firm Neville Russell earlier this year in connection with the commuted policies.

But the litigation is still a long way down the line from setting a court date, said Mr. Rew, though it is "progressing toward litigation." The action group will carry on its actions, however, until the market knows where it stands on the settlement issue. "It's a gigantic game of poker," he said.

"It's impossible to say when the action will come to court," said Jeff Walton, a solicitor at London-based law firm Eversheds, which is representing the Sturge Names Action Group. But, "we will move it ahead as quickly as possible."

Charles Lambrick, a partner at Eversheds, said, "This action focuses on the role and conduct of advisers to managing agents at Lloyd's. It is a further dimension of the unhappy saga of Lloyd's recent history."

But, there is a hitch for the names on syndicate 210. Under the terms of Lloyd's ambitious reconstruction and renewal plan, all underwriting years up to and including 1992 will be reinsured into Equitas Ltd., the proposed runoff company that will take over the market's pre-1993 liabilities.

But what will happen to names on syndicates like 210, which were trading in 1993 but have now gone into runoff?

Mr. Rew acknowledged that this may be a serious problem, particularly when the losses of the syndicate concerned are growing faster than expected, as 210's are. And it is a problem about which Lloyd's seems unsure.

On the one hand, Lloyd's Chairman David Rowland has told underwriting agents that so-called "orphan" syndicates—those that have no natural successor—will be reinsured into Equitas to provide "finality" for members.

On the other hand, this information has not been passed to the names, who still do not know

See **Lloyd's** *on next page*

Voting rights stall AXA, Generali talks

By MARIA KIELMAS

The very public exchange between two of Europe's largest insurance companies, France's AXA Group and Italy's Assicurazioni Generali S.p.A., about their future relationship appears to have stalled as each side considers its next move.

At the heart of the debate is the issue of corporate governance in France, insurance analysts say.

French corporate culture traditionally accords little influence to minority shareholders. Over the last several months, minority shareholders in several French companies have been trying to assert themselves by publicly commenting on corporate management. In the case of Companie Suez, shareholders actually succeeded in pressing for the ouster of company chairman, Gerard Worms.

Trieste-based Generali, the largest Italian insurer, has a large but indirect stake in Paris-based AXA, a situation that in Italy would give it significant clout in influencing or deciding corporate strategy.

The AXA-Generali relationship has been soured further by AXA's success in foreign acquisitions, even though it does not have the same funds at its disposal as Generali.

AXA's first-half results, which were published Oct. 5, show hefty gains in profits and gross premiums written.

Senior insurance industry sources have said that Generali would like to expand into foreign markets—especially Asia—through its relationship with AXA, but AXA has tended to rebuff Generali's approaches. Spicing the matter even further is the fact that Generali Chairman Antoine Bernheim is French.

"AXA has a good strategy, but the problem is a lack of money. Generali is a rich company but is not very dynamic. Now that the Generali chairman is French, maybe this will help to find a solution," said Claire Barberet, an insurance analyst at London-based stockbroker Smith New Court.

The public exchange between Mr. Bernheim and AXA Chief Executive Claude Bebear followed a heated debate in France this summer over shareholder influence in financial institutions.

On Sept. 28, just a week before AXA released its first-half financial results, Mr. Bernheim told a press conference that if Generali's stake in AXA does not give the Italian insurer a greater role in decision-making, particularly in foreign joint ventures, the stake should be sold.

Generali holds 40% of Midi Participations, a holding company that owns 42.3% of AXA S.A. The AXA Group is composed of AXA S.A. and several mutual insurance companies, which themselves hold 51.3% of AXA S.A.'s shares and 65.8% of the voting rights.

Generali's holding gives it an indirect stake in AXA S.A. of 16.9%, worth about 7 billion French francs ($1.41 billion).

Generali would like to participate with AXA in joint ventures in growing markets in the Far East, like Indonesia, Mr. Bernheim said.

See **AXA** *on page 30*

Hong Kong aims to improve safety

By MICHAEL BRADFORD

HONG KONG—Hong Kong's government is developing new legislation aimed at improving workplace safety and, in particular, reducing the number of construction accidents.

"We're proposing a safety management system in Hong Kong," which is long overdue, said Herman Cho, principal assistant secretary of the Education and Manpower Branch of the Hong Kong government.

The government in July released its review of industrial safety conditions in Hong Kong and has since met with labor unions, industries and citizens who attended public hearings. The government plans to begin drafting legislation based on the study and input from those groups later this year.

Mr. Cho said new legislation is particularly important because of problems within the territory's construction industry. The study showed that of 67 workplace fatalities in 1994, 51 were in the construction industry. There were 16,422 accidents among the construction industry's 59,710 workers. By contrast, the manufacturing industry, which employs 440,179 workers, recorded only seven fatalities in 10,706 accidents in 1994.

While Hong Kong's construction industry accounts for greatest number of workplace accidents, contractors actually have reduced that number in recent years. The number of construction accidents has fallen since 1988, when there were 58 fatalities among 27,125 accidents.

Still, Mr. Cho contends, "The main problem is with the construction industry." He pointed out that while that industry em-

See **Safety** *on next page*

Warehouse fire loss insured

TEESSIDE, England—Losses from an Oct. 9 warehouse fire at a British chemical plant are expected to total between 17 million DM and 20 million DM ($12 million and $14.1 million), according to its German owner, BASF A.G.

The blaze occurred at Imperial Chemical Industry's Wilton site in Teesside, England, early last Monday. About 200 firefighters fought for six hours to prevent the fire from spreading from a warehouse to other sections of the polyprophene plant.

BASF bought the plant from ICI last year. The warehouse contained bags holding 100,000 tons of polyprophene granules, which are small plastic pieces that are used to produce high-quality plastic products like car bumpers, and was not fitted with a sprinkler system. BASF reports no toxic material was released from the fire's dense smoke, but tanker trucks and workers at the facility were warned to stay away from the area.

BASF has an undisclosed deductible with its lead property insurer, Cologne, Germany-based Gerling Konzern Allgemeine Versicherungs A.G., and the German chemical manufacturer is reinsured via its domestic captive reinsurer, Lucura Rueckversicherungs GmbH in Ludwigshafen, Germany.

—By Don Lewis Kirk



AP/WIDE WORLD

A fire caused extensive damage at a BASF warehouse containing components for making plastic products, but insurance is expected to cover the loss.

INTERNATIONAL

Volcano brings skiing to halt

New Zealand resorts insured for business interruption losses

By KATE TILLEY

AUCKLAND, New Zealand—Two New Zealand ski resorts are expected to file business interruption claims totaling up to $1 million New Zealand ($663,300) per week for several weeks after the volcano on which the resorts sit erupted, forcing the resorts to close.

The resorts have not suffered any physical property damage yet, but their insurer has accepted the business interruption claims under a loss-of-access clause in the policies.

Mount Ruapehu, in the middle of New Zealand's north island, about 150 miles south of Auckland, erupted on Saturday, Sept. 24, and the slopes were closed by New Zealand's Civil Defense authorities. The Civil Aviation Authority also has banned all flights around the 9,200-foot mountain, which was shooting plumes of steam as high as six miles into the sky.

No aviation claims are expected, as flights were re-routed around the volcano, with no major flights being canceled.

There are three ski resorts on the mountain: Turoa, Whakapapa and a smaller resort, Tukino.

Stuart Murray, account manager with broker Willis Corroon Ltd. in Auckland, which is the broker for the Turoa and Whakapapa resorts, said property insurance coverage for both was placed with Wellington-based State Insurance Ltd.

Mr. Murray said the insurer had accepted the business interruption claims, though the extent of the loss of profits is still being assessed. He did not expect claims to be finalized before the end of New Zealand's ski season next month.

Stuart Robinson, finance manager for the Turoa resort, which is operated by Turoa Ski Resort Ltd., said executives of the two ski resorts met last week with Mr. Murray and other Willis Corroon representatives in Auckland. Willis Corroon is the broker for five of New Zealand's ski resorts.

Mr. Robinson confirmed that the Turoa resort was able to make a claim for loss of profits under a clause that covered the resort if it was unable to gain access to its facilities on the mountain. "We think the insurer is happy with that argument," he said. "We're negotiating with the insurance company now" over the size of the loss.

Mr. Robinson said he was uncertain of the policy limits and deductible level. The resort was closed for 18 days but was scheduled to partially reopen its facilities last Friday. However, the resort cannot operate its three T-bar lifts, which are less than two miles from the volcanic crater. Mr. Robinson said he did not know when the resort would be able to reopen those lifts.

The closure occurred during the height of the school holidays and the spring skiing season.

The losses "will be a reasonable sum," he said. The Turoa resort has 4,500 people a day on weekends and up to 3,000 skiers on weekdays.

Losses for Turoa and Whakapapa together could total $1 million New Zealand a week, said Joanne Savage, Turoa's marketing manager.

Whakapapa's marketing manager, Col Turner, agreed with that figure.

Ms. Savage said the mountain top was "still steaming away," but the volcano has been downgraded from a level 4 to a level 3 eruption, on a scale of one to five. She said that meant a major, life-threatening eruption was no longer imminent. No lava has flowed from the volcanic crater, but steam, ash and rocks had been flung into the air, and some of the ski field's equipment could be damaged by ash and rocks, Ms. Savage said.

She said no damage was expected at the resort's catering and administration facilities at the base of the slope. Mr. Robinson said the T-bars near the crater will be inspected for possible damage when the area is reopened.

When the resort was built 15 years ago, the main buildings were placed away from the path of any potential lava flow from Mount Ruapehu, Ms. Savage noted.

"It's an active volcano, so it was always a risk, but the resort was positioned out of mud-flow paths and is well protected," she said.

Turoa is the only resort with any facilities within 1.2 miles of the crater.

The mountain still has a 6½-foot snow base. Skiers are returning, though numbers are down, according to Mr. Robinson.

The Whakapapa resort, operated by Ruapehu Alpine Lifts Ltd., reopened Oct. 6 after closing for 11 days. Mr. Turner said no equipment had been damaged but confirmed that the resort's loss of profits claim is based on limited access to the site. The resort's policy has a 24-hour deductible, Mr. Turner said.

The resort, slightly larger than Turoa, can handle up to 7,000 skiers a day.

Although the volcano is "still steaming," there is no danger to skiers, he said.

The volcano erupted just before 6 p.m. on Sept. 24. Although skiing had stopped for the day, many skiers were in the resorts' bars watching a rugby match on television at the time.

"Most of them seemed more interested in the football," Mr. Turner said.

The volcano began steaming last January, and scientists have monitored its activity since then. Mount Ruapehu last erupted in 1945.

Officials at the third resort on Mount Ruapehu, Tukino, could not be reached as of late last week.

Mr. Turner said it is a small, club-owned resort with rope tows and may have suffered damage from ash. BI



AP/WIDE WORLD

New Zealand's Mount Ruapehu erupted late last month for the first time in 50 years. It caused no property damage, but did disrupt spring skiing.

Safety

Continued from previous page

ploys only about 7% of the workforce, it is responsible for 37% of all workplace accidents and 76% of the fatalities. "We are aiming to improve this situation."

The government said in its review that while in recent years there has been an "increasing sophistication" among the Hong Kong labor force to recognize that accidents are preventable, the concept of industrial safety "remains unclear and remote to many employers and employees, particularly those of smaller businesses."

The British colony's current law governing workplace safety is the Factories and Industrial Undertakings Ordinance, which was amended in 1989 to emphasize self-regulation among industries. Under the law, employers are responsible for taking steps to ensure the health and safety of workers, and workers are given the duty of exercising reasonable care and cooperating with employers on safety measures.

While the government wants to continue to emphasize self-regulation, its review states that the current law is inadequate in part because it does not identify and set minimum safety standards for all activities that may be hazardous.

And low fines under current legislation are ineffective, the study shows.

The current law's biggest drawback, however, "is that it does not help build up a safety culture among the employers and workers and bring about long-term improvements to the safety standards," according to the government report.

Therefore, the government wants to develop legislation that will create a safety management system that allows self-regulation while giving the government enhanced enforcement powers to make sure companies are implementing the system. According to the government review, a safety management system should require Hong Kong employers to establish:

- Company safety policies. These policies would set objectives for establishing a safe workplace. The documents would be distributed to employees, to make them aware of their responsibilities under the policies.
- Safety plans. The plans would lay out the actions to be taken to achieve the safety policies' objectives. The plans would identify the nature and magnitude of safety and health hazards, list emergency procedures, detail staff training and procedures for monitoring these actions.
- Safety Committees. Committees would comprise management and employee representatives and would meet regularly to discuss measures for improving safety and health conditions. Companies with 100 or more employees would be required to form committees with the requirement eventually applying to companies with 50 or more workers.
- Safety audits and reviews. Audits by auditors certified by the government's Labour Department would be required to determine whether employers are meeting statutory requirements regarding workplace safety. The audits would be mandatory for construction contractors with 100 or more workers at a site, ship builders and companies handling hazardous substances if they employ more than 100 workers, and utility companies.

Smaller companies would be required to conduct in-house safety reviews by an employee with special safety and health training. The training will be provided by the Occupational Safety and Health Council, which includes government, employer and employee members.

- General safety training standards for employees.
- Specific safety training standards for workers who handle hazardous substances.

Under the government's proposal, the Commissioner for Labour would have the authority to immediately stop work at a construction site if the commissioner believed conditions were unsafe, a power that office does not now hold. Under current law, a court order is required before work can be halted.

The government also would like to see heavier fines for workplace offenses. In 1994, the average fine was $8,900 Hong Kong ($1,151) for safety law violations.

In developing a culture in which workplace safety is heavily promoted, Hong Kong is playing catch-up to countries like Japan, Australia, Singapore and the United Kingdom, Mr. Cho acknowledged.

"We're making a late start in drafting the safety management system," he said. "But late is better than nothing." BI

The current law 'does not help build up a safety culture among the employers and bring about long-term improvements to the safety standards,' the government report says.

Lloyd's

Continued from previous page

what to expect under the proposed settlement agreement, particularly under these circumstances.

Meanwhile, the company formed to segregate Sturge syndicates' old liabilities, Ockham Holdings P.L.C., has announced that it has not completed an acquisition of motor syndicate 218 from managing agent Christopherson Heath Ltd.

Ockham was also planning to purchase Brentwood, Essex-based personal lines broker Boncaster Ltd., controlled by brothers Roger Heath and Duncan Heath, chairman and deputy chairman, respectively, of Christopherson Heath. That deal has also foundered, at least for the time being.

Talks expected to lead to the purchases were announced at the beginning of September, when Ockham noted "both transactions are subject to further negotiation as well as regulatory and shareholders' approval."

Ockham blames "the uncertainty surrounding the Lloyd's settlement offer" for a deal not being reached. But it notes that "the parties will remain in touch and will keep the matter under review, with a view to resuming discussions in 1996 as soon as circumstances permit." BI

Insurers react to tainted meat

Australian meat manufacturers brace for liability rate increases

By KATE TILLEY

ADELAIDE, Australia—Product liability coverage rates for Australian specialty meat manufacturers may increase due to several incidents involving tainted meat.

Consumers who became sick earlier this year after eating meat produced by an Australian meatpacker are expected to file claims after a recent inquest into the death of a 4-year-old girl found the company's tainted sausage responsible.

E. John Cloney, managing director of Sydney-based QBE Insurance Group Ltd., which wrote product liability coverage for Garibaldi Smallgoods Pty. Ltd., an Adelaide-based specialty meatpacker, said no claims have yet been received, but it's "just a matter of time."

Attorneys for the family of the 4-year-old, who died in February, and 23 other children who were hospitalized after eating Garibaldi products said claims will be filed.

About 150 people suffered food poisoning, leading to a variety of ailments, including internal bleeding, which doctors offering evidence at the inquest testified can cause long-term kidney damage.

The coroner at the inquest was told by Garibaldi employees that batches of meat used to produce various products was contaminated with some"green, slimy" meat.

The South Australian coroner, Wayne Chivell, said late last month that the child died of a brain hemorrhage. The hemorrhage was a complication of hemolytic uremic syndrome, which was caused by eating contaminated sausage. The coroner concluded the Garibaldi product was responsible.

Mr. Chivell also criticized the South Australian Health Commission, a state government body, for reacting too slowly to claims that Garibaldi products may have been responsible when the contamination was discovered last January.

Garibaldi is now in liquidation. John Irving, an Adelaide-based partner with the accounting firm Arthur Andersen & Co., which was appointed provisional liquidator by Garibaldi directors on Feb. 6, said the directors sought liquidation after public confidence in Garibaldi products was lost. The death and other illnesses received widespread publicity, affecting the sale of Garibaldi products and similar products by other manufacturers.

Mr. Cloney would not comment on the limits of the Garibaldi liability insurance policy, nor on any reserves that QBE may have set aside.

A new, mandatory code of safe practices for specialty meat manufacturers has been implemented Australia-wide since the Garibaldi contamination was discovered.

The Australian contamination follows a $15.6 million settlement in the United States in the Jack in the Box case, in which burgers tainted with e-coli bacteria killed two children in 1993 (*BI*, March 6).

Mike D. Grossman, regional casualty manager-Australasia for American Home Assurance Co., a unit of the American International Group Inc., said the Garibaldi case would definitely impact rates.

He said AIG did not write product liability for specialty meat manufacturers, and had made a decision not to do so more than five years ago, because of the time and temperature-sensitive processing required.

Australian meat exporters are also facing increased losses and rates for rejection coverage, which indemnifies exporters if the meat is spoiled once it reaches its destination.

Mr. Grossman said liability insurers writing meat export coverage had been shaken by the Jack in the Box case and other instances of meat contamination had made them "cautious."

AIG writes meat export coverage.

He said insurers had assumed the meatpacking industry's product safety standards were adequate, but incidents have shown that is not necessarily so. "It appears the Australian meat industry's problems are long term, and quality controls have not changed dramatically since the kangaroo meat substitution," he said. Kangaroo meat was discovered in prime beef exports sent to the United States in the 1980s.

Australian beef imports were temporarily rejected by the United States and Japan last November after chlorfluazuron residues were detected in beef from New South Wales and Queensland. Cattle were fed cotton trash, the waste left after cotton plants are harvested, because of a drought-induced feed shortage. The cotton plants had been treated with a pesticide containing chlorfluazuron. While the chlorfluazuron levels were not considered harmful, the meat did not meet U.S. Department of Agriculture standards.

Liability rates for Australia's meat exporters are increasing because of "the uneasiness" among underwriters, and capacity has tightened, particularly for exports to the United States, AIG's Mr. Grossman noted.

However, he noted that the period after a claim is "probably a good time to write the business," because a claim prompts better risk management procedures and therefore risks are "vastly superior."

In a related action, Australian marine underwriters who write meat rejection coverage as an extension of marine cargo policies are considering tightening wordings because of an increase in claims.

Don Brain, chairman of the Australian Meat Underwriters' Group, and New South Wales manager of Associated Marine Insurers' Agents Pty. Ltd., owned by Zurich Aust. Insurance Ltd. and Commercial Union Assurance Co. Aust. Ltd., said the underwriters had been "kicking around different viewpoints."

While some Australian beef was included in the meat processed for the Jack in the Box hamburgers, the contamination had occurred because the meat was undercooked, he said.

The premium pool for meat rejection coverage in Australia is only $1.5 million to $2 million Australian ($1.1 million to $1.5 million) because not all exporters buy coverage, according to Mr. Brain.

Chris Henri, marine manager of the Insurance Council of Australia, said the current wording on rejection coverage had been used for 20 to 30 years. Rejection levels are up, he said, particularly due to increased use of pesticides, the kangaroo meat substitution incident, and last year's cotton trash problem. BI

All of these securities have been sold. This announcement appears as a matter of record only.

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INTERNATIONAL

AXA

Continued from page 27

At a press conference Oct. 5, AXA's Mr. Bebear noted that Mr. Bernheim was looking for greater synergy between the insurers. But AXA later said the two have not discussed the subject further.

Stock analysts say the next move could come when AXA launches a public offering in the United States.

But, an AXA spokeswoman would not say when this might occur. "We will change our capital structure only if the opportunity is very, very good for us," she said.

Analysts say AXA's mutual status restricts its ability to raise capital but also has protected it from hostile takeovers.

"If AXA can get a return on equity which the U.S. market demands, then it can attract major new shareholders," said Angus Runciman of Barclay de Zoete Wedd in London. He added that AXA's return on equity, now only 6%, should be at least 11%, in line with the 12% to 14% earned by major U.S. insurers.

In its first-half results released earlier this month, AXA reported that profits rose 24.5%, to 1.302 billion French francs ($269 million). The company said that figure reflected improved non-life underwriting results in France and Canada, a strong performance from AXA Reassurance and earnings growth from U.S. operation Equitable Life Insurance Co.

Non-life gross premiums written in France grew by 7.3% to 8.8 billion French francs ($1.82 billion). Non-life business in France accounted for 291 million French francs ($60.1 million) of the group's net income, up from 145 million French francs ($26.7 million) in first-half 1994. AXA said this performance reflects strong improvement in underwriting results and lower commissions and expenses, but it did not provide figures for underwriting results.

Gross premiums written in the United States, through Equitable Life, fell 2.9% to 18.3 billion French francs ($3.78 billion), due largely to the dollar's weakening value against the franc. U.S. life business contributed 311 million French francs ($64.3 million) to AXA's profits, up from 224 million French francs ($41.2 million) in first-half 1994.

Consolidated net non-life premium was 15.2 billion francs ($3.14 billion) for the first half of this year, up from 13.0 billion francs ($2.39 billion) for the same period last year. Consolidated net life and non-life premium volume worldwide totaled 47.2 billion francs ($9.75 billion) in the first half of this year, up 5.3% from 44.8 billion francs ($8.23 billion) during the same period last year.

Reinsurance premium volume was 4.9 billion francs ($1.01 billion), down 14% from 5.7 billion francs ($1.05 billion) last year.

Acquisitions of Victoire Belgique in Belgium and of Boreal Assurance in Canada contributed 1.662 billion French francs ($343.4 million) to the group's total net premium volume.

Meanwhile, Union des Assurances de Paris, France's largest insurer based on gross premiums written, reported that its consolidated profits fell 5.5% to 806 million French francs from 853 million last year (to $166.5 million from $156.8 million).

UAP's consolidated gross premium volume in the first half of this year was 81 French francs ($16.74 billion), the same as reported for first-half 1994.

Life insurance premium volume increased in all continental European markets, including France, where UAP Vie increased its market share. Total life premium volume fell 8.4% in the first half to 35 billion French francs ($7.23 billion), due mainly to the poor U.K. results.

First-half property and casualty premium volume rose 7.4% to 46 billion French francs ($9.5 billion). And, UAP's combined ratio for non-life business improved to 99.6% from 105% in first-half 1994. BI

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Proposals shall be made in the format outlined in the RFP packet and shall contain full submission requirements. Packets may be obtained from the New York City Housing Authority, Treasury Department, 250 Broadway, Room 632, New York, New York 10007. Address all inquires to Augusto Montan, Assistant Director. Completed proposals must be received by **4:30 P.M. on November 21, 1995.**

A proposers' conference will be held on **October 25, 1995 at 2:30 P.M.** at the Authority's central office, located at 250 Broadway, 9th Fl. Board Room, New York, New York 10007.

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For the Record

Priorities established for Superfund sites

WASHINGTON—The Clinton administration wants to create a national risk-based priority system to ensure the worst Superfund sites are cleaned up first, according to a list of 20 reforms outlined recently.

Carol Browner, administrator of the Environmental Protection Agency, also called for the creation of an "EPA National Remedy Review Board" that would review the costs of cleanup proposals at certain sites to make sure they were appropriate to the site. Other reforms announced by Ms. Browner would: give stakeholders a bigger role in designing risk assessments and in some cases allow them to conduct their own assessments; compensate parties that agree to clean up sites for a portion of the so-called orphan share—cleanup costs for which no solvent responsible party can be found; increase fairness in the enforcement process; and provide clear information of remedy selection decisions.

Ms. Browner once again criticized Superfund reform bills put forth by Rep. Michael Oxley, R-Ohio, and Sen. Robert Smith, R-N.H., for being too lenient on polluters.

PBGC to check firms for premium payments

WASHINGTON—The Pension Benefit Guaranty Corp. will step up field examinations of medium-size and large pension plans to make sure employers are accurately counting the number of plan participants when calculating the premiums they owe the agency.

The PBGC estimates that as many as 20% of all pension plan premium filings may understate participant counts or funding levels. Employers with fully funded defined benefit plans pay the PBGC an annual base premium of $19 per participant, while employers with underfunded plans pay hefty surcharges on top of the base premium.

The PBGC says the field examinations, which will be done by an accounting firm, will center on plans with more than 1,000 participants and that have had significant swings in the number of participants and big changes in asset valuations. The examinations will involve current premium filings as well as those made during the last six years. About 50 pension plans will be examined during 1996, the agency said.

California indicts five in health care scam

LOS ANGELES—In one of the largest insurance fraud cases in California history, federal and state investigators said they filed charges against four attorneys and a man who assembled a network of chiropractic offices.

The charges filed Sept. 28 in the form of federal indictments follow a 10-month investigation into the defrauding of insurance companies and the lawyers' clients of more than $18 million through a system of kickbacks and inflated medical billings, according to the California Department of Insurance.

Authorities examined the financial records related to $100 million in insurance claims, the department said. Many more attorneys statewide could eventually be charged as a result.

Charged were attorneys Stanley Bauman and E. Andrew Matyas of Beverly Hills, Thomas M. Patterson of Santa Ana and Monroe Zalkin, a Miami attorney who operated the San Diego law office of Bauman & Rose. The charges against them include mail and tax fraud.

Additionally, Farajollah Morechai Banayan, the administrator of a statewide network of more than 100 chiropractic offices and owner of the Los Angeles-based Maimonides Health Center, was charged with fraud. Investigators said he referred personal injury and workers compensation patients to network members.

Investigators believe one scheme involved paying cappers up to $1,400 to search neighborhoods for people who had auto accidents or would be willing to fake accident injuries.

The victim would be referred to an attorney, who would then pass them on for medical attention. The medical provider would "treat" the problem and inflate the billing cost to the insurer. The attorney, as the client's trustee, would send out the claim.

Upon payment, the attorney would deposit the check into a trust account, pay the medical provider the inflated fee and give the balance to the client.

Acordia forecasts 14.9% drop in profits

INDIANAPOLIS—Acordia Inc. projects a 14.9% drop in profits for 1995, to $24.5 million from $28.8 million in 1994.

The Indianapolis-based broker, the world's seventh-largest based on 1994 gross revenues, said reductions in California workers compensation rates, increased competition in the state's managed care market and a slowdown in the state's construction activity all will hurt earnings in the third and fourth quarters.

And, the integration of Bain Hogg Robinson Inc., which Acordia acquired in January for $50 million (*BI*, Jan. 9), will result in lower-than-anticipated revenues due to an unexpected number of Bain Hogg Robinson producers leaving the company after the acquisition was completed.

Acordia previously announced it expects contingent commissions to be cut in the fourth quarter due to lower operating results by health insurers. Acordia expects to receive about $3 million to $4 million in contingent commissions compared with $6 million in the fourth quarter last year.

The broker also will report an $800,000 actuarial expense during the third and fourth quarters as a result of a change in actuarial assumptions. Acordia executives would not elaborate.

Pollution cover denied for Michigan company

DETROIT—Policyholders in Michigan cannot obtain coverage for pollution-related property damage under personal injury coverage provisions, the 6th U.S. Circuit Court of Appeals ruled last month.

In *Harrow Products Inc. vs. Liberty Mutual Insurance Co.*, the court held that personal injury coverage provisions do not provide coverage where "the essence of the claim is an injury to property." Furthermore, the court ruled that the standard pollution exclusion contained in Harrow's policy was clear and unambiguous and barred coverage for planned and intentional dumping of contaminants.

Harrow had demanded coverage from its insurer after it was required to clean up city wells contaminated by Harrow's Saranac, Mich., manufacturing plant. But the court ruled that the assertion by a Michigan regulatory agency that Harrow had polluted water sources constituted injury to property, not a personal injury. "When read in the context of the entire policy, allowing personal injury coverage would contradict the clear pollution exclusion for damage to real property," the court wrote.

Harrow Products Inc. vs. Liberty Mutual Insurance Co., 6th U.S. Circuit Court of Appeals; No. 93-2309.

Empire Blues get grip on past problems

NEW YORK—A 90-page report commissioned by New York Superintendent of Insurance Edward J. Muhl finds that Empire Blue Cross & Blue Shield, under the direction of president Michael Stocker, has made significant progress in correcting its well-documented problems but is still having trouble handling claims, detecting fraud and setting rates.

The report recommends that Empire, New York's largest health insurer, eliminate the use of "dummy codes" to process claims. The report said Empire paid $282.3 million last year using dummy codes.

With respect to fraud detection, the report said Empire identified only $17.3 million in fraud, which was equal to 0.4% of Empire's $4.5 billion in claims processed. The department is recommending that Empire beef up its anti-fraud staffing as well as improve the time it takes for an investigator to be assigned to a case.

Lastly, the report determined that Empire charged incorrect HMO premiums to groups that renewed in early 1993 and failed to adhere to department rating procedures. However, it made no recommendation on how the company should improve its rating.

Copies of the report as well as Superintendent Muhl's recommendation letter to Empire are available from the department.

Information in brief

The National Council of Compensation Insurance has filed a proposed 10.1% insurance loss-cost decrease with the **Utah** Department of Insurance, said Peter Strauss, NCCI's Denver-based director of government, consumer and industry affairs. If approved, the decrease would go into effect Jan. 1, 1996. . . .**Bonnie L. Boccitto** was named senior underwriting officer at Greenwich, Conn.-based Risk Capital Reinsurance Co. with responsibilities for all traditional reinsurance underwriting. Previously, Ms. Boccitto was senior vp at Prudential Reinsurance Holdings Inc. and its Prudential Reinsurance Co. unit. . .KPMG next year will become the first of the **Big Six** to do auditing work and publish its financial figures as a limited liability company, KPMG Audit P.L.C. of London. In similar moves to reduce the exposure of longtime partnerships to liability claims, the other largest accounting firms have become limited liability partnerships or service corporations. BI

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Bermuda

Continued from page 1

inceed it has been alive and well since the '70s. In 1994, it was decided that we should simply put the facts to the people and then have a referendum, say to the people of Bermuda: Do you want to become independent of the United Kingdom? Or do you want to maintain the status quo? It was overwhelming, 3 to 1, against independence.

Q: Is it still an issue?

Mr. Saul: I don't think the issue will ever go away and rightly so. Every decade we should ask the people of Bermuda and, depending on the circumstances, they might say no or one day they may say yes.

But clearly right now we asked the people and the people told us what they want and we are going to get on with other issues.

Q: Do you envisage a referendum every 10 years?

Mr. Saul: There will be another referendum at some time but it will be some time from now. It will not be over the next five years.

'When you have that fire power of experts you should follow their advice,' Mr. Saul says of the advisory panel.

Q: What is your own position on independence?

Mr. Saul: I'm completely neutral.

Q: You must have some opinion.

Mr. Saul: If you ask me did I go out and vote, yes I did.

But I have kept how I voted to myself and I shall continue to keep it to myself.

Q: What is your position with regard to the international business community? Will you be as supportive as the previous government?

Mr. Edness: This is a new government and new cabinet but it is not an opposition government, so by and large we have the same philosophy as far as international business is concerned. We are as supportive as the previous government.

Mr. Saul: This particular government is following the practice of the last one but you will see us market Bermuda internationally much more forcefully. We are going to go out and actively promote the island.

We are starting next month in the Far East and Hong Kong, and we are going in January to London and Geneva and later next year we have plans to go to New York, Boston, and Chicago.

Q: What will you be doing at these meetings?

Mr. Saul: We are going to reinforce the relationships which we already have and, at the same time, actively campaign for new business that does not come to Bermuda. Principally, that new business will be in Europe. Europe does not know us that well and on the insurance side they don't even know geographically where we are, let alone what we can offer them. There is great potential in Europe.

Ms. Milligan-Whyte: Over the past four or five years, the government has sent a delegation to the World Economic Forum in Switzerland and, at one point, there were as many at 12 delegates. We have had significant business coming out of Europe and that's just one conference. When we actually target specific cities I think we will go a long way to establishing our credibility in those markets.

Q: How much of Bermuda's gross domestic product is attributed to international business and insurance and reinsurance in particular?

Mr. Gibbons: International business accounts for about (28% of GDP or) $500 million. Of that, we figure that insurance and reinsurance is about $230 million. About 280 companies are actually physically here with someone working here for them and about 120 of these are insurance- and reinsurance-related.

Q: Will there be any changes with the relationship of the insurance and reinsurance industry and government?

Some people think that it is too cozy with the insurance executives here advising the government through the Insurance Advisory Committee on sensitive issues, including whether individual companies should be allowed to be established in Bermuda.

Mr. Saul: When it comes to those that wish to incorporate on the island what we do through the Insurance Advisory Committee and the Registrar of Companies' office is review the companies.

The major overwhelming reasons they recommend rejecting any applications is that the companies don't have the capital or they don't have the expertise. And if we then turn down the companies we tell them those are the reasons.

When you have that fire power of experts you should follow their advice. For those that say that (established companies) would necessarily mean they pull up the ladder, the facts belie that. The number of incorporations of insurance companies keeps going up, up, up and the caliber is not going down one bit; in fact, it is probably rising.

Mr. Gibbons: It's the cooperative partnership thing that has allowed us to grow to the extent that we have and yet maintain this essence of quality. We introduced extensive new regulations this year and six of our companies are now on the U.S. stock exchanges so the Financial Accounting Standards Board also has an impact on us here.

Q: What is going to be the shortfall in revenue as a result of the closure of the foreign military bases here and how are you going to replace that shortfall?

Mr. Saul: There is no shortfall in revenue, *per se*. The only shortfall that we are alert to is on the balance of payments side. The last figures that we compiled four years ago show that there was $53 million in foreign currency, earned for the country, not for the government, from the Canadian, British and American forces here.

Now with return of the base lands there is some 1,300 acres—or 800 acres if you take out the military airport—and we must find ways to utilize that to take up the slack, provide jobs, and bring new opportunities to the island to start earning some $53 million again.

It is metaphorically a gold mine and if we mine it correctly we can redress that balance of payments while at the same time enhancing government revenues.

Q: Can the international business community expect any additional costs of doing business to help support government?

Mr. Saul: We survived this past recession with a surplus on current account. We had a soft landing and there is no reason for any major pick-ups from international businesses, where all of a sudden to handle the return of the base lands we are going to start taxing them and crucifying them. That is not the case. We have set a pretty good economic and tax base for them and they will not see any major gyrations.

Mr. Gibbons: In the long term, we are seeing it as a source of diversification as opposed to having to go to international companies, which we see as partially being here because of the low tax environment that we do have.

Q: You say nothing major but there can be lots of things that are minor. Will there be any other ways of deriving revenue from international businesses here?

Mr. Saul: I have little doubt that there will continue to be lots of things that are minor like land tax or *ad valorem* customs duties that seem to go up as well as down every year. Every five years, there is generally a shake up of land tax and international businesses have just gone through their fifth year, so from the budgetary planning point of view I don't think they need to see any skeletons coming out of the closet over the coming years.

Ms. Milligan-Whyte: This government is also very committed to the concept of tax neutrality when it comes to international business.

Q: Another concern of international business is immigration. As Bermuda grows will they still be able to bring in the people to run the businesses?

Mr. Edness: Its been a policy for the government to cater to the special requirements of international business and that is still our policy. We recognize that as the business grows and diversifies there is going to have to be a provision of technical specialists to support it.

Mr. Saul: There are 2,000 people that work in international business in Bermuda and of that some 1,300 are Bermudian.

On the work permit basis now, any international company that sets up here does not even have to advertise the posts of their senior people, such as their president or chief financial officer.

They will get a three to five year work permit. Any other post they have they must advertise and if there is a qualified Bermudian for the post we don't have to insist they take them, they grab them with alarming speed because they don't have to worry about housing, etc.

Q: What are you doing to encourage the international businesses to train Bermudians?

Mr. Dill: We are in the midst of restructuring our entire education system and part of that restructuring focuses on senior level of education and the contribution which international business makes to the country.

We encourage certain firms to take on responsibility for students.

They sometimes sponsor by scholarships, sometimes by way of informal arrangement between the student and the company, they sometimes sponsor by way of a formal arrangement between the company and a particular school and we are constantly looking at ways we can build on this.

Q: Visiting business people often complain about the cost of doing business in Bermuda. What will you do to make Bermuda a less expensive place to visit?

Mr. Saul: We also want to make it easier for regular visitors to come to Bermuda.

We are working on some form of card which we can give to frequent business and tourist visitors. We shall set up a separate booth at the airport for them so they can just have this gold card with their picture on it that is speed read and they will be able to just whip right through. BI

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Quakes

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been reported from that second temblor.

Estimates on insured quake losses were not available late last week, said a spokesman in the international division of Mexico City-based insurer Seguros Comercial America S.A.

Although Seguros Comercial is expecting to receive local claims, as of last Friday it had received no reports of major losses from its multinational clients in Manzanillo, he said.

Most of the damage from the quakes was to low-income private dwellings, which are not expected to be covered by insurance, said Richard Atherton, general manager of Mexico City-based brokerage Asesores Kennedy, a subsidiary of Alexander & Alexander Services Inc.

The largest commercial loss was the collapse of the Costa Real hotel in Manzanillo, which was insured by Seguros Monterrey Aetna S.A., an affiliate of Aetna Casualty & Surety Co.

Overall, insured losses are not expected to be large, given that the earthquake deductibles vary between 2% and 3% of insured value, Mr. Atherton said. In addition, earthquake policyholders are required to pay coinsurance of 10% to 30%.

Mexican radio reported that government authorities had studied the possibility of expanding a system of earthquake alerts, which is in place along the Guerrero state coast, to the ports of Manzanillo, Puerto Vallarta and Puerto Escondido.

But Carlos Saenz Luna, the director general of civil protection in Manzanillo, was quoted in the radio reports as saying that such a project would be too costly. BI



AP/WIDE WORLD

The city of Manzanillo, where workers cleared the rubble of the Costa Real hotel, was hit hard by the earthquake.

Amtrak

Continued from page 2

Bermuda-based facilities: Transportation & Railroads Assurance Co. Ltd. and Railway Assn. Insurance Ltd.

TRAC offers liability limits of $25 million excess of $25 million, while the RAIL coverage has limits of $50 million excess of $50 million.

San Francisco-based Southern Pacific also has excess coverage above a self-insured retention, but a spokesman would not provide specifics.

Neither railroad spokesman knew of any claims or lawsuits filed as a result of the derailment.

Amtrak reservations have not been affected, according to the spokesman.

The accident occurred Oct. 9 when eight of the 12 cars behind two locomotives on Amtrak's westbound Sunset Limited, en route to Los Angeles from San Francisco, derailed near Hyder, Ariz., about 59 miles southwest of Phoenix.

Among the 248 passengers and 20 crew members aboard the train, one person died and 78 were injured, according to an Amtrak spokesman.

As the FBI continues to investigate the apparent sabotage, Amtrak has again intensified its safety measures.

"We have, dating back to the Oklahoma City bombing, increased security procedures and have increased them again at many stations and local facilities," according to the Amtrak spokesman.

Under federal law, all rail lines over which Amtrak trains run nationwide must be inspected at least twice weekly. Amtrak owns 750 miles of the 24,000 miles of rail track over which it runs nationwide.

Its own crews inspect the track it owns, which is in the Northeast corridor.

The other tracks are inspected under the various freight railroads' security programs.

Southern Pacific goes over the tracks in most areas several times daily, but additionally, the railroad crews are experts and able to look for problems every time they run on a track, the company's spokesman said.

The piece of track on which this accident occurred is inspected less frequently because it is used less frequently, he said.

The track was last inspected the Thursday prior to the accident, and a Southern Pacific freight train safely had traveled over the track the day prior to the accident.

Southern Pacific employees also have been told to be "extra vigilant," the spokesman said.

The railroad told its employees that "no matter how small and insignificant something seems, if it looks at all unusual, phone it in and we'll check it out," the spokesman said. BI

Opal losses rise as Roxanne rages

Tropical storm expected to strengthen

By SARA MARLEY

For the first time in several weeks, U.S. risk managers this weekend could breathe a sigh of relief that there was no hurricane barreling westward across the Atlantic.

Roxanne was downgraded to a tropical storm Thursday as it moved into the Gulf of Mexico, after lashing the resorts of Cancun and Cozumel with hurricane-strength winds of 110 mph.

By Friday afternoon, Roxanne was located 240 miles east of Tampico, Mexico, and moving northwest at 8 mph.

Roxanne's winds had increased to 60 from 50 mph and the storm was expected to continue to strengthen Saturday and turn southwest.

A hurricane watch was posted for the Tampico area and was expected to be extended north.

A flood watch also was posted for portions of the Texas coast.

Insurers spent the week watching Roxanne and tallying their losses from Hurricane Opal, which struck the United States' Gulf coast two weeks ago (*BI*, Oct. 9).

The insurance industry's tab for the storm will come to $2.1 billion, of which $1.5 billion occurred in Florida and the remainder in Alabama and Georgia, estimated the Property Claim Services division of the American Insurance Services Group Inc.

Opal may trigger the Florida Hurricane Catastrophe Fund for the first time in its two-year history, said Jack Nicholson, chief operating officer of the Tallahassee-based fund.

The cat fund could pay insurers between $50 million and $300 million for their Opal losses, Mr. Nicholson said.

Premiums and retentions are based on insurers' exposure in the state. Insurers elect to purchase coverage for 90%, 75% or 45% of their losses above their retention.

The Florida Windstorm Assn. may trigger the coverage it buys from the cat fund, Mr. Nicholson said.

Opal, a category 3 storm on the Saffir-Simpson Scale of hurricane intensity, struck the Florida Panhandle early this month.

Opal also caused tornadoes and flooding that resulted in damage in Alabama, Georgia, North Carolina, South Carolina and Tennessee and will generate a total of 375,000 claims, according to PCS.

By last Friday afternoon, Royal Insurance Group in Charlotte, N.C., had received only about 450 claims, both commercial and personal, for damage wrought by Opal from Panama City Beach, Fla., to Nashville, Tenn.

Allendale Mutual Insurance Co. of Johnston, R.I., had received fewer than 30 claims by midday last Friday. A spokeswoman for the company said its preliminary loss estimate was less than $5 million.

Bloomington, Ill.-based State Farm Group last week said it expects total expenses stemming from Opal to reach about $170 million, of which the actual claims payout is expected to be about $155 million.

State Farm expects total claims of 65,000. By comparison, Hurricane Hugo resulted in about 90,000 claims and a loss of about $430 million for State Farm.

USAA Group issued a preliminary estimate of more than $200 million in losses. The insurer, which writes coverage for military officers and their families, has received 18,142 claims. There are military bases in Fort Walton Beach, Fla., which was in Opal's path.

The Florida Residential Property & Casualty Joint Underwriting Assn. has set reserves of $13.6 million for Opal. The JUA has received 4,303 claims.

Nationwide Insurance Group revised its estimated loss to $12 million from the $50 million to $70 million predicted shortly after the storm. Nationwide has received 5,000 claims.

GEICO Corp. estimates $8 million worth of damage from more than 2,800 auto and homeowners claims. Sixty percent of the losses were in Florida, and 25% were in Atlanta.

Lloyd's of London's Claims Office had not been notified of any claims from Opal as of Friday.

Richard Keeling, underwriter for syndicate 362, said the storm was no great shake for the market.

"It's not a big deal (for Lloyd's) until it hits $3 billion," he said.

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Sarah Goddard and Mark A. Hofmann contributed to this story.

Insider Trading

Hilb, Rogal & Hamilton Co.: James S.M. French, director, indirectly sold 10,000 common shares at $13.38 each from Sept. 1 to Sept. 8. Mr. French now indirectly holds 40,000 common shares.

Hilb, Rogal & Hamilton stock closed at $14 a share on Oct. 6.

Lincoln National Corp.: John Patrick Barrett,. director, bought 1,000 common shares at $40.63 each on Aug. 11 and now directly holds 4,651 common shares.

Thomas D. Bell, director, purchased 500 common shares at $42.50 each on May 10. Mr. Bell now directly holds 1,079 common shares.

Peter Kenneth Dunsire, retired, exercised an option for 22,398 shares of common stock between $24.16 and $27.75 each from May 3 to May 12. He sold 16,606 shares between $41 and $42.88 each from May 3 to May 12 and now directly and indirectly holds 62,292 common shares.

Lincoln National stock closed at $46.63 a share on Oct. 6.

Marsh & McLennan Cos. Inc.: Lawrence J. Lasser, director, sold 558 shares of common stock at $72.50 each on May 24 and now directly and indirectly holds 97,200 common shares.

M&M stock closed at $85.63 a share on Oct. 6.

NAC Re Corp.: Ronald L. Bornhuetter, chairman, purchased 100 shares of common stock at $33 each on May 1. He bought 1,000 shares at $31.63 each on July 7 and now directly and indirectly holds 120,174 common shares.

NAC Re stock closed at $31.13 a share on Oct. 6.

Poe & Brown Inc.: V.C. Jordan, officer, indirectly disposed of by gift 20,833 shares of common stock at an unreported price on May 30 and now indirectly holds 106,914 common shares.

Charles W. Poe, director, sold 80,611 common shares at $24 each on Aug. 28. Mr. Poe indirectly sold 898,100 common shares at $24 each that same day. He sold 70,000 common shares at $24 each on Sept. 5. Mr. Poe now directly and indirectly holds 7,500 common shares.

Poe & Brown stock closed at $24.25 a share on Oct. 6.

SAFECO Corp.: Dan D. McLean, officer of subsidiary, exercised an option for 1,250 common shares of common at $33.75 each on May 1. To cover transaction costs, he turned in 737 of the shares for $57.19 each on May 1 and now directly holds 8,864 common shares.

Richard E. Zunker, officer of subsidiary, exercised an option for 4,800 common shares at $33.75 each on May 10. He sold 4,200 shares at $57.13 each on that same day and now directly and indirectly holds 7,569 common shares.

SAFECO stock closed at $65.38 a share on Oct. 6.

Transamerica Corp.: David R. Carpenter, retired, exercised an option for 90,500 shares of common stock between $35.19 and $41.63 each from July 5 to July 17. He sold 100,200 shares between $58.56 and $60.68 from July 5 to July 17 and now directly and indirectly holds 20,588 common shares.

Transamerica stock closed at $70.38 a share on Oct. 12.

Trenwick Group Inc.: Michael F. Mather, officer of subsidiary, exercised an option for 10,000 shares of common stock at $19.75 each on July 25. He sold 6,710 shares at $45.13 each on July 25 and now directly holds 11,041 common shares.

Trenwick Group stock closed at $51.25 a share on Oct. 6.

UNUM Corp.: James F. Orr, chairman, disposed of by gift 7,000 common shares at an unreported price on April 18. Mr. Orr indirectly acquired by gift 7,000 common shares at an unreported price that same day and now directly and indirectly holds 132,946 common shares.

George J. Mitchell, director, bought 300 common shares at $41.38 each on May 16 and now directly holds 500 common shares.

UNUM stock closed at $52.38 a share on Oct. 6.

USF&G Corp.: Norman P. Blake, chairman, indirectly bought 300 common shares at $14.63 each on May 1 and now directly and indirectly holds 55,365 common shares.

Gary C. Dunton, officer of subsidiary, sold 3,454 common shares at $15.13 each on May 5 and now directly and indirectly holds 8,000 common shares.

Robert J. Lamendola, officer of subsidiary, sold 4,027 common shares at $15.25 each on May 5 and no longer holds shares in the company.

USF&G stock closed at $29 a share on Oct. 6.

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Insider Trading, compiled by Invest/Net Trading Group Inc. of Fort Lauderdale, Fla., from reports filed with the Securities and Exchange Commission, tracks stock sales and purchases by insurance industry directors and officers. The column is distributed by Tribune Media Services Inc.

What's fair to ask in an interview

Guidelines clarify how employers can avoid ADA exposure

By ROBERT KAZEL

WASHINGTON—Employers continue to bear considerable potential liability under the Americans with Disabilities Act of 1990 for asking job applicants about disabilities before an employment offer is made, according to final guidelines released last week.

The U.S. Equal Employment Opportunity Commission's enforcement guidelines outline what interviewers may ask concerning disabilities as well as which types of medical examinations may be done as part of the application process. The new guidelines, which were presented in question-and-answer format with several practical examples, were meant to simplify more lengthy and highly detailed ADA rules issued in 1994 (*BI*, May 30, 1994).

The new guidelines, as did the old ones, state that employers are prohibited from asking about medical disabilities but are free to ask about job qualifications such as education, work history and other credentials. Applicants also can be asked to take a test of required job skills.

After the initial job offer, the EEOC specifies, the employer has more leeway: The applicant may be asked about disabilities and asked to undergo a medical exam. But, if the offer is withdrawn, the employer will have to show that the criterion on which it based the rejection was related to the job and is necessary to its business.

The additional guidelines, though primarily a less formal restatement of the previous rules, do show "at least a thread of sensitivity to the employer community," said David L. Weinstein, partner and head of the employment and labor practice group at Chicago law firm Rosenthal & Schanfield. If an applicant has an obvious, visible disability, for instance, the guidelines now permit at least some discussion at the interview.

"Employers are now entitled to be at least a little realistic," he said. "When the applicant rolls into the office in her wheelchair, the employer no longer has to pretend it isn't there."

'Employers are now entitled to be at least a little realistic,' says Chicago attorney David Weinstein.

Here is a summary of some of the major questions and answers in the new guidelines:

• May an employer ask if the applicant can do the job?

Yes, and the employee can be asked if the job can be performed "with or without reasonable accommodation." Accommodation means special help for disabled workers.

• May the employer ask if the applicant can satisfy the company's attendance rules?

Yes, and attendance records from previous jobs can be discussed.

• May an employer ask if the applicant can stand up, walk, etc.?

Usually not, because these questions generally are intended to get at information on disabilities.

• May the applicant be asked about his or her workers compensation history?

No.

• May the employer ask about current illegal use of drugs?

Yes.

• May the employer ask about current use of legal drugs?

Not if the answer might be related to the applicant's disability.

• May the applicant be asked about drinking?

Yes, except not about past or present alcoholism, because this is considered a disability.

Although the easy-to-read guidelines may help some personnel executives understand the ADA and learn how to avoid potential legal thickets, Mr. Weinstein said he disagrees with management lawyers who are praising the latest guidelines.

"I don't see it as quite so optimistic," he said. "In the enforcement area, I'm not sure this will actually help employers."

Many companies are still leaving themselves open to lawsuits because they don't understand ADA rules and are asking applicants questions that clearly violate the law.

"They don't realize they can't ask about history of hospitalization and workers comp on the application form," Mr. Weinstein said. "Certainly many companies need to be more vigilant in making sure the documents they're using wouldn't be extremely damaging in a claim." BI

Superfund

Continued from page 1

a letter on Oct. 6. After praising Sen. Smith's efforts, Sen. Dole wrote, "I, like you, would very much like to see at least a partial repeal of retroactive liability. I am concerned, moreover, that we find a funding mechanism other than tax credits to achieve the goals we both support."

As a result, the Senate reform measure is "in limbo until differences about the funding mechanism are worked out," said a spokeswoman for Sen. Smith.

She said that negotiations over how to finance Superfund reform are continuing, and "there's a chance the majority leader could support our tax mechanisms." She added, however, that there is no timetable for introducing a revised bill.

Some speculate that Sen. Dole's criticism of the funding mechanism in the Smith bill may reflect political differences between the two lawmakers. Sen. Smith has endorsed the presidential bid of Sen. Phil Gramm, R-Texas, one of Sen. Dole's chief rivals for the GOP nomination.

On the other side of the Capitol, Rep. Michael Oxley, R-Ohio, disappointed his own party's leaders when his Superfund reform bill also failed to repeal retroactive liability. Rep. Oxley had initially proposed repealing retroactive liability for pre-1987 acts, but an outline of his yet-to-be-introduced bill contained no such repeal. His legislative proposal opts instead for a "retroactive liability discount" that would absorb as much as 50% of a party's liability costs, depending on the funds available (*BI*, Oct. 2).

House Speaker Newt Gingrich and other key legislators want "to reopen the 1987 question" and deal with the "whole liability" area, said a spokeswoman for Rep. Oxley.

"Mr. Oxley is working through it with them," she said, but noted that there's no schedule for introducing the bill.

Superfund reform supporters are optimistic that the reconsideration of the proposals may yield greater liability reform.

'To significantly delay fixing Superfund because we can't agree on one part of the bill would be very unfortunate,' says CNA's David Cumming.

"It sounds much more hopeful with the leadership getting involved that real reform will occur," said David R. Haight, vp-government affairs for the Risk & Insurance Management Society Inc. and director-risk management for CF Industries Inc. in Long Grove, Ill.

RIMS supports repeal of pre-1987 retroactive liability.

"It's probably good because it was bad two weeks ago," Peter Lefkin, vp-federal affairs for Fireman's Fund Insurance Co. in Washington, said of the legislation's delay. "It's positive, but I have learned in the Superfund debate not to get your expectations up too high. This legislation has been a rollercoaster ride and it's impossible to predict," he added.

"I think it's probably good news though all of us regret acrimony or the perception of acrimony within the ranks of Republican leaders on this issue," said Joel Wood, vp-government affairs for the Council of Insurance Agents & Brokers in Washington. "The important thing is that Newt Gingrich, Mike Oxley, Bob Dole, and Bob Smith are all on the same page in terms of principles—it's how to get there. We have great confidence that if any funding gap exists at all, it is minimal and this opportunity should not be lost. Hopefully, with time and reason, we can find the political vision on how collectively to get there," Mr. Wood said.

But some insurers remain concerned that delay could ultimately harm the industry's interests.

"These are good bills. They have a lot of good features in them that have nothing to do with liability reform, such as remedy selection and risk assessment. Another piece of the bill, which is where it's falling apart, is liability reform. Superfund is one of the worst designed, least effective programs that have ever been created. To significantly delay fixing it because we can't agree on one part of the bill would be very unfortunate," said David Cumming, group vp and associate general counsel for the CNA Insurance Cos. in Chicago. BI

Updates

Ruling favors E.W. Blanch

Continued from page 2

that Cherokee had assumed and then ceded to them. Blanch did not select those companies.

Cherokee argued that Blanch would have detected problems with the three reinsurers if it had evaluated them using six financial strength tests that Cherokee's expert witness, an academic, devised specifically for this case. But Blanch showed the tests were unreliable. For example, six of 20 insurers that were considered secure in its 1984 database but which later failed passed the tests.

The court also rejected Cherokee's argument that Blanch should have known that intermediaries' standard review practices of reinsurers' financial strength were insufficient. The court ruled Blanch had no reason to doubt the adequacy of analysis it relied on from regulators and rating agency A.M. Best Co.

Individual implant suits

BIRMINGHAM, Ala.—Women may sue silicone breast implant makers individually if they are dissatisfied with a scaled down settlement plan now in the works, a federal judge has ruled following the collapse of a $4.3 billion global settlement proposal.

Declaring the earlier settlement dead, U.S. District Judge Sam C. Pointer ruled this month that women may opt out of the pending class action after Nov. 30.

By that time, plaintiffs are expected to have a revised settlement offer from three implant makers, Baxter International Inc., Bristol-Myers Squibb Co. and 3M Co. Terms are still being worked on, but lawyers close to the case have said the offer could total $3 billion (*BI*, Oct. 9).

Plaintiffs attorneys say they won't know how many women will opt out of the class action until the new offer is unveiled.

"Everybody is going to have to wait to see what the terms are of the new proposal," said Bruce Finzen, a lawyer with Robins, Kaplan, Miller & Ciresi in Minneapolis.

Meanwhile, Dow Corning Corp., a major participant in the earlier settlement until it filed for bankruptcy, has reached proposed settlements with several more insurers for a total of about $312 million.

They are: Lloyd's of London and London market companies, accounting for $233 million of the total; Ludgate Insurance Co. Ltd.; Zurich Insurance Co. and Zurich units American Guarantee & Liability Insurance Co. and Zurich International Ltd.; TIG Insurance Co.; Federal Insurance Co., a Chubb Corp. unit; Arab Insurance Group BSC of Bahrain; National Casualty Co., a Nationwide Mutual Insurance Co. unit; and North River Insurance Co., U.S. Fire Insurance Co. and International Surplus Lines Insurance Co., all Talegen Holdings Inc. units.

The settlements must still be approved by U.S. Bankruptcy Judge Arthur J. Spector, who said he would schedule a hearing if plaintiff or creditor groups objected to the agreements.

Coverage litigation against 40 other insurers involving more than 300 Dow Corning policies is scheduled to start Oct. 30 in Wayne County Circuit Court in Detroit. Dow Corning earlier reached settlements totaling more than $300 million with six other insurers (*BI*, Aug. 21).

Separately, a New York state judge has ruled that a plastic surgeon may sue implant makers over alleged damage to his practice caused by the uproar over implants. In what may be a first in the state, Supreme Court Judge John Leone ruled that a Staten Island plastic surgeon can proceed with a suit seeking more than $500,000 in damages from Bristol-Myers and two implant distributors.

Lloyd's to operate in Japan

LONDON—Lloyd's of London is a step closer to realizing its ambitious goal to have a "mini underwriting exchange" in Tokyo by 1997.

Lloyd's appointed Masahiro Yagiu, director of the insurance division of Tokyo-based Lloyd's agent Cornes & Co., as its first general representative in Japan.

An insurance law liberalizing the world's second-largest market, which becomes effective next April 1, made the move possible.

The law will allow Lloyd's to underwrite direct primary and reinsurance coverage in Japan through a local operation, named Lloyd's Japan Inc. Details on that unit still are being worked out, though 35 managing agencies representing 50 syndicates have expressed an interest in being founding members, said Frank Speight, head of development and operations in the Far East, Australasia and India section of Lloyd's international department.

Founding members will have a 10-year exclusive access to Japanese business through Lloyd's, he said. Lloyd's Japan will incorporate next year, said Mr. Speight. Despite the growing use of new technology in the insurance market, he felt that "the marketing, production and generation of business will still happen on the spot."

Briefly noted

The estate of bankrupt **Eastern Airlines Inc.** last week gave $7 million to the Pension Benefit Guaranty Corp., which in 1990 took over seven Eastern pension plans and their $585 million in unfunded liabilities. The PBGC earlier received $24 million and expects to collect another $20 million to $30 million. . . . **W.R. Berkley Corp.** is offering 3 million common shares to the public at $43.75 per share, with the proceeds to be used to fund the acquisition of MECC Inc., the holding company that is the parent of Midwest Employers Casualty Co. . . . **Alexander & Alexander Services Inc.** has completed its acquisition of most of the U.S. retail operations of Jardine Insurance Brokers Inc. (*BI*, Sept. 18). . . . The 6.2% **Social Security retirement tax** —paid by both employers and employees—will be applied on employees' first $62,700 of wages next year, up from the $61,200 limit in 1995, the Social Security Administration announced last week. In addition, the maximum deferral employees will be able to make to 401(k) plans next year is expected to $9,500 from $9,240 this year.

Benefit prefunding rejected

By DEBORAH SHALOWITZ COWANS

FORT WORTH, Texas—American Airlines flight attendants will no longer have to prefund retiree medical benefits and will be eligible for an early retirement program under a new contract issued by an arbitration panel last week.

The panel's 144-page decision ends three years of contract negotiations and arbitration between the airline and the Assn. of Professional Flight Attendants. About 20,000 flight attendants shut down American Airlines during a five-day strike in November 1993.

Flight attendants have been working since then under an agreement to abide by the arbitration panel's decision on a new contract.

The contract rescinded the plan American implemented Nov. 1, 1993, requiring flight attendants to prefund their retiree medical benefits. American in 1989 became one of the first major U.S. companies to begin phasing in a requirement that employees prefund retiree medical benefits (*BI*, Dec. 4, 1989).

The requirement was placed on salaried non-union employees and members of the Transport Workers Union beginning in January 1990.

An arbitration panel in 1991 rejected the same plan for members of the Airline Pilots Assn.

Flight attendants paid $10.78 per month to prefund their retiree medical benefits. The three-member panel ruled that American must return to flight attendants with interest any retiree medical payments already made.

While the panel recommended that the fight attendants' union give serious consideration to implementing prefunding, it decided the union should follow the precedent set by the arbitration between the Airline Pilots Assn. and the airline.

The contract also establishes an early retirement program, effective Oct. 30, for flight attendants who had at least nine years of seniority and at least five years of credited service as of Aug. 31, 1993, the date when American originally proposed the early retirement program.

Under the early retirement proposal, qualified flight attendants may receive either a lump-sum payment of between $7,800 and $55,000, depending on their age, or up to $700 per month until the plan's normal retirement age of 55, according to a spokesman.

To be eligible for the full benefits offered under the program, qualified flight attendants must have worked an average of at least 61 hours per month between Sept. 1, 1992, and Aug. 31, 1993.

Qualified flight attendants may receive reduced benefits if they have worked an average of at least 31 hours per month but less than 61 hours per month during the same period.

Some flight attendants may qualify for reduced benefits if they were on a leave of absence during that time.

Flight attendants have 45 days to accept the early retirement offer.

The flight attendants' new contract also increases wages for flight attendants an average of 17% from the last contract, with the increases spaced over several years and varying for attendants with different seniority levels. BI

Williamson new Scottsdale president

R. Max Williamson, who had been chairman, president and chief executive officer of holding company ACCEL International Corp. of Dublin, Ohio, was appointed president of Scottsdale Insurance Co.

He replaces **Vickie Kartchner**, who left the Nationwide Mutual Insurance Co. unit in June to join TIG Holdings Inc.

Thomas Freidberg replaces him at ACCEL.

In other insurer changes:

James Carey joined Chicago-based Coregis Group Inc. as senior vp/division leader of the public entity division. Previously, Mr. Carey was regional vp-mid Atlantic region for Fireman's Fund Insurance Co. in Philadelphia.

Markel Corp. announced appointments in various areas of the Glen Allen, Va.-based company: **Thomas S. Gayner** named vp-equity investments; **Thomas R. Fauerbach** named vp and chief actuary of Markel Insurance Co.; **Tom Wisneski** named vp-claims for Markel Insurance Co.; **Eileen Hull** named vp and business unit manager of the child care insurance division of Markel Underwriters & Brokers; **Tony Owens** named vp-underwriting and operations of Markel Underwriters & Brokers; and **Mark Hilsher** named vp-special property division at Essex Insurance Co.

Robert H. Benmosche joined Metropolitan Life Insurance Co. as executive vp in New York. He formerly was with PaineWebber Inc.

Continental Aviation Underwriters Inc. announced several new appointments in Memphis, Tenn.: **E.M. Saxon Jr.** named senior vp; and **Adrina Hardin**, **Ian Gregory**, and **Betsy Fulton** named vps.

Frank M. Boccio, **Steven R. Braden** and **Paul B. Morris** named senior vps at New York Life Insurance Co. in New York.

Joseph Smetana named vp-foreign general insurance at American International Group Inc. in New York.

Comings & Goings: Industry

Reinsurance

Debra M. O'Connor named senior vp and controller of Risk Capital Reinsurance Co., a unit of Risk Capital Holdings Inc. She previously was vp and controller of NAC Reinsurance Corp.

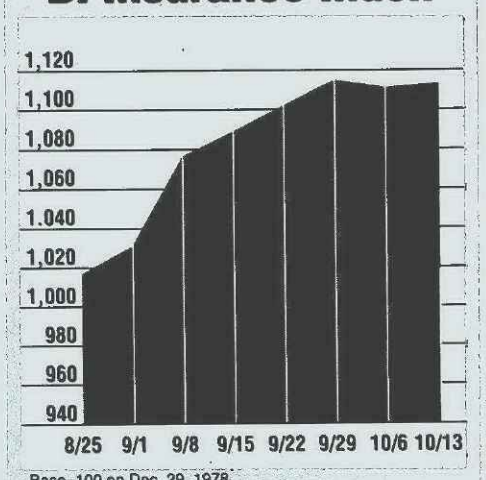
Susan M. Benson named vp-accident and health reinsurance for Sun Life Assurance Co. of Canada in Toronto. And **Graham J. Bancroft** named vp-life and financial reinsurance.

HMOs/PPOs

Fred Pendleton named to the newly created post of chief operating officer at Planned Behavioral Health Care Inc. in Dallas.

Dr. Antonio P. Legorreta joined Health Net as vp-quality initiatives in Woodland Hills, Calif. Previously, he was a medical officer of U.S. Healthcare Corp. in Blue Bell, Pa. BI

BI Insurance Index



Base=100 on Dec. 29, 1978
Source: Nordby International Inc.

PCS catastrophe options

As of Oct. 13

Call spread	Price bid/ask	Call spread	Price bid/ask
Eastern September 1995		Florida September 1996	
40/60	5.5/6	40/60	2/4.5
80/100	2.5/4.5	80/100	1.6/2.6
50/70	4/5.5		
Southeast Dec. 1995		Eastern Dec. 1995	
20/40	2/—	50/70	—/2

Total volume: 40 Total open interest: 212

For quotes, call the CBOT trading floor at 312-341-3342. For information on PCS cat options, call 312-435-3674.

Source: Chicago Board of Trade

British Issues

Oct. 12 Companies	Price pence	P/E	Div. pence	Yield %	1 week high—low
Commi Union	590	11.8	33.0	5.6	590—565
Genl Accident	623	9.1	36.3	5.8	624—605
Gdn Royal Exch	225	N/M	10.3	4.6	225—209
Independent	356	9.9	11.9	3.3	357—356
Royal	366	6.9	15.0	4.1	370—359
Sun Alliance	355	11.9	19.7	5.5	357—355
Brokers					
Bradstock	59	6.6	7.1	12.0	61—45
Fenchurch	127	8.9	10.0	7.9	128—127
CE Heath	150	9.4	20.0	13.3	154—150
JIB Group	117	10.2	9.4	8.0	118—117
Lloyd Thmpson	150	9.2	11.3	7.5	150—150
Lowndes Lmbrt	144	8.0	10.3	7.1	148—146
Nelson Hurst	165	12.8	8.3	5.0	165—165
Sedgwick Grp	108	9.8	8.1	7.5	109—108
Steel Brl Jones	37	4.3	11.3	N/M	38—37
Willis Corroon	127	N/M	8.3	6.5	128—126

Source: Philip Olsen, London

BI Industry Stock Report OCT. 9, 1995, THROUGH OCT. 13, 1995

		Price	Weekly % change	Year to date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt./Bk. value
BROKERS												
Acordia Inc.	NYS	24.75	0.00	-26.12	34.50	23.50	15	0.72	2.91	12	14.00	1.77
Alexander & Alexander	NYS	23.625	0.00	27.70	26.44	18.50	193	0.1	0.42	-11	19.17	1.23
E.W. Blanch Holdings Inc.	NYS	18.5	-1.33	-10.30	22.13	16.50	41	0.4	2.16	15	1.40	13.21
Gallagher Arthur J. & Co.	NYS	36.25	2.84	13.28	38.00	29.63	23	1	2.76	16	6.48	5.59
Hilb, Rogal & Hamilton	NYS	13.875	-0.89	14.43	14.00	10.50	81	0.56	4.04	17	1.21	11.47
Marsh & McLennan	NYS	86.875	1.46	9.62	89.38	71.50	512	3.2	3.68	17	19.95	4.35
Poe & Brown	NDQ	24.75	2.06	13.79	25.25	19.50	102	0.48	1.94	15	5.15	4.81
BROKERS	AVERAGE		0.6	6.1					2.6	11		
INSURERS/REINSURERS												
ACE Ltd.	NYS	34	0.37	45.45	34.75	20.75	686	0.00	0.00	0	22.45	1.51
Acceptance Insurance Cos.	NYS	15.5	-0.80	3.33	18.00	12.63	246	0.00	0.00	11	10.76	1.44
AEGON N.V.	NYS	37	0.68	45.67	37.50	23.38	53	1.07	2.89	14	17.28	2.14
Aetna Life & Casualty	NYS	72.125	-0.35	53.05	75.50	43.13	2457	2.76	3.83	53	48.85	1.48
AFLAC Inc.	NYS	42.25	2.11	32.03	44.75	31.88	790	0.52	1.23	13	17.58	2.40
Allied Group Inc.	NDQ	32.125	-0.77	29.80	33.25	22.00	120	0.68	2.12	7	21.81	1.47
Allmerica Prop. & Casualty	NYS	23.375	3.89	38.52	24.75	14.63	215	0.16	0.68	10	19.87	1.18
Allstate Corp.	NYS	35.75	2.88	50.53	37.25	22.63	4420	0.78	2.18	11	18.75	1.91
American Financial Group	NYS	29.625	0.00	41.07	32.13	22.00	364	1	3.38	329	24.94	1.19
American General	NYS	37.75	3.07	33.63	38.88	25.63	1244	1.24	3.28	14	17.03	2.22
American Heritage Life Ins.	NYS	19.625	-1.26	3.29	21.50	16.25	65	0.72	3.67	11	12.51	1.57
American Indemnity/Fin'l	NDQ	12.125	-1.02	19.75	13.25	9.00	14	0.3	2.47	8	15.92	0.76
American International	NYS	86.375	1.47	-11.86	86.75	58.88	2476	0.34	0.39	18	34.66	2.49
American Re Corp.	NYS	40.125	4.90	24.42	43.13	25.50	220	0.32	0.80	16	16.77	2.39
Aon Corp.	NYS	43.125	-0.58	34.77	43.88	29.25	1441	1.36	3.15	13	18.30	2.36
Argonaut Group	NDQ	29.75	-1.65	5.31	32.50	27.50	83	1.32	4.44	13	29.91	0.99
AVEMCO Corp.	NYS	17.125	0.00	11.38	18.25	13.38	22	0.48	2.80	15	6.28	2.73
Baldwin & Lyons Inc.	NDQ	15.0625	-1.23	2.12	17.63	14.69	47	0.32	2.12	12	13.90	1.08
Berkley W.R. Corp.	NDQ	43.75	-5.41	16.67	47.00	32.50	2482	0.48	1.10	21	34.46	1.27
Berkshire Hathaway Inc.	NYS	29650	-0.67	45.34	30600.00	18400.00	1	0.00	0.00	70	10089.11	2.94
Capital RE Corporation	NYS	29.125	-0.85	6.39	30.13	20.50	40	0.2	0.69	10	22.30	1.31
Capsure Holdings Corp.	NYS	13.375	-0.93	-8.55	14.88	12.13	27	0.00	0.00	13	14.61	0.92
Chubb Corp.	NYS	93.75	0.67	21.16	96.88	57.00	736	1.96	2.09	13	48.92	1.92
CIGNA Corp.	NYS	103	-2.49	61.89	108.00	61.13	2297	3.04	2.95	9	80.46	1.28
CNA Financial Corp.	NYS	120	8.47	84.97	120.00	60.75	188	0.00	0.00	13	71.13	1.69
EMC Insurance Group Inc.	NDQ	12.375	-4.81	30.26	15.25	8.75	16	0.52	4.20	8	11.13	1.11
Emphesys Financial Gr. Inc.	NYS	37.375	0.34	17.72	39.50	22.63	28	0.6	1.61	10	17.69	2.11
EXEL Ltd.	NYS	56.75	-2.16	43.67	60.00	36.88	735	0.00	0.00	0	31.47	1.80
Fremont General Corp.	NYS	29.125	8.37	24.60	29.13	18.88	366	0.8	2.75	8	19.04	1.53
Frontier Insurance Group	NYS	28.875	-1.28	32.00	32.00	16.75	70	0.48	1.66	21	14.65	1.97
Gainsco Inc.	ASE	8.875	0.00	7.58	11.00	7.75	114	0.04	0.45	12	3.98	2.23
General RE Corp.	NYS	147.25	-1.09	19.23	153.25	107.25	811	1.96	1.33	16	59.35	2.48
Guaranty National Corp.	NYS	16.375	-2.24	-10.88	19.00	15.13	58	0.5	3.05	9	11.60	1.41
Harleysville Group	NDQ	27.875	-2.62	14.95	30.00	22.00	14	0.76	2.73	10	20.72	1.35
Hartford Steam Boiler	NYS	46.25	-0.80	15.99	49.38	35.88	85	2.28	4.93	17	14.68	3.15
HCC Insurance Holdings	NYS	33.75	3.05	60.71	34.25	18.50	361	0.00	0.00	19	11.76	2.87
ITT (Hartford Group)	NYS	123.5	1.44	39.35	128.50	77.00	1225	1.98	1.60	10	45.46	2.72
Lincoln National	NYS	46.875	0.54	33.93	47.38	34.63	629	1.72	3.67	12	28.90	1.62
Markel Corp.	NDQ	71	-1.73	71.08	75.50	40.25	26	0.00	0.00	17	25.71	2.76
Mid Ocean Ltd.	NDQ	33.125	0.00	21.56	37.25	22.25	371	0.00	0.00	0	22.18	1.49
Mutual Risk Mgmt. Ltd.	NYS	38.25	-1.29	45.71	40.50	24.38	61	0.4	1.05	19	9.72	3.94
NAC Re Corp.	NDQ	33.25	3.50	-0.75	39.00	24.25	322	0.2	0.60	13	18.23	1.82
National Re Corp.	NYS	34	-0.37	29.52	35.38	22.25	22	0.16	0.47	19	17.05	1.99
Navigators Group	NDQ	16.75	-2.19	15.52	19.75	12.75	14	0.00	0.00	120	10.21	1.64
Nobel Insurance Ltd.	NDQ	11.625	-4.12	40.91	12.25	8.00	113	0.2	1.72	5	6.84	1.70
Ohio Casualty Corp.	NDQ	35.5	5.97	25.66	35.75	27.00	548	1.52	4.28	15	23.64	1.50
Old Republic Int'l	NYS	28.625	0.44	34.71	29.75	18.88	259	0.52	1.82	10	25.79	1.11
Orion Capital Corp.	NYS	43.625	-0.29	23.76	45.25	28.13	55	0.92	2.11	10	26.00	1.68
Partner Re Ltd.	NDQ	25.625	-1.44	23.49	28.38	18.50	259	0.00	0.00	0	20.37	1.26
Penn-America Group Inc.	NDQ	10.5	-2.33	42.37	11.50	6.50	53	0.12	1.14	11	6.40	1.64
Philadelphia Cons. Holding	NDQ	19.25	-5.52	57.14	21.88	12.00	11	0.00	0.00	18	9.05	2.13
Phoenix RE Corp.	NDQ	27.25	1.87	-3.54	29.75	21.00	115	0.6	2.20	5	21.27	1.28
Provident Life	NYS	27.25	0.93	25.29	27.50	20.50	54	0.72	2.64	13	22.34	1.22
Reliance Group Holdings	NYS	8	6.67	54.22	8.13	4.88	1254	0.32	4.00	12	3.42	2.34
Reliastar Financial Corp.	NYS	43.125	3.29	48.71	43.13	27.00	333	1	2.32	12	24.53	1.76
RenaissanceRe Holdings Ltd.	NDQ	24.75	7.61	NA	25.38	20.72	221	0.00	0.00	0	NA	NA
RLI Corp.	NYS	22.875	1.67	39.48	23.63	16.00	16	0.52	2.27	11	20.51	1.12
St. Paul Companies	NYS	57.875	-0.64	29.33	59.38	40.38	560	1.6	2.76	11	32.46	1.78
SAFECO Corp.	NDQ	66.4375	1.63	27.76	67.75	47.13	1027	2.12	3.19	12	44.95	1.48
SCOR U.S. Corp.	NYS	15.25	0.00	82.09	15.63	7.50	26	0.2	1.31	19	13.60	1.12
Selbels Bruce Group	NDQ	0.875	7.69	-65.00	3.25	0.69	116	0.00	0.00	0	0.04	21.88
Selective Ins. Group	NDQ	36.75	0.00	45.54	37.25	23.50	44	1.12	3.05	11	23.23	1.58
Sphere Drake Holdings	NYS	14.375	1.77	3.60	19.13	10.75	13	0.00	0.00	0	13.86	1.04
TIG Holdings	NYS	26.375	0.96	40.67	27.13	17.00	1272	0.2	0.76	20	16.62	1.59
Titan Holdings, Inc.	NYS	15.5	0.00	58.97	15.75	8.25	30	0.3	1.94	12	9.04	1.71
Tokio Marine & Fire	NDQ	53.25	-3.18	-12.35	62.00	49.88	9	0.4	0.75	47	57.72	0.92
Torchmark Corp.	NYS	43.875	3.85	27.17	44.38	32.38	1017	1.16	2.64	12	17.37	2.53
Transatlantic Holdings	NYS	66.75	2.30	19.46	70.38	47.75	329	0.4	0.60	13	33.30	2.00
Transnational Re Corp.	NDQ	23.375	3.31	-0.53	26.38	18.75	101	0.00	0.00	7	18.84	1.24
Travelers Corp.	NYS	54.25	2.60	67.57	54.25	30.38	3221	0.8	1.47	13	24.77	2.19
Trenwick Group Inc.	NDQ	51.125	-0.24	20.65	53.00	36.50	46	1.12	2.19	13	29.23	1.75
United Fire & Casualty	NDQ	34.875	-2.11	26.05	37.00	26.75	2	0.8	2.29	9	28.96	1.20
Unitrin	NDQ	47.5	2.01	10.47	50.50	41.50	236	2	4.21	13	37.51	1.27
UNUM Corp.	NYS	53.5	2.15	41.72	54.00	35.13	595	1.06	1.98	26	26.45	2.02
US Facilities Corp.	NDQ	19.5	0.00	95.00	20.38	9.13	282	0.2	1.03	10	11.66	1.67
USF&G Corp.	NYS	19.125	2.68	41.67	19.50	12.63	1432	0.2	1.05	9	10.86	1.76
USLIFE Corp.	NYS	30.375	4.74	30.65	31.63	20.63	233	0.93	3.06	11	38.45	0.79
Washington National	NYS	25	-1.48	31.58	25.38	17.75	58	1.08	4.32	10	25.13	0.99
Zenith National Ins.	NYS	23	-3.16	1.10	24.63	19.38	59	1	4.35	12	16.35	1.41
Zurich Reinsurance Centr.	NYS	29.25	-0.85	1.30	30.88	25.00	6	0.00	0.00	104	21.64	1.35
INSURERS/REINSURERS	AVERAGE		0.6					28.1	1.9	21.1		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	NDQ	23.5	-1.05	-8.74	30.00	19.50	905	0.00	0.00	81	28.15	0.83
Humana Inc.	NYS	20	1.27	-11.60	27.13	17.00	3241	0.00	0.00	17	6.56	3.05
Pacificare Health Sys.	NDQ	68.25	0.37	4.80	77.25	44.50	114	0.00	0.00	20	15.02	4.54
Safeguard Health Enter.	NDQ	12	-2.04	29.73	12.75	8.25	2	0.00	0.00	71	6.15	1.95
Sierra Health Services	NYS	26.25	4.48	-17.00	33.63	22.13	199	0.00	0.00	14	9.22	2.85
United Healthcare Corp.	NYS	48.75	-0.51	8.03	55.38	34.13	3109	0.03	0.06	25	16.17	3.01
U.S. Healthcare	NDQ	35.125	-1.75	-14.85	48.25	26.50	6539	1	2.85	14	5.66	6.21
Wellpoint Health Networks	NYS	29.875	-0.42	2.58	37.00	25.88	116	0.00	0.00	14	14.26	2.10
HMOs	AVERAGE		0.0					-0.9	0.3	28		
ALL COMPANIES	AVERAGE		0.4	11.1					2.1	24		

Top advancing issues: CNA Financial Corp., Fremont General Corp., Selbels Bruce Group. Leading decliners: Philadelphia Cons. Holding, Berkley W.R. Corp., EMC Insurance Group Inc. Most active issue: U.S. Healthcare. The BI Index rose 1.0%; the Dow Jones 30 Industrials rose 5.2%; the S&P 500 increased 3.4% and the NYSE Composite gained 4.0%.

System design: Nordby International Inc.

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