

Business Insurance

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Cayman Islands suspends insurance regulator amid probe

GEORGE TOWN, Grand Cayman—Gilbert Connolly, the Cayman Islands' deputy financial services inspector for insurance, has been suspended from office pending a government investigation.

The Cayman Islands is the world's second-largest captive domicile, with 372 captive insurers at year-end 1992 (BI, April 26).

Cayman Financial Services Inspector Jennifer Dilbert confirmed Mr. Connolly
Continued on next page

Washington's wheels turning

Clinton's basic plan offers mostly 'mainstream' benefits

By CHRISTINE WOOLSEY and JERRY GEISEL

WASHINGTON—Most corporate fee-for-service plans will not have to be upgraded to meet new Clinton administration standards, but many employers will have to improve their HMO benefits to match new HMO standards.

Most large employers that offer fee-for-service indemnity plans say their lowest deductible plan option is comparable to the standard fee-for-service plan proposed by President Clinton.

However, in several key areas, including the maximum percentage of family premiums that would be paid by employers, mental health benefits and vision care, many indemnity plans now fall short of the administration's proposals. And some benefits, like limited long-term health care benefits and hospice care,



generally aren't even offered by employer plans.

In areas like prescription drug coverage and dental benefits, some employer indemnity plans tend to provide richer benefits.

The president's plan calls for indemnity plan deductibles to be \$200 for individuals and \$400 for family coverage. The deductibles are similar to what many employer plans now require. However, large employers typically offer a range of deductible options, some as high as \$1,000.

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President Clinton and Vice President Gore last week released details of health care reform as well as a plan for 'reinventing' government.

Employers discover penalties in budget

By NANCY P. JOHNSON

WASHINGTON—Little-noticed health insurance reporting provisions in President Clinton's budget package are catching some benefit managers off guard.

And others are worried about the amount of data required and the penalties for breaking the rules.

Benefit managers are discovering that the law requires them to compile coverage information on groups of people they have never tracked before, like dependents of employees, retirees, dependents of retirees and former employees who are receiving health benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985.

And many seem unaware that the penalties for failing to report the information may run up to \$1,000 for each beneficiary or dependent not included.

Coverage data will go into a new data bank of Medicare/Medicaid secondary payers. The data bank is designed to recoup what the government estimates will be \$1 billion in claims over five years that should have been paid by employers, not Medicare (BI, Aug. 9).

All employers that offer group health plans will be required to
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Businesses endorse Gore plan

Workplace safety bureaucracy to be cut

By MARK A. HOFMANN

WASHINGTON—President Clinton's plans to "reinvent" government could mean fewer headaches for companies that maintain safe worksites.

As part of a package of recommendations presented by Vice President Al Gore last week, businesses would be permitted to have workplace safety reviews conducted by private contractors or non-management employees.

Companies that exceed standards set by the Occupational Safety & Health Administration would be rewarded by having to deal with less paperwork and fewer inspections. Companies that did not meet federal standards would be subject to stiffer fines than they currently face.

It's an idea whose time has come, some risk managers say.

"It's a marvelous idea. Obviously, all businesses are looking for ways to reduce paper-

work," said Millicent Workman, director of corporate risk management at Belz Enterprises, a Memphis-based real estate development firm that runs hotels and outlet malls. Ms. Workman, the 1992 *Business Insurance* Risk Manager of the Year, said that changes "could bring more equity to the inspection system" by requiring all worksites to be inspected more regularly than is now possible.

The proposed change in OSHA inspections is one of several general provisions in the report by

the National Performance Review that would affect risk and benefit managers directly.

Others include: eliminating the ERISA requirement that summary plan descriptions be filed with the Labor Department; encouraging market-based pollution abatement efforts; indexing civil fines to inflation; and increasing federal agency use of alternative dispute resolution.

Specifics on many of the recommendations are not expected
Continued on page 30

ADR savings depend on nature of dispute

By JOANNE WOJCIK

Because time is money, risk managers and insurers increasingly are urging their attorneys to use alternative dispute resolution to avoid protracted litigation that leads to higher legal fees.

However, some ADR approaches work better than others at holding down costs.

For example, non-binding court-ordered arbitration, which has been required in California to resolve personal injury claims for less than \$50,000, has not resolved the cases any quicker nor has it reduced the legal costs involved, a recent study found.

By contrast, binding arbitration and mediation are capable of producing significant savings by reducing the time it takes to resolve disputes, ADR experts say.

"Because of the early resolution" ADR can provide, "no doubt there's a profound cost savings," said Eric R. Galton, a partner with Wright & Greenhill in Austin, Texas, who has published a book on mediation.

"The use of an institutionalized mediation program can cut legal costs by one-third," he estimated.

While the size of settlements reached through ADR and those that go to trial often "are no less or more than they would be three years down the road, the real savings for the company is in legal fees," observed Joseph P. Decaminada, executive vp and general counsel for Atlantic Mutual Insurance Co. in New York, and chairman of the non-profit American Arbitration Assn.

"ADR—and in particular mediation—can be a valuable, cost- and time-saving strategy for resolving disputes when differences between parties are not too great and both par-

ties are willing to cooperate," said Eileen Scudder, a Deloitte & Touche partner in Chicago who co-authored a study on the growing popularity of ADR among Fortune 1,000 companies.

However, "in complex cases and certainly in cases when the ADR process is forced upon the parties, ADR may only add one more step to the already long and costly process of litigation," she pointed out.

Bud London, a partner with New York-based London/Fischer, agreed.

"If you can do it in a couple of days and there's not a lot of discovery, you can save a lot of money. But I haven't seen great efficiencies in big cases," Mr. London said. "If you've got a seven-figure case, you're looking at a protracted proceeding with hearings, discovery, etc. You might as well
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Update

Caymans suspend Connolly

Continued from previous page

was suspended Aug. 13, when disciplinary proceedings were instituted against him.

Cayman officials would provide no further details of the inquiry. Cayman sources say that government officials are considering Richard Clayton as a possible replacement for Mr. Connolly. Mr. Clayton was insurance adviser to the Bahamas government until he was dismissed earlier this year.

However, Ms. Dilbert said, "Pending the outcome of the proceedings, we are taking no further action as regards his replacement."

Florida cat fund proposed

TALLAHASSEE, Fla.—A state panel last week proposed establishing a state windstorm fund to cover some catastrophic losses.

Florida Gov. Lawton Chiles' Study Commission on Property Insurance and Reinsurance voted 8-4 to propose the pool, which would be funded through contributions of 10% of insurers' property premiums and 5% premium surcharges on property policyholders.

The pool would raise \$600 million per year that could support \$6 billion in bonds and would have the authority to assess an additional 2% emergency surcharge on policyholders.

If approved by the Legislature, the fund would pay for 75% of windstorm losses above \$10.8 billion for a single storm. Such a storm would be comparable to Hurricane Andrew, which caused an estimated \$15 billion of insured damage in Florida.

The proposal does not include transfer of risk to the state or mandatory payment of losses beyond the assets and borrowing power of the fund, as insurers had suggested.

The proposals are a compromise between the Insurance Department, which wanted insurers alone to fund the pool, and insurers, which wanted policyholders to foot the bill (BI, Aug. 23).

Other recommendations the commission will submit to the Legislature this week include:

- Allowing the Insurance Department to force insurers that pull out of the homeowners market to stop writing all lines of business in Florida.

- Capping non-renewals at 5% per year for three years in geographic zones to be established by the department.

New California comp proposals

SACRAMENTO—Before adjourning late last week, the California Legislature on Friday was expected to pass workers compensation cleanup legislation proposed by a conference committee.

Separately, Insurance Commissioner John Garamendi announced that the 7% rate reduction mandated by comprehensive workers comp legislation enacted this summer will apply to 1992 as well as to 1993 insurance policies, resulting in a total of up to \$590 million in lower costs to employers (BI, July 26).

Mr. Garamendi said that anti-fraud efforts have resulted in fewer workers comp claims over the past year, which means lower losses.

The conference committee proposals are mainly clarifications, sources said. Among them are stricter requirements for an injured worker to be eligible for a second vocational rehabilitation plan.

A substantive change, however, is the inclusion of an additional \$15 million appropriation for fraud investigation and prosecution, according to Joseph Markey, president of the California Self Insurers' Assn. and chairman of the governor's Fraud Assessment Commission.

The commission, which includes employer representatives, agreed last March to a \$25 million aggregate assessment to combat fraud, Mr. Markey said. Last year, \$10 million was appropriated for anti-fraud efforts.

Half of the \$25 million is to go to district attorneys who request funds and half to the Insurance Department's fraud division.

Emily damage estimates

Damage estimates continue to come in from Hurricane Emily, which hit North Carolina's Outer Banks Aug. 31.

The Property Claims Service division of the American Insurance Services Group estimates \$30 million in insured property damage from the storm.

The Federal Flood Insurance Program's preliminary estimate is 600 claims totaling \$6 million, a spokeswoman said.

The North Carolina Insurance Underwriting Assn., commonly known as the Beach Plan, estimates damages to property insured by the pool will total at least \$5 million.

The North Carolina Farm Bureau Mutual Insurance Co. reported \$6.4 million in damages on 527 homeowners and automobile claims so far.

State Farm Group expects to pay out a total of \$2.5 million.

Nationwide Insurance Group revised its estimate downward last week to 300 claims totaling \$1.5 million from 2,500 claims totaling \$3.7 million (BI, Sept. 6).

GM shifting costs to retirees

DETROIT—General Motors Corp. is requiring salaried retirees to pay monthly medical plan premiums for the first time in 1994.

To help ease its staggering health care burden—\$5.6 billion for employees and retirees in 1992, or about \$1,500 per car—GM also is requiring salaried active employees to pay more each month for coverage under various plans.

About 105,000 salaried retirees will be affected. Starting Jan. 1, retirees will pay monthly premiums ranging from \$20 to \$107, de-

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KWELM runoff proposal would pay 40% of liabilities

By ADRIAN LADBURY

LONDON—Policyholders and creditors of the KWELM group of insurance companies—among the largest insurance failures in history—have been sent a proposed scheme of arrangement that would provide them with about 40% of their claims over several decades.

Current estimates of the five insurance companies' unsecured liabilities are about \$5 billion. But, because of the large propor-

tion of long-tail U.S. liability risks written by the failed insurers, provisional liquidator Coopers & Lybrand estimates total liabilities could rise as high as \$9 billion over the next 20 to 40 years. The ultimate deficiency could be between \$3 billion and \$5 billion, the liquidator projects.

The scheme of arrangement—which is basically a plan to run off an insurer rather than liquidate it—proposes paying up to 40% of claims over a possible 40-

year period to the more than 100,000 creditors and policyholders. The first payments would be made sometime next year. A meeting is set for Nov. 17 in London to vote on the scheme.

The five insurers—Kingscroft Insurance Co. Ltd., Walbrook Insurance Co. Ltd., El Paso Insurance Co. Ltd., Lime Street Insurance Co. Ltd. and Mutual Reinsurance Co. Ltd.—were all subsidiaries of London United Investments P.L.C. The five

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Creative settlement effort backfires on libel victim

Court rejects drop down request

By DAVE LENCKUS

NEW ORLEANS—A doctor will appeal a federal appeals court ruling that a high-layer excess liability insurer for a television station does not have to drop down to provide coverage in an unusual libel award settlement.

A panel of the 5th U.S. Circuit Court of Appeals in New Orleans ruled 3-0 that Federal Insurance Co. is not obligated to contribute to an \$8.5 million settlement, even though it would have had to pay \$9.6 million of a \$31.6 mil-

lion jury award against its policyholder, Harte-Hanks Communications Inc.

The settlement the doctor reached with Harte-Hanks and some of its other liability insurers was designed to exhaust the company's first \$22 million of liability insurance—including excess layers written by two now-insolvent insurers.

However, the settling parties contended that the final loss to Harte-Hanks remained \$31.6 million and that Federal therefore would have to contribute to the settlement.

But the 5th Circuit panel ruled on Sept. 3 that Federal does not have to contribute to the settlement because it falls far below Federal's attachment point.

The plaintiff's attorney contends that the panel improperly interpreted Texas law, under which he says the jury award is considered the final loss.

Other attorneys say the ruling is not surprising, but does offer some valuable lessons to plaintiffs and policyholders.

Indeed, the court seemed "annoyed" at how the doctor, Harte-

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Merrett steps down

Keeling to be Lloyd's new deputy chairman

By ALINE SULLIVAN

LONDON—Stephen Merrett has resigned as deputy chairman of Lloyd's of London following heavy criticism in the market over possible conflicts of interest between his role as a Lloyd's official and chairman of underwriting group Merrett Holdings P.L.C.

Mr. Merrett also resigned from the Lloyd's Council and Market Board. His decision, announced Sept. 8, follows his announce-

ment in May that he would step down at the end of the year as underwriter for syndicate 418, and his offer last month to quit as chairman of Merrett Underwriting Agency Management Ltd. (BI, Aug. 23).

Mr. Merrett said in a letter sent last week to Lloyd's Chairman David Rowland that his workload at Merrett Group was already substantial and was likely to increase, making it impossible to continue combining the two jobs.

He declined Mr. Rowland's suggestion that he remain on the Council, saying that he would be unable to "resist continuing to be involved in a substantial way."

Richard Keeling, deputy chairman of managing agency Murray Lawrence & Partners Ltd., succeeds Mr. Merrett as deputy chairman of Lloyd's.

Mr. Keeling has been involved in the implementation of the market's business plan, particularly with proposals for resolving old and open underwriting years.

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Environmental risk management experts to be listed

The deadline is approaching for companies to return questionnaires to be listed in the *Business Insurance* directory of environmental risk management consultants, which will appear in the Nov. 22 issue.

The issue will also feature a Spotlight Report focusing on environmental liability topics.

There is no charge to be listed in the directory.

However, companies must fill out and return a BI questionnaire.

If your company is an environmental risk management consultant and you have not yet received a questionnaire, please request one from Assistant Directory Editor Cindy Bloom at 312-280-3195.

The deadline for returning completed questionnaires is Oct. 1.

Inside

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Learning to reduce health care demand

By CHRISTINE WOOLSEY

Reducing consumer demand for medical services will slash \$180 billion or more from the nation's \$900 billion annual health care tab, a consortium of health care experts contends.

And employers, which currently pay more than half of the country's medical costs, must play a major role in this endeavor by redoubling their employee education efforts, the group says.

Attempts to reduce health care

Employee education a new focus of cost containment efforts

utilization, such as wellness programs and coverage restrictions, only address part of the problem, the experts say. To be truly effective at reducing health care costs, employers must also provide employees and dependents with consumer-oriented medical education materials that stress self-management and, ultimately, reduce demand for health care services.

Already, a handful of corporations around the country have

succeeded in reducing their health care expenses an average of 20% in the first year after implementing such education programs, according to The Health Project, a consortium of leading U.S. corporations, labor groups, academics, government agencies and private institutions.

The Health Project locates, evaluates and distributes information about employer-based programs that effectively influence personal health habits and

sharply reduce the rate of health care inflation by minimizing unnecessary expenditures. The group's C. Everett Koop National Health Awards honor employers and communities that have accomplished these goals.

"Clearly, a lot has to be done about containing the costs of health care, which are now burdensome and rapidly becoming intolerable," noted Dr. James Fries, a professor of medicine at Stanford University Medical

Center in Palo Alto, Calif. Dr. Fries also is chairman of the Health Project's Selection Task Force.

According to the Health Care Financing Administration, U.S. employers are spending the equivalent of 48.3% of aftertax profits on medical care for employees and dependents, and HCFA expects that figure to exceed 60% by 2000, Dr. Fries said.

Those ominous statistics mean "Americans are going to have to accept increasing responsibility

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Photo by Todd Winters

Harris Bank has answered a Chicago school shutdown by offering classes for employees' children.

Banks at head of class

Employers step in to help with child care hassle

By SALLY ROBERTS

CHICAGO—With a teachers contract dispute delaying the opening of the Chicago public schools, two downtown banks are trying to help hundreds of employees cope with a child care nightmare.

Both Harris Bank Corp. and Northern Trust Co. have set up temporary learning facilities to run until the Chicago Teachers Union and the Chicago School Board settle a bitter dispute that has kept more than 400,000 local schoolchildren out of classes.

Scores of other area organizations are partici-

pating in alternative education programs around the city, but the rival banks may be the only local companies offering full-fledged school substitutes to employees' children.

"It's a business decision," said a spokeswoman for Harris Bank, which also ran a learning program for 17 days during a 1987 teachers strike.

"We view Chicago schools as part of our life line," said Karen Stoeller, vp-human resources and organizer of Harris' learning center. The bank draws heavily from the area's schools for hiring purposes.

"We need our employees at work," said Ms.

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Implant settlement proposed

By JOANNE WOJCIK

BIRMINGHAM, Ala.—Silicone breast implant manufacturers, liability insurers, doctors and others would jointly pay \$4.75 billion over 30 years to settle present and future breast implant suits under a proposal presented to a federal judge last week.

The amount that each party—including raw material suppliers and other health care providers—would contribute has not yet been determined, said Jim Jenkins, vp, secretary and general counsel for Dow Corning Inc. The Midland, Mich.-based company was the leading U.S. manufacturer of the implants until they were taken off the market amid health concerns last year.

The proposal came out of discussions between plaintiff and defense committees and was presented last week to U.S. District Judge Sam C. Pointer, who is presiding over consolidated implant litigation. The proposal is still subject to the approval of all involved parties.

"The funding issue will be one of the most challenging," said Mr. Jenkins.

One possibility that has been discussed is apportioning liability based on each manufacturer's share of the breast implant market, he confirmed. Such a distribution could determine which liability insurers would likely respond to claims.

Dow Corning and Mentor Corp. both have sued insurers seeking defense and indemnifi-

cation for implant claims (*BI*, Aug. 23; July 12).

Though it was proposed in a federal case, a settlement fund would also cover women who have sued in state courts. "The purpose of the settlement is to come up with a vehicle which allows all of these claims to be resolved at once," explained Mr. Jenkins.

Ernie Hornsby, a Dothan, Ala., lawyer who represents women with implants called the settlement proposal a "wonderful opportunity." But he warned that even \$4.75 billion may be insufficient to cover the thousands of claims that have been or will be filed.

Judge Pointer has been fostering state and federal court coop-

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Captive owners press for changes to fronting law

By MEG FLETCHER

Captive insurance company owners are stirring the pot in an effort to influence the next round of discussions over a controversial proposed model fronting bill.

Members of the Coalition of Alternative Risk Funding Mechanisms, an organization of risk managers and other captive supporters, are writing letters and directly contacting their insurance commissioners in an effort to make their voices heard locally where they have been rejected nationally.

To date, they have been unsuccessful in curtailing proposals in the model act that would increase disclosure and reporting requirements in fronting arrangements used by most captives.

A majority of regulators belonging to the Special Issues

Committee of the National Assn. of Insurance Commissioners is expected to give interim-level approval to the fronting measure at the organization's fall meeting, which will be held Sept. 19-21 in Boston.

NAIC "My feeling is we have pretty much completed the project, but you never know," said Sandra M. Siegel, assistant deputy New York insurance superintendent.

Ms. Siegel chaired the Special Issues Committee at the NAIC's summer meeting in Chicago (*BI*, June 28).

"If I bet, I bet it will get passed," conceded Jeffrey Johnson, an attorney with Primmer & Piper in Montpelier, Vt., who represents CARFM. The Montpelier-based coalition's members represent more than 5,000 companies paying about \$14 billion

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Business Insurance names judges for '94 risk manager award

Ten independent judges from all sectors of the risk management profession and the insurance industry will select the 1994 *Business Insurance* Risk Manager of the Year and the Risk Management Honor Roll.

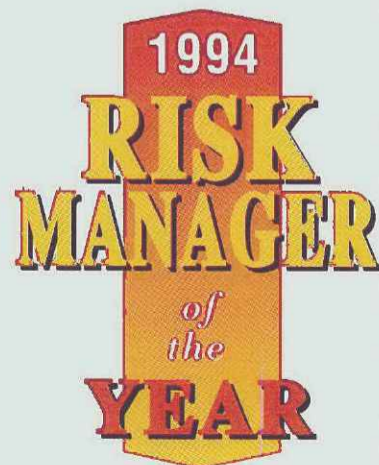
The winners of the awards, presented annually by *Business Insurance* to recognize excellence in risk management, are selected based on the 10 judges' assessments of the risk managers as detailed in their nomination forms.

Candidates for the 1994 awards can be nominated now. Nomination forms are available from *Business Insurance's* Chicago office.

Nominations must be submitted by Nov. 19.

The 10 judges who will select the 1994 honorees include the 1993 Risk Manager of the Year, three members of the 1993 Risk Management Honor Roll, two insurance company executives, two brokerage executives, a risk management consultant and an insurance educator.

The judges for the 1994 competition are:



• David G. Adler, risk manager of the Portman Cos. of Atlanta. Mr. Adler was named to the 1993 Risk Management Honor Roll, representing small companies.

• Norman A. Baglini, president of the American Institute for Chartered Property & Casualty Underwriters and the Insurance Institute of America in Malvern, Pa. Mr. Baglini is serving on the panel of judges for a

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KWELM scheme

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wrote varying amounts of insurance and reinsurance business from 1972 until 1990 through the failed underwriting pools managed by H.S. Weavers (Underwriting) Agencies Ltd. and C.R. Driver & Co. Ltd., which were leading underwriters of U.S. casualty business in the London market.

Chris Hughes and Ian Bond, the Coopers & Lybrand partners responsible for the scheme, over the next several weeks will give a series of presentations to policyholders and creditors in London and in the United States to explain the plan.

The provisional liquidators plan to visit Atlanta, Chicago, Los Angeles and New York on Oct. 7 and 8.

"It would be wholly wrong to

hold a meeting in London and not let the creditors in downtown Atlanta see the whites of our eyes," said Mr. Hughes.

Mr. Hughes said there is still an unknown number of creditors and policyholders that have not yet registered their losses with the provisional liquidators, adding that he hopes they can be reached during the tour and through advertisements.

For the scheme to be adopted at the Nov. 17 London meeting—where those eligible can either vote in person or by proxy—the provisional liquidators will need the approval of creditors representing at least 75% of the value of claims against the companies. If they fail to win that support, the insurers will be liquidated.

At a press briefing in London last Thursday, Mr. Hughes said the members of an informal creditors committee have fully

'The worst nightmare would be if we paid too much too quick,' liquidator Chris Hughes says.

supported the scheme and he hopes that most policyholders and creditors will follow suit. "We don't assume that we will get the 75%, but we are receiving a high level of confidence," he said.

The U.K. Policyholders Protection Board, which is liable to cover the claims of some of the U.S. policyholders (BI, July 19), is a member of the informal creditors committee and supports the scheme, said Mr. Hughes.

The PPB will pay protected

policyholders the 90%, or 100% in some cases, of the value of claims they are entitled to under the Policyholders Protection Act. It will then recover what money it can under the scheme of arrangement.

Coopers & Lybrand estimates that of the KWELM companies' current \$5 billion in unsecured liabilities, roughly 20% is attributable to policyholders covered by the PPB.

If the scheme is approved, initial payments by the insurers will range from 3% to 12% of creditors' claims, depending on the company. The first payments would be made "no later than June 30, 1994" to creditors with already agreed-upon claims. Additional payments would be made as the size of other claims is set and agreed upon.

"The payment percentage set for each company will rise as

further assets are collected and assuming that estimates of the total liabilities, including the special margin (for long-tail claims), stay the same or are reduced. The ultimate payment percentages may reach approximately 40%, although they will differ from company to company," explained Coopers & Lybrand.

But Mr. Hughes was keen to point out that the figures are by no means sacrosanct. "All we can say for certain about the estimates is that they are wrong. They will either be too high or too low. The worst nightmare would be if we paid too much too quick," he said.

The KWELM scheme hopes a special reserving system adopted by the provisional liquidators will ensure equity between the short- and long-tail creditors.

"The proposed scheme of arrangement means that the KWELM companies will make interim payments in respect of established claims. But cash assets would be retained with a view to enabling the companies to make the same percentage interim payments in respect of claims established in the future," the provisional liquidators explained.

The scheme would set aside \$4 billion as a "special margin" for long-tail claims, to ensure that the percentages agreed to can be maintained over time.

The most important factor in determining the ability of Mr. Hughes and his colleagues in achieving the 40% payment will be the attitude and ability of more than 600 reinsurers worldwide to pay up.

Currently, the KWELM companies theoretically have nearly \$500 million in assets available for distribution. More than \$280 million has been collected since the appointment of the provisional liquidators, including about \$180 million in reinsurance. "Further collections of between \$2 billion and \$3 billion are anticipated over the life of the scheme, mainly from the companies' reinsurers," said Mr. Hughes.

Reinsurance recoveries currently are "going well," he added.

"Reinsurers, those that are solvent, are generally paying up, and this seems to be the same with most schemes in London as far as we know," Mr. Hughes said.

But there is a potential threat to some of the reinsurance recoveries.

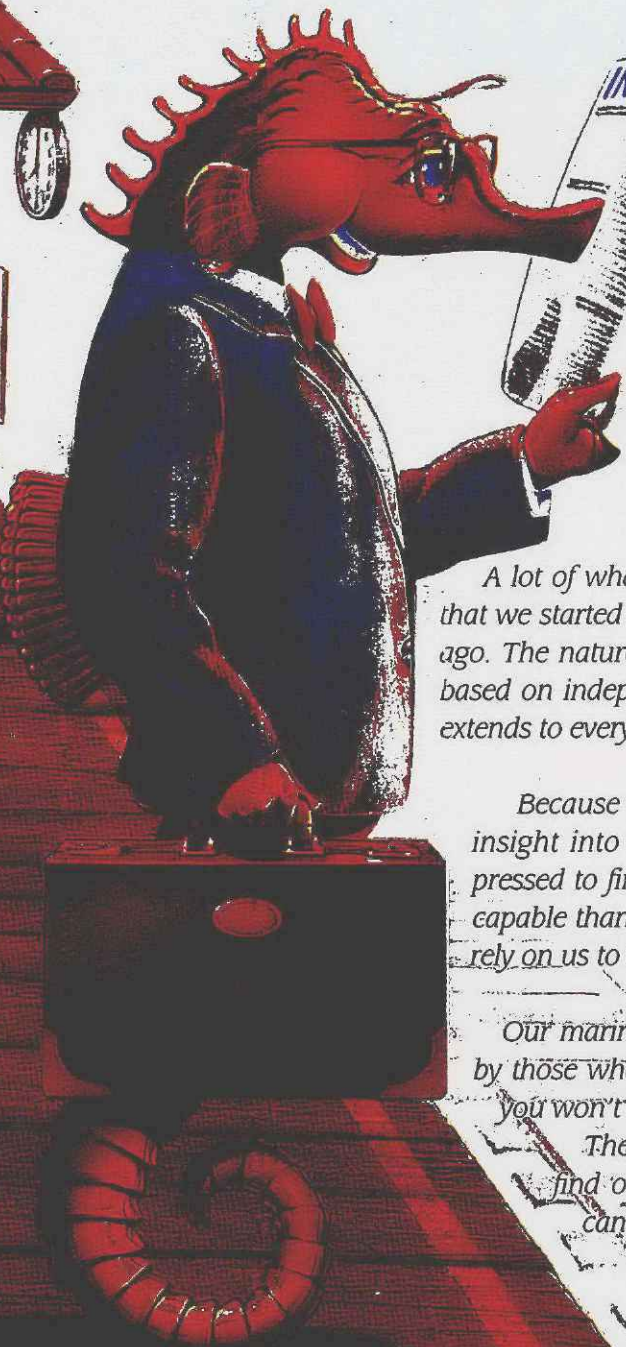
The U.K. Serious Fraud Office and Department of Trade and Industry are investigating allegations of fraud at Drivers, Weavers and LUI. Mr. Hughes could not say at what stage the investigations are, only that he believes they are ongoing.

"If they do decide that there has been out and out fraud, then it could well impact on some, not all, of the reinsurance recoveries. It depends on the type of reinsurance taken," said Mr. Hughes.

The key advantages of a scheme of arrangement, as opposed to liquidation, is that it is a cheaper, quicker and fairer means of recovering and distributing the available assets, according to Mr. Bond.

Creditors and policyholders "will receive payment sooner than in a liquidation. In a liquidation, a dividend would probably not be paid until most claims had been identified and valued, which would be likely to take many years," the provisional liquidators say. **BI**

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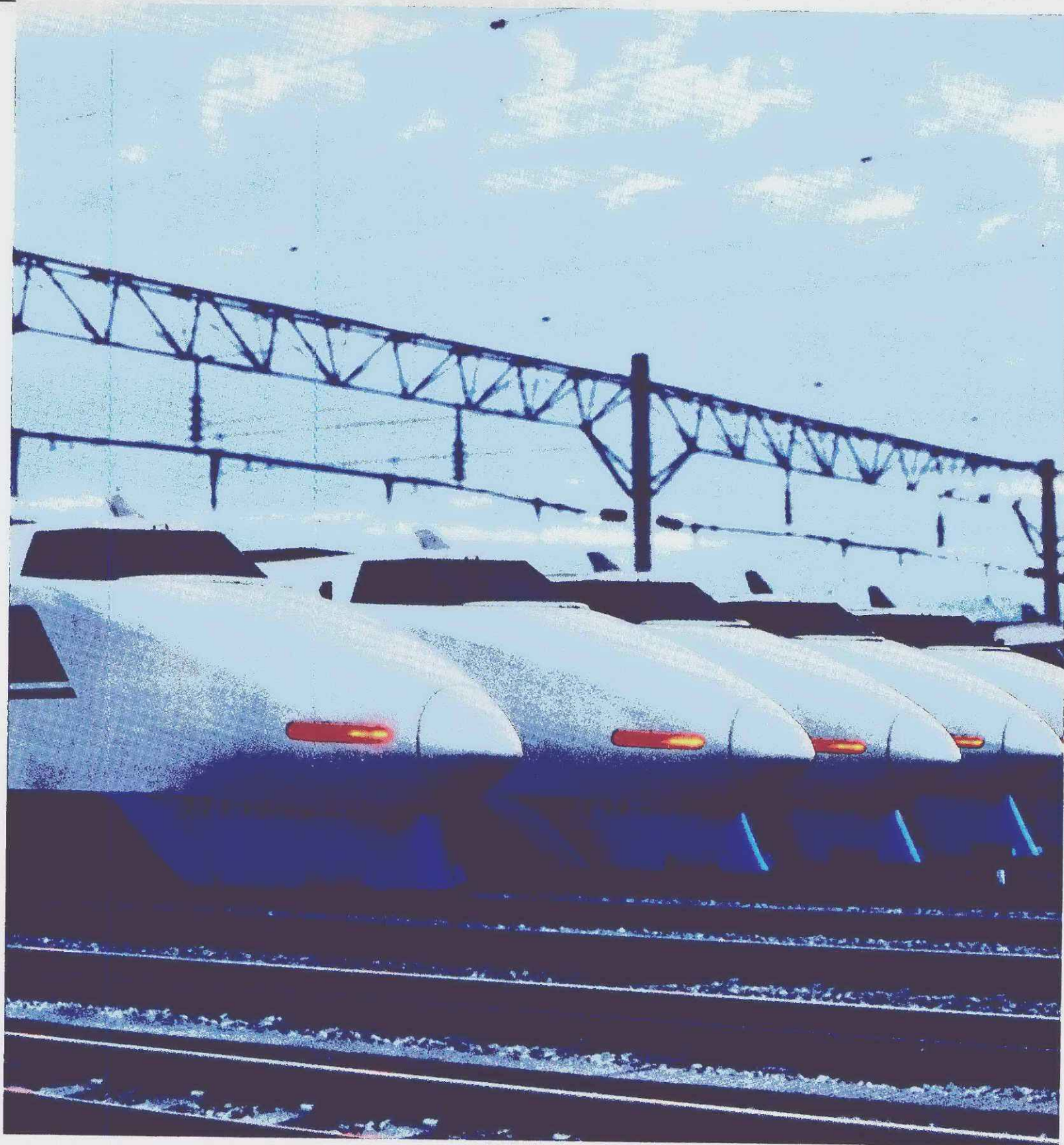
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Ford may restrict defined benefit plan

DEARBORN, Mich.—Ford Motor Co. reportedly has proposed excluding newly hired hourly employees from its defined benefit plan.

Instead, new employees would be offered only defined contribution retirement benefits in contract negotiations with the United Auto Workers.

Company and union representatives declined to comment on the contract proposal.

The UAW has selected Ford as its target company for negotiating a new labor contract with the Big Three automakers.

The contract struck with Ford, which is the strongest of the three automakers financially and has the best-funded pension plan, could set a pattern for sub-

Benefit Beat

sequent contract talks with Chrysler Corp. and General Motors Corp.

Under the reported proposal, new union employees would bear the brunt of pension benefit reductions and other cuts in pay and health care benefits rather than current hourly workers.

Under the proposed defined contribution plan, Ford would contribute only 2% of pay to new employees' retirement plan.

Current hourly employees would remain in Ford's defined benefit plan, according to the proposal.

—Crain's News Service

Flexible scheduling

Although employees say they want more flexible work schedules, only a small fraction of workers who have flexible schedule options use them.

The most popular flexible schedule option—used by 24% of workers—is one that permits employees to vary the time they start work, according to a new survey of 80 large companies representing 2.4 million workers.

The survey, which was conducted by Boston-based consultant Work/Family Directions Inc., found that less than 2% of employees chose part-time work, telecommuting or job-sharing, when available.

Charles Rodgers, president of

Rodgers & Associates, the research arm of Work/Family Directions, attributes the low usage of these options to resistance by managers, employee fear of a negative career impact and a general perception that flexible schedules make it difficult to run a business effectively. "Flexibility remains stalled at the level of accommodating a small number of high-performing employees and has not yet become an acceptable mode of managing the larger work force," he said.

"While an overwhelming number—85%—of companies say they offer one or more flexible work programs, in reality only about half that number have written policies governing such options and even when they do

they are usually subject to the discretion of managers," Mr. Rodgers noted. And, "most managers are stuck in their old patterns and view employees who don't work in the traditional mode as less than serious about their careers."

Copies of the survey are \$2.50 each and are available from Lynne Sarikas, Work/Family Directions Inc., 930 Commonwealth Ave. South, Boston, Mass., 02215; 617-278-4000.

—By Deborah Shalowitz

Time changes ESOP

NEW YORK—Time Inc. is making several changes to its employee stock ownership plan to take effect in 1994.

Chief among these is that the size of tax-deferred contributions made to employees by the company will be based solely on the annual performance of Time's New York-based magazines rather than the overall performance of its parent, Time Warner Inc.

Another change is that only the first two percentage points of the company's annual contribution to workers now will come in the form of Time Warner stock. The remainder of the company's contribution will go into an existing 401(k) plan, to be invested as the employee chooses.

Currently, Time contributes as much as 12% of an employee's eligible compensation directly to the ESOP in the form of Time Warner stock. In addition, management currently decides how much to contribute each year based on Time Warner's annual performance. In recent years, the company's contribution to the ESOP has been about 8% of eligible compensation.

The changes, which take effect Jan. 1, are being made to tie the ESOP contribution directly to the magazines' performance, which has been falling behind the rest of Time Warner, according to a Time Inc. spokesman. Time's 401(k) plan will not be affected by the changes in the ESOP. Employees will continue to be able to contribute 2% to 6% of pay with the company matching two-thirds of that contribution, up to \$2,000.

—By Michael Schachner

Austin extends benefits

AUSTIN, Texas—The capital of Texas will soon extend health care benefits to city workers' domestic partners and children.

Under the plan, which will take effect Jan. 1, health coverage for Austin's 10,415 workers will be extended to domestic partners of either gender.

To be eligible for benefits—which include access to three health plans as well as dental and life insurance—the couple must file an affidavit with the city stating that the couple lives in the same household and that the domestic partner lives "in a close, personal, intimate relationship" with the city employee.

Austin estimates that the extended coverage will cost the city \$704,963 in its first year, with about 472 city employees expected to add partners and children to the plan.

"We don't expect to see increases in claims costs," said Delia Hernandez, Austin's benefits manager.

—By Nancy P. Johnson

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Opinions

Boosting quality service

THE QUALITY MANAGEMENT revolution is coming to the insurance industry, and not a moment too soon for insurance buyers.

Increasingly, insurance companies and brokerage firms are adopting quality management programs to improve the efficiency and quality of the products and services they give to clients.

They are trying to respond to legendary customer complaints about the way the insurance industry does business: failure to deliver policies on time; failure to deliver an accurate policy the first, second and even third time; failure to respond to claims in a timely manner; failure to provide needed capacity; and failure to think creatively, among other criticisms.

We applaud the efforts of individual insurers to improve their own services. We are even more enthusiastic, though, about the potential for companies to come together to form a Quality Insurance Congress for the entire industry.

As we reported last week, a two-day meeting in Nashville, Tenn., in August could be the genesis of the Quality Insurance Congress.

As currently envisioned, the congress would be an industrywide effort to improve the quality of education in the business, to conduct uniform customer research to determine what the customer wants and customer satisfaction ratings, and to reduce the amount of duplication of effort and work in the industry.

The Quality Insurance Congress, through economies of scale and influence, could enhance the efforts of companies already committed to improving their quality of service and products. And, the congress could inspire improved service from even those companies that are desperately holding onto their old ways of doing business.



Buyers of insurance products and services, who are engaged in quality management programs themselves, are demanding that all their suppliers—including insurance companies and brokers—prove they are committed to improved quality, too. Insurance companies and brokerage firms will have to join the quality management movement or be left behind.

We encourage top management at insurance companies and brokerage firms to seriously consider becoming founding members of the Quality Insurance Congress. Those that do will be leaders of the quality management revolution in the insurance industry. Those that wait to see what happens will only be the followers.

Letters

Few obstacles seen to expanding workers comp policy

To the editor: I have read with much interest the letters to the editor about the lack of coverage for officers and fellow employees from employer liability claims under the standard workers compensation policy.

I don't believe anyone has yet addressed the error in the National Council on Compensation Insurance's response to Jesse Pagonis' original letter (*BI*, July 26), in which the NCCI indicated it was helpless to cure the problem because the coverages provided by the policy are mandated by the states.

I am not familiar with the workers compensation laws of all the states but I feel reasonably sure that very few mandate the terms of Coverage B—employers liability coverage.

I'm also reasonably sure that very few state laws of those that might mandate the terms of employers liability coverage preclude insurers from providing broader coverage than that mandated by law.

Why doesn't the NCCI proceed with filing broader employers liability coverage that would close the gap in the

40 or more states that would accept such a filing, rather than argue about whether it can do so in all 50 states?

Eric S. Tachau
President
Insurance Consultants Inc.
Louisville, Ky.

To the editor: My associate Donald Malecki and I have reviewed with interest a July 26 letter to the editor from Jesse Pagonis of Engelhard Corp. and subsequent letters in response to and in agreement with Mr. Pagonis.

Mr. Pagonis' letter referred to what is alleged to be a serious coverage gap in the standard workers compensation/employers liability insurance policy. Specifically, Mr. Pagonis states that officers and non-officer employees, such as a plant manager, are not covered under the employers liability coverage part of the standard workers comp policy. Mr. Pagonis also states that coverage for these individuals is excluded by liability policies such as the standard ISO commercial general liability and directors and officers liability policies.

We have addressed this alleged problem in a recent publication and, based on this, make the following observations:

- The employer liability exclusion in the standard ISO CGL forms and many commercial umbrella forms eliminates bodily injury coverage for the employer in the event of injury to the employee.

It does not generally preclude cover-

age for other insureds (officers, non-officers) seeking protection.

The severability of interest provision states that, with the exception of policy limits, coverage applies separately to each insured against whom a claim is made and suit is brought. Therefore, if suit is filed against one or more officers, the exclusion may not apply, depending, of course, on the facts alleged.

- That is the reason the workers compensation/employers liability policy does not include executives of a corporation (or non-officer managers) as insureds.

These individuals are not the employer and, therefore, they are properly the subject of coverage under ISO CGL and commercial umbrella forms (subject to exclusionary endorsements).

- If the party being sued is a manager who is considered to be an employee, and the alleged injury is to another employee or the named insured, that individual (not other insureds) may be subject to the fellow employee exclusion. However, even here there may be coverage.

For example, there have been instances where supervisors or managers have successfully argued that they were acting as executive officers for purposes of the incident involved, thus exempting them from the fellow-employee exclusion.

This position will become difficult to maintain under the 1993 proposed revisions to the ISO CGL forms. When these revisions take effect, the policy

Continued on page 12

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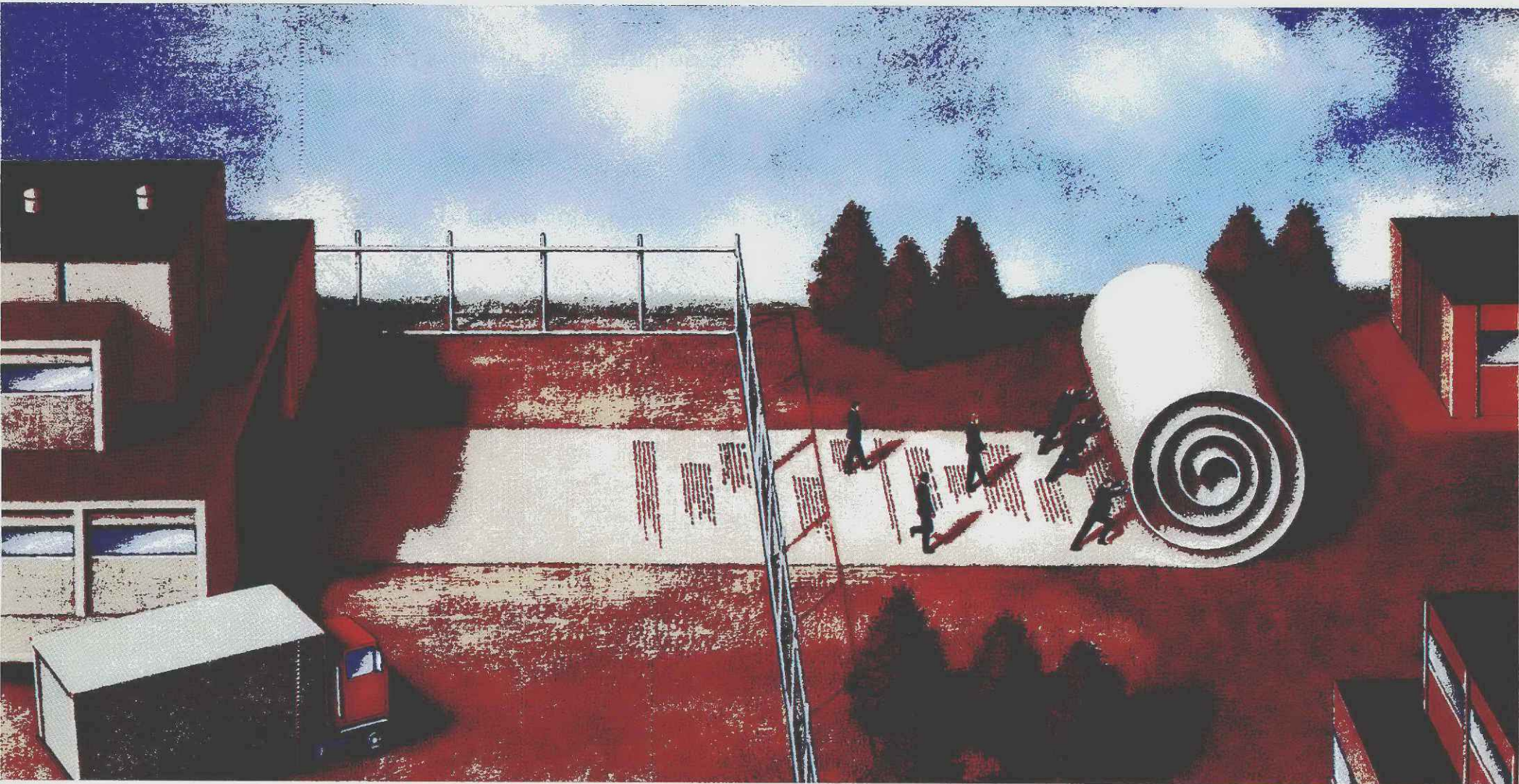
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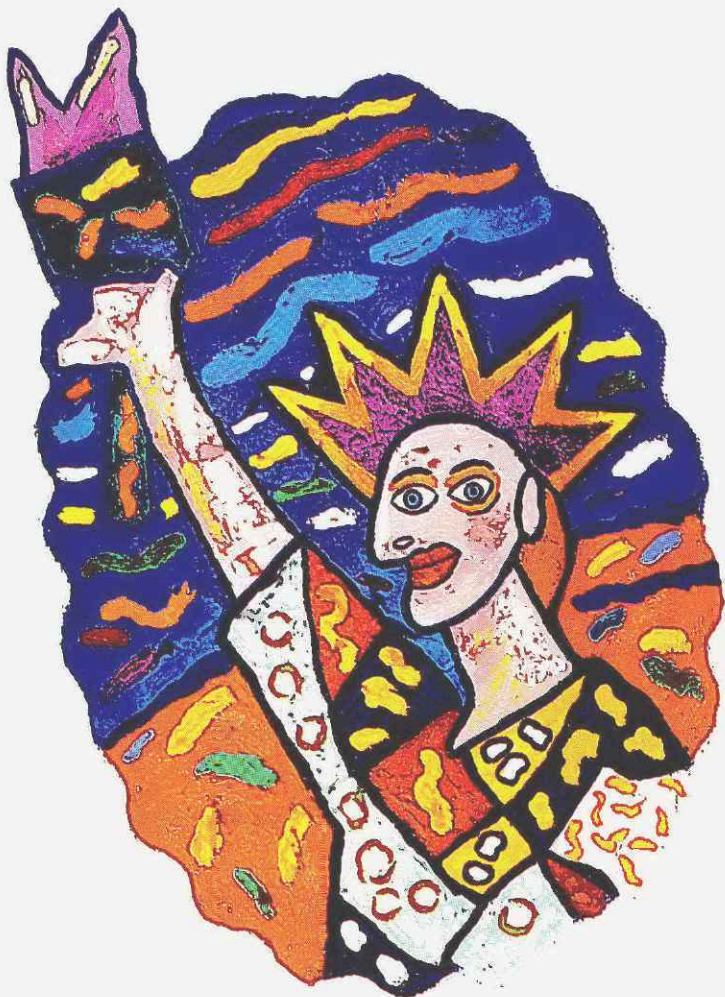
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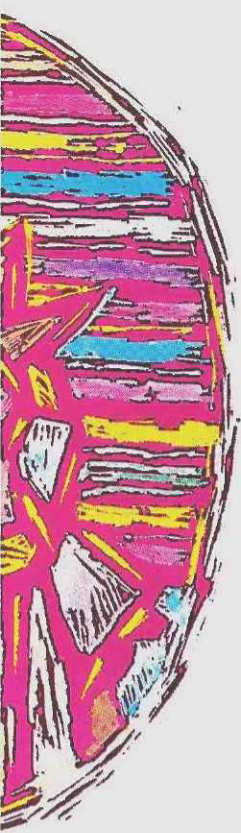
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Letters

Continued from page 8
will define "executive officer" to mean a person holding any one of the officer positions created by the named insureds charter. This will limit coverage accordingly.

The employers liability exclusion referred to by Mr. Pagonis does not, under the terms of the standard ISO CGL policies issued from 1985 on, apply to personal injury coverage (though it does in some umbrella forms). This could require the ISO CGL form to respond, for purposes of defense, in most instances and possibly even for partial indemnity depending on the facts involved.

Pete Ligeros
Pete Ligeros & Associates
Newport Beach, Calif.

Workers comp does not fit today's world

To the editor: Isn't it about time the unspeakable is spoken? Specifically, workers compensation is an antiquated concept whose time has passed.

For those who've forgotten, workers compensation was enacted at a time when personal health care was but a glimmer in the American Medical Assn.'s eye.

Since that time, health care has evolved into the proverbial 900-pound gorilla, and it is eating everything in sight.

Now, however, a seminal question is evolving: Can American employers afford to continue financing the duplicative systems of personal health and workers compensation insurance, especially when the government is proposing mandatory health insurance for all workers?

The answer, of course, depends on the stakeholder group to which you subscribe. Regardless of affiliation, I offer the following.

As imprecise as the published numbers are, if workers compensation insurance was abolished, enough new money could be directed to the health insurance pot to fund personal health insurance via managed care networks for all workers.

For the unemployed, a national health insurance program could be funded via a business license surcharge (a la California's Uninsured Employers Fund) administered by the respective state.

Indemnity payments could be made via existing state disability insurance programs and vocational rehabilitation benefits could be placed through community colleges. Dislocated insurance workers could be absorbed into the personal health insurance mainstream.

Finally, permanent disability awards could be eliminated. What is the real difference, anyway, between an arm that was fractured on duty vs. an arm that was fractured off duty?

When workers compensation

was born 80 years ago, our industrial world was entirely different than the one we face today.

The question, then, is: Do we as a nation really want to drag the 19th century notion of workers compensation into the 21st century's global economy?

Bruce A. Lepore
Health and Safety Administrator
East Bay Municipal
Utility District
Oakland, Calif.

NAIL opposes any changes to McCarran

To the editor: Your Aug. 9 editorial supporting "reform" of the McCarran-Ferguson Act is based on an erroneous assumption that House Judiciary Committee Chairman Jack Brooks and Assistant Attorney General Anne K. Bingaman, representing the Clinton administration, are willing to negotiate with insurers on the issue of loss trending.

We have heard nothing during the past few weeks—and over the past year in the case of Rep. Brooks—that would lead us to believe that either are ready to budge on this key issue.

Secondly, the vast majority of insurance companies still oppose any changes to McCarran-Ferguson, as evidenced by the statement of William L. Pollard on behalf of seven major trade associations at the July 29 hearing before Rep. Brooks' Economic and Commercial Law Subcommittee. These trade associations, which include the National Assn. of Independent Insurers, represent about 75% of the insurance business in the United States.

You dismiss our opposition to McCarran-Ferguson changes as "knee-jerk reaction." Far from it. McCarran-Ferguson and alternative "reform" proposals have undergone considerable study.

Our research indicates that McCarran-Ferguson, as it stands today, is consistently the best means for fostering a competitive insurance marketplace (particularly for small and midsize insurance companies) and making available to insurance customers the broadest range of insurance products at affordable prices.

Our analyses also indicate that outright repeal or any changes in McCarran-Ferguson would subject the insurance marketplace to dual government regulation, shrink insurance markets, sap their vitality, stifle innovation, reduce the availability of insurance and increase its costs.

A desire to get the issue behind them has prompted a few groups, a small segment of the industry, to work with backers of the legislation for a compromise.

We do not believe political expediency is a good reason for ditching a 48-year-old system of state insurance regulation that has served us—insurance companies and consumers—so well. So, we will continue to say "no" to any changes.

Jack S. Ramirez
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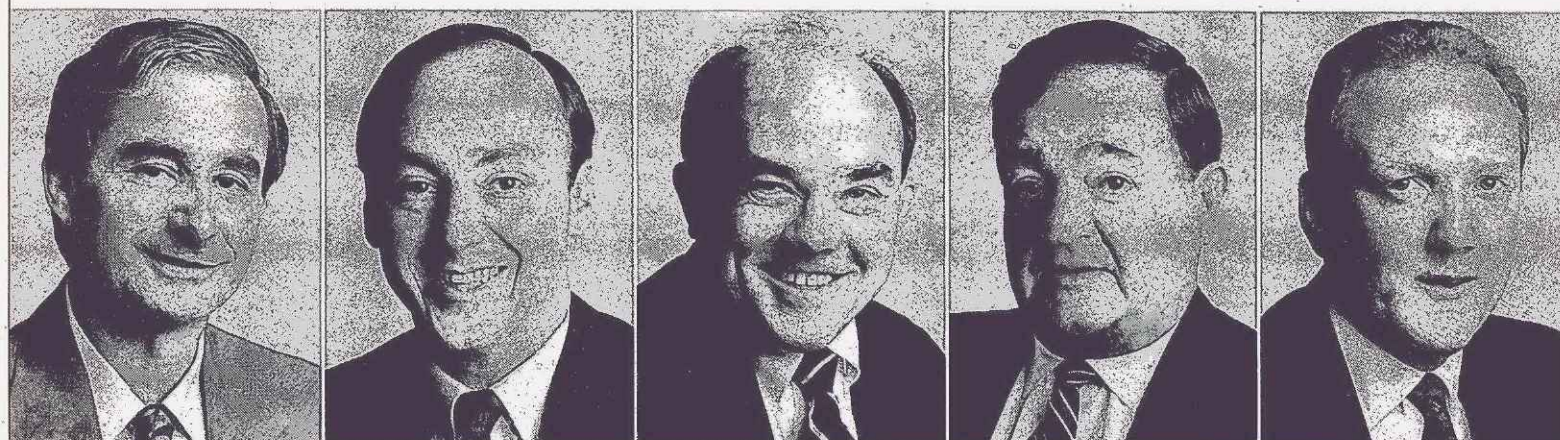
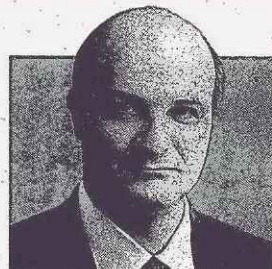
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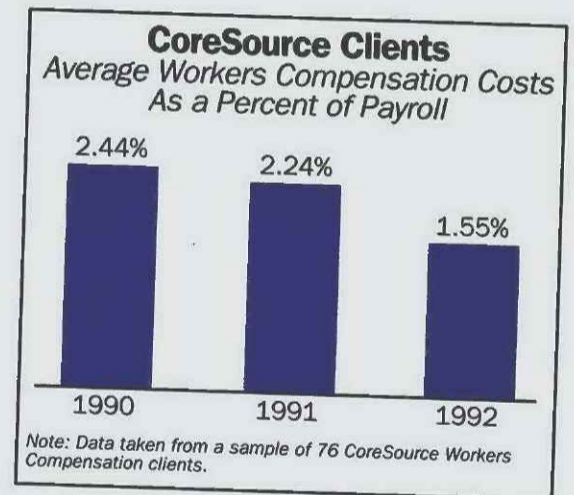
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Healthcare & Workers Compensation Solutions

Navistar sees cost savings down the road

By CHRISTINE WOOLSEY

CHICAGO—After participating in a pilot program designed to enhance quality and lower costs, Navistar International Transportation Corp. is convinced there is light at the end of the health care cost tunnel.

The Chicago-based truck manufacturer's health care burden is as bad, if not worse, than the cost problems plaguing many other U.S. employers. Navistar, which has nearly 14,000 employees, spent about \$16,000 per employee, or approximately \$203 million, on health care in 1992.

Managing these costs is a top priority for Navistar, which until recently provided self-insured health care coverage to employ-

ees and retirees at no cost (*BI*, Dec. 21, 1992; Aug. 3, 1992). Until now, though, the company had resisted establishing discount-based managed care networks for its workers.

"We don't favor discounts off provider charges because even if discounts may decrease our costs for the short term, they won't manage our costs for the long term," said Sylvia Grant Morrison, director of health management and safety in Chicago.

After undertaking a thorough analysis of its health care claims in the late 1980s, Navistar benefits executives realized a fair amount of unnecessary procedures were being performed, some with questionable results, she said. Benefits staff told top

'We believe by driving quality improvement into the process and by developing partnerships with providers, we can work together to improve health care for our people,' says Sylvia Grant Morrison of Navistar.

management that efforts should be made to improve health care quality before considering discounts. "Our cost problems are driven by quality and the amount of care our population receives," Ms. Morrison said.

Shortly after beginning its claims analysis, Navistar in 1989 agreed to participate in a pilot

health care project sponsored by the Midwest Business Group on Health, a coalition of 140 employers and providers in 11 Midwestern states.

As part of this three-year project, Navistar, along with a group of other Chicago-area employers and six area hospitals, implemented a program designed

to improve quality while reducing costs for certain selected medical procedures.

One phase of the project, called the Employers Purchasing Initiative for Quality, involved creating a "critical pathway" to improve the quality and reduce the cost of coronary artery bypass graft operations.

The critical pathway focuses on identifying the best health care practices from admission to discharge and seeks to eliminate duplication of services, needless delays and unnecessary risks.

Given its demographics, Navistar was particularly interested in reducing costs for this procedure. "We don't have a lot of maternities, but we do have a lot of coronary artery bypasses," Ms. Morrison explained.

Cardiovascular experts from participating hospitals developed a critical pathway for the surgical procedure, which has been used by four of the six participating hospitals.

In the first nine months of 1992, following this proscribed course of treatment resulted in a reduction in average length of stay for patients undergoing the procedure to 9.0 days from 11.6 days, said MBGH President Jim Mortimer. That reduction in length of stay resulted in a 5% to 10% decrease in hospital charges for this procedure, he said.

Navistar was able to trim its overall health care costs in Chicago partly as a result of the coronary artery bypass project, according to Ms. Morrison. The company enrolled about one-third of its Chicago workforce in the program, and increases in hospital costs for that group of approximately 7,000 employees, retirees and dependents were 22% less than increases seen in the rest of its workforce, she said.

This and other cost containment programs helped keep the company's health care cost increases below average nationwide in 1992, rising only 9.5%, Ms. Morrison said. Nationwide, health care costs rose 10.1% on average last year, according to a study by A. Foster Higgins & Co. Inc. (*BI*, March 1).

The MBGH project involved only one medical procedure performed on a small volume of people, making it difficult to identify what specific factors elicited the savings, Ms. Morrison noted. However, she added, "We do think our costs are lower because we got involved with providers everywhere and told them what we expect in terms of quality."

Navistar now plans to develop a managed care network as a result of its participation in the MBGH project. The company is seeking bids from a number of Chicago-area managed care companies and will probably contract with one of those firms in 1994, Ms. Morrison said. The vendor Navistar selects, though, will have to abide by the quality-improvement models created by the MBGH project, she said.

"We believe by driving quality improvement into the process and by developing partnerships with providers, we can work together to improve health care for our people," she said.

Navistar may use the savings it gains from a new managed care arrangement to pay for illness prevention programs for its employees, she added. **BI**

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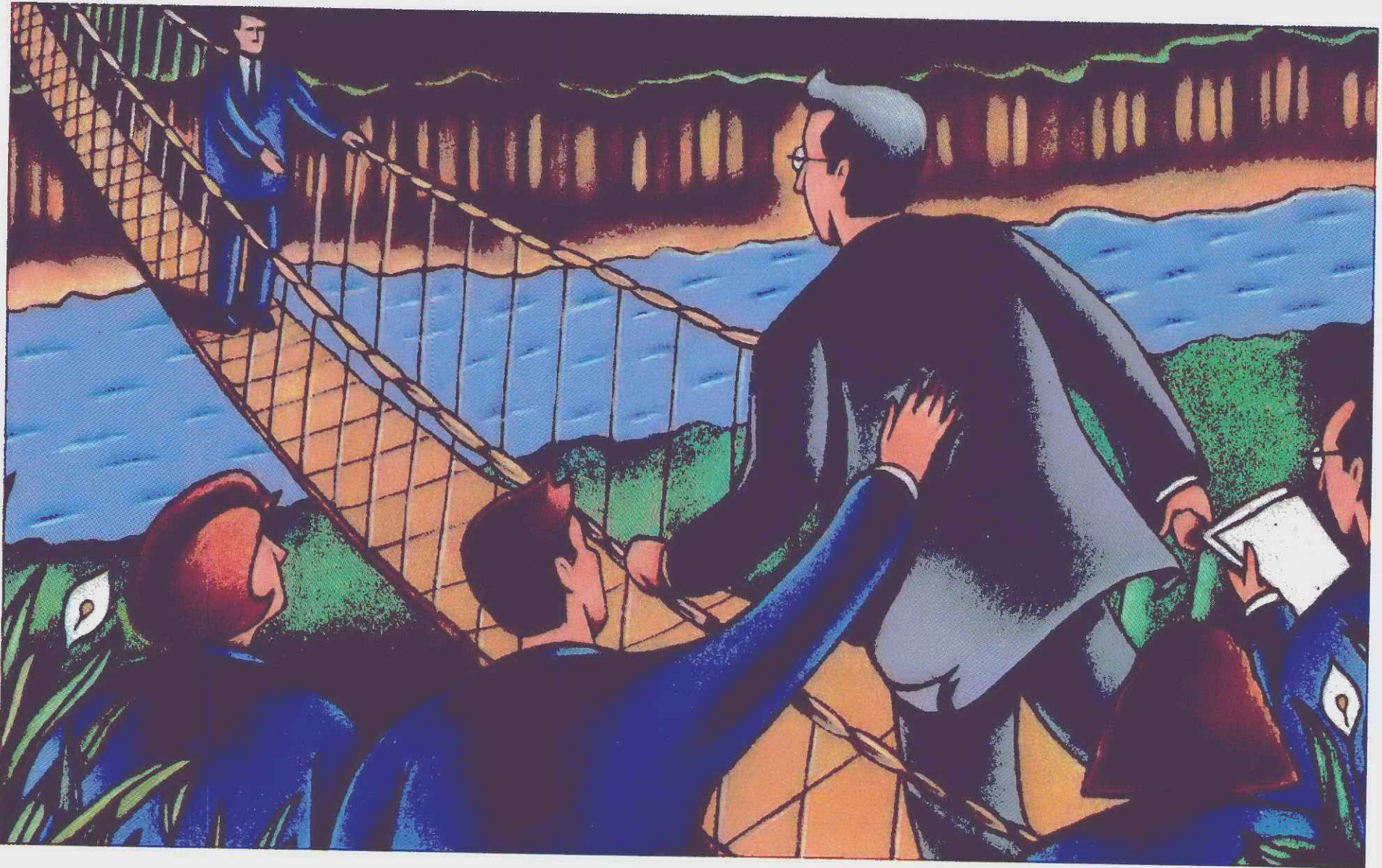
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Court rejects bias claim by overweight applicant

SAN FRANCISCO—Being overweight is not enough to qualify as a disability that is protected by state laws against job discrimination, the California Supreme Court has ruled.

However, excessive weight may qualify as a handicap if there is medical evidence showing it results from a physiological disorder, the court added in its Sept. 2 ruling.

The decision stems from a lawsuit filed by a 305-pound woman who was denied a job as a store clerk in a Santa Cruz, Calif., health food store.

The state Court of Appeal in San Jose had ruled in favor of Toni Linda Cassista's discrimination claim in July 1992, saying it is up to an employer to prove it would not have hired the job applicant even if her weight had not been considered.

But the Supreme Court declined to rule on that issue, finding only that the plaintiff had not established a prima facie case of discrimination against a disabled individual.

"Both judicial and administrative interpretations of the federal statute in which our law is modeled uniformly reject the argument that weight unrelated to a physiological, systemic disorder constitutes a handicap or disability," wrote Justice Armand Arabian for the court.

Cassista vs. Community Foods, S028230, California Supreme Court, Sept. 2, 1993.

Data for Best ratings is for confidential

ELIZABETH, N.J.—Information used to calculate A.M. Best Co. ratings is protected by a New Jersey shield law and the First Amendment, a state court judge ruled in a case involving the spectacular 1991 failure of Guarantee Security Life Insurance Co.

Florida regulators are suing several former officers of the junk-bond-laden insurer, among other defendants, for \$300 million, alleging they misled state officials, policyholders and the Securities and Exchange Commission about the Jacksonville, Fla., insurer's financial health (BI, May 11, 1992; Jan. 6, 1992).

The ratings information dispute arose when Margena Burnett, wife of Mark Sanford, who ran Guarantee Life's investment portfolio, subpoenaed the information in an attempt to prove she had not misled state regulators.

Judge Alexander Menza earlier this month quashed the subpoena by Ms. Burnett on the ground that Best publications are news media and New Jersey law and the First Amendment protect the media from being forced to disclose information sources or documents.

Florida's trial is scheduled for March 1995.

Limitation law upheld for work comp claim

HELENA, Mont.—The Supreme Court of Montana upheld the state's one-year statute of limitations for the filing of a

workers compensation claim by a man with degenerative arthritis in his elbow.

The five-member court unanimously ruled Aug. 5 that the state's Workers Compensation Court correctly dismissed a petition by Samuel J. Grenz of Stevensville, Mont.

Mr. Grenz was working for American Stud Co. in Flathead County, Mont., in 1984 when he injured his right elbow and began what the court described as "a seemingly endless stream of litigation."

The company's workers compensation insurer, Fire & Casualty Insurance Co. of Connecticut in Farmington, paid him disability and medical benefits for the "bumped elbow" until

1991, when the state Supreme Court found that he was not permanently and totally disabled as a result of the elbow injury.

Mr. Grenz, who left his job in 1985, filed a claim in 1991 saying his elbow injury was due to "a series of microtraumas associated with heavy lifting, jarring and vibrations of the machinery" at American Stud Co.

UR firm may merge with disability manager

BOSTON—Peer Review Analysis Inc. has proposed a merger with Core Management Inc.

Peer Review is a Boston-based utilization review firm, and Core Management is a privately held workers compensation disability program manager in Los Angeles.

If the proposed merger is completed, Peer Review shareholders

will own 55% of the new company, and Core Management shareholders will own 45%. Combined revenues will exceed \$17 million, the companies said.

Core Management was spun off from Baxter International Inc.'s Health Data Institute in 1990.

Core Chief Executive George Carpenter, who led the Baxter buyout, will be CEO of the combined company, to be headquartered in Boston. Alfred B. Lewis, president and CEO of Peer Review, will remain responsible for Peer Review's operations.

Injury at home/office compensable: Court

HARTFORD, Conn.—A Connecticut Appeals Court decision may broaden the scope of workers compensation protection for home-based workers.

The court last week ruled 2-to-

1 that a fatal heart attack a home-based salesman suffered after shoveling snow from his driveway so he could drive to sales calls was work-related. The salesman, 45-year-old Richard Tovish of Monroe, Conn., worked from his home for Gerber Electronics Inc. in Norwood, Mass.

In his dissent, Judge Edward Y. O'Connell said Mr. Tovish "was not engaged in a work activity, but rather, in a preliminary activity in preparation for work."

However, testimony showed that he had begun his workday in his basement office and was wearing business clothes when he shoveled his driveway in January 1987.

"If the Workers Compensation Act is to be extended to cover such activities (as snow shoveling), the extension must be ac-

Continued on next page



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Continued from previous page
 accomplished by legislation and not by a workers compensation commissioner," the Judge O'Connell added.

Gerber and its insurer, The Home Insurance Co., plan to appeal to the Connecticut Supreme Court.

The decision entitles Mr. Tovish's widow, Maureen C. Tovish, and two minor children to survivor's benefits since his death, starting at \$292 per week with cost-of-living increases.

OIL boosts limits of property policy

HAMILTON, Bermuda—In an effort to simplify its insurance offerings and balance premiums paid by its 48 members, Oil Insurance Ltd. is increasing the limits of its basic policy and making some optional coverages

mandatory.

OIL is boosting its basic property policy limits to \$200 million from \$150 million, and eliminating the optional \$50 million layer of excess coverage. Both changes are effective Jan. 1, 1994.

In addition, OIL will make restoration and redrilling coverage part of the basic coverage instead of optional.

"All in all, we're offering the same aggregate limits as before and we should collect roughly the same premiums next year as this year," said K. Doyle Stephens, president and chief executive officer. Mr. Stephens said OIL will collect about \$250 million in premiums from its members in 1994.

The change in policy limits and options was agreed on last week by OIL's shareholders to simplify the policy and create more uniform premiums among members,

he said. Mr. Stephens said the changes are not directly designed to improve OIL's underwriting results. Last year, OIL posted a combined ratio of 147%, mostly due to the explosion of the La Mede oil refinery near Marseilles, France (*BI*, Nov. 16, 1992).

Michigan enacts tort reform package

LANSING, Mich.—Michigan Gov. John Engler recently signed a tort reform package that, among other things, caps non-economic damages for malpractice cases.

Public Act 78, approved by the Michigan Legislature earlier this summer, caps non-economic damages at \$280,000 for most cases.

Caps are set at \$500,000 for cases involving brain or spinal

cord injury leading to permanent loss of limb function, for injuries resulting in severely and permanently diminished mental capacity, or for injuries to reproductive organs that result in infertility.

The law also imposes stricter guidelines on who may serve as an expert witness in medical malpractice trials.

For example, to qualify as expert witnesses, individuals must spend the majority of their professional time to either active clinical practice or instruction in an accredited school or residency program in the same health profession in which the defendant is licensed.

Quake, fire projections foresee huge losses

Large earthquakes and resulting fires along five of the West

Coast's major faults and the Midwest's New Madrid fault present exposures of up to \$168.9 billion in insured losses to commercial and residential property, research shows.

The projections were developed by Risk Engineering Inc. of Boulder, Colo., and EQE International Inc. in San Francisco. Their estimates are based on temblors of the following Richter scale magnitudes: 7.8 on the northern San Andreas fault, which would produce \$38 billion in losses; 7.1 on the Hayward fault, \$17.1 billion; 6.8 on the Newport-Inglewood fault, \$21.1 billion; 7.7 on the southern San Andreas fault, \$23 billion; 7.6 in the Seattle fault zone, \$12.6 billion; and 7.75 on the northern extension of the New Madrid fault, \$36.1 billion.

Resulting fires after earthquakes would cause an additional \$21 billion in damages, according to the estimates.

The research was distributed by the Insurance Information Institute for the National Committee on Property Insurance.

Information in brief

Heritage Life Insurance Co., a unit of Quaker State Corp., will appeal an Orange County, Calif., superior court ruling requiring Heritage to pay \$19.3 million in damages to the owners of Wescall Credit Insurance Agency, which was Heritage's managing general agent from 1984 to 1990. . . The state of Minnesota reached an out-of-court settlement with two insurers that will result in the rebidding of a contract to administer the state's **workers comp assigned risk plan**. The two insurers—Berkley Administrators and Wausau Insurance Co.—sued the state earlier this year over the awarding of the contract to Blue Cross & Blue Shield of Minnesota (*BI*, Feb. 15). . . **Primedex Health System Inc.** will close the workers comp clinics of its Primedex Corp. subsidiary in Southern California as a result of recently enacted workers comp reform (*BI*, July 26). The clinics provided medical-legal evaluations, which were restricted in the new legislation. . . UniCare Financial Corp., parent of California workers comp insurer **UniCare Insurance Co.**, has filed a registration statement for an offering of up to 1.25 million shares. . . The **Pension Benefit Guaranty Corp.** has awarded a \$2.6 million contract to HSF Inc. of McLean, Va., to modernize its system for billing and collecting the \$900 million employers pay annually to the agency in pension termination insurance premiums. . . **Ford Motor Co.** will pay a \$750,000 fine and improve its workplace accident reporting to settle citations by the Occupational Safety and Health Administration. . . The National Council on Compensation Insurance is calling for overall **workers comp rate increases** in Virginia of 17.5% in the voluntary market and 25.9% for assigned risks. . . **Premier Hospitals Alliance Inc.**, based in Westchester, Ill., will enter into a partnership program with Central Clinical Hospital at Kuntsevo in Moscow. Among the partnership's goals is to help the Russian medical center create managed care programs to offer American businesses with Moscow operations. . . **California Insurance Group** has agreed to pay \$500,000 and implement reforms, including anti-discrimination training of its staff, to settle redlining allegations brought by the state Insurance Department (*BI*, July 19). **BI**



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By JUDY GREENWALD

Xerox Corp. wins quick regulatory approval for restructuring

BASKING RIDGE, N.J.—Xerox Corp., the parent company of Crum & Forster Inc., is ready to dispose of Crum & Forster's insurance operations now that the operations' recapitalization and legal restructuring into seven stand-alone units has received regulatory approval.

The company says its plan has now received the approval of the insurance departments of all states in which Crum & Forster companies are domiciled.

Xerox said late last year it would realign Crum & Forster's operations into specialized units, with each focusing on specific market segments (BI, Dec. 21, 1992).

Until that point, all these businesses' capital had been pooled, along with those of discontinued operations and those in runoff.

A month later, Xerox said it planned to shed its remaining financial services businesses, including insurance, to focus on its core document-processing businesses (BI, Jan. 25).

Constitution Reinsurance Corp. and Viking Insurance Co. of Wisconsin, a non-standard personal auto insurer, were already stand-alone operations of Crum & Forster, which has been renamed Talegen Holdings Inc. The other units are:

- Coregis Group Inc., an un-

derwriting manager that specializes in professional liability, public entity and other property/

'The potential confusion as to what was going on has now been removed,' says Best's Mr. Snyder.

casualty programs (BI, Aug. 16).

- Crum & Forster Insurance, which writes commercial property/casualty insurance through a network of independent

agents.

- Industrial Indemnity Co., which specializes in workers compensation coverages and services.

- The Resolution Group, which is involved in reinsurance collection services and the management of runoff businesses.

- The Westchester Specialty Group, which includes the London Agency and Industrial Underwriters Inc., and specializes in umbrella, excess casualty and special property business.

Xerox Financial Services Inc., Crum & Forster's immediate parent, is contributing an additional \$235 million in cash and \$100 million in notes to Talegen to fa-

cilitate the restructuring.

In addition, another Xerox unit, Bermuda-based Ridge Reinsurance Ltd., will provide excess-of-loss reinsurance protection for installment premiums of \$32 million each year, plus related financing charges, which will be payable by Xerox Financial.

Talegen has increased the statutory surplus of the seven insurance groups to more than \$1.8 billion from \$1.6 billion at year end, a Talegen spokeswoman said.

Asked if there were any ongoing discussions concerning the units' sale, the spokeswoman responded: "I think it's fair to say the approval of the restructuring into these stand-alone units greatly facilitates our ability to have meaningful discussions with potential investors, so that as far as we're concerned, we're basically entering a new phase."

However, she added, "It may take several years to complete the disengagement."

The spokeswoman said she would not speculate on whether Talegen would spin off any of the units into public companies or what it would do if it could not find buyers for all the units.

"We intend to replace Xerox ownership in the Talegen operations. We're exploring all the options that may be available to do that," she said.

A spinoff is a possibility, said Michael Morrissey, a principal with Firemark Consultants Inc. in Parsippany, N.J.

"There are a lot worse companies that are in the public realm and whose stocks have actually done decently over the past year or so. If they're going to do it, this is the time," Mr. Morrissey said.

Mr. Morrissey also noted that "they've got some units that are clearly attractive to potential buyers," including Constitution Re, Viking, Coregis and the London Agency.

Other pieces of the business, including Crum & Forster Insurance, which has been affected by the soft market, hold less appeal, he said.

According to Charles Ronson, an analyst with Balestra Capital in New York, "It's still going to be a rough sale, and it's still going to be a sale where they're going to have to dish out lots of reinsurance guarantees and guarantees on reserves and reinsurance collectibles. Obviously, they need that."

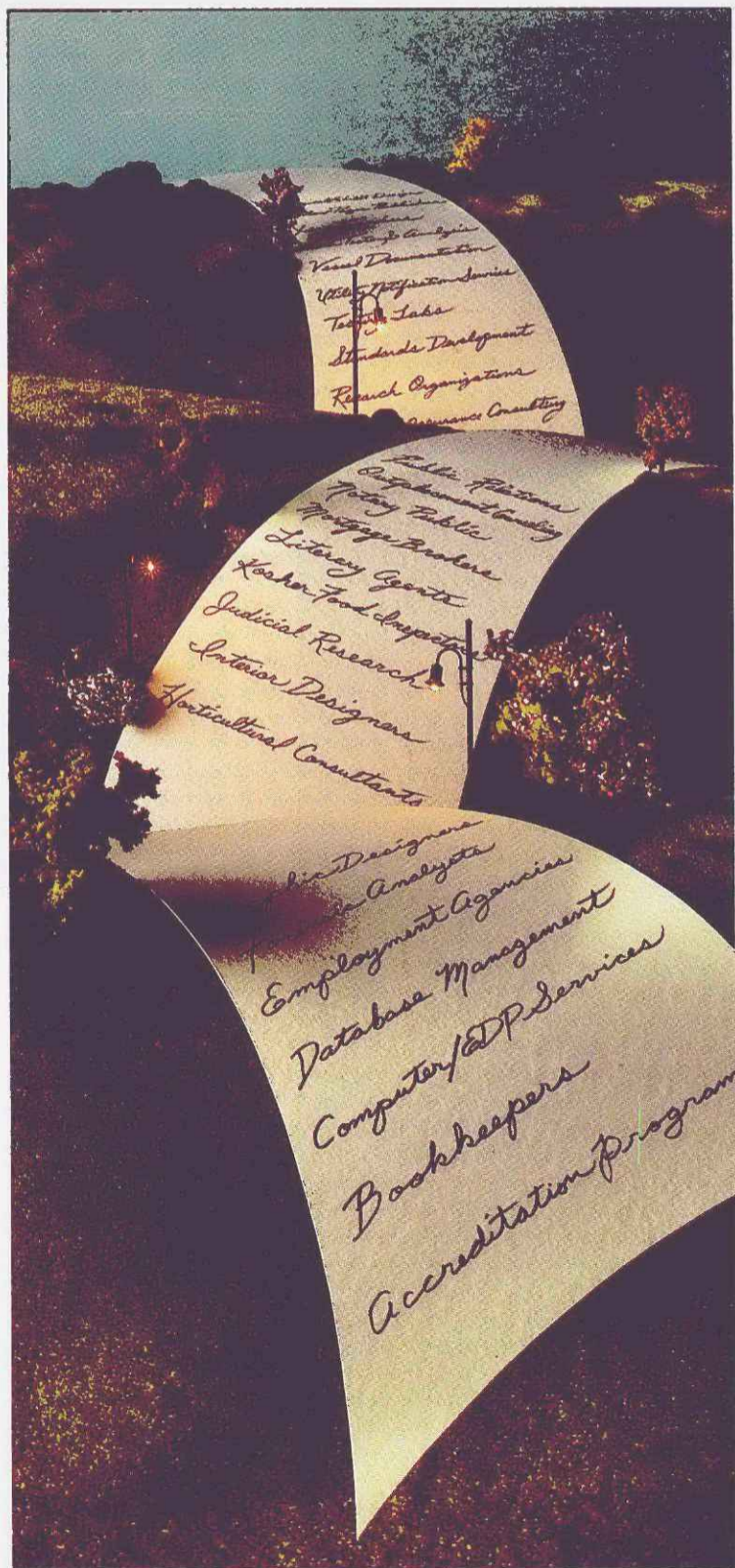
Observers praised Talegen's success in obtaining regulatory approval for its plan relatively quickly.

"I think that it's somewhat remarkable that it got done," said Russell R. Miller, chairman of insurance industry investment banker Russell Miller Inc. in San Francisco.

The regulatory approval is a "nice milestone" because "the potential confusion as to what was going on has now been removed," said John H. Snyder, senior vp at A.M. Best Co. in Oldwick, N.J. "There was a rush to get it done for that reason alone."

The Talegen spokeswoman explained that the name Talegen was derived from the words "talent" and "generate." The significance of that derivation is that "the talents of our people will generate value for our owners," she said. **BI**

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The Dyson-Kissner-Moran Corporation**Conning & Company****Coverage dispute***Continued from page 2*

Hanks and its insurers handled the case, observed policyholder attorney Scott Gilbert, a partner with Covington & Burling in Washington, who was not involved in the litigation.

The coverage dispute stems from the libel award that a state court jury in Texas ordered KENS-TV in San Antonio to pay Dr. Sudhir Srivastava.

The jury found in April 1990 that the TV station, a unit of Harte-Hanks, libeled the surgeon in 1985 news reports questioning the doctor's professional competence (*BI*, April 30, 1990).

The \$31.6 million award included \$17.5 million of punitive damages, which are insurable in Texas.

San Antonio-based Harte-Hanks had \$52 million of liability insurance. The first \$2 million was written by Continental Casualty Co.

The next two \$5 million layers were written by insurers that later became insolvent: Mission Insurance Co. and Western Insurance Co.

Columbia Casualty Co. and Hudson Insurance Co. jointly wrote the next \$10 million layer excess of \$12 million.

And Federal, a Warren, N.J.-based unit of Chubb Corp., wrote \$30 million of coverage excess of

\$22 million.

After the award, Harte-Hanks and its solvent insurers posted a bond with the court so they would not have to pay the judgment while they appealed. Harte-Hanks and the insurers also agreed that the insurers' reservations of rights would be preserved during the appeal process.

Federal earlier had said Harte-

Federal has no duty under Harte-Hanks' policy to drop down and cover any portion of a loss that is less than \$22 million.

In addition, the court rejected the doctor's argument that Federal acted in bad faith by not participating in settlement negotiations. "Federal's decisions were supported by reasonable bases at the time they were made," it ruled.

'The circuit court seemed annoyed at the facts of the case,' particularly the way the settlement was reached and the abandonment of appeal, says policyholder attorney Scott Gilbert, a partner with Covington & Burling in Washington.

Hanks gave the insurer late notice of the doctor's claim.

Dr. Srivastava then offered to settle the jury award for \$21 million, but Federal refused to participate in the negotiations because the offer fell below its attachment point.

In what many insurer and policyholder attorneys consider an unusual and clever attempt to force Federal to drop down and contribute toward the settlement, the doctor reached only a partial settlement with Harte-Hanks and its other solvent insurers.

Dr. Srivastava agreed to accept \$8.5 million from them, including about \$3.5 million from Harte-Hanks to cover the limits its insolvent insurers wrote. Continental contributed its full policy limits of \$2 million, and Columbia and Hudson together contributed \$3 million.

But, the doctor retained the right to collect from Federal the \$9.6 million that the insurer would have been obligated to pay under the \$31.6 million jury verdict.

Federal demanded that Harte-Hanks continue to appeal the jury award.

But, the insurer balked at the media company's request for Federal to substitute its own counsel and unequivocally acknowledge its obligation to pay \$9.6 million if an appeals court affirmed the award.

Harte-Hanks rejected the insurer's offer to pay its attorneys fees subject to future arbitration.

The appeal was subsequently dropped, and the bond was terminated in April 1991.

In litigation that Federal filed in federal court in Texas, the court ruled that because of the settlement, the insurer was not obligated to pay its share of the jury award to the doctor.

Dr. Srivastava appealed, and the 5th Circuit panel affirmed the lower court's ruling.

The 5th Circuit panel's decision, written by Judge Patrick E. Higginbotham, rejects the doctor's contention that Harte-Hanks' final loss was the \$31.6 million jury award and that the settlement exhausted Harte-Hanks' first \$22 million of coverage.

"Harte-Hanks' loss is determined by the actual value of the settlement with Srivastava—which includes both the amounts payable by the settling parties and the unextinguished portion of the judgment," or the \$9.6 million that the company would have sought from Federal to pay the jury award.

That total amount "does not reach the threshold of Federal's excess policy," the court ruled.

The panel also concluded that

If the doctor loses on appeal to the full 5th Circuit and does not pursue the case further, he cannot recover the \$9.6 million from Harte-Hanks or its other insurers.

Insurer and policyholder attorneys were less surprised by the ruling than by how the settling parties tried to force Federal to drop down and participate in the settlement.

"The (jury award) settlement that the plaintiff made with the defendants was kind of cute," observed insurer attorney David Spector of Mayer, Brown & Platt in Chicago.

Insurer attorney Stuart Cotton, a partner with Mound, Cotton & Wollan in New York, agreed. But the doctor "took a gamble" and lost, he said. The doctor "overrelied on the prejudice that courts generally have against insurers," Mr. Cotton said.

Noting that Federal had coverage questions, Mr. Cotton said, "I think what the court really did here was to say it would not permit an insured or a claimant to maneuver a case to prevent the insurer from fighting a coverage question."

Attorneys also said the court seemed concerned that Harte-Hanks let the appeal of the jury award drop.

"To me, there's an element here of Harte-Hanks leaving Federal hanging out there," said policyholder attorney Bill Boyd of Brobeck Phleger & Harrison in San Francisco. "Certainly, there's a flavor to it that Harte-Hanks wasn't being fully cooperative in just letting the appeal go."

"The circuit court seemed annoyed at the facts of the case," particularly the way the settlement was reached and the abandonment of appeal, said policyholder attorney Mr. Gilbert.

But, Federal elected not to appeal the award and offered little to Harte-Hanks to do so, said Dr. Srivastava's attorney, James Branton, a partner with Branton & Hall in San Antonio.

For plaintiffs and policyholders, the case underscores the importance in buyout settlements of determining the settlement's "effect on their ability to get to excess coverage," Mr. Gilbert said.

The case also highlights the importance of pursuing coverage from insolvent insurers through guaranty funds or the liquidation process, Mr. Gilbert said.

Federal's attorneys did not return phone calls.

Federal Insurance Co. vs. Sudhir Srivastava, M.D., et al., 5th U.S. Circuit Court of Appeals; No. 92-8342.

1 Of Every 10 Hospital Workers Is Injured On The Job

- Bureau of Labor Statistics, U.S. Dept. of Labor, 1990

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Award judges

Continued from page 3
second year, representing the academic community.

- Thomas E. Bell Sr., director of risk management for the Middle Cities Risk Management Trust in East Lansing, Mich. Mr. Bell was named to the 1993 Risk Management Honor Roll, representing self-insurance pools.

- Peter S. Christie, chairman and chief executive officer of Minet Group P.L.C. in London. Mr. Christie is serving on the panel for the first time, representing a global broker.

- June Dickinson, vp/risk manager at SunTrust Banks Inc. in Atlanta. Ms. Dickinson was named to the 1993 Risk Management Honor Roll, representing financial institutions.

- Richard C. Heydinger, director of risk management for Hallmark Cards Inc. in Kansas City, Mo. Mr. Heydinger was the 1993 Risk Manager of the Year.

- David Hoskins, president, Andreini & Co. of San Mateo, Calif. Mr. Hoskins is serving on the panel for the first time, representing a regional broker.

- Robert A. Mulderig, chief executive officer of Mutual Risk Management Ltd. Mr. Mulderig is serving on the panel for the first time, representing a stock company.

- William D. O'Connell, partner and national director of business insurance consulting for Deloitte & Touche in Dallas. Mr. O'Connell is serving on the panel for a second year, representing risk management consultants.

- James I. Taylor, president of Pennsylvania National Insurance Cos. in Harrisburg, Pa. Mr. Taylor, who also is serving on the panel for a second year, represents mutual insurance companies.

"These are highly talented leaders who have agreed to score the nominations for the 1994 Risk Manager of the Year and Risk Management Honor Roll," said Kathryn J. McIntyre, publisher and editorial director of *Business Insurance*.

"It is a substantial commitment of time on their part to the risk management community, for which we are very grateful," she added.

The judges score each of the candidates on 10 criteria (see box). The candidate with the highest score after the judging is completed is named Risk Manager of the Year. Then, the remaining nominees are separated by employment category:

- Corporations with sales exceeding \$300 million.
- Corporations with sales of less than \$300 million.
- Government entities.
- Tax-exempt or non-profit institutions.
- Financial institutions.
- Self-insurance funds and pools.

The highest-scoring candidate in each of the categories not represented by the Risk Manager of the Year is named to the Risk Management Honor Roll, subject to the judges' discretion. As many as five other nominees can be named to the Risk Management Honor Roll.

The 1993 honorees will be announced in the April 18, 1994, issue of *Business Insurance*, which will coincide with the annual Risk & Insurance Management Society Inc. conference to be held in New Orleans, April 17-22.

A candidate need not handle risk management functions full time, but he or she must be a full-time employee of the organization for which he or she directs the risk management program.

A candidate can be nominated by anyone familiar with the candidate's work. For example, any employee or group of employees may nominate

the organization's risk manager. A broker, insurer, consultant or some other service supplier can nominate a client. And, a risk manager can nominate a colleague. Nominations of risk managers based anywhere in the world are invited.

In addition to the completed nominating forms outlining the candidate's accomplishments, each nomination must include a letter from the sponsor nominating the candidate and a letter of endorsement by an executive of the candidate's organization, who may be the candidate's superior or any higher officer. The letter must certify the accuracy of the information submitted in the nomination.

All nominations will be kept in the strictest confidence, with only the honored candidates' names announced.

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publication, to recognize outstanding achievement in the field.

The Risk Management Honor Roll was created in 1981 to recognize

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To request a nomination form,

contact Karen Brown, Assistant to the Publisher, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611-2590; 312-649-5319.

Judging criteria for 1994 Risk Manager of the Year

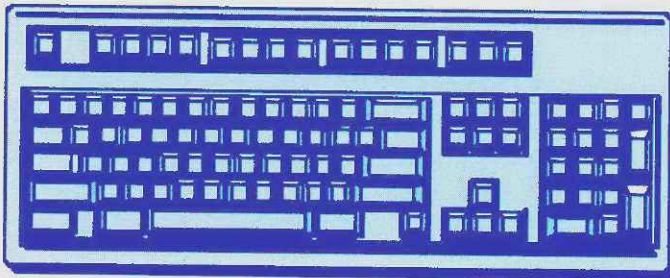
Ten criteria are used to score the nominations submitted for the *Business Insurance* Risk Manager of the Year Award and Risk Management Honor Roll.

The 10 independent judges of the nominations score each candidate on how well he or she:

- Established and implemented an effective risk management program within the organization.
- Tackled and solved one or more major problems for his or her organization.
- Innovatively applies the diverse tools of risk management and insurance.
- Creatively and effectively uses the insurance markets to structure an insurance program that serves the needs of the organization.
- Established a workable intelligence system

inside and outside the organization, culminating in a flow of information about events and activities that affect the organization's risk management and insurance.

- Skillfully performs the functions of management in the overall organization and within the risk management/insurance department.
- Achieves the most effective program at the optimum cost over the long term.
- Developed technical expertise in any or all of the broad categories included within risk management, leading to a better managerial grasp of the operations aspects of the job.
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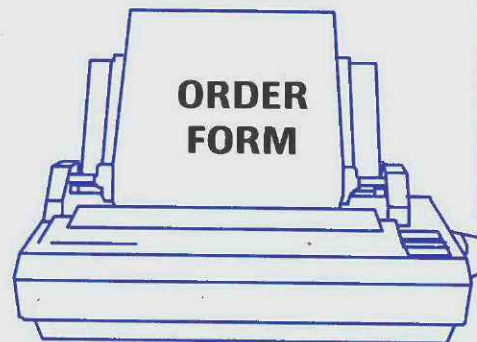
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Business Insurance

Broad cleanup cover ordered

Ruling relies on continuous trigger theory, favors policyholder

By MICHAEL SCHACHNER

SAN FRANCISCO—In the first environmental liability insurance coverage lawsuit to go to trial in San Francisco County, a trial court has ruled that costs associated with cleaning up unintended gradual pollution are covered from the time pollutants are released up to removal or abatement of the contaminant.

The recent ruling by a California Superior Court judge favors Horsham, Pa.-based Aydin Corp., as well as numerous other policyholders that have suits pending against their insurers in San Francisco County for pollution liability coverage, according to Aydin's lawyer.

As a result of the July 29 ruling, Aydin can tap up to \$10 million in excess liability coverage written in 1980 and 1981 by First State Insurance Co. to defray the \$10 million to \$20 million cost of removing polychlorinated biphenyls and other toxic solvents from soil and groundwater around a Palo Alto, Calif., manufacturing site that belongs to Stanford University.

Other liability insurers settled with the midsize manufacturer of telecommunications and electronic equipment before a final verdict was rendered.

This case stemmed from a 1986 cleanup order by the California Department of Toxic Substances Control. Aydin submitted claims for coverage of its cleanup costs to each of its insurers that wrote

varying primary and excess liability limits for the company between 1968 and 1984 but coverage was denied.

In addition to First State, Aydin's insurers included: three units of Commercial Union Insurance Co. that wrote between \$50,000 and \$500,000 in primary liability coverage between 1968 and 1979; National Union Fire Insurance Co. of Pittsburgh, Pa., which wrote \$1 million in primary coverage from 1980 to 1984 as well as \$10 million in excess coverage from 1982 to 1984; and U.S. Fire Insurance Co., which wrote \$5 million in excess coverage from 1972 to 1976.

Among other things, the insurers argued the pollution was grad-

ual and intentional, thus voiding coverage. They also rejected Aydin's contention that all of its liability insurers during the relevant period should be liable for cleanup costs.

However, during the first phase of a two-phase trial, the California Superior Court determined the trigger for coverage is continuous.

Under the continuous trigger theory, if injury or damage is continuous or progressive throughout successive policy periods, coverage is triggered under all of the policies in effect for relevant time periods.

The court also ruled that the word "sudden" as it is used in the standard pollution exclusion applies to the commencement of pol-

lution and does not require that property damage or bodily injury caused by the pollution occur quickly to be insured. And the court placed the burden of proving that pollution did not occur suddenly on the insurers.

In addition, the court rejected insurers' argument that the "owned property" exclusion contained in all of Aydin's liability policies barred coverage of damage to its own property. The court ruled the exclusion did not preclude coverage if the cleanup was ordered to protect third-party property damage. The court also granted Aydin cleanup coverage under each policy's personal injury clause, which is triggered by an invasion or wrongful entry; in this case, pollution seeping into groundwater and potentially causing damage to third-party property.

After these issues were determined in the first phase of the trial,

Aydin settled its claim with National Union for about \$4.5 million, said Donald Brown, of Brobeck, Phleger & Harrison in San Francisco, which represents Aydin.

Mr. Brown said Aydin's subsequent settlements with the Commercial Union companies and U.S. Fire are confidential.

First State chose not to settle and the case moved on to the second phase, during which the court determined that First State's policies were liable under the continuous trigger theory and that Aydin's pollution was neither expected nor intended.

A jury then ruled that First State failed to prove the pollution was not sudden or accidental as defined by the court and that Aydin was ordered to clean up its site to protect third-party property.

"This is the first case of its type to go to trial in San Fran-

Continued on next page

Coverage denied in gas explosion

PHILADELPHIA—Property damage resulting from an explosion that stemmed from the gradual leak of methane gas does not qualify as an insurable personal injury, a Pennsylvania appeals court ruled earlier this month.

The Superior Court of Pennsylvania on Aug. 3 ruled in *O'Brien Energy Systems Inc. vs. American Employers Insurance Co.* that methane gas that gradually escaped from a landfill outside Philadelphia, subsequently causing an explosion on neighboring property, was not equivalent to a "wrongful entry or eviction or other invasion of the right of private occupancy." Thus, it is not an insured personal injury under terms of standard comprehensive general liability policies, the court ruled, affirming a lower court's decision.

In addition, the court said coverage for damage caused by the explosion was barred by the standard pollution exclusions contained in the policies because the gas leakage and explosion did not occur suddenly and accidentally.

As a result of the ruling, O'Brien Energy Systems Inc., a local methane gas extractor hired by Montgomery County, Pa., to extract gas from a landfill site the county was leasing from SmithKline Beecham Corp., cannot tap its numerous CGL policies written by various insurers in the 1980s.

—By Michael Schachner

HMO

Indemnity

New Russian health insurance venture

Continued from previous page
cisco County," said Mr. Brown. "There are about 12 others pending that are very similar. We have the Shell Oil case out here, but that was in San Mateo County" (BI, Jan. 25; Dec. 26, 1988).

Don Joseph, of Siff Rosen & Parker in New York, which represents First State, declined to comment.

Mr. Brown said First State could seek a retrial and then file a motion to appeal.

The California Supreme Court is expected to review a continuous trigger ruling in another pollution case in California, *Montrose vs. Admiral* (BI, March 8; March 9, 1992).

•
Aydin Corp. vs. American Employers Insurance Co., et al, San Francisco County Superior Court, No. 857826.

MOSCOW—Russia has licensed a new insurer formed by an Illinois company that plans to develop a health care delivery system there patterned after the Blue Cross/Blue Shield system.

The insurer, American-Russian Plus, initially will focus on health insurance-related activities but eventually will also develop commercial property/casualty insurance products, according to Michael Burack, a principal and vp in Chicago with InPharma Inc.

The year-old InPharma holds a 49% stake in ARPlus, which Mr. Burack expects will be capitalized at \$3 million. The remaining stake is held by U.S. and Russian interests, including some small Russian insurers.

Under an agreement with a Rus-

sian insurance industry association, ARPlus will serve as an intermediary for Russian health insurers that provide health care benefits to business. ARPlus will collect the government taxes that businesses will be required to pay to cover the cost of mandatory medical benefits under Russia's new health care system.

The move to privatize the health care system and require private employers to offer a minimum package of health benefits began in the former Soviet Union. Since the break up of the Soviet Union, Russia has been implementing its own health care reforms.

Private employers in Russia now are required to pay a payroll tax of between 3% and 5% to fund health benefits for all citizens. Employers

can choose to either have the government provide the benefits for its employees or to purchase their own private group health coverage.

The insurer also will handle claims administration and actuarial work for Russian health insurers, said Mr. Burack, who also is president of MRM Group Inc. Chicago-based MRM is a third-party administrator, consultant and designer of captive insurance, self-insured health, disability, long-term care and supplemental insurance programs for companies and associations nationwide.

ARPlus also plans to develop and write supplementary hospitalization, disability and long-term care insurance for Russian citizens.

The insurer already has contracted with the Kremlin System,

a group of nine hospitals, to provide managed care services. Mr. Burack said the insurer and hospital system will operate "similar to an HMO arrangement."

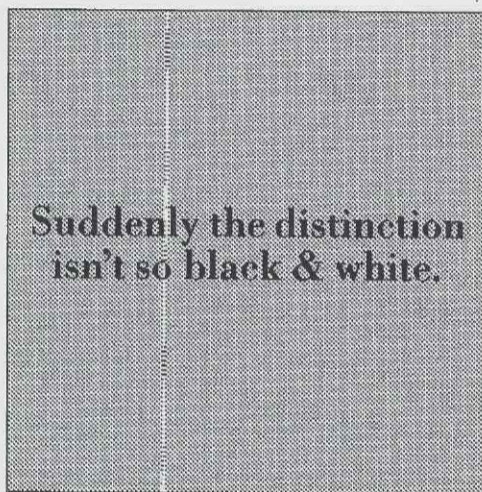
InPharma also is negotiating with producers of generic pharmaceuticals and medical equipment to develop those industries in Russia. "We want to start Blue Cross/Blue Shield all over again," Mr. Burack said.

Mr. Burack expects that Russia's demand for commercial property/casualty insurance will ignite next summer, when he expects that most of the privatization of business will be completed.

ARPlus is "getting closer" to obtaining reinsurance, Mr. Burack said. Underwriters at Lloyd's of London and some German market reinsurance companies "have expressed an interest" in reinsuring ARPlus, he said, refusing to elaborate.

Mr. Burack expects the new insurer will have a staff of about a dozen within a year. Most will be Russians that will be trained by MRM.

—By Dave Lenckus



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September schedule for insurance show

Several insurance-related topics will be addressed this month on the cable television program "The Premium Dollar Today."

The half-hour show, which airs every Thursday at 6 a.m. EST on the USA Network, addresses a variety of issues in the insurance industry.

The remaining schedule for September follows:

- Sept. 16: "Accelerated Death Benefits," with panelists Stephen Kraus, chief counsel-pensions for the American Council of Life Insurance; Per Larson, a financial adviser for the seriously ill; and Robert P. Hill, executive vp-individual insurance at Prudential Insurance Co. of America.

- Sept. 23: "Unlicensed Insurers," with panelists Robert B. Angle, president of the National Assn. of Professional Surplus Lines Offices Ltd.; David B. Simmons, executive vp of the National Assn. of Insurance Commissioners; and Thornton R. Land, senior vp and general counsel of Selective Insurance Group Inc.

- Sept. 30: "How to Buy Property/Casualty Insurance," with panelists Sean Mooney, senior vp and economist for the Insurance Information Institute; Courtney Wood, president-elect of the Independent Insurance Agents of America; and Jack Snyder, senior vp of A.M. Best Co.

"The Premium Dollar Today" is produced by Reliance National Insurance Co. and is co-sponsored by the Society of Chartered Property & Casualty Underwriters, KPMG Peat Marwick Financial Services and A.M. Best Co.

Business Insurance and the American Council of Life Insurance provide special editorial assistance.

Protecting employees from workplace violence

By MARK A. HOFMANN

WASHINGTON—As the type of violence associated with the nation's meanest streets enters its office towers, corporate security officials find themselves under increased pressure to protect personnel against physical harm and their employers against financial harm.

The task is made more difficult by the fact that no one can determine with certainty which employee or disgruntled customer is going to turn violent, said Roy N. Bordes, president of Bordes Group Inc., an Orlando, Fla.-based consultant.

"We can't run a beam through somebody's head" to identify potentially violent employees, observed Mr. Bordes.

But, he added, those officials responsible for corporate security can learn to watch for several specific warning signs that might indicate an employee could become violent.

Mr. Bordes offered his advice during an address on "Working in the 'Kill Zone'" at the American Society for Industrial Security's 39th annual seminar in Washington last month.

Mr. Bordes recited a bloody litany of recent workplace killings in California, Florida and Texas. One of these was a mass shooting in a Jacksonville, Fla., branch office of an automobile financing company. The gunman, upset over a contractual dispute, killed nine people before killing himself.

Ironically, it was learned after the session that only minutes before Mr. Bordes began his address, an armed employee walked into a suburban Washington, D.C., office and killed a co-worker before turning the gun on himself.

Mr. Bordes said the Jacksonville incident represented a combination of factors that a security officer cannot overlook in assessing a facility's safety.

For example, the open layout of the office made it easy for the gunman to kill so many people, he explained.

In addition, survivors' suits against the company showed that employees had filed memoranda expressing fears for their safety, and the home-office corporate security team had critiqued the office's security operations and recommended changes. Yet local managers took no action.

Mr. Bordes said that the reason for the lack of response won't be known until it is revealed in court, if the suits aren't first settled out of court.

But he said in similar cases the reasons have been simple: Such an attack hadn't happened before, and the cost of upgrading security would have to come out of the local office's budget.

He cautioned his audience that even experts can't always say why a given person snaps and begins shooting.

But potentially violent people are marked by several characteristics, he said.

According to Mr. Bordes, middle-age white males are often the perpetrators of workplace violence, as are bitter, dissatisfied people. Individuals who are suffering from depression or are potentially suicidal may also be perpetrators, Mr. Bordes said.

Other types of individuals cited

by Mr. Bordes as those who could become violent are: frustrated employees who are shuffled from low-level task to low-level task, frustrated professionals, people who refuse to accept blame for their own problems, people with pent-up rage, those with little or no support systems such as families or friends and sometimes people who "are prone toward firearms," he said.

Mr. Bordes ticked off several warning signs of potential violence that supervisors and other middle managers can be trained to spot. These signs include:

- Overreaction to changes in

corporate policy.

- Threats to co-workers or supervisors.
- Closing out or withdrawing large amounts of money from corporate credit unions.
- Repeated violations of corporate policy.
- Expression of an "everyone is against me" attitude.
- Referring to previous acts of violence, such as spouse or child abuse.
- Expression of a "plan to solve everything."
- Increased mood swings.
- Increased signs of alcohol or drug abuse.

ASIS meeting draws over 8,600

ARLINGTON, Va.—The American Society for Industrial Security is the world's largest organization of security professionals. The society, founded in 1955, has more than 22,000 members. ASIS officials stress that the organization is not a trade association and does not lobby. Instead, it seeks to promote the interests of the security profession as a whole.

As part of this mission, the society sponsors the Certified Protection Professional program. Candidates for the CPP designation must meet a variety of educational and experience requirements and pass a written exam. CPPs must qualify for recertification every three years through continuing education and other professional development activities.

ASIS holds an annual seminar and exhibits in late August or September. This year's event in Washington drew more than 8,600 people, including exhibitors.

For more information, contact the American Society for Industrial Security, 1655 N. Fort Myer Drive, Suite 1200, Arlington, Va. 22209; 703-522-5800; fax: 703-243-4954.

- Referring to weapon use, bragging about owning weapons and "declarations of proficiency" in using weapons.
- Mr. Bordes urged attendees to
Continued on next page

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Foreign investigations best left to experts

By MARK A. HOFMANN

WASHINGTON—Launching a security investigation in a foreign land can be daunting for U.S. security professionals, even if they know the language, according to an official of an international security firm.

But deciding whether to use a U.S.-based firm or a foreign one presents the U.S. security official with a balancing act, said Kenneth E. Rutledge, director-security services for the Ackerman Group of Miami Beach, Fla. Mr. Rutledge, whose firm is on retainer to Warren, N.J.-based Chubb & Son Inc., offered his advice during a session at the 39th annual meeting of the American Society for Industrial

Security in Washington last month.

"If you're a corporate investigator and you work in Minneapolis, it's not unusual that you'd conduct an investigation in California or Louisiana or New York," said Mr. Rutledge.

But "it's highly unusual" that domestic corporate investigators would carry out their own investigations overseas, Mr. Rutledge said.

The investigator generally won't know where to find pertinent records or how local customs affect investigations, he explained.

An outside professional with more experience in dealing with the particular country may be the wisest choice for the case,

Mr. Rutledge suggested.

A key concern is maintaining control over the investigation, in itself a delicate operation, he said. It's not feasible for the

to carry out the investigation generally provides greater control, Mr. Rutledge said. The U.S. company can usually be reached easily by telephone or fax,

he explained.

Using a domestic company also lessens communications problems because both client and investigator speak the same language and the time zone differences are less extreme. Clients also find it much easier to verify a domestic investigator's references, Mr. Rutledge observed.

Foreign investigators have their strengths as well. Chief among these is that they know how things operate in their countries and generally have better local access to information, Mr. Rutledge said.

Whichever approach is taken, "you want to do your homework" before embarking on an overseas investigation, Mr. Rutledge said.

This includes reading U.S. and foreign security journals and magazines, checking the "Security Industry Buyers Guide" and talking with colleagues in other companies, he said.

"It's really important that you go through a vetting process" to make sure that the company or person chosen is the right one for the job, he said.

"Just because someone's done a due diligence investigation in Argentina doesn't mean they can do a loss-control investigation in Thailand," according to Mr. Rutledge.

"Nobody does investigations of all kinds everywhere."

He also urged his listeners to check for the ultimate ownership of the firm hired to do the investigation.

"Who is the daddy or granddaddy?" he asked. It can be very embarrassing to find out that the investigator hired is an affiliate of the entity being investigated, Mr. Rutledge remarked.

James M. Dallas, president of Dallas Security Inc. in Glenside, Pa., also spoke at the session, describing various data bases available to domestic investigators. **BI**

Violence

Continued from previous page
develop a formal plan or guidelines, at least, to deal with corporate violence. While not spelling out a specific plan, he said corporate security officials should attempt to answer a list of questions as they devise their response.

For example, the plan should address what, if any, additional mechanical and electronic devices should be installed to enhance employee protection. It should also spell out who will conduct investigations if violence occurs and who will be the company's spokesperson to the media. The plan also must note whether the office includes people trained and designated to provide emergency aid to victims of violence.

Mr. Bordes said that in an era of ever-escalating legal liability, corporate security officials can't afford to overlook possible exposure to violence.

One often-overlooked exposure is parking lots, which have emerged as one of the greatest areas of liability for violence, he said. A company may find itself in trouble if it is sued for a violent incident that occurred in a parking lot and in court testimony can respond with measures taken to improve security within its physical plant. **BI**

'It's highly unusual' that domestic corporate investigators would carry out their own investigations overseas, says Mr. Rutledge. The investigator generally won't know where to find pertinent records or how local customs affect investigations, he says.

U.S.-based client to go overseas "and sit there and watch" the local investigator, Mr. Rutledge said.

Hiring a U.S.-based company

whereas it is not unusual to have to wait two days to reach a investigator in some less developed countries because of problems with telephones that don't work,

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A healthy idea for reform

By Gary G. Horvat

DESPITE initial difficulties, the Clinton administration appears committed to introducing proposals this month to implement comprehensive national health reform. Furthermore, it is likely that such legislation will be enacted within the next year. The national health care reform legislation will apparently be based in large part on "managed competition."

There is also growing consensus among consumer organizations and other observers that the incentives created by managed competition necessitate scrutiny of access, quality and patient satisfaction by an independent organization. Since health care plans will be paid on a capitated basis, like health maintenance organizations, incentives exist to minimize treatment and to create barriers to medical care access. Although the vast majority of providers will continue to provide high-quality care, the experience with HMOs that accept Medicare beneficiaries in areas of the country where patient recruitment was done without an adequate provider base, indicates the need for independent quality control.

Independent assessment of the quality of care is necessitated by the very concept of managed competition.

Since consumer choice "drives" the managed competition model, consumers must have access to information about the performance of competing providers. This information can help consumers select a health plan by assessing such factors as patient satisfaction, accessibility and quality of services.

The managed competition model also offers an opportunity to increase the amount of comparative data available to providers for their internal quality improvement efforts. For health plans, the information would be more specific and complex, describing variations in outcomes of care by different providers. An independent organization with access to centralized data and both clinical and analytical expertise can provide disease-specific process and outcome data to health plans. This information could also be used by the responsible state agency to ensure that all delivery systems meet minimal standards.

To accomplish these goals, an independent, statewide Quality Improvement Organization should oversee the quality of care provided in each state. The QIO could be

Monitoring quality vital to national health care

created by federal mandate or state initiative. The QIO's primary mission would be to work closely with the public, health alliances or insurance cooperatives and the responsible state agency to ensure that information is readily available to consumers about quality and access and that the economic incentives of managed competition do not adversely affect the quality of care.

The QIO should be a non-profit, independent organization with considerable consumer participation in its governance and activities. It also must be free of any conflict of interest—the organization must neither pay for nor directly provide health care services—and have expertise in a number of areas, including: medical peer review; data collection and analysis; dissemination of information to providers and consumers; patient education and advocacy; practice guidelines and other methods to make objective decisions about the delivery of medical care; and outcomes measurement, evaluation and other epidemiologic tools needed to improve the quality of care.

The QIO must have experience in working directly with consumers of health care services and with representatives of the provider community in all settings. The QIO must also have data-processing capability and experience and the ability to review and interpret findings from medical records. It is important that the QIO remains free of political and parochial influence to serve the public interest.

QIO activities should be structured to minimize the burden on each health plan and its network of providers. Existing data resources in each state should be used by the QIO whenever possible, instead of creating new data requirements. Although the QIO should work closely with each health plan to foster continuous quality improvement and to investigate consumer complaints, it should not interfere in the direct provision of care.

With the overall responsibility for ensuring that enrollees are provided with high-quality, accessible care, the QIO could accomplish this task as follows.

Consumer protection

- Establish an independent complaint and

grievance system for all citizens operating through a confidential telephone hot line and maintain a consumer educational program to inform consumers of their rights and responsibilities under the system.

- Establish a quality-monitoring system through individual case review and profile analysis activities. A sample of entire episodes of care must be reviewed to ensure each enrollee receives access to needed services and quality of care.

- Conduct patient-satisfaction and disenrollment surveys to provide insight into plan weaknesses to assist the plans in improving services in identified areas.

- Use its legal authority as necessary to act in response to health plan deficiencies with a full range of corrective actions.

Consumer information

Analyze demographic, utilization, patient satisfaction and other data describing the quality and effectiveness of health care delivery overall and by each health plan.

- In conjunction with the physician community, examine outcomes of care for specific conditions and measure compliance with practical guidelines describing appropriate treatment methods for specific clinical conditions.

- Feed these data back to health plans so improvements in quality can be made and measured.

An independent quality surveillance organization has an important role in the new health care system. The QIO can ensure protection of consumer rights, enable consumers to make informed choices among competing plans and it can analyze and disseminate comparative information to providers.

This will lead to real improvements in the quality of health care. **BI**



Gary G. Horvat is chief executive officer of the Michigan Peer Review Organization in Plymouth, Mich.

Deflating workers comp myths

By Richard Kunnes

THERE ARE SEVERAL misconceptions about workers compensation that are worth addressing.

Myth: It's virtually impossible to have a consistent, multistate managed workers comp product because state laws vary so widely.

Fact: Workers compensation "regs and legs" do vary significantly from state to state. However, none of these precludes a consistent, cost-effective, quality-intensive, managed workers comp program.

If the workers comp program advocates the employee's well-being and earliest return to work, there are little or no legal barriers to network-based, nationally consistent managed workers comp services. The multistate employer that takes steps to literally transport the impaired employee immediately into treatment and, if necessary, to work, will not suffer from differences in state workers comp laws.

The employer that mandates and monitors education for supervisors and provides substantive support for the injured employee will not be inhibited by states' legal inconsistencies. A corporate workers comp system that is employee-friendly and highly managed will encourage in-network care, less litigation and more rapid return to work—even in states most opposed to managed workers comp. A voluntary employee compliance program will enhance employer-employee workers comp consensus.

Myth: Integration of 24-hour or comprehensive

workers comp services with a managed group health product is virtually impossible because of differences in mandated workers comp benefits compared to group health benefits, and the importance of return-to-work and litigation issues.

Fact: Nothing short of federal pre-emption of state workers comp rules or the granting of first-dollar coverage for all group health care would or could make group and workers comp coverage exactly the same. However, "sameness" is not required for significant, comprehensive workers comp/group health integration.

As with varied state regulations, achieving integration and comprehensiveness is dependent on employer commitment to supervisory structural support for, and immediate employee entry into, an integrated workers comp/group health network, managed by a workers comp specialized case manager.

A toll-free hot line/advocacy line, member services, case management on a national and local basis, and specialist physician networks—all under the auspices of the group health program—can help create a comprehensive, integrated workers comp/group health system, irrespective of state workers comp mandates.

Unlike many health maintenance organizations, access must be accelerated, and gatekeeping, as opposed to managing, must be kept to a minimum.

Myth: Combining managed workers comp with managed group health programs isn't worth the hassle because medical costs don't usually make up

the majority of workers comp costs.

Fact: Workers comp medical costs usually are well below 50% of all the workers comp-related employer costs. All the more reason to emphasize a comprehensive, integrated program to lessen the costs of all four major workers comp components—medical claims, litigation, wage replacement and worker/staff replacement.

Studies indicate that early employee entry into the workers comp system, early case management and early return-to-work structures can generate substantial savings.

Using a workers comp/managed group health approach, an employer can contain workers comp medical claims. A comprehensive, network-based workers comp system that emphasizes easy return to work, job modification, supervisor coordination and education, can eliminate wage and staff replacement and litigation losses. Such an approach will pay for the managed workers comp system many times over. **BI**



Dr. Richard Kunnes is vp-medical services for Prudential Insurance Co. of America in Roseland, N.J.

Indoor air quality causing headaches

By JOANNE WOJCIK

'Sick' buildings rarely are, but perceived problems must be solved

LOS ANGELES—Your employees may be complaining that their office building is making them sick—but it probably isn't.

Unfortunately, telling those who are complaining of headaches, nausea and fatigue that their symptoms are imaginary "is like telling someone who's seasick that there's nothing wrong with him as he's heaving over the rail," said Stuart E. Salot, a certified industrial hygienist and president of CTL Environmental Services in Harbor City, Calif.

Indeed, ignoring a problem like "sick-building syndrome" can lead to costly litigation and reduced worker productivity, observed Clyde E. Hirschfeld, a partner with the Los Angeles law firm Cummins & White.

Several lawsuits have already been filed under the Americans with Disabilities Act by chemically sensitive people seeking "reasonable accommodations" from building owners, he said.

And other suits have been filed against multiple defendants in-

involved in management or ownership of problem buildings, according to Alan K. Stazer, counsel to Cummins & White.

Rather than ignoring indoor air-quality complaints, employers, building owners and managers should take so-called sick-building complaints seriously, the three experts advised attendees at a recent seminar on indoor air quality sponsored by Cummins & White.

Some indoor air-quality problems can occur when contaminants such as exhaust from motor vehicles, pollen or dust enter a building through its ventilation system.

This contamination usually occurs when rooftop or wall-mounted air intakes are located next to or downwind of building exhaust outlets or other sources of pollution.

Problems also can result if debris accumulates at the intake, obstructing airflow and potentially introducing microbes.

For example, poorly drained condensation pans for the cool-



ing-coil units sometimes contain slime that can serve as a medium for growing mold and bacteria.

"People with severe mold allergies can get hypersensitive pneumonitis," or inflammation of the lung, from breathing mold spores dispersed by ventilation

systems, said Mr. Salot. "I've seen mushrooms growing in air ducts."

And while most viruses usually die when circulating air dries them out, bacteria that causes measles, Legionnaires' disease and tuberculosis can be continuously transmitted via heating and air-conditioning systems, he added.

But, for the most part, "vague and varied" complaints such as eye, nose and throat irritation, headache, fatigue and nausea—which the National Institute of Occupational Safety & Health refers to as "building-related occupant complaint syndrome"—cannot be traced to any particular cause.

"Usually there is nothing clinically wrong with the people and no causative agent can be found," Mr. Salot said, adding that in 95% of the cases, inspections fail to turn up a "smoking gun."

"The only things that are real are the people and the complaints," he observed.

Coincidentally, "this is statistically a disease of female clerical government workers," who are regarded as the least empowered people in the workplace, he pointed out.

"I'm not sure if it's not more psychology than chemistry," Mr. Salot suggested. "Maybe this is a psychosocial problem."

Unfortunately, published reports confirming the existence of sick-building syndrome fuel the hysteria, Mr. Salot said, citing a 1-year-old incident at a Midwestern laboratory as an example.

While scientific researchers typically publish their noteworthy findings, one laboratory called a press conference after lab rats died after breathing carpet fumes, Mr. Salot said.

Since then, the EPA has recreated the experiment with different results: the rodents always live.

"They thought they found the smoking gun, but now the gun isn't smoking," he said.

But lack of scientific evidence to prove the existence of sick-building syndrome hasn't stopped lawmakers from introducing legislation to regulate it.

Rep. Joseph P. Kennedy II, D-Mass., and Sen. George Mitchell, D-Maine, have both introduced bills this year targeting indoor air quality.

Rep. Kennedy's H.R. 2919 would give the EPA authority to establish enforceable regulations with civil penalties for non-compliance, while Sen. Mitchell's S. 656 would mostly provide funding for the EPA to study sick-building syndrome and make suggestions for indoor air-quality regulation to Congress.

Washington insiders give Sen. Mitchell's bill better odds of passage because it made it out of committee before the close of the last session and is likely to win the support of the new Democratic administration.

Until recently, little has been done to study the quality of indoor air, even though people generally spend 90% of their time indoors, Mr. Salot observed.

"The EPA's mandate is not the worker, but the public—those most sensitive in the environment" such as small children and the elderly, he explained.

As a result, the only measurement of acceptable air quality has been the Occupational Safety & Health Administration's permissible experimental limits, or PELs, which pertain primarily to industry.

"But the typical office worker's exposure is minimal to the PELs set for industry," he said.

While NIOSH investigated na-

Continued on next page

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merous buildings since the 1970s and found that the majority of indoor air-quality problems were caused by lack of ventilation, "they didn't look at buildings without complaints," the same percentage of which are likely to be poorly ventilated, Mr. Salot said.

Even though the jury is still out on the existence of sick-building syndrome, employers, building owners and managers would be prudent to follow up on complaints by conducting air-quality tests, according to Mr. Salot.

They also should be willing to accommodate workers who allege multiple chemical sensitivity, according to Mr. Hirschfeld, who said a number of complaints have been filed citing the new

ADA law.

The two most recently publicized ADA complaints centered on the use of tobacco and perfume.

Three children with asthma and a woman with lupus filed suit this year against fast-food restaurants McDonalds, Burger King and Wendy's, claiming that by allowing smoking, these restaurants denied access to people with respiratory problems—violating the public accommodations sections of the ADA.

And last year, the city of San Francisco agreed to ban the use of perfume during council meetings after an employee complained the smell was making her sick, recounted Mr. Hirschfeld.

Other complaints have led to litigation against building

owners, contractors, developers, building managers, maintenance and service providers, architects and engineers, equipment and material manufacturers, real estate brokers—just about anyone who has anything to do with a problem building, Mr. Stazer said.

Among the charges are negligence, product liability, breach of contract, breach of express or implied warranties, failure to warn and fraudulent concealment or misrepresentation, he said.

A few of these cases have been settled out of court, such as the 1990 *Call vs. Prudential Insurance Co.* suit in which employees in a partially completed Los Angeles office building sought damages after strong, glue-like odors, emitted when a contractor

sealed holes in the HVAC system with a duct sealant, made them sick.

But other cases are still pending, such as *Watrous vs. Oklahoma Department of Veterans Affairs*, filed earlier this year against manufacturers of three cleaning products, the builder, architect and ventilation contractors at a Veterans Administration medical center. The plaintiffs, which consisted of current and former workers, claimed the chemicals in the cleaners used at the facility caused a variety of ailments.

In some cases, improving ventilation, banning smoking or simply adding a few oxygen-generating plants can be enough to satisfy worker complaints, according to Mr. Salot.

"Empower complainants, talk

to them about where they think the problem is," he urged. "If they think the problem is in the northeast part of the building, make sure you sample the air in that part of the building."

Mr. Salot stressed that "management must be willing to correct comfort issues. As long as workers are comfortable, the problem usually goes away."

However, he advised against using odor-control equipment containing charcoal filters or ozone, because charcoal filters restrict air flow and shed charcoal, and ozone products are toxic.

And ionizers, which purportedly alter the charge of atmospheric ions to make air cleaner, "probably have the same effect as eagle feathers on the door-knob," he quipped. **B1**

Health insurance reporting

Continued from page 1
give the Department of Health and Human Services information that includes:

- The name and Social Security number of each employee and former employee covered under their health plans.
- Whether single or family coverage is selected.
- The name, address and identification number of the plan covering the employee or the former employee.
- The name and Social Security number of each covered dependent.
- The period during the calendar year that coverage was in effect for each person.

However, some Washington observers say benefit managers may not have to worry much longer about the onerous reporting requirements.

"If ever there was a provision that is a candidate for repeal, this one is. It makes no policy sense, and it asks for huge amounts of information, 98% of which won't be used," said Frank McArdle, a consultant at Hewitt Associates in Washington.

"I understand why they are doing it, but at the same time, it is overkill," said Linda Laarman, a principal at William M. Mercer Inc. in Washington.

This "would entail soliciting information from our entire employee population, at a time when benefits departments are running pretty slim," said Dennis Nirtaut, manager-employee benefits at Continental Bank Corp. in Chicago.

The first report, covering the 1994 plan year, is due Feb. 28, 1995, the same date W-2 forms are due.

Consultants expect the government to issue more information about the form and compliance later this year.

Many companies are just learning of the reporting requirements and the penalties.

Benefit managers are responding "first with disbelief, then denial, then acceptance," said Henry Saveth, a principal at A. Foster Higgins & Co. Inc. in New York.

One problem they could run into is tracking the Social Security numbers of dependents. Federal tax law now requires children over age 1 to have Social Security numbers if they are claimed as dependents. However, consultants and benefit managers say, it will be tricky to ask employees to divulge these numbers, if indeed they have them.

Companies will also have to revise data-collection procedures. Some may choose to integrate payroll data with employee benefits

data, others may fold in data collection during enrollment for health plans, and others may turn the job over to a third-party administrator or health insurer—for a price.

Even if Congress were to amend or repeal the requirements in the future, benefit managers need to act now to ensure that 1994 data is compiled.

And if the rules are not repealed, they will still face sunset review in four years, Mr. McArdle pointed out. "Employers will have to go to the expense of gathering the data, which could conceivably be used only for a few years."

Nevertheless, given the heavy penalties for non-compliance, many consultants are urging employers to gather the required data during open enrollments for the 1994 plan year but to limit their investments in new reporting systems.

Another sore point with benefit managers and consultants: Just as the Clinton administration is calling for more efficient health care, it is creating new administrative problems.

The government is "adding a big administrative and cost burden to employers, none of which goes to provide health care," said Fred Hamacher, vp-compensation and employee benefits of Dayton Hudson Corp. in Minneapolis. And, the provision will be especially burdensome for high-turnover industries, in which employees change addresses frequently, he said.

It would make more sense for the government to require data only on employees older than 65 and on disabled employees, said Catherine Wooster, benefits planning manager at Barnett Banks Inc. in Jacksonville, Fla. Barnett Banks will include a questionnaire for dependent information in its annual flexible-benefit plan enrollment and has arranged for its health insurer to maintain the data, she said.

Companies that do not take similar action may pay a high price.

One set of penalties for not filing the coverage information is similar to that for not filing W-2 forms: an aggregate penalty with a limit of \$250,000 per employer.

Beyond that, the Department of Labor may impose another—and unlimited—set of penalties: up to \$1,000 for each "failure" to comply with these rules. For example, two unreported plan participants would constitute two "failures," or a \$2,000 penalty. And, consultants say, the language can be read to allow another \$1,000 penalty for each unreported covered beneficiary.

The provision raises numerous

questions for employers.

For example, it isn't clear whether employers must report on health plans for which Medicare doesn't pay benefits, like dental plans, said Ms. Laarman. Nor is it clear how frequently the data must be updated, said Ms. Wooster of Barnett Banks.

Just obtaining the data could also present problems.

"What if an employee doesn't send in the information on dependents?" asked Ms. Wooster. "How

do you figure out who didn't respond? How do you enforce it?"

And reports are required for "former employees," but no definition or cutoff date is given in the budget law, said Mr. McArdle. "Does that include retirees? We hope not."

Employers with benefit plans that cover the fiscal year may be required to file two reports on each covered individual—one for the fiscal year, one for the calendar year—if the individual changes cover-

age, he added.

The provision will raise even more questions regarding two-income couples. Two employers—or more, in the case of moonlighters—will be filing the same information on the same couple, consultants say.

Short of a quick repeal of the law, consultants say the best they can hope for now is that the final version of the law will provide benefit managers answers to some of these questions. **B1**

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OSHA reform

Continued from page 1
for weeks.

According to the report, the change in OSHA inspections is needed for a simple reason: The current system "doesn't work well enough."

"There are only enough inspectors to visit even the most hazardous workplace only once every several years," the report said, and OSHA only has the personnel to follow up on 3% of its inspections.

To remedy the situation, the report calls for new workplace safety and health rules, relying on private inspections by companies or non-management employees. OSHA would merely set standards and penalize firms that failed to meet them.

Safety standards, the report said, could be enforced much the same way accounting standards are now. "No army of federal auditors descends upon American businesses to audit their books; the government forces them to have the job done themselves. In the same way, no army of OSHA inspectors need descend upon corporate America," it said.

Instead, companies could hire private inspection firms or authorize trained non-management employees to conduct the inspections. OSHA could encourage companies to maintain safe workplaces by offering incentives like fewer audits and less-stringent reporting requirements.

Insurance and business groups were quick to praise the Gore recommendations.

"Contrary to the stuff we've seen on the Hill, this is moving toward non-adversarial" enforcement of workplace safety standards, said Tom O'Day, associate vp-federal affairs in Washington for the Alliance of American Insurers, which represents workers compensation insurers.

Calling the report "a good first step" toward OSHA reform, Mr. O'Day called on the administration to further distinguish violations caused by willful endangerment from those caused by ignorance and to differentiate reporting violations from those that pose a threat to life and limb.

"We think it's a good development. It's an idea that we have promoted," said Mark Stuart, associate director of risk management for the National Assn. of Manufacturers in Washington.

Praise was not unanimous, though. Labor unions quickly branded the proposal a step backward.

And, Joseph A. Kinney, executive director of the National Safe Workplace Institute in Chicago, said he was at best ambivalent about it.

"It would be nice to rely on the private sector, but there's substantial evidence that many companies can't be trusted even to keep accurate (safety) records," Mr. Kinney said.

Like many of the other Gore report recommendations, the OSHA proposal is not totally new. The Reagan administration attempted to create a voluntary compliance system in 1982. Labor unions and others objected strongly, and eventually the proposal was dropped.

The new version is far from identical to the proposal of a decade ago. In fact, employee-run inspections bear some resemblance to the mandatory employee-employer safety committees featured in some OSHA reform bills now before Congress. Business groups oppose such committees.

Belz Enterprises' Ms. Workman

said that relying on non-management employee inspectors could cause difficulties in lodging and other industries with high employee turnover. Risk managers would have trouble keeping employees trained and certified, she said.

The OSHA proposal is expected to run into substantial opposition, just as many of the other Gore report proposals will.

But, Mr. O'Day thinks the overhaul package has a shot. He points out that a Democratic president will present the idea to a Democratic-controlled Congress and will still be able to count on significant Republican support for many measures. What's more, many of the proposals can be implemented by executive order without any congressional action.

Other proposals that could affect risk managers and benefits managers include:

- Eliminating the ERISA requirement that summary plan descriptions be filed with the Department of Labor.

That requirement was designed to make the plans more accessible to participants and beneficiaries, the report said, but "since requests for copies are received on only about 1%, the cost to maintain the system and the administrative burden on employers far outweighs the public benefit."

Labor Department officials would not comment, as they had not seen details of the proposal.

Government sources said the original suggestion behind the reform was to continue to require companies to issue those reports to employees and for the department to retain authority to request summaries for employees who are too intimidated or uncomfortable requesting them themselves.

Many employers regard the

Labor Department filings as meaningless. Employees rarely request copies, and even when they do they often receive outdated material from government warehouses, said Henry Saveth, a principal with A. Foster Higgins & Co. Inc. in New York.

- Automate the processing of ERISA annual financial reports.

- Encourage market-based approaches to reduce pollution. "Rather than dictating exactly which technologies industry should use to reduce pollution, the government would set standards and let the market handle the details. The government could also assess fees based on the amount and nature of pollution emissions or discharges. Fees could reflect the quality, toxicity and other adverse characteristics of pollutants," said the report.

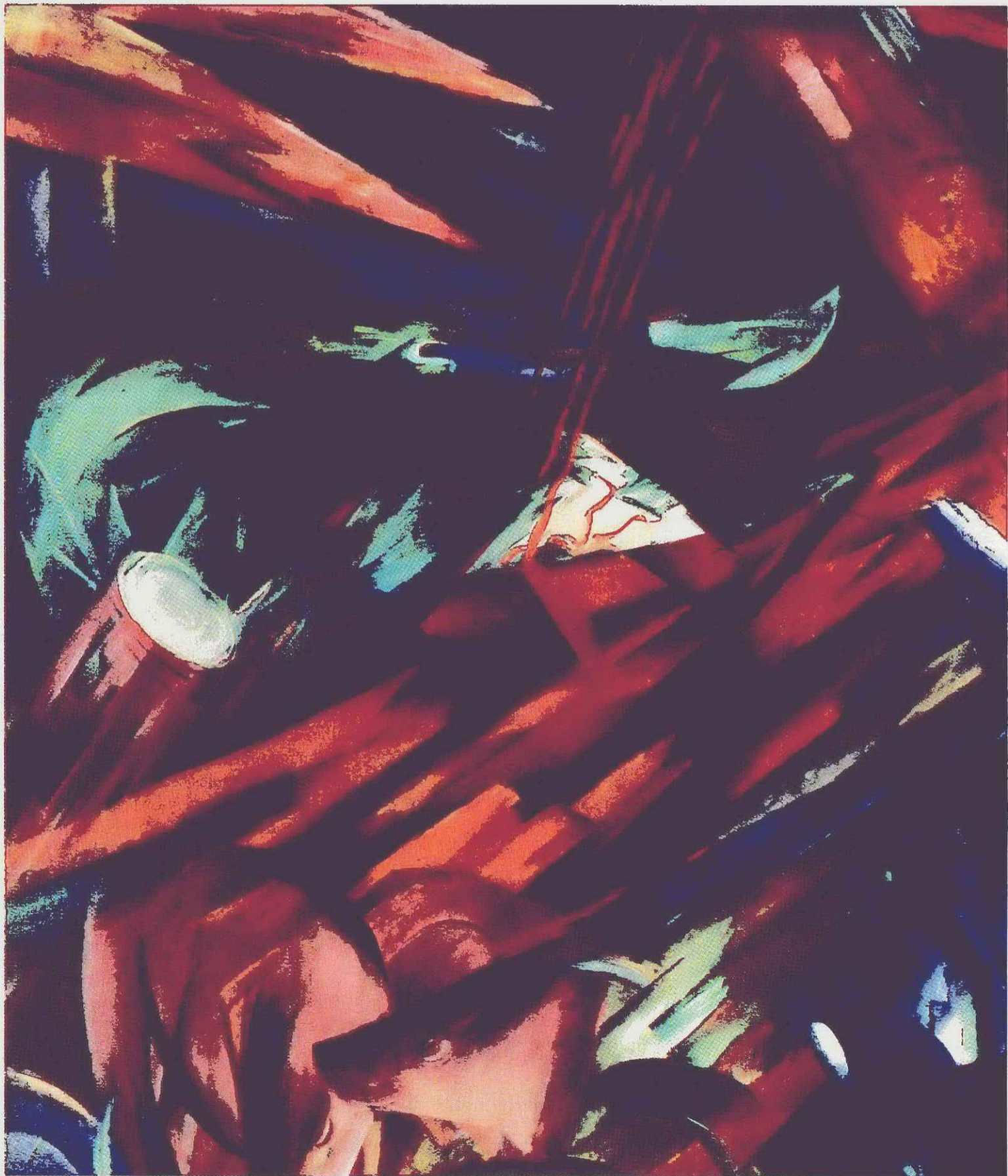
- Indexing monetary civil penalties to inflation.

"Civil monetary penalties have not been adjusted to keep up with inflation. Under this recommendation, a 'catch-up' adjustment would be made and the need for additional inflation adjustments would be automatically reassessed every four years," according to the report.

The Department of Justice, which represents the federal government in civil suits, would not comment on how this idea would work until it received a detailed proposal.

- Expanding the use of alternative dispute resolution by federal agencies.

The report notes that while litigation is often necessary to interpret regulations, "in many cases, no one really wins—and the taxpayer loses" because the dispute could have been settled outside the courtroom more quickly and much less expensively. **B1**



Corporate schools

Continued from page 3

Stoeller. "If our employees are happy and at peace, they'll be here and will do their jobs."

Offering employees the opportunity to put their kids in an alternative school gives parents "peace of mind," agrees a Northern Trust spokeswoman. "They know where they are and what they are doing."

Northern Trust is renting one floor in a nearby office tower and has divided the space into seven classrooms. Seven certified teachers were hired to teach the 110 children participating, who range between kindergarten and eighth grade.

The center operates from 7 a.m. to 6 p.m. with instruction from 8:30 a.m. to 3 p.m.

Northern Trust is assuming the entire cost of renting space, fur-

niture, equipment and materials, though it would give no specific amount.

Harris Bank will also assume all the costs involved with its learning center. Harris is using an empty floor in its downtown headquarters and is staffing the center with seven certified teachers who normally work in the bank's staff training division, said the spokeswoman.

Harris' center, which was up and running last Wednesday, also has 110 children participating, ranging from kindergarten through sixth grade. "It's not a day care," said the spokeswoman. "They're learning."

The center, which is open from 8 a.m. to 5:30 p.m., has separate rooms for classes, exercise, art, naps and computer training. Instruction runs from 8:30 a.m. to 4 p.m.

Equipment must be rented and

'We need our employees at work. If our employees are happy and at peace, they'll be here and will do their jobs,' says Karen Stoeller, vp-human resources and organizer of Harris Bank Corp's learning center in Chicago.

some workers will lose time away from their jobs, but "the benefits outweigh the costs," said the spokeswoman.

Some other big Chicago companies say that running in-house schools would be impractical.

Take Hyatt International Corp., for instance.

The Chicago-based hotelier has never considered setting up a learning center because of cultural differences among its employees, said Larry Stone, human resources manager. And because

its hotels operate on three eight-hour shifts, "many employees have child care already set up" during the day or at night, Mr. Stone said.

Hyatt will allow more flexibility to employees who may need it if the school shutdown continues, he said.

And advertising giant Leo Burnett Co. found it more feasible "to assist in the quality alternatives" by donating materials to the city than to set up its own learning center, said a spokes-

man for the agency.

Corporate educational programs are only part of local efforts that include programs offered by local libraries, museums and the YMCA.

Chicago public schools have been shut down since Sept. 1, when the school board and teachers' union could not agree on concessions to balance the budget, as required by state law.

Last week the teachers union unanimously rejected a "final" proposal from the school board that included larger classes, a longer school year, a salary freeze and a 2% of salary contribution to health care benefits. Teachers, who do not pay anything now, have offered to pay 1%. School authorities are also insisting that teachers transfer \$55 million from the teachers pension fund to the school operating fund. **BI**

Markets

Prudential contract for mail order drugs

LINCOLNSHIRE, Ill.—Caremark Prescription Service Division has been picked as the preferred mail order prescription drug firm for the Prudential Health Care System.

The service will be offered to about 24 million people covered by Prudential indemnity and managed care plans.

Caremark Prescription Service Division is a division of Caremark International Inc., which was spun off from Baxter International last year (BI, July 20, 1992).

Wyatt acquisition

WASHINGTON—The Wyatt Co. has acquired the Phillips Group of Cos.

Phillips is an Ottawa-based consultant that focuses on corporate culture and strategic plans, among other management consulting specialties.

Wyatt acquired a minority interest in Phillips in November 1992.

Phillips has 60 associates and offices in San Diego, Montreal and Toronto, in addition to Ottawa.

COMPARE alliances

MINNEAPOLIS—HealthCare COMPARE Corp. entered into two strategic alliances recently.

COMPARE will now provide utilization management services to certain Employee Benefits Plans Inc. clients on a national basis.

In addition, United HealthCare Corp. and HealthCare COMPARE have announced an agreement to integrate prescription drug management services.

UHC's Diversified Pharmaceutical Services will become integrated with HealthCare COMPARE's Medical Review Programs and the AFFORDABLE Medical Networks.

New offices

Chubb Corp. is opening an office at Olympic Towers, 300 Pearl St., Suite 900, Buffalo, N.Y., 14202; 716-855-0831.

Vermont Insurance Management Inc. has relocated its Arlington, Va., office to 1401 Wilson Blvd., Suite 203, Arlington, Va. 22209; 703-524-7744.

Hewitt Associates has relocated its Washington office to 2401 Pennsylvania Ave. N.W., Suite 450, Washington, D.C. 20037; 202-331-1155. **BI**

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Merrett

Continued from page 2

Mr. Rowland said at a press conference Sept. 9 that he will miss working with Mr. Merrett, but understood his decision to resign. Mr. Rowland declined to comment on speculation in the British press that Mr. Merrett would have been forced to relinquish his position had he not resigned.

"I have extremely high regard for Stephen and have enjoyed working with him, Mr. Rowland said. "Quite clearly, Stephen has problems he has to tackle—as do many others at Lloyd's—and quite clearly the point was reached where he was unable to continue."

Mr. Merrett has long been one of the most controversial figures in the market. Many names felt that his interests as an un-

derwriter and Lloyd's official conflicted.

He ranks as a leading underwriting of errors and omissions insurance coverage for Lloyd's underwriting agents. And, as deputy chairman, he has been working on a negotiated settlement of all outstanding legal disputes between disgruntled names and their agents. E&O underwriters will be closely involved in that settlement.

Mr. Rowland stressed that Mr. Merrett was not a formal representative of E&O underwriters in these negotiations. He said that great care had been taken to ensure that Mr. Merrett need not confront conflicts of interest in this undertaking.

However, Mr. Merrett also faces lawsuits from names on two Merrett syndicates, 418 and 421, who allege that their affairs were negligently handled in the

early 1980s. Last month, Mr. Merrett offered to step down as chairman of MUAM, his company's managing agency arm, to appease certain powerful members agents. The members agents had threatened not to direct

'Quite clearly, Stephen has problems he has to tackle—as do many others at Lloyd's,' says Mr. Rowland.

names to MUAM syndicates unless he resigned (*BI*, Sept. 6).

The Assn. of Lloyd's Members welcomed Mr. Merrett's resignation as Lloyd's deputy chairman.

"We feel it was best for Lloyd's

because Stephen Merrett undoubtedly does have conflicts of interest in his position as deputy chairman and as a Council member," said Val Powell, chief executive of the association. "But we hope that his expertise will still be available to Lloyd's on an informal basis."

Mr. Merrett now will focus on attracting corporate capital to the Merrett syndicates. The group is working with broker Marsh & McLennan Cos. Inc. and investment banker J.P. Morgan & Co. to form a company that will provide reinsurance protection for Merrett syndicates, and may be later converted into a corporate name that could invest in the syndicates.

New capital is badly needed at the nine syndicates managed by MUAM.

Names have been leaving in droves following heavy losses

from U.S. asbestos and pollution claims. Capacity at the group's biggest syndicate, syndicate 418, is expected to drop to about 50 million pounds (\$77 million) next year from its 1993 level of 150 million pounds (\$227.3 million).

Separately, Lloyd's announced last week that Robert Owen has been named a member of the Council of Lloyd's and the Lloyd's Regulatory Board, effective immediately.

Mr. Owen is deputy chairman of London-based merchant bank European Capital Co. Ltd., and a former chairman of the Securities and Futures Commission of Hong Kong.

His appointment has been approved by the governor of the Bank of England and the British Department of Trade and Industry.

Mr. Owen succeeds Andrew Large, chairman of Britain's Securities and Investments Board. According to Lloyd's, Mr. Large decided to resign from the Council because his commitments as chairman of the SIB did not allow him sufficient time to devote to Lloyd's. **BI**

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ADR potential

Continued from page 1
just have a judge," he said.

Because ADR is a relatively new legal concept, it is still evolving. Growing experience with ADR tools is helping to identify the less successful forms of dispute resolution.

For example, a new study of claims contested by the California State Automobile Assn. found that the current system of judicial arbitration often results in awards that are higher than a jury would likely have given.

The insurer obtained a more favorable result in 73% of the cases that went to trial after either the plaintiff or the insurer rejected an arbitration award, according to the study of 148 CSAA cases from 1991.

The study was published in the August 1993 issue of "For the Defense," a law journal.

Among the criticisms leveled by study authors Michael J. Brady of Ropers, Majeski, Kohn, Bentley, Wagner & Kane in Redwood City, Calif., and Peter R. Cubanske, assistant manager of claims for the CSAA's Inter-Insurance Bureau:

- Too many high-value cases are sent to arbitration.
- The quality of arbitration judges is inconsistent.
- Too few lawyers take the arbitration proceeding seriously.

In contrast, a recent Deloitte & Touche study of 246 corporate attorneys for Fortune 1,000 companies, found that 67% of ADR users reduced their legal costs, while only 3% saw an increase.

About half of the ADR users said their savings were in the range of 10% to 50% of the expected litigation costs, according to the Deloitte & Touche survey.

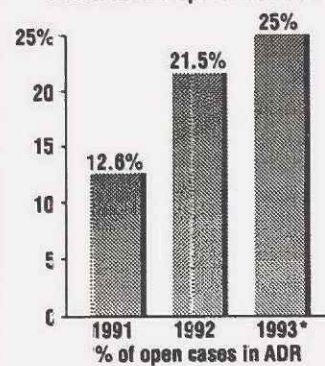
In addition, an in-house study by Design Professionals Insurance Corp. of Monterey, Calif., found that legal expenses and the size of losses associated with disputed claims have dropped as its use of ADR has increased.

DPIC projects its average legal expense will drop to \$17,391 per claim in 1993, compared with \$22,038 per claim in 1991. Similarly, the insurer's average loss per closed claim is declining to a projected \$103,005 in 1993, down from \$116,020 in 1991.

During this same period, DPIC's use of ADR has increased to as

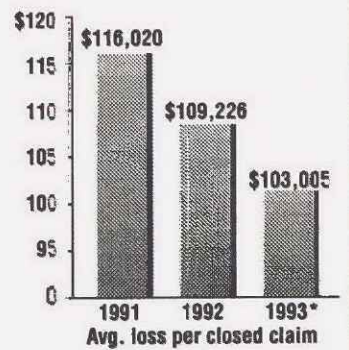
How ADR won over an insurer

As more cases were put into alternative dispute resolution...



*Figures are through May
Source: DPIC Companies, Inc.

...Costs fell



GRAPHIC BY M. KAPLAN

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much as 26% of its open claims files this year, from a low of 10% in 1991. On average, the insurer's use of ADR was 12.6% of open claims in 1991, 21.5% in 1992 and 25% in the first five months of 1993 (see chart).

When assessing the value of ADR, it's important to consider what methods are employed, points out Marjorie Crowder Briggs, a partner with Porter, Wright, Morris & Arthur in Columbus, Ohio.

For example, in non-binding court-ordered arbitration, "there are probably a lot of plaintiffs lawyers who don't take it seriously because they would get more money if they presented their case to a sympathetic jury," she said.

So, unhappy participants often seek a trial de novo—or a new trial with a rehearing of all the issues—which can prolong litigation.

In contrast, 95% of bodily injury cases and 85% of commercial litigation can be satisfactorily resolved through mediation, a process in

which both parties iron out an agreement with a mediator serving as a referee, according to San Francisco attorney Nelson C. Barry III, an ADR specialist who often serves as a mediator.

Since 95% of civil litigation settles before trial, there is no reason not to elect ADR for these cases, he said.

Many ADR advocates feel that much of the criticism of the system comes from lawyers who feel early dispute resolution threatens their livelihoods.

"The interest of defense attorneys is to maximize the time they have to spend on a case to increase the billable hours," said Jeff Krivis, a partner with Krivis, Passovoy & Spile in Encino, Calif.

Defense lawyers also "want to present as much evidence as possible that ADR doesn't work so they can convince (insurers) to take a case to trial," he added.

"Many lawyers are trained litiga
Continued on page 35

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cost containment n. efforts used to check, monitor and control the cost of rehabilitating disabled workers while at the same time ensuring that they receive quality care.

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Continued from page 34

tors, hired to argue," agreed DPIC Chief Executive Officer and President Peter Hawes. "It's kind of like asking the pitbull to become kinder and gentler."

So while few lawyers recommend ADR to their insurer clients, insurers have begun telling their lawyers to use ADR since loss-adjustment expenses are increasing at a faster rate than claims payments, said Atlantic Mutual's Mr. Decaminada.

And while many die-hard lawyers cling to traditional litigation methods, a growing number of innovative defense lawyers, realizing the threat dispute resolution poses, have turned it to an advantage by touting their ADR expertise as a marketing tool.

Even the American Bar Assn. has created a new dispute resolution section, and ADR is now being taught at virtually all law schools in the country.

"ADR is the wave of the future," said John K. Trotter, a retired judge who works as a mediator for the statewide Judicial Arbitration and Mediation Service in California.

"What I have been predicting for some time is now happening," said Mr. Galton, the Austin attorney and mediation expert. "Lawyers who do trial work are integrating ADR into their practice."

For example, he said, many firms are starting to assign two lawyers to a file: one with expertise in ADR, the other a litigation specialist. Only if the ADR expert fails to achieve early resolution does the litigation specialist take over.

Other firms, like Krivis, Passovoy & Spile, have established departments of specially trained dispute resolution attorneys whose compensation depends upon their

ability to achieve early resolution through the use of various alternative dispute resolution procedures.

"We have a check-and-balance system with the (insurers) that puts the control back in the claims department and makes lawyers accountable for their work product," Mr. Krivis explained. "Since over 95% of all cases are resolved without trial, our focus is on training our attorneys in mediation, arbitration and specialized negotiation skills. This reduces transaction costs for the (insurer) and increases our ability to close cases."

The ADR department is an offshoot of the firm's participation in a nationwide dispute resolution system for real estate errors & omissions claims developed by the Homeowners Group Inc. in Hollywood, Fla. Homeowners Group is the risk management services arm of POMG Insurance Co. Ltd., a Caymans-domiciled captive for real estate agents.

Under the Homeowners Group Risk Management System, both buyer and seller agree to the use of dispute resolution when they sign the real estate sales contract, explained Michael McDonald, vp of risk management for the organization. When a dispute arises, the real estate professional can access the network of ADR specialist lawyers via a toll-free phone number.

Mr. McDonald estimates that the use of ADR in resolving real estate transfer disputes has reduced legal costs about 15% to 20% since the system was implemented in March 1992.

"We know risk management is the solution to resolving disputes early on," and ADR is simply an offshoot of risk management, Mr. McDonald said.

According to the Deloitte & Touche survey, companies increasingly are including ADR provisions in contracts with suppliers, customers, labor organizations and joint venture partners.

Architectural and engineering firms traditionally have provided for ADR use in their contracts, according to DPIC's Mr. Hawes.

And the American Arbitration Assn. is helping insurers resolve claims from Hurricane Andrew in Florida and from the summer floods in the Midwest, according to Allison Weintraub, director of mediation in the AAA's San Francisco office.

But even ardent ADR supporters acknowledge that the process must be refined to become a realistic alternative to traditional litigation.

"Sometimes binding arbitration

can be costly," involving expensive discovery similar to that required to prepare for trial, said Ms. Briggs of Porter, Wright.

"Reinsurance arbitrations have in the last decade grown dramatically in scope and now resemble something more akin to litigation," observed Jonathan Bank, a partner with Buchalter, Nemer, Fields & Younger in Los Angeles. This is because "the clients have become more litigious, the lawyers haven't discouraged them and many arbitrators are going along with it—in this case, it takes three to tango."

"The trend is clearly to reduce costs and if ADR holds out the promise of doing that," it will have to be refined, Mr. Bank added.

"I believe the role of lawyers is to become 'process architects,'" said

Mr. Galton of Wright & Greenhill. "Their job will be to match the tool to the dispute," and ADR increases the number of tools available, he said.

"Corporate clients concerned with cost containment are delighted when firms have resources to resolve disputes early," Mr. Galton added.

"I think ADR is the trend of the future," agreed Mr. Decaminada of Atlantic Mutual. While there still will be cases that need to go to trial, such as those that will make new law, the vast majority can be resolved amicably outside the courtroom, he believes. Even the Supreme Court discriminates when deciding which cases to consider.

"Can you imagine what the courts would be like if every case went to trial?" Mr. Decaminada mused. **BI**

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Health education

Continued from page 3

for the state of their own health, and for shopping intelligently for medical care when it becomes necessary," said Carson Beadle, managing director at William M. Mercer Inc. in New York and president of The Health Project.

To accomplish this, though, employers, providers and communities must expand and develop programs that enable patients to be better health care consumers, he said.

Traditional wellness programs that discourage unhealthy lifestyles or stress the importance of preventive care are still a good idea, said Mr. Beadle. But employers and providers also need to "encourage people to learn more about their bodies and their illness so they can discuss

their treatment more intelligently with their doctors."

During the next decade, employers' cost containment efforts are expected to increasingly target individuals rather than providers. Strategies like utilization review and second opinions, which during the 1980s sought to reduce the supply of medical care, are expected to be supplemented by patient-oriented interventions in the future.

Encouraging patients to play a bigger role in health care decisions is the only way to successfully manage health care in the future, according to Joanne Dietch, national director for health care communications services at Towers Perrin in Saddle Brook, N.J. "Up until now, we've been doing things to employees, instead of making them part of the process," she said. "But em-

ployees are the most critical part of the equation. Demand is in consumers' hands."

In a recent article published in the New England Journal of Medicine, Dr. Fries and other members of The Health Project said "demand management" can significantly reduce the amount of money employers currently spend on health care.

While preventing chronic illness through wellness initiatives can reduce consumer demand for medical services, approaches that encourage self-management could potentially yield similar benefits, Dr. Fries said.

In fact, several studies "have demonstrated that providing medical consumers with information and guidelines about self-management can lower rates of utilization, often by 7% to 17%, with modest interventions," he said.

"If you want cost savings, it's very important to focus on consumer demand for medical services, rather than just consumer need for medical services," he added. "The need part takes longer, because employees don't adopt healthier lifestyles overnight. But demand management occurs right away."

The success of demand management programs, however, is dependent on widening access to information and increasing patient confidence about participating in their own health decisions, Dr. Fries noted. And, until now, demand management has been "an amazingly neglected area" even though materials to help consumers better manage their own health care have been available since the mid-1970s.

"The least costly way to do something about health care is with consumer information," said David Ellig, president of MedEd Inc., a Mesa, Ariz.-based health care information consulting firm. However, he added, "Probably only 2% to 3% of the population, including corpora-

president and chief executive of Access Health, a Rancho Cordova, Calif.-based company that runs a toll-free consumer information line for health plan members that is staffed by registered nurses. Callers can discuss their symptoms or health care concerns with the nurses, who do

Employers and providers need to 'encourage people to learn more about their bodies and their illness so they can discuss their treatment more intelligently with their doctors,' says Carson Beadle, president of The Health Project.

tions, individuals and health care providers," know what kind of consumer medical education materials exist.

As a result, a whole new industry dedicated to helping patients take control of their health and manage the health care services they receive has emerged in recent years. These organizations offer a variety of medical education and self-help materials.

Employers can provide materials ranging from textbooks and pamphlets to toll-free telephone services that allow employees and dependents to discuss their symptoms with registered nurses. In addition, computer-based medical libraries allow patients to tap into hundreds of published sources—from the most complex medical journals to general-interest magazines.

"Many times people don't seek information because it is hard to come by or it's not user-friendly," said Kenneth Plumlee,

not offer diagnoses but help callers determine the appropriate level of medical care they need.

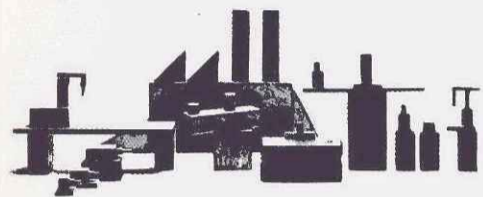
"Between 50% and 85% of ambulatory care visits are assurance visits," pointed out Mike Muhlbauer, an independent health care consultant in Milwaukee. The vast majority of routine care, and probably some related specialty care, that patients seek is for conditions that will cure themselves or because the patient needs more information, he said.

"About 90% of physician visits in the United States are for colds, even though the doctor doesn't know anything you don't," Dr. Fries explained. "But the physician has to bill for the office visit, and he may order chest X-rays or other tests," he noted.

Many patients are likely to forgo office visits if they are able to talk with medical profes-

Continued on next page

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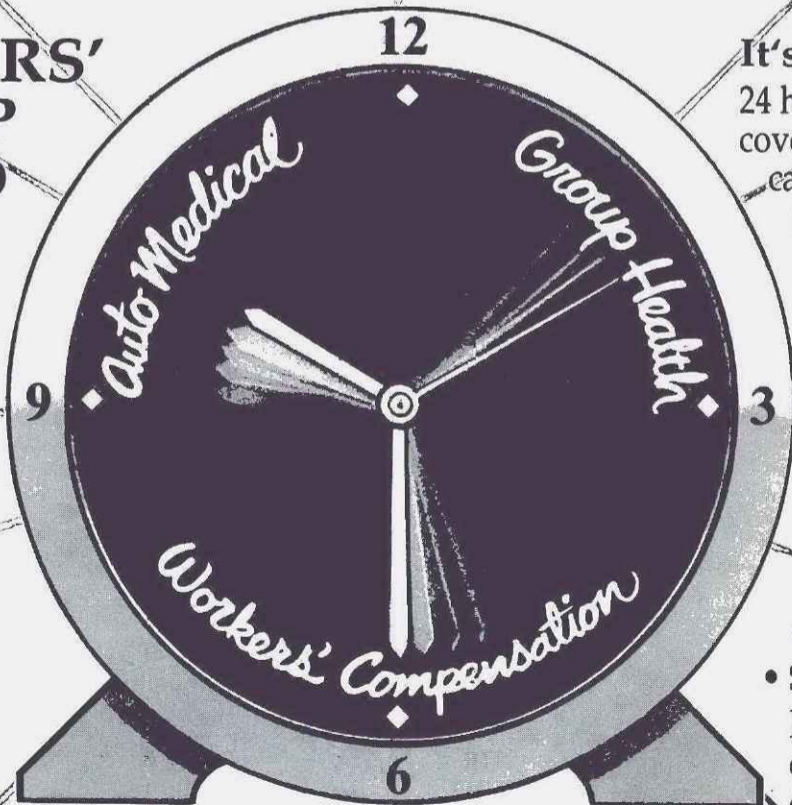
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Continued from previous page
 sionals about their problem, Mr. Plumlee said. By giving employees access to such information, employers can cut costs for unnecessary physician office or emergency room visits, he added.

While it's difficult to quantify the reduction in health care costs due to improved consumer decision-making, these types of calls do make a difference, Mr. Plumlee said. For example, after analyzing 2,500 separate calls to the Access Health's toll-free line, the company found that 75% of callers intending to seek medical care chose not to based on the information they received. Some individuals who call, though, are advised to seek care immediately based on the information the nurses receive, he noted.

Employers also can control consumer demand by distributing information that teaches employees and dependents to ask their providers more intelligent questions about their condition and suggested treatment.

Towers Perrin offers employers a communications program called "I'm in Charge," which consists of pamphlets and a video designed to teach employees consumer skills.

"These materials help employees get over their fear of questioning doctors," Ms. Dietch explained. The materials do not focus on costs, because "people aren't necessarily bottom line-driven. They want to be aware of choices, risks, alternatives and they want information to help them make decisions."

The pamphlets encourage employees to take note of the details of their medical problem and also suggest questions patients should ask their doctors when they have scheduled a non-emergency test, like: Why am I having this test? What will it show? Are there any alternatives to this test? Are there any risks? What is the cost of the test?

The pamphlets cost about \$1 each and the video costs \$2,500, but copies can be made for \$10 each, Ms. Dietch said.

Mr. Ellig of MedEd recommended that employers establish a medical library that employees can use to look up information about specific medical conditions. Such a library could cost as little as \$100 if it just includes several key sources of information, like a standard medical encyclopedia, a prescription drug book and a book explaining the most common medical procedures, he said.

Employers that want their workers to have access to more in-depth medical information can put in a computer-based program that allows employees and dependents to conduct on-line searches of medical journals and consumer magazines, Mr. Ellig noted.

Equipped with such information, employees can learn more about their specific condition or find out what types of treatments yield the best results, he said. Those individuals are then better prepared when they visit their physicians and can make better decisions regarding their care, he said.

Information Access Co., based in Foster City, Calif., offers subscribers on-line access to its data base, which contains thousands of medical periodicals, for a \$5,000 annual fee.

"Knowledge and education" are the keys to controlling health care costs, said Jeanine Decker, human resource manager for the Arizona State Compensation

Fund in Phoenix. In January, the self-insured fund established a Health Resource Center for its 300 employees, which includes a medical library and access to the computerized data base of medical periodicals.

The center cost about \$2,500 in equipment and resources, plus \$5,000 to subscribe to the medical data base, Ms. Decker said. "But compared to what you spend on one premature birth or one prostate surgery or one anything, that's chump change," she said.

"The problem we're all grappling with is it's not clear that each type of intervention is of equal value," Dr. Fries noted. And, to be truly successful, employers must continually communicate to employees the principles and benefits of their demand management programs, he said. **B**

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NAIC meeting

Continued from page 3
in annual insurance premiums.

However, Mr. Johnson is more optimistic about winning critical changes in the future, either before the full NAIC votes on the model at its December meeting or before individual state legislatures consider the measure.

In other sessions at the fall meeting next week, state regulators will also consider how best to impose risk-based capital standards on property/casualty insurers and a new, model investment law for both P/C and life/health insurers.

Under the current fronting proposal, an overwhelming majority of fronting arrangements used by captives—including all single-parent captives domiciled outside NAIC-accredited states and all group captives regardless

of domicile—would be subject to the disclosure and reporting requirements contained in the proposed model act.

So far, Colorado and Illinois are the only U.S. captive domiciles accredited by the NAIC.

In addition, the Special Issues Committee in June tightened guidelines for companies participating in a captive reinsurance pool that make it more likely a captive could be subject to the proposal.

Under the changes, to gain exemption from the proposal's provisions, each captive in a pool must be in the same industry, cede similar kinds of insurance coverage and retain more than 50% of its risks net of all other reinsurance cessions.

On a substantive level, those requirements "effectively destroy the single-parent captive exemption for any captive that

participates in a pool," CARFM's co-chairmen complained in a recent letter to New York Insurance Superintendent Salvatore Curiale, who is the formal chairman of the committee.

"Because pooling spreads risks, rather than increasing them, this is not a sound policy," contended the two chairmen: Richard C. Heydinger, director of risk management for Hallmark Cards Inc. in Kansas City, Mo.; and Jay B. Waters, director of risk management for Forest City Enterprises in Cleveland.

Also, "the current version of the fronting bill, which does not apply to life, credit and surplus lines insurance companies, is not an effective solvency tool," they wrote.

In a separate letter, the CARFM leaders asked that a new, separate committee be appointed to consider the fronting

issue because of an alleged "lack of procedural fairness" in the fronting discussion. They cited as examples a verbal request by the Reinsurance Task Force that individuals who had previously submitted written comments not address the task force, as well as a vote made on the issue by NAIC President Steven Foster, that allegedly violated Roberts Rules of Order.

"Given the power of the NAIC's accreditation process, we believe that there should be procedures in place which ensure that affected parties have a legitimate opportunity to comment on model bills," they wrote in a letter to David J. Walsh, NAIC vp and chairman of its Executive Committee.

In response, a NAIC spokesman says that regulators constantly seek comments, though would prefer not to hear state-

ments repeated that they previously considered and rejected.

In addition, the alleged violation of procedural rules is not only arguable, but also superceded by the NAIC constitution which guarantees each regulator a vote in such situations.

If the fronting bill is approved by the Special Issues Committee in Boston, it would next go to the NAIC's Executive Committee and could then be voted on by all NAIC members as early as December.

Also at the regulators' fall meeting, an NAIC subgroup will receive public comments on a proposed risk-based capital formula for property/casualty insurers.

The formula, which was generally praised when it was unveiled in June, is designed to give regulators a valuable analytical tool to determine when insurers are experiencing financial problems. It will be coupled with an enforcement regulation that will allow individual insurance commissioners to respond more quickly than they have been able to in the past (BI, June 28).

Risk-based capital standards for life/health companies will take effect with 1993 annual statements (BI, Sept. 28, 1992).

Regulators are seeking ways to handle some outstanding issues associated with the standards, including how the formula will treat loss-sensitive business, like retrospectively rated coverage, as well as liability coverage written on a claims-made as opposed to an occurrence policy form.

In addition, the risk-based capital subgroup is reviewing a proposal by the Alliance of American Insurers—the most vocal critic of the proposed P/C formula—that focuses on "cash-flow simulation modeling" as an alternative tool for gauging solvency.

The current timetable calls for the NAIC to hold another public hearing on the standards in November, followed by a special meeting of the NAIC's Examination Oversight Task Force. The regulators' goal is to have all members of the NAIC vote on the proposal at its December meeting.

In addition, NAIC regulators are seeking public comment at next week's meeting on a draft of a model law that would allow state insurance regulators to more effectively police insurance company investments.

The timetable calls for an NAIC subgroup to release a revised draft of the model in December, which will be followed by an opportunity for additional written comments and another public hearing in March 1994.

The investment model law draft would set specific guidelines that life/health and property/casualty insurers will have to follow in assembling their investment portfolio.

"The purpose of this act is to protect and further the interests of insureds by promoting insurer solvency and financial strength," said John Kummer, Florida's Deputy Insurance Commissioner, who is chairman of the NAIC subgroup that is working on the measure.

Among the provisions affecting insurers is that one investment source may account for no more than 3% of a life/health insurer's admitted assets, while the figure is 5% for a P/C insurer.

In addition, there are various caps on medium- and lower-quality bond holdings. **BI**

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The Generali Group has further strengthened its position as leader in insurance on an international scale. Among its activities in 1992, the most important related to the Spanish market where, following the agreements with Banco Hispano-Americano, Generali assumed management of the holding in which each has an equal share and which controls six insurance companies with premiums amounting to some 200 billion pesetas. Generali furthermore acquired control of the Federation Ins. Co. of Canada in Montreal, of Atlas of Lima, and of an English holding company. It increased its majority stakes in the BMA of Kansas City – now up to 100% – and in the Unione Mediterranea di Sicurtà of Genoa. It set up holding companies, into which it put insurance shareholdings, in Belgium and Ger-

many and it took over an Italian farming company. In the early months of 1993 Generali has taken control of Nacional in Ecuador; has participated in the establishment of a company in Rumania, Generala Asigurari, in which it has a majority stake, and has extended agreements with banking institutions for the distribution of insurance and financial products through banks' branches.

In addition, initiatives are underway towards the twin objectives of, on the one hand, optimising the Group's structure in some of its traditional territories such as Belgium and Germany (following Holland where such an operation has already been completed) and, on the other hand, expanding the Group's presence in Latin America, East Europe and the Far East.

1992 CONSOLIDATED STATEMENT

ASSETS (000 US\$)*	1992	1991
Building and farm property	6,696,845	5,515,968
Fixed-interest securities	25,583,504	18,906,858
Shares and equity participations	6,063,228	4,757,385
Loans	2,592,521	2,035,169
Deposits with Ceding Companies	514,688	427,105
Bank deposits	2,549,554	1,736,917
Accounts receivable and other assets	5,640,746	3,855,778
Total	49,641,086	37,235,180
LIABILITIES (000 US\$)*		
Provisions for insurance liabilities	38,355,118	27,276,307
Reinsurance deposits	486,430	462,756
Other liabilities	3,286,752	2,630,148
Minority shareholders' interest	1,508,723	1,160,565
Shareholders' surplus	5,613,120	5,322,018
Profit for the year	390,943	383,386
Total	49,641,086	37,235,180

* All figures have been converted at the rate of exchange of Lire 1,470.86 to the US\$

■ This statement consolidates 82 insurance companies (including 8 Europ Assistance companies) operating in some 40 markets, 27 holding companies, 23 property companies and 3 farming companies.

■ The profit is US\$ 390.9m., slightly above that of the preceding year, but nevertheless notable in that it was achieved under unfavourable economic conditions and

despite writedowns in security valuations. These were reflected in the account (US\$ 373.2m. against US\$ 142.7m. in 1991) and were exceptionally high due also to the extremely prudent criteria that were applied. Particularly satisfactory was the operating result, which improved by US\$ 92.4m. to reach nearly US\$ 271.9m.

■ Consolidated premiums amounted to US\$ 15,245m. against US\$ 10,881m. in 1991. This 40.1% rise was influenced also by the inclusion of new companies in the consolidation and by the effect of exchange rate variations. Premiums in Life insurance amounted to US\$ 6,290.5m., in Non-Life to US\$ 9,014.5m.

■ Claims paid amounted to US\$ 7,689.7m.

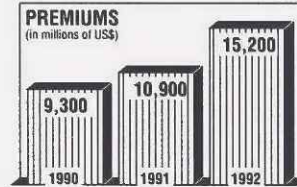
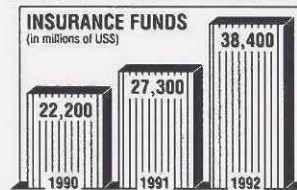
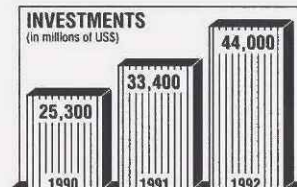
■ Provisions for insurance liabilities increased by US\$ 5,400.9m.

■ Production and administrative costs amounted to US\$ 3,668.2m. The ratio of costs to premiums declined from 29% in 1991 to 27.1%.

■ Investments rose to US\$ 44,000.3m. (+31.8%), against which provisions for insurance liabilities amounted to US\$ 38,355.1m.

■ Investment income totalled US\$ 3,623.7m. (+41.2%).

■ Overall shareholders' equity amounted to US\$ 7,053.4m., of which 79.6% pertains to the Parent Company.



Central Head Office in Trieste (Italy)

The Generali Group operates in the United States through: Assicurazioni Generali U.S. Branch, BMA-Business Men's Assurance and Generali Underwriters Inc.



THE INSURER WITHOUT FRONTIERS.

INTERNATIONAL

Japan to retain brunt of typhoon losses

By ADRIAN LADBURY

LONDON—Although Typhoon Yancy, which lashed southern Japan Sept. 2-3, is the most powerful storm to hit the country in the last 50 years, it will not cost insurers as much as 1991's Typhoon Mireille.

Few estimates of the size of insured losses were available last week, as the Japanese market awaited the first official estimate of Yancy losses from the Marine & Fire Assn. of Japan. The association's estimate is expected later this week.

But industry sources agree that

insured losses will not match the severity of the storm's wind, rain and flooding, which left almost 50 dead, destroyed nearly 600 homes and 1,500 other structures, tore up roads and left more than half a million homes without power. The storm, which carried winds of as high as 101 mph, caused flooding and mudslides as it hit the islands of Kyushu, Shikoku and part of Honshu.

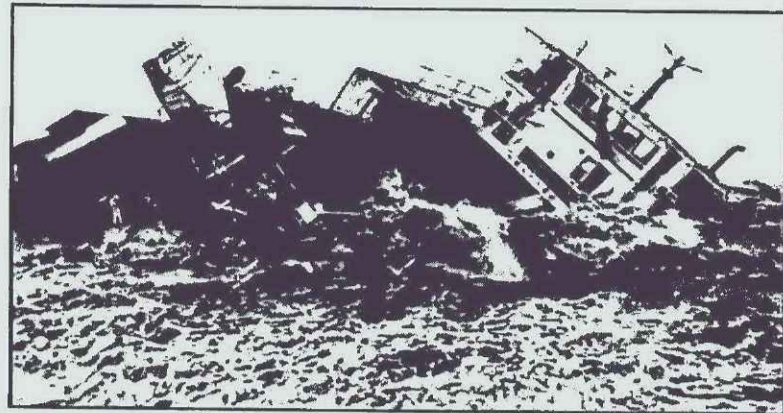
Brokers and underwriters in the London market believe that the smaller scale of the insured losses, coupled with the increased deductibles enforced on Japanese insurers after Typhoon

Mireille (*BI*, Feb. 17, 1992; Dec. 2, 1991), will leave London reinsurers relatively unscathed.

Typhoon Mireille caused \$5 billion in insured damages.

"There are some wild figures flying around the market at the moment, which seem to range between 50 billion and 200 billion yen (\$473.5 million and \$1.89 billion)," said a leading Lloyd's of London broker who specializes in Japanese risks. "But even if the number is at the upper end of these guesses, it will only affect the lower layers of the Japanese companies' pro-

Continued on page 41



AP/Wide World Photo

A ferryboat is driven onshore near Kagoshima by Typhoon Yancy.

Only certainty in Baltica's future is change

By MARIA KIELMAS

COPENHAGEN, Denmark—Denmark's Baltica Forsikrings says it expects the ownership of a major percentage of its shares to change "within a short span of years."

With so much of Baltica's stock up for grabs and the insurer reporting poor first-half results, stock market analysts are pon-

dering the company's future.

Speculation on the company's future increased when Chief Executive Hans Ejvind Hansen said late last month that the insurer will now focus on Danish business and will scale down international underwriting.

The main problems facing the insurer are: the runoff of credit guarantee business, which has generated big losses; outstanding loans

with the Baltica Bank; and uncertainty as to the company's future ownership structure.

After the restructuring of Baltica Holding units in the spring of 1993, Baltica Forsikrings became the parent company of the group and took over 28% of its own shares from its former parent (*BI*, March 29). The other principal shareholders in the insurer are: Den Danske Bank, with 32%; Gefion, the com-

pany created mainly to take over the former Baltica Holding's poorly performing real estate and debt, with 23%; and Codan Insurance Co., a Danish insurer that is mostly owned by the U.K.-based Sun Alliance Insurance U.K. Ltd. which took over the operating subsidiaries of the bankrupt Hafnia Holding of 1992 A/S, with 10% (*BI*, April 5). Den Danske Bank has made it known that it intends to

dispose of its stake in Baltica at some future date.

Baltica's future "is a total enigma," said Angus Runciman, insurance analyst Barclays de Zoete Wedd in London. "They (Baltica) could be biding their time until they are in a position to go to outside investors."

Mr. Runciman speculates that the block of shares held by Den

Continued on next page



Beer bottle recall uncaps dispute over liability

By ADRIAN LADBURY

LONDON—A protracted dispute is brewing between the insurers and lawyers of three Dutch beer makers and the manufacturer of 18 million beer bottles that have been recalled because of glass splinters found in some of them.

Heineken N.V.'s quality-control personnel on Aug. 26 spotted the defect in a batch of 33-centiliter (10-ounce) beer bottles for export markets and immediately announced the recall. The company said glass shards had been released from the neck of some bottles. A problem also was found with the newly designed bottle mouth.

The other brewers—Bavaria N.V. and United Dutch Breweries N.V.—followed Heineken's recall lead soon afterward.

Heineken had received three personal injury claims as of last week. Two had already been withdrawn after closer examination, while a U.K. claim is currently being investigated. Heineken would not elaborate on the claims.

Neither Bavaria nor United Dutch has reported receiving any personal injury claims yet.

The three brewers say they are insured for liabilities incurred from the faulty bottles and hold the bottlemaker, United Glassworks N.V., a unit of French food conglomerate BSN S.A., liable

Continued on page 41

Australian work comp reform

Report suggests ways to simplify complex system

By KATE McILWAINE

CANBERRA, Australia—Opening Australia's workers compensation system to competition among private insurers would save money and simplify the current system, according to a report by the Australian Industry Commission.

In an interim report released Aug. 23, the commission, which is conducting a 15-month study of the nation's workers comp system, also recommends adopting a common, nationwide workers comp benefit structure, as

well as common requirements for underwriters and open competition among insurers for workers comp accounts.

The report also suggests that all workers comp programs should offer employers the opportunity to self-insure their exposures, with appropriate regulation.

Australia currently has a mix of government-run and private workers comp plans. Differences in state regulations create "cross-border" problems and add to the cost and complexity of workers comp arrangements, the report states.

"This means not only are many firms unable to cover all their workers under one scheme, but they have to understand the details of all relevant jurisdictions

to conduct business Australia-wide," the report says. "Firms with employees who regularly work in more than one state, such as truck drivers, can be required to be fully covered in each jurisdiction, thus adding greatly to premiums."

The commission's report also backs proposals to base workers comp insurance rates on employers' claims experience. "Those employers whose workplaces impose the greatest injury and disease costs (should) make the greatest contribution to meeting these costs," the report states.

The commission, a government-funded independent advisory panel, will hold public hearings on the report in all Australian state capitals through

Continued on next page

Two U.K. insurers quit Japanese venture

By ADRIAN LADBURY

LONDON—General Accident P.L.C. and Norwich Union P.L.C., two of Britain's biggest multiline insurance companies, have pulled out of a joint venture that has operated in the Japanese insurance market since 1947.

General Accident and Norwich Union have left the operation, which is called British Insurance Group, in the hands of its third partner, Sun Alliance Group P.L.C. Sun Alliance will take control of BIG—whose head office is in Tokyo—as of Jan. 1, 1994.

BIG's premium volume in 1992 was 43 million pounds (\$65.2 million), which makes it the third-largest foreign insurer in Japan, according to Ian Toms, operations manager of Sun Alliance Overseas.

Nevertheless, foreign insurers only account for an estimated 3% of all premiums in Japan, most of which is written by American In-

LONDON

ternational Group Inc., market observers say.

"NU's decision to withdraw follows a strategic review of its operations which concluded that its share in BIG does not give it a major participation in the Japanese market," said a statement from the Norwich, England-based insurer. "Being a party to a long-standing cooperation agreement involving both Chiyoda Fire & Marine Insurance Co. Ltd. and Chiyoda Mutual Life Insurance Co., NU is satisfied that any future requirements for the provision of service in Japan to its international clients will be fulfilled by these companies," it added.

Said Perth, Scotland-based General Accident: "It was unprofitable and there was no reasonable expectation of change in the foreseeable future. Obviously

these (factors) are now looked at much more closely. It is a difficult market for foreign insurers," said Ian Cairns, project manager-overseas region.

Sun Alliance is prepared to wait for a change in the market.

"Our group strategy is to develop the Asian area, and Japan is key to that. We are trying to identify where we can develop profitable business, and BIG has had a profitable first half," said Mr. Toms.

"There are changes coming in the Japanese market over the next two to three years which would hopefully lead to a change in the pricing and wordings set by the Ministry of Finance. There is also a lot of foreign investment in Japan," he added.

Bradstock acquisition

Broker Bradstock Group P.L.C. is acquiring reinsurance broker Fox Craig Group Ltd. for

Continued on page 42

Australian comp

Continued from previous page
October. The panel will seek comment on its draft report and make recommendations in a final version, which it is expected to deliver to the federal government in February 1994 (BI, March 1).

Meanwhile, in the state of Queensland, the government-run Workers Compensation Board, to which all employers pay premiums, has agreed to compensate a victim of asbestos-related disease.

Terms of the award, to be made by the WCB on behalf of 11 stevedoring organizations for which the victim had worked, were ordered kept secret. The award was ratified by the Supreme Court in Brisbane.

Reg White, 51, is a former wharf laborer who loaded and unloaded asbestos in Brisbane from 1964 to

1969. He has contracted an asbestos-related lung disease and doctors say he has only five to 10 years to live.

The case is likely to be the first of the board's large payouts to workers alleging asbestos-related injuries, attorneys say.

Mr. White's attorney, Matthew Craswell, of the firm Peter Channel & Assn. in Brisbane, said his firm is taking six similar cases against the WCB to court in the next 12 to 18 months.

Secrecy agreements were requested when "large sums" were involved in the payout because the WCB was "very scared" about its potential liabilities, he said. The board had admitted the injury was compensable, but tried to avoid liability because of the time between exposure and when claims were filed, Mr. Craswell said. **BI**

Baltica

Continued from previous page
Danske Bank could be placed with outside investors, after which Baltica Forsikrings will try for a capital increase.

However, a Baltica spokesman said the company is not planning a capital increase in the future. The spokesman said that Danish regulators have granted Baltica Forsikrings a dispensation to retain ownership of its 28% stake for three years. After this period, it has to sell the shares or write down the capital. The remaining question about Baltica Forsikrings' ownership really will turn on the policy of Den Danske Bank, its largest shareholder, the spokesman said.

The insurer reported a first-half 1993 loss of 60 million Dan-

ish kroner (\$9.1 million). Baltica Forsikrings' 63 million loss (\$9.6 million) was offset by a 3 million kroner (\$457,000) profit from minority interests in subsidiaries. These figures cannot be accurately compared with first-half 1992 figures, because the earlier figures were for the now-defunct Baltica Holding.

Baltica Forsikrings conducts non-life business, while its subsidiary, Danica, writes life business. Danica's result was consolidated into the parent company's income statement.

Baltica said in a statement that the 63 million kroner loss was due to losses and provisions for credit guarantee business, which is being run off. The company lost 278 million kroner (\$42.3 million) on credit guarantee business in the first half of this year.

Baltica Forsikrings' gross premium income rose to 1.69 billion (\$257.4 million), up 1% from the first half of 1992.

The claims performance was unsatisfactory in the first half of 1993, the Baltica statement said, with a loss ratio of 93%. But insurance operations were strengthened by cuts in expenses. The expense ratio fell by 3% to below 30%, and staff has been cut 8% to 3,324 from 3,605 since the first half of 1992.

The company's shareholders' equity fell to 8.46 billion (\$1.29 billion) as of June 30 from 8.53 billion kroner (\$1.36 billion) at year-end 1992. The equity of the parent company, Baltica Fcrsikrings, fell slightly to 7.75 billion (\$1.18 billion) over the same period, from 7.82 billion (\$1.24 billion) kroner.

Baltica said that the settlement of debt with the former holding company, Gefion, is expected to proceed according to plan. Baltica Forsikrings made a 500 million kroner (\$79.5 million) deposit with the Baltica Bank after the company's initial restructuring in autumn 1992 and contributed 500 million kroner in supplementary capital. The bank is expected to repay this amount partly in cash and partly in real estate in the second half of 1993.

Mr. Hansen said the company's strategy is to continue as a Danish insurer. International activities will be limited or sold if they do not support the servicing of Danish customers. Baltica will only continue limited involvement with the VINCI cooperative association among European insurers writing international business.

Foreign operations will be sold or continued on a limited scale, except for Baltica (U.K.), which is expected to continue. **BI**

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INTERNATIONAL

Bottle recall

Continued from page 39
for any damages. None of the brewers would give details of the coverage.

It is unclear whether the bottle manufacturer has a separate product recall policy or whether it may try to claim on its standard product liability coverage.

"We hold the glass facility liable for the costs, and it is now in the hands of the insurance companies and the lawyers—which I believe will be a very complex operation," a Heineken spokeswoman said last week.

United Dutch is "fully insured and has adequate cover for any liabilities that may arise," said a spokesman for the brewer.

But the spokesman could not confirm the existence of product recall coverage in addition to liability coverage. He added that the company would have carried out the recall in the consumers' best interests regardless of the existence of insurance.

United Glassworks would not detail its coverage.

"Heineken and Bavaria are officially holding United Glassworks liable. The insurance company has duly been informed," the bottlemaker stated on Aug. 28.

A United Glassworks spokesman later expressed the opinion that the company would be covered under its normal product liability policy, which he said is with a "cluster of companies" based in Paris. "I think the insurers will be talking to each other for some time," he added.

None of the breweries has given accurate estimates of the total cost yet. But, during the Sept. 2 announcement of Heineken's first-half results, K. Vuursteen, chairman of the brewer's executive board, said the "direct damage caused by product withdrawal, destruction and replacement will amount to tens of millions of guilders."

Heineken has recalled 17 million bottles from eight different markets—Austria, the Canary Islands, Finland, Israel, Hong Kong, Hungary, Sweden and the United Kingdom. Bavaria and United Dutch have recalled bottles only from the United Kingdom, with the former taking 750,000 bottles off the shelves and the latter removing 250,000.

According to product liability experts in the London market, it is unlikely that the bottling company would have purchased product recall coverage. Therefore, they believe it could eventually prove to be a massive uninsured loss.

"There is not much of a product recall market in Europe and certainly not in the U.K., and so it could very well ultimately be an uninsured loss," said one London company market product liability underwriter.

"If it fell on the bottler's product liability policy, it would not be so cut-and-dried, because the standard PL policy requires there to be an injury to a third party or property. Economic loss would be covered under a separate contract if they had one. But if they tried to claim under the product liability policy, it would certainly not be straightforward," he continued.

The London underwriter also pointed out that the existence of product recall coverage is almost as closely guarded a secret as kidnap and ransom coverage, to prevent dubious claims. **B**

Typhoon Yancy

Continued from page 39
tections," which were very expensive, he said.

The broker added that the current Japanese market deductible for catastrophe reinsurance coverage is about 80 billion yen (\$757.6 million), compared with only about 10 billion yen (\$94.7 million) before Typhoon Mireille.

"Even if it reached 100 billion yen (\$947 million), it would only creep into the bottom layers (of catastrophe reinsurance), and if it were more like 50 billion yen (\$473.5 million), it would be fully retained," the broker said.

"The insured losses will be substantially less than was originally feared and will certainly be far less than Typhoon Mireille in 1991, particularly bearing in

mind the ferocity and scientific size of Typhoon Yancy. London underwriters will find the impact much greater in their minds than in their books," said a spokesman for Alexander & Alexander Services Inc. in Japan.

One Lloyd's catastrophe underwriter explained that the market had feared the worst on Friday, Sept. 3, because it appeared that Yancy was heading straight for Tokyo, after lashing the country's southern islands. "But it moved slowly into the Sea of Japan and petered out into a 'temperate depression' by Sunday—and the market breathed a sigh of relief," he said.

"There has been a lot of damage, especially to electrical systems. It headed toward the main-

land, but then went across the center and not Tokyo, so the damage was limited," said Ian Toms, operations manager of Sun Alliance Overseas, which underwrites in Japan through subsidiary British Insurance Group.

"Sun Alliance has no exposure except perhaps for its office in Kagoshima," on the island of Kyushu, he added.

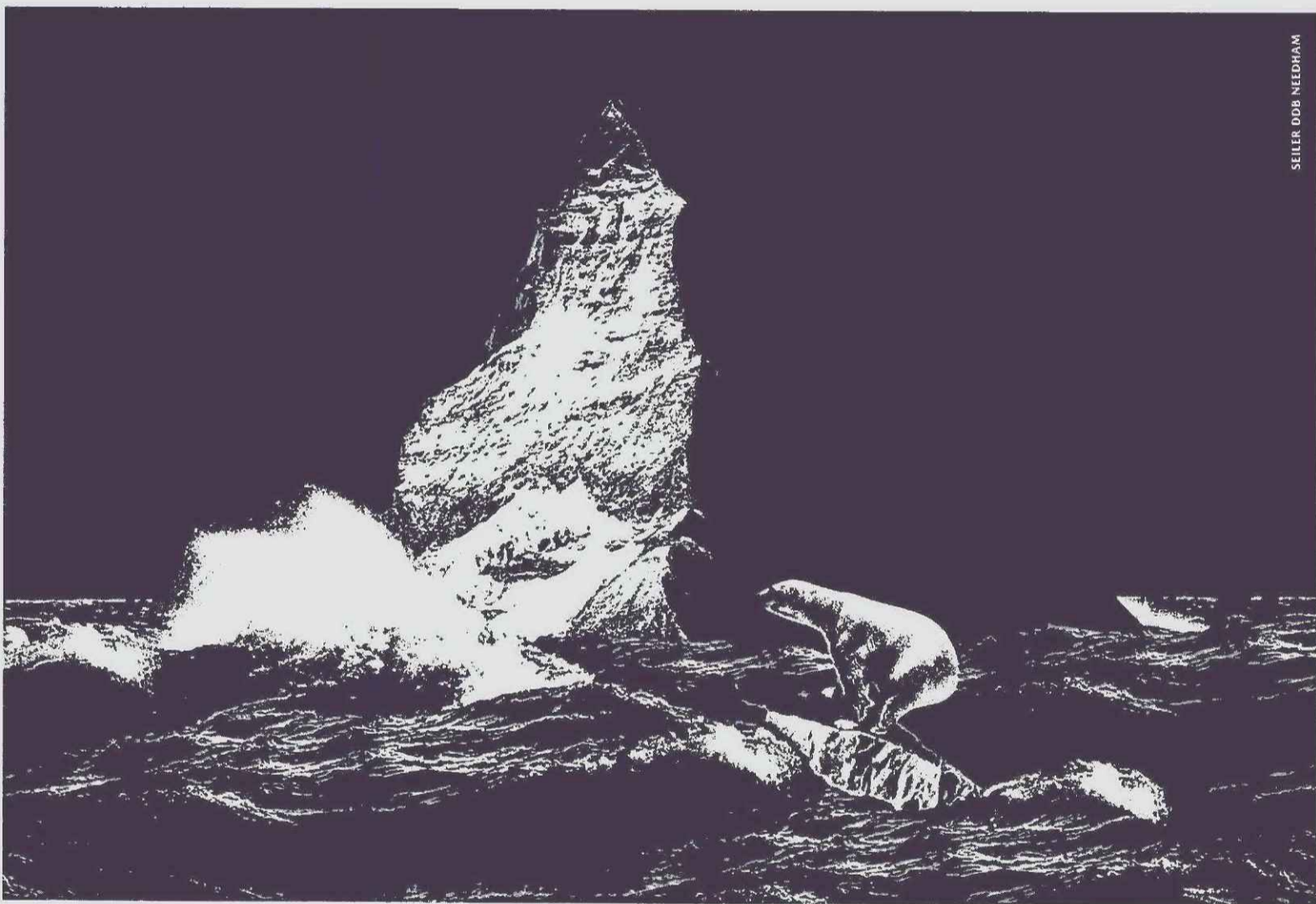
One Tokyo-based Japanese broker confirmed the London market is likely to escape unscathed from Yancy losses. "I do not think it is likely to hit the reinsurers. It is a big insurance loss and we are waiting for the local government estimates, so I cannot give any loss figures, but it looks smaller than Mireille," he said.

And, a Japanese broker based

in London said that the damage could be limited by the fact that the affected area is primarily rural.

"It is very difficult to give a figure at the moment, but it looks smaller than Mireille. We may know the damage but not how much is covered by the general insurance companies," said Gin H. Takahafi, managing director of Cosmos Jardine (Europe) Ltd. "Most of the farmers will be covered by mutuals, as with the big earthquake in July," he said (BI, July 31).

In the affected area, "very few families were covered at all and if they were, it was through a mutual. With Kyushu, it is harder to say, but it is likely a considerable amount will be insured by the mutuals," said Mr. Takahafi. **B**



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INTERNATIONAL

LONDON

Continued from page 39

2.5 million pounds (\$3.9 million). Fox Craig, which specializes in U.S. property/casualty business, is owned by its founder and managing director Tony Fox and fellow directors.

The owners, who will join Bradstock, will be paid in three installments over the next three years, mainly in Bradstock shares.

In announcing the deal last week, Bradstock said that it has been concerned that it only has had a "modest exposure" to U.S. property/casualty reinsurance business and the purchase will "balance" its business mix.

"Fox Craig's business is, in the main, U.S. property and casualty treaty reinsurance. With the arrival of Tony Fox and his team, we will strengthen our presence in the vitally important North American marketplace," said Robin Gibson, chief executive of Bradstock.

New runoff firm

Integrated Run-off Insurance Services Group Inc., a runoff services company jointly owned by Aon Corp. and Centre Reinsurance Holdings Ltd., has opened an office in London.

IRISC, which was formed in late 1989, provides reinsurance consulting and management of runoff services to insurers, captives and risk retention pools worldwide.

IRISC London Ltd. will offer runoff management services to insurers, reinsurers and brokers in the London market, said Jerry McArthur, managing director.

IRISC has been looking at London as a potential new market for "about 18 months," Mr. McArthur said. In the future, it could also provide runoff services to Lloyd's of London syndicates.

The new firm has 40 employees, many of whom are former London market brokers and technicians. Mr. McArthur previously worked for the now-defunct U.K. insurer English &

American Group P.L.C. and its runoff subsidiary Trinity Square Services Inc., based in the United States.

While several firms offer runoff services in the London market, most concentrate on systems and administration at the expense of managing the actual runoff, Mr. McArthur said.

"Our whole philosophy is claims driven, not processing driven. We do not simply administer the runoff; we want to also offer alternative solutions to varied situations.

Mr. McArthur said that the backing of Centre Re could be crucial in finding alternative solutions.

"With Centre Re behind us, we can offer exit routes from the London market. It may well come to the table to offer retroactive assumption of liabilities," he said.

Mr. McArthur also said IRISC will have more flexible pricing for its services than many competitors. The company will adopt an "incentive-based" fee structure rather than a fixed cost or

hourly charges.

"We will be willing to take a risk ourselves in accepting management of a portfolio. We will tell the client we can run the account at a lower cost than they can and share the savings between us," said Mr. McArthur.

Members agent folds

Consolidation within Lloyd's of London continues apace as a major managing and members agent announces plans to transfer its members to a rival agent.

Cuthbert Heath Underwriting Ltd. has signed an agreement to transfer all the business and good will of its members agency subsidiary to Octavian (Underwriting) Ltd.

Cuthbert Heath's 257 active names will join 965 active Octavian names. The combined members agent will have total 1993 capacity of 369 million pounds (\$559 million at appropriate exchange rate). The transfer will take place Oct. 1, barring any objection by Lloyd's.

Octavian will also assume the

management of the affairs of Cuthbert Heath's non-active names. David Foster, managing director of Cuthbert Heath Members Agency Ltd., and other "key members of the team" will follow the names to Octavian.

"We are convinced that this arrangement is in the best interests of all Cuthbert Heath names. Only the larger and more economic groupings will prosper in the new Lloyd's environment. Octavian has an excellent reputation, and we believe the enlarged agency will achieve considerable economies of scale," said David Hazlewood, chief executive of Cuthbert Heath Underwriting Ltd.

Minet in Australia

Broker Minet Group P.L.C. is expanding its Australian operations with the acquisition of Perth-based Allied Insurance Brokers.

Allied's offices will be merged with Minet's Perth office to form a new division named Allied Minet. **BI**

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Vice-Presidents, General Managers and Other Administrative Personnel 4,166

Financial:
Chief Financial Officers and Vice-presidents of Finance 2,526
Secretaries, Treasurers, controllers and other Financial Personnel 3,735

Risk/Employee Benefits:
Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations 15,035
Sub-total 28,114

Associations 392
Government, Unions and Educational Institutions 1,120

Commercial Consumers
Sub-total 29,626

Insurance Agents and Brokers 8,788
Insurance Companies 7,977
Accountants, Actuaries, Attorneys & Consultants 3,572
Adjusters, Appraisers, TPA's, Captive Managers & Health Care Providers 1,849
Others Allied to the Field 968
Single Copies 0
TOTAL 52,780

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Datebook

SEPTEMBER

SEPT. 19-21. Global Insurance Capacity 2000: Demand and Supply conference in London, sponsored by the Society of Chartered Property & Casualty Underwriters; \$950 for Society of CPCU members, \$1,150 for non-members. The Society of CPCU, 720 Providence Road, P.O. Box 3009, Malvern, Pa. 19355-0709; 215-251-2774.

SEPT. 19-21. Conference and Fellow, Life Management Institute Conferment in Toronto, sponsored by LOMA. Tim Kelley, LOMA, 5770 Powers Ferry Road, Atlanta, Ga. 30327-4308; 404-951-1770.

SEPT. 19-21. Public Risk Management Assn. Mini Conference in Park City, Utah; \$225 for PRIMA members, \$325 for non-members. Also Oct. 10-12 in Orlando, Fla. Public Risk Management Assn., 1117 N. 19th St., Suite 900, Arlington, Va. 22209; 703-528-7701.

SEPT. 20-21. Sixth annual ERISA Litigation Conference in San Francisco, sponsored by Prentice Hall Law & Business and Fordham University Law School; \$695. Also Sept. 27-28 in New York and Feb. 17-18, 1994, in Orlando, Fla. Dominic Vec-

chione, Prentice Hall Law & Business, 270 Sylvan Ave., Englewood Cliffs, N.J. 07632; 800-447-1717, ext. 8034.

SEPT. 20-21. Reimbursement: Coverage, Payment and Contracting conference in Washington, sponsored by International Business Communications; \$1,195. IBC USA Conferences Inc., 225 Turnpike Road, Southborough, Mass. 01772-1749; 508-481-7911.

SEPT. 20-21. Principles of Reinsurance seminar in New York, sponsored by The College of Insurance; \$525. The Center for Professional Education, The College of Insurance, 101 Murray St., New York, N.Y. 10007; 212-815-9021.

SEPT. 20-21. Workers Compensation: The Controllable Factors annual conference in San Francisco, sponsored by Conference Development Inc.; \$895. Conference Development Inc., 1000 Winter St., Suite 4000, Waltham, Mass. 02154; 800-872-0094.

SEPT. 20-22. Fundamentals of Insurance course in Minneapolis, sponsored by the Risk & Insurance Management Society Inc.; \$700 for RIMS members, \$800 for non-members. Also Oct. 25-27 in New Orleans and Dec. 6-8 in San Diego. RIMS, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

SEPT. 20-22. Techniques of Risk Management course in Chicago, sponsored by the Risk & Insurance Management Society Inc.; \$700 for RIMS members, \$800 for non-members. Also Dec. 8-10 in San Diego. RIMS, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

SEPT. 21. OSHA Process Safety Standard symposium in Schaumburg, Ill., sponsored by the Society of Chartered Property & Casualty Underwriters and the Loss Control Section; \$70 for Society of CPCU section members, \$95 for Society of CPCU non-section members, \$115 for non-members. Karen Willmann, Continuing Education Coordinator, The Society of CPCU, 720 Providence Road, P.O. Box 3009, Malvern, Pa. 19355-0709; 215-251-2774.

SEPT. 21-22. Cut Costs while Boosting Quality of Care through Workers' Compensation Managed Care conference in Washington, sponsored by the Institute for International Research's Health Care & Insurance Division; \$1,095. Conference Administrator, Institute for International Research, 708 Third Ave., Fourth Floor, New York, N.Y. 10017; 212-826-1260 or 800-345-8016.

SEPT. 21-22. Advanced Risk Management Analysis course in Phoenix, sponsored by the Risk & Insurance Management Society Inc.; \$750 for RIMS members, \$850 for non-

members. RIMS, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

SEPT. 21-23. Fundamentals of Risk Management program in Long Grove, Ill., sponsored by Kemper Risk Management Services; \$750. Kemper Risk Management Services, 1 Kemper Drive, K-4, Long Grove, Ill. 60049-0075; 708-540-4901.

SEPT. 22. Environmental Law Update program in New York, sponsored by the Practising Law Institute; \$575. Practising Law Institute, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700.

SEPT. 22. Reviewing Boiler and Machinery Coverages workshop in New York, sponsored by the Society of Chartered Property & Casualty Underwriters; \$85 for Society CPCU members, \$95 for non-members. Karen Willmann, Continuing Education Coordinator, The Society of CPCU, 720 Providence Road, P.O. Box 3009, Malvern, Pa. 19355; 215-251-2773.

SEPT. 22-23. Intermediate Reinsurance seminar in New York, sponsored by The College of Reinsurance; \$525. The Center for Professional Education, The College of Insurance, 101 Murray St., New York, N.Y. 10007; 212-815-9021.

SEPT. 22-24. International Risk

and Insurance Strategies course in Chicago, sponsored by the Risk & Insurance Management Society Inc.; \$850 for RIMS members, \$950 for non-members. RIMS, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

SEPT. 23. Protecting the Corporate Parent: Avoiding Liability for Acts of a Subsidiary program in New York, sponsored by the Practising Law Institute; \$595. Practising Law Institute, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700.

SEPT. 23-24. Insurance Claims Supervision seminar in Dallas, sponsored by the Defense Research Institute Inc.; \$425 for DRI members, \$475 for non-members. Defense Research Institute, 750 N. Lake Shore Drive, Suite 500, Chicago, Ill. 60611; 312-944-0575.

SEPT. 26-29. National Assn. of Mutual Insurance Cos. Annual Convention in Chicago; \$300 for NAMIC members, \$420 for non-members. NAMIC, 3601 Vincennes Road, Indianapolis, Ind. 46268; 317-875-5250.

SEPT. 26-29. Behavioral Healthcare Tomorrow conference in San Francisco, sponsored by the Institute for Behavioral Healthcare; \$595. IBH, 4370 Alpine Road, Suite 108, Portola Valley, Calif. 94208; 415-851-8411.

Continued on page 44

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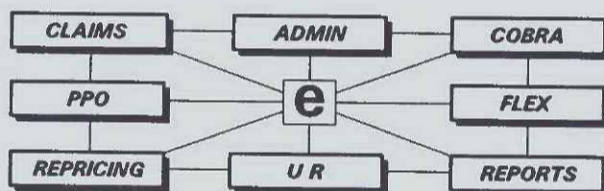
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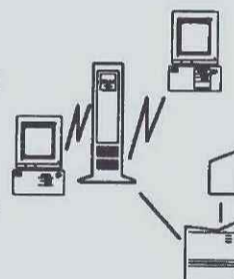
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Datebook

Continued from previous page
SEPT. 27-28. The 401(k) Course in Brookfield, Wis., sponsored by the International Foundation of Employee Benefit Plans; \$490 for Foundation members, \$540 for non-members. International Foundation of Employee Benefit Plans, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

SEPT. 27-28. Advanced Reinsurance seminar in New York, sponsored by The College of Insurance; \$525. The Center for Professional Education, The College of Insurance, 101 Murray St., New York, N.Y.

10007; 212-815-9021.

SEPT. 27-28. Workers Compensation and Claim Handling seminar in Long Grove, Ill., sponsored by Kemper Risk Management Services; \$500. Kemper Risk Management Services, 1 Kemper Drive, K-4, Long Grove, Ill. 60049-0075; 708-540-4901.

SEPT. 27-29. Reimbursement Planning: Implementing Customer-Focused Strategies to Assure Reimbursement in the New Healthcare Reform Environment program in Boston, sponsored by the Pharmaceutical Division of the Institute for International Research; \$1,195. Institute for International Research, 708 Third Ave., New York,

N.Y. 10017-4103; 212-661-3500.

SEPT. 27-30. Eighth Annual Seminar on Insurance Fraud in San Francisco, sponsored by the International Assn. of Special Investigation Units; \$275 for IASIU members, \$375 for non-members. IASIU, 110 William St., 24th Floor, New York, N.Y. 10038; 212-669-9200.

SEPT. 28. ADA: One Year Later conference in New York, sponsored by the New York Business Group on Health; no charge for NYBGH members, \$30 charge for non-members. Contact Stuart Lerner, New York Business Group on Health Inc., 622 Third Ave., 34th Floor, New York, N.Y. 10017-6752; 212-808-0550, ext. 12.

SEPT. 23. Climate Change and the Insurance Industry: The Next Generation seminar in New York City, sponsored by The College of Insurance; \$300. Contact The College of Insurance, 101 Murray St., New York, N.Y. 10007; 212-315-9201.

The Datebook 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 price, if any, of 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.

New York drafting regulation changes for excess market

By MICHAEL SCHACHNER

NEW YORK—The New York Insurance Department is rewriting a key provision in excess and surplus lines regulations to include several amendments recently mandated by state lawmakers.

In particular, regulators are redrafting a provision of the state's excess lines law that pertains to the placement of insurance in the non-admitted market.

Among other things, Regulation 41 requires brokers and other producers to document three rejections from admitted insurers before "exporting" business to the surplus lines market. In amending the regulation, the Insurance Department will add a list of what constitutes an "available" admitted market.

The list includes:

- Knowledge that a licensed insurer has recently written the kind of business being offered.
- Advertising for the business by a licensed insurer.
- Knowledge obtained by the broker from published sources, such as in a newspaper or magazine, that the business is welcome.
- Discussions with insurance professionals, risk managers and others indicating that the business can be written in the admitted market.

"These clarifications of what a diligent effort is should help brokers know when they can access the surplus lines market without question," said Stewart Keir, assistant deputy superintendent of the Insurance Department. "These guidelines should make a rejection easier to document."

Regulators will also remove an existing requirement that a piece of business must be split between the admitted and non-admitted markets if an admitted insurer is only willing to accept a portion of the risk.

Under the new regulation, brokers will be able to place the entire risk in the non-admitted market if the admitted market only agrees to write a fraction of the risk.

Also included in the Legislature's mandate to the Insurance Department is the elimination of the requirement that a broker submit a risk to a residual market before placing it with the non-admitted market. Exceptions to this rule, though, are private automobile liability, medical malpractice and other insurance that must legally be provided by a licensed insurer.

Brokers will be required, however, to first inform policyholders of the existence of a residual market.

The regulation will also be expanded to allow claims-made coverage to be written by the non-admitted insurers. Prior to the changes, the surplus lines market was restricted to writing occurrence-form liability coverage.

"While we don't expect people to run to the E&S market, it will certainly be easier to approach," said Alan Jay Martin, of Abrams & Martin in New York, which represents the New York-based Excess Line Assn. "Things are now on paper, supporting the fact that the E&S market is a professional market that's accessible." **BI**

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HARTFORD, CT—In response to customer requests, Industrial Risk Insurers has created Outreach '93, a two-day program of four seminars, which will be introduced in Phoenix, Arizona, preceding the November 14-17, 1993 NFPA (National Fire Protection Association) Fall Meeting.

IRI's two-day traveling program, scheduled for November 12 and 13, has been designed to address the needs of risk and insurance managers, plant managers, plant engineers, managers of safety and security, plant fire chiefs and others responsible for implementing

or overseeing industrial fire protection.

Registrants may select from three one-day seminars or choose the two-day seminar. Registration is free for IRI insureds with a materials fee per seminar of \$75. Others will be charged \$150, which includes the materials.

The two-day "Industrial Fire Control Concepts" seminar, held on November 12 and 13, will explore all aspects of the industrial fire problem with special emphasis on how to manage it.

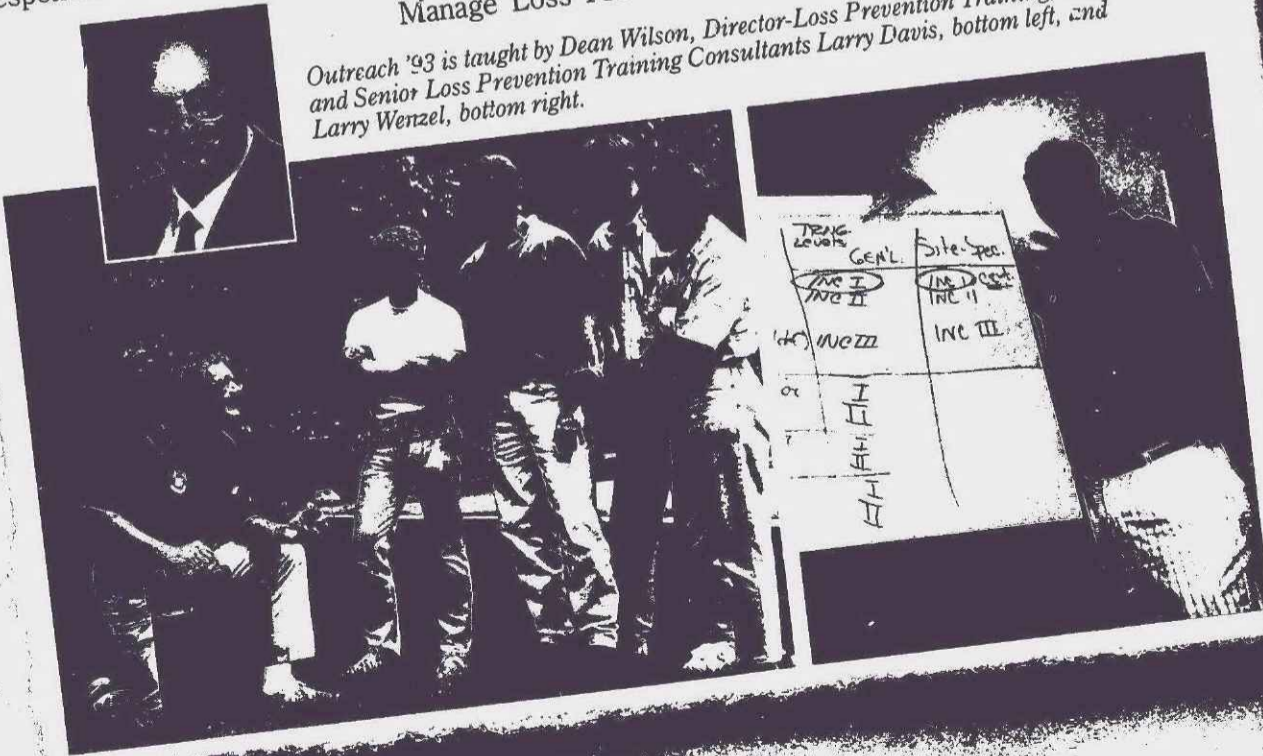
On Friday, November 12, other registrants will examine "OVERVIEW: A Strategy to Manage Loss Prevention and

Control". This seminar will help IRI customers apply modern management techniques to the protection of property, production and profits.

The two other sessions on Saturday, November 13 will include a seminar on "Developing Fire Brigade Training Programs" and one on the "Industrial Application of NFPA 72-1993, National Fire Alarm Code®." The fire brigade session offers proven methods that form the framework for a successful training program. The other seminar helps registrants develop a property protection surveillance plan.

Registration deadline for all seminars is October 29, 1993.

Outreach '93 is taught by Dean Wilson, Director-Loss Prevention Training, at left, and Senior Loss Prevention Training Consultants Larry Davis, bottom left, and Larry Wenzel, bottom right.



To register, telephone (203) 520-6027. For a brochure concerning Outreach '93, contact your servicing IRI office or call (203) 520-6027.



can make a difference

Clinton plan

Continued from page 1

In addition, employees would pay 20% of each medical claim, with annual out-of-pocket limits of \$1,500 and \$3,000 for individual and family coverage, respectively. That arrangement is comparable to cost-sharing provisions in many employer indemnity health plans.

In the aggregate, the standard fee-for-service health plan proposed by the administration "is very much in the mainstream," said Bob Bradick, a principal with A. Foster Higgins & Co. Inc. in New York.

The benefits that all indemnity plans would have to provide under the president's reform plan were disclosed by the administration last week as it prepares to unveil its entire reform package. The administration released more details late Friday in a 250-page document, and was expected to disclose more details over the weekend.

The administration also provided new details about benefits that would have to be offered by health maintenance organizations. For example, HMOs can not impose deductibles, but could levy other charges for certain benefits, like a \$10 copayment for doctor visits.

The administration has not yet disclosed the cost-sharing features in the third benefit option that employers would have to offer workers: a preferred provider organization-type plan.

And, many other details still remain to be disclosed. It isn't yet clear, for example, how flexible benefit plans, which allow employees to give up certain benefits in exchange for other benefits or cash, would be affected by the proposed minimum benefit requirements.

But other vital questions have been answered. Employers could continue to offer richer benefits than the standard package—at least until the year 2000—without employees being taxed on the employer's cost of providing the benefits.

In addition, lobbyists who have seen earlier briefing documents say, that the administration will propose capping the annual increases in premiums charged by health insurance companies.

Documents released late Friday indicated that health insurers' current exemption from federal antitrust law will be repealed. The documents did not propose any changes in property/casualty insurers' McCarran-Ferguson exemptions.

The documents indicate that the health alliances would cover people with work-related injuries. They also indicate that for workers within the alliances state laws that now ensure workers their choice of doctors would be overridden.

Work comp laws would remain the exclusive remedy under the Clinton plan. "Nothing in this policy alters or diminishes the effects of

Basic Clinton plan vs. Corporate health plans

	CLINTON PLAN*	CORPORATE PLANS
•LIMITATIONS•		
Deductibles	\$200 individual; \$400 family	Comparable
Coinsurance	20%	Comparable
Out-of-pocket limit	\$1,500 individual; \$3,000 family	Comparable
•BENEFITS•		
Preventive care	Full coverage for range of services like well-baby care and mammograms	Sometimes not covered at all; usually not full coverage.
Prescription drugs	Separate \$250 deductible; 20% coinsurance	Deductible often included in overall coverage limit
Vision care	Routine eye exams and glasses for children.	Only about 20% of plans cover vision care
Outpatient physical, occupational and physical therapy	Only to restore or minimize limitations from illness or injury.	Comparable
Dental	At first, only for kids and only for preventive care. In 2000, age limits removed and some orthodontia benefits added.	Both adults and children covered; orthodontia benefits tend to be lower.

*Fee-for-service plan

GRAPHIC BY KIM ROME

state workers compensation laws as the exclusive remedy for work-related injuries or illnesses," according to the document.

Overall, the administration pegs the cost of its standard benefits package at about \$1,800 for individual coverage and \$4,200 for family coverage. Costs could vary widely by region, based on such factors as the number of health care plans that compete for business.

These costs are somewhat less than current health care costs. For example, Foster Higgins earlier reported that total health care costs—including employer and employee contributions—averaged \$3,968 in 1992 (BI, March 1). Individual coverage averaged \$1,994 per employee, while the cost of family coverage averaged \$5,284.

And, the figures do not include costs for a long-term care benefit, which is going to be phased in between 1992 and 2000.

Employers remain extremely skeptical about the integrity of the administration's cost estimates.

"I don't believe the numbers," said Richard B. Spitznass, vp of compensation and benefits for Georgia Pacific Corp. in Atlanta.

"I have a lot of concerns about the accuracy of their cost estimates," agreed Richard Dreyfuss, director of executive compensation and employee benefits for Hershey Foods Corp. in Hershey, Pa.

Meanwhile, other aspects of the health reform package, which President Clinton is expected to formally unveil Sept. 22 in a nationally televised address, may be changing.

Under the centerpiece of the administration program, health care benefits would be offered through giant purchasing alliances, likely to be established by the states or other public entities. These alliances would contract with insurers, HMOs and other providers.

Employers with fewer than 5,000 employees would be required to join

the purchasing alliances, with the companies' role essentially limited to just paying premiums.

Employers with more than 5,000 employees could opt out of the alliances, but only if their health care plans met the basic standards offered through the alliances. Employers opting out of the alliances would have to pay a yet undisclosed fee to the alliances.

Much of the attention last week, though, was focused on the standard indemnity plan and HMO benefits that would have to be offered by health alliances or directly by large employers, if they opted out of the alliances.

Benefit consultants note that the standard package proposed by the administration would require employers to pay a higher percentage of the premium for family coverage than they now pay. Under the proposal, employers would have to pay 80% of the premium for individual and family coverage.

Employers tend to pay more than 80% of the premium for individual coverage. But firms, especially small ones, typically pay less for family coverage.

Foster Higgins found, for example, that among companies that require employees to pay a share of the premiums, employers last year paid an average of 74% of the premium. Employers with fewer than 500 employees paid just 69%.

However, some employers, in an effort to encourage employees to seek treatment from managed care networks, have considerably increased the level of cost-sharing for indemnity plan members.

Georgia Pacific Corp., for example, pays 80% of coverage costs for employees who use managed care providers, but only 50% for those who go elsewhere.

The administration proposal on mental health and substance abuse benefits also may be more generous—pending the disclosure of cer-

tain key details—than what employers now provide.

Under the proposal, which is subject to change, the standard indemnity plan would have to offer 60 days of inpatient mental health care with a one-day deductible and 20% coinsurance.

In addition, a 30-day per-episode limit would be imposed on inpatient mental health care.

For outpatient psychotherapy, 30 visits per year would be allowed with 50% coinsurance. In the year 2000, both inpatient and outpatient benefits would be upgraded. At that point, the 60-day limit on inpatient care for mental health and substance abuse would be raised to 90 days, while there would no per-visit limitation on outpatient mental health care. The 50% coinsurance requirement on outpatient mental health would be reduced to 20% for the first 12 days.

The most significant difference between these levels of benefits and what employers now provide is that employers often place a flat dollar limit—ranging from roughly \$50,000 to \$100,000—on lifetime mental health benefits.

Whether the administration will place a similar dollar cap on aggregate mental health and substance expenses paid by health plans is not clear.

"I find the mental health benefit very troublesome," Mr. Dreyfuss said. "Mental health care should be managed like anything else. Just putting an arbitrary limit on coverage encourages people to use up to the limit. And, it prevents people who really need more care from getting it."

Another difference is that the administration will propose that indemnity plans offer vision care benefits, including coverage for routine eye checkups and eyeglasses for children, for which employees would pay 20% of expenses. In the realm of employer-provided bene-

fits, vision care benefits are the exception rather than the rule.

Just 20% of employers now provide the benefit, according to Foster Higgins. However, where employers do provide vision care benefits, benefits are provided to both children and adults.

On the other hand, the prescription drug benefit proposed by the administration is decidedly less generous than many employer programs. Under the administration proposal, a \$250 deductible—separate from the overall medical plan deductible—would be imposed with a 20% coinsurance charge on prescription drugs. Employers rarely impose a separate deductible for prescription drugs now.

Georgia Pacific has a separate prescription drug deductible, but it is only \$50, after which the company pays for 80% of drug expenses, Mr. Spitznass said.

Dental benefits in the administration plan also are much more limited—at least initially—than those of many employers now.

Initially, only preventive care would be provided to children under 18 with 20% coinsurance. It is virtually unheard of for employers to limit dental benefits to children.

But in the year 2000, dental benefits would be expanded to include preventive care for adults with employees paying 20% of expenses. In addition, a new orthodontia benefit would be added with 50% coinsurance and a \$2,500 lifetime maximum benefit.

Employer plans now typically impose much lower lifetime limits—in the \$1,000 to \$1,500 range—for orthodontia expenses.

Meanwhile, benefits executives at large companies say the administration's HMO model offers more generous benefits than the more restrictive HMO models many employers are moving toward. For example, many HMOs do not offer dental coverage, while the administration's model would cover dental services for a \$10 co-payment.

And, very few HMOs currently provide hospice care, which the administration's HMO model would include at no charge. "That's an absolute sink hole," asserted Don Hoffman, senior vp of administration for Cincinnati Bell. Requiring HMOs to cover hospice care will only increase employers' costs, he said.

In addition, many HMOs require higher co-payments for prescription drugs than the \$5 the administration suggests.

Cincinnati Bell's HMO members, for example, now pay \$10 for each prescription and the co-payment is expected to increase in 1994, Mr. Hoffman said.

But, some HMO benefit levels proposed by the administration, particularly payments for preventive services, closely match the benefit levels provided by most HMOs. **BI**

Venture to evaluate new medical technology

By DAVE LENCKUS

WASHINGTON—A new source for information about new medical technology and treatments will be available next year to self-insured employers as well as health insurers, managed care companies, claims administrators and others.

Many benefit experts applaud the collaborative effort between the Blue Cross & Blue Shield Assn. and the California-based Kaiser Permanente health maintenance organization to evaluate new and emerging medical technologies and make these assessments available on a subscription basis.

However, an attorney who represents group plan participants and medical centers in coverage disputes raised concerns that a Kaiser representative to the program has been criticized by other medical experts for his evaluation of an emerging breast cancer treatment.

The representative, Dr. David Eddy, who will be the program's chief scientific adviser, says subsequent studies by even his critics support his position on that treatment. He also says he has recommended the use of other emerging technologies in most of his other assessments.

Dr. Eddy, who also is the senior

adviser for health policy and management for Kaiser Permanente's Southern California region and a professor at Duke University, is Kaiser's major contribution to the agreement.

The assessments, which the BC/BS Assn. has conducted since 1984 but has made available only to Blues plans, determine whether a technology improves health outcomes like length and quality of life and functional ability.

But the assessments will not recommend whether health care plans should cover technologies, some of which are at the center of high-profile coverage disputes between in-

surers and group health plan participants (BI, Jan. 4).

Since the inception of the BC/BS Assn.'s Technology Evaluation Criteria program in the mid-1980s, the Blues have conducted more than 200 assessments of emerging medical technologies, or about 20 annually.

The Blues expect to double the number of annual assessments under the collaborative effort with Kaiser, according to Susan Gleeson, executive director of medical and quality management for the BC/BS Assn. in Chicago.

The BC/BS Assn. bases its assessments of medical procedures,

devices, drugs and biological products on five criteria, including whether the technology improves net health outcomes and is as beneficial as any established alternatives.

The health insurer's criteria do not address cost, cost containment, comparative costs or other pricing issues.

The evaluations are reviewed by the BC/BS Assn.'s Medical Advisory Panel, which has just been expanded to include physicians and others who are not associated with Blues plans.

The assessments made by the col-

Continued on next page

Breast implants

Continued from page 3
eration by streamlining the discovery process and establishing a central depository in Cincinnati for documents related to the implants.

All other breast implant manufacturers—including Baxter International Inc., Bristol-Meyers Squibb Co., Bioplasty Inc. and Inamed Corp.—are involved in the global settlement talks. And Mentor, which reached a separate settlement with victims earlier this year, will be asked to participate, said Mr. Jenkins. Judge Pointer approved the Mentor settlement last week.

Bristol-Meyers currently is appealing a \$27 million jury award to a Houston woman who developed an autoimmune system disease after her silicone gel breast implants ruptured (*BI*, Jan. 4).

The award, which included \$20 million in punitive damages, was the largest to date against a silicone breast implant manufacturer. The second-largest award is believed to be \$7.3 million, which was awarded by a U.S. District Court jury in San Francisco to a California woman who became severely ill from a ruptured Dow Corning implant. The award is on appeal to the 9th Circuit (*BI*, Dec. 23, 1991).

Neither award would be affected by the settlement proposal. "They will be treated the same as the opt-outs," explained Mr. Jenkins. Women who opt-out of a global settlement would still be free to pursue their claims separately.

Despite its role in settlement talks, Dow Corning is not admitting liability for the physical ailments associated with the implants.

"We're encouraged by the growing body of scientific evidence from research done outside of Dow Corning that shows no conclusive link between breast implants and disease," Executive Vp Gary E. Ander-

son said in a company statement last week. "However, a settlement would move the implant controversy from a divisive issue to a responsible resolution for all interested parties."

"One of the things we at Dow Corning like about the proposal is that it would essentially act like a health insurance policy for women with implants," he added. "We also believe that any effective agreement must provide reasonable and timely options for women to resolve their claims or concerns, both now and in the future. It also must allow the research to continue so that any remaining scientific issues can be resolved."

Even though the committees pre-

sented their proposal to Judge Pointer on Tuesday, completing the deal will probably take years, said Mr. Jenkins of Dow Corning.

"If all the defendants agree, and their insurers agree, then notice will go out to plaintiffs who can choose to either accept it or opt out," he said. "Then public fairness hearings will occur. It may take three, four or five years for the whole settlement to be wrapped up."

But if a settlement is reached with the objectives outlined in the proposal, it could reduce the transaction costs that in prior mass tort cases have absorbed as much as to two-thirds of every dollar spent on settlements, he pointed out. **BI**

Punitive award denied in implant case

ATLANTA—A federal appeals court has ruled that a silicone breast implant manufacturer's actions did not warrant punitive or compensatory damages in a 1991 case.

In the 1991 case, a district court in Dothan, Ala., awarded \$2 million in punitive damages and \$275,000 in compensatory damages to a woman whose silicone breast implants ruptured.

But, the 11th U.S. Circuit Court of Appeals ruled Sept. 2 that because the implant's manufacturer, Heyer-Schulte Corp., a Baxter Healthcare Corp. unit, had issued a warning about the product's risks, its conduct wasn't "wanton" enough to warrant punitive damages.

In addition, the appeals court said that a report from the U.S. Food and Drug Administration on the risks associated with breast implants should not have been introduced because the findings were preliminary at that time. The appeals court then remanded the case to the district court.

Brenda Toole sued Heyer-Schulte and Baxter Healthcare after her silicone breast implants hardened and she required surgery. Her implants, which were implanted in 1981, ruptured during the surgery, causing silicone to spread throughout her body.

Since then, Ms. Toole has had several operations. In 1991, the district court ruled against the manufacturer and awarded Ms. Toole \$5 million in punitive damages and \$400,000 in compensatory damages—later reduced to \$2 million and \$275,000, respectively.

Baxter's product liability insurance and reserves for litigation should be adequate to cover the damages, a spokesman said.

Ms. Toole's attorney, Ernie Hornsby of Farmer, Price, Hornsby & Weatherford in Dothan, Ala., will seek a rehearing by the full appeals court.

—By Sally Roberts

Blues/Kaiser program

Continued from previous page
laborative effort will be available through newsletters, detailed scientific reports and conferences that will examine unpublished research on technologies as well as assessments.

Newsletters will cost \$300 annually. In-depth analyses have not been priced. The cost of conferences would be "typical," Ms. Gleeson said.

The joint program initially plans to make available 35 to 50 assessments that the BC/BS Assn. already has completed on emerging technologies, including home uterine activity monitoring devices for preterm labor and the Taxol drug treatment for breast cancer.

Among the technologies the collaborative program will study first are:

- Genetic therapy to treat various diseases.
- Small bowel with liver transplants.
- Intravascular ultrasound for imaging blood flow.

The Blues' budget for technology assessments will nearly double next year to \$3 million, according to Ms. Gleeson. And, all program subscription revenues will be channeled back into the program, she said.

The Blues/Kaiser program in January will enter a market consisting of dozens of other medical technology assessment organizations, including government offices.

Still, some observers welcome the collaborative effort between the Blues and Kaiser.

"This will really help bring a little order to what is essentially chaos among various managed care programs," especially small HMOs, in assessing medical technologies, said

Glenn Smith, managing consultant in the San Francisco regional office of A. Foster Higgins & Co. Inc.

Many programs do not have the resources to study existing data or conduct their own research, he said.

To fulfill their fiduciary responsibility to participants enrolled in their health plans, "Large employers may want to guide their (HMOs and TPAs) to use these standards," he said.

Large employers also should consider basing their decisions on which TPAs and HMOs to contract with in part on whether those providers subscribe to the Blues/Kaiser service, he said.

In addition, while other assessment organizations are reputable, potential subscribers to the Blues/Kaiser program can be even more confident that coverage decisions based on the new program's assessments will be clinically and legally defensible in court, said Bill McGivney, director for technology assessment and policy at Windsor, Conn.-based Aetna Health Plans, which will continue to conduct its own assessments.

The collaborative effort also could help reduce costs for some health insurers that pull together information on medical technologies and analyze the data themselves, said Kylanne Green, director of managed care for the Health Insurance Assn. of America in Washington.

But, Karen L. Illuzzi Gallinari, a partner with Anderson, Kill, Olick & Oshinsky in New York, said she is concerned about what Dr. Eddy's presence on the panel will mean for group health plan members.

Dr. Eddy's 1990 assessment of studies of a breast cancer treatment, in which he concluded it was not

proved to be better than alternative treatments, was criticized by many medical experts. The treatment, known as HDC/ABMT, involves high-dose chemotherapy and autologous bone marrow transplants.

"Dr. Eddy has not traditionally been known as a strong supporter of increasing patients' access to state-of-the-art medical treatment," Ms. Gallinari said.

But, Dr. Eddy defended his assessment of HDC/ABMT and his history of technology assessments.

The doctor noted that his assessment of HDC/ABMT was "carefully reviewed by and published in the most prominent journal in the field: *The Journal of Clinical Oncology*."

In addition, he said, "That my position that the effectiveness and balance between benefits and harm of that treatment is uncertain, and therefore requires more investigation, is supported by the fact that the National Cancer Institute has recently initiated randomized control tests to collect the very information that I thought was needed."

"Even some of the most prominent proponents of the treatment have said in even their most recent published papers that the effectiveness of the treatment needs confirmation by random control trials."

Dr. Eddy added that the majority of his assessments have recommended coverage.

For example, at about the same time that he released his assessment of HDC/ABMT, he recommended using high-dose chemotherapy for germ cell cancer, which is mostly found in testicles and ovaries.

He also pointed out that he is a non-voting member of the advisory panel. **BI**

Update

GM shifting costs to retirees

Continued from page 2

pending on their Medicare eligibility and the type of coverage they have. Annual deductibles and copayments will also be hiked for retirees under some plans.

Meanwhile, monthly premiums will increase for 73,900 U.S. active salaried employees on Jan. 1. Amounts vary by type of coverage.

State probe targets Blues plans

OLYMPIA, Wash.—Washington state insurance regulators are investigating the state's two largest health insurers—Blue Cross of Washington and Alaska and King County Medical Blue Shield—focusing on compensation for executives.

The special investigation, prompted by concerns raised by state lawmakers, will also review administrative expenses, subsidiary and affiliate relations, claims and sales practices, and rate-filing procedures, said Insurance Commissioner Deborah Senn.

"I think there is concern from the consumer level to many segments of the industry itself that non-profit health insurers have escaped regulation," she said. "Other states have simply waited for the ax to fall. I intend to track down these answers now."

Manslaughter pleas in death

CHICAGO—Three managers pleaded guilty to involuntary manslaughter last week and were sentenced in the fatal cyanide poisoning of a worker 10 years ago.

On the eve of a retrial, Steven O'Neil, president of Film Recovery Systems in Elk Grove Village, Ill., was sentenced to three years in prison; Charles Kirshbaum, plant manager, was sentenced to two years; and Daniel Rodriguez, who held a foreman-type position, was sentenced to 30 months probation, including four months home confinement, and 500 hours of community service.

"It's the first time in Illinois that managers will spend time in prison," said Cook County State's Attorney Jack O'Malley.

The first trial ended in 1985 with each of the three men found guilty of involuntary manslaughter and sentenced to 25 years in prison. An appeals court ordered a retrial in 1990 (*BI*, April 9, 1990).

Prosecutors emphasized that Film Recovery's mostly Polish and Mexican workforce "never received any safety training in any language." Workers had only paper masks and cloth gloves while leaching silver from X-rays. Several workers had complained of vomiting, headaches and skin rashes.

PRPs may do own risk studies

WASHINGTON—In a break with past policy, the Environmental Protection Agency says it may let potentially responsible parties do their own baseline risk assessments for Superfund site cleanup.

Following the settlement of a lawsuit against the agency by industry groups (*BI*, Dec. 10, 1990), the EPA announced that it is reconsidering a rule against private assessments that had been in effect since 1990.

The EPA says its regional offices will allow private assessments only if there is "complete confidence in the (PRPs) ability to generate an accurate and timely risk-assessment report." Regional offices must also get permission of the director of the EPA's Office of Waste Programs Enforcement.

Briefly noted

The Memorial Sloan-Kettering Cancer Center in New York filed suit against New York-based **Empire Blue Cross/Blue Shield**, seeking \$2 million in unpaid claims for treatments involving bone marrow transplants and Taxol, which the insurer considers experimental. . . **Travelers Corp.** has sold a portfolio of primarily foreclosed real estate and underperforming commercial mortgages to Quantum Realty Fund in a \$634 million cash transaction. Including this transaction, Travelers says it expects to sell real estate and mortgage loans with a book value of more than \$1 billion by year end. Through August its sales had totaled \$218 million and another \$200 million in sales is expected. . . Dallas-based **Southwest Airlines Co.** agreed to pay \$1.25 million to the Equal Employment Opportunity Commission to settle an age discrimination suit alleging that the airlines avoided hiring older pilots. . . Royal Insurance Holdings P.L.C. plans to sell its **Royal Reinsurance Co.** unit to Australia's QBE Insurance Group Ltd. for \$59 million. . . David H. Elliott, president and CEO of Armonk, N.Y.-based **MBIA Inc.** and of its operating subsidiary, **MBIA Corp.**, was named chairman of the financial guarantee insurer, effective Jan. 1. He succeeds William O. Bailey, who will continue as a board member. . . Standard & Poor's Corp. has assigned a BBB claims-paying ability rating to **Sphere Drake Insurance P.L.C.** The rating assumes that parent Sphere Drake Holdings Ltd. will complete an initial public offering of common stock by the end of the year. . . Investors in Maxicare Health Plans are not entitled to recover **punitive damages in a securities fraud case** under a California Supreme Court ruling that investors seeking punitive damages in such cases must prove they relied on alleged misrepresentations by the corporation and its accountants and advisers. . . **Piper Aircraft Corp.** does not have to set up a special trust for future product liability claimants before it can emerge from bankruptcy reorganization, a judge ruled on Friday (*BI*, May 24). . . The California Legislature last Friday was expected to pass a bill that would establish a **surplus line advisory committee** to strengthen the security review of non-admitted insurers. . . Asbestos plaintiffs last week filed a limited class action suit against **Fibreboard Corp.** as part of the previously announced \$3 billion-plus settlement with Fibreboard and insurers CNA Financial Corp. and Chubb Corp. (*BI* Sept. 6).

Second quarter is status quo

By LEONARD M. WILSON

Special to Business Insurance

CHANGE MAY BE THE THEME of the national political scene, but for the publicly owned insurance brokers, second-quarter reports heralded more of the same: a largely unchanged premium rate environment. Among most industry participants, resignation to a continuing soft market seems to prevail. The comments that follow represent a composite of our post-second-quarter contacts with the public brokerage firms.

Analyst: Let's jump right in and review the quarter's results in domestic retail insurance brokerage. Are you experiencing any acceleration in commission growth?

Contact: Domestic commissions increased about 2% year over year, excluding the effect of acquisitions or divestitures. Clearly, the markets are still sloppy. Property has tightened for catastrophic coverages and coastal risks, as you are aware from earlier discussions. In casualty, our pivotal sector, which generates about 60% of commissions, pricing is still weak.

Analyst: How weak? What kind of reductions are you seeing in current renewals?

Contact: We estimate the average casualty renewal is down 3% to 5%, with not much variation over the past two years, a painful stability. In some cases, renewals incorporate stiffer terms and conditions, but these hidden increases don't fatten our commissions.

Analyst: International brokerage is more robust, I hear. How would you characterize brokerage outside of North America?

Contact: Fortunately, insurance markets abroad are behaving more rationally. Pricing is generally quite firm in the United Kingdom and on the Continent. Our commissions on foreign retail brokerage advanced about 6%, excluding the effect of the stronger dollar, which depresses comparisons.

Analyst: How would you describe the quarter's results in reinsurance brokerage?

Contact: Reinsurance rates are running more or less parallel to primary rates. The well-advertised strength is in property, while casualty rates are essentially flat, a little better than the situation in primary markets. We are able to find capacity in reinsurance markets, but we are not able to satisfy client needs fully.

Our commissions probably rose in the range of 6% to 8% on a worldwide basis, again squeezing out the impact of currency.

Analyst: New capacity is entering reinsurance markets, particularly property. Could the tighter market be short-lived?

Contact: This is a risk if capital continues to flow into the reinsurance arena. But there is still a great deal of unsatisfied demand for property coverage that will have to be filled. So, in all probability, markets will remain firm for some period in spite of the additional capacity, which is currently very much needed.

Analyst: What about new business?

Contact: In domestic retail, we estimate our new business generation at 10% to 11% of commissions, while lost business stands at 5% to 6%. These are figures that have remained stable. Our net new business, therefore, is 5%. The longer the soft market persists, the less the inclination of clients to move around. Nonetheless, we are gratified by our production efforts, which are bolstered by initiatives in new industries and segments. It is our goal to target specific areas of opportunity and develop the necessary expertise.

Analyst: Is the economy exercising any discernible restraint on commission growth?

Contact: By now, the impact of the recession is pretty well attenuated. The economic expansion, while modest, has begun to feed into our operating progress. But there are still laggard sectors like construction, and, of course, California is a more difficult geographical area than the rest of the country.

Analyst: Fiduciary investment income has fallen now for a number of quarters due to much lower short-term interest rates. When do you expect a resumption of growth?

Contact: In the latest quarter, investment income dropped once again but more moderately than in earlier quarters. We are close to the point where year-over-year interest yields will be flat. With just a little growth in premium throughput, we can look forward to gains in investment income, probably this quarter or next.

Analyst: Insurance brokers generally have embarked on a pronounced push into benefit consulting during the past decade, which brought marked growth. Has consulting petered out as a growth sector?

Contact: Consulting has indeed faltered.

And we are actually encountering price competition within our consulting activities. Profit margins are under pressure. But, consulting still looks like a very attractive business. Clients are temporarily sitting on their hands because of indecision in Washington on health care reform. Once the logjam is broken, we expect our consulting operation will be very busy.

Analyst: Expenses rose modestly in the quarter. How much longer can you keep the lid on expense growth?

Contact: I often wonder whether investors' memories are not too long. In the early 1980s, some of us were late in responding to the soft market by reining in costs. We have now lived through six years of a soft market, a virtually unprecedented span, and demonstrated decisively that we can keep our expenses in check. If the soft market persists, we believe that an ingrained culture of cost control will be sustained.

Analyst: Almost everyone has proven too optimistic about a turn in premium rates. Insurance companies are paying up for some of their reinsurance coverage. Investment income is not increasing due to the lower level of interest rates. Combined ratios are certainly not declining. Aren't these the ingredients for rising prices?

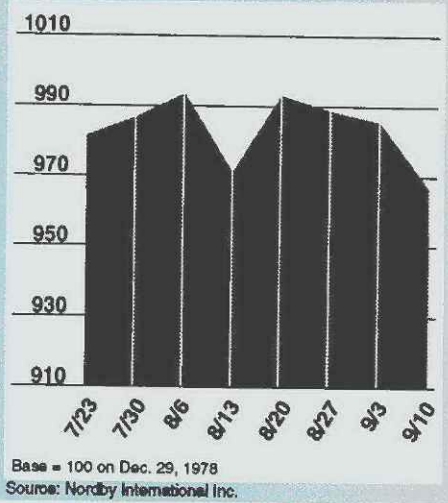
Contact: Let me ask you a question. Are the underwriters really hurting currently? Maybe reserving is too low or a number of companies are under duress. But look at the stock prices of leading carriers. They have performed remarkably well.

Apparently, investors like what they see despite the soft market. So this absence of distress doesn't suggest that pricing has to change. We would like it to happen, but we will remain firmly perched on the fence when it comes to predictions of a market turn. **BI**



Leonard M. Wilson is a senior vp with Lazard Asset Management Inc. He is a member of the New York Society of Security Analysts.

BI Insurance Index



Insurance industry stocks fell last week, as the *Business Insurance* Index lost 18.5 points to 967.5 Sept. 10 from 986.0 on Sept. 3. Advancing issues for the week were led by: Safeguard Health Enterprises, up 7.7%; Hilb, Rogal & Hamilton, up 7.5%; and Argonaut Group, up 4.5%. Declining issues followed: Seibels Bruce Group, down 20.0%; FHP International, down 9.9%; and PacifiCare Health Systems, down 9.3%. The most active issue was U.S. Healthcare, 7.3 million shares traded. The *BI* Index was down 1.9%; the NYSE Composite fell 0.1%; the Standard & Poor's 500 was up 0.8%; and the Dow Jones 30 Industrials fell 0.4%.

British Issues

Sept. 9 Companies	Price pence	P/E	Div. pence	Yield %	1 Week	
					High	Low
Comm Union	607	N/M	32.5	5.4	610-593	
Genl Accident	668	N/M	35.7	5.3	672-668	
Gdn Royal Exch	221	N/M	9.3	4.2	221-214	
Royal	315	N/M	6.7	2.1	317-307	
Sun Alliance	372	N/M	19.0	5.1	372-365	
Brokers						
Bradstock	139	16.3	6.8	4.9	139-139	
CE Health	411	19.7	20.5	5.0	411-405	
Hogg Group	226	20.0	10.9	4.8	226-225	
JIB Group	183	18.1	10.0	5.5	192-183	
Lloyd Thompson	312	25.2	7.5	2.4	312-308	
Lowndes Lmbt	431	15.7	18.8	4.4	433-431	
PWS Holdings	71	10.6	5.3	7.5	71-71	
Sedgwick Grp	190	22.9	8.0	4.2	191-189	
Steel Brt Jones	249	13.8	17.7	7.1	249-248	
Willis Corroon	234	21.9	8.8	3.8	234-226	

Source: Philip Olsen, London

BI Industry Stock Report

SEPTEMBER 6, 1993 THROUGH SEPTEMBER 10, 1993

BROKERS	Price	Weekly % change	Year to date % change	Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt./Bk. value	Price	Weekly % change	Year to date % change	Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt./Bk. value	
				High	Low										High	Low							
Accordia Inc	NYS	27.50	-0.45	27.91	27.63	15.13	15	0.44	1.60	16	9.57	2.87	39.50	-5.39	-2.47	46.00	30.50	37	0.28	0.71	20	11.39	3.47
Alexander & Alexander	NYS	24.75	1.54	-6.60	28.88	23.38	18	1.00	4.04	25	5.02	4.93	36.50	0.00	-9.88	44.75	27.50	120	0.16	0.44	46	17.23	2.12
E W Blanch Holdings Inc	NYS	22.38	-1.65	N/A	23.38	16.50	15	0.00	0.00	28	1.09	20.53	36.25	-1.69	-22.36	39.63	20.00	20	0.12	0.33	11	14.18	2.56
Gallagher Arthur J & Co	NYS	32.00	3.23	13.27	37.38	24.25	56	0.72	2.25	17	6.26	5.11	30.63	0.41	-5.77	35.25	28.50	7	0.00	0.00	22	16.99	1.80
Hilb, Rogal & Hamilton	NYS	14.38	7.48	-8.00	16.88	11.63	90	0.44	3.06	21	2.73	5.27	6.88	-3.51	17.02	8.25	4.25	125	0.00	0.00	3	6.84	1.01
Marsh & McLennan	NYS	91.38	0.97	0.00	97.63	82.50	367	2.68	2.93	21	15.03	6.08	69.00	0.36	9.31	69.00	59.00	124	2.84	4.12	12	45.85	1.50
Poe & Brown	OTC	18.50	0.00	10.45	21.25	11.75	23	0.40	2.16	33	2.60	7.12	27.25	0.46	9.55	27.38	21.50	220	0.44	1.61	9	21.06	1.29
BROKERS AVERAGE																							
1.6																							
6.2																							
INSURERS/REINSURERS																							
ACE Lid	NYS	33.88	-2.17	N/A	36.00	25.50	251	0.40	1.18	9	25.37	1.34	35.00	-3.40	125.40	38.25	9.00	421	0.20	0.56	-197	11.88	2.99
Acceptance Insurance	NYS	13.75	-3.51	42.86	15.25	6.00	82	0.00	0.00	15	4.62	2.98	29.25	-2.90	2.63	31.50	24.75	41	1.04	3.56	11	30.72	0.95
AEGON N V	NYS	49.63	1.79	19.22	49.75	39.25	12	1.22	2.46	9	32.78	1.51	14.00	-1.75	-15.15	16.63	12.63	49	0.28	2.00	21	14.76	0.95
Aetna Life & Casualty	NYS	59.63	0.00	28.23	60.50	38.00	830	2.76	4.63	26	65.43	0.91	8.00	-1.54	30.61	8.50	4.75	295	0.32	4.00	3	2.99	2.68
Allied Group Inc	OTC	31.00	2.48	46.46	31.00	16.50	96	0.52	1.68	9	10.45	2.97	24.63	-1.01	-0.51	26.63	18.88	76	0.56	2.27	11	18.62	1.32
Allmerica Prop & Casualty	NYS	58.88	-1.46	16.58	62.50	41.50	20	0.44	0.75	5	46.94	1.25	92.88	1.50	20.62	94.00	67.88	280	2.80	3.01	-13	52.24	1.78
Allstate Corp	NYS	32.13	0.78	N/A	32.75	27.13	1764	0.72	2.24	-56	12.26	2.62	63.38	-1.74	11.67	66.00	48.75	758	1.80	2.84	11	38.95	1.63
American General	NYS	35.00	-1.41	22.81	35.75	23.63	1365	1.08	3.09	13	21.31	1.64	15.75	0.80	-10.00	20.75	13.50	24	0.32	2.03	-	14.69	1.07
American Heritage Life Ins	NYS	23.25	-2.11	15.29	25.34	18.91	1	0.60	2.58	16	12.44	1.87	0.50	20.00	-73.33	2.88	0.38	120	0.00	0.00	0	1.90	0.26
American Indemnity/Fin'l	OTC	13.00	-2.80	116.67	16.25	4.75	13	0.12	0.92	4	16.18	0.80	27.00	1.89	22.73	29.00	19.00	68	1.12	4.15	20	22.92	1.18
American International (s)	OTC	98.88	2.73	27.86	99.00	61.91	2C23	0.40	0.40	18	40.25	2.46	13.13	-2.78	9.38	16.00	6.88	413	0.20	1.52	6	8.65	1.52
American RE Corp	NYS	35.25	-1.05	-4.73	41.75	31.38	78	0.00	0.00	35	6.67	5.28	26.50	-1.40	N/A	26.88	22.88	516	0.00	0.00	-9	17.14	1.55
Aon Corp	NYS	57.50	1.10	6.48	57.50	43.75	221	1.80	3.13	19	31.79	1.81	60.25	-6.23	25.52	87.00	43.25	18	0.00	0.00	-	57.72	1.04
Argonaut Group	OTC	35.00	4.48	14.75	35.25	27.00	89	1.00	2.96	11	25.52	1.37	58.13	0.00	2.42	64.75	49.38	372	1.12	1.93	15	15.15	3.84
AVEMCO Corp	NYS	18.00	2.13	-22.99	27.00	16.75	33	0.44	2.43	20	7.75	2.32	60.75	-0.82	8.24	61.50	37.00	32	0.28	0.46	19	24.57	2.47
Baldwin & Lyons Inc.	OTC	42.00	0.00	15.07	44.50	29.50	1	0.60	1.44	10	34.75	1.21	34.13	-0.36	25.23	34.75	17.13	993	1.60	4.69	5	31.77	1.07
Berkley W R Corp	OTC	46.50	-1.59	8.14	50.50	35.75	68	0.40	0.86	18	26.31	1.77	44.00	2.03	7.98	49.75	29.00	86	0.88	2.00	16	26.00	1.69
Berkshire Hathaway Inc	NYS	16800.00	-3.17	42.98	17800.00	9100.00	1	0.00	0.00	-	7742.67	2.17	37.50	0.00	-9.64	43.00	34.75	2	1.00	2.67	-	28.96	1.29
Chandler Insurance	OTC	4.63	0.00	-2.63	5.25	3.50	1	0.00	0.00	18	8.87	0.52	42.38	-2.59	-0.88	46.75	35.50	225	1.40	3.30	13	37.69	1.12
Chubb Corp	NYS	89.88	2.57	1.13	96.38	74.25	661	1.72	1.91	12	45.65	1.97	57.00	-0.44	7.55	60.13	38.50	674	0.80	1.40	15	21.25	2.68
CIGNA Corp	NYS	65.00	3.59	10.87	68.00	47.13	765	3.04	4.68	11	79.82	0.81	11.88	-2.06	18.75	13.00	6.50	262	0.00	0.00	14	10.48	1.13
CNA Financial Corp	NYS	88.25	0.43	-9.95	102.88	83.75	44	0.00	0.00	-10	75.07	1.18	18.38	0.00	46.48	19.63	9.88	794	0.20	1.09	-	9.63	1.91
Continental Corp	NYS	31.38	0.40	16.74	34.63	20.00	22	1.00	3.19	17	34.73	0.90	18.00	-3.36	0.00	20.00	15.00	18	0.24	1.33	-5	23.61	0.76
EXEL Ltd	NYS	47.63	-0.26	0.79	52.25	36.88	430	1.00	2.10	8	29.54	1.61	42.50	-1.16	17.24	43.38	29.34	129	1.20	2.82	13	39.48	1.08
Fremont General Corp	NYS	27.13	-2.69	-21.38	28.75	16.50	104	0.72	1.65	9	19.81	1.37	23.88	1.60	3.80	28.00	20.25	118	1.08	4.52	11	28.84	0.83
Frontier Insurance Group	NYS	45.00	-3.49	3.45	47.63	29.53	22	0.60	2.33	15	14.78	3.04	27.00	-4.85	36.71	29.25	16.38	133	1.00	3.70	17	15.82	1.71
Gamsco Inc	ASE	10.50	-4.55	-25.66	18.56	9.41	112	0.04	0.38	13	3.27	3.21	31.25	-1.57	N/A	36.38	30.00	132	0.00	0.00	-	23.99	1.30
General RE Corp	NYS	131.13	1.25	13.28	133.38	90.25	-18	1.88	1.43														

The snowshoe rabbit changes color with the season, adopting a white coat in winter and a brown coat in summer. This change, which is governed by the shortening length of day, enables the rabbit to blend into its background for protection.



The Ability To Adapt To The Environment Is Necessary For Survival In Nature. And In Benefits Management.

In nature, the ability to change and adapt is required for survival. In managing employee benefits programs, it's also becoming a necessity.

The Mutual of Omaha Companies recognize this need. Our experience in developing and offering PPO, EPO, HMO and point-of-service plans gives us the ability to work with companies to design benefit programs that can meet their changing needs. Our years of experience have taught us the best ways to prepare for change — and therefore, we're ready to help benefits managers meet it.

Nature is experienced at managing change. And so are we.

Find out what the Mutual of Omaha Companies Group Operation can offer your company. Call Patrick Moeschler, 1-800-877-1052.



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