

Business Insurance

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

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Updates

Florida commissioner sues manager, others in fund's collapse

TALLAHASSEE, Fla.—Florida's Insurance Department is accusing the manager of a workers compensation insurance fund and others connected to its operations with "looting" the insurer and contributing to its collapse.

In a lawsuit filed last month by Insurance Commissioner Bill Nelson in state court in Broward County, defendants are charged with wrongfully taking at least \$10 million from the Florida Employers Safety Assn. Insurance Fund. The Fort Lauderdale-based fund wrote workers comp coverage for

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ValueRx execs see buyout as prescription for success

By MICHAEL PRINCE

PLYMOUTH, Minn.—The pending sale of ValueRx, the nation's largest prescription benefit management company not owned by a pharmaceutical manufacturer, isn't likely to jolt the PBM market, consultants say.

Plymouth, Minn.-based ValueRx was acquired earlier this year when Columbia/HCA Healthcare Corp. bought its parent, Value Health Inc. of Avon, Conn., in a \$1.3 billion stock acquisition (BI, Jan. 20). But Columbia, amid a federal investigation over its

Medicare billing practices, has decided to shed all but one Value Health Inc. unit. Nashville, Tenn.-based Columbia announced the sale late last month, just a few weeks after its acquisition of Value Health was completed (BI, Sept. 1).

ValueRx's top management is moving forward with a bid to buy the PBM. A group including President and Chief Executive Officer Kevin Roberg has retained outside advisers and is planning to make an offer to Columbia for the company. Mr. Roberg said the group is in the process of interviewing

possible financial backers, including both lenders and equity partners.

Management's goal is to keep ValueRx independent, Mr. Roberg said, adding that the group believes an independent PBM can compete with PBMs owned by drug manufacturers. In fact, he said, the independence from a drug manufacturer "has been a real competitive distinction for us and is seen quite positively from the marketplace."

Over the past four years, several PBMs have been purchased by phar-

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New options to Medicare may benefit employers

By JERRY GEISEL

WASHINGTON—Employers will have to rethink how and whether they should provide retiree health care plans in the wake of a new federal law that for the first time allows an array of private plans to compete with Medicare for beneficiaries.

Retirees will be able to choose coverage from preferred provider organizations, high-deductible health insurance plans linked to tax-favored medical savings accounts, indemnity plans offered by commercial insurance companies or provider-sponsored organizations—HMO-like plans established by providers—as well as Medicare itself.

Retirees still will be able to receive coverage from Medicare risk health maintenance organizations. But changes in the new federal budget law that will increase federal payment rates to HMOs in more than 1,000 counties around the country will expand the availability of HMOs to millions of additional Medicare beneficiaries.

Each type of health care plan will receive the identical capitated payment rate from the Health Care Financing Administration, the federal agency that administers Medicare.

The rates, set on a county-by-county basis, will be based on what Medicare's costs have been to cover retirees in those counties.

In turn, the health plans will at a minimum have to provide the same benefits as the traditional Medicare program, though high-deductible health insurance plans linked to MSAs will be able to charge higher deductibles than Medicare does.

But after agreeing to offer the basic Medicare package, health care plans will have the flexibility to tailor

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Ballot battle in Ohio

Employers gird for fight over effort to kill workers comp reforms

By MEG FLETCHER

COLUMBUS, Ohio—Ohio business groups and labor unions are squaring off for a major statewide fight over a November ballot referendum that could kill recent workers compensation reforms sought by employers.

The AFL-CIO and trial attorney supporters—operating as the Coalition for Workplace Safety—landed the first punch earlier this summer by obtaining roughly twice the number of signatures required to place an initiative on the Nov. 4 ballot.

Under Ohio law, the coalition's filing of petitions with more than 400,000 signatures in late July halted

the new law's implementation just before it was to go into effect.

Employers expect "a very difficult



Ohio employers have launched a campaign to uphold the reforms.

fight" to persuade voters to mark the "yes" box on the ballot, approving actions previously taken by the Ohio Legislature and governor, said An-

drew Doe'nel, chairman of Keep Ohio Working. That is the name of the broad-based employer and business coalition supporting passage of the referendum and enactment of the law.

The difficulty stems from the complexity of workers compensation issues, he said. Also, a ballot measure requiring "a 'yes' vote is always more difficult to have people approve," said Mr. Doe'nel, who also is president of the Ohio Chamber of Commerce.

Ohio law determined the wording of the ballot measure, he said.

The latest workers comp law contains primarily pro-employer changes to improve the timeliness, duration

See Ohio on page 4

Events on hold as U.K. mourns

Cancellation claims filed after week of mourning Diana

By STACY SHAPIRO

LONDON—The tragic death of Diana, Princess of Wales, has prompted organizers to file insurance claims for cancellation or postponement of events during the week of mourning that followed her Aug. 31 fatal automobile accident in Paris.

Policyholders already had notified insurers last week of claims for two concerts that were canceled, one Michael Jackson was to perform and one by rock group Wet, Wet; for a horse show in Blenheim; a power boat show; and London West End theater performances.

Other claims are likely after the week culminating in Diana's funeral Saturday.

"There will be claims," summed up Keith Peacock, chief executive of Lexington Insurance Co. in London. "There may be (a number of claims) that surprise us."

Last Monday, Lloyd's of London had an impromptu minute of silence in its underwriting room at noon to honor Diana. Before and after the moment of silence, the single ring of the Lutine Bell signified the sad news.

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PHOTO: AFP

This view from the roof of Buckingham Palace shows mourners bringing flowers in tribute to Diana, Princess of Wales.

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Health care choices for retirees

Benefit options available to Medicare beneficiaries under budget law changes:

Traditional Medicare

Medicare risk HMOs

Provider-sponsored organizations

Medicare preferred provider organizations

Medicare MSAs

Private fee-for-service

Updates

Commissioner sues over fund

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about 3,400 self-insured employers before being placed in receivership last year.

The fund's collapse left unpaid liabilities of \$60 million to \$80 million that will have to be funded by the Florida Self-Insurance Fund Guaranty Assn., according to the Insurance Department.

The department's lawsuit says defendant David Sanz provided management and claims services through his company, Gulf Atlantic Management Group Inc. He is accused of collecting fees that should have been used to pay claims and illegally raising administrative fees without adding additional services, among other things.

Other defendants are Kenneth B. Wright and Charles B. Lembcke of the Jacksonville, Fla., law firm Datz, Jacobson, Lembcke & Garfinkel; and William L. Shores, an Orlando, Fla.-area accountant.

Underwriters eye Latin America

HAMILTON, Bermuda—X.L. Insurance Co. Ltd. and Risk Capital Reinsurance Co. plan to form a new Bermuda company that will specialize in Latin American reinsurance.

Latin American Reinsurance Co. Ltd., which will be capitalized at approximately \$100 million, will require regulatory approval and licensing from Latin American countries before it can begin operations, said Paul J. Malvasio, managing director for Risk Capital Re in Greenwich, Conn. Obtaining those licenses could be months away, he said, but plans call for Argentina, Chile, Colombia and Mexico to be the company's first markets in the region. Expansion to other countries is expected to follow.

Latin American Re, or LARe, will provide short-tail, multiperil property reinsurance, and to some extent casualty, marine, and aviation reinsurance. Reinsurance for other lines may be written in the future, such as workers compensation, directors and officers, and financial and finite reinsurance contracts on a treaty and facultative basis.

According to an agreement in principal between the two founding reinsurers, X.L. will contribute \$75 million and Risk Capital Re will contribute \$25 million.

Latin American economic growth and deregulation of insurance markets spurred the agreement to launch the venture, Mr. Malvasio said.

Richard Meyer, formerly an executive vp of Johnson & Higgins, will be chairman and chief executive officer of LARe.

Ruling favors asbestos makers

SAN FRANCISCO—A California Supreme Court ruling bars jury instructions in asbestos product liability cases from forcing defendants to prove their products did not cause a plaintiff's disease or death.

The Aug. 28 decision in *Theima L. Rutherford vs. Owens-Illinois Inc.* will make it more difficult for plaintiffs to win compensation given the long latency period for asbestos-related diseases and the multiple products that claimants often are exposed to, Justice Marvin Baxter acknowledged in the majority opinion.

Under existing law, plaintiffs do not need to prove "with medical exactitude" that a particular defendant's product caused the cancer, he wrote. Plaintiffs only need to prove there was a reasonable medical probability of causing or contributing to the development of cancer.

Therefore, the burden-shifting instruction is not necessary, and there is no justification for it, the court concluded. The decision came 10 days after another California Supreme Court ruling favorable to asbestos manufacturers and distributors (*BI*, Aug. 25).

The high court's most recent decision stems from a lawsuit originally brought by Charles Rutherford, a metal worker who won \$119,000 in pretrial settlements and jury awards. Although the trial judge erred by forcing Owens-Illinois to prove its product did not cause Mr. Rutherford's cancer, the error did not affect the jury's decision, so the verdict was not overturned, according to court documents.

Theima L. Rutherford vs. Owens-Illinois Inc., California Supreme Court; No. S046944.

Superfund vote postponed

WASHINGTON—A key Senate committee will not vote on the Republican leadership's Superfund reform bill this week, as members had initially planned.

The Senate Environment and Public Works Committee had been scheduled to mark up a revised version of the measure, S. 8, this Thursday. But after hearing the objections to the bill posed by Environmental Protection Agency Administrator Carol Browner during a hearing last week, committee members agreed to put a vote off until at least Sept. 18. The extension is so the panel's Republican and Democratic leadership can meet with Ms. Browner in an effort to iron out their differences, said a spokeswoman for Sen. Robert Smith, R-N.H., chief architect of S. 8.

Ms. Browner was particularly critical of a provision that would exempt certain parties at roughly 250 co-disposal sites from retroactive liability. Co-disposal sites receive both municipal and private wastes.

New Hampshire HMO sold

BEDFORD, N.H.—Blue Cross & Blue Shield of New Hampshire will pay \$46.5 million to acquire New Hampshire's oldest and second-largest health maintenance organization, Matthew Thornton Health Plan, which has been seeking a buyer.

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PBGC to drop annual list of worst-funded plans

By JERRY GEISEL

WASHINGTON—The Pension Benefit Guaranty Corp. is eliminating its annual list of the 50 worst-funded corporate pension plans because changes in federal law have made the list unnecessary, the agency's executive director says.

The list has been published annually since 1990 as a publicity vehicle to prod employers to better fund their pension plans and to make plan participants more aware of the funding levels of

their plans.

But PBGC Executive Director David Strauss says the Retirement



Mr. Strauss

Protection Act, which Congress passed in 1994, has eliminated the need for such a list.

"With the 1994 law, we have new and better tools" to as-

sure adequate funding and notification of participants of how well their plans are funded, he said.

Among other things, the 1994 law requires employers to accelerate contributions to underfunded plans, reducing the PBGC's risk that it will be hit with a big claim when companies develop financial problems and terminate their pension plans.

The law also requires employers with underfunded plans—defined as less than 90% funded for promised benefits—to disclose to

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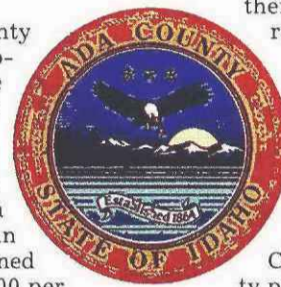
MSA may be eliminated

County may end program because of premium hike

By JERRY GEISEL

ADA COUNTY, Idaho—The first county to set up a medical savings account program for its employees may abandon the program in the face of a stiff rate hike proposed by its insurer.

Ada County, which includes the Boise area, captured considerable attention last year when it set up MSAs linked to a high-deductible health insurance plan (*BI*, June 24, 1996). The county also retained a traditional indemnity plan with a \$100 per person deductible and a 20% copayment above the



deductible, which covers about 660 employees and their dependents. Both plans are experience rated.

At the time, some county officials predicted that Ada County could cut its health insurance premiums by about \$70,000 through the MSA program, based on the roughly 160 employees and their families who said they would enroll in the program. In 1995, the year before the MSA program was launched, Ada County paid about \$2.1 million in indemnity plan premiums. Ada County pays the bulk

See MSA on page 6

Equisure fires CEO in stock delisting

MINNEAPOLIS—The strange tale of Equisure Inc. has taken another bizarre turn with the company announcing it has fired its recently appointed chief executive for allegedly agreeing to Equisure's delisting by the American Stock Exchange without permission from its board of directors.

Equisure, holding company for Belgian reinsurer Equihot Herverzekering N.V., last week fired Peter d'Orleans-Clarke, who was named CEO after the Amex halted trading of Equisure shares amid an investigation of possible insider manipulation.

In a series of press releases containing odd grammatical errors, Equisure said Mr. Clarke—whose real name it says is Peter Daniel Clarke—was not authorized to agree to the delisting. Equisure also said it could not confirm much of Mr. Clarke's claimed educational and job history and charged he conspired to devalue Equisure stock to invite a takeover bid. The company said it has been unable to locate Mr. Clarke since Aug. 28. Clarifying information in the announcements proved difficult.

Robert Sigveland, named in the releases as Equisure's contact, said he only learned of the releases after receiving calls on them last week. He said he was later told Equisure's board had prepared them and knows nothing of the charges against Mr. Clarke.

Other Equisure officials and Mr. Clarke could not be reached. An American Exchange spokeswoman declined to comment.

James Edward Sutter, who Mr. Sigveland said is a Minneapolis-area resident, has been named interim CEO. Mr. Sutter could not be reached.

—By Douglas McLeod

Directory of buyers ready next week

CHICAGO—The 1997/98 edition of the "Business Insurance Directory of U.S.-based Corporate Buyers of Insurance, Benefit Plans and Risk Management Services" will be available next week.

The annual directory includes information on more than 18,000 executives at more than 3,100 companies of all sizes in the United States. The directory will be available in a printed volume and on disk for IBM-compatible computers.

Listings consist of corporate data, including the names and titles of executives responsible for finance, risk management, employee benefits, human resources, pension/retirement planning, legal counsel and health plans. Corporate addresses and phone and fax numbers are included. Information on revenues or assets and the number of employees are provided, as well as a description of the business conducted. The directory also contains indexes, including one of companies by state, and rankings by number of employees and 1996 revenues or assets.

A similar directory for companies outside the United States will be available in October. The U.S. buyers directory costs \$95, the international buyers directory costs \$125; and either version is available on disk for \$595.

To order copies of the above editions, please call *Business Insurance's* Single Copy Sales Department at 800-678-9595 or 313-446-1623.

Inside

• AIG's response to regulators probing its dealings with Coral Reinsurance Co. Ltd. sends an ominous message to the industry, this week's editorial says. **PAGE 8**

• Senators voice their opposition to the proposed tobacco litigation settlement in hearings held last week. **PAGE 21**

• Despite privatization setbacks, companies still are excited about the prospects of private health insurance and other insurance products in India. **PAGE 23**

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Seeing benefits in online enrollment

Systems ease process for employees, free employers for strategic planning

By JOANNE WOJCIK

While a lot of employee benefit managers dread the thought of another open enrollment period, Aldy Duffield actually is looking forward to it.

This is the third year that Oracle Corp., her employer, will be conducting benefit enrollment online using Oracleflex, an Intranet-based system designed in-house with the help of consultant Watson Wyatt Worldwide.

Oracle and other high-tech companies are especially flocking to online enrollment systems, often designing their own systems. But there are also products and advisers out there for less computer-savvy employers that want to reap the same online benefits.

"It's been a great advantage to our employees as well as to our department," said Ms. Duffield, benefits manager for the Redwood Shores, Calif.-based programmer of computer databases. "They appreciate the fact that HR is embracing this technology."

The enrollment system also frees up benefit department personnel to handle more

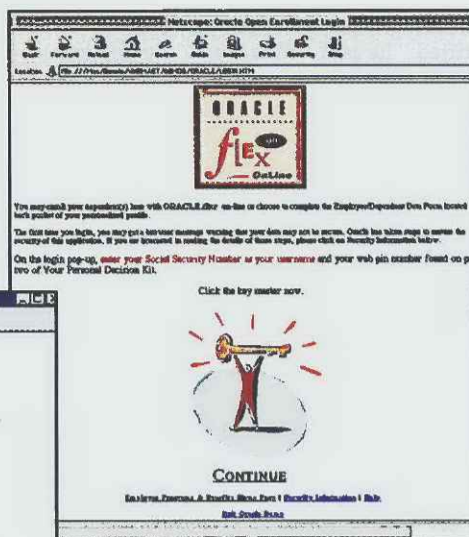
complex issues.

"Employees are asking more educated questions, the kind we really should have people here for," Ms. Duffield said.

In addition, she said, "Now we can concentrate on more project-oriented work and really be visionaries to the organization."

Besides allowing employees to enroll in their benefit programs online, Oracleflex

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Oracle Corp. uses Oracleflex, an Intranet-based system, to allow employees to enroll in benefit programs, which enables benefit personnel to focus on more complex issues.

Florida managing comp well, study says

By MICHAEL BRADFORD

Early findings in a study have not spotted any serious problems associated with implementing managed care in workers compensation in Florida.

The findings also are uncovering some of the keys to making those plans work along with a few trouble spots.

Florida law requires all employers beginning this year to treat injured workers under a managed care arrangement. Florida is the only state that makes managed care mandatory for its entire workers comp system.

Under an arrangement authorized last year by the Florida Legislature, the state's Division of Workers Compensation has contracted with the University of South Florida's College of Public Health to conduct a five-part study of managed care in workers comp.

The study's purpose is to give regulators and lawmakers information on managed care arrangements that have done best in audits by the state Agency for Health Care Administration.

The audits, which began last year as

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Proposal could rewrite rules on 401(k) advice

Labor Department studying plan that would allow investment recommendations

By SALLY ROBERTS

WASHINGTON—Sponsors of 401(k) plans could see more plan participation and reduced fiduciary liability if TCW Group Inc.'s precedent-setting proposal passes muster with the U.S. Department of Labor.

The Labor Department now is reviewing the money manager's proposal, under which TCW would provide investment options to 401(k) plan participants while offering participants investment advice.

Under the plan, Los Angeles-based TCW would use outside financial experts to provide plan participants investment advice and recommendations based on asset allocation models developed by those outside experts.

Plan participants would direct their investments into four commingled trusts. The trusts in turn would invest in TCW's Galileo family of 13 no-load mutual funds.

Those familiar with the product say that if this proposal is approved, other money managers will soon follow suit.

TCW has no comment on the proposal pending final approval from the Labor Department.

However, lawyers and consultants, who helped TCW develop its product, say they are optimistic that because TCW is using outside investment advisers, the department will exempt the fund manager from prohibited transaction provisions of the Employee Retirement Income Security Act. If the exemption is granted and the propos-

al is approved, TCW, and subsequently plan sponsors, would be shielded from potential breaches of fiduciary obligations relating to self-dealing, explained Bob Eccles, a partner in the Washington office of O'Melveny & Myers, the law firm that assisted TCW with its product.

Self-dealing could occur if a money manager were to be influenced by the level of fees associated with various investment options it was recommending. Subsequently, plan sponsors could face potential liability arising out of its decision to contract with the money manager.

Currently, Labor Department guidelines limit employers to providing general financial and investment information, not specif-

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Reinsurers savoring good results in first half

By JUDY GREENWALD

Barring a major catastrophe loss in the second half of the year, U.S. reinsurers are likely to continue to enjoy good results for the remainder of 1997.

U.S. reinsurers' results are aided by strong cash flow and investment in-

come, as well as a predominant focus on excess-of-loss business, which provides some insulation from the softness of the primary market.

For the long term, however, some market observers perceive indications of underlying deterioration in reinsurer results. There is concern, for example, that some reinsurers are writing increasing amounts of pro rata business, which generates more premium but also brings a greater exposure to the fortunes of the embattled primary market. Reinsurers also are writing more primary business, which again brings them closer to potential losses.

The 45 reinsurers surveyed by the Reinsurance Assn. of America reported a 101.5% combined ratio for the first six months of 1997, compared with a 104.8% combined ratio reported by a comparable group of reinsurers during the same period of 1996 (BI, Sept. 2, 1996). The first-half ratio is a deterioration, however, from the 100.9% combined ratio posted by the 46 reinsurers surveyed by the RAA in the first quarter (BI, June 2).

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12 judges to pick BI Risk Manager of the Year

Nominations for the 1998 *Business Insurance* Risk Manager of the Year and Risk Management Honor Roll, to be named in April, are due by Nov. 19.

The nominating forms and instructions are available now from *Business Insurance's* Chicago office.

The 1998 honoree will be the 21st person to receive this honor.

Business Insurance created the Risk Manager of the Year competition in 1977, on its 10th anniversary of publication, to

recognize outstanding risk management practices. The first award was presented in 1978.

"As we celebrate our 30th year of publication this year, we are proud to sponsor this award and the Risk Management Honor Roll awards," said Kathryn J. McIntyre, publisher and editorial director of *BI*.

Business Insurance created the Risk Management Honor Roll in 1981 to recognize outstanding achievements in risk

management in different types of employment categories.

Twelve independent judges from all sectors of the risk management profession and the insurance industry will select the 1998 *Business Insurance* Risk Manager of the Year and the Risk Management Honor Roll.

The honorees are selected based on the judges' assessments of the risk managers' programs as detailed in their nomination forms.

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Mr. Carey



Mr. Corbett



Mr. Davis



Mr. Duperreault



Mr. Kaddatz



Ms. Kutska



Ms. Lindenmayer



Mr. Lockton



Mr. Opferkuch



Mr. Powell



Ms. Sedwick



Mr. Witthun

MSA

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of the premium.

With somewhat smaller-than-projected enrollment—about 150 employees and their families opted for the plan—Ada County has saved about \$39,000. Those savings are after the county made contributions to employees' MSAs, which employees can use to pay for uncovered health care-related expenses or take as taxable cash.

But the program has not been a success for Regence Blue Shield of Idaho, which underwrites the high-deductible plan and the traditional indemnity plan. It told Ada that if the county retained the high deductible-linked MSA program, premiums would increase an extra \$328,000.

With that proposed increase, county officials initially decided to issue requests for proposal for a point-of-service plan and to drop the MSA high-deductible plan.

"We reacted strictly to the costs quoted to us," said Frank Walker, an Ada County commissioner. In response to complaints from the MSA industry that the county was not giving MSAs a fair test, Ada County now will seek proposals for a POS plan and a POS operating alongside a high-deductible plan linked to MSAs.

If a POS and an MSA-linked high-deductible plan result in a higher premium—as the county's broker believes it will—the county will drop the MSA option, Mr. Walker said.

Both county and Regence Blue Shield officials say the MSA program has resulted in adverse selection. While the county's premiums were reduced, the claims costs for the traditional plan increased slightly. That is because employees who would have filed the fewest claims—regardless of the type of program the county offered—enrolled in the MSA, while employees with the highest health care claims cost stayed in the traditional plan, which has low deductibles.

With this type of dual-choice program, "you have less premium to pay for claims," said Scott Haas, director of underwriting at Regence Blue Shield of Idaho in Lewiston.

"From an insurer standpoint, they are collecting smaller premiums, but they are getting the same claims. The same people are getting sick," said Terry Johnson, Ada County's director of human resources.

Benefit consultants say the Ada County experience illustrates what can happen when MSAs are offered alongside a traditional plan. With the exodus of employees to the MSA program, the average claims cost of employees in the traditional plan will increase substantially, said Mary Case, a principal with The Kwasha Lipton Group in Fort Lee, N.J.

But MSA advocates have a different view of the Ada County experience. Tenna Merchant, an assistant vp with Golden Rule Insurance Co. in Indianapolis, said the situation in Ada County simply may be a result of program rates being inadequate rather than an example that MSAs and traditional plans cannot successfully operate together.

Others say the county could save the most money by canceling the traditional indemnity plan and moving everyone to an MSA plan. Such a change could save the county about \$300,000, said Gary Glenn, a former county commissioner who pushed the MSA program. Mr. Glenn also says enrollment in the MSA plan was held down by a poor education program.

Like other MSA programs, Ada County's is part of a high-de-

ductible medical plan. For example, employees in the MSA selecting family coverage to cover at least three persons are responsible for the first \$3,000 of medical bills. By contrast, employees choosing family coverage in the traditional plan have a \$100 per person deductible and pay 20% of bills above the deductible, up to an \$800 per person cap.

By dramatically increasing deductibles, Ada County was able to reduce the rate charged by Regence Blue Shield. The Regence rate in the traditional plan is \$494 a month. Ada County pays \$336 and the employee pays \$158.

By contrast, the monthly rate for family coverage in the MSA plan is \$194; employees pay \$158 and the county picks up the remaining \$36. For Ada County, that results in a monthly premium savings of \$300 per family or \$3,600 a year.

With its \$3,600 in annual premi-

um savings, the county contributes \$2,100 to employees' MSAs. Because the county has to pay Social Security taxes on MSA contributions, it actually costs Ada County \$2,260 to make a \$2,100 MSA contribution.

Including its \$432 insurance pre-

'If I had to redo it today, I would give some serious thought' before enrolling in the MSA program, says Terry Johnson.

mium and \$2,260 MSA contribution, the county's health care-related costs for families of three or more who opt for the MSA plan is \$2,692. That is a \$1,340 savings compared with the county's \$3,600 family coverage premium for those enrolling in

the traditional plan.

The county's cost savings for employees in smaller family units or those opting for single coverage is less. The county's health care cost savings for an employee choosing the MSA plan for himself or herself is \$524 and just \$16 for those with single coverage.

Under the MSA plan, the county funnels contributions to a money market fund administered by a bank. Accounts have been established for each employee participating in the plan.

When employees incur a medical expense, they file a voucher with the bank for reimbursement. Funds can be withdrawn from MSAs for non-medical purposes. But, in that case, state taxes and a 10% penalty are applied. Employees can keep unused funds in the account—while earning interest—and use them in succeeding years. Funds withdrawn after age 59½ are not subject to the

10% state penalty. MSA contributions, though, are added to federal taxable income. Ada County's MSA contributions do not qualify for the special tax breaks that small employers with MSA programs enjoy. Those tax breaks, which Congress approved last year, are only available to employers with 50 or fewer employees.

One employee who is having second thoughts about the MSA program is Terry Johnson, the county's human resources director. Mr. Johnson, who is single and has been healthy, broke his ankle in May and needed surgery. His bills exceeded \$4,000. At the time, Mr. Johnson's MSA account had just \$400 in it. With a \$2,000 deductible, Mr. Johnson had to go to his bank to pay the medical bills.

"If I had to redo it today, I would give some serious thought" before enrolling in the MSA program, he said. **B**

Protection

Factory Mutual System

Diana

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As the week wore on and the sea of flowers and people of all ages swelled outside St. James and Kensington palaces, it was clear there would be scores of postponements and cancellations of events during the week.

Had Diana been an official member of the Royal Family, the British government would have called a national period of mourning, and everyone would have been obliged to shut their shops and call off their events at least on the day of her funeral.

Because Diana was not considered a Royal since her divorce a year ago, when she lost the title Her Royal Highness, closures and cancellations were voluntary as a sign of respect.

Nevertheless, just about every

shop, bank and restaurant had announced closing either all or part of Saturday, and sporting venues, theater performances, concerts and special events had announced cancellations.

Harrods, owned by Mohammed Al Fayed, whose son Dodi Fayed was killed in the car with Diana and their chauffeur, was scheduled to be closed the entire day of Diana's funeral.

The Scottish Football Assn. had decided that a World Cup qualifying soccer match between Scotland and Belarus should be played on the day of her funeral. The game eventually was postponed because of huge opposition, including from the British government.

However, "there is no insurance in place" for the cancellation or postponement of such soccer matches, said Jonathan Ticehurst, director of sports insurance at

London-based Windsor Insurance Brokers Ltd.

The soccer clubs don't need it because they are required to complete all their matches in the year, so the games will be played at another time, Mr. Ticehurst said. Also, there were no Premier League soccer matches scheduled for Saturday, he said.

Typical cancellation and abandonment insurance policies cover "cancellation, abandonment or curtailment (of an event) which is due to a cause beyond the control of the insured, unless it's excluded," summed up Kelvin Mercer, underwriter for the Enterprise Consortium at Lloyd's.

Had a period of National Mourning been called, then any cancellations or costs of postponement would have been covered automatically, because they would have been beyond any policyholder's control, said Mr. Mercer.

However, "this isn't quite the case" because of Diana's position, said Mr. Mercer. As a result, underwriters will assess each claim, he said.

"It depends on how technical you want to become," said Mr. Peacock. "I don't want to comment (on how insurers might respond), but my view is fairly positive."

"There's no doubt whatsoever" that there will be cancellation claims as a result of the death of Diana, said Brian Freeman, director of broker Tyser & Co. "In the true letter of the insurance policy, it might not be covered" because a national period of mourning was not declared, though underwriters might consider the circumstances.

"It's a tricky one," added another London broker. "You do have Royal inclusions in special event insurance policies, but Diana wasn't strictly a Royal. But underwriters are trying to be understand-

ing," the broker said.

"I think there will be several claims, there may be quite a few," said Mr. Mercer of the Entertainment Consortium. "But I can't imagine there will be as many as there would have been if the funeral had been on a weekday."

Each claim will not be huge. The postponement of a West End theater matinee on Saturday in London might each be five-figure sums. But a rock concert in a stadium where there are 50,000 people at £20 (\$31.67) per ticket would be at least £1 million (\$1.56 million). Rescheduling rather than canceling a rock concert would be a "fraction of that," he said.

Meanwhile, claims started rolling in last week.

There was a claim notification for the cancellation and rescheduling of a Michael Jackson concert in Ostend, Belgium, on the Sunday of Diana's death under a cancellation and non-appearance insurance program, confirmed Iain Ward, contingency underwriter for Reliance National Insurance Co. (Europe) Ltd. Reliance led a coverage for the London Calling ticket agency, whose claim will be paid because the loss was beyond the agency's control, said Mr. Ward.

Lexington also had a minor claim from one of the caterers of the Michael Jackson concert, said Mr. Peacock.

Underwriters expected to pay rescheduling costs for a Wet, Wet, Wet concert in Glasgow that was postponed to Sunday night from the day of the funeral, confirmed Mr. Peacock, whose company Lexington is one of the main insurers on the risk. The rescheduling costs will include the band's Sunday concert in Birmingham, which also had to be rescheduled after being pre-empted by the Glasgow postponement. The claim is not expected to be more than \$50,000.

Other claims insurers were notified of, said Mr. Peacock, included: a canceled matinee of Ben Elton's "Popcorn" play; a horse show at Blenheim, which was rescheduled for Sunday; and a power boat event, which would be rescheduled.

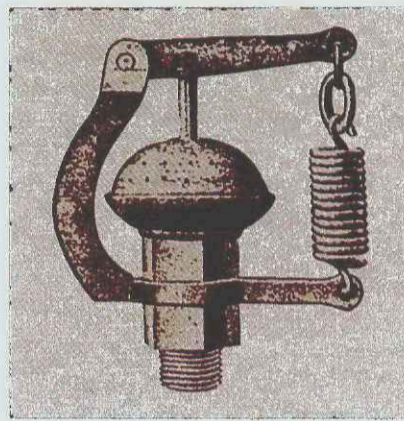
Diana will be sorely missed particularly by the six main charities she represented and the scores of others she helped. However, last week no one in the London market knew of any cancellation/abandonment or life insurance coverages bought by the charities. "It is fairly unusual insurance and not bought very often," said one London broker who specializes in charity insurance programs. "We're all optimists and work on the fact that people who say they will turn up do turn up."

Meanwhile, news reports in London last week suggested that Mohammed Al Fayed's Ritz Hotel in Paris, which supplied the driver of the fatal accident, may be held liable for any compensation to the families of the three passengers, including Diana's children, Princes William and Harry. The driver, Henri Paul, allegedly had a blood-alcohol level three times higher than the legal limit for driving in France.

Michael Cole, a spokesman for Mr. Al Fayed at Harrods, told *Business Insurance* that Mr. Al Fayed had instituted a civil suit for damages against the photographers who followed the Mercedes and allegedly caused the accident.

He said Mr. Al Fayed and his brother own the Ritz in Paris independent of Harrods. Although Mr. Cole did not know any details about the Ritz's insurance coverage, he said, "I assume the Ritz is insured" for any such event. **BI**

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Opinions

Might doesn't make it right

THE INTRIGUING CONTROVERSY surrounding Coral Reinsurance Co. Ltd. highlights some unpleasant truths not only about Coral's sole client, American International Group Inc., but also about the state regulators charged with examining AIG's insurance subsidiaries.

After a year-long shoving match with regulators, three AIG units have agreed to commute much of the business they had ceded to Coral, a thinly capitalized Barbados reinsurer that collected \$1.6 billion in AIG reinsurance premiums from its formation in 1987 to 1993 (*BI*, Sept. 1; Oct. 14, 1996).

AIG ceded much of that business under treaties that covered it for uncollectible reinsurance from other reinsurers. Regulators charged that the treaties transferred no underwriting risk and amounted to accounting "window dressing" designed to inflate the surplus of AIG underwriting units. Coral, they added, appeared to be nothing more than a facade, controlled behind the scenes by AIG.

AIG countered by arguing that, among other things, regulators were unreasonably holding its Coral treaties to accounting standards that were not adopted until well after the treaties were in force.

We are no fans of heavy-handed insurance regulation, especially of commercial insurers whose policyholders are sophisticated enough to look after themselves. But AIG's conduct in the Coral affair invited—in fact, demanded—regulatory scrutiny.

First, there is AIG's assertion that its relationship with Coral is arms-length. AIG has stuck with this story despite the discovery that it helped organize the private placement that capitalized Coral for the sole purpose of reinsuring AIG; designed Coral's reinsurance treaties, which gave AIG an unusual amount of control for a ceding company; and managed Coral through American International Management (Barbados) Ltd. While AIG itself never had an equity stake in Coral, several Coral shareholders and directors have ties to the insurance giant.

The relationship clearly is not arms-length, and AIG's denial of the obvious was a challenge to regulators to uncover the truth.

Then there is AIG's reaction to examiners' questions about Coral: It stonewalled. Delaware, New York and

Pennsylvania examination reports are peppered with complaints about AIG units' lack of cooperation and failure to provide requested information.

American Home Assurance Co., for example, turned away repeated requests for details of the investment yield on more than \$800 million ceded to Coral, saying this was "third party" information not available to the insurer. The yield was part of a retrospective rating formula used to calculate final premiums due under Coral treaties, and New York examiners reasonably found it "inconceivable" that AIG would not have this information.

Lexington Insurance Co. similarly told Delaware examiners that Coral's board had voted not to provide a requested actuarial opinion supporting Coral's reserves.

Again, AIG's recalcitrance only invited closer regulatory scrutiny.

The scrutiny it finally received, however, highlights a troubling fact of life.

The three insurance department exam reports—two of them released only last month—cover AIG's financial filings for year-end 1991 and come years after AIG's business with Coral hit its peak.

About \$1.1 billion of Coral's AIG premiums date to its first three years of operation in the late 1980s. At that time, AIG needed the reinsurance capacity to bolster its surplus and support explosive growth in premium volume.

AIG no longer needs that capacity, and its use of Coral has fallen off in recent years, an AIG official has said, suggesting that the reinsurer served its intended purpose.

Insurance department examiners deserve credit for exposing Coral's veiled workings, but that exposure comes too late to make much practical difference. In negotiations with regulators, AIG units have agreed to commute much of their remaining Coral reinsurance and have made various other concessions. The price of those concessions to AIG is small, though, and amounts to little more than a tap on the wrist and a promise not to do it again.

The message delivered here is that a company of AIG's power and complexity can afford to be openly hostile to state oversight and, in the end, have things pretty much its own way.

That is a disheartening message, indeed.

Letters

PBGC rules led to drop in defined benefit plans

To the editor: I feel compelled to comment on the Aug. 25 article, "PBGC May Eliminate its List of the 50 Worst-Funded Plans," which infers an improvement in the efficiency and effectiveness of the Pension Benefit Guaranty Corp. because it had a \$869 million surplus in 1996 vs. a \$1.5 billion deficit in 1988.

Although no doubt factual, it fails to mention that the PBGC's enforcement of ill-conceived rules has been the single biggest cause of the rapid demise of defined benefit pension plans over the past two decades. The result removes the most valuable retirement funding vehicle from the availability of millions of American workers.

The substitution of defined contribution plans doesn't begin to fill the void left by abandoned defined benefits

plans—primarily due to Internal Revenue Service caps on contributions and the almost immediate vesting mandates.

The primary reason the PBGC has such a surplus is because the number of plans remaining are in a dormant mode and have frozen benefit levels or restricted entry for new hires.

When you or I make a mistake, we usually fail to meet our objectives. When a government entity makes one, it often results in having the exact opposite effect intended. Many of the individuals

Robert Kuntz remembered

To the editor: I didn't learn about Robert E. Kuntz's untimely death until I read Laura Brugger's Letter to the Editor in the Aug. 25 issue of *Business Insurance*. I echo Ms. Brugger's comments.

Bob Kuntz was an asset to the insurance and risk management community. His clear thinking was known by all whose pleasure it was to have known him. We will all miss him.

Donn McVeigh
Creative Risk Concepts International
Oakland, Calif.

whose retirement security was to be protected by this government program now have no defined benefit pension plan.

But, then, they always have Social Security.

David J. Westfall
Mission Viejo, Calif.

1970 OSHA act aids safety

To the editor: The July 21 letter to the editor, "Employers Provide Valuable Input on Safety," makes the comment that lost time injuries increased 50% since 25 years ago.

Without seeing the data that this view was based upon, my response is the reason for the increase is because of better reporting of injury data.

Yes, I believe that the government has gotten into regulatory overkill. But, for the most part, individual employees are being provided a safer and healthier workplace because of the Occupational Safety and Health Act of 1970.

Rocky Myers
Loss Prevention Specialist
Risk Management Administrators
Indianapolis

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Retirees

Continued from page 1
their programs in order to attract beneficiaries.

Managed care plans will offer extra benefits, such as risk HMOs now do, to entice retirees. They will be in a good position to do so as their own costs, if they are well managed, will be substantially lower than the capitated rate they will receive from the Health Care Financing Administration.

Benefit consultants expect private fee-for-service plans to tout better service and in some cases access to physicians who don't participate in the Medicare program because they think the fees aren't high enough.

It will be several years before all of these plans are fully available. But, by the turn of the century, re-

tirees—much like many employees—will have the opportunity during an open enrollment period each fall to decide on a health care coverage plan.

That will be a radical change from the current system, in which retirees must enroll in the traditional Medicare program, an old-style indemnity plan, or risk HMOs in parts of the country where they are available.

"It is a whole new health care playing field for retirees," said Steve Coppock, a consultant with Hewitt Associates L.L.C. in Rowayton, Conn.

It also will be a new ball game for employers that now offer retiree health care plans.

Typically, those plans were designed in an era when the traditional Medicare program was the only health care plan available to retirees. Employer plans were intended to fill in the cracks, offer-

ing benefits, such as prescription drug coverage, that Medicare does not provide.

But with so many alternatives to the traditional Medicare program to be available—some of

are out there, the more employers will question the need to provide access to health care coverage through their plans," says Mary Case, a principal with The Kwasha Lipton Group in Fort

'The broader the choices that are out there, the more employers will question the need to provide access to health care coverage through their plans,' says Mary Case.

which will provide even greater benefits than the corporate Medicare supplemental plans—more employers will be asking what, if any, kind of retiree health care plan they should offer retired workers.

"The broader the choices that

Lee, N.J.

Joseph Martingale, a principal with Towers Perrin, concurred, saying, "With all these choices, employers will be asking what their role will be."

Some employers may conclude that the most logical and cost-ef-

fective approach will be to subsidize, such as by paying any premiums charged by these new Medicare alternative programs, while dropping their own supplemental plans or making them less attractive to retirees.

"Employers may say, 'We will subsidize these plans in an area,' and tell retirees, 'to the extent you want something else, you are on your own,'" said Mr. Martingale of Towers Perrin.

"Employers will ask whether they need a supplemental plan at all," said Henry Saveth, a principal with William M. Mercer Inc. in Washington.

Other observers, though, see employers assuming a role that some already have taken on with risk HMOs.

Some employers, for example, will negotiate with the new health care plan alternatives to try to gain enhanced benefits for retirees.

Many employee benefits experts view the coming changes as positive for employers, especially if large numbers of employers' retired workers move out of company supplemental plans and into the new Medicare alternative plans.

"This will expand managed care options to retirees, which should help employers control cash costs," said Rich Stover, a principal with Buck Consultants Inc. in Secaucus, N.J.

Still, there are plenty of potential problems and questions to be addressed. One of the most pressing questions for employers will be to decide how their own health care plans, if they decide to keep them, will integrate with the health care plans chosen by retirees, points out Chip Kerby, a principal with Mercer in Washington.

So far, no mechanism has been set in place for employers to even find out which of the alternative plans—or the traditional Medicare program—retirees will select each year.

"This becomes a real administrative concern. How will employers manage this process?" asks Mercer's Mr. Kerby.

"Tracking what is going on during open enrollment periods" will become an issue for employers, concurs Mr. Coppock of Hewitt Associates.

The biggest of other unknowns might be whether health care plans will take advantage of the new opportunities to provide health care coverage for Medicare beneficiaries.

For example, while medical groups lobbied Congress heavily to be able to enter the Medicare market, it isn't known how successful those groups will be in competing against already-established health maintenance organizations.

While so-called PSOs will at least in theory have a leaner administrative structure than HMOs, some retirees may shy away from them because of a lack of a track record in providing care, noted Jack Doerr, senior national group practice leader with Sedgwick Noble Lowndes in Chicago.

Indeed, the Health Care Financing Administration has yet to develop solvency standards for PSCs and is not expected to do so until sometime next year.

Other health care plan options will be sharply limited under the law.

For example, a maximum of 390,000 MSAs, which will be linked to high-deductible health insurance plans, will be allowed under the law. **BI**



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Mother, son arrested in fraud scheme

By DAVE LENCKUS

YUMA, Ariz.—From North Carolina to California, a mother and son team for years allegedly staged slip-and-fall accidents in fast-food and discount store chains and then ripped off the businesses' liability insurers when adjusters failed to ask the pair some tough questions.

But, the pair, whom authorities say sometimes faked up to four or five accidents daily, were tripped up last month in western Arizona.

Arrested Aug. 26 in Yuma, Ariz.,

were Robert Bengé, 26, and his mother, Mary Alessi, 55, both of North Carolina. Each faces numerous felony charges of fraudulent schemes and attempted fraudulent schemes, according to Daniel Kiley, an Arizona assistant attorney general. A fraudulent scheme conviction carries a minimum six-year prison term.

Authorities in Yuma last week were detaining the pair, who were unable to post bond set at \$25,000 each. The pair is expected to be moved shortly from Yuma County Jail to the Phoenix and the Tucson, Ariz., areas

to enter pleas on the fraudulent schemes charges, Mr. Kiley said.

An estimate of how much the pair allegedly bilked from insurers was unavailable last week, because authorities still were trying to determine how many ruses the pair allegedly committed.

While the mother and son team allegedly often struck in Arizona, they also are suspected of staging accidents in at least 10 other states. Mitch Rea, a special agent in the Arizona Insurance Department's fraud unit in Phoenix, has linked the pair to scams

in Arkansas, California, Georgia, Louisiana, New Mexico, North Carolina, South Carolina, Tennessee, Texas and Virginia.

While the pair allegedly hit many gas stations and truck stop restaurants, they also targeted fast-food chains, including McDonald's, Burger King, Wendy's, Carl Jr., Chili's, Whataburger and Golden Corral restaurants, said Mr. Rea, who tracked down the pair in Yuma. They also staged accidents in Kmart and Wal-Mart discount stores, he said.

After allegedly staging an accident,

the pair would head for a hospital emergency room and use "buzzwords" to elicit expensive medical tests, such as MRIs and CAT scans.

With a medical treatment bill in hand, they then would contact the liability insurer for the business where they allegedly faked the accident and seek a quick settlement, Mr. Rea said. The pair often would tell adjusters they were from out of town and preferred to settle the claim quickly to avoid delays in their travel plans.

Settlements ranged from \$1,000 to \$8,000, often including a payoff in addition to the medical expenses for not pursuing the claim further, Mr. Rea said.

Some previous medical problems the pair actually had and that were expensive to treat often aided them in their alleged scams, Mr. Rea said. Mr. Bengé has had a cornea transplant, and Ms. Alessi has had back surgery.

If the pair sensed an insurer's adjuster was balking, they would complain that their accidents aggravated their previous medical problems, Mr. Rea said.

Suspicious adjusters did not always scare off the pair. Occasionally, an adjuster would catch inconsistencies in how the pair and a hospital spelled their names. Sometimes, an adjuster would spot a problem with the Social Security numbers the pair provided, Mr. Rea said.

Mr. Bengé and Ms. Alessi would explain either that they mistakenly provided incorrect information right after their accidents when they were in pain or that hospital personnel provided the insurer wrong information.

The explanations often satisfied adjusters, Mr. Rea said.

If adjusters persisted in questioning the pair, Mr. Bengé and Mr. Alessi sometimes would accept settlements that did not cover the full amount of their medical bills.

The pair stopped pursuing their claims only in the relatively few cases when an adjuster persisted in questioning the inconsistencies, Mr. Rea said.

Mr. Rea said he began investigating the pair in 1991, when an insurer notified him of its suspicions about a man injured in a slip-and-fall accident. The man ran up unusually high medical expenses, and there were some irregularities in his Social Security number, Mr. Rea said.

Further investigation, including long database searches and a random stop at a Tucson truck stop where Mr. Rea discovered the pair had claimed to be injured, led Mr. Rea to believe the pair was very active and often used aliases that were derivations of their real names.

Some luck, though, led to the pair's arrest, Mr. Rea said.

During a conversation with an adjuster about a month ago, the adjuster mentioned a suspicious slip-and-fall claim. The details closely matched those in many other cases in which the pair were suspects, Mr. Rea said.

The insurer's information led the fraud unit to Yuma, where the unit staked out Mr. Bengé's residence. The unit eventually caught up with Mr. Bengé, who was arrested by the state's Department of Public Safety. The fraud unit cannot make arrests.

The fraud unit, though, did not know where Ms. Alessi was.

The unit's break came while it was executing a search warrant of Mr. Bengé's residence. A woman who did not identify herself left several phone messages for Mr. Bengé to contact her. The phone's caller identification system led authorities to a nearby motel where Ms. Alessi had registered using her real name.

The pursuit of the pair also was not without some irony. After the arrest Mr. Rea learned Mr. Bengé had been working as a security guard at the motel where Mr. Rea was staying in Yuma while he was tracking down Mr. Bengé. **B**

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P i c a s s o

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CGL doesn't cover patent award

CHICAGO—A federal judge in Chicago recently ruled that a can manufacturer has no coverage under its commercial general liability policy for a previous patent infringement judgment.

If it loses its appeal of the ruling, American National Can Co. of Chicago would be fully responsible for at least a \$102.4 million patent infringement judgment to Viskase Corp. of Chicago.

In that underlying case, a jury found in November 1996 that the can company willfully violated Viskase's patent on heat-shrinkable thermoplastic film, used primarily to wrap pre-cut meat sold in food stores.

The patent infringement judgment already is one of the largest on record but still could grow, said David S. Osborne with

Chicago-based Pretzel & Stouffer Chartered. He represented the can company's insurer, The Home Insurance Co. Pending motions about the willful nature of the violation could triple the award under federal patent law, he said.

The can company, a subsidiary of Pechiney S.A. of France, provided its own defense in the underlying case because "apparently it did not occur to anyone... that its CGL policies might cover Viskase's claims," Judge James B. Zagel explained in his Aug. 11 ruling on the coverage issue.

In this case, the can company subsequently contended "its insurance covered advertising injury which potentially arose out of Viskase's patent infringement claims and therefore triggered The Home's duty to defend (the

can company) against Viskase," the judge said in his 14-page decision.

The Home wrote advertising injury coverage as part of the can company's CGL policies during portions of 1989-1991. However, "the record shows that no connection existed between (the can company's) advertising activities and Viskase's injuries that triggered The Home's duty to defend," the judge said.

In addition, the can company "breached the notice provisions contained within its CGL policies, thereby relieving The Home of any obligations to provide insurance coverage" to the can company, Judge Zagel also ruled.

The standard for notice is that it be provided in "a reasonable amount of time," insurer attorney

Mr. Osborne said. "Courts have interpreted that to mean a month or two, but not the 37 months the can company took," he said. The can company finally notified the insurer in early 1997 that "an unfortunate mistake may have been made" regarding notification, according to court records.

As Judge Zagel saw it: "... this mistake is not a justifiable excuse, especially where the consequences of accepting this excuse would be to severely prejudice The Home." He also questioned the credibility of the can company's claim because it admitted discovering in May 1995 that it had a potential basis for holding the insurer liable.

The can company last week decided it will appeal the decision, said Robert T. Markowski of Jenner & Block, which represented the company.

—By Meg Fletcher

Judges

Continued from page 3
tions.

The 12 judges who will select the 1998 honorees include the 1997 Risk Manager of the Year, the five members of the 1997 Risk Management Honor Roll, two insurance company executives, two brokerage executives, a risk management consultant and an insurance educator.

The judges for the 1997 awards are:

- John J. Carney, vp-risk management for National Freight Industries Inc. of Vineland, N.J., and a member of the 1997 Risk Management Honor Roll, representing companies with sales under \$300 million (*BI*, April 14).

- Richard Corbett, professor in the Department of Risk Management and Insurance at Florida State University in Tallahassee. He is serving on the panel for a second year, representing insurance educators.

- Dwight E. Davis, president and chief operating officer of Wausau Insurance Cos. of Wausau, Wis. He is serving on the panel for a second year, representing mutual insurers.

- Brian Duperreault, chairman, president and chief executive officer of Hamilton, Bermuda-based ACE Ltd. He is serving on the panel for the first time representing stock insurance companies.

- Michael M. Kaddatz, a principal of ARM Tech in Lake Forest, Calif. He is serving on the panel for a second year, representing risk management consultants.

- Betsy Kutska, executive director of the Park District Risk Management Agency in Wheaton, Ill., and a member of the 1997 Risk Management Honor Roll, representing self-insurance pools (*BI*, April 14).

- Judy Lindenmayer, vp-Fidelity insurance and risk management for FMR Corp. in Boston and the 1997 Risk Manager of the Year (*BI*, April 14).

- John T. Lockton III, chairman and chief executive officer of Lockton Cos. in Prairie Village, Kan. He is serving on the panel for a second year, representing insurance brokers.

- Russell Opferkuch, vp of corporate risk and insurance for Bankers Trust Co. in New York and a member of the 1997 Risk Management Honor Roll representing, financial institutions (*BI*, April 14).

- William R. Powell, manager of the risk management department for the Salt River Project in Phoenix and a member of the 1997 Risk Management Honor Roll, representing government entities (*BI*, April 14).

- Jeannie Sedwick, managing director property/casualty at AHA-Insurance Resource Inc., a Chicago-based subsidiary of the American Hospital Assn. that provides financial and insurance products to the health care market. Ms. Sedwick was a member of the 1997 Risk Management Honor Roll representing not-for-profit institutions for her work as director of risk management at Wake Medical Center in Raleigh, N.C. (*BI*, April 14).

- Frank C. Witthun, president and chief executive officer of Acordia Inc. in Indianapolis. He is serving on the panel for the first time representing insurance brokers.

The judges score each of the candidates on 10 criteria (see related story). 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.

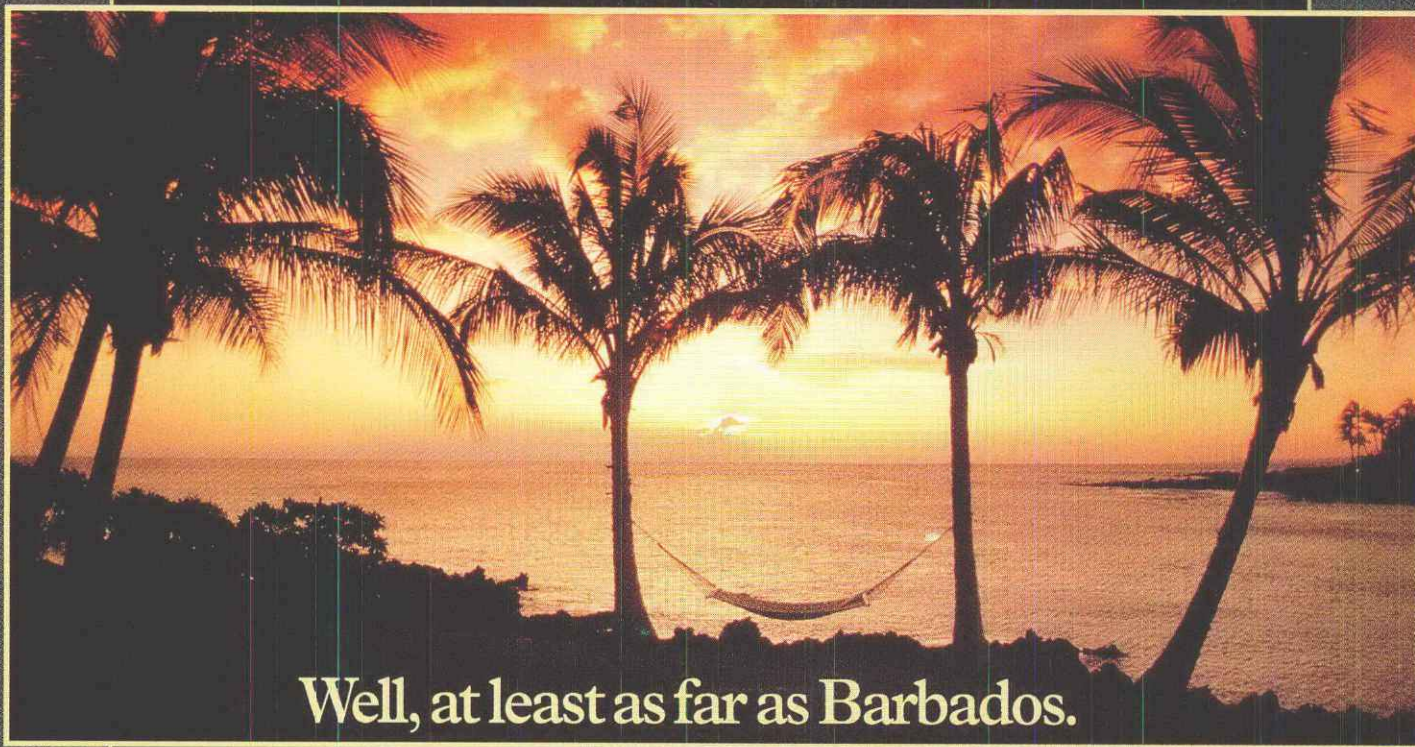
- Financial institutions.

Continued on next page

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Continued from previous page

• 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.

The 1998 honorees will be announced in the April 27, 1998, issue of *Business Insurance*, which will coincide with the annual Risk & Insurance Management Society Inc. conference April 27-May 1 in San Diego.

To be nominated, 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 other service supplier can nominate a client. And, a risk manager can nominate a colleague.

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.

To request a nomination form, contact Karen Tucker, assistant to the publisher, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611-2590; 312-649-5319. **BI**

Topic: "Securitization of Insurance Risks: Myths and Realities"

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Tuesday, October 14, 1997 8 - 11:45 a.m. Ritz-Carlton Hotel, Chicago

Program: In recent years the insurance industry has been challenged and its capacity stressed by the catastrophe losses from hurricanes and earthquakes. There are concerns about the industry's ability to cope with similar losses in the future. A response has been the development of devices that affect the "securitization of insurance risks" through alternative risk financing that will bring additional capital to the marketplace at the time of catastrophic losses. Such devices include corporate "cat bonds," "act of God bonds," catastrophe futures and options, and "catastrophe puts." A panel of experts from the insurance financial markets, the brokerage community, and insurer corporate users of such devices will discuss the issues, interpret what is going on, and explain how the securitization of insurance risks — both catastrophic and others — will provide opportunities and challenges for you, your company, and all participants in the insurance industry.

Moderator: Donna Galer, Executive Vice President, Zurich-American Insurance Group.

Sponsors: *Business Insurance*, Zurich-American Insurance Group, Kemper Companies, KPMG Peat Marwick, and Katie Insurance School.

Information/Advance registration: Call (309) 438 - 3021 or (800) 697 - 8692 or fax (309) 438 - 7753.

Criteria used in judging

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 panel of 12 independent judges will score each nominated candidate on a scale of one to 10, according to 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 (specifically addressing the types of policies purchased and manuscripted policies, if any).

• 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 (how the risk manager secures information from other departments and the use of risk management information systems are addressed in this criterion).

• Skillfully performs the functions of management in the overall organization and within the risk management/insurance department.

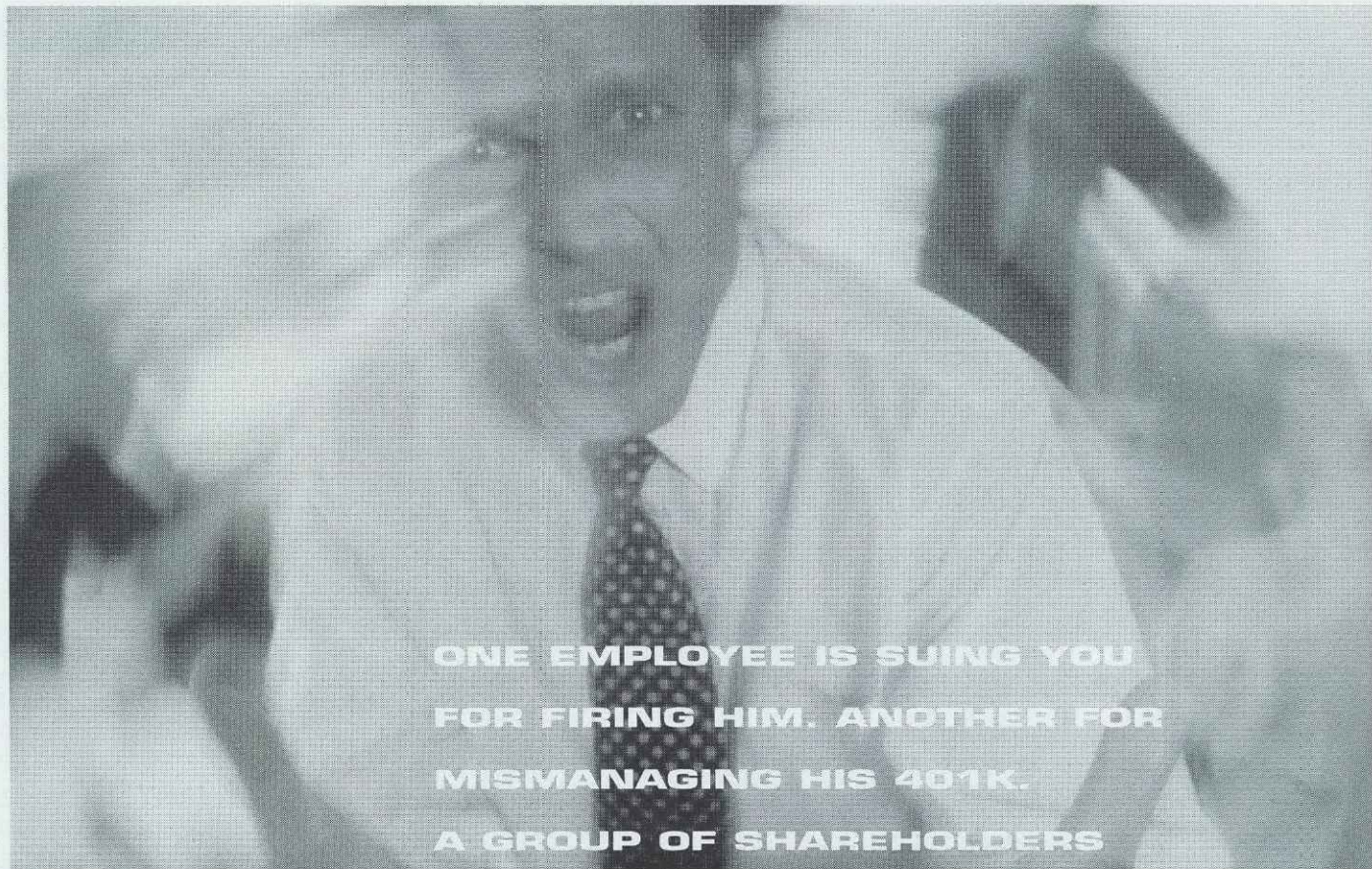
The functions include planning, organizing, directing and controlling.

• 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 operational aspects of the job.

• Exhibits an attitude and performs activities fostering the advancement of the risk management profession (such as professional activities, speaking engagements, teaching and related activities).

• Develops in his or her career (as exhibited by job history, including current job description, education, honors and memberships).



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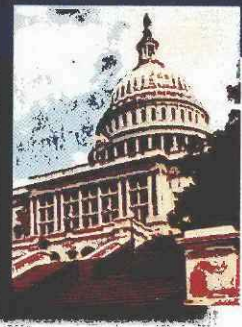
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WHO SHOULD ATTEND

Risk managers, loss prevention and safety managers, workers compensation administrators and analysts, employee benefit executives, plus insurers, brokers, consultants, representatives from HMOs and PPOs, state and local government representatives, association members, attorneys and providers from a broad range of companies and institutions.

PROGRAM AGENDA

MONDAY, OCTOBER 27

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

3:00 PM
EARLY REGISTRATION

4:30 - 5:30 PM
EMPLOYERS PRIVATE ROUNDTABLE

Moderator:
Kathryn J. McIntyre
Business Insurance

5:30 - 6:30 PM
COCKTAIL RECEPTION:
Hosted by Liberty Mutual Group

TUESDAY, OCTOBER 28

7:45 - 9:00 AM
REGISTRATION CONTINENTAL BREAKFAST:
Hosted by
Kemper Insurance Companies

9:00 AM
OPENING REMARKS
Alexandra Scott
International Business Forum

9:05 AM
KEYNOTE SPEAKER
**THE CASE FOR INTEGRATION:
SORTING OUT THE MYTHS AND
REALITIES OF DISABILITY
INTEGRATION MANAGEMENT**

Dwight E. Davis
Wausau Insurance Companies

9:45 AM
**ERGONOMICS: EFFECTIVE
WORKPLACE PRACTICES
AND PROGRAMS**

Moderator:
Wayne S. Maynard
Liberty Mutual Group
Michael Lichtenberger
BOC Gases

Russell C. Opferkuch
Bankers Trust Company
Cynthia R. Parks
Turner Broadcasting System, Inc.

Michelle Robertson
Herrman Miller, Inc.

Neal J. Taslitz
National Repetitive Strain Injury Foundation

10:45 AM
**TABLE-TOP EXHIBITS
REFRESHMENTS:**
Hosted by Commonwealth Risk

11:15 AM
**DEVELOPING A SUCCESSFUL
ANTI-FRAUD PROGRAM**

Moderator:
Peter C. Madeja
GENEX Services Inc.
Donald Elisburg, Esq.
Department of Labor Fraud Commission

William Kizorek
InPhoto Surveillance

Christopher E. Mandel
PepsiCo Restaurant Services Group

Philip J. Polazzo
Olsten Corporation

12:15
LUNCHEON:
Hosted by Intracorp

1:15
LUNCHEON SPEAKER
Adam W. Potter
Continental Airlines Inc.

**SOARING TOWARD THE
YEAR 2000**

1:45 PM
BREAK

2:00 PM
**INTEGRATING OCCUPATIONAL
WORKERS COMP WITH NON-
OCCUPATIONAL SHORT-TERM
AND LONG-TERM DISABILITY
PLANS**

Moderator:
Kathryn J. McIntyre
Business Insurance
Elizabeth M. Lindner
Kemper Insurance Companies

Ruth D. Theule
Steelcase North America

Jenny Parker Emery
Towers Perrin

Charles A. Amis
Provident Companies Inc.

3:00 PM
**TABLE-TOP EXHIBITS
AND REFRESHMENTS**

3:30 PM
CONCURRENT SESSIONS
**Concurrent Session A:
RETURNING EMPLOYEES
TO WORK**

Moderator:

Rebecca S. Bruce
Aon Management Institute

Daniel L. King
Host Marriott Services Corporation

Larry Kurtz
The Achievement Institute

Rosemary Osman
University of Pennsylvania Health System

**Concurrent Session B:
WORKERS COMPENSATION
TRENDS IN CALIFORNIA
TODAY: WHERE IS REFORM
GOING?**

Moderator:

John G. Pasqualetto
American Home Assurance Company

Rachel Kaganoff Stern
RAND

Edward C. Woodward
California Workers Compensation Institute

**4:30 PM
CONCURRENT SESSIONS**

**Concurrent Session A:
IDENTIFYING FACTORS
THAT DRIVE WORKERS
COMPENSATION COSTS:
CASE STUDY OF AN
INNOVATIVE APPROACH**

Introduction by:

Christopher Mandel
PepsiCo Restaurant Services Group

Christopher A. Duncan
Frito-Lay

I. Jeff Turshen
The MEDSTAT Group

**Concurrent Session B:
CREATIVE INCENTIVES AND
PAY-FOR-PERFORMANCE
METHODOLOGIES**

Michael Gibney
Rollins, Inc.

Lizbeth Mackenzie
Coors Ceramics Company

**5:30 PM
COCKTAIL RECEPTION**

WEDNESDAY, OCTOBER 29

**7:45 - 9:00 AM
CONTINENTAL BREAKFAST:
Hosted by GENEX Services Inc.**

**9:00 AM
OPENING REMARKS FROM
THE CHAIR**

**9:05 AM
OUTCOMES MEASUREMENT—
MANAGED CARE VS.
MANAGED COSTS**

Moderator:

Maddy E. Bowling
Intracorp

Mary Furnanz
Levi Strauss & Company

Brenda Olsen
J & H Marsh & McLennan, Inc.

Richard A. Victor
Workers' Comp Research Institute

**10:00 AM
TABLE-TOP EXHIBITS
REFRESHMENTS:
Hosted by
Wausau Insurance Companies**

**10:30 AM
ALTERNATIVE RISK
FINANCING**

John Kessock, Jr.
Commonwealth Risk

Art Engel
Southwest Marine, Inc.

Keith Terrano
Labor Ready, Inc.

**11:30 AM
CONCURRENT SESSIONS
Concurrent Session A:
NEW MEDICAL APPROACHES
TO OLD PROBLEMS**

Moderator:

Mary Stoik Dymond
ACX Technologies Inc.

Peter G. Hanson, M.D.
Hanson Peak Performance Clinic

Robert S. Ivker, D.O.
American Holistic Medical Association

**Concurrent Session B:
RISK MANAGEMENT
INFORMATION SYSTEMS**

Moderator:

David P. Duden
Deloitte & Touche LLP

Michelle DeLizio
CompReview

Tim East
The Walt Disney Company

Scott Lund
SAC3

**12:30
LUNCHEON:
Hosted by
American International Group, Inc.**

**1:30
LUNCHEON ADDRESS
Sandra M. Jensen
CNA Insurance Companies**

**INNOVATIVE PRINCIPLES
FOR REDUCING WORKERS
COMPENSATION CLAIM
COSTS**

**2:00 PM
BREAK**

**2:15 PM
CONCURRENT SESSIONS**

**Concurrent Session A:
SCREENING OUT YOUR
PROBLEMS—HOW FAR CAN
YOU GO?**

Moderator:

Jeffrey W. Pettegrew
Western Staff Services

Chris Berka
Psychomedics Corporation

Brent A. Winans
Avert, Inc.

**Concurrent Session B:
BUILDING A LABOR/
MANAGEMENT TEAM TO
WORK TOGETHER IN
REDUCING WORKERS
COMPENSATION COSTS**

William C. Bruce, Esq.
Mayo, Gilligan & Zito

Catherine M. Hopkins
The New York Times

**3:00 PM
CONFERENCE ADJOURNS**

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"The conference has been an informative experience containing many applicable theories to present to management for consideration."

Jennifer A. Beukers • Disability Coordinator • The BOC Group, Inc.

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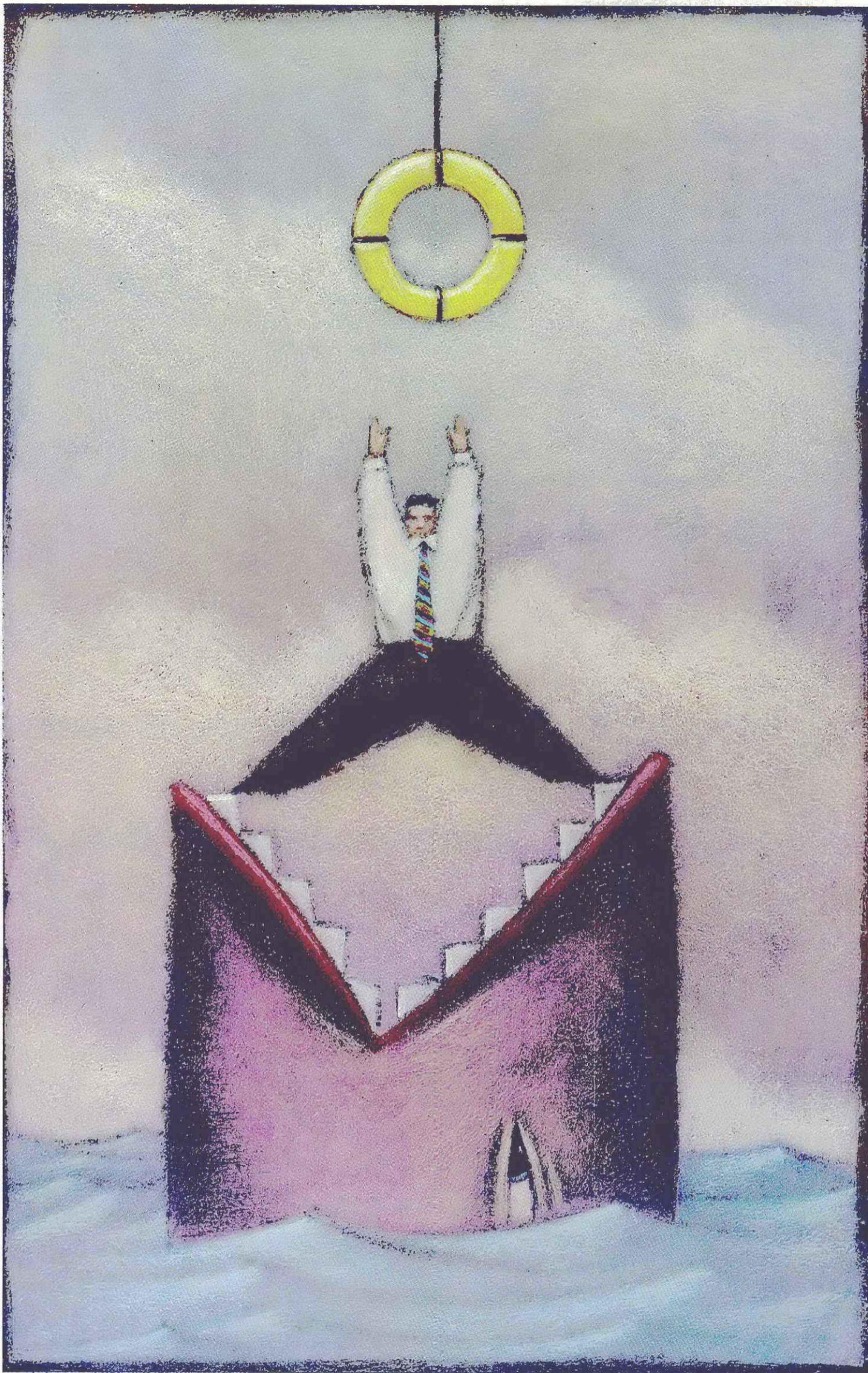
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Please forward information about sponsorship opportunities, or call Alexandra Scott at (212) 279-2525, ext 30.

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Ask your health plan what it's asking itself

By William C. Popik

ALARGE WEST-COAST utility company recently polled its various health plans about their commitment to ethical business practices. Among its questions: "Do you have an ethics committee to review medical coverage determinations?" One plan's blunt response left the utility's benefits manager aghast. In essence, it said, "We don't need an ethics committee because our role is limited to administering coverage—our providers make all the medical decisions."

For more and more corporate purchasers of health care insurance in today's rapidly evolving managed care environment, that kind of answer gets a flunking grade. While costs still are a key concern, employers are increasingly focusing on quality and value when selecting and evaluating health care plans. In making value-based purchasing decisions, savvy employers are starting to ask health plans some tough questions about ethical issues raised by managed care. As stiff competition—particularly in mature managed care markets—makes it harder for plans to compete on cost, they are promoting ethics-based initiatives as a point of differentiation.

Consider that just a few years ago, most health insurers were primarily claims-payers. But today, these companies' primary focus is on the delivery of care, driven by employer and consumer demand for quality care at lower costs. Managed care organizations are also under pressure to meet the needs of providers, while at the same time keeping their shareholders satisfied. Balancing the sometimes conflicting interests of all these stakeholders raises ethical questions for health plans.

Employers have a right to know how managed care companies are addressing these questions, including: Can MCOs deliver care in a cost-effective way without compromising on quality? Do physician reimbursement schemes tied to utilization improperly create incentives to limit care? How do MCOs determine whether to cover investigational treatments? How are MCOs responding to the challenges posed by new medical technologies? Is open communication between physicians and patients encouraged? How effective is the grievance and appeals process for enrollees and providers? Are enrollee medical records kept confidential? Do marketing campaigns promise more than MCOs can deliver?

Questions with ethical implications, like these, defy simple, straightforward answers. The idea of ethics itself is often elusive. The subject conjures up images of dusty tomes on morality and professorial lecturing about good and evil. But the ethical delivery and management of health care is not just an academic matter. Given current competitive market pressures, health plans are starting to pay closer attention to ethical concerns raised by employers, consumers and providers. Of course, ethics isn't something that is "discovered" overnight. Responsible companies in any industry have long known that acting ethically is both the right thing to do and good for business, because it earns the long-term trust of customers.

Asking a health plan whether it acts ethically or whether cost-cutting has hurt the quality of care is unlikely to elicit much more than a self-serving answer. A better approach is to inquire whether it has some kind of formal process for addressing ethical issues. Some MCOs, for instance, rely on a set of guiding ethical principles, or use decision-making tools, or direct questions through an internal ethics committee. These initiatives are typically not designed to answer case-specific questions—such as whether to pay for a particular organ transplant—but to instill a sense of values and provide a reliable, consistent road map for health plans to use when faced with difficult ethical decisions.

Although many health plans' ethics programs still are in their infancy, employers shouldn't shy away from inquiring about their details. If a plan has set up an ethics committee, find out what the panel's purpose and function is, who its members are, how often it meets, and what it has accomplished. An MCO with a new ethics council that has just held its initial meeting may not have any concrete results yet, but the council's very existence at least shows that the plan is thinking about the ethical challenges managed care presents.

By asking detailed questions such as these, employers can gauge the sincerity of health plans' commitment to ethics. Be wary of MCOs that have established ethics committees or other initiatives primarily as a public relations device to drive sales. Some plans adopt ethics campaigns because they see it as a popular thing to be doing, or as a way to combat the public's doubts about managed care. An ethics board whose sole achievement is drafting a code of ethical conduct or statement of values that gets pinned on the office bulletin board and is soon forgotten has failed in its mission.

Ethics committees should be devoted to identifying and addressing their plans' ethical responsibilities to the various stakeholders. Beyond that, committees should develop a working mechanism for handling ethical challenges as they arise. Find out, for instance, if the plan's medical directors use a decision-making tool that lays out ethical considerations they are expected to follow when making coverage determinations. If the plan uses such guidelines, ask to see them. When reviewing the guidelines, ask yourself

Prudent employers shopping for health care coverage for their employees or evaluating existing health plan relationships are asking plans how they deal with tough ethics-laced issues.

whether the values and judgments they express are compatible with your company's.

The primary purpose of an ethics program should be to integrate concepts of fairness, respect and integrity into all health plan activities—from underwriting to care management. In time, a plan's dedicated approach to ethics will become evident to employers, enrollees and providers which, in turn, will become its own selling point.

Health plans with bona fide ethics programs are training senior managers, medical directors, nurse case managers and marketing executives to recognize and handle challenging ethical issues. Video instruction, seminars, and role-playing are some of the training techniques used. The membership of an ethics committee is also a tip-off as to how seriously the plan heeds its ethical obligations. A 10-member panel consisting of nine attorneys and the marketing director is a pretty strong indication that its main purpose is to protect the plan from legal liability and public relations embarrassments.

Some plans also use ethics initiatives to reach out to the community: for instance, permitting the public to observe meetings of their medical technology panels, which assess patterns of treatment, or even letting local citizens serve on panels as consumer members.

Increasingly, managed care companies, seeking to quickly establish solid ethics programs, are retaining professional ethicists from the academic and business worlds. These ethicists help chart plans' approaches to establishing ethical guidelines and provide training in medical ethics. Still other plans have arrangements with academic medical centers in which professors with expertise in state-of-the-art medical research and clinical practice offer guidance in particularly challenging cases, such as whether to cover treatments of last resort. Many employers applaud the use of external ethics consultants who have no affiliation with the health plan, because it brings an extra layer of objectivity to the process.

Prudent employers shopping for health care coverage for their employees, or evaluating existing health plan relationships, are asking plans how they deal with tough ethics-laced issues, including:

- Coverage decisions. Perhaps one of the most difficult challenges faced by MCOs is whether to cover complex, often emotional cases involving organ transplants, last-resort cancer treatments, or investigational procedures. An MCO may cover treatments it considers "investigational" if the treatment shows promise of being effective or the patient would likely die within the year if not treated, such as bone marrow transplants in combination with high-dose chemotherapy for terminally ill patients. But plans also must consider the impact of untested procedures that prove

ineffective and even harmful to the patient's quality of life. In deciding these cases, health plans typically rely on several factors: internal ethical guidelines that consider what's best for the patient within the context of the total enrollee population, the best scientific evidence, the opinions of outside medical experts, and treatment costs. Whatever process the plan uses, it should be designed to encourage open discussion of the patient's options and gain his or her trust.

- Marketing. The marketing of health care services is a particularly touchy subject because modern medicine is so complex, and consumers lack the knowledge to make truly educated choices. And unlike most goods and services, medical care is a necessity. In its zeal to capture market share in a competitive environment, an MCO may make a sales pitch that doesn't live up to the details contained in the fine print of its agreement with the employer. Be alert to advertising claims that can't be substantiated, like "we have the best surgeons." Employers want their employees to be educated during open enrollment meetings, not forced to listen to high-pressure sales tactics. MCOs with in-home access to a company's retirees must be especially sensitive to steer clear of coercive sales rhetoric. A health plan's marketing and sales force should be trained to provide a straightforward and clear, balanced message that helps employees understand how they can access care.

- Confidentiality. Another sensitive ethical issue involves the patient's right to privacy. Increasingly, patient information is kept in a health plan's computer database because it is easily and quickly available. But as the volume of information expands and becomes more detailed and accessible, preserving the patient's confidentiality will become a difficult ethical challenge. Health plans must balance the patient's right to privacy in medical records with the legitimate interests of their physicians, care manager and others, such as plan researchers using file data to evaluate outcomes or cost-effectiveness of treatments. Employers too, need to be careful that certain legally protected confidential health information, such as an employee's disability, substance abuse, or HIV status, isn't directed by a plan into the wrong hands. Employers should make sure their health plans have a clear policy on what types of information will be shared and under what circumstances, and that plan personnel who handle patient records are adequately trained on confidentiality issues.

One way to assess managed care companies' commitment to ethics is to judge them by their own proclamations. Employers should not be shy about asking plans whether, and to what extent, they are complying with the affirmation many have made during the past year to inform members about:

- Benefits covered and excluded, including out-of-area and emergency coverage.
- The basis for a specific utilization review decision.
- How participating physicians are paid, including financial incentives.
- The procedures and medically based criteria used to determine whether potentially investigational treatments and technologies should become covered services.

Our nation's health care system is undergoing great change. The transition from an indemnity, fee-for-service, hospital-centric world to a more complex, cost-conscious delivery system with multiple stakeholders naturally has led to a sense of upheaval. These changes, while ultimately for the better, are unsettling in the short term and raise some ethical concerns. By addressing those concerns, health plans will go a long way in giving employers and employees peace of mind as they travel down the managed care path into the next century. EJ



Dr. William C. Popik is senior vp and national medical director for CIGNA HealthCare in Bloomfield, Conn. He leads the company's quality health management program and medical cost containment initiatives.

With caution, terminations won't backfire

By John W. Mahoney

IT TOOK THE JURY less than an hour to reach its decision. After slogging through the court system for more than four years and spending thousands of dollars in litigation, a non-profit organization in Florida was hit with more than \$132,000 in damages. The money went to an employee who claimed she was fired in retaliation for objecting to unsanitary and improper practices.

The situation described above is real—and all too common. More than 80% of all employment-related lawsuits result from the firing of an employee. Wrongful termination also is the one issue most frequently cited as the source of directors and officers liability insurance claims. The time, money and resources lost in such a process can all but wipe out an organization. To avoid the risk of a costly lawsuit, officers and directors of non-profits and other organizations must implement ethical procedures and prudent decision-making processes during employee termination.

Generally, organizations can reduce exposure to a lawsuit by following basic guidelines in employment and termination procedure, including:

- Giving clear warning about complaints and instructions for procedures. Never assume that employees "should have known" what was expected of them. Every employee should understand clear rules of conduct.
- Applying all policies equally. It is important that no exceptions be made to the standards and policies that are set, and that rules are enforced consistently.
- Providing candid employee evaluations. Supervisors should be frank about an employee's job performance, so that accurate documents are kept and mixed signals

To avoid the risk of a costly lawsuit, officers and directors must implement ethical procedures and prudent decision-making processes during employee termination.

are avoided. Discrimination cases are often the result of an employee receiving a good evaluation but later being terminated for poor performance.

- Assuming everyone wants a promotion. All qualified employees should be considered for potential advancement and promotion. Employees should be given equal opportunity to apply for a promotion through some form of job postings or internal communications.
- Providing equal training opportunities and counseling. Instead of wrongfully assuming an employee's performance cannot be improved, the organization should provide counseling and training opportunities.
- Taking the employee's viewpoint into consideration. One of the oldest mottos: Supervisors should treat employees in the way that they would want to be treated if they were in the subordinates' position. Supervisors should listen to employees' complaints and to "their side of the story."
- Promoting the "open door" policy. Supervisors should make sure that their "door is always open" for an employee to discuss job-related complaints. Communication should be a continuous loop, not one-way.

Still, the real key to preventing problems during employee termination comes from understanding the legal definitions and guidelines of discrimination, and proactively avoiding potentially risky situations. Some types of discrimination are easily apparent, irrefutably wrong and prohibited by law. For example, when a person is not hired or not promoted strictly on the basis of their sex, that is clearly unlawful sexual discrimination.

However, other forms of discrimination and

workplace behavior are not so plainly defined.

Organizations can avoid charges of discrimination in wrongful termination by understanding unlawful workplace actions, such as:

- Unequal treatment of similarly situated employees. This treatment occurs when an employer treats a member of a minority group differently than a similarly situated employee who is not a member of a minority group. For example, if two employees, one African-American and the other white, violate the same personnel policy, both must be reprimanded equally. Not doing so would be a case of unlawful racial discrimination.
- Decisions based on stereotypes or assumptions. All employment related decisions must be made on relevant facts concerning performance, capability and the individual, not assumptions or stereotypes about such things as appearance, age or physical characteristics. For example, if a 50-year-old man is not hired on the basis that he could not do the heavy lifting required by the job, it would be a case of unlawful discrimination on the basis of age.
- Unlawful retaliations. Federal and state laws extend to protect an employee who brings a discrimination charge or files a complaint from any form of retaliation. A supervisor must treat any employee who complains about discrimination or files a discrimination charge no differently than any other employee.
- Sexual harassment. Any questionable behavior by employees, or by third parties, such as volunteers, could bring the claim of sexual harassment against non-profit employers.
- Failure to accommodate a disability or religious affiliation. Employers are required to "reasonably accommodate" the needs of employees in the areas of religion and disability. For example, a person with a disability must be provided with accommodations to perform the job, within reason—without affecting the employer's operations, threatening anyone's health or safety, or causing excessive financial burden on the employer.

In a wrongful termination lawsuit, employees can claim more than one type of discrimination. Take for instance a case that is pending against a non-profit country club in California. A 50-year-old black minister, who worked with the organization for more than 15 years, first was denied a promotion and finally fired because he was unable to work Sunday mornings due to religious obligations. The club then hired a younger, less-qualified white applicant to fill the promotion position. The lawsuit claims racial discrimination for denial of promotion; racial discrimination for his dismissal; wrongful discharge; interference with civil rights; and race and religious discrimination and retaliation. If found liable, the organization faces financial costs of back pay, compensatory damages for economic, physical and emotional injuries, and punitive damages.

To further reduce the risk of a lawsuit when firing an employee, non-profit organizations should consider two important concepts: notice and fairness. As a safeguard against hasty and unsubstantiated firings, employers should place the employee on notice, or under warning, preferably in writing for documentation. The employer should also exhibit fairness by giving the employee opportunity to improve performance. Without these two measures, the decision to terminate an employee may be premature and could be risky.

At the same time, federal and state employment laws do not require organizations "to be fair." The law simply states that employers must refrain from discrimination. However, juries often associate unfair treatment with discrimination. As a result, employers who give notice and are fair in termination situations are sued less often, and those who are sued lose their cases less often.

As a preventive step, before firing an employee for performance-related reasons, the employer should be able to answer these questions:

- Have all the facts pertinent to the situation been presented?

- Was the investigation fair and objective?
- Did the employee know and understand what was expected in terms of job performance, conduct or other workplace rules?
- Was the employee duly aware of the possible consequences of repeated inappropriate behavior or poor performance?
- Did the employee have fair and reasonable opportunity to change the situation?
- Are there any mitigating factors that justify giving the employee additional time to improve performance?
- Is the discipline or termination appropriate for the seriousness of the offense?
- Is there adequate documentation that proves both "notice" and "fairness?"
- Have similarly situated employees been treated in a consistent fashion for similar violations?
- Is there a more appropriate or fair alternative to firing the employee?
- Has anything been done that would give the

As a safeguard against hasty and unsubstantiated firings, employers should place the employee on notice, or under warning, preferably in writing for documentation.

employee reason to claim discrimination?

- Is the termination consistent with and in the spirit of other personnel policies?

In all terminations, an employer should ensure that the personnel/human resources department has been consulted prior to the decision. Once the decision is made, termination should be conducted in a timely and professional manner. Employers who wait too long to actually fire the employee weaken their case for termination. Exit interviews should be organized and release of liability forms signed, if appropriate.

Employee termination, even after going through the process of reaching a principled decision, is not a cut-and-dry act. With the resolve to fire an employee comes a series of decisions regarding settlement terms, considerations and conditions. In exchange for benefits, the organization should obtain various commitments from the employee, such as: a confidentiality agreement, protection against suits or complaints, the return of all documents and property, or no admission of liability. For the terminated employee, release negotiations may include allowances, such as:

- Severance pay.
- Continuation of health insurance.
- Letters of reference.
- Forgiveness of loans or outstanding debts.
- Relocation assistance.
- Eligibility for unemployment compensation.

The termination process can become a financial sinkhole for non-profit organizations. What protects an organization is a general understanding of discrimination law and simple preventive actions such as: giving clear warnings, documenting all complaints and investigations, and upholding clear, consistent policies. Although not eliminating costs entirely, these proper precautionary measures can significantly reduce loss and help protect organizations from time-consuming, costly and potentially damaging allegations and lawsuits. **BI**



John W. Mahoney is program director of the nonprofit directors and officers liability program at Coregis Insurance Co. in Chicago.

Senators voice opposition to tobacco deal

White House support predicted by deal's key proponent

By MARK A. HOFMANN

WASHINGTON—The White House could weigh in on the proposed global settlement of tobacco litigation as early as this week, according to the settlement's most visible architect.

No matter if and when the president weighs in on the deal, the settlement still faces considerable opposition, as was evident on Capitol Hill last week.

"Frankly, I think next week we'll see the president of the United States come on board," said Mississippi Attorney General Mike Moore, who subsequently testified about the proposal before the Senate Labor and Human Resources Committee last week.

The White House, however, did not return calls asking for comment on Mr. Moore's assessment.

"I think it's time for action. I feel good," Mr. Moore said before testifying, noting that the tobacco industry has reached separate settlements to reimburse the states of Mississippi and Florida for smoking-related Medicaid costs (*BI*, Sept. 1; July 7). Those settlements guarantee that those two states will receive payments from cigarette manufacturers, even if the proposed \$368.5 billion global settlement between the tobacco industry and 40 states fails to win congressional approval (*BI*, June 23).

Among other things, the proposed global settlement would end class-action lawsuits against tobacco companies while maintaining the rights of individuals to sue; subject the tobacco companies to additional fines if certain targets for reducing youth smoking aren't met by specific deadlines; and limit the awarding of any punitive damages to claims for conduct that occurred after the settlement is approved.

Comments and testimony presented to the Labor and Human Resources Committee last week, however, indicated the tobacco settlement remains far from being a done deal.

Although the hearing focused on public health questions, most notably how the proposal would reduce the number of underage smokers, the matter of how much the tobacco industry should pay and whether cigarette-makers should enjoy the broad immunity from class-action lawsuits contained in the agreement was clearly on the minds of senators and some witnesses alike.

"It has become abundantly clear that the proposed settlement is grossly deficient in fundamental ways," said the committee's ranking minority member, Sen. Edward M. Kennedy, D-Mass.

"The amount of the settlement must be doubled if federal taxpayers are to be fairly compensated for the damage smoking has done. The Congress will be derelict in its responsibilities if it accepts anything less," said Sen. Kennedy.

Sen. Kennedy said the federal government should be reimbursed for its smoking-related Medicare costs, as the pacts with Florida and Mississippi would do. By agreeing to pay the states' Medicaid expenses, the tobacco industry "has conceded the validity of such claims," according to the senator. "Now that the industry has made a de facto admission of liability for Medicaid costs, there is no credible basis for them to deny liability for similar costs in Medicare and other federal health programs," he said.

Mr. Moore addressed the question in his testimony.

"The federal government doesn't have a case against the tobacco companies. They didn't sue the tobacco companies," he said.

Mr. Moore noted that state attorneys general who worked out the proposed settlement with the tobacco industry cannot collect on behalf of the federal government.

Under later questioning from Sen. Kennedy, Mr. Moore said it was his "understanding" that the proposal's limit on suits by governmental entities to collect additional money from the tobacco companies does not extend to the federal government.

The limits on future legal action against tobacco companies drew the particular ire of John R. Garrison, chief executive officer of the American Lung Assn.

"I wish I could join the other panelists here today to tell you that the proposed deal is basically sound, that

the compromises are fair and that the tobacco industry has changed. Unfortunately, none of this is true," said Mr. Garrison before he urged "Congress to throw out the proposed deal."

After detailing a number of concerns about the public health aspects of the proposal, giving particular emphasis to what he considered the proposal's inadequate protections against environmental tobacco smoke—better known as "second-hand smoke"—Mr. Garrison addressed the tort provisions of the settlement.

"Under the agreement, the tobacco companies will be immune from punitive damages. State laws will be pre-empted. The tobacco companies

also will be immune from disclosure of potentially revealing documentary evidence of their past actions. Finally, the tobacco companies will be immune from consolidated litigation. If these three provisions become reality, successful litigation against the tobacco companies will be highly unlikely," he said.

"Before Congress rushes to enact a deal negotiated in back rooms, it should fully examine the consequences. Only the tobacco industry fears court. We are not worried about the states proceeding with their individual cases; in fact, we welcome it," Mr. Garrison said.

The Labor and Human Resources Committee's hearing was the fifth before a Senate panel since the proposal was unveiled June 20. The committee plans to hold another hearing later this month, and other Senate com-

mittees will pursue the matter as well.

The House of Representatives, however, has yet to hold a single hearing on the proposal.

House Majority Leader Dick Armey, R-Texas, indicated last week that the House isn't likely to take up the matter any time soon, thus casting further doubt on the agreement's viability.

In another potential setback for the settlement, 10 senators sent President Clinton and Senate leaders letters urging that further consideration of the settlement not be put off until literally millions of pages of tobacco industry documents sealed under attorney-client privilege be made public. The senators also urged the chairmen of Senate committees that have jurisdiction over the settlement to subpoena the sealed documents before proceeding. **BI**



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Datebook

SEPTEMBER

SEPT. 14-16. A.M. Best's 10th Annual Insurance Information Services Conference: Managing the Info Tidal Wave in Washington, sponsored by A.M. Best Co.; \$475. A.M. Best Co., Ambest Road, Oldwick, N.J. 08858; 908-439-2200.

SEPT. 14-17. 1997 Excess/Surplus Lines Claims Assn. 29th Annual Conference in South Lake Tahoe, Nev., sponsored by the Excess/Surplus Lines Claims Assn. Inc.; \$275. Joanne Moore, Tokio Re Corp., 1 Liberty Plaza, New York, N.Y. 10006; 212-267-3300.

SEPT. 14-17. National Assn. of Mutual Insurance Cos. annual convention in Denver, sponsored by NAMIC; \$365 for mem-

bers, \$485 for non-members. NAMIC, 3601 Vincennes Road, P.O. Box 68700, Indianapolis, Ind. 46268-0700; 317-875-5250.

SEPT. 15-16. D&O Liability Management forum in San Francisco, sponsored by the Institute for International Research; \$1,795 for the conference and workshop, \$1,295 for the conference only; Customer Service Manager, Institute for International Research, 708 Third Ave., Fourth Floor, New York, N.Y. 10017; 800-999-3123.

SEPT. 15-19. The Essentials of Multiemployer Trust Fund Administration workshop in Brookfield, Wis., sponsored by the International Foundation of Employee Benefit Plans; \$1,375 for members, \$1,625 for non-members. Registrations Department, IFEBP, P.O. Box 69, Brookfield, Wis. 53008-0069; 888-334-3327, option 2.

SEPT. 15-19. Fundamentals of Money Management workshop in Philadelphia, sponsored by the International Foundation of Employee Benefit Plans; \$2,075 for members, \$2,325 for non-members. Registrations Department, IFEBP, P.O. Box 69, Brookfield, Wis. 53008-0069; 888-334-3327, option 2.

SEPT. 15-19. Industrial Ergonomics: Human Factors in Occupational Health and Safety course in Boston, sponsored by the Center for Continuing Professional Education; \$1,145. Harvard School of Public Health, Center for Continuing Professional Education, 677 Huntington Ave., LL-23, Boston, Mass. 02115-6096; 617-432-1171.

SEPT. 15-19. International Union of Marine Insurance conference in Paris, sponsored by the IUMI; 5,600 French francs. Organizing Committee, AFSAT, 20 rue

Vivienne, F-75082 Paris Cedex 02; 33-1-42-96-12-13.

SEPT. 16-17. Administering An Employer's Workers' Compensation Program in Dearborn, Mich., sponsored by the Human Resources Education & Training Center, Michigan State University; \$695. **Also Oct. 7-8** in East Lansing, Mich., **Oct. 15-16** in St. Louis, **Oct. 22-23** in Philadelphia, **Nov. 5-6** in Minneapolis, **Nov. 12-13** in Chicago. HR Education & Training Center, Michigan State University, 422 S. Kedzie Hall, East Lansing, Mich. 48824; 517-355-9591.

SEPT. 16-17. Introduction to Derivative Products seminar in New York, sponsored by the College of Insurance; \$895. The College of Insurance Center for Professional Education, 101 Murray St., Room 426, New York, N.Y. 10007; 212-815-9201.

SEPT. 17-19. 7th Annual Texas Workers'

Compensation Education Conference in Austin, Texas; International Workers' Compensation Foundation Inc., P.O. Box 11697, Daytona Beach, Fla. 32120-1697; 904-258-3511 or 904-252-2013.

SEPT. 17-19. Advanced Pension Conference in Chicago, sponsored by Cortel; \$695. Corbel Client Services, P.O. Box 47720, Jacksonville, Fla. 32247; 800-326-7235 ext. 1139.

SEPT. 17-21. National Assn. of Professional Surplus Lines Offices annual convention in Orlando, Fla., sponsored by NAPPSLO; \$560 for members. Members only. For groups with more than five members, each additional member is \$400. NAPPSLO, 6405 N. Cosby Ave., Suite 201, Kansas City, Mo. 64151; 816-741-3910.

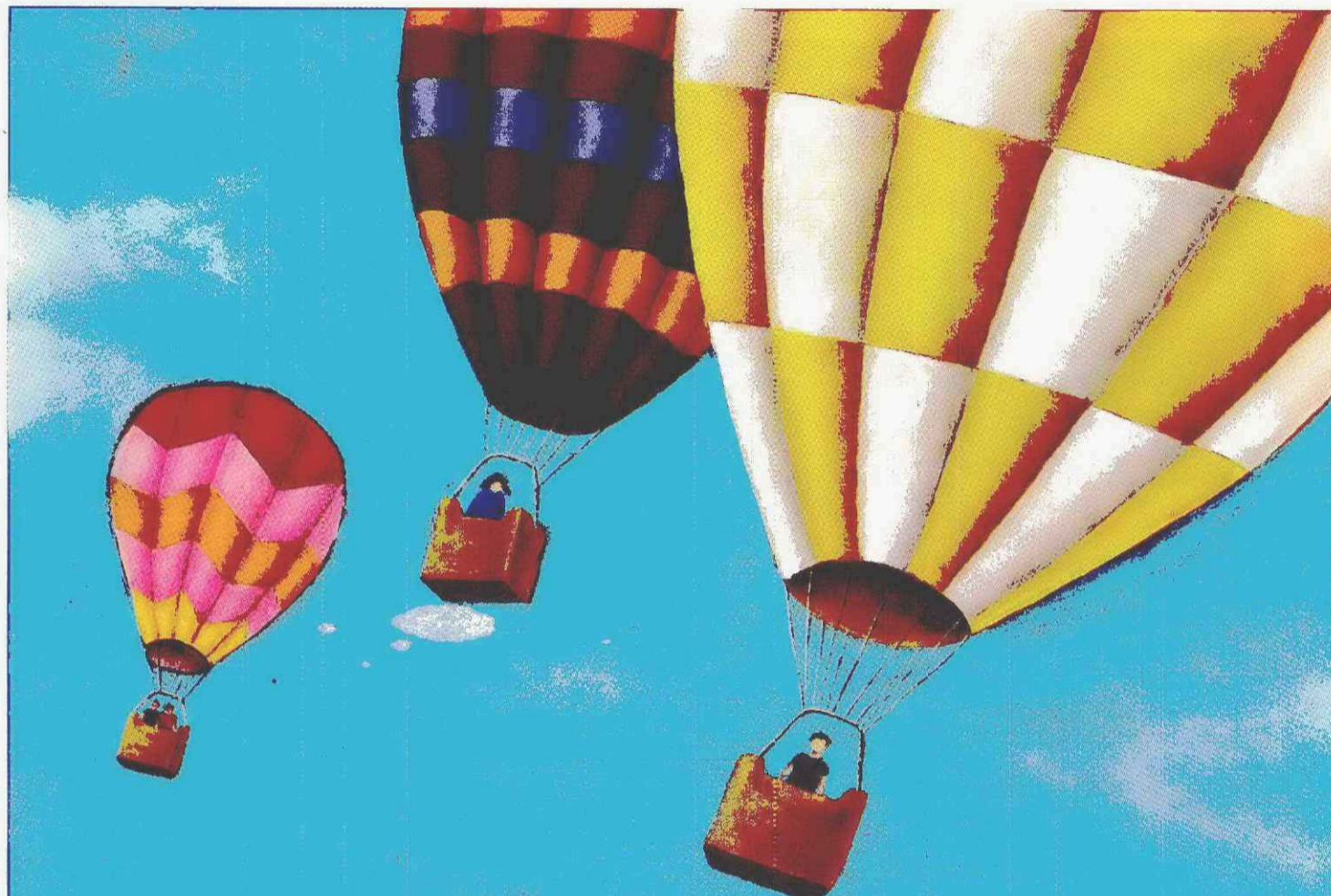
SEPT. 18. Issues, Strategies and Solutions: The Chicago Reinsurance Conference in Chicago, sponsored by Tribler Orpett Palmer & Crone P.C.; \$125. Bill Wall, Tribler Orpett Palmer & Crone P.C., 30 N. LaSalle St., Suite 2200, Chicago, Ill. 60602; 312-201-6408.

SEPT. 18. Protecting Shippers' Interests seminar in Minneapolis, sponsored by the Transportation Consumer Protection Council Inc.; \$250 for members, \$300 for non-members. **Also Sept. 24** in Saddlebrook, N.J., **Oct. 1** in Atlanta, **Oct. 8** in Berkeley, Calif. TCPC, 120 Main St., Huntington, N.Y. 11743-6936.

SEPT. 18-19. Aligning Work and Rewards seminar in San Francisco, sponsored by American Management Assn.; \$1,300 for members, \$1,495 for non-members. **Also Sept. 25-26** in New York, **Oct. 16-17** in Chicago, **Nov. 3-4** in Atlanta. American Management Assn., P.O. Box 169, Saratoga Lake, N.Y. 12983; 800-262-9699.

SEPT. 18-19. International Securities Markets conference in New York, sponsored by the Practising Law Institute; \$995. PLI, 810 Seventh Ave., New York, N.Y. 10019-5818; 800-260-4754.

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INTERNATIONAL

Global Briefs

Lloyd's of London has met its solvency margin for 1996, according to information submitted Aug. 29 to the U.K. Department of Trade and Industry. For non-life insurance business written by Lloyd's syndicates, the market's assets excess of liabilities were 8.4 times greater than the minimum required solvency margin, compared with assets 5.1 times the margin at the end of 1995. Lloyd's said this confirms its strong financial position after the implementation last year of its reconstruction program. . . . Lloyd's has appointed John Young as chairman of its **Regulatory Board**, succeeding Sir Alan Hardcastle, who retires at the end of November. Mr. Young, who was nominated to the Council of Lloyd's in 1996, currently is a non-executive director of the Securities and Investments Board, of which he was chief executive from 1993 to 1995. . . . Under a new dividend policy, **Hannover Reinsurance Co.** is distributing its entire 1996 aftertax profit of 76 million deutsche marks (\$49.4 million) to shareholders, resulting in a dividend of 3.15 deutsche marks (\$2) per share. It said the portion of earnings that would have been retained under a conventional dividend policy could be regained from shareholders by enabling them to use part of their dividend to buy new shares at 112 marks (\$62) each. The company is increasing its share capital by 2.27 million deutsche marks (\$1.2 million) to 147.7 million marks (\$81.2 million). . . . **David Newbigging**, chairman of Lloyd's syndicate reinsurer Equitas Holdings Ltd., will become chairman of Friends Provident, a U.K. mutual insurance and investment group, effective in April. He has been a member of the Friends Provident board since 1993 and deputy chairman since 1996. . . . P&I club **The London Steam-Ship Owners' Mutual Insurance Assn. Ltd.** says in its annual report for 1996-97 that accumulated free reserves available to meet claims rose by 21% last year to \$98 million. Total assets increased 9.6% to \$408 million. The club says it maintained its insured tonnage level at just more than 25 million gross tons, "despite a fiercely competitive renewal season." . . . London's two aviation underwriting associations, Lloyd's Aviation Underwriters' Assn. and the Aviation Insurance Offices' Assn., have formed a joint executive committee to promote closer cooperation. They said the joint approach is intended "to expedite matters of common interest and to help create a unified position on London market aviation insurance and reinsurance issues." . . . The **Zurich Insurance Group** reported consolidated profits for the first six months of 1997 of 809.3 million Swiss francs (\$557 million), up 40.4% on the first half of 1996. Capital and surplus increased by 3.2 million francs (\$2.2 million) to 16.9 million francs (\$11.6 million). The company said that while financial markets have been considerably more volatile so far in the second half, it nevertheless "expects to achieve yet another very good overall result in the course of this year."

Investors still hold hope for India

Health sector deregulation is on hold, but insurers expect eventual change

By KAUMUDI MARATHE

BOMBAY, India—Private companies still see India as a potential market for health insurance and other more profitable products despite the defeat last month of a bill that would have begun the process to liberalize the nation's health insurance system.

The withdrawal from Parliament of the pivotal 1996 Insurance Regulatory Authority bill signifies a stumbling block in the process of deregulating India's insurance industry. If it had been approved, the IRA bill would have been the first step toward establishing guidelines for the entry of private sector competition into India's health insurance field, the first, and at least for now, only area to be liberalized.

"It doesn't affect our plans (for India) in any way," said Howard Kahn, vp-health for Aetna International. "We are disappointed (about the bill), and I think it was a tactical move by the

opposition," but "such a delay could have occurred anywhere in the world."

Most companies have publicly reiterated their desire to invest in the health and other insurance sectors that might open, optimistic that the hiatus is short term.

Experts said that because of the high costs of providing health insurance in India, private companies most likely see investing in health insurance more as a stepping stone to be in place for other insurance opportunities down the line.

Dr. Prathap C. Reddy, chairman of Apollo Hospitals Group, an Indian organization planning to collaborate with more than one foreign insurer, said the decision to withdraw the bill was disappointing.

"All our enthusiasm was washed away," he said.

"There is so much potential to improve the quality and quantity of health insurance and

See India on page 27

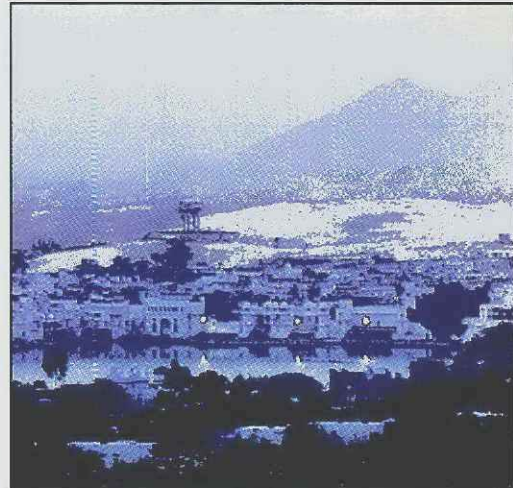


PHOTO: AFP

India is striving to liberalize its economy in many areas, including the health insurance sector.

Insurer advice sought in disaster education

By KATE TILLEY

ADELAIDE, Australia—Insurers should settle post-disaster claims faster and get more involved in disaster mitigation by educating policyholders and the public about risks, an emergency specialist says.

Australia is "not considered internationally as a major disaster-prone country," said Alan Hodges, director-general of Emergency Management Australia, a federal agency in Canberra.

But the country's insurers can do more in the form of "public-spirited programs" to reduce claims after natural disasters, he told an audience at the Australian Insurance Law Assn.'s annual conference last month in Adelaide.

Insurers should "sponsor public education campaigns in areas of particular risk and work with public safety agencies" to educate the public, highlighting the risks of building in disaster-prone areas, he said.

"Although our disasters have caused relatively few deaths, very substantial economic losses are often sustained," Mr. Hodges said.

Last year, Australia had 23 events—mainly severe storms—that caused damage totaling \$1.3 billion

Australian (\$1.03 billion). So far this year, 16 events have caused \$410 million Australian (\$300.1 million) in total damage, he noted.

Insurers should make quicker settlements after disasters because claims tend to escalate as the cost of repairs increases, Mr. Hodges said. In addition, "the speed and appropriateness of settlement will result in publicity of inestimable value," he said.

He criticized some insurers and loss adjusters' actions after Australia's Newcastle earthquake. The December 1989 quake devastated the city of Newcastle, about 60 miles north of Sydney. Insurers paid out about \$1 billion Australian (\$727.8 million) in losses.

Communication with policyholders had been "a problem" after that quake, while some adjusters adopted "aggressive attitudes" toward policyholders and were involved in fraudulent deals with builders to obtain more money, Mr. Hodges said.

He also said the Newcastle experience demonstrates that a major disaster still would result in significant problems in administering insurance claims.

See Educate on next page



P&I Clubs looking to other reinsurers

By EDWIN UNSWORTH

LONDON—The International Group of P&I Clubs is considering giving reinsurers outside the London market a chance to write a bigger slice of its \$2 billion reinsurance coverage program, which traditionally has almost entirely been written by London-based companies.

The consideration of a shift in the International Group's reinsurance program comes as part of a strategic review initiated by the hiring of a new broker to jointly work with the program's existing broker.

The International Group, an association of 15 mutual insurance companies for shipowners, insures about 90% of the world's merchant shipping fleet. The group's reinsurance contract is the largest in the marine market and in the past has been almost entirely reinsured in London.

"At the moment, we're still considering all the options," said Bryan Gaze, deputy chair-

man of A. Bilbrough & Co., which manages the London Steam-Ship Owners' Mutual Insurance Assn. Ltd., known as the London Club.

Mr. Gaze added that his personal view is that "it's foolish to be over-dependent on any one market."

Stephen James, chairman of the International Group's Reinsurance Subcommittee and chairman of Thomas Miller P&I Ltd., managers of the U.K. P&I Club, confirmed it "is interested in widening the scope of cover."

He said the International Group has long considered purchasing its reinsurance from companies with a wider geographical spread, though it has continued to keep the bulk of its coverage in the London market.

Mr. James said this was partly because other reinsurance markets previously could not match London's capacity and terms and partly because the London market has an excel-

See P&I Clubs on page 27

Curbing product liability losses

Companies must control exposures before they lead to losses

By KATE TILLEY

ADELAIDE, Australia—A comprehensive risk management program is critical for minimizing a company's exposure to product liability losses, an attorney says.

Without a program in place to identify and eliminate potential product risks, a company's exposures could also include criminal charges, punitive damages and adverse publicity, she warns.

Bad publicity from a product liability claim, in fact, may be more damaging to a company than the claim's legal ramifications, a public relations executive warns.

A company must have internal procedures in place to detect product risks early, Ellen Beer-

worth, a product liability specialist and partner with law firm Freehill Hollingdale & Page in Sydney, advised during a session at the Australian Insurance Law Assn. conference in Adelaide last month.

Possible sources of such early information, she said, are consumer complaints, the media, and feedback from suppliers and retailers.

A company's failure to recognize and respond to a potential product risk can be the basis for criminal charges, punitive damages and adverse publicity, Ms.

Beerworth warned.

Once risks are identified, there has to be a system to pass on the information. "Who reports to whom and when? What procedures are in place for hot line reporting," she asked. "How is information collated and analyzed, and what triggers an investigation?"

Ms. Beerworth said directors and senior management need risk management skills and knowledge to deal with potential product liability claims.

"I have seen instances when well-run companies sit on a potential disaster because senior management doesn't know what to do with it," she said.

"It can take months, even years, before they seek advice on the

ramifications. During that time, a lot of information is produced which may not be privileged and can therefore be used against the company in a prosecution," she said.

Efforts to minimize product risks should involve a comprehensive, not ad hoc, approach. "You should not rely on insurance as your risk management strategy; insurance should be a fallback when everything else fails," she said.

Ms. Beerworth said her own research shows that insurance policies for 60% of Australian manufacturers and importers "have little or no relationship to their exposures" for product liability risk.

See Liability on next page



Liability

Continued from previous page

As a result, Ms. Beerworth said companies need to audit their insurance programs regularly to ensure their coverage fits their exposures.

A mismatch between an organization's exposures and its coverage often is only picked up when litigation starts, "and that's too late," she said.

For a comprehensive product liability risk management strategy to succeed, it requires: top-level commitment; a program to identify, evaluate, and prioritize risks; and the design and implementation of loss prevention solutions. Constant monitoring and updating is required, she added.

"Minimize your most substantial risks first, and look at your claims history and commercial sensitivity," she said.

"It is critical for any company that wants to save commercial embarrassment, money and the odd prosecution or two, to implement a risk management strategy," she said.

Ms. Beerworth also said companies have to be aware of the ramifications of not acting quickly and decisively when a problem with a product emerges.

If a product liability problem occurs, a company needs a "lean, mean team" of senior management to deal with it, including legal, technical and public relations personnel, she advised.

"The desired outcome is to get the best legal and commercial results, but it's not always easy to balance both," she said.

For example, if a product recall is required, a company needs technical people to find out what was wrong, legal people to advise on the duty to recall and any alternatives, and public relations personnel to manage the company's image.

Ms. Beerworth recommended that legal personnel also evaluate all public relations material to ensure it does not contain inadvertent admissions of liability.

Lawyers and public relations personnel see product liability claims differently, said Richard Lazar, managing director of Sydney, Australia-based Professional Public Relations Pty. Ltd.

"An adverse finding in the court of public opinion can be more harmful than an adverse finding in the courts," he said. "The court of public opinion doesn't follow the due processes of law."

Mr. Lazar said lawyers typically consider first whether the client is liable and, if so, what mitigating factors could assist in presenting the best possible case.

However, he noted, "In the public relations sense, the mitigating factors are more important."

"People expect things to go wrong, but how it's dealt with is how a company is judged," Mr. Lazar said.

The public makes its judgment according to response time, who sets things right, how the company helps those at risk and how the media handle the issue.

Mr. Lazar said research shows that for companies without public relations crisis plans, a crisis lasts 2.5 times longer than for companies that

have plans and implement them when needed.

"If you aren't ready and haven't practiced, you can't get in front of the crisis," he said.

His six steps of crisis management are: prevention, preparation, recognition, containment, resolving the problem, then reaping profits from successfully managing the problem.

He told AILA delegates that companies should maintain watch lists of potential problems and monitor them, develop friends in the media, form crisis management teams and perform drills and rehearsals.

A crisis must be recognized early. When asked for media comment, companies should avoid merely saying "no comment" but rather get the facts quickly and inform the media, Mr. Lazar advised. "The problem doesn't get smaller with time," he added.

From a media perspective, a well-managed crisis is old news quickly. If a product recall is required and it happens quickly, the media soon loses interest, he said.

Mr. Lazar was critical of the crisis response of Melbourne, Australia-based Kraft Foods Ltd. and General Foods Pty. Ltd., subsidiaries of the U.S. corporation Kraft General Foods Inc. (BI, Aug. 25; Sept. 2, 1996), which were involved in one of Australia's largest and most publicized product recalls last year.

Mr. Lazar said Kraft was unprepared when it had to recall contaminated peanut butter. "It took 28 days for the recall to happen, and that meant 10 weeks of media interest. Kraft wasn't prepared with its communication strategy," he said.

If a company is perceived as acting truthfully during a product contamination or other product liability problem, that helps its public profile, he said.

"Never express concern for the business, but communicate," he said. "You don't want stakeholders to be getting their information from the media." BI

Educate

Continued from previous page

But conference delegate Jeff Gray, principal of Sydney, Australia-based loss adjusting firm Harrison Gray and a former president of the Australian Chartered Institute of Loss Adjusters, said Mr. Hodges gave a "one-sided, incorrect view of the industry's response in Newcastle." Although two adjusters were charged with fraud after the Newcastle quake, they were acquitted, Mr. Gray said.

He admitted Australian adjusters suffer from a lack of earthquake knowledge, which "showed in attempts to quickly settle claims."

He rejected Mr. Hodges' suggestion that claims should be settled faster, saying insurers should reassure claimants and measure the damage immediately, with claims settlement and permanent repairs coming later.

Mr. Hodges told insurers to be more discriminating in setting premiums, to encourage policyholders to reduce their exposure to disasters.

"There should be a reward—for example, lower premiums, lower deductibles, no-claim bonuses or higher levels of coverage—for those seeking insurance for well-designed buildings appropriate to the risks confronted," he said. Insurers need to provide specific information about vulnerable areas and help policyholders minimize losses.

If insurers highlight the risks of construction in disaster-prone areas, they could pressure local governments into "responsible land-use planning," Mr. Hodges said. BI

Aussie ruling to aid recoveries

But premium increases could result

By KATE TILLEY

ADELAIDE, Australia—A ruling by Australia's High Court will make it easier for policyholders to win indemnification of expenses incurred without insurer approval, though it could also increase their premiums.

Reversing an appellate court ruling, the High Court found last month that a prominent Australian businessman and racehorse owner-breeder, Sir Tristan Antico, was entitled to indemnification of expenses he incurred defending claims by investors, even though he and his broker failed to notify the insurer of the circumstances that led to the claims.

The High Court also said that though Sir Tristan's broker, the Sydney office of Heath Fielding Australia Pty. Ltd., had breached its duty of care to Sir Tristan by not notifying the insurer on his behalf, the breach did not cause the policyholder's underlying losses. Sir Tristan's losses stemmed from investor lawsuits filed against him after his racing syndicates failed.

The High Court's decision widens the interpretation of Section 54 of Australia's Insurance Contracts Act. Section 54 bars an insurer from denying indemnity purely on technical grounds. It states that an insurer cannot refuse to pay a claim on the basis of an act or omission of the policyholder unless that act or omission was the cause of the loss. However, if an act or omission occurs, the insurer's liability can be reduced by "the amount which fairly represents the extent to which the insurer's interests were prejudiced as a result of the act."

In this case, the High Court said that even though Sir Tristan didn't notify the insurer of circumstances that later led to a claim, the lack of notification did not cause his loss.

The High Court ruling reverses an appeals court decision that Sir Tristan was not entitled to be indemnified by his D&O insurer, Sydney-based C.E. Heath Casualty & General Insurance Ltd., for legal expenses. The appeals court found the insurer had not been notified by either Sir Tristan or his broker of circumstances that led to claims against Sir Tristan and that Sir Tristan had not obtained his insurer's consent before spending \$1 million Australian (\$726,000) on legal fees. The court ruled that Sir Tristan was unable to use Section 54 on the basis that there was no entitlement to indemnity, because the insurer had not granted consent.

The High Court reversal is "very significant" and means the protection for policyholders is "very broad," according to Kevin Nicholson, a barrister based in Adelaide, Australia. He spoke last month at the Australian Insurance Law Assn. national conference in Adelaide, South Australia.

Past court cases have drawn a distinction between an omission, which would not be covered by

Section 54, and an "inaction," but the High Court has now widened the protection the section offers policyholders by removing the distinction between an omission and an inaction, said Geoff Masel, an insurance law specialist with the Melbourne, Australia, office of law firm Phillips Fox. The High Court ruling says that a policyholder can do virtually nothing to notify its insurer and still receive payment for a claim, less the amount to which the insurer has been prejudiced, he said.

Mr. Masel said the decision may prompt some professional liability insurers to "look closely at the class and premiums."

"There is a real risk of premiums going up," he said.

He warned that insurers are likely to review the basis of claims-made coverage and that, while the decision appears to benefit policyholders, premiums are likely to rise because there is far less certainty for insurers.

Mr. Nicholson said the High Court decision makes Section 54 a "broad brush to assist insureds and deprive insurers of the ability to distinguish between failure and non-election." In other words, he said, the High Court refused to distinguish between a failure to notify the insurer and an election not to inform the company because the policyholder thinks it is unnecessary.

The appeals court panel had noted: "Section 54 allows a court to intervene to prevent an insurer denying indemnity on account of some act or omission of the insured. It does not allow the courts to intervene and take control of the insurer's other rights under the contract. The insurer is entitled to decide for itself whether or not to grant consent."

For that reason, the appeals panel decided, Sir Tristan's claim for indemnification had to be rejected.

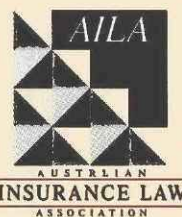
But High Court Chief Justice Sir Gerard Brennan disagreed, arguing in his judgment that "none of the insured's omissions contributed to his incurring the legal expenses for which he claims an indemnity."

The High Court ordered that the case now be sent back to the New South Wales Supreme Court for a hearing.

Michael Ball, solicitor with the Sydney office of Allen Allen & Hemsley, which represented Sir Tristan, said an initial hearing to set a trial date is expected within a month.

He said the new trial will determine the extent of prejudice against the insurer, with Sir Tristan then likely to seek damages from Heath Fielding for the amount he would have been able to claim from C.E. Heath.

Phillips Fox's Mr. Masel said Australia's insurance regulator, the Insurance and Superannuation Commission, should consider recommending legislative change to the act to "confine the open-ended nature of insurers' liability."



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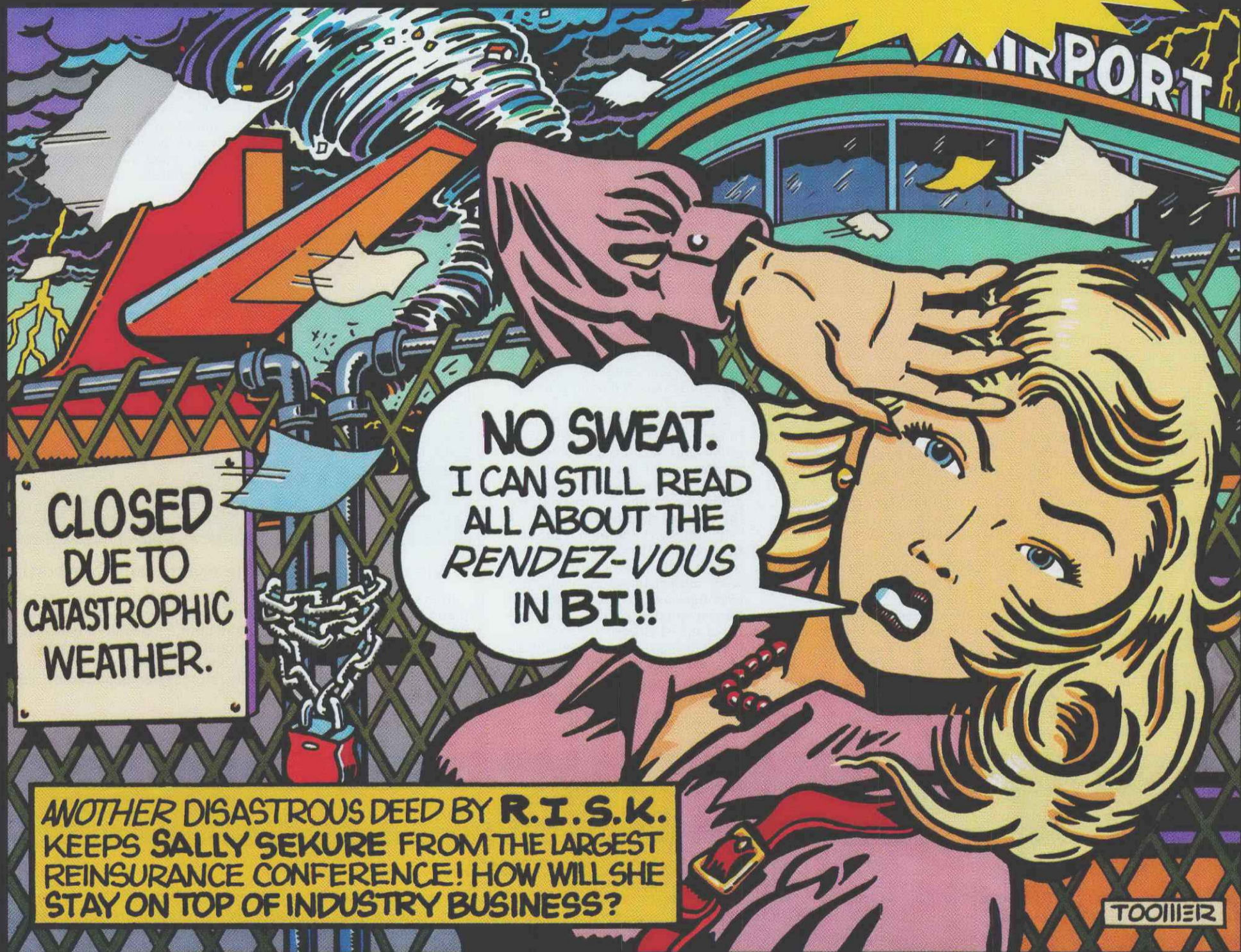
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E.U. insurance market retains restrictions

Fifteen years later, cross-border underwriting remains a difficult goal to achieve

By EDWIN UNSWORTH

LONDON—Insurers and consumer group representatives say the 15 countries of the European Union still are a long way from achieving an unrestricted insurance market, more than five years after passage of E.U. directives designed to open the borders to cross-border insurance business.

Opening a hearing last week on the non-life insurance market, Roger Bowley, deputy chairman of the British Insurers' International Committee, which represents the British insurance market on European issues, said a U.K. insurer still is unable to issue a standard U.K. policy to someone in another country because the policy normally will need to be in a different language and comply with the insurance regulations of the other country.

"This situation will inevitably continue for some time," he said during the one-day hearing organized by the Economic and Social Committee of the European Communities.

The committee will prepare a report for the European Parliament to consider when framing further legislation.

Marie-Louise Rossi, chief executive officer of the London International Insurance & Reinsurance Market Assn., said, "There is not a common level playing field for reinsurers."

It is LIRMA's aim to achieve this, she said.

Ms. Rossi also pointed out that there is no common E.U. framework to regulate brokers, but she welcomed the fact that the Bureau International des Producteurs d'Assurances & de Reassur-

ances—a Brussels, Belgium-based federation of brokerage associations—is working to achieve this.

A number of other speakers complained about rules requiring a fiscal representative, usually an accountant or broker, to be based in each country where an insurer wants to underwrite direct business.

The main purpose of this representative is to collect insurance premium taxes for the local government.

Complaints about the requirements for a local fiscal representative centered on the length of time some countries take to process applications for these agents and the high costs, which often dissuade an insurer from trying to do business in a country where it is feared the returns may not justify such high costs.

Arielle Pouget, London sales manager for ITS Fabry S.A., a Maubeuge, France-based company that helps insurers set up their fiscal representatives in other countries, complained that it took the French Finance Ministry 12 months merely to confirm that when operating through a broker, an insurer does not need fiscal representation in France. She said that when fiscal representation is required, the costs can be very high. In Greece, for example, the minimum fee for fiscal agency representation is £600 (\$955) to £800 (\$1,270) a month in fixed costs alone.

William Green, underwriter and assistant vp for professional liability at London-based CNA Reinsurance Co. Ltd., criticized the fiscal representation requirement for being "burdensome" and for adding to costs smaller insur-

ers cannot afford.

He said one problem is that insurers are allowed only one agent per country.

The most logical agent would be a broker, because "he's someone you know and trust" and would also be most likely to be willing to do the job at a reasonable cost. The conflict that arises, however, is that other brokers the insurer deals with in that country would have to provide confidential details of business done with the insurer to that agent, Mr. Green said.

He maintains the solution would be to alter the rules so an insurer can have more than one fiscal agent per country, thus enabling the insurer to appoint each broker used in that country as an agent.

Several speakers also commented on the inequalities of taxation across the European Union. This includes problems resulting from both varying levels of insurance premium taxes and of corporation taxes.

Basically, taxes should be paid in the country where a risk originates, but Ms. Pouget said this creates problems for multi-national companies underwriting global programs to break down the value of risks by country.

It also was claimed that tax rules created problems for customers, who were unsure if they were subject to paying insurance premium taxes at rates existing in their own country or in the country of their insurer.

The discussions revealed a wide division between the insurance community in the United Kingdom and that of its continental European partners over the de-

gree to which the European insurance industry should be allowed to self-regulate.

Mr. Bowley emphasized the success in Britain of voluntarily policing the industry, particularly through the Code of Practice for the Selling of General Insurance developed by the Assn. of British Insurers. All ABI members are required to comply with the code, as are syndicates within Lloyd's of London.

However, continental insurers often were unfamiliar with such voluntary practices and were

skeptical about their effectiveness in regulating an EU-wide insurance sector.

Barbara Saunders, chairman of the consumers' panel of the U.K.'s Personal Investment Authority, questioned whether in a European context it would be possible for trade and consumers' associations to monitor the performance of insurers.

She said an independent body operating across Europe probably would be necessary if the E.U. were to adopt voluntary means of insurance regulation. **BI**



PHOTO: AFP

Vietnam Airlines plane crashes in Cambodia

There is no hull insurance for the Russian-built Vietnam Airlines plane that crashed near Phnom Penh airport last week, killing 65 people and injuring one child. The airline's liability insurance is reinsured with the Vietnam National Reinsurance Co., which in turn retrocedes the coverage in London, led by Westminster Aviation Insurance Group. The liability retrocession is placed by Willis Corroon Group P.L.C.

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INTERNATIONAL

P&I Clubs

Continued from page 23

lent claims-paying record. However, the clubs have decided that they should not be complacent but should examine options for cover in Bermuda, Europe and elsewhere.

One sign of a shift away from London is the International Group's appointment of Greig Fester International Ltd. as joint reinsurance broker with existing broker Miller Marine, part of Miller Insurance Group Ltd.

Mr. Gaze said the appointment signifies no dissatisfaction with the service provided by Miller, which "has done a very good job." Rather, "Fester

will bring new ideas and possible access to new markets."

Mr. James said the International Group's reinsurance contract has grown "so big that we needed another pair of eyes to help with our strategic thinking."

That strategic thinking could entail deciding whether the 1998 reinsurance program is placed in markets in addition to London, and how the various layers could be structured.

Meanwhile, one of the P&I clubs that belong to the International Group is threatening it might sue the European Union if the E.U. rules the group's renewal procedures are in violation of E.U. competition rules.

In June, the European Commis-

sion's Competition Directorate accused the International Group of restricting the ability of shipowners to switch P&I clubs. The directorate took issue with the group's "International Group Agreement," which governs the transfer of shipowners from one P&I club to another.

The agreement means that if a shipowner decides to move to a new P&I club that belongs to the International Group, its rates with the new club for the first year will be based on its claims with the previous insurer. Effectively, the rule discourages shipowners' movement between clubs to obtain an immediate better rate.

The E.C. directorate also objected to the International Group's method of

pooling shipowners' catastrophic risks in excess of its reinsurance program.

While the International Club moved to reduce members' exposure to catastrophic claims, it has refused to revise the IG Agreement. The group contends the agreement is crucial to the continued existence of its pooling arrangements for sharing claims.

In 1985, the International Group received a 10-year exemption from European competition regulations and since 1995 has been trying to have its exemption renewed.

Graham Edmiston, chairman of A. Bilbrough & Co., the London Club manager, said that suing the E.U. "is an option," though he emphasized

that no decision to take legal action has been made.

Mr. Edmiston maintains that under European law, the Competition Directorate cannot withdraw an exemption previously given unless there has been a material change in circumstances. There has not been any such change, he says.

The International Group has said it will respond to the E.U. Competition Directorate by the Sept. 16 deadline. No decision on legal action will be made until the Competition Directorate has ruled on its response. If legal action is taken, it would most likely be against Karel van Miert, the European Commission competition commissioner. **BI**

India

Continued from page 23

bring better health care to the majority, while making a significant contribution to business. If there are more players, better products will emerge."

Dr. Reddy said India should not blindly imitate systems in the United States or United Kingdom but develop its own.

The Associated Chambers of Commerce and Industry of India called the bill's withdrawal unfortunate. A spokesman said that the entry of private capital in the insurance sector "would have not only enlarged the insurance business, helped bridge the technology gaps and mobilized resources, but also enabled the global insurance companies to invest a part of the worldwide savings in India."

The bill would have given the IRA authority to regulate foreign investors. The bill's framing followed Finance Minister P. Chidambaram's 1997-98 budget announcement to liberalize the health sector.

The bill would not have changed the Life Insurance Corporation Act and the General Insurance Corporation Act, which grant monopoly rights to the state-run insurers. The Life Insurance Corporation Act enabled the government to nationalize the life insurance industry in 1956 and establish the state-run Life Insurance Corp. The General Insurance Corporation Act nationalized the non-life industry and led to the formation of the state-run General Insurance Corp. in 1974. The bill would have allowed for the restructuring of the GIC and LIC into smaller, more competitive units.

However, the political opposition voted down the legislation, sponsored by the United Front, the majority ruling party. The opposition is comprised of the Congress Party, the Bharatiya Janata Party and various

parties of the Left, the most important being the Communist Party of India, or CPI; and the Communist Party of India-Marxist, or CPI-M.

The strongest protest to the United Front government's proposal to empower the authority that would regulate private investment and functioning came from the BJP and the Left.

Each political party has its own agenda. While the Congress Party initiated the liberalization process several years ago, the United Front is trying to implement it.

Atal Behari Vajpayee, leader of the opposition, has expressed concerns about foreign companies being allowed, saying in the Times of India, "Although the Finance Minister says foreign companies will not be allowed, still there are apprehensions."

The CPI General Secretary and representative, D. Raja, said at a news conference in New Delhi, "Opening up the insurance sector would prove detrimental" to the economy.

Labor groups also opposed the act. The Professional Workers Trade Union Center of India's Mr. Nigam said, "So far this sector is insulated, being run by the government. Deregulation will jeopardize the safety and solvency of funds."

The resistance to the bill also contained an element of politicking. "When (the opposition) realized that there was poor floor management in Parliament, they went for the kill to embarrass the government," said K. Ashok Rao, president of the National Confederation of Officers' Assns. of Central Public Sector Undertakings, or the NCOA.

The Prime Minister, Inder Kumar Gujral, withdrew the bill without any objections. V.K. Dhall, additional secretary-insurance, in an address to the International Conference on Insurance the day after the bill was rejected, said: "A thorough debate may sometimes seemingly slow down or

modify a reform process, but the consensus which finally emerges only makes the reforms more durable and sustainable. Thus there is no reason to be impatient or despondent. The government was always keen that the regulatory mechanism should be put in place before any opening up so that new players are guided in a professional way."

The move to liberalize the insurance industry began in 1993, when R.N. Malhotra, a former governor of the Reserve Bank of India, was appointed to head a committee to study the issue. The committee report in 1994 recommended, among other things, that foreign insurers be allowed to operate in India if they establish joint ventures with Indian insurers and the Indian companies retain the majority ownership (*BI*, March 28, 1994).

Progress has been slow since then. The matter will remain undecided until the November Parliamentary session, when the amended document may be reintroduced. Meanwhile, potential foreign investors do not seem unduly concerned. Nor is decamping from the Indian scenario an aim. In his budget speech earlier this year, Mr. Chidambaram had pointed out that only about 2 million Indians of the 950 million population have health insurance.

That is because only a limited portion of the middle class receives health insurance through their employers, government policies already compensate citizens in some instances and because many Indians are not aware the health insurance is available or cannot afford it. In addition, there is not a perceived need for insurance since medical costs are not as expensive for the middle and upper-middle classes.

Mr. Kahn said that Aetna wants "to capitalize on emerging markets and on opportunities that arise."

Clarifying that Aetna would cus-

tomize its products for the Indian context, he added, "We are in the research stage (studying the Indian health system, status and financing) to create a product right now."

Yet, while foreign investors discuss tapping the gigantic Indian middle class, it is unclear whether the target has the finances to merit such investment. For India, the need of money for better equipped and more public or private primary health centers, general practices and hospitals must be more of a priority than attracting insurance industry investors.

Dr. Amit Sengupta, general secretary of the Delhi Science Forum, a private organization that tries to bridge the gap between science and society, noted: "While the problems of private health insurance in the West are well-documented and the U.S.A. has the worst parameters and the highest costs, their government still contributes about 44% to health care." In India, where the contribution is nearer 22%, health care spending must increase first, he said.

For private companies, investment will be an uphill battle as there are no standardized insurance plans and little broad-based infrastructure. As many companies already subsidize health insurance benefits, the middle class that investors are targeting may already have some coverage.

Those who cannot afford even Indian insurance may not benefit from private and foreign companies, for whom offering premiums competitive with the GIC would be unprofitable. Rather, the plight of this segment may worsen as government-controlled subsidies and compensation shrink with deregulation.

So, given the minimal market opportunity for health insurance, the state of India's health system, and primitive claims settlement procedures, experts think companies would invest only to get a foot in the door for other insurance opportuni-

ties. Dr. Sengupta said, "In health insurance, the possibilities are limited." Corporate hospitals could link up with insurers, and there is a small potential health insurance market for near-retired or retired middle-class professionals, he said.

Indians fear private investment in a hitherto bureaucratic but secure government body. The insurance sector was initially nationalized because its track record as a private sector—consisting of about 245 local companies and foreign ones—was poor. The GIC and LIC are heavily subsidized and already invest in public welfare projects such as utilities, health and roadworks. These would stop with the influx of profit-oriented entrants.

Another important aspect of insurance for an agrarian nation, crop insurance, is unlikely to appeal to foreign insurers. Also, Indian policyholders would have little legal redress against foreign insurers since most do not have the means to pursue a claim.

"Firstly, in a poor country like ours, where savings are not only marginal but a matter of life and death, security is more critical than quantity or quality of services and products," said Mr. Rao. "Secondly, whatever controls the IRA may have, it will not have the power to dictate to a foreign company." He cited the Union Carbide Bhopal gas tragedy in 1984 as an example that "these issues are not being discussed but brushed aside."

For example, the IRA bill does not address safety measures such as solvency checks on entrant companies.

Even the Indian private sector may be getting cold feet about liberalization. As one expert observed: "They realize that they will be reduced to being brokers and middle men for foreign companies. Also given the very low amount of equity they hold and the large amount of dormant equity held by state financial institutions like insurance, access to funds will be lost." **BI**

KWELM dominates U.K. guaranty fund

By STACY SHAPIRO

LONDON—The so-called KWELM companies still dominate the work of the Policyholders Protection Board, which administers a type of guaranty fund against insolvent insurers.

But policyholder creditors of the former insurers of defunct London United Investments Group P.L.C. aren't the only ones to benefit from the fund. According to the board's annual report and accounts for year-end March 31 published last week, there are 13 defunct non-life insurers and two life insurers whose creditors may be entitled to money from the fund. They include policyholder creditors of Anglo American Insurance Co. Ltd.,

which underwrote on the same line slip as the KWELM companies; Bermuda Fire & Marine Insurance Co. Ltd.; English & American Insurance Co. Ltd.; Municipal Mutual Insurance Ltd.; and Trinity Insurance Co. Ltd.

The Policyholders Protection Board also may become involved in the provisional liquidation of Sovereign Marine & General Insurance Co. Ltd., the board's secretary, Derek Wright, confirmed.

KWELM still dominates payouts from the guaranty fund, however. The Policyholders Protection Board paid out a total of £32.6 million (\$53.4 million) to relevant policyholder creditors of the 13 non-life companies at year-end March 31, about half of the £62 million

(£106.2 million) paid out as of fiscal year-end 1996. About 59%, or £19.3 million (\$33.1 million), of the 1997 fiscal year's payouts was paid to KWELM policyholders.

Altogether, in the 1990s the Policyholders Protection Board has collected £340 million (\$539.1 million) from various annual levies on authorized U.K.-based insurance companies to pay for the losses. Of this, about £236 million (\$374.2 million) has been paid out in claims. At year-end March 31, the board had £155.4 million (\$254.8 million) in assets.

In light of the money available and the forecasted claims in the next year, the board decided in March 1997 not to call another levy on life or non-life insurers' gross

written premiums at year-end 1995.

In accordance with the Policyholders Protection Act 1975, the Policyholders Protection Board must make sure each individual policyholder, including partnerships comprised of individuals, be paid a minimum of 90% of their liabilities when a U.K.-authorized insolvent insurer is in liquidation or provisional liquidation. This includes North American policyholders insured with London market insurance companies.

However, in March this year the Policyholders Protection Act 1997 was passed by Parliament, introducing significant amendments to the 1975 act. The amendments will exclude risks and commitments lo-

calated outside the United Kingdom and the rest of the European Economic Area, which includes non-E.C. countries, such as Switzerland.

The new law is not in effect yet and won't be until the Department of Trade and Industry publishes a "statutory instrument" that sets out the detail of the law, said Mr. Wright.

Though the new law stressed that the amendments should not be retroactive, there is still some debate whether the DTI will make the amendments retroactive in the statutory instrument, said Mr. Wright.

If so, many U.S. policyholders seeking redress from the Policyholders Protection Board could be affected.

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PBGC

Continued from page 2

participants their funding levels as well as the limits of PBGC benefit guarantees if the plans are terminated and taken over by the agency.

Mr. Strauss, who joined the PBGC about two months ago after serving as deputy chief of staff for Vice President Albert Gore Jr., also said it was unfair to put companies on a public list when they met or exceeded all funding requirements.

In its early years, the list was studied with plans that were grossly underfunded. Indeed, the 1990 list, based on 1988 information, included 14 employers whose plans were 50% or less funded, and six companies on that list later terminated plans, saddling the PBGC with more than \$2 billion in losses.

By contrast, none of the plans of the employers on the 1996 list, based on 1995 information, was less than 50% funded. On average, the plans were 88% funded, a reflection of greater contributions many of those companies have made to their plans and high investment returns employers have earned on plan assets.

By including even relatively well-funded plans on its top 50 list, "we singled out plans that did not pose a significant risk to the PBGC or to participants," Mr. Strauss said.

Indeed, since 1975, just 19% of PBGC's \$5.6 billion in losses came from plans that were at least 50% funded, and only 2.1% of claims came from plans that were at least 75% funded. By contrast, 78% of claims came from plans less than 50% funded when they were terminated and taken over by the PBGC.

The list's elimination drew raves

from employer trade groups and benefit consultants. One persistent criticism was that the list overstated liabilities by using unrealistically low interest rate assumptions, noted Frank McArdle, a consultant with Hewitt Associates L.L.C. in Washington.

But James Lockhart, the PBGC chief during the Bush administration, who made the decision to release the list, criticized the axing, noting it prompted some companies to accelerate contributions.

Elimination of the list is premature in view of the substantial underfunding that still exists, said Mr. Lockhart, now a partner at NetRisk Inc. in Greenwich, Conn.

But Larry Sher, a principal at The Kwasha Lipton Group in Fort Lee, N.J., said the tough 1994 pension funding rules make it much tougher for plans to become poorly funded. **BI**

Columbia

Continued from page 1

maceutical manufacturers, though a couple of them operate as independent subsidiaries: Medco Cost Containment Services Inc. was bought by Merck & Co. Inc. in 1993 for \$6.6 billion but began operating independently of Merck in 1995; Diversified Pharmaceutical Services Inc. was bought by SmithKline Beecham Corp. in 1994 for \$2.2 billion; PCS Health Systems Inc. was purchased by Eli Lilly & Co. in 1994 for \$4 billion but operates as an independent subsidiary; and MedPartners/Mullikin acquired Caremark International for \$2.5 billion in 1996.

The sale of ValueRx won't have a significant impact on the PBM market, said Todd Swim, a principal and health care actuary with Buck Consultants Inc. in Chicago. If the management buys the PBM, "it puts ValueRx to the point they were before the purchase" by Columbia, he said.

Prior to Columbia's acquisition offer, in fact, Value Health Inc. had planned to spin off ValueRx, which

in 1995 had acquired another PBM, Diagnostek Inc., for \$216 million. At year-end 1996, ValueRx had \$1.59 billion in gross revenues.

Analysts noted in January that Value Health was ripe for a takeover after acquiring Diagnostek. While that acquisition made its ValueRx unit the largest independent PBM, Diagnostek's faltering performance strained Value Health, according to analysts.

Under most acquisition scenarios, ValueRx "would continue to do business very similarly to the way they have done business in the past," said Jack Doerr, national group benefits practice leader with Sedgwick Noble Lowndes in Chicago.

If ValueRx were bought by a pharmaceutical company that already has a PBM, the combination would enable it to extract large discounts from all pharmaceutical makers, he said.

A takeover by a drug manufacturer may be unlikely, though. The lack of success of earlier forays into the PBM market by pharmaceutical companies might make others leery of pursuing ValueRx, said Buck's Mr. Swim.

Furthermore, Mr. Doerr said, because the drug makers have not seen the returns they anticipated from their earlier purchases of PBMs, ValueRx wouldn't fetch the price paid for some of the others.

Indeed, some deals have generated struggles for the drug makers. For example, Lilly said in June that it would take a \$2.4 billion second-quarter non-cash charge to write down the value of PCS, the nation's

largest PBM, to \$1.6 billion (BI, June 30).

While ValueRx may not be taken over by a drug manufacturer, Mr. Swim said that, in his opinion, all PBMs will eventually become part of a large health care company. "It's just a matter of time before ValueRx is part of a larger organization," he said, because the nature of a PBM fits with larger managed care companies or pharmaceutical companies. "There are a lot of ways a PBM can fit in the health care continuum we see today."

Mr. Swim said pairing a PBM with a managed care company makes sense to deliver health care. "The companies that can look at drug utilization and health utilization at once will have the most effective entity," he said.

Meanwhile, ValueRx's Mr. Roberg said the management group is proceeding quickly. "Our plan is to make a bid as soon as we have a competitive package."

Mr. Roberg declined to say how much ValueRx management intends to offer for the PBM. He said other potential purchasers are planning to submit a bid to Columbia's adviser, Merrill Lynch & Co., but Columbia/HCA would not comment on possible other bidders or the bidding process.

Mr. Roberg said the sale of ValueRx will help both the PBM and Columbia. By shedding the company, Columbia can concentrate on its core business. And, he added, the ongoing investigation of Columbia has hurt ValueRx. "It adds another set of questions that people ask," Mr. Roberg said. **BI**

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Results

Continued from page 3

The 20 largest U.S. reinsurers, based on net premiums written, reported a 100.8% combined ratio in the first half vs. a 105.5% combined ratio reported by the 19 largest reinsurers for the same period a year earlier.

Business Insurance has combined on a pro forma basis the 1997 and 1996 RAA results of American Re Corp. and Munich American Reinsurance Co., which were officially merged as of July 1, though they have been operating as one company since earlier this year. The Top 20 also includes the results of the Berkshire Hathaway Group, which does not participate in the RAA survey, and Gerling Global Reinsurance Corp. of America, formed in January (BI, Jan. 27).

The 45 reinsurers in the RAA survey reported \$9.8 billion in net premiums written in the first half, an 8% increase from the comparable period of 1996. Excluding Gerling, the 19 largest U.S. reinsurers reported \$9.08 billion in first-half premiums, an 8.6% increase from 1996's first half.

The market remains "extremely competitive," said Adrienne W. Reid, senior vp and chief treaty underwriting officer for Zurich Reinsurance Centre in New York. "We saw that with the July 1 renewals."

In spite of the competition, results continue to be excellent, said Craig Elkind, a director at rating agency Standard & Poor's Corp. in New York. "Light catastrophe activity continues to benefit results in the reinsurance market, as it has for the last couple of years." The industry's results also were not affected by increased reserve strengthening, "so it's a fairly clean result."

"The only issue that continues to burn" is whether casualty reserving is being done as conservatively as it has been the past few years, said Mr. Elkind.

While premium growth for reinsurers has slowed, it still is growing faster than the overall primary markets, "so we're still seeing primary companies moving risk into the reinsurance market quicker than they're writing it themselves," said Michael

Smith, an analyst with Salomon Bros. in New York.

Reinsurers participating in the RAA survey also reported that first-half investment income increased 11.8% to \$1.78 billion in 1997 compared with 1996.

"The phenomenal bull market in terms of equities has really helped surplus and investment income," said John L. Ward, CEO of the Cincinnati-based Ward Financial Group. He added that "reinsurers have historically invested more heavily in equities than has the industry in general."

"Some of that investment income is coming from new funds that have been injected into the reinsurance sector," said Mr. Smith. A number of companies have increased surplus "fairly dramatically," he said. "A lot of it was foreign insurance companies boosting the capital of their American subsidiaries to enhance their American presence in the market."

He pointed, for instance, to Gerling Global, which received a \$100 million contribution to surplus from its parent company, Gerling Global Reinsurance Co. of Cologne, Germany, bringing its total to \$295.9 million as of June 30.

"The only comment I have to make on results is, can you believe them?" said John Berger, president of F&G Re Inc., a Morristown, N.J.-based unit of USF&G Corp. "Is the industry really running a 101.5% ratio?"

The results "look awfully good" given the soft rates in the market, he said.

Gary Ransom, senior vp at Conning & Co. in Hartford, Conn., said the 101.5% combined ratio reported by the industry reflects lower additions to reserves, which he said is "some combination" of what reinsurers believe about their exposures today and changes in belief about previous years, including environmental losses.

"It's not really that surprising that the reinsurers have good results in terms of combined ratios," he said. "There haven't been any catastrophes. Primary companies have retained more, so it's moved the reinsurers up generally, and there's less likely to be claims," said Mr. Ransom.

Mike Schell, senior vp of North

American underwriting for St. Paul Re, said despite the relatively low combined ratios, once capital gains are removed, reinsurers are realizing less than 10% on equity on their operating earnings, which is "clearly unsatisfactory," particularly in light of the low catastrophe losses.

One factor that could affect reinsurers' future earnings is a perceived trend toward more pro rata business.

"Over the past six months, pro rata deals have increased dramatically," said John Sullivan, president of Hartford Re North American in Hartford, Conn. "Several major companies have switched to buying pro rata."

"I think it does tie you closer to the primary market, where the rates are declining," said Mr. Sullivan. By contrast, writing excess-of-loss business can "to a certain extent decouple yourself a little bit from the primary company's experience," he said.

Mr. Sullivan also noted that, unlike the case with excess-of-loss business, reinsurers pay primary insurers ceding commissions for pro rata business, which cuts into their margins, while brokerage commissions also are increasing.

While he does not necessarily see an increase in pro rata business, "clearly that's going on," said F&G Re's Mr. Berger. "You've got some big quota shares being done, and there's a lot of premium, but margins are pretty darn small."

Salomon Bros.' Mr. Smith said, however, "It looks to me like there is more business being written on a quota-share basis, particularly among the smaller players, and the insufficient pricing in the primary market is going to very quickly move into the reinsurance sector, where you are seeing those quota-share programs."

"Some insurers are realizing that the insurance rates they're charging are probably inadequate" and are decreasing their retentions and buying more pro rata business than they did formerly, said St. Paul Re's Mr. Schell.

In addition, he predicted that "more large companies will consider reducing retentions or will consider more pro rata reinsurance, once industry cash flow or their own cash flow turns negative."

S&P's Mr. Elkind said that while

he does see a trend toward more pro rata business, which generates more premium volume for reinsurers, "these are better controlled, not the uncapped contracts that killed people" with Hurricane Andrew.

George O'Shaughnessy, chief financial officer of American Re in Princeton, N.J., said the reinsurer is writing a somewhat greater proportion of pro rata business, but this business is written with finite features, "while maintaining the risk-transfer aspects of a contract." The amount of quota-share business "may be slightly up, but not a great deal more than we have been doing," he said.

Meanwhile, there also is a trend of reinsurers writing more primary business.

Pointing to reinsurers' premium increase in the first half, Mr. Schell said, "I don't believe that's reinsurance premium. I believe that's coming from insurance premium."

"Many reinsurers have set up insurance company capabilities to issue insurance policies and—at least partly due to the soft reinsurance market and emphasis on top-line growth—many reinsurers who formerly were very conservative about writing (managing general agency) books of business have set up insurance companies in order to specifically write MGA business," said Mr. Schell.

"It's either in the form of them taking on the business with their insurance company paper, or them being a pro rata reinsurer of first dollar insurance business, often produced by managing agents," said Mr. Schell. "I don't believe there's growth taking place in traditional reinsurance business."

Mr. Elkind agreed reinsurers are writing more MGA business, particularly excess, surplus lines and special programs business "that fall through the cracks."

In spite of the changes in the nature of their business, reinsurers are expected to continue to post good results for the rest of 1997—barring any major catastrophes.

In the future, "increasingly weak commercial rates will start showing up to a greater extent in reinsurers' results," said Bard E. Bunaes, chairman and CEO of Constitution Reinsurance Corp. in New York.

"The loss reserve cushions of the late 1980s have largely evaporated, but still I think 1997 could be a decent year if we don't have a major hurricane, and perhaps the last decent year we have, in what I would term as a bear market for reinsurers."

Pointing to declining primary and reinsurance rates, Mr. Bunaes added, "It's no fun out there."

"Assuming no major catastrophes, I would think we're going to amble along with the same decreased rates on each renewal," said Hartford Re's Mr. Sullivan.

Results will continue to be good "as long as the wind doesn't blow the wrong way and the earth doesn't shake," agreed Mr. Elkind. "I don't see why results can't continue to be good this year end," he said, adding it will take "an emergency on the casualty side or a big loss on the property side to affect results."

Though there is more pro rata business, the "lion's share" of what U.S. reinsurers are writing remains on an excess-of-loss basis and, with higher attachment points, it takes a bigger catastrophe to "shake up the market," said Mr. Elkind.

The market will continue to be competitive, however.

"I certainly expect the second half of the year to be at least as competitive as last year," said Charles D. Troiano, president and CEO of Gerling Global Reinsurance Corp. of America in New York.

"Financial markets continue to be strong, the economy is in very good shape, there haven't been any significant catastrophes in five years, certainly none that affect the domestic reinsurers, so all indications are that most reinsurers will be very aggressive in protecting their top line, and I would expect that some may be sacrificing the bottom line to some extent in order to retain or grow new market share," Mr. Troiano said.

"I think we have to get used to competition," said Kaj Ahlmann, chairman, president and CEO of Employers Reinsurance Corp. of Overland Park, Kan. "I don't think the market will change dramatically."

Furthermore, he said, the "financial markets' interest in the whole risk transfer process means more competition, plus plenty of available capital out there." **BI**

Largest U.S. reinsurers' first-half 1997 results

Ranked by net reinsurance premiums written. All amounts in thousands of dollars.

Reinsurers	Net reinsurance premiums written 1997	Net reinsurance premiums written 1996	Policyholders surplus (reinsurers only)	Net income 1997	Losses & loss adjustment expenses	Loss ratio	Underwriting expenses	Expense ratio	Combined ratio 1997	Combined ratio 1996
1. General Re	1,522,268	1,378,403	5,973,943	368,465	1,067,438	67.2	491,559	32.3	99.5	99.1
2. American Re*	1,467,576	1,302,825	2,228,469	42,063	917,812	69.1	478,805	32.6	101.7	97.2
3. Employers Re	863,434	887,992	4,587,600	288,855	611,713	70.5	293,950	34.0	104.5	105.5
4. Berkshire Hathaway	720,600	534,500	N/A	N/A	365,400	85.9	30,600	7.2	93.1	104.0
5. Transatlantic/Putnam	517,749	507,874	1,065,999	69,617	368,362	74.0	132,991	25.7	99.7	101.0
6. Everest Re	482,417	462,436	837,454	78,521	343,867	71.2	150,611	31.2	102.5	103.8
7. St. Paul Re	428,557	432,942	N/A	N/A	278,598	72.4	129,614	30.2	102.7	103.2
8. Hartford Re Co.	349,032	304,607	N/A	N/A	261,922	77.8	96,352	27.6	105.4	108.2
9. Zurich Re Centre	346,616	364,832	737,862	21,839	268,999	74.0	114,908	33.2	107.2	103.5
10. Swiss Re America	338,832	359,983	1,379,563	131,057	235,083	66.7	126,967	37.5	104.2	104.2
11. TIG Re Co.	285,083	281,571	550,265	37,437	184,776	73.2	83,962	29.5	102.6	101.9
12. SCOR U.S. Group	283,468	121,578	423,259	32,323	221,384	71.3	95,838	33.8	105.1	105.1
13. Kemper Re	273,108	260,667	513,613	16,160	189,143	75.3	90,547	33.2	108.5	230.6
14. NAC Re	257,212	236,309	684,948	36,664	163,391	65.9	94,668	36.8	102.7	101.3
15. F&G Re	235,704	246,827	N/A	N/A	190,326	73.4	46,516	19.7	93.1	89.4
16. Constitution Re	231,393	258,224	369,426	21,785	186,521	73.6	71,595	30.9	104.6	102.8
17. Underwriters Re	194,356	194,111	635,959	16,816	126,470	74.1	54,758	28.2	102.2	102.2
18. Signet Star Re	140,377	129,272	262,668	5,125	92,444	71.8	44,484	31.7	103.5	102.9
19. Chartwell Re	138,142	95,389	247,740	9,882	86,698	68.0	47,829	34.6	102.6	104.5
20. Gerling Global Re	128,854	—	295,852	(13,241)	45,340	77.2	32,572	25.3	102.5	—
Totals for Top 20	9,204,778	8,360,342	20,794,620	1,163,368	6,205,687	71.4	2,709,126	29.4	100.8	105.5
Total for all companies	9,802,161	9,074,070	25,391,759	1,425,679	6,629,284	69.8	3,105,034	31.7	101.5	104.8

* BI estimate including the business of Munich American Reinsurance Co.
Source: Reinsurance Assn. of America and Business Insurance

Florida

Continued from page 3

employers started to implement managed care to treat injured workers, are one requirement for authorization of a plan to provide the care.

Information gathered will help to establish best practices, develop educational and technical assistance programs and make policy decisions regarding managed care in workers comp. The study's last phase is expected to be completed by year end.

The study gives regulators "tremendous opportunities" to work with insurers, managed care arrangements and employers in implementing programs and educating workers, said Jay Wolfson, a professor at the University of South Florida and a researcher of the study.

In the recently released first phase, which examined 18 managed care arrangements, the study suggests that, "Perhaps the MCAs which displayed the fewest compliance problems will be useful in guiding the Division in understanding how these MCAs have organized their resources, developed educational tools for program implementation, initiated utilization management/quality assurance programs and established grievance procedures and systems. The Division and AHCA may be able to use this information to provide technical assistance and education to MCAs experiencing higher levels of compliance problems."

Plans that had the fewest deficiencies identified by the AHCA audits were found to have characteristics that included:

- Provider networks that had an identifiable medical care coordinator and properly credentialed providers.
- Medical providers knowledgeable of rules governing treatment of injured workers.
- A commitment to early return to work.
- Communication of the provisions, restrictions and limitations of the plan to employers.
- Accurate and confidential medical records.
- A clearly defined quality assurance plan covering areas including peer review, clinical outcomes and evaluation of employee satisfaction.
- Grievance procedures clearly communicated to employees and providers.

The study did note some "weaknesses and deficiencies in access to medical specialties, hospitals and primary care physicians" in rural areas. The audits also turned up a number of violations related to utilization review and quality assurance standards.

And, 15 of the 18 MCAs violated portions of the standards related to grievance procedures.

Information gathered by the study won't be used to penalize arrangements not in strict adherence to state standards, said Linda Knopf, assistant director of the Labor Department's Division of Workers Compensation.

"The managed care mandate has only been in effect for about nine months," she said. "We're taking a positive, educational approach," rather than forcing the arrangements to make immediate changes as a result of the study.

"It's premature to draw anything other than preliminary conclusions," Ms. Knopf added.

"The results should be viewed in the context of an evolving new system," agreed Catherine K. Johnson, one of the researchers and president of HJH Group Inc., a Tampa-based consulting firm that specializes in workers comp and integrated disability management.

Ms. Johnson said the study found indicators of whether an MCA would largely be in compliance with regulations.

The analyses showed that fewer deficiencies appeared in audits of arrangements that involved a single managed care organization providing services than those involving several service providers.

Arrangements with corporate offices in Florida rather than another state also scored higher. Such plans may be more familiar with Florida law and have established relationships with regulators, the study said.

Timing also was a factor. "The early audits, which were initiated in the fall of 1996, appear to have been less comprehensive," the study said. "As the audit process progressed through early 1997, and as field audit staff became more familiar with the workings of workers compensation managed care, the characteristics of the regulations and the operations of different types of MCAs, the audits became more comprehensive."

The second phase of the study, which should be completed soon, is examining how employers select, implement and communicate plans to workers.

Copies of the first phase of the study are available for \$20 from HJH Group Inc., 3837 Northdale Blvd., No. 352, Tampa, Fla. 33624.

401(k)

Continued from page 3

ic investment advice, in part, for those reasons.

However, as 401(k) plans have become the retirement vehicle of choice among employers, plan sponsors have been beefing up their investment education and trying to push the definition of education to include investment advice, benefit consultants say.

As people are living longer and the future of such entitlement programs as Social Security and Medicare is uncertain, "it's pretty clear

that has been overlooked."

Under the proposal, TCW would collect financial information from a client's plan participants in the form of a questionnaire, which would then be analyzed and evaluated by the independent financial experts. Each participant would receive a written recommendation of an appropriate investment trust.

Benefit consultants and benefit managers have mixed reactions to TCW's proposed product.

"This is another weapon in (an employer's) arsenal for 401(k) encouragement," said Henry Saveth, a principal in the Washington Resource Group of William M. Mercer

manager agrees.

While providing plan participants investment advice "is a good concept," TCW's product "is not something I feel comfortable with," said Evon Beland, manager of benefits and benefit systems for Millipore Corp., in Bedford, Mass.

"I prefer to educate participants," she said. "I want to teach them how to assess their own risk tolerances, to set their own goals and to fit that into some sort of investment strategy."

The chemical equipment manufacturer has an 84% participation rate in its 401(k) plan. While every plan sponsor would like to get to 100%, Ms. Beland said she would prefer spending more time and effort educating the remaining 16% than having a piece of paper tell them what they should be doing.

Donna Benoit, a retirement plans specialist at Pulte Home Corp. in Bloomfield Hills, Mich., on the other hand, is a proponent of models like TCW's as a good way to help increase participation in 401(k) plans.

In fact, in a pilot program that is being continued on an annual basis, plan participants of Pulte's 401(k) plan can receive investment recommendations on types of investments in line with the funds the company offers, based on a questionnaire of their risk tolerance and other financial information. The information is analyzed and recommendations are given from an outside company not affiliated with the money managers offering funds in the plan, Ms. Benoit said.

"It's a good idea to get those folks investing," Ms. Benoit said referring to the employees not participating in plans. "Part of the reason they are not investing is because they don't know enough. They are more confident if someone is saying this is what you should do." **BI**

The proposed product 'is not something I feel comfortable with. I prefer to educate participants,' says Evon Beland of Millipore Corp.

that appropriate utilization of 401(k) plans is more important than ever before," noted John J. Mulligan, president of Retirement Plan Strategies Inc., the Braintree, Mass.-based consulting firm that assisted TCW on its product.

While offering investment advice can be beneficial for most participants, it is especially important to meet the needs of those employees that would rather be offered solutions than be educated on how to invest appropriately, he said.

Most of the 401(k) products that have been developed, like asset allocation models and interactive software, were developed for those "do-it-yourselfer" employees, Mr. Mulligan said.

TCW's product is made "to serve the needs of the employee segment

Inc. "It's another tactic to make employees feel comfortable in investing."

"The proof will be in the pudding," he said. "It's an interesting approach. I don't know if it will work."

Margaret-Ann Cole, a principal with The Kwasha Lipton Group in Fort Lee, N.J., expressed more skepticism with the proposal.

"To a certain extent, I'd like to see it go through to see if it works," she said. However, "I'm a proponent of people taking an active role" in their retirement investments, educating themselves and making their own decisions.

"People spend more time planning a vacation than planning for their retirement," she said.

At least one employee benefit

Updates

New Hampshire HMO sold

Continued from page 2

The combination of the two non-profit companies would create the largest managed care plan in New Hampshire, a spokeswoman for Matthew Thornton said. Manchester-based BC/BS of New Hampshire has 264,000 members, 110,000 of which are in a variety of managed care programs. Matthew Thornton, founded in 1971, has nearly 155,000 members. Combined, the two plans would cover almost 40% of the state population of New Hampshire, with approximately 419,000 participants.

The deal, which is subject to the state attorney general's and insurance commissioner's approval, is slated to be approved by Nov. 1, a spokesman for BC/BS of New Hampshire said.

"It makes perfect sense for Blue Cross & Blue Shield to buy Matthew Thornton," said Jim Kinney, managing executive, New England region, for Sedgwick Noble Lowndes in Boston. "They're the biggest operation up there, and they've always been concerned with Boston-based HMOs like Harvard Pilgrim and Tufts" expanding into New Hampshire, he said.

In the past two years, Matthew Thornton has seen the collapse of two separate proposals for merging with Brookline, Mass.-based Harvard Pilgrim Health Care. The Matthew Thornton spokeswoman declined to comment on either deal. The July 1997 proposal was to have brought a sale price of \$75 million.

BC/BS of New Hampshire's bid for Matthew Thornton has three parts: a \$24 million purchase price to Matthew Thornton's owner, Lebanon, N.H.-based Dartmouth Hitchcock Medical Center; \$17.5 million from future earnings, of which an undecided amount will be used to create a non-profit health care foundation; and \$5 million to the Lahey Hitchcock Clinic in Lebanon, a network provider to BC/BS and Matthew Thornton.

U.S. ruling favors Lloyd's

LONDON—Lloyd's of London is welcoming a decision by the 5th U.S. Circuit Court of Appeals in New Orleans that U.S. members do not have a right to take Lloyd's to court in the United States.

The court ruled late last month on two cases filed by members seeking to sue Lloyd's in the United States despite signing contracts stipulating any disputes should be heard in English courts.

The ruling was the sixth by a U.S. appeals court in favor of Lloyd's on this issue. Two weeks ago, the 9th U.S. Circuit Court of Appeals, which had been the only appeals court to support litigating members on this issue, decided to rehear its earlier decision Oct. 23 (BI, Sept. 1).

Peter Lane, managing director of Lloyd's North America, said Lloyd's is "very pleased that, once again, a U.S. court of appeals has supported our view on this important issue. Contractual undertakings of this kind are very common in international trade. The weight of judicial opinion supporting the enforceability of such contracts is now very considerable."

The 5th Circuit ruled on decisions by a federal district court in the cases of *Haynsworth et al. vs. Lloyd's* and *Charles Robert Leslie vs. Lloyd's and R.W. Sturge & Co.* In *Haynsworth*, the members were appealing a decision in favor of Lloyd's, while in *Leslie*, Lloyd's was appealing a decision in favor of a member. The appellate court decided to hear the cases together as they both dealt with legal jurisdiction.

According to the 5th Circuit, plaintiffs, who previously have enjoyed the benefits of Lloyd's contractual obligations to them, must honor their contractual obligations as well. The court concluded that anti-waiver provisions of U.S. securities laws do not bar enforcement of forum-selection and choice-of-law clauses in international transactions.

Briefly noted

A federal judge has reduced the amount of punitive damages awarded against ABC News to \$315,000 from \$5.5 million in the suit brought by Salisbury, N.C.-based **Food Lion Inc.** The supermarket chain won the award at trial in January over a 1992 broadcast of "PrimeTime Live." Food Lion claimed the broadcaster used fraud in conducting its undercover investigation of the chain. . . . A.M. Best Co. has assigned an A rating to the **Copenhagen Reinsurance Co. Ltd.** in Denmark. The rating is based on the company's diversified portfolio, strong capitalization and profitable underwriting since 1993, Best said. The rating also will apply to Copenhagen's U.K. and Singapore subsidiaries. . . . Oregon Department of Consumer and Business Services Director **Kerry Barnett** has announced he will resign by year's end. Mr. Barnett is the state's insurance commissioner and superintendent of banks. . . . The North Carolina General Assembly adjourned without passing the controversial "**Fronting Disclosure Act**" supported by the state Insurance Department (BI, Dec. 2, 1996). The proposal, which the Risk & Insurance Management Society Inc. opposed, would have imposed new record-keeping and reporting regulations on certain group captive insurers. The measure passed the state Senate but failed to move out of a House committee before the lawmakers ended the 1997 session. . . . A Texas jury ordered **Ford Motor Co.** to pay \$2.5 million to the driver of a Ford F-350 pickup and his wife who claimed a 1994 accident caused by an engine drive belt that failed left the driver disabled. . . . Pension Benefit Guaranty Corp. Executive Director **David Strauss** testified last week before the Senate Government Affairs Committee, which is investigating campaign financing. Mr. Strauss, an aide to Vice President Albert Gore Jr. before recently being named to the PBGC position, was questioned about whether a 1996 Democratic Party luncheon the vice president attended at a Buddhist temple was a fund-raising event.

Benefits

Continued from page 3

provides Internet links to health plan provider directories that employees can use to either review and select plans or look for primary care physicians.

Oracle offers its employees a choice of six health plans, including two health maintenance organizations and four other plans administered by Aetna Healthplans Inc.

Oracle also is piloting Fidelity Investment's Net Benefits program, which allows employees to make 401(k) investment changes online.

The company also has selected San Francisco-based 401(k) Forum to provide online investment education via the Intranet's links to the Internet.

This year Oracle also is introducing a "Life Events" module designed by Watson Wyatt that helps employees make the benefit plan changes necessary when they have a significant life event, such as getting married or having a baby.

Even though Oracleflex has links to the Internet, it is not accessible via the World Wide Web. Employees access the company's system either from their desktop personal computers, which are connected to the company's Intranet, or from home via modem.

All the Oracleflex information is stored off-site on a computer Watson Wyatt maintains.

For the most part, development of the system has gone smoothly, and the online enrollment program's costs—less than \$400,000—have met the employer's projections, according to Ms. Duffield.

Perhaps the biggest problem Oracle has faced in implementing its Intranet-based enrollment system is capacity, she said.

"Our biggest concern is network 'bandwidth' during peak usage. Some people complain they can't get on because of the network traffic. We had to increase the bandwidth threefold, and that still isn't enough," she said, referring to the system's data capacity.

She advised employers to make sure their computer systems will be able to handle the traffic an online enrollment system can create.

"It's a concern for any employer. If they're using a transaction-based application on an Intranet or the Internet, they should make sure their data center can support it," she said.

While Oracle had the skills to build its system from scratch, some new products also are on the market for employers that want to make open enrollment easier by going online but may lack the skills in-house.

Off-the-shelf online benefit plan enroll-

ment systems have been developed by such companies as San Diego-based cyberNET and Network Management Services of Minneapolis (BI, March 3; Oct. 28, 1996).

Perhaps the newest entry in this field is "Help Yourself," developed by Novato, Calif.-based EnWisen.

"Help Yourself" and its companion EnWisen programs cost \$130,000 for a company with an already-established corporate Intranet. And the system can be accessed with any Internet browser, such as Netscape or Internet Explorer.

"Why build it from scratch when you can buy it off the shelf?" asked EnWisen President Jerry McLaughlin.

Besides the "Help Yourself" module, which provides benefit information in a question-and-answer format, EnWisen programs include a "Life Events" module similar to the feature on the Oracle-Watson Wyatt program; "Articles," which provide benefits information in a narrative format; a calculator for making 401(k) investment projections or for comparing out-of-pocket costs in the various health plans; an online enrollment module; and Internet links to vendor sites, such as health plans and 401(k) plan administrators.

Cisco Systems Inc. of San Jose started out building its own system but decided to buy the "Help Yourself," "Life Events" and "Articles" modules of EnWisen's software when it found out it would cost less, according to Deepjot "D.J." Chhabra, senior manager of information systems for human resources.

Cisco already had developed its own online enrollment program, called "Cisco Employee Connection," as part of its benefit information system.

Mr. Chhabra estimated it would cost Cisco another \$150,000 to develop the other modules itself. Those estimates may be conservative, because Cisco is in the software development business.

Implementing a system such as EnWisen "will reduce the number of calls to benefits people so they can focus on strategic benefit planning and communication," Mr. Chhabra said.

This November will mark the second year Cisco will conduct its annual open enrollment online.

While Oracle and Cisco already have embraced interactive Intranet technology, other employers are treading more slowly.

Rosemead, Calif.-based Edison International Co., for example, is offering its employees "read-only" access to benefit information via the Internet.

The Edison program, developed by Health Pages, a New York-based consumer health magazine and information service, gives em-

ployees access to a database of providers participating in the company-sponsored health plans, as well as report cards and customer satisfaction survey results, according to Suzanne Mercure, Edison's health benefits manager.

"Employees generally think physician or hospital before they think 'plan,'" she said. "But we as employers tell them they've got to pick a plan. This way the employee can pick a doctor and then find out what plan they belong to."

Ms. Mercure explained that one reason Edison hasn't yet put its health plan enrollment online is the fact that many of its plan participants do not have computers.

"Only half of our people have access through the worksite," she said.

At some companies, though, employee sophistication is driving employers toward greater use of Internet technology to deliver benefits information.

After the California Public Employee Retirement System started providing benefits information via the Internet, its members asked for more, according to Bill Branch, a public information officer in Sacramento, Calif.

A home page for CalPERS' health division and several subpages with information on how to choose a health plan, open enrollment information and report card information are available to anyone who calls up <http://www.calpers.ca.gov> on the World Wide Web.

And by this week, the page will feature the entire text of four different open enrollment booklets so members can download them, Mr. Branch said.

"The only problem is, they want more of it. They want it to be more interactive," he said.

Unfortunately, CalPERS won't be offering online enrollment just yet, said Mr. Branch.

"We do have our consultants and experts looking into the possibility," he said. "But we have other priorities."

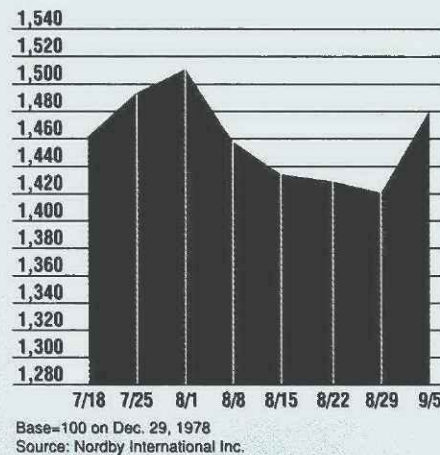
The first priority, he explained, is to network the corporate databases so that the retirement, health plan and other systems are all speaking the same language.

Next, CalPERS will expand remote access to its system so that health plans and the health benefits officers at the various government agencies whose employees have coverage through CalPERS can access the information.

In the interim, CalPERS is exploring the use of interactive voice response as a transitional enrollment technology for its more than 1 million members.

"It looks like IVR would be one of the most feasible first steps," Mr. Branch said. **BI**

BI Insurance Index



PCS catastrophe options

As of Sept. 5		Call spread	Price bid/ask	Call spread	Price bid/ask
Eastern September 1997					
40/60	-/3.0	40/60	-/1.0		
60/80	-/2.5	80/100	-/1.3		
80/100	-/—				
National Annual 1997					
80/100	-/4.0	Western Annual 1997		40/60	-/1.2
60/80	1.8/6.0			50/70	-/1.0
Southeastern September 1997					
40/60	-/2.4				
60/80	-/2.0				
80/100	-/—				

Total volume: 330 Total open interest: 17,621

For information on PCS cat options, call the Chicago Board of Trade at 312-435-3674.
Source: Chicago Board of Trade

British Issues

Companies	Price pence	P/E	Div. pence	Yield %	52-week high—low
Comm Union	739	11.4	35.8	4.8	767—583
Genl Accident	964	6.6	35.4	4.6	978—631
Gdn Royal Exch	283	4.0	12.2	4.4	311—248
Independent	1040	11.0	14.2	1.7	1043—565
Royal & Sun	527	14.7	19.7	4.7	561—393

Brokers	Price	P/E	Div. pence	Yield %	52-week high—low
Bradstock	81	11.8	6.4	9.9	90—54
CE Heath	142	9.2	1.5	1.3	143—74
Lmbrt Fenchurch	128	8.6	8.4	8.2	135—101
Lloyd Thompson	173	NA	NA	NA	206—163
Nelson Hurst	182	16.6	8.6	5.9	192—121
Sedgwick Grp	121	9.8	7.4	6.1	144—115
Steel Bri Jones	26	NA	1.5	7.4	38—22
Willis Corroon	122	12.3	6.6	6.8	165—117

Note: All figures are Sept. 4 closings.
Source: Nordby International Inc.

BI Industry Stock Report

SEPT. 1, 1997, THROUGH SEPT. 5, 1997

BROKERS

	Price	Weekly % change	Year to date % change	Year to date			Price	Weekly % change	Year to date % change	Year to date			Price	Weekly % change	Year to date % change	Year to date							
				High	Low	Vol.(000)				High	Low	Vol.(000)				High	Low	Vol.(000)					
Aon Corp.	NYS	52.06	2.21	25.70	56.13	32.63	721	Everest Reinsurance	NYS	38.50	6.29	33.91	40.38	23.75	328	SCOR	NYS	43.50	5.78	26.55	44.50	34.00	63
E.W. Blanch Holdings Inc.	NYS	29.38	0.00	45.96	30.63	18.00	109	Executive Risk Inc.	NYS	62.00	7.24	67.57	62.38	33.38	179	SAFECO Corp.	NDO	51.00	3.82	29.32	52.38	32.13	1918
Gallagher Arthur J. & Co.	NYS	36.00	0.70	16.13	37.75	29.13	90	EXEL Ltd.	NYS	57.38	4.56	51.49	58.25	31.75	448	Seibels Bruce Group	NDO	7.88	0.00	-4.55	11.25	5.88	61
Hilb, Roggal & Hamilton	NYS	16.75	-1.11	26.42	17.25	12.13	93	Fremont General Corp.	NYS	42.06	5.49	35.69	43.44	26.38	222	Selective Ins. Group	NDO	50.63	4.34	33.22	54.00	32.25	3
Kaye Group Inc.	NDO	8.38	9.84	59.52	8.38	4.38	10	Frontier Insurance Group	NYS	36.25	3.57	89.54	36.25	18.13	544	Sphere Drake Holdings	NYS	9.06	3.57	2.11	10.50	8.50	139
Marsh & McLennan	NYS	72.56	6.32	39.54	78.25	45.50	1054	Gaisco Inc.	NYS	9.06	1.40	-5.84	10.88	8.13	322	TIG Holdings	NYS	31.50	0.80	-7.01	38.00	26.38	854
Poe & Brown	NDO	37.13	-0.34	40.09	38.50	23.75	5	General RE Corp.	NYS	198.00	2.13	25.52	208.88	140.75	644	Titan Holdings, Inc.	NYS	21.75	1.46	31.82	25.00	12.75	163
Sedgwick Group PLC	NYS	10.00	0.00	-3.61	10.88	9.38	5	Gryphon Holdings	NDO	16.30	0.79	13.27	17.75	12.13	57	Tokio Marine & Fire	NDO	58.63	0.43	25.74	66.00	42.00	92
Willis Corroon Corp.	NYS	10.06	-2.42	-12.50	13.50	9.38	252	Guaranty National Corp.	NYS	27.50	-2.44	64.18	29.00	14.00	51	Torchmark Corp.	NYS	39.31	3.80	55.69	40.00	21.13	733
BROKERS AVERAGE				1.62	26.44																		

	Price	Weekly % change	Year to date % change	Year to date			Price	Weekly % change	Year to date % change	Year to date			Price	Weekly % change	Year to date % change	Year to date								
				High	Low	Vol.(000)				High	Low	Vol.(000)				High	Low	Vol.(000)						
ACE Ltd.	NYS	86.63	4.21	44.07	88.00	46.13	297	IPC Holdings Ltd.	NDO	29.38	0.00	31.28	30.50	19.50	376	Trenwick Group Inc.	NDO	35.94	-1.20	16.55	39.63	30.75	56	
Acceptance Insurance Cos.	NYS	24.00	7.87	21.52	24.13	17.13	156	ITT Hartford Group	NYS	82.25	3.13	21.85	88.81	51.75	1562	Unico American Corp.	NDO	11.00	0.00	1.15	11.50	7.38	5	
AEGON N.V.	NYS	77.31	4.12	22.23	78.88	49.13	419	LaSalle Re Ltd.	NDO	33.34	-3.38	16.03	35.63	22.38	63	Unionamerica Holdings	NYS	20.38	1.88	14.79	22.75	14.75	17	
Aetna Life & Casualty	NYS	101.25	6.09	26.56	118.13	60.13	2517	Life Re Corp.	NYS	51.30	-0.61	32.04	56.00	31.25	102	United Fire & Casualty	NDO	38.75	0.65	9.93	40.50	29.75	1	
AFLAC Inc.	NYS	56.69	2.95	32.60	57.88	32.88	1346	Lincoln National	NYS	69.00	3.08	31.43	73.00	43.13	849	Unilin	NDO	62.00	3.33	11.21	64.75	47.75	284	
Allied Group Inc.	NYS	44.69	0.99	38.97	53.63	24.88	126	MAIC Holdings Inc.	NYS	53.25	6.50	57.20	53.25	28.25	133	UNUM Corp.	NYS	43.00	2.69	19.03	48.44	30.50	747	
Allstate Corp.	NYS	75.31	3.08	30.13	79.94	45.63	3209	Markel Corp.	NYS	145.00	0.78	61.11	147.50	83.00	33	USF&G Corp.	NYS	23.06	5.43	10.48	25.50	16.00	2127	
AMBAC Indemnity Corp.	NYS	82.19	1.70	23.82	85.88	53.75	232	MBIA Insurance Group	NYS	120.00	5.96	18.52	122.00	80.00	452	Vesta Insurance Co.	NYS	53.50	8.49	70.52	54.00	24.50	195	
American Bankers Ins.	NDO	65.69	-0.47	28.48	70.50	44.50	76	Meadowbrook Insur. Group	NYS	25.44	-0.97	21.13	28.50	15.25	26	Washington National	NYS	32.38	9.75	17.73	32.38	27.13	1496	
American Financial Group	NYS	45.75	5.78	21.19	49.25	30.88	216	Mitl Ocean Ltd.	NYS	58.94	3.85	12.26	61.00	39.25	118	Zenith National Ins.	NYS	27.25	1.16	-0.46	28.38	24.63	65	
American General	NYS	51.19	6.23	25.23	54.75	35.75	2351	MMI Cos. Inc.	NYS	25.19	0.50	-21.90	32.75	20.75	54	Zurich Reinsurance Centr.	NYS	39.44	0.00	26.20	39.50	28.75	0	
American Heritage Life Ins.	NYS	37.13	5.13	41.43	38.75	19.75	20	Mutual Risk Mgmt. Ltd.	NYS	49.38	6.76	33.45	49.63	28.25	96	INSURERS/REINSURERS AVERAGE				2.65	25.94			
American Internat'l/Fin'l	NDO	12.75	4.08	24.39	14.00	9.50	10	NAC Re Corp.	NYS	48.00	1.86	41.70	49.50	32.63	242	HEALTH MAINTENANCE ORGANIZATIONS								
American Indemnity	NYS	101.13	7.15	40.13	106.88	62.63	5043	Navigator Group	NDO	19.25	4.05	5.48	20.63	15.75	9	Humana Inc.	NYS	24.44	3.71	28.62	25.00	17.38	2793	
Argonaut Group	NDO	33.50	3.08	8.94	36.38	26.75	129	Nobel Insurance Ltd.	NDO	14.63	0.86	16.42	15.38	11.25	29	Oxford Health Plans	NDO	77.38	5.81	32.12	89.00	40.38	4155	
Baldwin & Lyons Inc.	NDO	19.00	-1.94	3.40	22.63	17.38	3	NYMag Inc.	NYS	24.31	0.78	35.07	24.31	17.00	5	Pacificare Health Sys.	NDO	70.00	5.66	-13.85	86.25	55.50	218	
Berkley W.R. Corp.	NDO	58.06	4.97	14.41	60.50	43.00	437	Ohio Casualty Corp.	NDO	45.88	-1.34	29.23	48.06	31.75	85	Safeguard Health Enter.	NDO	12.00	-1.03	-31.43	20.75	9.63	14	
Berkshire Hathaway Inc.	NYS	43800.00	5.54	28.45	48600.00	30000.00	1	Old Republic Int'l	NYS	37.13	3.30	38.79	37.38	21.75	566	Sierra Health Services	NYS	34.63	5.12	40.61	35.50	22.38	115	
Capital RE Corporation	NYS	52.19	2.71	11.93	56.38	36.88	54	Orion Capital Corp.	NYS	43.13	1.91	41.72	45.00	25.00	198	United Healthcare Corp.	NYS	53.00	9.00	17.78	60.13	35.13	5375	
Capital Transamerica Corp.	NAS	26.00	0.00	-15.45	27.50	14.13	2	Partner Re Ltd.	NYS	40.00	0.63	17.65	42.50	27.88	304	Wellpoint Health Networks	NYS	55.69	2.41	62.00	57.50	28.25	470	
CapMac Holdings Ltd.	NDO	27.81	0.23	-16.																				

Construction
site

Shanghai

9 April
1100 hrs



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