

Business Insurance

Reporting weekly for corporate risk, employee benefit and financial executives • \$2.00 a copy; \$80 a year

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Federal judge bars offsets in Transit Casualty liquidation

KANSAS CITY, Mo.—A reinsurer of Transit Casualty Co. cannot offset amounts it owes the now-defunct insurer by amounts Transit owes the reinsurer in unpaid premiums, a federal court has ruled.

The decision could allow Transit's liquidator to recover between \$150 million and \$300 million in reinsurance proceeds, said Burleigh Arnold, Transit's special deputy receiver.

Transit was placed into receivership
Continued on next page

Airlines' rates could increase 250% to 300% upon renewal

By STACY SHAPIRO

LONDON—Airline hull and liability insurance rates are ready to take off when major world airlines begin to renew their coverage on Oct. 1.

Although no airline has yet completed its autumn renewal, underwriters and brokers say that rates could climb as much as 250% to 300% compared with last year's renewals.

Rates have been steadily rising all year, but no airline has been hit with increases of this magnitude.

In addition, airlines that renew their coverage in November could see even more severe rate increases, some brokers say.

All told, airlines representing 77% of the world's fleet value renew their insurance programs in the fourth quarter.

While the size of the potential rate increases is attracting the at-

tention, insurers are focusing on the increase in the actual premiums paid by the airlines. Premiums for airlines are based not only on the rate but also on the value of an airline's fleet and the number of revenue passenger miles it logs.

Cash-hungry aviation underwriters are seeking sharply increased premiums to help them pay for their year-end excess-of-loss reinsurance placements, many sources agree. Aviation excess-of-loss reinsurance costs are expected to rise 400% to 500% compared with a year ago, if the coverage is available at all.

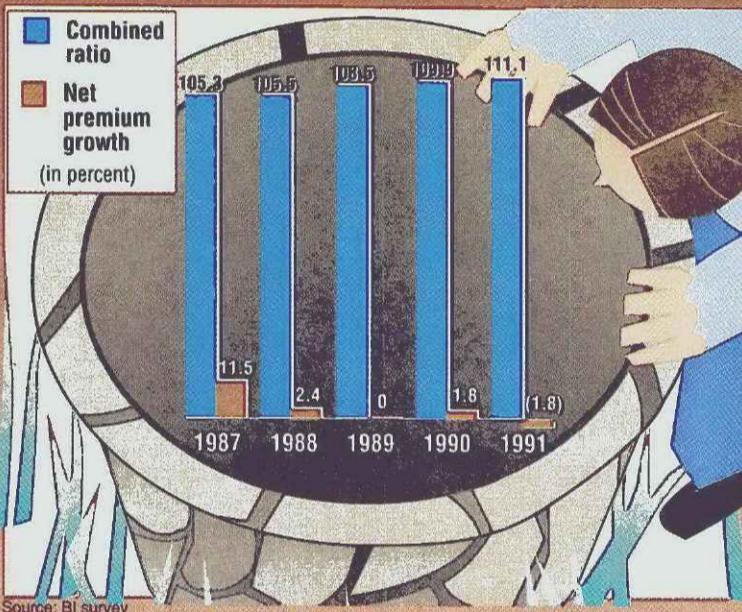
Not only are rates rising, but aviation insurers, to ensure they have the cash needed to buy reinsurance, are insisting that airlines pay their premiums more quickly.

The Oct. 1 aviation renewal season "is going to be painful," summed up Geoffrey Hargreaves,
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P/C results gloomy, but health profits up

Is the bottom in sight?

Commercial property/casualty insurers' first-half combined ratios pierced the 110% mark for the first time since 1985 while premium volume actually declined in the first half.



Combined ratios jump sharply

By DOUGLAS McLEOD

Commercial property/casualty insurers' results continued their long, slow decline in the second quarter with no signs of improvement on the horizon.

Unabated rate competition, weather-related losses and other factors combined to produce more of the same sad song: stagnant or falling premium volume, widening combined ratios and flat earnings.

For the first six months of this year, the 30 U.S. property/casualty insurers tracked by *Business Insurance* reported a 1.8% drop in net premium volume, a sharp increase in their combined ratio to 111.1% from 109.9% and a 0.9% decline in net income, even after profits were boosted in some cases by signifi-

cant capital gains.

"It was somewhat disappointing. We were hoping for improvement," said Alan Levin, senior vp with Standard & Poor's Corp. in New York. "Clearly, the industry is not engaging in very restrictive underwriting. They are still competing too much."

"Basically, I saw a continuation of the trends that have been in place in 1990 and through 1991," including low rates, increasing weather-related claims and disappointing underwriting results, said Michael Lewis, first vp with Dean Witter Reynolds in New York.

"There's basically nothing new. It's the same old story," agreed Gloria Vogel, first vp with Lehman Bros. in New York.

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Health insurer competition may return

By LORI BLOCK

Group health insurers are pleasantly surprised at how well their bottom lines held up during the first six months of the year, especially in light of predictions that 1991 could mark the start of a competitive market.

Three factors in particular helped stave off a downturn for health insurers: actual experience has been lower than the insurers' trend factors, improved earnings within many insurers' managed care operations and growth in some insurers' administrative-services-only business.

However, benefit managers looking for relief from huge premium increases also are getting some good news: There are signs of increasing competition among group health insurers, which could translate into lower insurer profits, perhaps as early as 1992.

"It's clear that health results held up more positively than expected," said Mike Touhy, a managing director in New York with Tillinghast, a division of Towers, Perrin, Forster & Crosby Inc. "It's been a surprise."

"We've been expecting the worst. Thank God we haven't realized it yet," said Jim Galasso, vp and actuary with Metropolitan Life Insurance Co. of New York.

"I guess I would have expected to see a slowdown of results by now," said Dave Young, a consultant in the Washington, D.C., office of The Wyatt Co. Instead, the numbers look decidedly good, he said.

In fact, five of the seven major group health insurers contacted by *Business Insurance* reported that profits rose in the first half.

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Agency halts rate rollbacks

Garamendi plans to appeal blockage

By LOUISE KERTESZ

SACRAMENTO, Calif.—California Insurance Commissioner John Garamendi's plan to invoke emergency regulations implementing Proposition 103 this week and order more than \$2.5 billion in refunds to policyholders is again stalled.

The California Office of Administrative Law, which reviews state regulations, last week blocked Mr. Garamendi's emergency request to approve formulas that would implement the controversial initiative, including his proposal to allow insurers only an aggregate 10% rate of return in determining rate rollbacks. The OAL said no emergency exists.

In addition, insurers' legal

challenges to Mr. Garamendi's regulations are increasing.

More than 100 insurers have joined a state court action begun in April by 84 companies that seeks, among other things, a halt to hearings implementing Proposition 103.

And several insurers last week filed challenges to the Proposition 103 regulations in federal court, contending the regulations would violate their constitutional rights.

Mr. Garamendi likened the insurers and their attorneys to "the plotters of the botched Kremlin coup" and called the OAL's decision to block Proposition 103 refunds "misguided." He said he would appeal the OAL's decision to Gov. Pete Wilson.
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Health insurers targeting fraud by rolling medical labs
Page 3

Liberty Mutual underwrote comp coverage for N.C. plant
Page 2

NFL owners ordered to pay \$36.6 million to pension plan
Page 4

Transit reinsurer denied offset

Continued from previous page in December 1985.

U.S. District Judge D. Brook Bartlett's Aug. 28 ruling came after American Re-Insurance Co. of Princeton, N.J., requested that such offsets be made. American Re claimed that the reinsurance contract states the contract is subject to New York law, which allows reinsurance offsets.

However, Judge Bartlett ruled that Missouri law applied because Transit was incorporated and domiciled there.

Applying Missouri law, the judge found that there was no statutory or common law right to reinsurance offsets.

American Re is considering appealing the decision, said Robert M. Hall, general counsel and secretary. "We think the decision is wrong. A broad right of offset is appropriate in these circumstances."

Lloyd's acts to boost capacity

LONDON—Lloyd's of London is reverting to its old way of calculating syndicates' gross premium capacity to increase the market's real capacity next year in anticipation of rate increases.

The Council of Lloyd's last week agreed with an interim recommendation by a task force that syndicates should be allowed to exceed their allocated premium capacity by 25% next year.

However, this allowance will be granted only if the syndicate proves that 25% of its business is ceded to reinsurers on quota-share basis, said Lloyd's Chief Executive Alan Lord.

If Lloyd's total allocated capacity drops nearly 10% next year, as expected, to about 10 billion pounds (\$16.95 billion at current exchange rates) from 11.1 billion pounds (\$21.42 billion at applicable exchange rates) this year, then allowing syndicates to exceed their allocated premium capacity will enable the market to write up to 2.5 billion pounds (\$4.23 billion) of additional premiums.

Syndicates were allowed to exceed their allocated capacity by 30% until 1988, after which they were restricted to writing up to their allocated limits (BI, Aug. 29, 1988).

Mr. Lord said speculation that record member resignations will leave Lloyd's short of capacity next year has been "overdone." This action will "make sure that the capacity we have is better used," he said.

"In my considered judgment, Lloyd's will have more than enough capacity in 1992," he said.

Mr. Lord also responded to allegations that Lloyd's has violated requirements of the U.S. Securities and Exchange Commission (see earlier story, page 29). Lloyd's held "extensive" discussions with the SEC in 1988, he noted. "We are perfectly clear that what we've done to recruit members in the United States is within SEC requirements."

A federal judge in Denver has ruled that he lacks jurisdiction to hear a U.S. member's suit alleging that Lloyd's breached U.S. securities law by not registering with the SEC. Lloyd's maintains that members can sue only in British courts.

Work comp insurer insolvent

HARRISBURG, Pa.—A Pennsylvania state judge has ordered the liquidation of Rockwood Insurance Co., a workers compensation insurer based in Rockwood, Pa., that regulators say is insolvent by \$81.4 million.

Rockwood—which had been placed in rehabilitation July 27—has 3,436 open claims in 33 states, including 1,427 in Pennsylvania. Of the Pennsylvania claims, 1,130 stem from workers comp policies and 297 are stem from other property/casualty policies, the Pennsylvania Insurance Department announced.

The liquidation order does not affect Rockwood Casualty Co., a Rockwood subsidiary that continues to write business, the Insurance Department said.

Separately, the Pennsylvania department has obtained a liquidation order against Building Industries Exchange of Pottstown & Vicinity Group Health & Disability Plan, an unlicensed Pottstown, Pa.-based group health insurer. BIE Plan wrote group health coverage for about 220 small businesses in the Pottstown area, the department says.

Pennsylvania regulators ordered BIE Plan to cease operations in May and filed a liquidation petition June 5.

Lloyd's moves Gooda members

LONDON—Lloyd's of London is appointing a substitute agent to handle the affairs of 240 members now managed by members agent Gooda & Partners Ltd. who have been hit with losses by syndicates managed by sister agency, Gooda Walker Ltd.

Lloyd's last week announced that it would create Additional Underwriting Agencies (No. 6) Ltd. to take over the management of Gooda & Partners. AUA (No. 6) will be operated by Oxford Members Agency Ltd., a subsidiary of Sturge Holdings P.L.C.

The fate of Gooda Walker Ltd. remains unclear. Although attempts have been made to sell the underwriting agency, no announcements have yet been made. Lloyd's Chief Executive Alan

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Errors and omissions

• A story and chart in the Sept. 2 issue incorrectly reported the market value of the Old Republic International Corp. stock owned by Chief Executive Officer A.C. Zucaro. Mr. Zucaro actually held 56,246 shares with a value of \$1.7 million. The story and chart had included stock that is held by Old Republic pension and other benefit programs under Mr. Zucaro's name.

• An article in the Sept. 2 issue incorrectly reported that Phil Gallagher, a U.S. member of Lloyd's of London, would join litigation against Feltrim Underwriting Agencies Ltd. if such an action were filed.

GOP health proposal

Republicans may revive cap on tax-free benefits

By JERRY GEISEL

WASHINGTON—A Senate Republican task force is resurrecting a Reagan administration proposal to tax employees on a portion of their benefits, but it also is proposing to strip tax breaks from employers that offer expensive health care plans or that do not require employee copayments.

Under the draft proposal, employees would be taxed on employer-paid health care premiums that exceed a certain—but not yet specified—level. And employers would not be allowed to take tax deductions on health care expenses that exceed that level.

Employers also could not take a tax deduction for any health care costs if their health care plans did

not require employees to pay at least 20% of claims for physician expenses.

However, the draft proposal would exempt some small employers from laws requiring insured health plans to cover specific procedures. Small employers would be exempt if they form special group purchasing cooperatives and purchase health insurance with a certain—but not yet specified—level of coverage.

In addition, the proposal would exempt certain managed care plans from state laws regulating the plans (BI, Aug. 19).

The draft proposal also would revamp medical malpractice laws to limit the size of malpractice awards against physicians and hospitals. And, it would increase

tax incentives for the self-employed to buy health insurance.

Finally, the proposal calls for states to establish new programs to provide health care plans for people earning less than 200% of the federal poverty level. It does not specify how such programs would be funded.

The draft proposal, which benefit experts say could be changed considerably before it is officially released, is being prepared by a task force of about a dozen Republican senators chaired by Sen. John Chafee, R-R.I.

Benefit observers say the draft proposal is an effort to reduce the party's potential political vulnerability on health care issues.

Both Senate and House Demo-

Continued on page 18

HMO/PPO information requested

Business Insurance will publish its fifth annual Managed Care Market Report in December, listing health maintenance organizations and preferred provider organizations nationwide along with reports on the state of the alternative health care market.

The report will be published as a special issue in addition to the regular weekly edition of BI. All subscribers will receive this issue free of charge.

In addition to addresses and phone numbers, the directories will provide information on individual HMOs and PPOs, including federal and state qualification; model type; number of participating physicians, hospitals, pharmacies and diagnostic labs; service areas; services offered and rating options; and the number of employers contracting with the organizations.

The directories are published as an editorial service. There is no charge to be included, but HMOs and PPOs must complete and return a BI questionnaire by Sept. 30.

HMOs that have not yet received a questionnaire should contact Editorial Assistant Karen Armaganian at 312-280-3195. PPOs should contact Directory Editor Sarah Polster at 312-649-5279.

Liberty Mutual covers workers in N.C. plant fire

By DOUGLAS McLEOD

HAMLET, N.C.—Liberty Mutual Insurance Co. writes the workers compensation coverage for the food processing company whose North Carolina plant was the site of one of the nation's worst industrial fires.

Twenty-five people died and at least 54 were injured Tuesday in a flash fire that swept through an Imperial Food Products chicken processing plant in Hamlet.

The fire was caused by a leak of pressurized, combustible hydraulic fluid that vaporized and ignited after splattering against the side of a 26-foot-long deep frying vat, according to Dave Campbell, an arson investigator with the North Carolina State Bureau of Investigation.

A high-pressure hose that helped drive a hydraulic motor had recently been replaced and came uncoupled, creating the leak, Mr. Campbell said.

The fire, he added, "was strictly an industrial accident" and was not caused by any safety violation or crime.

A carbon dioxide fire extinguishing system installed above the fryer, designed to put out grease fires, was not activated by the fire, said Mr. Campbell.

The building had no sprinkler system. And though Mr. Campbell said the state building code did not require one for the plant, state of-

ficials are investigating whether the lack of sprinklers violated building and fire safety codes, said Tim Bradley, a deputy North Carolina insurance commissioner and head of the Insurance Department's fire and rescue services division.

Mr. Campbell expressed doubts that sprinklers could have extinguished the fireball that rapidly filled the building with smoke.

The 25 people killed died of carbon monoxide poisoning.

Fire exits were not marked, and two doors leading out of the building were locked, according to Mr. Bradley.

He added that the lack of marked fire exits "apparently" was a violation of fire safety codes, though the nature and extent of the violation is still under investigation.

The state building code would require a similar plant built today to have a sprinkler system, while the fire code requires regular maintenance and inspection of such systems, Mr. Bradley said.

Safety and health inspectors from the state Department of Labor never inspected the Imperial Food plant because of a lack of manpower, a department spokesman said.

North Carolina is one of 23 states that operates its own workplace safety inspection program with approval from the federal Occupational Safety and Health Administration.

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Inside

✓ National Football League owners must pay \$36.6 million into a players' pension plan to make up for payments they refused to make to the overfunded plan. **PAGE 4**

✓ Mandatory introduction of information about a defendants' wealth likely will be used to determine the depth of the defendants' pockets before seeking punitive damages, says this week's editorial. **PAGE 8**

✓ Reviewing insurers' second-quarter results, stock analyst Myron M. Picoult notes that his firm recently lowered 1991 and 1992 earnings estimates for most property/casualty insurers. **PAGE 39**

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Vol. 25, No. 36—Business Insurance (ISSN 0007-6864) is published weekly by Crain Communications Inc., 740 N. Rush St., Chicago, Ill. 60611-2590. Second-class postage is paid at Chicago, Ill., and at additional mailing offices. Postmaster: Send address changes to Business Insurance, Circulation Department, 965 E. Jefferson Ave., Detroit, Mich. 48207-3185; 800-678-9595 or 313-446-1611. Copyright 1991 by Crain Communications Inc.

House could act on fraud bill this fall

By MARK A. HOFMANN

WASHINGTON—A bill that would create federal criminal penalties for insurance fraud could become part of broader legislation expected to be considered by the House of Representatives later this fall.

The bipartisan House measure is drawing a positive response from regulators and insurance trade groups, both of which earlier had praised similar, though not identi-

cal, insurance fraud legislation passed by the Senate.

The House bill, H.R. 3171, was introduced last month by Reps. John D. Dingell, D-Mich., and Jack Brooks, D-Texas. It was referred to the House Judiciary Committee, which is chaired by Rep. Brooks.

A spokesman for the Energy and Commerce Committee, which drafted the measure, said it is "likely" that H.R. 3171 would be attached to an omnibus crime bill sponsored by Rep. Brooks.

That is the same approach used in the Senate, where insurance fraud provisions closely paralleling the House bill were attached to S. 1241, an omnibus anti-crime measure. That bill was passed in July (BI, July 15).

Like the Senate measure, the House bill would make several acts a federal crime, including:

- Knowingly filing a fraudulent financial statement or report with a state insurance regulator.
- Falsifying company records

with the intent to defraud an insurer or policyholder.

• Tampering with proceedings before state insurance regulators.

But the House and Senate measures differ in several areas:

- Maximum penalties under the House measure would be a \$500,000 fine per organization per violation or a \$250,000 fine per individual per violation/and or 10 years in prison. Under the Senate bill, the maximum penalties would be \$1 million in fines/and or 30

years in prison.

In explaining the lighter penalties contained in the House proposal, a House Energy and Commerce committee staff memorandum accompanying the draft version of the bill said that the Senate penalties, drawn from federal standards dealing with bank fraud, "are grossly out of sync with regular criminal fraud penalties (typically five years)."

The House measure also would
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Insolvencies prompt firms to reconsider safety of GICs

By CHRISTINE WOOLSEY

COLORADO SPRINGS, Colo.—



Employers whose savings plans purchase guaranteed investment contracts are more closely scrutinizing the insurers that issue

GICs amid growing concern over insurer solvency, a survey shows.

However, the vast majority of benefits executives surveyed say they are confident their firms' defined contribution plan fiduciaries are fulfilling their duties in evaluating, selecting and monitoring GIC issuers.

Registrants at the annual International Foundation of Employee Benefit Plans' Corporate Benefits Conference last month responded to an informal IFEBP survey on

GIC issuers.

Of the 139 respondents, 71—or 51.1%—said their companies sponsored participant-directed defined contribution plans that offer a GIC investment option. Of those people, 45% said that their companies had conducted additional evaluations of issuers within the past three months specifically because of solvency concerns.

"I think there's a lot of nervousness out there on the part of employers," said Craig J. Davidson, an IFEBP research associate who prepared the survey.

"You've got employers out there that have contracted with a GIC provider back when that provider was rated triple-A. Then the employer goes back to making widgets or whatever and next thing you know, a company like Executive Life goes under."

Employer concern over the fi-
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Appeal planned after judge hikes bad faith award

By STACY ADLER

SAN DIEGO—Maryland Casualty Co. says it will appeal a bad faith judgment awarded to a former policyholder as well as the decision of a San Diego trial judge to more than triple the size of his original award.

Characterizing the insurer's actions as "vile, despicable and loathsome," San Diego Superior Court Judge Donald Meloche on Aug. 26 increased an insurance bad faith award against Maryland Casualty to \$7.9 million after the plaintiff's attorney sought review of the award. Judge Meloche had awarded the plaintiff \$2.4 million when he issued his original verdict in June.

The amended award includes \$375,000 in compensatory damages and \$7.5 million in punitive damages.

Maryland Casualty is appealing the award. "We feel very strongly that our position will be upheld on appeal," the company said.

The award came in a case in which the Baltimore-based insurer

was accused of bad faith in refusing to defend a commercial automobile and comprehensive general liability policyholder sued for negligence.

While judges have the power to increase or reduce a jury award based on the facts of the case, it is highly unusual for a judge to increase an insurance bad faith award, attorneys say.

In fact, several attorneys who specialize in insurance bad faith litigation said they have never before seen a judge triple a bad faith award.

"This is very unusual," said Michael O'Connor of Christensen, White, Miller, Fink & Jacobs in Los Angeles.

"While judges do have a lot of discretion at the trial level, because this is so unusual the appellate court will look at it closely," Mr. O'Connor predicted.

"It's hard for insurers to complain too loudly when a judge exercises his discretion to increase a damage award," said Royal Oakes of Barger & Wolen in Los Angeles.
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Risk Manager of the Year

Ten independent judges to select 1992 winner, honor roll

Ten independent judges from all sectors of the risk management profession and the insurance industry will select the 1992 *Business Insurance* Risk Manager of the Year and the Risk Management Honor Roll.

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

Candidates for the 1992 awards can be nominated now. Nomination forms are available from *Business Insurance's* Chicago office.

Nominations must be submitted by Nov. 19.

The 10 judges who will select the 1992 honorees include the 1991 Risk Manager of the Year, the three members of the 1991 Risk Management Honor Roll, two insurance company executives, two brokerage executives, a risk management consultant and an insurance professor.

The judges for the 1992 competition are:

• Donald D. Batchelor, risk manager for Union Planters Corp. in Memphis, Tenn. Mr. Batchelor was named to the 1992 Risk Management Honor Roll representing financial institutions.

• Percy Chubb III, vice chairman of Chubb Corp. in Warren, N.J. Mr. Chubb is serving on the panel of judges for the first time, representing a stock insurance company.

• Arnold L. Davenport, vp-risk management for Marriott Corp. in Bethesda, Md., and the 1991 Risk Manager of the Year.

• Mary L. DeCampi-Stewart, risk manager for the Metropolitan Washington Airports Authority in Washington, D.C. Ms. DeCampi-Stewart was named to the 1991 Risk Management Honor Roll, representing government entities.

• Larry D. Gaunt, professor of risk management and insurance in the College of Business Administration at Georgia State University in Atlanta. Mr. Gaunt, who is serving on the panel for a second year, represents the academic community.

• H. Felix Kloman, a vp and principal with Tillinghast, a division of Towers, Perrin, Forster & Crosby Inc. in Stamford, Conn. Mr. Kloman, who also is serving on the panel for a second year, represents risk management consultants.

• John A. Kohler, chairman of Brandow Howard Kohler & Rosenbloom Inc. in Minneapolis. Mr. Kohler was named to the 1991 Risk Management Honor Roll representing financial institutions.
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Mr. Batchelor



Mr. Chubb



Mr. Davenport



Ms. DeCampi-Stewart



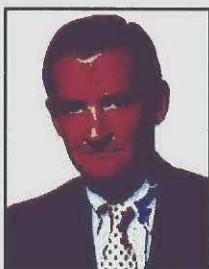
Mr. Gaunt



Mr. Kloman



Mr. Kohler



Mr. Trowbridge



Mr. Umscheid



Mr. Wallace

Stung by alleged fraud, they increase vigilance

Labscam jolts insurers

By LOUISE KERTESZ

LOS ANGELES—Health insurers—stung for tens of millions of dollars in allegedly fraudulent claims by a Southern California rolling medical lab scheme alone—are building their arsenal against similar schemes.

Operations patterned after the Smushkevich rolling labs in Southern California are operating nationwide, though on a smaller scale, insurers say. They add that health insurance fraud is generally on the rise.

But, beefed-up fraud detection staffs are tipping off health insurers to possible fraudulent claims,

preventing the payout of millions of dollars in phony claims, insurers say.

And, the fraud detection staffs are now using computer programs—designed to spot irregularities involving providers' tax identification numbers on claim forms, among other things—to flag possible fraudulent claims.

Insurers say they are now more alert to the problem of rolling labs, but they believe employers, employees and lawmakers can do more to combat health care fraud.

For example, insurers want policyholders to ask their employees to be alert for fraud and to report it. Indeed, several insurers have es-

tablished toll-free numbers individuals can call to report suspected fraud.

Some insurers are paying "bounties" to employees and dependents enrolled in group health insurance plans who report questionable billing practices.

Meanwhile, a bill is wending through the California Legislature that calls for taxing health insurers and employers that self-insure their health care plans to pay for increased investigations and prosecution of health care insurance fraud.

A federal grand jury in Los Angeles on July 8 returned a 175-
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Court orders NFL pension contributions

By LORI BLOCK

RICHMOND, Va.—National Football League owners must contribute \$36.6 million into a players' defined benefit pension plan to make up for payments they refused to make to the overfunded plan, a federal appeals court has ruled.

However, the 4th U.S. Circuit Court of Appeals on Aug. 30 ruled 3-0 that NFL management trustees did not breach their fiduciary duty in how they handled the pension funding dispute with the NFL Players Assn.

The decision centers on the Bert Bell National Football League Retirement plan, a Taft-Hartley plan established in 1969 that covers players active through the 1983 season. The plan, which was funded by some player contributions, is jointly administered by

management and player trustees.

Beginning with the 1989 season, players have been covered by the Pete Rozelle NFL Player Retirement Plan, a defined benefit plan funded and administered solely by team owners.

Both plans offer identical retirement, disability and death benefits. The Rozelle plan succeeded the Bell plan following negotiations between owners and players in 1988 and 1989.

The dispute—in which both sides filed suits and countersuits beginning in 1987—arose over the interpretation of the 1982 collective-bargaining agreement between the owners and the players. The contract requires owners to make annual contributions of \$12.5 million to the Bert Bell plan.

However, in 1987, NFL owners sought a ruling that would allow

them to defer contributions because the plan was overfunded. They argued that since the plan was overfunded, their contributions would not be tax-deductible. The 1982 collective bargaining agreement specified that the contributions would be deductible.

Trustees representing the players argued that the owners should increase monthly benefits to eliminate the surplus. Doing so would allow the owners to receive a tax deduction for their contributions, the player trustees contended.

But the owners countered that the collective bargaining agreement does not authorize them to change plan benefits.

When the owners refused to improve the plan's benefits, the players' trustees charged that they had breached their fiduciary duty.

The appeals court upheld a fed-

eral district court ruling that the owners had to continue contributing to the plan. The appeals court explained that the club owners misinterpreted a section of the Bert Bell plan that reads: "The employers guarantee that contributions will be paid into the trust on or before the last day of each plan year, provided that such contributions are allowable as deductions under the applicable provisions of the (Internal Revenue) Code."

The appeals court said: "The clubs assert that this provision obligates them to pay only those contributions that are allowable as deductions when paid. We agree with the district court, however, that the term 'allowable as deductions' contains no temporal limitation. Because under the Internal Revenue Code the clubs can carry forward any contributions not de-

ductible in the year they are paid, the plan requires that the full \$12.5 million be paid each year."

The court also ruled that the board of trustees has authority to increase plan benefits, "and the exercise of that power would largely resolve the problem of which the clubs complain": that their contributions are not deductible because the plan is overfunded.

However, the 4th Circuit overturned a portion of the district court's decision and ruled that the management trustees did not breach their fiduciary duty in refusing to improve plan benefits. The court, in refusing to order the benefits be improved, ruled that "it is for the trustees and not for the courts to determine the extent of any benefit increase."

An NFL spokesman stressed that the appeals court in this portion of its ruling sent a message to the players' union that increases in benefits should be negotiated, not sought in the courts.

"After four years of litigation, no benefit increases have been ordered" by the court, the NFL spokesman observed.

Neither side plans to appeal the decision.

The \$36.6 million award includes the \$17.8 million in principal that club owners said in their 1987 lawsuit they did not have to contribute to the plan because it was overfunded, according to players' attorney Joseph A. Yablonski, a partner with Yablonski, Both & Edelman in Washington, D.C.

The rest of the judgment represents interest and attorneys' fees, Mr. Yablonski said.

The funds will be paid from an escrow account established by the league when the dispute initially arose, according to the NFL spokesman.

In the meantime, the owners and players still are litigating over the owners' refusal to make a nearly \$1.2 million contribution to the Rozelle plan for the same reasons they stopped contributing to the Bert Bell plan.

The federal district court ruled for the players in the Rozelle case, and the owners appealed. However, both sides agreed to a stay of the litigation until the 4th Circuit ruled in the Bert Bell case.

"The player trustees are now armed with a ruling" supporting their position, Mr. Yablonski said. "I would imagine that the management trustees... will go along" with the decision, he said.

In a related case settled in June, NFL owners agreed that the administrators of the Rozelle plan will comply with the Employee Retirement Income Security Act and provide plan information to the players. This suit was filed in February (BI, Feb. 25).

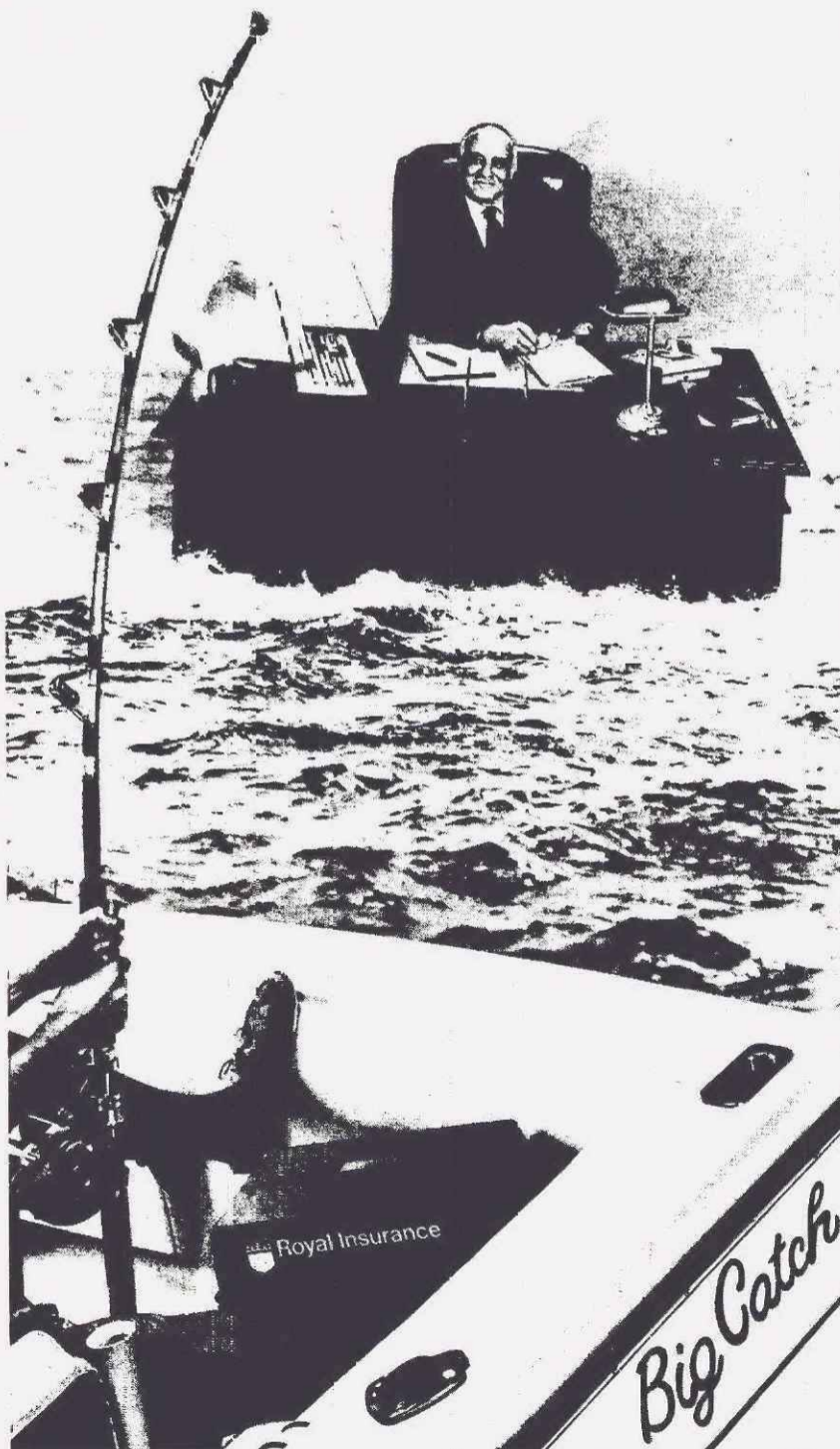
William V. Bidwill et al vs. National Football League Management Council et al, U.S. Court of Appeals for the 4th Circuit; No. 91-2308.

New BI bureau in California

Business Insurance Association Editor Judy Greenwald, who has been based in BI's New York bureau since 1984, will open a new Northern California bureau this week.

Ms. Greenwald, who will continue to report on insurance and reinsurance industry topics among other subjects, can be contacted starting Sept. 11 at 540 Latimer Circle, Campbell, Calif. 95008; 408-379-1790; fax: 408-379-3257.

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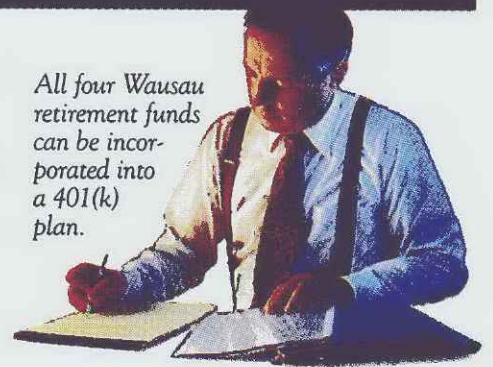
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Opinions

Rulings don't add up

TWO "RIGHTS" CAN make a "wrong," as a recent California Supreme Court ruling proves. The ruling, which requires evidence of a defendant's wealth to be introduced before punitive damages can be assessed, could result in large, financially strong companies being hit with even larger punitive damage awards.

The first "right" was a March U.S. Supreme Court ruling that held that the Constitution requires proper jury instruction in cases involving punitive damages and significant judicial review of punitive awards, thereby signaling Congress, judges and state legislatures that unbridled punitive damages is a problem ripe for reform.

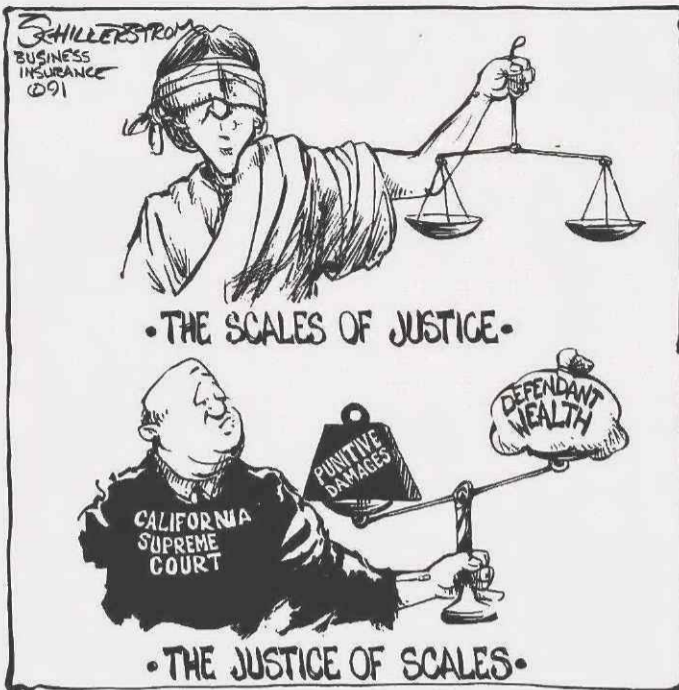
The second "right" came last month as the California high court, in responding to the Supreme Court's decision, ruled that plaintiffs must introduce evidence of a defendant's wealth before punitive damages can be awarded by a jury (BI, Sept. 2). Judge Marvin Baxter, in writing for the majority, noted that even if a punitive award is entirely reasonable in light of the defendant's misconduct, "the award can be so disproportionate to the defendant's ability to pay that the award is excessive for that reason alone."

We agree with Judge Baxter's reasoning. We do not believe that defendants that have behaved abhorrently should get off the hook for only the cost of that behavior, but we also do not believe that juries should have the right to punish companies for small transgressions by assessing multimillion-dollar punitive awards—and possibly bankrupting the companies.

While agree with the spirit of the decision, we have doubts that it will be applied in that spirit. Rather than protect companies from excessive punitive awards, we believe that mandatory introduction of information about defendants' wealth will be used to determine the depth of the defendants' pockets. The wealth of the defendant—rather than its actions—will be the determining factor in assessing a punitive award.

While evidence about a defendant's wealth already is introduced by plaintiffs' attorneys in most cases in which punitive damages are sought, in order to identify deep pockets, the California court's ruling will just formalize this injustice.

We also are disturbed that the California court did not define how a defendant's wealth should be assessed. We're convinced that creative plaintiffs' attorneys will stress the indicator of a defendants' "wealth"



that will result in the largest award for their clients, whether that be revenues, profits, net worth, etc.

We believe the size of the punitive damage award should be in proportion to the wrongfulness of the defendant's conduct, not the depth of his pockets. Defendants should not be assessed large punitive damage awards simply because of their size.

Finally, the California court may have intended to help defendants, but we wonder what benefit they will derive from the requirement to have their bank account balances, loans, real property values, stocks, bonds and other investments probed. As Judge Stanley Mosk said in his dissenting opinion: "If this requirement, this compulsory invasion of privacy, is being fundamentally fair to defendants, one wonders what the majority would consider to be unfair."

Both the U.S. and the California supreme courts' rulings—while well-intended—will result in even more unfair punitive damage awards. The rulings further underscore the need for state and federal laws strictly limiting the size of punitive awards.

Judge Baxter admitted in the California ruling that "the determination of whether an award is excessive is admittedly more art than science." We think it's time to remove this artistic interpretation from the punitive damage process.

Letters

Federal regulation would end many MEWA problems

To the editor: I read with interest the article "Federal Certification of MEWAs Proposed" in the July 22 Washington column.

H.R. 2773 is long overdue, and we commend Rep. Thomas E. Petri, R-Wis., for his initiative and leadership in introducing this legislation. The Self-Insurance Institute of America Inc. supports federal regulation of self-funded multiple-employer welfare arrangements and is pleased to have played an early role in developing a federal approach to the MEWA problem, which led to the introduction of H.R. 2773.

Passage of H.R. 2773 will eliminate the current confused regulatory climate that

threatens the existence of thousands of viable MEWAs that provide affordable health coverage to small businesses. H.R. 2773 also will eliminate abuses in the practices of certain MEWA operators who lack the knowledge to manage such plans on a sound ongoing basis.

However, we take objection to several comments made by Wisconsin Insurance Department General Counsel Fred Neple.

The states have had the right to regulate self-funded MEWAs since the passage of the 1982 amendment of the Employee Retirement Income Security Act of 1974. However, few states have taken responsible regulatory action.

Instead, many states have taken the position that such arrangements were unauthorized insurance and have attempted to shut them down rather than develop proper regulation that recognizes the right of financially sound MEWAs to continue to operate. Federal action will go a long way to solve the problem.

In addition, the National Assn. of Insurance Commissioners was invited to participate in a joint federal and state approach to regulation of MEWAs under

an earlier draft of the proposed bill; however, we understand it rejected the offer.

With the passage of H.R. 2773, legitimate MEWAs sponsored by associations, chambers of commerce or other multiple-employer business groups that can meet federal certification requirements will be able to operate free of state regulation and fill a very important need for the small business community. Those MEWAs that fail to meet the requirements will fall squarely on the shoulders of state regulators, thus ending the jurisdictional debate.

Hundreds of industry associations and employers, administrators and excess insurers support Rep. Petri's federal approach. We would hope that state regulators and the NAIC will join in support of this legislation, too. By doing so, we should be able to weed out the "bad guys" and provide an opportunity for the "good guys" to continue to provide a much-needed service.

James A. Kinder
Executive Vp
Self-Insurance Institute
of America Inc.
Washington, D.C.

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At issue

How do you encourage 401(k) plan participation?



Kevin M. Bolton
Senior Director-
Employee Ben-
efits/Contract
Plans
**Greyhound
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Some non-highly compensated employees stopped contributing to our 401(k) plan when we filed for Chapter 11. However, response has been good since we changed our match to 100% for the first \$1,200 contributed, from 50% for the first 6% contributed. We also contribute \$100 into every employee account so that non-participants receive a quarterly statement.



Ellen C. Lobato
Manager-
Benefits &
Compensation
Guaranty National Insurance Co.,
Englewood,
Colo.

We offer employees a means of saving for retirement via a 401(k) plan. Employees can contribute 2% to 10% of their pretax earnings annually. They have the choice of two investment funds, a fixed fund and a diversified equity fund. Our high participation ratio is associated with the match we provide, which for the past five years has been 100% up to 6%.



Tom Harrison
Manager-Cor-
porate Benefits
& Services
Stratus Computer Inc.,
Marlboro, Mass.

Participation in our 401(k) plan is currently at 71%. I'm committed to improving that number to an 80%-plus level by educating non-participants. All employees will receive a personalized letter showing their total if they had been participating at 3% of their pay for four years. If our young employees realize the match money they're losing, maybe they will join the plan.



Beverly E. Khosh
Manager, Em-
ployee Benefits
American Restaurant Group Inc.,
Newport Beach,
Calif.

We have offered a 401(k) plan for three years. We made several significant changes to our plan this year: daily valuation, a loan feature and a company match. Enrollment has increased by almost 30% in the past six months! For a comparatively small benefit expenditure, we have been able to offer a successful "win-win" program to our employees.

Compiled by Sara Harty

Fraud legislation

Continued from page 3

impose a maximum prison term of 15 years for cases of fraud that jeopardize the safety and soundness of an insurance company.

• The House bill would levy civil penalties for violations of the law, whereas the Senate did not address civil penalties. H.R. 3171 would authorize the imposition of a civil penalty of up to \$50,000 for each violation, or an amount equal to the amount of compensation that person received or offered for the illegal conduct, whichever is greater.

Also under the House bill, "if the offense has contributed to the insolvency of an insurer which has been placed under the control of a state insurance regulatory agency or official, such penalty shall be remitted to the regulatory official of the insurer's state of domicile for the benefit of policyholders, claimants and creditors of such insurer."

• The House bill would require that any act of embezzlement covered by the proposal involve at least \$5,000 to qualify as a federal crime. The Senate version sets a \$100 minimum.

According to the staff memo accompanying the draft version of H.R. 3171, the lower Senate threshold could clog federal courts with minor cases best dealt with by state courts.

Despite their differences, the House measure has attracted widespread support from regulators and insurers, both of which also supported the Senate legislation.

"We're very supportive of either the House or the Senate bills," said James Long, North Carolina insurance commissioner and president of the National Assn. of Insurance Commissioners. The Senate insurance fraud provisions were based on an NAIC model law introduced earlier this year.

Mr. Long downplayed the significance of any differences between the House and Senate legislation. "What we're interested in is the overall thrust" of the legislation.

"We stand ready to work with the House and the Senate to resolve the differences to enact a law that makes insurance fraud a federal crime," Mr. Long said.

"We do prefer the House bill over the Senate version," said Melissa Wolford, director of federal affairs for the American Insurance Assn. in Washington, D.C.

"It's a much tighter bill. It has a civil cause of action that provides that the return of funds would be to the insurer," said Ms. Wolford. She noted that the original NAIC model bill on which the Senate measure was modeled also lacked civil recovery provisions.

David M. Farmer, vp-federal affairs for the Alliance of American Insurers in Washington, D.C., also praised the House measure. "We believe that the general concept of an insurance crime bill is a good approach in that it is a targeted approach to specific problems."

The provision in the House bill that specifies that civil penalties assessed against those deemed responsible for an insurer's insolvency be paid to the insolvent insurer's estate is "an interesting and novel idea," Mr. Farmer said.

The AIA's Ms. Wolford said that provision was particularly attractive because "we're trying to make the policyholder as whole as possible."

"Overall, state regulation is improving by the day. This proposal would be a key companion to the overall state-federal cooperative venture," said Mr. Farmer, referring to proposals that would give the federal government a role in the regulation of insurers. He added, however, that the Alliance continues to believe that the states should have the primary responsibility for insurance regulation. ■

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Benefit managers take the 'life span' approach

By CHRISTINE WOOLSEY

COLORADO SPRINGS, Colo.— Meeting the needs of an increasingly diverse workforce is the newest challenge facing employee benefit professionals, a human resources consultant says.

A number of workforce changes are affecting the four R's of human resources, which are: recruiting, retention, retraining and retirement, according to Victor S. Barocas, president of Strategic Management, a New York-based consulting firm that focuses on aging, benefits and human resource management.

For example, women and older workers comprise an increasingly larger portion of America's workforce.

In addition, the emergence of a global marketplace is forcing U.S. benefit managers to examine what their overseas competitors are doing in the area of benefits and compensation.

Moreover, "the complexion of American businesses is changing," Mr. Barocas said. "The 1980s saw mergers and acquisitions. Now in the 1990s, we're in an era of restructuring and downsizing," which has caused many employees to become disillusioned, he said.

However, several human resources strategies are available to help employers cope with those workforce changes, Mr. Barocas said during a session at the third annual Corporate Benefits Conference sponsored by the International Foundation of Employee Benefit Plans in Colorado Springs last month.

American businesses that want to maintain employee loyalty and morale must begin thinking in terms of "a life span approach to human resource management," which includes offering employees

a choice of work arrangements, Mr. Barocas said.

For example, some employers may wish to offer alternative work arrangements like flextime or working at home, he said.

Flextime allows full-time employees to complete work responsibilities on a schedule other than the standard 9 a.m. to 5 p.m., but usually requires employees to work a set number of hours, he said.

Work-at-home programs typically allow employees to complete their full- or part-time responsibilities at home and may or may not involve computers or other electronic ties to the office, he said. Working mothers, in particular, favor this flexibility, he added.

Another strategy—the "life plan-

early-career employee "will probably change jobs seven times before he retires. He is likely to have one or two divorces, he is highly mortgaged, living on credit and is highly dependent on the employer for benefits," Mr. Barocas explained. As a result, employers should "teach these employees good saving habits and stress the importance of starting early."

Mid-career employees, on the other hand, may have to care for "dependent parents or children," Mr. Barocas said. "They are stressed and strapped financially, but they are in their peak earning years." Employers should focus on ways to help this group save money and should offer them benefits like child care and elder care, he said.

Late-career employees may want advice on how to make the nest egg they have saved over their working lives last through retirement, according to Mr. Barocas. This type of guidance is extremely useful, especially in an era of uncertain economic times, he said.

For example, "retirees who say that their home is their nest egg may have to be counseled about the soft real estate market," he explained. "Old homes aren't necessarily selling, so maybe these retirees should think about relocating."

The life planning approach also enables corporations to communicate their human resources philosophy to employees, enhances the corporate image and improves employee relations, he noted.

Phased retirement is another strategy available to employers. Mr. Barocas defined this strategy as "a discrete and voluntary human resource practice allowing active employees to reduce their regular work schedule prior to retirement."

Phased retirement "hasn't been used in the United States much; it's much more popular in Europe," Mr. Barocas said. However, "it

Continued on next page

'Now in the 1990s, we're in an era of restructuring and downsizing,' says Mr. Barocas.

ning" approach—allows employees to develop personal, flexible "blueprints" to achieve their work and retirement goals, Mr. Barocas said. Companies that have embraced this human resources approach educate employees on financial planning, health and welfare benefits, career development and legal and estate planning, he explained.

"Employers are saying to employees, 'We can no longer be paternalistic, but we can provide you an education so you will be secure,'" he said.

If taking the life planning approach, employers must differentiate among the needs of early-career, mid-career, late-career and retired employees, he said.

For example, younger employees could require education about financial planning, he said. An

GIC issuers

Continued from page 3
Financial stability of GIC issuers has been triggered by the collapse of Los Angeles-based Executive Life Insurance Co., which California regulators seized in April (BI, April 22).

Executive Life sold about \$1.9 billion of GICs to savings plans, generally 401(k) plans.

A proposed agreement between the National Organization of Life & Health Insurance Guaranty Assns. and the California Insurance Department that would make whole most individual policyholders of Executive Life Insurance Co. will offer no relief to holders of the insurer's GICs, who could receive only an estimated 81 cents on the dollar (BI, Sept. 2).

Several employers whose savings plans purchased the Executive Life GICs are being sued by participants, who are demanding that the employers cover any benefit losses resulting from the insurer's collapse (BI, May 27).

Still, 31% of the respondents said their companies had not evaluated GIC issuers in the past three months. "You have to wonder why they didn't, or if they know something you don't," Mr. Davidson said.

Fourteen percent of respondents did not know whether such evaluations had been made, and 10% did not answer.

"Some have suggested the controversy surrounding a small segment of the insurance industry will

prompt organizations to change their policies toward sponsoring GICs," according to Mr. Davidson.

Eighty-two percent of the benefit executives said their companies fulfilled their fiduciary duties of monitoring their GIC issuers' financial condition by periodically evaluating those issuers. Seven percent said their companies did not conduct periodic evaluations, 3% did not know and 8% did not respond.

Of those conducting periodic evaluations, 14% said they were conducted monthly; 38% said quarterly; 7% said semiannually; 22% said annually; and another 7% of the respondents said evaluations were conducted at time intervals other than those listed.

Twelve percent of respondents whose companies did conduct periodic evaluations of their GIC issuers' financial condition either did not know how often their companies conducted the evaluations or did not respond.

Mr. Davidson pointed out that despite concerns about the solvency of insurers that issue the contracts, 85% of respondents said they were satisfied that their organization's defined contribution plan fiduciaries are fulfilling their responsibilities for evaluating, selecting and monitoring GIC issuers.

Four percent expressed dissatisfaction, and 11% either did not respond or did not know.

Many benefit executives also re-

ported using a variety of ways to choose among the insurers that issue GICs. Most—63%—said their companies took into consideration the recommendations of outside, independent advisers.

Other popular strategies included using published ratings from independent ratings agencies, used by 51% of the respondents, and relying on assessments by in-house staff, used by 48%.

Only 8% of the respondents said their companies used information shared with other plan sponsors. Another 8% cited other methods, and 3% said they were unsure how their companies selected GIC issuers.

Nearly one-fourth—23%—of those surveyed said their companies had changed or planned to change their policies regarding GIC contracts because of recent insurance company failures.

One respondent wrote: "We have recently purchased a company with GICs and plan to move away (from them) as they become mature."

Another commented that it had "decreased (the) number of GICs held from 20 to one."

A free copy of the survey, "Fiduciary Responsibility: The Plan Fiduciary/GIC Provider Relationships," is available from the Public Relations Department, International Foundation of Employee Benefit Plans, P.O. Box 69, Brookfield, Wis. 53008; 414-786-6700.



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**International Foundation
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Self-insuring: Is it good for what ails work comp?

By CHRISTINE WOOLSEY

COLORADO SPRINGS, Colo.— Employers should consider self-insuring their workers compensation risks to contain skyrocketing costs and to guard against the lack of commercial workers comp insurance in some states, a risk management consultant suggests.

However, employers that self-fund workers comp risks must set up comprehensive loss control and claims management programs to control costs, he added.

"Workers comp is fast becoming

the top risk management issue of the 1990s," said James A. Swanke Jr., director of risk management services for The Wyatt Co. in Boston.

"The workers compensation system is no longer accomplishing the goals set out" when it was created, he said during a workshop at the third annual Corporate Benefits Conference sponsored by the International Foundation of Employee Benefit Plans last month in Colorado Springs.

A hard workers comp insurance market haunts employers across the country, Mr. Swanke said. "Workers comp premiums on a percentage basis have outstripped the Consumer Price Index" in the

Continued on next page

'Life span' benefits

Continued from previous page may be an approach we have to look at with the aging workforce," he said.

By allowing workers to reduce their hours, rather than entirely end active employment, phased retirement allows a company to retain experienced workers for a longer period, which can minimize the negative impact and skill losses that result from mandatory retirement or workforce reductions, Mr. Barocas said. In addition, it "provides an on-the-job mentor to train a prospective replacement," he said. And, keeping older workers as active staff members provides added contributions to the company's pension plan, he noted.

Employees favor phased retirement because it often provides a smoother transition into retirement and also enables retirees to explore different post-retirement work or leisure options before actually becoming a "retiree," Mr. Barocas said.

However, this strategy also poses some disadvantages both to employers and to employees, he said. For example, employers may find book-keeping and timekeeping more complex if the program is not well-managed. And, coverage problems may arise if employers do not establish a clear benefits policy for phased retirees. Among other things, employers must decide whether these workers will receive full or pro-rated benefits, Mr. Barocas said.

Employees, on the other hand, may suffer reduced income, reduced Social Security benefits and possibly reduced pension benefits if they agree to phased retirement, he noted. In addition, some phased retirement programs compress rather than reduce the job responsibilities so that employees end up doing the same amount of work in less time, he said. And, a phased program can lower an employee's perceived job status, since he or she is working less than full time.

Retiree skill banks represent another strategy for dealing with the aging workforce, Mr. Barocas said. This creates a "temporary pool of former employees who are hired on an ad hoc, periodic or contractual basis," he explained.

Using retiree skill banks can reduce expenses associated with temporary services and recruitment, he said. And, because the retiree knows the company, he will provide technical and project-specific expertise that an outside temporary worker could not provide.

In addition, retiree skill banks provide part-time employment for retired workers who desire meaningful activity but prefer to work somewhere more rewarding than the local discount store, Mr. Barocas said.

Richard P. Day, executive vp of business development at Ameritas Life Insurance Corp. in Lincoln, Neb., moderated the session. ■

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AIG Life taps O'Connell as president

Robert J. O'Connell named president and chief executive officer of AIG Life Insurance Co. of Wilmington, Del., the domestic life branch of American International Group Inc.

Since joining AIG two years ago from New York Life Insurance Co., Mr. O'Connell had been senior vp of its international life insurance division. Mr. O'Connell replaces **Paul A. Finkel**, who resigned.

Also at AIG, **Ron Judd**, the long-time executive director of the Risk & Insurance Management Society Inc., joined the insurer as a consultant.

And **Robert Patterson** promoted to vp in the pollution legal liability division of AIG subsidiary Commerce & Industry Insurance Co.

Other insurer changes:

Walter E. Farnam appointed chairman and chief executive officer of General Accident Corp. of America, a Philadelphia-based unit of General Accident Fire & Life Assurance Corp. P.L.C. of Scotland. He replaces **James C. Corcoran**, who is retiring after 15 years as chairman. Succeeding Mr. Farnam as president and chief operating officer is **Frank J. Coyne**, who had been executive vp.

At Blue Shield of California, **Charles W. Stewart** named to succeed **Thomas C. Paton** as chief executive officer. Mr. Paton has announced he will retire as CEO at year end. Mr. Stewart is now president and chief operating officer. Other appointments have not been announced.

Ronald F. Wilkins named manager of the Toronto branch of un-

Comings & goings: industry

derwriting manager **Wm. H. McGee & Co. of Canada Ltd. Patricia Bodkin** and **Teri Bourne** were named claims managers at the Toronto branch.

Gary Pingel appointed vp-underwriting at Pioneer State Mutual Insurance Co. of Flint, Mich.

Fireman's Fund Insurance Co., an Allianz A.G. Holdings unit in Novato, Calif., announced these changes: **Joe Stinnette**, formerly head of the personal insurance division, named chief administrative officer; and **John Meyer**, who had been senior vp and chief financial officer for Fireman's Fund's personal insurance division, named chief financial officer and executive vp.

Thomas D. Nimmo elected senior vp and controller for Ranger Insurance Co., an American Ranger Inc. unit in Houston.

Elaine Netz promoted to vp of commercial underwriting administration at Guaranty National Insurance Co., an Orion Capital Corp. unit in Englewood, Colo.

Zurich-American Insurance Group, a Zurich Insurance Co. unit in Schaumburg, Ill., announced these changes: **Jeanne H. Eddy**, who had been an executive vp with USF&G Corp., named president of the group's national accounts division; **Richard C. Brady** named to head reverse flow operations at a new Zurich office in Glendale, Calif.; and **Vincent A. DeConti** named director of field opera-

tions for reverse flow business.

Continental Corp. of New York announced these changes: **Timothy L. Mitchell** named senior vp and chief underwriting officer in Continental's Special Operations Group; succeeding Mr. Mitchell as president of the group's Continental Insurance Healthcare division is **Joan Wilson**; **Allan B. Pooler** named vp-underwriting for the special operations group; and **Bonita Boone** named senior vp-underwriting in the health care division.

Leland H. Beman promoted to vp in the financial division of Orion Capital Corp. in Farmington, Conn. Orion Capital, where Mr. Beman will be responsible for corporate ceded treaty reinsurance and pool and association run-off obligations, is the parent of five speciality property/casualty companies.

Richard W. Caby promoted to resident vp in Tampa, Fla., with Fidelity & Deposit Cos., a Baltimore-based Swiss Reinsurance Co. unit.

Herman J. Hebbeler, the national underwriting manager for property and commercial multiperil coverage in the commercial lines division, named a vp at Chubb & Son Inc., a Chubb Corp. unit in Warren, N.J.

John H. Pritchett named vp of casualty underwriting with Alliance General Insurance Co. of Chicago.

Donald B. Sharp elected vp at Crum & Forster Corp. of Basking Ridge, N.J., where he will be respon-

sible for corporate ceded treaty reinsurance and corporate risk management.

Harrison Rose named senior vp with The Navigators Group Inc. of New York, where he will be responsible for the ceded reinsurance operations of Navigators' insurance units.

Dennis M. Hyland named vp of underwriting for Harleysville Mutual Insurance Co. of Harleysville, Pa.

Nationwide Mutual Insurance Co. of Columbus, Ohio, announced these changes: **Jerry D. Daughtry**, a vp who had been in charge of Virginia operations, will run the Canton, Ohio, office, succeeding **Larry Nightingale**, who is retiring after 36 years with Nationwide. Replacing Mr. Daughtry in Lynchburg, Va., will be **James P. McCormick**; **Reuben A. Gainey** will replace **Ralph A. Rhodes**, who is retiring, as vp and manager of the New England operations in Wallingford, Conn.; replacing Mr. Gainey, who had been vp-manager of the Gulf States region is **C. Thomas Starr**; and **Thomas L. Crumrine**, who has been vp of agency services, named manager of a consolidated office in Columbus.

Steven S. Zeitman promoted to executive vp and chief underwriting officer and **Mary Jane Robertson** to executive vp and chief financial officer with United Capitol Insurance Co. of Atlanta.

Agents/brokers

Frank B. Hall & Co. Inc. announced these changes: **Thomas E. Reed** joined Frank B. Hall & Co. Inc. of Fairfield/Westchester as vp; and **Frederick W. Lydic** joined Frank B. Hall & Co. of Missouri Inc. of St. Louis as a vp and manager of loss control services.

Marc Federman joins Near North Insurance Brokerage Inc. of Chicago as senior vp in its Beverly Hills, Calif., office.

Sedgwick James Ltd. announced these changes: **George Siekielski**, who had been vp of Sedgwick James of Houston, appointed regional director of Sedgwick James' Sedgwick Power & Nuclear Services division; and, in the Houston office, **Steven B. Steinberg** joined as vp of risk management services and **James P. Hancock** joined as vp.

Lionel McCray promoted to vp of Jardine Insurance Brokers Arizona Inc. in Phoenix.

Alexander & Alexander Services Inc. of New York announced these changes: **Daniel J. McCutcheon** named managing vp of the A&A Inc. office in Philadelphia; and **Warren J. Mula** appointed managing vp of the Lyndhurst, N.J., office.

Reinsurance

Laurence W. Cheng named senior vp and chief financial officer of Centre Reinsurance Holdings Ltd. of Bermuda. Mr. Cheng had been president and chief executive officer of Zurich International (Bermuda) Ltd., a unit of Zurich Insurance Co., which is a major Centre Re shareholder.

Edward J. Stanco, who had been a vp with Balis & Co. in Philadelphia, joined Reliance Reinsurance Corp. of Philadelphia as senior vp. And **James C. Clausing** named vp with Reliance Re.

Paul A. Giacobbe joined National Reinsurance Corp. of Stamford, Conn., as vp/account executive in the treaty marketing department.

David A. Buzen appointed chief financial officer of Capital Re Corp. of New York, succeeding **Raymond J. Krepfle**, who is resigning.

Jean M. Stalcup promoted to vp and manager of the facultative medical/professional department with Employers Reinsurance Corp. of Overland Park, Kan.

Michael J. Schell appointed senior vp-domestic underwriting for St.

Paul Re, a unit of The St. Paul Cos. Inc. in St. Paul, Minn. Succeeding Mr. Schell as vp-ceded reinsurance is **John J. Coderre Jr.**

Roy B. Pomerantz and **George R. Nebel** promoted to senior vps at the management unit of Security Reinsurance Co., an Orion Capital Corp. unit in Farmington, Conn.

American Re-Insurance Co. of Princeton, N.J., announced these changes: **Kenneth J. LeStrange**, who will remain executive vp of subsidiary Am-Re Managers Inc., promoted to senior vp; **Joseph O'Dowd** named vp in the claims division; **Frederick Roe** named vp in the facultative division; **Akiharu Amano** named vp of Afro-Asian operations in Tokyo; **Thomas Vicenik** promoted to vp in the Chicago office; and **Diana Wiebers** appointed vp of underwriting management services.

Diane V. Bistany was promoted to vp with General Reinsurance Corp. of Stamford, Conn.

Lawrence P. Johnsen named vp-contract wording in the treaty casualty department of Prudential Reinsurance Co. of Newark, N.J.

Other suppliers

Marilyn J. Willenbrink named vp at Crawford & Co., a risk management services and claims adjusting firm in Atlanta. She will also be director of Sentinel Medical Review Services, a division that sells a software program for auditing doctors' bills for work-related injuries.

Andrew McComb named senior vp-client services for Alexander Insurance Managers Ltd. in Hamilton, Bermuda, a captive management subsidiary of Alexander & Alexander Services Inc.

Olwen Maher has been appointed development manager in Continental Europe for Alexander Insurance Managers. He will be based in the Dublin, Ireland, office.

Stephen D. Linehan appointed chief executive officer with American PsychManagement Inc. of Arlington, Va., a managed health care subsidiary of Value Health Inc.

Francis J. Lattanzio joined Price Waterhouse as managing partner in the actuarial consulting services group in Hartford, Conn., part of the accounting firm's insurance services group.

Deborah D. Gould has joined Carolyn Davis Associates Inc. of White Plains, N.Y., a professional search firm for the insurance industry.

Donald W. Goon named president of Benefits Consultants Inc. of Eden Prairie, Minn., an employee benefit consulting firm that Mr. Goon helped found.

Dr. Edward H. Lipson joins Ernst & Young as director of its Northern California actuarial, consulting and benefits practice. Dr. Lipson, who had been a principal and head of managed care network consulting with William M. Mercer Inc., will be based in San Jose.

Dr. H.G. Whittington named medical director of Managed Health Network Inc. of Los Angeles. Dr. Whittington had been program executive with the managed mental health division of Prudential Insurance Co. of America.

Robert W. Webb joined A. Foster Higgins & Co. Inc. as a managing consultant and retirement income practice leader for the Central region in Cleveland.

Pagnani, Ruderman, Semel & Rosenblum, a White Plains, N.Y., law firm that maintains an insurance defense practice, named two new partners: **James B. Rosenblum**, formerly a partner with Wilson, Elser, Moskowitz, Edelman & Dicker of New York; and **Patrick J. Filan**.

Henry C. Drews joined Insurance Consulting Services Inc. of Northbrook, Ill., as principal and claim consultant.

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Bad faith award

Continued from page 3

"Plenty of carriers have benefited from the exercise of judicial discretion in the other direction. In this case, though, the idea of tripling an award that started out in excess of \$2 million seems irresponsible," Mr. Oakes said.

Maryland Casualty contends in a statement that Judge Meloche "made significant errors of law and fact" in reaching his decision.

"There is a strong body of law in California and other states that supports our position that there is no coverage," the insurer said. It would not comment beyond the

prepared statement.

The policyholder's attorney, Bruce Sulzner of Sulzner & Belsky in San Diego, refused to return repeated phone calls after issuing a press release announcing the amended award.

The policyholder, James E. Etheridge, owner of Etheridge Trucking Co., was one of several people named in a civil lawsuit brought in 1985 by the family of a 5-year-old boy who was seriously injured when he was crushed by a concrete slab in a dump where the defendants—including Etheridge Trucking—had been hauling dirt and debris. Mr. Etheridge eventually faced a judgment of \$4.4 million

stemming from the case, according to Mr. Sulzner's press release.

Maryland Casualty alleges that Mr. Etheridge failed to pay premi-

'Tripling an award that started out in excess of \$2 million seems irresponsible,' says Mr. Oakes.

ums and that the comprehensive general liability and commercial automobile policy had been can-

celed months before the accident. However, despite Mr. Etheridge's failure to pay his premiums, Maryland Casualty still provided him with a "rigorous defense" for more than a year, the insurer said.

When advised by outside counsel that the claim was probably not covered, Maryland Casualty then filed a lawsuit in San Diego Superior Court seeking a declaration that it did not owe any coverage.

"There was an order entered by (a Superior Court judge) that absolved Maryland Casualty of any obligations whatsoever toward Mr. Etheridge based on a finding that his claim was not covered," according to the Maryland Casualty

statement.

That order was later set aside, but the insurer still believed that it did not owe Mr. Etheridge a defense.

Mr. Etheridge subsequently sued Maryland Casualty for bad faith refusal to pay the claim.

The day before the bad faith trial began, Maryland Casualty paid the injured boy's family \$3.3 million to settle the \$4.4 million judgment against Mr. Etheridge.

Maryland Casualty noted in its statement that no efforts were made to obtain the money from Mr. Etheridge until all efforts were exhausted to obtain the money from Maryland Casualty. ■

GOP health care proposal

Continued from page 2

ocrats have been aggressively pushing their own health care reform proposals. For example, Senate Democratic leaders in June introduced legislation that would require employers to offer health care coverage or pay new taxes (BI, June 10).

And a new bill introduced by House Ways and Means Committee Chairman Daniel Rostenkowski, D-Ill., also would impose new taxes on employers that do not offer health care plans. The Rostenkowski bill also would gradually lower the age at which retirees would be eligible for federal Medicare benefits to 60 from 65. Employers and employees would be hit with new taxes to fund a new public health care plan for the uninsured as well as the costs created by lowering the Medicare eligibility age (BI, Aug. 19).

With Democrats promoting these plans, "Republicans feel a need to respond. It isn't enough for Republicans to say, 'We oppose national health insurance or mandated cov-

erage.' They need an alternative," said Frank McArdle, a consultant in the Washington, D.C., office of Hewitt Associates.

"Republicans feel they need a positive program rather than just being negative," agreed Dr. Roger Taylor, a consultant and national leader for health care at The Wyatt Co. in Washington, D.C.

But one element of the Republican draft proposal—taxing employees on a portion of employer-paid health care premiums—is not a new idea. In 1984, as part of tax reform legislation, the Reagan administration proposed that employers' health care expenses that exceeded \$175 a month for family coverage and \$70 a month for individual coverage be included as taxable income to employees.

That proposal later was withdrawn amid a barrage of opposition from employers, insurers and labor unions.

The latest proposal by the Republican Senate task force does not yet specify at what level the taxes would begin.

And, unlike the Reagan administration plan, the Republican task force plan also would bar employers from taking tax deductions for health care expenses that exceed this benchmark.

Employer opposition, which helped kill the earlier tax cap, has not abated.

Business groups contend that the proposal would penalize employers and employees simply because they are located in areas with high medical costs. For example, two companies could offer health care plans that provide identical benefits. One company—located in the area of the country with relatively high costs—would be affected by the provision because the cost of its plan exceeded the limit in the proposal. But the other, located in an area with lower costs, would be unaffected.

"It is impossible to have a health care tax cap that is rational and equitable," asserted Ellen Goldstein, director of health care policy at the Assn. of Private Pension and Welfare Plans in Washington, D.C.

Other benefit experts say employees could be exposed to big medical bills under a provision that would bar employers from taking tax deductions on their health care plan expenses unless their plans required at least a 20% copayment for physician expenses.

"Unless there would be a stop-loss provision capping out-of-pocket expenses, there would be a point in time where the costs would be too much for employees," said Henry Saveth, a principal with A. Foster Higgins & Co. Inc. in New York.

Other observers say, however, that the GOP draft proposal does contain some features that would benefit employers, like pre-empting state laws regulating managed care plans.

"This does some positive things for managed care," said Stuart J. Brahs, vp-federal government relations in the Washington, D.C., office of The Principal Financial Group, a diversified insurance and financial services company.

The malpractice reform propos-

als were also well received by benefit experts.

Among other things, the draft proposal would cap medical malpractice awards for non-economic damages at \$350,000, while periodic payments would be required for all awards exceeding \$100,000.

In addition, joint and several liability would be eliminated for non-economic damages in cases involving multiple defendants. Each defendant's liability for damages would be limited to his or her percentage of fault.

The draft proposal also would cap attorneys fees in medical malpractice cases to 25% of the first \$150,000 of an award or settlement and 15% on amounts exceeding \$150,000.

"Getting a handle on malpractice costs is vital if you want to try to control health care expenses. If you can control costs, you can improve access to health care," Mr. Brahs said.

"A lot of frivolous suits could be eliminated," said Wyatt's Dr. Taylor. ■

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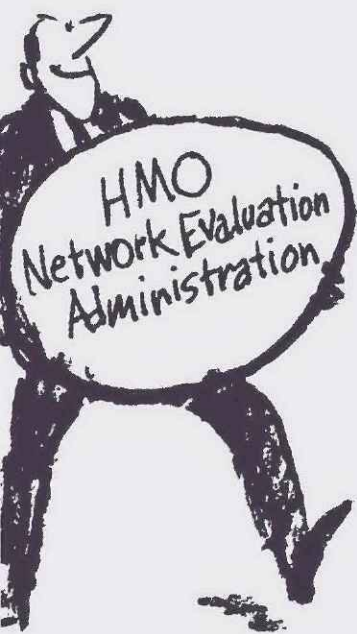
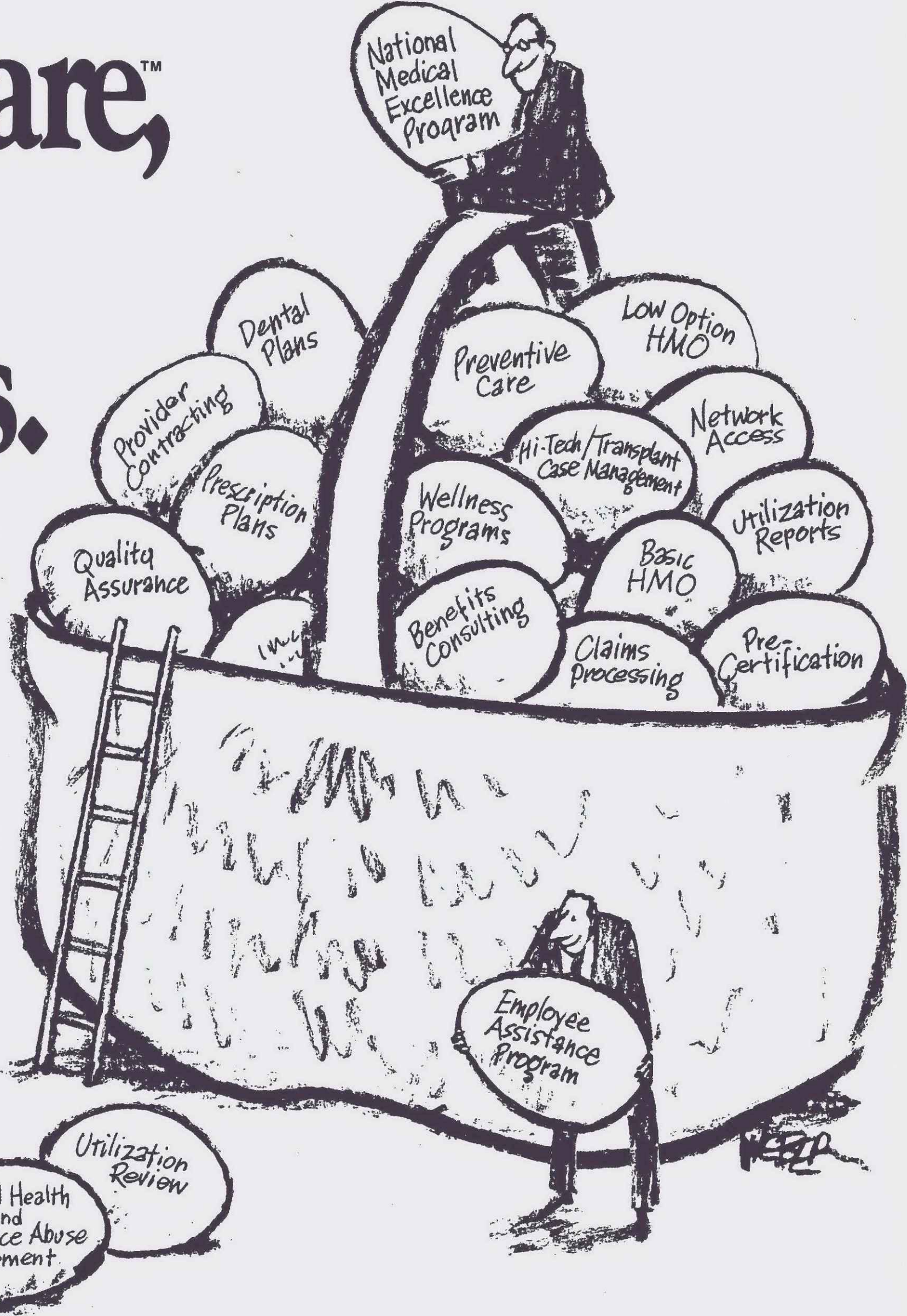
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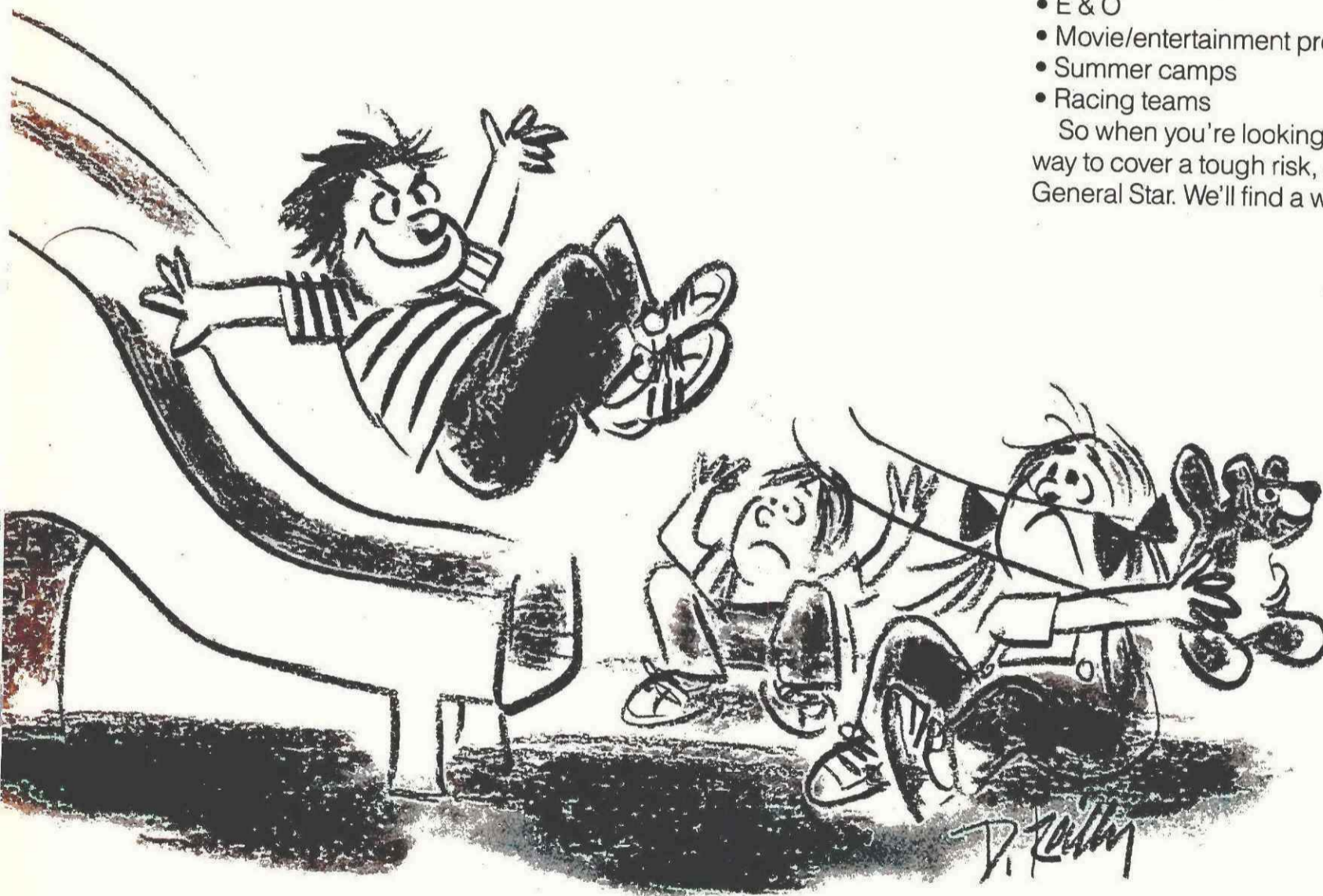
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ASK A BENEFITS MANAGER

Flexible accounts offer rare win-win situation

Q

Flexible spending accounts appear to be fairly popular. My company currently does not offer such a plan. Keeping in mind that we do not want to incur additional cost, should we consider offering a flexible spending account plan?

A

Flexible spending accounts are one of the few plans that can be a win-win situation for both employers and employees.

From a cost perspective, there certainly will be initial start-up costs to the employer to cover legal documentation and

communication expenses, but most ongoing administration expenses can be offset if the plan is designed to have expenses paid by employee forfeitures. Additionally, employees do not pay FICA taxes on any amounts deferred in an FSA. Since the employer matches the FICA taxes paid by the employee, the employer saves the expense of those FICA taxes.

An FSA can be a substantial positive for employees who have eligible dependent care expenses and/or health care expenses not reimbursed by a medical plan. The benefits to the employee are the taxes not paid on both dependent care and health care expenses. For example, if an employee is incurring \$5,000 of dependent care expenses plus \$1,000 of health care expenses, this employee could save up to \$2,319 in taxes annually. This assumes a federal tax rate of 28% (\$1,680), a state tax rate of 3% (\$180) and the FICA tax rate of 7.65% (\$459). Employers, too, will undoubtedly react positively to saving additional tax dollars.

To see the positive aspects of an FSA plan, it is helpful to compare it to a 401(k) savings plan. Most employees appreciate the value of 401(k) plans as demonstrated by high participation rates. One of the key elements of a 401(k) plan is that it saves the employee current tax dollars and defers the taxation of income to a time (retirement) when the employee is in a lower income bracket. An FSA plan takes the

Why offer a flexible spending account? Surveyed employers say the most common reason is to ease the impact of employee cost sharing in group medical plans.

tax savings one step further—you never pay taxes on amounts deferred in an FSA.

In the above example the employee avoids \$2,319 in taxes. If the employee were to defer the same \$6,000 of income in a 401(k) plan, the employee could defer only the payment of \$1,860 in taxes, since FICA taxes must be paid on amounts deferred in a 401(k) plan. Therefore, in an FSA the employee is avoiding taxes that would have been paid on the amount deferred, compared with the 401(k) plan in which the payment of taxes is deferred and the amount of taxes lowered—but not eliminated.

Why offer an FSA?

According to a Hewitt Associates survey on this issue, the most common reason employers gave for offering a health care FSA was to ease the impact of employee cost sharing in group medical plans. As health care costs continue to escalate, many employers have shifted the increasing burden of health care costs through increased deductibles and

copayments. Since the deductible and copayment amount paid by the employee can be reimbursed through an FSA, the impact of these larger costs can be minimized. The net result is that the employee is paying for a portion of his or her medical cost on a pretax basis.

The most common reason employers gave for offering a dependent care FSA was to meet the demand for a day care benefit, the survey found. As the number of dual wage earner and single-parent families continues to increase, the demand for day care also rises. Since daycare costs are reasonably high, employees are looking for some relief from these expenses. A dependent care FSA provides the opportunity for employees to pay for their dependent care expenses on a pretax basis.

Both health care and dependent care FSAs are well appreciated by those employees who use the plan. In today's competitive marketplace, having an FSA to offer to employees provides employers with another vehicle to attract and retain the high quality employees they desire.

How does a health care FSA work?

Employees are given the opportunity annually to decide to participate in the health care FSA and, if so, at what level. Plans will generally specify a minimum and maximum amount that employees can contribute to an FSA health care account. According to surveys, the average employee contribution is \$564, while the average maximum contribution for a health care FSA is approximately \$2,900. Contributions to the FSA are taken from each paycheck throughout the year.

Once an employee makes a decision regarding the amount to contribute, that amount cannot be changed nor can contributions be suspended unless there is a change in "family status." A family status change includes: marriage or divorce; death of spouse or dependent; birth or adoption of child; a significant change in health coverage of the employee or spouse due to the spouse's unemployment; or an unpaid leave of absence taken by the employee or employee's spouse.

Any change in FSA contributions must be consistent with the specific family status change. For example, if a child is born, one would expect the amount contributed to the account to increase.

Expenses that may be reimbursed from the health care FSA are medical expenses incurred during the specific plan year that are not reimbursed by an insurance plan. Expenses also must meet definitions outlined in Section 213 of the Internal Revenue Code. These regulations have been interpreted to mean those expenses incurred primarily for the prevention or alleviation of a physical or mental defect or illness.

(Although it may not sound appealing, reviewing the IRS regulations can be entertaining. For example, I found that an eligible covered medical expense is "clarinet and (clarinet) lessons for alleviation of severe teeth malocclusion." At the same time, I found that a "fallout shelter for prevention of disease" was denied eligibility.)

Employers must decide whether their plan will reimburse all expenses as outlined in Section 213, or an employer may choose to be more restrictive in defining the items to be reimbursed.

Typical items employees may consider as eligible expenses include:

- Medical and dental plan deductibles and copayments.
- Eye exams, contact lenses and eyeglasses.
- Expenses for hearing care.
- Prescription drugs.
- Uncovered orthodontia or other dental expenses.

Examples of items that would not be considered covered medical expenses include non-prescription drugs and vitamins, health club memberships or programs not prescribed by a doctor for health reasons.

Once an employee incurs an eligible expense, the proper documentation would be sent to the plan administrator for reimbursement. IRS guidelines provide that employees be reimbursed on at least a monthly basis and when the total amount of reimbursable expenses equals a specified reasonable minimum amount (e.g., \$50).

A key element of an FSA—and one that concerns many employees—is the "use it or lose it" rule. What this means is that employees who don't use all of their FSA funds by the end of the coverage period forfeit any remaining funds.

Reviewing the IRS regulations can be entertaining. For example, I found that an eligible covered medical expenses is "clarinet and lessons for alleviation of severe teeth malocclusion."

These forfeitures can be used to offset the employer's expenses of administering the plan, to reduce a participant's contribution to the plan in the following year or may be returned to all plan participants as dividends or premium refunds.

When making such refunds, though, the allocation to employee accounts cannot be based on actual claims experience of the participants. According to a study conducted by the Employers Council on Flexible Compensation and William M. Mercer Inc., 16% of participants on average failed to use the entire amount available in their accounts in 1990, with an average forfeiture of \$102.

It is interesting to note the approach taken by employers regarding what was done with the excess in the plan. The survey found that the most common practice by far was to pay administrative expenses (53%), and "keeping it" was the second most common practice (19%). Various other uses included returning it to participants.

A recent change in the regulations for health care FSAs (revised IRS regulations became effective for 1990 plan years) now provides for what I call a "deficit account," which also is called the "uniform coverage" requirement. What this means is that employees must be entitled to their full amount elected annually on the first day of the plan year. Employers may no longer limit reimbursements to the amount actually contributed to date. A deficit account is best explained by an example.

An employee enrolls in the company's health care FSA plan for an annual amount of \$1,200. Fifty dollars is deducted from each paycheck and contributed to the employee's reimbursement account. During January, the employee incurs \$800 of unreimbursed medical expenses and submits those expenses to the FSA plan administrator in early February. At this time, a total of only \$100 had been contributed to the employee's account. However, the employer is obligated to reimburse the employee for the full amount of expenses (in this case, \$800) up to his annual projected contributions.

When the regulations regarding deficit accounts were announced, employers with FSA plans promptly announced their concerns about the potential of absorbing additional costs under these plans. Some actions taken by employers in response to these regulations included:

- Reducing the maximum allowable contribution to the plan.
- Limiting those items that may be reimbursed under the plan.
- Implementing waiting periods for participation in the FSA.

According to the ECFC/Mercer study, the actual impact of the regulations during the first full year of operation was very favorable. Ninety-four percent of companies reported that financial results were

Continued on next page

Flexible spending accounts

Continued from previous page

equal to or better than they expected when the regulations were proposed. The main reason for excess reimbursements was due to employees terminating employment.

How does a dependent care FSA work?

A dependent care FSA generally works in the same manner as a health care FSA. The major differences between the health care and dependent care FSA are:

- Annual maximums for a dependent care plan generally are higher.
- The "deficit account" does not apply to the dependent care plan.
- An employee can spend the accumulated funds in a dependent care account after the employee's termination.

The annual maximum amount that can be contributed to a dependent care account is \$5,000, or \$2,500 if an individual is married and filing a separate tax return. If an employee and spouse both participate in dependent care reimbursement accounts, the total maximum contribution to both accounts is \$5,000. For example, if an employee contributes \$3,000 to a dependent care FSA, the spouse could not contribute more than \$2,000.

According to IRS guidelines, an employee and spouse must be at work during the time the eligible dependent is receiving care. Expenses must be for a dependent claimed on one's federal income tax return. Eligible dependents include:

- A child, under age 13, who the employee claims as a tax exemption.
- A dependent who is physically or mentally incapable of caring for himself or herself. This includes an elderly parent who is handicapped or ill.

Another requirement is that the dependent must spend at least eight hours a day in one's home.

Although the "use it or lose it" concept also applies to dependent care FSAs, there is a difference as to how these accounts operate. In the health care

FSA, an expense must be incurred while an employee is employed in order to be eligible for reimbursement from the account. With the dependent care account, expenses can be incurred after termination of employment and still be reimbursed from the account.

Another significant difference with the dependent care account is that the deficit account requirement does not apply. Therefore, reimbursements are limited to the amount actually contributed to the employee's account.

Implementing the FSA plan.

If you are interested in implementing an FSA, you need to keep in mind that the IRS regulations in Sections 125 and 129 determine most of the plan design. The IRS code determines: eligible expenses; maximum contribution for dependent care (\$5,000); "use it or lose it" rules; and "deficit account" or uniform coverage requirements. Key plan design decisions that must be made include:

- How soon employees can participate. The key decision for enrollment is if you have a single annual enrollment or if you will allow new employees to enroll when hired.
- Plan minimum contribution. You usually would want to set a minimum to avoid very nominal amounts, like \$120 per year.
- Frequency of reimbursement. Under a dependent care FSA, weekly reimbursement is the norm since the employee is dependent on the reimbursement to make the payment to the dependent care provider. Twice a month or monthly is more common for health care FSAs.
- How excess funds will be disposed. As indicated earlier, use of these funds to pay for the plan's administrative expenses is the norm.

If you do decide to implement an FSA plan, do not expect significant participation levels in the plan, particularly in the dependent care FSA. According to the ECFC/Mercer survey, 20% of eligible employees on average participated in a health care FSA. According to a separate TPF&C survey, approximately 18% participated in health care

FSAs, while only 3.3% participated in dependent care FSAs.

Keep in mind that many of your employees probably incur very little health care expense on a regular basis. The same is true of dependent care. The one item employees are more concerned about with an FSA is the "use it or lose it" rule. Most employees are generally conservative and do not want to put their money at risk. However, those employees who do utilize an FSA greatly appreciate the benefit. What other benefit plan can we offer to employees where they can totally avoid paying taxes on a portion of their income? ■

Would you like advice from an experienced colleague on a risk management, benefits management or actuarial problem? Four features in the Perspective section of Business Insurance can give you some answers.

Ask A Benefit Manager, Ask A Risk Manager, Ask A Benefit Actuary and Ask A Casualty Actuary answer written questions from readers on risk and benefits management issues and actuarial problems.

This month's column on employee benefit

management issues is written by Dennis J. Nirtaut, manager of employee benefits at Continental Bank Corp. in Chicago. Susan M. Werner, director of risk management at Hardee's Food Systems Inc. in Rocky Mount, N.C., answers questions on risk management issues. William J. Miner, an actuary with The Wyatt Co. in Chicago, answers actuarial questions on benefits issues. And, Richard E. Sherman, a principal with



Mr. Nirtaut

Coopers & Lybrand in San Francisco, answers actuarial questions in the casualty field.

Mr. Nirtaut's and Ms. Werner's columns appear on the second Monday of alternate months. Mr. Miner's and Mr. Sherman's columns appear alternately on the first Monday of each month.

Mr. Nirtaut's next column will appear in November. Address your questions to ASK, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. Please give us your name, title and employer; however, Business Insurance will consider unsigned letters.

In case of fire, read the law

Fire legal liability has a much broader meaning overseas

By Douglas N. Smith

A MULTINATIONAL company rents space for a sales office in an office tower in Paris. The office manager secures seemingly sufficient insurance for the perceived exposure to contents and for the potential liability resulting from operations. However, when a fire starts on his premises and spreads to several other floors, he is startled to learn that not only must he reimburse the landlord for damage to the space the sales office occupies, but for the entire structural damage caused by the fire! What happened?

"Fire legal liability," to an American, is used to describe the responsibility to others for property in one's care, custody and control. However, in many countries in the world, the term has a much broader meaning that assigns legal responsibility for all fire damage (including explosion) to a landlord's property to the tenant in whose space the fire started. This is referred to as tenants liability.

A duty can also be owed to neighboring tenants for fire damage. In effect, this means that the tenant who only occupies a small portion of a building could be held liable for the fire damage to the entire building both

International issues

to the owner and any damaged tenants.

Therefore, when leasing premises for business operations, risk managers must give careful attention to the loss exposure that civil codes and lease agreements impart. "Fire legal liability" is not as straightforward as it may sound.

European countries primarily base their commercial codes on civil law. In general, civil law is very specific about when liability for damage is incurred and where responsibility lies; this differs from the common law system in the United States, which follows precedents and allows some latitude for court interpretations. The Napoleonic Code of France, for example, under Articles 1733, 1734 and 1302, itemizes a tenant's liability to a building's owner. Except for the United Kingdom, which also adheres to common law, other European countries have similar civil codes.

The Napoleonic Code assigns responsibility for any damage caused by fire to the lessor's (or owner's) property to the tenant in whose premises the fire started. The burden is on the tenant to prove that he or she is not liable for circumstances allowed

under the code. His or her defense could be:

- That force majeure applies; i.e., the cause of the fire was beyond the control of the tenant.
 - That the fire was a result of a defect in the building's construction.
 - That the fire started on other premises in the building or in an adjacent structure.
- Civil laws also can impose liability for damage to third parties. The codification of neighbors liability may not be as explicit as tenants liability and, therefore, may be resolved around common law principles. That is, it must be proven that:
- The cause of the fire was a result or fault of negligence.
 - The fault or negligence resulted in loss.

It is important to realize the implication of civil codes. In France, for example, the landlord need not prove fault or negligence, because the Napoleonic Code has already assigned to the tenant responsibility for fire damage.

Landlords may not always include in a tenant's lease agreement the responsibilities outlined in the Napoleonic Code or other civil codes. Thus, an understanding of the civil law and insurance practices may be in order to fully understand the

exposure. In general, a tenant in a large multitenant building must account in his or her company's risk planning for damage to or destruction of the entire building. If it is unclear where the fire starts, the tenants may be found jointly and severally liable.

Since tenants are faced with the prospect of insuring a liability under the code that includes not only their own leased space but the entire building, risk managers are best advised to negotiate a reduced liability in the lease agreement. In many cases, lease agreements are standard packages offered without much opportunity to change provisions. However, depending on circumstances, it may be possible to incorporate some of the following lease provisions, which could reduce exposure to the financial consequences of fire damage in countries with civil liability based on the Napoleonic Code, by:

- Assigning the responsibility of insuring the real property of the premises (including attached fixtures) to the landlord.
- Agreeing to restrict liability to the leased premises.
- Specifying a limited amount of liability that equates to a foreseeable loss. Limiting the amount of liability

Continued on page 26



OUR ANSWER ISN'T JUST ANOTHER PLUG.

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

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Fire coverage

Continued from page 24

may also be accomplished by excluding responsibility to the extent of any insurance claim collectible by the landlord.

In the first case, the landlord may be willing to provide insurance (as few landlords are willing to rely on the actions of tenants for their insurance), but may require the tenant to be responsible for damage within the deductible. It may be desirable, therefore, to specify an agreed deductible level or maximum liability amount in the lease.

When relying on lease provisions to assign insurance responsibility to another party, a tenant must make proper provisions for potential subrogation by the insurance company. It is usual, but not required, that an insurer's right of subrogation will be waived—if such waiver is granted by the policyholder before a loss. Thus, if the landlord's policy is relied upon to provide protection, it should be confirmed that the waiver of subrogation is allowed.

Absent any lease provisions to the contrary, it may be problematic for the occupant of a building with multiple tenants to estimate the proper amount of insurance. Furthermore, it is impractical for each tenant to insure to the full value of the building (although in its strictest construction that is what is required under the

Napoleonic Code). Therefore, in some countries, notably France, a multiple of the rent is used as the property value for reporting to insurers and establishing policy limits.

As for tenants liability, it is often difficult to estimate the amount of insurance necessary to cover liability vis-a-vis neighbors. An office exposure may present quite a different limit requirement than occupancy of a multitenant warehouse.

Since other countries use civil codes

Negotiating around local fire codes should leave no surprises for landlords if a tenant is involved in a 'towering inferno.'

similar to the Napoleonic Code, the question of which policy should account for a tenant's obligations must also be reviewed. Thus, whereas in France it is usual to account for fire legal liability in property forms, other countries may follow a different practice. For example, in:

- Denmark, they are covered under the general liability policy (with legal obligations defined in common law).
- Germany, they are covered under the liability program either as part of the liability policy or as a separate placement.
- Greece, tenants' and neighbors'

obligations are covered under the fire policy.

- Italy, obligations are covered under the fire policy and liability policy.

- The Netherlands, obligations are covered under the general liability policy.

- Spain, tenant obligations are covered under either the fire policy or the liability policy.

- Switzerland, obligations to neighbors are insured under the general liability policy, whereas special arrangements for tenants liability must be made usually with restrictive terms and conditions.

The civil codes of some countries like Sweden make no provision for tenants and neighbors liability. In others, like Denmark and the United Kingdom, liability for fire damage may be based on common law similar to that of the United States.

In countries where tenants legal liability is covered under the fire policy, there is no specific provision for bodily injury or death. Thus, liability coverage and limits must be separately evaluated based on the exposure of neighboring tenants.

Tenants and neighbors legal liability as defined in civil codes extends beyond European countries. Japan, for example, has embodied in its civil code provisions for legal liability, but only for cases of gross negligence. In Japan it is usual to endorse the fire policy for tenants liability and for

neighbors liability to be included in the liability policy as premises-operation hazard. The actual cash value is used as a limit for tenants liability and is calculated at one-third of the building's property rate subject to negotiation.

Thus, for legal liability resulting from fire starting in occupied premises, multinational companies face a patchwork of civil codes. Not all assign a strict liability to the tenant for the landlord's property, but in Napoleonic Code countries, the responsibility of the tenant can be burdensome. It is best for risk managers to review civil codes in some countries where they have operations to determine the extent of a tenant's obligations. Although difficult to accomplish, negotiation of lease agreements to reduce exposure may be considered. Adequate coverage for and accounting of liability to neighbors must be included in liability or property programs. If these actions are taken, there should be no surprises if a tenant is involved in a "towering inferno." ■



Douglas N. Smith is vp and manager of Johnson & Higgins' International Department. His column usually appears the first Monday of the month.

How to stay out of the headlines

"Professional Liability Insurance"

By Robert A. Bregman and Jack P. Gibson
Published by International Risk Management Institute Inc., 12222 Merit Drive, No. 1660, Dallas, Texas 75251-2217
\$195.00

By Kevin M. Quinley

ASK ANY PROFESSIONAL, "What's new?" and you are liable to be shown a summons and complaint, along with directions to the courthouse.

A review of current news headlines shows vividly that professional liability remains a significant risk for many businesses. Risk managers, insurance buyers and anyone exposed to professional liability can help stay out of the headlines by reading and heeding the advice contained in this two-volume set on professional liability coverage by Jack Gibson and Robert Bregman.

Mr. Bregman and Mr. Gibson work for the International Risk Management Institute Inc., a Dallas publishing company. Among the professionals whose insurance they discuss are: directors and officers, accountants, lawyers, architects and engineers, insurance professionals, and government and non-profit employees.

One of the useful sections in the book pertains to insurance markets. It nicely combines the theoretical with the practical. Mr. Bregman and Mr. Gibson not only describe what to look for in professional liability insurance, but they also list specific companies writing the coverage.

Aside from its usefulness to risk managers, no broker or agent placing professional liability coverage should be without this book. Retail agents and brokers can use the manual to sell to prospects and retain clients by arranging the best insurance protection for premium dollars. Surplus lines brokers will love the competitive edge this manual gives in identifying markets and superior policies for specific types of professional liability coverage.

The manual's strengths lie in:

New reference manual on professional liability sets standards for field

Books & ideas

Given today's legal minefield, for anyone working with professional liability coverages, not having and using this reference would seem to border on professional negligence.

- Evaluating and choosing among policy forms.
- Spotting areas within which to negotiate modifications in a particular insurer's policy.
- Deciding whether a particular policy covers a claim made against a risk manager's company.
- Avoiding embarrassing and costly coverage gaps when buying claims-made professional liability policies.

The book is divided into two main sections. Volume one deals with general information like underwriting considerations, the marketplace, coverage triggers and policy provisions common to professional liability, errors and omissions and D&O policies. Volume two addresses specific coverage analyses of particular professions. Following these is a detailed provision-by-provision dissection of significant similarities and differences among insurers' forms.

The book gives specific underwriting and loss control considerations and examines the peculiarities of the market for each line of coverage. The practical tie-in benefits from having a sample policy form and application included for each line.

Brokers, agents and buyers will benefit from the coverage checklists that the authors provide for each policy provision.

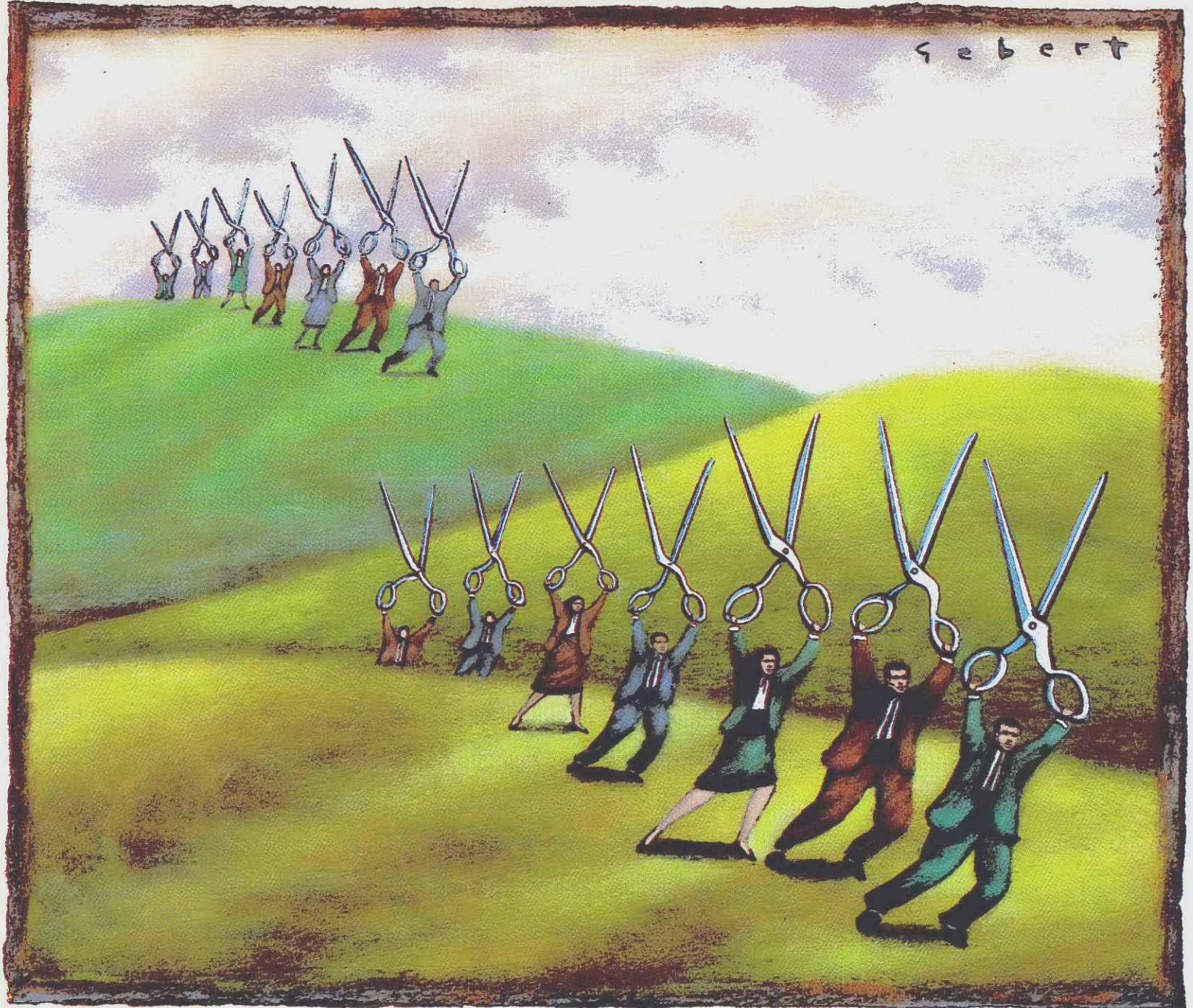
Given today's legal mine field, an overlooked or missed coverage opportunity can spell financial doom to an individual or firm. This weighty (figuratively and literally) work by IRMI provides the ammunition to address these exposures before losses occur and to maximize recovery after a loss.

The glaring omission in this text is the absence of any discussion of medical professional liability. After all, medical malpractice is what most immediately comes to mind when one thinks of professional liability. With the loose-leaf format, however, IRMI will fill this gap with supplement issued in mid-1991.

The ponderous size of this set may intimidate some users, and its weight may send others to a hernia specialist. However, a book like this is meant to be used more as a manual for reference rather than something to be read from cover to cover. The authors have done their best by using tabbed sections to make this 900-page tome as user-friendly as possible, and it would be a shame if potential users were daunted by its heft. For anyone working with professional liability coverages, not having and using this reference would seem to border on professional negligence.

For practicing risk managers and insurance professionals, "Professional Liability Insurance" is now the standard by which other references in this field will be compared. Companies using and heeding the advice in these pages will improve their odds of remaining in business and out of the news headlines. ■

Kevin M. Quinley is vp of risk services for MEDMARC Insurance Co. Risk Retention Group Inc. and subsidiary Hamilton Resources Corp., both of Fairfax, Va. Mr. Quinley holds the Chartered Property & Casualty Underwriter and Associate in Risk Management designations.



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Judges

Continued from page 3

Kohler, who is serving on the panel for the first time, represents regional insurance brokerages.

• Edward K. Trowbridge, chairman and chief executive officer of Atlantic Mutual Insurance Co. of

Madison, N.J. Mr. Trowbridge is serving on the panel for a second year, representing mutual insurance companies.

• Rod Umscheid, risk management director for the University of California in Berkeley. Mr. Umscheid was a member of the 1991 Risk Management Honor Roll, representing non-

profit institutions.

• J. Bransford Wallace, chairman of Corroon & Black Corp.'s Brokerage Services Group, a unit of Willis Corroon P.L.C., based in Nashville, Tenn. Mr. Wallace is serving on the panel for the first time, representing national insurance brokerages.

"We're pleased that such a distinguished panel of experts will select the Risk Manager of the Year and the Risk Management Honor Roll," said Kathryn J. McIntyre, *Business Insurance's* associate publisher and editor.

"The four past honorees on the panel have a first-hand knowledge of risk management excellence. And the other members of the panel will judge the nominees from a variety of viewpoints," Ms. McIntyre said.

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

Judges to use 10 standards

Ten criteria will be used to score nominations for the 1992 *Business Insurance* Risk Manager of the Year Award.

The 10 independent judges will score each candidate according to how well he or she:

- Established and implemented an effective risk management program within the organization.
- Solved one or more major problems for his or her organization.
- Innovatively applies the diverse tools of risk management and insurance.
- Creatively and effectively uses the insurance markets to structure an insurance program that serves the needs of the organization.
- Established a workable intelligence system inside and outside the organization, culminating in a flow of information about events and activities that affect the organization's risk management and insurance.
- Skillfully performs the functions of management in the overall organization and within the risk management/insurance department.
- Achieves the most effective program at the optimum cost over the long term.
- Developed technical expertise in any or all of the broad categories included within risk management, leading to a better managerial grasp of the operations aspects of the job.
- Exhibits an attitude and performs activities fostering the advancement of the risk management profession.
- Develops in his or her career. ■

- Government entities.
- Tax-exempt or non-profit institutions.
- Financial institutions.
- Self-insurance funds and pools.

The highest-scoring candidate in each of the categories not represented by the Risk Manager of the Year is named to the Risk Management Honor Roll, subject to the judges' discretion.

As many as five other nominees can be named to the Risk Management Honor Roll.

The 1992 honorees will be announced in the March 30, 1992, issue of *Business Insurance*, which will coincide with the Risk & Insurance Management Society Inc. conference to be held in Anaheim, Calif.

A candidate also 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 manage-

ment program.

A candidate can be nominated by anyone familiar with the candidate's work. Nominations of risk managers based anywhere in the world are invited.

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

All nominations will be kept in the strict confidence, with only the award winners' names announced.

To request a nomination form, contact Karen Brown, Assistant to the Editor, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611-2590; 312-649-5398. ■

Risk Managers of the Year

Arnold L. Davenport
Vp-Risk Management
Marriott Corp.

Stephen M. Wilder
Director of Corporate Risk Management
The Walt Disney Co.

Jeffrey W. Pettegrew
Risk Manager and Chief Administrative Officer
Contra Costa County Municipal Risk Management Insurance Authority

William L. Mather
Administrator of Risk Management
The Gillette Co.

Edith F. Lichota
Senior Vp.
Irving Trust Co.

Donald Nelson
Director of Risk Management
ARA Services Inc.

Harold C. Lang
Director of Insurance and Risk Management
Leaseway Transportation Corp.

Richard M. Inserra
Director of Insurance and Risk Management
American Can Co.

John A. O'Connell
Executive Director and Risk Manager
Holy Cross Shared Services Inc.

Eckhart Russell
Risk and Insurance Manager
Alcan Aluminium Ltd.

Duane E. Allen
Assistant Treasurer
Hanna Mining Co.

Thomas V. Hallett
Risk Manager
General Motors Corp.

Edward L. Erickson
Director of Insurance
American Broadcasting Cos. Inc.

Howard T. Weber
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issue:	September 16	— Reader Service
closing:	September 3	
editorial feature:	Workers Compensation	— Directory: Safety Consultants & Rehabilitation Services
demographic section:	Insurer Topics: Compensation & Benefits	
issue:	September 23	
closing:	September 10	
editorial feature:	Reinsurance: Monte Carlo Rendez-Vous Report	
issue:	September 30	Bonus Distribution: IIAA
closing:	September 18	
issue:	October 7	Bonus Distribution: AEA/RIMS & NACSA-NACSE
closing:	September 24	
editorial feature:	International: Benefits & Risk Mgmt.	— Directory: Intl. Insurers & Benefit Networks
demographic section:	Agent/Broker Topics: Contracting For Services	

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Risk Management Honor Rolls

Donald D. Batchelor
Union Finster Corp.
Financial Institution

Rod Umscheid
University of California
Not-for-Profit Institution

Mary L. DeCampli-Stewart
Metropolitan Washington Airports Authority
Government Entity

Josephine Goode Johnson
University of Maryland Medical Service System
Self-insurance Funds

Roger D. Oaks
Tennessee Farmers Cooperative
Small Corporation

M. Michael Zuckerman
Thomas Jefferson University
Not-for-Profit Entity

John A. Lindquist
Browning-Ferris Industries Inc.
Large Corporation

J. Douglas Higley
State of Louisiana
Government Entity

Gregory L. Daniels
American National Red Cross
Not-for-Profit Entity

Stephen A. Finley
City of Lakewood, Colo.
Government Entity

Timothy G. Galarnyk
Luna Construction Co./
Phoenix Steel Inc.
Small Corporation

Edward G. Weiss
First of America Bank Corp.
Financial Institution

Susan M. Werner
Hardee's Food Systems Inc.
Large Corporation

Mark F. Wilson
First Mississippi Corp.
Small Corporation

Delmer Ison
Washingt. Metropolitan Area
Transit Authority
Government Entity

William E. Rogers
Conemaugh Valley
Memorial Hospital
Not-for-Profit Entity

Susan N. Weiner
Dade County Public Schools
Government Entity

Eva F. Goodrich
Cincinnati Electronics Corp.
Small Corporation

Sidney D. Blatt
Holloway Cos.
Small Corporation

Gene Snyder
State of Oregon
Government Entity

Jerri Nelson MacMillan
Aetna Life & Casualty Cos.
Real Estate Investment Department
Large Corporation

Robert L. Sinclair
Metropolitan Government of
Nashville and Davidson County
Government Entity

Spencer J. Traver
BF Goodrich Co.
Runner-up

Paul B. Harvey
Ponderosa Homes
Small Corporation

George N. Pierce
Orange County, Fla.
Government Entity

Gene M. Marsh
General Conference of
Seventh-day Adventists
Not-for-Profit Entity

Robert Bieber
Westchester County
Government Entity

William Ryan
University of Michigan
Not-for-Profit Entity

INTERNATIONAL

U.S. court dismisses suit by member against Lloyd's

By GAVIN SOUTER

LONDON

LONDON—The first round of a legal action brought by a U.S. Lloyd's of London member against the corporation has been won by Lloyd's.

Last month U.S. District Judge Jim Corrigan of Denver ruled that he lacked jurisdiction over a suit filed by the member seeking damages from Lloyd's.

The member, Ronald Riley, said he will appeal the dismissal of his suit to the 10th U.S. Circuit Court of Appeals in Denver.

In his suit, Mr. Riley alleges that Lloyd's has breached U.S. securities laws by not registering under the Securities Exchange Act.

A Lloyd's member since 1980, Mr. Riley acknowledges that his losses have been "substantial." Much of his losses stem from his participation on syndicates managed by Feltrim Underwriting Agencies Ltd. and Gooda Walker Ltd.

The dismissal of Mr. Riley's action will not affect a group of about 100 U.S. members planning to sue Lloyd's in federal court New York. The members, who allege similar violations of the Securities Exchange Act, have collected about \$250,000 of the \$500,000 they need to finance the litigation (BI, Sept. 2).

Had Lloyd's registered under the

securities law, the members allege, more information would have been available to potential investors and Lloyd's would have been more closely regulated in the United States.

"New members are coming forward every day saying they want in," said Steve Feigenbaum, a lawyer with Proskauer, Rose, Goetz & Mendelsohn, the New York firm representing the members.

Lloyd's is seeking an injunction against one of the New York members, Dale Jenkins, to prevent a suit in U.S. courts.

Since 1987, Lloyd's says, all members have signed agreements that any disputes with Lloyd's would be settled in English courts.

Jardine to be listed?

Jardine Matheson Holdings Ltd., the Hong Kong trading company, is considering putting a minority interest in its insurance brokerage unit up for sale on the London Stock Exchange.

No final decision has been made on a sale, said John Barton, chief executive officer of Jardine Insurance Broking Group Ltd. Merchant bank Robert Fleming & Co. Ltd.

and stockbroker Cazenove & Co. have been appointed to advise the company on the possible sale.

Stock analysts are reluctant to put a price on the brokerage, but one suggested that 250 million pounds (\$422.5 million at current exchange rates) "might be in the right region."

Jardine is the world's eighth-largest broker based on 1990 gross revenues (BI, July 1).

In a statement issued to the Hong Kong Stock Exchange, where Jardine Matheson shares are listed, the company said: "The proposals under consideration are for the partial flotation of JIB with Jardine Matheson Holdings retaining the majority interest. The company believes that the flotation of JIB would facilitate its expansion."

Jardine's insurance brokerage interests date to at least the mid-19th century, but the current brokerage was built up in the 1970s, Mr. Barton said.

JIB reported 1990 revenues of 168.1 million pounds (\$324.5 million). Of that total, 59% came from retail brokerage, 12% from wholesale brokerage and 12% from reinsurance.

Mr. Barton is to visit Hong Kong in two weeks to discuss the possible flotation with Jardine Matheson executives.

Meanwhile, JIB has formed a

Continued on next page

German brokers expect Lloyd's to emphasize European risks

By DON LEWIS KIRK

BONN, Germany—German brokers expect Lloyd's of London to focus increasingly on European business after incurring major losses on U.S. risks in recent years.

However, brokers and reinsurers are divided over whether Lloyd's troubles will be German reinsurers' gain.

Lloyd's posted global losses of nearly \$1 billion in 1988, the most recent year closed under Lloyd's three-year accounting system. And, analysts say Lloyd's 1989 losses could exceed \$2 billion.

As a result, German brokers expect Lloyd's to dump what they consider an "overload" of U.S.

risks and to increasingly target continental European business.

Jurgen Grupe, partner and chief executive-reinsurance for Hamburg-based broker Jauch & Huebener, said Lloyd's current ills can be traced to what he called its "top heavy" coverage of large U.S. risks.

Although Lloyd's 1988 pure underwriting results produced a small profit of 68 million pounds (\$131.2 million at appropriate exchange rate), the need to add a whopping 577.7 million pounds (\$1.11 billion) to reserves to pay for past U.S. long-tail liability business plunged Lloyd's into the red for the first time in 21 years.

In addition to long-tail losses,

the market's 1989 accounts also will be hammered by claims from Hurricane Hugo, winter weather losses in the southern United States, the San Francisco earthquake, the Exxon Valdez oil spill and the explosion at a Phillips Petroleum Co. petrochemical plant in Texas.

"Lloyd's has placed too much stock in U.S. catastrophe business," Mr. Grupe said. "Large losses are forcing it to reduce U.S. commitments considerably."

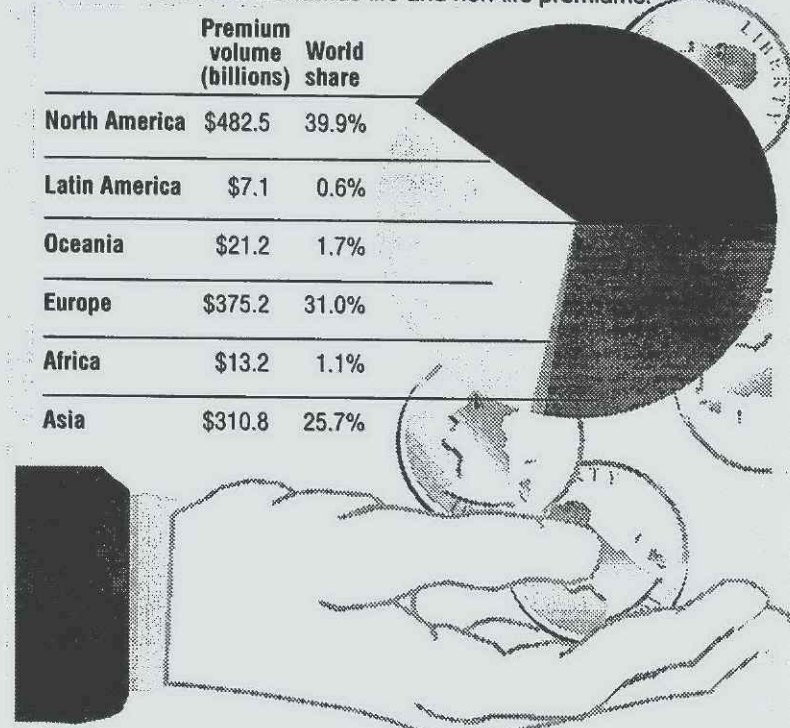
As an alternative, Lloyd's may step up its activity in the European market, he said. "Just recently, efforts have increased dramatically."

Continued on next page

Premium volume by continent

North America and Europe in 1989 accounted for the largest shares of worldwide life and non-life premiums.

	Premium volume (billions)	World share
North America	\$482.5	39.9%
Latin America	\$7.1	0.6%
Oceania	\$21.2	1.7%
Europe	\$375.2	31.0%
Africa	\$13.2	1.1%
Asia	\$310.8	25.7%



Source: Swiss Re

GRAPHIC BY KIMBERLY MART

Premium volume around the globe grew 3.9% in 1989

By STACY SHAPIRO

ZURICH, Switzerland—Falling volume in the U.S. and Japanese life and non-life insurance markets—the world's two largest markets—helped cut worldwide premium volume growth in half to 3.9% in 1989 in real terms from 8% in 1988, according to SIGMA, the research arm of Swiss Reinsurance Co. in Zurich.

Adjusted for inflation, worldwide life and non-life insurance premium volume in 64 countries totaled \$1.21 trillion in 1989, according to the SIGMA report.

SIGMA blames the slowdown primarily on U.S. and Japanese market slumps.

Together, the two nations account for 59.4% of the world's premium volume, the research group says in its report on results for 1989, the most recent year analyzed.

Real growth of total premium volume for U.S. insurers fell to 1.7% in 1989 from 2% a year earlier. Total U.S. premium volume totaled \$453.2 billion in 1989, or 37.5% of the world total, SIGMA found.

The decline in premium volume growth for Japanese insurers was even sharper. Their premium volume fell to 4.2% in 1989 from 18.9% in 1988, according to SIGMA.

Japan's total premium volume in 1989 was \$264.7 billion, 21.9% of the world total.

SIGMA also reports that the Swiss again spent more on insurance per capita—\$2,376—than citizens in any other country.

Before the study's results were collated, it appeared the Japanese might

Continued on next page

Continental restructures global activity

By STACY SHAPIRO

LONDON—Continental Corp. is restructuring its international operations to focus on its multinational client base.

New York-based Continental is closing its marine underwriting operations in Europe and Australia, while developing a link with Italian insurer Assicurazioni Generali S.p.A.

Continental has decided that its international strategy over the next decade should be to concentrate on what the company feels it already is expert at—servicing multinational clients, said Michael Marchesani, president of the Continental International division in Cranbury, N.J.

By pulling out of indigenous single-risk foreign marine and non-marine business, the insurer can

devote more resources to multinational accounts, he explained.

"Stand-alone marine and non-marine (foreign) businesses won't help us with our international strategy or North American strategy," he said.

Mr. Marchesani also told brokers in London last week that Continental had decided to cease writing a London market account through its member companies in the Institute of London Underwriters, which includes Lombard Continental Insurance P.L.C. and Continental Insurance (U.K.) Ltd. The companies wrote primarily marine and London market business.

In addition, Continental International will cease underwriting marine accounts written by managing agents in France, Belgium, Holland and Denmark.

And, the group will stop writing

a marine account in Milan, Italy, as of Dec. 31.

The group also has decided to cease writing strictly marine accounts in Australia and Hong Kong.

The Marine Office of America Corp., a Continental subsidiary, will continue to write marine business in the United States, although it is among the insurers that are withdrawing from the American Hull Syndicate (BI, Aug. 26).

Despite the closing of many of its foreign marine accounts, Continental International will continue to service multinational clients in Europe and the Pacific Rim, Mr. Marchesani said.

Continental International also will continue to write marine business as part of its multinational client insurance programs, he said.

"Continental International is de-

dedicated to serving the needs of its multinational clients, and we believe that these changes will enable us to redeploy our resources to better meet their global insurance needs, whether they are American businesses operating abroad or European businesses expanding into global markets," Mr. Marchesani told London brokers.

As part of this new focus on multinational clients, Continental also announced last week that it had entered into an agreement to underwrite and service the North American exposures of Generali's multinational accounts. That job previously had been handled by Aetna Life & Casualty Co., but Mr. Marchesani said Generali's relationship with Continental is "more structured."

Continental and Generali will "provide mutual access to their

worldwide facilities in support of multinational activities (and) pursue joint marketing and production of multinational risks," the companies jointly announced.

The two insurers together also will explore new opportunities worldwide, Mr. Marchesani said.

"Generali is one of the last major European insurers without a U.S. link," he told *Business Insurance*. This new business arrangement will allow both groups to expand their multinational expertise worldwide, he said.

Generali is Europe's second-largest insurer, with annual worldwide gross premiums of about \$12.1 billion. It operates in 48 countries through 170 companies.

Continental Corp. wrote \$4.59 billion in gross premiums last year and reported \$5.71 billion in gross revenues.

INTERNATIONAL

LONDON

Continued from previous page
new London-based accident and health division to place direct and reinsurance coverage for the U.S. accident and health market.

The new division will place coverage for private companies and government agencies, said Peter Robinson, managing director of the division.

"The boundaries between direct and reinsurance placing of accident and health coverages sometimes get a bit blurred so we thought it would be better to bring it all together into one division," Mr. Robinson said.

Previously, direct coverage for JIB clients was placed in London by Jardine Insurance Brokers Ltd. and reinsurance coverage was placed by Jardine Thompson Graham Ltd., he said.

More huge losses seen

Lloyd's of London losses for the 1989 underwriting year could hit 1.4

billion pounds (\$2.4 billion), more than double its record loss for 1988, says a market analyst.

Results for the 1989 underwriting year will be announced next year under Lloyd's three-year accounting system. A 1 billion pound (\$1.69 billion) pure underwriting loss for 1989 plus up to 400 million pounds (\$676 million) of losses on past years of accounts not yet closed would more than double the 1988 loss of 509.7 million pounds (\$983.7 million), according to market analyst Chatset Ltd., which publishes Lloyd's League Tables.

"The 1989 underwriting year will be particularly bad, not only because of the catastrophic losses suffered in the year and U.S. general liability claims for past years, but also because of the large stop-loss claims that will fall on the market," said Charles Sturge, co-editor of Lloyd's League Tables.

Although the size of the Lloyd's members' stop-loss claims that will be paid by Lloyd's syndicates for 1989 will not be known until next summer, the signs are not encouraging.

"It is bound to be a nightmare closing 1989 off," Mr. Sturge said. As many as 25 to 30 syndicates may not close their 1989 accounts on schedule, he warned.

Broker Holman Wade Ltd., which claims to place 70% of the personal stop-loss insurance underwritten for Lloyd's members, predicts that its customers will file claims totaling 60 million pounds (\$101.4 million) for the 1988 accounting year (BI, Sept. 2).

Lloyd's members have already paid about 350 million pounds (\$591.5 million) in advanced cash calls for the 1989 year and 110 million pounds (\$185.9 million) for 1990, Mr. Sturge said.

Lloyd's will also post a loss for its 1990 accounting year, which will close at year-end 1992, Mr. Sturge pointed out. "It is very unlikely that it will be as bad as 1989, but it must produce another loss for the market," he said.

Meanwhile, Chatset says that figures released by Lloyd's on the size of cash calls on members are misleading.

Lloyd's says that only 2.1% of its

members paid out more than 50,000 pounds (\$84,500) for losses from the 1988 accounting year.

Chatset points out, though, that this estimate does not include the payment of U.S. federal income taxes or advanced cash calls for 1989 and 1990 made this year. And, Lloyd's estimate assumes a 35% U.K. income tax recovery for the members, Chatset says.

In fact, Chatset says its survey of 78 members shows that 38.5% of members will pay out more than 50,000 pounds (\$84,500) this year. That figure takes into account U.S. income taxes and advanced cash calls.

Chatset and Lloyd's also differ widely on the estimated percentage of members who have suffered smaller losses this year.

Lloyd's says that 19.4% of members lost less than 10,000 pounds (\$16,900); 30.9% lost between 10,000 and 20,000 (\$16,900 to \$33,800); 12% lost between 20,000 and 30,000 (\$33,800 and \$50,700); and 5.4% lost between 30,000 and 50,000 (\$50,700 and \$84,500).

But in its survey, Chatset found

that 7.7% of members lost less than 10,000 pounds; 9% lost between 10,000 and 20,000; 11.5% lost between 20,000 and 30,000; and 17.9% lost between 30,000 and 50,000.

In total, Lloyd's estimates that 69.8% of members lost money on 1988; Chatset puts that figure at 84.6%.

Lloyd's denied that its figures are misleading.

"Chatset's figures for the 1988 year and runoffs were derived from a survey of less than 80 names. Lloyd's figures are based on a computer calculation carried out by the solvency and reporting department of the entire membership participating in the market in 1988," said Lloyd's Chairman David Coleridge.

Even if the 35% tax recovery is not included, Lloyd's contends in a statement, only 8% of members lost more than 50,000 pounds.

Omitting tax recoveries, Lloyd's says that 29% of members made a profit this year; 23% lost 10,000 pounds or less; 18% lost between 10,000 and 20,000; 11% lost between 20,000 and 30,000; and 11% lost between 30,000 and 50,000. ■

Worldwide premium volume

Continued from previous page
rank first in per-capita insurance expenditures, but the Japanese actually ranked second to the Swiss at \$2,150 per capita due to the weakness of yen to the dollar.

U.S. citizens ranked third, spending \$1,817 per capita in premiums.

Insurers in most of the 64 countries studied generated at least \$100 million in gross premium volume. Data from Kuwait and Iraq are not included because of disruptions caused by the Persian Gulf War.

The premium data gathered from the International Monetary Fund, Wharton Econometric Forecasting Associates and national supervisory authorities refers to gross premium volume of direct business of all private domestic and foreign insurance companies.

Wherever possible, only domestic business was taken into account, especially in countries like Great Britain, where foreign business accounts for a large portion of total premium volume.

According to SIGMA, worldwide premium volume for 1989 is broken down as follows:

- 39.9%, or \$482.5 billion, in the United States and Canada.

- 31%, or \$375.2 billion, in Europe, with Germany leading with

\$76.53 billion in premiums; followed by Great Britain, \$76.39 billion; and France, \$63.27 billion.

- 25.7%, or \$310.8 billion, in countries belonging to the Assn. of Southeast Asian Nations, including China, India, Indonesia, Iran, Israel, Japan, Pakistan, the Philippines, Singapore, South Korea and Thailand.

- 1.7%, or \$21.2 billion, from Oceania countries, like Australia and New Zealand.

- 1.1%, or \$13.2 billion, from Africa, where South African insurers dominate with \$9.39 billion in premiums.

- 0.6%, or \$7.1 billion, from Latin American countries, where Mexican insurers dominate with \$2.34 billion.

Ranked by continent, European insurers reported the highest real premium growth—7%—in 1989, according to SIGMA. Insurers in Cyprus, France, Great Britain, Ireland, Luxembourg, Portugal and Sweden all reported real premium volume growth of between 10% and 20%, the researchers said.

ASEAN insurers, whose premium volume had been growing the fastest in recent years, fell to second position, with real premium growth of 5.6%.

But, there was hardly any growth—0.4%—in premium volume among

U.S. and Canadian insurers in 1989, SIGMA said.

Real growth in premium volume exceeded 20% for insurers in only five nations, the report said: Brazil, Chile, South Korea, Thailand and Zimbabwe.

In most countries, life insurance premium volume is growing at a far greater rate than non-life business, SIGMA found.

Non-life premium volume is growing faster than life business only in Australia, Denmark, Spain and Switzerland.

SIGMA reports that the non-life insurance accounted for only 48.9% of the total premium volume written in 1989 by insurers in the 24 Organization of Economic Cooperation & Development countries, which include the United States, Canada, Great Britain, Germany and Japan. That is a sharp decrease from 59.8% of total volume in 1980.

Life business grew to 51.1% of total premium volume in 1989 from 40.2% in 1980 for those countries.

Asian insurers, including those in Japan, reported the largest share of the world's total life premium volume of \$633.3 billion in 1989: 36% of total life premiums, or \$228.3 billion.

North American insurers account for 32%, or \$202.6 billion, of the

world's total life insurance premium volume in 1989.

However, European insurers reported the fastest growth in life insurance business in 1989, with growth exceeding 20% in Cyprus, Greece, France, Great Britain, Ireland, Luxembourg, Portugal, Sweden and Turkey. Europe accounts for 28.8%, or \$182.4 billion, of total life insurance premium volume.

SIGMA found that life insurance premium volume as a percentage of total premium volume was greatest among South Korean insurers: 81.8%.

Life insurance premium volume as a percentage of total premium volume was lowest among Yugoslavian insurers: 0.8%.

North American insurers still generate the largest portion of the world's non-life premium volume: 48.6%, or \$279.9 billion, of the total 1989 non-life premium volume of \$576.3 billion. U.S. insurers alone accounts for 46%, or \$265 billion, of that total.

Although total U.S. non-life premium volume grew 4.2% in 1989, the country's non-life premium volume fell in real terms by 0.7%, according to SIGMA.

Europe accounts for 33.5%, or \$192.8 billion, of the world's total

non-life premium volume.

Countries in which insurers' growth in non-life premium volume exceeded 20% were Brazil, South Korea and Thailand.

Countries in which insurers' non-life premium growth ranged from zero to 5% growth include many European countries and Japan.

Free photocopies of the SIGMA report on world insurance premium volume in 1989 are available by contacting George Chimes, Assistant Manager of Public Relations at North American Reinsurance Corp., 237 Park Ave., New York 10017; 212-907-8174.

German market

Continued from previous page

For example, in Europe, "Lloyd's is offering underwriting capacity in reinsurance, particularly in commercial lines," he said.

Many Lloyd's syndicates are looking to increase their presence in con-

tinental Europe. In fact, some underwriting agencies have set up European offices to attract more business (BI, Sept. 2).

Meanwhile, at least one German reinsurer feels Lloyd's exposure to U.S. catastrophes was exacerbated

by the so-called LMX spiral, in which the same risk is retroceded over and over among London market excess-of-loss reinsurers.

Willhelm Zeller, an executive director of Cologne Reinsurance Co in Cologne, Germany, said Lloyd's

held onto an antiquated retrocessional system for too long. "Lloyd's has been swimming against the stream, trying to maintain a system that doesn't work," he said of the LMX market. "Current woes only make that more evident."

Other observers are split over whether German reinsurers will profit from Lloyd's recent troubles.

"Large insurers are going to place their business elsewhere," contends Norbert Strohschen, management board member of Cologne-based Gerling Global Reinsurance Group.

German brokers, though, discount any benefit to German underwriters stemming from Lloyd's troubles.

Continental European reinsurers have little if any interest in U.S. business, and Lloyd's large underwriting capacity still makes it a formidable competitor, Mr. Grupe pointed out.

"It's unlikely American cat, XLs or contracts for U.S. assumed accounts will be covered by other European markets," he said. "They just don't have the capacity."

Abraham Simhony, who oversees London market placements for Stuttgart-based broker Gradmann & Holler, agreed business will not flow from Lloyd's to the German market. "It's very questionable. German reinsurers are wary of the U.S. market and that is likely to continue." ■

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Business Insurance

Summary of major property/casualty insurers' first-half results

Ranked by change in net income. All amounts in thousands of dollars.

Rank 1991	Corporate			Property/casualty operations										
	Consolidated revenues 1991	Net income 1991	Percent increase (decline) 1990-1991	Combined ¹ ratio 1991	Combined ¹ ratio 1990	Net premiums written 1991	Percent increase (decrease) 1990-1991	Pretax underwriting income (loss) 1991	Percent increase (decline) 1990-1991	Pretax investment income 1991	Percent increase (decrease) 1990-1991	Policyholders surplus 1991	Percent increase (decrease) 1990-1991	
1	Home Insurance Co.	1,160,000	50,000	186.2	110.2 ²	109.4 ²	922,000	(19.0)	(111,000)	9.0	144,000	(12.2)	761,000	(1.2)
2	Royal Group (U.S. subs.) ²	N/A	11,400	128.0	125.6	124.6	776,300	(26.8)	(191,200)	26.0	168,100	1.2	823,900	15.2
3	Hartford Insurance Group	4,567,000	231,000	68.6	108.2	108.5	3,096,000	0.7	(277,000)	7.7	519,000	11.6	3,024,000	17.1
4	Continental Corp.	2,669,900	55,200	59.1	115.0 ²	113.8 ²	2,121,000 ²	(5.8)	(315,600) ²	(2.2)	363,400	(1.0)	1,992,000	(1.2)
5	CNA Financial Corp.	5,440,000	271,900	49.3	114.9 ²	114.9 ²	3,470,000 ²	6.1	(532,300) ²	(3.1)	616,900 ²	11.5	3,500,000	10.4
6	Lincoln National Corp.	2,232,100	117,800	25.1	112.6 ²	108.6 ²	1,163,600	(5.0)	(135,500)	(31.0)	137,300	(10.3)	1,325,000	10.6
7	Crum & Forster Inc.	1,886,500	81,600	23.1	115.8	113.8	1,232,700	(21.7)	(197,500)	13.6	301,700	0.6	1,412,600	7.6
8	Old Republic Int'l	646,699	58,909	18.5	107.8 ²	104.7 ²	346,691	2.0	(30,819)	1.6	83,284	8.9	813,199	17.2
9	Chubb Corp.	2,199,600	261,300	17.8	98.6 ²	101.7 ²	1,562,400	9.6	14,000	150.2	232,500	5.0	1,512,200	13.5
10	Ohio Casualty Corp.	835,238	44,620	15.4	105.1 ²	106.5 ²	753,696 ²	1.0	(40,257)	21.3	92,778	2.8	551,311	7.4
11	CIGNA Corp.	9,457,000	218,000	9.0	116.1	114.6	2,602,000	(6.1)	(444,000)	(4.7)	429,000	0.9	1,990,000	(9.5)
12	American International Group	8,195,740	776,419	7.3	99.3 ²	98.9 ²	4,618,818	(1.4)	41,831	(18.8)	566,961	11.0	N/A	N/A
13	Fremont General Corp.	289,375	14,174	3.7	105.6	104.8	214,055	0.3	(11,786)	(17.6)	32,137	(13.2)	187,802	(4.1)
14	General Re Corp.	1,574,500	310,900	2.2	101.7 ²	99.0 ²	1,104,100	9.3	(11,900)	(58.7)	373,500	7.6	3,023,000	7.8
15	Hartford Steam Boiler	309,126	40,186	0.0	90.4	86.2	162,930	10.8	15,361	(24.2)	20,561	0.6	385,108	10.0
16	The St. Paul Cos. Inc.	2,084,679	187,883	(1.5)	104.8 ²	103.9 ²	1,546,669	5.0	(79,271)	(42.4)	318,162	2.6	1,594,790	4.7
17	Argonaut Insurance Co.	240,347	36,723	(3.1)	110.5 ²	102.8 ²	190,384 ²	(6.8)	(21,943) ²	(166.1)	61,350 ²	0.4	441,986	6.2
18	Sentry Insurance Cos. ²	758,072	24,398	(4.4)	106.7	105.5	620,823	9.4	(43,977)	(19.6)	79,032	7.3	704,540	10.9
19	Travelers Corp.	5,951,900	183,800	(4.9)	112.7	113.8	2,201,700	(5.7)	(292,400)	16.0	379,800	0.6	1,948,900	(9.2)
20	Transamerica Ins. Group	1,090,111	29,069	(13.4)	112.5	110.6	937,581	5.7	(119,559)	(20.8)	130,008	3.2	1,079,658	4.7
21	Berkshire Hathaway Group	362,905	104,815	(13.5)	135.2	118.4	308,909	152.8	(66,832)	(174.3)	172,837	9.1	N/A	N/A
22	SAFECO Corp.	1,682,392	106,504	(19.5)	111.2	106.1	791,756	(5.3)	(91,880)	(82.4)	142,996	2.5	1,117,382	6.4
23	Aetna Life & Casualty Co.	9,402,200	296,900	(22.6)	116.3	114.0	2,989,600	(6.0)	(472,300)	(7.1)	532,700	(0.7)	2,462,000	(3.8)
24	Fireman's Fund Ins. Cos.	1,647,960	40,833	(66.8)	120.6 ²	117.0 ²	1,371,407 ²	(2.5)	(287,400) ²	(16.2)	303,517 ²	23.2	1,488,222	12.6
25	Reliance Ins. Co. & subs.	1,703,939	4,769	(97.3)	110.5 ²	108.0 ²	873,787	(11.0)	(71,100)	(1.3)	107,211	(0.5)	N/A	N/A
26	USF&G Corp.	2,154,000	(111,000)	(298.2)	119.4 ²	110.5 ²	1,624,000 ²	(14.8)	(292,000)	(71.8)	236,000	(18.9)	1,454,000	10.7
	Commercial Union Ins. (U.S.) ²	N/A	N/A	N/A	113.3 ²	110.2 ²	696,200	1.2	(103,700)	(25.7)	85,200	(0.4)	605,000	3.8
	Kemper National P/C Cos. ²	N/A	N/A	N/A	111.1	115.3	1,597,064	7.7	(186,499)	21.3	176,351	13.1	1,544,637	(7.6)
	Nationwide Mutual Ins. Co. ²	N/A	N/A	N/A	106.2	106.8	3,031,885	4.1	(191,203)	17.2	396,322	14.1	3,425,697	13.6
	Liberty Mutual Ins. Co. ²	N/A	N/A	N/A	117.3	113.3	3,421,271	3.8	(536,678)	(59.7)	559,785	5.1	2,555,769	4.1
	Cumulative	68,541,283	3,448,102	(0.9)	111.1	109.9	46,349,326	(1.8)	(5,084,412)	(6.9)	7,762,392	4.3	41,723,701	5.4

¹ After dividends ² Statutory ³ Before dividends N/A—Company did not provide data

P/C results

Continued from page 1

Second-quarter results were "as expected in an industry with abundant capacity," noted Barbara Stewart, president of Stewart Economics in Chapel Hill, N.C.

Even meager profits add to the industry's capital base and relieve the pressures that would force insurers to "hit the panic button" and raise rates, said Sean Mooney, senior vp with the Insurance Information Institute, in a written commentary on insurers' second-quarter results (see story, page 33).

Underreserving is partly responsible for the scant returns, industry analysts say.

"The earnings seem to continue to be holding up despite the downturn in the property/casualty underwriting cycle," creating the suspicion that insurers are adjusting their reserving practices to produce profits, observed Michael A. Smith, another first vp with Lehman Bros. in New York.

The industry's ratio of paid to incurred losses also continues to rise, another indication of underreserving, said Joyce Culbert, director of research with Firemark Inc. in Morristown, N.J.

"Underreserving marches on," Ms. Culbert said. "I don't know how long that can keep up."

"There aren't too many people who have stepped up to the bar in the first half to strengthen their reserves," Mr. Levin agreed, estimating that industry-wide reserves may be deficient by up to 10%.

"It's quite clear we are in a down cycle and it will be a little bit of time before we can turn this around," Mr. Smith said.

First-half results of insurers surveyed by *Business Insurance* show that:

- Underwriting losses widened 6.9% to \$5.08 billion from \$4.76 billion in the first half of 1990. This compares with a 2.7% increase in underwriting losses for all of 1990 and a

22.6% increase in 1990's first half (*BI*, April 1; Sept. 10, 1990).

- Net written premium volume slid 1.8% to \$46.35 billion in the first half of 1991 from \$47.21 billion in the first six months of 1990. Volume had increased 1.8% in both all of 1990 and in last year's first half.

Price competition is responsible for much of the decline, observers say.

"Pricing conditions continue to worsen," Mr. Culbert said, predicting that this will go on until results weaken for alternative risk financing markets, low-cost producers that have drawn profitable business away from traditional insurers.

"When low-cost producers get in trouble is when you get a pricing turn," she said.

"If anything, I thought that competition picked up in the second quarter," Ms. Vogel said.

"The big story is what's not happening," Mr. Levin agreed, referring to insurers' failure to halt rate erosion. "Pricing is entirely inadequate."

- With cash flow shrinking and interest rates declining, investment income once again grew only modestly, expanding 4.3% to \$7.76 billion in the first half from \$7.45 billion in first six months of 1990. Investment income had expanded 4.8% for all of 1990 and 5.8% in the first half of last year.

To improve cash flow, insurers would have to start raising prices, but instead, their response typically has been to "wring their hands and say the guy across the street has been cutting prices and has to stop," Mr. Smith observed.

- Policyholder surplus for 27 of the 30 surveyed companies rose 5.4% to \$41.72 billion at June 30 from \$39.57 billion at June 30, 1990. Surplus for a similar but not identical group of companies had increased 4.1% by year-end 1990 and 2.7% at mid-year last year.

- Net income for 26 of the companies slid 0.9% to \$3.45 billion for the first half from \$3.48 billion for the same period in 1990. For all of 1990, insurers had posted a 27.4%

drop in net income, compared with an 8.6% decline for the first six months of last year.

Among individual insurers, the biggest surprise to analysts was General Re Corp., which reported an \$11.9 million first-half underwriting loss, compared with a \$7.5 million loss in the first half of 1990. General Re also reported a combined ratio of 101.7%, up from 99%.

General Re Chairman Ronald E. Ferguson blamed the "unsatisfactory" results on higher-than-expected claims activity, including workers compensation losses from prior years and higher property and property catastrophe losses during the first six months of this year.

General Re's results "knocked the wind out of a lot of people's sails," observed Ms. Culbert.

The results of other insurers within the group of 30 varied widely:

- The Home Insurance Co. reported first-half net income of \$50

million, compared with a loss of \$58 million for the same period last year. Last year's first-half numbers included substantial losses from The Home's portfolio of junk bonds while under the ownership of AmBase Corp. The Home was sold earlier this year to a group led by Swedish insurer Trygg Hansa SPP Holding AB (*BI*, Feb. 18).

- Chubb Corp.'s combined ratio dropped to 98.6% from 101.7%, and its net income rose 17.8% to \$261.3 million from \$221.9 million.

- Aetna Life & Casualty Co. reported net income of \$296.9 million for the first half, down 22.6% from \$383.6 million in 1990's first half. Aetna's second-quarter results suffered partly from \$12 million in net aftertax capital losses that included \$78 million in reserves for mortgage loan losses and real estate write-downs, partially offset by gains from the sale of its interests in La Estrella S.A. de Seguros, a Spanish insurer,

and mutual bond insurer MBIA Inc.

- CIGNA Corp.'s net income rose 9% to \$218 million for the half from \$200 million in 1990's first half on the strength of realized investment gains of \$41 million in the first half of 1991 compared with \$9 million in the corresponding period of 1990.

Continued on next page

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Health insurers

Continued from page 1

In many cases, group health insurers' trend factors—which are used to project premium hikes and which include both health care inflation and increases in utilization—were higher than their actual experience.

Take, for example, The Principal Financial Group in Des Moines, Iowa. Its 1991 pricing assumptions were based on a 21% to 24% trend factor, but costs have actually risen only 18% to 19%, explained Richard H. Neil, senior vp-group.

Partly because of that, the mutual insurer posted statutory earnings from its group life and health insurance business of \$116 million during the first half of 1991.

This year marked the first time in its 112-year history that the insurer has released six-month results. Harlan Bergman, The Principal's vp-corporate accounting and controller, said the results were released to counter consumer uncertainty over the solvency of life and health insurers. The company was unable to provide comparable figures for 1990.

Mr. Neil said the difference between actual and predicted trends is "the primary engine driving (The Principal's) profits."

Met Life set its group indemnity plan premiums using a trend of 22% and its managed-care plans using trends of 12% to 18%. In reality, costs have risen about 18% to 19% for indemnity plans and 10% for managed care plans, said Mr. Galasso.

Met Life led the group life and health insurers examined, with a nearly 16% increase in profits for the first half. The company posted \$88 million in profits during this period, up 15.8% from \$76 million in the first half of 1990.

Cooling medical inflation is partly fueling the reduction in insurers' actual trends. For the six months ended in July, the medical care component of the Consumer Price Index rose an annualized 7.5%, according to the

P/C results

Continued from previous page

"Although CIGNA's second-quarter net income was up, our operating results continued to be constrained by weak property/casualty performance, which still reflects inadequate industry prices," Chairman Wilson H. Taylor said.

- Reliance Insurance Co. and its units reported that first-half net income fell 97.3% to \$4.8 million from \$174.4 million in 1990. The 1990 figure included a \$245.5 million gain from the sale of General Casualty Insurance Co., partially offset by \$80.7 million in aftertax losses from the sale or write-down of investments.

- CNA Financial Corp. reported a 49.3% increase in net income to \$271.9 million in the first six months from \$182.1 million in the same period last year. Excluding net realized investment gains, however, CNA's net income would have been \$188.8 million, up 6.2% from \$177.1 million for the first six months of 1990.

While most insurers are complaining about the soft market's impact on their bottom-line results, few observers hold out any hope of the competition easing soon.

Losses from Hurricane Bob, while possibly affecting some insurers more heavily than others, will not have any significant impact on market conditions, observers agree.

"It will be a factor, but nothing enormous," Mr. Lewis said.

In discussing market conditions, brokers and underwriters "are even less encouraging than they were three months ago," Mr. Lewis added. "There's nothing we see that gives any indication of any near-term recovery in the primary and reinsurance sectors."

"There is no sign that there is going to be any change in the market," Ms. Stewart said.

Asked about the possibility of a 1992 market turn, Ms. Culbert replied, "Humbug." ■

U.S. Department of Labor's Bureau of Labor Statistics. While this still soars above the CPI's modest overall increase of 2.2% for the same period, it does reflect a slowdown from the 9.6% rise in the medical care component in the first half of last year.

Why insurers' forecasting of trends proved so favorable is a subject of debate.

One factor may be that "the trend has basically stayed at the same level for two years now," explained John P. Cole, executive vp and chief executive officer-employee benefits division at Lincoln National Corp. of Fort Wayne, Ind. Lincoln National boosted its group life and health profits by 9.8% during the first half of the year to \$16.8 million, compared with \$15.3 million for the first half of 1990.

Charles T. Bell, senior vp-health plans for Aetna Life & Casualty Co. in Hartford, Conn., said: "Inflation has been fairly steady the past two or three years. The longer it stays

steady, the better you are at predicting (the trend)."

Aetna's predictions helped it post a 6% increase in group health and life profits to \$142 million for the first six months, up from \$133.9 million in the same period last year.

"We have been on top of the cost trends," said Thomas E. Burton, vp and actuary with Travelers Corp. of Hartford, Conn. Hence, "profits are pretty much tracking revenue growth."

Specifically, Travelers' roughly 5% rise in group life and health revenues resulted in a 7.5% boost in profits, he said. For the first six months, the company's managed care and employee benefits operations posted profits of \$50.4 million, compared with \$46.9 million for the same period last year.

Yet Mr. Neil won't go so far as to declare that group health insurers have mastered the trend game. "I don't know that I would say the industry is getting better" at predicting trends. "Nobody has been real good

about predicting the future. You're fortunate when you guess high and it goes the other way," he observed.

"It's a predictive game. You take your best shot and see which way it goes," said Mr. Fitzgerald, chief financial officer of the employee benefits division at Philadelphia-based CIGNA Corp.

Another factor behind some insurers' improved results is growth in managed care businesses.

At CIGNA, for example, first-half group life and health earnings fell to \$111 million from \$116 million in 1990. But second-quarter results have stabilized year-to-year and HMO business "continues to improve," said Mr. Fitzgerald.

CIGNA's results include EQUICOR Inc., which it bought in March 1990.

The profit decline, Mr. Fitzgerald asserted, was due more to "isolated incidents" in its indemnity business than anything else.

Sharply lower HMO losses played a significant role in Aetna's earnings growth. Aetna has cut first-half

losses from its HMO business nearly in half, to \$12.7 million this year from \$22 million in 1990.

"I think we said entering this year that a big factor for us would be the improvement in the HMO business," said Mr. Bell. That prediction held up, even if the HMO business is still spilling red ink on an otherwise healthy income statement.

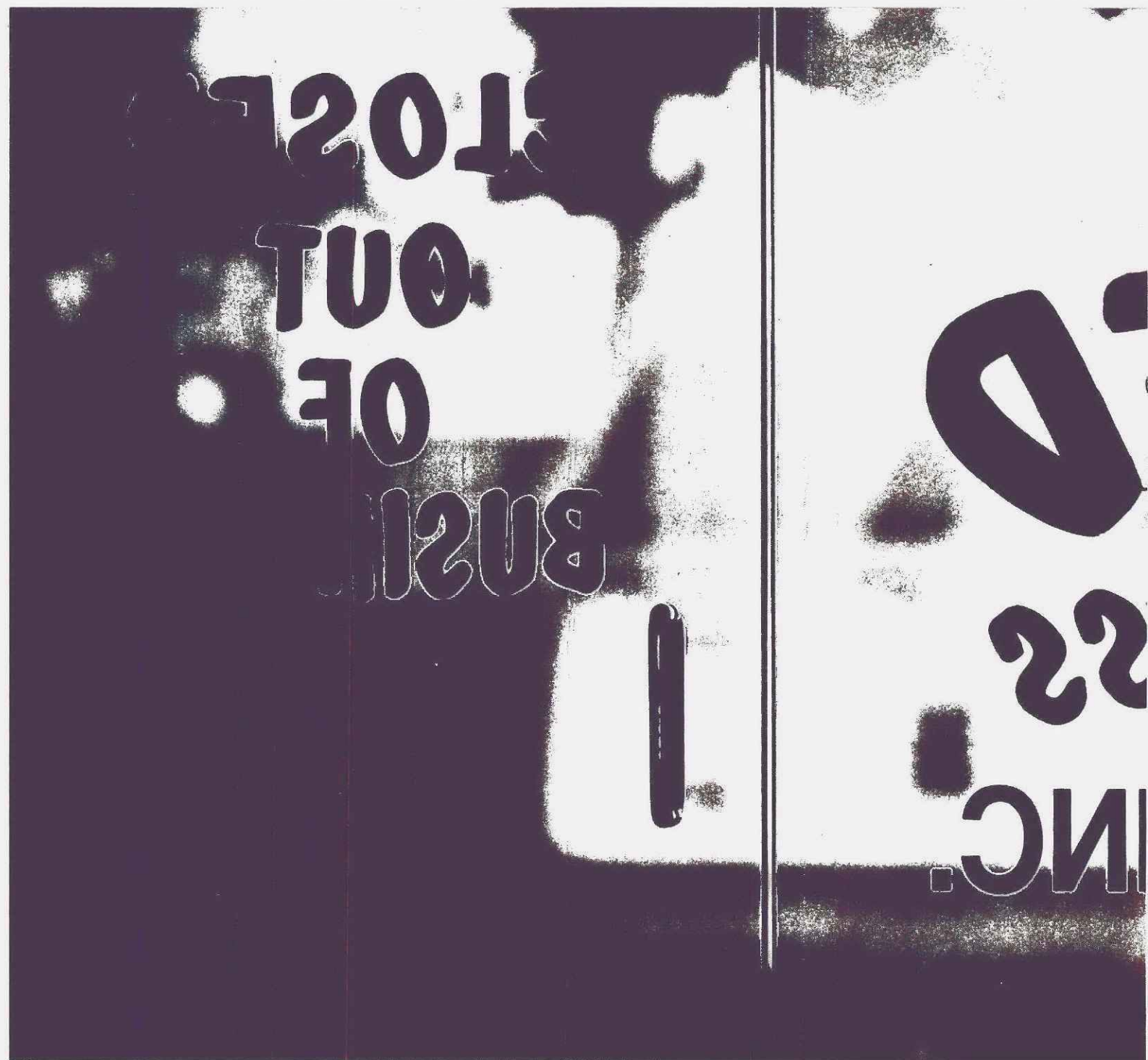
"Even though it's not at a satisfactory level, it's clearly pushing (profits) in a positive direction," Mr. Bell said of the HMO results.

He added that the insurer is hoping its HMO business will "break into the black next year."

Mr. Cole said Lincoln National continues to build upon its success at bringing managed care plans to small businesses. Both sales and profit margins are good for this segment of the business, according to Mr. Cole.

Improving results for Lincoln National's managed care business are due to better administration of, and

Continued on next page



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Continued on next page

more participation in, the plans. "We've become more efficient, and have more people sited in managed care," explained Mr. Cole.

Another element boosting some group health insurers' bottom lines is the growth in their administrative-services-only business. Under ASO contracts, insurers administer claims and handle other chores for employers that self-fund their health care plans.

"One of the trends we've seen developing for several years is the increase in service arrangements," Mr. Burton observed. For instance, 40% of Travelers' managed care and employee benefits premiums and premium equivalents consists of ASO agreements. "That is a factor that will serve to stabilize the (insurance) business," he said.

At Aetna, the reliance on ASO agreements is even higher; Mr. Bell reported that 65% of the group health and life claims handled by the company come from this area. "That's not

a risk-based business," he explained. Hence, it is "inherently stable."

"There's been a big push by insurance companies to get out of the insurance business," said Ed Freedman, managing director-national health and welfare practice for Alexander Consulting Group in Lyndhurst, N.J. They are increasingly moving into managed care, consulting and ASO business, he said.

But ASO business isn't likely to grow much more, according to The Principal's Mr. Neil, who reported that 30% of the company's group health and life premiums and premium equivalents comes from this area. "ASO business, where we transfer the risk to the customer, represents predictable income to the insurance company," he said.

Principal therefore would like to see this become a larger portion of its business. But that can only happen at the expense of other insurers, said Mr. Neil. "The self-funding market is pretty saturated."

However, some new ASO business

will be generated as the number of participants required to make self-funding viable is dropping, Mr. Neil said. "It used to be 500 participants, then 250, now it's pushing down to 100."

Despite the better-than-expected profits in the first half of the year, insurers say a downward turn is looming on the horizon. Indeed, some of the insurers already report some increasing competition.

Mr. Cole observed that health insurers are not yet charging premiums below their trend factors, but "it will happen," albeit in a more controlled, strategic manner than in previous cycles.

And as pricing becomes more competitive and medical inflation continues to cool, premium hikes should shrink.

"That's good news for the consumer," declared Fred Cue, senior vp-finance with the Blue Cross & Blue Shield Assn. in Chicago. The non-profit association's plans posted combined earnings of \$758 million

during the first half of 1991, a 3.8% drop from \$788 million during the same period last year.

Despite the drop, Mr. Cue said the Blues' first-half results were running ahead of 1991's projections.

"The trends are still going up at double-digit rates," said Mr. Cue, alluding to increases in both health care costs and the premiums insurers charge. "I don't see much abatement of that."

However, he noted that for the last six months, overall rate increases have been running at 19% to 20%, while as recently as the middle of last year, rate increases were hovering around 25%.

Partly in light of that, Mr. Cue predicts that health insurers' results will turn downward in 1992, though "it isn't going to be as bad as past down cycles."

Travelers' Mr. Burton is seeing evidence that the good times for health insurers may be drawing to a close. Competition is growing intense "and that's putting some pressure on

prices," he said.

The improvement in first-half profits clouds the fact that there has been "a fair amount of shopping" among insurers by small and medium-sized companies looking to cut costs during the lingering recession, he said.

Companies also are both laying off workers and reducing the health care benefits they provide because of the recession, Mr. Burton reported. If these trends continue, insurers are sure to feel the pinch, he said.

"I don't really see an easing of competition. Possibly, if there is a strong economic recovery, some of the shopping of business will ease a bit, but we're not counting on that," Mr. Burton said.

"And when you start seeing competitiveness, that's usually the start of the downturn" in health insurers' results, observed Met Life's Mr. Gallaso. As a result, "we are somewhat nervous about whether we are on the verge of an underwriting down cycle," he added.

Yet none of the insurers contacted expects the impending change in the group health insurance market to be as traumatic as previous competitive markets.

For instance, while Mr. Neil believes 1992 will be less profitable, "I wouldn't call it a bad year."

Meanwhile, CIGNA's Mr. Fitzgerald is actually predicting a slight turnaround for that company's group health business. "I'm not sensing at this point that the down cycle is prevalent. We expect to make more money in '92 than in '91."

Mr. Fitzgerald's view reflects the fact that the company is expecting its specialty products, like substance abuse and mental health coverage, to benefit from the trend among companies to carve out these types of coverages from their basic health care plans.

Meanwhile, Mr. Young of The Wyatt Co. remains unsure about what to expect in '92. "We're looking at a health care delivery system that is undergoing tremendous change." ■

P/C insurers report profits of \$6.23 billion

The overall property/casualty insurance industry is faring better than the predominantly commercial insurers tracked by *Business Insurance*.

The U.S. property/casualty industry's net income rose 22.7% in the first half to \$6.23 billion from \$5.08 billion in the first six months of 1990, according to a survey by the Insurance Services Office Inc. in New York and the Des Plaines, Ill.-based National Assn. of Independent Insurers.

By contrast, commercial insurers surveyed by *BI* reported net income fell by 0.9% in this year's first half (see story, page 1).

Net premiums written by the industry rose 2.6% in the first half to \$112.52 billion from \$109.65 billion in the corresponding period of 1990. The insurers surveyed by *BI* reported that premium volume fell 1.8% in the first half of 1991.

The industry's underwriting losses decreased by 3.4% to \$10.55 billion in the first half from \$10.92 billion in the first six months of last year. The insurers surveyed by *BI* reported that underwriting losses rose by 6.9%.

The insurance industry reported an aggregate combined ratio of 109% in this year's first half, an improvement over 109.4% in the first half of 1990. The insurers surveyed by *BI* reported an aggregate combined ratio of 111.1% in this year's first half, compared with 109.9% a year ago.

While the industry's first-half combined ratio improved, its second-quarter combined ratio deteriorated to 110.4% in 1991 from 109.9% in 1990. *BI* does not track combined ratios on a quarterly basis.

The insurers surveyed by *BI* account for about 41% of the overall industry's premium volume. ■



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Health care fraud

Continued from page 3

count indictment charging 12 defendants in what authorities allege is the largest medical insurance fraud scheme ever uncovered (see story, page 36).

Victims of the alleged scheme include insurers, self-insured employers and the Civilian Health and Medical Program for the Uniformed Services (CHAMPUS), the federal health care program for the armed services.

According to the indictment, mobile diagnostic labs—allegedly run by brothers Michael and David Smushkevich—would advertise “free exams” and would require patients only to assign their insurance benefits to the lab. The lab then would fabricate diagnoses, perform unnecessary tests, bill the insurer and often pass along information to other labs in the network so they could submit more claims, the indictment says.

The labs submitted about \$1 billion in claims to insurers, the U.S. Attorney's office charged.

Insurers denied a vast majority of the claims, but they still paid about \$50 million of fraudulent claims, according to U.S. Attorney's office (BI, July 15).

When claims were denied, the Smushkevich labs often sold them as accounts receivable to billing firms, which resubmitted the claims, according to Edward Baer, assistant general counsel at Metropolitan Life Insurance Co. in New York.

“They got millions out of that,” Mr. Baer charged.

Met Life, Aetna Life Insurance Co. of Hartford, Conn., and Employers Health Insurance Co. of Green Bay, Wis., last year won an \$18 million civil racketeering judgment against the Smushkevich brothers (BI, Feb. 26, 1990). However, “we haven't been able to collect on that because they fled the country,” Mr. Baer said, though he said some money that was allegedly laundered could possibly be recovered.

“We feel that Met and Aetna were in the forefront in stopping this fraud. It would have been 10 times greater if we hadn't commenced this RICO action and gotten a judgment,” Mr. Baer asserted.

Insurers say they still face a daunting challenge in attempting to stop health insurance fraud but that they are well-armed.

The Smushkevich operations are “so big, I believe many of them will get away,” said Michael Lohnberg, vp of corporate audit and head of the fraud investigation unit at Blue Cross of California.

The volume of suspect claims from rolling labs in California has declined every year since 1985 and is now “a trickle,” said William J. Rodgers, vp of investigation at the Prudential Insurance Co. of America in Parsippany, N.J. “But there is still some activity from the Smushkevich operations,” he alleged.

And, though claims from rolling labs have dwindled, “the amount of medical care payments keeps going up astronomically, and we're sure health care fraud is going up” proportionately, Met Life's Mr. Baer said.

When the Smushkevich operation was at its peak in mid-1988, Aetna was receiving about \$2.5 million a month in suspicious claims, said James Garcia, director of claims support and core services at Aetna.

Aetna received a total of about \$50 million in suspicious claims from the operation and paid about \$3 million, he said.

One tipoff for Aetna was the fact that some labs were billing for services from post office box numbers. “That was a key indicator,” Mr. Garcia said.

Now, copycat labs are operating in Texas, Florida, Illinois and New York and market their services the same way the Smushkevich labs did, Mr. Garcia said.

But, “fortunately we haven't seen them in the magnitude” of the

Smushkevich labs, he said.

The offshoots and copycats of the Southern California operation have billed only about \$5,000 to \$6,000 per patient, compared with \$10,000-\$15,000 per patient billed by the Smushkevich labs, Mr. Garcia said.

At the same time, Aetna has increased its fraud investigation staff “tremendously,” he said.

“We started our medical fraud detection unit in 1982, with one person. Today we have 18 people in our home office” dedicated to medical fraud detection and approximately 60 to 70 people in the field who work at fraud detection part of the time, Mr. Garcia said.

“Our resources have increased, and so have statistics and findings” on insurance fraud operations, he continued. As a result, “last year alone we prevented over \$150 million” in payments of phony health insurance claims, he said.

In response to grand jury subpoenas, Blue Cross of California has turned over \$100 million in potentially phony claims to investigators, Mr. Lohnberg said. The insurer first reported potentially phony claims from the Smushkevich operation in 1985 and has since denied \$86 million in claims, largely attributable to its fraud-detection staff, he said.

Blue Cross of California receives between \$1 million and \$2 million a month in suspicious claims, according to Mr. Lohnberg. From January through March of this year, the insurer flagged \$2.3 million in suspicious claims that the insurer believes were submitted by “a form of a rolling lab,” he said.

Of that amount, the insurer rejected \$1.9 million, or 5,300 claims, he said.

“We have initiated educational programs within our organization on fraud awareness. Our employees recognize phony claims and deliver them directly to me,” Mr. Lohnberg said.

Employees have been given “four pages of clues to potential fraud,” he explained.

No one clue indicates a claim may be fraudulent, but many clues appearing on a single claim will trigger further scrutiny, Mr. Lohnberg pointed out.

For example, Blues employees look for:

- Many claims for a variety of tests run on the same individual that are submitted by different clinics with different tax ID numbers that are based at the same location.

- Claims submitted for the same individual by separate clinics whose tax ID numbers are identical except for the last few numbers.

The clues to possible fraud were developed “as a byproduct of the investigative process” in the Smushkevich case, Mr. Lohnberg explained.

Computers with highly developed software “enable us to look more quickly” for these warning signs, Mr. Lohnberg said.

“We make thousands of payments every week, so just accessing payments to the same address was a monumental task” prior to the development of a computer system, he said.

In addition, the cost of software and hardware had dropped so that computer searches now are less costly and are performed more often in the effort to detect fraud, he said.

Prudential's anti-fraud efforts have been formalized “in response to a general perception that health insurance claim fraud is on the increase,” Mr. Rodgers explained.

Prudential formalized its antifraud efforts in 1987 by establishing its Anti-Fraud Network, or AFNET, which “has open communication channels with all Prudential claim paypoints for both group and individual insurance products,” Mr. Rodgers said.

Depending on their size, the so-called paypoints—which are Prudential's six regional offices—are each staffed with at least one person responsible for fraud detection, he explained. Prudential also has increased fraud-detection training for

its claim examiners.

And, “AFNET puts out a monthly newsletter dealing with fraud that is disseminated to all claim examiners,” Mr. Rodgers said.

Given Prudential's size, “we're surprised that we paid as little as we did in the Smushkevich scheme, and we believe it's something of a tribute to our AFNET people that our losses were as low as they were,” he asserted, declining to elaborate.

Met Life's “claims offices are more attuned” to fraud, and employee training and computers have helped in fraud detection, Mr. Baer said.

“We had to have a dedicated staff” to work on the Smushkevich case, Mr. Baer said. “But, we don't have as many people working on that anymore” because the volume of suspicious claims associated with rolling labs in Southern California has decreased, he said.

In addition, “we're wise to them and we don't pay,” he said.

However, because attempted health care fraud in general is on the rise, Met Life has not let down its guard. “We have employers more attuned to recognizing fraudulent claims from employees,” Mr. Baer pointed out.

“We've issued instructions to employers about various kinds of fraud. A problem area is employees that get to handle claims. They know the system, so from time to time we find them involved in submitting fraudulent claims,” Mr. Baer said.

Employers Health has had a special investigations unit in place since 1985 and currently has nine investigators deployed across the country, said John Malloy, director of special investigations for the Wisconsin-based insurer.

Employers Health also has increased its employee training and has developed systems for its computers that help detect fraud, Mr. Malloy said, declining to elaborate.

Many health insurers, including Employers Health, also are members of the Washington, D.C.-based National Health Care Antifraud Assn., which was established in 1985.

The association's 21 insurer members have developed a data base that will allow them to share information on suspected fraudulent activity “in a controlled, legal manner,” said Executive Director William Mahon.

Data on suspected fraudulent activity—based on evidence from member insurers' investigations—will be collected and shared with other members, which may use the information in their own investigations.

However, members have adopted guidelines that prevent them from denying claims from a provider solely because that provider's name appears in the data base. “This is in no way a blacklist,” Mr. Mahon explained.

The association also will evaluate the data “with an eye toward turning it over for further investigation and prosecution,” he added. Several public agencies, including the U.S. Justice Department, are association members.

So far, data on suspected fraudulent activity has been collected in Pennsylvania, Florida, Illinois, New York and Ohio, but the association plans to expand the project nationwide.

Meanwhile, employees and dependents covered by health insurance plans also can help insurers detect fraud by reporting to their employers or insurers any discrepancy on the explanations of benefits they receive from the insurer.

“There are companies that pay rewards to employees that detect billing errors,” Blue Cross' Mr. Lohnberg pointed out. Some of those errors may in fact be fraudulent claims, he said.

And as part of its “lightning bonus” program, Blue Cross rewarded a Blues employee who detected \$30,000 in claims from the Smushkevich operations that Blue Cross determined were phony, Mr. Lohnberg said.

Met Life sends mailings to the homes of employees covered under

Labscam: The players and their alleged crimes

LOS ANGELES—After more than five years of investigation by several federal and California state agencies, a dozen people face criminal charges for what authorities allege is the largest medical insurance fraud scheme ever uncovered.

Diagnostic laboratories run by Michael and David Smushkevich conducted up to \$1 billion in unnecessary or phony tests over the past five years, according to a 175-count grand jury indictment of the 12 defendants. Although insurers paid only a fraction of the amount billed, they paid \$50 million in fraudulent claims, according to the U.S. Attorney's office in Los Angeles (BI, July 15).

The indictment names:

- The Smushkevich brothers and their wives, Alla and Tamara, all four of whom allegedly directed and managed the operations.
- Randolph Shipley, an attorney for the operations.
- Adriana Tobena, allegedly the head of the labs' billing operations.
- Boris Ivaskov, who allegedly ran the operation's telemarketing.
- Michael Faiman, who allegedly owns a clinic used in the scheme.
- Arthur Lucero, who allegedly managed several of the clinics.
- Carolyn Vasquez, who allegedly managed a clinic.
- Dr. William O. Kupferschmidt, who allegedly was medical director of several clinics.
- Dr. Ameer M. Dikshit, who allegedly was employed by many of the clinics.

Under this indictment and earlier indictments stemming from the mobile lab operations, the defendants face charges of mail fraud, conspiracy wire fraud, theft of government property, false claims against a government agency, interstate/foreign transportation of property obtained by fraud, travel in aid of racketeering, passport fraud, false statements to federal agencies, money laundering, and violations of the Racketeer Influenced and Corrupt Organizations act.

If convicted on all counts, Michael Smushkevich faces up to 1,980 years in prison and more than \$156 million in fines. David Smushkevich faces up to 675 years in prison and more than \$124 million in fines and other penalties. The remaining defendants face sentences ranging from a low of 210 years in prison and more than \$107 million in fines to a high of 890 years in prison and \$128 million in fines and other penalties.

Bogich Jovovich, an officer of several of the Smushkevich operations who had been charged in previous indictments, pleaded guilty to mail fraud and conspiring to defraud insurers. He was not named in the latest indictment.

—By Louise Kertesz

Met Life health plans asking them to be on the alert for fraud.

“Some of our units pay a bounty” to patients who report an insurance bill that is inaccurate, Mr. Baer noted. “Our units will pay 50% up to \$1,000 to the employee who turns in” the inaccurate bill, he said.

“We also have an 800 number that subscribers can use to report anything irregular” regarding their health insurance payments, Mr. Baer said.

Employers Health also has had an anti-fraud hot line in place for 3½ years, which covered lives are putting to good use, Mr. Malloy says. “What we're finding is that people are becoming more educated and aware of these problems.” Since the alleged Smushkevich scam, people “are more knowledgeable, and they're contacting us,” he said.

“Employees are our eyes and ears. They're our best defense,” Aetna's Mr. Garcia asserted.

When the Smushkevich labs were operating at their peak, “we should have been flooded with calls, and we weren't,” Mr. Garcia said.

Even now, with all the publicity about insurance fraud, “it looks like only the insurance company was ripped off. But we were all ripped off. Fraud definitely impacts premiums, deductibles and quality of care,” he asserted.

Mr. Garcia said the best way to educate policyholders' employees to be alert to health insurance fraud is “to let them know they are the victims, they're viewed as dollar signs.” Employers should tell employees, “Don't trust your life and health to their hands,” he said.

Continued on next page

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Health care fraud

Continued from previous page

"Costs don't make that much of an impression" on employees, Mr. Garcia said. "But tell them their health is in jeopardy because of these types of individuals," he advised.

In addition, insurers "still don't have what I call a complete ability to share information," Mr. Garcia said.

To combat fraud effectively, the insurance industry needs more freedom than currently is allowed under antitrust laws to share information about providers or individuals suspected of filing phony claims, Mr. Garcia believes.

"Aetna detected the rolling labs

in late 1985. It would have been nice if we could have been able to inform other insurance companies and other payers of what we were finding and alert them. We would have prevented a lot of dollars" paid to the Smushkevich operations, he said.

"And, we don't have a law that addresses health care fraud on a national basis," Mr. Garcia complained.

However, individual insurers and the American Council of Life Insurance, an industry trade group, support S.B. 894, pending in the California Legislature. The bill calls for assessing health insurers and self-insured employers to fund increased investigation and prosecution of fraudulent health insurance claims in California.

Insurers and self-insured employers would be assessed 10 cents per covered life annually, said Leah Carabruno, a consultant with the California Senate Insurance Committee. There is as yet no estimate of how much money the bill would raise annually, she said.

The bill, introduced by Sen. Alan Robbins, D-North Hollywood, would "provide for the release of information regarding health insurance fraud to specified authorized governmental agencies."

The bill would exempt insurers and others releasing such information from "civil liability for libel, slander or any other relevant tort cause of action."

It also would stiffen penalties for

submitting fraudulent health insurance claims to up to five years in prison and/or a \$50,000 fine.

S.B. 894 has been passed by the Senate and is now before an Assembly committee. Gov. Pete Wilson is expected to sign the bill if passed.

Mr. Lohnberg of Blue Cross of California said he supports S.B. 894 "in principle." But, he added, the bill does not affect the licenses of "medical practitioners guilty of wrongdoing."

He noted that David Smushkevich, who is named in the Los Angeles indictment, was previously convicted of health insurance fraud involving Medicare and was directing the alleged mobile lab operations from prison before his release. ■

Insider trading

American International Group Inc.: M. Bernard Aidinoff, director, purchased 100 shares of American International Group common stock at \$83.13 per share on July 17.

Mr. Aidinoff now directly holds 2,399 common shares.

AIG stock was trading at \$84.25 per share on Aug. 30.

Chubb Corp.: Philip J. Sempier, vp, exercised an option for 5,452 shares of common stock at between \$24.50 and \$43.25 per share from July 9 to July 31.

Mr. Sempier now directly holds 6,452 common shares of Chubb Corp. stock.

Chubb stock was trading at \$65.25 per share on Aug. 30.

The Hartford Steam Boiler Inspection & Insurance Co.: Donald M. Carlton, director, sold 3,000 shares of common stock at \$56 per share on July 29.

Mr. Carlton now directly holds 30,332 common shares.

T. Skipwith Lewis, vp, exercised an option of 6,100 shares of common stock on July 8 and now directly holds 28,021 common shares.

Hartford Steam Boiler stock was trading at \$52.75 per share on Aug. 30.

Marsh & McLennan Cos. Inc.: Peter Coster, director, exercised an option for 8,000 shares of common stock at \$33.19 per share on July 30, 1991, and now directly and/or indirectly holds 23,559 common shares.

Marsh & McLennan stock was trading at \$76.50 per share on Aug. 30.

Poe & Associates Inc.: V.C. Jordan, president, sold and disposed of by gift 51,100 shares of common stock at an unreported price per share from July 19 to July 30 and now directly holds 171,210 common shares.

William F. Poe, chairman, indirectly sold 70,000 shares of common stock at \$11.88 per share on July 19 and now directly and indirectly holds 1.28 million common shares.

W.F. Poe Syndicate Inc., beneficial owner, sold 70,000 shares of common stock at \$11.88 per share on July 19 and now directly holds 474,969 common shares.

Poe & Associates stock was trading at \$11.50 per share on Aug. 30.

SAFECO Corp.: William G. Reed, director, indirectly sold 25,000 shares of common stock at \$40 per share from June 11 to June 14 and now directly and indirectly holds 569,830 common shares.

John W. Ellis, director, purchased 500 shares of common stock at \$28.50 per share on Aug. 13 and now directly holds 3,512 common shares.

SAFECO Corp. stock was trading at \$38 per share on Aug. 30.

UNUM Corp.: Kevin P. O'Connell, officer of a subsidiary, exercised an option for 2,000 shares of common stock and sold 2,000 common shares at between \$30.31 and \$66 per share on May 3.

Mr. O'Connell now directly and indirectly holds 4,282 common shares.

UNUM stock was trading at \$63.13 on Aug. 30.

Insider Trading, compiled by Invest/Net Trading Group Inc. of Fort Lauderdale, Fla., from reports filed with the Securities and Exchange Commission, tracks stock sales and purchases by insurance industry directors and officers. The column is distributed by Tribune Media Services Inc.

The IRI Difference:

Agents and Brokers Play a Vital Role in Servicing Your Needs

"One of the unique aspects of The IRI Difference is the overall service an insured gets from *two* organizations—your agent or broker *and* IRI," said Gail Norstrom, Jr., IRI Senior Vice President—Operations. "Our challenge is to provide superior service to our producers so that *together* we can satisfy your needs.

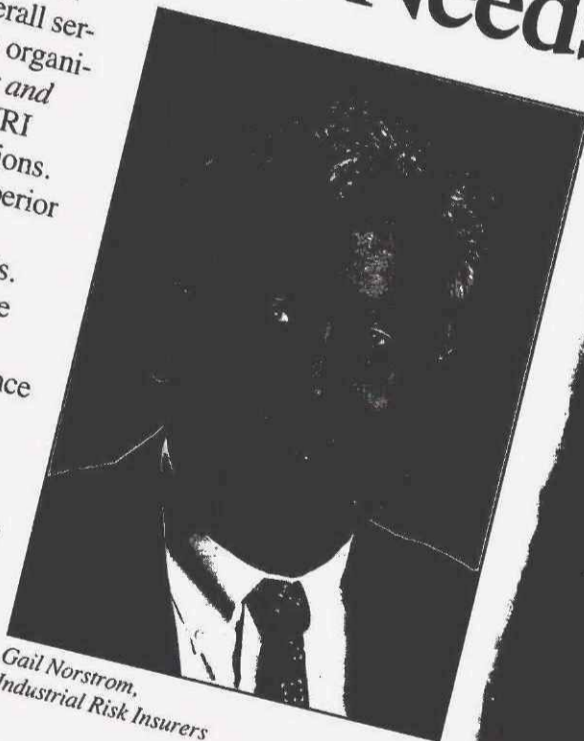
"Agents and brokers have one job—making sure your insurance needs are met. They're your insurance consultants. They help you identify your coverage and service requirements and they find the most financially stable insurer able to provide the right services and products for you. Many producers also have loss prevention specialists to help you protect your facilities. Others have claim specialists to represent you in the claims adjusting process.

"And all producers offer you a current awareness of the marketplace, which is invaluable when balancing needs and costs," he said.

"IRI appoints a team to work with your agent or broker, and you, on every account," Mr. Norstrom added. "This team includes an account executive, an underwriter, a loss prevention

representative and, in many cases, a claims adjuster. Their job is simply to provide the best of the services your agent or broker and you have decided to purchase.

"IRI insureds have two teams of insurance professionals representing their interests," he said. "This kind of extraordinary service is a key component of The IRI Difference."



Gail Norstrom, Jr.
Industrial Risk Insurers

IRI

can make a difference

Aviation rates

Continued from page 1

a director of the aviation division of Sedgwick Group P.L.C. "There's a mood among underwriters that they must develop more premium, and they are looking at autumn renewals to start back on the road to profitability."

Although Mr. Hargreaves would not be more specific, he said that there would be "dramatic increases in rating levels" for airline hull and liability coverages. "The loss figures have been piling up, and underwriters have to have more money."

In addition, the sensational contraction of the excess-of-loss reinsurance market "is part of the trigger" for rate increases, Mr. Hargreaves pointed out.

"We as underwriters are seeking substantial improvement in terms," said Graham Lilley, underwriter on the European/Middle East division for the British Aviation Insurance Group, London's largest aviation insurer. "It is improper to mention percentages, but we are trying to get rates up."

Airline insurance rates had fallen for four consecutive years from 1986 to 1990, wiping out aviation insurers' profits. In 1990, for example, insurers collected \$275 million in premiums, but paid out almost \$775 million in claims, according to Bain Clarkson Reinsurance Brokers Ltd. (BI, June 3).

But rates began to climb earlier this year. On Feb. 1, for example, USAir Group Inc.'s hull rates increased 119% and its liability rates increased 135% (BI, Feb. 11). However, because USAir reduced the value of its fleet and the number of revenue passenger miles flown, USAir's overall premium increased only 28% from the previous year.

By the spring and early summer, aviation brokers and underwriters said that hull rates on average had risen by 46%, while liability rates had grown by 48%.

During summer renewals that were placed around July 1, some airlines were socked with rate increases of about 100%, according to underwriters (BI, Sept. 2).

One London underwriter, for example, said that the hull rate for Continental Airlines' \$6.55 billion fleet increased by 108%, while the rate for the airline's \$1 billion in liability coverage rose 24%.

Jeffrey J. Gehrke, senior director-risk management and insurance for Houston-based Continental, denied that Continental's rates rose that sharply. Rather, increases were "in the middle of the ballpark," he said.

However, Mr. Gehrke said he anticipates that rates will increase for several years.

The hull rate for Northwest Airlines' \$8.36 billion fleet rose 103% at its July renewal, while the rate for Northwest's \$1 billion of liability insurance rose 156%, London underwriters said.

The risk manager for St. Paul, Minn.-based Northwest did not return phone calls.

Air Canada's hull rate for its \$4 billion fleet rose 78% when it renewed its coverage this summer, while liability rates rose 117% for \$1.25 billion in coverage limits. Officials at the Montreal-based airline could not be reached.

Now, underwriters are expected to make a push to double and triple rates during the last quarter of the year, when most major airlines renew their coverage. Although the rate hikes are being led by London aviation underwriters, American insurers are considering similar increases.

"If you don't increase rates now and keep them the same as at renewal, then you are leaving the vast majority of airline (premium) income alone until the end of next year," said John Chapman, director of Bain Clarkson Reinsurance Brokers Ltd. "By that time (the aviation underwriters) won't have any money."

More than 20 airlines renew their hull and liability insurance programs in October, including such

'I think (year-end reinsurance renewals) will be a nightmare,' Mr. Chapman says.

giants as British Airways, United Airlines, Trans World Airlines, Pan American World Airways, Lufthansa Airlines, Singapore Airlines and Thai Airways.

Brokers last week were only starting to negotiate these renewals.

"It's been difficult so far to know what's going to happen, because there is no pattern" for October renewals, said one airline underwriter. "European underwriters have been talking 200% to 300%. London underwriters have been talking 100% rate minimums."

Speculation abounded in the London market last week that British Airways, a Sedgwick client that renews its coverage on Oct. 1, is being quoted a hull rate of between 7.5 cents and 8.5 cents per \$100 of insured value, compared with 2.5 cents last year. The renewal is not expected to be completed until later this month.

If British Airways' hull rate indeed does double or triple, it will be a clear sign that rates are skyrocketing industrywide, a London broker concluded. British Airways has no major losses on its books "so if it gets three times increases, those with losses could get more like four or five times," the broker said.

A significant increase in British Airways' rates "would be good psychologically for London" underwriters, added another London broker. "If the order is given, it's a hardening sign. Then there could be 300% increases in hull rates and a doubling of liability rates."

Sedgwick's Mr. Hargreaves would not comment on the speculation about British Airways' renewal. "I can't talk about it," he said, though he added that "underwriters generally are looking for increased rates" for all airlines.

"Forget the percentage (rate) increases," he said, noting that insurers are more interested in the amount of extra premiums airlines will be told to pay.

Mr. Lilley of BAIG, who reportedly quoted the hull rate of 8.5 cents per \$100 of value for the British Airways account, also would not comment.

Aviation underwriters also are insisting that airlines pay their premiums more quickly. Underwriters want 50% payment within 60 days of the coverage's inception, another 25% within 90 days and the final 25% within 120 days.

Previously, aviation underwriters have allowed airlines to pay 25% of their premiums every 90 days.

"There is a general feeling that we should get our cash in quicker," said Mr. Lilley, though he would not comment on the details of the

payment schedule.

The move to hike airline premiums and insist on more prompt payments is being fueled by the major contraction in the capacity offered by excess-of-loss reinsurers, including Lloyd's underwriters. Several Lloyd's excess-of-loss and aviation syndicates have shut down this year, observers note.

Aviation underwriters will need additional cash—to be generated by increased airline premiums—to cope with anticipated 400% to 500% increases in reinsurance costs. In addition, reinsurers likely will withdraw capacity if they are not satisfied with the front-end rates charged by aviation insurers.

"The XL market will be like nothing seen before," said Mr. Chapman of Bain Clarkson. Aviation underwriters are anticipating extra reinsurance costs "and I think that's good. . . Things have changed so dramatically since (the spring). Although we knew the XL market would be difficult at year end, the fact that much of it has disappeared is a surprise. I think (year-end reinsurance renewals) will be a nightmare."

Airlines that renew their coverage later in the year could see even larger premium increases as aviation underwriters begin to renew their excess-of-loss reinsurance programs, Mr. Chapman said. "Those (airlines) up for November renewals may be worse off because the realization of what is happening will have dawned on people."

However, Mr. Lilley disagrees that the push to move airline insurance rates upward is being triggered by the reinsurance market. He attributes the rate hikes to "the general market environment, where underwriters know that they need to make profits." ■

Plant fire

Continued from page 2

Forty state Labor Department safety and industrial hygiene inspectors are assigned to cover 180,000 North Carolina workplaces, according to the spokesman.

The Labor Department had requested a \$17.5 million budget for 1991—intending to add 108 to 110 safety and health inspectors—but instead had its budget and staff cut, the spokesman said.

Imperial Food, a privately held Atlanta-based company that operates another plant in Cumming, Ga., has insurance to cover the deaths and injuries, as well as the property damage caused by the Hamlet fire, according to Dan McLaughlin, the company's controller.

Mr. McLaughlin declined to comment on the coverage, though, and said he had no estimate yet of the property damage caused by the fire.

"As you can imagine, it's a mess up there," he said.

A Liberty Mutual spokeswoman confirmed that the insurer provides Imperial Food's workers comp coverage and said claims representatives have visited injured workers at several North Carolina hospitals.

"Liberty Mutual is moving quickly to provide workers compensation benefits to the families of those employees of Imperial Food Products who died in the fire and to those employees who were injured," the insurer said in a statement.

"We have catastrophe claims teams on the scene, and several Liberty Mutual rehabilitation nurses are with (the) critically injured and their families at six area hospitals."

North Carolina workers comp statutes provide for death benefits equal to two-thirds of a worker's average weekly salary including overtime for 400 weeks,

according to James J. Booker, chairman of the state Industrial Commission.

The law also provides for maximum disability payments of \$406 per week for injured workers, though Mr. Booker said injured Imperial Food workers—who made between \$5 and \$6 per hour—are unlikely to reach the maximum payment.

A recent North Carolina Supreme Court ruling also could expose Imperial Food to lawsuits by the survivors of those who were killed in the fire.

In an Aug. 14 ruling, the high court found that injured workers or the families of those killed on the job are not necessarily limited to the benefits provided by state workers comp law.

"When an employer intentionally engages in misconduct knowing it is substantially certain to cause serious injury or death to employees, and an employee is injured or killed by that misconduct, that employee or the personal representative of the estate in case of death may pursue a civil action against the employer," the court concluded in reinstating a wrongful death lawsuit thrown out by lower courts.

Whether such lawsuits could be supported in the Imperial Food case and whether or not the company would have any coverage if the suits were successful is uncertain, according to workers comp experts.

The employer liability section of workers comp policies typically excludes coverage for bodily injuries intentionally caused or aggravated by the employer, experts note.

If an employer were unable to collect from its workers comp insurer in such a situation, it might turn to its general liability insurer, though general liability policies also typically exclude coverage for losses "expected or intended" by the policyholder, experts note. ■

N.J. approves trust fund for uncompensated care

Around the states

TRENTON, N.J.—New Jersey's on-again, off-again provision for reimbursement of hospitals providing health care to the uninsured is alive once more after the state Senate recently approved a health care reform measure that, among other things, calls for the one-year renewal of New Jersey's Uncompensated Care Trust Fund.

Gov. James Florio, who last year opposed perpetuating the fund but supported a host of the other health care reforms contained in the measure, signed S.B. 3251 last month.

At the heart of the measure is the restarting and renaming of the Uncompensated Care Trust Fund, which adds a 19.7% surcharge to hospital bills paid by insured patients, self-payers, and state and local government agencies.

The money held in the revitalized New Jersey Health Care Trust Fund is distributed to hospitals hardest hit by uncompensated care.

The fund, which began in 1987 and was extended for two years in 1989, had expired Dec. 31, 1990. During the fund's lapse, hospitals had been applying their own surcharges to offset uncompensated care.

In addition to restarting the fund, the new law also: requires hospitals to contribute \$72 million over the next two years to fund community health care centers; extends Medicaid eligibility to pregnant women and children; ensures that more social workers will be located in emergency rooms to enroll people in Medicaid; and calls for the state to conduct a thorough study of the demographics of uncompensated care recipients.

"As it relates to the issue of un-

compensated care, the legislation contains some positive reforms," said Jim Morford, vp of the New Jersey Chamber of Commerce. "We're pleased with the expansion of Medicaid and it's good that there will be more social workers at hospitals to enroll people into Medicaid."

Dawn Perrotta, director of health and federal issues with the New Jersey Business & Industry Assn., a trade group representing employers, said she was glad the law caps the hospital bill surcharge at 19.7%.

"Without the cap, uncompensated care surcharges could easily go above 25%. Then you have people driving out to suburban hospitals that don't have the uncompensated care problem and only place a 3% surcharge on their bills. We don't want that," she said.

Ms. Perrotta also said employers are glad the law passed instead of a recommendation made last year by Gov. Florio's Commission on Health Care Costs to impose a special \$450 million payroll tax on all New Jersey employers to finance health care for the uninsured (BI, Nov. 5, 1990).

After signing the bill, Gov. Florio said he would not renew the fund next year after it expires June 30.

—By Judy Greenwald

New regulatory team

ST. PAUL, Minn.—Minnesota Commerce Commissioner Bert McKasy recently announced the formation of a team of analysts to conduct a special examination

into the financial health of 135 life/health insurers and 149 property/casualty insurers licensed in Minnesota.

The program, called the Special Accelerated Financial Exam Review, or SAFER, requires a temporary expansion of staff analysts and monthly—rather than annual—reporting by insurers. Commissioner McKasy has temporarily reassigned seven bank examiners and three members of the state's market conduct team to the project and will contract with area accounting firms for six Certified Public Accountants.

The SAFER department has already begun to compile data on the insurers, which as part of the Minnesota Commerce Department's ongoing rating program had been rated as 3, 4 or 5 on a 1-to-5 scale that measures capital, assets, management, earnings and liquidity. The CPAs will analyze the data and highlight potential problem areas like reinsurance, investments and cash flow.

Results will be referred to the Commerce Department's supervisory action review committee, which renders final evaluations on the financial health of insurers and makes recommendations to the commissioner.

Based on the results of the SAFER examination, regulators may require insurers to file additional information, like more detailed business and investment plans. Regulators also plan to use the SAFER results to help identify insurers for on-site field examinations.

—By Laura Mazzuca

Proposition 103

Continued from page 1

Proposition 103, approved by voters in November 1988, mandated that most property/casualty insurance "charges" in effect between November 1988 and November 1989 be rolled back to 20% below the November 1987 levels. However, the law granted relief to any insurer that could prove that the rate rollback and subsequent refunds to policyholders threatened it with insolvency.

The California Supreme Court subsequently upheld the rollback provision, but ruled that insurers were entitled to a fair rate of return, which it did not specify (*BI*, May 8, 1989). The Insurance Department, under former Commissioner Roxani Gillespie, then began to draft regulations to implement the rollback. However, Mr. Garamendi scrapped those rules and proposed his own regulations when he took office in January as the state's first elected insurance commissioner.

Although the OAL denied Mr. Garamendi's request for emergency approval of formulas that would determine the size of rate rollbacks and refunds, including the regulations that would grant insurers a maximum 10% rate of return on business written between November 1988 and November 1989, the office already has approved—on an emergency basis—

Insurers and their lawyers don't seem to appreciate 'the power of democracy' says Mr. Garamendi.

general regulations drafted by Mr. Garamendi that interpret Proposition 103 (*BI*, April 1; Feb. 18; Jan. 14).

However, OAL Director Marz Garcia told *Business Insurance* last week that the agency's approval of those regulations was "an error because there is no emergency."

After hearings on Mr. Garamendi's regulations concluded in late July, he amended them and submitted the general rules to the OAL as emergency regulations, Mr. Garcia explained. However, Mr. Garamendi should have observed a 30-day comment period after he amended the rules, as required by the state's regular rulemaking procedures, Mr. Garcia said.

Following regular rulemaking procedures is particularly important considering the magnitude of the refunds—\$2.5 billion—that Mr. Garamendi indicated he would order, Mr. Garcia said.

After the OAL approved the general regulations, it submitted them to the secretary of state and those regulations are now in force on a temporary basis even though the OAL acted erroneously, Mr. Garcia explained. Nevertheless, he said, more public hearings must be held before the general regulations become permanent.

Mr. Garcia said that Mr. Garamendi has three options for implementing the formulas governing the rate rollbacks that the OAL rejected last week because it says no emergency exists. "He can appeal to the governor, which he indicated he would do. Or he can resubmit them and establish that an emergency exists, which would be extremely difficult. Or he can go through the normal procedure," which would be to hold further hearings and accept comments on the regulations, Mr. Garcia said.

The Assn. of California Life Insurance Cos. had argued in earlier hearings held by the commissioner that no emergency existed, noted Wayne D. Wilson, western regional

vp. "The OAL acted appropriately," he said.

"We continue to believe (Mr. Garamendi) doesn't have the authority" to promulgate the type of regulations that he has established, Mr. Wilson said.

Meanwhile, in an amended complaint filed Aug. 30, about 100 insurers joined the original 84 companies that filed suit in Los Angeles Superior Court in April claiming that Mr. Garamendi has no power to reconsider issues that already had been decided by Ms. Gillespie (*BI*, April 8).

Superior Court Judge Dzintra Janavs later denied the 84 insurers' petition to halt hearings on Mr. Garamendi's proposed regulations (*BI*, April 15). The insurers have appealed that ruling.

The new plaintiffs now are joining the original insurers—led by subsidiaries of Hartford Group Inc., Travelers Corp. and Chubb Corp.—in litigating other issues still pending in Judge Janavs' court, said insurer attorney Steven H. Weinstein, a partner with Barger & Wolen in Los Angeles.

"The primary focus" of the amended complaint, according to Mr. Weinstein, is to enforce a portion of Judge Janavs' April decision that insurers that oppose the regulations have the right to company-specific hearings, which have been denied by Mr. Garamendi.

Michael Strumwasser, the Insurance Department counsel for Proposition 103 matters, said "the complaint is without merit and we expect that this challenge will be disposed of like the others have."

The new plaintiffs include National Union Insurance Co. of Pittsburgh, Pa., a unit of American International Group Inc.; Allstate Insurance Co.; GEICO Corp.; and United Services Auto Assn.

Meanwhile, in the first Proposition 103-related actions filed in federal court, Fireman's Fund Insurance Cos. of Novato, Calif., and several subsidiaries last week filed suit in U.S. District Court in San Francisco seeking a declaration that Mr. Garamendi's regulations are unconstitutional and an injunction to halt their implementation.

U.S. Fidelity & Guaranty Co. of Baltimore and several subsidiaries filed a similar but separate suit in the same court.

"We had chosen to avoid litigating earlier in the hopes that the process by which the commissioner has been developing the regulations would produce something that was workable or, at a minimum, constitutional," said Fireman's attorney Terry Houlihan, a partner with McCutchen, Doyle, Brown & Enersen in San Francisco. "That doesn't seem to have happened and we are now at a point that we know the results of the rulemaking process initiated by the commissioner in January are not going to be fair and workable. So the way to resolve the controversy as quickly as possible is to get a declaration from the federal court," he said.

Fireman's Fund filed suit in federal court because the regulations contain numerous violations of constitutional rights, he charged, explaining that the regulations are confiscatory and deny First Amendment rights.

In addition, "the way expenses are regulated and taxes are treated in the regulations does interfere with the regulation of insurance by other states, and that violates the McCarran-Ferguson Act and commerce clause principles of the Constitution," according to Mr. Houlihan.

In addition to the federal actions, several units of Seattle-based SAFECO Corp. filed suit in Los Angeles Superior Court claiming the regulations are unlawful.

In other Proposition 103-related developments, a San Francisco Superior Court judge last week or-

dered Attorney General Dan Lungren to approve a \$750,000 contract between the Insurance Department and two former state Justice Department attorneys who are defending the department in Proposition-103 related litigation.

Mr. Lungren had alleged that the contract violates the state's "revolving door" statutes prohibiting former state employees from profiting from state contracts.

"While we disagree with the court's limited ruling in this respect, we will be reviewing this matter in its entirety to determine a future course of action in this unusual case," he said in a statement.

"The timing of this ruling is especially propitious in light of the barrage of industry lawsuits filed yesterday seeking once again to stop the implementation of Proposition 103 in its tracks," Mr. Garamendi said. "Like the plotters of the botched Kremlin coup, the industry and its lawyers can't seem to understand and appreciate the power of democracy. Their relentless and cynical attempt to thwart a legitimate vote of the people of California in favor of Proposition 103 will fail. They will be forced to pay up—with interest." ■

Update

Lloyd's moves Gooda members

Continued from page 2

Lord said he had nothing to say about the fate of the underwriting agency.

Three Gooda Walker syndicates have ceased underwriting after large cash calls on their as-yet-unclosed 1989 and 1990 accounts (*BI*, Aug. 5). Members are considering suing the members agencies that placed them on the troubled syndicates (*BI*, Sept. 2).

Briefly noted

San Francisco-based broker **American Business Insurance Inc.** last week finalized its acquisition of Charleston, W.Va.-based McDonough Caperton Insurance Group. The combined broker projects that its 1991 gross revenues will exceed \$120 million. McDonough offices will continue to operate under their current name. . . **Edward Meehan**, deputy commissioner at the Vermont Department of Banking, Insurance and Securities, will resign next month after 11 years with the department, during which he oversaw the state's development as the largest domestic captive domicile. Mr. Meehan will join Vermont Insurance Management, a Montpelier-based captive manager, and also will start his own firm, Regulatory Assistance Corp., which will aid state insurance departments in examining captives, risk retention groups and commercial insurance companies. A successor has not been named. . . **Chris Rome**, one of Lloyd's of London's most charismatic underwriters, says rumors that his syndicate 662 is shutting down next year are untrue. But, the syndicate will be smaller, "like many marine syndicates," he said.

Insurers applaud no-fault proposal

By LOUISE KERTESZ

LOS ANGELES—Although California's insurance commissioner has raised the ire of insurers with his proposals to implement Proposition 103, the insurance industry is embracing his plan to impose a no-fault auto insurance system in the state.

The nine-point proposal, which was unveiled by John Garamendi last week, would combine a no-fault system with strict controls on costs that drive up auto premiums.

While Mr. Garamendi's proposal is being praised by insurers, it is being scorned by his usual supporters, including consumer advocate Harvey Rosenfield, the author of Proposition 103.

"We are shocked that an insurance commissioner elected by the people has adopted the position and point of view advocated by the insurance industry and repudiated by the voters in November 1988 when they passed Proposition 103," Mr. Rosenfield said.

While voters approved Proposition 103, which was drafted in an attempt to reduce rising auto insurance premiums in California, they overwhelmingly rejected an insurance industry-sponsored no-fault auto insurance proposal that appeared on the same ballot (*BI*, Nov. 14, 1988).

The no-fault system proposed by

Mr. Garamendi would pay claims for most minor accidents "with litigation as an option to claimants only in cases of serious injury or where (a motorist's) own insurance company refuses to pay," the Insurance Department said.

In addition, the proposal includes medical cost containment features such as, among other things, a fee schedule pegged to increases in workers compensation rates, removal of mandatory medical coverage from auto insurance policies and discounts for policyholders who make their personal health insurance their primary payer of medical costs of auto accidents, the department said.

Auto repair costs would be contained under the plan by a voluntary repair referral system, a mandatory \$500 deductible for collision and comprehensive coverages and strict standards on auto repair shop licensing, the department said.

Mr. Garamendi's proposal also calls for a study of the feasibility of subsidizing lower auto insurance premiums with a tax on gasoline.

The commissioner plans to introduce the proposal as an amendment to a bill already before the Legislature.

Several insurance groups applauded Mr. Garamendi's proposal.

"At last," the commissioner "has

taken action to fulfill the promises of Proposition 103," said Wayne Wilson, vp of the American Insurance Assn. in Sacramento.

"With his rollback orders stalled, the commissioner has embraced the notion that the only way to reduce the price of insurance is to do something about the costs associated with paying claims. His plan addresses the major factors that are responsible for high premiums: litigation, car repairs, medical costs and fraud," he said.

"The Legislature should act on the commissioner's proposal without delay," Mr. Wilson said.

"We are delighted he has come to this conclusion in supporting no-fault," said a spokesman for the Assn. of California Insurance Companies.

"We are cautiously enthusiastic" about the commissioner's support of no-fault auto insurance, said a spokesman for the Schaumburg, Ill.-based Alliance of American Insurers.

Among other caveats, though, the spokesman said the "pay-at-the-pump" proposal might backfire and result in "the poor subsidizing the rich."

In addition to the support from insurer groups, consumer groups including Consumers Union, which publishes *Consumer Reports* magazine, also are backing Mr. Garamendi's proposal. ■

Datebook

SEPTEMBER

SEPT. 24. Maximizing Coverage: Minimizing Costs workshop in Philadelphia, sponsored by The Society of Chartered Property and Casualty Underwriters and the Philadelphia Chapter; \$115 for society members; \$135 for non-members; add \$15 after Sept. 10. Bonnie Kinsley, Continuing Education Coordinator, The Society of CPCU, 720 Providence Road, P.O. Box 3009, Malvern, Pa. 19355-0709; 215-251-2775.

SEPT. 25-27. Claims Management course in Boston, sponsored by the Risk & Insurance Management Society Inc.; \$545 for RIMS members; \$645 for non-members; less than six weeks prior to course add \$50. **Also Nov. 20-22** in New Orleans. Education Department, RIMS, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

SEPT. 25-28. Southern Employee

Benefits Conference meeting in Naples, Fla.; \$500 for SEBC members; \$550 for member applicants; \$650 for non-members. SEBC, P.O. Drawer 47309, Atlanta, Ga. 30362; 404-458-6233.

SEPT. 26. Introduction to Risk Management seminar in New York City, sponsored by The College of Insurance; \$225 for college sponsors; \$275 for non-sponsors. **Also Nov. 13.** The College of Insurance, Professional Programs, 101 Murray St., New York, N.Y. 10007; 212-815-9201; 212-962-4111, ext. 201.

SEPT. 26-27. Insurance Coverage for Environmental Liability Claims seminar in Boston, sponsored by the Defense Research Institute; \$370 for DRI members; \$420 for non-members; special discounts are available. DRI, 750 N. Lake Shore Drive, Suite 500, Chicago, Ill. 60611; 312-944-0575.

SEPT. 26-27. Insurance Regulation Course in New York City, sponsored by Executive Enterprises Inc.; \$1,045. **Also Oct. 28-29** in Chicago. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

SEPT. 29-OCT. 2. Managed Healthcare: Turning Promise into Performance seminar in Phoenix, sponsored by the American Assn. of Preferred Provider Organizations; \$575 for AAPPPO members; \$675 non-members; some discounts are available. AAPPPO, P.O. Box 809109, Chicago, Ill. 60680-9109; 312-245-1555.

The Datebook is compiled from notices sent to *Business Insurance*. Notices should be sent at least eight weeks in advance to Datebook, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611-2590. Please include the price, if any, of the meeting and information on registration.

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