

AUGUST 23, 1993

Update

Business Insurance

Reporting weekly for corporate risk, employee benefit and financial executives / \$2.50 a copy; \$80 a year

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Merrett may resign MUAM post to appease members agencies

LONDON—Stephen Merrett, chairman of Merrett Holdings P.L.C., has offered to resign as chairman of the company's managing agency following pressure from eight Lloyd's members agents.

The members agents threatened to decimate capacity for syndicates managed by Merrett Underwriting Agency Management Ltd. for 1994 unless management changes, including Mr. Merrett's resignation as chairman of MUAM, were made.

Willis Faber & Dumas (Agencies) Ltd. led
Continued on next page

CIGNA units taken out of rating game

By GAVIN SOUTER

PHILADELPHIA—CIGNA Corp.'s highly unusual request that Standard & Poor's Corp. no longer rate the claims-paying ability of its property/casualty units is expected to cause the insurer only minor problems with policyholders.

Because of property/casualty insurers' relatively healthy levels of surplus, policyholders are less sensitive to property/casualty claims-paying ratings than to life insurers' ratings, say brokers, analysts and risk managers.

CIGNA's request that its rating be withheld came after S&P downgraded the company's property and casualty operations—which S&P refers to as the CIGNA intercompany pool or CIP—to BBB+ from A+ earlier this month.

S&P attributed the downgrade to poor underwriting results over the past several years, including the pool's 131% combined ratio in 1992. It also questioned CIGNA's commitment to its property/casualty units, even though it has contributed \$150 million to their surplus this year.

In a statement, the rating agency said that "the protracted poor historical returns on capital offered by (CIP) and the possibility of inferior future performances due to past problems may discourage parent CIGNA Corp. from giving CIP more than a limited amount of support in the event of a further downturn."

A CIGNA spokesman faulted the
Continued on page 22

Texas comp law in peril

By NANCY P. JOHNSON

SAN ANTONIO, Texas—The 1989 Texas law credited with cutting workers compensation costs by millions of dollars faces an uncertain future after a state appeals court ruled the law as a whole runs afoul of the Texas Constitution.

In a 171-page opinion, a deeply divided court held that key portions of the law violated workers' rights to jury trials, access to courts and equal protection of the laws. Among other things, the law sets compensation levels for specific injuries, and requires injured workers to use administrative channels before suing.

Risk managers, business groups and insurer groups contend that the Workers Compensation Act provided significant advantages to injured workers while generating considerable cost savings for the

Court rules reform is unconstitutional

state workers comp system.

But labor groups argue that those cost savings come at the expense of injured workers.

The Texas Attorney General's office is seeking a new appellate hearing. Failing that, the state says it will appeal to the Texas Supreme Court. In the meantime, the law remains in effect.

It is unclear what would happen if the Texas Supreme Court eventually struck down the law. Possible scenarios include: The state workers comp system would revert to the pre-1989 law; there would be a void, to be filled by the courts and law-

makers; or the governor would call a special session of the Legislature to enact a new workers comp law.

Business interests say the Aug. 11 ruling may have a chilling effect on the Texas workers comp market—and on the Texas economy.

"This ruling sends a bad message to Texas employers and to comp insurers," said Pam Beachley, president and general counsel of the Business Insurance Consumers Assn. of Texas in Austin.

"Businesses may have to shut their doors or go bare," predicts Mary Isbell, risk manager at Houston-based Bank United of Texas, which owns 70 banks in the state.

But another risk manager is far more sanguine. "I think most businesses in Texas who were actively involved in this
Continued on page 4

Florida still feeling Andrew's ill winds

By SARA MARLEY

One year after Hurricane Andrew cut a path of destruction across southern Florida, risk managers throughout the state are feeling the ill winds of rising insurance rates, diminished availability and restrictive policy terms.

Commercial property insurance policyholders hope to avert the crisis that has engulfed the homeowners insurance market, a crisis that has prompted a moratorium on non-renewals and a governor's task force to seek market reforms (BI, May 24).

Many questions about the future of the Florida market may not be answered until Nov. 15, when that moratorium expires. The governor's task force,

which also is including commercial coverage in its deliberations, is to make recommendations to the State Legislature by Sept. 15.

As more homeowners land in the Residential Joint Underwriting Assn., businesses fear they may not be far behind.

Insurance Commissioner Tom Gallagher maintains that commercial property insurance is still available in Florida. Yet he has instructed a commercial JUA, dormant since its 1986 formation, to develop rates in case it is activated. Surplus lines insurers are challenging that move.

"We recognize the problems in homeowners, and we want to be pre-
Continued on page 21



Photo by AP/Wide World

A year after Hurricane Andrew, Florida property owners face higher insurance rates.

Clinton plan under attack

Employers, others criticize specifics as they emerge

By JERRY GEISEL

WASHINGTON—While many questions remain unanswered about President Clinton's health care reform package, employers and consultants are criticizing several of the elements that have been made public.

As the president reached out for support for his plan from the nation's governors last week (see related story), administration officials elaborated on a recent briefing paper that broadly outlined the reforms that will be sent to Congress next month (BI, Aug. 16).

Additional information provided since the brief-
Continued on page 10



Photo by AP/Wide World

President Clinton sought support for his health care reform plan last week from the National Governors' Assn.

Governors seek flexibility

States insist they be given freedom to test own reforms

By CHRISTINE WOOLSEY

TULSA, Okla.—Although President Clinton is relying on support from the nation's governors to pass his health care reform package, little consensus exists among the governors over how to solve the health care crisis.

During the president's visit to the National Governors' Assn. annual meeting here last week, the governors remained adamant that they be allowed to pursue their own health care reforms and stressed their desire to retain some flexibility within a na-
Continued on page 12

Merrett offers to resign

Continued from previous page

the charge when it announced earlier this month it was not prepared to furnish capacity to MUAM syndicates for 1994 (BI, Aug. 9). Then, seven other agencies—Anton Members Agency Ltd., Sedgwick Lloyd's Underwriting Agents Ltd., Murray Lawrence Members Agency Ltd., R.W. Sturge Ltd., London Wall Members Agency Ltd., Philip N. Christie & Co. Ltd. and Wellington Members Agency Ltd.—wrote to Mr. Merrett, demanding the changes. Willis subsequently added its signature without joining the seven-member group.

MUAM officials met with members agents on Friday. In a letter sent to agents later that day, MUAM Managing Director Dennis Purkiss said MUAM was "happy to agree" with the suggestion that Mr. Merrett resign by "the middle of October."

However, Steven Cane, an MUAM director, said Mr. Merrett will resign only if it is clear at an Aug. 31 meeting with members agents that his resignation is the only way of attracting sufficient capital next year.

If Mr. Merrett does step down as MUAM chairman, he will continue in his role as chairman of Merrett Holdings and deputy chairman of Lloyd's, "where he has plenty to do, especially with corporate capital," added Mr. Cane.

Was Hunter offered Texas job?

AUSTIN, Texas—Gov. Ann Richards' appointment book may indicate what type of person will be the state's next insurance commissioner.

Over lunch last Wednesday at the governor's mansion, consumer advocate J. Robert Hunter told Gov. Richards that he is not interested in the post, confirmed a spokeswoman for the governor. The spokeswoman though, would not confirm whether the job was actually offered to him.

Mr. Hunter, president of the National Insurance Consumer Organization in Alexandria, Va., is one of the insurance industry's most outspoken critics.

Gov. Richards is expected to name a new commissioner by Sept. 1, the date by which the current commissioner, Georgia Flint, has said she would like to leave office.

The post will become far more important under a recent law that transfers many of the powers now exercised by the state Board of Insurance to the commissioner's office (BI, Aug. 16).

Reform tab \$43 billion: Study

WASHINGTON—President Clinton's anticipated health care reform package will cost the federal government \$42.7 billion a year if universal coverage is immediately implemented, a new study reports.

The study by research firm Lewin-VHI Inc. of Fairfax, Va., is based on a number of assumptions about the package. Among them are that federal subsidies would be provided to employers with 25 or more employees that contribute more than 7% of payroll to employees' health insurance premiums and to employers with fewer than 25 employees that contribute more than 3.5% of payroll to employees' health insurance premiums.

Federal subsidies also would be provided to individuals to keep their premium contributions under a maximum of 2% of family income, the study assumed.

The study estimates that the gross cost to the federal government of subsidizing health care premiums for employers and individuals would be \$75.4 billion in 1994. That cost would be partially offset by \$32.7 billion in federal savings, including reduction of Medicaid and Medicare costs and elimination of special payments now made to hospitals with a disproportionate share of uninsured patients. That would bring the net cost to \$42.7 billion.

The study was commissioned by the HealthCare Leadership Council, a Washington-based group of about 50 insurers and other health care providers.

Big Prop. 103 rebates expected

LOS ANGELES—Two ardent foes of Proposition 103's rollback provisions are giving up the fight.

Allstate Insurance Co. has agreed to pay \$110 million in Proposition 103 rebates and SAFECO Insurance Cos. agreed to issue \$40 million in rebates to policyholders under the rollback provisions of the controversial voter-approved initiative.

Both insurers also agreed to drop all legal challenges to Insurance Commissioner John Garamendi's rollback regulations.

Allstate's rebate—which represents 5.3% of its California written premium volume of more than \$2 billion in 1989—is the largest single rebate expected of the estimated \$725 million to be refunded. However, it is less than half of the \$243.5 million that Mr. Garamendi originally ordered Allstate to refund in October 1991. SAFECO's rebate is 12.5% of its 1989 written premium of \$318.8 million. Mr. Garamendi originally ordered SAFECO to refund \$110.3 million.

Continued on page 22

Errors & omissions

• The consolidation of two insurers to form Allianz Life Insurance Co. of America did not result in any personnel reductions nor are any planned (BI, Aug. 9).

• Bankers Insurance Co. Ltd. policies are written on a claims-made basis, not an occurrence basis as the company reported in the July 19 issue. In addition, BICL can be accessed through non-U.S. brokers, not directly, as reported.

Pay-at-the-pump possible

By MARK A. HOFMANN

WASHINGTON—Commercial auto insurance policyholders may end up paying through the nose if a plan to ensure that Americans breathe cleaner air becomes law, warn insurance trade groups.

A plan under consideration by the Clinton administration is a variation of the "pay-at-the-pump" insurance concept first advocated several years ago by financial writer Andrew Tobias. The proposal is one of many that an administration task force is reviewing as part of a strategy to reduce emission of "greenhouse gases" to 1990 levels by the year 2000, thus keeping a promise the president made in April.

The task force, including several cabinet officials, had initially intended to unveil its plan this month but postponed its release at least a month.

Proposal could penalize commercial policyholders

Under the pay-at-the-pump concept, motorists pay a surcharge on each gallon of gasoline they buy. The surcharge goes into a liability insurance pool that ultimately is allocated among motorists. Proponents of pay-at-the-pump hold that it can streamline the insurance process by eliminating individual underwriting and promoting energy conservation by increasing the price at the pump.

Under the plan the administration is considering, "states could collect part of insurance-related revenues through a per-gallon fee collected when purchased. Insurers would receive these revenues, according to some formula tied to the number of

Continued on page 20

ELIC rehabilitation plan OK'd, but challenges will continue

By JOANNE WOJCIC

LOS ANGELES—Although the California Insurance Department hopes it has finally quashed all the enemies of its Executive Life Insurance Co. rehabilitation plan, the opposition keeps resurfacing with new attacks.

The plan approved Aug. 13 by Los Angeles Superior Court Judge Kurt Lewin is being appealed by muni-GIC holders, the same forces that have held up the ELIC rehabilitation for more than two years.

Meanwhile, some muni-GIC holders have been discussing a possible settlement with Aurora National Life Assurance Co., the successor company to ELIC.

Soon after Judge Lewin in his ruling rejected their motion to rescind the ELIC junk bond sale, the holders of municipal bonds backed by Executive Life GICs began preparing another appeal to the 2nd District Court of Appeal. The muni-GICs have won two previous appeals. Among other things, they are seeking to rescind the sale of ELIC's junk bond portfolio to a French group

(BI, Jan. 6, 1992).

After rejecting an earlier settlement offer that would have given policyholders a 1.4% bonus, muni-GIC holders from Texas Commerce Bank rejoined the rescission motion.

Attorneys for Texas Commerce Bank, a minority muni-GIC holder, had recommended that the bank's board of trustees approve the settlement, but the trustees voted it down. Together with a group of other muni-GIC holders, the bank's muni-GIC holders represent

Continued on page 19

Pru Re off block; IPO considered

NEWARK, N.J.—Prudential Insurance Co. of America is considering spinning off its Prudential Reinsurance Co. unit in a public offering after abandoning efforts to find a private buyer.

Prudential last week said it is no longer actively seeking a buyer for Pru Re, which it put on the block in March at an asking price of \$1.2 billion (BI, March 15).

Instead, Prudential is "exploring other options for maximizing the company's value, including alternatives in the public market," William P. Link, a Prudential executive vp, said in a statement.

Prudential's plans for Pru Re are in "preliminary stages," according to a spokesman, who said he could not comment on how an initial public offering of Pru Re stock might be structured or what options other than an

IPO Prudential is considering.

Meanwhile, Robert E. Riley, who has been chairman and chief executive of Prudential Residential Services Co., was named chairman and chief executive of Pru Re. He replaces Mr. Link, to whom he will now report.

Mr. Riley joined Prudential in 1983 after holding positions with the former Shearson American Express, Putnam Investments Inc. and Putnam's parent, Marsh & McLennan Cos. Inc.

James E. Dwane, Pru Re's president, will report to Mr. Riley.

Analysts took a wait-and-see attitude toward a possible public offering by Pru Re.

Initially, Prudential will probably have to retain a significant stake in Pru Re, because the IPO market may not be big enough to absorb a sale of 100% of the com-

Continued on page 16

Reinsurance brokerages to be listed

The deadline is approaching to return questionnaires to be listed in the upcoming *Business Insurance* directory of reinsurance intermediaries.

The annual directory will be published in the Nov. 1 issue, which will include a Spotlight Report on reinsurance topics. U.S.- and Bermuda-based reinsurance intermediaries will be listed.

There is no charge to be included in the directory; however, companies must fill out and return a questionnaire provided by *Business Insurance*.

To receive a questionnaire, please call Assistant Directory Editor Cindy Bloom at 312-280-3195.

The deadline for returning questionnaires is Sept. 10.

Inside

✓ Johnson & Johnson expects about 1,000 employees nationwide to accept an early retirement offer. **PAGE 6**

✓ California law precludes a bank from collecting punitive damages from an insurer it accused of acting in bad faith, a judge has ruled. **PAGE 7**

✓ President Clinton must somehow build support for health care reform, this week's editorial says. **PAGE 8**

✓ How strong are your actuarial skills? A quiz appears in Perspectives. **PAGE 15**

✓ ACE Ltd. is offering to buy Corporate Officers & Directors Assurance Ltd. **PAGE 17**

✓ Rate increases are helping U.K. insurers to report improved results. **PAGE 17**

Departments

Advertiser Index.....	20
Ask a Casualty Actuary.....	15
Benefit Beat.....	6
Classifieds.....	18
Insurance Services Guide.....	19
International.....	17
Legal Briefs.....	15
Letters.....	8
London.....	17
Opinions.....	8
Perspectives.....	15

Vol.27, No.35—*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 1993 by Crain Communications Inc.

U.S. liability system: Stopping innovation or promoting safety?

By JOANNE WOJCIK

NEW YORK—The growing litigation stemming from silicone breast implants illustrates that reform of the U.S. tort system is necessary to ensure justice while still permitting companies to make and sell new products, a defense lawyer contends.

On the other hand, products should not be released for public use until they have been thoroughly tested, and the tort system's purpose is to provide a remedy for those who are harmed by unsafe products, counters a plaintiff's attorney.

"Mass torts, asbestos, Bendectin and now breast implants have caused a crisis in our legal system," asserted attorney William Griffin of Brobeck, Phleger & Harrison in San Francisco, who serves as national counsel for Santa Barbara, Calif.-based Mentor Corp. in breast implant litigation.

Bendectin was an anti-nausea drug commonly prescribed for pregnant women that was later involved in litigation as allegedly causing birth defects (BI, June 20, 1983).

The crisis in the civil justice system carries a cost, Mr. Griffin told lawyers attending a session on breast implant litigation during the recent American Bar Assn. annual meeting in New York.

"Part of this cost is the increase in the price of goods, and the inhibiting effect the liability system has on product innovation. It has been assumed that liability rules promote safety, but at least some have suggested that the unpredictability of our laws deters innovation," he said.

For example, a 1991 study by the Brookings Institution, "The Liability Maze," said liability law "will not promote anything systematically if it is imposed capriciously, if it imposes costs on superior options or if it assesses damages that swing wildly," Mr. Griffin said, quoting the study.

Two recent large jury awards to women whose faulty implants ruptured are examples of such outrageous damage awards, according to Mr. Griffin.

Relatively few lawsuits related to faulty breast implants

were filed in the first 30 years they were on the market. But, after a \$7.5 million verdict to a Sebastopol, Calif., woman made headlines in 1991, filings of breast implant cases began to increase dramatically, he said.

Another "sensational" case late last year, in which a Texas jury awarded \$25 million to a Houston woman, exacerbated the problem, he added (BI, Jan. 4). The defendant, New York-based Bristol-Myers Squibb Corp., is appealing the decision.

"Prior to the late fall of 1991, Mentor Corp. had only a handful of breast implant lawsuits. Over the next year-and-a-half, Mentor was served in over 1,000 cases representing almost 2,000 individual claimants and class actions representing thousands more," Mr. Griffin said.

"We have thousands and thousands of breast implant cases that are being filed every month. . . . If things run their course as they have in the past, this litigation is going to be around for another decade. . . . and a lot of companies will be driven into bankruptcy, a lot of companies will stop manufacturing products."

The way mass tort cases are handled today "deters safety innovation as well as just new products."

"A lot of companies stay away from products" because they fear the cost of proving their innocence in the U.S. tort system, Mr. Griffin said.

The storm of publicity and pressure on the U.S. Food and Drug Administration to act resulted in the FDA's indefinite moratorium on silicone breast implants, which prompted Mentor and other manufacturers to voluntarily stop selling the devices (BI, Jan. 13, 1992).

After the FDA announced that breast implants with silicone gel would be available only through controlled clinical studies, only Mentor Corp. was permitted to resume the manufacture and sale of the devices, Mr. Griffin said.

Since that time, Mentor has been hit with hundreds of product liability suits filed in both state and federal courts.

In response, the company

Continued on page 12

'Business as usual' seen in first-half P/C results

By JUDY GREENWALD

The prospect that commercial property/casualty insurance rates will harden significantly anytime this year is slight, insurance executives and analysts say.

Insurers' first-half results essentially reflected "business as usual," with no signs of any broad-based turn, insurance industry insiders contend.

"My sense is that the industry as a whole is kind of still dancing around the issue of the need for price change," said David McDonald, senior vp and chief underwriting officer for the Royal Insurance Group in Charlotte, N.C.

Except for property insurance for risks with coastal exposures,

there has been little movement in pricing, he said. "For all intents and purposes, the year is over" because any price changes made now will not have an impact on year-end results, he added.

Hopefully, he added, the industry will recognize the need

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for price changes commensurate with loss exposures and that will influence next year's strategies.

"Clearly, there's no change in direction in the near future that we can see, as much as I would like to say otherwise," said Ce-

dric McCurley, president of American States Insurance Cos. in Indianapolis, a unit of Lincoln National Corp.

"I don't think we're going to see a sudden and significant change in the market. There's going to be subtle changes here and there, but there's not going to be a change in the general direction in our view," he said.

"It's tough, it really is," said George Yonker, assistant comptroller at SAFECO Corp. in Seattle. "We've been looking at this for three years, waiting for a turn. There just isn't anything that's changing right now that to me would indicate we're going to see a turn."

"I've been waiting a long

Continued on page 16

Subrogation suits beginning \$10 million suit filed in World Trade Center bombing

By MICHAEL SCHACHNER

NEW YORK—In what may be the first of many subrogation suits related to the World Trade Center terrorist attack, Phoenix Assurance Co. is seeking up to \$10 million from the Port Authority of New York and New Jersey, alleging the agency's negligence made the bombing possible.

Insurers have until Feb. 26, 1994, to file subrogation suits related to the bombing. More suits are expected by the deadline, said Jeffrey Green, risk manager for the quasi-governmental Port Authority.

Several major U.S. insurers facing property and business in-

Continued on page 19



Photo by AP/Wide World

A subrogation suit was filed last week against the Port Authority for losses paid in the February bombing of the World Trade Center.

Budget law affects benefits

By DEBORAH SHALOWITZ

WASHINGTON—Employers may spend more money on health care for adoptive children and children of divorced parents as a result of provisions in the new federal budget law.

However, the law also enables employers to save money on health care costs associated with disabled employees who are no longer working.

Under the law, group health care plans must provide coverage to adoptive children from the time they are placed with a family; previously, in some cases group health coverage began only when an adoption became

Health care rules for adoptions altered

final, which can be many months after placement.

In addition, the law prohibits group health care plans from restricting coverage for adoptive children solely on the basis of a pre-existing condition. This provision of the law is expected to facilitate the adoption of children with special needs, like disabled children or those with Down's syndrome.

The law defines a child as an individual who is not yet 18 years old at the date of place-

ment or adoption.

According to the National Council For Adoption in Washington, in 1986, the most recent year for which statistics were available, 51,000 children were adopted by people who were not stepparents. About half of these adoptions involved children older than 2 years of age.

"You have to treat an adopted child as you would any other newborn child" under the new law, explained John Piro, a consultant in the Rowayton, Conn., office of Hewitt Associates.

While the law may result in higher health care costs for some employers, "I don't think it'll be

Continued on page 19

Sedgwick to acquire benefit consultant Noble Lowndes

By ADRIAN LADBURY and CHRISTINE WOOLSEY

LONDON—Sedgwick Group P.L.C. will purchase Noble Lowndes & Partners Ltd. in a move designed to strengthen the brokerage's benefit consulting business and shelter it from the volatility of the property/casualty insurance market.

Combined with Sedgwick's existing consulting units to form Sedgwick Noble Lowndes Group, the firm could be the world's fourth-largest benefit consultant based on 1992 worldwide revenues of

193.9 million pounds (\$293.7 million).

Sedgwick announced last week that it will buy Noble Lowndes for 110 million pounds (\$163.7 million) from U.K. bank TSB Group P.L.C.

The new entity, which will be one of Sedgwick's core business units, will employ roughly 2,750 staffers in 44 locations around the world.

Since January, Sedgwick has been contemplating strategies to organize its business into two distinct categories: worldwide insurance/reinsurance brokerage and consulting.

Buying Noble Lowndes gives the world's third-largest broker—based on 1992 revenues of \$1.21 billion—a better mix of business and "is a significant step forward in expanding our consulting services," said Sax Riley, Sedgwick's chief executive.

"The growth in the fee-earning business moves us further away from the cyclical property/casualty business," he added.

"It has been our avowed intention for years to balance the scales a bit. Now we have about 30% (benefits) and our ambition is for it to be 50/50, which will give

the shareholders the best possible situation," he said.

"The whole benefit market is changing rapidly these days and both organizations have been moving rapidly to change with it and to continue to change as need be in the future," said Peter Brew, currently chief executive of Noble Lowndes' U.S. operations.

"Noble Lowndes welcomes the acquisition because it expands our critical mass in a number of countries, including the United States," said Mr. Brew, who—

Continued on page 9

Texas work comp

Continued from page 1

believe the law will be upheld by the Texas Supreme Court," said James E. Green, risk manager at Fort Worth-based Justin Industries Inc., a boot manufacturer.

In *Texas Workers Compensation Commission vs. Hector Garcia Jr.*, the 4th Court of Appeals District in San Antonio affirmed a lower court ruling that the workers comp act as a whole violates the state constitution.

The underlying suit was filed just weeks before the law went into effect on Jan. 1, 1991. The plaintiffs are the Texas AFL-CIO, the Texas Legal Services Union Local No. 2 and three workers.

The appellate court found the following provisions of the law unconstitutional:

- The use of American Medical

Assn. guidelines—which prescribe specific benefits for specific injuries—for evaluating permanent impairment. The workers and labor groups argued primarily that the guidelines allow no benefit for certain injuries, like mental trauma and chronic pain.

Under the old system, benefits were determined by the injured worker's loss of wage-earning capacity.

The appellate court found use of the AMA guidelines violates the Texas constitution by denying workers equal protection of the laws, right to jury trial and right to "open courts" in which to seek a remedy according to the due course of law.

- The law's judicial review provisions, which replaced the state's unusual trial de novo system with a system of administrative hearings that must be fol-

lowed before a claim can go to trial.

The court found this provision denies injured workers their right to a jury trial.

The appellate court also agreed with the lower court that the law violated Texas' constitution by

other employers are able to do; limiting the amount of compensation a claimant's lawyer may receive while not limiting compensation for insurers' lawyers; and allowing differing standards of judicial review for different issues.

While the case 'certainly has been a cloud hanging over what we feel are exemplary reforms, we are not going to change direction,' says Jack Armstrong, of Travelers Corp., the largest workers comp insurer in Texas.

limiting supplemental benefits to claimants with 15% or greater impairment; not allowing employees hired after the act's effective date to opt out of the state workers comp system as

The appellate court upheld provisions allowing the Texas Workers Compensation Commission to appoint an impartial doctor to determine a disputed impairment rating, and several

minor provisions of the law.

However, the 4-3 decision included a blistering 48-page dissent, written by Justice David Peeples.

"This is the work of a court hell-bent on striking down the act, not a court dispassionately reviewing a statute from a coordinate branch of government to see if it is rationally related to valid goals," he wrote.

Business groups say the strongly worded three-judge dissent makes them optimistic about their chances before the Texas Supreme Court. They add that the San Antonio court is considered the most labor-oriented in the state.

Business groups joined insurers and state regulators in hailing the comp law when it was enacted (BI, Dec. 18, 1989).

The law was designed to stem soaring workers comp costs by reducing litigation and preventing injured workers from doctor-shopping.

Ironically, the appeals court ruling comes at a time when the law is being credited with significant savings. The Texas Workers Compensation Facility, the state assigned risk pool, recently announced a \$345 million surplus for 1991 and 1992, compared with a deficit of \$2 billion from 1985 to 1990, pointed out Rick Gentry, regional vp of the Insurance Information Institute in Austin.

Cost savings or not, the law is unfair to workers, argues the Texas AFL-CIO's counsel.

"If you do away with the payments to injured workers, of course you can reduce costs," said Bill Whitehurst, senior partner at Whitehurst, Harkness, Watson, London, Ozmun & Galow in Austin.

"I think it is important for employers to have a system that is fair to employees, and this act is not fair."

Business groups counter that the law did benefit injured workers. It boosted the average weekly benefits to \$248 from \$190, and nearly doubled the maximum weekly compensation rate to \$456 from \$238, said Ms. Beachley of the Business Insurance Consumers Assn.

Under the old system, seriously injured workers were undercompensated while workers with minor injuries were able to get an unreasonably large settlement at trial, argued Ted Roberts, vp and general counsel at the Texas Assn. of Business in Austin.

Workers comp insurers, which had recently regained interest in the Texas market, were not surprised by the appellate court's decision.

"We had anticipated that the case ultimately will be decided by the Texas Supreme Court," said a spokesman for Boston-based Liberty Mutual Insurance Co. "We believe the Texas Supreme Court will support the work of the Texas Legislature."

If the law is struck down, it would turn the Texas comp market "into a morass," said Wayne Stratton, regional vp of the Alliance of American Insurers in Austin.

Travelers Corp., the biggest writer of workers comp insurance in the state, says it will not be deterred by the ruling. While the case "certainly has been a cloud hanging over what we feel are exemplary reforms, we are not going to change direction," said Jack Armstrong, second vp-commercial lines government affairs for Travelers in Hartford, Conn. **BI**

This List is Incomplete.



That's because there are more service businesses than you can think of, let alone list. And nearly every one of them has an errors and omissions exposure, meaning that in their everyday line of work, these companies risk getting sued for making mistakes. They may end up having to pay at least attorney's fees, even if they didn't make a mistake!

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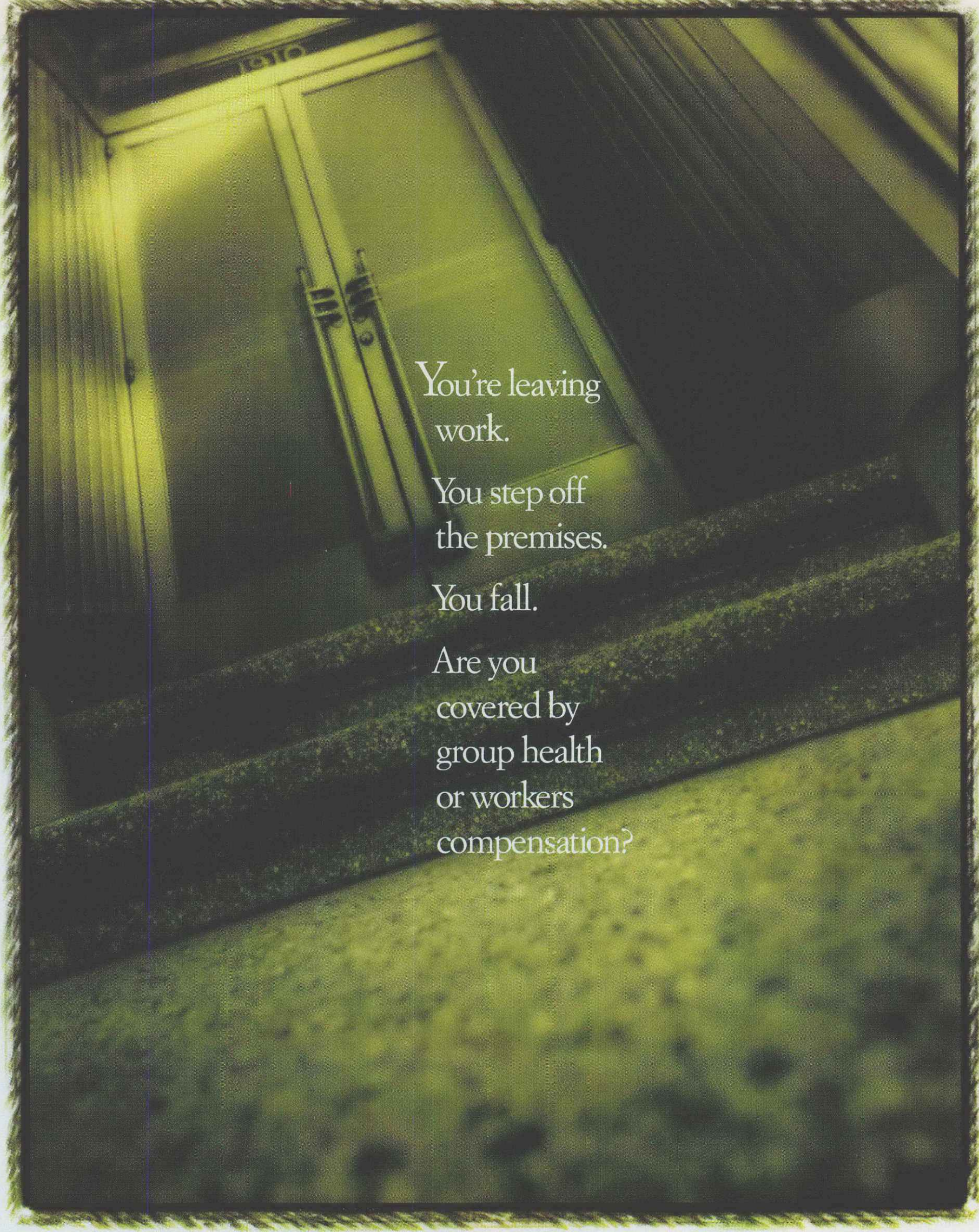


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J&J expects 1,000 takers for early retirement

Johnson & Johnson is expecting about 1,000 employees nationwide to take part in a voluntary early retirement program that is part of a larger global job-elimination campaign.

Employees at the company's New Brunswick, N.J., headquarters who are at least 50 years old with seven years of service are eligible. Five years of age and three years of service will be added to their defined benefit pension calculation formula.

Managers of J&J's 28 U.S. subsidiaries must decide independently whether to offer the same program to their eligible employees.

In total, about 200 home office employees and about 800 subsidiary employees are expected to take part, a J&J spokesman said.

The employees who choose early retirement will be eligible for immediate retiree health and life insurance benefits.

Participants will receive a severance payout equal to two weeks of salary for every year of service, up to a maximum of 26 years of service.

The programs will cost the company an estimated \$200 million initially, which will be covered by a reserve that J&J set up last year for increased accounting expenses for current and future retiree medical benefit liabilities. Beyond that, J&J expects to generate annual savings of about \$100 million.

Employees can opt for early retirement beginning Sept. 1. The program will run through year end.

—By Michael Schachner

Benefit Beat

the most recent cuts is "not defined yet," he said. However, it will be spelled out "relatively soon, business unit by business unit," so employees know what to expect, he said.

—By Louise Kertesz

Legal benefits offered

As part of a benefit program arranged by the Special Agents Mutual Benefit Assn. Inc., active and retired members of the Federal Bureau of Investigation and other federal investigative agencies can access basic legal services through a special toll-free

telephone line.

Since April, FBI agents have been able to obtain free legal advice pertaining to documents, wills, deeds, promissory notes and other matters by phoning a network of about 500 lawyers.

LAWPHONE, as the program is known, is a nationwide prepaid legal plan that the agents finance through monthly payroll deductions. Agents who choose to use the plan pay \$14 per month.

LAWPHONE users also can obtain \$3 million in professional liability insurance covering their actions through the program's administrator, Advisory Communications Systems Inc. of Lanham, Md. The insurance costs \$6 per month.

Because at least 15% of telephone inquiries are situations that require further attention, LAWPHONE lawyers are authorized to make referrals to an additional network of about 5,000 lawyers. This group of lawyers then provides services at 25% below normal fees.

The legal plan also covers the immediate family members of agents.

—By Michael Schachner

Health care choice

The majority of U.S. workers would not give up their choice of physicians or hospitals to help control health care costs, according to a new survey.

Nearly 54% of 1,000 employed

adult Americans said they would not agree to a restricted choice of physicians, and 56% said they would not agree to a restricted choice of hospitals to help control U.S. health care costs, according to the survey by Colonial Life & Accident Insurance Co.

The survey, which covered work and family and health care reform issues, also found that most workers want more flexible work schedules to allow them to meet family needs.

Free executive summaries of "Workplace Pulse" are available from Tracy L. Whited, Colonial Life & Accident Insurance Co., 1200 Colonial Life Blvd., P.O. Box 1365, Columbia, S.C. 29202; 803-798-7000.

—By Deborah Shalowitz

IBM severance charge

International Business Machines Corp. has taken a \$6 billion pretax second-quarter charge for provisions covering the voluntary retirement or lay-off of about 85,000 workers worldwide through 1994.

Included in that total are the 35,000 workers that the company said earlier this month would be eliminated from IBM payrolls.

The \$6 billion charge is part of an \$8.9 billion consolidation charge announced earlier this month by IBM Chairman Louis V. Gerstner Jr. The \$6 billion covers the cost of severance packages and post-retirement pension and benefit adjustments for the approximately 50,000 employees who were cut from IBM's worldwide operations through the end of June under plans announced in December 1992.

At that time, IBM announced plans to cut 25,000 workers, but another 25,000 voluntarily left the company under incentive programs, and several thousand more were laid off in the Hudson Valley earlier this year.

The \$6 billion charge also covers severance provisions for the most recent round of cuts—targeting 35,000 employees—the bulk of which is in Europe.

After July 1, IBM scaled back its severance package for U.S. workers to a maximum of 26 weeks' pay and six months of medical coverage (BI, April 19).

Though each of IBM's 13 primary business units can "customize" severance packages for its workers, the packages can't exceed those basic guidelines, the spokesman said.

The severance package to be offered to employees affected by



Punctuation error costly for D&O insurer

By MARK A. HOFMANN

LOS ANGELES—A federal appeals court panel has ruled that California law precludes a bank from collecting punitive damages from an insurer it accused of acting in bad faith in settling a directors and officers liability claim.

But, Judge Alex Kozinski of the 9th U.S. Circuit Court of Appeals also chided the insurer, American Casualty Co. of Reading, Pa., for faulty punctuation in describing the policy's retention levels, a grammatical ambiguity that ultimately cost the insurer \$490,000.

California law doesn't provide punitive damages for simple breaches of contract, even if the

breach was willful, Judge Kozinski wrote in his decision.

In fact, punitive damages are recoverable only when the defendant "acted with the intent to vex, injure or annoy" and even then are generally awarded only in cases involving "small plaintiffs, usually ones that are in distress of one form or another," Judge Kozinski wrote.

The decision partially overturned a district court decision that, among other things, had awarded Los Angeles-based Fidelity Federal Bank \$5 million in punitive damages from American Casualty, a unit of Chicago-based CNA Financial Corp.

"Nothing in California law suggests a refusal to provide coverage as requested by an insured,

when the refusal is supported by a reasonable, good faith argument, can form the basis for punitive damages," the judge wrote.

In overturning the punitive damage award, Judge Kozinski also wrote that Fidelity Federal "has ready access to legal advice and controls substantial assets, placing it on a relatively equal footing with American. Neither the bank nor American faced a threat to its existence or financial stability because of this dispute; each simply went about its business while the controversy percolated. Such rough equality of economic power and sophistication precludes a find of oppression; American's refusal to pay the claim simply could not

have oppressed the bank."

The case arose out of shareholder suits brought against Ralph S. Slottow, president of Fidelity Federal's Fidelity National Trust subsidiary, for alleged breach of contract, negligence and breach of fiduciary duties. Mr. Slottow and Fidelity National Trust settled the shareholder suits for \$4.8 million. Mr. Slottow was indemnified by the bank for his portion of the settlement—\$4.6 million—and the bank sought reimbursement from American Casualty, which wrote Fidelity's D&O coverage.

The insurer denied the claim, "maintaining that Slottow's actions as president of FNT weren't covered by the policy, that the bank had failed to exhaust the

policy's retention and that too much of the settlement was allocated to Slottow," according to Judge Kozinski.

The parties' disagreement revolved around policy provisions outlining Federal Financial's retentions. Because of a lack of punctuation, it was unclear which of two retentions pertained to the coverage clause on company reimbursement.

The bank and Mr. Slottow then sued American Casualty for breach of contract and bad faith. American Casualty countersued. The U.S. District Court for the Central District of California ruled that American Casualty had acted in bad faith and awarded the plaintiffs nearly \$10.4 million, \$5 million of which was punitive damages. The court declined, however, to award Fidelity Federal legal fees, so both parties appealed.

Judge Kozinski upheld the district court's ruling that American Casualty had to reimburse the bank for Mr. Slottow's share of the settlement and also agreed with the district court that the policy included a retention of \$10,000, not \$500,000 as claimed by American Casualty.

The judge said that "the retention provision lacks the punctuation necessary for us to ascertain its meaning. . . American could have written the policy so as to eliminate the ambiguity by inserting what is obviously missing from this provision—punctuation. We see no reason to give it the benefit of the doubt created by its own careless drafting."

Ralph S. Slottow, *Fidelity Federal Bank vs. American Casualty Co. of Reading, Pa., and Fidelity Federal Bank vs. American Casualty Co. of Reading, Pa.*; No. 91-55698 and No. 91-55804, 9th U.S. Circuit Court of Appeals, Aug. 4.

Insurance fraud probes studied

WASHINGTON—The number of fraudulent cases investigated by health insurers increased 12% in 1992, resulting in a net savings of \$100 million, a recent study says.

Last year, 26,755 fraud cases were investigated, compared with 23,850 in 1991 and 15,246 in 1990, according to the Washington-based Health Insurance Assn. of America, which conducted the survey. Net savings from anti-fraud activities increased 88.7% in 1992 to \$100 million from \$53 million in 1991. Savings totaled only \$40 million in 1990.

Nearly 90 companies representing large, medium-sized and small insurers responded to the HIAA's survey on health care anti-fraud activities.

According to the study, providers account for 65% of the fraudulent activities, while 35% is committed by consumers. Of the provider fraud, fraudulent diagnoses or dates represent 43% of the activity, billing for services not rendered represents 34%, waiving copayments or deductibles represents 21%, and other provider fraud represents 2%.

Of the consumer fraud performed, 40% is from falsifying claims, 25% comes from falsifying records of employment or eligibility, 5% is from false representation in applications and 30% comes from other types of consumer fraud.

For more information on the study, call Kathleen Fyffe at the HIAA, 202-223-7808. **BI**

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Opinions

Gloomy outlook for reform

THE YEAR DAWNED with truly great promise for health care reform. A new administration was deeply committed to significant changes in the health care system. Elected officials, keeping in mind their campaign rhetoric, pledged to work hard to pass meaningful reform. And, the public—including business leaders—finally had become “mad as hell” at the health care system and were demanding big changes.

Nearly eight months later and following the narrowest possible victory in the all-important battle over the budget, President Clinton finally is turning his full attention to health care reform. However, he's finding the skies have darkened dramatically since April, when he put off major work on health care reform to concentrate on the economy.

While the president has not yet released the full details of his health care reform proposal, it has already generated intense criticism. Although it is loosely based on the managed competition model, members of the Jackson Hole Group have lashed out at the president, calling the reform plan constructed by Hillary Rodham Clinton's health care task force “dead on arrival.” How much of the criticism is justified and how much stems from the failure of the administration to adopt the group's proposals in their entirety is debatable.

Of course, the views of the Jackson Hole Group may be among the least of President Clinton's worries. Various factions of Congress are likely to oppose the president's package, including House Democrats who favor the Jackson Hole Group proposals, House Democrats who favor a single-payer system and Republicans in both houses who believe that only minor reforms are needed. At the same time, the nation's governors argue that individual states should have great flexibility to design their own reform packages. Small-business groups are howling over the requirement that all employers offer and pay for health care coverage, while larger businesses will oppose an expected provision that allows only companies with 5,000 employees to form their own health care alliances.

And, we haven't even mentioned what the insur-



ance and health care industries will say about the final proposal.

In short, President Clinton will have to improve on his political skills if he is to forge a coalition that will shepherd his health care reform package through Congress. Based on the budget battle, we're not sure he's up to the job. Already, the president has blundered badly by needlessly sniping at businesses and insurers in the outline of the plan released earlier this month. While alluding to insurers that “try to rob you of your benefits” and bosses that “tell you what doctor to go to” is a way to win votes on Election Day, it's not a way to build coalitions on Capitol Hill.

Business leaders should ignore these slurs and consider the Clinton proposal on its merits. Obviously, there are going to be some provisions that will hurt every employer. But, rather than oppose the president's plan on a knee-jerk basis, businesses must decide what would be worse: supporting the reform process or continuing to allow the health care system to careen out of control.

Letters

Customize benefits communication to employees

To the editor: Benefits communication continues to be an important element in any benefits program. However, a general communication approach can allow some employees to fall through the cracks, which results in poor choices that frustrate the employee and increase benefit costs. Most employee groups have a wide range of individual abilities and interests about benefits. Because of this, it can pay to customize communications to the individual when necessary.

The goal is to assist our employees to be better-educated, prudent and responsible consumers. This is important no matter what type of health care system is in place.

For our small company, that means an open-door policy. Employees and dependents can ask questions, have prob-

lems solved and become more aware of their use of medical services and the cost. Tracking all claims in-house allows our employees to see exactly what services they use and how a claim was processed. Tracking also helps discover and correct processing errors.

One-on-one conversations are an effective approach and provide a chance to educate employees at a time when they are receptive. This also is an excellent opportunity to gather information about care providers, discover fraud and errors in bills, and solicit employee comments about benefits. The result is cost savings and employees with more control.

Any changes made in the health care system must address the fundamental need for knowledge. There are no classes in which a person can learn about the health care system, nor are there any well-known sources of reliable information. My experience is that people do want to understand the health care system and they want some control over their health care costs, which doesn't happen when they really don't know the nature of the beast. Having a place to start is beneficial for everyone.

Virginia Chaffin
Benefits Manager
RIBI Immunochem Research Inc.
Hamilton, Mont.

Offshore insurers also often legitimate

To the editor: I, too, read with interest and alarm the July 5 article on the “new breed” of insurance commissioners and I was pleased to read Richard M. Bouhan's response in the Aug. 9 issue. I agree with most of his comments, though he appears to have committed that same type of error he accuses the commissioners and consumer advocates of committing. Specifically, he implied that offshore operations can “ignore surplus lines laws, rob, pillage

and plunder the U.S. insurance market, and then leave the country.”

Please let it be known that reputable, alien or offshore insurers can be bona fide surplus lines carriers and that they can provide a legitimate source of insurance to the consumer.

James Budish
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Published by Crain Communications, Inc., Chicago

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Published weekly at 740 Rush St., Chicago, Ill. 60611-2590, Telex 6871241, Fax 312/280-3174, Cable CRAINCOM. Offices: 220 E. 42nd St., New York, N.Y. 10017-5806, Fax 212/210-0704, CRAIN COM NYK; 1 Northpark, East Suite 114, 8950 N. Central Expressway, Dallas, Texas, 75231-6415, Fax 214/696-1936; Suite 814, National Press Building, Washington, D.C. 20045-1801, Fax 202/638-3155; 6500 Wilshire Blvd., Suite 2300 Los Angeles, Calif. 90048-4947, Fax 213/655-8157; 540 Latimer Circle, Campbell, Calif. 95008, Fax 408/379-3257; Cowcross Court, 2nd Floor, 75-77 Cowcross St., London EC1M 6BP, England, Fax 71/608/1173. \$2.50 a copy. \$80 a year in U.S. Canada add \$38 for surface mail. First-class mail to U.S. add \$95; to Canada add \$105. All other foreign \$200 per year expedited delivery. SHEILA GORMLEY, circulation manager. Four weeks' notice required for change of address. Send subscription correspondence to Circulation Department, Business Insurance, 965 E. Jefferson Ave., Detroit, Mich., 48207-3185, or phone 800-678-9595 or 313-446-1611, Fax 313/446-1650. Microfilm copies are available from University Microfilms, 300 Zeeb Road, Ann Arbor, Mich. 48103. Microfiche copies available: Bell & Howell, Micro Photo Division, Old Mansfield Road, Wooster, Ohio 44691. Portions of the editorial content of this issue are available for reprint or reproduction in other media. For information and rates to reproduce in general circulation media, contact: JOSEPH P. HANLEY, Crain News Service, 220 E. 42nd St., New York, N.Y. 10017-5806, 212-254-0890. For reprints or reprint permission contact: KAREN BROWN, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590, 312-649-5319, Fax 312/280-3174.

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Sedgwick

Continued from page 3

when the deal is completed in mid-September—will become one of two group managing directors of Sedgwick Noble Lowndes.

Sedgwick stands to more than double its consulting revenues with the deal. In 1992, its combined worldwide consulting gross revenues were 71.4 million pounds (\$108.1 million); Noble Lowndes' totaled 122.5 million pounds (\$185.5 million).

Both firms have a considerable benefit consulting presence in the United States, though Noble Lowndes primarily serves medium-size employers. In 1992, they had combined total U.S. consulting revenues of 49.1 million pounds (\$74.4 million): 25.9 million pounds (\$39.2 million) for Sedgwick and 23.2 million pounds (\$35.1 million) for Noble Lowndes.

Noble Lowndes was the world's sixth-largest benefit consulting firm in 1992 (BI, Dec. 21, 1992).

Mr. Brew said Noble Lowndes "is very pleased" that the new entity will be among the largest benefit consulting firms. "We now can offer a robust range of services to clients all over the world."

'We now can offer a robust range of services to clients all over the world,' says Peter Brew.

The acquisition was announced last Tuesday at a meeting called to announce Sedgwick's midyear results (see story, page 17).

The deal, plus the planned acquisition of a Norwegian broker, will be financed by Sedgwick through a one-for-five rights issue, which is expected to raise about 143.7 million pounds (\$213.9 million).

Mr. Riley said that TSB had made it known some time ago that Noble Lowndes was for sale.

A number of market considerations apart from the need to limit its exposure to the global property/casualty cycle convinced Sedgwick that it should increase its benefit consulting business, Mr. Riley explained.

"Current trends and events are likely to lead to increased opportunities for employee benefits consultants. Many governments are facing budgetary pressures, the demographic structure of developed countries is changing and many companies are reviewing the cost implications of their employee benefit structure," all of which will provide work for benefit consultants, Mr. Riley said.

In addition, the U.S. health care system is about to undergo major changes, Mr. Riley observed.

The acquisition of Noble Lowndes also rounds out Sedgwick's geographic spread in benefit consulting.

"Geographically it's a good fit," said Rob White-Cooper, Sedgwick's vice chairman. Mr. White-Cooper will become executive chairman of Sedgwick Noble Lowndes.

"Noble Lowndes has no presence in Canada but Sedgwick does and it's the reverse situation in New Zealand and Aus-

tralia," Mr. White-Cooper explained. The combined operation's benefit consulting business will be strongest by region in the U.K. and Ireland, he added.

Each company's client base will complement the other, Sedgwick officials said.

"Noble Lowndes is a lot stronger in the middle market while Sedgwick is stronger among the major corporations," explained Stuart Tarrant, group finance director of Sedgwick.

The marriage, however, will not be entirely painless.

Sedgwick has earmarked some funds from the rights issue for a "reorganization" of Noble Lowndes after the acquisition is completed, said Mr. Tarrant.

"Most of this (reorganization) will be in the United States," said Mr. Tarrant. "The U.S. operation has already gone through

a big reorganization over the last two to three years," which resulted in a staff decrease to 550 from about 750.

Up to four of the firm's 11 U.S. offices may be closed, Mr. Tarrant predicted.

Yet Mr. Brew adamantly denied that any U.S. offices will be closed. "That's inaccurate. There are no such plans," he said. But he added that dual offices in the same location may be combined.

Sedgwick began expanding its consulting operations in March when it purchased 94.9% of Medisure Marketing & Management Ltd., a U.K. health insurance underwriting manager and consultant, for just over 11 million pounds (\$16.4 million).

Noble Lowndes has purchased nine benefits-related businesses over the last six years, most of which have already been assimilated, Mr. Brew said. **BI**

MEWA regulation upheld

NEW YORK—Connecticut may regulate a self-funded multiple employer welfare arrangement as if it were an insurer, the 2nd U.S. Circuit Court of Appeals has ruled.

A panel of the court decided that Atlantic Healthcare Benefits Trust is a MEWA subject to state regulation under the Employee Retirement Income Security Act of 1974.

Atlantic and an affiliate, United Healthcare Assn. of America Inc., sued the Connecticut Insurance Department and Commissioner Robert R. Googins last year, arguing that ERISA pre-empts state regulation of MEWAs.

Neither a federal judge nor the appeals panel agreed. In its Aug. 2 ruling, the appeals panel found that a 1983 amendment to ERISA specifically allows states to regulate self-funded MEWAs to the ex-

tent that the regulation is not inconsistent with ERISA.

Finding Connecticut's regulations consistent with the federal law, the panel also rejected Atlantic's argument that the state should develop rules tailored specifically to MEWAs rather than regulating MEWAs as insurance companies.

The appeals court also dismissed the Insurance Department—but not Mr. Googins—as a defendant, noting that the department is immune from suit under the 11th Amendment of the U.S. Constitution, and denied Atlantic's request to amend its complaint to argue that it is a single-employer plan rather than a MEWA.

A similar case pitting Atlantic against Pennsylvania regulators is pending before the 3rd U.S. Circuit Court of Appeals.

—By Douglas McLeod

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Reform plan

Continued from page 1
ing paper was released earlier this month includes:

- All employers would be required to provide health care coverage to employees, but the mandate would be phased in, probably over five to seven years, according to Senior Domestic Policy Adviser Ira C. Magaziner.
- While employers generally would be required to pay no less than 80% of employees' health care premiums, the employer contribution would be capped at about 7% to 7.5% of payroll.
- Those contributions would be funneled to health alliances, which would use the revenues to purchase coverage from insurers, health maintenance organizations and other providers.
- Very small, low-wage firms would have their premium contri-

butions subsidized so that their contributions would not exceed roughly 3.5% of payroll.

- Medicare would be expanded to provide prescription drug benefits for low-income retirees.

The administration earlier proposed that middle- and upper-income retirees over age 65 receive prescription benefits if they agreed to receive care through health purchasing alliances.

- Revenues from any so-called sin taxes, like higher excise taxes on cigarettes, are imposed, could be used to provide long-term health care benefits.

Even with these additional details, many questions about the health reform package remain unanswered until the entire proposal is released in September.

"The goals—universal coverage and lower costs—may be laudable. But the administration has been short on hard facts," said Bob

Eicher, a principal with A. Foster Higgins & Co. Inc. in New York.

Meanwhile, some of the disclosed details have drawn skepticism or criticism.

For example, if employer premium contributions are capped at 7% or 7.5% of payroll, "it does not make sense to me that enough revenue would be generated" for alliances to purchase comprehensive health care coverages, said Bob Dankmyer, vp of corporate benefits at Marriott Corp. in Bethesda, Md.

A study by The Wyatt Co. released this month estimated health care purchasing alliances would have to charge a payroll tax of 11.4% to purchase coverage equivalent to what a typical large employer now provides to employees (BI, Aug. 16).

And the provision that larger employers can establish their own alliances also is viewed as a good

news/bad news situation.

On the one hand, employers are pleased the administration has agreed to allow large companies to form their own health alliances, rather than join an alliance that would be established by states or other government entities.

"We like the flexibility of having our own plan," said Michael Pikelnny, employee benefits director at Hartmarx Corp. in Chicago.

On the other hand, employers say the minimum size required—a threshold of 5,000 employees is expected—is too high.

If all employers with fewer than 5,000 workers must join public alliances, those groups would be so big that larger employers' private alliances would have difficulty competing against them.

"Who will care about large employers if 90% of the employed population is in public alliances? If public alliances are so large, it will

become very hard for those large employers outside the alliances to negotiate with providers," said Sean Sullivan, president of the National Business Coalition on Health in Washington.

"Even a very large employer or group of employers could be tiny compared to a state alliance. We could get cost-shifted" as state alliances cut deals with providers, said Fred Hamacher, vp of compensation and benefits at Dayton Hudson Corp. in Minneapolis.

Thus, benefit managers say they may have no choice but to join state purchasing alliances, resulting in a de facto single-payer system.

Others question if newly formed public alliances would have the administrative skills to handle the influx of tens of thousands of small and midsize companies.

Some employers also say the premium split proposed by the administration—employers would pay 80% while employees would pay 20% of the health care premium—as well as being forced to pay at least a portion of the cost of coverage for all part-time employees is more generous than what many employers now provide. Such requirements, some employers say, could wipe out profits.

"This will break the backs of a number of employers," said Marriott's Mr. Dankmyer. Marriott, which pays about 65% of employees' premiums and doesn't provide coverage to employees working fewer than 30 hours a week, estimates the Clinton package could increase its annual health care costs by about \$160 million, or nearly double its 1992 profits of \$85 million.

For small employers, the biggest objection to the administration package remains the requirement that all employers offer coverage.

"The employer mandate is a killer for us. It is poison," said Leslie Aubin, a health care policy analyst with the National Federation of Independent Business in Washington.

While capping small employers' health care costs at about 3.5% of payroll is helpful, "that does not change the fact that many employers will be saddled with costs they cannot afford," Ms. Aubin added.

Benefit managers were baffled that the administration chose to attack employers in a briefing paper it sent to Congress this month outlining the health care reform package.

For example, the paper said health reform is needed "so your boss" can't take away benefits. Under the Clinton plan, "no boss will be able to tell you what doctor to go to or what health care plan to choose."

"How does the administration hope to build consensus and get cooperation if it is going to use a bashing employer approach? The language in the briefing paper drove me up the wall," said Dayton Hudson's Mr. Hamacher.

"It is almost as if they have written off employers as potential allies," said Frank McArdle, a consultant with Hewitt Associates in Washington.

Indeed, in another administration briefing paper, no employer organization is cited in a list of groups congressmen should contact to line up support for the health care reform package.

Those statements about employers, however, are less strident than those made about insurers in the briefing paper.

The administration said, for example, that the Clinton package would eliminate health insurance company "price baiting and gouging."

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The result will be improved quality of life, lower drug therapy costs, and real savings for the healthcare system. That's why we believe Coordinated Pharmaceutical Care is the right medicine for America.



Governors

Continued from page 1
tional health reform program.

The NGA early this year released a policy statement generally supporting the managed competition approach embraced by President Clinton (BI, Feb. 8). But during a speech preceding President Clinton's address to the NGA, Colorado Gov. Roy Romer acknowledged that the nation's governors don't see eye-to-eye on all health care reform issues.

Some governors, for example, do not support President Clinton's proposal that all businesses purchase health care coverage for employees.

Such a mandate would pose "an undue burden to small businesses" and could stymie job creation in the small business sector—jeopardizing the nation's already weak economy, suggested South Carolina's Republican governor, Carroll Campbell Jr.

"We know not every governor will agree with all the pieces" of President Clinton's health reform proposal, said Gov. Romer. "But the American people want health care reform and they want us to learn the art of compromise. Because of the complexity of the issue, we can't move forward with a proposal without compromise."

The nation's governors want President Clinton's plan to give the states considerable flexibility in shaping their own health care system changes, though such leeway is generally opposed by business leaders.

Employers operating in more than one state, for example, are concerned they will have to contend with a patchwork quilt of reforms that will add more complexity to their already burdensome health plans.

While the president seems prepared to allow the states some flexibility, he has not indicated

how much.

"We as governors are working to ensure health care reform maintains strong state flexibility," asserted Gov. Campbell.

"The states should be encouraged and assisted in our health care reform efforts," Gov. Campbell said, noting "the states have been leaders and are experimenting with reform options" while the federal government is still developing its own version.

Gov. Campbell said that disagreement over approaches to health care reform "can't be dismissed as partisan differences. There are philosophical differences because each state is different."

Several states—including Florida, Minnesota, Oregon and Wisconsin—have moved ahead with their own health care reforms because of the uncertainty over national reform and a desire to address their own health system concerns, noted Nancy Barrand, senior program officer for The Robert Wood Johnson Foundation, a national health care philanthropy.

Ms. Barrand, addressing the NGA's Task Force on Health Care, said 35 states have already submitted proposals to the foundation requesting grant money to test their own health care reforms.

The states are serious about cost control, but their proposed methods to achieve it vary, ranging from global budgets and rate setting to relying on savings gleaned from administrative efficiency and increased competition, Ms. Barrand said.

To finance expanded coverage, some states have suggested single-payer plans, while others want to maintain an employer-based system and establish purchasing cooperatives, Ms. Barrand explained.

"There is very little convergence on a strategy that will work in all states," Ms. Barrand

observed. "States vary in their use and view of regulation, fiscal capacity and economic makeup. Any successful national health care reform scheme will have to recognize these differences."

The federal government also will have to accept states' requests to waive federal laws prohibiting state reform of Medicaid and Medicare programs, said Ms. Barrand.

"Until barriers like ERISA are removed, states will be severely limited in terms of the reform they'll be able to achieve," she said.

Some governors agree.

"If the federal government can't send money, they should at least send states permission" to reform their Medicaid programs, said Gov. Arne Carlson of Minnesota.

Several governors are seeking to privatize Medicaid programs in an effort to control costs, saying they can pay for indigent care more cheaply by contracting with private providers than with the Medicaid program.

Tennessee Gov. Ned Ray McWherter, for example, is seeking a waiver from the federal Medicaid program to allow his state to enroll Medicaid beneficiaries in managed care plans. Tennessee state employees have been enrolled in a preferred provider program for four years, and cost increases for that plan have averaged in the single digits and actually decreased in 1992, while costs for Tennessee's Medicaid program soared 18%, said Gov. McWherter, who is a Democrat.

Ms. Barrand also pointed out that states do not have the infrastructure needed to build huge data bases that will help them monitor the price and quality of health care services. If building such a data base remains an integral piece of national reform, "states will need funding and technical assistance" from the federal government, she added. **BI**

Superfund bill taking shape

By JOANNE WOJCIK

NEW YORK—The Clinton administration expects to produce a Superfund reauthorization bill by the end of November that will have the support of House and Senate leaders, a U.S. Senate staff member says.

The reauthorization will likely give states a larger role than in the past because President Clinton is a former governor, and because new EPA Administrator Carol Browner is the former state EPA administrator in Florida, the staff member says.

However, the administration is unlikely to include in its bill a proposal made a few years ago by American International Group Inc. Chairman Maurice Greenberg that would apportion cleanup costs among policyholders and insurers, said Leonard Shen, majority counsel to the U.S. Senate Superfund Subcommittee in Washington.

"The expectation is that (a) single vehicle will move forward very quickly because it will ideally have had the imprimatur of the House and Senate leaders on both sides of the aisle and will

Reauthorization likely to focus on states' role

incorporate a relatively balanced approach to Superfund reauthorization," Mr. Shen told a group of lawyers during a session on environmental law at the annual American Bar Assn. convention Aug. 6-11 in New York.

"I think that reflects the fact that over the past few years up on the Hill there has been increasing concern about how the program is operating, not only administratively but legislatively," Mr. Shen said.

The goal is to conclude reauthorization by the end of 1994 because funding for the existing Superfund program will run out in December 1995, as well as to avoid disruption similar to that which followed Superfund's last reauthorization in 1986.

"There was a lot of concern about the time that Congress took to reauthorize the statute and the substantial impact and prejudice on the program while Congress deliberated," he said.

"And there was a sharp drop-
Continued on next page

Breast implants

Continued from page 3

has negotiated a \$24 million settlement that requires it to eventually stop making implants, even for the FDA study. A hearing to finalize the settlement is scheduled for Sept. 9.

The alternative to settling was bankruptcy, according to Mr. Griffin.

Mentor has projected that the costs of defending all implant claims, including those not yet filed, will exceed the company's net profits, he said.

The company is also in litigation with its 11 liability insurers over coverage for the settlement. *Mentor Corp. vs. St. Paul Surplus Lines Insurance Co.* was filed in the Superior Court in Alameda County, Calif., in June 1992.

As of early this summer, Mentor has incurred more than \$4.5 million in defense costs and has spent \$600,000 on the litigation with its insurers. The insurers stopped making payments after making an initial contribution toward Mentor's defense costs.

Dow Corning Corp. also has filed suit against its insurers for failing to defend and settle Dow's breast implant claims (BI, July 12).

"The system needs reform," Mr. Griffin asserted. "We need understandable, uniform federal tort law. We must limit punitive damages; we must have a workable, enforceable standard for injury and damages before filing suit; we must limit the size of jury awards for non-economic loss; and we must standardize nationally what duties are owed by manufacturers to their customers. Lawsuits should not be lottery tickets."

However, plaintiff's attorney Denise Dunleavy of New York, who has filed numerous breast implant suits, contends that manufacturers should not be permitted to market products

that have not been proved safe.

Safety studies "should have been done upfront—before this product was ever implanted," she said.

Ms. Dunleavy also said that many doctors didn't find any connection between silicone implants and complaints of illness made by their patients "because they were told there was no connection to make."

Instead, they often labeled these patients as suffering from psychosomatic illness, Ms. Dunleavy said.

Even after silicone injections were banned as dangerous because scientific studies showed that silicone migrates to other parts of the body, manufacturers maintained that silicone in breast implants "delayed" migration and was therefore safe, Ms. Dunleavy said, adding that the silicone has been found to sometimes leak through the implants.

But Mr. Griffin disagreed that any scientific link exists between silicone and illness.

"The science isn't there," he said. "The FDA still says there is no substantial evidence that silicone gel causes autoimmune or rheumatoid disease."

"I think most of the women who have filed cases don't have any injury at all," he said. "I'm not saying they're psychosomatic, I'm saying the complaints are written out of computers that all say the same thing."

"They are complaining of vague symptoms of fatigue, headache and joint pain, which probably half the people in the United States have."

Ironically, before the recent rise in litigation, none of the earlier claims alleging faulty silicone gel breast implants included complaints of autoimmune or connective tissue disorders, according to Mr. Griffin. **BI**

Universal care best way to control costs: Clinton

By CHRISTINE WOOLSEY

TULSA, Okla.—President Clinton contends that the goal of universal health care coverage can best be attained by building on the current employment-based system, rather than adopting any of several alternative reform approaches.

In addition, a system of universal coverage is the only way to control the runaway costs of the nation's health care system, he says.

"If you don't achieve universal coverage, in my judgment, you will not be able to control the costs adequately," Mr. Clinton said during a speech outlining his health care program to the National Governors' Assn.

Without universal coverage, "you'll continue to have cost-shifting," he said. "If you have uncompensated care, the people who give (that care) will shift the cost to the private sector or to the government."

Of the four options available to achieve universal coverage, Mr. Clinton said, "three of them are not—at least based on what I have seen and heard—very good options in practice as opposed to theory."

For example, adopting a single-payer system, like Canada's, to lower administrative costs "would require us to replace over \$500 billion in private insurance premiums with nearly that much in new taxes. I don't think that's a practical option," he said. This approach also would dislocate thousands of insurance industry employees, he added.

Requiring individuals—rather than employers

and employees—to purchase health insurance has some support, primarily among Republicans, but also is problematic and raises significant questions, the president said.

"If you have an individual mandate, on whom is it imposed? And don't you have to give some subsidy to low-income workers just the way you'll have to give some subsidy to low-income businesses if there is an employer mandate? Who gets it and who doesn't?" he questioned.

President Clinton also said individual mandates may encourage "every other employer" to dump employees from their employment-based health plans.

The third option—doing nothing to achieve universal coverage—is not a viable alternative either, he said. "You could just say, 'Well, we'll have all these other reforms,' " like lowering the cost of insurance and simplifying premiums and creating large purchasing pools so that "sooner or later somehow everybody will be covered. The problem is that there is a lot of evidence that some people will still seek a free ride. And make no mistake about it, people that never see themselves as free-riders still ride the system, because everybody in this country who needs health care eventually gets it."

That leaves the fourth option—building upon the current system, President Clinton said.

He did not elaborate on his health care plan beyond the details provided in an outline of his health reform plan released last week (BI, Aug. 16). But Senior Domestic Policy Adviser Ira Magaziner discussed the plan further during a briefing Monday (see story, page 1).

Superfund bill

Continued from previous page
off in cleanups, there was a great deal of disruption within the agency, and it took really a couple of years after the 1986 reauthorization for programs to get back on track.

"A number of members of Congress, having lived through that situation, are very concerned that we not face that again this year with this Congress."

The administration's Superfund reauthorization bill will focus on four key areas: the states' role; cleanup standards; remedies; and liability.

"The states over the past several years are concerned that they have been essentially shut out of the Superfund process, that their role in selecting remedies is clearly a secondary (or) tertiary role to the EPA, (and) that their own cleanup standards are largely disregarded by the EPA; and the states already are lobbying heavily to see if they can get a much greater role," Mr. Shen said.

Given the mood of Congress and the perspectives of President Clinton and Ms. Browner, it is likely the states will get what they want, he said.

Another area of concern is cleanup standards and remedy selection, according to Mr. Shen.

"There's a question, for example, of land use, and whether it should be more integrally taken into account when EPA goes about selecting a remedy," he said.

The existing cleanup standards also may not be appropriate to address groundwater contamination, because it is so difficult to extract chemicals that have seeped into underground aquifers, he said.

This issue comes up in about two-thirds of all Superfund sites, according to Mr. Shen.

Other contaminants, such as heavy metals, may pose similar cleanup problems, he added.

The value of risk assessments also is being studied to determine whether the amount being spent on them is justified, he added.

"Innovative technologies is another issue that has captured the imagination of many in Congress," Mr. Shen said. "There was a bill recently introduced and marked up successfully in the Senate Environment Committee... designed to promote the creation of innovative technologies and to remove barriers in the existing law to the development of these technologies."

Liability changes are likely in the Superfund reauthorization bill since the current system of forcing polluters to pay isn't working, Mr. Shen said.

However, it is unlikely that a proposal by AIG's Mr. Greenberg, which essentially would distribute the cost of Superfund cleanups among the insurance industry and polluters, will be given any attention given the national distaste for additional taxes, Mr. Shen said.

"There are significant concerns from the administration and from members of Congress about whether such a public works approach really makes sense in the current economic climate," he said.

"In fact, if you look back over... the intense budget debates... there were promises that there would be more spending cuts and fewer tax increases," thus precluding such an approach to Superfund funding.

Instead, the administration is considering a proportional liability approach in which each potentially responsible party would pay its fair share and the Superfund itself would pick up any leftover cost, he said.

B1

ABA task force

NEW YORK—The American Bar Assn.'s Tort and Insurance Practice Section has formed a Superfund reauthorization task force to help federal officials formulate a more expeditious system for resolving environmental litigation.

The task force decided at its initial meeting held in Washington in June to expand its membership to other ABA sections. Members also are being recruited from academia.

The task force hopes to present its preliminary ideas to the ABA House of Delegates in February, in time to influence the reauthorization legislation expected to be introduced this November (see story, page 12).

—By Joanne Wojcik

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Litigation sparks innovation in pollution coverage market

By JOANNE WOJCIK

NEW YORK—A new market for pollution insurance is emerging in the aftermath of the courtroom-fought coverage war.

Admittedly, "the insurance community backed off" when it saw the courts awarding coverage for environmental cleanups under the commercial general liability policy, according to James Cox, vp of Johnson & Higgins' Construction Group in New York.

While insurers initially thought they could limit their exposure to such risks by offering only sudden and accidental coverage, "the courts broadened that," Mr. Cox said.

So "in the early 1980s, the absolute pollution exclusion came back, but this time it was complete," he said.

"They actually had risk managers signing off on absolute pollution (exclusion) endorsements to their policies to make sure that their corporations understood that this policy would not respond to pollution claims," Mr. Cox said.

"But the story is getting better," Mr. Cox told a room of lawyers attending a session on environmental risks at the recent American Bar Assn. convention in New York.

A specialty pollution insurance market has started to evolve, he said, and "today there is much more capacity, better terms and stronger pricing."

ABA Some of these new products provide coverage directly to property owners for either first-party or third-party property damage.

Other products insure consultants and contractors hired to remove pollutants, such as asbestos.

Because property owners are not covered during cleanup, Mr. Cox recommends that contracts with cleanup providers specifically transfer to them potential liabilities that could arise out of their work.

In the mid-1980s, only two underwriters provided pollution liability coverage: American International Group Inc. and Reliance Insurance Co. through a managing general agent ECS Underwriting Inc.

But "as the insurance companies have better experience underwriting these exposures, we're finding more and more of them coming back into this marketplace," he said.

For example, Zurich-American Insurance Co. entered the market about a year ago with a range of environmental policies (BI, Nov. 23, 1992). Other pollution coverage underwriters include Chubb Corp., Great American Insurance Co., ERIC Reinsurance Co., The Home Insurance Co., Aetna Casualty & Surety Co., CIGNA Corp., CNA Insurance Cos., Lloyd's of London underwriters, Gulf Insurance Co., Evanston Insurance Co. and United Coastal Insurance Co.

The increasing capacity also has allowed for innovative new products to be developed, according to Mr. Cox.

The first pollution liability policy, introduced 12 years ago, was a legal liability policy that filled gaps in CGL coverage by providing third-party liability insurance and indemnification for offsite bodily injury and property damage.

"It's appropriate for any firm that has any type of environmental exposure. It could be the leaky tank. It could be the Bhopal sort of scenario," he said, referring to the chemical disaster

that killed more than 2,500 people in central India (BI, Dec. 10, 1984).

Other new programs include:

- Contractors pollution liability, which is available on either a blanket or job-specific basis to cleanup contractors.

It is essential that property owners require consultants and contractors hired to remove pollutants to purchase this coverage since property owners generally are not covered themselves during the removal period, Mr. Cox explained.

- Pollution errors & omissions coverage, or professional liability coverage, for consultants, risk assessment firms, laboratories, architects and engineers.

The professional services coverage under the policies must be itemized, he noted.

- Combined contractors pollution liability and E&O coverage.

"This has evolved out of clients' requests when the firm that does the design work is also doing the hands-on work," Mr. Cox explained.

- Environmental remediation insurance, which is a first-party property program that site owners can purchase to protect themselves from potential cleanup costs.

"It's also there for the unknown or undisclosed elements of a piece of property that you might be getting involved with through a sale or through an acquisition or divestiture. This insurance has been very popular with financial institutions," he said.

Environmental remediation coverage can help facilitate some property sales because "you can name the lending institution, the buyer and the seller all on one insurance program," according to Mr. Cox.

- Asbestos abatement coverage, which can be used as a "check and balance" to ensure a firm hired to perform this work is capable of doing so.

Unlike most other pollution coverages, asbestos abatement coverage is available on an occurrence basis, Mr. Cox pointed out.

- Hazardous waste transporter liability coverage.

- Underground storage tank programs, which respond to Environmental Protection Agency requirements.

- Owner-controlled programs, dubbed "the dirty wrap-up," which are becoming popular among firms that do not have coverage during remediation work. **BI**

The Average Adverse Medical Malpractice Verdict Is \$227,000

— Medical Economics, August 1992

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ASK A CASUALTY ACTUARY

Actuarial concepts quiz helps risk managers gauge their knowledge

Q What are the most common fallacies you have encountered in how claim experience is evaluated?

A Evaluating claims experience is a tricky business. It is very easy to analyze losses and come up with incorrect or misleading conclusions. There are many intuitively appealing ideas that are at the root of these common pitfalls in actuarial analysis. To

test the reader's level of knowledge about these fallacies, I have worked up a true/false test. Take out a sheet of paper and write down your answers. An answer key has been provided at the end of the article.

1. Normally the best cost-allocation plan is to charge each department or division for its actual losses.
2. Suppose you have compiled the following ratios of total losses (from a claims tabulation) to payroll: accident year 1989, 7.5%; 1990, 7.3%; 1991, 6.8%; and 1992, 5.3%. Since these ratios are declining, it is good evidence that loss experience is improving.
3. It is best to apply one method to project losses to an ultimate basis. This eliminates confusion and uncertainty because two methods might produce noticeably different projections.
4. Current accounting standards do not allow insurance companies to set up a contingency reserve for catastrophes that have not yet occurred.
5. The best way to properly estimate IBNR for all years is to start with the premiums, take out a percentage for expenses and then subtract paid losses and case reserves.
6. Claims tabulations provide an accurate picture of ultimate claim liabilities.
7. Suppose that, on the average, claims settle for 15% to 20% less than the case reserves. This is strong evidence that case reserves are generally redundant.
8. A high Best's rating provides no guarantee that an insurance company is solvent.
9. Report-year data is just as good as accident-year data in evaluating the adequacy of

total loss reserves.

10. A good way to estimate allocated loss adjustment expense (ALAE) reserves is to apply the ratio of paid ALAE to paid losses to the outstanding case reserves.
11. Loss development methods do not need to be modified to reflect significant changes in the number of exposures over successive years.
12. If losses limited to \$25,000 per claim have been increasing at a rate of 6% per year, losses excess of \$25,000 per claim should also be increasing at 6% per year.
13. If two or more methods are applied, it is best to simply take the average of the projections. This is known as the "doctrine of equal ignorance."
14. There is usually no relationship between how long a group of claims has been open and the average claim size.
15. Claims audits provide an accurate picture of total ultimate liabilities.
16. An insurance company that fails four or more IRIS—Insurance Regulatory Information Systems—test results is, in all likelihood, a troubled company.
17. By definition, an IBNR reserve cannot be negative.
18. A good way to test the adequacy of case reserves is to see if the average open claim is greater than the average closed claim.
19. Calendar month or year averages do not provide a reliable indicator for evaluating the adequacy of claim reserves.
20. The annual statement now provides sufficient information to accurately assess the financial condition of most insurance companies.
21. Properly evaluating the feasibility of self-insurance should only involve consideration of one scenario—the one you believe is the most likely.
22. Loss development methods do not need to be modified to reflect significant changes in the mix of exposures by deductible or limit.
23. If most of the claims for a particular accident year or report year are closed, just accept the case reserves as the best estimate of claim liabilities. There is then no real need to apply a "tail" factor to project losses to an ultimate basis.
24. Our case reserves are more adequate now than they have ever been in the recent past. Therefore, there is no need to anticipate any potential shortfall in those reserves.
25. The incurred loss development method is usually the most accurate method—even if there have been significant changes in the adequacy of case reserves in recent years.
26. A clean audit opinion provides a virtual guarantee that an insurance company is in good financial condition.
27. The effect of retentions in limiting how large

big claims can get should be reflected in applying any loss development method.

28. You are reviewing loss experience where there has been only a small number of claims. If there are only a few unusually large development factors in the triangle you are evaluating, you should simply ignore them when selecting representative factors for each stage of development.

29. Projections based on the paid loss development method are generally accurate even if there have been major shifts in the rate of closure of claims in the recent past.

30. The effect of structured settlements on loss development does not need to be considered.

31. If you are a bit conservative at every step in an actuarial analysis, you will be sure your projections are high enough. However, you probably won't have any idea how conservative your estimates are.

32. Loss development methods do not need to be modified to reflect significant changes in the proportion of property vs. liability claims in evaluating multiperil loss experience.

33. We won't have a claim larger than \$XXX,XXX because we never had one that big in the past.

34. By definition, the estimate of ultimate losses at the 50% confidence level is the *expected* value.

ANSWER KEY: Questions 4, 8, 19, 27 and 31 are true. In my opinion, all other statements are false. **RATING YOURSELF:** 0-20 correct: Pure guessing might work as well; 21-27 correct: A little knowledge is a dangerous thing; and 28-34 correct: Ever thought of taking the actuarial exams?

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

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

This month's column on actuarial issues in the casualty field is written by Richard E. Sherman, president of Pacific Actuarial Resources (PAR) Excellence in Ashland, Ore. William J. Miner, an actuary with The Wyatt Co. in Chicago, answers actuarial questions in the benefits field. Susan M. Werner, director of risk management at Hardee's Food Systems Inc. in Rocky Mount, N.C., answers risk management questions. And Dennis J. Nirtaut, manager of employee benefits at Continental Bank Corp. in Chicago, answers questions on employee benefit plans.

Mr. Sherman'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.



Mr. Sherman

ERISA allows pension plan to reimburse innocent fiduciary's legal fees

The 7th U.S. Circuit Court of Appeals ruled that the Employee Retirement & Income Security Act did not void a provision in a pension plan allowing indemnification of a fiduciary who had been absolved from wrongdoing.

Joseph Kratville was an officer and director of Packer Engineering Inc. and also served as chairman of the firm's pension plan administrative committee. Mr. Kratville was responsible for selecting the plan's investments. In August 1987, the bank holding the plan's funds proposed to invest a greater portion of the portfolio in common stock.

Mr. Kratville quit on Aug. 29, during a period of company turmoil

arising out of the alleged cantankerousness of the firm's founder, Kenneth Packer. Upon quitting, Mr. Kratville allegedly left the bank instructions to maintain the current investment strategy until further notice. The bank nonetheless shifted about \$350,000 to common stock, which dropped precipitously during the October 1987 crash.

Packer Engineering, the pension plan and Kenneth Packer, as trustee of the plan, sued Mr. Kratville alleging breach of his duties under ERISA. A jury exonerated Mr. Kratville of the

charges and the court awarded him \$38,500 for legal expenses and costs on the authority of a section of the pension plan which indemnified members of the governing committee except in cases of gross negligence or willful misconduct.

On appeal, the pension plan argued that the indemnification section of the plan was voided by ERISA, thus scuttling the award to Mr. Kratville. However, the court said that ERISA does not nullify an indemnification provision where the fiduciary has been found to be not liable. "Making a faithful fiduciary whole hardly 'relieves' the fiduciary of responsibility or liability," the court said. Furthermore, the court said, how

could anyone take seriously the proposition that ERISA forbids the indemnification of fiduciaries *wrongly* accused of misconduct, when ERISA itself allows a court to award fees to the prevailing side? The trial court decision was affirmed.

Packer Engineering Inc. vs. Kratville, 7th U.S. Circuit Court of Appeals, May 22, 1992 (BI/02/My.-\$10).

BI

These abstracts were prepared by Mayo H. Stiegler. Copies of these decisions are available by sending a \$10 check payable to Mayo H. Stiegler, to Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590. List the number for each opinion.

Legal Briefs

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

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

Corporate				Property/casualty operations										
Rank 1992	Consolidated revenues 1993	Net income 1993	Percent increase (decline) 1992-1993	Combined ¹ ratio 1993	Combined ¹ ratio 1992	Net premiums written 1993	Percent increase (decrease) 1992-1993	Pretax underwriting income (loss) 1993	Percent increase (decline) 1992-1993	Pretax investment income 1993	Percent increase (decrease) 1992-1993	Policyholders surplus 1993	Percent increase (decrease) 1992-1993	
1	USF&G Corp.	1,695,000	47,000	840.0	110.4 ²	113.7 ²	1,278,000 ²	(4.3)	(125,000)	36.2	218,000	(12.8)	1,535,000	3.6
2	Aetna Life & Casualty Co.	8,620,600	338,700	360.8	117.0	118.9	2,316,300	(7.6)	(370,100)	20.5	427,400	(3.5)	2,367,800	11.2
3	Hartford Insurance Group	4,953,000	230,000	193.9	105.8	113.0	3,207,000	2.9	(211,000)	46.3	337,000	(25.6)	3,006,000	(1.1)
4	SAFECO Corp.	1,728,286	204,732	61.0	102.3	108.7	965,042	8.1	(21,632)	70.6	138,972	(0.4)	1,474,328	22.6
5	Continental Corp.	2,586,700	94,400	48.0	108.7 ²	109.5 ²	2,211,800 ²	10.4	(200,800) ²	2.1	250,800	(13.9)	1,968,000	3.3
6	Sentry Insurance Cos. ²	786,406	35,249	42.1	104.7	105.8	631,812	(9.5)	(36,322)	24.3	89,263	2.3	885,075	11.2
7	Reliance Ins. Co. & subs.	1,439,603	57,949	35.9	110.0	108.0	886,616	3.2	(73,853)	(35.8)	112,305	20.9	895,508	19.4
8	Berkshire Hathaway Group	416,326	130,584	15.7	116.4	140.0	374,517	22.3	(37,988)	48.2	184,463	(1.3)	N/A	N/A
9	American International Group	9,658,476	977,555	13.8	99.6 ²	100.4 ²	5,079,050	9.8	25,189	258.8	659,023	7.0	N/A	N/A
10	Hartford Steam Boiler	328,600	23,300	9.9	102.1	93.0	230,100	6.2	3,800	(131.7)	17,300	(8.0)	302,900	(6.2)
11	Old Republic Int'l	813,994	83,260	8.9	108.3 ²	108.5 ²	391,740 ²	11.3	(34,276) ²	0.6	84,822 ²	(4.6)	1,132,268	18.3
12	Chubb Corp.	2,521,100	294,300	7.6	98.9 ²	98.9 ²	1,727,300	7.0	5,800	(37.0)	259,900	8.7	1,897,400	12.1
13	Ohio Casualty Corp.	859,576	50,955	5.5	109.5 ²	107.0 ²	662,680 ²	(15.2)	(69,168)	(14.7)	97,696	(0.9)	696,019	10.2
14	Argonaut Insurance Co.	102,822	47,277	0.1	99.6 ²	102.5 ²	132,985 ²	(10.2)	2,831 ²	173.4	50,139 ²	(12.5)	553,422	10.5
15	Travelers Corp.	5,376,000	287,200	(1.0)	112.2	112.9	1,903,500	(3.4)	(215,600)	17.2	334,800	(8.5)	1,837,300	(2.1)
16	General Re Corp.	1,768,800	344,400	(6.0)	103.3 ²	104.8 ²	1,247,000	6.7	(37,600)	(37.7)	376,800	0.4	3,534,400	8.5
17	CNA Financial Corp.	5,546,000	388,400	(33.8)	121.0 ²	117.5 ²	3,139,000 ²	(4.8)	(669,000) ²	(14.1)	532,500 ²	(13.7)	3,332,000	6.3
18	CIGNA Corp.	8,937,000	134,000	(36.5)	128.4	118.3	2,099,000	(16.2)	(618,000)	(28.0)	328,000	(14.1)	1,720,000	(6.0)
19	The St. Paul Cos. Inc.	2,183,366	196,528	(39.6)	106.6 ²	106.8 ²	1,520,749	(0.1)	(101,852)	(2.9)	325,304	1.8	1,897,153	13.8
20	Lincoln National Corp.	3,840,900	99,800	(41.1)	110.9	112.9 ²	913,600	(12.4)	(91,700)	36.8	128,000	(10.9)	1,468,600	3.5
21	Home Insurance Co.	1,246,000	39,000	(43.5)	110.3 ²	106.6 ²	1,013,000	13.1	(102,000)	(37.8)	127,000	(9.3)	944,000	(0.7)
22	Royal Group (U.S. subs.) ²	N/A	27,700	(56.0)	118.7 ³	118.4 ³	850,400	13.0	(167,500)	(19.5)	154,300	(7.8)	843,300	0.2
23	Fremont General Corp.	320,790	19,356	(67.8)	101.5	104.6	236,908	16.4	(3,380)	63.3	29,696	(3.9)	178,820	15.1
24	TIG Holdings	963,400	(228,800)	(1,405.3)	142.2	120.4	762,600	(4.2)	(327,700)	(93.9)	114,900	(5.7)	795,000	1.9
—	Commercial Union Ins. (U.S.)	N/A	N/A	N/A	107.8 ³	108.7 ³	795,300	5.2	(70,800)	3.5	95,100	3.7	912,300	24.7
—	Nationwide Mutual Ins. Co. ²	N/A	N/A	N/A	108.0	107.0	3,595,983	9.2	(301,697)	(25.1)	437,657	4.5	3,770,899	(1.1)
—	Kemper National Ins. Cos. ²	N/A	N/A	N/A	111.1	111.2	1,623,807	(1.7)	(184,441)	4.7	174,685	(1.2)	1,834,641	3.7
—	Liberty Mutual Ins. Co. ²	N/A	N/A	N/A	112.9	115.8	3,187,742	(1.5)	(404,353)	12.0	511,866	(6.9)	3,013,173	7.7
Cumulative		66,692,745	3,922,845	7.3	110.3	112.6	42,983,351	2.7	(4,438,142)	3.5	6,597,691	(5.3)	42,795,306	5.8
¹ After dividends		² Statutory		³ Before dividends		N/A—Company did not provide data								

¹ After dividends

² Statutory

³ Before dividends

N/A—Company did not provide data

P/C insurer results

Continued from page 3

time," said Louis Paglia, senior vp of New York-based TIG Holdings Inc., the holding company for property/casualty insurer Transamerica Insurance Group. And, he says he's still waiting, except for higher prices for some property and cat covers.

"We're not running our business based on any turn in the cycle—let's put it that way," Mr. Paglia said.

Meanwhile, insurers' results in the second quarter were little different than in the first three months of the year, according to Gloria Vogel, first vp with Lehman Bros. in New York.

"There were fewer catastrophe losses, but for the most part the trend pretty much continued. You had weak investment income growth—if there was any—you had sluggish premium growth, and you had very little evidence of prices changing. It was really kind of a dull quarter," Ms. Vogel said.

The rest of the year, she predicted, will be "more of the same. I don't really see anything really material. I think (the market) is in the process of turning, but it's turning gradually."

Peter M. Mahon, a senior insurance industry analyst at Piper Jaffray Inc. in Minneapolis, agreed the second half will be essentially the same for insurers as the first. "I think the price increases are going to be hard won, and they're going to come first to those companies who are very finely focused in submarkets where they can get their increases, if they get any at all. I certainly see no broad signs of an across-the-board increase."

First-half net income for the 24 out of the 28 insurers surveyed by *Business Insurance* that report this information increased 7.3% to \$3.92 billion from \$3.66 billion. This compares with only a 1% increase in net income during the first quarter to \$2.09 billion (BI, March 22).

First-quarter profits had been held back by the most disaster-rid-

dled first quarter on record, primarily due to the East Coast blizzard and the World Trade Center bombing. Total insured catastrophe losses totaled \$2.8 billion in the first quarter of 1993, compared with \$810 million in the first quarter of 1992.

Mother Nature dealt insurers a better hand in the second quarter: Catastrophe losses totaled only \$1.13 billion, compared with \$3.38 billion in the corresponding period last year.

Other first-half 1993 results reported by the 28 insurers surveyed by BI indicate:

- Net written premiums increased 2.7% to \$42.98 billion from \$41.85 billion. This compares with a 0.1% decline in the first quarter to \$21.04 billion, and a 2.9% decline for all of 1992 to \$81.33 billion.

- Underwriting losses fell by 3.5% to \$4.44 billion from \$4.6 billion. This compares with a 12.4% increase in underwriting losses to \$2.32 billion for the first quarter, which reflected the first-quarter catastrophes and slow-reported claims from Hurricane Andrew.

- The combined ratio improved to 110.3% from 112.6% in the first six months of 1992. The insurers' combined ratio had stood at 110.9% in the first quarter.

- With continuing low interest rates, investment income fell 5.3% to \$6.6 billion from \$6.96 billion in the year earlier period. This compares with a 6.7% decline in the first quarter to \$3.3 billion.

- Policyholder surplus for the 26 companies reporting this data increased 5.8% to \$42.8 billion from \$40.43 billion in the first half of 1992.

"In terms of results it seemed like more of the same," said Joyce Culbert, an analyst with the Chicago Corp.

"I think second-quarter results were pretty good, actually better than expected, because we believe the fundamentals in the industry have not improved," said Alan

Levin, senior vp at Standard & Poor's Corp. in New York.

"One way that companies can get stronger financial results is to understate loss reserves," he added.

"When the loss reserve analyses are completed for the year, there may be some surprises," he said.

"What we saw was no broad-based turn in premium rates, continued decline in investment income and I guess selected premium strengthening, mostly in property reinsurance," said Jay Cohen, an analyst with Salomon Bros. in New York.

Mr. Cohen said he hopes to see a "broader-based strengthening of premium rates towards the end of the year, moving from the property to the liability side."

"The surprises leaned towards the positive, which wasn't particularly surprising given that you had, with few exceptions" relatively little impact from catastrophes in the second-quarter, "especially when taken in the context of the industry's recent experience," said Ronald W. Frank, an analyst with Smith Barney Harris Upham & Co. in New York.

"I think that absent major catastrophe losses, which of course is always the big assumption, results for the balance of the year are going to reflect trends that are already in place," including increasing distinctions between strong and weak companies' commercial underwriting results and incremental pressures on investment income for all companies, he said.

"Generally, it was a somewhat positive quarter for the industry, definitely more favorable than the first quarter was," said John L. Ward, CEO of the Ward Financial Group in Cincinnati, an investment banking and management consulting firm specializing in the insurance industry.

"Earnings are fairly solid, with quite a bit of capital gains-taking," said Robert Hogue, an analyst with Firemark Consultants in Parsip-

pany, N.J. "I see more net income coming from capital gains than from the operating side."

"Underwriting hasn't been all that bad," observed SAFECO's Mr. Yonker. This is partly because of the economy, said Mr. Yonker, explaining that insurers "see declines in loss costs when the economy is slow."

James S. Kemper III, executive vp-commercial lines for Kemper National Insurance Cos. in Long Grove, Ill., said while property business has renewed at higher rates, particularly for large accounts, there has been no change in casualty rates.

"Right now, I don't see any change in the market," Mr. Kemper said.

Some observers say any turn in the market will be slow.

"We're not expecting or sensing a dramatic across-the-board upturn," said Bruce Ballentine, an analyst with Moody's Investors Service Inc. in New York.

"It's sort of like watching grass grow in a drought. Very slow," said Gordon D. Luce, assistant manager at Brown Bros. Harriman & Co. in New York.

"In a sense, all this 'niche-ing' and focusing and contracting is a different form of an up cycle, I guess. It's a reaction, obviously, to pressure on earnings," Mr. Luce added.

"The true hard market will be long and deliberate and we'll get there over a slow pace over time," said Mr. Ward.

"I think we'll see gradual improvements right away, and it could be a couple of years before we get back to where the pricing curve catches up to where the losses have been," he said.

"We haven't seen it yet, and to be truthful, I personally don't expect to see it," said Firemark's Mr. Hogue. "There's still a lot of capacity in the marketplace."

Mr. Hogue said one indicator of a market turn is economic growth, "where the need for insurance will start to outstrip supply."

Another factor that should encourage hardening prices is low investment yields, say observers.

"The whole investment climate that we're dealing with today is clearly going to have an impact on underwriting strategies," said Mr. Kemper. Not only are interest rates low, but there are fewer real estate investment opportunities and the stock market cannot be expected to grow at the same pace that it has for the past decade, he said.

"It's a much less lucrative (investment) market than it was," so insurers must make up for it in their underwriting, said Mr. Kemper. **BI**

Pru Re IPO

Continued from page 2

pany, said John H. Snyder, senior vp with the property/casualty division of A.M. Best Co. in Oldwick, N.J.

Citing the spinoff of Transamerica Insurance Group as an example, Mr. Snyder predicted that Prudential might first sell a minority or bare majority stake in Pru Re to the public. Once the spun-off company has been operating a while, Prudential could then sell the balance of its stake in secondary offerings.

Prudential's asking price of \$1.2 billion for Pru Re, along with buyers' demands for loss-reserve guarantees, became stumbling blocks to a private sale of the reinsurer, analysts say.

Several parties were rumored to have negotiated with Prudential, including General Electric Financial Services Inc., parent of Employers Reinsurance Corp., and an investor group led by Texas billionaire Robert Bass and Centre Reinsurance Holdings Ltd. (BI, Aug. 16).

The Prudential spokesman would not confirm specific negotiations and said only that the price and other terms of offers Prudential received were unacceptable.

"We felt that private buyers were not acknowledging the value we had placed on Pru Re," he said.

—By Douglas McLeod

INTERNATIONAL

ACE to pay \$250 million for CODA

By GAVIN SOUTER

HAMILTON, Bermuda—The proposed purchase of Corporate Officers & Directors Assurance Ltd. by ACE Ltd. for \$250 million will cut underwriting costs at the directors and officers liability underwriter, the companies' executives say.

The deal will also meet CODA's shareholders' desire to obtain a substantial return on their original investment, said Donald E. Snyder, chairman of CODA.

The deal will be closed in November if it is approved by CODA's board and shareholders.

CODA writes primary and excess D&O coverage with limits of \$25 million. The company was formed in 1986 by Johnson & Higgins and Chase Manhattan Bank. Since 1987, CODA has been managed by ACE.

Mr. Snyder is the only CODA employee. Underwriting and claims handling services are provided by ACE.

The CODA policies fit well with ACE's own D&O coverages, said William J. Loschert, executive vp at ACE. "It's a good mix of business and fits in well with our book. We will be able to handle the business more simply, and we will only have one board of directors rather than two," he said.

ACE offers \$50 million of D&O coverage excess of \$25 million.

The two companies have common policyholders and the acquisition will enable them to service the business more efficiently, said Jack Snyder, senior vp at A.M. Best Co. in Oldwick, N.J.

The deal will also provide a handsome payment to the CODA shareholders. The company

has 51 shareholders and 191 policyholders, CODA's Mr. Snyder said.

The original 53 shareholders paid \$10,000 per share in 1986. The ACE deal would pay the shareholders \$18,182 per share and comes one month after CODA paid a \$650 per share dividend, he said.

Several of the shareholders have said they would now like a return on their investment in CODA, Mr. Snyder said.

"This transaction gives liquidity to CODA's shareholders and continuity of coverage under ACE's ownership. The long association between our two companies makes this a natural fit," CODA's Mr. Snyder said.

ACE itself offered its shares on the New York Stock Exchange in March (BI, Feb. 1). However, this would not be a realistic option for CODA, Mr. Snyder said.

"CODA has no full-time employees apart from me, so we have no infrastructure of our own. It would have been more difficult to develop the infrastructure than to look for somebody else (to buy CODA)," he said.

Mr. Snyder will retire from CODA if the transaction is approved. CODA will retain its name as a subsidiary of ACE and will be headed by Walter A. Scott, ACE's chairman.

CODA shareholders include: Eastman Kodak Co., General Electric Co., USX Corp. and Upjohn Co.

As of June 30, ACE Ltd. had approximately \$1.3 billion in shareholders equity and approximately \$2.3 billion in assets.

CODA had \$518 million in assets as of June 30. As of Oct. 31, 1992, it reported earned premiums of \$34.7 million and net income of \$29.5 million. **BI**

Plans must cover same-sex partner

TORONTO—Ontario Blue Cross will appeal a ruling that orders the health plan to provide coverage for the same-sex partners of plan members.

Under the ruling earlier this month by the Ontario Human Rights Commission Board of Inquiry, Blue Cross and York County Hospital must pay \$4,000 Canadian (\$3,041) in damages to a nurse, Elizabeth Clinton, and extend health benefits to her partner.

The board also ordered Blue Cross to delete the term "of the opposite sex" from its policies when defining dependents. The board ruled that no employee benefit plan in Ontario can limit common-law conjugal benefits to persons of the opposite sex.

The ruling comes after a prece-

dent-setting case in 1992 in which lawyer Michael Leshner of Toronto won full pension benefits for his male partner.

In the Blue Cross case, the board of inquiry accepted Ms. Clinton's testimony that the only difference between her common-law relationship and that of a heterosexual couple is that neither she nor her partner is male.

"The two have celebrated a 'Holy Union' ceremony in their church, have joint wills and financial arrangements and are planning to have a child," a statement from the board said.

Blue Cross will appeal the decision in the divisional court of Ontario in Toronto, said Gerald Devlin, vp and general counsel of Ontario Blue Cross.

—By Gavin Souter

U.S. market hinders U.K. broker results

By ADRIAN LADBURY

LONDON

LONDON—Lack of capacity in London and stubbornly flat rates in core U.S. markets are holding back the recovery at both Sedgwick Group P.L.C. and Willis Corroon P.L.C., both of which reported first-half results last week.

Still, profits increased for both brokers compared with last year's first half, and both reported underlying brokerage and fee revenue growth of 2%.

But rates still are too low in the United States, and the beneficial effects of hardening rates in London was offset by delining premium volume because of lost capacity, the two brokers reported.

Willis Corroon's first-half 1993 pretax profit increased 16.6% to 63.1 million pounds (\$94.1 million) from last year's first-half profit of 54.1 million pounds (\$103 million).

Executive Chairman Roger Elliot and Chief Executive Richard Miller said in a joint statement that all parts of the company had benefited from premium increases "outside North America." But they see "some signs of hardening for (North American) property risks, especially

those with major exposures," such as the high-risk areas of Florida and Hawaii.

Continued on page 18

U.K. market upturn

U.K. insurers' improved results reflect rate increases

By ADRIAN LADBURY

LONDON—Rate increases and more selective underwriting are the cornerstones of recovery in the U.K. insurance industry as three of the United Kingdom's biggest multiline insurers reported profits for the first six months of this year.

Rate increases, especially in property lines, and selective underwriting were also given the credit for General Accident Fire & Life Assurance Co. P.L.C. and Commercial Union Assurance Co. P.L.C.'s improved U.S. performances in the first half of this year compared with the same period in 1992.

But Royal Insurance Holdings' U.S. results worsened because of large weather-related losses in the first quarter.

Guardian Royal Exchange P.L.C., which will report its first-half results at the end of this month, and Sun Alliance Group P.L.C., which will report next month, are also expected to increase their profits.

General Accident led the turnaround with an improvement in overall profit of almost 142 million pounds (\$211.8 million) over 1992's first half (BI, Aug. 24, 1992).

General Accident even produced a rare U.K. underwriting profit of 3.5 million pounds (\$5.2 million) in the first six months of 1993, compared with a loss of 104.8 million pounds (\$199.5 million) in the same period last year.

The insurer reported a first-half 1993 pretax profit of 126.2 million pounds (\$188.2 million at the appropriate exchange rate), compared with a loss of 15.4 million pounds (\$29.3 million) last year.

"An outstanding feature of this result is the achievement of an underwriting profit in the U.K. where the benefits of rating action, more selective underwriting procedures and cost controls produced a substantial and continuing improvement," said Chief Executive Nelson Robertson.

Mr. Robertson also praised GA's U.S. operations, which he said had "applied corrective action to unprofitable lines" and continue to "benefit from the successful introduction of rating increases."

The insurer's U.S. premium volume totaled 679.2 million pounds (\$1.01 billion) in the first six months of this year, compared with 681.5 million pounds (\$1.02 billion) in the United Kingdom. The U.S. underwriting loss narrowed by a little more than 9% to 74.1 million pounds (\$110.5 million) in 1993's first half from 81.6 million pounds (\$155.3 million) for the same period last year.

U.S. premium income fell marginally for the period because the rate increases were not enough to offset the lower policy count caused by the company's more selective underwriting policy this year.

"There was an improvement in all the major lines during the first half of this year except personal property, which was adversely affected by weather claims in the first quarter. Both property accounts also were adversely affected by a very significant increase in reinsurance premiums," said Mr. Robertson.

Commercial Union produced a better-than-expected overall pretax gain over the period of 83.6 million pounds (\$124.7 million). It turned a profit of 65.5 million pounds (\$97.7 million) in the first half of this year, compared with a loss of 18.1 million pounds (\$34.5 million) in the first six months of last year.

"This reflected significantly better results from general insurance operations, particularly in the United Kingdom market. Conditions for general insurance are improving in most territories, and management action has improved profits through the implementation of rate increases, tight control of underwriting and claims, and a further reduction in the expense ratio," said Chief Executive Tony Brend.

Even though Commercial Union could not match General Accident's global recovery, it made a healthy U.S. profit of 29.6 million pounds, (\$44.1 million), 70.1% higher than 17.4 million pound (\$33.1 million) profit in last year's first half. The increased profit was made despite a 63.6% increase in catastrophe claims to 18 million pounds (\$26.8 million) from 11 million pounds (\$20.9 million) in the first half of 1992.

"It was basically improved rating in the U.S.," said Peter Foster, CU's general manager. "We are seeing

Continued on page 19



Photo by AP/Wide World

Hotel cover unclear

BANGKOK, Thailand—Property losses stemming from the collapse of the Royal Plaza Hotel in Korat, Thailand, are not covered by insurance, according to published reports quoting a hotel official.

In addition, the Royal Plaza's managing director said the hotel's management was ready to pay compensation from sources other than its liability insurance to the families of the 102 people killed in the disaster.

The six-story hotel collapsed Aug. 13, allegedly under the weight of water tanks on the roof.

The hotel had a 5 million baht (\$198,650) third-party liability policy written by New Hampshire Insurance Co., a unit of New York-based American International Group Inc., sources in Bangkok said.

AIG declined to comment.

Insurance sources in London and Bangkok said that the hotel, which was owned by a Thai consortium, carried a 125 million baht (\$4.9 million) fire insurance policy issued by Bangkok Insurance Co. However, Thai fire policies do not cover collapse.

—By Mark A. Hofmann

INTERNATIONAL

LONDON

Continued from page 17

Sluggish rates did not stop the U.S. operation from leading the broker's growth in operating revenue. Revenue from U.S. operations grew by 22.9% to 209.6 million pounds (\$312.6 million) from 172 million pounds (\$327.4 million).

U.K. operating revenue for the first six months of 1993 was 168.2 million pounds (\$250.9 million), a 5.5% improvement over the 159.3

million pounds (\$303.2 million) for the same 1992 period. Revenues from its business in the rest of the world increased 6.9% to 15.4 million pounds (\$23 million) from 14.4 million pounds (\$27.4 million) for the same periods.

At Sedgwick, increased revenues in retail brokering and consulting helped push up pretax profits for the first half of 1993, said Chief Executive Sax Riley.

But insurance capacity shortages in London and losses from its insurance company investments limited the profit growth to 4.6%, he said.

Sedgwick earned pretax profits of 54.1 million pounds (\$80.7 million) in the first six months of 1993, compared with 51.7 million pounds (\$98.4 million).

Gross revenues increased 14.8% to 401.2 million pounds (\$598.4 million) in the first half of 1993 from 349.6 million pounds (\$665.5 million) in 1992's first half.

Sedgwick has worked hard to increase brokerage revenues in the first half of 1993, Mr. Riley pointed out. "This has gradually been reflected in the results of our retail and consulting operations, although

some London market operations continue to suffer from lack of capacity."

The results also were tarnished by losses at London-based River Thames Insurance Co., in which Sedgwick has a 49% stake. Losses for the first half of 1993 at River Thames rose to 2.4 million pounds (\$3.6 million) from 1.9 million pounds (\$3.6 million) in 1992. "Insurance rates have, however, significantly hardened in certain areas in 1993, and this will benefit River Thames Insurance," Mr. Riley said.

Brokerage revenues and fees at

Sedgwick's retail units grew by a healthy 21.5% to 238.4 million pounds (\$355.6 million) from 195.6 million pounds (\$372.3 million) in the two corresponding six-month periods, and Sedgwick Consulting Group brokerage and fees grew by 15% to 52.8 million pounds (\$78.8 million) from 45.8 million pounds (\$87.2 million).

Meanwhile, brokerage and fees at Sedgwick Payne, its reinsurance unit, grew by 5.6% to 41.1 million pounds (\$61.3 million) from 38.9 million pounds (\$74 million).

Continued on page 19

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Secretaries, Treasurers, controllers and
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and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations 15,035
Sub-total 28,114

Associations 392

Government, Unions and Educational
Institutions 1,120

Commercial Consumers

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Insurance Agents and Brokers ..8,788

Insurance Companies 7,977

Accountants, Actuaries, Attorneys & Consultants 3,572

Adjusters, Appraisers, TPA's, Captive Managers & Health Care Providers 1,849

Others Allied to the Field 968

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LONDON

Continued from page 18

Ship losses down

The number of ships and the amount of tonnage lost worldwide decreased in the first half of 1993 compared with the same period last year, but the number of lives lost increased, according to the Institute of London Underwriters.

The ILU reports that 56 ships had been lost by the end of including-ships classified as total losses—15.2% fewer than the 66 lost during the same period last year.

The decrease in lost tonnage is even more impressive. The 56 losses

totalled 306,395 gross tons, more than 50% below the first-half 1992 total of 634,122 gross tons.

The ILU also reported a fall in the number of partial losses, but it believes some of these will become total losses.

The ILU acknowledged the heavy loss of life. "Although it is difficult to collate figures accurately, our casualty reports show that 424 people were either killed or reported missing as a result of total and partial losses in the first half of 1993—against 386 for the whole of 1992. And our statistics apply only to ships of 500 gross tons or over, so that many small fishing vessels and other craft are excluded."

The decrease in total losses is attributed to the growing withdrawal

of substandard and old ships. According to the ILU, that withdrawal is a result of "greater selectivity in underwriting" and the January 1992 introduction of the structural condition warranty survey.

The warranty survey system was set up by the Joint Hull Committee, made up of ILU and Lloyd's of London underwriters, to weed out the growing number of substandard ships.

Underwriters may refer any risks they deem dubious for a survey by the Salvage Assn. After receiving the survey results, the insurer may accept, refuse or raise the rates on the risk.

An ILU spokesman said almost 80% of the risks since January 1992 had been referred for a survey. **BI**

U.K. insurer results

Continued from page 17

modest increases in personal lines averaging about 5% and rate increases in commercial lines of about 4%.

"We are also seeing good rate increases in U.S. marine business, and there has been good increases in the homeowners account, but the most significant aspect was in workers compensation."

Mr. Foster also said CU is pleased with its ongoing policy of reducing involvement in involuntary business, notably Massachusetts auto.

Royal's results were not as good as expected, but Chief Executive Richard Gamble said he is pleased

with the improvement to a profit of 52 million pounds (\$77.6 million) this year from a loss of 95 million pounds (\$180.8 million) in the first six months of last year.

As with GA and CU, Mr. Gamble pointed to the United Kingdom as the "main contributor to the improved result."

"The (U.K.) pretax profit of 79 million pounds (\$117.8 million) was 152 million pounds (\$289.3 million) higher than at the same stage last year. The maintenance of firm underwriting disciplines in the hardening market conditions led to a general reduction in claims frequency, with all lines other than lia-

bility showing improvement," said Mr. Gamble.

Royal managed a profit in the United States, but as with CU, the figure was depressed by big weather claims. "In the U.S., after the unusually high level of weather losses in the first quarter, there was a doubling in the level of the second-quarter pretax profit to 11 million pounds (\$16.4 million). At the half-year stage the pretax profit was 1 million pounds (\$1.49 million), with the shortfall more than accounted for by the weather losses, which were 22 million pounds greater (\$32.8 million) than last year," Mr. Gamble said. **BI**

Executive Life

Continued from page 2

close to 20%, or \$1.8 billion, of the claims against the failed insurer. Pension plan GIC holders, who represent about \$1 billion of the claims against ELIC, already agreed to the terms of the settlement (*BI*, June 14).

In their appeal, the muni-GIC holders also plan to challenge a proposal to give lower payments to policyholders that opt out of the settlement. Such a distinction would not comply with *Commercial National Bank vs. Superior Court*, a state appeals court ruling that found a two-tiered payment plan in the first rehabilitation plan was discriminatory. The bank is based in Shreveport, La.

Meanwhile, questions remain whether holders of muni-GICs and pension plan GICs issued after a 1989 law took effect—which removed the GICs' status as insurance instruments—are entitled to receive funds from the settlement. Legislation to extend policyholder status to holders of post-1989 GICs is pending (*BI*, May 17).

Under the latest rehabilitation plan, policyholders would get 86 cents on the dollar if they keep their policies with the successor company, Aurora, and 81 cents if they cash out. Both regulators and Judge Lewin

say the differing payments are appropriate.

Mr. Garamendi says that the *Commercial National Bank* decision doesn't require "absolute equality of ultimate recovery."

But, policyholder advocacy group Action Network for Victims of Executive Life argued that the new plan discriminated by reducing payments to structured settlement annuity holders and other policyholders whose contracts were valued at more than \$100,000. Policyholders with contracts valued at \$100,000 or less are being made whole under a side agreement with the National Organization of Life & Health Guaranty Assns.

ANVEL dropped its objections when the settlement offer was sweetened to give policyholders an extra 1.4 cents on the dollar in exchange for not criticizing the plan. However, ANVEL member Wallace Albertson, a 68-year-old widow, has asked the American Civil Liberties Union and San Francisco District Attorney Arlo Smith to attack the gag order as an unconstitutional infringement on free speech.

Judge Lewin set a Sept. 1 deadline for the appellate court to decide whether to hear the appeal and issue a stay of the new rehabilitation plan. **BI**

Subrogation

Continued from page 3

interruption claims—including Travelers Corp., CIGNA Corp., and Home Insurance Co.—said they had not filed notices of claim but still consider subrogation an option.

Others, like Royal Insurance Group, which incurred only nominal claims, and ITT/Hartford Group Inc., which faces 40 claims totaling \$10 million, said no subrogation is planned.

As of last week, only Phoenix Assurance, a unit of Sun Alliance Group P.L.C. of London, had filed suit. Its Aug. 13 suit, filed in New York State Superior Court, seeks repayment for \$2.5 million in property and business interruption claims paid to Teleport Communications Group Inc., which maintains phone systems and peripheral equipment for the Port Authority.

Teleport, which occupies space on the 51st floor of One World Trade Center and space below Two World Trade Center, had \$10 million in coverage. Its losses are still being adjusted and may ultimately approach \$10 million, said Blair C. Fensterstock, a lawyer with Sutherland, Asbill & Brennan in New York, which is representing Phoenix

Assurance.

The lawsuit alleges that the Port Authority negligently and recklessly ignored four or more comprehensive reports or reviews that concluded that the World Trade Center was both a prime target for a terrorist attack and that the facility's security was inadequate.

Specifically, the suit points to a 1986 report that concluded that the parking garage, where the Feb. 26 bombing occurred, was vulnerable to a terrorist attack and that the complex had no comprehensive security system, no senior director of security and an electronic security system that did not deter terrorists.

The report recommended better lighting, a manned checkpoint at the garage entrance, restricted pedestrian access to parking areas and patrols including bomb-sniffing dogs.

According to the lawsuit, none of these recommendations was adopted.

However, the suit points out that "as a direct result of the bomb blast, the Port Authority has now allocated more than \$300 million to update and enhance the safety and security of the World Trade Center."

The suit also alleges another outside firm, Science Applications International Corp., also concluded security at the World Trade Center was deficient. Two other reports also faulted security, the suit says.

All these reports and recommendations were largely ignored, asserts Mr. Fensterstock. "The essence of this complaint is that the Port Authority, as though through a crystal ball, had anticipated and foreseen the potential of a terrorist attack and were forewarned about the means by which an attack could be carried out," he said. "This is an example of neglect and disregard of the rights of individuals and corporations that were Port Authority tenants."

Mr. Green, the Port Authority risk manager, contends it will be "virtually impossible" to prove negligence. And, he said, "It's well-established that you can't collect from a public agency or private landlord for criminal or terrorist acts unless negligence caused the act."

So far only two other insurers have even filed notices of claim, Mr. Green said: a unit of Kemper National Insurance Co. and Commercial Union Insurance Co. **BI**

Adoption

Continued from page 3

a big-cost item," said John Hickey, a partner with consultant Kwasha Lipton in Fort Lee, N.J.

The law also requires group health plans to extend coverage to children of divorced parents even if they are not living with the parent who is enrolled in the health plan, if a settlement agreement or a court orders that parent to provide health care coverage.

The child health care coverage provisions of the law became effective Aug. 10, when President Clinton signed the law.

A separate provision of the law relieves employers of primary responsibility for health care coverage for disabled employees who are no longer working and are eligible for Medicare.

Previously, under the Social Security Act, employers were required to pay all benefits to which individuals would be entitled if they were not eligible for Medicare. Then, Medicare would cover benefits that the employer's plan did not cover, explained Linda Laarman, a principal in the Washington resource group of William M. Mercer Inc.

These rules apply to people older than age 65 who are still working, people with end-stage renal disease and so-called "disabled active indi-

viduals."

Disabled active individuals generally are interpreted by the government as those receiving employer-provided short- or long-term disability benefits, regardless of when those individuals stopped working, Ms. Laarman said.

Disabled individuals generally are eligible for Medicare 30 months after they stop working.

Under changes set forth in the budget law, though, "only if somebody is actively working and is disabled will Medicare be the secondary payer," she said. In the vast majority of cases in which the disabled individual is not working, Medicare now becomes the primary payer. The change will result in a direct reduction in medical plan costs, Ms. Laarman pointed out.

And, the change will be favorable for accounting for post-employment benefits under Financial Accounting Standard 112, she added. Ms. Laarman explained that because of employers' reduced medical costs for disabled employees, the charge against earnings will also be reduced.

This provision, which became effective Aug. 10, applies to all companies with 100 or more employees.

The law also states that group health plans will be the primary payer of claims incurred by individuals eligible for Medicaid. **BI**

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Pay-at-the-pump

Continued from page 2

premiums they cover," Assistant Secretary of Energy Susan F. Tierney wrote in an Aug. 6 letter to Robert E. Vagley, president of the American Insurance Assn.

Mr. Vagley had written to Energy Secretary Hazel O'Leary a few weeks earlier, criticizing the "pay-at-the-pump" approach in general.

"Drivers would maintain their policies with their current insurers; differential rates would still be used to assign risk to different classes of drivers," wrote Ms. Tierney. "The only change required would be to eliminate the use of expected miles of driving as a factor in determining actuarial risk, since this would be accounted for at the pump."

"The federal government could encourage states to adopt this simplified system by granting them emissions credits in their state implementation plans (under the Clean Air Act); any additional insurance reforms would not earn additional credits," she wrote.

Ms. Tierney added, however, "I want to emphasize that no decisions have yet been made concerning the option under consideration except to estimate its likely costs and benefits for fur-

'It's a gas tax' that the administration lacks the political strength to pass on its own,' says the AIA's Debra Ballen.

ther review."

Ms. Tierney was unavailable for comment, and a spokesman for the Department of Energy said the agency wouldn't discuss details of the emissions reduction plan until they are presented to the president.

However, Debra T. Ballen, a senior vp at the AIA, said the proposal's likely cost would be high and its benefits minimal, especially for commercial auto policyholders.

"They have not given us any indication of how the mechanics of this would work and they also don't seem to understand how policies are rated," Ms. Ballen said.

For example, the proposal as it now stands doesn't indicate how the insurance premiums collected at the pump would be allocated, she said. The administration hasn't made clear whether a one-car fleet and a 20-car fleet, each covered by single policies, would receive the same credit under the plan.

In fact, the program shifts the liability burden from high-risk drivers to high-mileage drivers, many of whom are employed by commercial enterprises, Ms. Ballen said.

"Basically, it's a gas tax" that the administration lacks the political strength to pass on its own, she said. Ms. Ballen noted that the administration hasn't specified how much per gallon motorists would be charged under the plan. By presenting the price hike as an insurance premium rather than a tax, the government "wants us to take the public anger for it," she said.

"It is a tax and they're trying to justify it through other means," agreed Paul Brown, director of government and public affairs for the Risk & Insur-

ance Management Society Inc. in New York.

Mr. Brown said that what little is known about the plan raises serious questions such as how the proposal would affect companies that self-insure their commercial auto risks. And, it could be tough for multistate companies to administer commercial auto insurance programs if some states institute a pay-at-the-pump system but others do not.

"Other than possibly seeing the money flow from the purchaser of the fuel to the state government and on to the insurance companies who theoretically will return it to their policyholders, I do not see any great benefit as an individual or commercial consumer. In fact, I would have greater concerns that once the gas tax begins to flow, that it would be redirected to other needs and develop into a windfall for the government or the insurance industry and not totally find its way back to the consumer," said David G. Adler, risk manager for The Portman Cos., an Atlanta-based architect and property management firm that has an 18-vehicle corporate fleet.

"I am a firm believer that anything the government can do, private industry can probably do more efficiently and more effectively. . . . If this is intended to be continued growth of the government into the insurance industry, I would be extremely hesitant and cautious of such a move," Mr. Adler said.

"In theory it sounds appealing, but in practice it's a nightmare," said a spokeswoman for the Alliance of American Insurers in Washington. She added that the impact on businesses could extend beyond just paying a higher price for gas at the pump.

For example, "Are you going to have to take your garbage to a central location because" garbage pickup has been scaled back due to the added cost of fuel? she asked.

The AIA's Ms. Ballen added, "Our view is, even with the most optimistic scenario, the environmental impact would be limited." She said pay-at-the-pump would penalize drivers in rural areas that already tend to have better air quality than cities while subsidizing urban dwellers, thereby doing nothing to discourage emissions in the most polluted areas. **BI**

ADVERTISER INDEX

Issue of August 23

Advertiser	Page #
Advanced Ergonomics	14
AIG Corporate	13
Business Insurance	9,10
Institutes, The	20
Media/Professional Ins.	4
Merck	11
MMI Companies	14
Reliance National	24
Reliance Re	6-7
Safeco Insurance Company	13
Seak Inc.	14
Wausau Insurance Company	5

Pooling hurricane losses

Insurers, regulators offer plans to Florida governor's task force

TALLAHASSEE, Fla.—A coalition of insurers and the Florida Insurance Department are offering separate proposals to establish statewide pools to cover catastrophic hurricane losses.

Insurers last week formally presented their Hurricane Catastrophe Trust Fund proposal to Gov. Lawton Chiles' Study Commission on Property Insurance and Reinsurance. Elements of the insurers' proposal include:

- Policyholders would pay a premium surcharge to raise at least \$630 million a year to finance the catastrophe fund. The total amount would equal 25% of the statewide premium base, but policyholders would be assessed on an individual basis according to their location and type of structure.

- The fund would pay 30% of hurricane damage claims beginning July 1, 1994. The payout would increase incrementally to 50% by Jan. 1, 1998.

- Buyers of commercial multiperil, homeowners and farm owners policies would be issued a separate windstorm policy from the trust fund.

The trust fund would issue windstorm policies on its own paper. Insurers writing property coverage would act as servicing carriers for the trust fund's windstorm policy.

- Trust fund coverage would be triggered by Category 4 and 5 hurricanes, as well as Category 3 hurricanes that cause insured property damage three times greater than Florida's total direct property premiums written, or a total of about \$7.5 billion.

The proposal is endorsed by the Alliance of American Insurers, the American Insurance Assn., the Florida Assn. of Insurance Agents, the National Assn. of Independent Insurers and the National Assn. of Professional Insurance Agents.

Insurers backing the proposal include Allstate Insurance Co., Chubb Corp., Foremost Insurance Cos., Liberty Mutual Insurance Co., Nationwide Insurance Co., Prudential Insurance Co. of America and State Farm Insurance Co.

An Allstate representative told the study commission last week that establishment of the trust fund would dramatically reduce the insurer's need to non-renew po-

licies in the state.

However, the Florida Insurance Department is instead proposing that a state reinsurance fund be created to reimburse insurers for a portion of their catastrophic windstorm losses.

Insurers would contribute up to 20% of annual property insurance premiums to the reinsurance pool until enough funds are collected to cover a catastrophe.

Other reforms proposed by the department include:

- Increasing capital requirements for property/casualty companies to \$4 million from \$2 million and for surplus lines insurers to \$15 million from \$2 million.

- Requiring insurers to provide rate reductions or credits against deductibles as an incentive for homeowners to install windstorm protection.

- Limiting annual cancellations and non-renewals to 5% per insurer in any line of business and in any designated risk district.

The governor's commission wants "to tie whatever happens in Florida closely into a federal solution" to problems posed by catastrophes like hurricanes and earthquakes, said commission member Franklin W. Nutter, president of the Reinsurance Assn. of America. "A single state with limited resources is unlikely to be responsive to a true megacatastrophe."

However, "the committee and the Legislature are doing as much as they can without reliance" on the federal plan.

Bills to create a federal catastrophe fund were introduced in the U.S. House and Senate earlier this month (BI, Aug. 9).

"A federal catastrophe fund is the best answer," said state Rep. John Cosgrove, D-Miami, co-chairman of the commission and chairman of the House Insurance Committee. "Unfortunately it's not the easiest answer because of the politics involved."

Both the insurers' and the department's proposals have the same objective, pointed out Ronald S. Gass, assistant general counsel of the American Insurance Assn. in Washington: "To permit the accumulation of moneys free from federal and state tax."

One major difference, however, is how the state funds would be financed. Depleting existing premium does not make sense, Mr. Gass said. "It's the same size pie. They are not creating any new capacity."

—By Sara Marley

Florida market

Continued from page 1

pared" for an availability crisis in commercial, Mr. Gallagher said in a recent interview.

The commercial market may just be tightening now because businesses were slower than residents in rebuilding, said state Rep. John Cosgrove, D-Miami, chairman of the House Insurance Committee.

"For each shopping center that reopens, hundreds of small businesses will be looking for coverage," Rep. Cosgrove said. "If insurance companies are nervous about providing coverage for homeowners in coastal areas, why would they be more interested in providing coverage for commercial exposures?"

The commercial market has been tightening throughout the year, said John Lubatti, vp and client services manager of Sedgwick Inc. in Fort Lauderdale.

"As we progress through 1993, windows of opportunity for certain classes of business are closing," Mr. Lubatti said.

For example, in the first few months of the year, insurance for joisted masonry buildings was available in the admitted market. Now only surplus lines insurers will write this coverage.

"There is still insurance available" to business owners, Mr. Gallagher said. "It's more expensive, and more is done in surplus lines. That's what surplus lines are there for. They're providing a good piece of the market. The competitive market is still operating."

"More expensive" may be an understatement.

Property premiums at renewal went up tenfold for the Dade County Public Schools after the hurricane. And Susan Weiner, assistant superintendent of the

school system's office of risk and benefit management, considers herself lucky to have obtained coverage at all.

The district's three-year property insurance program, brokered by Arthur J. Gallagher & Co., expired on May 1, 1993.

Prior to Andrew, Dade County Schools paid \$770,000 in premium for \$150 million in coverage. Appalachian Insurance Co. wrote the first \$25 million and Hartford Fire Insurance Co. wrote \$125 million above that. The district had a \$1 million windstorm deductible.

"After Andrew, we had a terrible time getting companies to discuss layers," Ms. Weiner said. "Nobody wanted to take the lead layer."

Instead, the district went to a quota-share arrangement. Now the first \$100 million is shared by 17 companies, some of them surplus lines insurers. Individual participation ranges from \$7.5 million to \$350,000. Wausau Insurance Co. writes a \$25 million layer above \$100 million, while three more \$25 million layers revert to quota-share arrangements, which include Lloyd's of London syndicates.

The final price tag for the \$200 million in coverage is \$8 million, Ms. Weiner said.

The new windstorm deductible is 2% of the building value, with a \$1 million minimum and \$10 million maximum deductible.

"I recognize where the industry is coming from, but I wish they had been kinder to the taxpayers of Dade County," Ms. Weiner said.

Other catastrophes and rising reinsurance rates aside, insurers may have overreacted in their rates in Florida, she said.

Rates for Florida exposures have tripled—to 30 cents per dollar of

Continued on next page

Gallagher stands by hurricane response

By SARA MARLEY

TALLAHASSEE, Fla.—Tom Gallagher makes no apologies for his actions after Hurricane Andrew rocked southern Florida one year ago this week. Or for anything else, for that matter.

"Our job is to see that insurance is affordable and people have the ability to buy coverage they need, especially personal lines," said Mr. Gallagher, who serves as Florida's insurance commissioner and treasurer.

The second part of his mission is to see that insurers "doing business are reliable, they have the money to pay claims and they pay claims with it."

Mr. Gallagher's most dramatic step toward those goals is the moratorium on non-renewal of homeowners policies, which he proposed in May and the Legislature approved (BI, May 24). The insurance commissioner proposed a 90-day moratorium, which the Legislature extended until Nov. 15.

"I recognize that (the moratorium) is not something that makes insurers comfortable," Mr. Gallagher said. "We are telling them how to run their business. We're telling them that their contract is extended and they have to renew for another year. That does not make them very happy."

"On the other side, there are the people that are being non-renewed, and that doesn't make them very happy. And there are a lot more of them."

"The moratorium has been a headache-saver for a lot of peo-

ple who would have been on the verge of hysteria," said Susan Weiner, assistant superintendent of the office of risk and benefit management for Dade County Public Schools in Miami.

Those sentiments have earned Mr. Gallagher, a 49-year-old Republican, a reputation as a pro-consumer insurance commissioner, though he came from the insurance industry. He was Florida regional vp for Liberty Mortgage Insurance Co. from 1973 to 1975. He spent the next 10 years with Ticor Mortgage Insurance Co. as vp and Southeast regional sales manager.

"We have a very consumer-oriented insurance department," said Bill Winters, president of the Florida Surplus Lines Assn. and vp and branch manager of wholesaler Burns & Wilcox Ltd. in Daytona Beach. "Florida is one of the few states where the commissioner is still an elected official."

Twelve states elect their insurance commissioners.

Mr. Gallagher began his political career while he was an insurance executive, serving in the state House of Representatives from 1974 to 1986. He also made unsuccessful gubernatorial runs in 1982 and 1986.

Prior to being elected commissioner and treasurer in a 1988 special election, Mr. Gallagher was appointed secretary of the Florida Department of Professional Regulation.

Before the moratorium, Mr. Gallagher issued 20 emergency rules in the aftermath of Hurricane Andrew, covering everything

from the price of construction materials to establishing a deadline for settling claims.

Some of those rules were clearly outside the commissioner's authority, some contend.

"The industry responded exceptionally well in handling and settling of claims," Mr. Winters said. "All of that would have happened without emergency rules. Most



Insurance Co. over the non-renewal of homeowners policies (BI, July 12).

"It was made to get their attention," Mr. Gallagher said of the maximum fine of \$20,000 per non-renewed policy set by the Legislature. Each policy is treated as a separate violation, and there is no maximum fine.

While some insurers resisted the

'I'm very happy I took senior executives of insurance companies out one week after Andrew to let them see, feel, touch and smell the hurricane firsthand. They could feel some compassion. I hope it made a difference.'

—Tom Gallagher

were unnecessary and many were frivolous. They were made to make the Insurance Department look good in the eyes of the voters."

Florida Rep. John Cosgrove, D-Miami, chairman of the House Insurance Committee, contended the rules were "an extraordinary response under extraordinary circumstances."

Mr. Gallagher has also displayed some heavy-handed enforcement of the moratorium. At one point, he threatened to levy a \$400 million fine against Home

moratorium, "others took a responsible attitude," Mr. Gallagher said.

To solve the market problems Andrew left behind, Mr. Gallagher endorses both a federal and a statewide catastrophe reinsurance fund to be financed by insurers (see related story).

Other changes he has proposed are a mediation program for claims disputes, stricter building codes and stricter code enforcement, and "universal adjusters" who would be assigned to visit all policyholders in a designated

area, not just one insurance company's policyholders.

"Companies have the desire to take care of their customers specially, but cooperation is necessary," Mr. Gallagher said.

More disaster preparation is also in order, but "you can never be fully prepared for anything," he noted. "You think you have a plan, and something comes along that is bigger than you planned for."

Overall, the commissioner is pleased with his department's response to Andrew.

"I'm very happy I took senior executives of insurance companies out one week after Andrew to let them see, feel, touch and smell the hurricane firsthand," Mr. Gallagher said. "They could feel some compassion. I hope it made a difference."

Andrew has not changed the commissioner's goals.

"I just want to keep my head above water and not drown," he jokes.

Mr. Gallagher says he has not decided about running for reelection when his four-year term expires at the end of 1994. Filings for that post will not take place until next July, he noted.

The Florida press cites him often as a potential gubernatorial candidate, up against the likes of Jeb Bush, son of former President George Bush, and state Attorney General Jim Smith.

When asked about his future, he answers: "My current job is very challenging. I don't want politics to interfere with our work."

Florida market

Continued from previous page
coverage from 10 cents—according to the industry-sponsored Florida Insurance News Service. At the same time, retentions have tripled and limits are down nearly 50%.

Ms. Weiner, however, acknowledged that the school district would have had to pay its \$770,000 premium annually for almost 200 years to cover its \$150 million insured loss from Andrew.

Others aren't so understanding. "Florida may have been underpriced a little bit, but proposals of a 50% rate increase are totally unnecessary," said J. Robert Hunter, president of the National Insurance Consumers Organization. "They are out of line with the real risk."

Damage on the scale of Andrew's should not have surprised insurers, he contends. "Saying you need to cancel 30% of your business is a bald-faced admission of mismanagement. How can they act surprised when the (University of Miami) football team's nickname is the Hurricanes?"

The problems experienced by Dade County Schools are becoming more and more common.

Municipalities are having difficulty finding coverage because of the concentration of risk.

And for all commercial accounts, coverage endorsements such as those for off-premises power transmission lines are nearly impossible to find, and windstorm deductibles of between 1% and 5% of insured values are uniform. But the Insurance Department has proposed a ban on setting deductibles as a percentage of total loss or limits.

Insurers are often using their leverage to write an account on their terms, said Sedgwick's Mr. Lubatti. "They want the casualty as well as the property. Some are only doing renewals or only

doing new for selected agents."

Allstate Insurance Co. has temporarily stopped accepting new commercial business in six coastal counties, though it is renewing all commercial policies, a spokeswoman said.

Although buyers are forced to start looking for coverage months before their policies expire, insurers are delaying binding coverage until the last moment.

"Underwriters are playing the waiting game. They want to be sure they haven't left any money laying on the table," Mr. Lubatti said.

Despite more difficulty placing coverages, insurance still is available in the admitted and non-admitted markets, said Bill Winters, president of the Florida Surplus Lines Assn. and vp and branch manager of wholesaler Burns & Wilcox Ltd. in Daytona Beach.

Almost all complaints have involved prices, not availability, Mr. Winters said. "It is not an emergency. There is still an adequate voluntary market to write property risks all over Florida."

Much of that market is now written by surplus lines insurers, which could scare buyers because the insurers are not covered by a guaranty fund.

But Ms. Weiner has no concerns about the surplus lines insurers that participate on Dade County Schools' program.

"If another major hurricane hits, the guaranty fund may not be able to respond," she said. "I'd rather rely on a commercial insurance company than a state-funded guaranty approach."

Rates are increasing from a depressed base, Mr. Winters said. While policyholders in the past enjoyed 85% to 90% discounts off manual rates, now they are being charged the full rate.

"Those buyers are objecting strenuously, but they've been getting a good deal for several years," Mr. Winters said. "Now they have to pay the price to live

in Florida."

Homeowners insurance would also still be available, he contends, but the Department of Insurance "wouldn't let the market forces work."

Agents were instructed not to place risks in the non-admitted market and took their business to the residential JUA instead, Mr. Winters said.

If activated, the commercial JUA may be plagued by the same problems as the residential JUA, said Ted Ostrander, chairman of the Florida Assn. of Insurance Agents and president of Lasser-Ware Inc. in Leesburg.

Agents and brokers fare poorly in the residential JUA. The commission is only 10%, compared with an average 15% for commercial insurers. And, separate policies must be placed for contents and jewelry coverages, which the JUA does not write.

"The JUA is supposed to be the market of last resort, and in some places it's cheaper than the standard companies," Mr. Ostrander said.

Florida needs a solution to a short-term problem, NICO's Mr. Hunter said.

"I think the whole problem will be gone in two years. The market is taking care of itself," said Mr. Hunter, citing new offshore catastrophe reinsurers that are providing billions in new capacity (BI, June 28; June 21).

"Wind insurance has always been available privately," he said. "Government should not involve itself. It should control the transition and not allow 50% rate increases or 30% terminations."

"In 20 years, I've seen enough of soft markets and hard markets," said Ms. Weiner. "It's a local, coastal state issue that will resolve itself if there are no storms for a couple of years. But we'll never get back to the premium level we had last year."

"I don't know if the market will ever go back to normal," Mr. Lubatti agreed. **[E]**

CIGNA units

Continued from page 1

rating, insisting that S&P had not given adequate weight to steps CIGNA has taken to shore up its casualty operations. Those steps include bringing in new management and reviewing its book of business.

Gerald A. Isom, who in March replaced Caleb Fowler as president of CIGNA's domestic property/casualty operation, is overseeing that review, the spokesman said.

"Strong steps have been taken to bring us closer to our producers, and we are totally re-underwriting some of our books of business," the spokesman said.

In reaction to the downgrade, CIGNA withdrew from the S&P rating process. The insurer had paid \$35,000 a year to be rated.

S&P will issue a qualified rating for CIGNA in the next several months.

No U.S. insurer has withdrawn from the S&P ratings since specialty auto insurer Progressive Corp. did so more than a year ago, said Alan Levin, S&P senior vp.

Two Japanese life insurers withdrew earlier this year after receiving downgraded ratings (BI, July 12).

Mr. Levin predicted the decision would hurt CIGNA. "Either they will lose business or they will fail to gain some new business. Risk managers and agents are calling us and asking us what this means," he said.

CIGNA realizes that its move may hurt the company, but it views it as the best way to register its disagreement with the downgrade, the spokesman said. "Once the downgrade was made, there was no wonderful response to make it all better, but silence and acceptance would not be the right approach."

Outside observers say CIGNA's decision is unusual but will not cost it much business.

"It's a bit like a kid saying, 'It's my football and you can't play with it if I can't play the game,'" said Michael Smith, insurance analyst at Lehman Bros. in New York.

Jay Cohen, a Salomon Bros. insurance analyst, said the effect of the withdrawal would be only marginal. "People are generally less sensitive about property and casualty claims-paying ratings than they are about life companies."

While property/casualty insurers are posting poor results (see story, page 3), the industry's surplus remain plentiful, Mr. Cohen said. "When two big companies go bust, people may start caring more about (claims-paying ratings)."

Even Hurricane Andrew, which cost insurers more than \$15 billion, was not enough to make a significant dent in the industry's surplus, points out Frank White, president and CEO of Willis Corroon America in Nashville, Tenn.

"We still have an industry that has \$160 billion in capital, and CIGNA still has a good claims-paying rating from A.M. Best and substantial reserves to pay claims," Mr. White said.

A.M. Best affirmed its A- rating of CIGNA in June. "Based on other financial criteria, I am frankly not concerned about CIGNA," he said.

Few clients of Sedgwick James Inc. are worried about the CIGNA withdrawal, said Charles Ruoff, senior vp in New York. "We haven't had one CIGNA customer call us and ask us about it."

And Sedgwick itself is not concerned, he said. "We use a number of different rating agencies as well as a lot of information from the company, and we have not determined the same things (S&P) has."

CIGNA's management changes and the other steps it has taken should help improve its results, Mr. Ruoff said.

Even risk managers who purchase coverage from CIGNA say they are not troubled by the withdrawal.

"They have lost money, but they are doing something about it... and they are still in Best's, which is a more widely accepted standard," said William L. Mather, director of risk management at The Gillette Co. in Boston. Gillette plans to keep its coverage with CIGNA, he said.

So does the city of Virginia Beach, Va., according to the city's risk manager, Robert W. Esenberg.

"I don't think (the withdrawal) will have a significant impact on CIGNA's business," Mr. Esenberg said. "It's an industrywide problem that they are going through, and they are taking action to correct it." **[E]**

Update

Big Prop. 103 rebates expected

Continued from page 2

Mr. Garamendi said the rebates were lower than initial orders because the department was working with newer information.

The California Supreme Court still intends to review a Superior Court judge's ruling in a suit filed by 20th Century Insurance Co. that found the rollback regulations unconstitutional (BI, March 8).

NME unit suing insurers

SANTA MONICA, Calif.—NME Psychiatric Properties Inc., the psychiatric subsidiary of National Medical Enterprises Inc., filed two new lawsuits last week against 19 health insurers alleging conspiracy, consumer fraud, defamation and restraint of trade.

The suits seek more than \$250 million in damages as well as treble damages and punitive damages.

NME also had filed suit against the insurers in July 1992 just prior to the insurers' own suit against the mental health provider that alleged NME had filed fraudulent claims (BI, Aug. 3, 1992).

Among the defendants in the new actions are Travelers Insurance Co., Aetna Life Insurance Co., Prudential Insurance Co. of America, Metropolitan Life Insurance Co., Mutual of Omaha Insurance Co. and Massachusetts Mutual Life Insurance Co.

NME Acting General Counsel Scott Brown charged the insurers "have delayed or denied payment for preapproved care and unlawfully attempted to divert patients away from our hospitals. Further, they have spread false rumors about NME."

"This further offensive move by NME is diversionary and appears to be for the benefit of its stockholders and image," countered a Massachusetts Mutual spokesman.

Study: HMOs not satisfying

BALTIMORE—Patients are less satisfied with outpatient visits in large HMOs than in other types of medical practices, according to a study in the Aug. 18 Journal of the American Medical Assn.

Given these findings, national health care policymakers may not want to "discourage small practices and favor large managed care organizations," the study authors say.

Researchers asked 17,671 patients in Boston, Chicago and Los Angeles in 1986 to rate outpatient visits in different practice settings. Among the findings: 64% of patients receiving treatment in solo or single-specialty physician practices, including prepaid and fee-for-service arrangements, rated their visit as excellent. By contrast, only 49% of HMO patients and 48% of patients visiting multispecialty group practices rated their visits as excellent.

Patients complained most about access to services, including waiting times, office locations, time spent with providers and getting through by telephone. Such problems were worse in large organizations, "especially HMOs," according to the study. A 1990 follow-up study reported similar results, but figures are not available.

However, prepaid arrangements do not necessarily lead to patient dissatisfaction. "Small, single-specialty practices, even when prepaid on a capitated basis," provide better care than large managed care organizations, particularly staff-model HMOs, the researchers said.

Briefly noted

The Home Insurance Co., acquired in 1991 by an investor group led by Trygg-Hansa SPP Holding AB, is said to be pursuing plans for an initial public offering. A Home spokeswoman declined comment. . . **Darryl Sragow** is leaving his post as California deputy insurance commissioner to run the **exploratory gubernatorial campaign of Commissioner John Garamendi**. . . An investor group including Robert M. Bass has agreed to buy **Unionamerica Insurance Co. Ltd.**, a London-based unit of Continental Corp. . . A New Orleans federal judge has sentenced **Gordon L. Rush Jr.** to 46 months in prison. Mr. Rush was convicted in January of multiple fraud and conspiracy charges related to his operation of **Presidential Fire & Casualty Insurance Co.** Peter McDermot II, convicted of supplying securities the insurer fraudulently reported as assets, was sentenced to 41 months. . . **Thomas O. Pyle** was named chief executive officer at Metropolitan Life Insurance Co.'s HMO subsidiary, MetLife HealthCare Corp. . . **Empire Blue Cross & Blue Shield** named G. Robert O'Brien president and CEO, effective immediately. Mr. O'Brien recently retired as executive vp with CIGNA Corp. and president of CIGNA's employee benefits unit. . . Former Ohio Gov. **Richard Celeste** will head the Democratic National Committee's **"National Health Care Campaign"** in support of President Clinton's health care reform package. Also, former USA Today reporter **Kevin Anderson** will become the White House's chief spokesman on health care reform. . . A Cook County Circuit Court judge dismissed a lawsuit against seven **cellular telephone manufacturers** and a Baby Bell unit that charged wireless phones pose health risks. . . A joint venture between **American International Group Inc. and Pohjola Insurance Co. Ltd.**, called First International Insurance Co. of Latvia, has been licensed in Latvia. . . Southern Pacific Transportation Co. agreed to pay \$13.5 million to settle more than 3,000 suits arising from a **July 1991 pesticide spill** in Dunsuir, Calif. . . Insurers under contract with the **Health Care Financing Administration** to process Medicare claims typically use high school graduates without any medical backgrounds, the General Accounting Office reports. Claims examiners are expected to process as many as 400 claims a day and only one in 10 claims are reviewed for medical necessity, the GAO said. . . Texas Commissioner **Georgia Flint** has fined seven **ITT Hartford Insurance Group** units \$180,000 for disobeying regulatory orders and other infractions. . . **Arizona lawmakers** will meet in a special session to restore governments' immunity from suits for failure to warn of road hazards.

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