

Business Insurance

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U.S. Lloyd's member must plead case in English courts

WASHINGTON—Lloyd's of London scored a victory last week in the long-running battle over whether U.S. members can press their claims over huge losses in U.S. courts.

The Supreme Court let stand a 10th U.S. Circuit Court of Appeals ruling that a suit by a U.S. member should be heard in English courts (BI, July 27).

The member, Ronald Riley, alleged that Lloyd's had breached U.S. securities laws by not registering under the Securities Ex-

Continued on next page

NAM discovers support for health benefits tax

By JERRY GEISEL

WASHINGTON—More than one-third of employers say that, under certain conditions, they would favor capping the amount of health care coverage that employees receive tax free.

But fewer employers who responded to a National Assn. of Manufacturers survey were in favor of imposing limits on their ability to fully deduct health care premiums and costs as a business expense.

The NAM survey, which was released last week, also found more than half of employers oppose the "play or pay" approach of expanding health care coverage, unless it is accompanied by reform of the health care delivery system.

If the current health care delivery system is retained, employers say that competition and negotiations between providers and payers—rather than government controls—will eliminate cost shifting, the survey found.

According to the survey, most employers also believe that the current health care financing system needs to be fundamentally changed. But employers also say they should remain the major provider of health care coverage to their employees.

These are among the findings of a new survey of 1,445 NAM members, conducted in conjunction with benefit consultant A. Foster Higgins & Co. Inc.

Perhaps the most surprising

Continued on page 11

Willing to compromise?

More than a third of companies favored capping the tax break employees get on health benefits, at least if the tax revenue was used to expand access to care. Fewer companies were willing to give up their own tax deductions.

Favor capping employee tax exclusion?



Favor capping employer tax deduction?



Source: National Assn. of Manufacturers

GRAPHIC BY A. TRANCHITA

Screening foreign insurers

NAIC plans to lobby Congress for role as U.S. gatekeeper

By MEG FLETCHER

ATLANTA—State insurance regulators plan to ask Congress to empower the National Assn. of Insurance Commissioners to serve as "gatekeeper" for non-U.S. insurers and reinsurers seeking to do business in this country.

Under a proposed federal act adopted last week, an NAIC unit would be authorized by the Department of Treasury to expand its screening of non-U.S. property/casualty and life/health companies.

The proposed legislation aims to ensure that only solvent and well-run insurers and reinsurers

have the opportunity to underwrite U.S. risks.

The NAIC plans to forward its proposal to Congress in 1993 and "aggressively" pursue passage of the legislation.

About two dozen states already limit non-U.S. insurers writing on a non-admitted

basis. The states restrict underwriting to companies that receive positive evaluations in a screening process conducted by the NAIC's Non-Admitted Insurers Information Office, which operates from its Kansas City, Mo., headquarters.

Under the proposed act, the NAIC would be permitted to regulate non-U.S. insurers and reinsurers by setting minimum requirements for net worth, collateralization and reporting requirements, among other mea-

sures.

Exempt from NAIC oversight would be large, single-parent or group captive writing insurance for related businesses, as well as the U.S. domestic subsidiaries of a non-U.S. insurer or reinsurer.

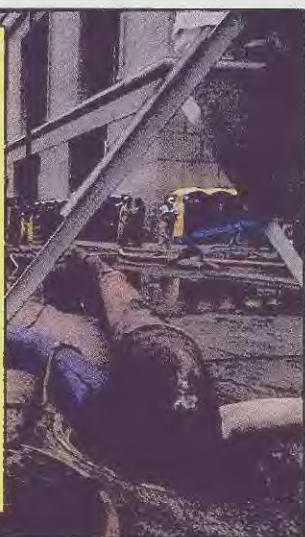
The proposal is the NAIC's response to criticism from Congress. Lawmakers have repeatedly cited the association's lack of authority over non-U.S. insurers and reinsurers as a key weakness in insurance regulation by states (BI, July 20).

However, the proposal did not emerge from the NAIC winter meeting in Atlanta last week free of controversy: A sizable minority of regulators voted against the measure, claiming it could lead to greater federal intervention in regulation.

The NAIC Executive Committee approved the proposal on an

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Insurers paying Chicago flood claims	Pursuing subrogation
Allstate Insurance Co.	Yes
Chubb Corp.	Yes
CNA Insurance Cos.	Undecided
ITT/Hartford Group Inc.	Yes
Kemper National Insurance Cos.	Undecided
Protection Mutual Insurance Co.	Undecided



Insurers subrogating Chicago flood losses face big obstacles

By SARA MARLEY

CHICAGO—Illinois tort and sovereign immunity laws will be the major challenges facing property insurers that intend to subrogate against the city of Chicago and a contractor in an effort to recover losses caused by April's massive underground flood.

Only plaintiffs who have suffered personal injury or physical damage losses can seek to recover economic damages from a defendant, state law says. Attorneys say the law applies in subrogation suits as well.

Most businesses that suffered business interruption losses did not sustain property damage, insurers say.

The city also is expected to claim immunity from liability under the state's sovereign

immunity law.

But, while the bulk of flood-related claims were filed by businesses that sustained economic losses but did not suffer property damage, the largest losses were suffered by businesses with property damage claims.

Only one insurer has so far filed a subrogation suit: ITT/Hartford Group Inc. filed suit in Cook County Circuit Court on Dec. 1 against the city and Great Lakes Dredge & Dock Co.

But other insurers say they intend to file such actions.

Flooding began April 13 when a section of an underground freight tunnel system beneath the Chicago River collapsed (BI, April 20). More than 250 million gallons of river water coursed through the turn-of-the-century tunnels and into many

Continued on page 29

Managed competition model

Cincinnati firms try to change provider practice patterns

By CHRISTINE WOOLSEY

CINCINNATI—As Bill Clinton searches for solutions to the health care crisis in his first 100 days as president, local employer coalitions may provide insights on reforms that could work on a national basis.

Employers increasingly are banding together to form purchasing groups to significantly boost their clout in dealing with health care providers. The idea is to exert pressure on local hospitals and physicians to improve the health care delivery system so that it provides more cost-effective and higher quality medical care.

Four large Cincinnati employers have recently teamed up for such an effort. Their hope is to slash runaway health care costs in the area by as much as \$120 million annually by changing phy-

sician practice patterns at the area's 14 hospitals.

The Cincinnati project is not unique: Employers in other areas of the country—including Chicago, Cleveland, Memphis, Tenn., and Minneapolis—also have undertaken initiatives to measure the cost and quality of performance at the hospitals that serve their employees and dependents (BI, July 13; Feb. 19, 1990). Some employers then directly contract with the hospitals that outshine their competitors.

These projects may serve as the early models of managed competition, employer coalition members say.

The managed competition concept was promoted in a recent proposal by the Conservative Democratic Forum, a group of 57 House Demo-

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Update

Lloyd's jurisdiction win stands

Continued from previous page

change Act. A federal judge in Denver ruled that he lacked jurisdiction to hear the claim, a ruling which the 10th Circuit upheld.

Two similar cases also raising the jurisdiction issue are pending in federal appeals courts. The 7th Circuit last week heard oral arguments in a suit against Lloyd's by three members. And a suit by 116 members is scheduled to be heard by the 2nd Circuit (BI, Aug. 24; July 27).

New 24-hour coverage proposal

SACRAMENTO, Calif.—Legislation to create 24-hour health insurance for all California residents by 1995 is being considered by the state Senate.

The bill, S.B. 38, introduced last week by Senate Insurance Committee Chairman Art Torres, D-Los Angeles, would eliminate the medical components of all insurance policies—auto, health and workers compensation—and provide health care coverage under a single plan. Under that plan, all Californians would be guaranteed a comprehensive package of benefits.

Employers and employees would pay equal premiums into the plan, though the state would subsidize low-income workers and small employers.

The new plan would be administered by joint public-private health insurance purchasing corporations.

Similar legislation backed by Insurance Commissioner John Garamendi passed the Legislature this year but was vetoed by Gov. Pete Wilson (BI, Oct. 5).

AT&T, Bells settle benefit suit

NEW YORK—American Telephone & Telegraph Co. and several Bell telephone companies have agreed to pay at least \$20 million to settle a class action suit by current and former employees who say they were illegally denied pension credits and other benefits when they moved from one divested AT&T company to another after the AT&T breakup.

At least 200 individuals will be covered by the tentative settlement, AT&T said. Several hundred more also could be included, said lead plaintiffs' attorney Henry D. Levine, a partner with Morrison & Foerster in Washington.

The suit centered on the Tax Reform Act of 1984, which was designed to ensure that the pensions and other benefits of certain Bell system employees would be portable (BI, July 2, 1984). However, the Bell system companies narrowly interpreted the number of employees eligible under the act to transfer benefits.

Under the settlement, each plaintiff would receive about \$100,000 in pension benefits, credits and cash on average, Mr. Levine said.

A federal judge in Manhattan preliminarily approved the settlement last week. Final approval is expected in April.

Malpractice ruling reversed

SPRINGFIELD, Ill.—The Illinois Supreme Court has reversed its 1991 ruling that essentially limited the malpractice damages that clients could seek from their lawyers.

The high court ruled 7-0 last week that clients could sue their lawyers under either tort or contract law, not exclusively under contract law as it held last year in *Collins vs. Reynard* (BI, Nov. 25, 1991). Under the earlier ruling, clients could seek to recover only the amount they paid their attorneys. Tort law would also allow recovery for damages caused by attorney negligence.

Last year's 5-2 decision caused an uproar among plaintiffs' attorneys, which prompted the court to grant a rehearing.

The Dec. 4 ruling paves the way for Dorothy J. Collins of Bloomington, Ill., to proceed to trial against her lawyer, Charles Reynard. She alleges that Mr. Reynard failed to protect her rights in the sale of her business.

Navistar retiree health plan

CHICAGO—Navistar International Corp. says it may issue more stock to fund a certain level of retiree health care benefits in exchange for benefit concessions from retirees.

A new stock issue was discussed in the latest round of talks between Navistar and the United Auto Workers.

The Chicago-based truck manufacturer did not provide details about how many shares it might issue or how the plan would work.

Meanwhile, Moody's Investors Service has lowered the company's preferred stock rating to Caa from B2. Moody's placed all the ratings of Navistar and its subsidiaries under review with "direction uncertain," and said there is a "heightened risk" to security holders from the possible restructuring of Navistar's health programs.

Navistar and the UAW have been trying to reach an agreement since August on retiree health care benefits. The company had sought court permission to cut benefits for its 40,000 retirees and 23,000 dependents to avoid bankruptcy (BI, Aug. 3). A group of Navistar retirees and UAW officials sued the company a few weeks later (BI, Aug. 31).

The federal judge hearing the case put it on hold until Dec. 21.

Updates continued on page 30

Errors & omissions

• Due to a composing error, the listings of Tillinghast and Tol Test Inc. were transposed in the Nov. 23 directory of environmental consultants. The proper placement appears on page 14.

Illinois court finds coverage for gradual pollution damage

By DOUGLAS McLEOD

SPRINGFIELD, Ill.—The pollution exclusion in comprehensive general liability policies does not bar coverage for gradual pollution if the release of pollutants was not expected nor intended by the policyholder, the Illinois Supreme Court has ruled.

Reversing a lower court ruling, the state high court found that a clause granting coverage for "sudden and accidental" pollution is ambiguous and therefore should apply if the discharges were unexpected and unintended, regardless of how rapidly the pollution occurred.

idly the pollution occurred.

The ruling hands policyholders a victory on an issue that had divided Illinois appellate courts.

Illinois now joins the high courts of several other states in siding with policyholders on the interpretation of "sudden and accidental." Others siding with this view include Colorado, Florida, Georgia and Wisconsin.

Supreme courts in at least five other states—Massachusetts, Michigan, New York, North Carolina and Ohio—have ruled that coverage of pollution liabilities is barred except where a discharge is "sudden" in a temporal sense.

The Illinois Supreme Court also ruled that the costs of complying with government-mandated cleanups are "damages" under CGL policies.

But, it ruled that coverage is barred when there is a substantial probability that a policyholder knew of a loss at the time its policies were written.

Insurers involved in the case were considering whether to ask the state Supreme Court to reconsider the ruling, lawyers in the case said last week.

The Dec. 4 ruling came in a case pitting Outboard Marine Corp. of Waukegan, Ill., against a

Continued on page 22

But with a twist: CIGNA competitor added in Baltimore

Allied-Signal renews POS plan

By SALLY ROBERTS

MORRISTOWN, N.J.—Allied-Signal Inc.'s nearly 5-year-old point-of-service plan, which protects the company from big health care cost increases, is being extended for another two years—with one change.

CIGNA Corp., which administers the managed care program nationwide for Allied-Signal employees, will now have added

competition in Baltimore.

Both parties had agreed that if a plan is underperforming "financially and non-financially," Allied-Signal will look at alternative networks in the community, said Gary Yeaw, director of group insurance for the manufacturing and engineering company.

"We were not happy with (CIGNA's) performance in Baltimore," said Mr. Yeaw, adding, though, that Baltimore is a "rough area" for managed care and a "fairly new area for CIGNA."

Starting Jan. 1, the roughly

3,000 Allied-Signal employees in Baltimore can begin using one of two point-of-service programs: CIGNA's or one from MD-Individual Practice Assn. Inc., a Rockville, Md.-based HMO.

Both HMOs offer essentially the same benefits, including no deductibles, he said.

Employees that go outside the two networks face annual deductibles equal to 1% of annual base pay for individual coverage, and 3% of annual base pay for family coverage.

Preliminary figures indicate that approximately 10% of the

Continued on page 20

Listings due for directory of TPAs

The deadline is approaching for companies to return questionnaires to be listed in the *Business Insurance* annual directory of third-party administrators. The directory will appear in the Jan. 25 issue, which will also contain a report on trends in self-insurance.

There is no charge to be listed in the directory. Companies need only fill out and return a BI questionnaire.

If your company offers claims administration, adjusting or auditing services for self-insured clients and you have not received a questionnaire, please request one immediately by calling Cindy Bloom at 312-280-3195.

The extended deadline for TPAs to return the completed form is Dec. 28.

Icahn backs agreement between TWA, PBGC

By JERRY GEISEL

WASHINGTON—Trans World Airlines owner Carl Icahn will step up contributions to the airline's massively underfunded pension plans and assume limited liability if the plans terminate under an agreement reached last week with the Pension Benefit Guaranty Corp.

The agreement will enable TWA to emerge from bankruptcy. It calls for the airline to issue about \$300 million in 15-year notes, secured by its international routes and Kansas City, Mo., maintenance base.

Payments on those notes, to be held by the trustee of the settlement, will be used to help fund

the \$30 million to \$35 million in minimum federally required annual payments to the plans. The plans have \$1.05 billion in unfunded vested benefits, including \$730 million in liabilities that the PBGC would have to guarantee if the plans collapsed.

In addition, an Icahn-owned company will make supplementary contributions to the plans, including \$80 million over the next five years.

If the plans, which have about 40,000 participants, are terminated, a group of Icahn-controlled companies would have to pay \$240 million to the PBGC. Payments of \$30 million would be made in eight annual installments.

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Inside

✓ The Health Insurance Assn. of America's health care reform proposal is a welcome first step, this week's editorial says. **PAGE 8**

✓ A U.K. appeals court ruling was the first to impose strict liability for gradual pollution. **PAGE 23**

✓ A London high court trial could have wide implications for reinsurance and insurance. **PAGE 23**

✓ Guaranteed investment contracts remain popular investment options, a study shows. **PAGE 28**

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Manville payout plan back to square one

Manville claims bog down

AUGUST 26, 1982

Manville Corp. files for Chapter 11 bankruptcy protection.

DECEMBER 1986

New York bankruptcy judge approves amended reorganization plan, which creates the Manville Personal Injury Settlement Trust.

MAY 1990

Manville Trust runs out of money to cover current claims.

NOVEMBER 19, 1990

Asbestos plaintiffs file a class action complaint and simultaneously propose a settlement that would revise procedures for allocating trust assets and paying claims.

JANUARY 1991

Other former asbestos manufacturers object to the proposed settlement.

JUNE 27, 1991

A revised restructuring plan is approved in a court order that also stays legal proceedings against the Manville Trust and restricts suits against Manville.

FEBRUARY 24, 1992

2nd U.S. Circuit Court of Appeals hears arguments of asbestos plaintiffs and former asbestos manufacturers objecting to the restructuring plan.

DECEMBER 4, 1992

Panel of the 2nd Circuit Court of Appeals throws out the plan.

By **DOUGLAS McLEOD**

NEW YORK—Asbestos victims, manufacturers and others are trying to decide how they will respond to a federal appeals panel's decision throwing out the restructured Manville Personal Injury Settlement Trust.

A panel of the 2nd U.S. Circuit Court of Appeals on Dec. 4 overturned a 2-year-old plan that had revised the Manville Trust's procedures for paying hundreds of thousands of asbestos victims' claims.

Those changes were made in 1990 when the trust—the cornerstone of the bankruptcy reorganization of Johns-Manville Corp.—was swamped with claims and ran out of cash.

In a 2-1 decision, the appeals panel found that the restructuring violates federal procedural rules and bankruptcy law.

Among other things, the plan

does not adequately consider the competing interests of different classes of asbestos claimants and of asbestos manufacturers named as co-defendants with Manville Corp. in asbestos litigation, the panel ruled.

Though the appeals court said it reached its decision on the innovative plan "with considerable regret," the ruling has raised numerous questions about how the Manville Trust can be revised yet again to allow equitable distribution of its assets.

"What people are trying to digest now is what to do about the opinion: What, if any, other resolution could be achieved either by negotiation or litigation that would satisfy the rules and questions" raised by the appeals panel, said Elihu Inselbuch, a lawyer with Caplin & Drysdale in New York, acting as counsel to plaintiffs' lawyers in the case.

In an order issued last week,

U.S. District Judge Jack B. Weinstein noted that the appeals panel had declared the restructuring "unacceptable in the legal world even if workable and fair in the real world."

Judge Weinstein, who oversaw the trust's restructuring, issued stays of litigation and claims against the trust and ordered the parties in the case to submit new proposals to resolve problems cited by the appeals panel.

The order raised a number of questions, including whether the Manville Trust itself should declare bankruptcy.

Judge Weinstein also urged lawyers and others involved in the case to cooperate "so that we can at long last give some succor to those injured by asbestos."

"The temptation to conclude that our legal system, as presently constituted, cannot cope with this crisis must be firmly

Continued on page 29

GRAPHIC BY KIMBERLY MART

ERISA pre-emption dispute

California challenges workers comp cover through benefit plan

By **LOUISE KERTESZ**

SAN FRANCISCO—Can a company that offers workers compensation benefits through a self-insured benefit plan avoid state workers comp regulations by claiming ERISA pre-emption?

That is the question confronting U.S. District Court Judge Stanley Weigel, who is receiving briefs this month in a suit filed by an employee leasing firm that provides workers comp benefits through its self-insured benefit plan.

The firm argues that ERISA pre-empts state regulation of its plan.

On the other side is the state of California, which contends that allowing benefit plans to be used this way would fundamentally undermine its authority to regulate workers compensation.

Earlier this year, the California Department of Industrial Re-

lations ordered the firm, STAF-COR of Torrance, to either obtain workers comp insurance or cease operations.

STAF-COR, a unit of Employee Staffing Services Inc. of Dallas, contended that ERISA pre-empts the state's authority to regulate its self-insured plan.

Because the plan provides medical benefits for work-related and non-work related injuries and illnesses, ERISA should shield it from state regulation, the company argues.

Title I of ERISA, which gives states the exclusive right to regulate occupational illness and injury benefits, applies to plans that are "maintained solely for that purpose," said James Baker with Littler, Mendelson, Fastiff & Tichy in San Francisco, which represents STAF-COR. However, he said, "Our plan is a multibenefit plan, not one drafted solely to comply with occupational illness and injury benefits."

STAF-COR's plan "contains a written guarantee that the level of benefits will be equal to or greater than paid through state-approved workers comp pro-

grams," added Karen Ford, who is also with Littler, Mendelson.

The STAF-COR benefit plan is funded by a trust fund and reinsured by syndicates at Lloyd's of London, said Ms. Ford.

One reason STAF-COR provides workers comp benefits through the benefit plan is California's steep security requirement for employers that self-insure their workers comp exposures, said Mr. Baker. The requirement is 135% of anticipated claims or a minimum of \$220,000.

In October, Employee Staffing and STAF-COR, which lease workers to garment manufacturers, obtained a temporary restraining order allowing STAF-COR to continue operations indefinitely. STAF-COR now seeks a preliminary injunction enforcing that order.

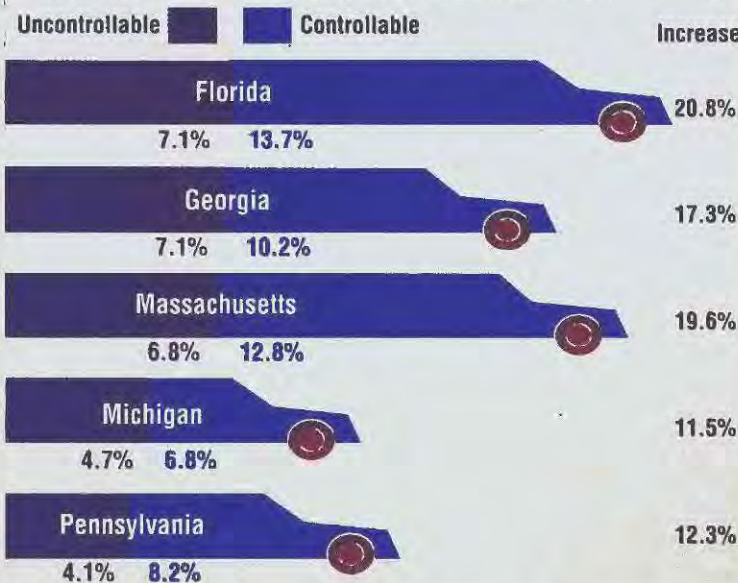
State law requires every employer in California to buy workers comp insurance or obtain a certificate of self-insurance from the Department of Industrial Relations, regulators said in an Oct. 8 bulletin.

"Employee leasing companies,

Continued on page 29

What's driving workers comp costs?

'Additional' cost drivers, which are factors over which workers comp systems have control, dominated the growth in workers comp costs in selected states from 1984 to 1988. By contrast, 'natural' cost drivers, which result from natural economic forces, accounted for a much smaller portion of overall costs.



Source: Workers Compensation Research Bureau

GRAPHIC BY KIMBERLY MART

Strategic benefit planning

More firms using benefits to meet long-range goals: Study

By **LAURA MAZZUCA**

NEW YORK—More companies are applying strategic planning methods to their employee benefit plans in an attempt to cope with skyrocketing health care costs, stricter legislative and regulatory requirements and a changing benefits environment, according to a new study.

In a survey of 183 U.S. corporations conducted by The Conference Board, nearly three-quarters of the executives responding—74%—said their companies have used some sort of strategic, long-range benefit planning. Of the respondents whose companies use such an approach, 45% found strategic benefit planning to be "highly useful"; 38.3% said it was "useful"; 9% considered it "inval-

able"; and 6.8% considered it only "somewhat useful."

The respondents who favor strategic benefit planning said it was particularly useful for introducing new benefits, improving plan administration and supporting the company's quality movement.

Strategic benefit planning is a dynamic activity that emphasizes long-term changes in benefit plans to ensure they meet the company's self-image and goals, the study suggests.

The report's findings are based on a questionnaire completed by corporate senior executives of mid-sized and large corporations. In-depth follow-up interviews were conducted with the respondents in the first quarter of 1992. The follow-up questions emphasized long-term changes in

the design, administration and management of employee benefits.

Executives from more than 70% of the companies engaging in strategic benefit planning said their primary goal is cost containment. Fifty-two percent report that the planning process is part of an overall change in benefit programs, while 40% said it was part of a corporate trend toward strategic planning. The aggregate exceeds 100% because of multiple responses.

Strategic benefit plans typically support the company's corporate philosophy; broaden the definition of benefits; clarify the relationship between compensation and benefits; and assume a longer-term time frame for results, said Victor S. Barocas, se-

Continued on page 12

Study says controllable work comp cost drivers a big part of increases

By **MEG FLETCHER**

Soaring workers compensation costs may be ripe for cost containment efforts, a new study suggests.

Increased emphasis on returning injured employees to work sooner could have a particularly significant impact.

Factors within the control of workers compensation systems are a major component of growing workers comp costs, the study shows.

In fact, these cost drivers accounted for 46% to 67% of the average annual increase in workers comp costs within six selected states from 1984 to 1988. The remainder of the increases was due to "natural cost drivers," which result from economic

activity outside the control of comp systems, according to the study.

"This is the first study that quantifies the cost drivers in workers compensation," said Richard A. Victor, executive director of the Workers Compensation Research Institute, which conducted the study.

"It provides much-needed focus and sets priorities for cost containment," he said of the findings, which will be available later this month.

The study uses data on six states—Florida, Georgia, Illinois, Massachusetts, Michigan and Pennsylvania—collected from detailed claim information supplied by the National Council on Compensation Insurance.

Continued on page 27

NAIC proposal

Continued from page 1
8-6 vote, with two members abstaining.

When put before all members for a vote, Commissioner Jim Brown of Louisiana asked that the committee reconsider its decision. However, state regulators voted 33-to-15 to sustain the proposal, according to reports of the votes, which were held in closed meetings.

The key facet of the proposal is setting up minimum requirements for non-U.S. insurers covering property or risks located within the United States.

Also, it would prohibit U.S. insurers from claiming as an asset or a deduction from liability any reinsurance ceded to non-U.S. insurers or reinsurers that do not meet the NAIC guidelines.

The guidelines would require most non-U.S. insurers or rein-

surers to have three years of operating experience and meet minimum net worth and collateralization requirements, typically by establishing a trust fund in a qualified U.S. financial institution.

For example, a single insurer that wants to write on a direct basis must have a net worth of \$15 million and maintain a trust fund equal to at least the greater of \$2.5 million or its U.S. insurance obligations, up to \$10 million.

Non-U.S. insurers and reinsurers underwriting risks in the United States also would be required to file an application; submit to NAIC examination and the jurisdiction of U.S. courts; provide annual proof of good standing from regulators in their domiciliary country; furnish biographical information on senior officers; and pay certain administrative fees.

In the case of a non-U.S. in-

surer or reinsurer with a U.S. operating subsidiary or branch that underwrites risks in the United States, the proposed review would apply only to its non-U.S. operations.

Different types of reinsurers would face different financial requirements.

For example, the non-U.S. operations of a reinsurer composed of "individual unincorporated underwriters," like Lloyd's, would be required to maintain a trust fund equal to the amount of its U.S. reinsurance obligations plus \$100 million.

"A group of incorporated insurers under common administration," like the Institute of London Underwriters, would have to have an aggregate net worth of \$10 billion and maintain a trust fund equal to the group's U.S. reinsurance obligations plus \$100 million.

Many captives would be ex-

cluded from the act. Neither single-parent nor group captives would be covered as long as they write business related to the risks of their "industrial insured" owner or group of owners.

The bill defines such an owner as one: that employs a full-time insurance manager or buyer, or the services of a regularly and continuously retained qualified insurance consultant; whose aggregate annual premiums for insurance on all risks meet a minimum total to be specified in the act; and that has at least 25 full-time employees.

The Risk & Insurance Management Society Inc. "signed off on" this exemption, said James W. Schacht, chief deputy director of the Illinois Insurance Department and drafting committee chairman.

Also under the act, the NAIC would establish a national intelligence database on individuals and companies involved with il-

legal insurance activities.

The proposed federal legislation, "imposes requirements that don't exist now, especially on non-U.S. reinsurers," said Mr. Schacht. "Undercapitalized and underregulated alien reinsurers have been involved in numerous fraudulent schemes in the U.S.," he said in a report to the Executive Committee.

"It's a way Congress can help the NAIC regulate the industry," said new NAIC President Stephen T. Foster, who is Virginia's insurance commissioner. "It really supports the primacy of state regulation."

Not all regulators were persuaded.

"New York always has been philosophically opposed to 'white listing,' " in which a list of approved insurers is created after regulatory review, said New York Insurance Superintendent Salvatore Curiale.

"I don't think even the federal government would be able to adequately determine if foreign insurers and reinsurers are sound," he added. His department relies on up-to-date collateralization requirements, such as the trust funds, to protect U.S. consumers, he said.

Missouri Insurance Director Lewis Melahan said he opposed the act because, "I don't think the problems it is trying to address are regulatory problems but 'crook' problems."

"I think it invites the federal government to take an ill-defined role in an ill-defined subject, which leads to bad regulation."

Outgoing NAIC President William McCartney also opposed the measure.

Surprisingly, the measure, which had been discussed at both open and closed sessions for more than a year, was quietly adopted in closed sessions.

The Alliance of American Insurers "is dismayed that they would take a step to actively seek federal legislation without giving us a chance to comment on the substantive merits of the bill," said Lenore S. Marema, vp-legal and regulatory affairs.

Representatives of the Alliance and the National Assn. of Independent Insurers questioned the need for federal legislation and said they feared Congress could use the proposal as a vehicle to squeeze out the NAIC and simply set up a federal agency to accomplish the same goals.

They also contend that the proposed legislation would give non-U.S. companies an unfair advantage. Non-U.S. companies could use a "single port of entry" while U.S.-based companies writing on an admitted basis must seek approval to write in each individual state.

The NAIC plans to actively lobby Congress beginning early next year. But first its leaders need to discuss which legislator to approach to sponsor the proposed act, Mr. Foster said.

In other business conducted at the winter meeting, the NAIC:

- Adopted risk-based capital standards for life insurers and continues to work on standards for property/casualty insurers (BI, Sept. 28).
- Accredited five more states—Alaska, Missouri, Nebraska, New Hampshire and Utah—bringing the total to 19 (BI, Dec. 7).
- Agreed to continue discussion on exempting some captives from proposed limits on fronting arrangements.
- In addition to Mr. Foster, elected as new officers: Vp David Walsh of Alaska; and Secretary David Lyons of Iowa.

PLAN NO 1352812

OCCURRENCES PAID

TYPE OF SERVICE

HOSPITAL ROOM AND BOARD

ANCILLARY

SUBTOTAL

OUTPATIENT HOSPITAL

OTHER FACILITIES

SUBTOTAL

PRACTITIONER

SURGEON INPATIENT

SURGEON OUTPATIENT

MENTAL HEALTH

TRACTOR

SOMEONE SHOULD BE READING BETWEEN THE LINES.

At ITT Hartford, we think a claim report should be more than words on a page or letters on a screen. To turn data into useful information, we're equipped to analyze and interpret medical claim activity for all our clients.

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THIS COMPANY CAN OVERHAUL JET AIRCRAFT. BUT IT COULDN'T GET A RETIREMENT PLAN TO FLY.

The employees at Bizjet International, one of the Tulsa-based Hardesty Companies, had a profit-sharing retirement plan. But employee enthusiasm for the plan was low.



Wausau handles the administration and paperwork, helps with employee enrollment, and reports to employees on performance of The Hardesty Companies' 401(k).

"We were convinced our employees would be interested in the benefits of a 401(k), but we didn't have the time or the means to administer one. Wausau's 401(k) answered our concerns," says Roger Hardesty, Founder and President of The Hardesty Companies, including Bizjet, a jet aircraft remanufacturer.

The plan was so well received, in fact, that Mr. Hardesty switched all his companies to the 401(k) plan. It was up to Wausau to explain the benefits and help enroll the employees.



"Wausau had to understand the diverse audience they were speaking to and the individual needs of each employee. I didn't go out and try to sell our employees on the benefits; Wausau did that. As a result, employee acceptance of the 401(k) program company-wide is tremendous."

The Hardesty Companies wanted a retirement plan their employees would be enthused about. With a Wausau administered 401(k), it took off.



L.A. health plan costs most expensive: Study

By MICHAEL SCHACHNER

Benefit Beat

Small employers in Southern California and Florida continue to pay the most for traditional health care indemnity plans, in part because doctors' cost of doing business in those states is extremely high, according to a new study.

Physician practice styles and higher business-related expenses like medical malpractice insurance, employee salaries and of-

fice space are the big cost drivers, the study found.

These expenses are still driving health care costs in Southern California, Florida and many major cities nationwide much higher than the national average, according to the annual study by Milliman & Robertson, a Seattle-based benefit and actuarial

consulting firm.

The annual survey ranks more than 1,000 U.S. cities based on small group indemnity plan costs.

Other factors such as physician self-referral and the costs of treating AIDS also were a factor in high indemnity plan costs, said Mark A. Chesner, an actuary in Milliman & Robertson's New York office, and author of the study.

The 1992 study was based on

the small-group manual rates of 18 of the country's largest health insurers.

The study focused on plans that required a \$250 individual deductible and requires employees to pay 20% of their eligible medical expenses above the deductible. Benefits provided by the studied plans included hospitalization, surgical care, doctor visits, lab tests, radiology and drugs.

Among the 1,050 cities sur-

veyed, the 89 most expensive cities were located in either California or Florida, with Los Angeles employers paying the highest small group premiums in the United States: \$667.50 per month per person.

Health care costs in Los Angeles, according to the study, were 78% higher than the national average of \$375 per month per person.

Last year's national average for a plan with a \$100 deductible was \$365 per month per person (BI, Oct. 28, 1991).

"Not much has changed in L.A. or anywhere else," said Mr. Chesner. "Physician practice styles, whether it be self-referrals or the number of Caesarian sections performed, vary by region, as do salaries, taxes, rents and other business costs."

"If it's expensive to do business in Los Angeles or New York, one can expect health care costs to be expensive. It isn't surprising to see costs 25% below the national average in Iowa and Oregon. If rents are low and utility prices are low, doctors don't need to charge as much to meet their overhead," he explained.

This year's study, like last year's, found great disparity in costs between cities, but annual inflation in all areas remained stable and manageable, said Mr. Chesner.

"We found about 1% inflation per month, or about 12% per year when you factor in the fact that we used a higher deductible this year. I think this is better than the 20% annual inflation that has been reported in the press," he said.

In addition to California and Florida, other major metropolitan areas where costs exceeded the \$375 national average include: New York City, \$525 per month per person, or 40% higher than the national average; Houston, \$480, or 28% higher; and Chicago, \$438.75, or 17% higher. These cities' costs in relation to the national average were relatively unchanged from a year earlier.

"Very little is changing except in the rare place where a city undergoes major changes in how health care is delivered. The most expensive cities now were the most expensive 10 years ago when we first started tracking regional costs," said Mr. Chesner.

Major cities that fell below the \$375 national average include: Columbus, Ohio, \$307.50, or 18% lower; Minneapolis, \$318.75, or 15% lower; and Baltimore, \$367.50, or 2% lower.

The least expensive areas continue to be smaller cities and towns in rural areas.

For example, costs in Iowa were about \$266 per month per person, or 29% below the national average, while in Elmira, N.Y.; Terre Haute, Ind.; and Eugene, Ore., costs ranged from 27% to 25% below the national average.

The survey also found that in the most populated city in each of the 50 states, including the District of Columbia, only 17 were above the national average.

Non-competitors of Milliman & Robertson Inc. can obtain a copy of the 1,050-city study for \$1,950 by contacting Mark A. Chesner at 2 Pennsylvania Plaza, New York, N.Y. 10121-0088; 212-279-7166; fax: 212-629-5657.

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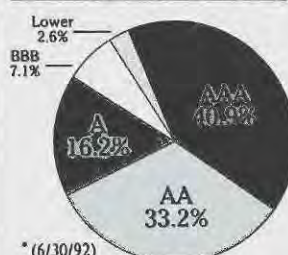
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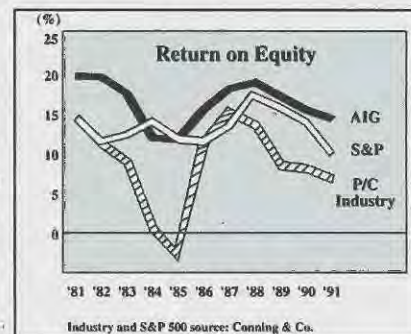


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assets is excellent, with new cash flow invested primarily in investment-grade fixed-income securities.

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Opinions

HIAA plan a good sign

WE WELCOME a new health care reform proposal from the Health Insurance Assn. of America—even if we do not entirely agree with it.

At the core of the proposal, approved by HIAA directors and now being delivered to members for comment, is that all Americans have a right to "essential" health coverage, which the government would help to define.

All employers would have to provide basic coverage to employees, though companies would not initially be required to pay for it. Individuals buying health insurance would be allowed to deduct the cost of the essential benefit package from their income taxes. The government would pay for coverage for the poor.

But if universal coverage is not achieved this way, employers might be required to help fund the basic plan.

Also under the HIAA proposal, insurers could not deny coverage based on prior medical history or other factors. In addition, all purchasers of health care services—the government, insurers, employers—would pay similar rates.

In short, the proposal recognizes several principals. It recognizes that it is unacceptable for 36 million Americans to be uninsured and that new government programs are needed to help fund coverage for the very poor.

It also recognizes that government's Medicare and Medicaid programs have to pay realistic rates so that providers no longer inflate charges for insured patients to compensate for inadequate government reimbursement.

Finally, the proposal recognizes that insurers have to reform their own underwriting practices.

Implicit in the HIAA proposal is that the system can be reformed without a government takeover. We concur. Our health care system is terribly flawed—we spend too much and too many people lack even basic coverage. But those flaws can be fixed without creating a new bureaucracy to be the sole provider of health services.

But we can't, at least not yet, endorse the HIAA board proposal to tax employees on health coverage that exceeds a certain level to help fund benefits for the poor.

Pragmatically, we recognize that the government can't afford to lose tens of billions of dollars in revenue each year by allowing employers to pro-



vide unlimited, tax-free health benefits.

And, if benefits above a certain level are to be taxed, the revenue should, as the HIAA board recommends, be used for coverage for the poor.

But taxing health benefits is a quagmire. Any definition of "essential" health benefits surely will provoke a hue and cry on what should be considered and what should not.

Even if a consensus can be achieved, some awfully sticky problems would remain. Take flexible benefit plans. Large employers would have to make thousands of calculations to determine by how much the benefits selected by workers with company-provided flex dollars exceeded the essential health package.

This isn't to say that finding an equitable way to tax health benefits—without causing a huge administrative mess—is impossible. But it is something to be approached with extreme caution.

Above all, the HIAA board proposal is a sign that the nation's largest health insurer trade group wants to be a major player in the health reform debate.

Reform will come that much sooner and be better structured when trade groups get involved in the debate rather than sit on the sidelines and just complain.

long enough to take credit or blame for its results. However, Mr. Brown was, until earlier this year, president and chief executive officer of Fireman's Fund Insurance Co. Fireman's Fund's current problems and current loss ratio stem almost exclusively from prior management (of which he was a part), market calculations and to a general "management in a vacuum" approach to doing business.

To the editor: As a business advocacy organization, the Indiana Chamber of Commerce has long opposed one-size-fits-all governmental mandates. This includes the family leave legislation, which *Business Insurance* endorsed in October (BI, Oct. 5).

Since the legislation is a *fait accompli* with Gov. Clinton's election, it will serve no purpose to argue philosophy. However, the premise upon which you base your support—that a uniform na-

Besides American International Group Inc., Chubb Corp., General Reinsurance Corp., Scottsdale Insurance Co., and maybe just a couple more, the entire property/casualty industry is managed in a sheepish, follow-the-leader approach, regardless of whether the CEO is a "financial" person, an insurance company insider, or whatever.

Mike Morris
Valencia, Calif.

Family leave bill no boon to multistate firms

tional standard will be of help to multistate companies—is faulty.

The federal bill contains no *pre-emption* of state law. Without this, companies could potentially face several different and confusing requirements.

Kathy McKimmie
Vp-Human Resources
Indiana Chamber of Commerce
Indianapolis
Letters continued on page 10

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Letters

Insurer CEO's background has little impact

To the editor: In the Nov. 23 article, "Transamerica Plans IPO," I take issue with analyst Michael Morrissey's comment that "many successful property/casualty companies are run by financial rather than insurance executives." He then pointed to Joseph W. Brown Jr., chairman of Crum & Forster Corp., as an example of such an executive.

What are the successful P/C insurers that Mr. Morrissey is referring to, especially with respect to Mr. Brown?

It would not appear to be Crum & Forster, because he hasn't been there

Business Insurance welcomes letters from its readers. Please keep your comments as brief as possible. We reserve the right to edit letters for clarity or space. We will not publish unsigned letters. Send your comments to Letters to the Editor, Business Insurance, 740 N. Rush St., Chicago, Ill., 60611-2590.

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ITT HARTFORD



Letters

Ditto: Pollution rulings are ridiculous

To the editor: The March 1990 edition of the FC&S Bulletin notes in reference to the pollution exclusion in the Insurance Service Offices Inc.'s

Lloyd's sole market to pay claims in full

To the editor: I generally agree with your editorial conclusions in "No Easy Way Out" (BI, Nov. 30) about John Rew's proposal for helping Lloyd's of London rebound. Mr. Rew seems to want Lloyd's to give up its uniqueness and to operate the way all markets do. Your opinion that Mr. Rew's proposal won't work because it would doom Lloyd's seems to me to be right on the mark.

However, I think you miss the point and go too far when you state that "No risk manager in his or her right mind would continue to buy coverage from a market that as a matter of policy does not pay claims in full." I do, and so does every risk manager I know.

In fact, if your statement were literally true, no right-minded risk manager would use any market other than Lloyd's. What market, other than Lloyd's, pays claims in full as a matter of policy? Certainly not the U.S. market, where each underwriting company stands up for its own claims but not for claims against other underwriting companies in that market.

W.T. Howard

Director of Risk Management
Arch Mineral Corp.
St. Louis

Awareness is what boosts EAP usage

To the editor: Sally Roberts' article, "Employee Assistance Programs Can Prevent Post-holiday Blues," assumes that EAP utilization correlates with problem incidence. Actually, EAP utilization correlates with program visibility, the perception that life can and should be better, and the credibility of the employer and resources offered by the employer.

While people have special problems during and after the holidays, the increased utilization is more likely a result of the special promotions than a measure of incidence.

The faulty logic reveals a larger paradigm conflict between insurance and EAP services. Under insurance, every claim is a loss, and the goal is to reduce losses and improve the loss ratio. EAPs, on the other hand, operate from a procurement paradigm of looking for problems (claimants) as a way of providing services that have value.

What one sees as risk, the other sees as opportunity for value added.

Lee Wenzel

The Wenzel Group Inc.
Eden Prairie, Minn.

1986 commercial general liability policy form: "The only pollution liability that can be inferred to be covered is that resulting from certain off-premises exposures within the products-completed operations hazard."

If *Park-Ohio Industries vs. The Home Insurance Co.* (BI, Oct. 5), in which a federal appellate court ruled that the pollution exclusion in the 1986 commercial general liability policy bars product liability coverage when damage is caused by a product's release of pollutants, and the 1990 Michigan federal district court ruling in *Horner Equipment Co. vs. Insurance Co. of*

North America and Federated Mutual Insurance Co. are to be the exclusionary rule, what products and completed operations coverage is afforded under the all-inclusive definition of pollutant?

Richard K. Fox is absolutely correct when he characterized in his letter to the editor (BI, Nov. 16) as "ridiculous" those court decisions where pollution is a contingent or collateral factor within what should be broader products and completed operations coverage.

William A. Mahoney

Senior Vp
Marsh & McLennan Inc.
Tampa, Fla.

IIE syndicates settle dispute over a medical malpractice policy

CHICAGO—The Illinois Insurance Exchange and all 14 syndicates have agreed to pay about \$5 million to \$7 million to settle medical malpractice coverage litigation filed against seven syndicates.

The seven syndicates, which wrote excess policies for a group of mostly emergency room doctors, will pay the first \$3 million. Remaining claims will be paid from assessments against the other syndicates based on their underwriting volume.

A federal judge in Chicago earlier this year ordered the seven syndicates to pay all pending claims. The syndicates appealed, arguing they were not made aware of the scope of the risk and terms of the coverage when it was placed (BI, Aug. 17).

The IIE has made a \$3 million claim against its directors and officers liability coverage with Zurich-American Insurance Group.

"These claims arose as a result of a former exchange broker's actions," said James M. Skelton, IIE president and chief operating officer, referring to Irving E. Shainberg, who resigned last year as IIE vice chairman.

"None of the syndicates were aware of some of the actions taken but agreed to accept collective responsibility," he said.

—By Meg Fletcher

Is someone
else
profiting
from
your loss
experience?

NAM survey

Continued from page 1

survey result is that so many employers now say they favor taxing employees on the value of their health care coverage beyond a certain dollar amount.

Under the Internal Revenue Code, employer-paid health care premiums or costs are not included as taxable income to employees.

Such a change would increase employees' income tax burden and employers' FICA taxes by billions of dollars and would impose significant administrative problems on employers.

Nearly 32% of respondents said they would favor a cap on tax-free employer-provided health care coverage if two conditions are met: the change is part of an otherwise acceptable health care reform package and the revenue is used to expand access for the uninsured.

In addition, 4.2% of employers endorse a cap on tax-free health care coverage even if the revenue is not used to improve access to coverage.

On the other hand, 44.9% of employers oppose taxing employees on employer-provided coverage, while 19.1% are unsure.

Benefit experts say the fact that so many employers—more than a third—would support such a tax cap represents a sea change in employer attitudes.

Only a few years ago, employers, along with insurers and unions, led the charge against proposals to cap the amount of health care coverage employers could provide without employees being taxed.

While unions remain staunchly opposed to a so-called health care tax cap, insurer attitudes—like those of employers—may be changing.

Earlier this month, the board of directors of the Health Insurance Assn. of America, in a stunning policy reversal, endorsed taxing workers on employer-provided health care coverage that exceeds an "essential" package of benefits.

The HIAA board said the billions of dollars that would be reaped annually from such a tax should be used to fund coverage for the poor (BI, Dec. 7).

Employer attitudes on health care benefit taxation also are changing as they realize that they now are footing the bill for care provided to the uninsured either through hospital cost shifting or higher taxes to help support public hospitals, says Henry Saveth, a Foster Higgins principal in New York.

If more people were covered by health insurance plans, presumably there would be a reduction in cost-shifting by hospitals, which

now inflate charges for insured patients to help cover their costs of providing uncompensated care to the uninsured.

More employers also may now support taxing health care benefits for strategic reasons. If benefits were taxable, unions would be more reluctant to demand costly benefits for members, said Sharon Canner, assistant vp-industrial relations with NAM.

More employers are opposed to another way to raise revenue to fund coverage for the uninsured: capping the employer tax deduction for health care expenses.

Nearly 54% of respondents said they are against a cap on employers' tax deductions for health care expenses, while more than 25% said they would favor such a cap if the revenues were used to improve access to coverage.

About 15% said they were unsure if the employer tax deduc-

tion should be capped, while just over 4% said the deduction should be capped—even if the tax revenue that is raised isn't used to expand health care access.

NAM also found that employer attitudes on play-or-pay reforms vary depending on whether the approach is coupled with a fundamental overhaul of the health care delivery system.

Under play or pay, employers either would have to offer a health care plan meeting specified standards or pay a payroll tax to help fund coverage for the uninsured.

The survey found that 54.6% of employers oppose play or pay, while 25% favor it and 20.4% are unsure.

But if play or pay were coupled with significant reform of the health care delivery system, 55.3% of employers said they would favor the concept, while 23.4% would not and 21.3% were unsure.

An overwhelming majority—78.4%—of employers say the current health care financing system should be overhauled, while 8.6% don't believe fundamental change is needed and 13% aren't sure.

However, the majority of respondents—57.5%—also say that employers should continue to be the major providers of health benefits to their employees, while 22.5% think employers should not continue to bear the primary responsibility of providing benefits and 20% were not sure. Just 10.5% of employers say the government should take over the financing of health care services through a national health insurance program.

"While most employers believe the health care system has to be changed, they don't want to see it turned over to the federal government," NAM's Ms. Canner said.

If the current health care system is retained, nearly 90% of employers say competition and negotiations between providers and purchasers of health care services are the best ways to eliminate provider cost shifting.

Only about 8% of employers favored government price controls on providers to stop cost shifting.

Employers are fairly evenly divided over whether national limits on health care spending—an idea under consideration by the incoming Clinton administration—should be a component of a health care reform package.

For example, 34.2% of employers said they would favor an annual cap on overall health care spending, while 29.2% are opposed and 36.6% were unsure.

But most employers—57%—say criteria, such as age or health limitations applied to organ transplants, should be established in allocating resources to pay for health care, while 20.5% were opposed to such criteria and 22.5% weren't sure.

NAM also found that the majority of employers—85.1%—cited medical malpractice awards more than any other factor as contributing to higher health care costs.

However, more than 70% of employers also cited fraud and abuse as well physician and hospital fees for higher costs.

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Copies of "Health Care Reform and Costs: Summary of Findings," are available from the National Assn. of Manufacturers, Publications Coordinator, 1331 Pennsylvania Ave. N.W., Suite 1500—North Tower, Washington, D.C. 20004-1703; 800-637-3005 or 202-637-3086 in Washington. The cost is \$10 for NAM members and \$20 for non-members. A 7.25% sales tax should be added for orders from California; a 6% sales tax should be added for orders from the District of Columbia.

Strategic planning

Continued from page 3

senior research associate at The Conference Board, a New York-based worldwide non-profit organization of businesspeople.

Ten years ago, benefits were not as important as they are today because they constituted "a smaller portion of the compensation pie," and because their cost was a considerably smaller corporate expenditure than it is today, according to Lance Tane, partner at benefit consultant

Kwasha Lipton in Fort Lee, N.J.

Back then, employee benefits were considered just another uncontrollable overhead expense, and companies simply paid the bills with little thought to long-term planning, he said.

As benefit costs rose and federal legislation dealing with employee benefits became more common, CEOs started to look at benefits as an expenditure in need of cost containment measures.

The changing corporate relationship with employees has also

brought strategic benefit planning to the forefront.

At one time, salary was the primary indicator of the employee's relationship with the company, said Mr. Tane. Today, this relationship is measured in benefits, in which employee tenure, "paternalism vs. partnership," and other issues are reflected, he said.

But, except for a few leaders, most companies have been "reactive" in their benefit planning—responding to legislative requirements, short-term costs,

competition and employee pressure, according to Mr. Tane. "The result was really a benefit package that was sub-optimal," he said.

And because employee benefits were addressed individually rather than simultaneously, they sometimes ran contrary to a corporation's goals.

For example, a company that encourages a "more dynamic" workforce and fast employee turnover, as opposed to one that aims to cultivate long-term workers, counteracts its goal by

offering a traditional, final average pay pension plan. "This is a definite, significant inconsistency," Mr. Tane said.

One of the leaders in long-term benefit planning is American Telephone & Telegraph Co., which participated in The Conference Board survey.

The communications giant, with more than 240,000 U.S. employees, has practiced some form of strategic benefits planning since 1913, when its predecessor Bell Systems introduced pension and death benefits, said A. Fromme, benefit planning director for the Berkeley Heights, N.J.-based corporation.

AT&T's forced divestiture of its local subsidiaries in the early 1980s also called for some creative benefit planning, according to Mr. Fromme. Although the resulting operating companies are autonomous, their master benefit plan comes from the corporation.

And AT&T since then has acquired companies with their own benefit plans that now have the option of choosing from a "menu" of benefits within a specially designed program rather than "loading" the AT&T plan on top of an existing plan, Mr. Fromme explained. This flexibility allows the acquired company to remain competitive in its field.

Another creative example of strategic benefit planning is RJR Nabisco Inc.'s introduction of a new defined benefit pension program, said William J. Miner, an actuary at The Wyatt Co. The program provides a steady accrual of benefits to allow employees who serve the company for a shorter time to realize more substantial earnings (BI, Oct. 12).

The RJR program is "a classic case" of designing a benefit program to meet specific objectives, he said.

In order to establish a strategic benefit plan, a corporation first must have a solid overall business strategy focused on human resources—detailing the type of people it wishes to hire and the best programs to attract them, according to Mr. Tane.

"It makes no sense to do a strategic benefit plan if your company doesn't have an overall strategic plan," he added.

Once the program is in place, any changes made to the benefit program will appear more orderly to employees because "there is a communication of a process going on," Mr. Tane said.

However, there are caveats in establishing a strategic benefit plan, consultants say. Such plans seem to work best for large corporations, which can afford the time and the consultants to set it up, Mr. Miner noted.

Many companies, especially those that are short-staffed or "in a constant state of flux" because of aggressive acquisitions, do not have an overall business strategy or an environment that fosters such programs, he added.

In the Conference Board study, the 35 corporations that did not use strategic benefit planning are generally smaller. Although almost 94% of these corporations engaged in some form of strategic business planning, the effort is not extended to benefits because executives do not view them as contributing to the corporation's success.

Copies of "Strategic Benefit Planning" are available from The Conference Board, 845 Third Ave., New York, N.Y. 10022. Contact Victor Barocas at 212-339-0324.



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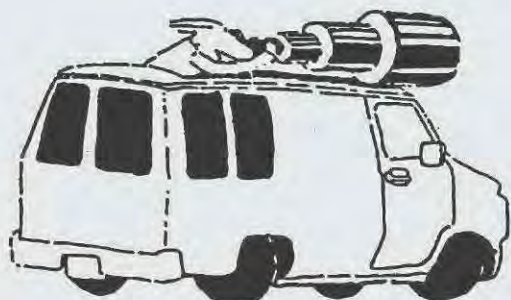
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Datebook

JANUARY

JAN. 11-13. Environmental Regulation Course in Dallas; Washington; and Salt Lake City; sponsored by Executive Enterprises Inc.; \$1,090. Also **Jan. 13-15** in Birmingham, Ala.; **Jan. 20-22** in San Francisco; **Jan. 27-29** in New York City; **Feb. 22-24** in Cincinnati; **March 10-12** in Cherry Hill, N.J. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

JAN. 13. Untangling the Web: Managing Workers Compensation Medical and Medical-Legal Costs sponsored by The California Workers Compensation Institute; \$165 for members; \$245 for non-members. Also **Jan. 14** in Long Beach, Calif.; **Jan. 15** in Ontario, Calif.; **Jan. 19** in Millbrae, Calif. Virginia Sullivan, California Workers Compensation Institute, 120 Montgomery St., Suite 1300, San Francisco, Calif. 94104; 415-981-2107.

JAN. 13-15. Winter Health Care Management & Cost Containment Conference in San Diego, sponsored by *Business Insurance* and IBF Conferences; \$795; group discounts are available. IBF Conferences/International Business Forum, 50 Charles Lindbergh Blvd., Suite 400, Uniondale, N.Y. 11553-3619; 516-229-2375.

JAN. 13-15. Behavioral Health Programs in HMOs: Making Quality a Reality conference in Lake Tahoe, Nev., sponsored by the Group Health Assn. of America; \$570 for GHAA members; \$670 for non-members; add \$80 after Dec. 11. Group Health Assn. of America, 1129 20th St. N.W., Suite 600, Washington, D.C. 20036; 202-778-3225

JAN. 14-15. Premises Liability for Violent Crimes Seminar in Tampa, Fla., sponsored by the Defense Research Institute; \$375 for DRI members; \$425 for non-members; some discounts available. Defense Research Institute, 750 N. Lake Shore Drive, Suite 500, Chicago, Ill. 60611; 312-944-0575.

JAN. 19. Pollution Liability: The

Law and Available Insurance workshop in Allentown, Pa., sponsored by the Society of Chartered Property & Casualty Underwriters and the Lehigh Valley chapter; \$75 for society members; \$85 for non-members. Karen Williman, continuing education coordinator, Society of CPCU, 720 Providence Road, P.O. Box 3009, Malvern, Pa. 19355; 215-251-2773.

JAN. 20. CPCU Leadership Forum in Denver, sponsored by the Society of Chartered Property & Casualty Underwriters; \$250. Karen Williman, continuing education coordinator, Society of CPCU, 720 Providence Road, P.O. Box 3009, Malvern, Pa. 19355; 215-251-2773.

JAN. 20-22. Risk Management—New Tools of the Trade conference in Atlanta, sponsored by Atlanta Chapter of the Risk & Insurance Management Society Inc.; \$100 for RIMS members; \$125 for non-members; \$25 for students. Sally Wissel, Worldspan, 300 Galleria Parkway No. 2030, Atlanta, Ga. 30339; 404-916-7813.

JAN. 21-22. Industrial Health and Safety Regulation Course in St. Louis, sponsored by Executive Enterprises Inc.; \$1,090. Also **Jan. 25-26** in Cleveland; and **Feb. 4-5** in Atlanta. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

JAN. 21-23. West Regional Managed Health Care Congress in San Francisco, sponsored by the National Managed Health Care Congress; \$795; \$895 on site. Sara Evangelous, 617-487-6723.

JAN. 24-27. Continuing the Debate of the Workers Compensation Issues of the '90s seminar in State-line, Nev.; sponsored by the International Workers Compensation Foundation; \$250 for government representatives; \$350 for private sector attendees; \$25 for guests. Robert B. Collyer, treasurer, 1575 Aviation Center Parkway, Suite 512, Daytona Beach, Fla. 32114; 904-252-2915.

JAN. 26-27. Health Care Cost Con-

tainment workshop in Los Angeles, sponsored by the Health Research Institute; \$595. Also **March 16-17** in San Francisco; **April 6-7** in Atlanta; **May 4-5** in Chicago; **June 8-9** in New York. Workshop Coordinator, Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 510-676-2320.

JAN. 27. National Academy of Forensic Engineers Annual Meeting in Kona, Hawaii, sponsored by the NAFE; \$250 for members; \$300. E. Joyce Dixon, 174 Brady Ave., Hawthorne, N.Y. 10532; 914-747-1123.

JAN. 28-29. Understanding Today's London Insurance Market conference in New York City, sponsored by Executive Enterprises Inc.; \$1,090. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

JAN. 28-29. Putting Theory into Practice: How Providers and Payers Use Medical Guidelines and Outcomes Research seminar in Washington, sponsored by Capitol Publications Inc.; \$595. Peggy Dwyer, Capitol Publications Inc., 1101 King St., Suite 444, Alexandria, Va. 22314; 800-847-7772.

JAN. 29. Advanced Care Cost Containment workshop in Los Angeles, sponsored by the Health Research Institute; \$595. Also **March 19** in San Francisco; **April 9** in Atlanta; **May 7** in Chicago; **June 11** in New York. Workshop Coordinator, Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 510-676-2320.

FEBRUARY

FEB. 1-2. Developing Profit Opportunities in Alternative Insurance Markets seminar in Chicago, sponsored by Infoline; \$995. Infoline Inc., 225 Turnpike Road, Southborough, Mass. 01722-1749; 508-481-6400.

FEB. 7-10. 1993 American Bankers Assn. National Security and Risk Management Conference in Orlando, sponsored by the ABA; \$730 for ABA members; \$970 for non-

members. American Bankers Assn., 800-338-0626.

FEB. 8-9. The 1993 Insurance Risk-Based Capital Conference—Improving Your Risk-Based Capital Position conference in New York, sponsored by Executive Enterprises Inc.; \$1,090. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

FEB. 11. Spotlight on the Employer's Risk Management Burden seminar in London, sponsored by the Assn. of Insurance & Risk Managers in Industry & Commerce; 100 pounds (\$160) plus VAT for members; 130 pounds (\$208) plus VAT. AIRMIC Secretariat, 6 Lloyd's Ave., London EC3N 3AX; 071-480-7610.

FEB. 14-16. American Assn. of Insurance Services Annual Conference in Orlando, Fla., sponsored by the AAIS; \$345, group discounts available. AAIS, 1035 S. York Road, Bensenville, Ill. 60106; 708-595-3225.

FEB. 23-24. Workers Compensation Research Institute Annual Issues & Research Conference in Cambridge, Mass.; \$225 for WCRI members; \$425 for non-members; add \$50 after Feb. 16. WCRI, 101 Main St., Cambridge, Mass. 02142; 617-494-1240.

FEB. 25-26. Product Liability—Restructuring for a Leaner and Meaner Defense conference in New Orleans, sponsored by the Defense Research Institute; \$375 for DRI members; \$425 for non-members; group discounts available. DRI, 750 N. Lake Shore Drive, Suite 500, Chicago, Ill. 60611; 312-944-0575.

The Datebook is compiled from notices sent to Business Insurance. Notices should be sent at least eight weeks in advance to Datebook, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590. Please include the price, if any, of the meeting and information on registration for interested readers. Business Insurance reserves the right to select meetings of most interest to its readers and cannot guarantee notices will be printed.

Environmental consultant listings corrected

Due to a composing error, the following companies were incorrectly positioned within the Nov. 23 directory of environmental consultants.

Tiller Consulting Group Inc.
2833 N. Geyer Road, St. Louis, Mo. 63131; 314-567-7480; fax: 314-567-7480

Founded: 1986.
Environmental services: Frequent risk financing.
Other services: Frequent actuarial forecasting of environmental claims.
Staff: Two total; both environmental professionals who are principal consultants. Professional designations in-

cludes ARMs.

Compensation: By the hour.
Officers: Margaret W. Tiller, president; Michael H. Tiller, principal.
Contact: Margaret W. Tiller.

Tillinghast, a Towers, Perrin Co.
245 Park Ave., New York, N.Y. 10167; 212-490-3460; fax: 212-351-4157

Founded: 1946.
Environmental services: Frequent regulatory and public policy analysis, risk financing; occasional waste minimization plans, litigation support.

Other services: Frequent environmental consulting to insurers and public policy makers, general risk management consulting, actuarial claims management, general management consulting.

Staff: 256 total; one environmental professional who is a consultant. Professional designations include one PE, two attorneys, 17 ARMs, 13 CPCUs.

Clients: 1,438 total; 26 environmental consulting clients.

Specialties: Financial and policy analysis in all industries.

Branch offices: Arlington, Va.; Atlanta; Bloomington, Ill.; Boston; Chicago; Dallas; Denver; Hartford and Stamford, Conn.; Irvine and San Francisco, Calif.; Jacksonville, Fla.; Kansas City, Kan.; Minneapolis; New York; Philadelphia; San Antonio; St. Louis; Amsterdam, Netherlands; Bermuda; Brussels, Belgium; Cologne and Frankfurt, Germany; Geneva; Hong Kong; London; Madrid, Spain; Melbourne and Sydney, Australia; Milan, Italy; Montreal and Toronto, Canada; Paris.

Compensation: By the hour: principal consultant, \$220-\$350; consultant, \$130-\$250.

1991 gross revenues: \$51.8 million total, 0.5% from unbundled environmental risk management consulting services.

Officers: Mike Tuohy, managing principal; W. James MacGinnitie, man-

aging principal-property/casualty division; Robert W. Sturgis, vp/director; Thomas J. Wander, risk management leader; Howard Veit, managing principal-health division; Neil Anderson, managing principal-life division.

Contact: Amy S. Bouska, 4601 N. Fairfax Drive, Suite 1100, Arlington, Va., 22203; 703-527-7500; fax: 703-528-6814.

Tol Test Inc.
1916 N. 12th St., Toledo, Ohio 43624; 419-241-7175; fax: 419-241-1808

Founded: 1927.
Environmental services: Frequent real estate audits, manufacturing plants audits, design and analysis of remediation plans, UST management and removal, clean air act consulting, regulatory compliance, NPDES consulting, spec consulting; occasional litigation support.

Other services: Frequent remediation activities.

Staff: 175 total; 90 environmental professionals including 10 principal consultants, 80 consultants. Professional designations include six PEs.

Clients: 40 total; 50 environmental consulting clients, 10% with gross revenues less than \$10 million, 20% with \$10 million-\$24 million, 40% with \$25 million-\$99 million, 25% with \$100 million-\$1 billion, 5% with more than \$1 billion.

Specialties: Manufacturing, oil companies, pipeline companies, federal and state agencies.

Branch offices: Pittsburgh; Plymouth and Monroe, Mich.

Compensation: By the hour.

1991 gross revenues: \$12 million total, 60% from unbundled environmental risk management consulting services.

Officers: William F. Boyle, president; Michael P. Boyle, executive vp; Patrick W. Boyle, vp.

Contact: David L. Richardson, sales account manager. **BI**

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Analyst says insurers in for a rude awakening

By MICHAEL SCHACHNER

NEW YORK—The primary property/casualty insurance marketplace is dangerously ill and its recovery will be slow and painful, an industry analyst says.

"Since I entered the business 28 years ago, I have not seen insurer balance sheets as mucked up as they are today, and I'm not sure how executives are keeping their jobs," said Myron M. Picoult, managing director and senior insurance analyst with Oppenheimer & Co. in New York.

"A 'General Motors effect' may, and probably should, surface in the industry in the near future," he said. During a recent speech at the ninth annual gathering of the Assn. of Professional Insurance Women and the New York chapter of the Society of Chartered Property & Casualty Underwriters, Mr. Picoult assailed primary insurers for their recent underwriting and accounting practices.

Executives of property/casualty insurers are in for a rude awakening if they expect ample reinsurance to be available next year, he said.

"As of Nov. 23, catastrophe losses (in 1992) totaled \$17.5 billion, which is more than the previous six years combined. The \$10.7 billion in losses we're hearing about from the hurricanes will probably grow to \$15 billion to \$17 billion with business interruption claims and housing reconstruction costs," Mr. Picoult said.

"But what's truly amazing is that primary companies still believe that it's business as usual in the reinsurance field. What they're going to find out next year is that reinsurance availability will be like Swiss cheese, especially for catastrophe reinsurance," he said.

Mr. Picoult said that while reinsurance pricing will probably escalate somewhat next year, a severe crimping in reinsurance capacity will crush the primary market. "Reinsurers can just sit back and let the business come to them."

Primary property/casualty insurers will also be starting 1993 in a hole, Mr. Picoult said. "As much as \$7 billion in hurricane losses will be carried into next year, which already makes 1993 the second-biggest catastrophe year in history. Primary companies are in bad shape, and digging themselves out of this type of hole won't be easy."

Also adding to insurers' woes is the likelihood that they will be subjected to tighter accounting rules, which will curtail their ability to manipulate financial results.

"Currently, disclosure requirements are abominable. They're downright pitiful," he exclaimed. However, he noted that the Financial Accounting Standards Board, the Securities Exchange Commission and American Institute of Certified Public Accountants are all pushing for stricter accounting and disclosure requirements for insurers.

"This will help us," he said, referring to analysts. "Right now when I see a company with a 110% or 112% combined ratio, I know those numbers are finagled. Hopefully, we can learn a little more about what these companies are really doing."

"Things are tough now and they're going to get tougher. The industry will have fewer opportunities to pull accounting and financial gimmicks with these new rules and risk-based capital requirements," he said.

In summary, Mr. Picoult said the primary industry has fallen into the worst financial and managerial shape in quite some time. He said the few companies that are currently maintaining strong balance sheets will pick up market share at the expense of companies with poor balance sheets.

"Things are bad. Companies will have a tough time raising capital because the stock market isn't there like it used to be," he said. Thus, stock companies may be forced to reduce dividends, which will anger stockholders and could cause a backlash, Mr. Picoult suggested.

"Some companies are going to go under; there's no doubt about that," he concluded. **BI**

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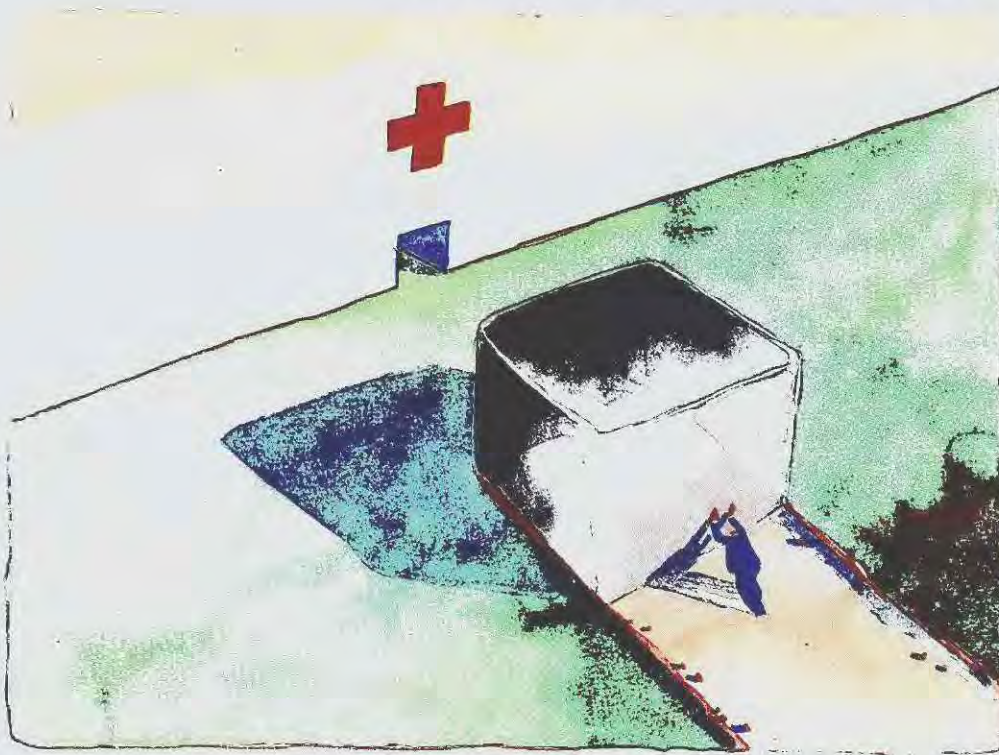
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HEALTH CARE MANAGEMENT CONFERENCE AGENDA

WEDNESDAY, JANUARY 13

6:00 p.m. - Early Registration and
7:30 p.m. Cocktail Reception
Hosted by The Upjohn Company

THURSDAY, JANUARY 14

7:45 a.m. Continental Breakfast & Registration

9:00 a.m. OPENING REMARKS BY CONFERENCE
CHAIRMAN

Kathryn J. McIntyre
Publisher/Editorial Director
Business Insurance

James M. Burcke
Editor
Business Insurance

9:15 a.m. LATEST DEVELOPMENTS IN HEALTH
MAINTENANCE AND PREFERRED
PROVIDER ORGANIZATIONS

This panel discussion, moderated by James
Burcke of *Business Insurance*, will focus
primarily on the impact managed care has
had on the delivery and financing of health
care and on the range of options now
available to employers. The panel will
analyze the following models in terms of
their ability to deliver affordable quality
care:

- ▶ Exclusive Provider Organizations
- ▶ Point-of-service plans
- ▶ Managed fee-for-service

- ▶ Utilization review
- ▶ Specialty networks

Moderator:
James M. Burcke
Editor
Business Insurance

Larry Goelman
President & Chief Executive Officer
Cost Care, Inc.

Chip Sharkey
Senior Vice President,
National Marketing
Cigna Corporation

Ed Zalta
Chairman of the Board
& Chief Executive Officer
CAPP CARE, INC.

10:30 a.m. Mid-morning Refreshments &
Table-Top Exhibits

11:00 a.m. SPECIAL PRESENTATIONS ON THE NEXT
GENERATION OF MANAGED CARE

New models are in the making as managed
care continues to evolve and establish itself
as the preferred approach in delivering
quality care at an affordable cost. Two
distinguished experts in the health care
field will share their perspectives and
insights on the future direction of managed
care and what the implications are for
purchasers in the health care marketplace.

Joseph W. Duva
Partner
Ernst & Young

Jacque J. Sokolov, M.D.
President
Sokolov Strategic Alliance

12:15 p.m. Luncheon for Speakers and Attendees
Hosted by John Hancock
Financial Services

1:00 p.m. KEYNOTE LUNCHEON SPEAKER

Stephen M. Wilder
Assistant Treasurer, Risk Management
Walt Disney Company

1:45 p.m. Break

2:00 p.m. Concurrent Session A:
DIRECT CONTRACTING: SELECTING AND
STRIKING A DEAL WITH A HOSPITAL

- ▶ Selection criteria
- ▶ Negotiating and cutting the deal
- ▶ Case Studies: State of Utah and
Safeway, Inc.

Linn J. Baker
Director - Public Employees
Health Program
State of Utah

Nancy Hughes
Group Insurance Manager
Safeway, Inc.

Dr. Arnold S. Milstein
Managing Director
William M. Mercer, Inc.

2:00 p.m. Concurrent Session B:
WORKERS COMPENSATION WORKSHOP:
APPLYING MANAGED CARE
TECHNIQUES TO CONTAIN WORKERS
COMPENSATION COSTS

- ▶ The range of services required
- Specialized networks
- Case management
- Practice guidelines

HEALTH CARE MANAGEMENT CONFERENCE AGENDA

- **Fraudulent claims: Who is the culprit?**
 - Closing the loopholes
 - Implementing a prevention program
- **The working model**

Charles Jacobs
President
InterQual, Inc.

Jerry A. Miccolis
Vice President & Workers Compensation
Practice Leader
Towers Perrin

Ed Zutler
President
FHP Insurance Group

3:30 p.m. **Mid-afternoon Refreshments & Table-Top Exhibits**

4:00 p.m. **HEALTH CARE COALITION UPDATE**
As organizations committed to purchasing quality health care for their members and as lobbyists for health care reform, coalitions have spearheaded research projects that have been at the forefront in exploring creative solutions to the health care crisis. Ms. Hubers of The Alliance will discuss how employers can purchase health care based on value. Ms. Powers of the Bay Area Business Group on Health will outline current projects, with special emphasis on the coalition's preventive care initiatives.

Debra Hubers
Director of Marketing
The Alliance

Patricia E. Powers
Executive Director
Bay Area Business Group on Health

5:00 p.m. **COCKTAIL RECEPTION**

FRIDAY, JANUARY 15

7:45 a.m. **Continental Breakfast & Table-Top Exhibits**

9:00 a.m. **REMARKS FROM THE CHAIR**

9:15 a.m. **THE AIDS/HIV CRISIS: ONE EMPLOYER'S RESPONSE**
With no cure in sight, AIDS has challenged employers to respond to a worldwide

epidemic that is affecting all aspects of corporate life and the bottom line. Digital Equipment Corporation has established and implemented a coordinated, integrated strategy on behalf of all employees and their families. Worldwide in scope, Digital's HIV/AIDS program encompasses education and outreach that has increased productivity, maintained excellent employee relations and contained health care costs.

Paul A. Ross, Ed.D.
Corporate Manager,
HIV/AIDS Programs
Digital Equipment Corporation

10:00 a.m. **Mid-morning Refreshments & Table-Top Exhibits**

10:30 a.m. **PREVENTIVE CARE: INTEGRATING PREVENTIVE CARE INTO BENEFIT PROGRAMS**

- Financial incentives to promote healthy behavior
- The ingredients of a successful wellness program
- Effective employee communication

Michael Fox
Managing Consultant
A. Foster Higgins & Co.

Lynn Gilfillan
Community Wellness Development
Coordinator
Coors Brewing Company

Allen Iampaglia
Risk Manager
City of Glendale, Arizona

11:30 a.m. **Concurrent Session A: NEW DIRECTIONS IN FLEXIBLE BENEFITS**

- New ways to manage flexible benefits administration
- Flexible benefits for retirees

Larry Atkins
Manager, HR Systems
Barnett Banks, Inc.

Sally Gottlieb
Manager of Benefits Administration
Apple Computer, Inc.

11:30 a.m. **Concurrent Session B:**

BALANCING QUALITY AND COST IN PRESCRIPTION DRUG BENEFIT PLAN DESIGN

- Critical factors in plan design
 - Quality versus cost in prescription drug benefits
 - Appropriate drug utilization review
 - Patient-focused pharmaceutical care
- Coordinating a full service pharmaceutical benefit
- Utilizing mail-service in combination with pharmacy networks

James Heenan
Director, Corporate Accounts Sales
The Upjohn Company

12:30 p.m. **Luncheon for Speakers and Attendees Hosted by FHP, Inc.**

1:15 p.m. **KEYNOTE LUNCHEON SPEAKER**

Frank McArdle
Partner
Hewitt Associates

1:45 p.m. **Break**

2:00 p.m. **AN IN-DEPTH LOOK AT THE CANADIAN HEALTH CARE DELIVERY SYSTEM**
With the health care crisis continuing unabated, the United States has looked with increasing interest to other nations' health care delivery systems. The Canadian health care system has received considerable attention for its ability to deliver universal health care.

Dr. Robert M. MacMillan
Executive Director
Health Insurance Division
Ministry of Health, Ontario

2:45 p.m. **DEBATE ON THE CANADIAN SYSTEM**

Dr. Anthony R. Masso
Vice President, Managed Care and
Insurance Products
Health Insurance Association of America

Howard Weizmann
Vice President
Aetna Benefits Consulting Practices
Aetna Life & Casualty

3:30 p.m. **END OF CONFERENCE**

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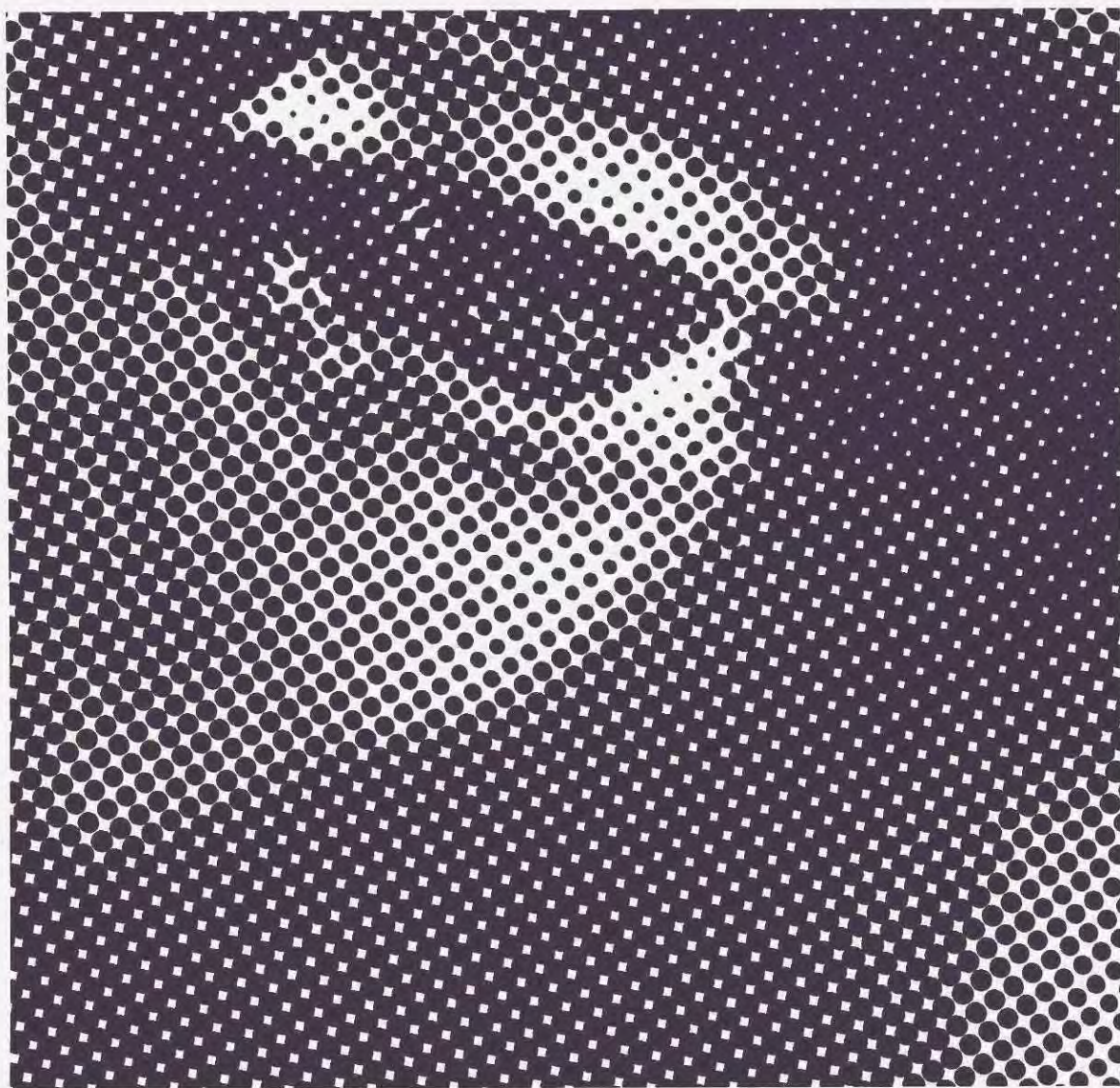
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ASK A RISK MANAGER

Holiday pressures spur violence in the workplace

Q

The threat of violence on the job is a big concern today. My managers have asked me to develop a security program to protect our employees. What are the most important areas to consider?

A

It is an unfortunate sign of the times that stress, fueled by massive layoffs and employee dissatisfaction on the job, has contributed to a marked increase in violence in the workplace. Once considered a safe haven from such behavior, the business

environment too often becomes a battleground in a war of employee vs. employee, or employee vs. employer. The picture today appears bleak and will not improve until society recognizes that human beings are made of flesh and blood and that life is a right, not a perishable commodity.

According to FBI reports, violent crime has increased 30% since 1987. In addition, 90% of the current prison population has been convicted of one or more violent offenses.

Executives once thought of themselves as safe and secure in the cocoon of their penthouse offices. No more! There is easy access into the business and personal lives of our business leaders. One has only to read front page headlines to learn the sordid details of kidnappings and violence in the business world.

The holiday season normally brings a rush of violent incidents, driven by the thirst for easy cash during the spend-crazed period between Halloween and Christmas. Those of us in the retail business sector have been conditioned to expect an increase in robberies and theft as part of the holiday business cycle. What remains most horrifying, however, is the threat of physical harm.

It's no wonder security issues are increasingly important to an organization's economic survival. White collar crime has become a well-known term as fraud, embezzlement and sabotage schemes cost businesses and insurance companies millions of dollars each year. I could expound further on this subject but will focus my comments on the impact of violent crime and three important tools available to deal with it: education, prevention and control.

• Education.

As is the case with the creation and implementation of any new program, employee education is vital to dealing successfully with crime. Everyone within the organization should recognize the crippling effects of criminal activity on people and profits. A risk manager's primary focus is to protect the company's assets—of which people, property and cash are most important. Employees should be trained in the use of any special security equipment, and should be taught whom to call in the event of an emergency.

It's also important to teach employees how to recognize and report suspicious activity. Most of us have a "sixth sense" that alerts us when things just don't seem right. Employees should be taught how to tune into this perception and avoid hidden danger. This coaching carries an added benefit: Employee can take what they have learned about workplace security and safety and apply it to their personal lives.

Many companies now offer self-defense training to employees. Often, just knowing "what to do and when" helps to control the paralyzing fear that can overwhelm a person before and during a physical attack.

• Prevention.

Prevention activities include training programs, as well as physical tools like alarm systems and guards. Also included in this category are pre-employment screening activities.

The types of alarms currently available vary significantly in type and price. It's a good idea to perform a security needs survey before purchasing an alarm. A couple of basic, critical questions to consider: Are funds available to purchase the appropriate equipment for the amount of protection required? Are several remote monitors required as well as sensory detecting capabilities?

It's best to select a vendor and system that can also tie into a fire protection system. In addition to alarm systems, security guards should be employed wherever and whenever practical.

Again, the size of the guard force and the scope of their coverage depends on your organization's security profile.

Is your organization doing an adequate job of screening potential employees by conducting thorough background checks? Remember, every employer is responsible for providing its employees with a safe, secure workplace. The majority of crimes are inflicted by repeat offenders. Background checks weed out the "bad guys" before they have an opportunity to infiltrate the work environment.

• Control.

Controls are meant to deter or minimize the physical, emotional and financial impact of security-related losses.

For example, physical controls of the premises prohibit or delay access by intruders. Such controls include fences, dead bolt locks or window bars. Another element would be alarm systems or surveillance cameras intended to reveal when and where forced or illegal entry has been made. A third element is composed of operational procedures for handling money, securities or other valuables.

And finally, the company must recognize the emotional and psychological toll criminal activity takes on its victims. Employee assistance programs can be an invaluable counseling tool.

As you can see, the three tools are intertwined, because education, prevention and control share the same objectives and involve similar responsibilities. The first step is to recognize the need to react to criminal behavior in the workplace.

It isn't easy to act as the catalyst for security within your organization. But, the definition of risk management has expanded greatly over the past decade. Surely, security matters will continue to be an important focus of future risk management programs. **BI**

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

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

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

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

Ms. Werner's next column will appear in February. 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.



Ms. Werner

Comp claim upheld for off-premises injury

Employees who must cross a public way that bisects an employer's premises and who are injured on that public way are entitled to workers compensation benefits, according to the Supreme Court of Tennessee.

Cora L. Copeland left her workplace and exited onto the public street or sidewalk, which ran between her workplace and the employee parking lot. She was suddenly knocked into the street by another employee who was fleeing for his own safety from a non-employee, who was chasing him because of a romantic disagreement, court papers say.

Ms. Copeland was injured by a passing truck. She filed for but was denied workers compensation benefits.

The appellate court said that it was the employer who created the necessity

Legal Briefs

of employees crossing a public street between a noncontiguous parking lot and the plant itself. Because such travel was necessary by Ms. Copeland, the court said her injury on the public way was compensable.

Copeland vs. Leaf Inc., Supreme Court of Tennessee, March 23, 1992 *Rehearing denied* April 13, 1992 (BI/02/J.-\$10).

Interest on embezzled funds

Interest lost from monies stolen by a company's former president was not recoverable under a fidelity insurance policy, according to the Court of Appeals of North Carolina.

Empire of Carolina Inc. was covered

under a fidelity insurance policy issued by Continental Casualty Co. The policy covered loss of money and securities through the fraudulent or dishonest act of an employee up to \$500,000 per officer. From 1977 through 1982, a former president of Empire misappropriated \$502,201.99 from the company, of which \$278,759.51 was stolen during the policy periods. Empire sought recovery of the latter sum. Empire was fully reimbursed later through an action by the Securities and Exchange Commission. Empire then modified its claim against Continental to interest on the \$278,759.51, which was computed from Jan. 1, 1981, until Sept. 22, 1988, at \$560,000. Empire sought at least the policy limit of \$500,000. Continental refused to pay. Empire sued and lost in the trial court.

On appeal, Empire argued that the phrase "loss of money" in the policy covered the principal plus interest. But, the court countered that the term "money" was defined in the policy as "currency, coins, banknotes and bullion, and travelers checks, register checks and money orders held for sale to the public."

Empire of Carolina vs. Continental Casualty, Court of Appeals of North Carolina, March 17, 1992 (BI/03/D.-\$10).

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.

Cincinnati

Continued from page 1

crats, and is gaining widespread recognition among other policy-makers, including Mr. Clinton.

Steps outlined in the proposal include establishing health care purchasing pools and setting national health benefit policy standards (BI, Sept. 21).

Cincinnati employers say they are creating a micro-model of managed competition.

"The goal is to obtain data from the hospitals that shows us which among the 14 are the highest-quality and most cost-effective providers of medical care," said Tom Murphy, group vp of human resources and labor relations for The Kroger Co.

"We'll use that information and leverage our size as a purchaser to directly contract with" the best hospitals, he said.

"This is the first time true market conditions would prevail in the purchase of medical care."

"Up to now, we've had more and more hospitals and doctors, and while increased supply helps keep down prices in a supermarket environment, it doesn't help control costs in the health care market. Before we began this project, all we could do was negotiate discounts with HMOs. But, if you have an indemnity plan, the cost would just be shifted to that plan," he said.

Kroger and three other large self-funded employers—Procter

& Gamble Co., General Electric Aircraft Engines and Cincinnati Bell Telephone Co.—cover about 168,000 employees and dependents in a community of more than 365,000.

The companies have contracted with San Mateo, Calif.-based medical information company Iameter Inc. to collect and analyze data to measure hospital and physician performance in the Cincinnati area.

After completing the first phase of the study, the corporate sponsors concluded that if all employers that paid for employee health care in Cincinnati used the most cost-efficient hospitals in 1991, they would have saved \$120 million. That figure represents 20% of the \$600 million that private payers in Cincinnati spent on health care that year, Mr. Murphy said.

"It's not inconceivable that those savings could go into a pool to finance health care for people without insurance," he added.

Mr. Murphy said that Kroger will likely be ready to decide by mid-1993 which facilities to contract with directly. "We have data now about who is the most cost-effective, but we wanted to give the hospitals time to improve their results," he said.

Not all of the employers involved will use the data to make that type of decision, though.

Representatives of GE Aircraft, Cincinnati Bell and

Procter & Gamble say it is too early to say how they will use the data.

But, the employers say that whatever strategy they develop will not result in cost-shifting to smaller and mid-sized companies in the area because they will share their findings with the rest of the business community. As a result, all area employers will benefit from the program, they say.

Iameter is collecting data on every major diagnostic category and its subgroups to see how hospitals stack up against each other in terms of cost, lengths of stay, outcomes and quality-improvement efforts.

Iameter already has collected 1991 data, which will serve as a benchmark to measure each hospital's against its performance in 1992. Data for 1992 is being collected now.

Among the diagnoses Iameter is studying are cardiology and circulatory problems, which account for 23% of the health care dollars spent in Cincinnati, said Iameter President Lawrence Frye.

After adjusting for severity, Iameter found there is wide variation in the cost and lengths of stay for various procedures in that category.

For example, the charges for one of the most expensive procedures—coronary bypass grafts—varied by as much as \$7,000, he said, noting that the average cost of the procedure in Cincinnati is about \$33,000. Charges for balloon angioplasty, in which a patient's arteries are expanded, varied by as much as \$8,000, he said. That procedure costs \$11,500 on average.

"There are two reasons why charges differ so much: price and efficiency of physicians," Mr. Frye explained. "The most expensive high-tech instrument in a hospital is the physician's ordering pen. Doctors are responsible for 70% to 80% of all provider services," so it is critical to maximize their efficiency, he said.

"Some hospitals might decide, based on the data, that they can't reduce costs enough to compete in certain areas, like cardiac intensive care. So, they'll focus on what they do well, like orthopedic surgery," Mr. Murphy said.

The hospitals paid at least \$20,000 to have access to reports and analysis of the data. The employers would not divulge how much they are paying Iameter for the study.

The participating hospitals are

pretty comfortable with the data analysis, Mr. Frye said. "A couple of hospitals were hesitant to participate at first. Historically, they've been in a position of control, and this is different. This is wresting control back to the people writing the checks," he said.

Some hospitals also were nervous about breaching confidentiality, but Iameter's data does not identify individual patients or doctors.

Others expressed some reservations about the quality of the data being collected but agreed that the process had to be started somewhere.

"We aren't negative about this," said Jack Cook, president of The Christ Hospital in Cincinnati. "We think this is the way the world is going to go. But, we'd like to collect and analyze more data than Iameter does. It gives you a first pass at data that should be helpful to corporations and hospitals, but it doesn't give you enough information on what a specific doctor has to do to improve."

"Some hospitals are still reticent about making data available because we still don't know what the data illustrates," said Sandy Metzler, director of the American Hospital Assn.'s division of quality resources in Chicago.

"We are all on a learning curve about this. We agree it needs to be done because we all need to be accountable for the care and the services we provide," she said.

But, Ms. Metzler cautioned, "We have to be careful that we all understand things in the same way, because data can easily be misinterpreted."

Kroger's Mr. Murphy believes the Cincinnati approach is a sure-fire way to improve the quality of medical services and therefore lower costs. He said the company plans to conduct similar projects in all 25 states in which it operates.

Employers nationwide hope federal policymakers will pay attention to their efforts, particularly policymakers who favor managed competition.

Employer coalition members

Allied-Signal

Continued from page 2

employees in Baltimore will move to MDIPA's network, Mr. Yeaw said.

Many Baltimore employees were not satisfied with CIGNA, said Mr. Yeaw. By adding the new network, Allied-Signal hopes to improve the satisfaction and potentially save money by getting more people to participate in one of the managed care programs.

"This is not a major change in the program" as a whole, he pointed out. "The relationship (between Allied-Signal and CIGNA) is still strong."

Of Allied-Signal's 70,000 employees in 40 states, 45,000 are currently enrolled in the managed care program, Mr. Yeaw said.

Since the program began almost five years ago, health care cost increases for the managed care program have been held to single digits.

The plan's cost trend is half that of Allied-Signal's indemnity plans, Mr. Yeaw said. "Since the program's inception, our trend line has been 8% to 10% on average vs. a 7% to 20% trend line for our indemnity plans," he explained.

Allied-Signal launched the managed health care program—Health Care Connection—in March 1988. The program replaced about 100 HMOs and indemnity plans previously offered by the company.

The Health Care Connection

say their group purchasing activities could serve as a model for the health care purchasing pools envisioned as part of the managed competition approach.

Lessons could be learned from the coalitions' "ability to assess different health care plans and their ability to be a conduit for small and large employers to purchase health care," said James Mortimer, president of the Chicago-based Midwest Business Group on Health.

The coalitions are working with other parties interested in fostering managed competition as a means to reform the health care system.

One of those groups is the National Business Coalition on Health, a membership organization representing 50 employer coalitions, which recently met with representatives from the Jackson Hole group to discuss managed competition.

The Jackson Hole group consists of physicians, academics and health care economists who believe that managed competition—rather than a single-payer system—will alleviate many of the nation's health care system ills.

Sean Sullivan, president and CEO of the Washington-based NBCH, noted that the group also has started to work with Rep. Jim Cooper, D-Tenn., and other sponsors of the Conservative Democratic Forum bill.

"We are trying to (educate them) about why the community-based reform movement is a critical approach to health care system reform."

"Our members dedicate themselves to working with providers to change the structure and incentives in their local health delivery systems. We favor managed competition because it relies on market forces, and it lets (purchasers and providers) work out arrangements among themselves," Mr. Sullivan said.

Forms of federal intervention—such as establishing a national health insurance program or introducing price regulation—are not compatible with this approach, he said. **BI**

marked the first time an insurer had agreed to absorb cost increases beyond a certain level on a multi-year basis (BI, Feb. 22, 1988).

With this renewal, the "guaranteed cost contract" will be extended until 1994, Mr. Yeaw said.

The renewal is "certainly a confirmation that the relationship is still strong and the managed care program is working well," he said.

Under the contract, CIGNA again must hold health care cost increases

'The relationship (between Allied-Signal and CIGNA) is still strong,' says Allied's Mr. Yeaw.

"well into the single digits," Mr. Yeaw said. If it does not, the insurer will absorb the difference, he said.

Linda Hacker, executive director for CIGNA Health Plan in Columbia, Md., said, "We're always disappointed when competition is added, but we understand the decision."

CIGNA is working on improvements in Baltimore, such as expanding the primary care network, she said. **BI**

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Illinois ruling

Continued from page 2

group of primary and excess liability insurers over the estimated \$20 million cost of cleaning up polychlorinated biphenyls, or PCBs, Outboard Marine dumped into Lake Michigan.

Insurers named in the litigation wrote primary or excess coverage for Outboard Marine at various times between the early 1950s and 1978.

The defendants are Commercial Union Insurance Co.; Insurance Co. of North America, a unit of CIGNA Corp.; International Insurance Co., a unit of Crum & Forster Corp.; Liberty Mutual Insurance Co.; and Northbrook Excess & Surplus Insurance Co., a defunct unit of Allstate Insurance Co.

The U.S. Environmental Protection Agency and the state of

Illinois sued Outboard Marine in 1978 to force the company to clean up the PCBs from its die casting operations that the company dumped in Waukegan Harbor over several years.

But, the insurers refused to defend the company, claiming their policies did not cover gradual pollution incidents and the cost of complying with government cleanup orders. Coverage litigation ensued.

In a key finding, the Illinois Supreme Court ruled that the pollution exclusion in most of Outboard Marine's policies may not bar coverage because the discharges could be considered "sudden and accidental."

The high court's decision overturned a finding of a 2nd District Appellate Court panel that the word "sudden" is unambiguous and must be read to mean "abrupt."

Instead, the Illinois Supreme Court found the word ambiguous. Construing the ambiguity in favor of the policyholder, the court interpreted the word to mean "unexpected and unintended."

The court also rejected the insurers' argument that interpreting "sudden" this way would make it synonymous with "accidental," rendering the word "mere surplusage."

The Supreme Court noted that the policies' definition of occurrence describes an "accident" as a "continuous or repeated exposure to conditions" that cause property damage.

"To construe 'sudden' to mean 'abrupt' results in a contradiction if one accepts the insurers' own definition of the term 'accident,'" the court wrote.

"Such a construction would result in the pollution exclusion

exception clause retriggering coverage for toxic releases which are 'abrupt' and gradual or 'continuous or repeated' releases. Clearly, under such a construction, this clause would be rendered absurd."

Reversing the lower court's summary judgment ruling in favor of the insurers on the pollution exclusion issue, the Illinois Supreme Court remanded the issue for trial to determine whether and when Outboard Marine "expected or intended" the PCB contamination.

If a court finds that the company expected or intended the release, the "sudden and accidental" exception would not be triggered, and the pollution exclusion would remain intact, barring coverage, the court found.

The state Supreme Court also reversed a summary judgment

that the insurers had no duty to defend Outboard Marine. The court concluded that cleanup liabilities are potentially covered by the policies despite uncertainties about interpreting the pollution exclusion and, therefore, the broad duty to defend is triggered.

In a dissenting opinion, one of the Supreme Court's seven judges argued that "sudden" must be given a temporal meaning.

"Even if the term 'sudden' is considered ambiguous, I do not believe that the incidents at issue here can be said to fall within the exception to the pollution exclusion," the judge said.

"I fail to see how occurrences continuing for more than a decade may be considered 'sudden' under any reasonable reading of that word," he said.

The majority also ruled that one of Outboard's insurers—International Insurance Co.—is not liable for providing a defense or covering cleanup costs under its policy, which contains a pollution exclusion that differed from the standard exclusion in the other policies.

International's policy specifically excluded coverage for gradual pollution and did not contain any "sudden and accidental" exception, the court noted.

However, the Illinois Supreme Court affirmed the appellate court's rulings that:

- The federal and state cleanup actions against Outboard Marine are considered "suits seeking damages" under the insurance policies, even though the actions initially did not seek monetary damages but only sought equitable or injunctive relief.

- Whether (Outboard Marine) expends the money and conducts the cleanup itself or pays the money to the government as the injured public's representative and the government conducts the cleanup is of little consequence," the court found.

"In either case, (the company) would have to expend money to remedy the environmental damage it has caused. For precisely this purpose, (Outboard Marine) insured itself by purchasing CGL policies."

- INA owes no duty to defend or indemnify Outboard Marine, since its policy period began one month after Outboard was hit with an EPA administrative order, making the PCB contamination a "known loss" at that point.

INA attorney Mark Seplak of Clausen, Miller, Gorman, Caffrey & Witous in Chicago said he was pleased with the ruling on the INA policy but disappointed with the court's interpretation of the pollution exclusion.

Commercial Union attorney Jay Krafusur also expressed disappointment with the reading of the "sudden and accidental" exception.

"Those words meant something and the Supreme Court is telling us they do not mean something," said Mr. Krafusur, who is with Rivkin, Radler & Kremer in Chicago.

But, Mr. Krafusur noted that Outboard Marine still faces trial on whether the company expected or intended the pollution and thus whether coverage is barred under the pollution exclusion.

Outboard Marine Corp. vs. Liberty Mutual Insurance Co., et al, Illinois Supreme Court; Nos. 71753, 71761

Benefits/Market Report
Where are health care costs heading in 1993? Insurers, brokers, consultants and benefit managers talk about future trends in the group health insurance market, including the latest innovations in managed care. This issue includes BI's Benefit Consultants Directory, the most comprehensive resource of its kind, plus a ranking of the largest consultants.
Publishing: December 21
Ad Closing: December 8

Year-In-Review
BI reported the significant news as it unfolded in 1992. To help prepare for the future, this recap reports on readers' views of the most important events and developments in risk management, employee benefits, health care, self-insurance and reinsurance, and what impact these events had on corporate management decisions.
Publishing: December 28
Ad Closing: December 14

Property/Casualty Market Report
Hurricane Andrew generated intense speculation about the direction of the property/casualty insurance market. Will the market turn at year-end? Will rates rise for some types of coverage? What can risk managers expect as they renew their coverages in 1993? Up-to-date market conditions will be tracked by brokers, insurers and risk managers in the U.S. and London.
Publishing: January 4
Ad Closing: December 21

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Business Insurance
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INTERNATIONAL

Hafnia reviewing bids for insurer units

By MARIA KIELMAS

COPENHAGEN, Denmark—Hafnia Holdings A/S is in the process of selecting three insurance companies with which to enter into detailed negotiation for the sale of its insurance subsidiaries, a spokesman confirmed last week.

The three are being chosen from among seven insurers that were invited to submit bids for the subsidiaries of the ailing

Hafnia. In August, Hafnia suspended payments to creditors after it split into two companies (BI Aug. 24). The insurance units have continued to pay claims.

U.K. life insurer Scottish Provident Institution is negotiating to buy Hafnia's U.K. based life affiliate, Prolific Group, the spokesman in Copenhagen confirmed. He would not identify any of the other final bidders.

However, a spokesman for Skandia Group in Stockholm,

Sweden, said that it was among the insurers invited to bid for the Hafnia affiliates.

Ironically, it was largely Hafnia's failed bid to acquire Skandia that weakened the Danish insurer. Skandia previously offered to acquire Hafnia, but Hafnia's institutional investors rejected the offer (BI, May 11; April 20).

Hafnia's adviser on the sale, Morgan Stanley Group Inc., will begin detailed negotiations with

the three potential buyers, and a decision on the winning bidders is expected in January, the Hafnia spokesman said.

Hafnia still holds 33.5% of Denmark's largest insurer, Baltica Holding A/S. This stake is divided between Hafnia's holding company and its operating subsidiaries. The Hafnia spokesman said that the company is trying to work out a way for Hafnia Holding to acquire the entire Baltica stake so that any

buyer of its operating subsidiaries would not inherit the shares.

The Skandia spokesman confirmed the group's interest in Hafnia's Danish life and non-life insurance operations. But Skandia has still made no decision on the offer.

"It depends on the package, on how it will look and the price," the spokesman said.

In separate Scandinavian de-

Continued on next page

Insurers losing claims-made disputes

By ALINE SULLIVAN

Claims-made policies, which cover only those claims submitted within the policy period, are under attack in Europe.

Courts in Belgium, France and Spain recently have ruled against insurers in coverage disputes under such policies. The decisions are prompting many underwriters to review their exposure in these countries.

The Lloyd's Non-Marine Assn. sent underwriters in the market a memo earlier this month reviewing the trend toward ruling against claims-made policies in Europe. An association official said the problem appears to be limited to France, Belgium and

Spain, but declined to comment further.

Until recently in Europe, only professional indemnity and specialty coverages like errors and omissions and directors and officers liability, were written on a claims-made basis. But for the past five years, underwriters throughout Europe, following the example of their U.S. counterparts, have been switching their liability coverage from an occurrence basis to a claims-made basis, especially for long-tail risks like pollution and product liability.

Now, however, because of the opinion of the courts and some new legislation and regulation, changes in other lines of business

may be delayed, if not entirely prevented.

A Belgian insurance law, announced in June and due to go into effect at the beginning of 1993, essentially outlaws claims-made policies. A provision of the law dealing with liability insurance stipulates: "The insurer's liability extends to claims reported after the expiry of the contract when the insurable event occurred during the course of the contract."

The Belgian Insurance Assn. is lobbying against the new law. The industry says it was caught by surprise by the law, a consumer protection measure.

Any change, however, will require new legislation and is un-

likely to take place in the near future, underwriters said.

In Spain, the Direccion General de Seguros, the government insurance regulator, recently required a local insurer to modify its policy conditions to provide coverage for losses incurred during the policy period, even if the claim was made after the policy had expired.

This decision was based on a March 1991 Spanish Supreme Court ruling in a case involving a medical malpractice claim made after the cancellation of the policy but relating to wrongful acts committed during the policy period.

Lloyd's underwriter Bob Wal-

Continued on next page

U.K. court holds firm strictly liable for pollution

By GAVIN SOUTER

LONDON—British companies could soon be turning to insurers from past years to help pay for damages caused by gradual pollution in the wake of a United Kingdom appeals court decision last month.

The decision was the first modern ruling in U.K. courts to impose strict liability on landowners that unintentionally polluted adjacent land.

Unless the decision is overturned by the House of Lords, companies that are found strictly liable for gradual unintentional pollution will call on past liability insurers to pay damages, observers say.

The polluter in the case—Eastern Counties Leatherwork P.L.C.—faces damages and costs of around 1.5 million pounds (\$2.4 million).

For several years, perchloroethylene, a cleansing agent known as PCE, was delivered to the company's tannery in 40-gal-

Continued on page 25

Names plan to sue over Merrett losses

By STACY SHAPIRO and GAVIN SOUTER

LONDON—Angry Lloyd's of London members facing potentially huge U.S. asbestos and pollution liability losses plan to sue members agents for damages after a leading trial lawyer told them last week that they had a strong case.

But, it could take up to two years to get a hearing in the case against members agents who placed the members on syndicate

LONDON

418/417, managed by Merrett Underwriting Agency Management Ltd. The members also plan to sue the syndicate's auditor, Ernst & Whinney, which has since merged with another accounting firm and is now known as Ernst & Young.

Furthermore, before some of the members can pursue damages, they must overcome a six-

year statute of limitations on bringing the case.

The claim centers on 11 runoff reinsurance contracts written between 1978 and 1983 by John Emney, the former deputy underwriter of syndicate 418/417. The syndicate's underwriter was Stephen Merrett, one of the newly elected deputy chairmen of Lloyd's.

The runoff contracts are similar to the 31 policies written by Lloyd's underwriter Richard Outhwaite that were the focus of

a lengthy court case earlier this year, according to trial lawyer Anthony Boswood. Mr. Boswood offered his assessment in an opinion submitted to the 1,436 members of the Merrett Syndicate 418 (1985) Names' Assn.

Mr. Boswood was the plaintiffs' lawyer in the Outhwaite case, which was settled out of court for 116 million pounds (\$185.7 million at current exchange rates) earlier this year (BI, Feb. 17).

Continued on page 25

Reinsurance dispute may have wide impact

By STACY SHAPIRO

LONDON—A trial in London's High Court regarding a defunct Lloyd's of London syndicate's runoff reinsurance policy could have wider implications for all reinsurance contracts and settlements between policyholders and insurers.

The defendant is claiming that a reinsurer is only responsible for paying a claim if the ceding company can prove that it was legally liable for the loss. This stance could mean that a reinsurer is not automatically required to pay claims that result from out-of-court settlements between a policyholder and its

insurer.

An out-of-court settlement often excludes any admitted liability by the insurer.

Last week, trial began in a case pitting Lloyd's underwriter Paul Toomey against reinsurer Eagle Star Insurance Co. Ltd., which is refusing to pay claims on defunct syndicate 640's unlimited runoff

reinsurance policy.

Toomey vs. Eagle Star is unusual because the reinsurer had honored the runoff policy for the past 18 years and had paid a total of \$29 million in claims before it halted payments in June 1991 (BI, Nov. 16).

Witness Leonard Toomey, the plaintiff's father and un-

derwriter for the syndicate until he retired in 1989, alleged that Eagle Star's action forced syndicate 640 to keep its 1989 year open with \$37.5 million in outstanding losses and ultimately caused the syndicate to shut down.

The runoff policy, which was

Continued on next page

New Zealand earthquake coverage to change in 1993

By KATE McILWAINE

WELLINGTON, New Zealand—Long-awaited legislative changes that will make earthquake insurance non-compulsory for commercial and industrial property in New Zealand will take effect Jan. 1.

However, capacity for earthquake coverage has decreased since the changes were first explored by the New Zealand government in 1988, which means many businesses will be unable to insure all their risks in the commercial market.

Until now, New Zealand earthquake risks have been insured by the govern-

ment-owned Earthquake and War Damage Commission, which was established in 1944. A levy of 5 cents per \$100 New Zealand (\$52) of insured value is paid on residential and commercial property, which goes into the fund. Another levy of 6.5 cents per \$10 NZ (\$5.19) of insured value is paid for fire-fighting services after a quake. The levies are also subject to a goods and service tax.

Companies placing their coverage offshore can avoid the earthquake levy, though they still must pay the fire levy.

Under the changes, compulsory earthquake cover will be phased out over three years, with companies able to place

75% of their risks through the EQWDC in the first year.

However industry sources say the government may be forced to extend the phase-out time if businesses are unable to obtain adequate coverage in the open market because of a capacity shortage and increased rates.

David Sargeant, chief executive officer of the Insurance Council of New Zealand, says the ICNZ has discussed that possibility with the government.

Maurice McTigue, New Zealand's associate minister of finance, said the delays in getting the legislation before Parliament were caused by the complexity of

the changes (BI, Feb. 3, 1992).

Mr. McTigue said the government had decided to deregulate earthquake insurance for several reasons.

"Commercial activity should be undertaken by the commercial sector. Healthy businesses should not need to rely on government provision of commercial services," he said.

Mr. McTigue said commercial businesses should have a choice about where and with what company they place disaster insurance. The government does, ever, have a responsibility to provide basic protection to individual home-

Continued on next page

Hafnia negotiation

Continued from previous page
velopments:

• Skandia denied Swedish press reports that Stockholm's public prosecutor had ordered an investigation into the actions of the board of directors of bankrupt credit insurer Svenska Kreditforsakringaktiebolaget.

Skandia and Sweden's second-largest insurer, Trygg Hansa SPP Holding A.B., are major shareholders in Svenska Kredit, and their chief executives, Bjorn Wolrath and Bjorn Sprangare, respectively, held seats on the Svenska Kredit board.

In September, the Swedish association of small shareholders, Aktiespararna, sent a letter to the public prosecutor requesting an investigation into the affairs of the credit insurer.

The Skandia spokesman said the prosecutor told him the shareholders' request had not been acted upon

and that, as yet, no such investigation is under way.

• Baltica has had a change in top management. The chief executive of Baltica Holding, Peter Christoffersen, who this month was to assume the post of chief executive of the Baltica life subsidiary, Baltica Livsforsikring, has been dismissed.

Both his current and future positions are being taken over by Steen Hemmingsen.

Mr. Christoffersen pioneered a series of acquisitions that have soured and brought the company into its current financial plight. These acquisitions included buying Baltica Bank, which has been hit by a book of bad loans; a real estate and waste incineration project in Gibraltar; the former state-owned life insurer, Statsanstalten for Livsforsikring A/S, which now trades under the name Danica; and a stake in French insurer Group Victoire as a defensive hedge against a possible takeover by Hafnia. **BI**

Reinsurance suit

Continued from previous page
bought in 1973, covered "all claims payments" on an "unlimited" basis for 1965 and prior years. The policy stated that it was "not cancelable or voidable." The premium was about 1.33 million pounds in 1973 currency (\$2.1 million at the current exchange rate).

Eagle Star's trial lawyer, John Donaldson, told the court the reinsurer had stopped paying after it hired accountants to audit syndicate 640's underwriting claims for 1965 and prior years. The accountant discovered that some claims had been paid without any evidence of the nature of the claim in the syndicate's files, he said.

However, Eagle Star didn't query any payments for "18 long years," Mr. Toomey said in court. "I was an old man when they finally refused."

At the same time, Eagle Star stopped paying other claims as well,

he alleged.

Some confusion occurred in court last week over what was being argued, primarily because Eagle Star had not entered a complete summary of its arguments.

Judge Anthony Diamond said that the parties were being "frivolous" if they did not know what their arguments were by the time they came to court.

Mr. Donaldson argued, though, that Eagle Star wanted Judge Diamond to decide a preliminary point before the court ruled on whether Eagle Star is liable to continue paying losses on the runoff policy.

That point is Eagle Star's contention that it is only liable to pay claims resulting from a settlement between syndicate 640 and policyholders if the settlement "reflects a liability," said Mr. Donaldson. The settlement also must be "reasonable," he added.

A reinsurer is obliged to pay a claim from a settlement without proof of liability only if there is a formal settlement clause in the reinsurance contract, argued Mr. Donaldson.

However, Jonathan Mance, Mr. Toomey's attorney, said that Eagle Star's position is contrary to standard claims negotiations. Underwriters frequently settle claims without proving liability to reduce losses and legal costs, Mr. Mance said.

"You're saying that in common law, a settlement between insured and insurer is irrelevant" when the insurer is seeking payment from its reinsurer, summarized Judge Diamond to Mr. Donaldson. "The insured must prove in fact that he was liable."

"Your case really is that in each case the reinsured must prove he was liable to payment and quantum," said the judge.

Mr. Donaldson agreed with the summary.

"This is an important point because it will affect all reinsurance contracts," Judge Diamond said.

"Indeed, every reinsurance policy," agreed Mr. Donaldson.

The trial continues this week, with the runoff policy's broker, John Pincham, being cross-examined by Mr. Donaldson. **BI**

New Zealand earthquake insurance

Continued from previous page
owners, he added.

Another reason is that the EQWDC had limited resources. The fund has \$2.2 billion NZ (\$1.14 billion) in reserves and provision for reinsurance of about another \$1 billion NZ (\$519,000), he said.

"A single, large earthquake could use up all the EQWDC's resources, leaving no contingency for future events," he said.

Demetra Kennedy, acting general manager of the EQWDC, explained that the phase-out of the commission's coverage of commercial entities would take four years, with 75% cover being provided in the first year, 50% in the second and 25% in the third. No cover will be provided in the fourth year.

The phase-out has been extended beyond its original two years because of the hardening of the catastrophe reinsurance market worldwide, which will make it difficult for the insurance industry to gain the capacity it needs to offer adequate limits of earthquake coverage, Ms. Kennedy said.

As of Jan. 1, companies that still wish to obtain their earthquake coverage from the EQWDC must apply in writing. Coverage will be available for up to 75% of an agreed indemnity value.

Risk managers are currently assessing their portfolios and the capacity and price available for the cover on the commercial market before deciding whether to remain with the government fund.

"The EQWDC has recognized that the industry wants flexibility," she said. Ms. Kennedy did not know how many companies would want to still use the EQWDC coverage, but expected it will be a "significant proportion."

"It's hard to see the numbers yet," she said.

Shaun Wilkinson, group risk and insurance manager for Auckland-based Fletcher Challenge Ltd., New Zealand's biggest corporation, said he is pleased the changes are finally being implemented. "We have lived under a cloud of uncertainty for so long," he said.

But he agreed they would exacerbate capacity problems in the hardening market.

Mr. Wilkinson said the shortage of capacity means New Zealand corporations unable to find enough coverage will be forced to change their attitude toward insurance or, if they are large enough, to pool their worldwide risks to get better terms on catastrophe coverage.

"A lot of boards are used to thinking everything should be in-

sured for replacement value. It will be a culture shock to some to see they cannot buy that much earthquake cover," Mr. Wilkinson said.

He predicted "a lot" of companies will stay with the EQWDC.

Fletcher Challenge is likely to "work through the run-down with some of the bigger risks," Mr. Wilkinson said. Its energy-related risks have always been placed offshore because there was no expertise to write them among New Zealand-based underwriters.

Allan Morris, a broker with Auckland-based Willis Corroon McNicoll, said earthquake exposures will need to be better managed and some sub-standard risks will be uninsurable.

"The market will need to get more sophisticated," he noted. "New Zealand, like Australia, lost a lot of expertise with cash-flow underwriting in the soft market. There will be a steep learning curve for clients and insurers" as prices rise and capacity tightens, he said.

Mr. Morris chairs the Corp. of Insurance Brokers of New Zealand's technical committee, which assisted government representatives in drafting the EQWDC changes. He said a lot of business would stay with the EQWDC because it would be cheaper in the current market and capacity is available, at least for 75% of a risk.

Buyers moving into the private market will need to look harder at security and service; premiums are only one factor in the decision, he noted.

Jake E. Lush, insurance manager for Auckland-based Carter Holt Harvey Ltd., a large, diversified timber and manufacturing company, said he would make a decision on his company's insurance before Christmas.

"If the numbers are right, we wouldn't use (the EQWDC)," he said.

The ICNZ's Mr. Sargeant said the severe shortage of reinsurance capacity would hinder the local commercial insurance market's ability to underwrite earthquake insurance and will push up the price.

The New Zealand government has not managed the fund correctly, which is why it now has insufficient funds to cover a major catastrophe, he contends. The government had treated it as "a cheap source of finance" instead of a reserve fund for future liabilities.

Mr. Sargeant also called for greater supervision of non-life insurers in New Zealand, saying the ability to meet claims in the event of a major disaster is the most impor-

tant consideration in establishing any new insurance regime.

"A force 7.5 earthquake, for example, would cause an estimated \$5 billion to \$6 billion NZ (\$2.6 billion to \$3.11 billion) damage in the Wellington region alone," he said.

An earthquake with a magnitude of 7 on the Richter scale is a major quake capable of widespread, heavy damage.

Mr. Sargeant said New Zealand is the least regulated insurance market in the world, which is "often a cause of dismay and bemusement within international insurance markets."

While many commercial risks went offshore during the uncertainty created by the length of time it took the new legislation to be passed, Fletcher Challenge's Mr. Wilkinson said the shortage of capacity in the New Zealand market means many will be unable to come back onshore.

Onshore underwriters would favor clients with which they had developed long-term relationships, he explained.

Meanwhile, the EQWDC is retroactively seeking additional levies from businesses that had insured only a portion of their earthquake risks, rather than for the full indemnity value.

The EQWDC's decision to seek the additional levies, which could amount to "several million dollars," according to Ms. Kennedy, came after it won a case in the Privy Council in London in November 1991. The EQWDC sued Waitaki International Ltd., a Christchurch-based meat packer and exporter that had insured its assets on a first-loss basis for \$50 million NZ (\$26 million), although replacement values on its properties throughout New Zealand were valued at \$350 million NZ (\$181.7 million).

It paid levies to the EQWDC based on the \$50 million NZ figure. After a series of legal actions in New Zealand, the Privy Council in London, which is the highest court of appeal for members of the British commonwealth, overturned a New Zealand Court of Appeal decision. It found for the EQWDC and ordered premium to be paid on the full values of the risks.

Ms. Kennedy said that, as a result of the court decision, the EQWDC had asked other businesses that had paid levies based on a lower insured amount to recalculate their levy based on a full replacement value.

The EQWDC is now searching its records to determine which other companies could be billed for additional premium. **BI**

Claims-made policies

Continued from previous page
lace of syndicate 386 said the syndicate is reviewing its exposure in Spain after the court decision.

"We as a syndicate have a significant amount of business that is written in Spain on a claims-made basis," he said. "That business is under review. But we need more information before we make any firm decisions."

The outlook for insurers is equally gloomy in France. In a June case concerning a claims-made policy, the appeals court, the Cour de Cassation, ruled against British insurer Commercial Union P.L.C., which had inserted a claims-made clause into a professional indemnity policy. The court held that claims-made clauses deprive the policyholder of benefiting from the insurance because the coverage trigger is an act that the policyholder cannot control. The court argued that this situation allows insurers to receive premiums without carrying any obligation.

This ruling follows seven decisions made by the Cour de Cassation in December 1990 denying the validity of a claims-made trigger clause in liability insurance policies. At that time, the court judged that the claims-made clause "deprived the insured of the necessary consideration received in return for the payment of insurance premiums for the policy period, thus creating an illicit advantage, without cause, to the profit of the insurer."

Underwriters said changes in legislation or regulations in Belgium, France and Spain are particularly of concern to German and Swiss reinsurers operating in those countries. Claims-made policies are rare in the German and Swiss insurance markets.

In contrast to their continental European counterparts, British courts continue to uphold claims-made wordings, said Ben Hawkes, an insurance attorney at the London law firm Clifford Chance.

"There has been a tendency toward claims-made policies in Britain since the mid-1980s," said Mr. Hawkes. "It is not clear whether the movement derives from insurers or the reinsurers. Insurers were finding it difficult to get cover in the reinsurance market if their policies were not claims made."

Like its counterpart in Belgium, the French insurance association Assemblée Plénière des Sociétés d'Assurances Domages is lobbying

government officials. The association has also developed a strategy for insurance companies to counteract the legislation. Suggestions include:

• Maintain claims-made provisions in policies proposed to clients rather than increasing the premiums.

• Challenge the 1990 case law before the courts. APSAD prepared a list of arguments and a standard brief that was distributed to all member insurance companies in September.

• Maintain unity among members. APSAD's members are bound by convention not to invoke the 1990 case law against other insurance companies. **BI**

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INTERNATIONAL

U.K. pollution

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ion drums, court papers say. As it was poured from the drums into machines, the chemical was regularly spilled on the ground.

The chemical pooled in the ground and gradually seeped through the chalk into adjacent land, the court papers say.

In 1976, the Cambridge Water Co. Ltd. bought a site 1.3 miles away from the tannery, which it used to draw water for public consumption, court papers say. Three years later, it commissioned the Sawston Mill pumping station at the site.

"(The utility) satisfied itself before purchasing Sawston Mill that the water from the borehole was wholesome in accordance with the then-current standards of water quality," court papers say.

But water quality standards soon changed. In 1980, the Council of the European Communities issued a directive that changed the requirements for water meant for human consumption. By the new standards, the Sawston Mill water was unfit for human consumption due to the level of PCE, the papers say.

Consequently, the utility company stopped pumping water from Sawston Mill.

After tracing the pollution back to the adjacent tannery, the utility sued ECL, claiming the leather company was liable on both negligence and nuisance grounds. The utility sought 1.5 million pounds in damages for the cost of setting up an alternative pumping station.

The high court judge dismissed the negligence charge on the grounds that the tanning company could not have foreseen that spilling the cleansing agent would cause pollution.

He also dismissed the nuisance claim, saying that the area around the site had long been used as a tannery, and that the company provided benefits to the community through employment. Therefore, the storage of PCE was "a natural use of the land," court papers say.

However, the appeal court overturned that decision, saying that there should be no distinction made between deliberate pollution and spillages that were inherently likely to occur.

"It was sufficient that the defendant's act caused the contamination," the appeals court said.

The change in water standards was also not relevant, said the appeals court's decision.

"We cannot attach any importance to the fact that the appellant suffered damage only when quality standards were raised three years after its abstraction commenced and many years after the respondent has ceased to spill PCE," the appeals court said.

Though based on precedents set in an 1885 case, *Ballard vs. Tomlinson*, this ruling is important because it sets strict liability for pollution clean up in a contemporary case, observers say.

The appeal court judges refused ECL's request for permission to appeal to the House of Lords.

Now the company will petition the House of Lords directly, said Timothy Moore, managing director of ECL. If the judgment stands, ECL will turn to its liability insurers to pay the damages, he said.

"We are having discussions with all of the insurers which we have had over the past 25 years, and we still have all of the relevant policies," Mr. Moore said.

Insurers will have to decide among themselves who will pay, said Sarah Shemmings, a partner at London law firm Berryman's,

which represented ECL.

Neither Mr. Moore nor Ms. Shemmings would name the insurers involved.

Some market observers said the decision could result in large pollution liability claims in the future, claims for which insurers have not reserved.

The case is significant for insurers as it imposes liability without fault for damages on people who pollute adjacent land, said Nicholas Hughes, a partner at London law firm Barlow Lyde & Gilbert, who represented the water company in the case.

Most British insurers now exclude gradual pollution from their standard liability policies (*BI*, Feb. 4, 1991). But liability policies written before last year would cover gradual pollution, he said.

The decision could leave liabil-

ity insurers open to a new batch of pollution claims, agreed Alan Rickman, environmental director in the risk management division of Willis Corroon P.L.C.

"It could be a problem for insurers as many old liability policies are silent on pollution," said Mr. Rickman.

The decision will have far-reaching consequences for insurers and industry, said Brian Street, director of operations at ECS Underwriting Ltd.

"It's a milestone because the court has made the polluter strictly liable for past pollution," he said.

And insurers will now be asked to pay claims they have not reserved for, Mr. Street said.

"The insurers will all have to ask themselves what have they written in the past that is coming home to roost now," he said. **BI**

LONDON

Continued from page 23

Mr. Outhwaite left his syndicate's 1982 account year open due to the uncertainty of asbestosis and pollution claims covered by the runoff policies.

But, Mr. Merrett did not leave an account year open for his syndicate until 1985, Mr. Boswood said.

As a result of Mr. Merrett's decision to close the earlier years, members who joined the syndicate or increased their underwriting line on the syndicate after 1982—and were still on the syndicate in 1985—are exposed to huge liabilities through the reinsurance-to-close methods used at Lloyd's, Mr. Boswood said.

When underwriters close a year at

Lloyd's, the members on one year pay a reinsurance premium to the syndicate's members during the following year to cover any outstanding liabilities.

"Had either the 1982 or the 1983 underwriting year, or any earlier year, been left open, then those (1985) names would not have been exposed to the losses which now confront them," Mr. Boswood said.

Since the 1985 account year is open, there is no way to accurately assess future liabilities.

However, the members so far have lost 77%—or 134.7 million pounds (\$156.3 million at year-end 1984 exchange rates) of their investment in the syndicate, which had a 1985 capacity of 175 million pounds (\$203 million). The final deterioration could be as much as 350%, said Ian Henderson, the names association's

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1992

1993

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INTERNATIONAL

LONDON

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deputy chairman.

In 1985, there were 4,018 syndicate members.

Earlier years should have been left open due to the uncertainty of the future liabilities, Mr. Boswood said.

"On the basis of the material we have seen, we are quite unable to understand how the active underwriter... felt able to arrive at a premium for the reinsurance to close the 1982, 1983 or 1984 years of the syndicate," said Mr. Boswood, who prepared the opinion with colleague Stephen Moriarty.

Concerns about old U.S. asbestosis and pollution claims were widely known in the Lloyd's market in the early 1980s, he said.

"Accordingly, we consider that MUAM acted negligently and in breach of the duties it owed to the succeeding year's names in closing those years," Mr. Boswood said.

Consequently, the 1985 members who joined the syndicate or increased their line after 1982 have a good case against their members agents, who are liable for the breaches of duty by MUAM, he said.

Mr. Boswood told the members at last week's association meeting that they should also sue the syndicate's auditor.

"We are also quite unable to understand how Ernst & Whinney felt able to state their opinion, without material qualification, that the syndicate accounts for the relevant closed years gave a true and fair view of the syndicate's affairs," he said.

However, even if the action against the members' agents and the auditors is successful, some of the members that plan to sue their members' agents may still not re-

ceive compensation, Mr. Boswood warned.

Members who joined the syndicate and increased their investment before the 1985 underwriting year and are not party to a protective writ filed earlier this year seeking that their legal action not be time barred first must attempt to avoid being time-barred from taking legal action, Mr. Boswood said.

The members could argue that under the Latent Damage Act 1986 they are allowed to bring an action within three years of receiving sufficient information to do so, he said.

The members also could argue that under the Limitation Act 1980 they are not time-barred because information pertaining to their case was deliberately concealed from them, Mr. Boswood said.

"We cannot pretend there is any simple and easy solution to this problem. Neither do we believe, however, that the difficulty is insuperable," he said.

Approximately 430 action group members must confront the time-bar ruling, Mr. Henderson said.

Members will run up approximately 800,000 pounds (\$1.3 million) in legal costs on this issue alone, which a court may resolve next year, Mr. Henderson said.

The main case probably will not go to court for two years and will cost members approximately 4.4 million pounds (\$7 million), he said.

MUAM is reviewing Mr. Boswood's opinion and will give its response shortly, said Chief Executive Dennis Purkiss.

Coleridge eyes capacity

Lloyd's of London's capacity will drop 14% to 17% next year, the market's outgoing chairman predicts.

Even so, corporate capital may not be the answer to replace capacity withdrawn by individual investors, adds David Coleridge. That

contradicts the position of Lloyd's next chairman, David Rowland (BI, Dec. 7).

Though membership for next year is still uncertain, Mr. Coleridge said last week that Lloyd's capacity probably will drop to about 8.5 billion to 8.75 billion pounds (\$13.6 billion to \$14 billion) in 1993, from 10.2 billion pounds (\$19.07 billion at appropriate exchange rate) this year.

His estimate of 1993 capacity is the first from Lloyd's officials to be less than 9 billion pounds (\$14.4 billion).

The uncertainty about next year's membership revolves around Lloyd's decision last month to allow tax rebates from 1989 to be counted in a member's solvency test for 1993. This means that some members who wouldn't comply with Lloyd's solvency without the rebate now can continue underwriting.

Corporate capital may not be the answer to boosting Lloyd's capacity, said Mr. Coleridge. Lloyd's recently discussed the implementation of corporate capital into the market and found that it was "a difficult subject" and would need "a lot of alteration of regulation," he said.

Lloyd's would have to change the way it's been working for the past 100 years "for a small amount of capital" that corporations would bring in, he said.

Besides, it's unlikely that corporate capital would be introduced into Lloyd's before 1995 or 1996 and by that time, Lloyd's should be profitable and "will probably have sufficient capacity from our own present sources," Mr. Coleridge said.

Despite Mr. Coleridge's position, the managing agency for which he is chairman, Sturge Holdings P.L.C., is considering a setup that, in effect, would introduce corporate capital into Lloyd's, said Peter Davis, deputy chairman and finance director of Sturge.

Sturge has held discussions with

the U.K. Department of Trade and Industry about setting up an insurance company that provides quota-share reinsurance for Sturge syndicates as early as 1994, he explained. The insurer—which would need between 25 million and 50 million pounds (\$40 million and \$80 million) of capital—would attract corporate investors such as pension funds, he said.

No new regulations would be needed because Lloyd's bylaws already allow each syndicate to increase its capacity by up to 25% with quota share reinsurance.

If Lloyd's changes its regulations to allow corporate capital to invest directly into Lloyd's syndicates, then the insurance company could be the vehicle to do this, said Mr. Davis.

Separately, Messrs. Coleridge and Davis announced Sturge's results for the 12 months ending Sept. 30. Revenues, including investment income, dropped 17% to 36.8 million pounds (\$65.5 million at appropriate exchange rate), from 44.1 million pounds (\$76.7 million at appropriate exchange rate) at Sept. 30, 1991.

This was largely due to a decline in Lloyd's underwriting profit commissions to 5.9 million pounds (\$10.5 million) from 14.1 million pounds (\$24.5 million), which was caused by the market's poor results.

Sturge reported pretax profits of 7.8 million pounds (\$13.9 million), down from 8.9 million pounds (\$15.5 million) in fiscal 1991.

Sturge managed 23 syndicates this year with total capacity of just over 1 billion pounds (\$1.87 billion), down from 1.27 billion pounds (\$2.45 billion) in 1991.

Next year, Sturge will manage 22 syndicates, but it is not yet known what total capacity will be.

Eagle Star capital boost

B.A.T Industries P.L.C. is investing 450 million pounds (\$720 million) in subsidiary Eagle Star Insur-

ance Co. Ltd. to boost the multiline insurer's solvency margin.

The move came two days after Moody's Investor Service Inc. on Dec. 7 downgraded Eagle Star's financial strength rating to A2 from A1.

Moody's last week also downgraded the financial strength rating of rival insurer Sun Alliance Group P.L.C. to Aa3 from Aa2.

Both insurers have suffered large losses from mortgage indemnity guarantee business, the rating agency said.

The investment by B.A.T in Eagle Star will raise the insurer's solvency margin to over 50%, said an Eagle Star spokesman.

The announcement was not prompted by the Moody's downgrading of Eagle Star's financial strength rating, he said.

Bombing settlement

After months of negotiation, the Baltic Exchange has received a 27.6 million pound (\$44.2 million) lump sum settlement from insurers to repair its building, which was ravaged by an Irish Republican Army explosion in April.

The Baltic Exchange carried 100 million pounds (\$160 million) in coverage for its circa 1903 building, which is listed by government-funded English Heritage as being of historical significance.

The coverage, led by Royal Insurance Holdings P.L.C., paid for building renovation and repaired damage caused by the terrorist bombing, said Jim Buckley, chief executive of the Baltic Exchange.

The exchange doesn't want to restore the building's total 100,000 square feet of office space, because in today's economic climate it would not all be filled, he acknowledged. However, the exchange has an obligation to restore the building to its original condition under the rules of English Heritage, he said. **[B]**

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WCRI study

Continued from page 3

"This was a time of dramatic escalation in costs—as much as 20% a year," said Mr. Victor, who co-authored the study with John A. Gardner, a WCRI senior economist, and Daniel Sweeney, a former research assistant.

During the period studied, the state with the largest average annual increase in total costs was Florida, which saw a 20.8% increase, followed by: Massachusetts, 19.6%; Georgia, 17.3%; Pennsylvania, 12.3%; Michigan, 11.5%; and Illinois, 10.8%. Illinois data, though, only covers 1985 to 1988.

Of these increases, factors within the comp system's control—termed "additional cost drivers" by the study—account for a disproportionate amount.

Three of the states experienced "rapid" growth in these additional cost drivers: Florida, 13.7% per year on average, or 65.9% of overall increases; Massachusetts, 12.8%, or 65.3% of overall increases; and Georgia, 10.2%, or 59% of overall increases.

The remaining three states experienced "moderate" growth in these costs, although additional cost drivers still comprised a large portion of overall cost increases. The states with more moderate growth of these costs were: Pennsylvania, 8.2% per year on average, or 66.7% of overall increases; Michigan, 6.8%, or 65.3% of overall increases; and Illinois, 5%, or 46.3% of overall increases.

The study divided the so-called additional cost drivers into three categories:

- Front-end cost drivers, which are factors affecting the number of claims paid. According to the survey's authors, these include such factors as: an expansion of the scope of compensability, whether by statute, courts or practice; a reduction in employer efforts to promote

safety or increased worker carelessness; and increased use of workers comp, such as might occur in a recession or tight labor market.

Increased medical costs attributable to increases in the number of claims—above what could be attributed to natural employment growth—is included in front-end cost drivers.

- Back-end cost drivers, which affect the size of a claim once compensability has been established. These include such factors as: the disability's duration; the propensity of claimants to receive permanent partial disability benefits or wage-loss benefits; the likelihood of receiving a lump sum settlement; and attorney involvement and litigiousness, among other things.

- Medical prices and utilization, which is slightly different from total medical costs, the survey's authors say. This measure captures such cost drivers as: rising medical prices; increased use of new technology; more services being provided; and changes in billing practices.

Adding to these additional cost drivers are the so-called natural cost drivers, which result from normal economic activity, the study says. "These include employment growth, wage growth and general inflation," according to the study's authors.

The WCRI analyzed the data the same way you peel an onion, explained Mr. Victor. The researchers started with the annual average rate of growth of costs in each of state and broke it down into these successively smaller layers to uncover the cost drivers, he said.

Among their conclusions was that growth in medical prices and utilization were significant cost drivers, though they generally accounted for less than the growth in back-end claims costs.

For example, as a percentage of additional cost drivers, medical prices/utilization contributed 19.1% per year on average in Massachu-

setts, while back-end costs contributed 52.9% annually in that state.

Previously, many system observers thought medical costs were the single biggest cost driver behind workers comp costs, the study noted.

The largest factor driving medical costs was "the growing intensity of treatment and billing practices by medical providers other than hospitals," according to the WCRI.

"For the past decade, medical practice has succeeded in reducing the incidence and average length of stay of hospitalization. Many procedures that formerly required inpatient surgery are now performed as outpatient services. So physician services and other products or services, such as drugs or attendant care, now account for a larger share of the medical cost dollar," the survey's authors explain.

Back-end cost drivers were the largest cost drivers in all states but Pennsylvania.

"The back-end of the claim is the place where a large number of factors come together," the study says.

Many factors that affect the size of a claim are determined at this juncture, the WCRI notes, such as whether: an injured worker returns to work or not; total temporary disability payments are continued; or a claimant is entitled to permanent partial disability or wage-loss benefits.

"In most states, this is a primal focal point for litigation," the WCRI says. "Standards for decision making are frequently subjective, attorneys are frequently involved, hearings requested. . . In short, it is a major friction point in the system."

Despite their contribution to overall workers compensation costs, the WCRI says that few recommendations for system reform have addressed the back end of claims. "Historically, it has been difficult for policymakers and study com-

missions to untangle the nature of the beast," the authors say.

As a result, "activities aimed directly at improving outcomes at the back end of the claim would appear to have a high payoff," the WCRI says. These activities could include statutory and administrative changes that affect these costs, efforts by employers and insurers to reduce litigation and, in particular, efforts by all parties to return injured employees to work sooner.

Front-end cost drivers were a greater factor in "rust belt" states—Illinois, Michigan and Pennsylvania—than in "sun belt" states of Florida and Georgia, according to the researchers.

This suggests that business cycle fluctuations are an important contributor to these front-end costs, the researchers conclude. The three rust-belt states experienced significant recessions in the early 1980s, followed by rebounds after 1984, whereas Florida and Georgia experienced steady economic growth over the survey period.

One possible explanation for this phenomenon is that in an economic recovery, hiring increases and inexperienced workers have higher injury rates, the WCRI says.

Though the data studied by the researchers comes from the mid 1980s, the findings provide a "good" description of cost drivers in 1992, according to the WCRI.

The study should be of interest to anyone interested in containing workers compensation costs, the WCRI says.

However, Mr. Victor cautions that "cost containment is not an end in itself, but one of several critical system goals."

Other important goals include giving injured workers adequate and equitable benefits promptly and without litigation, as well as timely and quality medical care.

In addition, a workers comp system should provide for speedy return to work and encourage injury prevention.

Achieving those goals often requires legislators to balance the interests of injured workers, who want the system to provide broad compensation, and those of employers, that want the system to be more affordable and cost effective.

The WCRI plans to continue its research into cost drivers and has received an unspecified financial commitment to study these and other costs drivers in at least 15 additional states, according to Mr. Victor.

"Cost Drivers in Six States" will be available for \$75, plus 5% tax for Mass. residents, in late December from the Workers Compensation Research Institute, 101 Main St., Cambridge, Mass. 02142; 617-494-1240.

Panel suggests health reform guidelines

SANTA MONICA, Calif.—Any health care reform package drafted by the Clinton administration should call for universal coverage, says a panel of medical, banking and insurance executives.

An open "Memorandum to the President-Elect," drafted by top representatives in the three industries, sets forth a 10-point plan for Bill Clinton to consider.

The plan, "Parameters for Health System Reform," appeared in the Nov. 18 issue of the Journal of the American Medical Assn. Many of the features in the reform package jibe with Gov. Clinton's campaign proposals regarding health care, but others go beyond his recommendations (BI, Nov. 9).

The proposal was drafted during a week-long meeting held this sum-

mer at the Rand Corp. in Santa Monica, Calif.

The memo suggests that a health reform package should:

- Require universal insurance coverage at some defined minimum level, either from existing insurers or from a government-sponsored default source.
- Focus on cost containment by creating "economic incentives for efficiency" for insurers, buyers, and providers and users of care.
- Build on the existing employment-based insurance system, while allowing for diversity of choice.
- Encourage reform at the state level.
- Limit the portion of insurance premiums exempt from personal income tax and other favorable tax treatment of premiums, which will promote cost consciousness by insurance purchasers and generate revenue to subsidize insurance for the poor.
- Enact a payroll tax or other assessment on employers that do not offer sufficient health care coverage.
- Create regional purchasing co-operatives to spread small group or individual risks.
- Collect and analyze data on health status and evaluate the process, outcomes and appropriateness of care.
- Create institutions to establish standards of care to reduce waste and improve efficiency.
- Find ways to set expenditure targets for public and private health care spending.

The memo, though, denounces attempts to adopt a single-payer, Canadian-style health care plan.

—By Laura Mazzuca

Garamendi eyes reform prospects

WASHINGTON—The prospects for comprehensive health care reform are brighter than ever before because of three developments, California's insurance commissioner told health insurers.

"First, there is soaring and widespread public concern about the nation's health care crisis; second, there is a growing consensus absent for many years about how to solve that crisis; and third, as of next January, we will have the presidential commitment necessary to forge public concern and emerging consensus into public policy," said John Garamendi.

"Every American is one job or illness away from having no health insurance," which has made health care a "middle-class crisis," the commissioner said at a Health Insurance Assn. of America meeting last month.

As a result, the traditional divisions between liberals and conservatives within the Democratic Party have blurred on this issue, he said.

Reformers now promote the ideas of a "new consensus based largely on employing the means most associated with conservatives—market competition—to achieve the ends associated with social liberals—universal access," Mr. Garamendi explained.

The result will be using private means to reach social ends.

The best model of this is the type of managed competition that Gov. Bill Clinton endorses. In this model, people would be organized into large groups—usually employment-based—and insurers and providers would bid for the group's insurance and medical services business. And, insurers could not refuse coverage to individuals based on preexisting conditions.

"Insurers and other health plans would be forced to compete on price and service," Mr. Garamendi said.

—By Mark A. Hofmann

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Despite lower returns, GICs remain popular

By MICHAEL SCHACHNER

Although the average rate of return on guaranteed investment contracts and the percentage of funds allocated to GICs declined in 1991, the contracts remain the most popular investment option among savings plan participants, a new study shows.

The average GIC rate of return fell to 8.29% in 1991 from 8.94% the previous year, reports A. Foster Higgins & Co. Inc.

With yields falling, the portion of employee-directed funds in GIC options also fell, by 6.9%.

GICs remain by far the most popular option among savings plan participants that have the option of directing funds, though both plan sponsors and beneficiaries are rethinking their strategies.

Foster Higgins attributes the shift away from the contracts to a slow economy, a surging stock market and recent disruptions in the GIC industry.

Only 64% of plans in 1991 offered a GIC option, down from 71% in 1990, Foster Higgins

found. It surveyed 432 plans offering GICs with year-end assets of more than \$50 billion, or about 33% of the entire GIC market.

Nevertheless, total allocations to GICs in 1991 were more than double those of the next most popular options, according to the survey.

GIC allocations totaled 54% of all employee-directed funds in 1991, down from 58% in 1990. But the next most popular investment options—company stock and money market funds—received 25% and 22% of employee-directed money, respectively.

Balanced equity funds received 22% of employee-directed money, while actively managed equity funds received 21%, the study said.

"People are definitely spreading out their investments. There is a slight move away from GICs toward more bond and equity funds, but it's not a wholesale switch," said Brian C. Ternoey, a Foster Higgins principal in Princeton, N.J.

"Participation in GICs is down because the rates have really fallen," he said. "Many old issues that carried rates of more than 10% are maturing, and if they were renewed now it would be at 6% or 7% interest. That's simply too low for many investors."

Another of the survey's key findings is that plan sponsors are giving employees more control over their savings plan investments.

Last year, the percentage of plans in which employees could direct investment of all funds—both employer and employee contributions—climbed to 70% from 63% in 1990.

The employee was responsible for the investment of some money, usually only his or her own contributions, in 20% of plans last year, down from 30% in 1990. Employers retain responsibility for the investment of all funds in 10% of plans, up from 7% in 1990, according to the study.

Plan participants are also being allowed to transfer funds among investment options more

frequently, the study found.

In 1991, 13% of plans allowed for unlimited, or daily, transfers, up from 3% in 1990. Monthly transfer capability existed among 11% of the plans last year, up from 7% the year before.

However, quarterly transfer capability remained the most common frequency, with 49% of plans allowing employees to transfer funds only once every three months, up from 44% in 1990. The number of plans permitting only one or two transfers per year fell to 25% last year, from 42% in 1990.

"Flexibility is a trend that began emerging a few years ago and is continuing," said Mr. Ternoey. "Employees seem to be more comfortable knowing they can move their money to more places more often."

Yet employees rarely actually move funds more than once or twice a year, Mr. Ternoey added. "Transfer options are like fire insurance; you feel good having it, but you don't really want to use it."

Other findings from the survey

include:

- Among plans in which participants direct the investment of some or all contributions, the number of investment options from which they can choose now averages 4.2, up from 4.0 in 1991 and 3.5 in 1990.

- In 1991, about half the respondents were already in compliance with recently enacted Section 404(c) regulations, which require employers to offer savings plan participants at least three diversified investment options (BI, Oct. 12).

- Plans offering GICs are seeking shorter-term contracts due to low interest rates and questionable issuer security. The expected average maturity for 1992 GIC investments is 3.7 years.

A limited number of copies of the survey, "Employee Savings Plans and Investments-1992," are available free from A. Foster Higgins & Co., 212 Carnegie Center, Princeton, N.J. 08543. Contact Karen Foley at 609-520-2280.

McFerson new CEO of Nationwide's P/C units

D. Richard McFerson, president of Nationwide Mutual Insurance Co.'s property/casualty companies, has assumed the additional title of chief executive officer.

Mr. McFerson succeeds John E. Fisher, who will remain general chairman of Columbus, Ohio-based Nationwide Mutual until April 1994.

In other insurer changes:

Walter R. Bateman elected president and chief operating officer of Harleysville Group Inc. and its principal operating subsidiary, Harleysville Mutual Insurance Co., both of Harleysville, Pa.

Mr. Bateman, who fills a post vacant since 1991, previously was executive vp in charge of all property/casualty operations.

Liberty Mutual Insurance Co. announced two new appointments in Boston: Alfred J. Dicepolo elected vp and Douglas M. Hodes appointed corporate actuary and manager of the corporate actuarial department.

Continental Insurance Co. appointed Robert Rich vp in charge of the agency and brokerage group's Richmond, Va.-

Comings & Goings: Industry

based custom markets operations. He previously was vp and manager in charge of New England.

Phil Broughton succeeds Mr. Rich as vp and manager of the New England Region.

Marine Office of America Corp., a Continental Insurance unit, announced two new appointments: Gary C. Beaton appointed vp, claims manager of the Canadian region in Toronto; and John K. Weber appointed vp, excess liability and marine casualty in New York.

Klaus G. Dorfi has been appointed senior executive vp of the Atlantic Mutual Insurance Co. in New York. Mr. Dorfi was previously executive vp-insurance operations.

Patrick M. Gallagher, has been named vp-international of The Home Insurance Co. in New York. Mr. Gallagher will be responsible for market coordination, administration and supervision of new branch operations outside the United States.

Michael R. Steed was appointed senior vp-investments for ULLICO Inc. in Washington.

Steven J. Bohacz has joined The State Life Insurance Co. as regional vp in northwestern Illinois and southeastern Wisconsin.

Walter E. Stooksbury has been promoted to executive vp of the property/casualty division of The Horace Mann Cos. in Springfield, Ill. Previously, Mr. Stooksbury was senior vp of the casualty division.

S. Alicia Celso has been promoted to vp financial/valuation actuary for American Heritage Life Insurance Co. in Jacksonville, Fla.

Marilee Roller was named president and chief operating officer of Pacific Corinthian Life Insurance Co., a new Pacific Mutual Insurance Co. unit in San Diego.

Charles G. Lynch has been named a vp in the group insurance department of New York Life Insurance Co.

Agents/brokers

Donald C. Brain Jr. has been named president and chief executive officer of the Kansas City, Mo., office of Jardine Insurance Brokers Inc. He succeeds Rick Shanks, who has assumed the role of chairman of JIB Kansas City.

James M. Corroon has been named chairman of Willis Corroon Corp. in Boise, Idaho.

Ralph J. Ursillo has been appointed regional vp of NIA Ltd. in Freehold, N.J.

Rob Johns has joined Rollins Hudig Hall of Oregon as vp. Previously, Mr. Johns was with Frank B. Hall & Co. in Michigan.

Mac D. Nadel, formerly a sales manager in the middle market department, has been appointed a vp in the Stamford, Conn., office of Johnson & Higgins.

Joseph M. Rotyiano joined Jones & Hawkins Insurance Agency in St. Petersburg, Fla., as a benefits account executive.

Louise M. Seebold has been named director of risk management services for Andreini & Co. in San Mateo, Calif. She had been a regional manager in the casualty division of American Home Assurance Co.

Other suppliers

PacificCare Health Systems, Inc. in Cypress, Calif., recently announced that Dr. Roger S. Taylor is joining the company as senior vp and chief medical officer. Previously, Dr. Taylor was national leader-health care for The Wyatt Co. in Washington.

Ted Carpenter appointed vp and regional manager of the Kaiser Foundation Health Plan of North Carolina in Raleigh.

Richard M. Mastaler named executive vp of sales and marketing for Qual-Med Inc., a managed care company in Pueblo, Colo.

Peter L. Tamayo promoted to vp of Inter Valley Health Plan, a non-profit HMO in Pomona, Calif. Previously, he was director of marketing for the company.

Dr. David C.K. Chin Jr. has

been named president and chief operating officer of Novalis Corp., a managed care integrator of software technology, benefit designs and physician organizing models in Albany, N.Y.

Lifeguard Inc., a Milpitas, Calif.-based HMO, recently announced the following appointments: Ron Wojtaszek to chief financial officer; Terry Leuthauser to vp-business development; Nina Auger to vp-operations; and Thomas H. Carter to vp-marketing and sales.

David Stokely recently joined the Pasadena, Calif. office of Alexander & Alexander Benefits Services Inc., the U.S. benefits brokerage subsidiary of The Alexander Consulting Group Inc.

Preferred provider organization MedView Services Inc. of Farmington Hills, Mich., announced two promotions: Valerie Wilson, formerly director of operations for the company's claims operations, to vp in Chicago; and Russell L. Whatmore, formerly director of operations for the provider contracting division, to vp in Colorado Springs, Colo.

Reinsurance

William Wetherell has been named vp of Am-Re Services Inc., a subsidiary of American Re-Insurance Co. in Princeton, N.J.

The Great Lakes Reinsurance Co., U.S. branch, promoted Sidney P. Wattstein to vp in New York. Previously, he was claims manager for U.S. operations.

General Reinsurance Corp. promoted J. Daniel Hickey to vp in Stamford, Conn.

Excess/surplus

Ed Levy has been promoted to manager of the Hatboro office of the Delaware Valley Underwriting Agency Inc., from vp.

Jesse S. Kiefer has been named vp of non-marine claims at Tokio Marine Management Inc. in New York, which is the U.S. manager of The Tokio Marine & Fire Insurance Co. Ltd. of Japan. [BI]

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Flood subrogation

Continued from page 1
buildings causing an estimated \$300 million of insured damage.

The city says the tunnel wall was punctured in 1991 by bridge pilings that Great Lakes installed.

A state judge last month applied the state's so-called "economic loss" doctrine in dismissing purely economic damage claims by businesses that were part of a class-action suit filed against the city and others (BI, Nov. 16).

Attorneys say subrogation actions are likely to be consolidated for discovery purposes with the class-action suit and therefore subject to that ruling.

"The fact that it's subrogation doesn't make a difference," said Dwight Palmer, an attorney with Keck, Mahin & Cate in Chicago. "They still have to show direct physical injury."

"No matter who sues, the city's position is the same," said Richard Bollow of Jenner & Block in Chicago, which represents the city in the flood action. Subrogation "has no effect one way or the other," he said.

The city, which self-insures its liability coverage, also will likely claim sovereign immunity under the Illinois Governmental Tort Immunity Act. The law shields the city from liability except in cases of "willful and wanton disregard of a known danger," or a failure to exercise "ordinary care" in maintaining property.

If the city prevails in this defense, Great Lakes could be held liable for the total flood loss.

Under Illinois comparative fault law, any party that is held 25% or more at fault is subject to joint and several liability.

However, for parties found less than 25% at fault, liability is limited to its portion of fault.

Oak Brook, Ill.-based Great Lakes has \$100 million of liability insurance placed in the London marine market that would apply to flood damage (BI, April 27). The coverage is led by Commercial Union P.L.C. It was placed by Lloyd Thompson Group P.L.C.

One defense that the city will not likely press is that Hartford was not required to pay claims and therefore has no subrogation rights, one attorney says.

Insurers had some difficulty initially determining coverage for the unusual event. If the event were considered a flood, policyholders would have had to have flood insurance to be covered.

If the loss were considered water damage, it would be covered in many standard policies. After the Illinois department met with many insurers, most decided to cover the loss (BI, June 1).

"Courts want to encourage insurance companies to pay claims," said insurer attorney John McCabe of Claussen, Miller, Gorman, Caffrey & Witous in Chicago. "Public policy is against accepting that argument."

In its lawsuit, Hartford is seeking reimbursement for more than \$3.4 million of business interruption and property damage losses it has paid to 20 policyholders (BI, Dec. 7).

Hartford's total flood-related losses are much higher: It has paid \$8.1 million on 68 flood claims. But, the insurer would not say why it is not subrogating for the full amount.

Hartford argues that the city failed to exercise ordinary care in the ownership, maintenance and control of the tunnel system. It says the city failed to:

- Provide the contractor with diagrams of the tunnels.
- Repair the tunnel after a cable television crew videotaped leakage in the tunnel in January and reported it to the city.
- Notify businesses about the situation.

Hartford also argues that Great Lakes did not exercise ordinary care in driving the wooden pilings. The insurer says the company:

- Failed to review diagrams of the underground freight tunnel system.
- Changed the placement of the pilings from the contract specifications.
- Failed to inspect the tunnels once the work was done.

Hartford also charges that Great Lakes breached its contract with the city. It argues that Hartford policyholders, as taxpayers, were also parties to the contract and therefore the insurer should be able to recover their economic losses under contract law.

The suit also accuses both the city and Great Lakes of willful and wanton misconduct.

Even if insurers' subrogation ac-

tions for business interruption losses are dismissed, insurers could recover a substantial amount of their flood losses because the largest claims typically include property damage.

Nearly the entire amount—\$3.38 million—sought by Hartford relates to a single claim paid to the Lurie Co., the owner and operator of four buildings that are located in the flood area.

Lurie's loss may rise as repair work continues on the buildings, the lawsuit notes.

One Lurie property took in 10 feet of water and had to be fitted with a new electrical switch room, a new telephone control room and a new elevator control panel.

Jurisdictional questions raised by the lawsuit Great Lakes has filed against the city of Chicago in federal court have delayed some insurers' subrogation actions, said insurer attorney Mr. McCabe. A ruling on jurisdiction is expected from the federal judge on Dec. 30.

But Allstate Insurance Co. will pursue subrogation in conjunction with other insurers, a spokesman said. Allstate has paid nearly \$1.4 million to 17 policyholders, including the owner of a water-damaged building.

Chubb Corp. also plans to subrogate. Chubb has paid \$3.5 million so far in settling half of its 56 flood-related claims.

But the insurer's largest claims—including those from the Chicago Board of Trade—are not yet closed.

The remainder of the unsettled claims are for business interruption, which is time-consuming for policyholders to document, said William J. Falsone, vp of property claims.

"People seem to be having difficulty getting the information together to present to us," Mr. Falsone said. "It's surprising even to me."

Two of the insurers hardest hit by the flood have not decided whether they will subrogate.

Kemper National Insurance Cos. has paid \$21 million gross to 30 flood claimants, said Don Pence, property claim officer.

Kemper insures retailer Carson Pirie Scott & Co., whose flagship store suffered water damage and was closed for two weeks.

Protection Mutual Insurance Co. also has not decided whether to subrogate. The insurer has paid \$12 million after taxes and reinsurance to flood claimants.

Protection Mutual insures two retailers that were crippled by the flood: Marshall Field's and Filene's Basement, whose Loop stores were shut down for weeks while water was pumped out of subbasements.

Chicago-based CNA Insurance Cos. also has not decided whether to subrogate.

"Most of our insureds suffered only economic damages," a spokeswoman said. CNA, which has paid \$2 million in flood claims, an-

Manville Trust

Continued from page 3
resisted," he wrote.

Failure to reach a compromise "would not only constitute a second disaster for those injured, but would leave the law properly subject to criticism as incapable of sensibly and sensitively responding to new and critical needs of hundreds of thousands of injured persons."

Lawyers in the case and others insisted, though, that the appeals ruling has not dealt a severe blow to the Manville Trust or to other innovative mass tort settlements.

"You just have to do them within the framework of the law," one lawyer observed.

The appeals court limited its review mainly to a federal procedural rule governing class action settlements that do not allow class members to opt out, said Lawrence Fitzpatrick, president of the Center for Claims Resolution.

"I don't think this decision precludes attempts at innovative solutions using other rules and other methods," he said.

"If anything, assistance from a court like the 2nd Circuit in explaining the requirements will be helpful, not hurtful," Mr. Inselbuch added.

"There are some very positive indications in that opinion that if we proceed using the signposts (the court) set out, we can have a successful conclusion to this litigation," said Patricia G. Houser, executive director of the Manville Trust.

The Manville Trust was the centerpiece of a Chapter 11 bankruptcy reorganization plan confirmed for Johns-Manville in 1986. The trust was funded with more than \$2.7 billion in cash, bonds and stock of the reorganized Manville Corp., which was then insulated from further asbestos claims.

Initially, the trust was to pay claims on a "first in, first out" basis, and claimants had the right to sue the trust if their claims were not processed within 120 days.

The number and size of the claims that poured in far exceeded estimates, though, and by early 1990 the trust had run out of cash. A court-appointed special master reported in November 1990 that current and future claims against the trust were estimated at \$6.5 billion while trust assets amounted to only \$2.1 billion to \$2.7 billion.

Judge Weinstein and parties in the case then set out to restructure the payment procedures.

Under the restructuring—approved in 1991 as the settlement of an asbestos victims' class action complaint—the revised plan scrapped the "first in, first out" method and created two separate classes for seriously ill and less seriously ill victims.

The most seriously injured were to receive up to 45% of their claims within the first two years of the plan's operation, and the others were to receive up to 45% in the third year. Claimants in both classes would later receive additional pro rata payments as funds were available.

Manville Corp. had agreed to put in up to another \$520 million in cash to fund the restructured payouts.

nounced in July that it would deny most of its 95 claims because policyholders had standard Insurance Services Organization Inc. commercial property policies, which CNA does not believe afford coverage (BI, Aug. 3).

ITT/Hartford as Subrogee of Bardo & Associates Inc. et al vs. City of Chicago and Great Lakes Dredge & Dock Co., Circuit Court of Cook County; 92L014894.

The revised plan also would have barred asbestos victims and manufacturers named as co-defendants in asbestos cases from suing Manville or the trust or pursuing claims outside the settlement procedures.

Manufacturers would also have been barred from arguing in asbestos suits that the Manville Trust is jointly and severally liable.

The restructuring triggered objections from two groups: Asbestos victims whose payments would be cut under the new plan, and co-defendant manufacturers who argued that they would be improperly saddled with hundreds of millions of dollars of added liabilities.

In its Dec. 4 ruling, the appeals court agreed with some of the arguments made by the two groups and threw out the restructuring plan.

The panel found that the class action that gave rise to the plan improperly lumped together in the same class claimants and co-defendant manufacturers with adverse interests.

Dividing asbestos victims between the seriously ill—who would receive quicker payments under the revised plan—and the less seriously ill creates two classes with conflicting interests, which should be separately represented, the court ruled.

The court suggested creating two new subclasses of those who would have received full payment under the original plan and those who probably would receive nothing because of the shortage of funds. Each of these groups could then be subdivided into the seriously ill and less seriously ill, the court said.

The panel found an even clearer conflict in including victims and co-defendants in the same class.

Regardless of whether the restructured trust would shift asbestos liabilities to the co-defendants or whether this is "fair," the plan cannot be approved for a class that includes both asbestos producers and victims, the court ruled. "The conflict is overwhelming."

These objections to the restructuring apply only under federal rules governing class action settlements that do not allow class members to opt out and pursue their claims in court, the panel noted.

If the plan is revised again to allow claimants to opt out, asbestos victims would not need to be split into subclasses, the panel said.

In his order last week following the appeals ruling, Judge Weinstein asked the parties for suggestions on whether this is a viable option.

The appeals panel also found that the restructuring violated bankruptcy law because it modified the approved reorganization plan of Johns-Manville. While raising the possibility that trust claim payments could be revised through a bankruptcy filing for the trust itself or through a new reorganization plan for Manville, the appeals panel did not elaborate on these options.

Judge Weinstein has invited comment on these possibilities also.

In re Joint Eastern and Southern District Asbestos Litigation; In re Johns-Manville Corp.; U.S. Court of Appeals for the 2nd District, Nos. 900-913, 1071.

ERISA pre-emption dispute

Continued from page 3
like all other employers, must comply with this requirement," said Larry C. White, staff counsel for the Insurance Department in San Francisco.

In support of their argument, state insurance officials point to an advisory opinion from the U.S. Labor Department. The state requested an opinion on whether STAFCOR could use a benefit plan instead of workers comp insurance or self-insurance.

The Labor Department based its advice on *Shaw vs. Delta Airlines Inc.*, a 1983 case in which the U.S. Supreme Court held that a New York law governing disability benefits was not pre-empted by ERISA, but its provisions could not be enforced by regulation of ERISA plans.

Applying the Shaw ruling to workers compensation regulation, the Labor Department said, "It is clear that a state may require employers to provide workers compensation benefits through a separate plan maintained solely for that purpose."

California employers are required by state law to either buy coverage from a licensed insurer or obtain a certificate of self-insur-

ance, the Labor Department noted.

"STAFCOR refuses to meet either requirement," the Labor Department said. STAFCOR maintains that its plan, "while providing for workers compensation-type benefits, is established for purposes other than compliance with the state law, such as for the purpose of providing other benefits, and therefore is covered by ERISA."

In rejecting that argument, the Labor Department again quoted from Shaw: "The fact that state law permits employers to meet their state-law obligations by including disability insurance benefits in a multibenefit ERISA plan... does not make the state law wholly unenforceable as to employers who choose that option... If the state is not satisfied that the ERISA plan comports with the requirements of its disability insurance law, it may compel the employer to maintain a separate plan that does comply."

Under Shaw, the Labor Department said, California may compel employers to maintain separate plans to provide workers comp coverage.

"California has done exactly that through its law," said Mr. White of

the California department. The state simply does not permit an ERISA plan to substitute for workers comp insurance, he said.

Whatever STAFCOR's arguments about the merits of its plan, "the legal point ought to come first—which is that ERISA does not pre-empt state workers comp laws. That's the threshold issue."

The Labor Department advisory "nailed shut the argument," agreed Eric Oxfeld, assistant general counsel for the American Insurance Assn. in Washington. "It clearly states that having an ERISA plan does not allow you to escape state law if it does not authorize an ERISA plan for workers comp."

One important point is unaddressed in the Labor Department advisory, Mr. Oxfeld said. "Should a state choose to allow an employer to use an ERISA plan to satisfy the workers comp obligation, to what extent does the state then have authority to regulate and control the delivery of benefits under that plan?"

Meanwhile, state authorities have been investigating for several months the sale of ERISA plans by brokers as a substitute for workers comp coverage, said Mr. White. BI

TWA, PBGC deal

Continued from page 2

ments. The payments would begin 18 months after the plans are terminated.

The pension agency estimates the present value of the commitments from TWA and Mr. Icahn at \$350 million to \$500 million.

As part of the agreement, the

TWA pension plans will be frozen, with participants not accruing any new benefits.

PBGC Executive Director James B. Lockhart III says the accord, which still must be fully documented and approved by a bankruptcy court, protects the airline's pensions.

"PBGC fought hard to protect TWA's pensions and the insur-

ance program's premium payers. I am pleased that we could work out a solution that does help to protect TWA's pensions and revitalizes the airline," he said.

But the agreement falls short of the agency's original demand that Mr. Icahn fully fund the pension plans in exchange for the agency approving Mr. Icahn's plan to sell the company. **[B]**

Fund seeks to finance Andrew claims

JACKSONVILLE, Fla.—The Florida Insurance Guaranty Fund, foundering under the weight of nearly \$500 million in hurricane claims left unpaid by six failed insurers, plans to issue bonds to finance the shortfall.

The fund paid \$142 million in claims, but needs \$300 million to \$350 million more, reports Jerry Service, its general manager.

The sixth and latest casualty of Hurricane Andrew is Nova Southern Insurance Co. The Miami-based insurer, which shut down last week, wrote general liability insurance for small contractors and other commercial risks.

The Insurance Department reported that Nova Southern wrote \$6.1 million in 1991 premiums, and as of June 30, 1992, had \$8.3 million in assets and \$6.3 million in liabilities. Policyholder surplus totaled \$1.9 million.

The fund last month exhausted its capability to assess insurers to make up the shortfall (*BI*, Nov. 23; Nov. 2). Assessments on insurers are limited to 2% of premiums written.

State insurance regulators are asking the state Legislature to allow the bonds to be issued on a tax-free basis. Tax-free bonds would lower interest costs to the guaranty fund. The 10-year bonds will be sponsored by the

city of Homestead.

Insurance Commissioner Tom Gallagher last week also asked the Florida Legislature to approve an additional 2% guaranty fund assessment on insurers.

Meanwhile, the huge toll from Hurricane Andrew is forcing State Farm Group to consider ways to cap its exposure in southern Florida.

Losses from Hurricane Andrew total \$2.1 billion for the insurer, which buys no reinsurance.

While no decision has been made on how State Farm would limit its exposure, a spokesman confirmed that one proposal is to cap the amount of commercial and personal lines coverage written by individual agents at \$750,000 apiece.

The spokesman said any decision would involve limitations only on new business and State Farm would continue to provide coverage for its current policyholders.

Prudential Property & Casualty Co. will stop writing new residential policies in Florida for at least 60 days under a deal negotiated with the Insurance Department. Regulators had accused the Newark, N.J.-based insurer of redlining for refusing to write new policies in all but 12 central Florida counties. PRUPAC expects to pay \$1.2 billion in storm claims (*BI*, Sept. 28).

In other Hurricane Andrew-related developments:

- Allstate Insurance Co. last week increased its loss estimate from Hurricane Andrew to \$2.5 billion after reinsurance. The after-tax impact on earnings would be \$1.65 billion, up from \$1.15 billion, it projects.

- Independent Fire Insurance Co. of Jacksonville estimates after-tax losses from Andrew at \$43.2 million, up from \$26.1 million.

- NAC Re Corp. increased its net after-tax impact from Hurricanes Andrew and Iniki to \$31 million from \$25 million.

- The department has closed Guardian Property & Casualty, a small Miami insurer that wrote homeowner's insurance, CGL and commercial auto coverages.

Guardian's problems weren't related directly to hurricane claims, although those losses further weakened the insurer's finances, according to an insurance department spokeswoman.

The spokeswoman confirmed Guardian is the subject of a criminal investigation by the Insurance Department but would not release details.

Guardian's assets totaled \$13.4 million as of Sept. 30 and liabilities amounted to \$20.7 million. It reported a deficit in policyholder surplus of \$7.2 million. **[B]**

For the Record

ACLI, HIAA oppose discriminatory limits

WASHINGTON—The directors of both the American Council of Life Insurance and the Health Insurance Assn. of America have voted unanimously to oppose discriminatory limits on medical benefits for people with AIDS.

The two insurance groups' actions came in response to the U.S. Supreme Court's refusal to hear *Greenberg vs. H&H Music Co.*, in which an employer reduced lifetime benefits for AIDS and some other diseases to \$5,000 from \$1 million after learning that an employee had AIDS (*BI*, Nov. 16).

Separately, Rep. Bill Gradison, R-Ohio, said last week that he is considering an offer from the HIAA to succeed Carl Schramm as the trade group's next president.

Employers split on FAS 106 obligations

NEW YORK—Employers preparing to comply with Financial Accounting Standard 106 are almost evenly divided on whether they will take a one-time charge for accumulated retiree health care liabilities or amortize the liabilities.

Among employers who have decided how to recognize accumulated liabilities, 51% will amortize the liabilities, generally over a 20-year period, while 49% will take a one-time charge against earnings,

reports a survey by A. Foster Higgins & Co. Inc. of New York.

Meanwhile, several employers recently took charges against earnings for FAS 106 obligations.

Goodyear Tire & Rubber Co. said adoption of the rule resulted in a one-time, after-tax charge of \$1.07 billion to be taken in a restated first quarter of 1992.

Also, PepsiCo Inc. will take a \$575 million pretax charge in the fourth quarter to recognize its FAS 106 obligations. Reynolds Metals Co. will take an after-tax charge of \$610 million in the fourth quarter for FAS 106, in addition to restating its reports from the year's first three quarters to include \$34 million in charges. And chemical and petroleum products manufacturer Witco Corp. will take a \$14.7 million charge against first-quarter 1992 earnings to recognize its accumulated liabilities.

State funds pay more in new Mutual plan

TRENTON, N.J.—State guaranty fund associations will pay interest of at least 5% annually for certain policyholders in the Mutual Benefit Life Insurance Co. rehabilitation plan, although the associations do not have to contribute the full amount of benefits.

Individual state guaranty associations may waive statutory limits governing how much they can contribute to policyholders. These waivers may or may not deny policyholders the full value of their contracts.

"The effect this new provision will have on how much policyhold-

ers will collect is unquantifiable at this point," said a Mutual Benefit spokeswoman.

The National Organization of Life & Health Guaranty Assns. declined to comment on the cap provision, saying the details still need to be worked out.

Last week, New York regulators decided to join in the rehabilitation plan after the participating guaranty associations agreed to provide at least 5% annual interest.

Under the amended agreement, more than 100,000 Mutual Benefit life insurance and tax deferred annuity policyholders, whose contracts will be covered by the guaranty associations of 47 states and Puerto Rico, will receive at least 5% interest.

The original plan, submitted in August for court approval, called for guaranty associations to provide minimum annual interest of 3.5% during the seven-year bailout period (*BI*, Aug. 10).

New York Insurance Superintendent Salvatore Curiale had withheld support for the plan, claiming 3.5% annual interest was too low (*BI*, Oct. 26).

Also, the previous plan sacrificed interest levels for the guarantee of full benefits.

The guaranty associations would have been required to pay policyholders' full account values regardless if payments exceeded statutory caps.

The new plan, which must still be approved by a New Jersey Superior Court judge, also calls for New York to provide a variable interest rate that is tied to the yield of three-year Treasury notes. The current level of interest in New York under this provision would be about 5.8%. **[B]**

Update

AMA switch on self-referrals

NASHVILLE, Tenn.—Reversing its earlier opinion, the American Medical Assn. House of Delegates now holds that it is generally unethical for physicians to refer patients to diagnostic centers or clinics in which they have a financial interest.

In passing a resolution, the House—the AMA body that sets medical practice policies—rescinded a June opinion that virtually allowed unrestricted self-referrals (*BI*, July 6).

The new AMA resolution states that physicians may acquire stakes in health facilities, products or equipment but should not refer patients to these facilities due to potential conflicts of interest.

But some self-referrals would be allowed, for instance, when the only proper facility in an area is owned by the referring doctor.

First Capital Life officers sued

LOS ANGELES—Three former officers of First Capital Life Insurance Co. are being blamed for the insurer's 1991 failure in a lawsuit filed by California Insurance Commissioner John Garamendi.

The suit, filed last week in Los Angeles Superior Court, charges the three with breach of fiduciary duty, constructive fraud and violation of state insurance law.

Robert Weingarten, the founder of parent First Capital Holdings, and former company officials Gerry R. Ginsberg and Phillip A. Fitzpatrick engaged in a "systematic, concerted course of conduct," conspiring and aiding and abetting each other "in the commission of acts and business practices which wasted First Capital's assets and usurped the company's corporate opportunities," the suit alleges. All three were officers of the insurance unit.

First Capital Life was placed in conservation in May 1991.

Ruling may curb member suits

LONDON—A House of Lords ruling last week could discourage many Lloyd's of London members from suing members agencies to recover millions of pounds in losses.

Under the ruling, members of syndicate 317/661, managed by R.H.M. Outhwaite Underwriting Agencies Ltd., must reimburse their stop-loss insurers out of the 113 million pound (\$175.6 million) settlement from their suit against 81 members agencies.

If members believe that they are only suing for the benefit of their stop-loss underwriters, they may not pursue litigation against their members agencies (*BI*, Nov. 23).

Among the 986 Outhwaite members who sued, 246 carried stop-loss coverage, said Richards Butler, which represented the members. Stop-loss underwriters will recover about 15 million to 20 million pounds (\$23.3 million to \$31.1 million) out of the total settlement.

Briefly noted

A total of 125 catastrophe insurance futures contracts were traded at the Chicago Board of Trade as of late afternoon Friday, the first day of trading on the contracts, said trader Avi Goldfeder, vp with Quantum Financial Services Inc. Of the 125 contracts, 75 were Eastern and 50 were national contracts, he said (*BI*, Nov. 2). . . Insured losses from the **October 1991 fires in Oakland, Calif.**, are now estimated at \$1.7 billion, the California department says based on a survey of insurers. Fire losses were originally estimated at \$1.2 billion (*BI*, Oct. 28, 1991). . . New Jersey Gov. James Florio on Friday declared a **state of emergency** in 10 counties as wind gusts of up to 90 mph and flooding led to the evacuation of coastal areas and the shutdown of railway systems. . . The International Union of Electronic, Electrical, Salaried Machine and Furniture Workers is suing in federal court to try to block **Unisys Corp.** from phasing out retiree health care coverage (*BI*, Nov. 9). . . Horst Jannott, chairman of **Munich Reinsurance Co.**'s board of management, will step down in early 1993. Vice-director Hans-Jürgen Schnizler will succeed him on the board of management. . . U.S. Healthcare Inc. has signed an agreement to buy Mutual of Omaha Cos.' **Omaha Financial Life Insurance Co.** unit. . . Standard & Poor's Corp. has **lowered Kemper Corp.'s ratings** to A- from A on about \$176 million of senior debt. S&P also lowered the claims-paying rating of Kemper Reinsurance Co. to A+ from AA. . . Negotiations to secure **terrorism coverage** for about \$8 billion worth of property owned by the City of London collapsed last week when reinsurers pulled out. The lead property insurer for the city is Sun Alliance P.L.C. . . **Richard Braddock**, former president of Citicorp, will become CEO of Medco Containment Services Inc., a prescription drug benefit company, Jan. 15. . . **Lincoln National Corp.** has filed a registration statement with the Securities and Exchange Commission for a public offering of 4 million common shares in 1993. Proceeds of the offering would go toward general corporate purposes. . . Baxter International Inc. completed the previously announced spinoff of **Caremark International Inc.** into a separate public corporation last month. Caremark consists of Baxter's home health care, physical therapy and prescription service businesses. . . **Penn Central Corp.** says it plans to sell its defense services and diversified industrial companies and use the proceeds to buy property/casualty insurers. Penn Central already has four property/casualty units. . . Eric R. Spitzer resigned as president and CEO of utilization review firm **Peer Review Analysis Inc.** . . The \$1.8 million originally awarded to the family of a man who claimed The Upjohn Co. sleeping pill **Halcion** caused him to murder his best friend was reduced to \$1.1 million (*BI*, Nov. 16). . . **UNUM Corp.** and Colonial Cos. Inc. announced a merger earlier this month. UNUM will exchange common stock worth about \$570 million for outstanding shares of Colonial stock. . . **Axa Group** is selling 20% of International Technology Underwriters to Prudential Reinsurance Co., a major reinsurer of Intech's, for around \$3 million. Axa bought the specialist space insurer for \$15 million less than a year ago.

Dissecting the third quarter

By LEONARD M. WILSON

Special to Business Insurance

THIRD-QUARTER REPORTS for brokers have receded from view amid widespread and eager anticipation of a soft market beating a hasty retreat. We customarily perform a quarterly ritual of speaking with our contacts at the publicly owned brokers to dissect the latest operating results. The insights that follow are a representative cross-section:

ANALYST: We were unable to discern any acceleration in commission growth during the third quarter. Do you see a glimmer of improvement in top-line growth?

CONTACT: Domestic brokerage commissions advanced roughly 3% in the quarter, pretty much consistent with the pace set over the past eight quarters. You should not expect any impact from firmer rates until the first quarter of 1993, at the earliest.

ANALYST: Does that mean premium rates were still intensely competitive during the third quarter?

CONTACT: Intense may overstate it, but underwriters remain aggressive in most non-property lines. Across our entire primary, domestic book of business, we estimate that premium rates were down about 5%, again consistent with the last 18 months. Of course, some lines have already firmed, such as marine, energy, aviation and, of course, reinsurance. And we all know that the London market had tightened even before the hurricane season.

ANALYST: With higher rates, how did reinsurance brokerage fare in the quarter?

CONTACT: Our reinsurance brokerage revenues gained modestly in the quarter. Here we face a dilemma. Prices are undeniably rising, and that helps the flow of reinsurance brokerage commissions. But the shrinkage in capacity and the difficulty in finding coverage works in the opposite direction.

ANALYST: Employee benefit consulting has slowed, but at least you and other brokers are

not facing price competition.

CONTACT: Revenues from benefit consulting were more or less flat in the quarter. Benefits activity was high for several years and we were able to post strong double-digit gains in fees. Now clients are not eager to spend on semi-discretionary areas. We are optimistic that consulting activity will be stimulated by health care changes initiated under the new administration.

ANALYST: Investment income declined around 20% in the quarter. That is a pretty substantial drag on a year-over-year basis.

CONTACT: Monetary experts call attention to the steepness of the interest rate yield curve, the 4% spread between short-term and long-term interest rates. Interestingly, our investment income gets hurt by monetary policy that is contra-cyclical.

ANALYST: Could you discuss the behavior of costs in the quarter?

CONTACT: We are emphasizing expense restraint on three fronts: headcount, compensation and what we like to call rationalization. Headcount overall was steady in the third quarter. We are adding staff only in the high-priority functions like production. Unfortunately, the easing of inflation has facilitated our controls in the compensation area. Finally, we are rationalizing operations on a continuing basis by closely analyzing where we are not receiving an adequate return on effort.

ANALYST: But profit margins are not widening.

CONTACT: That's true, but as you pointed out in your last article (BI, Nov. 16), the spread between revenue growth and expense growth determines the level of profitability. We aren't yet able to demonstrate the effects of our cost programs until revenue growth improves.

ANALYST: Tell me about the status of the new business effort.

CONTACT: We are producing new business at a steady rate of 10% to 11% of the exist-

ing book of business. We perceive no slackening in the production effort. Our lost business is holding at 4% to 5%. So the arithmetic of net new business is 5% to 6%.

ANALYST: Will new business accelerate as the market tightens?

CONTACT: It has in the past. We ascribed the new business bounce in a tight market to our professionalism and market clout. The cycle, though, seems different this time, given the rolling readjustment in rates. While new business in dollars ought to benefit from rising rates, we can't assume categorically that a spike in new business lies ahead.

ANALYST: Can you provide a curtain raiser on the outlook for premium rates in this tumultuous insurance market?

CONTACT: Rates on commercial property, umbrellas and property reinsurance are moving forward. We have yet to see increases in the mainstream liability coverages. We hope that liability rates will advance later in 1993, but we have no definitive indication of a market shift at this point.

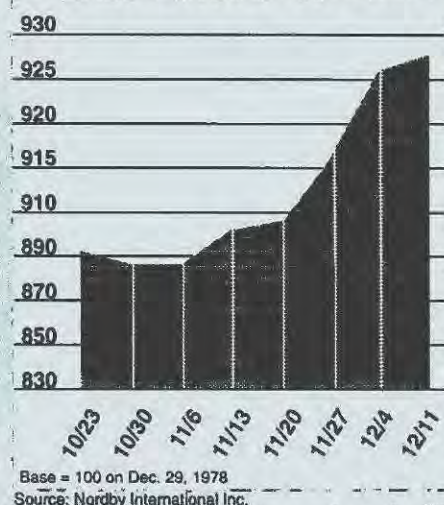
ANALYST: When will your profit plan be ready so that we can expand on the question of the outlook for 1993?

CONTACT: Come around early next month. We are putting the figures to bed right now. Profit plans are under review. Let me leave you with one thought about 1993: Despite the run-up in property and casualty stocks generally, and our still incomplete budgets, we have to manage for a soft market until the evidence of broad tightening is definitive. **BI**



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BI Insurance Index



Insurance industry stocks continued to rise last week, as the *Business Insurance Index* climbed 1.7 points to 927.5 on Dec. 11, from 925.8 on Dec. 4. Advancing issues were led by Statesman Group Inc., up 16.7%; National Re Corp., up 9.1%; and Frontier Insurance Group, up 8.6%. Decliners followed Seibels Bruce Group, down 18.2%; Harleysville Group, down 9.4%; and Continental Corp., down 6%. Orion Capital Corp. completed a 5-for-4 stock split during the period. The most active issue was U.S. Healthcare Corp., 2.8 million shares traded. The *BI Index* was up 0.2%; the NYSE Composite was up 0.36%; the Standard & Poor's 500 was up 0.39%; the Dow Jones 30 Industrials rose 0.5%.

British Issues

Dec. 10 Companies	Price pence	P/E	Div. pence	Yield %	1 Week	
					High	Low
Comml Union	584	NM	31.5	5.4	596-583	
Genl Accident	552	NM	35.7	6.5	567-552	
Genl Royal Exch	172	NM	10.0	5.8	175-172	
Royal	273	NM	7.0*	2.6	273-260	
Sun Alliance	332	NM	19.0	5.8	332-327	
Brokers						
Bradstock	109	12.2	6.3	5.8	112-109	
CE Heath	328	19.0	21.3*	6.5	328-326	
Hogg Group	150	14.1	10.9	7.3	152-150	
JIB Group	140	10.7	10.0	7.1	144-140	
Lloyd Thompson	234	18.9	7.5	3.2	234-234	
Lowndes Lomb	313	12.2	16.8	5.4	313-313	
PWS Holdings	49	5.6	5.3	10.8	49-44	
Sedgwick Grp	150	11.9	8.0*	5.3	150-145	
Steel Brl Jones	194	9.5	17.7	9.1	195-194	
Wills Coroon	176	11.2	17.6	10.0	179-175	

Source: Philip Olsen, London * Estimated

BI Industry Stock Report

DECEMBER 7, 1992 THROUGH DECEMBER 11, 1992

BROKERS

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
Acordia Inc.	NYS	20.88	-5.65	N/A	22.25	15.13	120	0.36	1.72	-	7.01	2.98
Alexander & Alexander	NYS	26.75	0.00	30.49	27.38	18.00	499	1.00	3.74	96	10.00	2.68
Gallagher Arthur J. & Co.	NYS	27.38	-0.45	22.35	29.00	20.00	371	0.64	2.34	18	6.35	4.31
Frank B. Hall	NYS	2.88	0.00	-32.35	5.50	2.63	0	0.00	0.00	-3	N/A	N/A
Hibb, Rogal & Hamilton	NYS	15.00	-1.64	13.21	15.63	11.00	100	0.44	2.93	23	3.11	4.82
Marsh & McLennan	NYS	93.25	1.36	14.59	94.50	71.25	354	2.68	2.87	22	14.40	6.48
Poe & Associates	OTC	15.75	-1.56	31.25	16.75	11.25	12	0.40	2.54	20	2.64	5.97
BROKERS AVERAGE			-1.1	11.4					2.3	25		

CONGLOMERATES & HOLDING COMPANIES

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
Berkley W.R. Corp.	OTC	43.75	0.00	43.44	47.75	27.25	132	0.36	0.82	16	23.51	1.86
Berkshire Hathaway Inc.	NYS	11205.0	3.27	23.81	11400.0	8300.0	0	0.00	0.00	45	6437.25	1.74
ITT (Hartford Group)	NYS	69.75	-2.96	20.78	72.00	50.00	764	1.84	2.64	16	68.23	1.02
Sears (Allstate)	NYS	43.25	-1.98	14.19	48.00	32.50	2529	2.00	4.62	42	40.18	1.08
CONGLOMERATES AVERAGE			-0.4	25.6					2.0	30		

INSURERS/REINSURERS

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
AEGON N.V.	NYS	41.63	2.15	18.93	42.75	33.00	47	2.68	6.44	7	34.06	1.22
Aetna Life & Casualty	NYS	47.75	0.00	8.52	48.25	36.50	1380	2.76	5.78	15	67.08	0.71
Allied Group Inc.	OTC	32.50	4.00	91.18	32.50	16.25	78	0.64	1.97	10	11.29	2.88
American General	NYS	52.75	0.24	18.54	54.75	40.13	517	2.08	3.94	11	39.89	1.32
American Heritage Life Ins.	NYS	30.25	-1.22	-1.22	32.50	22.13	6	0.84	2.78	15	16.51	1.83
American Indemnity/Fin'l	OTC	6.00	4.35	26.32	9.25	4.63	1	0.06	1.33	3	14.43	0.42
American International	NYS	116.75	0.43	18.68	116.75	82.00	1024	0.56	0.48	16	54.21	2.15
Argon Corp.	NYS	50.50	-0.74	27.44	51.63	37.38	187	1.68	3.33	13	27.17	1.88
Argonaut Group	OTC	29.00	1.75	22.11	30.00	21.75	102	0.84	2.90	8	21.70	1.34
AVEMCO Corp.	NYS	22.63	0.56	-9.50	28.00	21.50	7	0.40	1.77	25	7.33	3.09
Baldwin & Lyons Inc.	OTC	36.50	0.00	41.75	36.50	25.00	1	0.48	1.32	9	30.85	1.18
Chandler Insurance	OTC	4.25	-2.86	30.77	7.63	3.19	4	0.00	0.00	19	8.63	0.49
Chubb Corp.	NYS	88.25	2.62	14.61	89.75	62.38	597	1.60	1.81	14	40.67	2.17
CIGNA Corp.	NYS	56.25	-2.81	-7.98	61.75	47.13	882	3.04	5.40	11	81.73	0.69
CNA Financial Corp.	NYS	95.50	2.69	-2.55	104.50	78.50	63	0.00	0.00	12	80.24	1.19
Continental Corp.	NYS	25.50	-5.99	-7.69	34.75	20.00	1687	1.00	3.92	19	38.32	0.67
EXEL Ltd.	NYS	45.88	2.80	22.33	46.38	32.13	701	0.92	2.01	9	N/A	N/A
Fund American Corp.	NYS	72.00	-1.71	3.04	74.50	62.50	37	0.68	0.94	17	81.85	0.88
Fremont General Corp.	OTC	26.75	2.88	9.74	27.25	17.00	171	1.00	3.74	7	25.62	1.04
Frontier Insurance Group	NYS	41.00	8.61	51.85	41.00	22.16	33	0.60	1.46	15	13.97	2.93
Gaisco Inc.	ASE	14.38	-4.96	54.02	15.63	7.72	67	0.04	0.28	20	2.65	5.42
General RE Corp.	NYS	114.13	1.22	12.02	117.00	77.50	798	1.80	1.58	16	46.07	2.48
Guaranty National Corp.	NYS	17.63	-0.70	21.55	20.38	13.00	7	0.48	2.72	11	9.12	1.93
Hanover Insurance Co.	OTC	50.50	2.80	41.26	50.50	33.00	137	0.44	0.87	8	40.44	1.25
Harleysville Group	OTC	24.00	-9.43	12.94	28.25	17.75	71	0.64	2.67	10	16.77	1.43
Hartford Steam Boiler	NYS	56.63	0.89	-1.52	59.25	45.13	69	2.12	3.74	22	19.74	2.87
Kemper Corp.	NYS	27.88	-3.88	-26.89	45.13	20.75	568	0.92	3.30	20	37.65	0.74
Lawrence Insurance Group	ASE	8.38	-4.29	-24.72	11.13	7.00	4	0.48	5.73	19	4.66	1.80
Liberty Corp.	NYS	28.25	0.44	27.68	32.88	20.13	717	0.56	1.98	11	18.43	1.53
Lincoln National	NYS	71.88	-1.20	31.28	73.00	49.38	412	3.04	4.23	11	58.92	1.22
Market Corp.	OTC	31.25	6.84	42.05	31.25	18.00	150	0.00	0.00	8	15.44	2.02

		Price	Weekly % change	Year to Date % change	Annual High	Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
Mutual Risk Mgmt. Ltd.	NYS	37.75	-0.66	7.47	40.00	25.75	68	0.24	0.64	22	7.51	5.03
NAC Re Corp.	OTC	40.50	8.00	28.57	42.00	21.75	470	0.16	0.40	36	13.60	2.98
National Re Corp.	NYS	30.00	9.09	N/A	31.00	17.00	348	0.12	0.40	14	N/A	N/A
Navigators Group	OTC	34.50	1.47	-15.85	48.25	28.50	18	0.00	0.00	24	15.69	2.20
Nobel Insurance LTD.	OTC	5.50	-2.22	37.50	6.00	3.75	86	0.00	0.00	4	3.91	1.41
NWNL Companies	NYS	48.50	4.58	55.82	48.50	26.00	256	1.48	3.05	13	46.21	1.05
Ohio Casualty Corp.	OTC	59.75	-2.25	20.71	66.63	46.25	168	2.68	4.49	11	43.08	1.39
Old Republic Int'l	NYS	24.88	0.00	40.14	26.50	16.00	502	0.40	1.61	8	18.63	1.34
Orion Capital Corp.	NYS	32.25	7.14	27.47	41.00	29.00	109	1.00	3.10	6	28.62	1.13
Phoenix RE Corp.	OTC	14.50	5.45	38.10	14.50	8.75	259	0.20	1.38	-21	13.32	1.09
Provident Life	NYS	28.38	7.08	22.04	28.38	20.00	184	1.00	3.52	12	30.38	0.93
Re Capital Corp.	ASE	15.38	0.00	6.96	16.38	12.25	7	0.24	1.56	27	16.88	0.91
Reliance Group Holdings	NYS	6.63	-1.85	60.61	6.68	3.50	311	0.32	4.83	3	2.94	2.25
RLI Corp.	NYS	24.38	4.28	47.73	24.38	15.50	9	0.52	2.13	10	16.15	1.51
St. Paul Companies	NYS	74.00	-1.33	1.54	80.75	66.50	578	2.72	3.68	11	59.79	1.24
SAFECO Corp.	OTC	56.75	0.00	16.41	57.00	41.88	399	1.64	2.89	14	35.37	1.60
SCOR U.S. Corp.	NYS	18.00	-1.37	17.07	19.50	13.13	3	0.28	1.56	17	14.39	1.25
Seibels Bruce Group	OTC	1.13	-18.18	-79.55	6.50	0.38	197	0.36	32.00	0	6.22	0.18
Selective Ins. Group	OTC	21.50	-2.27	28.35	23.50	16.00	34	1.12	5.21	9	20.22	1.06
Statesman Group Inc.	OTC	11.38	16.67	97.83	11.38	5.00	898	0.00	0.00	6	6.71	1.70
Tokio Marine & Fire	OTC	48.25	5.75	-6.31	55.25	32.25	3	0.00	0.00	97	70.93	0.68
Torchmark Corp.	NYS	52.88	2.67	37.04	54.50	34.41	500	1.04	1.97	15	14.87	3.56
Transamerica	NYS	47.00	-1.57	17.87	47.88	35.63	245	2.00	4.26	21	35.86	1.31
Transatlantic Holdings	NYS	51.25	-0.73	31.83	53.00	29.38	48	0.28	0.55	18	21.85	2.35
Travelers Group	NYS	24.50	-2.49	13.29	25.50	17.13	1642	1.60	6.53	-14	43.85	0.56
Trenwick Group Inc.	OTC	39.50	0.00	-38.60	42.00	25.00	152	0.80	2.03	16	23.87	1.65
United Fire & Casualty	OTC	39.75	-5.36	32.50	42.50	29.16	11	1.00	2.52	17	28.47	1.40
Unitrin	OTC	38.00	-3.18	6.29	39.50	31.00	295	1.20	3.16	12	36.51	1.04
UNUM Corp.	NYS	53.38	1.67	31.79	53.38	32.00	924	0.64	1.20	15	21.83	2.45
US Facilities Corp.	OTC	9.50	2.70	-36.13	19.00	7.00	135	0.00	0.00	10	9.64	0.99
USF&G Corp.	NYS	13.75	2.80	89.66	15.00	5.63	1228	0.20	1.45	-26	10.29	1.34
USLI&CO Corp.	NYS	17.50	2.94	-5.41	20.38	16.75	50	1.00	5.71	25	29.80	0.59
USLIFE Corp	NYS	52.75	1.93	10.18	52.75	39.00	219	1.80	3.41	10	64.90	0.81
Washington National	NYS	22.63	0.00	42.52	23.63	14.00	34	1.08	4.77	18	30.27	0.75
Zenith National Ins.	NYS	18.00	7.46	6.67	19.50	13.75	277	1.00	5.56	13	14.81	1.22
INSURERS/REINSURERS	AVERAGE		0.8	20.2					-3.4	15.4		

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