

Business Insurance

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

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Updates

Bain Hogg divestiture expected; A&A, Aon both possible buyers

LONDON—Inchcape P.L.C. is expected to announce this week its plans for divesting broker Bain Hogg Group.

In the running to purchase the world's 11th-largest broker are Alexander & Alexander Services Inc., which has made a preliminary bid, and Aon Corp., whose interest had cooled by late last week.

Inchcape has been discussing the sale of Bain Hogg, which generated \$331.1 million in 1994 revenues, with several parties over the last few months in lieu of a public offer.

See Updates on next page

Tax proposal rattles captives

Experts criticize bill that could imperil tax breaks for most captives

By DOUGLAS McLEOD

WASHINGTON—Captive insurance experts are roundly criticizing a tax provision in the Clinton administration budget that would throw premium deductions for most captive owners into doubt.

The proposal, unveiled with the administration budget earlier this month, would permit owners to take deductions only for premiums paid to captives that draw more than 50% of their net premiums from risks unrelated to their owners (BI, Dec. 11).

The proposed rules would eliminate deductions for captive owners unwilling to significantly boost their captives' third-party underwriting, experts say.

The rules would also define a "re-

lated" party as anyone owning 10% or more of a captive, which experts say would damage group captives with few shareholders.

Captive owners and experts last week were just beginning to organize opposition to the rules, which caught most by surprise.

The Coalition of Alternative Risk Funding Mechanisms, an industry group, was preparing to send letters of objection to members of Congress, said George Rusu, president of consultant Captive Resources Inc. in Schaumburg, Ill., and a CARFM member.

"To come in and take a simple, formulaic approach to what is and is not insurance is just unsound taxation and unsound legislation," observed James Blankenship, a tax partner with KPMG Peat Marwick in Bermuda.

Mr. Blankenship and other experts, however, worried that the proposal might not get enough attention in the midst of a high-pressure budget debate that includes so many hotly contested issues.

"This belongs in another legislative vehicle where there is adequate time for all interested parties to discuss it," Mr. Blankenship said. "I certainly hope the Treasury Department was not trying to pull a fast one."

The captive tax proposal is a small part of a package of revenue raising proposals that target what the administration has identified as "corporate welfare."

Some proposals, such as disallowing interest deductions on loans from corporate-owned life insurance policies,

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Investor education guidance offered

Key 401(k) plan tools endorsed

By RODD ZOLKOS

For the first time, the U.S. Department of Labor is indicating that employers that want to provide investment education for employees can use two valuable tools—asset allocation models and interactive software—without exposing themselves to fiduciary liability for any investment losses.

There is one important caveat, though: models and software can only be used to provide general information, not specific investment advice.

In particular, the department said:

- General investment information should be "based on generally accepted investment theories that take into account the historic returns of different asset classes over defined periods of time."

- Asset allocation models should not single out specific alternatives within asset classes. In other words, if the model includes bond funds, it should mention all the bond funds an employer offers, not just one.

- Both models and interactive investment materials should be accompanied by statements advising participants that in using them, they should also consider their other assets, income and investments.

That guidance comes in a long-awaited 18-page draft interpretive bulletin on defined contribution plan investing that the department recently released. Under the draft guidelines, companies also could continue to provide plan information and general financial information.

The guidelines differ from some other benefits regulations in an important way. In developing its investor education guidelines, the department examined what employers were already doing in this area and then wrote the guideline to endorse those activities. Benefits experts could cite no examples of employers currently doing anything that would be prohibited under the guidelines.

"I think the release is helpful and generous in that it seems to suggest that the practices used by employ-

See Investing on page 16

Mergers yield benefit options

By DEBORAH SHALOWITZ COWANS

Employee benefit managers take note: Mergermania is back.

This year probably will set a record in both the number of mergers and acquisitions completed and the value of those deals.

Most of those deals have common goals like improving efficiency or adapting to rapidly evolving markets. But one thing that most M&A transactions do not have in common is how employee benefit plans are handled.

"Each acquisition... presents a different set of options," said Fred Hamacher, vp of compensation and benefits for Dayton Hudson Corp. in Minneapolis, which has acquired two

other major retailers in the last two decades.

"We don't have any set way of doing it," he said.

More and more companies are having to figure out how to handle benefits in a merger or buyout.

In 1994, for example, there were a record 4,500 deals valued at \$5 million or more each involving at least one U.S. company in which two companies merged or at least 40% of a company was acquired, said James Quella, director of Mercer Management Consulting, a unit of Mercer Consulting Group Inc. in New York. He predicts that number will be exceeded in 1995 and beyond.

In each deal, companies must figure out what to do with both benefit pro-

grams. Companies typically use one of three methods:

- Both benefit plans continue to operate, with employees of the original companies remaining in their respective plans.

- The acquired company's benefit plans are terminated and employees of that company are transferred to the buyer's plans.

- A new plan is developed for employees of both companies.

While companies may begin the process of mapping out what will happen to benefit programs as soon as a merger or acquisition is announced, typically it takes at least a year or longer until new programs are in place or employees have been absorbed into

See Mergers on page 20

Textile mill covered for fire devastation

By GAVIN SOUTER

LAWRENCE, Mass.—Malden Mills Industries Inc. is "completely and amply insured" for damage caused by the devastating fire that engulfed its major manufacturing plant last week, said Aaron Feuerstein, president of the company.

Highly protected risk coverage for the fabric manufacturer is underwritten by Commerce & Industry Insurance Co., a New York unit of American International Group Inc., sources say.

The fire could affect several other companies that rely on Malden Mills as a principal supplier of Polartec and Polarfleece, fabrics that are used in winter sports apparel and other outdoor clothing.

The fire, which broke out at 8 p.m. on Dec. 11, seriously damaged four manufacturing buildings at the Malden Mills complex. The headquarters office building, a power plant, water treatment facility and two other buildings were not damaged. About 500 people were working on the night shift when the fire broke out. Thirty-three people were injured, eight critically.

The cause of the fire has not been officially determined. The culprit may have been a boiler ex-

plosion which incapacitated the sprinkler system at the facility, said a spokesman for the Methuen, Mass., fire department which responded to the fire.

No official damage estimates were available late last

week. One source said the property damage was expected to be near \$140 million. Malden Mills would not comment.

HPR coverage for Malden Mills is placed with Commerce & Industry, sources say. Commerce & Industry would not comment.

Investigators for Hartford Steam Boiler Inspection & Insurance Co. were on the scene in Lawrence last week, though neither the insurer nor Malden Mills would confirm that the Hartford, Conn.-based company wrote boiler and machinery coverage for factory.

Even if the HPR coverage excludes boiler and machinery damage, though, the HPR insurer will still normally cover the damage caused by the resultant fire after an explosion, according to sources.

Malden Mills is one of a few companies that produces lightweight fleece linings for ski clothing and other outdoor clothing. It expects sales of \$425 million in 1995.

The fire destroyed "a substantial amount" of Malden Mills' manufacturing capacity, said Mr. Feuerstein in a statement.

It does, though, "retain the ability to produce

See Malden on page 4



Four manufacturing buildings were severely damaged in last week's fire at Malden Mills, which produces lightweight fleece linings for outdoor clothing.

Captives

Continued from page 1

would raise billions of dollars. The captive insurance proposal would generate about \$62 million over seven years, the Office of Management and Budget estimates.

Under the proposed rules, coverage placed with a captive would be considered valid insurance for tax purposes only if less than 50% of the captive's net premiums come from insurance or reinsurance risks of "related persons" that own 10% or more of the captive.

Shareholders of captives that meet this test will be entitled to deduct premiums. If the captive fails the test though, premiums would be classified as payments for risk management services and only a small portion would be deductible as business expenses, tax experts say.

The administration argues that the

rules are needed because the "lack of clarity" in current law "has encouraged aggressive planning and excessive controversy."

The proposal would effectively overturn a landmark 1989 ruling on premium deductibility involving Humana Inc., noted Robert Dumont, a lawyer with Baker & McKenzie in New York. In the Humana ruling, the 6th U.S. Circuit Court of Appeals established that subsidiaries of a company are allowed to deduct premiums paid to their parent's captive (BI, Aug. 7, 1989).

Possibly fearing a spread of the Humana precedent, the Internal Revenue Service has settled similar disputes rather than challenge taxpayers in court, Mr. Dumont said.

From the IRS's point of view, "Humana would be reason enough to get legislation," he observed.

The proposed rules also raise the level of unrelated business required for parent company deductions to

50% from the 30% threshold established in a 1991 Tax Court ruling involving Harper Group (EI, Feb. 4, 1991). Since the Harper ruling, some captive owners have tried to insure deductibility of their premiums by pushing their captives' unrelated premium volume toward the 30% threshold, experts say.

In many cases, Mr. Dumont explained, this has consisted of "related unrelated" business: risks of the parent company's joint venture partners, suppliers, customers and others whose exposures the parent understands. Many of these captives, though, "are lucky to get to 30%" and would probably have a tough time finding enough controlled third-party business to reach the new 50% threshold, he said.

"I think in the case of single parent captives, a 50% rule would eliminate most deductions," he predicted.

The proposed rules would also eliminate deductions for group cap-

tive participants where those owning more than 10% of the captive's stock collectively produce more than 50% of its net premiums.

For example, the proposal would treat a group captive with nine equal owners with equal premiums as not involving insurance risk, despite "substantial actual risk shifting and risk distribution," a Baker & McKenzie summary warns.

Critics charge the proposed rules are internally inconsistent and would produce illogical results.

For example, the owner of a single parent captive with 60% unrelated business would be entitled to a premium deduction, Mr. Rusu noted. However, a one-third owner of a three-member group captive that draws its business equally from the three owners would not get a deduction despite the fact that two-thirds of the captive's business is unrelated to each individual owner.

The rules represent a kind of re-

treat to the 1970s, when IRS internal documents discussed using a 50% threshold to determine premium deductibility, Mr. Dumont said.

The IRS later adopted the "doctrine" theory—rejected by the Tax Court in a 1991 ruling involving Sears Roebuck & Co.—that no amount of third-party business can render parent company premiums deductible. In the Sears case, 99.75% of the business written by its Allstate Insurance Co. unit was unrelated to the parent. The loss of the Sears case may have encouraged the IRS to seek a bright-line test for its agents to use in deciding when premiums are deductible.

Ironically, the 50% threshold pursued by many captives in the 1970s led to horrific losses on third-party business and the insolvency of many captives. "Everybody learned from the late 1970s and early 1980s what third-party business can do to you," Mr. Blankenship said. "A lot of people lost their whole enchilada back then."

While few expect captives to repeat those mistakes, some see the 50% test as a step backward. "We have evolved to where we started," Mr. Blankenship noted. "That's not much evolution, is it?" **BI**

Malden

Continued from page 1

significant quantities of our Polartec and Polar fleece fabrics," he said. "A number of our facilities were undamaged, and we hope to begin producing fabric shortly."

The company expects to be producing 80% of its Polartec and Polar fleece fabrics within 30 days and be back to full production within 90 days, a spokeswoman for Malden Mills said.

Malden Mills is laying off an undisclosed number of workers after the fire.

It will continue to pay employees for 30 days and it will make health insurance payments for the next 90 days. As it restores its facilities it will reemploy workers, Mr. Feuerstein said.

Major customers of Malden Mills include clothing manufacturers L.L. Bean Inc. in Freeport, Maine, and Patagonia Inc. in Ventura, Calif.

L.L. Bean was assessing sources of future supplies last week, said Steve Hewitt, director of risk management.

Malden Mills supplies fabrics for several L.L. Bean products, he said.

"There are still a lot of questions as to whether they will be able to supply us for next year. . . We are trying to figure out what they will be able to do and whether there are alternative suppliers we can use," he said.

L.L. Bean might have some business interruption coverage that would kick in when a sole supplier ceases production, Mr. Hewitt said.

"Business interruption coverage normally stops at your door, but we have been looking into trying to expand our coverage," he said.

Patagonia has sufficient supplies to produce its clothing lines that use Malden Mills' fabrics to last the company until fall 1996, a spokeswoman said.

"We are in daily contact with Malden Mills and we are reviewing what we will be able to offer for the fall. We will continue to offer our customers quality products for the season," she said.

Patagonia has business interruption coverage but it plans to "make minimal use" of the coverage, the spokeswoman said. **BI**

Paula Marshall-Chapman, CEO
Bama Foods, Ltd.

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Opinions

Louisiana putting RRGs at risk

WE'RE GLAD that the nation's risk retention group industry is challenging a new Louisiana law and application procedures that—if allowed to stand—could cripple a vital part of the alternative risk market.

As we report on page 1, Louisiana legislators, apparently at the suggestion of commercial insurers and others, earlier this year passed legislation that requires risk retention groups licensed in other states to meet hefty capital and surplus requirements, deposit funds in the state and pay certain fees. In addition, the Louisiana Insurance Department—before it will allow a risk retention group to operate—requires the groups to submit to an unusual application procedure, which includes yet more fees and a narrow time frame on when the groups may file their applications.

There is no shade of gray in the issue here. Louisiana's law, as we believe a federal court will find—is clearly pre-empted by the federal Risk Retention Act.

The Louisiana statute and other requirements go to the very heart of what Congress was attempting to stop when it passed the Risk Retention Act in 1981 and later broadened the law in 1986.

Federal legislators wanted to give insurance buyers an alternative to a commercial insurance market and its frequent up and down swings in pricing. If the commercial market wouldn't fairly price coverage, then buyers, Congress said, should have an alternative to the market. That alternative, Congress decided, was risk retention groups.

Without broad pre-emption of state insurance laws, risk retention groups simply would not be able to get off the ground.

Consider, for example, just one element of Louisiana's requirements for risk retention groups. The state requires risk retention groups to file applications between March 1 and Sept. 30. What if another state set a different filing period? Or what if a third state only allowed risk retention groups to file an application on one day of the year?

Obviously, such requirements would make it impossible for a risk retention group to operate nationwide.

In a nutshell, federal legislators agreed that after meeting the licensing requirements of one state, risk retention groups could operate nationwide without meeting the individual and sometimes impossible to meet requirements of other states.

Certainly, we understand why some state regulators resent the Risk Retention Act: Some of their authority was pre-empted.

But regulators shouldn't forget that the federal law has left them with plenty of power over the groups.



Regulators are entitled to receive copies of risk retention groups' financial reports and they have the authority to go to court to shut down groups in hazardous financial condition.

Yes, risk retention groups have failed, as have many commercial insurance companies. No regulatory system is perfect.

But, in the aggregate, we believe risk retention groups have been a great success. They have, in some cases, forced commercial insurers to price their programs more competitively and given buyers new alternatives. The very existence of those alternatives has effectively kept pricing swings in check.

Louisiana's law and other requirements—if left unchallenged and allowed to spread—pose a direct threat to that success. We would see, no doubt, the enactment of a maze of laws and other requirements that would make it impossible for risk retention groups to do business.

Fortunately, the National Risk Retention Assn., the trade group that represents the risk retention group industry, and several individual RRGs are challenging Louisiana's law and requirements.

Those groups deserve the support of corporate buyers. One day, the commercial market may again tighten and insurers may again "panic price" coverages, as they did for liability insurance in the mid-1980s.

If Louisiana's example is allowed to stand and spreads, buyers may find themselves without alternative risk financing programs when they need them the most.

Letters

USAir program may fall short of convergence

To the editor: In an article in *Business Insurance's* Nov. 27 issue, "USAir Uses Credit for Cash," a security restructuring arrangement for a large-deductible program is touted as "the epitome of convergence" between insurance and financial transactions.

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If, however, the transaction is factually correct as it was outlined in the article, it hardly appears to be more than a misbegotten attempt at risk financing rather than an example of actual convergence.

First of all, the transaction—as described—has no material balance sheet effect on USAir.

The movement of "restricted cash" to "unrestricted cash" will have no effect on the shareholders' equity in the company.

Nor, by the way, will there be any positive effect on income statement position.

Secondly, USAir will continue to have an outstanding GAAP liability of \$115 million, presumably for which it has yet to take a deduction against income.

Thirdly, if the \$70 million in newly available cash is invested in company operations, it very well may be subject to a negative return noting that USAir Group Inc. has operated at a loss for the past five years—including a \$5.73 per share loss in the most recent 12-month period, according to Standard & Poor's Corp.

While a program might have been devised that would result in deep balance sheet restructuring, favorable tax treatment and positive investment income on a prospective basis, the transaction described in your pages would seem to fall severely short on these critical objectives.

Robert M. Hunt
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Petaluma, Calif.

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Comp

Continued from page 3
 Helmcamp noted.

In drafting the schedule, the state's workers compensation commission followed "all the procedures as required by the Administrative Procedures Act," he contended.

In its re-hearing request, the workers compensation commission will cite what it says are incorrect factors that the appellate court considered in its judgment and other factors that the commission argues were not adequately considered.

The rule, which remained in effect last week because the appellate court judge had not signed an order that would invalidate it, will remain effective upon the commission's motion for re-hearing or appeal, according to a spokesman for the attorney general's office.

In a 1992 suit, the Texas Hospital Assn. and three other health care-related plaintiffs charged that the rule violated state administrative law because in some

are hoping to eventually recoup some of the money they believe was lost.

Mr. Bailey said the alleged underpayments are related to tens of thousands of claims dating back to 1992 when the rule became effective.

There are no estimates on how much the hospitals feel they were underpaid.

The fee schedule, Mr. Bailey said, is unfair because it considers costs at all hospitals to be the same.

"Our concern is the application of a per diem for all hospitals. The cost of operating is different for different hospitals," he said.

Mr. Helmcamp said if the rule is eventually held to be invalid, hospitals could on a case-by-case basis argue before the workers compensation commission for additional payments "if they could show that the reimbursement did not cover actual costs." Decisions on additional payments would be made by the TWCC.

Considering the number of cases that hospitals have handled since the rule took effect in 1992, such a process would be "complicated

Texas hospitals 'perhaps didn't agree with the ultimate decision but they did have input' in the process, says Dewey E. Helmcamp III, assistant attorney general.

cases the TWCC did not justify payment levels that were set below the actual cost of services.

But the TWCC claims that hospitals were part of the rule-making process and had the opportunity to hear and provide input on any concerns regarding the fee schedule.

Mr. Helmcamp pointed out that there were two hospital representatives on an advisory committee that provided advice to the TWCC in the rule-making process.

"They perhaps didn't agree with the ultimate decision but they did have input, and through them, so did the Texas Hospital Assn. and other hospitals," he said.

Earlier this year, a trial court judge denied the plaintiffs' request for declaratory and injunctive relief.

While it isn't clear whether hospitals could collect additional payments or how those payments would be determined, plaintiffs

and time-consuming," said Mr. Helmcamp.

Liberty Mutual Insurance Co. of Boston, the state's third-biggest workers comp insurer behind CNA Insurance Cos. and the state workers comp fund, wrote about \$120 million in workers comp premiums in Texas last year and may raise rates if a large amount of reimbursements are granted, said a Liberty Mutual spokeswoman.

"Liberty Mutual has been able to reduce workers comp premiums" in Texas as a result of the reform legislation, she said.

"If the decision is upheld and there is a reimbursement, that would affect our ability to keep premiums low," the spokeswoman said.

The Liberty Mutual spokeswoman added that "fee schedules, when fairly drawn, are proven to be effective in providing high-quality medical care while controlling costs." **BI**

Tax

Continued from page 3
 clause.

However, the federal government argues in the current case that subsequent Supreme Court decisions rendered *Thames & Mersey* moot.

According to the solicitor general, the export clause of the Constitution does not outlaw general taxes provided that they do not discriminate against exported goods or services related to exports.

It is the broader application of the export clause that concerns the government, according to both parties in the dispute.

"In terms of the excise tax itself, it's not clear that that is a very important issue. In a number of situations, the government has waived the excise tax under bilateral treaties, which is an indication that it is becoming a bit of an anachronism," said James R. Atwood, a partner in the Washing-

ton law firm Covington & Burling, who is representing IBM.

He said that the tax was designed to address a tax imbalance, but now that imbalance has in most cases been corrected because foreign underwriters are subject to income tax in their own domiciles.

"The government's main concern is not this case but the harbor maintenance fee litigation," said Mr. Atwood, referring to another levy that could be in jeopardy if *United States vs. IBM* is upheld.

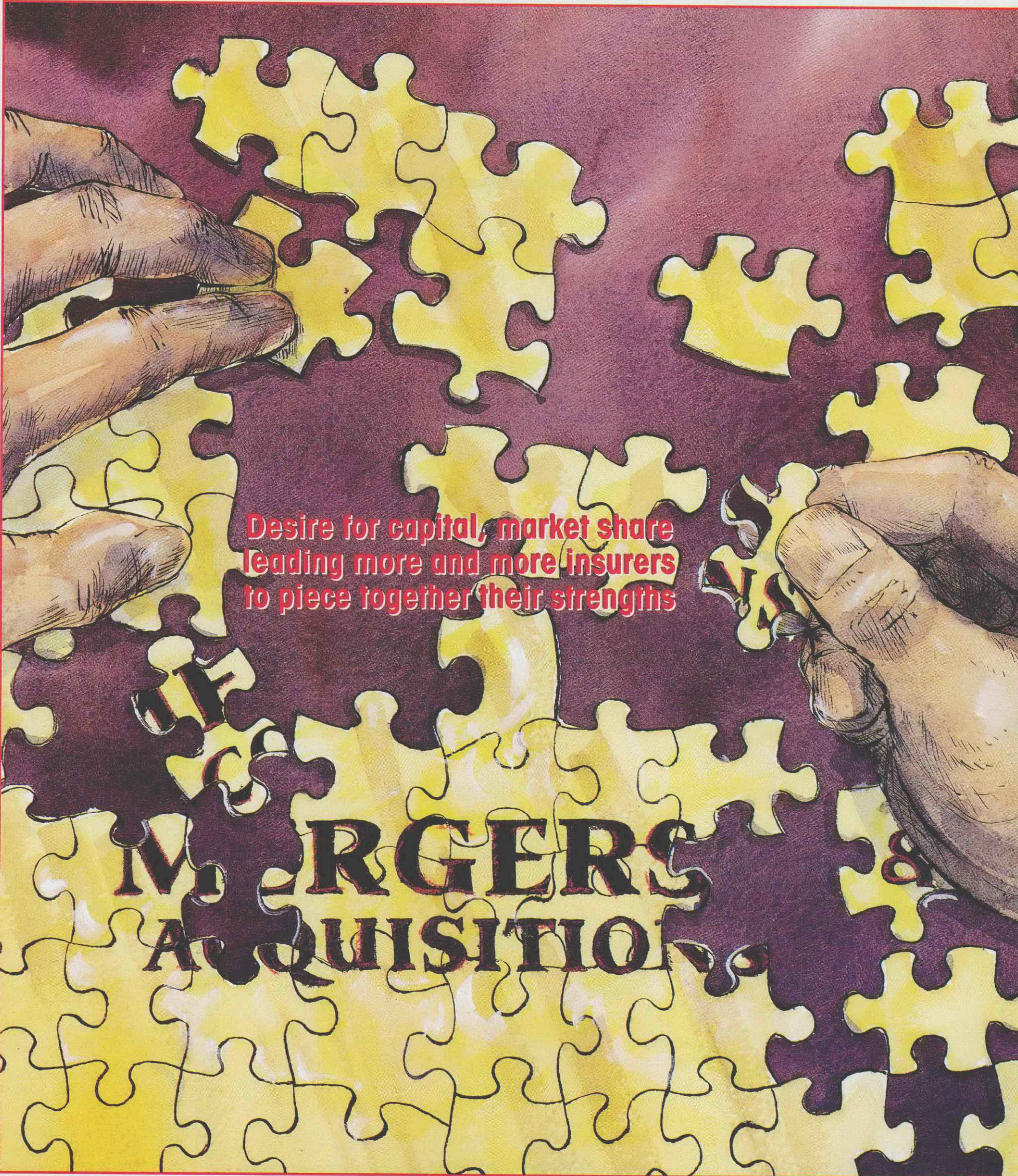
The government's response to IBM's argument against the Supreme Court granting review notes as much.

The response cites an Oct. 25 decision by the U.S. Court of International Trade, which held that the federal "tax on any port use" is unconstitutional when applied to goods for exports.

That earlier decision involves more than \$500 million in tax revenues that have already been collected. **BI**

Insurer Topics

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An illustration featuring a dark purple background with numerous yellow puzzle pieces. Two hands are shown: one on the left placing a piece into a gap, and another on the right holding a piece. The puzzle pieces are interlocking, symbolizing the process of merging or acquisition.

Desire for capital, market share
leading more and more insurers
to piece together their strengths

MERGERS & ACQUISITION

No slowdown in industry dealmaking

Merger and acquisition activity expected to continue for most segments of industry

By JUDY GREENWALD

Competitive pressures, the need to achieve economies of scale and a thirst for more capital will continue to fuel the insurance industry's unrelenting drive toward mergers and acquisitions.

Eventually, though, smaller companies in the industry may

be the primary players.

Mergers and acquisitions have been common among large companies because generally they have not been well managed, "particularly from an expense standpoint," explained Doug Moat, chairman of the Manhattan Group, a New York-based consulting firm.

"Sooner or later, this has to slow down on the larger company side. I think there aren't go-

ing to be that many large companies left," said Paul O'Connell, principal with Coopers & Lybrand L.L.P. in New York.

"If there is going to be future consolidation and merger activity, it will be more likely on the medium to small company level," he said.

Herb Goodfriend, managing director-capital strategies, specializing in insurance, for KPMG Peat Marwick in New York, disagrees

that activity will be focused on smaller firm.

"I think you'll see continued major activity across the front, irrespective of size," he said. "Clearly, when you start to run out of big companies, the focus in the media, but not necessarily in the marketplace, will shift toward lesser size."

"But it's only begun, and clearly it's not confined to stock companies—it includes the mu-

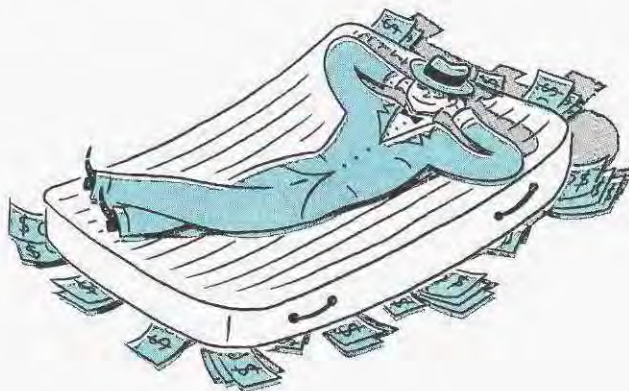
tuals. Nor is it life only or only P/C. It's across the board, functionally and by corporate structure, and if anything, it's going to accelerate," said Mr. Goodfriend.

Among the recent headline-making deals in commercial insurance are: Travelers Corp.'s \$4 billion proposed deal to acquire Aetna Life & Casualty Co.'s property/casualty operations (*BI*, Dec. 4); the Zurich Insurance Group's acquisition of much of the business of The Home Insurance Co.; and the CNA Financial Corp.'s acquisition of Continental Corp. (*BI*, Dec. 12, 1994).

"In an industry that is facing competitive pressures, there is a need to consolidate, to shore up your strength in all areas. That's sort of dealing with the M&A in the large," said Fred Dopfel, president of San Francisco-based Russell Miller Inc., an investment banking firm specializing in the insurance industry.

"Then I think there's the M&A in the small," he said. "We're working with a number of small to medium-sized companies that are really in need of capital to grow and seeking greater

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Mergers & Acquisitions



strength and thereby hoping to team up with other partners."

The trend is expected to continue. "I think the pressures are there," said Mr. Dopfel. "A lot of companies are feeling pressure from the rating agencies and thereby seeking to expand into new lines of business and new geographic areas."

Media attention on recent deals may also be a contributing factor.

"I can't help but believe that mergers and acquisitions will become the thing to do. It will become a fad with the investment bankers encouraging it," said Barbara Stewart, president of Atlanta-based consulting firm Stewart Economics.

"And you can see why it would be an appealing thing, because companies are increasingly realizing that they can't grow. The business is still glutted with capacity, and it will continue to be because none of these deals are taking capacity out. In fact, they're increasing capacity," she said, pointing to CIGNA Corp.'s efforts to fence off 80% of its environmental and asbestos liabilities in a new runoff subsidiary (*BI*, Dec. 4).

"CIGNA, I think, is eventually going to be acquired," she added. "But I think the activity is not going to be just with the larger companies," said Ms. Stewart. "It will probably go all the way

See **Mergers** on page 12D

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Mergers

Continued from page 12B

throughout the spectrum, particularly with those companies that are more weighted on the commercial side, because the commercial insurance market continues to shrink, and the only way companies can grow and survive is to merge."

She draws an analogy to the airlines. "Over the last 20 years, there's been a tremendous amount of consolidation, say, in terms of the number of airlines that are out there, yet competition is as fierce as ever."

"There's no reason to believe any of this activity is going to change market conditions. It's going to give the appearance of accomplishment, and it's one way to get investors' eyes off the ball as to what's really going on."

But, she said, "The fundamentals of the business are just as bad."

Soft pricing has also been a factor in recent deals.

"The larger, well-positioned companies are looking for opportunities to acquire businesses that will allow them to take on increased efficiencies," said Coopers & Lybrand's Mr. O'Connell. With some of these deals, "people are acquiring large blocks of business with probably only a minimal additional expense cost."

With the CNA-Continental deal, for instance, CNA was able to acquire billions of dollars of business "and do that with only a minimal marginal expense increase," according to Mr. O'Connell.

"The prolonged soft market cycle has induced M&A activity to allow companies to deliver product at a lower cost. It's driven by the scenario of achieving economies of scale," said John L. Ward, chief executive officer of Cincinnati-based consultant Ward Financial Group.

"I think with the soft pricing and the flat growth, this has accelerated the pace of companies looking to increase market share, and that's been a market condition that's induced more M&A activity," he said.

Sean Mooney, senior vp and economist at the Insurance Information Institute in New York, also said competition is driving commercial property/casualty insurers' merger and acquisition activity.

"The factors that appear to be working seem to be an excessive amount of competition in that area," Mr. Mooney said.

In an industry where the biggest player, CNA, has only a 7% market share, there is very little price discipline, he said.

However, unlike some observers, Mr. Mooney said he does not believe economies of scale are a major factor, at least in the property/casualty area. "What doesn't seem to be the case in

property/casualty insurance is that the M&A activity is related to returns to scale.

"In other words, in the banking business, when you get two banks merging together, the costs of the whole are lower, much lower, than the cost of the individual parts because you have a lot of duplication in the banking business."

"You can consolidate a lot of the back-room computer work, you can consolidate issues of marketing. When you sell a loan to a business, instead of representative of each separate bank going after the customer, you just need one," he said.

'The larger, well-positioned companies are looking for opportunities to acquire businesses that will allow them to take on increased efficiencies,' says Paul O'Connell.

"There's very little evidence that there's return to scale in our business, property/casualty, and that's the nature of the business." However, he added, on the life side, there are "much more opportunities to look for returns to scale."

Also driving M&A activity is

the financial weakness of some companies, caused by factors such as environmental liabilities.

"Larger companies had been seeing some of their environmental and asbestos liabilities coming home to roost," said Mr. O'Connell. Both Continental and The Home, for instance,

"needed to find someone to help them out," he said.

Some recent deals, according to Mr. Ward, "have been catastrophe-driven, others have been prolonged soft market-driven, but we're seeing a lot of big, major companies being acquired because of troubled situations."

The CNA-Continental merger would also fall into this category, he said, in addition to the Zurich-Home deal as well as American International Group Inc.'s purchase of a stake in Woodland Hills, Calif.-based 20th Century Industries (*BI*, Oct. 3, 1994).

Continued on next page



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Mergers

Continued from previous page

At least to some extent, the weaker companies in transactions often "didn't move with the times and ended up probably with expense levels higher than they should be," said Mr. Mooney.

"Certainly many of the properties that are up for sale or appear to be targets... have been poor performers and have some kind of question mark about the quality of the company, and you see buyers emerging that believe they can get improved results as a function of controlling expenses," agreed Carol Manning,

vp with Prudential Securities Inc. in New York.

"But," she added, "you also have Berkshire Hathaway acquiring the balance of the GEICO shares it didn't own at a premium to the market price of what the company had been trading at and a very strong valuation, which reflects the strategic value of GEICO and its exceptionally good record."

Mr. Ward also pointed to the interest of New York-based leveraged buyout firm Kohlberg Kravis Roberts & Co. in Aetna's property/casualty business, an interest that ultimately went unfulfilled, as a contributing factor in the merger and acquisition trend.

"When players like KKR enter the scene with extremely large amounts of capital at a time when the industry is having some problems, that accelerates the rate of M&A activity," said Mr. Ward.

The consolidation momentum is also expected to continue on the life side of the insurance industry.

"I think we have seen an accelerating kind of momentum of more and more companies talking about, and ultimately more activity in mergers, demutualizations, joint ventures, strategic alliances," said Rick Berry, managing principal for the Tillinghast division of Towers Perrin in New York.

Various forces lie behind that

trend.

"Basically, companies are concluding they're not big enough, they don't have the right resources to see sort of a long-term future, so they're looking for partners where they can achieve some sort of complementary set of resources, whether capital, investment, management, some functional skill, so as a bigger entity they can prosper," said Mr. Berry.

"Why are people doing that?" he asked. "I think it's because just in general the financial services business is getting a lot tougher. You've got stricter capital requirements imposed by regulators and rating agencies," said Mr. Berry.

Rating agencies, which once focused solely on financial solvency, also now cast a critical eye on a company's overall prospects for growth and profitability, he said. And it is getting tougher and tougher to make money selling ordinary life policies, he said.

In the industry overall, merger and consolidation activity is expected to continue.

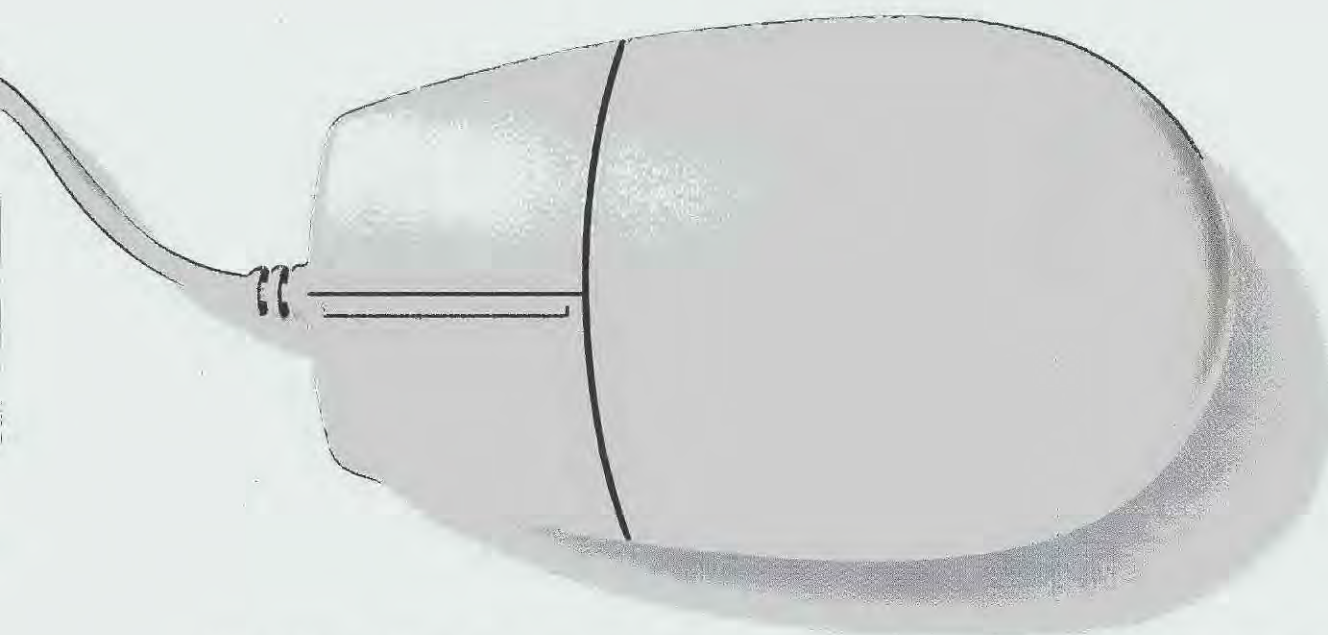
"I think the industry is probably one to two years behind the banking industry, and I think we're going to see massive consolidation, which will include mutuals," said Gloria Vogel, managing director and senior insurance analyst at Ladenburg, Thalmann & Co. Inc. in New York.

What is less clear is which segments will have the most activity.

Companies that merge or acquire because they are troubled seemed

See Mergers on next page

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Insurer Topics

Mergers

Continued from previous page
to be primarily on the P/C side, said Mr. Ward.

Though consolidation is going on throughout financial services, Ms. Vogel said she expects the most dramatic to be on the life insurance side.

David Seifer, an analyst with Donaldson, Lufkin & Jenrette Inc. in New York, cited a few reasons why life insurers would continue to merge and buy each other.

Mr. Seifer.

Harry Fong, director at C.J. Lawrence/Deutsche Securities Corp. in New York, pointed to both the property/casualty and life segments. "I think that life insurance is a fine area for M&A. I also think the P/C industry could be every bit as exciting," Mr. Fong said.

There could be more merger and acquisition activity in the managed care business as well, say observers.

Aetna, for example, has said it is interested in investing at least some of the proceeds from the

'I think that life insurance is a fine area for M&A. I also think the P/C industry could be every bit as exciting,' says Harry Fong of C.J. Lawrence/Deutsche Securities Corp.

More compatible software makes it possible for life insurers to achieve significant expense reductions, and life insurers do not carry some of the liability concerns that property/casualty companies can.

"I guess going back to the '80s life insurance companies had more asset problems, but a lot of those have been addressed," said

impending \$4 billion sale of its property/casualty operations in this area.

Companies such as Aetna as well as CIGNA are "looking at the prospect of investing incremental capital to strengthen their position in managed health care," said Weston Hicks, an analyst with Sanford Bernstein & Co. in New York. **BI**

Evading—or embracing—mergermania

Companies can take steps to deter or encourage acquisition

By JUDY GREENWALD

For companies hoping to avoid an unwelcome acquisition attempt, the best deterrent is financial strength, experts say.

On the other hand, those insurers that are seeking a merger partner are advised to first find an investment banker or knowledgeable consultant to guide them along the proper path.

With increasing M&A activity expected throughout the industry, many insurers ultimately may have to consider whether they want to acquire, be acquired, or merely be left alone.

"The best deterrent to being acquired, if a company doesn't want to be, is good performance," said John L. Ward, chief executive officer of the Cincinnati-based consulting firm Ward Financial Group.

"What attracts hostile suitors and sometimes friendly suitors are underperforming companies, so the best deterrent other than poison pills and things like that is to perform well, perform efficiently, and raise the value of the stock, and price alone would keep would-be

suitors away. There are situations where acquirers have identified a real desirable target with a lot of franchise value and are willing to pay a big multiple, but more often than not, companies get taken over because of not realizing their full potential or experiencing financial trouble, and that is what attracts a suitor," Mr. Ward said.

Doug Moat, chairman of the New York-based consulting firm Manhattan Group, agreed that a strong operation is the best deterrent to an unwelcome takeover.

"You just run your operation so well that you make it difficult for someone to really afford to pay you what your firm is really worth," he recommended. "If a company is really well run, if it's tightly managed and profitable, most companies can't afford to come in and buy it."

Fred Dopfel, president of San Francisco-based Russell Miller Inc., an investment banking firm specializing in the insurance industry, said, "if you don't want to be acquired, you develop a very rapid corporate development plan of your own that may be growth by acquisition or internal growth, so that you become a fish that is a lit-

tle bit too big to bite. . . . If one fish can take you in a small bite, you're more vulnerable."

"On the opposite side of the coin, if you don't have a good strategy in place for your corporate development, you may be vulnerable to someone seeing a bargain and finding an opportunity to pay a fair price," said Mr. Dopfel.

However, he qualified his remarks by adding: "It seems that these days there may be no limit when you consider some of the enormous deals that have been done such as the Continental and the Aetna-Travelers deals."

Paul O'Connell, principal with Coopers & Lybrand L.L.P. in New York, said he does not believe unfriendly acquisitions are a big issue in the industry—at this point, anyway. None of the recent acquisitions has been hostile, and, given that there are so many firms willing to be acquired, it is unlikely a company would become a reluctant takeover target. "I don't know if there's a problem or worry at this point in time," he said.

In fact, "the insurance business has not been known for hostile

Continued on next page

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PUBLISHING DATES AD CLOSING DATES

January 29 January 17

March 25 March 13

May 27 May 15

September 2 August 21

October 7 September 25

November 11 October 30

Continued from previous page deals," said Barbara Stewart, president of Stewart Economics in Atlanta. One reason might be "you really want to understand the company you're taking over."

This requires investigating factors like reserves, particularly in the property/casualty area. And that is difficult to do with an uncooperative takeover target, she said.

But, "If you're an attractive company, I don't think there's a whole lot you can do," said Ms. Stewart.

As for companies that may want to be acquired, "It would be in their best interests to get into a situation where there's some competitive bidding," said Mr. Ward.

"The typical approach would be to use an investment banking firm to assist in finding potential buyers and communicating the strong points of the organization to the marketplace," he said.

Mr. Dopfel also suggested turning to investment banks for help. "I think if you want to be acquired, you must develop a plan of who you think would be the ideal partner and why, and then I would seek the advice of people who work in that profession, i.e. investment bankers.

"Otherwise, you face the risk of putting yourself in play and losing control of the process. That's the real risk, you know. It's nice to talk (but) if you're talking, you may attract candidates that you really don't want to deal with and the process may take on a life of its own," Mr. Dopfel said.

However, be sure to talk to experts knowledgeable about insurance rather than generalists, recommended Mr. Moat. "I am absolutely convinced from our experience that if a seller takes the time to plan it and do it right with knowledgeable people, he can actually get more money...and, frankly, substantially more money."

"A knowledgeable business broker or consultant will know far more people than the company would ever know as to who might be interested in their business," said Mr. Moat. Also, companies need to be aware of a wealth of tax and structural issues.

"If you want to be acquired, I think you do the kind of thing that CIGNA is doing, try to fob off the old, unprofitable book and you develop an interesting story about yourself, be it a particular focus, a particular expertise or a particular market niche," said Ms. Stewart.

CIGNA is now seeking to fence off 80% of its environmental and asbestos liabilities in a new runoff subsidiary (BI, Dec. 4)

"I don't think the companies that want to be acquired are having too many problems," said Mr. O'Connell. "I believe there's certainly an active market. A lot of the investment bankers are very actively shopping around. If (the insurers) have very realistic expectations about price, then I think a company that wants to be acquired will find a ready buyer." ■

Computer systems must be considered in merger

By ROBERTO CENICEROS

Integrating two insurance companies' information systems following a merger or acquisition can be similar to overhauling the engine of a car traveling at 60 miles per hour.

"You can't stop the car and pull it over to the side of the road," said Kenneth M. Corey, director of insurance for Coopers & Lybrand L.L.P. in Hartford, Conn.

"Keeping the two entities going full-blown while you are integrating the two technologies, it's

very expensive and it's a one-time cost that is initially overlooked," according to Mr. Corey.

The potential for overlooking all the costs of melding information systems is a fundamental lesson learned by those who have led insurance company mergers and acquisitions.

All one-time costs in a merger—such as severance, startup and technology integration expenses—can be much higher than first anticipated, Mr. Corey said.

Another fundamental: a multi-disciplinary approach is critical. See **Systems** on next page



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Systems

Continued from previous page

in the M&A process because no single part of the operation is unaffected by changes in the other. That means decisions about melding the two technologies cannot be made in a vacuum. They must be driven by the overall vision for the emerging enterprise, he said.

Insurers are focusing more on information systems as the industry increasingly looks for data to better serve the customer and to drive future profitability.

Accessing the vast amounts of information insurers have available depends on technology, and the M&A process presents great opportunities to cull "synergies" from two information system departments.

But the intense attention required during integration, coupled with the continuing need to manage day-to-day business, can limit managers' ability to think beyond what both insurance companies have at the time of a merger.

Those who have been through

Mergers & Acquisitions



mergers and acquisitions say that getting the most out of the process and not missing those opportunities requires planning and a discussion of strategy beforehand.

"We counsel our clients to look at these kinds of attributes way up in the front of the concept when the marriage or the romance is beginning to blossom," Mr. Corey said. "We have them move the merger integration issues way up stream in their discussions and their thinking. They tend to follow after due diligence has begun or some kind of letter of intent has been initiated. It's too late (by then). You're too emotionally committed to the transaction at that point."

The 1994 acquisition of Continental Corp. by CNA Financial Corp. has been described in computer publications as a how-to model for getting the most out of two combined information systems.

Yet, even in that deal, more information might have been squeezed out of the initial process.

Although CNA was able to evaluate Continental's technology before the merger, it was legally taboo to share business information, said Joe Roecker, systems information officer for CNA's professional liability group in New York.

So CNA was limited in the amount of pre-merger planning it was able to do. But, greater rewards from post-merger synergies might have been culled had a team been prepared ahead of time

to focus on those prospects.

"Now we are talking, 'Let's use technology as a strategic business advantage,'" Mr. Roecker said. "Pre-merger, we couldn't do that. But we probably could have been positioned so that as soon as the deal was signed we put a group looking at that, saying, 'OK, we saw how these things will be blended together,' now you go in as a special hand-picked task force and say, 'OK, can we take this further.'"

Once the merger was taking place, "we all got so hung up in our own business units' needs" that a team wasn't in place to try to leverage the two companies' system resources.

The integration of CNA and Continental's information systems is particularly respected because of CNA's success in pulling the best and the brightest talent and technology from both organizations.

Although picking the best of two is an often-espoused theory on integration, it is usually difficult to do, analysts say. Managers can fall short by other distractions, such as a desire to select the employees with whom they are most familiar.

Cost savings goals are another potential pitfall. Observers say it is very easy to slash in the wrong place.

"Make sure you have the most cost-efficient system going," said Michael Lewis, senior insurance industry analyst for Dean Witter Reynolds in New York. "Don't duplicate things, people, processes. But don't cut to the bone. You have got to get rid of what is not necessary and meld the best together, but make sure you have a working system."

When CNA acquired Continental, a concerted effort to pull the best from both companies was the overriding concern, observers say. CNA's business units picked a mix of managers and employees from CNA and Continental to run key functions, including information systems.

Teams from both companies spent long hours evaluating the systems and technology. Much of that work was accomplished in hotel meeting rooms, where suspicion and skepticism were present at first, as the teams worked to determine which company's information systems would survive.

However, long days and meals spent together eventually helped smooth relations. Most of CNA's systems survived as business units decided to adopt the larger insurer's business process. But some of Continental's newer client/server systems also made the cut.

Observers say the process was successful because the overriding business unit decisions were linked to the key strategic and tactical issues that drove the acquisition and to CNA's post-acquisition goals.

That should always be a basic tenet, experts say.

"When we are sorting through the 'Do we keep your system or do we keep my system?' we will come

right back to what is it we are trying to achieve consistent with our strategic objectives of the merger and which will enable us to go forward most expeditiously," Coopers & Lybrand's Mr. Corey said.

"Don't start with what you have. Start with the end in mind," said Joseph M. Zubretsky, business assurance partner for Coopers &

Lybrand in Hartford. "Define the model you need to execute the strategy."

That approach could lead to scrapping both companies' systems, rather than choosing one over the other, he said.

Another objective to remember is that the transaction has to be seamless from the customer's

viewpoint, he explained. The mere mention of a merger or acquisition can send policyholders looking for coverage elsewhere.

"You cannot give the customer any excuse to leave. And as you know, in this business, customer service is highly dependent on the efficiency and capability of the technology." **BI**

Insurers must face global changes

By REGIS COCCIA

Changes in the global economy and in customer expectations are causing a revolution in insurance, say risk management and insurance executives.

"Customers are leading us, driving us to change," said Richard A. Riley, president of Aon Corp. unit Rollins Hudig Hall Co. in Chicago. "We'll either be dragged there kicking and screaming or as willing partners. The winners are going to be those who are willing partners."

Facing competition from banks and other players on one hand, and insurance buyers' increasing sophistication on the other, the insurance industry must evolve a new way of meeting customer needs, said the executives, who participated in a panel discussion on distribution systems at the Fifth Annual Insurance Executive Forum in Chicago last month. The meeting was sponsored by the Katie School of Insurance at Illinois State University in Normal.

One way insurers, reinsurers and brokers can do that is to form "strategic partnerships" with their clients and each other, they said.

"The relationship between the client and insurer or broker is a partnership. It has to create value for the customer or don't do it," Mr. Riley said.

"Any strategic partnership has to create new value. It's not one plus one equals two; it's one plus one equals three in a new way to serve the customer," he said.

That idea was echoed by Siri S. Gadbois, vp-risk management at Educational & Institutional Insurance Administrators Inc., a Chicago-based property/casualty program administrator for a consortium of 110 colleges and universities in 39 states.

"I need a resource that isn't going to just point to a part of a policy and say, 'You're covered.' I need a resource that is going to help me work through those difficulties" that colleges face and must respond to every day, she said.

Ms. Gadbois, who worked at Arthur J. Gallagher & Co. before joining the consortium in 1991, said she expects brokers to make her a partner in building risk management programs.

Constantine Iordanou, president and chief operating officer of Zurich-American Insurance Group in Schaumburg, Ill., said he has seen two major trends in the last 25 years: the elimination of structural inefficiencies and a broadened defi-

nition of "risk."

Insurers and brokers have been led to streamline their operations by the customer's desire "to find a better way to deliver products and services," he said.

Citing Lloyd's of London as an example, he said more attention to efficiency likely would have spared Lloyd's its recent financial troubles.

"In the business press, you never hear about structural inefficiencies associated with this wonderful institution," he said. "Lloyd's has traditionally had an economic oligopoly."

But, after a string of billion-dollar losses, Lloyd's has been forced to become more efficient.

"In my view, this is a very strong example of what the customer wants and how that affects our business," he said.

And, changes in the business world have expanded policyholders' definition of risk. Protecting against natural perils is only one facet of insurance today, Mr. Iordanou said. "Most large corporate clients have needs going far beyond fortuitous risk; they have economic risks, business risks."

Insurers and brokers must respond to this and change the way they service clients' needs.

"In the higher end of our business, with this expansion of risk, we need to form strategic partnerships," he said.

RHH's Mr. Riley offered some advice: "Get lean, get mean, add value or get the hell out."

Emphasis on streamlined, efficient operations will mean some big changes in the way insurance is sold, the executives agreed.

Direct sales to customers, of the sort that Washington-based GEICO Corp., for instance, has used successfully in personal auto coverage, will be the winning distribution channel in personal lines, Mr. Iordanou said.

"Efficiency, efficiency, efficiency is going to win the day," he said.

"There has been a lot of experimentation in the distribution system," Ms. Gadbois said. She sees a major role for the Internet, predicting that the global computer network will take over as a means of selling personal lines coverages.

"Brokers who recognize that insurance remains a people business and have access to technology and sophisticated insurance products will gain market share," she said. "Insurers that realize brokers are important will, too."

Large commercial risks, however, are too complex for that kind of distribution and will continue to require more traditional placements,

she said.

Improved efficiency is not the only reason companies change the way they sell coverage, though.

Zurich Reinsurance Centre Inc., for example, redesigned itself to keep pace with customer demands, said Richard E. Smith, president and chief operating officer of the New York reinsurer.

"We avoid adversarial relationships. We told our brokers that we must provide our clients access to risk-bearing decision-makers," he said. "We set service standards, something our clients valued. And we frequently share our underwriting analysis with clients."

From a reinsurance perspective, he said three areas of innovation will be the future of the distribution system:

- Broker-driven innovation.

"Brokers and markets are more frequently working together, for example, asking ZRC to go prospecting with them," Mr. Smith said. That is very different than what was done in the industry 10 years ago.

- Capital market-driven innovation.

Buyers are looking more closely at what capital is available, including reinsurance, Mr. Smith said. "It looks like right now there are immense possibilities" for investment vehicles like catastrophe futures as a source of reinsurance capacity, he said.

- Client-driven innovation.

Strategic partnerships built to satisfy customer needs will necessitate changes both in service and compensation structure in the insurance industry, according to Mr. Smith. "Ultimately, the customer will determine what it is willing to pay for. There will be serious discussions about what the customer wants." **BI**

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NAIC

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available, or to justify their decision to pay for another venue.

NAIC regulators also plan to continue using conference calls as a less expensive alternative to in-person meetings of subgroups.

As a planned expansion of its open meetings policy, the NAIC approved new procedures for interested people to participate in conference calls, effective Jan. 1.

Scheduled conference call meetings will be listed on the NAIC's World Wide Web site at "www.naic.org." Interested people can arrange to participate by contacting Executive Teleconferencing Services at 1-800-279-3874.

In related action, the NAIC also approved bylaw changes that require an annual public budget hearing and add a treasurer's duties to the secretary's post (BI, Sept. 4).

The next official opportunity for NAIC regulators to take formal action will be at the quarterly meeting in Detroit, March 23-27. However, commissioners may hold a voting session when they meet at their annual conference in January to prioritize working group agendas.

Other meeting business included discussion of the following issues.

Risk retention groups

The NAIC leadership will consider shifting responsibility for the ongoing study of how best to regulate risk retention groups organized as captives.

The topic emerged in June after regulation of such entities was temporarily removed from accreditation requirements (BI, June 12).

That smoothed the way for the Vermont Insurance Department to become accredited in September (BI, Sept. 18).

The topic then was assigned to a working group chaired by Utah Insurance Commissioner Robert Wilcox, who asked captive supporters to provide a detailed review of general accreditation requirements and demonstrate why they should not apply.

Captive supporters, who want the NAIC to adopt Vermont's regulatory approach, generally declined to participate in that broad review.

Greater weight should be given to "performance-based criteria," like Vermont's regulatory record. Of the 12 risk retention group insolvencies so far, 11 have occurred in states outside Vermont and only one in Vermont, though Vermont is the domicile for more than 40% of U.S. risk retention groups, executives of the Vermont Captive Insurance Assn. and the National Risk Retention Assn. said in a letter to regulators.

Their differences resulted in "an impasse," Mr. Wilcox said at the meeting.

To resolve it, both sides recommended changing the forum for discussion to the NAIC's Results-Oriented Working Group of its Subcommittee on Financial Regulation Standards and Accreditation. That working group's efforts to streamline accreditation standards may resolve some of the existing disparities as part of its work.

Workers comp option

A company that employs workers who regularly split their time between risky and less risky duties may be able to save money on its workers compensation premi-

ums as early as next April 1.

New "interchange of labor" rules in a redrafted basic manual may benefit a limited number of mostly small employers with multitasked workforces, said Joseph R. Volman, vp at the Boca Raton, Fla.-based National Council on Compensation Insurance, following a presentation before a subgroup of the NAIC's Workers Compensation Task Force.

Under the old manual, an employee who split his time between being a machinist and a company driver, for example, was only assigned to the driver class because it was usually more highly rated for losses and therefore cost more to insure.

Under the new manual, the cost of insuring such an employee can be split between the two classes that represent his different duties, if proper records are kept.

"The employer would now get the savings that result," Mr. Volman said.

However, the new flexibility is limited to employers that already report their workers compensation premium using multiple classifications. In addition, employees engaged in clerical and sales duties are excluded, Mr. Volman said.

"It is hard to determine the dollar amount of the impact (of the change), because the NCCI doesn't know the extent to which employers will seek to exercise their new option," he said.

Also, some employers may discover that the cost and effort involved in recordkeeping could outweigh any potential premium savings.

The basic premium manual has already been approved in 28 jurisdictions, according to Mr. Volman.

Interstate compacts

The concept of using interstate insurance compacts is alive and well for coordinating multistate insurer liquidations and is being considered to ease anti-fraud data sharing activities.

However, state insurance regulators at the NAIC rejected the concept for improving guaranty fund operations and regulating various types of operating insurers.

The most successful version of an insurer compact to date is designed to enhance the efficiency of multistate insurer receiverships (BI, Sept. 25; June 5).

It was drafted and approved by the NAIC's Midwest Zone, though not the organization as a whole.

Four states—California, Illinois, Nebraska and New Hampshire—have enacted legislation to participate in that compact.

Other states, like Wisconsin and Michigan, are likely to consider similar legislation next year, regulators say.

In addition, Iowa wants to sit in on implementation talks planned for early next year, said Peter G. Gallanis, special deputy receiver with the Illinois Insurance Department.

At the recent NAIC meeting, members of a Special Committee on Interstate Compact that studied the issue during the past year decided to distribute an NAIC legal opinion and copies of additional research information about the concept to members, before voting to disband.

"What the special committee has done is provide a useful forum for exploration of the idea," said Robert H. Myers Jr., an attorney with Morris, Manning, Martin & Player in Washington.

As a result, more focused groups within the NAIC—like an anti-fraud subgroup—are now more comfortable with considering a compact as a way to regulate data and information-gathering activities while preserving confidentiality.

"States should continue to explore" use of interstate compacts, despite critics' concerns about states losing individual sovereignty and questions about the compact governing board's appropriate level of authority, said James M. Jackson, vp and deputy general counsel with Transamerica Occidental Life Insurance Co. in Los Angeles.

New model proposals

The NAIC as a whole now will consider adopting two model laws dealing with experimental health care treatments and victims of domestic violence, both of which its Accident and Health Insurance Committee recommended at the

meeting.

A still-controversial proposed model provides minimum standards of coverage for health services that insurance companies may have previously deemed experimental, "clinical investigative" or educational.

If the NAIC approves the model and states enact it, "health carriers will no longer be able to deny coverage for treatments written up in peer-reviewed medical literature that are demonstrated to be as effective as other standard treatments," according to the NAIC.

The model law is needed because some health benefit plans contain ambiguous or misleading provisions that many consumers do not understand, according to the NAIC.

The model calls for minimum standards of coverage that will aid consumers in comparing plans.

However, a Blue Cross & Blue Shield Assn. representative at the meeting obtained a commitment from regulators that they will continue working to resolve differences in the model bill before it is presented for a vote.

In other action, the NAIC:

- Accredited Alabama as its 47th jurisdiction to meet solvency regulation standards.

Outside the fold are Arkansas, Hawaii, Nevada and New York. The New York Insurance Department lost its accreditation after state legislators refused to adopt additional model law requirements.

An emerging positive relationship between Mr. Atchinson and New York State Senate Insurance Committee Chairman Guy J. Velella, who visited the NAIC's meeting, may help to resolve that problem.

- Discussed the final Medicare proposal endorsed by the congressional conference committee, which reflected a more significant role for state regulators than did the original House proposal (BI, Nov. 13).

However, several questions remain because redrafting continues following President Clinton's veto.

- Adopted the proposed Life Disclosure Model Act, which de-

fines the standards that are to be followed when illustrations are used in selling life insurance policies.

However, regulators adopted two changes recommended by Utah Insurance Commissioner Robert Wilcox, who chaired the drafting effort.

The changes broadened the definition of group universal life to include all non-term, cash-value group policies similar to universal life.

They also eliminated a requirement that an insurance company clearly disclose to consumers the method it used to allocate expenses, since that is hard to explain.

However, they added new language to make the illustration more understandable.

- Recommended for formal NAIC approval a model act that creates a legal framework for a retailer to sell service contracts.

The model provides coverage for consumers, apart from warranties or maintenance agreements, according to Michael A. Bownes, general counsel of the Alabama Insurance Department, who oversaw its drafting.

Large retailers like Sears and Montgomery Ward oppose the model because it regulates a non-insurance transaction and treats retailers differently from manufacturers, said Zack Stamp, an attorney at Peterson & Ross in Springfield, Ill., who represents Sears and Montgomery Ward on this issue.

However, manufacturer General Electric Co. favors the model because it may lead to greater uniformity among consumer protection laws now in 29 states, according to Peter Reinert, senior counsel-transactions in the company's Louisville, Ky., office.

- Urged public comment on various topics by proposed deadlines, including: the shopper's guide to long-term care, Dec. 27; the model law on insurer investments and the operating requirements for non-U.S. insurers, both Feb. 1.

- Awarded its highest individual honor, the Robert Dineen Award, to Norris Clark, deputy commissioner of the California Department of Insurance. **BI**

Dispute

Continued from page 2

greedy broker willy nilly attempting to replace an underwriter and an administrator in order to get higher brokerage fees," argued Blair C. Fensterstock of Brock, Fensterstock, Silverstein, McAuliffe & Wade in New York, who also represents Zurich-American in the dispute.

Both sides are now awaiting a New York Supreme Court judge's decision in response to a motion filed by Bertholon-Rowland asking that units of The Home and PLUM be found guilty of contempt.

The brokerage is also asking that a preliminary injunction be issued to prevent the defendants from using information related to the policies pending the court's approval of an August arbitration order that affirms the broker's ownership of this data. Zurich-American would be included in the action as well.

PLUM has filed a cross motion in the action seeking attorney's fees, costs and sanctions, and asking that the brokerage be ordered to comply with the arbitration award, which also awarded PLUM and Zurich funds on certain other issues.

The focus of the dispute is the

professional liability insurance program developed by Bertholon-Rowland in the 1960s. The program—which had been placed with The Home since 1982 (BI, April 24)—generated slightly less than \$60 million in annual premiums, said Mr. Bickford. Also involved is a much smaller program of the Boston Bar Assn.

The New York bar group's program has accounted for close to half the revenues of the employee-owned 100-person brokerage, Mr. Bickford said.

According to papers filed by Bertholon-Rowland, the New York Bar Assn. told the brokerage to change insurers after The Home's ratings were downgraded last year. The brokerage wrote to The Home and PLUM in January that, effective July 5, it was terminating its producer agreement.

The brokerage then arranged to have the program placed with Interstate Fire & Casualty Co., a Chicago-based unit of Fireman's Fund Insurance Co. Much of The Home's business was later acquired by Zurich Insurance Group.

A dispute developed, however, and Bertholon-Rowland filed suit against units of the Home and PLUM. One of the issues involved was the brokerage firm's charge that in an attempt to retain the

business, the defendants were using information on the policies' "expirations," which traditionally are for the broker's exclusive use. The broker said this was in violation of a 1989 producer agreement.

"Expirations" are files and records containing information regarding price, underwriting considerations, service and renewal of specific policyholders' insurance policies.

The dispute was brought before an arbitration panel. The final order in August said in part that Bertholon-Rowland Corp. continued to own the expirations of all policies under the program, in accord with the 1989 producer agreement, despite its termination. It also ordered the brokerage to pay \$300,000 to The Home Insurance Cos. and an additional \$125,000 to PLUM related to other issues that were arbitrated.

PLUM, however, contends that in addition to the \$125,000 arbitration award it is owed, it is due another \$405,000 in premiums.

But Bertholon-Rowland claims this money has been offset by other funds due to the brokerage under terms of the arbitration agreement, according to Mr. Bickford.

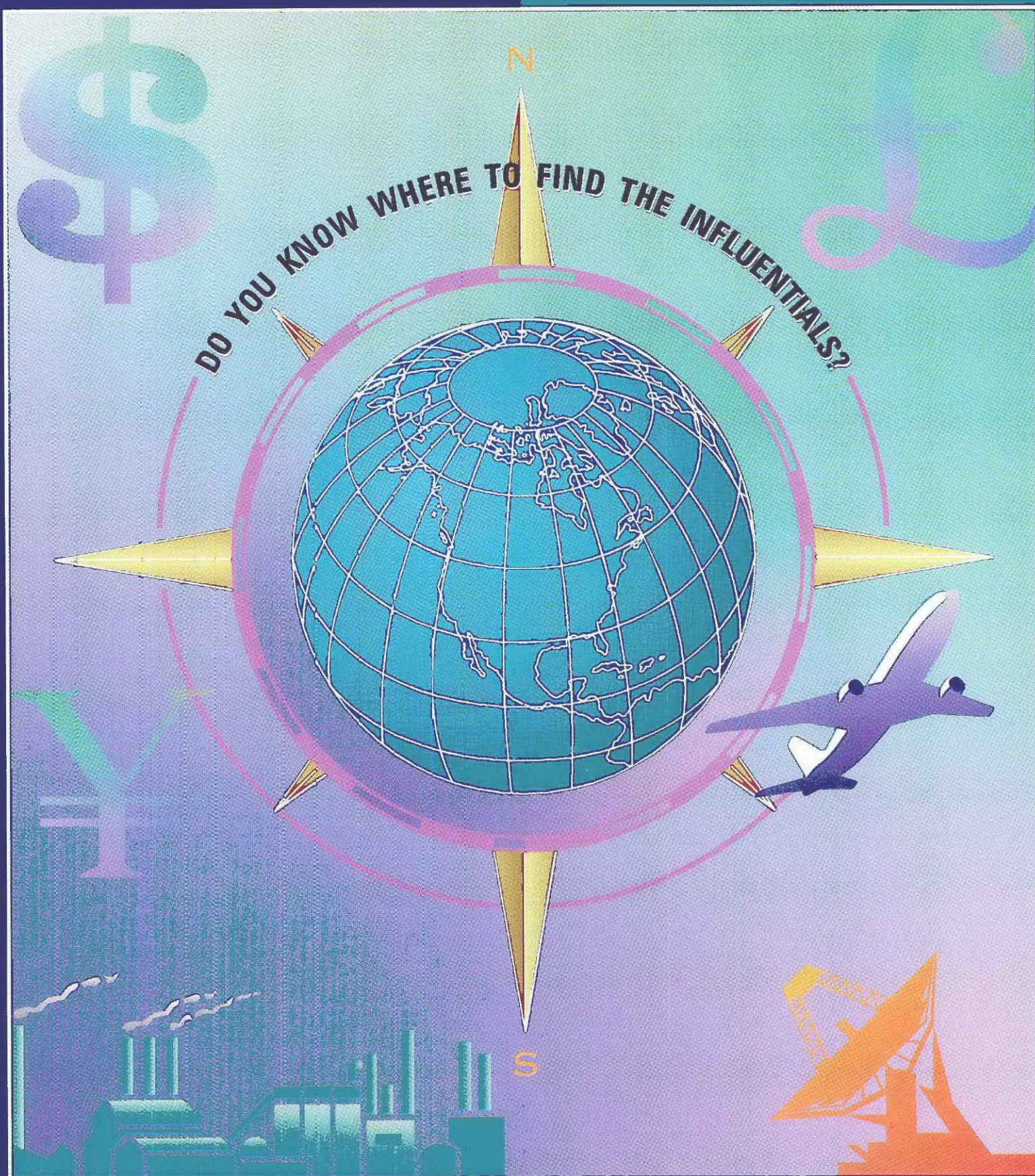
The issue of the money is only a "diversion," said Mr. Bickford. "The main issue from Bertholon-

Rowland's perspective... is the use of the expiration data."

The Home is taking advantage of Bertholon-Rowland's relatively small size, said Mr. Bickford. If The Home or any insurer behaved as they had to a big broker, they would be told to "knock it off, and they would," he said. But as a modestly sized brokerage, it doesn't "have that kind of economic power," Mr. Bickford said.

If Home or any insurer behaved as they had to a big broker, they would be told to 'knock it off,' says Peter H. Bickford.

However, PLUM denies charges by Bertholon-Rowland that it has attempted to make any inappropriate use of the expiration information to keep the business. "Nobody ever wanted the expirations," said Mr. Fensterstock. "That was a given. The issue from our perspective was Bertholon-Rowland's wrongful act, in an attempt to recover greater commissions" by placing the business with another insurer. **BI**



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Defending CIGNA restructuring

By George K. Bernstein

IN RECENT WEEKS, we have seen further efforts to discredit the proposed recapitalization and restructuring plan of CIGNA Corp.'s property and casualty operations.

Not content to express their opposition at the regulatory hearing called by the Pennsylvania Insurance Department, certain competitors have mischaracterized the plan in press releases and public forums. This opposition is not because the plan threatens policyholders, past or future, or creates potential liabilities for state guaranty funds.

The real fear of these competitors is that under the plan both run-off and active CIGNA P&C entities will be in sounder financial condition than previously, and the active CIGNA P&C insurers will again be competitive forces in the marketplace. I also believe they are concerned that the comprehensive approach taken to reserve on an ultimate basis for asbestos and environmental exposures may set a new industry standard.

The plan accomplishes three goals by:

- Improving the financial condition of all insurance subsidiaries of CIGNA P&C.
- Providing dedicated income-producing assets for the run-off insurer sufficient to fund future obligations with a comfortable margin of safety.
- Providing capital support that would permit the run-off insurer to improve its rating from A.M. Best Co. and also to permit the active insurers to continue to qualify for an A- rating.

As a result of the plan, developed after several months of consultation with, and evaluation by, the Pennsylvania Insurance Department and other insurance departments, CIGNA P&C's operations are strengthened overall, making it more likely that all policyholder obligations of both the active and run-off insurers will be paid in full. The plan will also permit CIGNA P&C to continue as a major employer, providing essential insurance coverage and services to its policyholders.

Although those competitors, who would maintain the status quo and condemn CIGNA P&C and its policyholders to the greater uncertainties of doing nothing, have tried to depict the plan as a good-bank, bad-bank transaction and a disavowal of CIGNA P&C's obligations to policyholders, neither of these representations is supported by the facts.

Parent corporations are not liable for the obligations of their subsidiaries and, if CIGNA P&C intended to set adrift its insurer subsidiaries with asbestos and environmental exposures, it could do that under existing law without adopting the proposed plan. CIGNA P&C did not take this course of action, but chose to develop a comprehensive and good faith approach to its asbestos and environmental exposures that protects the financial security of existing policyholders while revitalizing the ongoing insurance franchise.

It is that impact on the active ongoing insurers that provides CIGNA and its stockholders the economic justification for the level of financial support provided to the run-off insurer as part of the plan. If the plan is not implemented, there would be strong economic incentive for CIGNA to allow the existing business with its A&E exposures to run its course without upgrading the security of existing policyholders.

If CIGNA P&C had failed to address its A&E exposures in a responsible manner, then there would have been a greater danger that it might not be able to honor its policyholder obligations. The quality of risks it would have been able to write would have declined precipitously as only second-class business would flow to a B+ rated insurer. Cash flow would have diminished significantly. The combination of fewer premiums and lower quality business is the classic prescription for financial disaster.

These difficulties for CIGNA P&C would offer tremendous opportunities for its competitors. The better business could be skimmed off with great profit potential for its rivals. Moreover, if the plan were not

Criticism of proposal blamed on competitors' fear that plan could make CIGNA stronger

Speaking Out

to be implemented and the property and casualty companies of CIGNA P&C do ultimately fail, because of the long-tail nature of A&E exposures, their competitors would have reaped significant profits, far offsetting any distant potential liability to guaranty funds.

Only because of the plan, and conditioned upon its approval by the regulators, has Best indicated it will give an A- rating to the active insurance pool, and a B+ rating to the run-off company. These new Best ratings will remove uncertainty from CIGNA P&C's operations, enabling its parent, INA Financial, to attract capital and permit both the active property and casualty insurers to go forward on a sound financial basis and to compete in the insurance marketplace, making essential insurance available.

It is difficult to conceive of any plan other than that proposed by CIGNA P&C that more honestly, openly and fairly addresses its A&E problems. Even more importantly, I cannot think of a situation under the plan where any policyholder of the run-off insurer is worse off after the transaction than before.

I cannot think of a situation under the plan where any policyholder of the run-off insurer is worse off after the transaction than before.

Recapitalization of insurers is not unique. What is different about this plan is the thoroughness with which the parties and the Pennsylvania Insurance Department have approached the problems to be resolved, the comprehensive nature of the analyses performed to assure the financial soundness of the both active and run-off insurers and full payment to policyholders, and the very real commitments of monies by the parent to the run-off insurer. Early on in the regulatory process, the Pennsylvania department retained Tillinghast, a nationally respected actuarial firm with extensive expertise in the asbestos and environmental claims area.

Tillinghast conducted a bottom-up, six-month long review of CIGNA P&C's A&E exposures and prepared a report for the department. That report, which includes a number of improbably conservative assumptions, confirms CIGNA P&C's own analyses and stress tests showing that under the plan, the run-off insurer is adequately capitalized and fully able to meet its future liabilities.

In addition, Milliman & Robertson was retained by CIGNA P&C to review its actuarial methodology and to evaluate the approach adopted by management. M&R not only found that CIGNA P&C's approach to evaluating ultimate A&E exposures was reasonable, but also found that CIGNA is ahead of its peer companies in the methodology, use of external data sources and the handling of coverage defenses.

Houlihan Lokey Howard and Zukin, a specialty investment banking firm, valued the CIGNA P&C insurers before and after the recapitalization and found that if the plan were implemented all of them would be solvent, adequately capitalized, able to pay their debts as they became due and would satisfy applicable state insurance standards for solvency. Houlihan Lokey also retained William M. Mercer Inc., who conducted an independent peer review analysis of Tillinghast's methods and assumptions, finding them

reasonable.

J.P. Morgan & Co. Inc. was also retained to opine on the fairness of the plan. Morgan found that under the plan, the run-off insurer ends up with a greater increase in the net present value of assets than of liabilities, indicating an increase in the economic value of the insurer.

Morgan concluded that the plan is fair from a financial point of view to the policyholders of the run-off insurer in the aggregate.

Among the assurances of solvency are: \$500 million in capital support to the run-off insurer; \$500 million in aggregate excess of loss reinsurance to the run-off insurer; the prohibition, without prior regulatory approval, of CIGNA P&C divesting either the active or run-off insurers separately; the \$100 million in tax benefits that can only be realized if the run-off insurer remains part of the consolidated group; the confidence expressed by certain of the active CIGNA P&C insurers who will be reinsuring 100% of their pre-1987 general liability business in the run-off insurer; the continuation of many of the run-off insurer's policyholders as policyholders of the active insurers, thus providing an ongoing incentive for the run-off insurer to handle claims fairly; the prohibition, without prior regulatory approval, of even ordinary dividends from the run-off insurer; and the insulation of run-off policyholders from what many in the insurance industry have claimed is a major threat to industry solvency—catastrophic losses from natural disasters—to which active insurers will continue to be exposed.

In view of the capital contributions to be made to the run-off insurer, as well as the reinsurance to be provided by INA Financial and the other linkages maintained between the active and run-off insurers, it is not surprising that the experts who reviewed the plan found that it protected both active and run-off policyholders under even unusually conservative scenarios.

In a last-ditch attempt to deflect attention from the protections to policyholders that are the essence of the plan, some critics ask that INA Financial guarantee the A&E obligations of the run-off insurer. Aside from the fact that these competitors know that such guarantees are commercially not feasible, it is telling that none of them has ever proposed to provide parental guarantees of the comparable A&E liabilities of their own policyholders. Not one of these competitors has undergone the bottom-up analysis of its A&E reserves to which the Pennsylvania Insurance Department subjected CIGNA P&C. Until these competitors undergo the same type of rigid A&E reserve scrutiny, it ill behooves them to posture about the need for additional policyholder protection. If corporate guarantees were a serious proposal, it is the competitors of CIGNA P&C who should consider them.

The plan now before the Pennsylvania Insurance Department stands securely on its own. It protects the financial security of all of CIGNA P&C's policyholders, including those of the run-off insurer, while enabling the active companies to again become a competitive market force. The plan has been found by independent experts, including those retained by the Pennsylvania department, to be reasonable and adequate to protect all valid interests.

Under these circumstances, neither individual competitors nor state insurance guaranty funds have any valid concerns about the plan. **GB**

George K. Bernstein is an attorney with more than 38 years of experience in insurance regulation, including serving as the first federal insurance administrator and first deputy superintendent and general counsel of the New York State Insurance Department.

Mr. Bernstein testified on INA Financial Corp.'s behalf at a Nov. 28 public hearing on the insurer's restructuring proposal.

Ax not automatic for benefit staff

Continuity of benefit plans after M&A seen as big factor behind job security

You're happily toiling away in your company's employee benefit department when a surprise announcement is made: your company is being sold or merged with another.

Is your job in jeopardy?

Not necessarily. Whether a job is lost generally depends on whether the two benefit programs will continue as is, or if they will be combined into a single program, experts say. If both benefit programs continue, chances are that most benefit administration jobs will be maintained.

However, if the benefit programs are combined, "you almost for sure don't have a future; that's called eliminating overhead," said Steve Rabinowitz, a principal at Kwasha Lipton L.L.C. in Fort Lee, N.J.

Nonetheless, "there are usually winners as well as losers" in these situations, Mr. Rabinowitz added. Those who remain or board after a merger or acquisition often end up with the same job for a larger organization or luck into new opportunities. "By definition, the results can't be negative for both benefits departments," he said.

All of the former benefit personnel of Chicago-based Continental Bank were let go following the bank's sale to San Francisco-based BankAmerica Corp.

"It was kind of dire circumstances" for people working in the benefits department of Continental Bank, said Dennis Nirtaut, formerly the bank's vp of employee benefits. However, "everybody made out just fine" and got new jobs, said Mr. Nirtaut, who currently is a managing director of compensation and benefits at Arthur Andersen & Co. S.C. in Chicago.

Furthermore, BankAmerica eased the pain of job elimination in several ways, Mr. Nirtaut said.

First, BankAmerica was very up front about its intentions; the company told people nearly a year before they actually were let go that their jobs would be terminated. "It kind of takes the sting out of it," knowing of the terminations very far in advance, he said.

And, BankAmerica offered employees a retention bonus to stay and work until the date when their jobs would be terminated. Everyone in the benefit department except Mr. Nirtaut stayed until the termination date, he said.

In some situations, however, benefit personnel are not let go after a merger or acquisition.

For example, when Kirkland, Wash.-based Costco Wholesale Corp. merged in 1993 with San Diego-based Price Co., no one in either benefit department was fired.

Benefit personnel who lived in the San Diego area were given the opportunity to move to the Seattle area and continue to work for the new combined company, according to John Matthews, senior vp for human resources for PriceCostco Inc. in Kirkland. Several people who worked in Price's former benefit department did decide to move to the Seattle area.

"We took a philosophy in the merger that we're going to try to protect employment for all employees," Mr. Matthews stated.

And no one in either benefit department lost his or her job following Mattel Inc. and Fisher-Price Inc.'s 1993 merger, according to William Whitman, director of worldwide compensation and international benefits for Mattel in El Segundo, Calif.

"Both staffs are very lean to start with," he commented, pointing out that the benefit department of each company has only four people. While Mattel officials will determine the strategic direction of the company's benefits, many of the day-to-day operations of Fisher-Price's benefit department will continue to take place in the company's East Aurora, N.Y., headquarters, he said.

—By Deborah Shalowitz Cowans

Mergers

Continued from page 1
a different plan.

Which method is right depends on the specifics of the transaction. Expert advice and corporate experience illustrate when the different methods are the most suitable.

Maintain separate plans

Maintaining two separate benefit plans after a merger or acquisition can be the right approach for companies in different industries or that are otherwise very dissimilar, said Mark Arian, a principal and attorney at Hewitt Associates L.L.C. in Bedminster, N.J.

Maintaining separate plans also may make sense if an acquiring company only plans to hold on to its acquisition for a short time, or if the decentralized structures of two companies would make it difficult to administer a single plan.

Sometimes companies choose to retain their plans following a merger simply because they do not want to fix something that already works.

Take, for example, Mattel Inc., which bought fellow toymaker Fisher-Price Inc. in 1993.

Mattel decided to leave the "fairly similar" programs separate, at least initially, said William Whitman, director of worldwide compensation and international benefits at El Segundo, Calif.-based Mattel.

"We did not want to make changes for the sake of making changes," Mr. Whitman said. The company is "more concerned with having equal value of all benefits than with having one plan."

Even if Mattel had wanted to terminate the Fisher-Price plans, it faced obstacles. Mattel offers only a defined contribution plan, but the company it bought had both a defined contribution plan and a "very overfunded" defined benefit plan, said Mr. Whitman.

Overfunding has often tempted acquirers to terminate plans and remove the so-called surplus assets. That move wouldn't have worked in the Fisher-Price case. Its plan provides that any acquiring company that terminates the plan within five years would have to distribute the surplus assets only to participants.

Mattel does not now expect to terminate the plan when the five-year period expires, said Mr. Whitman.

Abolish one, keep the other

Often when a large company buys a smaller company in the same industry, the acquiring company abolishes the smaller company's benefit plan and offers employees its own benefit program.

This "almost always happens" in

these situations, said Steve Rabinowitz, a principal with Kwasha Lipton L.L.C. in Fort Lee, N.J.

For companies with strong similarities between products, employees, locations and culture, offering only one benefit plan to all workers can be easier administratively and can produce cost efficiencies, Mr. Arian pointed out.

Mattel pursued this course when it bought San Francisco-based Kransco Group Cos. in 1994. Mattel abolished Kransco's benefit program and moved all employees of the firm to Mattel's benefit program.

Kransco "was much smaller, so their benefit programs were not as sophisticated" as Mattel's, nor as generous, Mr. Whitman explained. At the time of the acquisition, Kransco had about 1,200 employees; Mattel had 3,000. And, Mattel closed a small corporate office Kransco had in San Francisco.

When Dayton Hudson Corp. bought the smaller Chicago department store chain Marshall Field & Co. Inc. in 1990, it brought all of Field's employees into its program.

There were several reasons why, said Mr. Hamacher of Dayton Hudson. At the time, Marshall Field's was a division of Louisville, Ky.-based Batus Inc., and employees received Batus' benefits so Field's would have had to change its benefit program anyway after the deal.

What's more, the Dayton Hudson package was better than what Batus offered. "Overall, it was a clear win for the Marshall Field's employees," said Mr. Hamacher.

However, Dayton Hudson did not buy from Batus pension assets and liabilities earned by Field's employees before the deal, he noted. As a result, any retirement benefits earned by Field's employees before the deal will be paid by Batus.

Integrating the retirement plan of an acquired company into the buyer's plan can be one of the toughest benefit challenges that buyers face.

However, for companies committed to providing one plan to all employees this is a short-term hurdle.

"There are lots of traps for the unwary," cautioned Mr. Arian. For example, even if both companies offer similar 401(k) plans, absorbing employees of an acquired company into the buyer's plan can affect non-discrimination testing.

Things get even more complicated with defined benefit plans.

Some corporate finance officials who are involved in merger or buy-out talks lack a "really keen understanding" of pension terminology, said Mr. Arian. Many, for example, do not know what "well funded" means. So he recommends that companies involve employee benefit experts in acquisition talks.

To minimize problems when moving employees from a defined benefit plan into another plan, "freeze the old (plan) and don't let it perpetuate into the future," Mr. Rabinowitz recommended. Grandfathering "is often used to ease the transition to a new program, but you do add considerably to the administration of the new program."

When BankAmerica Corp. bought Chicago-based Continental Bank Corp. last year, it faced just this kind of defined benefit challenge.

Abolishing Continental's health plans and shifting employees into BankAmerica's was not complicated. But switching from Continental's defined benefit plan to the cash balance plan of its San Francisco-based parent was "one of the most complex benefit items I was ever involved with," stated Dennis Nirtaut, who was then vp of employee benefits at Continental and is now a managing director of compensation and benefits at Arthur Andersen & Co. S.C. in Chicago.

Several actuaries had to be hired

to figure out how to convert the value of one plan to the equivalent of the other plan, said Mr. Nirtaut. To avoid hurting people near retirement, the banks did grandfather in the defined benefit plan for them.

Create a hybrid or new plan

Another option for companies involved in mergers and acquisitions is to craft a new benefit plan for employees of both companies—either a hybrid of the two existing plans or a completely new plan.

Sometimes it is wise to develop a completely new benefit package instead of combining two old ones.

"The problem with splitting the difference is that employees focus on whether they got less than before," warned Kwasha Lipton's Mr. Rabinowitz. That's harder for them to do when a merged company develops a new plan.

"Large mergers give you the opportunity to step back" and design a benefit package from scratch, he said. "You can fix things all in one fell swoop. The companies that do elect to do this usually end up very happy that they did."

For example, in a 1993 deal valued at \$1.7 billion, Kirkland, Wash.-based Costco Wholesale Corp. merged with San Diego-based Price Co. and officials of the new company developed a new compensation package that incorporated parts of each company's former programs. Health, retirement and ancillary benefits were evaluated, as well as other kinds of compensation, such as salaries and vacation allowances.

But it wasn't easy. PriceCostco Inc. spent all of 1994 deciding how total compensation should be determined and how the two plans should be combined, said John Matthews, senior vp for human resources for PriceCostco in Kirkland.

PriceCostco developed a new retirement plan that was "a hybrid between what both companies had," Mr. Matthews said. Price had offered a 401(k) plan with a company match and a retirement plan to which the company contributed a set dollar amount. Costco had offered only a 401(k) plan. The new plan is a 401(k) plan that includes a company match based on an employee's contribution and an additional contribution of a percentage of income that increases based on years of service.

In the health arena, PriceCostco decided to offer a flexible benefit package so employees could choose among old and new options.

Before the merger, about two-thirds of Costco's employees were members of health maintenance organizations and the remaining third participated in an indemnity plan, Mr. Matthews explained. Meanwhile, half of Price's employees used preferred provider organizations and the other half had a flexible benefit package that offered a range of health care options. **BI**

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Everything's negotiable

New York hospitals may move to open rate competition

By GAVIN SOUTER

NEW YORK—Large employers in New York may be able to negotiate rates with hospitals next year.

A task force studying the way hospitals are reimbursed in New York recommended earlier this month ending state-set hospital reimbursement rates.

Open competition would constrain growth in health care costs more effectively, the task force advised.

The proposals could lead to better deals for large employers that have the expertise to negotiate with hospitals, said Harvey Sobel, principal and consulting actuary at Buck Consultants Inc. in Secaucus, N.J.

Large employers may be able to negotiate experience-rated deals with hospitals depending on the final form of the new regulations, he said.

The ability to negotiate terms directly with hospitals should reduce health care costs for employers, said David Edwards, director of benefits at Eastman Kodak Co. in Rochester, N.Y., who was a member of the task force.

"It will provide the opportunity for purchasers to go into the market and search for the highest quality and best value products," he said.

However, if rate-setting is abolished, a new surcharge on hospital payments will be introduced to generate \$2 billion to finance health care for indigent patients.

If the recommendations are adopted, the new system will be in place in June, when authorization for the current system expires.

"The task force recommendations represent significant change in the state's approach to health care fi-

nancing, and provide a framework for achieving a more efficient and effective health care system within the changing health care environment," said State Health Commissioner Barbara A. DeBuono, chairwoman of the task force.

The recommendation to allow direct rate negotiation with hospitals reflects dramatic changes in the health care market due to the emergence of managed care, she said.

The abolition of rate-setting will require a new method for financing medical care for the poor, Dr. DeBuono said. The task force recommended three options: a 12% surcharge on non-Medicare hospital payments; an 11.5% surcharge on non-Medicare hospital and clinic payments; or a 7.6% surcharge on non-Medicare hospital, clinic and physician payments. **BI**

RRG

Continued from page 2

siana law and licensing requirements could cripple the ability of risk retention groups to operate nationwide, says NRRA Washington Counsel Philip Olsson.

"A lot is at stake in this case," said Mr. Olsson, who also is a partner with Olsson, Frank & Weed in Washington.

Supporters of the Louisiana risk retention group law and requirements say they are necessary to ensure that risk retention groups do not have a competitive advantage over other insurance companies.

"We wanted a level playing field. Everyone doing business in the state should abide by similar rules," said Dennis Vidrine, secretary-treasurer of the Louisiana Fire & Casualty Co., a small commercial insurer trade group based in Baton Rouge.

Mr. Vidrine said the Louisiana risk retention group legislation was unanimously approved by the state Senate and House. The sentiment among legislators, he noted, was to make capital and surplus requirements even stiffer for risk retention groups, roughly in the \$25 million range.

If the Louisiana law and licensing requirements are struck down, the Louisiana insurance industry will work on putting together a new statute.

"We will be back with something we can sell to a federal judge. If you do business in our state, you have to abide by our rules," Mr. Vidrine said.

In their suit, the NRAA and the three RRGs argue that when Congress enacted the Risk Retention Act it did so with the intention of pre-empting state regulations and statutes—other than those in the state in which the risk retention groups are domiciled—that in the aggregate would "thwart" the operation of risk retention groups.

"The statutes and regulatory procedures which Louisiana is now attempting to apply to non-domiciliary RRGs are exactly such thwarting laws and implementing requirements pre-empted" by the Risk Retention Act, the groups said in their memorandum of law filed in U.S. District Court in Baton Rouge.

Louisiana has no authority to set a minimum and capital surplus requirement, a posting of bond or a \$1,000 annual examination fee, the groups charge.

"For a RRG with only one or a few insureds in Louisiana, this fee could exceed its Louisiana premium income. It is an amount which will be burdensome for almost every RRG," the groups said in their legal papers.

The groups also contend that if Louisiana's requirements are al-

lowed to stand, it could lead to a "domino" effect in which other states might follow Louisiana's lead and impose similar requirements and effectively prevent risk retention groups from operating nationwide.

But the Louisiana Insurance Department, in papers filed in court of its behalf, says it is not trying to regulate non-domiciliary risk retention groups but "rather satisfy itself that they are financially suitable to conduct business and provide liability coverage."

The intent of Congress in passing the Risk Retention Act, the department said, was not to pre-empt "but rather (to) designate authority to the states to make certain that financial suitability and viability was a prerequisite to doing business in the state and protect its citizens and policyholders."

The challenge to Louisiana's risk retention group law and application procedures comes at a time when risk retention groups continue to grow, despite the soft commercial property/casualty insurance market.

Premium volume among risk retention groups is expected to rise by just over 9% in 1995 to about \$640 million, compared with an 11.1% rise in 1994 to \$585.8 million in premiums, according to a survey conducted by The Risk Retention Reporter, a Pasadena, Calif.-based publication.

Sixty-seven risk retention groups now operate. About 40% of the groups are licensed in Vermont; no groups are currently licensed in Louisiana.

Within certain niches, most notably professional liability coverage for health care providers, risk retention groups have become a significant force in the market, said Karen Cutts, The Risk Retention Reporter's managing editor.

Under the federal Risk Retention Act, RRGs can write all commercial liability risks—except workers compensation—for policyholder member-owners.

A year ago, risk retention groups suffered a setback when the 11th U.S. Circuit Court of Appeals upheld the legality of a Florida financial responsibility law that requires taxi companies and other passenger carriers to buy the first \$30,000 of liability coverage from insurers that are members of the state guaranty association (BI, Nov. 7, 1994). Under the federal statute, risk retention groups cannot be members of state guaranty funds.

The ruling focused on the relationship between sections of the Risk Retention Act that pre-empt state laws discriminating against risk retention groups and other sections that protect from pre-emption state laws requiring companies in certain industries to buy insurance. **BI**

For the Record

Cigarette filter makers win Texas jury case

CHICAGO—The family of a man who claimed asbestos in Kent cigarette filters caused the cancer that eventually killed him will appeal a U.S. District Court jury's verdict in favor of the companies that made the cigarettes and filters.

The jury decided that Lorillard Inc., the maker of Kent cigarettes, and Hollingsworth & Vose Co., which produced the material used in Kent Micronite filters, were not responsible for the death of Norman Braun in 1994.

The plaintiffs' case was lost when Judge Blanche Manning told the jury not to consider testimony that indicated the same type asbestos fibers in the filters were found in the lungs of Mr. Braun, who died last year from a type of cancer caused by asbestos exposure, according to plaintiffs' attorney Rick Schoenfeld of Schoenfeld & Swartzman in Chicago.

The testimony was stricken because the judge questioned the reliability of the methods used in gathering and identifying the fibers, Mr. Schoenfeld said.

While specific damages were not detailed in the suit first filed last year, Mr. Schoenfeld said he had discussed figures between \$6 million and \$7 million with the jury during the trial.

Asbestos liability increase hinders settlement

CINCINNATI—A federal bankruptcy court's increased estimates of Eagle-Picher Industries Inc.'s asbestos-related liabilities are a setback for the company's Chapter 11 reorganization plan.

The court overseeing Eagle-Picher earlier this month raised the Cincinnati-based company's previously estimated present and future asbestos-related liabilities by about \$1 billion to \$2.5 billion.

The court's estimate, which resulted from a motion filed this summer by Eagle-Picher asking the court to assess the company's ultimate liabilities for the purpose of distributing payments to asbestos claimants and creditors, effectively quashes a February settlement agreement that called for approximately 150,000 asbestos claimants to receive 42.5% of the value of their claims.

An Eagle-Picher spokesman said

the court and Eagle-Picher will have to "re-evaluate what can be paid to current claimants, future claimants as well as unsecured creditors and equity security holders. Logic says asbestos claimants will receive less than the previous 42.5%."

Eagle-Picher has exhausted its \$175 million in applicable insurance (BI, Nov. 15, 1993), and it posted only \$48.7 million in net earnings.

Thus, funding a trust to compensate claimants and creditors adequately will be difficult. Nevertheless, the company said having a revised asbestos liability estimate from an overseeing bankruptcy court will help it form "an appropriate distribution scheme in a plan of reorganization."

401(k) investment choice, communication increase

Employers are giving their employees more savings plan investment options to choose from, as well as adding new technology to improve communication and administration.

Employers with retirement savings plans, like 401(k) plans, now offer employees an average of 6.3 investment options, up from an average of 5.2 in 1994 and just 3.5 in 1990, according to a survey of more than 700 employers released last month by A. Foster Higgins & Co. Inc.

On average, 78% of eligible employees participate in savings plans. The overwhelming majority—92%—of eligible highly compensated employees participate in savings plans compared with 77% of rank-and-file employees.

Not surprisingly, the likelihood that employees will participate in company savings plans is directly related to the generosity of company matching contributions.

In plans in which employers match at least 50% of employee contributions, an average of 84% of eligible employees participate. That compares with an average participation rate of 73% in plans where employers match less than 50% of employees' contributions.

As prices continue to fall, employers are adding new voice interactive systems to improve communications—such as allowing employees to get up-to-date information on their account balances—and plan administration.

In the last year alone, the number of employers using interactive

voice response technology for the savings plans increased to 50% from 35%, while another 14% intend to use an interactive response system within the next two years.

"Computer and phone systems continue to absorb tasks and functions," said Brian Ternoe, a Foster Higgins principal in Princeton, N.J.

Copies of "Survey on Employee Savings Plans 1995," are available from Lisa Gilleen, A. Foster Higgins & Co. Inc., 125 Broad St. New York, N.Y. 10004; 212-574-9025. The cost is \$100.

Information in brief

A federal judge's recent approval of Prudential Securities Inc.'s \$110 million settlement offer clears the way for settlement of a class-action lawsuit over speculative limited partnerships sold by the Prudential Insurance Co. of America unit. Separately, through a fund being administered by the Securities and Exchange Commission, Pru has paid out about \$850 million (BI, Jan. 3, 1994). . . . The Virginia Corporation Commission has approved decreases in both voluntary market and assigned risk workers compensation rates. Loss costs for the voluntary workers comp market dropped by an average of 13.1%, while those for the assigned risk market dropped an average of 17.3%. The reduced rates go into effect Jan. 1, 1996. . . . London broker Fenchurch P.L.C. will buy U.K. regional retail broker Houlder Insurance Brokers Ltd. for £3.7 million (\$5.7 million). . . . In a ruling that could bode well for it in U.S. disputes over derivatives losses, Bankers Trust Co. won a ruling from the Commercial Court in London that an Indian firm, PT Dharmala Sakti Sejahtera, had to pay \$69.2 million plus legal expenses under 1994 swaps contracts. Dharmala may appeal. . . . Beginning in March, insurers in New Mexico will have to pay for hospital stays of at least 48 hours for most mothers and their newborns under a new regulation from the New Mexico Department of Insurance. . . . The Overseas Private Investment Corp. issued a record \$8.6 billion in political risk insurance during fiscal year 1995, a 43% increase over the previous record \$6 billion in political risk insurance issued during the previous fiscal year. **BI**

Hospital covered for \$42 million award

DALLAS—A Dallas hospital says its self-insurance and excess medical malpractice coverage are adequate to cover the \$42 million that a Texas state court jury awarded late last month to a Fort Worth man who was paralyzed after receiving treatment for ankle pain.

St. Paul Medical Center, which has not decided whether to appeal, self-insures medical malpractice claims up to \$7.5 million and then buys excess coverage, said a spokeswoman.

She would not identify the excess insurers.

The jury said St. Paul Medical Center must compensate Matt

Langston, 30, for the injuries he suffered in 1990 when he walked into the hospital for treatment of a previously broken ankle and left as a paraplegic.

The award included \$28.6 million in actual damages and \$1 million in punitive damages, according to Ken Link, a Fort Worth attorney who represented Mr. Langston.

Prejudgment interest pushed the total to \$42 million.

Mr. Link said his client, a former car salesman, was paralyzed after receiving too much medication through a spinal catheter administered at the hospital.

—By Michael Bradford

CIGNA

Continued from page 2
approval, the spokesman said.

Missouri's concern—the latest obstacle to CIGNA's plan to reserve for and wall off its environmental and asbestos liabilities—was outlined in a Dec. 7 letter to Gerald Isom, president of CIGNA Property & Casualty Insurance Co. Mr. Isom would head CIGNA's combined active operation under the proposed reorganization.

Regulators in Pennsylvania, CIGNA's domicile, already are well into their assessment after working on the plan for 10 months.

But, the plan and the state's review process has drawn criticism from CIGNA policyholders and competing insurers, who contend the department and CIGNA are shrouding information that they need to evaluate its financial viability (*BI*, Nov. 6).

At the latest hearing on the plan, Dec. 8 in Harrisburg, Insurance Commissioner Linda S. Kaiser affirmed her earlier decision that plan evaluations by the department's and CIGNA's actuaries would not be released because they contain proprietary data. She also has rejected requests by the plan's critics for an opportunity to cross-examine CIGNA witnesses during public hearings.

A Missouri department spokesman criticized Pennsylvania's review process: "If they were going through the same requirements that we are going to impose, which is looking out for the interests of the Missouri policyholders as well as providing for some ability for the policyholders to get input into the decision, we wouldn't be having to take this role."

Pennsylvania regulators will not respond to a letter sent by another regulator to a third party, a department spokeswoman said of the Missouri letter. But, she added, while Pennsylvania is taking the lead in evaluating CIGNA's reorganization plan, "CIGNA will need to abide by each respective state's laws."

The Missouri letter follows a similar interpretation of the CIGNA plan by a state guaranty fund association at the Dec. 8 hearing, which drew a similar response from CIGNA.

Under its interpretation of the planned reorganization, the National Conference of Insurance Guaranty Funds said state guaranty funds likely would not respond to claims if the runoff operation failed.

That's because the runoff operation would not be the issuing insurer of the business that it would assume through the planned restructuring, the NCIGF reasoned (*BI*, Dec. 11).

Applying the same reasoning, a group of CIGNA policyholders has argued for months that CIGNA must first obtain their approval to move policies from one unit to another.

A policyholder attorney applauded the Missouri department's position. "We think every jurisdiction that has some nexus to this should be looking at this more thoroughly than the Pennsylvania department has," especially because many CIGNA policyholders in other states did not have ample notice of the Pennsylvania hearings, said John N. Ellison, a partner with Anderson Kill Olick & Cshinsky P.C. in Philadelphia.

Besides the guaranty fund testimony, the Dec. 8 hearing also featured other objections to the plan by CIGNA policyholders and insurers that sold CIGNA AFIA Worldwide Insurance 12 years ago. AFIA was then the nation's second-largest international property/casualty network for U.S. multinationals.

But, an actuary hired by Pennsylvania regulators to review CIGNA's plan defended the financial strength of the proposed runoff operation and said that reinsurance would more than cover any shortfall in reserves under a worst-case scenario.

CIGNA asserts that its planned restructuring into active and runoff insurance operations not only adequately addresses its long-tail liability exposures but also is necessary for its active companies to keep an A- rating from A.M. Best Co. A lower rating would jeopardize the active operation's survival and hamper its ability to meet long-tail claims, CIGNA says (*BI*, Dec. 4).

Under CIGNA's plan, the subsidiary with the greatest amount of environmental and asbestos liabilities, Insurance Co. of North America, would be divided in two. The entity that would retain INA's long-tail liabilities after the division would be named CCI Indemnity Co. and then merged with a few other CIGNA companies into Century Indemnity Co., another CIGNA unit.

Century would become the lead company in a separately capitalized runoff operation that still would be part of CIGNA Corp. The other half of the divided INA would retain its moniker and remain a part of CIGNA's active operations.

The runoff operation would have about \$7.3 billion of funding to pay environmental and asbestos claims, CIGNA says. Those claims would include the 20% of long-tail liabilities that the active operation would retain after the reorganization and then cede to the runoff company through a reinsurance agreement. The active operation, though, would write \$500 million of excess-of-loss reinsurance for the runoff operation.

Missouri's Mr. Divine cites language in CIGNA's plan in building the department's case that the plan violates Missouri law.

He noted in his three-page letter that INA survives the reorganization as the same entity it was before the division and continues as a Missouri-licensed insurer. CCI, though, will be a new entity with its own articles and bylaws and therefore will not be licensed in Missouri, he wrote.

Quoting CIGNA's plan, he notes that INA's liabilities would be "transferred to and vested in CCI."

But, Missouri law prohibits a Missouri-licensed insurer from transferring its policyholder obligations to an insurer that is not licensed in the state, Mr. Divine wrote.

CIGNA could avoid that problem by using an assumption reinsurance agreement to move INA's Missouri policyholder obligations to Century after the CCI merger. But, that move would be subject to prior approval by Missouri regulators and INA's Missouri policyholders, he wrote.

He also noted that violating the Missouri statute is a felony, which could cost INA a license revocation and expose its officers, directors and stockholders to criminal prosecution.

However, CIGNA argues that, under Pennsylvania's corporate division law, the surviving INA in CIGNA's reorganized active operation no longer would be the "issuing" insurer for policies that cover long-tail liabilities. CCI, as the legal successor to INA under that law, would retain those obligations because CIGNA would allocate them to CCI during the division, CIGNA explained.

As a result, the movement of INA liabilities to Century occurs through CCI's merger with Century, CIGNA said. After that merger, Century legally becomes the "issuing" insurer for the INA policyholders with long-tail liabilities, it said.

The process that CIGNA proposes is no different than other mergers between insurers, which are not considered novations and therefore do not require policyholder approval, a CIGNA spokesman explained.

CIGNA officials are scheduled to meet Missouri regulators Wednesday to explain the reorganization plan. That meeting would come a week before the next scheduled public hearing on the plan, at which CIGNA

policyholders and competitors are to testify.

At the Dec. 8 hearing, an attorney for St. Paul Fire & Marine Insurance Co. said the timing of CIGNA's 1984 acquisition of AFIA from St. Paul and other insurers with a stake in the network precludes CIGNA from creating a separate runoff facility for its long-tail liabilities.

The sale agreement and the sellers' agreement to reinsure CIGNA for certain London market-related losses and unrecoverable reinsurance pre-date Pennsylvania laws that allow the kind of corporate division that CIGNA plans to follow, said Peg J. Birk, senior corporate counsel for St. Paul, a unit of The St. Paul Cos. Inc. of St. Paul, Minn. Therefore, she contended, any "transfer of INA's obligations" to AFIA's sellers to another CIGNA unit would violate several provisions of Pennsylvania's and the U.S. Constitution.

St. Paul fears that the runoff facility may not have enough capital to cover reinsurance liabilities for AFIA business that AFIA's former owners wrote but which CIGNA assumed when it acquired the network. St. Paul fears that the liabilities would revert to St. Paul if the runoff operation were to fail.

Total net reported incurred losses on those reinsurance contracts exceed \$525 million, but St. Paul cannot estimate future losses because INA possesses that documentation, Ms. Birk said. A "substantial portion" of those losses are attributable to environmental and asbestos liabilities, she said.

An attorney for a group of insurers that bought so-called "cut-off" coverage from AFIA for their environmental and asbestos exposures said the companies fear CIGNA's long-tail liabilities through AFIA may not have been "adequately stated" for Pennsylvania regulators.

That exposure has "exploded" to between \$40 million and \$100 million, even though they seemed "virtually run off" when the coverage was written in 1977, testified attorney Thomas N. Tartaro of Preston Gates Ellis & Rouvelas Meeds of Washington.

The law firm represents Nationwide Mutual Insurance Co. of Columbus, Ohio; Württembergische Feuerversicherung A.G. of Stuttgart, Germany; and FAI General Insurance Co. Ltd. of Sydney, Australia, a subsidiary of FAI Insurances Ltd.

But, only \$90 million of losses have developed since 1994 on the reinsurance liabilities that CIGNA assumed from AFIA's previous owners, the CIGNA spokesman noted. That represents 17% of the \$525 million of total losses reported to date.

A principal with Tillinghast, the actuary that the Pennsylvania department hired to evaluate CIGNA's plan, testified that the runoff operation's assets would be short by at most \$259 million under the most adverse case. But, that does not account for either the operation's \$500 million reinsurance coverage from the active operation or the expected savings from settlements with policyholders, said Ollie L. Sherman Jr., a Tillinghast principal in Arlington, Va.

That scenario also assumes high liabilities, a very fast payout and a drop in investment yield to 6% from the more than 7% current yield on assets that support CIGNA's current inactive pool of companies, he said.

Meanwhile, Pennsylvania Gov. Thomas Ridge has not answered letters from two former regulators who oppose the plan. Former Pennsylvania Commissioner Herb Denenberg and former Texas regulator J. Robert Hunter, now director of insurance for the Consumer Federation of America, also want Ms. Kaiser, a former CIGNA attorney, recused from the case (*BI*, Nov. 20). ■

Updates

Asbestos firm off hook

NEW YORK—A large British asbestos producer will not have to pay \$110 million in asbestos abatement costs and other damages sought by Chase Manhattan Corp., a federal court jury has ruled.

Chase sued U.K.-based T&N P.L.C. in U.S. District Court in New York, asserting that T&N was liable for damages related to the spray-on asbestos insulation T&N units supplied for the 1959 construction of Chase's 60-story Manhattan headquarters.

Chase began an asbestos abatement program in 1986, removing the material during major renovations. About two-thirds of the building is now asbestos-free.

Chase sought to recover abatement costs, lost rent and diminution of the building's value from T&N, alleging that T&N failed to warn of the risks of asbestos and was guilty of design defects, negligence and fraud.

The jury earlier this month rejected all but one of these claims, finding only that T&N was negligent in failing to warn Chase. However, it also found that the negligence did not contribute substantially to Chase's losses and awarded Chase no damages.

Chase expects to ask that the verdict be set aside, or to appeal if it is not, a Chase official said.

Secondhand smoke award

CLEVELAND—The federal government will pay death benefits to the husband of a Veterans Administration nurse who claimed she developed lung cancer from exposure to secondhand cigarette smoke while caring for mentally ill veterans.

The award by a federal workers comp hearing examiner is believed to be the first Federal Employees' Compensation Act award related to any type of secondhand smoke claim, said Dennis Mankin, special assistant in the U.S. Department of Labor's Office of Workers' Compensation Programs.

While the decision may lead to more claims, they are not expected to burden employers because such factual situations rarely occur, and death-related cases are usually hard for a claimant to win, said Merton E. Marks, an attorney with Lewis & Roca in Phoenix (*BI*, Feb. 8, 1993).

In the case, Philip E. Wiley, now of Charlotte, N.C., sought death benefits after his wife, Mildred, 56, died a month after being diagnosed with lung cancer in 1991. He claimed her only exposure to smoke came during the 18 years she worked in the psychiatric ward of the VA hospital in Marion, Ind., where patients smoked heavily.

The claim was rejected twice, but new medical evidence ruled out other causes of exposure to the cancer-causing agent. In addition, the hospital's own expert witness conceded that he could not rule out that secondhand smoke caused her cancer.

The firm representing Mr. Wiley also filed a separate product liability lawsuit against all the major U.S. cigarette makers, said Will Riley of Young & Riley in Indianapolis.

Mr. Wiley is now entitled to about \$1,000 in funeral benefits and \$21,500 annually, which is half his wife's annual salary. However, any award he may receive from the civil suit could be subject to subrogation by the federal workers comp authorities.

Briefly noted

SCOR S.A. unit SCOR Merger Sub Corp. purchased at \$15.25 a share nearly all of the 3.47 million outstanding shares, totaling \$53 million, of SCOR U.S. Corp., effectively taking the U.S. arm of the French reinsurer off the New York Stock Exchange (*BI*, Nov. 13). . . **CIGNA Corp.** has agreed to pay a \$442,500 fine following a California Department of Insurance exam that turned up numerous rating and documentation errors that cost customers \$1.3 million. CIGNA has repaid customers the \$1.3 million, mostly for directors and officers liability insurance policies. . . **Protection and indemnity** clubs will pay about 15% less for their reinsurance for 1996. Premiums for the 15 members of the International Group of P&I will be cut by about \$60 million. The coverage is led by Lloyd's of London syndicates managed by Janson Green. . . New York-based J.P. Morgan & Co. Inc. says it plans to invest \$200 million for a 3% stake in the new holding company to be formed from the combined property and casualty insurance operations of Travelers Corp. and Aetna Life & Casualty Co. (*BI*, Dec. 4). . . The New Hampshire Insurance Department approved a 7.1% decrease in average pure premium loss costs for workers compensation insurance. Insurers can use that advisory data in calculating employers' rates beginning Jan. 1. . . Standard & Poor's Corp. has placed its AA+ ratings of Nationwide Mutual Insurance Co. on CreditWatch with negative implications following the Columbus, Ohio-based insurer's announcement that it's adding \$1.1 billion to reserves for asbestos and environmental claims. A.M. Best Co. affirmed its A+ rating of Nationwide based on the added reserving, which will give the insurer \$1.5 billion in total reserves for asbestos and environmental claims. . . Philip Singer, a partner with Coopers & Lybrand, and Mark Riley, a partner with accounting firm Clark Whitehill, have been appointed joint provisional liquidators to Belgian reinsurance companies Dai Ichi Kyoto Reinsurance Co. S.A. and Kobe Reinsurance S.A. Mr. Singer also has been appointed equitable receiver over the assets of Ecuadorian insurer El Fenix del Ecuador CA. . . General Motors Corp. is making a one-time, lump-sum retirement benefit payment of \$161 million to approximately 350,000 retirees and surviving spouses. The payment, which will go out to those who retired prior to Oct. 1, 1993, will range up to \$570 per person. Surviving spouses will receive as much as \$342. Payments will be made from GM's operating income, not the pension plans of salaried or hourly employees. . . The Property Claims Service division of New York-based American Insurance Services Group expects many relatively small claims from the high winds and rain that pummeled Northern California, Oregon and Washington early last week. Insured damage estimates will be available this week.

Quality

Continued from page 3

"This gives employers a way to measure economic value and quality of care. They really have no way of doing that now," he said. "They may find that HMOs are best in one market, while it's the PPOs in another."

Tom Burns, managing director-employee benefits with NYNEX Corp. in White Plains, N.Y., called the study "critical," because it gives employers something more to communicate to employees about the cost and quality of their health care plans beyond just the employer's good word.

"This type of information allows employees to vote with their feet," he said. "It's more reassuring to them. They can see something that proves their HMOs are quality outfits."

He also said the study gives employers more information for negotiating with health plans. "Previously, all we had was a basic cost index. But this is a tool that allows us to go beyond costs to include quality parameters. It standardizes quality in a nice, distilled fashion."

To rate cost efficiency, Hewitt is obtaining estimated or actual health plan costs from employers for 1996, and then adjusting that information to reflect differences in plan design and enrolled population, including age and gender mix, geographic location and levels of dependent coverage. For cost efficiency, insured and self-insured indemnity plans are included.

The end result of the cost/quality analysis is that plans will be rated along a regional cost/quality matrix. That matrix will let companies see how their plans stack up against others.

"We're absolutely comfortable that we can be accurate in our scoring of plans, because we have done a lot of quality and cost studies for individual employers," Mr. Beauregard said. "The plans know what we're doing, and so do the participants. The only thing different here is we're doing it by market and we're making adjustments to come up with accurate cost-efficiency scores. I think clients will agree that the difference between \$3,000 and \$2,000 in raw costs is meaningless unless it is adjusted, allowing employers to make apples-to-apples comparisons between plans."

Those are just the sort of comparisons for specific regions that Nestle USA Inc. is looking for, said Steve Fussell, vp-compensation, benefits and human resources information systems with the company in Glendale, Calif. Nestle,

Dayton Hudson Corp., International Business Machines Inc., Marriott International Inc. and NYNEX Corp., are some of the major employers involved in the project.

"Health care is really delivered in local markets, so getting these cost comparisons will be important to us," said Mr. Fussell. "We get a lot of information on the supply side, so getting more on the demand side should help."

In addition to the cost/quality matrix showing where plans rank by region, participating companies will receive estimates of their individual financial savings opportunities by region, estimates of quality-improvement opportunities by region, tabular results for all 75 regions, graphic illustrations for each employer's five largest markets, quality-index scores for every managed care plan and financial index scores, including participant scores for which plans scored highest and lowest.

"One of the goals is to come up with a target premium for every participant and every plan, which allows both employers and health plans to assess whether they meet, beat or fall below targets. In terms of targeting quality, that may be easier because it's not specific to enrollment," said Mr. Beauregard.

Transfers

Continued from page 3

cated that the rules won't have much of an impact," said Michael Sternklar, a principal with Kwasha Lipton L.L.C. in Fort Lee, N.J.

For example, at Marriott International, 401(k) plan deferrals are transferred on the same day an employee is paid to the plan custodian and immediately invested.

"The Labor Department rules will have no impact on us," said Deborah Iwig, Marriott's vp-retirement benefits and human resource services in Bethesda, Md.

But some big companies will have to speed up transfers. For example, Hartmarx Corp. wire transfers deferrals once a month.

"If we had to transfer money every time a payroll was run in a different division, it would add to administrative expense and not be very efficient," said Michael Pikely, corporate actuary with the Chicago-based clothing company.

And some companies take even longer. Gary Blank, an independent retirement and 401(k) plan consultant in San Francisco, says very de-

The method Hewitt is using to come up with quality indices involves interpreting Health Plan Employer Data and Information Set (HEDIS) 2.5 data reporting elements. Earlier this month Hewitt distributed a questionnaire to all plans being evaluated. Questions covered clinical quality criteria like utilization rates, clinical results, provider management and quality improvement initiatives.

It also sought information related to administrative effectiveness, including member services, access, ID card issuance and retiree coverage. The final category is organizational stability, including membership and accreditation.

Responses are measured against accepted standards and other national benchmarks, and then clinical quality is given 45% weighting, while administrative effectiveness receives 35% and organizational stability 20%.

Hewitt will also be making regional cost and quality information available to nonparticipating employers on a fee-for-service basis. While those companies will not be able to see how their plans would score, they will be able to obtain more general information from Hewitt's data base.

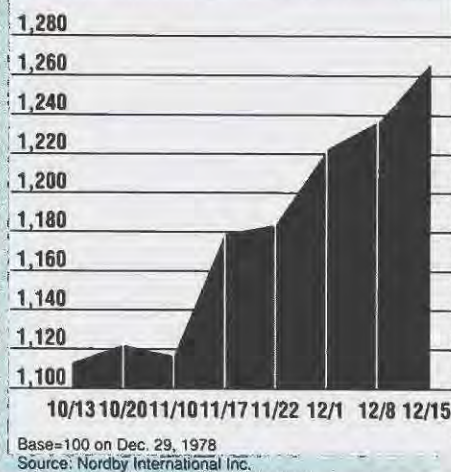
centralized companies can take as long as a couple of months to transmit deferrals. It can take that long to verify payroll and other information from worksites, he said. "The rules could change the way some companies administer their benefit programs."

The Labor Department's proposed rules come as the department is investigating more than 300 companies for possible misuse of 401(k) plan assets. It said it has reached agreements with about 100 companies—generally those with well under 100 employees—that they restore about \$2.5 million in employees' salary deferrals that were never deposited. Employers today sponsor some 149,000 401(k) plans, which have assets that the department estimates at \$650 billion.

Despite the publicity from that investigation, few employees apparently are worried about the safety of their 401(k) assets.

"We haven't gotten calls and we think that is because we have communicated our plan very well. Employees are pleased with the plan and know that the plan is being managed by a reputable financial institution," said Jim Bell, director of benefits at forest products company Mead Corp. in Dayton, Ohio.

BI Insurance Index



PCS catastrophe options

As of Dec. 15			
Call spread	Price bid/ask	Call spread	Price bid/ask
Eastern September 1996			
40/60	5.4/6	10/20	1/1.4
50/70	4/6.5	5/15	2/4.2
80/100	2.5/4		
Southeast Sept. 1996			
80/100	2/4	California Annual	
		40/60	2/4.5
Total volume: 38 Total open interest: 904			
For information on PCS cat options, call 312-435-3674.			
Source: Chicago Board of Trade			

British Issues

Dec. 14 Companies	Price pence	P/E	Div. %	Yield %	1 week high-low
Comm Union	639	12.8	35.0	5.5	639-632
Genl Accident	663	9.5	38.8	5.9	663-650
Gdn Royal Exch	272	9.1	11.3	4.2	272-261
Independent	335	7.4	13.8	4.1	335-335
Royal	385	7.8	18.8	4.9	385-378
Sun Alliance	398	8.7	21.3	5.4	398-382
Brokers					
Bradstock	72	12.0*	7.1*	9.9	75-66
Fenchurch	141	9.5*	10.6*	7.5	142-141
CE Heath	150	9.4	12.5	8.3	150-146
JIB Group	104	10.9	9.4	9.0	105-104
Lloyd Thompson	164	10.1*	11.3*	6.9	164-146
Lowndes Lmbt	146	7.9	11.0	7.5	147-144
Nelson Hurst	143	9.5	9.5	6.6	143-142
Sedgwick Grp	124	10.9	8.1	6.5	124-116
Steel Brl Jones	37	4.6	5.6	15.1	38-37
Willis Corroon	146	13.3	8.3	5.7	146-137

Source: Philip Olsen, London * Actual. Others estimated.

BI Industry Stock Report DEC. 11, 1995, THROUGH DEC. 15, 1995

BROKERS																													
		Price	% change	Year to date % change	Annual High	Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt./Bk. value			Price	% change	Year to date % change	Annual High	Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt./Bk. value				
Accordia Inc.	NYS	28.875	0.87	-13.81	34.50	23.50	31	0.72	2.49	16	14.00	2.06	National Re Corp.	NYS	34.375	1.85	30.95	35.38	22.88	98	0.2	0.58	17	17.05	2.02				
Alexander & Alexander	NYS	19.625	-5.99	6.08	26.44	18.50	404	0.1	0.51	-16	19.17	1.02	Navigators Group	NDO	18.875	-3.21	30.17	19.75	12.75	27	0.00	0.00	18	10.21	1.85				
E.W. Blanch Holdings Inc.	NYS	22.5	4.05	9.09	22.50	16.50	169	0.4	1.78	18	1.40	16.07	Nobel Insurance Ltd.	NDO	11.5625	0.54	40.15	12.25	8.13	151	0.2	1.73	5	6.84	1.69				
Gallagher Arthur J. & Co.	NYS	36	1.41	12.50	38.00	29.63	99	1	2.78	14	6.48	5.56	Ohio Casualty Corp.	NDO	38.625	2.32	36.73	38.75	27.00	168	1.52	3.94	21	23.64	1.63				
Hibb, Rogal & Hamilton	NYS	13.75	-2.65	13.40	14.38	10.50	122	0.6	4.36	17	1.21	11.36	Old Republic Int'l	NYS	34	-1.09	60.00	35.25	19.50	768	0.52	1.53	11	25.79	1.32				
Kaye Group Inc.	NDO	7.5	3.45	-23.08	10.75	6.75	8	0.1	1.33	8	NA	NA	Orion Capital Corp.	NYS	44.75	3.17	26.95	45.25	31.75	116	0.92	2.06	10	26.00	1.72				
Marsh & McLennan	NYS	89.375	0.85	12.78	90.13	75.25	748	3.2	3.58	17	19.95	4.48	Partner Re Ltd.	NDO	25.375	-3.79	22.29	28.38	18.75	694	0.00	0.00	0	20.37	1.25				
Poe & Brown	NDO	24.375	0.52	12.07	25.25	19.75	43	0.48	1.97	15	5.15	4.73	Penn-America Group Inc.	NDO	14.5	1.75	96.61	14.50	6.50	74	0.12	0.83	12	6.40	2.27				
BROKERS	AVERAGE		0.3	3.6					2.7	13			Philadelphia Cons. Holding	NDO	16.625	-2.21	35.71	21.88	12.00	13	0.24	1.44	14	9.05	1.84				
													PXRE Corp.	NDO	25.75	6.19	-8.85	29.75	21.00	71	0.72	2.80	5	21.27	1.21				
													Provident Life	NYS	29	0.00	33.33	29.75	20.50	99	0.72	2.48	13	22.34	1.30				
													Prudential Reinsurance	NYS	22.25	4.71	NA	22.38	18.50	870	0.12	0.54	13	NA	NA				
													Reliance Group Holdings	NYS	8.375	0.00	61.45	9.25	4.88	972	0.32	3.82	12	3.42	2.45				
													Reliastar Financial Corp.	NYS	43.375	-0.57	49.57	44.50	27.38	376	1	2.31	11	24.53	1.77				
													RenaissanceRe Holdings Ltd.	NDO	31.125	3.75	NA	33.13	20.72	370	0.00	0.00	0	NA	NA				
													Risk Capital Holdings	NDO	21.375	5.56	NA	22.50	19.88	106	0.00	0.00	0	NA	NA				
													RLI Corp.	NYS	24.5	1.03	49.39	24.75	16.00	56	0.52	2.12	33	20.51	1.19				
													St. Paul Companies	NYS	57.5	3.84	28.49	59.38	42.00	1377	1.6	2.78	10	32.46	1.77				
													SAFECO Corp.	NDO	37.125	-0.34	42.79	37.75	25.00	2214	1.06	2.86	12	44.95	0.83				
													SCOR U.S. Corp.	NYS	15.25	0.00	82.09	15.75	7.50	2	0.2	1.31	17	13.60	1.12				
													Seibels Bruce Group	NDO	1.1875	-9.52	-52.50	3.06	0.44	109	0.44	37.05	-1	0.04	29.69				
													Selective Ins. Group	NDO	37.75	-1.31	49.50	38.38	23.75	31	1.12	2.97	11	23.23	1.63				
													Sphere Drake Holdings	NYS	14	-2.61	0.90	19.13	11.13	36	0.00	0.00	0	13.86	1.01				
													TIG Holdings	NYS	27.75	1.83	48.00	28.25	17.50	803	0.2	0.72	16	16.62	1.67				
													Titan Holdings, Inc.	NYS	14.625	0.00	50.00	15.75	9.13	78	0.3	2.05	11	9.04	1.62				
													Tokio Marine & Fire	NDO	61.375	2.72	1.03	62.00	49.88	34	0.4	0.65	54	57.72	1.06				
													Torchmark Corp.	NYS	43.75	-0.57	26.81	44.75	34.00	560	1.16	2.65	12	17.37	2.52				
													Transatlantic Holdings	NYS	73	2.64	30.65	73.88	51.00	167	0.48	0.66	13	33.30	2.19				
													Transnational Re Corp.	NDO	24.875	-0.50	5.85	27.25	18.75	78	0.00	0.00	7	18.84	1.32				
													Travelers Corp.	NYS	60.5	-0.82	86.87	63.00	30.75	3955	0.8	1.32	13	24.77	2.44				
													Trenwick Group Inc.	NDO	53.125	2.16	25.37	54.00	36.88	198	1.12	2.11	12	29.23	1.82				
													United Fire & Casualty	NDO	43.75	21.53	58.13	43.75	26.75	23	0.9	2.06	11	28.96	1.51				
													Unirun	NDO	48.5	1.31	12.79	50.50	41.50	90	2	4.12	13	37.51	1.29				
													UNUM Corp.	NYS	55	-0.90	45.70	56.38	37.63	998	1.06	1.93	15	26.45	2.08				
													US Facilities Corp.	NDO	21.125	-5.06	111.25	23.38	9.38	206	0.2	0.95	9	11.66	1.81				
													USF&G Corp.	NYS	17.125	-3.52	26.85	19.50	13.38	2116	0.2	1.17	10	10.86	1.58				
													USLIFE Corp.	NYS	29.375	-7.48	26.34	32.00	22.63	388	0.93	3.17	10	38.45	0.76				
													Washington National	NYS	25.125	-0.50	32.24	26.00	17.75	109	1.08	4.30	10	25.13	1.00				
													Zenith National Ins.	NYS	20.875	-2.34	-8.24	24.63	19.38	47	1	4.79	28	16.35	1.28				
													Zurich Reinsurance Centr.	NYS	29.75	1.71	3.03	30.88	25.00	77	0.00	0.00	106	21.64	1.37				
													INSURERS/REINSURERS	AVERAGE	1.2	34.1						2.4	17.1						
HEALTH MAINTENANCE ORGANIZATIONS																													
													RHP International	NDO	29.25	2.18	13.59	30.00	19.50	1402	0.00	0.00	154	28.15	1.04				
													Humana Inc.	NYS	27.125	1.40	19.89	28.00	17.00	3396	0.00	0.00	23	6.56	4.13				
													Pacificare Health Sys.	NDO	86	0.58	32.05	88.00	44.50	54	0.00	0.00	24	15.02	5.73				
													Safeguard Health Enier.	NDO	12	6.67	29.73	13.25	8.25	32	0.00	0.00	30	6.15	1.95				
													Sierra Health Services	NYS	31.125	-3.86	-1.58	33.63	22.13	259	0.00	0.00	16	9.22	3.38				
													United Healthcare Corp.	NYS	64.875	5.27	43.77	64.88	34.13	4398	0.03	0.05	32	15.17	4.01				
													U.S. Healthcare	NDO	44.625	1.42	8.18	47.50	26.50	5383	1.1	2.46	18	5.66	7.88				
													Wellpoint Health Networks	NYS	32.625	1.56	12.02	37.00	27.00	587	0.00	0.00	15	14.26	2.29				
													HMOs	AVERAGE	1.9	19.7						0.3	35						
													ALL COMPANIES	AVERAGE	1.1	19.1						2.6	21						

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