DECEMBER 22, 1997

Business Insurance®

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

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YEAR IN REVIEW

1997

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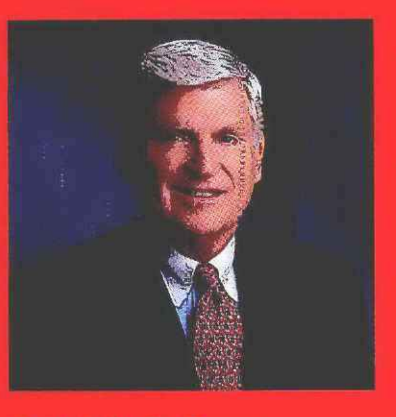

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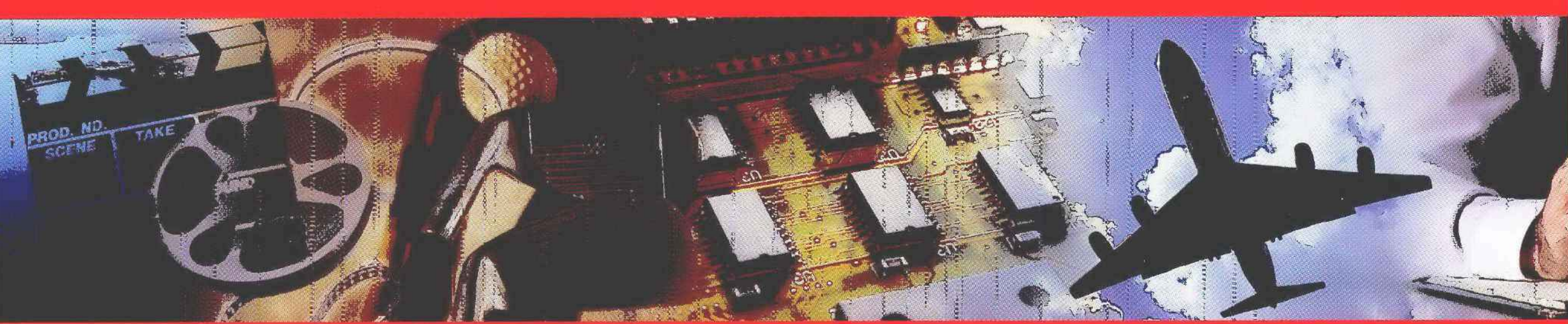

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Updates

Lloyd's wins agreement for reinsurance of Lioncover

LONDON—Lloyd's is reinsuring Lioncover Insurance Co. Ltd. into Equitas Ltd.

In an 11th-hour agreement reached late last week with the blessing of the U.K. Department of Trade and Industry, Equitas, the runoff reinsurer of Lloyd's 1992 and prior liabilities, will take over Lioncover for a £601 million ($1 billion) premium.

The deal was pushed through by Lloyd's as Lioncover's sole shareholder, because the Lioncover board could not reach unanimous agreement. Lloyd's set up Lioncover in 1987

See **Updates** *on next page*

Surcharge to raise costs

Massachusetts follows New York's lead with levy on health bills

By JERRY GEISEL

BOSTON—Health care payers soon will be liable for another state-mandated surcharge on hospital bills.

The new Massachusetts surcharge, currently 5.06%, will affect third-party claims administrators, insurers, health maintenance organizations, preferred provider organizations and employers nationwide that self-administer their health care plans that make payments to Massachusetts acute care hospitals and ambulatory surgical centers on or after Jan. 1.

"Generally, those responsible for the payment of bills of those who use Massachusetts hospitals must pay," said Charles L. Donahue, president of HealthCare VALUE Management Inc., a health care plan network in Norwood, Mass.

However, health care payers whose Massachusetts hospital bills were less than $300,000 in 1996—such as TPAs outside Massachusetts, for example—can escape the surcharge if by Jan. 15 they register with the state's Division of Health Care Finance and Policy as an "infrequent payer" and pay a $2,400 fee.

However, if in any calendar year an infrequent payer makes at least $300,000 in payments to Massachusetts' hospitals, it would be liable for the surcharge in the next year.

The new surcharge is designed to fund annually a $100 million pool the state will use to reimburse hospitals for uncompensated care provided to the uninsured.

When the new law takes effect Jan. 1, Massachusetts will join New York as the two states to establish hospital bill surcharges directly paid by the buyers of health care services.

See **Surcharge** *on page 42*

Health care taxation without representation?

Key elements of Massachusetts' new hospital bill surcharge:

- A 5.06% surcharge will be assessed on payments made to acute care hospitals and ambulatory service centers.
- Surcharge is paid by any party—including TPAs, insurers, HMOs and self-administered employers—that pays hospital bills, regardless of whether they are located in the state.
- Health care payers that paid less than $300,000 in Massachusetts hospital bills in 1996 can temporarily escape surcharge by paying a $2,400 fee by Jan. 15.
- Workers compensation, Medicare and Medicaid programs will be exempt from the surcharge.

GRAPHIC BY JOHN HALL

Business applauds 'junk science' ruling

By MARK A. HOFMANN

WASHINGTON—Business groups believe the Supreme Court's decision in a case involving expert testimony will make it harder for what they consider "junk science" to be used in court.

The case, *General Electric Co. et al. vs. Joiner et ux.*, reaffirmed the 1993 Supreme Court decision in *Daubert vs. Merrell Dow Pharmaceuticals Inc.*, which made district courts—not appellate courts—responsible for evaluating scientific evidence for reliability and relevance before being admitted.

The *Daubert* decision clarified what district court judges must do before allowing expert testimony to be heard, including determining whether the reasoning or methodology on which the testimony is based is scientifically sound and whether the reasoning and methodology are relevant to the facts in a particular case.

Despite the standards set by the high court in *Daubert*, the 11th U.S. Circuit of Appeals in reviewing the *Joiner* case overturned a district court's decision banning the testimony of certain expert witnesses and decided to undertake its own review of the expert testimony in question.

In its review of the circuit court's action, the Supreme Court ruled 8-1 last week that the appellate court had been wrong to second-guess the district court.

The high court's decision won praise from legal experts and business groups.

"I think the court's decision is good news for those of us who are

See **Ruling** *on page 39*

Comp increase sought

Study offers new ammo for California legislation

By ROBERTO CENICEROS

SACRAMENTO, Calif.—Bolstered by new research on California's workers compensation system, labor representatives and claimant attorneys are planning to renew lobbying for legislation that would increase workers comp benefits.

Proponents of the legislation contend that billions of dollars in savings that payers have realized in the wake of 1993 workers comp reforms should be shared with employees in the form of higher benefits. Their lobbying on this issue led both chambers of the state Legislature this year to pass identical bills calling for increased workers comp benefits.

The workers comp bills are in policy committees in each chamber and can be taken up again in the next session, which begins in January.

Proponents of the measures are more confident of their chances of winning increases in permanent partial, permanent total and temporary disability benefits because of a report released last month by the Rand Corp.'s Institute for Civil Justice.

Among the Rand study's findings is that in the first five years after reporting permanent disability injuries, employees on average lose 40% of their wages but receive only 33% of those losses back in benefits (*BI*, Nov. 24).

Rand was hired by California's Commission on Health and Safety and Workers Compensation to evaluate the PPD component of workers compensation. The commission was created as part of the state's 1993 workers comp reforms to evaluate the PPD system and oversee workers comp changes.

"We now have this Rand study that makes it very clear that people who are getting disability benefits are grossly undercompensated, so we have a little more ammunition from a source that might be considered less biased," said Tom Rankin, president of the California Labor Federation AFL-CIO in Sacramento. "I'm sure a benefit bill will be placed on the governor's desk sometime during the year. What form it will finally take, I'm not sure."

Joseph Markey, president of the California Self-Insurers Assn. in Sacramento, said he also expects legislation to increase

See **Comp** *on page 39*

Employers Re enters primary market with purchase of IRI from pool members

By GAVIN SOUTER

HARTFORD, Conn.—Employers Reinsurance Corp. is moving into the primary property market with the purchase of highly protected risk insurer Industrial Risk Insurers for an undisclosed sum.

But the purchase will not lead to ERC competing significantly with its existing clients for primary business, said Kaj Ahlmann, chairman, president and chief executive officer of ERC.

Other reinsurers have strained relations with clients as they searched for premium growth by writing more primary business (*BI*, Nov. 10).

But few existing ERC clients write HPR business, so there will be little overlap of interests with the purchase of IRI, Mr. Ahlmann said.

IRI will give ERC a specialty in primary HPR property insurance, said Mr. Ahlmann.

"As a leader among HPR carriers and with its skilled workforce, IRI will permit ERC to expand the scope of services it provides for its global clients," he said.

The purchase will bring certainty to IRI, an association writing HPR coverage for more than 20 insurers that only commit to the pool for a year at a time, said Gail P. Norstrom, president and CEO of IRI in Hartford, Conn.

The sale also will give the member companies the opportunity to cash out of IRI, which has shrunk its premium base and turned significant losses into small profits over the past two years, he said.

GE Capital Services Inc., which owns ERC in Overland Park, Kan., will buy the assets of IRI and transfer them to ERC, which will reinsure the in-force policies and assume the renewal rights of IRI.

IRI will remain an association, but 99.5% of the underwriting capacity will be provided by ERC and 0.5% by the Hartford Steam Boiler Inspection & Insurance Co. in Hartford. HSB will provide inspection services for IRI clients, Mr. Norstrom said.

ERC and HSB will establish a joint

See **IRI** *on page 44*

New owners at IRI

The purchase of Industrial Risk Insurers will change the structure of the property insurance pool

New underwriting capacity:	
Employers Reinsurance	99.5%
Hartford Steam Boiler	0.5
1997 underwriting capacity:	
Hartford Fire	23.5%
Hartford Steam Boiler	23.5
Zurich Insurance Co.	23.5
Lloyd's syndicate 362	7.0
American Re-Insurance	5.0
Fireman's Fund	5.0
Lloyd's syndicate 376	2.5
National Re	2.5
Lloyd's syndicate 138	2.0
Lloyd's syndicate 510	1.5
CIGNA	1.0
12 insurers, each with less than 0.5%	3.0

Source: Industrial Risk Insurers

GRAPHIC BY MIKE GARVEY

Updates

Lioncover goes into Equitas

Continued from previous page

to reinsure syndicates managed by PCW Underwriting Agencies Ltd., WMD Underwriting Agencies Ltd., and Richard Beckett Underwriting Agencies Ltd. and syndicates 2 and 49.

Almost 3,000 names were members of the syndicates, which collapsed in 1982. An internal Lloyd's investigation found evidence of fraud, but no one was prosecuted.

When Equitas opened last year, Lioncover could not be included because of disputes with reinsurers. These have now been settled, said Ian Barrett, managing director of Syndicate Underwriting Management Ltd., the organization managing Lioncover.

The agreement between Lloyd's and Equitas is "a satisfactory outcome for all concerned," said a statement issued by the Assn. of Lloyd's Members. ALM chairman Sir David Berriman said he thought it was the "right bargain," noting Lloyd's still retains responsibility to pay any additional liabilities.

The premium Lloyd's paid, comprising Lioncover reserves and an "additional premium" to Equitas, is £100 million ($166.6 million) less than estimated by Equitas' reserving project as at the end of 1995 due to claims settlements and reinsurance recoveries. In fact, Lloyd's paid £25 million ($41.5 million) more in the "additional premium" than it estimated in its reconstruction and renewal offer.

In total, Lloyd's has put £591 million ($984.7 million) into Lioncover.

Equitas' surplus will be boosted by £70 million ($116.6 million) as a result of the deal.

Tort reform law overturned

SPRINGFIELD, Ill.—The Illinois Supreme Court has rejected the state's 1995 tort reform law, saying the law's $500,000 limit on non-economic compensatory damage awards in personal injury lawsuits "specifically discriminates against the most seriously injured plaintiffs" and usurps the judiciary's power.

While the court's opinion suggested that some aspects of the law might comply with Illinois' constitution, it held that many do not, leading it to overturn the law in its entirety.

Among other aspects with which the court took issue was the law's provision allowing businesses being sued access to all medical records of the plaintiff, even if they are not directly related to the lawsuit or the injury in question.

The tort reform law was passed in the spring of 1995 as "fast track" legislation after Republicans took control of both chambers of the Illinois General Assembly. They since have lost their majority in the Assembly's House of Representatives.

Surplus to exceed $300 billion

NEW YORK—The property/casualty insurance industry's surplus will exceed $300 billion at year-end, according to estimates by the Insurance Information Institute and Standard & Poor's Insurance Rating Services.

The industry's surplus will be $307.3 billion at year-end, up 20.3% from 1996.

And the industry is expected to report a 102% combined ratio, which would be the lowest since 1979. That compares with a 105.8% ratio in 1996.

Sean Mooney, senior vp and economist with the III, estimates earned premiums will increase 3.3% in 1997, to $272 billion, and losses and loss expenses will fall by 3.1% to $200 billion.

After expenses and dividends, the 1997 underwriting loss is estimated at $7.2 billion. After investment income and other items, the industry will report after-tax net income of $34.7 billion, up 42.2% from 1996.

Among the factors improving 1997 results were estimated 1997 insured catastrophe losses of $3.5 billion, down 52.7% from 1996 and the lowest since 1990's $2.8 billion, Mr. Mooney noted.

In 1998, the industry's combined ratio is expected to increase to 105% according to Standard & Poor's. The industry's after-tax income is projected to fall to $26 billion in 1998.

Court clarifies timeline for suits

WASHINGTON—The six-year deadline for underfunded multiemployer pension plans to sue to recover withdrawal liability payments from an employer that has left the plan does not begin to run until an employer fails to make payments on a schedule set by plan trustees, the Supreme Court ruled last week.

At issue in last week's decision is when the clock starts on a statute of limitations provision in the Multiemployer Pension Plan Amendments Act, the 1980 law that requires employers leaving underfunded plans to pay a share of a plan's promised but unfunded benefits.

In a unanimous decision in a case involving a San Francisco laundry that withdrew from the Bay Area Laundry & Dry Cleaning Pension Trust, the justices said the six-year statute of limitations doesn't begin until a multiple-step process is complete.

First, the trustees must calculate the debt, set a schedule of installment payments and then demand payment. Second, the employer must default on an installment that is due and payable under the trustees' schedule.

The court also said the six-year statute applies separately to each scheduled payment. As a result, if a plan was too late in filing suit to demand the first due withdrawal liability payment, it still could sue to recover succeeding liability payments.

Workplace injuries down in '96

WASHINGTON—The incidence of workplace injuries and illnesses is continuing to drop, according to the U.S. Department of Labor.

The department's Bureau of Labor Statistics released its annual

See **Updates** *on page 42*

Indiana seizes insurer

Company was linked to two now-defunct IIE syndicates

By DOUGLAS McLEOD

INDIANAPOLIS—Indiana regulators have seized control of Classic Fire & Marine Insurance Co., a property/casualty insurer and affiliate of two now-defunct syndicates on the Illinois Insurance Exchange.

The Indiana Insurance Department obtained a rehabilitation order Dec. 10 against Classic Fire, charging that its policyholder surplus may be overstated and noting "significant turnover in management," including resignations this year of its president, vp-general counsel and corporate secretary.

An Indiana state judge also issued a seizure order allowing regulators to take possession of the Concord, Calif., offices of Concord General Corp., Classic Fire's parent company, and several affiliates. These include JBW & Co. Inc., Concord Information Systems Inc. and Lobo Claims Management Inc., court records show.

The orders are the latest blow to the crumbling insurance empire of California businessman Jeffrey W. Beresford-Wood, owner of Concord General and JBW. In September, United Southern Assurance Co., a Classic Fire unit writing commercial auto coverage in Florida, agreed to be liquidated by Florida regulators.

In July 1996, Illinois regulators placed Geneva Assurance Syndicate Inc., an IIE syndicate owned by United Southern and JBW, into liquidation.

Classic Syndicate Inc., another IIE member and Classic Fire subsidiary, withdrew from the exchange in 1995 and was absorbed by its parent company.

See **Classic** *on page 44*

Allianz, Generali negotiate to end rivalry to buy AGF

By MARIA KIELMAS

PARIS—Allianz A.G. Holding and Assicurazioni Generali S.p.A. are in negotiations likely to end their contentious battle for control of French insurer Assurances Generales de France.

A proposed deal is expected to give Germany's Allianz control of AGF, while Italy's Generali will withdraw its bid and receive from the two companies shares in other European insurers.

Stock analysts say the proposed solution is a winner for Allianz and Generali, though AGF shareholders may get less than they would have if a bidding war had ensued. One analyst called it a political rather than business solution.

Executives with Allianz and Generali declined to comment on the structure of the deal while they are negotiating.

"There are negotiations, but we still don't know what will happen," said Benito Pagnanelli, deputy managing director of Generali in Trieste, Italy.

An Allianz spokesman in Munich, Germany, said, "We are a good way along to get a decision before Christmas, but nothing is signed yet."

However, an AGF executive in Paris confirmed that the basic elements of the accord had been resolved, though details still were being negotiated.

The main points of the agreement, the executive said, are that Generali will withdraw its hostile

See **Negotiate** *on page 40*

WTO pact includes insurance

By GAVIN SOUTER

GENEVA—The World Trade Organization's agreement on financial services may create a more efficient insurance market for multinational buyers.

The range of commitments given by the countries that signed the agreement Dec. 13 will mean greater certainty for insurers acquiring operations overseas and a fixed system of remedy if any countries renege on the agreement.

"This is a historic accomplishment," said Gordon Cloney, president of the International Insurance Council in Washington.

The agreement, which takes effect in early 1999, covers more than 98% of the world's insurance business in more than 60 countries, he said.

Still, there were some notable exceptions. For example, Malaysia held out against U.S. pres-

See **WTO** *on page 41*

Six-month delay for exemption

Employers must first comply with mental benefit parity law

By ROBERT KAZEL

WASHINGTON—Employers whose health plan costs go up at least 1% after complying with a new federal law on mental health care benefits will have to wait until July 1 to apply for an exemption from the law.

The mental health parity law, which takes effect Jan. 1, prohibits employers from imposing annual or lifetime dollar caps on mental health care that are lower than caps on care for physical sickness.

The law, however, permits other restrictions on mental health benefits, such as limits on the number of covered visits and higher copayments for mental health care treatments than treatments for physical conditions.

While these permitted limitations should permit employers to comply with the law while holding mental health care cost increases below 1%, a vaguely worded section of the law also provides an exemption for employers whose costs rise at least 1%.

To clarify the application of this exemption, the

See **Parity** *on page 41*

Inside

- Editorial Cartoonist Roger Schillerstrom reviews the year in verse. **PAGE 8**
- Asian companies must be prepared for more liability lawsuits including product liability and directors and officers actions, conferece attendees are told. **PAGE 35**
- A loss adjuster thinks claims will total about $4.4 million from the fire this month at Heathrow Airport. **PAGE 35**
- Almost Donothing does something: He hooks onto a trend. **PAGE 44**

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YEAR IN REVIEW 1997

TOP STORIES

EMPLOYEE BENEFITS

1. Mergers and acquisitions sweep the employee benefit consultants
2. The Pension Benefit Guaranty Corp. reports its first surplus
3. PARCA health care legislation worries employers and insurers
4. Group health care costs remain stable, but increases loom on horizon
5. Initiatives proposed to improve health care plan quality
6. Clinton launches new proposals to expand health coverage
7. High court exposes employers to benefit suits by dismissed employees
8. Congress gives retirees new options to Medicare program
9. Sears, Roebuck & Co. cuts back on retiree benefits
10. UPS and Teamsters square off on multiemployer pension plans

RISK MANAGEMENT

1. Consolidation continues to shrink the brokerage industry
2. Tobacco companies, states propose settlement of litigation
3. Supreme Court rules against mass tort settlements
4. Lloyd's of London reports record profits for 1994 year of account
5. USAA creates special reinsurer to issue catastrophe bonds
6. J&H Marsh & McLennan Inc. memo details new replacement strategy
7. Awareness of Year 2000 computer problems, solutions grows
8. Insurer restructurings, acquisitions continue
9. Watered-down federal product liability reform wins support
10. Bermuda insurers and reinsurers aggressively diversify

GRAPHICS BY ADAM DOI

Benefit managers busy putting laws into practice

By ROBERTO CENICEROS and JOANNE WOJCIK

Complying with changes mandated by the Health Insurance Portability and Accountability Act and other new federal benefits laws are among the issues that preoccupied employers during 1997.

And benefit managers expect more legislative changes to fill their plates in 1998, especially since President Clinton and Rep. Charlie Norwood, R-Ga., have already started promoting new federal health care consumer protection legislation.

However, not all of the past year's developments were viewed negatively.

For example, some benefit managers believe the spate of HMO mergers will produce some benefits for employers.

"To a certain extent, it probably makes life easier for us" because "it gives us a handful of less people to have to contact and deal with," said Paul Jemison, corporate benefits manager in Palo Alto, Calif., for Hewlett-Packard Co.

"I think the most significant change that has affected everyone throughout the industry during 1997 has been the recognition by the Congress and the president that they can legislate incrementally, that they can mandate benefits most people would consider so tiny but are sometimes very expensive in their implementation," observed Helen Darling, manager of international compensation and benefits at Xerox Corp. in Stamford, Conn.

"For example, if you were going to mandate anything, wouldn't you pick a second hospital day for healthy moms and babies?" she asked.

"For governing officials, it's the best of all possible worlds. They can look good and please constituents, especially narrow special interests and groups that want some special consideration," Ms. Darling said.

"But neither the special groups nor the ones doing the mandating have to consider the implications" of their actions, she pointed out. Instead, employers and the health care industry end up picking up the tab, she said.

For example, even though the cost impact of these new benefit laws will be negligible for Hartmarx Corp., the communication effort has been significant, according to Michael Pikelny, benefits consultant and corporate actuary in Chicago.

As mandated, Hartmarx on Jan. 1, 1998, will comply with the new federal law prohibiting lower annual and lifetime benefits for mental disorders than for physical disorders. However, most of the work of reorganizing the company's plan and notifying 1,600 employees of those changes occurred during 1997, Mr. Pikelny said.

See **Review** on page 6

Broker consolidation tops risk management news

By MICHAEL PRINCE and MICHAEL BRADFORD

Big brokers getting bigger is the biggest news story of 1997, according to many risk managers.

"The big story is consolidation," said Arnold L. Davenport, vp-risk management for Bethesda, Md.-based Marriott International Inc., echoing the opinion of other risk managers.

Other issues noted include the increasingly important role of the risk manager, the growth of non-traditional programs and the Year 2000 computer problem.

Despite the overwhelming agreement on the importance of consolidation, opinions varied on its long-term effect.

Greg Turk, director of risk management and employee benefits at Electrolux Corp. in Atlanta, said many risk managers "have a lot of fear and trepidation about consolidation."

Bruce Evancho, manager-corporate insurance and risk management for E.I. du Pont de Nemours & Co., of Wilmington, Del., also said he's unsure of consolidation's impact on policyholders.

Consolidation is a double-edged sword, he said. The economies of scale of a large organization could benefit the policyholder. On the other hand, consolidation may concentrate too much power in the hands of a few players. To date, "it weighs more to the positive side than the negative side," he said.

So far, noted Mark DeLillo, vp-risk management at Celotex Corp. in Tampa, Fla.: "There have been no negative signs. I guess that is a positive sign in itself."

Broker consolidation has not affected Fidelity, said Judy Lindenmayer, vp-Fidelity insurance and risk management for FMR Corp. in Boston, better known as Fidelity Investments. It hurts some risk managers, however, who want a relationship with more than one broker, she said.

Mr. Turk of Electrolux said: "I'm not overly concerned about it. I think there will always be the big brokers, middle-tier and small-tier brokers. But that's the big story."

Microsoft Corp. and other policyholders, however, "have experienced a loss of focus on the part of service providers," because of consolidation, said Scott Lange, director of risk management for Redmond, Wash.-based Microsoft. This is a short-term problem, however, and in a year "we will finally start to see some of the benefits" of consolidation, he added.

Although Marsh & McLennan Cos. Inc.'s purchase of Johnson & Higgins has been "seamless" to Arnold Garcia, manager-risk management and safety for Coltec Industries Inc. in Charlotte, N.C., he is concerned that these "superbrokers" might not offer the same level of service to policyholders as in the past.

With practically no alternative broker,

See **Risk** on next page

Risk

Continued from page 3

these policyholders may have to accept the poor service, he said. This problem would be especially acute with smaller accounts that the big brokers don't see worthy of first-rate service, Mr. Garcia said.

That could, however, present the opportunity for regional brokers to grab clients by providing a high level of service, he said.

Continuing consolidation of brokers and insurers will make headlines in 1998, Mr. Turk of Electrolux suggested.

"I think '98 will be the year when we can begin to determine the impact of consolidation," said Mr. DeLillo of Celotex. "There will be some indications whether the efficiencies we have been promised will be delivered."

He said mergers among insurers, brokers and financial institutions likely will continue in 1998, though not at the same pace as this year.

But, said Marriott's Mr. Davenport, "I don't know how much more consolidation in the broker field there is left out there," with many of the major players already aligned through mergers.

Another 1997 story drew the attention and opinions of risk managers: the soft market.

Much of the commercial market will remain soft in 1998, but the California workers compensation market should start firming, predicted Earl H. Sherman, director of risk management at Ralph's Grocery Co. in Los Angeles.

"Prices are firming up as the (comp insurers) are buying each other, and they're going to close the market off."

He looks for a "minimal increase in mid-1998 and then a strong hardening in 1999." To avoid that increase, Ralph's will stick with its self-insured workers comp program, he added.

Microsoft's Mr. Lange expects the soft market for most coverages to continue.

"Who's going to raise prices and get away with it?" he asked. "There is a lot of excess capacity out there."

Mr. Davenport agrees. "The market is still declining," and that isn't likely to change soon, the Marriott risk manager said. In fact, most are wondering "where the bottom is," he noted.

"I think I've given up on predicting what's going to happen next," Mr. Davenport added. "I'm not sure what it's going to take to change it."

But Ms. Lindenmayer predicts rates may have bottomed out. "I don't see how the market can continue to soften," she said. "And if it does, I think the whole industry is in trouble."

> **'I think '98 will be the year when we can begin to determine the impact of consolidation,' says Mark DeLillo, vp-risk management at Celotex Corp.**

While everyone has been talking about broker consolidation, some risk managers said other newsworthy issues surpassed broker consolidation in importance.

Microsoft's Mr. Lange said the year's biggest story was the continued evolution of the risk manager's role within an organization. "It will affect the entire profession and all risk managers," he said.

The changes include senior executives' increased expectations of risk managers. Also, top management has been paying closer attention to risk management issues.

"We're on the road to a fundamental shift as to how risk management is viewed in organizations," he said.

To survive, risk managers must know the business of their employers and try to identify different types of risks, he said. It's important for risk managers to stop thinking only about "insurance-relevant areas," Mr. Lange said. "It's going beyond this and thinking about how the non-insurable risk affects the overall organization."

Mr. Lange said this shift forces risk managers to adapt to their role. If they don't adapt, "their time may be limited," he said.

"It's Darwinian," he added. "It's survival of the fittest."

He expects this trend to continue into 1998. "We're not going back on this one," he said.

Ms. Lindenmayer of Fidelity said besides consolidation, another big story of 1997 was insurers' "willingness to listen to more non-traditional types of lines."

More insurers now look to write financial risk, operating risk and "a broader spectrum of business risks" than in the past, she added.

Insurers previously have responded to risk managers' demands for non-traditional coverage, Ms. Lindenmayer said. But in the second half of 1997, she said, insurers have taken the lead by developing products to meet those needs.

Du Pont's Mr. Evancho shares that view. One result of the soft market is that insurers are more interested in creative deals, he said, particularly with excess liability.

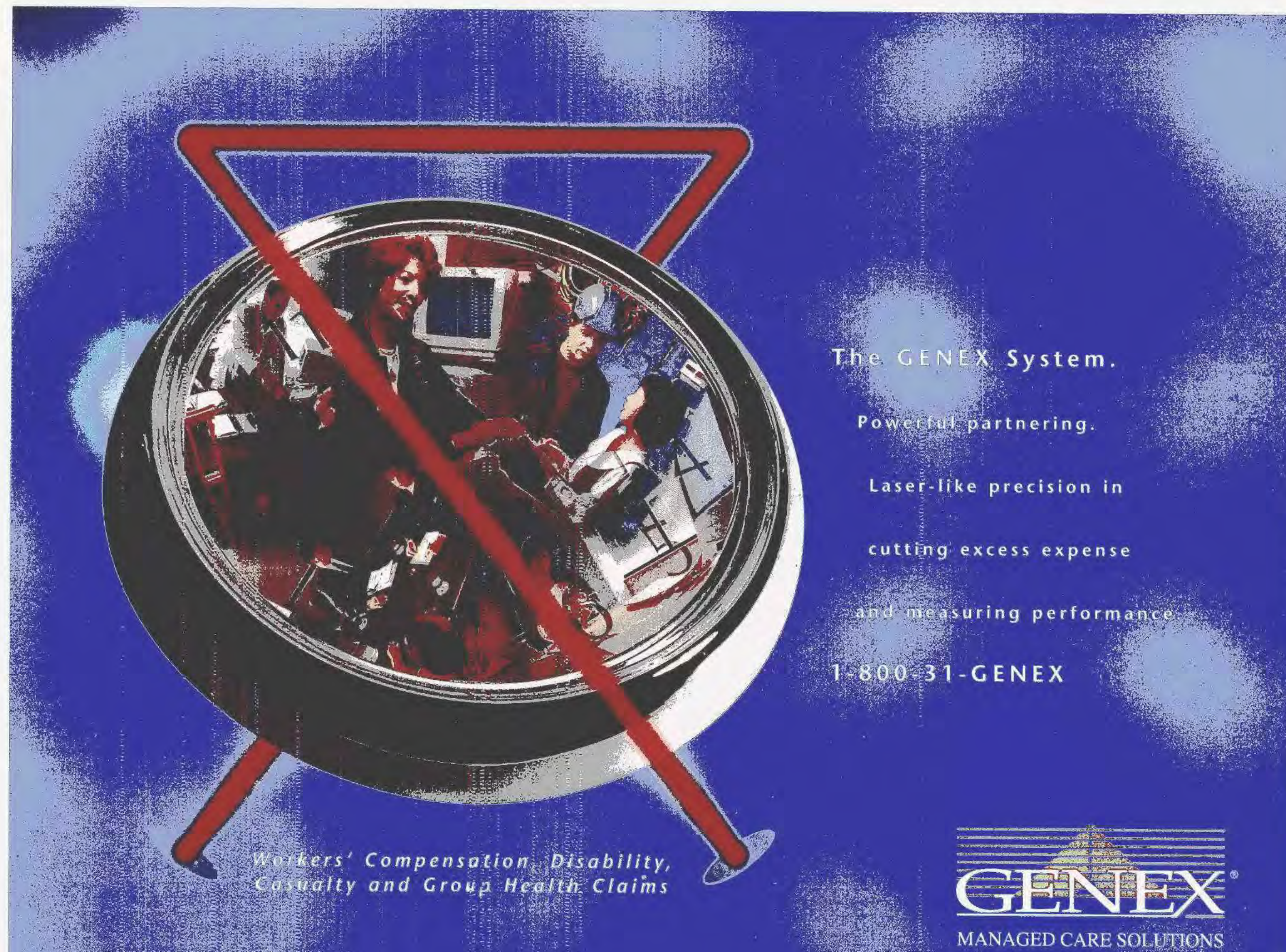
"Up until this year, there was a hesitancy with insurers to use unconventional approaches," he said.

These unconventional approaches include multiyear, single aggregate products. In the past, insurers talked about such tailored products, but "this year was the first one where I really saw evidence of that," Mr. Evancho said.

Earl D. Varney, risk manager for The Vanguard Group of Investment Cos. in Malvern, Pa., said, "The whole Year 2000 issue and the insurance around that has been a very big issue for me."

Mr. Varney is recommending that Vanguard purchase an insurance product that would protect the company from losses related to the potential computer problem.

"We haven't decided to buy that coverage, but I'm trying to press the organization to go in that direction," he said earlier this month. BI



Review

Continued from page 3

"It's a communication project to let everyone know," he said

That project consisted, in part, of sending out a benefits bulletin, which is likely to be followed with a newsletter article on plan changes.

Complying with a HIPAA mandate that companies certify employee coverage created additional work for Tresia A. Franklin, director of benefits administration for Hallmark Cards Inc. in Kansas City, Mo.

"I hope we have everything put to rest," she said after a year spent fine-tuning her company's benefits package so that it mixes well with new federal laws, including one that requires health maintenance organizations to pay for two-day hospital stays for normal child deliveries.

Ralph Kimmich, director of benefits and compensation for Southwest Airlines in Dallas, predicts that too many mandates may eventually do to health plans what the Employee Retirement Income Security Act of 1974 did to pension plans

"While ERISA provided protection for pensions, the administration was so onerous that companies stopped starting defined benefit pension plans," he said. That led to the growth of defined contribution plans such as 401(k) plans.

"The same is likely to happen with health plans," he said.

Instead of offering defined benefit health plans, such as HMOs, Mr. Kimmich predicts that employers will increasingly offer medical savings accounts, which let workers use their discretion in purchasing health care services.

Not all the issues the benefit managers dealt with in 1997 were externally influenced.

For example, Hewlett-Packard's Mr. Jemison spent much of his time working on the centralization of personnel records and benefits management for the company's 68,000 U.S. employees

Many of those functions previously were carried out by local benefits representatives at company locations in several states.

'Election years can influence lawmaking, and patients' rights is a great flag to wave,' says Dennis Nirtaut.

While Hewlett-Packard moved toward centralization at the end of 1996, many of the adjustments and learning experiences came in 1997, Mr. Jemison said.

"It took more of our time and it was very much a big structural change," he said. "We had so many locations in the United States that the expertise and experience varied. As our organization gets bigger and crosses more locations in the country, it was going to be harder for managers and employees to get the quality and service we would like them to have (from dispersed locations)."

By comparison, tackling the HIPAA and mental health parity changes were simple, he said, partly because HIPAA requirements were handled by a third-party administrator.

For many employers, like Public Service Electric & Gas Corp. 1997 was a year of rolling out innovative new communication tools, many using Internet technology.

"Our greatest accomplishment was taking the next step in innovative employee benefit communications and administration by establishing an employee benefits Web site on the Internet and using it for our annual open enrollment and in making access to an array of benefit information available to our employees and retirees worldwide 24 hours a day," said Richard Quinn, director of performance and rewards for the utility in Newark, N.J.

Corporate restructuring as a result of merger and acquisition activity in recent years also created some challenges for benefit managers this year.

"It's been very, very difficult in merging benefits, and merging culturally and merging policies. That has been our biggest issue," said Triny Jauco Lee, manager of employee benefits for Lockheed Martin Missiles & Space in Sunnyvale, Calif. Lockheed and Martin Marietta merged in 1995.

For her Lockheed unit, arranging mental health parity was not a difficult issue for employees in managed care plans because the company offers them a standardized HMO design, Ms. Jauco Lee said. Although the company does not have many indemnity plans, they presented more of a challenge on the parity issue because many of those plans are tied to union contracts, and each had to be reviewed to assure compliance.

With Washington lawmakers poised to review managed care, Hallmark's Ms. Franklin expects to spend part of 1998 watching that debate.

"I don't necessarily anticipate anything getting passed next year, but I do expect that issue to heat up," she said. "It clearly will be on the front burner and get debated."

She won't be alone.

"Election years can influence lawmaking, and patients' rights is a great flag to wave," said Dennis Nirtaut, managing director of compensation and benefits at Andersen Worldwide in Chicago.

Preparing for potential health plan rate increases will be another paramount issue in 1998, predicts Hewlett-Packard's Mr. Jemison.

He expects HMO rate increases to average between 7% and 8% nationwide.

Mr. Kimmich of Southwest agrees, predicting that for-profit plans will raise rates to recoup the earnings blow they took on Wall Street.

"Oxford's losing its shirt," he said of Oxford Health Plans Inc.

"You know they're going to come around and try to get that corrected," Mr. Nirtaut concurred. "With the way the financial world is today health care organizations have to look at their bottom lines very carefully. They can only low-ball the market for so long."

However, in some cases, the mergers will create some economies of scale that should help keep HMO overhead down, according to Mr. Nirtaut.

"When organizations come together, there should be some gains," he said.

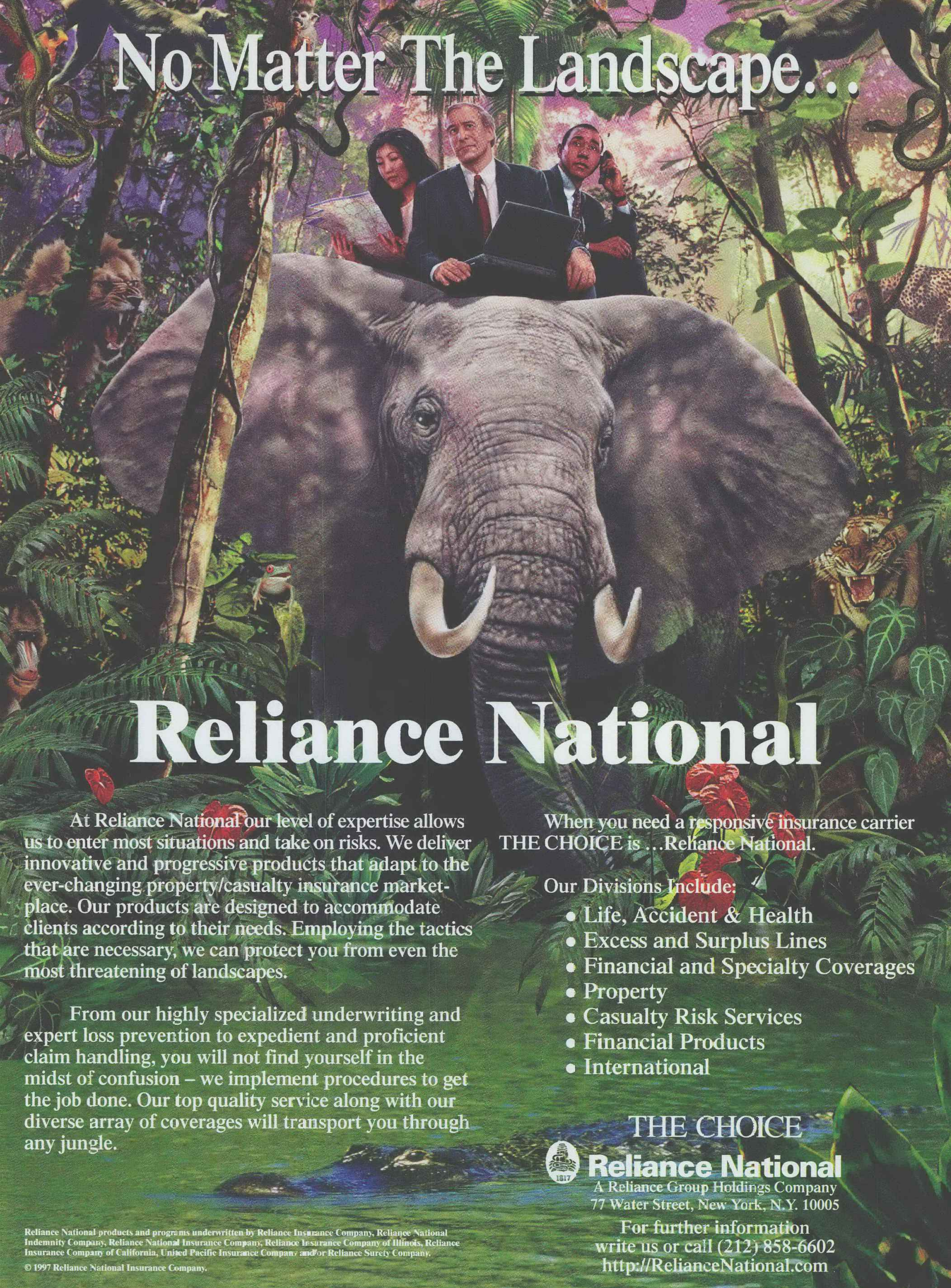
While "consolidation eventually can be detrimental at some point by eliminating competition, it's a while before we have to worry about that," he said.

With all the talk about health care premium hikes, Mr. Nirtaut said he hopes benefit managers don't lose sight of other important issues in 1998.

"Benefit managers should get more involved in investment education," he suggested.

He expressed concern that last year's stock market fluctuations may have caused some young 401(k) plan participants to erroneously shift their investments into more conservative vehicles, even though they have plenty of time to recoup any losses.

"We've given them the tools, but we need to educate them on how to use them," he urged. ■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Happy Holidays from *BI*

"Jacob Marley?" cried Scrooge,
"What are you doing here?
I've mended my ways since
you first filled me with fear!"

"Dear Scrooge," mumbled Marley,
"I'm only the M.C.!
Past, Present and Future
are puzzled and need thee!"

The Past floated forward
and started to sing
of all the year's doings,
skipping barely a thing.

"The brokers are merging!
Oh, they've gotten quite large.
And benefit consultants
have joined in the charge."

"Plus, Medicare reform
brought in competition,
while tax reform passed with
employer direction!"

"But what's that, over there?"
Scrooge waved with his hand.
The Past became quiet
and the Present began....

"I've not much to offer.
The pickings are slight.
Managed care is assailed...
doesn't know how to fight!"

"The stock market's swinging
in up and down crooks
but benefits are safe
with long-term outlooks."

"And still," Scrooge pointed out,
"you've not answered all night!
What's that in the corner
you've kept out of my sight?"

The ghost of the Future
sobbed uncontrollably
then sniffed loudly and sighed,
"That should be the load for me!"

"Increased costs are a given;
catastrophes flare;
risk management triumphs;
benefits provide care."

"But, the future's filled with
mostly unfinished fare:
product liability,
Superfund and health care."

"These three," cried the Future,
"rightly belong to me!
But, they're rooted in Past,
Present and me, equally!"

"You just need a fourth ghost!
That's the answer for you!"
Old Scrooge laughed to himself,
"Now, be gone all of you!"

Then Scrooge dreamed of next year
and another night's hue
from Past, Present, Future
and the ghost Deja Vu.

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Top risk management stories lead to sense of deja vu

By MARK A. HOFMANN

The words may have changed, but the tune pretty much stays the same.

That sums up several of this year's Top 10 risk management stories. The top stories of 1997 include the risk management equivalents of remixed golden oldies, longtime hits that refuse to drop from the charts and the occasional totally new tune. Variations on the theme of industry consolidation, diversification and restructuring continue to appear prominently on the list, as evidenced by 1997's top story (see story, page 14).

In fact, atop this year's chart is a follow-up version of last year's No. 5 story, the acquisition of Alexander & Alexander by Aon Group.

This year's version of the continuing story of brokerage consolidation, however, was performed by the Marsh & McLennan Cos. Inc.

The story began early in the year, when M&M acquired French broker CECAR and confirmed it was in negotiations to acquire Minet Group from The St. Paul Cos. Inc. The moves came after a wave of acquisitions made by rival Aon, which had become the world's largest retail brokerage with its earlier acquisition of A&A.

On the heels of its purchase of CECAR, M&M announced it had purchased Johnson & Higgins for $1.8 billion. The deal catapulted M&M back into the No. 1 spot and proved to be a windfall for the directors of J&H, many of whom became multimillionaires.

Aon struck back a month later with its announcement that it would buy Minet Group from The St. Paul Cos. The surprise deal took away a target of M&M, which had been in talks to acquire Minet since January.

The story didn't end there, either. Nine months after M&M acquired J&H, a group of retired J&H directors sued the former J&H directors who had approved the sale to M&M (*BI*, Dec. 3). The retirees claimed they had been fraudulently deprived of their fair share of the windfall profits from the sale.

The year's No. 2 story was also a variation on a theme first performed by cigarette manufacturer Liggett Group Inc., which broke ranks with the rest of the tobacco industry in 1996 by offering to settle claims for smoking-related illnesses made against it by a group of state attorneys general. Liggett announced it had reached a deal in March, admitting cigarettes are harmful and addictive and that it has marketed to teenagers.

Within weeks, representatives of the major tobacco companies began talks with state attorneys general on a proposed global settlement of tobacco litigation. Ultimately, the tobacco industry agreed in June to a $368.5 billion settlement with the states that would, among other things, protect the companies from future class-action litigation (see story, page 16).

But the settlement remains unrealized, because Congress must approve it. House and Senate committees met throughout the summer, hearing witnesses and attempting to sketch the parameters of legislation to implement the deal. By the time Congress recessed for the year in November, several bills to implement the deal had been drafted, but none seemed likely to win quick passage.

The year's No. 3 story also involved class-action suits—the area of mass tort settlements in general and courts' increasing skepticism of them—with implications for any tobacco deal. In one of its last decisions of the 1996-97 term, the Supreme Court dealt a sharp blow to a key litigation strategy for businesses by rejecting a $1.3 billion class-action settlement of asbestos claims.

The 6-2 majority in *Amchem Products Inc. vs. Windsor et al.* held that the members formed for the class were too diverse and that many potential class members would not even be aware of their eligibility though they would be barred by the pact from suing. Citing the decision, a federal judge in August rejected a proposed class action settlement of tobacco litigation against Liggett Group (see story, page 16).

Meanwhile, the Dow Corning Corp. breast implant litigation saga continued through the summer, with Dow Corning issuing a new settlement offer to silicone breast implant claimants that would pay them $2.4 billion, or $400 million more than its offer before entering bankruptcy protection.

But in a separate case in December, a Louisiana judge decertified the class in the country's first silicone breast implant case scheduled for trial, following the precedent set by the *Amchem* ruling. Members will have to pursue their cases individually or participate in the bankruptcy reorganization process.

The No. 4 story underscored the improved financial condition of Lloyd's of London, which announced in late spring record profits for the 1994 underwriting year (see story, page 16). The profits were driven significantly by the absence of huge additions to reserves, which characterized the market for several years prior to the creation of the market's runoff reinsurer Equitas Ltd. In October, Lloyd's won its first marketwide ratings from Standard & Poor's Corp. and A.M. Best Co. Lloyd's sought the ratings to provide a clearer basis for comparison with other global insurers.

The No. 5 story represents something new—the creation by United Services Automobile Assn. of a special-purpose reinsurer to issue $477 million in East Coast hurricane catastrophe bonds, which will provide USAA with $400 million in excess cover in the event of a cat loss. The cat bond deal, a watershed event in capital market forays into risk financing, is oversubscribed by investors. Subse-

See **Risk Review** *on page 12*

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Risk review

Continued from page 10

quently, Swiss Re and Tokio Fire & Marine issued cat bonds for quake risks (see story, page 18).

The year's No. 6 story echoes the No. 1 story, although in a manner off-key to some risk managers. An October J&H Marsh & McLennan memo outlined a new strategy to place certain insurance business through six regional offices rather than local offices nationwide. That memo sparked concern among risk managers who viewed the move as evidence of the world's largest broker throwing its clout around at their expense.

Something also was ominous about the No. 7 story of 1997. The Year 2000 computer problem became more urgent for risk managers and insurers as time runs out for companies to begin conversion projects. Several insurers unveiled products aimed at covering losses from the Year 2000 exposure of companies or their suppliers. Congress also appeared likely to step further into the matter when Sen. Bob Bennett, R-Utah, introduced a bill in November that would require companies to reveal their Year 2000 exposures and their strategies—including insurance—for coping with them.

The year's eighth-place story sounds a familiar refrain—the continued restructuring of insurers. CIGNA Corp. once again found its controversial reorganization plan—which numbered among the top 10 stories of 1995 and 1996—in trouble when a Pennsylvania appellate court ruling vacated the state insurance commissioner's approval of its reorganization. The court also ordered new, trial-like hearings to be held in the case.

Another controversial reorganization, that of The Home Insurance Co., also made news in March when New Hampshire regulators placed The Home under formal state supervision after the insurer fell nearly $552 million short of its risk-based capital requirements. In late fall, Trygg-Hansa SPP Group transferred its shares in troubled Home Holdings Inc. to a bank trust as the first step in a plan to restructure Home Holdings and its debt.

Meanwhile, in a far less-contentious move that will nonetheless reshape the insurance landscape to some degree, SAFECO Corp. bid $2.8 billion in June to acquire American States Financial Corp. from Lincoln National Corp. The steep price buys SAFECO small and midsized commercial accounts and inroads into the Midwest.

A month later, Munich Reinsurance Co. restructured its primary insurance holdings to give it a larger presence in that market, which makes it Germany's second-largest primary insurer in addition to being the world's largest reinsurer. The strategy runs counter to the 1994 strategy of No. 2 Swiss Re to divest its primary insurance operations.

The Swiss continued to follow their own strategies in August when—in a major combination of insurance and financial services—Winterthur Insurance Co. and Credit Suisse Group agreed to a merger designed to provide each other's clients with one-stop shopping. And in mid-October, Zurich Insurance Co. proposed a merger with the financial services unit of B.A.T Industries P.L.C., which would create one of the world's largest insurance and asset management companies. The deal is not expected to be completed before late 1998, however, because of the regulatory approval required in the United States and elsewhere.

Elsewhere in Europe, two insurers in October became involved in a complex bid for control of Assurances Generales de France. Italian insurer Assicurazioni Generali S.p.A. made an unsolicited bid to acquire insurer AGF. The French insurer's managers, however, rejected the bid. Meanwhile, Allianz A.G. Holding entered with a friendly takeover offer that AGF embraced. Generali's board subsequently approved raising additional funds and was expected to counteroffer. Ultimately, however, Allianz and Generali in December worked out an arrangement under which Allianz would gain control of AGF, while Generali would obtain shares in two insurers held by Allianz and AGF (see story, page 2).

Weighing in at ninth place is the latest development in the now nearly 20-year long effort to enact federal product liability reform legislation. In early October, a discussion draft of proposed product liability reforms worked out between the White House and Sen. John D. Rockefeller IV, D-W.Va., won the backing of President Clinton, who had vetoed a 1996 bipartisan bill approved by the previous Congress.

The measure, however, was considerably watered down from other reform bills. For example, it capped punitive damages for only the smallest of defendants and placed no limits on joint liability for non-economic damages in product liability cases. Reform advocates, though welcoming the president's change in position, did not rush to support to the proposal. As of year's end, the chief Senate reform advocates—Sens. Rockefeller and Slade Gorton, R-Wash.—had failed to draft a bill that would satisfy the president or each other.

Rounding out the Top 10 risk management stories of the year is the continued diversification of Bermuda insurers. In late winter, the Bermuda Commodities Exchange won authorization to begin trading contracts based on catastrophe insurance risks. The facility, with initial members American International Group Inc., Guy Carpenter & Co. and Chase Manhattan Bank, planned to trade contracts based on a new catastrophe index created by Carpenter. Ultimately, however, a series of delays postponed the exchange's opening until November, by which time some 20 members had joined the exchange.

Diversification continued throughout the year. Catastrophe reinsurer Partner Re Ltd., with its $950 million acquisition of French reinsurer SAFR, changed its long-held view that cat companies should remain monoline companies. The deal, centered around the minority shares Swiss Reinsurance Co. holds in both companies, greatly expanded Partner Re's geographic reach while diversifying its portfolio.

Bermuda's excess liability insurers continued to aggressively diversify with EXEL Ltd.'s $637 million acquisition of property catastrophe reinsurer GCR Holdings Ltd., the holding company for Global Capital Reinsurance Ltd. The move followed ACE Ltd.'s 1996 purchase of cat reinsurer Tempest Re. The trend continued with ACE taking a more direct stake in the U.S. market via its acquisition of Westchester Specialty Group Inc. Later in the year, EXEL acquired Folksamerica General Insurance Co., giving EXEL direct access to the U.S. market for the first time.

Bubbling under the Top 10 was a mix of old standards, such as proposed reform of Superfund and of the Occupational Safety and Health Administration, continued squabbles over the EMLICO controversy and yet another rebuff to the state of Louisiana in its efforts to regulate risk retention groups despite the fact that the federal Risk Retention Act preempts such moves.

But there were some significant new developments as well, including the naming of Linda Lamel as executive director of the Risk & Insurance Management Society Inc., and an unusually mild Atlantic hurricane season, courtesy of El Nino. BI

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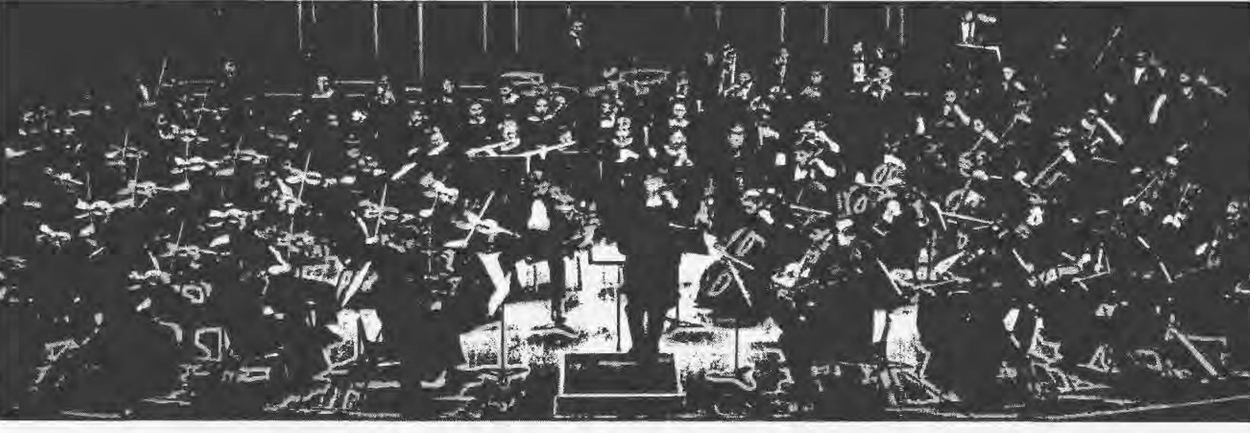

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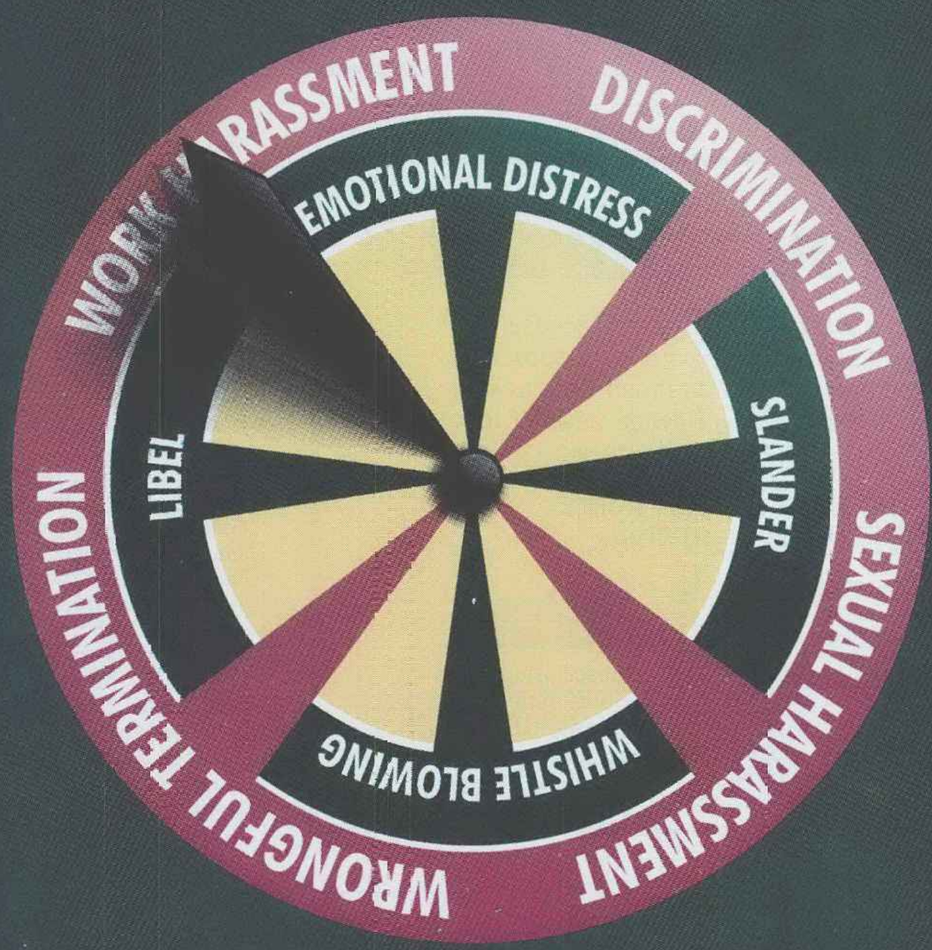

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Insurance broker consolidation claims top 20 firms

The universe of insurance brokers keeps getting smaller as the brokers get bigger.

Aon Corp.'s 1996 takeover of Alexander & Alexander Services Inc. was only a warmup for the feeding frenzy that hit this year: Four of the world's 20 largest brokers in 1996 have been absorbed by larger competitors since January, and most of the rest have been transformed by mergers of their own.

Marsh & McLennan Cos. Inc. not only swallowed Johnson & Higgins and French broker CECAR but went on to gobble up former J&H correspondent brokers AB Max Matthiessen in Sweden, Bonnor & Co. A/S in Denmark and Brockman y Schuh in Mexico.

Aon, not to be outdone, this year followed its 1996 takeovers of A&A and Bain Hogg Group P.L.C.

by acquiring Minet Group and former J&H German correspondent Jauch & Huebener KGaA.

Meanwhile, JIB Group P.L.C. merged with Lloyd Thompson Group P.L.C. to form Jardine Lloyd Thompson Group P.L.C.; Lowndes Lambert Group Holdings P.L.C. merged with Fenchurch P.L.C. to create Lambert Fenchurch Group P.L.C.; Forbes Group Ltd. announced a takeover of Nelson Hurst P.L.C.; and Gras Savoye S.A. of France sold one-third of itself to the as-yet-unacquired Willis Corroon P.L.C.

To top it off, publicly traded C.E. Heath P.L.C. was bought out by its management.

Brokers, in other words, have been busy, and not just with servicing clients.

The growing gap between the world's largest brokers and their smaller competitors prompted *Business Insurance* this year to rank only the world's top 10 brokerages, down from the 20 largest in previous years.

The consolidation frenzy mirrors similar trends in the insurance and reinsurance markets and has been driven by some of the same forces.

Brokerage clients, for example, have expanded into far-flung corners of the world while demanding increasingly sophisticated risk financing services. Brokers have had to keep up, providing local offices worldwide and expertise global clients require.

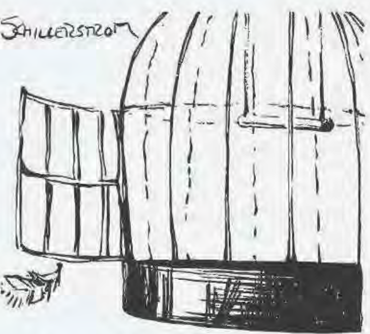
The longtime soft property/casualty insurance market also has put the squeeze on brokers' operating margins at the same time that the business has demanded huge investments in technology to handle fast-moving and complex transactions. Taken together, these factors favor mergers that cut operating expenses and spread the cost of capital investments.

"You build shareholder value by spreading cost across a broader revenue base," John Wicher, managing director with San Francisco-based Russell Miller Corporate Finance Inc., observed earlier this year.

Acquisitions also get brokers into worldwide insurance and reinsurance markets they may not have been able to tap previously. Size gives brokers clout with those markets, or at least allows them to keep pace with the power of international insurers and reinsurers that are themselves growing through mergers and acquisitions.

Finally, the merger frenzy has been fueled partly by the hot stock market, which has provided brokers the capital they need to complete deals.

Whether all the merging and acquiring turns out to be a good thing for buyers is debatable,



though, and there have already been plenty of bumps in the consolidation road.

The increasing power of the new megabrokers has worried some risk managers—those supposed to benefit from the brokers' marketing clout.

For example, J&H Marsh & McLennan Inc., Marsh & McLennan Cos. Inc.'s brokerage unit, stirred concerns this fall with an internal memo directing that all middle-market business placed with Chubb Corp. go through the broker's regional rather than local offices.

J&H Marsh & McLennan contends that the arrangement is more cost-effective for clients and insurers.

Some risk managers and competitors fretted, though, that the broker's move amounts to an attempt to control the market, increase brokerage commissions and—if applied to larger accounts—disrupt relationships between risk managers and local underwriters.

Broker mergers also can create internal turmoil, as account managers are forced out or jump ship. This in turn can disrupt brokers' longstanding relationships with clients.

Redmond, Wash.-based Microsoft Corp., a longtime J&H client, moved most of its retail brokerage business to Aon this year after the J&H-Marsh merger.

Every acquisition is different, and each can create unpleasant surprises.

When privately held J&H sold out to Marsh, for example, its director-shareholders probably didn't expect that they would be sued for fraud by a group of their retired counterparts. It happened last month, though, and the retirees are now charging that J&H's active directors intentionally cut the retirees out of the sale negotiations to ensure payouts of at least $36 million each for the active directors.

Whatever the potential pitfalls of these deals, though, brokers are probably not through with acquisitions.

Through mid-December, rumors continued to swirl that the two biggest wallflowers at the consolidation dance—Sedgwick Group P.L.C. and Willis Corroon—would merge with each other or be taken over by another competitor.

While both brokerages steadfastly deny the recurring rumors, 1998 is sure to produce more takeover stories.

—*By Douglas McLeod*

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Tobacco settlement's future clouded

The outlook remains hazy at year's end for a proposed $368.5 billion settlement of smoking-related suits in return for limits on class actions against cigarette makers.

The very idea of such a proposal would have seemed a fantasy a year ago. Cigarette makers always had been adamant that their products do not cause cancer and other illnesses and had racked up an impressive list of judicial victories in liability cases.

In fact, at the start of 1997, only one small cigarette maker—Liggett Group Inc.—had expressed any willingness to work out a deal with states seeking to recover smoking-related Medicaid costs from cigarette makers.

Liggett agreed in March to settle with the then-22 states that had sued tobacco companies for Medicaid reimbursement. Liggett agreed to label its products that "smoking is addictive" and to assist the states in their suits against other tobacco companies by providing access to internal documents and documents produced in conjunction with other tobacco companies. Both sides acknowledged the

states weren't likely to see any money, because Liggett was not profitable.

At the time of the Liggett deal, other tobacco companies downplayed the significance of the agreement. Philip Morris Cos., for example, issued a statement saying the settlement "has nothing to do with the rest of the industry, and it changes nothing."

But the action of one relatively minor player set the stage for the unprecedented settlement offer. The proposed deal, worked out between major tobacco companies and 40 state attorneys general led by Mississippi Attorney General Mike Moore, was nothing short of revolutionary.

Under the proposal, announced June 20, tobacco companies would pay about $368.5 billion over 25 years. The deal doesn't provide absolute immunity, because individuals still could file suits. Most class-action suits, however, would be barred under the agreement.

The companies would pay most of the $368.5 billion in annual payments to states that sued to cover the Medicaid costs associated with smoking. But $50 billion of the total would be considered punitive damages. The states would use half of that for health care for uninsured children. The other $25 billion would be earmarked for a special trust fund for health care. An additional fund of up to $5 billion a year would compensate individuals for lost wages, pain and suffering and "future punitive damages."

The companies also would pay attorneys' fees associated with negotiating the settlement, drop all pending suits over advertising, regulation by the federal Food and Drug Administration or against "whistle blowers." The companies also would accept curbs on advertising and a ban on vending machine cigarette sales.

The deal, however, would require congressional approval and the president's signature. While attorneys general urged swift congressional action without greatly changing the proposal, the deal was assaulted by some people as too lenient and by others as setting a dangerous precedent.

Meanwhile, the tobacco companies began settling with some of the states, including Mississippi. A federal judge dealt a blow to Louisiana's unique attempt to sue tobacco industry insurers by ruling that the case would remain in federal court.

Bills embodying portions of the settlement were introduced during the final days of this year's congressional session. No legislation to date totally follows the blueprint set out in June; most bills call for more money from the tobacco companies in exchange for the limited immunity from suits.

This month, one of the tobacco industry's erstwhile allies—House Commerce Committee Chairman Thomas Bliley, R-Va.—said he planned to release at least some of more than 800 internal tobacco industry documents by year's end. With the release of the documents and the promise of more legislation next year, the smoke surrounding the proposed settlement appears unlikely to clear until well into the new year, if at all.

—By Mark A. Hofmann

Courts, plaintiffs lash out at mass tort settlements

Class-action settlements, once thought to be the solution to the mass tort epidemic, came under fire this year, with courts following the U.S. Supreme Court's precedent when it rejected a landmark asbestos pact.

But the courts weren't the only ones displeased with the mass tort settlement process: Disgruntled plaintiffs in a Texas case tried to force their lawyers to forfeit legal fees because they thought a settlement the lawyers negotiated was inadequate.

Despite the setbacks, defendants' and plaintiffs' lawyers still are trying to streamline mass tort litigation. For example, the American Arbitration Assn. has created a new national panel to help resolve complex, protracted mass claims and mass torts.

In September, plaintiffs' lawyers litigating over the popular diet drugs Fen-Phen and Redux filed an application with the Judicial Panel on Multidistrict Litigation in Washington seeking to consolidate the suits rather than seek class-action certification.

The high court's 6-2 rejection in August of a $1.3 billion asbestos class-action settlement in *Amchem Products Inc. et al. vs. Windsor et al.* is already chilling other settlement efforts.

Amchem turned on the question of whether Rule 23 of the Federal Rules of Civil Procedure, which govern civil cases, allowed certification of a class for purposes of a global settlement of future asbestos-related claims.

Under the proposal, 20 former asbestos manufacturers that had formed the Asbestos Claims Facility offered to compensate future victims according to the diseases they manifested as well as some claims not in the categories of compensable diseases. Everyone exposed to asbestos but who had not filed a claim against any CCR member could opt out or remain in the class and agree to use the settlement to resolve any future claim.

A federal judge approved the settlement in 1994, but a panel of the 3rd U.S. Circuit Court of Appeals overturned it. The appeals court held that the $1.3 billion settlement violated Rule 23 because disparity among the claimants' illnesses was greater than their commonality. The judges also said classes formed for settlement purposes had to meet the same standard as classes formed for litigation.

The CCR members appealed to the Supreme Court, but a 6-2 majority agreed with the appeals court.

Writing for the majority, Justice Ruth Bader Ginsburg said the "sprawling class" did not meet the requirements of Rule 23. The named parties in the class "with diverse medical conditions sought to act on behalf of a single giant class rather than on behalf of discrete subclasses."

While at first some experts thought the *Amchem* decision wouldn't hamper the proposed tobacco settlement, Liggett Group Inc. became the first mass tort defendant to feel the fallout.

Citing the Supreme Court decision, West Virginia Chief Judge Charles H. Haden II vacated preliminary approval of a class-action settlement that would have shielded Liggett from future smokers' claims.

Shortly after the *Amchem* decision, the high court also declined to review a proposed mass tort settlement between Fibreboard Corp. and thousands of people who could file asbestos-related injury claims.

Earlier this month, a Louisiana judge decertified the class in the nation's first silicone breast implant class action to go to trial against Dow Corning Corp. Plaintiffs now will have to pursue suits individually.

Besides the courts, some plaintiffs also took part in the backlash.

A group of 46 plaintiffs in a class-action settlement with Phillips Petroleum Co. in 1991 over a Texas chemical plant explosion sued their lawyers, charging they negotiated the settlement without their knowledge or consent. The group sued after learning plaintiffs represented by other lawyers received larger amounts.

Legal experts predict more personal-injury cases will jam already overcrowded courts as a result of the Supreme Court's *Amchem* decision, putting extra pressure on Congress to step in to clarify how such "future-looking" settlements can be structured.

—By Joanne Wojcik

Lloyd's profit, R&R plan end market's dark days

LONDON—Finally past the dark days before Equitas, Lloyd's of London announced record results without the threat of market failure looming.

In May, Lloyd's reported a £1.1 billion ($1.88 billion) profit for the 1994 underwriting year, up from its previous year's £225 million ($349.4 million) profit. The five prior years' combined losses reached almost £8 billion ($12.56 billion).

The profit was the feather in the reconstruction and renewal cap. Earlier, Lloyd's efforts to secure its future were recognized when Chairman David Rowland was knighted in the Queen's New Year's honors list.

The scale of the 1994 profits and healthy profit predictions for 1995 and 1996—currently £913 million ($1.4 billion) and £600 million ($1.03 billion), respectively—made Lloyd's R&R plan possible. On that foundation, Lloyd's was able to fund Equitas, which took over all pre-1993 liabilities in September 1996.

In fact, the reduction of reserves for prior-year closed accounts possible because Equitas assumed the pre-1993 liabilities added £113 million ($193.2 million) to 1994 profits. The comparable reduction of reserves amounted to £485 million ($753.2 mil-

lion) for the previous accounting year. After members' expenses were factored in, the 1994 year profit was £1.01 billion ($1.73 billion), down from £1.08 billion ($1.68 billion) in '93.

But even as these figures were issued, warnings were given on expected returns for '97 and '98. The Assn. of Lloyd's Members said, "Lloyd's will be lucky to escape a marketwide loss in the current down cycle."

That hasn't deterred a surge of corporate investors. Nine of the 10 syndicates set up for the 1997 underwriting year had corporate backing. New parents included Nissan Fire & Marine Insurance Co. Ltd., which set up the first syndicate fully backed by Japanese capital, and CNA International Reinsurance Co. Ltd.

Of the £10.3 billion ($17.64 billion) of 1997 Lloyd's capacity, more than £8 billion ($13.7 billion) was managed by 44 agencies wholly or partly owned by corporate investors.

Corporate investors' involvement also grew through agency takeovers. Among the first in 1997, USF&G Corp. acquired 80% of Ashley Palmer Holdings Ltd. A joint venture between Aon Corp. Inc. and Unionamerica Holdings Ltd., called Unionamerica Insurance Co. Ltd., bought a 49% stake in JMA Holdings Ltd. MMI Cos. Inc. acquired Unionamerica this month. With that acquisition, MMI owns 39.2% of JMA Holdings. Commercial Union P.L.C. became the first—and so far only—U.K. composite insurer to invest in Lloyd's when it bought 51% of Marlborough Underwriting Agency Ltd.

Soon after, corporate spread funds, those trusts that spread their investment over several syndicates, stepped up their own acquisition activity.

As corporate capital grew, however, Lloyd's said that to keep some parity among the various categories of members, unlimited liability names would have to up the assets backing their underwriting and deposit a greater proportion with their agents. The feeling that Lloyd's was shifting its loyalty from individual investors was reinforced when Sir David announced he will convert his underwriting to limited liability status when he steps down as chairman at the end of this year.

Lloyd's also began internal reorganization. The Corporation, the service and regulation arm of the market, organized into business units, operating on a "user pays" principle.

A consultative document issued by Lloyd's anticipated a government proposal that an external body eventually oversee Lloyd's regulation. Details on interim measures are pending.

Regulators in 1997 handed out bans, fines and reprimands to those who failed to meet Lloyd's increasingly tough regulatory standards.

In October, Standard & Poor's and A.M. Best Co. rated Lloyd's A+ and A, respectively, giving the market independent verification of its security.

It still has some issues to settle, however. Names' litigation in the United States continues; certain syndicates writing in 1992 and 1993 still can't close their books; and a group of U.K. members is challenging aspects of R&R in the British courts.

On the plus side, New York regulators have halved the securitization requirements for Lloyd's syndicates writing surplus lines business in the United States.

This month, Equitas and the Department of Trade and Industry gave Lloyd's its most wanted present by agreeing to reinsure the liabilities of Lioncover Insurance Co. Ltd., set up in 1987 to run off the accounts of several syndicates and agencies that had traded fraudulently in the late 1970s and early 1980s.

—By Sarah Goddard

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Catastrophe bonds take risk financing by storm

United Services Automobile Assn.'s offering of bonds linked to its exposure to catastrophe losses proved a watershed event in risk securitization.

The $477 million cat bond issue that provided USAA with a high-level reinsurance layer for East Coast hurricane risks proved so popular with investors that the size of the issue was increased dramatically from the $150 million bond sale the company had planned.

Ultimately, the USAA transaction in June also provided a model for similar catastrophe bond deals undertaken by Swiss Reinsurance Co. and

Tokio Marine & Fire Insurance Co. Ltd. as those companies also looked to capital markets for reinsurance capacity.

That model saw the companies creating independent special-purpose reinsurers to be the bonds' formal issuers and then used the proceeds to provide reinsurance coverage.

In USAA's case, the bonds were issued by Residential Reinsurance Ltd., a Cayman Islands company created by USAA in 1996 as it worked with Merrill Lynch & Co. to craft a $500 million cat bond deal that never came to fruition.

In this year's deal, Residential Re's charge was to manage the bond proceeds and administer a $400 million reinsurance contract it provided USAA. The cat bond transaction provided USAA with 80% of its $500 million reinsurance layer for losses from a single East Coast hurricane this year.

The reinsurance contract with Residential Re covered USAA for a loss from a single Category 3, 4 or 5 hurricane resulting in insured losses between $1 billion and $1.5 billion to USAA policyholders in an area stretching from Texas, around the state of Florida and north along the Atlantic Coast to Maine.

The company never has suffered a $1 billion loss, but at the time of the deal Robert T. Herres, USAA's chairman and chief executive officer, noted that "that size natural disaster is possible with large populations residing in coastal areas and other areas vulnerable to hurricanes."

While USAA's planned 1996 deal never came to market for several reasons—among them unattractive pricing and an inability to get the issue to market before a series of hurricanes made potential investors skittish—this year's deal, co-managed by Merrill Lynch and Goldman Sachs & Co., was structured to satisfy investors.

The $477 million privately placed issue was split between two tranches, one of $163.8 million in which investors faced no risk to principal, and the other of nearly $313.2 million in which all of the investors' principal is at risk if there is a loss.

In exchange for the greater risk, investors in the larger portion earn a higher return—the London Interbank Offered Rate plus 576 basis points.

In contrast, the no-principal-risk tranche pays LIBOR—the rate at which prime banks operating in the London Eurocurrency market offer Eurodollar deposits to other prime banks—plus 273 basis points.

The two-tranche structure let certain investors buy bonds who would have been precluded from investing in bonds putting principal at risk.

The bonds' stated maturity is one year. If here is a covered loss before it matures in June 1998, USAA's reinsurance contract gives it the right to extend the maturity for six months while settling claims. USAA must pay investors interest during that time, though the principal is at risk only for the one-year period.

Meanwhile, if there is a loss, the principal-protected securities will be extended another 10 years, with no additional interest payments during that period.

While the total issue was for $477 million, only $400 million went to providing reinsurance. The remaining $77 million was set aside to purchase zero-coupon securities that would enable USAA to repay the principal-protected investors if there is a loss.

The Swiss Re deal in July and the Tokio Marine & Fire issue in November also found receptive markets, each providing variations on the theme of the USAA deal.

Swiss Re's $137 million two-year catastrophe bond deal provided $112.2 million in California earthquake coverage through SR Earthquake Fund Ltd., a Cayman Islands company that issued the notes.

The Swiss Re deal is split into several tranches exposing investors to various degrees of principal risk. And, unlike the USAA deal, which is based strictly on losses to USAA's book, the Swiss Re deal is tied to industry losses due to a single California earthquake.

Two of the deal's three tranches had trigger points at $18.5 billion, $21 billion and $24 billion, all considerably beyond the $12.5 billion in industry losses caused by California's 1994 Northridge earthquake. The third tranche was sold without a rating and was said to carry lower trigger points.

Tokio Marine's $100 million deal let the company obtain $90 million in reinsurance for Tokyo-area quakes.

Those 10-year bonds were sold through Cayman Islands-based special-purpose reinsurer Parametric Re Ltd. To meet Japanese regulations, Swiss Re actually provided the reinsurance contract to Tokio Marine, retroceding the risk to Parametric Re.

Setting the Tokio Marine deal apart was that instead of being tied to insured losses like the USAA and Swiss Re transactions, the repayment of its investors' principal is tied to the magnitude, location and depth of earthquakes in the Tokyo area.

At the time of USAA's cat bond deal, Mr. Herres said tapping capital markets for reinsurance "is essential for the long-term strength of the nation's property and casualty insurers."

—By Rodd Zolkos

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Consolidation, legislation lead benefit news

By JERRY GEISEL

Consolidation and legislation generated the top employee benefit stories of 1997.

The No. 1 benefits story of 1997 is the wave of acquisitions and mergers that swept across the employee benefits consulting industry.

The new year had just begun when Mellon Bank Corp. announced it would buy Buck Consultants Inc. Two weeks later, Coopers & Lybrand L.L.P. said it would buy Kwasha Lipton L.L.C.

Also in January, Aon Corp. completed its takeover of Alexander & Alexander Services Inc., and through that transaction integrated The Alexander Consulting Group, A&A's benefit consulting unit, into its own consulting operations.

In March, Marsh & McLennan Cos. Inc. announced it would purchase Johnson & Higgins. Through that transaction, J&H's benefit consulting division, A. Foster Higgins & Co. Inc.,

would be folded into M&M's benefit consulting unit, William M. Mercer Cos. Inc.

Although all these acquisitions and mergers were unprecedented in scope and size, the reasons for them varied.

Buck, for example, was looking for a strong parent to help finance an expansion of its benefits outsourcing business, while Kwasha Lipton feared its relative small size was hurting its ability to compete against benefit consulting behemoths.

Whatever the reasons for the deals, the new combinations presented opportunities and problems for benefit managers (see story, page 25).

The No. 2 story of 1997 is the remarkable turnaround of the Pension Benefit Guaranty Corp., the federal agency that guarantees basic benefits for employees and retirees in pension plans.

Only a few years ago, the PBGC's financial position had so deteriorated that some believed that only a bailout from the U.S. Treasury would be able to keep the PBGC afloat.

But a combination of factors—especially the passage of legislation in 1994 ending loopholes in federal law that had allowed employers to underfund their pension plans—has put the PBGC on a sound financial footing. Last year, the agency recorded its first surplus in 22 years of operation.

That's good news for employers that support the PBGC through a premium assessed on their defined benefit plans. A financially secure PBGC means stable or perhaps eventually lower PBGC premiums (see story, page 26).

By contrast, the No. 3 benefits story of 1997—the introduction of the Patient Access to Responsible Care Act—is not something employers are cheering about.

PARCA, ostensibly intended to curb what its sponsors see as abuses by managed care plans, would force virtually all health care plans to overhaul their practices. For example, plans would have to cover services by all state-licensed health care professionals, even, for example, those offered by massage therapists.

The price tag would be steep. Actuarial consulting firm Milliman & Robertson Inc. estimate that premiums could shoot up between 7% and 39% if the bill passes. The fate of the measure rests with several congressional committees, which are expected to consider it next year (see story, page 27).

Ranked as the No. 4 employee benefits story of 1997 is the waning stability of group health care costs.

From 1994 through 1996, group health care costs for many employers have been virtually flat or even declining, a welcome change from the late 1980s, when costs were rising annually by double digits.

Key reasons for those years of price stability were the shift of a high percentage of employees to lower-cost managed care plans from expensive traditional indemnity plans, as well as rate cutting by health maintenance organizations as they battled one another for market share.

But now rates are climbing again, though still at relatively modest levels compared with the last big surge of cost increases in the late 1980s.

Reasons health care costs are increasing include HMOs seeking to bolster earnings after more than a year of lackluster results and rising medical costs (see story, page 28).

The No. 5 story of 1997 also has a legislative focus: the drive to assure greater quality of services provided to enrollees in managed care plans.

For example, early in the year, Sen. Edward Kennedy, D-Mass., and Rep. John Dingell, D-Mich., introduced legislation to give health care plan enrollees a "Bill of Rights."

Among other things, health care plans generally could not deny coverage for emergency room treatments but would have to give patients with serious medical conditions direct access to specialists.

At the same time, state legislators got into the fray by passing a flurry of bills, which, among other things, ban so-called gag clauses that had prevented providers from discussing all treatment options with patients.

These efforts were a response to what legislators saw as a public backlash against certain managed care practices (see story, page 29).

The employee benefits story ranked as the sixth most important of 1997 is President Clinton's strategy to expand health care coverage gradually rather than seek massive reforms in one fell swoop.

Nearly five years ago, President Clinton began a crusade to overhaul the U.S. health care system when he named a task force to develop a plan to achieve universal coverage.

The plan emerged in September 1993 but was dead just a few months later as Congress rejected a package that would have herded much of the population into government-established buying cooperatives.

While some congressional Democrats, most notably then Senate Majority Leader George Mitchell, D-Maine, blamed special interest lobbying for the defeat of the president's plan, Mr. Clinton accepted responsibility for the debacle.

The failure to achieve health care reform was because he tried to do too much at once, he said. The only way to achieve change in the health care field, the president said, is incrementally.

That is a strategy the Clinton administration has stuck to with success. For example, at a key juncture last year, the administration lent its support to legislation curbing the ability of health care plans to deny coverage

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Benefits

Continued from previous page

for pre-existing conditions.

The administration also backed two pieces of legislation that passed last year. One requires health care plans to offer at least 48 hours of inpatient care to mothers and their newborns after a normal delivery and 96 hours of coverage after a Caesarean section. The other measure bans discriminatory annual and lifetime dollar limits in group health plans for coverage of mental disorders.

This year, President Clinton also has pursued a modest health care agenda. He jumped into the quality debate by establishing a 34-member commission to come up with quality standards for managed care plans.

In November, President Clinton embraced the commission's recommendations, which include requiring health plans to provide more information to enrollees about covered benefits and the experience of professional staff, and to establish procedures for resolving complaints.

And President Clinton made clear that in the year ahead he will be doing more to try to expand coverage—gradually. For example, the administration is interested in getting legislation passed to ensure coverage for employees who retire before 65 and are not yet eligible for Medicare.

The president said something should be done—possibly through federal subsidies—so that lower-income workers who lose their jobs can afford to pay for COBRA health care continuation premiums.

In addition, the president said he wants legislation passed to ban so-called drive-through mastectomies. President Clinton described as "horrifying" situations in which women are denied coverage for an overnight stay in a hospital after a mastectomy.

The seventh most important benefits story of 1997 involves a unanimous Supreme Court decision that opens the door to lawsuits against employers by employees who charge that their dismissal was motivated to prevent them from receiving health care and other employee benefits.

The justices ruled that a section in the Employee Retirement Income Security Act that bars employers from discharging or discriminating against employees to prevent them from receiving benefits applies to all types of employee benefit plans.

That decision in May overturned a 9th U.S. Circuit Court of Appeals ruling that held the intent of Section 510 of ERISA was limited to pension plans in which participants' benefits vest after a certain period of service.

The impact of the decision is that employees' suits charging dismissal or discrimination to prevent them from obtaining benefits can't be "knocked out of the box" just because the actions involve benefits, such as health care, that do not vest.

Some experts feared the decision could lead to an outbreak of suits against employers who have aggressively outsourced traditional functions to cut benefit and other costs.

But other experts cautioned against such an interpretation. They said that Section 510 would not apply if there were "fundamental business decisions" for corporate actions—such as companies deciding to concentrate on core businesses—that resulted in employees losing their jobs and their rights to benefits.

The No. 8 benefits story of 1997 is the enactment of legislation opening the traditional Medicare program to more competition, a development employers and retirees alike welcomed.

Under the new law, retirees will be able to choose coverage from preferred provider organizations, indemnity plans offered by commercial insurance companies, or provider-sponsored organizations—HMO-like plans established by providers—and Medicare itself.

Retirees also will be able, as they are now, to receive coverage from Medicare HMOs as well as from the traditional Medicare program.

Each type of plan will receive the identical capitated payment rate from the Health Care Financing Administration, the federal agency that administers Medicare. If they are run well, many of these plans will be able to offer far more generous benefits than the traditional Medicare program and at a very low cost.

With so many choices of health care plans available to retirees, employers may be able to save a considerable amount of money by cutting back or even eliminating plans they sponsor that now supplement Medicare. And retirees may end up getting more generous benefits than they do now.

In fact, the benefits story ranked as ninth most important of 1997 is the decision of Sears, Roebuck & Co., to cut back on its retiree benefit plans.

Employees who retire after 1999 no longer will be eligible for the company's premium contributions for a supplemental health benefits plan when they become eligible for Medicare at 65, while life insurance for many current retirees is being sharply reduced and is being eliminated for those retiring after the turn of the century.

Sears portrayed the move as a way of keeping the costs of its benefit plans in line. Even with the cutbacks, its benefit plans are much more generous than those of other retailers.

While Sears is not the first company to slash retirees' benefits, it was a jarring development from a company famed for the generosity of its benefits' programs. The retailer is facing litigation from retirees challenging the legality of the retailer's actions.

Rounding out the Top 10 benefit stories of 1997 was the multiemployer pension plan implications of the International Brotherhood of Teamsters strike this summer against package delivery company United Parcel Service of America Inc.

UPS proposed to leave multiemployer plans—many of which are underfunded—covering its 185,000 Teamster-represented employees. UPS said it wanted to leave the plans at a price of $700 million in withdrawal liability payments and set up its own plan because it was tired of paying benefits for employees and retirees who never worked for UPS. That referred to situations in which companies in multiemployer plans have gone broke, leaving the remaining employers, like UPS, picking up the benefit obligations for retirees and employees of bankrupt companies.

But UPS's multiemployer demand led to a Teamsters strike. Union negotiators called the UPS demand a deal-breaker, and in the end, UPS caved and dropped that demand.

That decision, while perhaps costly in the long run to UPS, is a victory for multiemployer plans and the employers that contribute to them.

Had UPS succeeded in leaving the plans, that would have delivered a devastating blow to some of the Teamster plans to which UPS contributes. In all, UPS contributes more than $1 billion a year to the plans, and those funds represent roughly 15% to 18% of all contributions to the plans.

If UPS had been able to pull out, trustees of some of the multiemployer plans would have had no choice but to raise contributions for the remaining employers in the plans.

That could have caused more employers to withdraw, leading to a possible death spiral for some plans in which the withdrawal of one or more employers triggers the withdrawal of more until there remains an insufficient number to support the plan.

The fear of such a scenario developing explains why the Teamsters labeled the UPS demand to leave the plans as a deal-breaker. BI

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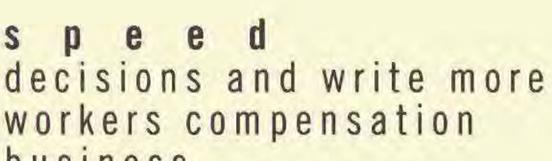

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Benefit consultants jump on consolidation bandwagon

The urge to merge and acquire, which has swept across industry after industry, hit the employee benefit consulting business in 1997.

During the first three months of the year, six of the 10 largest benefit consulting firms initiated or completed major mergers or acquisitions.

Those transactions included:

- Buck Consultants Inc.'s purchase by Mellon Bank Corp., one of the nation's top 25 banks.
- Coopers & Lybrand L.L.P.'s acquisition of Kwasha Lipton L.L.C.
- Aon Consulting's absorption of The Alexander Consulting Group.
- William M. Mercer Cos. Inc. absorption of A. Foster Higgins & Co. Inc.

To be sure, the Aon-Alexander and Mercer-Foster Higgins' linkups were driven by the consultants' parents—Aon Corp. and Marsh & McLennan Cos. Inc., respectively—to cut brokerage costs and expand revenues.

But trends sweeping the employee benefits consulting business very much drove the purchases of Buck Consultants and Kwasha Lipton.

In the case of Buck, an 80-year-old New York based-firm that had been owned by employees, client demands for outsourcing services were a key factor behind selling to Mellon.

Mellon is a huge financial services company. Buck executives reasoned that with Mellon as its parent, Buck would be able to draw

upon far more resources to make the massive technological investments necessary to become an outsourcing powerhouse.

Indeed, at the time of the purchase, Buck President and CEO Joseph LoCicero said Buck might not be able to succeed in the outsourcing field without Mellon's assistance.

Now, nearly a year after the purchase was announced, Mr. LoCicero says growth in outsourcing has been substantial. In all, Buck, the world's eighth-largest benefit consulting firm, estimates benefit consulting revenues climbed 26.4% from 1996 revenues to $302 million in 1997. A good chunk of that growth, though, came from Buck's purchase in late 1996 of WF Corroon, the benefit consulting unit of Willis Corroon Group P.L.C., the U.K.-based insurance broker. WF Corroon had 1995 revenues of about $50 million.

The situation was somewhat different for Fort Lee, N.J.-based Kwasha Lipton. Kwasha Lipton has been known for its creativity—it came up with, for example, the innovative cash balance pension plan concept—and its success in winning the benefit consulting business of Fortune 500 companies.

Yet, when Kwasha Lipton executives looked at what the future might hold for the company, they were concerned. While the consultant was not losing existing business, potential clients were passing up Kwasha Lipton because they questioned the firm's staying power. With just $79 million in 1996 revenues, Kwasha Lipton was dwarfed by the largest consultants, whose revenues were anywhere from seven to 10 times larger.

By linking up with Coopers & Lybrand, which at the time of the purchase was the sixth-largest benefit consultant and now is the fifth, Kwasha Lipton joined a firm with many practices and offices worldwide.

The combination has worked for both firms. Over the past eight months, "business has grown by leaps and bounds," said Robert

Byrne Jr., managing principal of the Coopers & Lybrand unit known as The Kwasha Lipton Group.

Mergers and acquisitions also were a boon to clients, consulting firm executives and others say.

Mercer's acquisition of Foster Higgins gave Foster Higgins clients access to a depth and breadth of services that Foster Higgins could not match. Foster Higgins, for example, lacked a compensation consulting practice and was only a small player internationally. Mercer, by contrast, generates more than 40% of its revenues internationally and is one of the largest benefit consultants in the United Kingdom, Australia and New Zealand.

Still, while only a fraction of Mercer's size, Foster Higgins had some of the top consultants in the country and its annual survey of health care costs has no equal at any firm.

The Aon and Alexander consulting combination brought together two smaller firms—Aon Consulting was the ninth-largest consultant in 1996 and Alexander Consulting Group the 10th largest—to create the sixth-largest firm.

Still, from the client perspective, these mergers and acquisitions can have some drawbacks.

Inevitably, when benefit consulting firms merge, some consultants find they don't fit in well at the merged firms and leave. That can disrupt longstanding relationships employers have with their consultants.

Yet, employers say they aren't worried that the wave of mergers and acquisitions will reduce competition and ultimately increase costs.

Right now, benefit managers say there are enough consultants to choose from so that competition for employer contracts continues to be intense.

—By Jerry Geisel

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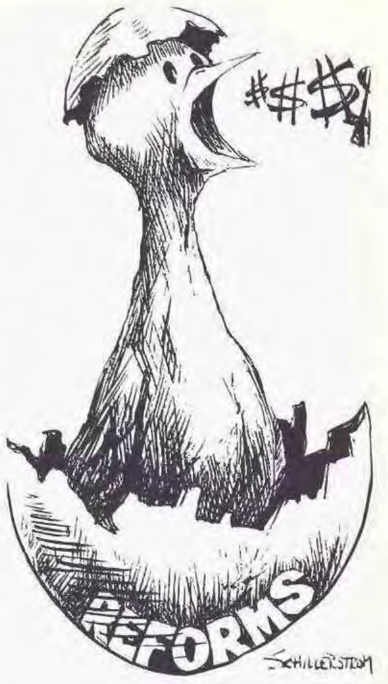
PBGC's finances, reforms cheer employers



When it comes to the financial condition of the Pension Benefit Guaranty Corp., what a difference a few years can make.

Since the late 1980s, the PBGC's financial position was deteriorating each year until it hit rock bottom in 1993 with a deficit of $2.9 billion in its main insurance program used to guarantee benefits to participants of failed pension plans the agency has taken over.

Federal legislators, among others, feared it was only a matter of time before the PBGC would need a U.S. Treasury bailout to avert a collapse and continue to be able to honor its obligations to participants in pension plans it had taken over.

Today, with an $869 million surplus, the agency's financial condition has so dramatically improved that benefits lobbying groups say it may be time for the agency to ask Congress to lower the insurance premiums that

employers with defined benefit plans pay the PBGC.

Of several reasons for the PBGC's dramatic turnaround, the most significant has been the enactment of legislation in 1994 that gradually has ended loopholes in federal law that had allowed employers to underfund their plans and expose the PBGC to big losses when those plans were terminated.

The most significant change in the 1994 law requires employers with underfunded plans to speed up contributions. For example, a special rapid-funding rule that had required employers whose pension plans that were less than 35% funded to amortize new liabilities over roughly five years was extended to plans that were less than 60% funded.

Another change mandated the use of a conservative mortality table to end such abuses in which employers grossly underestimated their employees' life expectancies, which minimized plan liabilities and reduced their required contributions to the plans.

At the same time, the 1994 law boosted the PBGC's revenues by requiring employers with underfunded plans to pay higher premiums to the agency.

These changes have had the desired effect. Today, pension plan funding has never been better, while PBGC losses from plan terminations have sharply declined. Assets in its insurance programs exceed liabilities.

Other factors have played roles in the PBGC's recovery. The bull stock market of the past few years has provided the agency high returns on its equity investments, contributing to its improved financial condition.

The PBGC's improved financial condition is not just a triumph for the agency. It also is good news for employers. A sound financial base and a significantly reduced exposure to losses translates to stable—and perhaps eventually lower—PBGC insurance premiums for employers with defined benefit plans.

The agency's newfound financial strength also gave it the confidence to implement other changes.

In 1990, the PBGC began annual publication of its so-called Top 50 list, a compilation of the 50 worst-funded corporate pension plans. Agency officials thought corporate fear of the bad public relations generated by landing on the list would prod companies to boost plan funding. Publicity was one of few weapons the PBGC had—at a time of weak funding rules—to pressure employers to put more money into their underfunded plans.

But this year, PBGC Executive Director David Strauss, who assumed the top agency position after the sudden death of predecessor Martin Slate, axed the Top 50 list. With tougher funding rules and new requirements mandating employers to better communicate pension plan underfunding to employees, the Top 50 list had become obsolete, Mr. Strauss said. That move was welcomed by business groups who for years criticized the list because, they charged, the list inflated plan liabilities—and unnecessarily scared participants about the security of their benefits—by using interest rate assumptions that were too low.

The PBGC also scored points with employers for three other actions it took this year. One action involved the PBGC's audit program, used to determine if targeted employers have paid the correct termination insurance premiums to the agency.

Effective since October, the PBGC said employers selected for audits generally only would have to supply three years of premium-related information. The agency had been requiring six years of information.

That move was cheered by employers who said it was difficult and expensive to come up with old records. Under the change in policy, six years of information only will be sought if the PBGC discovers problems in its audits of an employer's first three years of premium-related information.

The two other actions involved giving employers terminating fully funded pension plans more time to meet various deadlines associated with the termination process and waiving for small employers a reporting rule for companies that fail to make required quarterly contributions.

While 1997 was a year of triumph for the PBGC after years of unrelenting bad news, all still is not bright and rosy for the agency. It still must deal with a steadily shrinking base of pension plans—roughly 3,000 to 6,000 pension plans terminate each year—as more employers shift to defined contribution plans.

But the PBGC's Mr. Strauss said he will use his position as executive director to rally support for defined benefit plans, which he said are a superb retirement income vehicle.

—*By Jerry Geisel*

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Employers scramble to turn Congress against PARCA

One of the top news stories of 1997, the introduction of and reaction to the Patient Access to Responsible Care Act, surely will play out next year.

Benefit lobbyists expect the chief sponsor of the PARCA legislation, Rep. Charlie Norwood, R-Ga., to push for a committee vote on the measure within a month or two of Congress returning to Washington in January after a nearly three-month recess.

The measure, H.R. 1415, which garnered support from nearly half of the House of Representatives, caught employer groups by surprise and they have since been scrambling to lobby Congress to oppose the bill.

The PARCA legislation was presented to lawmakers as an effort to curb managed care plan abuses. Employers, though, contend it would wreak damage on all types of plans.

Already, employer lobbying and protest is having an effect, albeit a limited one, on the legislation.

Rep. Norwood has modified a key provision in the original bill that would have allowed employees to sue their employers in state court and recover applicable damages under state law—including punitive damages—for personal injuries incurred in connection to services they received through their health plans.

Those liability provisions in the legislation would have specifically amended the Employee Retirement Income Security Act, which preempts state rules and laws that relate to employee benefit plans. Under the federal ERISA statute, employees can only sue for actual damages and, in some cases, legal expenses.

As originally introduced, the legislation, PARCA critics say, would have exposed employers to potentially huge damage awards in state courts for actions over which they had little or no control. For example, an employer that contracted with physicians to set up a health care network could face liability if a physician made a mistake and harmed an employee.

Responding to employer complaints, a bill introduced last month by Rep. Norwood to modify PARCA would preserve the ERISA shield against damages awarded under state law if an employer exercised "discretionary authority to review and make decisions" on claims for plan benefits.

That's an improvement over the original bill, but not by much, benefit experts say. They note the new bill offers only limited liability protection because many employers, in fact, only review decisions made by plan administrators involving large claims.

Even with that change, employers point out that the heart of the PARCA proposal—an attack on basic health care plan practices—would remain intact.

For example, while employers now can decide which type of health care-related services they want to cover, the legislation would bar employers and other payers from discriminating in the "participation, reimbursement or indemnification" of health care professionals certified under state law.

In effect, that requirement could force employers to provide coverage for services delivered by naturopaths, homeopaths and even massage therapists—as long as they are certified by the state—which are alternative services that many companies never intended to cover under group medical plans.

In addition, the measure would erode employers' ability to establish preferred provider networks. Under the bill, an employer that selects a hospital and its accredited physicians to be in its network could not bar other physicians from being in its network because they were not affiliated with or did not have admitting privileges to the hospital with which it contracted.

That provision, critics say, would cripple employers' ability to selectively contract with physicians on the basis of quality, cost and service.

Indeed, critics say PARCA has far more to do with protecting the incomes of health care professionals than curbing managed care abuses.

While that point will be debated by congressional legislators in the months ahead, health care analysts already are putting a price tag on the legislation.

A study released last month by Milliman & Robertson, an actuarial consulting firm, estimated that employers' annual health care premiums could rise anywhere from between 7% and 39% if PARCA is enacted.

—*By Jerry Geisel*

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Flat health care rates soon to be a thing of the past

The three-year hiatus from rising health care costs and premiums is definitely over.

Next year, observers say, employers can expect group health care rates, which already have started an upward trend, to continue to rise in response to higher health care costs, after a period of flat or decreasing rates.

The first signs appeared as far back as January that after three years of small increases in health care costs, the run of health care cost stability was coming to an end.

In 1996, group health care costs for active and retired employees had risen just 2.5%, according to benefit consultant A. Foster Higgins & Co. Inc. of New York, which conducted a survey of 3,290 employers.

But, in the wake of deteriorating financial results, many health maintenance organizations that had frozen or lowered rates over the previous three years were boosting rates 2% to 6% in 1997.

One reason was that managed care may have been nearing its saturation point. "The best way to achieve savings is to get employees to move from traditional indemnity plans to managed care plans. That shift has happened," said John Erb, a principal in William M. Mercer Inc.'s Miami office.

Towers Perrin also concluded from a new survey that group health care costs for active employees would rise an average of 3% in 1997.

Mark Jamilkowski, an HMO analyst with Conning & Co. in Hartford, Conn., said larger, more well-established HMOs had an improved outlook for 1997 "as their pricing is ahead of anticipated medical trends and they seem to have a firmer grasp on the cost drivers both from the medical and administrative sides."

First-quarter HMO earnings continued to suggest that HMOs were beginning to emerge from the trough of the competitive pricing cycle as rate hikes took hold.

"Generally, the first quarter was better than it has been, but the outlook for the second half is a lot better" particularly when compared with 1996, Mary O'Connell, an HMO analyst with Louis Nicaud & Associates in San Francisco, said earlier.

Then the signs at midyear renewal season confirmed what had been anticipated: Health care coverage costs were increasing, and the mid-single-digit increases many saw for this year could possibly lead to premium increases approaching double digits in 1998.

"I expect many HMOs as well as insurers will start reporting that the heat is on," said Joseph T. Lynaugh, president and chief executive officer of NYLCare Health Plans Inc. in New York. "I think health care cost inflation is definitely coming back."

In addition to inflation, another potential cost factor that emerged was legislative mandates, such as laws outlawing "drive-through" mastectomies; perceived public ire over managed care practices spurred such bills.

Some experts think mandates will mean higher premiums. "If you legislate certain procedures, it will increase costs," said Lee Exton, a consultant with Watson Wyatt Worldwide in Los Angeles.

However, at least for now, the impact of these legislative mandates should be minimal. "I have never seen any HMOs say they are going to increase rates" because of a mental health care benefit mandate, said Mary Case, a principal at The Kwasha Lipton Group in Fort Lee, N.J.

Meanwhile, by their first-half earnings reports, HMOs' rate hikes were beginning to work their way to the bottom line, said observers.

Arun N. Kumar, director at New York-based rating agency Standard & Poor's Corp., said the HMO industry could "expect margins to improve modestly through the second

half and '98 to be a much better year than '97."

By earlier this month, HMO executives and others said they were expecting another 2% to 6% in rate increases in 1998.

However these observers said employers can expect rates for traditional indemnity plans to increase 8% to 15%, roughly in line with this year's rate increases, with preferred provider organization rates expected to rise 8% to 12% next year.

Rates for point-of-service plans generally will continue to be one to two percentage points more than rate hikes for traditional HMOs.

Managed care executives said years of flat or falling rates as HMOs battled one another for market share took their toll, and the rate hikes are needed to improve margins and restore battered bottom lines.

"We think there's a general recognition in the marketplace that rates had probably gone too far," said David Olson, vp-investor relations for Foundation Health Systems Inc. in Woodland Hills, Calif.

A spokeswoman for Oakland, Calif.-based Kaiser Permanente, the nation's largest non-profit HMO, with about 8.8 million enrollees, offered a similar viewpoint. "Our rates have been, frankly, too low over the last several years, and that actually is contributing to what in '97 is our first projected loss for the program as a whole, so clearly we have to look at not only controlling costs but also at rate increases," she said.

But employers may still find they have at least some leverage in negotiating their health care premiums. Helen Darling, manager of international compensation and benefits at Xerox Corp. in Stamford, Conn., said, "There is a lot more wiggle room than anyone ever talks about."

—*By Judy Greenwald*

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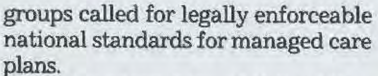
Health care pressure point shifts to quality



The quest for quality became the mantra of health care buyers, legislators and even some providers during 1997.

The year began with one employer overhauling its group health plan with the goal of encouraging a higher level of competition and quality among its managed care plans.

On New Year's Day, Rancho Cordova, Calif.-based Vision Service Plan instituted a program allowing its 1,200 employees in its home office to change health plans as frequently as every month.

Democratic congressional leaders entered the fray in March when they introduced a so-called "Health Insurance Bill of Rights" that would regulate how health maintenance organizations and other managed care plans treat patients. The measure, S. 353 in the Senate and H.R. 820 in the House, was introduced by Sen. Edward M. Kennedy, D-Mass., and Rep. John D.

Dingell, D-Mich.

The bill specifies in some detail what rights patients would have in obtaining emergency and specialist care through their managed care plans. The proposal also mandates a host of quality assurance programs, including collection of basic performance and outcome data. Both houses of Congress held committee hearings on the bill in October, but no further action has been taken.

That same month, a survey by Watson Wyatt Worldwide and the Washington Business Group on Health showed that large employers increasingly are buying health care based on quality concerns and less on cost considerations.

In March, the Midwest Business Group on Health called for performance measurements of individual health practitioners. These measures would include rating of practitioners' "caring attitude and communications skills"; morbidity and mortality rates; length of time patients take to return to work after treatment; Caesarean section rates; and past records of malpractice litigation.

In May, providers proffered their own proposition. The Washington-based American Assn. of Health Plans issued new guidelines that called for more physician involvement in health plan decisions. The group, which represents more than 1,000 HMOs and other managed care companies, said managed care plans should allow physicians to direct quality assessment and improvement programs and to be involved in their design and implementation. The guidelines also said patients should have access to appeals mechanisms at various stages in the health care delivery process.

In September, a coalition of three HMOs and two patient advocacy groups called for legally enforceable national standards for managed care plans.

The American Assn. of Retired Persons, Families USA, Group Health Plan Cooperative of Puget Sound, HIP Health Plan of New York and Kaiser Permanente joined forces in issuing 18 health care consumer protection principles.

Among other things, the principles state that: health care services should be available 24 hours a day, seven days a week; individuals should have a choice of health plans; health plans should cover emergency care; loss ratios should be disclosed; and health plans and provider groups should develop written standards similar to those used by the National Committee for Quality Assurance for hiring and contracting with physicians, other providers and health care facilities.

The quality of managed care organizations varies across the country and even within regions, the NCQA found last fall. In its first annual "State of Managed Care Quality" report released in September, the NCQA said managed care quality varies considerably in terms of preventive care, treatment of acutely and chronically ill patients, and member satisfaction.

However, in many cases, managed care plans provide better care than traditional fee-for-service medicine, according to the NCQA report. The report also noted there is little correlation between premiums paid for coverage from HMOs and enrollee satisfaction.

Also in September, the Pacific Business Group on Health published data about 49 California physician groups and nine others in the northwest United States based on written questionnaires returned by patients.

The information, available via the Internet and a toll-free telephone number, is unique because it focuses on individual doctors' groups, not the HMO or other managed care network to which they belong. The scores cover areas including overall satisfaction, quality of care, ease of getting care and referrals, doctors' communication skills, percent reporting blood pressure and cholesterol under control, and the availability of preventive care counseling on such topics as smoking, motor vehicle safety and sexually transmitted diseases.

By year-end, even the highest level of government was involved in the quality debate.

In November, a 34-member panel appointed by President Clinton recommended requiring health plans to provide more information to enrollees about covered benefits, experience of professional staff and procedures for resolving complaints.

Other recommendations of the panel include giving enrollees access to emergency services 24 hours a day, providing direct access to specialists for patients with complex or serious conditions and allowing physicians to provide information on all treatment options to patients.

President Clinton said he would direct every federal agency that administers or manages health plans to adopt the panel's recommendations.

—By Deborah Shalowitz Cowans

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A look at the year in risk management news

1997 RISK MANAGEMENT

JANUARY

■ Superfund reform legislation is introduced in the Senate that would provide some liability relief for small businesses, municipalities and transporters of waste, though the proposal would not repeal retroactive liability. The measure, S. 8, also would create a new system for allocating liability for multiparty waste sites. It is still pending.

■ The Occupational Safety and Health Administration and the National Institute for Occupational Safety and Health sponsor a forum for businesses, labor unions, researchers and others to share information about ergonomics programs and practices.

FEBRUARY

■ California insurance regulators seize control of Golden Eagle Insurance Co., citing inadequate reserves and unsecured loans made to its chairman, John Mabee. The department subsequently accepted a bid from American International Group Inc. to take over Golden Eagle. That decision later was overturned by a state court judge, who, after an acrimonious battle for control of the company, instead awarded it to Liberty Mutual Insurance Co.

MARCH

■ Chubb Corp. sells its life insurance operations for $875 million to focus on property/casualty operations.

■ CIGNA Corp. vows to appeal a Pennsylvania appellate court ruling that vacates the state insurance commissioner's approval of its controversial reorganization. The ruling also ordered new, trial-like hearings to be held in the case.

■ New Hampshire regulators place The Home Insurance Co. under formal state supervision after the insurer fell nearly $552 million short of its risk-based capital requirements.

■ France adopts a $3.46 billion rescue package for insurer Groupe des Assurances Nationales, recapitalizing the company after writing off real estate losses and poor underwriting results. The package is expected to pave the way for the government to privatize GAN.

■ Broker Marsh & McLennan Cos. Inc. acquires Johnson & Higgins for $1.8 billion. The deal assures M&M's lead over competitor Aon Group Inc. and is a windfall for the directors of J&H, many of whom will be made multimillionaires.

■ Lloyd's of London will appeal a 9th U.S. Circuit Court of Appeals ruling that overturned a lower court decision and allows U.S. members to sue Lloyd's in U.S. courts. The court, which hears the appeal en banc in October, has yet to rule. In June, the U.S. Supreme Court declined to hear a conflicting 4th Circuit case that held U.S. members must bring suit in the United Kingdom.

■ Liggett Group Inc. breaks ranks with the other tobacco companies and reaches a proposed settlement with 22 state attorneys general. In the settlement, Liggett admitted that cigarettes are harmful and addictive and that it has marketed to teenagers. Those admissions are expected to harm other tobacco companies' efforts to defend themselves from lawsuits.

■ Property/casualty insurers reported 1996 profits were $24.1 billion, up 17% over 1995 earnings. Underwriting losses were 5.4% smaller, while consolidated surplus gained 11.5% to $256.5 billion.

APRIL

■ Bermuda catastrophe reinsurer Partner Re Ltd. makes a $950 million acquisition of French reinsurer SAFR. The deal, centered around the minority shares Swiss Reinsurance Co. holds in both companies, will diversify Partner Re and greatly expand its geographic reach.

■ The soft market has forced a risk retention group, American Justice Insurance Reciprocal, to shut its doors and shift its book of business to CNA Insurance Cos. Later in the month, members of a Tennessee RRG, Clinic Mutual Insurance Co., opted to place the facility in runoff and join a newly formed risk purchasing group. Clinic Mutual's decision was prompted by changes in statutory liability for its members, as well as the soft market.

■ Merger mania among the world's largest brokers heats up, with Aon Group Inc.'s announcement that it will buy Minet Group. The surprise deal takes away a target of broker Marsh & McLennan, which had been in talks to acquire Minet since January.

■ Representatives of the major tobacco companies begin talks with state attorneys general on a proposed global settlement of tobacco litigation. The tobacco industry in June agrees to a $368.5 billion settlement with the states that would protect the companies from future class-action litigation. The settlement ultimately must be approved by Congress.

MAY

■ Workers compensation insurers and some employer groups are challenging a California regulator's move to alter permanent disability ratings, contending the official lacked the authority and oversight to make such changes. Workers comp payers contend the changes will raise their costs.

■ Bermuda's excess liability insurers continue to diversify with X.L. Insurance Co. Ltd.'s $637 million acquisition of the holding company of property catastrophe reinsurer Global Capital Reinsurance Ltd. The move follows competitor ACE Ltd's 1996 purchase of cat reinsurer Tempest Re.

■ The 5th U.S. Circuit Court of Appeals strikes down a Louisiana law that set numerous standards for risk retention groups. The ruling affirms a lower court ruling that held the federal Risk Retention Act pre-empted the Louisiana state law.

■ A panel of the National Assn. of Insurance Commissioners is considering broad deregulation of rates, forms and market access for "industrial insureds," or large commercial policyholders. The NAIC group throughout the year continues to draft its position on deregulation and unveils it for public comment in December.

JUNE

■ Lloyd's of London announces record profits for the 1994 underwriting year, driven significantly by the absence of huge additions to reserves, which characterized the market for several years prior to the creation of the market's runoff reinsurer, Equitas Ltd.

■ Two proposed catastrophe product liability facilities for pharmaceutical companies are shuttered, failing to attract interest in a soft market flush with capacity. A third such facility collapses later in the year.

■ California ergonomics standards win final approval from regulators, setting the stage for July 1 implementation of the nation's first mandated ergonomics standards. California employers, however, are largely sanguine about the new rules, noting many already are in compliance via voluntary work site improvements.

■ SAFECO Corp. bids $2.8 billion to acquire American States Financial Corp. from Lincoln National Corp.

■ Colorado State University hurricane forecasters predict 11 named storms in 1997, including three major hurricanes, which would continue several years of hefty windstorm losses. However, underwriters and U.S.

Continued on next page

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is pleased to announce that

STEWART KEIR, CPCU, CFE, CIE,

formerly Assistant Deputy Superintendent and Chief Examiner of the New York Insurance Department, is a non-lawyer professional who has joined our staff as an insurance/reinsurance consultant, resident in New York.

In addition to 32 years of experience with the NY State Insurance Department, Stewart Keir has chaired numerous NAIC committees and helped fashion much of the U.S. regulatory structure for surplus lines, reinsurance, risk retention groups, reinsurance intermediaries, managing general agents and many other property/casualty regulatory areas. Mr. Keir will continue to focus on insurance regulatory and related issues.

September 15, 1997

New York ◆ Washington ◆ Los Angeles
London ◆ Moscow ◆ Hong Kong ◆ Singapore

Continued from previous page
risk managers ultimately escape 1997's hurricane season relatively unscathed, thanks to El Nino's hurricane-dampening effects in the Atlantic.

■ The United Services Automobile Assn. creates a special purpose reinsurer to issue $477 million in East Coast hurricane catastrophe bonds, which will provide USAA $400 million in excess coverage in the event of a cat loss. Subsequently, Swiss Re and Tokio Fire & Marine issue cat bonds for quake risks.

■ In a sharp blow to a key litigation strategy for businesses, the U.S. Supreme Court rejects a $1.3 billion class-action settlement of asbestos claims. The 6-2 majority in *Amchem Products Inc. vs. Windsor et al.* held that the members formed for the class were too diverse and that many potential class members would not even be aware of their eligibility though they would be barred by the pact from suing. Citing the decision, a federal judge in August rejects a proposed class action settlement of tobacco litigation against Liggett Group Inc.

JULY

■ A report listing insurance companies that provided coverage of Nazi death camps during the Holocaust has prompted at least one company to cancel coverage placed with Allianz Insurance Co. Holocaust survivors also are suing Allianz and other insurers in U.S. and European courts over their alleged failure to honor life insurance policies of Jews and other victims of Nazi persecution.

■ U.S. District Judge Sam C. Pointer Jr. convenes a panel of four physicians to hear and assess scientific evidence on whether silicone gel breast implants cause illness or disease. Judge Pointer has been named to hear all federal breast implant product liability cases against Dow Corning and Dow Chemical.

AUGUST

■ In a major combination of insurance and financial services, Winterthur Insurance Co. and Credit Suisse Group agree to a merger designed to provide each other's clients with one-stop shopping.

■ Central Sprinkler Corp. comes under scrutiny after media reports that the company's Omega fire sprinklers failed to operate during tests and actual fires. Omega responds that it has improved the Omega model by no longer using rubber O-rings. In November, however, the company announces it inadvertently made 20,000 more sprinklers with the potentially flawed design.

■ Hudson Foods Co. is uninsured for the costs of a product recall of more than 1 million pounds of ground beef after some patties in Colorado were found to be tainted with E. coli bacteria. The government later expands the recall to 25 million pounds.

SEPTEMBER

■ Dow Corning Corp. issues a new settlement offer to silicone breast implant claimants that would pay them $2.4 billion, or $400 million more than its offer before entering bankruptcy protection. The company's offer also would require a single causation trial in attempt to put to rest claims that silicone implants cause injury.

■ Ohio labor unions and trial attorneys obtain 400,000 signatures to put a measure on the ballot that would repeal workers comp reforms enacted early in the year. In the Nov. 4 general elections, the ballot measure is defeated, erasing the pro-employer reforms.

OCTOBER

■ Lloyd's of London wins its first marketwide ratings from Standard & Poor's Corp. and A.M. Best Co. Lloyd's sought the ratings to provide a clearer basis of comparison with other global insurers.

■ A bipartisan congressional group unveils a new Occupational Safety and Health Administration reform bill. A cornerstone of the proposed measure would allow employers to obtain OSHA compliance evaluations from independent third- party safety auditors. Labor Secretary Alexis Herman later vows to push for a veto of the measure.

■ A J&H Marsh & McLennan memo outlining a new strategy to place certain insurance business through six regional offices rather than local offices nationwide is sparking concern among risk managers who see the move as evidence of the world's largest broker throwing its clout around at their expense.

■ A discussion draft of proposed product liability reforms wins the backing of the Clinton administration, which was a key obstacle to reform in the previous Congress. The measure, however, is considerably watered down from other reform bills.

■ The Year 2000 computer problem becomes more urgent for risk managers and insurers as time is running out for companies to begin conversion projects. Several insurers have unveiled products aimed at covering losses from the exposure of companies or their suppliers, though the industry also drafts policy exclusions.

■ Zurich Insurance Co. proposes a merger with the financial services unit of B.A.T Industries P.L.C., which would create one of the world's largest insurance and asset management companies. The deal is not expected to be completed before late 1998, however, because of the regulatory approvals required.

■ The collapse of financial markets in Southeast Asia creates potential losses for investors as well as export credit risks for companies doing business in the region. Political risk insurers expect growing demand for coverage to protect exporters from the shaky Asian business climate.

NOVEMBER

■ A proposal to dust off and reform the Resource Conservation and Recovery Act of 1976—a predecessor to Superfund—is announced in Congress in the wake of a GAO report recommending a few targeted regulatory reforms to save more than $1 billion annually in cleanup costs.

■ After three syndicate insolvencies from late 1996-early 1997 and a sharp decline in premium volume, the Illinois Insurance Exchange gets a shot in the arm with new syndicates and high-profile directors. Kemper Insurance Cos. also forms a new syndicate to enable the company to write surplus lines business. The exchange also renames itself INEX to signal the new direction.

DECEMBER

■ Trygg-Hansa SPP Group has transferred its shares in troubled Home Holdings Inc. to a bank trust as the first step in a plan to restructure Home Holdings and its debt.

■ Retired directors of Johnson & Higgins file suit alleging that active directors of the company fraudulently structured the sale of the broker to Marsh & McLennan Cos. Inc. The retirees allege the deal was improperly structured to enrich active directors and without prior approval from the retired partners.

■ In a case watched closely by business, the Supreme Court ruled in *General Electric vs. Joiner* that trial court judges—and not appeals court judges—should determine whether expert testimony meets scientific standards for admissibility. Businesses viewed the decision as a victory in their efforts to keep so-called "junk science" out of the courtroom. BI

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A look at the year in employee benefit news

1997 EMPLOYEE BENEFITS

JANUARY

■ Mellon Bank Corp. reaches an agreement to acquire Buck Consultants Inc., marking the first time a financial services company has bought a major benefit consulting firm. The acquisition is intended to give Buck greater resources to become an industry outsourcing powerhouse. A few weeks later, Coopers & Lybrand L.L.P. announces that it will buy Kwasha Lipton L.L.C.

■ For the third year in a row, group health care costs are remaining nearly stable. Group health care costs rose only 2.5% to an average of $3,915 per employee in 1996 from $3,821 per employee in 1995, according to an A. Foster Higgins & Co. Inc. survey. While cost increases were modest, benefit experts warn that larger increases are on the horizon as health maintenance organizations will seek higher premiums from employers to improve their financial results.

■ A labor welfare fund files suit in federal court, challenging a 1996 New York law that imposes huge surcharges—up to 57.27%—on hospital and other medical bills. The suit, which says the Employee Retirement Income Security Act pre-empts the surcharges, is still pending.

FEBRUARY

■ Telecommunications giant US West Inc. will absorb $8 million in future pension administration costs to settle a class-action suit by retirees. The retirees alleged that US West was not authorized by its defined benefit pension plan to pay administrative expenses out of plan assets.

■ Oxford Health Plans Inc., a Norwalk, Conn.-based large health maintenance organization, is beginning an innovative plan to use nurse practitioners as primary care providers.

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MARCH

■ Asserting a need for broad federal rules, two powerful congressional Democrats—Sen. Edward Kennedy, D-Mass., and Rep. John Dingell, D-Mich.—are backing legislation that would impose federal quality standards on health maintenance organizations and other network providers. The bill, seen as a congressional response to public anger over certain managed care plan practices, is still pending.

■ Pension Benefit Guaranty Corp. Executive Director Martin Slate, who played a key role in the 1994 successful drive to enact legislation to shore up the PBGC's financial base, dies suddenly of a heart attack. He was 51. His death precedes the release of a PBGC report showing the agency for the first time has achieved a surplus.

APRIL

■ New federal regulations will ease the administrative burden on employers of complying with a 1996 law—soon to go into effect—that curbs the ability of health care plans to deny coverage for new employees' pre-existing medical conditions. The regulations, among other things, provide a model notice that employers can provide to departing employees listing how long they were covered by the employer's health care plan.

■ Travelers Corp.'s much-ballyhooed stock option program linked to its 401(k) plan is on hold after the Internal Revenue Service, for unspecified reasons, said it wanted to reexamine the proposal, which would give Travelers and its employees tax advantages not available under traditional stock option plans.

MAY

■ For the first time, the Equal Employment Opportunity Commission has proposed an approach employers can follow to accommodate employees with mental illnesses so they can continue in their present jobs. Reasonable accommodations for employees with psychiatric illnesses include part-time schedules and reduction of noise in the work area.

■ A U.S. Supreme Court decision could open the door to lawsuits by fired or laid-off employees who charge their dismissals were meant to prevent them from receiving health care and other employee benefits. The justices ruled that a section in ERISA that bars employers from discharging or discriminating against employees to prevent them from receiving benefits applies to all types of employee benefit plans and not just to pension disputes involving vesting of benefits.

JUNE

■ Employees in Pennsylvania no longer will be taxed on contributions made to flexible benefit plans to cover their health care expenses and premium contributions. Newly signed legislation makes clear that contributions to flex plans are exempt from Pennsylvania's 2.8% state income tax. That makes New Jersey the only state to still tax contributions to flex plans.

■ New York has the right to impose taxes on receipts collected by hospitals in the state owned by a longshoremen's union, the U.S. Supreme Court says. The decision is the latest by the high court chipping away at ERISA's pre-emption of state laws and rules that relate to employee benefit plans.

■ Employer members of the Pacific Business Group on Health will see their 1998 premium rates rise an average of 1%. While the increase is far lower than projected cost increases for other health plans nationwide, it follows three years of flat and falling rates for PBGH members.

■ Employers are lobbying Congress to drop a provision in a tax bill that would require employees to obtain spouses' written consent before they could take lump-sum withdrawals or loans from 401(k) plans. Backers of the provision, attached to a Senate tax bill by Sen. Carol Moseley-Braun, D-Ill., said some employees had drained funds from the plans and left spouses with nothing. Critics said the provision would increase plan administrative costs and reduce employee participation. A congressional conference committee later drops the proposal.

JULY

■ Tax legislation sent to President Clinton will ease administrative burdens for employers with pension

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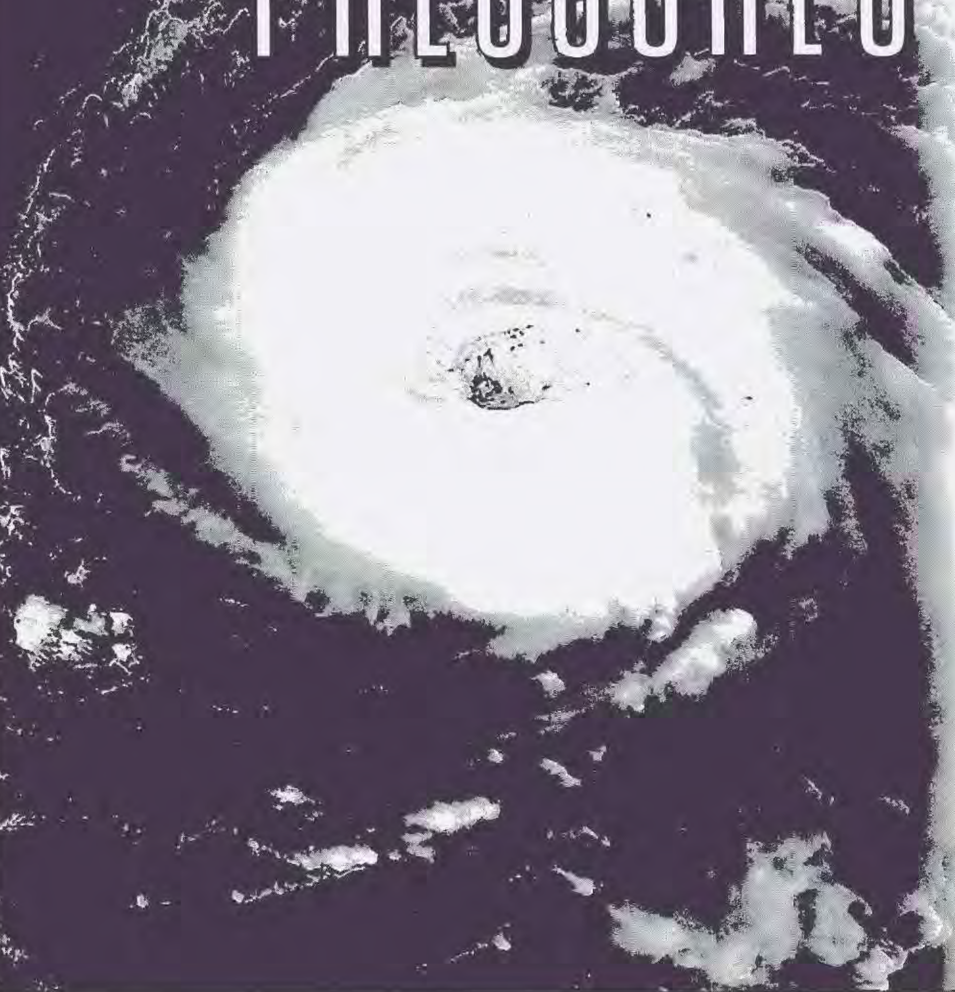

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Continued from previous page
plans. Among other things, the legislation makes it easier for employers to remove from their pension rolls former employees with small accrued benefits, exempts public pension plans from non-discrimination rules and exempts employers from filing certain previously required reports. The president later signs the bill.

■ A group of Hawaiian employers is challenging a state law that forces them to provide health care benefits to anyone an employee deems a "reciprocal beneficiary," whether or not the employee has a connection with the beneficiary. In a later settlement, the state attorney general agrees to apply the law only to traditional indemnity plans, which cover only 5% of employees in the state.

AUGUST

■ The International Brotherhood of Teamsters strikes United Parcel Service of America Inc. after UPS demands to withdraw from multiemployer pension plans covering Teamster employees. UPS says it wants to leave the underfunded plans—at a cost of $700 million in withdrawal liability charges—because it doesn't want to pay for benefits for other employees in the plans. Benefit experts say if UPS leaves the plans it could result in sharply higher contributions for remaining employers. To settle the strike, UPS later drops its demand.

■ Columbia/HCA Healthcare Corp., is selling ValueRx, the nation's largest prescription benefit manager not owned by a pharmaceutical manufacturer, amid a federal investigation over Columbia's Medicare billing practices. The sale still is pending.

SEPTEMBER

■ Federal budget legislation signed by President Clinton will give retirees new health care alternatives to the traditional Medicare program. Among other things, retirees will be able to choose from provider-sponsored organizations, Medicare preferred provider organizations, private-for-service plans and medical savings accounts linked to high-deductible indemnity policies.

■ The Pension Benefit Guaranty Corp. is dropping its list of the 50 worst-funded corporate pension plans, a list the agency has published annually since 1990 to encourage companies to put more money in their plans. Changes in federal law, including faster funding rules and more disclosure to plan participants, have made the list obsolete, says PBGC Executive Director David Strauss.

■ After a series of legislative successes, President Clinton is targeting new areas to expand health care coverage. Specifically, President Clinton says he wants legislation passed to ban so-called drive-through mastectomies and end so-called gag rules in managed care plans. President Clinton also says something needs to be done to expand coverage for retirees too young to be eligible for Medicare and workers who lose their jobs and can't afford to pay COBRA premiums.

■ A health care purchasing alliance is issuing a report card on how satisfied patients are with their providers. What is new about the reports issued by the Pacific Business Group on Health is that doctors' groups—not the HMO or other managed care network to which they belong—are the ones being judged.

■ Sears Roebuck & Co., known for generous employee benefits programs, is cutting back. The huge retailer says for competitive reasons it will cease contributions to a supplemental health care plan for future retirees and scale back life insurance benefits for most current retirees and eliminate it altogether for future retirees.

OCTOBER

■ The quality of managed care varies widely across the country, according to a new report. The report by the National Committee for Quality Assurance found little correlation between premiums paid to health maintenance organizations and enrollee satisfaction. The report could be a starting point for benchmarking the managed care industry.

■ In anticipation of a Jan. 1, 1998, effective date of a new federal law, many employers are eliminating dollar caps on their mental health care benefits programs. The law bars employers from offering, as most plans now do, lower annual and lifetime benefits for mental disorders than for physical disorders.

■ In the wake of a one-day fall of more than 500 points in the Dow Jones Industrial Average, 401(k) plan participants are keeping their cool. While benefit administration centers were flooded with hundreds of thousands of phone calls, only a tiny percentage of participants moved money out of equity funds into more stable investment options.

■ Shares in managed care companies are walloped by the Oct. 27 stock market plunge. The biggest loser is HMO Oxford Health Plans Inc., whose value fell by about two-thirds in one day after it disclosed that accounts receivable were not being collected on time. Its stock continues to drop. Shares in other managed care companies, though, rebound sharply the day after the crash.

NOVEMBER

■ New Internal Revenue Service rules will make it easier for employees to change their flexible benefit plan decisions. While many decisions—such as how much to contribute to a flexible spending account—made before the start of a plan year are typically irrevocable, the IRS says there can be exceptions. Some of those exceptions include situations when employees move during a plan year and an HMO they had selected is not where the employee now resides.

■ Employers, insurers and managed care organizations are fighting legislation—backed by about half of the House of Representatives—that business lobbyists say would be even more damaging than the Clinton health care reform plan. The measure, the Patient Access to Responsible Care Act, introduced by Rep. Charlie Norwood, R-Ga., taps the well of growing public concern about certain managed care practices. But the bill has less to do with managed care and more to do with protecting the income of medical and other health care-related professionals, business groups charge.

■ A presidential panel backs recommendations to improve patients' access to quality health care. Among other things, the panel, in proposing a "Consumer Bill of Rights and Responsibilities," says health care plan enrollees should have access to emergency room services 24 hours a day and direct access to specialists for serious or complex conditions. Physicians also should be allowed to provide patients information on all treatment options.

DECEMBER

■ Total employee benefit costs—which include pension and health care expenses, as well as paid time off—slipped 3.9% in 1996 to an average of $14,086 per employee, according to a new survey by the U.S. Chamber of Commerce. Stable health care expenses and falling pension costs are responsible for the decline in benefit costs. But with health care costs increasing in 1997 and 1998, total benefit expenses soon could be marching upwards again. BI

A look at 10 who commanded attention

With the International Brotherhood of Teamsters winning what many called the most significant organized labor victory in years, union President **Ron Carey** should be ending 1997 as one of the country's most powerful labor leaders.

Mr. Carey

Instead, 1997 closes with the invalidation of his re-election this year to the top Teamsters post over James P. Hoffa because of campaign finance irregularities and his disqualification from seeking the union's presidency in a new election set for March.

Whatever Mr. Carey's current troubles, many viewed the Teamsters contract settlement with United Parcel Service of America Inc. in August after a 15-day strike as a major win for labor after nearly two decades of few triumphs and far more setbacks.

Refusing to back down in the face of UPS' "best offer," the company's 185,000 Teamsters won concessions on pay and pension issues and a company commitment to convert thousands of part-time jobs to full-time status. UPS Chairman James P. Kelly later said the Atlanta-based company's dropping of a demand to withdraw from the multiemployer pension plans and create its own plan for Teamster-represented employees was its biggest concession.

* * *

If there ever was an individual who clearly learned the lessons from the past, at least on employee benefit issues, it is **Bill Clinton**.

Three years ago, President Clinton's health care reform package went down in flames, a victim of overambition and perhaps some administration arrogance.

How things have changed. Scaling back his goals, last year President Clinton lent his support—at a critical time—to gain passage of a modest measure curbing pre-existing condition exclusions in health plans.

President Clinton

This year President Clinton, responding to a public backlash against practices associated with managed care plans, appointed and embraced recommendations from a blue-ribbon panel on health care quality.

He also promised that his drive to further reform the health care system would be limited in scope.

During the year, President Clinton also made an impact on risk management. Last year, President Clinton vetoed a federal product liability reform bill but said he would support what he considered a "reasonable" bill. He followed that statement this October by indicating his support for a compromise product liability reform proposal worked out by members of his staff and Sen. John D. Rockefeller IV, D-W.Va.

* * *

The secretive society of **Johnson & Higgins directors** became famous this year for two things: selling the 150-year-old private company and making a huge amount of money for themselves doing it.

J&H ended a century and a half of ownership by its directors in March when its board, led by Chairman David A. Olsen, sold the brokerage to rival Marsh & McLennan Cos. Inc. for $1.8 billion in cash and Marsh stock.

The move followed years of internal debate among J&H officials, who maintained publicly that the company was not for sale while fretting privately that it was losing ground to consolidating rivals, hindered by its inability to make acquisitions for stock.

Mr. Olsen

The deal that ended that debate shocked many inside J&H, where private ownership was a deeply ingrained part of the corporate culture.

Whether the takeover ultimately proves a good thing for the company and its clients remains to be seen. Without question, though, it was good for J&H's board.

According to a recent lawsuit, the 24 directors pocketed more than half of the purchase price, with Mr. Olsen collecting about $63 million, former J&H Vice Chairman Richard A. Nielsen about $55 million and the remaining 22 directors at least $36 million each.

Other top J&H managers received an undisclosed cut of the proceeds, while $500 million was earmarked for roughly 600 key employees and another $297 million went to 45 retired directors.

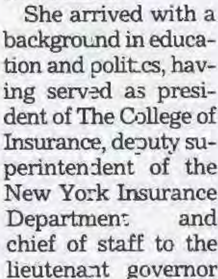
Some aren't happy. Nine retirees, including former J&H Chairman Robert V. Hatcher Jr., are suing J&H's board for allegedly rigging the sale to benefit themselves.

"It's going to be real messy," one J&H official predicted of the litigation.

* * *

The emphasis is on education at the Risk & Insurance Management Society Inc. under new executive director **Linda H. Lamel**.

Ms. Lamel became only the third executive director to head the 47-year-old society, replacing Eugene Ricci, who retired.


Ms. Lamel

She arrived with a background in education and politics, having served as president of The College of Insurance, deputy superintendent of the New York Insurance Department and chief of staff to the lieutenant governor of New York. She left a position as a principal with Management Consulting Services in South Orange, N.J., to take the RIMS job.

Among her top priorities is to establish the Fellow in Risk Management, an advanced professional designation program similar to one in place in Canada.

Since Ms. Lamel arrived at RIMS, the society has hired Amy Geffen as director of professional development. Ms. Geffen will focus on using technology to make it easier for risk managers to take continuing education courses.

The society in September cut six staff support positions after a review of operations revealed redundancies in some areas. The cuts will save about $250,000, which will be used to hire new personnel in 1998, most of whom will work to develop RIMS' educational programs.

* * *

Mississippi Attorney General **Mike Moore**'s crusade against the tobacco industry began showing results this year.

Mr. Moore became the standard-bearer in the flood tide of lawsuits against tobacco makers, leading the charge with Mississippi's 1994 suit seeking recovery of its Medicaid costs for treating smokers' illnesses.

Mr. Moore

Liggett Group Inc. was the first to settle, reaching an agreement with 22 attorneys general to create a fund to reimburse the states. Liggett also agreed to acknowledge on a warning label that cigarettes are addictive, and it admitted marketing cigarettes to teenagers.

In June, the rest of the industry agreed to a proposed settlement of more than $360 billion with dozens of states that had joined the effort led by Mr. Moore. The industry agreed to make the payments in return for some immunity against future lawsuits.

Shortly after that agreement, Mississippi came to terms with the industry in a separate arrangement that ensures the state receives more than $3 billion to resolve the lawsuit it had filed against tobacco makers. If the proposed national settlement is approved, it will supersede the Mississippi settlement.

Florida subsequently negotiated a similar arrangement.

The national proposal still needs Congressional approval. Mr. Moore and other experts predicted at a symposium in Washington in October that that approval would come in 1998.

* * *

By training, **Rep. Charlie Norwood**, R-Ga., is a dentist. But he made many employers want to gnash their teeth after they finished digesting a major piece of health care legislation introduced by the two-term Georgia congressman.

Rep. Norwood

Rep. Norwood's bill—the Patient Access to Responsible Care Act of 1997—has garnered support from nearly half of the House of Representatives.

The bill is a response to a managed care industry that wants "all of the power and none of the responsibility," says Rep. Norwood, 56.

No public policy establishes minimum protection for participants in self-insured managed care plans, and it is up to Con-gress to do something about it, he says.

Rep. Norwood has his own prescription. The PARCA bill, among other things, would open up managed care plans and all other types of plans, to punitive damage awards. It also would make it a lot more difficult for employers to establish preferred provider networks but would mandate coverage for services that many employers' plans do not cover.

Rep. Norwood intends to press for congressional consideration of his legislation next year.

* * *

Headlines, rumors and accolades continued to follow **Patrick G. Ryan** throughout 1997.

After acquiring Bain Hogg Group P.L.C. and then Alexander & Alexander Services Inc. in the fourth quarter of 1996, the chairman and chief executive officer of Chicago-based Aon Group Inc. kept up his growth by acquisition strategy in 1997 with the acquisitions of London broker Minet Group, Canadian broker Sodarcan Inc. and German broker Jauch & Huebener KGaA.

Mr. Ryan

Acquisitions catapulted Aon's 1996 gross revenues up 130% to nearly $4 billion, more than securing its spot as the world's second-largest broker.

Despite ongoing worldwide integration, Aon continues to be the focus of acquisition rumors throughout the brokerage industry.

Mr. Ryan maintains at the moment that Aon is interested in acquiring boutique brokers in geographic areas where integration is not an issue.

For his efforts in building Aon, Mr. Ryan was named Executive of the Year in June by *Crain's Chicago Business*, a sister publication of *Business Insurance*, and was later named The College of Insurance's 1997 Insurance Leader of the Year.

* * *

A.J.C. Smith started 1997 in an unusual position: head of the world's second largest retail brokerage.

As chairman of Marsh & McLennan Cos. Inc. Mr. Smith had been used to occupying the No. 1 one spot on the retail brokerage list, which had been M&M's for decades. But through the takeover of Alexander & Alexander Services Inc., Aon Group Inc. had usurped M&M's position at the head of the retail brokerage standings in December 1996.

But in March Mr. Smith and M&M leaped back to the No. 1 spot with the $1.8 billion takeover of one of the jewels of the brokerage industry, Johnson & Higgins.

Mr. Smith

The move firmly planted M&M back in its usual position, but Aon continued to cause M&M headaches.

M&M had been negotiating for months to buy London-based Minet P.L.C. from St. Paul Cos. Inc. M&M still was haggling over the price in May, when Aon stepped in and took Minet into its stable.

In September, Aon again outbid M&M. This time it was in Germany, and the target was the former Johnson & Higgins partner Jauch & Huebener.

But despite Patrick G. Ryan's best efforts, Mr. Smith is finishing the year at number one.

* * *

When **David Strauss** was selected in July to be the new executive director of the Pension Benefit Guaranty Corp., it wasn't surprising that many in the pension community were saying "David who?"

While Mr. Strauss, as deputy chief of staff for Vice President A[l] Gore, had been a senior official in the Clinton White House, he did not—unlike most of his predecessors at the PBGC—have extensive experience in pension issues before joining the agency.

Mr. Strauss

But in his first si[x] months at the PBGC, Mr. Strauss has become not only well known but also very popular among pension professionals due to a series of his decisions.

He drew raves from employers for his decisio[n] to eliminate the PBGC's Top 50 list—the agency's annual compilation of the 50 worst-funde[d] corporate pension plans. Mr. Strauss said the li[st] had become obsolete.

He received accolades for trimming the burden of a PBGC audit program used to check employers have paid the correct amount of pension insurance premiums.

Perhaps most refreshing of all for a government official was Mr. Strauss's attitude. He sai[d] he views employers as customers who are entitled to good service from the agency.

* * *

1997 was the best of times and the worst [of] times for **Stephen Wiggins**. For most of the yea[r] the chairman and founder of Oxford Healt[h] Plans basked in adulation for the company['s] success. The meteoric rise of the company, from its founding in 1986 to a Fortune 300 company and the country's fastest-growing managed health care company within a decade, made Mr. Wiggins a star.

Mr. Wiggins

Some headline-making moves by the company this year include using nurse practitioners as primary care providers, providing coverage for alternative care providers and permitting en[rollees] direct access to health care specialist[s]. Employers and individuals took notice. Enrol[l]ment skyrocketed and profits surged—or so Ox[]ford thought.

The cheering ended, however, during a tra[in] wreck of a day in October. Amidst the stoc[k] market's Oct. 27th collapse, Oxford unexpecte[d]ly announced that computer problems cause[d] the company to write off millions of dollars [in] uncollected bills. As a result, the company said [it] would lose more than $78 million in the thi[rd] quarter. Wall Street took immediate actio[n] knocking down the stock price from more tha[n] $68 a share to $25.88 in one day, a drop of 62.6[%]. Since then, the stock has slipped even lower.

Shareholder lawsuits followed the stoc[k] plunge. And Oxford has said it has misjudged [] medical costs and will post a loss this year.

For Mr. Wiggins, the crash tarnished his onc[e] stellar reputation. But if he returns Oxford to [] former heights, he could add turnaround arti[st] to his list of titles.

Global Briefs

Rating agency A.M. Best Co. has given an A+ (superior) rating to German reinsurer **Hannover Ruckversicherungs A.G.** and its subsidiary E+S Ruckversicherungs A.G., reflecting the reinsurer's underwriting practice, liquidity and geographical spread. The group has conservative reserves, professional management, an efficient operating structure and has been successful in its strategic acquisitions, A.M. Best said. . . Liberty International, the international arm of Boston-based Liberty Mutual Group, is buying **Skandia Seguros Generales S.A.** for an undisclosed sum. Skandia writes personal lines auto and life and health insurance in Colombia and has about $40 million in gross written premiums. Liberty International plans to use the company as a platform to launch into the workers comp market in Colombia. . . . Benefit consultant **William M. Mercer Ltd.** has expanded its U.K. operations by opening an office in Liverpool, England. The office is headed by Senior Investment Consultant Mike Reid. . . Ken Haddon, chairman and chief executive of AXA Reinsurance (UK) P.L.C. and also chairman of the London International Insurance & Reinsurance Market Assn., has been appointed **chairman of the London Processing Centre Ltd.** The LPC provides a central claims processing, policy checking and settlement facility for members of LIRMA and the Institute of London Underwriters. . . . Lloyd's of London has reached an agreement with broker J&H Marsh & McLennan to join the broker's **Global Broking System**, enabling syndicates to electronically connect with J&H Marsh & McLennan. . . . Loss adjuster Crawford-THG has set up a U.K. **special investigations branch** to help clients fight insurance fraud, which it estimates costs the British insurance industry £600 million ($990.7 million) each year. . . Letizia Moratti, former chairman of Italian broker Nikols S.R.L., has been named a **non-executive board member of Sedgwick Group P.L.C.** after the completion of a joint venture between the two brokers. . . . **Winterthur International Insurance Co. Ltd.** has increased the share capital of its London operations to £120 million ($198.1 million). At the same time, Willi Suter has been appointed chairman of the board, Kees van der Ploeg has been appointed managing director, Malcolm Newman has been appointed finance director and company secretary, and Rene Vuille-dit-Bille and Albert Guntli have been appointed regional managers. Ivo Furrer will be returning to Switzerland from London to head a new global property and casualty underwriting operation. . . U.K. insurer Guardian Royal Exchange Group **acquired PPP Healthcare Group P.L.C.** from PPP Healthcare Foundation P.L.C. for £435 million ($718.3 million). PPP Healthcare is the U.K.'s second-largest private medical insurer, with an estimated 28% market share. . . **Sir David Rowland** will become president of Templeton College at Oxford University upon his retirement from Lloyd's at the end of this year.

Lloyd's non-marine group to get update

Non-marine group to revamp operations

By EDWIN UNSWORTH

LONDON—Acknowledging it has failed to keep up with vast changes taking place within Lloyd's of London, Lloyd's Non-Marine Assn., the largest representative body of Lloyd's underwriters, says it intends to become a more businesslike operation.

David Clarke, the NMA's managing director, said that while the reconstruction and renewal program has revitalized the rest of Lloyd's, the NMA "has lost its way over the past few years."

Speaking after the group's annual general meeting late last month, Mr. Clarke said, "The idea is to be very professionally run—to run it as a business."

The NMA's newly created policymaking council, whose members will take office Jan. 1, will focus on developing strategies for the association, representational issues and lobbying, he said. The council's establishment is one of a number of changes agreed upon at an extraordinary general meeting called last October to discuss modernizing the association.

Apart from creating the council, other changes include opening up the NMA's membership to make it more representative of those active in Lloyd's non-marine market and reducing the number of association committees to make them more focused and accountable.

"The NMA, like Lloyd's itself, is changing rapidly to meet the challenges of the modern world," said Graham Williams, a director and underwriter of Methuen Underwriting Ltd. who was elected chairman of the council. Apart from Messrs. Williams and Clarke, the council will consist of nine other newly selected members, including Nick Marsh, an underwriter and a director of Atrium Cockell Underwriting Ltd., and Bill Rendall, an underwriter for R.J. Kiln & Co. Ltd. syndicates, who were elected deputy chairmen.

Messrs. Williams and Clarke acknowledged that one of the most significant changes agreed to at the October meeting is the opening up of the NMA's membership, previously limited to active underwriters, to include deputy underwriters and other senior syndicate personnel. This has enabled the NMA's membership to more than double to 240 from 90.

Mr. Clarke said this will give the association a wider electorate so that it can more truly represent Lloyd's non-marine underwriters.

Three standing committees of association members will meet monthly to cover matters in underwriting and technical issues, claims and development of information technology. They will be supported by a number of business panels representing various sectors of the market. The council also will issue an annual business plan.

Mr. Williams said the idea is to use these standing committees and panels as a replacement for the hundreds of committees that currently exist "so we can respond to issues as and when they arise."

He said one issue that will be examined next year is access to the Lloyd's market. In June, Lloyd's issued a discussion document on a review of the regulation of Lloyd's brokers and intermediaries.

The NMA already has said it does not thinks Lloyd's still can attempt to totally regulate approved brokers. BI

Large natural cats a threat to insurers

Reinsurance underutilized, Swiss Re warns

By EDWIN UNSWORTH

Reinsurance coverage for natural disasters in most major markets of the world is insufficient, according to a study by a leading reinsurance company.

The study also says catastrophe reinsurance rates are lower than they were in 1994 and could fall further in the short term as long as there are no major natural disaster claims.

"Prices are now moving into a range in which it will be very difficult for the rate of return required by reinsurers to be met. In the long term, the unfavorable price situation will result in reinsurers with poor capitalization and little diversification being squeezed out of the market," warns the study by Swiss Reinsurance Co.'s economic research unit.

The report, one of Swiss Re's Sigma series, concludes that reinsurance coverage in heavily populated areas is inadequate when measured against "reference losses," or insured losses caused by low-frequency major natural disasters, such as one-in-100-year storms or one-in-500-year earthquakes.

In the case of extreme events, insured losses could threaten insurers' solvency.

The report warns that in certain markets, losses could be so great that insurers would need to raise additional equity capital to avoid being taken over, seek state support or go bankrupt, leaving policyholders with unpaid claims.

The study covers the United States, the United Kingdom, Germany,

See **Report** *on next page*

Asia may be flirting with litigious culture

By YVETTE HIGGINS and KATE TILLEY

SINGAPORE—Asian companies, especially those expanding globally, must be prepared for more liability lawsuits, including for products and actions by directors and officers, insurance specialists say.

Speakers told the First AIDA Asia Pacific Insurance Law Conference in Singapore Nov. 9-11 that Asian risk managers and corporate buyers are finding they might need more corporate coverages, including D&O, fidelity and product liability. However, one speaker said the Japanese culture would prevent a flood of product liability suits.

Masato Ata, deputy manager-liability insurance section, nonmarine underwriting department of Tokyo-based Mitsui Marine & Fire Insurance Co., Ltd., said product liability claims are increasing in Japan. Between 1994 and 1995, the number of product liability claims reported to his company increased by 49.1% to 1,753, he said.

In the past, Japanese consumers were reluctant to sue corporations because they wanted to avoid public confrontation and settle disputes through non-public negotiation, he said.

But Japan's Products Liability Law, which took effect July 1, 1995, but was passed more than a

See **Asia** *on next page*

Heathrow tallies losses

Insured claims from fire to top £2.7 million

By EDWIN UNSWORTH

LONDON—Insured losses will total about £2.7 million ($4.4 million) from a fire earlier this month at Heathrow Airport.

The sum includes insured damage to the airport terminal, mainly to its roof, and some expected business interruption claims, said Barry Woodward, managing director of Property & Casualty Services of Manchester, England, a loss adjuster for the fire.

The fire occurred Dec. 12 in Heathrow's Terminal 1, which serves domestic and intra-European flights. Although use of the terminal returned to near normal within 24 hours, commuter access to the airport was disrupted for several hours, and many flights were canceled or delayed (*BI*, Dec. 15).

Investigators still are determining the cause of the blaze. Early reports from firefighters said it began in a ventilation duct above a Burger King restaurant in the terminal. The fire was confined to the terminal's ceiling space, though the passenger concourse had minor smoke and water damage.

Mr. Woodward said the estimate of £2.7 million in claims for the British Airports Authority P.L.C., which operates Heathrow, is a "reasonable reserve" figure based on anticipated claims.

Business interruption claims from the BAA and airlines are expected to be relatively minor, though, since most of the flights that were canceled that day were rescheduled over the next couple of days, meaning the airport lost little in takeoff and landing fees.

Mr. Woodward said business interruption claims likely would be filed by some of the numerous concessionaires occupying Terminal 1, where the fire occurred.

Those claims would go to the concessionaires' own property insurers, unless BAA is proven to have been negligent, in which case the concessionaires' insurers might try to recoup any payments from BAA's insurers.

Alternatively, they and the BAA may seek compensation from Burger King, or its insurers, if the fire investigation proves the restaurant operators at fault.

Although the Burger King chain is owned by what is now Diageo P.L.C., a company formed last week by the merger of Grand Metropolitan P.L.C. and Guinness P.L.C., the franchise for Burger Kings at U.K. airports and train stations is operated by Select Service Partners, a unit of catering group Compass Group Services Ltd.

London-based Independent Insurance Co. Ltd., one of the BAA's co-insurers, appointed PCS to adjust the claim.

The lead insurer for the BAA's coverage is Royal & Sun Alliance Insurance Group P.L.C. Willis Corroon Group P.L.C. is the BAA's broker.

PHOTO: AFP

The roof suffered most of the property damage from a recent fire at Heathrow Airport's Terminal 1.

Asia

Continued from previous page

year earlier (*BI*, July 18, 1994), "increased the probability of more product-related lawsuits in the future," Mr. Ata said.

He noted that until the law came into effect, introducing strict liability, a plaintiff in Japan had to prove negligence. Proving negligence "had been a daunting task for consumers because, in most cases, they usually do not have information or knowledge pertinent to prove a manufacturer's negligence in producing goods, as such information is hidden in the corporate archive beyond their reach," Mr. Ata said.

The law broadens the definition of manufacturers, which means more industries are open to claims. Mr. Ata said premium volume for product liability coverage almost doubled to 40.4 billion yen ($307 million) after the law was passed.

So far, under the law, six cases have been filed, but none has been settled. Despite the small amount of each claim, the suits show a trend toward litigation.

- A man is seeking 910,000 yen ($6,900) in damages after he allegedly cut his finger on the edge of the pull ring on a container.
- A plaintiff is suing a bacon manufacturer for 950,000 yen ($7,220) after he ate dried bacon and allegedly suffered an acute stomach ache.
- A plaintiff who was not injured alleges he was sold a defective snow-melting machine and is seeking 51 million yen ($387,600) from the manufacturer.
- A plaintiff whose daughter died of food poisoning is seeking 73 million yen ($592,700) in an action against Sakai city's administration, which allegedly provided a contaminated school meal that also made other students ill.
- Another plaintiff is seeking 33 million yen ($250,770) in damages from a sea urchin importer and an intermediary after eating an "infected sea urchin" and becoming ill.
- Relatives of a woman killed by a falling elevator in a multilevel garage are seeking 18.5 million yen ($140,582) in a suit against the garage manufacturer.

Although no claims have been resolved in court since the new law came into effect, industry-based alternative dispute resolution organizations have been established and have settled many claims, Mr. Ata noted.

Five industry bodies, the Electronics, Automobile, Gas & Kerosene Devices, Beverage Products and Consumer Products Product Liability Centers, each had dealt with more than 1,000 claims in fiscal 1995, he said. Most were settled out of court.

Mr. Ata predicted that a legal procedure revision expediting court cases involving claims of less than 300,000 yen ($2,280) would prompt more claims. Under a revision of Japan's Code of Civil Procedures that takes effect Jan. 1, judgments on small claims would be made on the first day of trial after each side presented evidence.

Japanese insurers, anticipating increased claims, might seek higher deductibles, "redefine their underwriting guidelines" and be "less aggressive" in selling policies to corporations with high exposures, Mr. Ata predicted.

But he also predicted "there will be no explosive increase of the product liability suits in Japan, due to Japanese cultural mindset and the legal system."

Another threat to Asian corporations is the increasing risk of claims against directors and officers, Aruno R. Salvi, general manager/principal of Singapore-based Reliance National Asia Re Pte. Ltd., told the conference.

Ms. Salvi said Asian directors and officers no longer are immune from risk as they increasingly become part of the global market and consumers become more litigious.

More Asian companies are expanding globally and raising capital on international markets, and "it is no longer possible to ignore the Australian or American litigation scene as something far-fetched and of no impact on Asian directors," Ms. Salvi said.

Once an overseas company trades on a U.S. stock exchange, it must comply with U.S. securities legislation and is subject to litigation in the United States, which means Asian directors could be sued in U.S. courts, even if their companies don't have offices there, she noted.

Asian corporations increasingly are setting up offshore branches or subsidiaries, so directors now operate where new potential legal risks exist.

Ms. Salvi said Asian companies listed on domestic or overseas stock exchanges now face onerous disclosure requirements.

For example, under Singapore law, directors must confirm their businesses are satisfactorily maintained, have no undisclosed circumstances affecting company values, no undisclosed contingent liabilities and that current asset book values can be realized.

"Directors can be caught for misleading statements, errors or omissions, and several cases have already surfaced in Asia," Ms. Salvi said.

Corporatization and privatization have changed the role of directors and officers who previously had statutory protection. Management styles have to change, and more accountability and transparency of transactions is required, she said.

Asian company directors also increasingly face claims for environmental damages, Ms. Salvi said.

The Year 2000 computer "millennium bug" also poses a problem to Asian companies, and directors cannot claim ignorance of its potential impact as a defense if they are sued.

"While D&O is one answer, risk management should be an integral part of good management," she said.

Ir M. Iqbal, technical and marketing director of Indonesian insurer PT Asuransi Bintang, agrees that Asian companies have to address risk management, not only to reduce liability risks but to minimize exposure to fraud.

The fidelity insurance market is underdeveloped, particularly in Indonesia, but the risk is high, and claims are increasing, he told the conference.

Risk managers can minimize exposures by careful staff selection and implementing and enforcing strict procedures and controls for handling financial transactions. For example, they can require two or more signatures before money is transferred or checks drawn, he said.

Managers also can implement financial audit programs and maintain good staff relations so the motivation to commit fraud or embezzlement is eliminated, Mr. Iqbal said. BI

Report

Continued from previous page

France, Canada, Japan, Australia, Belgium, Italy, the Netherlands, Israel, South Africa and Mexico.

It shows that while buyers over the past few years have been purchasing more catastrophe excess-of-loss reinsurance coverage, known as CatXL coverage, premium volume has not risen sharply.

During 1997, ceding companies in these countries bought CatXL limits totaling $52.9 billion, up 31% from 1994, while the premium volume fell 19%, to $2.8 billion.

The fall in premium volume can be explained by an increase in retentions and a drop in prices for CatXL coverage. The report says that in the 13 countries covered, during 1994-1997, CatXL rates fell an average of 33%. For example, CatXL rates fell 22% in the United States and 48% in South Africa.

The study also shows that during the same period the average margin—realized price less risk premium—in CatXL fell to 0.5% from 3.6%.

Of the 13 countries studied, the United States accounts for by far the biggest share—one-third—of 1997's CatXL coverage. Among individual countries, the United Kingdom holds the second-largest share, 11%, while combined European coverage represents 27%.

Of the $2.8 billion of CatXL premiums paid in 1997, the United States accounted for almost half. Europe again represented 27% and the rest of the world 26%.

•

The study, Sigma No. 7/1997, "Too Little Reinsurance of Natural Disasters in Many Markets," is available free from Swiss Re Economic Research, 200 Park Ave., 16th Floor, New York, N.Y. 10166; 212-973-5194, fax: 212-973-5050; or from Swiss Reinsurance Co., Economic Research Section, P.O. Box 8022, Zurich, Switzerland; 41-1-285-25-51; fax: 41-1-285-47-49.

Services Guide

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Lloyd's profit drop predicted

LONDON—Lloyd's of London results for 1995 and 1996 will not match the record profitability of 1994, its last closed year, according to a forecast.

The Assn. of Lloyd's Members, the biggest representative body for Lloyd's investors, predicted last week that Lloyd's as a whole will produce a return on allocated capacity of 10.5%, equating to a profit of £1.08 billion ($1.68 billion) for 1995, the next year to be reported in its three-year accounting system.

The prediction for 1996 is a return of 6.5%, a £647.6 million ($1.11 billion) profit.

However, even these estimates are better than Lloyd's' own forecasts—issued last spring when it reported a record profit for 1994 of £1.1 billion ($1.88 billion)—of a 1995 profit of £913 million ($1.42 billion) and a 1996 profit of about £600 million ($1.03 billion) (*BI*, June 2).

While the ALM points out that its forecasts still would make 1995 and 1996 the fourth and fifth successive years of good profits for Lloyd's after a five-year period previously when losses totaled almost £8 billion ($13.08 billion at the Dec. 15 exchange rate), it attributes the earnings decline to deteriorating trading conditions.

It says that in both years, Lloyd's quoted corporate investment vehicles will produce profits "significantly" below the market average, producing returns in 1995 of 9.31% and in 1996 of 5.5%.

A small number of syndicates is expected to show losses on capacity of more than 20% in both years.

In the worst case, motor syndicate 913 is forecast to show losses of 21.5% and 27.5% in 1995 and 1996, respectively.

Meanwhile, a separate results estimate for Lloyd's from Sedgwick Oakwood Lloyd's Underwriting Agents Ltd., predicts 1997 will show a return on allocated capacity of 5%, or a little less than £542 million ($886.4 million).

The return is expected to be about 5.8% for non-marine business and 8% for marine business. However, the return on aviation business will weaken to under 4%, while the forecast predicts the motor account will lose more than 6% of capacity.

—*By Edwin Unsworth*

Sedgwick denies Aon talks

Rise in stock price spurs break in broker's silence

LONDON—Sedgwick Group P.L.C. has taken the unusual step of issuing a statement saying it has not held merger talks with Aon Group Inc. for the past year and that no such talks are in progress.

London-based Sedgwick was prompted into breaking its traditional silence on market rumors after the broker's share price began rising early last week after a weekend press report that Aon was poised to unveil a £1 billion ($1.65 billion) agreed bid for Sedgwick.

The recent rumors of an Aon/Sedgwick deal began after Patrick G. Ryan, chairman and chief executive officer of Chicago-based Aon, made a 24-hour trip to London earlier this month.

Mr. Ryan was attending a retirement party for Alan Colls, chairman of Aon Group Ltd., who is leaving the company at year end.

Aon would not comment on the rumors.

Sedgwick shares opened 16 pence higher last Monday at 164 pence ($2.68) after a press report that had appeared the previous day. However, most of the gains were lost immediately after the company issued its statement.

Earlier this year, Sedgwick and Willis Corroon Group P.L.C., London's other major independent broker, denied they were in merger talks, and Sedgwick also has refused to comment in the past on rumors that it had been the subject of a due diligence review by Aon.

—*By Edwin Unsworth and Sally Roberts*

Airport found negligent in fire

By DON LEWIS KIRK

DUSSELDORF, Germany—German airports are reviewing their property risk management procedures after a court ordered Dusseldorf Airport GmbH to return 20 million deutsche marks ($11.3 million) to insurers that had paid business interruption claims to airport tenants resulting from an April 1996 fire.

In the first of several expected subrogation cases by insurers against the airport, a regional court last week found the company guilty of gross negligence. The April 11, 1996, fire killed 17 people and injured 87 (*BI*, April 15, 1996). The airport's attorneys are reviewing its coverage to see if liability insurance would respond to the award, an airport spokesman said.

However, airport liability insurer Provinzial A.G. says the airport is not insured for the damages, because so-called performance liability damages are excluded from the company's liability policy. Performance liability results from the failure of the policyholder to fulfill contractual obligations, such as the lack of access to airport restaurants and businesses. The insurer said this coverage was available by endorsement.

Even if the airport had purchased the additional coverage, however, German law prohibits liability insurance from covering gross negligence.

The Dusseldorf court found the company was grossly negligent in using flammable insulation material in the construction of the airport. Polystyrene panels rapidly spread the fire after it was ignited by sparks from a welding crew, whose company was fined 5 million deutsche marks ($2.8 million) by the court for negligence.

The court also found that Dusseldorf Airport GmbH failed to inspect the welding crew's working area to determine the risk of a fire.

The spokesman for Dusseldorf Airport said the company has not decided if it will appeal.

The court ruling came in a case filed by insurance companies representing restaurants and other businesses at the airport that sustained business interruption losses from the fire. The court dismissed the director of the airport's building division from the case.

Last April, Dusseldorf Airport and its six lead property insurers agreed to a settlement of 245 million deutsche marks ($138 million) for property damage resulting from the fire. The property insurers canceled the airport's coverage after paying the claim, and the airport found new insurers.

Total property damages at the airport are estimated at 350 million deutsche marks ($197.1 million), while the overall cost of rebuilding the airport is about 2 billion deutsche marks ($1.13 billion).

Meanwhile, a liability insurance pool for aviation victims is paying a total of 20 million deutsche marks ($11.3 million) to the estates or families of 17 people who died in the blaze. Luftpool, comprising 90 liability insurers, paid the claims.

Dusseldorf Airport GmbH still faces a subrogation suit filed by insurers of airlines seeking to recover more than 130 million deutsche marks ($73.2 million) in business interruption losses they incurred from the airport's shutdown during the blaze. BI

Environmentalism can clean up image

By KATE TILLEY

SYDNEY, Australia—Companies that want to prosper must succeed in an area that has proven difficult for them: controlling environmental liabilities, an environmentalist says.

The corporate sector needs to see environmental liabilities as opportunities to make money and win public favor at the same time, said Ian Kiernan, executive chairman of Sydney-based Clean Up Australia, an organization dedicated to improving the environment.

Mr. Kiernan launched a clean-up program in 1989 for Sydney because he was "horrified" at pollution on Sydney's beaches and in the water. When the operation became an annual event in Australia, he spearheaded Clean Up the World in 1993. The last world clean-up day had 40 million volunteers, he said.

Mr. Kiernan told the 21st national conference of the Assn. of Risk & Insurance Managers of Australasia, held last month in Sydney, Aus-

See **Cleanup** *on next page*

PINE TOP INSURANCE COMPANY LIMITED
NOTICE OF PERMANENT INJUNCTION

YOU ARE HEREBY NOTIFIED THAT ON DECEMBER 10, 1997, THE UNITED STATES BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK ENTERED AN INJUNCTION PURSUANT TO THE APPLICATION OF THE SCHEME ADMINISTRATOR OF PINE TOP INSURANCE COMPANY LIMITED ("PINE TOP"), CASE NO. 94B-41928(JLG), PERMANENTLY ENJOINING AND RESTRAINING ALL PERSONS FROM, AMONG OTHER THINGS:

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Cleanup

Continued from previous page

tralia, that "sensible, practical environmentalism will affect the balance sheet." Risk managers must make the environment their No. 1 issue, because "without it, no other issues are relevant," he said.

Mr. Kiernan said examples of "sound environmentalism" in the corporate sector include Sydney's parks and gardens, which are involved in a $7 million Australian ($4.6 million) project to use runoff water and treated effluent to water the gardens.

The Homebush Bay site for the main stadium and facilities for the 2000 Olympic Games is another example, he said. "Homebush Bay has the largest collection of dioxins in the world," he said. "We're now cleaning the site. As industrial land it was an unknown liability, but using technology available now, we can increase its value as real estate" after the Games.

Australian businessman Dick Pratt, owner of Pratt Industries Ltd., a Melbourne, Australia-based paper and plastics producer, is another example. Mr. Pratt is buying waste paper for $15 a ton and converting it to a product with recycled content that was sold for $1,500 a ton, Mr. Kiernan said. Mr. Pratt is now investing $20 million Australian ($13.2 million) in a project to recycle plastics.

"Being green isn't easy, but it's not hard, either," he said.

Stephen Wilder, president of the New York-based Risk & Insurance Management Society Inc. and vp-risk management for The Walt Disney Corp. in Burbank, Calif., said corporations are becoming more environmentally sound.

"Industry thinking is changing; we are seeing waste as a business opportunity," he told the conference.

"For a company to be world-class, it must have environmental strategies at its core," said Mr. Wilder.

He warned that corporations that fail to implement "environmentality" will not survive. "No one wants to harm the environment; and they don't want bad public relations."

Paul Gilding, former executive director of Greenpeace International, now managing director of Sydney-based Ecos Corp. Pty. Ltd., an environmental consulting firm, said corporations are more likely to improve their environmental performance for profit, not social responsibility.

Ros Kelly, a former Federal Environment Minister and now Sydney-based group executive, Asia and Australia, for the global environmental consultant Dames & Moore, told the conference that Australian companies are good at managing market, financial, technical and sovereign risks but "consistently fall down with environmental and social issues."

The "green movement is well-organized globally, and companies that think they can ignore it will not be successful," she said.

Risk managers must understand people's perceptions, because they often are unrelated to the actual damage but can be damaging to a company, Ms. Kelly said.

Public anger has to be taken into account along with the magnitude and probability of specific risks, she said.

Farmers, for example, do more environmental damage than the mining industry, but are perceived as being "more natural than industry," she said.

She told risk managers to "talk and listen. How many of you try to put yourselves in the public's position?"

Good environmental management is "simple lessons you learned in childhood," Ms. Kelly added.

"Tell the truth, ask first before you do it, clean up your own mess, share with the community, and say you're sorry." BI

ARIMA meeting draws more than 400 to Sydney

SYDNEY, Australia—The 21st annual conference of the Assn. of Risk & Insurance Managers of Australasia attracted 440 delegates.

The conference was held Nov. 9-12 at the Sydney Hilton.

At the ARIMA annual general meeting during the conference, Brian Crews, insurance officer for Unilever Aust. Ltd., in Sydney, was re-elected president. Caroline Crompton, risk and insurance coordinator for West Australian Petroleum Pty. Ltd., was elected senior vp.

The 1998 conference, on the theme Risk, A Profit Source?, will be in Melbourne, Australia, Nov. 15-18.

For information, contact: Conference Secretariat, Intermedia, P.O. Box 1280, Milton, Queensland, Australia, 4064; 61-7-3369-0477; fax: 61-7-3369-1512; electronic mail: arimaconf@im.com.au

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Category	Count
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CEO's, Presidents, and Owners,	2,499
Vice Presidents, General Managers and Other Administrative Personnel	4,696
Financial:	
Chief Financial Officers and Vice Presidents of Finance	3,084
Secretaries, Treasurers, controllers and other Financial Personnel	3,028
Risk/Employee Benefits:	
Vice Presidents, Directors, Managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations	15,387
Sub-total	**28,694**
Associations	305
Government, Unions and Educational Institutions	1,046
Commercial Consumers Sub-total	**30,045**
Insurance Agents and Brokers	8,462
Insurance Companies	7,336
Accountants, Actuaries, Attorneys & Consultants	2,823
Adjusters, Appraisers, TPA's, Captive Managers & Health Care Providers	1,648
Others Allied to the Field	915
Total Qualified	**51,229**
Non-qualified/Paid Subscriptions	31
Single Copy Sales	2
TOTAL CIRCULATION	**51,262**

★ *Source Business/Occupational breakdown of qualified circulation, May 26, 1997 Issue, as submitted to BPA for June 1997 BPA Publisher's Statement*

Ruling

Continued from page 1

concerned about junk science in civil litigation. The role of the trial judge as a gatekeeper, which was first established in *Daubert*, was reaffirmed, and the duty of the trial judge to examine scientific evidence and assure that it is both relevant and reliable is underscored in *Joiner*," said former U.S. Attorney General Richard Thornburgh, who has written on the issue.

"The court makes it clear that the only test to be applied in reviewing the judge's gatekeeper role is whether or not the trial judge abused his or her discretion and rejected the notion that there is some kind of 'preference' for admissibility; that's what the 11th Circuit had held and that was reversed in this case," said Mr. Thornburgh, counsel to Kirkpatrick & Lockhart L.L.P. in Washington.

The Risk & Insurance Management Society Inc. praised the decision.

"RIMS is pleased with the Supreme Court's decision, and we hope the decision will encourage more judges to exercise their gatekeeper responsibilities. By using all the tools available to them, judges may be able to guard against at least some of the abuses that currently burden our legal system," said Paul Brown, RIMS' director of government and legal affairs.

The *Joiner* case began when Mr. Joiner, an electrician for the city of Thomasville, Ga., discovered he had small-cell lung cancer in 1991. He sued GE and two other manufacturers of electrical equipment in 1992, claiming he had been exposed to polychlorinated biphenyls—better known as PCBs—as well as PCB derivatives polychlorinated dibenzofurans and polychlorinated dibenzodioxins while working with the equipment. He claimed the substances and the PCBs had caused his lung cancer.

He relied on expert witnesses to substantiate his claim. But the U.S. District Court for the Northern District of Georgia held that Mr. Joiner's experts failed to show there was a link between exposure to PCBs and development of Mr. Joiner's type of cancer. In fact, the court said the expert testimony did not rise above "subjective belief or unsupported speculation."

But the court of appeals held last year that the district court had gone too far in banning the testimony. The court held that because "the federal rules of evidence governing expert testimony display a preference for admissibility, we apply a particularly stringent standard of review to the trial judge's exclusion of expert testimony." The appeals court said the experts' testimony had a sound scientific basis when considered in its entirety rather than individually.

The majority of the high court disagreed. After discussing the particulars of the case, Chief Justice William Rehnquist wrote:

"We hold, therefore, that abuse of discretion is the proper standard by which to review a district court's decision to admit or exclude scientific evidence. We further hold that, because it was within the district court's discretion to conclude that the studies upon which the experts relied were not sufficient, whether individually or in combination, to support their conclusions that Joiner's exposure to PCBs contributed to his cancer, the district court did not abuse its discretion in excluding their testimony."

In a concurring opinion, Justice Stephen Breyer wrote that district court judges, faced with complex scientific questions, should take advantage of offers of review from respected outside experts when examining evidence. Justice Breyer noted that the New England Journal of Medicine had proposed such a cooperative effort in a brief in the *Joiner* case.

Justice John Paul Stevens concurred with part of the decision and dissented in part.

Business groups cheered the majority opinion as providing better balance in determining what sort of testimony can be admitted in cases involving scientific evidence.

"It's great for business. It reaffirms what the Supreme Court held in 1993, which is (that) it is the role of the trial judges to act as gatekeepers in deciding whether to admit or exclude so-called expert testimony. I think this is just going to make things more balanced," said Robin Conrad, vp of the National Chamber Litigation Center in Washington.

But an attorney who had filed a brief supporting Joiner before the high court disagreed that the decision was pro-business. "This is not a pro-plaintiff or pro-defendant decision; it is a pro-district court decision," said Arthur Bryant, executive director of Trial Lawyers for Public Justice.

"It gives much more discretion to the district court to either exclude or permit expert witness testimony; it gives much less authority to the appellate courts to overturn or control those decisions. What it means as a practical matter is whether cases get to the jury will depend a great deal on who the district court is. Before some district courts, there will be a bias in favor of allowing a case to go to jury. In some district courts, there will be even-handed approach, and in some district courts there will probably be a bias against letting cases go to the jury," he said.

"The decision ultimately creates a lot less work for the courts of appeal by giving much greater discretion to the district court. Unfortunately, it creates a system where whether you get to the jury or not will depend a great deal on who the judge is. It creates a system where the exact same case will go to the jury in front of one judge and not to a jury in front of some other judges, which may save appellate courts some work but is hardly the best way to run the system if you're interested in uniformity of result," said Mr. Bryant.

But business groups had little problem with any lack of uniformity of result.

"It could be double-edged in some cases, but the point that we wanted to make is that the fundamental decisions over the admissibility of evidence should be made at the trial court, because the standard that the Supreme Court established in *Daubert* gives the trial judge proper guidances on what to admit, and it's not necessary to second-guess those judges through expensive and time-consuming appeals," said Quentin Riegel, deputy general counsel of the National Assn. of Manufacturers.

Mr. Thornburgh said: "I think there are enough safeguards. I am particularly impressed by the concurring opinion by Justice Breyer, who points out the usefulness of the court's appointing its own experts to help in the assessment of admissibility."

Washington-based NAM's Mr. Riegel added that the decision fit into a larger framework that includes the high court's 1996 decision in the landmark punitive damages case *BMW of North America Inc. vs. Ira Gore*, which said punitive damage awards could be so disproportionate to actual damages as to be unconstitutional.

The *Joiner* decision is "kind of relevant to the punitive damages issues. We have been arguing for years that punitive damages should be subject to certain constitutional limits, and finally the Supreme Court issued guidance to the trial courts on how to specify when punitive damages are appropriate, so the ball is back in the trial court's court, so to speak," said Mr. Riegel.

•

General Electric Co. et al. vs. Joiner et ux., U.S. Supreme Court; No. 96-188, Dec. 15, 1997.

Comp

Continued from page 1

workers comp benefits, in some form, will land on Gov. Pete Wilson's desk.

The CSIA and employer associations fear their costs will increase excessively if lawmakers heed the arguments of labor and employee attorneys.

Self-insured employers, in particular, would be harmed, Mr. Markey said. Much of the savings that benefit-increase proponents cite in their call for higher benefits comes from insurance premium reductions that have resulted from a competitive insurance market and the introduction of open rating, he explained.

"We certainly would be complaining if somebody said self-insurers should pay increased benefits based upon the savings incurred by the insured community," he added.

Members of his organization benefited slightly from the 1993 reforms because the legislation reduced benefits for such things as vocational rehabilitation and psychological claims, Mr. Markey said.

But they also increased benefit payouts in an amount roughly equal to 50% of the $1.5 billion in savings expected from the reforms at the time they were passed, he said.

Therefore, members' costs have remained relatively constant, increasing about 1% to 2% per year, Mr. Markey estimated.

Other employers have experienced even greater cost increases, particularly large, self-insured companies with high-wage earners.

Theresa Muir, manager of the workers compensation division of Southern California Edison Co., said Edison's average incurred cost per claim has risen each year and nearly doubled from 1993 to 1996, rising to $10,138 from $5,665 in that period.

Increases in medical payments account for a portion of that, but most of it has been driven by "sharp increases" in indemnity associated with permanent disability and temporary disability claims, she said, adding that those increases are typical for large employers with high wage earners.

But attorneys and labor representatives argue that since the workers comp reforms in 1993, employers have saved billions of dollars and that those savings should be shared with injured employees.

Attorneys and labor argue that workers comp savings should be shared with injured employees.

Proponents of increasing benefits dispute some of the employer reports that their costs have increased in the wake of the reforms. They point out that in 1991, when claims costs in California peaked, employers were pouring about $9.8 billion—including workers compensation premiums and claims payments—into the system, an amount that has dropped since then to about $6.3 billion each year.

Therefore, employers have saved about $15 billion since 1991, and more of that should go to injured workers, said Frank D. Russo, president of the California Applicants Attorneys Assn., a professional association of lawyers who represent workers comp claimants. He points to the fact that claims frequency is down about 30% from a peak in 1991. Mr. Russo also said he doesn't believe insured employers could see a drop in costs, while self-insureds would not.

"Both insured employers and self-insured employers have had a tremendous drop in the amount they have had to pay in compensation since the 1993 reforms," he said. "Anybody who says they are not saving money, that just defies all logic. When insurance premiums plummet by a third, there is no reason to believe that other peoples' costs wouldn't go down by a similar amount."

Mr. Russo charged that employers are trying to renege on a promise made during the push for the 1993 reforms that half of all savings would go to injured employees. That pledge was never put into legislation, but it was contained in a press release issued by Gov. Wilson when he announced the signing of the reform legislation. Other than that, it was a gentlemen's agreement, Mr. Russo said.

The bills awaiting action in Sacramento, however, would make sharing of any cost savings law.

The bills state: "The Legislature finds and declares that employer savings have already exceeded the $1.5 billion originally estimated to result from reforms enacted through 1993. . . It is the intent of the Legislature to allocate equally between workers, in the form of benefit increases, and employers, in the form of reduced workers' compensation expenses, all of the savings that resulted from workers compensation reform legislation."

The bills also would increase benefits for temporary disability by an indexed amount and provide a 15% across-the-board increase for all categories of permanent partial disabilities, according to a Senate Industrial Relations Committee spokesman.

The legislation would increase annual premium costs 4.6%, or $271 million, according to an

Continued on next page

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Comp

Continued from previous page

analysis by the committee. Factoring in increased utilization due to higher benefits, the annual cost increase could rise to $366 million, according to the analysis.

The state does not track self-insured employers' costs, but the Senate committee analysis suggests that adding in self-insured costs would raise the amount by another 30% to 40%.

Employers say that a 30% reduction in claims frequency that proponents of the bills cite is misleading.

The number of claims has dropped, but not as sharply as has been said, they contend. Employers say that the current level of claims is being improperly compared with peak years that were influenced by a recession when many employees likely filed claims as a result of job losses.

In addition, the reduction in claims frequency is also due to a crackdown on workers comp fraud launched before the reforms. Also, the reduction in overall claims has come from other factors, such as a drop in the number of employees at some companies.

For example, Edison has experienced a decline in claims frequency to 1,400 in 1996 from 2,113 in 1993. But in 1992, the company had 20,000 employees, and today it has about 13,500, Ms. Muir said.

Employer representatives point out that attorneys representing employees in workers comp cases earn most of their income by billing 12% to 15% of the amount paid out in permanent partial disability benefits to applicants. Therefore, employers argue, they have a vested interest in raising these benefits.

Both sides, however, agree that some form of benefit-increase legislation will pass through the Legislature because Democrats control both chambers. But compromises are likely before anything is signed into law, because Republican Gov. Wilson would probably veto some aspects of the two existing bills.

One provision likely to be struck would award death benefits to be paid to a worker's surviving spouse for life in the same amount as temporary total disability indemnity would have been paid to the employee.

Employer groups are prepared to lobby against the bills when legislators reconvene.

"Using data from the Workers' Compensation Insurance Rating Bureau, the opposition's spin doctors have circulated their own version of just how much employers have saved," states a recent bulletin from the Sacramento-based Californians For Compensation Reform. "However, their calculation of the savings is inaccurate and speculative at best, and does not take into account that while claim frequency is down, the cost of each claim continues to rise dramatically." BI

Negotiate

Continued from page 2

bid for AGF, allowing a friendly takeover offer to be submitted to AGF shareholders. In return, Generali will receive a number of AGF's current and potential assets.

According to the AGF executive, under the deal:

• Generali will assume Allianz's 5% stake and AGF's 33.5% stake in Aachener & Munchener Beteiligungs A.G., Germany's third-largest insurer.

AGF will keep an AMB subsidiary, Royal Netherlands Life Insurance Co., which the French insurer owns completely, the AGF executive said.

Negotiations also are under way about Allianz's indirect holdings in AMB. Munich Reinsurance Co. holds 8.6% of AMB, while Dresdner Bank holds 14.7% of AMB. Allianz, in turn, holds 25% stakes in both companies.

Ugo Pastori, an insurance analyst at London stockbroker Robert Fleming Securities, said he thinks that after acquiring the Allianz and AGF shares in AMB, Generali eventually will make a bid for 100% of the Aachen, Germany-based insurer. That view was echoed by other analysts late last week.

"Deutsche Bank and Munich Re may sell their shares to Generali. We don't know yet, but Generali will probably bid for 100% if it can," Mr. Pastori said.

Because Allianz would own more than 50% of AMB through its direct and indirect holdings after acquiring AGF, German antitrust rules would force the company to dispose of any shares in excess of a majority stake.

• Generali will take control of about one-third of Athena Assurances, a Paris-based multiline insurer, while the remainder of the company will be held by AGF.

AGF, in conjunction with an Italian holding company, this month completed its acquisition of 97.2% of Athena's parent, French financial conglomerate Worms & Cie. The October offer for Worms was seen as the catalyst for the takeover offers that emerged for AGF (*BI*, Oct. 20; Oct. 13).

• The position of political risk and credit insurer Coface, in which AGF has a controlling interest, remains up in the air.

Reports in the French press during the bidding war for AGF have said the French government does not want foreign ownership of Coface. In addition to writing private credit and political risk insurance, Coface acts as an agency for French state guarantees in medium and long-term political risk insurance.

"We don't see why we should sell, but if the government wants us to sell, then we will sell," the AGF executive said.

Mr. Pastori of Robert Fleming Securities speculated that AGF would retain the short-term private sector credit insurance business that accounts for 60% of Coface's premium volume. The medium and long-term business transacted on behalf of the French state probably would be sold to another French company, he said.

Risk manager reaction to the deal was mixed.

"It's an understatement to say this (the takeover) is due to globalization. We have fewer and fewer brokers and fewer and fewer insurers. It's a problem we have less and less choice in insurers and brokers," said Thierry van Santen, director of risk management at Group Danone, a Paris-based food and agribusiness company.

"When you merge two companies, you don't get more capacity. We now have less and less choice in insurers and so maybe we have to go more to find partners in the reinsurance market. In a way, I regret the acquisition of AGF by Allianz. I'm not sure this will improve services in the coming years and I don't see more capacity," said Mr. van Santen, who also is a member of the executive committee of the Assn. pour le Management des Risques et des Assurances de l'Entreprise, the French risk management association.

"There are certain attractions to having a larger capital base and certain skills can be developed in large companies. There are too many insurance companies in France. I wonder how they survive," said Christopher Lajtha, corporate risk manager at Schlumberger Ltd., a Paris-based oil field services multinational.

"There is too much capital chasing too little business. If you take a long-term view, this kind of consolidation was probably well overdue," said Mr. Lajtha, who also serves on the French risk management association's executive committee.

The AGF executive said the insurer realized when Generali launched its hostile bid that AGF would lose its independence.

The insurer is pleased, he said, with the solution offered by Allianz, which will give Allianz 51% of AGF while the AGF board and its executives remain French and autonomous. "This is the best way to lose independence," the executive said.

Although Allianz will have a majority stake in AGF, it will have only a minority representation on the AGF board of directors. The AGF executive said this is because the German company is sensitive to lingering anti-German feelings in France dating from World War II.

Analysts do not expect Allianz to stay on the sideline for long.

"My feeling is that in the long term, Allianz will get a majority on the board," said Mr. Pastori.

"This is the friendly face of Allianz, and they will treat you with kid gloves. It's an ongoing thing, but it is true it will change," said Michael Lindsay, insurance analyst at investment bank Lehman Brothers in London.

Allianz is by far the winner in the whole story, he said.

"Allianz is looking good. They came out of this without having to counterbid. Generali has come out OK. They have always had their eyes on AMB. The AGF shareholders have come out worse, because they didn't get a bidding war" to drive up the purchase price, Mr. Lindsay said.

"Generali and Allianz basically got what they wanted without having to overspend," agreed Mr. Pastori. "This is a very political solution. It's not really a business solution, but it is the best that can be accomplished. In a normal situation, you would see Allianz and Generali bidding again. But this market is not like the U.S." BI

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Deloitte & Touche LLP	26	SAFECO Insurance Company	6
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First State Management Group	25	Swiss Re America	22-23
Fortis Inc.	21	Wausau Insurance Company	5
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WTO

Continued from page 2

sure to guarantee that insurance companies with existing operations in the country would be allowed to continue 100% ownership.

American International Group Inc. in New York, which has had operations in Malaysia for 51 years, lobbied strongly for a "grandfathering" concession for existing foreign-owned operations.

Although that provision was not included, AIG Chairman and Chief Executive Officer Maurice Greenberg nevertheless joined other international insurers in hailing the agreement.

"Significant benefits will result for both producers and consumers of financial products. The market opening and investor protections. . .will lead to lower costs, enhanced product innovation and the mobilization of needed domestic and international capital to address the requirements of both developing and developed nations," Mr. Greenberg said in a statement.

The central feature of the agreement is the commitment most countries made to allow entry to their markets by foreign insurers:

- Forty-five countries, including the United States, members of the European Union, Japan and Mexico, signed up to allow 100% ownership of subsidiaries and allowing them to enter markets via branch offices.
- Seven countries—Brazil, Chile, Indonesia, Jamaica, Nicaragua, South Africa and Venezuela—agreed to allow 100% ownership of subsidiaries but no entry through branches.
- Nine countries, including the Philippines and Singapore, agreed to allow majority ownership.
- Five countries—the Dominican Republic, Honduras, Malaysia, Sri Lanka and Tunisia—will only allow minority ownership for new operations. Malaysia will allow only 51% ownership of existing operations.
- Four countries—Costa Rica, El Salvador, India and Kuwait—made no insurance commitments.

While many of the countries merely reaffirmed their existing policies, there still were some significant concessions, said Mr. Cloney.

For example, Indonesia agreed to allow 100% ownership, whereas prior to the WTO agreement, foreign insurers could only have a minority ownership of Indonesian operations, he said.

And while Malaysia refused to grandfather existing operations, the U.S. government still will be permitted to negotiate with Malaysia bilaterally on this issue, Mr. Cloney said.

In the near term, the agreement will be a significant boost to international insurers, he said.

"The situation before, where you had to fight your way in everywhere, is being changed to a situation where everywhere we are building markets to the benefit of everybody," Mr. Cloney said.

The agreement gives international insurers a new level of comfort, said Brant Free, vp of international external affairs at Chubb Corp. in Washington. "What it means for us is more predictability," he said.

Even though the WTO agreement merely affirms the existing practice in many countries, insurers will now have a recourse if countries breach those policies, Mr. Free said.

If, for example, a country is found in breach of the agreement, the WTO—which will oversee the agreement—may permit countries that suffer from that infraction to take retaliatory action.

The WTO agreement has been a long time coming. U.S. insurers first called for trade rules for services in 1973. In 1995, many countries signed an interim agreement, but the United States refused to sign, saying it did not guarantee enough access to developing markets (*BI*, July 31, 1995). BI

Parity

Continued from page 2

Clinton administration last Friday released a regulation stating that employers can seek the exemption after six months if they document a cost increase of at least 1% and provide 30 days notice of the exemption filing to participants and to the federal government. Once an exemption is obtained, it is good for the entire duration of the law, which sunsets on Sept. 30, 2001.

The new rule, expected to be published in today's Federal Register, is a win for mental health advocates and a disappointment for business interests that had been lobbying for the right to do a prospective analysis of the cost of complying with the new regulation.

Private employers with 50 or more employees have three months, starting in January, to bring plans in line with the parity rules, though the government must be notified in writing if the grace period will be used.

'We'll try to apply it in practice and see if it's workable,' says Neil Grossman of the APPWP.

According to government-sponsored studies, about 30,000 benefit plans, or approximately 10% of plans covered by the new rule, are likely to be able to prove that their costs have gone up at least 1%. These plans cover 11 million people, the government said.

Business advocates criticized the new regulation as expensive for employers and difficult to apply. Employers seeking the exemption would have to amend health benefits in the middle of a plan year and reduce a benefit, which would prove unpopular, said Neil Trautwein, manager of health care policy for the U.S. Chamber of Commerce in Washington. He said he hopes that the rule will be repealed.

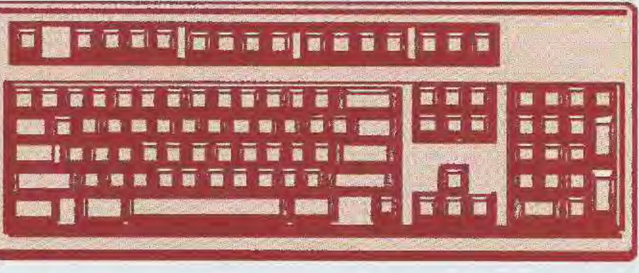
The Clinton administration was not swayed by several letters sent last week to key government officials by the Washington-based National Assn. of Manufacturers, said lobbyist Julie Cantor-Weinberg. "We asked for prospective relief," she said. "Clearly it's an example of how the administration is hostile to the employers in this arena."

Neil Grossman, vp for legal and regulatory affairs at the Washington-based Assn. of Private Pension & Welfare Plans, said: "We'll try to apply it in practice and see if it's workable. If not, we may go back to Congress."

How employers will use the 1% rule is largely a moot point for the year ahead, according to Rich Stover, consultant for Buck Consultants Inc. in Secaucus, N.J. The federal government has delayed providing guidance for so long that most employers already have seen their open enrollment periods come and go, he said, and major decisions regarding benefit parity already have been made. Many plan sponsors already have equalized mental and physical coverage (*BI*, Oct. 27).

Few plans are likely to seek the 1% exemption, predicted Judy Bauserman, a consultant in the Washington office of William M. Mercer Inc., because other permit-

See **Parity** on next page



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Surcharge

Continued from page 1

The Massachusetts surcharge, though, is much less costly than New York's, which can go as high as 57.27% per medical claim.

The Massachusetts surcharge—while not without complexities—also imposes fewer administrative burdens than New York's. Calculating the Massachusetts assessment is simple, while New York's has a number of variables, including where in New York employees live and the location of the hospital providing services.

"We have tried to develop a system that, while not perfect, is as simple as possible," said Katharine London, policy development manager with the Massachusetts Division of Health Care Finance and Policy in Boston.

Still, the new surcharge—typically paid by TPAs—ultimately will mean higher costs passed onto employers and perhaps employees.

"If TPAs have to absorb this cost, they can't stay in business. To survive, they will have to pass it on" to clients, said Stephen Zubiago, an attorney in the Providence, R.I., office of Edwards & Angell.

Employer groups say they should not be the ones to bear the cost of funding coverage for the uninsured.

"It is not a fair system. Employers end up paying twice: once for their own employees and once for the uninsured," says Richard Lord, executive vp of legislative policy for the Associated Industries of Massachusetts in Boston, a business trade group.

In the end, employers may ask employees to shoulder some of the added costs.

"Employers are reluctant to take on new costs. Eventually, it may be pushed back to employees," said Keith Dallas, a principal with Buck Consultants Inc. in Boston.

Others worry that if two states—New York and Massachusetts—now have a system of hospital bill surcharges to help finance uncompensated care, others may not be far behind.

"The issue isn't so much that one or two states have done this. The issue is, what if every state does something like this? Imagine the cost and administrative burden of trying to keep track and comply with dozens of state surcharge rules," said Fran Bruno, an attorney with William M. Mercer Inc. in New York.

"If all 50 states do this, I'm looking for another job. It is getting out of control," said William McKelvey, president of Medical Claims Services Inc., a TPA in Quincy, Mass.

And, a provision in the Employee Retirement Income Security Act that pre-empts state laws and regulations that "relate" to employee benefit plans—once thought to be an impregnable barrier to such state laws—may not provide as much protection as previously believed.

That is because in 1995 the Supreme Court ruled that an earlier New York hospital bill surcharge law was not pre-empted by ERISA because it had only an "indirect effect" on choices made by health care buyers (*BI*, May 1, 1995).

The new surcharge is the result of a bill passed earlier this year by the Massachusetts Legislature. That bill amended an earlier system of funding uncompensated care.

Previously, the state assessed hospitals a surcharge on their bills. The revenue was collected by the state and returned to hospitals based on how much uncompensated care they provided. The new surcharge on payments made to hospitals will allow the assessment hospitals have to pay to be cut to 3.9% from 6.2%.

The new surcharge legislation was passed in July and was to go into effect Oct. 1. However, a second bill passed in November delayed the effective date until Jan. 1, 1998.

It was at that point that "everyone began to wake up and realize what happened," said William Breidenbach, president of Health Plans Inc. in Worcester, Mass.

Because the surcharge does not go into effect until Jan. 1—rather than Oct. 1 as originally intended—the 12-month revenue goal of $100 million will have to be raised in nine months.

As a result, when the surcharge is adjusted next year for the 1999 fiscal year, it should be decreased to about 3.25%, as revenues then will be collected over a 12-month period.

'Employers are reluctant to take on new costs. Eventually, it may be pushed back to employees,' Buck Consultants' Keith Dallas says of the hospital bill surcharge.

Questions on surcharge answered on phone, online

BOSTON—In February 1998, an insurance company settles and pays claims totaling $14,500 with a Massachusetts hospital for services delivered in 1993, 1994 and 1995.

Does the insurer owe a surcharge on the payments? Yes.

The Massachusetts 5.06% surcharge applies to payments made to hospitals in the state on or after Jan. 1, 1998—regardless of when the services were delivered or when the bill is sent. In this example, the insurer would owe the Commonwealth of Massachusetts $733.

Answers to questions like this and many others about the Massachusetts surcharge on hospital payments are provided on a World Wide Web site maintained by the Massachusetts Division of Health Care Finance and Policy. The address is www.state.ma.us/dhcfp.

In addition, questions can be sent to the division through electronic mail at pool.help@ state.ma.us. For those without access to the Internet, the division can be reached at 800-888-2250 or 617-988-3328.

—By Jerry Geisel

Parity

Continued from previous page

ted plan design changes can control costs. In addition, self-insured employers will not want to incur the cost of figuring mental health care expenses, she said.

Bethesda, Md.-based Marriott International Inc., which now has a lifetime mental health benefit maximum of $50,000, compared with $1 million for medical and surgical care, will change its plan to comply with the rule, said Robert Dankmyer, vp-corporate benefits.

"Our objective is not to get around it by using the 1%," he said. "Our objective is to be in compliance." Mr. Dankmyer added that other restrictions—which are still undetermined—would be adopted to limit mental health expenses.

The administration's rule on the exemption is welcomed by mental health care advocacy groups. They had warned that prospective analysis of health costs would lead to massive defections of employers from the rule's umbrella.

"We were very pleased with the outcome," said Al Guida, vp of government affairs for the Alexandria, Va.-based National Mental Health Assn.

"It appears the implementation of the law will take place well into the 1998 plan year, and we hope we'll have a positive experience and long-term impact. It's our hope since the cost of the proposal is so minor, the actual exemption process will be rarely used," he said.

Although happy with the new rule, mental health advocates continue to criticize what they term major loopholes inherent in the law. Because plan sponsors are free to limit psychiatric care by number of inpatient days or number of outpatient sessions, for instance, these groups said employers still will be able to offer low levels of mental health care benefits.

"Anyone who wants to undermine (the rules) can undermine them," said Russ Newman, executive director for professional practice of the Washington-based American Psychological Assn. "People can still sabotage and undermine the intent of the parity legislation."

The new rule does not compel an employer to offer to its employees mental health care coverage or basic medical insurance, but analysts said that they expected few employers to drop these benefits.

The new rule also attempts to address the complexities that will arise when employers have more than one cap for various physical illnesses.

The rule specifies a weighted average of all covered physical conditions and sets mental health parity equal to that average. For instance, a group plan has a $100,000 annual limit on cardiopulmonary diseases, and 40% of the plan payments are for these illnesses. The remainder of claims, 60%, are covered at a maximum of $1 million.

The cap for mental health would be the weighted average annual limit, or 40% multiplied by $100,000 plus 60% multiplied by $1 million, or $640,000. **BI**

'People can still sabotage and undermine the intent of the parity legislation,' says Russ Newman.

Updates

Workplace injuries down in '96

Continued from page 2

workplace survey last week, covering 1996. The rate of reportable non-fatal injuries and illnesses in private industry workplaces dropped to 7.4 cases per 100 full-time employees last year, down from 8.1 a year earlier and from 8.9 in 1992, the survey found.

The rate was higher for what the bureau terms "goods-producing industries," such as manufacturing and construction, than it was for "service-producing industries" such as transportation. Manufacturing had the highest incidence of workplace illnesses and injuries, at 10.6 cases per 100 employees in 1996; finance, insurance and real estate had the lowest, at 2.4 cases per 100 employees.

The survey does not state reasons for increases or decreases in injury and illness rates. The survey released last week is one of three workplace safety surveys by the bureau. Its survey on 1996 fatalities—which showed a five-year low for the number of workers killed on the job—was released in August (*BI*, Sept. 1). A more detailed survey on seriously injured and ill workers and the circumstances of their illness and injury is slated for release in April 1998.

Kaiser to pay family

DALLAS—Kaiser Permanente is paying $5.35 million to the family of a man who collapsed and died in one of Kaiser's Texas clinics in 1995.

In a process used to encourage out-of-court settlements, a non-binding jury trial was held in state court in Dallas to hear allegations that the health maintenance organization's North Texas operations failed to diagnose heart problems that led to the collapse and death of 56-year-old Ronald Henderson.

Kaiser confirmed the settlement amount but did not return calls seeking more information regarding the case.

Jurors are unaware in such trials that their decision is non-binding. In this case, the jury reportedly returned a verdict that would have called for Oakland, Calif.-based Kaiser to pay a much higher award.

Airline settles with EEOC

MILWAUKEE—Midwest Express Airlines Inc. has agreed to pay $115,000 and to fund new workforce diversity and training programs as part of a settlement agreement reached last week.

Six airline maintenance workers filed suit in U.S. District Court in Milwaukee last May, alleging the airline's hiring and promotion practices discriminated against African-American employees.

In addition to paying $115,000, which will be divided among the six individuals, and establishing new training diversity programs, Milwaukee-based Midwest Express, in its settlement with the Equal Employment Opportunity Commission, also agreed to: form a two-year partnership with the Milwaukee Urban League to help identify, recruit, interest and orient potential minority employees to positions such as aircraft groomer, technician and other career opportunities; and make available at least seven scholarships covering tuition, fees and books to Wisconsin technical colleges that offer aircraft maintenance certification programs. As part of the settlement, the company would not divulge the total cost of the programs.

Midwest Express agreed to settle all of the EEOC's claims to avoid litigation costs. It denies any racial discrimination.

Standard to demutualize

PORTLAND, Ore.—Standard Insurance Co. is developing a plan to demutualize and become a publicly traded stock company.

If the plan is approved by Portland, Ore.-based Standard's board, its policyholders and regulators, the demutualization process will occur over an 18- to 24-month period. Upon completion of the demutualization, more than $500 million in stock could be distributed to the Standard policyholders, depending on the valuation of the company.

Company officials say conversion to a stock company will allow Standard, principally a group life and long-term disability insurer, to become more competitive because it will have greater access to capital.

Briefly noted

Insurance swindler Martin Bramson has pleaded guilty in the U.S. District Court in Baltimore to conspiracy, money laundering and mail fraud charges related to his operation of a string of bogus offshore insurers (*BI*, Nov. 10). He is scheduled for sentencing Feb. 11 and faces a statutory maximum of 30 years in jail, though his term under federal sentencing guidelines will likely be less. . . .Aetna U.S. Healthcare said **James H. Dickerson Jr.**, its chief financial officer, is leaving the company, and it expects to name a replacement shortly. Parent Aetna Inc. reported lower-than-expected third-quarter earnings, which has been attributed to its U.S. Healthcare Inc. acquisition and the problems inherent in digesting a major acquisition (*BI*, Nov. 17). . . .**Larry Lombardo** and **Fiona Luck** have been promoted to executive vps from senior vps at ACE Insurance Co. Ltd. Mr. Lombardo will have overall responsibility for ACE's underwriting operations and Ms. Luck, who already heads the financial lines operations, will also be responsible for joint ventures. . . .**ESG Re Ltd.**, a new specialty reinsurer, will be capitalized at $243 million after its initial public offering was oversubscribed. Originally, the reinsurer was to be capitalized at $210 million, but just before the IPO the number of shares for sale was increased. . . .Nearly 80% of insurers selling tax-favored **medical savings accounts** said sales have been below expectations. Reasons for subpar sales include lack of agent and consumer understanding of the product, according to a General Accounting Office report expected to be released this week.

Santa leaves coal, not capacity

By MYRON M. PICOULT
and JODI PICOULT VAN LEER
Special to *Business Insurance*

'Twas six weeks before Christmas at Nearly Defunct
And the firm was a-humming with holiday spunk.
The employees thought nothing at all would spoil it—
All but Almost Donothing, who sat in the toilet.

Hemming and hawing and quaking with nerves,
He sat in the stall and let his mind swerve
Toward the coming board meeting (a-ha—the plot thickens...)
At which he would stand up and lie like the Dickens.

Donothing stood and he zipped and he flushed.
My G-d, his board members would surely be crushed
If they sound out the truth—that the firm must be cursed,
Since business had gone from just bad to much worse.

For two years now he'd managed to hide from the bosses
That he'd benefited from light catastrophe losses.
And—at first Donothing couldn't believe his eyes—
But paid-loss trends were actually beginning to rise.

They'd written multiyear contracts and raised retentions. . .
Pricing in the commercial line stunk, come to mention. . .
Asbestos and environmental losses rose
And they were about to generate negative cash flows.

Growing investment income was getting harder
And reserves? Well, they'd scraped the bottom of the larder.
Oh, yes. If he told them the truth, Donothing feared,
The board would just toss him right out on his ear.

And so, he'd come up with a marvelous plan.
It was—granted—stop-gap, and yet it would span
The length of this last meeting of 1997
Just long enough to keep Donothing thanking heaven.

For you see, in a moment of brilliance he'd steered
The company toward a merger that he'd engineered.
And all of these problems would be squashed like a roach
When they joined an outfit that was above reproach.

With a smile and a flourish he entered the room
Shaking hands, patting backs, warding off coming doom.
He moved to his seat and said with a fake grin,
"Friends, you won't believe the shape that we're in."

But before he could finish, there arose such a clatter. . .
Donothing rushed to the door to see what was the matter.
And what, to his undying relief should appear,
But a jolly old elf and seven reindeer.

"Well! This is a surprise!" Donothing cried,
"Shed your bells! Take a seat! Come on inside!"
Santa entered and nodded, his expression strained.
The seven reindeer followed, extremely well-trained.

Donothing put his arm 'round Mr. Claus,
Turned to the board and said, after a pause,
"Ladies and gentlemen, with no further urging,
Let me introduce a potential merging:

Claus Industries and Nearly Defunct—let's hear it—
Does that not put you in the holiday spirit?"
Santa edged away slightly, to stand alone.
"Nothing," he muttered, "has been cast in stone."

Donothing fought off the panic that rose.
Laying his finger aside of his nose,
He said, "Santa, you joker, don't scare me like that!"
And was met by the silence of the guy in the red hat.

Tom Katt, head of underwriting, said "Something's unclear.
I thought there were supposed to be *eight* reindeer."
"Hey, this is the '90s," said Santa. "Get real!
Downsizing's part of the corporate deal."

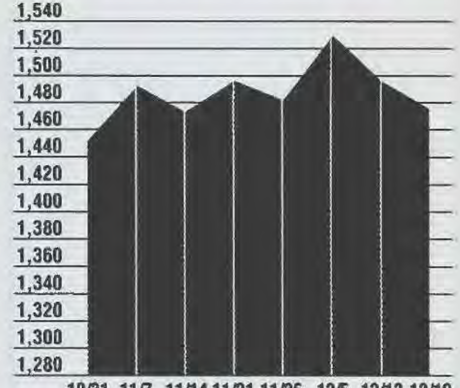
He turned to Donothing, a gaze that could burn.
"That's something you bozos would be wise to learn."
He pulled bifocals from his suit, and said, "Now, I fear
That you guys have been screwing around this past year.

"I've poured through these financial statements and pa-
pers—
And I can't believe some of this company's capers!
Why, I'm so appalled that I feel fairly weak.
I'll let my cohorts take the reins, so to speak."

"On Dan, on Harry, on Peter, on Ted—
On Don and on Gavin, and Mike," Santa said.
He nodded to one very large funny beast,
Who got to his hooves looking rather displeased.

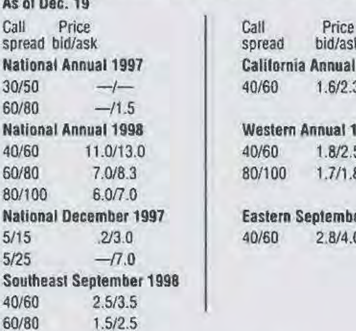
Continued on next page

BI Insurance Index



Base=100 on Dec. 29, 1978
Source: Nordby International Inc.

PCS catastrophe options


As of Dec. 19

Call spread	Price bid/ask
National Annual 1997	
30/50	—/—
60/80	—/1.5
National Annual 1998	
40/60	11.0/13.0
60/80	7.0/8.3
80/100	6.0/7.0
National December 1997	
5/15	.2/3.0
5/25	—/7.0
Southeast September 1998	
40/60	2.5/3.5
60/80	1.5/2.5
California Annual 1998	
40/60	1.6/2.3
Western Annual 1998	
40/60	1.8/2.5
80/100	1.7/1.8
Eastern September 1998	
40/60	2.8/4.0

Total volume: 140 Total open interest: 19,423

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

British Issues

Companies	Price pence	P/E	Div. pence	Yield %	52-week high—low
Comml Union	852	13.3	35.8	4.1	912—630
Genl Accident	1030	7.4	35.4	4.0	1158—729
Gdn Royal Exch	322	4.9	12.2	3.6	350—257
Legal & Gen	480	13.6	11.6	2.8	551—363
Royal & Sun	594	21.3	19.7	3.9	651—429
Brokers					
Lmbrt Fenchrch	107	7.3	8.4	10.1	138—101
Lloyd Thmpson	179	14.9	10.8	7.5	206—151
Sedgwick Grp	146	11.9	7.4	5.1	171—115
Willis Corroon	145	16.7	6.6	5.6	165—116

Note: Closing prices from Dec. 19 for all but Lmbrt Fenchurch and Lloyd Thompson; those prices from Dec. 18. All other numbers from Dec. 18.

Source: *Nordby International Inc.*(nordby.com) Boulder, Colo

BI Industry Stock Report DEC. 15, 1997, THROUGH DEC. 19, 1997

BROKERS		Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)
Aon Corp.	NYS	55.13	0.57	33.10	58.44	40.25	884
E.W. Blanch Holdings Inc.	NYS	33.63	-1.10	67.08	35.69	18.63	179
Gallagher Arthur J. & Co.	NYS	35.38	-1.74	14.11	38.25	29.75	90
Hilb, Rogal & Hamilton	NYS	18.75	1.69	41.51	19.63	12.50	102
Kaye Group Inc.	NDQ	6.50	-1.89	23.81	9.00	4.38	28
Marsh & McLennan	NYS	73.19	-2.66	40.75	80.00	51.13	1435
Poe & Brown	NDQ	41.25	-6.25	55.66	47.00	25.50	16
Sedgwick Group PLC	NYS	12.19	-6.25	17.47	13.25	9.38	143
Willis Corroon Corp.	NYS	12.88	8.42	11.96	13.50	9.75	583
BROKERS	AVERAGE		-1.22	34.04			
INSURERS/REINSURERS							
ACE Ltd.	NYS	93.56	1.70	55.61	101.06	55.75	731
Acceptance Insurance Cos.	NYS	24.69	-2.47	25.00	28.63	17.75	70
AEGON N.V.	NYS	87.50	1.16	38.34	89.69	54.25	97
Aetna Life & Casualty	NYS	67.94	-13.94	-15.08	118.13	67.06	7095
AFLAC Inc.	NYS	50.00	4.17	16.96	57.88	37.50	1359
Allied Group Inc.	NYS	28.94	1.76	33.05	35.75	20.06	149
Allstate Corp.	NYS	89.31	-0.56	54.32	94.38	56.25	4550
AMBAC Indemnity Corp.	NYS	43.50	1.90	31.07	47.56	31.00	1192
American Bankers Ins.	NDQ	44.25	10.11	73.11	44.25	23.69	497
American Financial Group	NYS	38.88	0.65	2.98	49.25	32.38	339
American General	NYS	53.56	-0.23	31.04	56.25	36.50	2549
American Heritage Life Ins.	NYS	37.63	-1.47	43.33	40.50	23.50	47
American Indemnity/Fin'l	NDQ	12.38	-1.00	20.73	15.50	10.13	0
American International	NYS	104.88	3.01	45.32	112.56	71.00	6294
Argonaut Group	NDQ	31.38	-4.56	2.03	38.13	26.75	129
AXA-UAP Group	NYS	39.00	3.65	23.81	39.88	29.25	324
Baldwin & Lyons Inc.	NDQ	24.44	-7.78	32.99	28.75	17.38	11
Berkley W.R. Corp.	NDQ	41.25	-0.90	21.92	46.38	28.81	249
Berkshire Hathaway Inc.	NYS	46000.00	0.66	34.90	48600.00	30000.00	1
Capital RE Corporation	NYS	60.06	-1.44	28.82	62.63	38.75	93
Capitol Transamerica Corp.	NAS	21.75	-4.40	6.10	28.13	17.63	73
CapMac Holdings Ltd.	NYS	34.38	0.55	3.77	36.00	22.50	655
Capsure Holdings Corp.	NYS	15.00	0.00	30.43	15.38	8.50	0
Centris Group Inc.	NYS	21.94	-6.90	11.78	24.00	17.88	88
Chartwell Re	NYS	31.00	-4.25	15.89	36.25	24.50	252
Chubb Corp.	NYS	77.06	1.31	43.37	78.50	51.13	1875
CIGNA Corp.	NYS	158.44	-0.98	15.97	200.75	132.25	1476
CNA Financial Corp.	NYS	123.94	-0.65	15.83	132.25	96.38	116
CNA Surety	NYS	14.75	-0.42	-1.67	16.50	12.88	165
EMC Insurance Group Inc.	NDQ	13.50	-3.57	12.50	15.00	10.75	5
Enhance Financial Services	NYS	58.00	0.54	58.90	59.25	34.13	462
Everest Reinsurance	NYS	38.00	0.33	32.17	43.00	25.63	385
Executive Risk Inc.	NYS	68.69	1.10	85.64	72.75	33.88	114
EXEL Ltd.	NYS	60.00	1.48	58.42	65.19	36.75	780
Fremont General Corp.	NYS	50.44	1.38	62.70	50.88	26.38	327
Frontier Insurance Group	NYS	22.00	3.53	15.03	39.25	18.38	1615
Gainsco Inc.	NYS	8.25	0.76	-14.29	10.19	8.00	225
General RE Corp.	NYS	207.88	-4.09	31.77	221.25	151.00	882
Gryphon Holdings	NDQ	17.00	2.26	20.35	17.75	12.88	8
Harleysville Group	NDQ	23.88	1.06	56.56	27.50	14.38	96
Hartford Steam Boiler	NYS	53.81	0.82	16.04	56.69	44.00	200
HCC Insurance Holdings	NYS	21.13	9.74	-11.98	32.69	18.06	540
ING Groep N.V.	NYS	40.75	-1.21	15.60	53.00	38.88	515
IPC Holdings Ltd.	NDQ	31.00	0.40	38.55	31.88	22.00	243
Hartford Financial Services	NYS	88.94	2.01	31.76	91.50	64.75	1183
LaSalle Re Ltd.	NDQ	33.25	0.76	13.68	36.13	25.50	285
Life Re Corp.	NYS	61.38	4.91	58.90	62.25	36.75	140
Lincoln National	NYS	74.25	-0.50	41.43	77.00	49.00	1039
MAIC Holdings Inc.	NYS	28.31	4.14	67.16	30.50	15.13	36
Markel Corp.	NYS	152.00	1.00	68.89	161.13	85.00	9
MBIA Insurance Group	NYS	64.19	-0.19	26.79	67.25	45.44	1312
Meadowbrook Insur. Group	NYS	24.13	-1.28	14.88	26.63	20.25	77
Mid Ocean Ltd.	NYS	55.81	0.22	6.31	66.75	44.13	233
MMI Cos. Inc.	NYS	25.13	0.00	-22.09	32.75	20.75	167
Mutual Risk Mgmt. Ltd.	NYS	27.13	1.64	46.62	29.75	15.50	408
NAC Re Corp.	NYS	45.63	-0.82	34.69	52.88	32.63	549
Navigators Group	NDQ	18.38	-1.34	0.68	22.50	15.75	82
Nobel Insurance Ltd.	NDQ	13.13	-1.87	4.48	15.38	11.88	50
NYMagic Inc.	NYS	26.44	-1.63	46.88	29.81	17.63	7
Ohio Casualty Corp.	NDQ	44.88	-1.91	26.41	51.00	34.00	93
Old Republic Int'l	NYS	36.69	-0.84	37.15	40.19	24.63	578
Orion Capital Corp.	NYS	44.38	-0.84	45.19	51.00	29.75	212
Partner Re Ltd.	NYS	44.56	1.13	31.07	45.13	30.75	413
Penn-America Group Inc.	NDQ	18.25	2.10	69.77	21.75	10.38	62
Philadelphia Cons. Holding	NDQ	18.00	9.92	54.84	23.25	11.25	281
PXRE Corp.	NYS	31.50	2.65	27.27	33.63	23.50	183
Reliance Group Holdings	NYS	13.63	3.81	49.32	15.13	8.50	866
Reliastar Financial Corp.	NYS	39.44	2.10	36.58	40.75	27.00	861
RenaissanceRe Holdings Ltd.	NYS	42.44	6.09	28.60	50.00	32.50	163
Risk Capital Holdings	NDQ	22.06	-0.84	13.87	23.38	16.00	68
RLI Corp.	NYS	48.56	4.16	45.51	48.56	30.50	118
St. Paul Companies	NYS	83.44	0.60	42.32	85.50	57.38	786
SCOR	NYS	48.00	-2.29	39.64	52.13	34.00	10
SAFECO Corp.	NDQ	47.88	-3.77	21.39	55.38	36.50	1964
SCPIE Holdings Inc.	NYS	26.94	-5.27	34.69	32.13	19.13	NA
Seibels Bruce Group	NDQ	7.63	0.00	-7.58	9.63	5.88	64
Selective Ins. Group	NDQ	25.25	-7.34	32.89	27.88	18.31	182
Tera Nova Insurance Co. Ltd.	NYS	25.06	-2.67	16.57	30.00	18.00	32
TIG Holdings	NYS	31.94	-0.97	-5.72	38.00	26.38	810
Titan Holdings, Inc.	NYS	21.69	0.58	31.44	25.00	15.13	105
Tokio Marine & Fire	NDQ	51.00	15.74	9.38	66.00	41.25	244
Torchmark Corp.	NYS	40.13	-2.43	58.91	42.81	24.75	1148
Transatlantic Holdings	NYS	69.94	-2.19	30.32	76.56	50.13	143
Travelers Property	NYS	40.69	0.46	15.02	43.56	31.38	1427
Travelers Corp.	NYS	53.00	0.59	75.21	57.38	28.69	18582
Trenwick Group Inc.	NDQ	34.75	-4.47	12.70	39.63	30.75	66
Unico American Corp.	NDQ	12.44	1.53	14.37	14.13	9.38	14
United Fire & Casualty	NDQ	44.56	-2.06	26.42	47.00	29.75	7
Unitrin	NDQ	63.00	-1.56	13.00	68.50	48.50	153
UNUM Corp.	NYS	52.56	4.99	45.50	52.81	33.63	1672
USF&G Corp.	NYS	22.44	2.57	7.49	25.50	15.63	3384
Vesta Insurance Co.	NYS	58.56	3.88	86.65	64.50	30.50	422
Zenith National Ins.	NYS	26.06	0.24	-4.79	28.75	24.63	55
INSURERS/REINSURERS	AVERAGE		0.27	28.28			
HEALTH MAINTENANCE ORGANIZATIONS							
Humana Inc.	NYS	19.56	-6.57	2.96	25.31	17.38	2881
Oxford Health Plans	NDQ	15.19	-2.99	-74.07	89.00	14.88	13838
Pacificare Health Sys.	NDQ	50.00	-0.25	-38.46	85.63	48.13	230
Safeguard Health Enter.	NDQ	13.38	-3.60	-23.57	18.75	9.63	17
Sierra Health Services	NYS	33.69	-3.92	36.80	41.63	23.75	278
United Healthcare Corp.	NYS	47.56	-3.30	5.69	60.13	42.44	5455
Wellpoint Health Networks	NYS	39.31	-9.89	14.36	61.13	32.25	1995
HMOs	AVERAGE		-4.36	-10.90			
ALL COMPANIES	AVERAGE		-1.77	17.14			

Top advancing issues: Tokio Marine & Fire, American Bankers Ins., Philadelphia Cons. Holding. Leading decliners: Aetna Life & Casualty, Wellpoint Health Networks, Baldwin & Lyons Inc. Most active issue: Travelers Corp. The *BI* Index fell 1.4%; the Dow Jones 30 Industrials lost 1.1%; the S&P 500 fell 0.7% and the NYSE Composite fell 0.5%. Average P/E: Brokers, 26.5; Insurers/reinsurers, 37.2; HMOs, 19.4.

Source: *Nordby International Inc.* (nordby.com), Boulder, Colo.

Classic

Continued from page 2

Mr. Beresford-Wood and Bob Roy, Classic Fire's chief executive, could not be reached.

Classic Fire, based in Crown Point, Ind., wrote a variety of surplus lines and reinsurance coverages, including taxicabs, commercial auto, garagekeepers liability and one-day event covers. The insurer's biggest-volume year was 1994, when it wrote gross direct premiums of $73.8 million, according to figures published by A.M. Best Co.

By 1996, Classic Fire's direct volume had dwindled to only $2.8 million and the bulk of its remaining business consisted of reinsurance of United Southern's auto risks, according to Best.

Indiana regulators filed their rehabilitation petition against Classic Fire in Marion County Circuit Court in Indianapolis Dec. 10.

According to the petition, the insurer's financial condition has deteriorated rapidly since the end of 1996, when it reported having $139.6 million in admitted assets and $12.2 million in policyholders surplus.

On Sept. 18, the petition notes, United Southern was ordered into liquidation in Florida, resulting in a "significant reduction" of Classic Fire's capital and surplus.

In its Sept. 30 quarterly financial statement, Classic Fire's total assets had fallen to $104.8 million and its surplus had been cut nearly in half, to $7 million, the filing says.

A large part of the $104.8 million in assets, regulators added, is held in a trust set up in Illinois to cover liabilities of Classic Syndicate after it withdrew from the IIE.

In addition, Classic Fire's surplus "may be overstated" by another $2.9 million to $4.6 million, which would put it in the "mandatory control level" under statutory risk-based capital guidelines, the petition says.

The Indiana department also said it "does not have confidence in the competence and continuity" of Classic Fire's management. Since January, several top officials have resigned, including President James H. Ryan, Vp and General Counsel Brian D. Bethke and Corporate Secretary Alexandra G. Jensen.

Along with the rehabilitation order, Indiana regulators also obtained an order to seize offices not only of Classic Fire but also of parent Concord General, JBW and affiliated companies.

Indiana Insurance Department officials had taken control of those offices last week, according to Richard T. Freije Jr., a lawyer with Baker & Daniels in Indianapolis, representing the department.

Meanwhile, shortly after the rehabilitation petition was filed, regulators completed a complex restructuring of liabilities and other transactions related to Classic Fire's defunct IIE affiliates, Mr. Feije confirmed.

In December 1995, regulators and Concord General officials had reached an agreement under which Geneva—then in runoff—reinsured all of its liabilities with Classic Syndicate, which then withdrew from the exchange and was absorbed into Classic Fire (*BI*, Jan. 8, 1996).

As part of the reorganization, Geneva and Classic Syndicate put virtually all of their assets in trust funds in Illinois. The inactive Geneva was ordered liquidated several months later (*BI*, July 15, 1996).

Indiana regulators and Illinois officials liquidating Geneva started negotiating a commutation of Classic Fire's reinsurance obligations to the Geneva estate several months ago, and a deal was finalized last week, Mr. Feije said.

Under the agreement, Classic Fire commuted all of its liabilities to Geneva for a cash payment and a transfer of stock in an affiliate of Exstar Financial Corp. of Solvang, Calif., he said.

The agreement also included a restructuring of various other transactions between companies controlled by Mr. Beresford-Wood and affiliates of Exstar, which is controlled by Peter J. O'Shaughnessy, Mr. Freije said.

Exstar is the parent of Illinois-domiciled Alpine Insurance Co. (*BI*, Aug. 19, 1996). Another Exstar unit, Transco Syndicate #1 Ltd., transferred its assets and liabilities to Alpine after withdrawing from the IIE at the end of 1995, according to Best.

Companies operated by Mr. Beresford-Wood and Mr. O'Shaughnessy entered a number of financial deals over the past decade, one of which at one point involved a pledge by Mr. Beresford-Wood of Classic Fire stock, Securities and Exchange Commission filings show.

The terms of the commutation between Classic Fire and Geneva are confidential, according to Dick Darling, chief operating officer of the Illinois Insurance Department's Office of the Special Deputy Receiver.

Exstar officials could not be reached. BI

IRI

Continued from page 1

venture management company to run IRI.

Mr. Norstrom will remain president of IRI, but no determination has been made as to who will be chief executive officer, he said.

ERC will use the expertise of IRI to offer specialized loss prevention services to all its clients and particularly in Asia and Latin America, where there is high demand for those services as the regions develop, Mr. Ahlmann said.

The combination of the business of the companies will enable ERC and IRI to offer new products and services, Mr. Ahlmann said.

"The combination of IRI's property underwriting expertise, HSB's technical insurance and loss prevention capabilities, and the financial and underwriting resources of ERC will make it possible for us to bring an array of new products and services to the large commercial property market," he said.

The purchase will be ERC's biggest foray into the primary insurance market. Currently, the reinsurer's only primary business is a small amount of errors and omissions insurance for insurance agents, and some media liability business.

But the HPR business is more akin to large facultative reinsurance than traditional property insurance, Mr. Ahlmann said.

Consequently, IRI is a good fit for ERC, a large liability reinsurer seeking to increase its property business, he said.

"There is a lot of talk about consolidation in the reinsurance industry, but most of the time it is reinsurers buying other reinsurers and at a high price. What we try to do is find something that is supportive of our overall business and adds value for our clients," Mr. Ahlmann said.

ERC often has been part of the speculation about further consolidation in the reinsurance business as some observers think it does not meet the earnings expectations of its parent, GE Capital.

But ERC has consistently met GE Capital's expectations, said Mr. Ahlmann. "Employers Re has met its targets and will continue to meet its targets," he said.

The purchase marks the continuing trend of reinsurers to move outside of their traditional business in search of premium growth in a soft market, said Jay Cohen, insurance analyst at Merrill Lynch & Co. Inc. in New York.

"The reinsurance market is highly competitive, and it is difficult to grow reinsurance premiums. At the same time, many reinsurers have ample or excess amounts of capital, so they are looking to expand into other areas," he said.

The purchase of IRI will allow the HPR insurer to better plan for the future, said Mr. Norstrom.

"We've been talking for some time about governance issues at IRI and the difficulties they presented when we had to think strategically. At the same time, this was an opportunity for members of IRI to recognize the value of IRI," he said.

IRI has been through some troubled times over the past several years.

In 1994 it lost $163.3 million, and in 1995 it lost $438 million. In an effort to turn around its fortunes, the association shrunk its book of business. For example, it cut back on oil and petrochemical risks and primary coverage for power generation business.

The strategy seemed to work; in 1996, IRI made a profit of $11 million, and in 1997, the insurance pool made a profit of $25 million.

With the change in strategy, IRI became significantly smaller. In 1995 it had gross premiums of $643 million; in 1996, that dropped to $500 million; and in 1997, its gross premiums fell to $400 million.

The composition of the underwriting capacity also has changed, and fewer companies made up the bulk of the capacity recently (see chart, page 1).

Continued from previous page

His name—it was Harry—and he was no fool
(In spite of an incident with a leaky pool. . .)
He said, "There's no reason to go ho-ho-ho,
The industry's reporting a negative cash flow."

Reindeer Ted's thoughts were not on
Bob Cratchit or Jacob Marley—
But instead on a rather sweet little Harley
He'd left snug and garaged in the good old North Pole.
But he stood, and he sighed right down deep to his soul.

"Good friends," Ted exclaimed. "If I may be so bold:
Distribution, it seems, just can't be controlled!"
From Reindeer Dan, there was nary a peep.
A brand-new fawn at home had robbed him of sleep.

So his mind was on formulas, diapers and bottles
Till a jab from a fellow deer brought him full throttle.
"Ah. . .oh! Sorry!" he said, rapidly blinking.
"The feeding frenzy on substandard auto has got me thinking:

"Since there aren't signs that it's about to stop—
Might that not suggest a market top?"
Reindeer Peter, who spent summers out on the Cape,
Leaned back in his seat and massaged his sore nape,

And wondered why Santa couldn't merge with. . .well, say. . .
A boat company, like good old O'Day.
Even Santa, he knew, would lose his nerve
When he reached into his sack and found no more reserves.

Reindeer Don was a favorite—that was a fact.
He'd give you the shirt off his very own back
(If reindeer wore shirts, which of course they do not,
But Don would have done it, no matter what.)

"Why use money," he asked, in a slight state of shock,
"To consider it an investment to buy their own stock?"
Reindeer Mike had left the street of the Wall
To answer a snowy and much higher call.

Bully for the analyst who had his say
And then goes to consult right on Santa's own sleigh.
He said, "Let me tell you a little joke."
"It's about an actuary, and another bloke."

" 'Hey—I see a snowman there!' The bloke cried.
'I don't know,' said the actuary, 'Gotta see the other side.' "
Reindeer Gavin stood up, his bells all a-jangle.
From Bermuda, he saw things from a tri-again-angle!

"Santa, look at the numbers! Success is out of reach!
These guys don't know their ass from their Elbow Beach!"
He turned to his boss, that jolly old gnome.
"Can we pack up the sleigh, St. Nick, and just go home?"

Santa sighed and he nodded, genuinely weary.
"Donothing," he said, "can't you see why I'm leery?"
I could quickly forgive one or two oversights
But Almost Defunct has done nothing right!

"The heck with this merger!" he said with a frown.
"If I hook up with you, you'll just drag me down!
There's no way I'll buy into an industry that's caving
Especially when it's not me who needs saving!"

And laying a finger aside of his nose,
And whistling to the reindeer, Santa Claus rose.
He turned to Donothing at the boardroom's big door.
"Here's the part," he said, "where I say one thing more.

About Christmas to all, and having a good night—
I'm afraid in this case the future's not bright.
In fact, this whole trip has been so unpleasant
That I'm not coming back—I'll Fed Ex your present.

"But don't expect goodies from the North Pole—
More likely than not you'll find some lumps of coal."
With a sigh and a shake, Santa bid his farewells,
And then all they could hear was the faint sound of bells.

The board members ducked heads and shuffled their feet,
As Donothing shifted in his big leather seat.
Staring at him were 20 anxious eyes,
All eagerly awaiting his word to the wise.

Donothing smiled, the oily old goat,
And cracked his knuckles, and cleared his throat.
"Natural resources!" he cried. "That's the catch!
We've squeaked by before, we'll get past this rough patch!"

Then Donothing smiled, suddenly spunky.
"Call the investment department," he yelled to a flunky.
"I want them all working, every last soul—
Tell them I said to go long on coal!"

Myron M. Picoult is a vp and senior insurance analyst at Wasserstein Perella Securities Inc. in New York. He is the past president of the Assn. of Insurance & Financial Analysts and a member of the New York Society of Security Analysts.

Jodi Picoult Van Leer is his daughter and the author of several novels, including "Picture Perfect." Her next novel will be published in Spring 1998.

Mr. Picoult

Ms. Picoult Van Leer

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