

Business Insurance

Former Caymans regulator facing corruption charges

GEORGE TOWN, Grand Cayman—Authorities in the Cayman Islands earlier this month formally charged Gilbert C. Connolly, the domicile's former chief insurance regulator, with four counts of corruption and one count of conspiracy in connection with the regulation of Olympus Fire & Casualty Ltd., formerly known as ReCo Ltd.

The charges allege Mr. Connolly, who was suspended as insurance superintendent in August, received about \$50,000 in loans and financial benefits from Anthony J.

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Reporting Weekly For Corporate Risk, Employee Benefit and Financial Executives / \$4.00 a copy

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Texas limits punitive damages for bad faith

By JOANNE WOJCIK

AUSTIN, Texas—Policyholders suing insurers for bad faith in Texas will find it much more difficult to win punitive damages following a state Supreme Court decision.

The court's Feb. 2 ruling, its second conservative ruling on bad faith damages in recent months, indicates that one of the nation's most liberal state courts is moving to the center on liability issues.

Under Texas law, punitive damages are permitted only when the defendant's conduct is found to be at least grossly negligent, if not some greater degree of wrong. Simple failure to pay claims on time would not qualify as gross negligence, the court ruled.

Rather, a plaintiff would have to show that an insurer knew that denying payment would likely result in "extraordinary" harm like death, grievous physical injury or financial catastrophe.

The "decision clearly puts us on a par with the rest of the nation," said Joanne Vorpahl, an insurance defense attorney with Porter & Hedges in Houston.

In another recent ruling, the Texas high court ruled that state law does not permit injured third parties to sue insurers for bad faith without first obtaining a summary judgment against the policyholder (BI, Dec. 6, 1993).

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Superfund bill doesn't suit all its critics

Some provisions win praise

By DAVE LENCKUS

WASHINGTON—Critics of President Clinton's Superfund reauthorization proposal say it will exacerbate, rather than ease, the litigation that is choking the current system.

But, business officials do applaud several provisions that would lead to lower costs by basing cleanup requirements on the intended future use of sites.

In addition, financial institutions hail a provision that would give the U.S. Environmental Protection Agency authority to limit their Superfund liability. The provision became significantly more important following a Feb. 4 federal appellate court decision that strips the EPA of that authority (see story, page 29).

President Clinton on Feb. 3 unveiled his plan to reform the Comprehensive Environmental Response, Compensation and Liability Act of 1980, which created Superfund. Rep. Al Swift, D-Wash., introduced the plan, H.R. 3800, in the House later that day.

Insurer and business leaders, including the Business Roundtable—an association of more than 200 chief executives from major corporations—had hoped the administration would replace the current system of strict, retroactive and joint and several liability for cleanup costs. They support financing cleanups with a broad insurer tax and some increased taxes on corporations and small business.

The current "polluter pays" system has led to tremendous litigation over liability for Superfund cleanups and over whether insurance coverage exists for those cleanups. The cost of that litigation represents about one-third of the private sector's Superfund costs and 88% of insurers' costs, Rand Corp. reports (BI, Nov. 8, 1993; April 27, 1992).

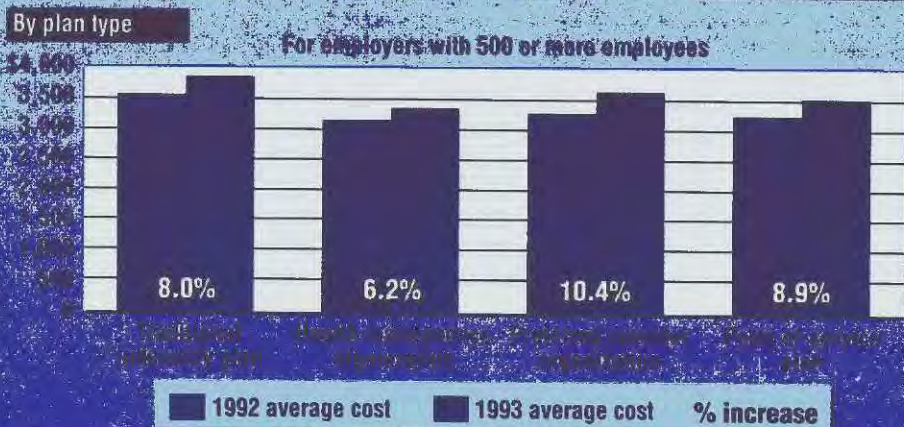
Instead, the administration's proposal retains the current liability system, though it adds a non-binding allocation system to establish liability among a hazardous waste site's potentially responsible parties

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1993 group health care costs

Increases in group health care costs are slowing, as evidenced by the 8% average rise in costs between 1992 and 1993, which is the lowest increase since 1987.

By company size	1993 average cost	1992 average cost	% increase
Overall average	\$3,781	\$3,502	8.0%
Under 500 employees	3,240	3,058	5.9
500-999	3,681	3,443	6.9
1,000-4,999	3,885	3,558	9.2
5,000-9,999	3,852	3,532	9.1
10,000-19,999	4,013	3,665	9.5
20,000 or more employees	4,537	4,150	9.3



Health plan inflation held to 8% in 1993

By JERRY GEISEL

The era of double-digit annual increases in group health plan costs is over.

Total health care benefit costs—including indemnity plans, health maintenance organizations, prescription drug plans, dental and vision care plan costs—rose 8% to an average of \$3,781 per employee in 1993 from \$3,502 in 1992, according to a survey of 2,395 employers to be released this week by benefit consultant A. Foster Higgins & Co. Inc.

Last year's 8% increase ended five consecutive years of double-digit increases in group health plan costs, including a three-year stretch in the late 1980s when costs surged by more than 15% each year.

Rising health care benefit costs and at-

tempts to control them became over the last few years one of the biggest challenges facing corporations.

Those rising costs, along with big increases in the number of individuals without coverage, also made health care a top domestic issue, which Bill Clinton successfully exploited during his 1992 presidential campaign when he charged George Bush with indifference to curing the nation's health care ills.

But, with cost increases slowing in the group market, one of the Clinton administration's principal arguments for its sweeping health care reform package—that government intervention is needed to rein in costs—no longer is as strong as it would have been a few years ago.

Exact dollar comparisons with earlier Foster Higgins studies can't be made be-

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Risk-based capital's impact to vary

Fallout from formula

By JUDY GREENWALD

Risk-based capital requirements for property/casualty insurers will not be the cataclysm that many insurers had predicted, but they could change the way many do business.

At a minimum, the requirements will be an additional factor that well-capitalized insurers will have to factor into their business strategies. But risk-based capital could affect poorly capitalized companies more profoundly, prompting mergers or buyouts.

"For some companies, it will be kind of a non-event," summed up Stephen Broadie, vp of the Alliance of American Insurers in Schaumburg, Ill. "For some companies, it will make life much harder. It depends on where you come out on the formula."

The National Assn. of Insurance Commissioners, which formally adopted the formula

in December, will require property/casualty insurers to report risk-based capital levels in their 1994 statutory statements, which are due in March 1995 (BI, Dec. 13, 1993).

The formula, which could be refined further during the coming year, is designed to become more stringent during the 1995 and 1996 accounting years.

A comparable formula for life/health companies takes effect with 1993 annual statements to be filed in March (BI, Sept. 28, 1992).

Risk-based capital rules essentially require more capital to support assets and liabilities that are considered risky. Most states now set a minimum capital of \$1 million to \$3 million for property/casualty companies and then limit the premium insurers can write against their capital. That type of standard does not

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Updates

Cayman regulator charged

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Damoulis, principal of Olympus and its resident manager, Delta PFC Inc., in exchange for failing to perform regulatory duties with respect to Olympus. Olympus is now in liquidation and the subject of a U.S. investigation (BI, Sept. 20, 1993).

The charges also allege that Nile Fraser Schuh III participated in the scheme. However, no charges have been filed against Messrs. Damoulis and Schuh because they are not Caymanian citizens, said Inspector Joseph Woods of the Caymanian police department.

Mr. Connolly was freed on \$10,950 Cayman (\$13,688) bail. A March 7 court date has been set.

Meanwhile, John Darwood has been named chief insurance regulator by the Caymanian Financial Services Supervision Department. Mr. Darwood was Cayman's first insurance superintendent from 1980 to 1984 and most recently headed the National Assn. of Insurance Commissioners' non-admitted insurers office.

Anthony B. Stelling, director of Midland Bank Trust Corp. (Cayman) Ltd., praised the appointment. "In light of what has happened, this is very good. He effectively put in our insurance guidelines back in 1980, and with his NAIC experience, the learning curve should be quite small."

CalPERS cuts HMO premiums

SACRAMENTO, Calif.—The California Public Employees' Retirement System has cut its health maintenance organization premiums by 1.1%, the third year in a row that the state health care purchasing cooperative has held down cost increases.

CalPERS—which is viewed as an example of the health care purchasing alliances included in the Clinton administration's health care reform proposal—has limited premium increases over the last three years to an average of 6.4%, significantly lower than the national average of 30.1% during the same period.

This year's 1.1% reduction in HMO premiums, which was achieved without any benefit changes or cost shifting to employees, translates into about \$321 million in savings.

While the cost of health care has been the primary focus of negotiations with health plans, CalPERS also is developing a "Quality Care Report" on plan effectiveness. The report will include data on indicators drawn from National Committee for Quality Assurance guidelines, like childhood immunizations, mammography, prenatal care and cervical cancer screening.

The report's findings will be distributed to plan members before the 1995 open enrollment period to help them make plan selections, said Tom Elkin, chief of CalPERS' health care program.

CalPERS buys coverage for state, county and municipal employees, and employees of school districts, covering 920,000 employees and retirees and their dependents who are enrolled in 24 plans, including 18 HMOs, four PPOs and two self-funded indemnity plans that include PPO options.

Fewer insurers sanctioned

NEW YORK—State insurance regulators took action against 47 U.S. property/casualty insurers in 1993, down from 68 in 1992, according to Standard & Poor's Corp.

They include 30 property/casualty companies with liabilities totaling more than \$300 million, the fewest since 1987, when 19 were sanctioned.

Property/casualty results improved because of lower underwriting losses and continued high levels of realized and unrealized capital gains, said Steven Dreyer, director of S&P's insurer solvency review.

Regulators also took financial regulatory action against 17 life/health insurers with about \$1.3 billion in liabilities, the fewest since 1986, when 16 insurers were sanctioned.

Life/health insurer results improved because of a rising stock market, substantial owner contributions, a generally favorable market for health insurance, and renewed consumer interest in tax-deferred life and annuity products following passage of higher individual income tax rates, he said.

The outlook for all insurers is still turbulent because of the potential for natural catastrophes as well as "falling investment yields, continuing price competition with significant barriers to steep increases, stubbornly high medical costs and continued uncertainty in the environmental liability arena," Mr. Dreyer said.

Surgeons back single-payer

WASHINGTON—The American College of Surgeons supports a single-payer national health care plan because it would preserve patients' right to choose their own physician and would offer the best way to reduce administrative burdens.

The 60,000-member physician group does not endorse a specific single-payer proposal, though Rep. Jim McDermott, D-Wash., is sponsoring such a bill in Congress.

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Errors & omissions

- The Jan. 31 issue incorrectly reported that ITT Hartford Group Inc. bought Voluntary Plan Administrators Inc. The two currently are discussing various business relationships.

- The Feb. 7 issue misidentified the software program used by RLI Corp. to calculate its earthquake losses. The insurer uses Risk Management Software Inc.'s IRAS program.

Bel-Aire owner convicted of bilking policyholders

By DOUGLAS McLEOD

ST. LOUIS—Former Bel-Aire Insurance Co. owner Arthur A. Blumeyer III is facing a long jail term after being convicted of using Bel-Aire and a string of bogus offshore insurers to defraud policyholders of more than \$43.5 million.

A federal jury found Mr. Blumeyer guilty of 27 conspiracy, fraud and money laundering charges contained in a 34-count indictment filed last year.

After a month-long trial and six days of deliberations, the jury also convicted John W. Peckham Jr., an officer of one of Mr. Blumeyer's companies, of six fraud charges.

Two others named in the indictment—former Missouri state representative Dewey G. Crump and

Texas attorney Marvin Lewis—were acquitted.

Mr. Crump, ex-chairman of the Missouri House Insurance Committee, had been charged with taking \$110,000 from Mr. Blumeyer to stall regulatory action against Bel-Aire, which primarily wrote business for about 20 risk purchasing groups.

A federal judge revoked Mr. Blumeyer's bond and remanded him to the custody of U.S. marshals following the verdict. He is scheduled to be sentenced April 22.

Mr. Blumeyer, currently president of St. Louis-based Evergreen Management Services Ltd., faces a maximum jail term of five to 20 years on each count, though his total sentence will more likely amount to between nine and 11 years under federal sentencing

guidelines. He also faces fines of \$250,000 to \$500,000 on each count.

Mr. Peckham faces a maximum of five years on each of six mail and wire fraud counts.

The four men were indicted last March on charges of using fraudulently capitalized insurers, including the now-defunct Bel-Aire, to bilk policyholders of \$43.5 million in premiums between 1987 and 1993 (BI, March 22, 1993; Aug. 9, 1993).

Mr. Blumeyer personally pocketed at least \$4.9 million of the money, some of which he laundered by wiring it to offshore accounts in Anguilla and Panama, prosecutors charged.

Among other things, prosecutors charged that Mr. Blumeyer obtained a Missouri license for

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Insurers tallying losses

Some insurers report claims exceeding high retentions

By JOANNE WOJCIK

LOS ANGELES—Catastrophe reinsurers are likely to feel rumblings from the Los Angeles earthquake as some insurers report that claims payments are exceeding their retentions.

But even with reinsurance protection, many property insurers are feeling the pinch—especially those whose books of business are concentrated in disaster-prone California—due to higher retentions as a result of contraction in the catastrophe reinsurance market.

The Property Claim Services division of the American Insurance Services Group Inc. last week estimated the industry's total insured earthquake losses would reach \$2.5 billion, but many industry observers expect that figure to rise.

Prior to that estimate's release, many observers estimated insured losses at \$3 billion or more (BI, Feb. 7).

"I would feel very uncomfortable betting that \$2.5 billion is the last word on this catastrophe," said Ron Frank, vp of research at Smith Barney Harris Upham &

Co. in New York. "Look at Hugo, Andrew, even Loma Prieta—they all increased over time," he said.

Also expected to drive up quake loss estimates is that the intensity of the quake was raised last week by the National Earthquake Information Center to 6.8 on the Richter scale from 6.6.

Several primary property insurers reported last week that their earthquake losses will pierce their reinsurance coverage.

SAFECO Corp. expects its earthquake losses to exceed its \$50 million retention, triggering

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Deadline approaching for EBIS directory

Business Insurance will publish its annual directory of employee benefits information system vendors in the March 21 issue, along with a Spotlight report on trends in employee benefit plan design and administration.

The directory will contain information on computer software systems designed to manage corporate employee benefit plans.

If your company produces and supplies such proprietary software products to corporate employee benefit departments, you are eligible to be listed.

There is no charge to be included in the directory. However, to be listed, companies must complete and return a BI questionnaire by the Feb. 25 deadline.

If you have not yet received a questionnaire and would like to be included, please call Kerry Dziubek at 312-280-3195.

TakeCare sale on hold as other offers viewed

By CHRISTINE WOOLSEY

CONCORD, Calif.—TakeCare Inc. is entertaining acquisition offers from other suitors, leaving an agreement in principle to merge with FHP International Corp. twisting in the wind.

FHP, a Fountain Valley, Calif.-based health maintenance organization, and Concord, Calif.-based TakeCare last month announced plans to combine forces. Together, they would have become the second-largest California-based HMO and one of the largest in the country, with about 1.6 million members (BI, Jan. 17).

Under the initial agreement, TakeCare was required to negotiate exclusively with FHP through Feb. 7. Now, TakeCare says other companies are expressing an interest in acquiring it. According to an internal memo to TakeCare employees, the company

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Inside

- It is better to delay action on Superfund than to settle for flawed reform, this week's editorial says. **PAGE 8**

- The team designing NewCo., Lloyd's proposed runoff reinsurer, is considering whether to cap all Lloyd's members' liabilities. **PAGE 23**

- German corporate policyholders are demanding representation on the commissions that determine rates for large property risks. **PAGE 23**

- A House Energy and Commerce subcommittee held the first in a series of hearings on the Superfund reform bill. **PAGE 29**

- The Health Insurance Assn. of America says that health coverage under the Clinton reform plan will cost 33% more than the administration estimates. **PAGE 30**

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Vol. 28, No. 7—*Business Insurance* (ISSN 0007-6864) is published weekly by Crain Communications Inc., 740 N. Rush St., Chicago, Ill. 60611-2590. Second-class postage is paid at Chicago, Ill., and at additional mailing offices. Canadian Post International Publications Mail Product (Canadian Distribution) Sales Agreement No. 0293512, GST No. 136760444. Printed in U.S.A. Postmaster: Send address changes to *Business Insurance*, Circulation Department, 965 E. Jefferson Ave., Detroit, Mich. 48207-3185; 800-678-9595 or 313-446-1611. Copyright 1994 by Crain Communications Inc.

CBO takes issue with estimates in Clinton proposal

By JERRY GEISEL

WASHINGTON—A new Congressional Budget Office report concluding that the Clinton administration's health care reform package is seriously underfinanced likely will put new pressure on the administration to alter the package.

The administration estimated that its reform package would cut the federal deficit by \$56 billion between 1995 and 2000. By contrast, the CBO says the plan would swell the deficit by \$74 billion in that period.

Among the reasons the CBO gave for the \$130 billion difference:

- The administration significantly underestimated the cost of health benefits provided through a new system of regional alliances.

The administration had estimated that the premium in 1994 for single coverage would be \$1,932; CBO pegs the premium at \$2,100. The premium for a family with two adults, the CBO says, would be \$5,565, or 27.6% more than the administration's estimate of \$4,360.

Because the cost of coverage offered through regional alliances would be so much higher, administration estimates of the cost of government subsidies to employers and individuals are too low, the CBO said.

While the administration said federal subsidies to employers, such as capping payments to regional alliances at 7.9% of payroll, would cost \$33 billion in the year 2000, the CBO says the subsidy would cost \$58 billion, or 76% more.

- Certain administration revenue estimates, such as eliminating the tax breaks on medical coverage through flexible benefit plans, are too high.

In the year 2000 alone, the administration may have overestimated the revenue effects of the flexible benefit provision by

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'A bit further up the ladder'

Lloyd's chairman says recovery will continue even if offer is rejected

Lloyd's of London members today are to decide whether to accept Lloyd's 900 million pound (\$1.35 billion) offer to resolve litigation between members and their agents.

But, Lloyd's Chairman David Rowland vows that Lloyd's will continue its quest to reinvent itself, even if the members shun the settlement offer.

Foremost, Lloyd's is continuing its efforts to set up a reinsurance facility, dubbed NewCo. for the moment, to assume syndicates' pre-1986 liabilities and other open years of account (see story, page 23).

In the wake of the introduction of corporate capital as of Jan. 1, Lloyd's is continuing to examine its capital structure, including possible changes in members' voting rights and placing a value on participation in the most profitable syndicates.

Lloyd's also will publish a new business plan by the end of April to outline future steps



in its evolution.

"It feels to me the whole time that what we are trying to do is build one more step so we can take another step," sums up Mr. Rowland, who is entering his second year as Lloyd's first full-time chairman. "The whole of last year was like that... Now we're into the next steps and a bit further up the ladder."

Mr. Rowland spoke to *Business Insurance* Editor James M. Burke and International Editor Stacy Shapiro earlier this month about the members' vote and the future of Lloyd's of London.

We're coming up to the deadline of the settlement offer. How do you feel about the prospects of settlement?

If members do not accept in a sufficient majority—which may well be the case—then I shall be very sorry. I think many of them will rue the day.

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Repetitive motion claims increase

By SARA MARLEY

Employees report more injuries as information widens

ATLANTA—Repetitive motion injuries have corporate America crying out in pain.

These injuries have increased in number and cost every year for the past decade, said Louise Vallee, loss control industrial hygiene manager for Chubb Corp. in Warren, N.J.

"Only 5% are full-blown carpal tunnel syndrome, but they get all the attention because they are so expensive," she said.

As an employer, Chubb typically pays out \$35,000 to \$75,000 per carpal tunnel case on the East and West coasts and \$12,000 to \$20,000 in the Midwest.

Sometimes, "cases are being reopened because surgery has not resolved the issue," Ms. Vallee said. In those cases, payouts can reach \$150,000 to \$200,000.

A review of its accident records revealed that 45% of Chubb's workers compensation costs in-

volve repetitive motion injuries.

Reasons for the sizeable percentage of repetitive motion claims include the time that computers have been in the workplace, the aging workforce and publicity, according to Ms. Vallee.

Although typewriters were used for decades without many claims, the typical data-entry job today involves less variety than the clerical jobs of the past. Computers process information more quickly

and workloads are often heavier.

Educating the public about repetitive motion injuries does not necessarily result in fraudulent claims, Ms. Vallee added. People simply recognize their symptoms and are more likely to seek treatment.

Companies can save money on these claims through early intervention, so they should foster an environment in which employees

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Piper not obliged to form claims trust

By DAVE LENCKUS

MIAMI—An attorney representing Piper Aircraft Corp.'s future product liability claimants will appeal a bankruptcy court ruling that says Piper does not have to develop a plan to pay future claims before it can reorganize.

The court misinterpreted the U.S. bankruptcy code and its legislative intent in ruling that future claimants do not currently hold claims against Piper since they did not have a relationship with the com-

pany before it filed for reorganization, says an attorney representing the claimants.

Until the future claimants' case is resolved, the sale of the financially revitalized company could be delayed, though Vero Beach, Fla.-based Piper continues to be wooed by potential suitors.

The company, which makes single- and twin-engine airplanes, entered Chapter 11 reorganization in July 1991 in part because of the approximately 60 product liability claims it faced. For several years,

Piper self-insured its product liability exposures because of the high cost of insurance for general aviation manufacturers.

Piper's reorganization most likely will involve the sale of its assets to another organization, at which point Piper Aircraft Corp. will no longer exist, according to attorneys involved in the case.

The legal battle over future claimants' rights in Piper's bankruptcy case was set off when Piper accepted an early suitor's buyout plan that included a compensation ar-

rangement for the future claimants (*BI*, May 24, 1993).

The suitor, Pilatus Aircraft Ltd. of Stans, Switzerland, has since dropped out of the picture. None of about eight other potential bidders for Piper's assets wants such an arrangement to be part of the deal, especially because all but a few states prohibit future claimants from suing successor companies for their predecessors' actions, said Glenn Parr, general counsel for Piper.

In addition, Piper has since deter-

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Avoiding a legal slippery slope

State laws limit ski areas' liability for injury

By DEBORAH SHALOWITZ COWANS

Cutting through almost blinding powder and falling snow, a neon-clad skier flies down a mountain slope, oblivious to the small tree in his path.

Later, immobilized and in critical condition at a local hospital, the skier is told he may never walk again—much less ski—after crashing into the tree and injuring his spine.

Is the next scenario likely to be a lawsuit against the ski area operator, seeking millions of dollars in damages?

Not necessarily.

Although stories about the litigiousness of American society are legion, ski area operators' liability is often limited by state laws that say skiers must accept the risks inherent in the sport. A ski area operator must be

proved guilty of some form of negligence to be held liable.

Twenty-five of the 41 states with downhill skiing areas have passed legislation addressing the responsibilities or liabilities of skiers or ski area operators, according to the National Ski Areas Assn. in Lakewood, Colo.

The extensive array of state ski area liability laws is "something that I think is unique to the ski industry," said Steve Wild, vp of the leisure division of K&K Insurance Group Inc. in Fort Wayne, Ind., which underwrites liability coverage for ski areas.

Often these kinds of recreational liability immunity laws are "an economic development issue," commented Diane Swenson, director of legislation for the American Tort Reform Assn. in Washington. There are other kinds of recreational liability immu-

nity laws, like those providing protection from liability for skating rink operators and petting zoo operators, she noted.

"Most (of the laws) simply say when you're skiing, you assume the risks associated with the sport," explained Brian Derouin, a ski area insurance broker with Derouin Associates in Henderson, Nev.

These risks include encountering differing weather conditions and possible obstacles on the slopes like trees, rocks, signs and other skiers.

Injuries caused by ski lift malfunctions, though, generally are not covered by the immunity laws. If an accident occurs due to improper maintenance or operation of a ski lift, ski area operators generally are not protected from liability under state ski area liability laws.

However, ski areas are subject to several

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Photo by John Kelly/Image Bank

Quake

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reinsurance payments in the first layer of its \$150 million catastrophe reinsurance program.

A consortium of reinsurers—including Lloyd's of London underwriters, Bermuda companies, and domestic and foreign reinsurers—will pay 90% of SAFECO's losses between \$50 million and \$200 million.

20th Century Insurance Co. reported that its roughly \$160 million in earthquake losses will exceed the limits of its reinsurance coverage by approximately \$50 million. 20th Century's reinsurers will pay 75% of claims payments between \$10 million and \$100 million, said Rick Dinon, senior vp. 20th Century's reinsurance is placed with domestic, London and other foreign reinsurers.

SCOR U.S. Corp. estimates it will incur pretax losses from the quake of approximately \$20 million to \$25 million after reinsurance. The company's catastrophe reinsurance program provides protection above \$20 million.

The state's largest earthquake coverage writers, though, are not reinsured for quake losses.

State Farm Group expects to pay out at least \$600 million for the Los Angeles quake, for which it has no reinsurance. But, "The numbers could rise if additional damage is uncovered," the insurer said last week.

The dollar payout would be State Farm's second largest for a catastrophe, surpassing the approximately \$450 million tab for Hurricane Hugo in 1989 and trailing only the \$3.6 billion it paid for Hurricane Andrew in 1992.

Allstate Insurance Co. expects about \$350 million in insured

losses, for which it has no reinsurance (BI, Feb. 7).

Farmers Group Inc. has not yet put a dollar figure on its quake losses, but last week reported it had received 22,662 homeowners claims and 3,021 commercial claims, up from 20,622 and 2,821, respectively, a week earlier.

New York-based Standard & Poor's Corp. is keeping an eye on insurers that have suffered significant earthquake losses and expects to release a report listing the 10 most-exposed and the 10 least-exposed insurance companies early this week.

"A company only has capital and surplus to depend on to pay these losses, and four of the eight largest catastrophes in the last four years have occurred in California," pointed out S&P Managing Director Alan Levin. "After a while, those losses start to accumulate."

Fortunately, "so far, none of these companies have reported earthquake losses that are solvency-threatening," said S&P Director Steve Dreyer.

But this latest catastrophe, coming on the heels of several other expensive disasters, "could put them more at risk when the next one hits," he added.

Contributing to an uncertain loss picture is the fact that many of the types of claims triggered by the temblor were not anticipated by underwriters.

For example, San Francisco-based computer modeling firm Risk Management Software Inc. is recalculating its initial estimate of insured losses in the \$1.5 billion to \$2 billion range (BI, Jan. 24). That estimate is proving too low because RMS's data base did not include information on some types of damage triggered by the quake, like damage to overhead fire

sprinkler systems and damage generated by the greater magnitude of the quake.

"Sprinkler damage wasn't something underwriters would consider" associated with an earthquake, explained RMS President Tom Hutton.

Underwriters also hadn't considered the possibility of inventory losses due to water damage caused when the temblor set off sprinklers in retail strip malls, he added.

Another potential wild card for insurers is the possibility of business interruption claims, said Joanne Morrissey, principal with Firemark Consultants in Parsippany, N.J.

Many business owners, even those that did not sustain direct earthquake damage, may seek coverage for income lost when Los Angeles Mayor Dick Riordan imposed a dawn-to-dusk curfew on the city in the week following the quake, as well as for subsequent losses caused by negative publicity from the event. Similar claims were filed after the 1992 Los Angeles riots (BI, May 25, 1992).

Many San Fernando Valley merchants already are describing the once-booming Ventura Boulevard business district as a "ghost town."

A survey by a city panel that oversees planning for 17 miles of the boulevard estimates that businesses in Sherman Oaks incurred at least \$27 million in property damage, while those in Woodland Hills suffered \$1.9 million; in Tarzana, \$2.1 million; Encino, \$2 million; and Studio City, \$7.1 million.

While the earthquake alone is unlikely to bankrupt any insurers, the cumulative effect of back-to-back disasters in recent years is taking its toll on insurers' bottom lines, said Smith Barney's Mr. Frank. "The increased retentions that companies have taken... are being exposed."

While some companies may have intentionally assumed the higher retentions because of their strong capital base, "they now are experiencing the earnings volatility that goes with that decision," he said.

"By far the lion's share of (quake) losses will remain with the primary companies," said Willis T. King Jr., chairman and chief executive of Willcox Inc. Reinsurance Intermediaries in New York. Reinsurers will be hit with "a relatively modest percentage of the total loss."

While insured losses from the quake will hit \$3 billion, Mr. King guessed that only 10% to 15% of the total loss will be born by reinsurers.

The reinsurance covers likeliest to be hit are pro rata and per-risk treaties, but these have occurrence limits and other restrictions added in recent renewals to limit reinsurers' exposure, Mr. King observed.

Lawrence Doyle, chief executive of Global Capital Reinsurance Ltd. in Bermuda, added that retrocessionaires may carry the largest portion of reinsured losses.

Global Capital itself will suffer losses of no more than \$10 million, an estimate it made shortly after the earthquake predicated on \$3 billion in industrywide claims, Mr. Doyle said.

One underwriter at Lloyd's of London estimated that the earthquake loss will cost that market no more than \$400 million spread between 1993 and 1994 underwriting years, depending on when affected policies were placed.

Douglas McLeod contributed to this report.

Tim Jonke/The Image Bank



"Never say never."

When surplus lines producers try to place specialty programs with most insurance companies, they usually find themselves getting nowhere fast.

Many companies have no idea what to do with programs that aren't run-of-the-mill. To buy time, they box producers in with a flurry of petty procedures. That kind of competitive disadvantage just doesn't work in today's market.

At United National Group — one of the largest surplus lines insurers in America — specialty programs are the rule, not the exception. Our companies are resourceful, flexible, and inventive, and when it comes to writing specialty programs, we never say never.

United National Group. Wise enough to listen, strong enough to act.



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Westinghouse strengthens financial position

PITTSBURGH—Westinghouse Electric Corp. said it will contribute \$200 million of the company's common stock to its underfunded pension plan as part of a number of actions designed to strengthen the company's financial position.

The Pittsburgh-based electrical products giant also plans a \$350 million pretax charge for restructuring, associated primarily with corporate-wide layoffs of about 3,400 employees over the next two years. Westinghouse has more than 100,000 employees. A \$185 million charge will be taken in connection with the resolution of various legal disputes. A "small portion" of the \$185 million will be used to recognize costs related to the environmental cleanup of sites in Bloomington, Ind., a spokesman said.

A 1985 consent decree provided for the construction of an incinerator to dispose of PCBs, which had been used in capacitors produced by a Bloomington-based Westinghouse plant. Scrap capacitors had been dumped in local landfills. Because incinerators have subsequently become unpopular, the funds will be used to pursue other means of disposal, he said.

—By Judy Greenwald

IBM mutual funds

STAMFORD, Conn.—International Business Machines Corp. has put up for sale five diverse mutual funds it runs for employees as IBM attempts to move away from business not related to technology.

IBM has run the mutual funds through its IBM Credit Corp. unit since October 1990, offering them as an investment option for employees.

However, IBM is moving slowly with the potential sale, because the mutual funds have been very successful. When the Armonk, N.Y.-based computer and business equipment maker began offering the funds, they had combined assets of less than \$100 million. They now have assets approaching \$700 million, an IBM Credit spokesman said.

"We're now asking ourselves if managing a handful of mutual funds is consistent with the core business of a financial credit company. That question hasn't been answered yet, so I can't predict if and when we'll sell these funds or for how much," he said.

Fewer than 10 IBM employees actually manage the funds. Most of the fund management is performed by State Street Bank of Boston and its subsidiaries.

The spokesman declined to comment on reports that the funds could sell for about \$10 million.

—By Michael Schachner

Wisconsin coalition

KENOSHA, Wis.—A coalition of employers in Kenosha, Wis., will develop a family health center to provide primary care services to their employees, beginning in June.

The Kenosha Health Care Partners Inc., a consortium of three employers with 5,500 employees and dependents, wants the facility to provide employees a full range of primary health care services, including preventive, acute and continuing care. The three sponsoring employers are Kenosha County, the city of Kenosha and Manu-Tronics Inc., but additional employers may be allowed to use the facility.

The family health center will be established and operated by JSA Healthcare Corp., a Columbia, Md.-based managed health care company that owns and manages free-standing primary care centers. JSA was

Benefit Beat

awarded the contract after the three employers placed an ad in the Wall Street Journal in June 1993, asking providers for advice on how to reduce their health care costs. More than 100 consultants and vendors responded; 25 submitted proposals.

The Kenosha facility will offer "one-stop" family health services, including preventive services like well-baby visits and immunizations. Onsite laboratory, radiology, mammography and pharmacy services will also be provided. JSA is developing a network of physicians and has negotiated contracts with two local hospitals.

The employers could save between

\$20 million and \$36 million over the next 10 years, JSA predicts. The three expect their combined health care budgets during that period to be about \$100 million.

If the program is a success, all three employers could freeze their 1994 health care budgets to 1992 levels, with increases in subsequent years limited to the Consumer Price Index. Without the plan, the employers face an increase of about 14%, or more than \$1.5 million, in 1994 alone, according to JSA.

—By Christine Woolsey

Work/family survey

Despite news accounts hailing corporate America's "family-friendliness," most employers do not have formal work/family programs other

than the federally mandated family leave law and pregnancy leave, according to a new survey.

Fifty-four percent of the 99 senior human resources and benefits professionals who responded to an Alexander Consulting Group survey said they do not have formal, written work/family policies in place. And, only 14% have a designated work/family manager or committee.

Among executives who participate in deciding what benefits will be offered to employees, work/family programs are "not very" or "not at all" important to senior management at 30% of the companies, according to respondents. Eighteen percent of respondents said work/family programs are of "average" importance to senior management, and 29% said the programs are "somewhat" im-

portant to management. Only 6% said work/family programs are "extremely" important to senior management. Other respondents were unsure of senior management's viewpoint on work/family benefits.

Among employers that offer work/family benefits, the most popular benefit is dependent care spending accounts, offered by 48% of respondents. Other popular benefits, in descending order, are: flexible schedules, offered by 47% of respondents; information and referral services, offered by 25%; and job-sharing, offered by 21%.

For free survey copies, contact Claire Crawford, The Alexander Consulting Group, 125 Chubb Ave., Lyndhurst, N.J. 07071; 201-460-6648.

—By Deborah Shalowitz



The exposure on the left could

Now is the time to minimize future environmental losses; a proactive plan could make the difference between a \$40 million loss and a \$4 million one.

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Skiing risk

Continued from page 3

safety standards regarding ski lift operation. For example, some states have regulatory boards that oversee the operation of ski lifts. And, all ski lifts must be built in accordance with standards issued by the American National Standards Institute. Most, if not all, ski lifts also are inspected daily.

The state laws protecting ski area operators from liability vary widely, though the effect is generally the same.

All the state laws are "pretty effective" at defining the responsibilities of skiers and ski resorts, said Brooks W. Chase, a vp at Willis Corroon Corp. of New Hampshire in Rochester, which places ski area liability coverage.

When an injured skier or the skier's attorney "is presented with the

uphill battle he's going to have" with a lawsuit because of a ski liability law, people often are deterred from suing ski areas, Mr. Chase said.

James H. Chalat, a ski accident plaintiff's attorney with the Denver law firm Chalat & Co. P.C., notes in a newsletter he publishes on ski safety that eight of the 25 state ski area liability laws "preserve the rule that both skiers and ski area operators must exercise reasonable care."

The other 17 states "have adopted various forms of 'inherent danger' statutes," Mr. Chalat wrote.

The defense of ski areas' liability generally centers on the doctrine of "volenti non fit injuria," which basically means one who voluntarily takes part in a sport assumes the risk of injury.

In 1951, a federal court in Vermont ruled that a ski area was shielded from liability for a ski accident because of this doctrine.

The federal court's decision and subsequent case law in the state supported the doctrine until 1978, when a Vermont state court ruled otherwise in the landmark ski area liability case *James Sunday vs. Stratton, Vt.*

Mr. Sunday was skiing in Stratton when he hit a snow-covered bush and became a paraplegic, recounted Peter Rietz, a defense attorney for ski area operators with the law firm White & Steele in Denver. Mr. Sunday sued the ski area operator and was awarded \$1.5 million by a jury, Mr. Rietz said.

The state court ruled that the assumption-of-risk doctrine did not apply because Vermont's tort rules had changed to comparative negligence from contributory negligence, explained Joe Parkinson, executive director of the Vermont Ski Areas Assn. in Montpelier. Therefore, the court found that the ski area liability case law no longer applied. The

award was upheld by the Vermont Supreme Court upon appeal.

"It shook up the whole industry nationwide," said Mr. Parkinson. The decision "made other states nervous," even though the ruling only pertained to Vermont, he said.

Following the ruling, liability insurance rates rose for ski areas nationwide and some insurers balked at writing the coverage, Mr. Parkinson said.

The assumption-of-risk doctrine now is part of many of the state laws because of the lobbying efforts of ski area operators in the wake of that ruling.

Vermont's ski area liability law, which was passed in 1978, after the *Sunday* decision was handed down, states: "A person who takes part in any sport accepts as a matter of law the dangers that inhere therein insofar as they are obvious and necessary."

A two-paragraph "legislative in-

tent" adds that it is the purpose of the law to establish "that there are inherent dangers to be accepted by skiers as a matter of law."

"All we were trying to do was reaffirm what we felt had always existed, at least since 1951," said Mr. Parkinson, who was involved in drafting the 1978 law.

The Colorado Ski Safety Act, which was passed in 1979, sought to "define the legal responsibilities of ski area operators and their agents and employees; to define the responsibilities of skiers using such ski areas; and to define the rights and liabilities existing between the skier and the ski area operator and between skiers," according to the text of the law.

The nine-page law was amended in 1990 because "ski area operators of this state continue to be subjected to claims and litigation involving (ski) accidents," according to the law.

The amended Colorado law limits to \$1 million the amount of damages a plaintiff can collect in the event of a ski accident not involving a ski lift. The law also imposes a two-year statute of limitations.

Although minor ski-related injuries abound, major ski accidents are almost one in a million, according to the National Ski Areas Assn.

For example, in the 1992-1993 ski season, there were 42 fatalities and 29 serious injuries out of 54 million skier-days. Serious injuries include those resulting in comas, major spinal and head traumas, and people becoming paraplegics and quadriplegics. A skier-day equals the number of skiers paying for one day of skiing. This amounted to a rate last year of 1.31 serious injuries or deaths per 1 million skier-days. Since 1985, the rate of serious injuries or deaths has hovered around one for every 1 million skier days, according to the NSAA.

Liability insurance for ski area risks not covered under the state laws, or for operators in states without such laws, is generally widely available, brokers say.

Markets for the coverage include, among others:

- K&K Insurance Group, a managing general agent for Transamerica Insurance Group Inc. in Woodland Hills, Calif., offers primary, umbrella and excess liability coverage with limits of up to \$25 million. K&K writes ski area liability coverage for about 150 resorts, Mr. Wild said.

- Willis Corroon Corp. of New Hampshire offers primary, excess and umbrella liability coverage written by various American International Group Inc. units. Limits of up to \$75 million are available.

"The ski area insurance business has generally tracked the general (liability) insurance marketplace," said Mr. Chase, adding that rates have been softening "since whenever the market started softening."

Willis Corroon writes ski area liability insurance for about 150 ski areas, he said.

- Seattle-based broker Pettit-Morrey Co. also offers ski area liability insurance under a program provided by Arlberg Insurance Co., a Washington-based insurer jointly owned by a venture capital firm and about 100 ski areas.

Arlberg offers primary and umbrella liability insurance with limits of up to \$30 million, according to Arlberg President Chuck Lewis. Arlberg insures about 127 ski areas, Mr. Lewis said.

- A Vermont captive insurer, General Eastern Ski Insurance Risk Retention Group Inc., also writes general liability insurance for its five ski area members. General Eastern provides \$10 million in limits.



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Opinions

Superfund proposal flawed

THE CLINTON administration's Superfund reform package, unveiled earlier this month, was delivered to Congress so late that many now say lawmakers will be hard-pressed to act on the proposal before they recess for the November elections.

No tears should be shed if that's what happens.

That's not because the administration didn't put a lot of thought into the proposal. In fact, much of what has been proposed represents a definite improvement over the current costly, chaotic and cumbersome Superfund program created by the Comprehensive Environmental Response, Compensation and Liability Act of 1980.

Unfortunately, the proposal retains—and even bolsters—some of the problems in the current law that make Superfund so costly, chaotic and cumbersome.

For example, the current system of retroactive liability remains intact, holding potentially responsible parties liable for cleaning up materials that were dumped in accordance with pre-Superfund law. The proposal also formally spells out for the first time what courts have held for years—Superfund permits the imposition of joint and several liability on PRPs.

In the name of liability reform, the proposal calls for the non-binding allocation of cleanup costs among PRPs, after small polluters and municipalities have settled their liabilities for little or nothing. The remaining PRPs can accept a neutral allocator's assessment of what they should pay to clean up a given site.

But the allocation—unlike that recommended last fall by the Chemical Manufacturers Assn.—is non-binding. A PRP that accepts the allocation isn't released from future liability unless it pays what the proposal calls a "premium" above and beyond its allocated costs. Any PRP can decline its allocation and take its chances in court, facing the possibility of having to pay jointly and severally to cover unallocated cleanup costs.

In an attempt to cut the horrendous transaction costs created when PRPs sue their liability insurers, the administration proposes to set up an Environmental Insurance Resolution Fund. A special tax to be paid by certain liability insurers and reinsurers would go into a fund that would pay policyholders a portion of the cost to clean up sites polluted before Jan. 1, 1986. The tax would initially raise about \$500 million annually and rise to about \$700 million annually after three years. If the taxes weren't sufficient, the government could levy higher taxes on the insurers.



However, what is proposed by the administration is much different from what insurers had in mind when they initially proposed a \$300 million tax on themselves in return for an end to retroactive liability (BI, Oct. 11, 1993). Under the Clinton proposal, insurers would pay much more tax than they envisioned, but they would still be liable for huge sums from PRPs if they opt out of the fund.

Some insurers speculate that only policyholders with weak cases will tap the fund, while those with strong cases will settle for nothing less than the maximum they can get in court. As insurers see it, they'll be paying a tax for the continued privilege of being sued.

The retention of Superfund's liability provisions, despite the window-dressing of a non-binding allocation system, basically maintains the status quo. The prospect of continued costly policyholder/insurer litigation despite a Rube Goldberg-like resolution fund could make the status quo even worse.

There are fewer than 70 legislative days left in the 103rd Congress to pass the administration's Superfund bill. Given the time constraints, it's more than reasonable to let the clock run out on this proposal and reauthorize Superfund in its present form for a year. It would be better to delay action than to settle for flawed reform.

Letters

Health care reformers need another perspective

To the editor: While the Clinton administration's health care reform package reflects extensive consideration of the problems in health care financing and delivery, it nonetheless represents only one perspective. There are many other perspectives that must be reviewed.

Our principal objection with the president's proposal is that it does not take adequate account of the experience of those of us who have devised working solutions. Our own track record of designing, implementing and managing health care programs that provide quality care while lowering costs demonstrates that with proper management and a focus on local needs, prevention and claims controls, meaningful results can be achieved.

We offer for consideration the following thoughts:

- Health care reform is a marathon, not a sprint. Passage of legislation is not expected until sometime next year, and implementation will certainly take sev-

eral years. We believe it is important for businesses to continue to take responsibility for addressing rising health care costs in their own benefit programs.

- Our experience has taught us that if you do not manage health care costs locally, and if you do not set goals, you cannot manage costs effectively. Health care, at its essence, is a personal interaction between patient and provider. The key to reducing and controlling costs is managing that interaction effectively by facilitating non-adversarial relationships between all parties—payers, providers and consumers. Any program must rely on this vital principle to be successful.

- Price controls, in any form, have never worked, and we do not anticipate they will work. Appropriate utilization of health care is the key to cost-effectiveness and quality. The cooperation of employees, families, employers and providers, including doctors and hospitals, is integral to any effective solution.

- Can a government that is \$4 trillion

in debt help you reduce your health care costs? Can our government suddenly become less bureaucratic and provide a more efficient health care system?

- Paying for a national health care plan by demanding that employers pay 80% of the bill will not be healthy for American business. We hope to see other strategies considered, especially since 11 million of the 37 million uninsured have chosen not to be covered by an employer or another available insurance plan.

- The freedom of an employer to choose the type of plan and the method of funding has been a key element of past success in reducing and controlling costs. That freedom of choice must be preserved.

We do not believe that the U.S. health care system is inherently flawed. It merely needs to be redesigned to increase its efficiency while preserving its many strengths.

Jerry Naumoff
The Naumoff Group
Oak Park, Ill.

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Published by Crain Communications, Inc., Chicago

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Bad faith

Continued from page 1

The latest ruling—*Transportation Insurance Co. vs. Moriel*—changes the procedure for awarding punitive damages in two ways. Insurance lawyers say it will not only curb future requests for punitive damages, but also could result in the reversal of punitive damage awards on appeal.

Under the ruling, appellate courts must apply the strict new gross negligence standard prescribed in the ruling to cases under review, explained Transportation's lawyer, Charles I. Hadden of Ross, Dixon & Masback in Washington.

In addition, the jury must decide the amount of punitive damages separately, only after it has found that the defendant commit-

ted gross negligence.

Such bifurcations usually are considered favorable to defendants.

In defining "gross negligence," the Texas court made it more difficult for policyholders to win punitive damages from insurers in bad faith cases at the trial court level.

"An insurer's delay or refusal to pay an insured's claim, even when the insurer has no reasonable basis for doing so, is not gross negligence," the court said. "It is bad faith. An insurer is liable for punitive damages only if the bad faith tort was accompanied by gross negligence."

In addition, "the harm must be independent and qualitatively different from the sort of injuries that typically result from bad faith or breach of contract," the court continued.

"It's the rare case in which an

insurance company is aware that what it is doing will cause death, physical injury or financial ruin," Mr. Hadden said. "The higher-ups are not making decisions on that

ers in coverage issues.

"By telling appellate courts to look at bad faith cases with a more jaundiced eye, the decision may ultimately limit policyhold-

An insurer's refusal 'to pay a claim cannot justify punishment unless the insurer was actually aware that its action would probably result in extraordinary harm not ordinarily associated with breach of contract or bad faith denial of a claim,' the court says.

basis."

Many bad faith punitive awards could now be reversed on appeal because the decision requires the intermediate courts to apply this strict new gross negligence standard, points out Kerry L. Neves, a partner with Neves & Crowther in Galveston, who represents insur-

ers' ability to obtain punitive damages," said Mr. Neves.

"This gives more teeth to the appellate review process," Mr. Hadden agreed.

Previously, Texas appellate courts usually let stand punitive damage awards if a single piece of evidence presented at trial mer-

ited them. Now, however, an appellate court will have to consider all the evidence and explain in detail why it is upholding or overturning a punitive damage award, he explained.

"For the past 13 years, for the most part, courts have affirmed punitive damage decisions as long as there was a brick's worth of evidence," Mr. Hadden said.

But a brick is not a wall, the Texas Supreme Court said in its decision.

"Simply because a piece or pieces of evidence are material in the sense that they make a 'fact that is of consequence to the determination of the action more...or less probable' does not render the evidence legally sufficient," the court said.

While the court did not specifically direct trial courts to review jury awards with that same jaundiced eye, it said "on the filing of a motion for a new trial, the trial judge must enumerate his reasons for upholding the award," observed Ms. Vorpahl.

The decision also will reduce the frequency of punitive damage awards since future trial courts must separate the punitive damages determination from the remaining issues, Ms. Vorpahl pointed out.

"If information on the defendant's net worth is given early on in the trial, it tends to prejudice the jury" Ms. Vorpahl said. But now, "evidence on the defendant's net worth won't come in until later."

But Mr. Neves suggested that holding back the information concerning a defendant's wealth until later in the process won't have much effect if a jury has already found a large corporation was grossly negligent.

"Once you get a jury mad enough to award punitive damages, they may go harder on rich defendants," he said.

The case stemmed from a 1986 workers compensation claim filed by Juan Moriel, an employee of Cashway Building Materials in El Paso, Texas, from injuries he suffered when a stack of countertops fell on him.

Transportation Insurance paid hospital bills from Mr. Moriel's injuries, but delayed payment for follow-up outpatient tests and emotional counseling related to impotence he suffered after the accident. The CNA Financial Corp. unit denied payment on the ground that Mr. Moriel's impotence was unrelated to his on-the-job injury.

After receiving a collection notice from the medical providers in 1987, Mr. Moriel filed a bad faith claim against the insurer.

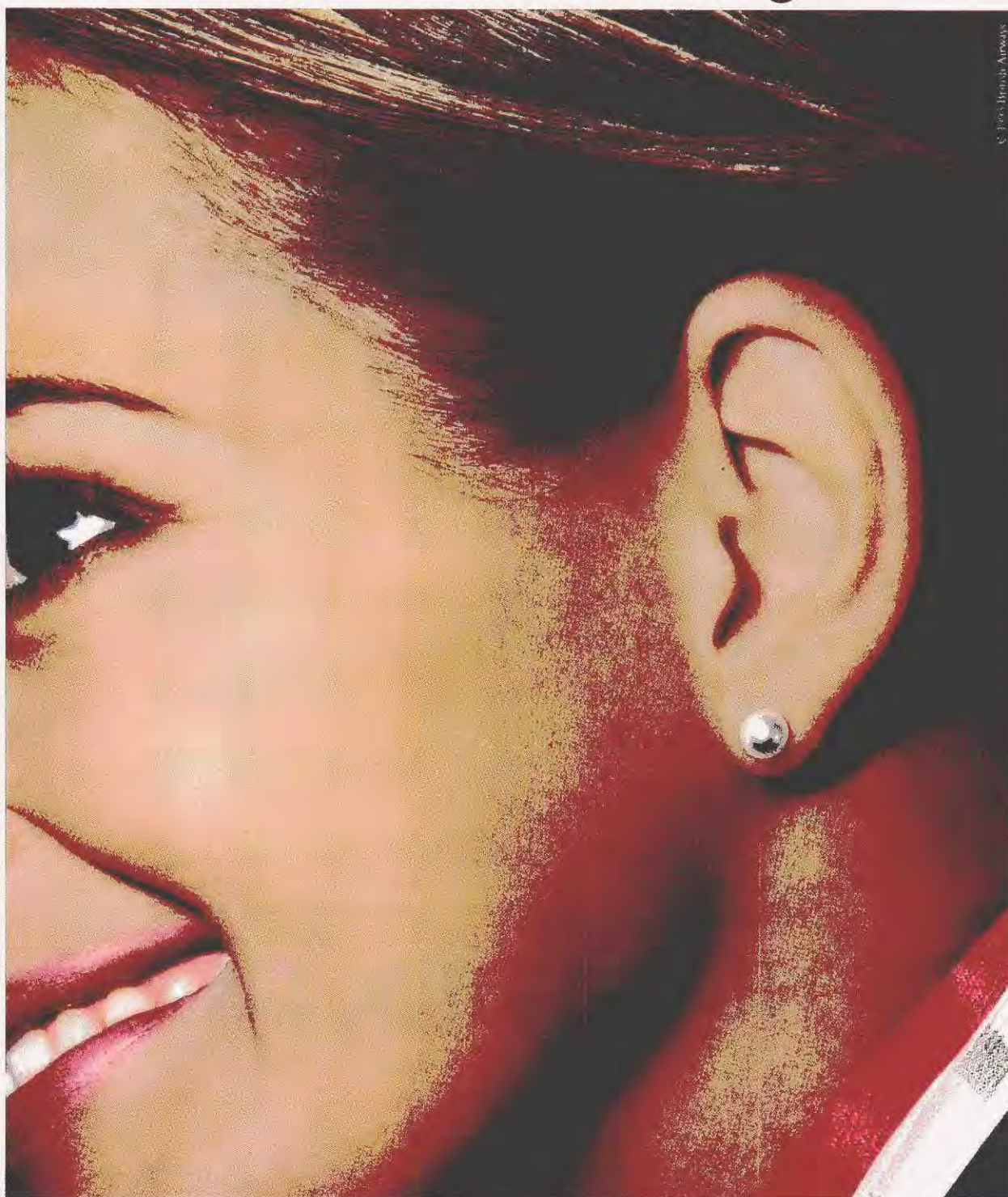
At trial, the jury found that Transportation unreasonably delayed paying the medical bills, that it knew or should have known that it had no reasonable basis to delay payment, and that it acted "with heedless and reckless disregard" of Mr. Moriel's rights.

The jury awarded Mr. Moriel \$1,000 in actual damages, \$100,000 for mental anguish and \$1 million in punitive damages. The awards were upheld on appeal.

The Texas Supreme Court's decision overturns the award and remands the case for a new trial based on its clarification of the gross negligence standard as it should be applied to insurance bad faith cases.

Transportation Insurance Co., petitioner, vs. Juan Carlos Moriel, respondent, No. D-1507, Supreme Court of Texas, Feb. 2, 1994.

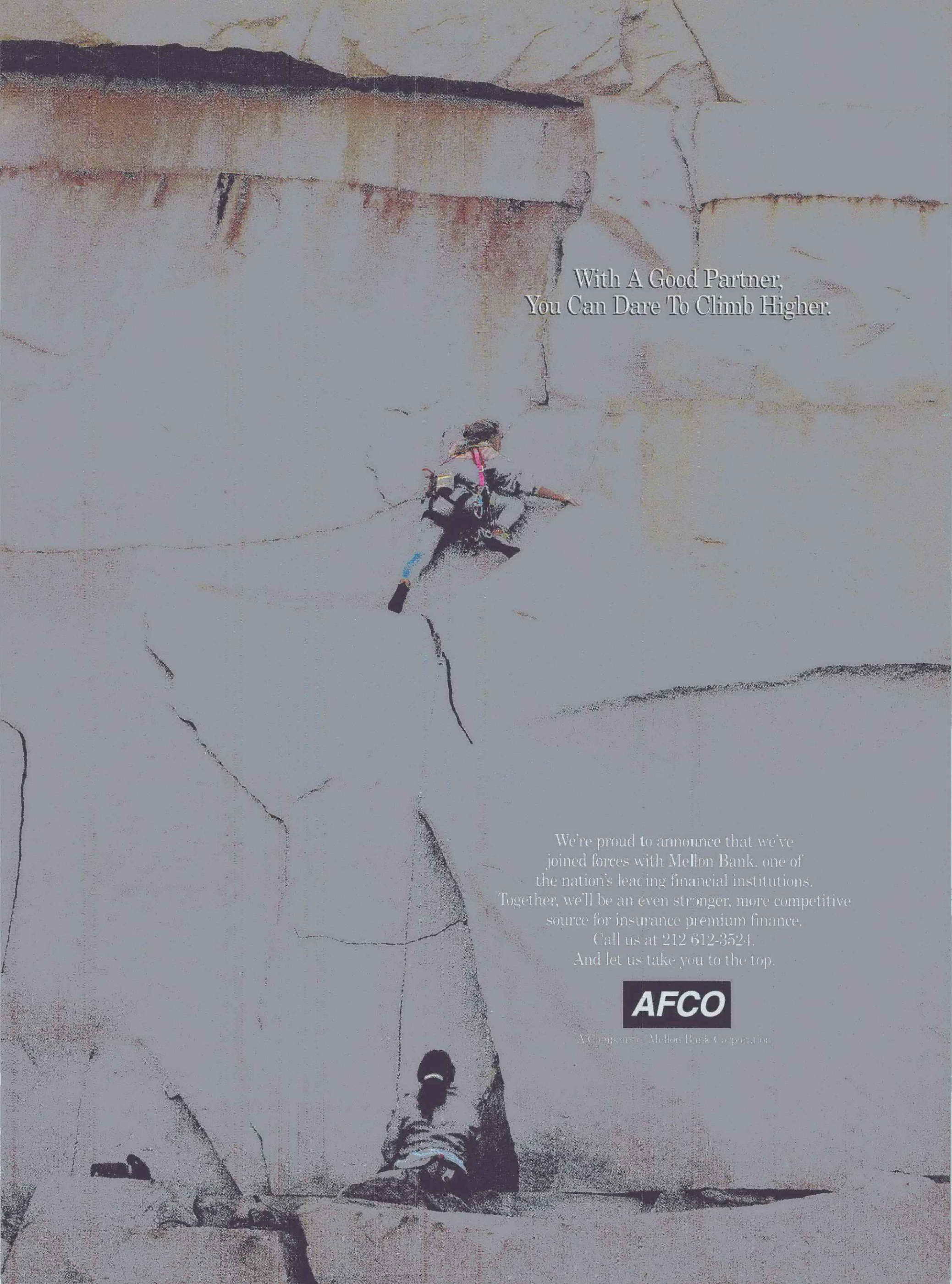
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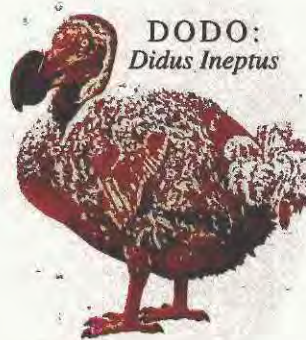
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Rowland

Continued from page 3

But I've done everything I can to help them.

After (the vote) I think it is very important that we concentrate on the next step, which is very much NewCo. and the resolution of the old years (of account).

If people then come forward as a result of anything that's happening in the courts or elsewhere and say, "Will you consider helping us resolve the disputes" in some sort of fashion I can't envisage, of course we'll listen.

But as far as I'm concerned, we draw the line (after the offer lapses). I've done the best I can. Now they must get on with it and fight it through the courts.

So if the offer is rejected, there's nothing more that Lloyd's will do?

You'll sit on the sideline and see what happens in High Court?

In monetary terms, there's nothing more that we can do. That's quite different to being sympathetic, caring and concerned for the names, which it is my duty to be. But there's no question that there is not any more money to be constructed out of the offer. I've said that from the beginning.

Peter (Middleton, Lloyd's chief executive) and I felt very strongly when we set out on this course that, although we hoped very much to succeed, we actually thought making the offer was the most important thing. If we had not strained everything we could to try and resolve this, then people could legitimately say that Lloyd's really didn't try. But we've done our best. If that is not considered to be enough by the names, well I'm very sorry. But there's nothing more we

can do about it.

Members at the action group meetings seemed to say that they would agree to an offer if Lloyd's put a cap on their future liabilities. Is there any way of offering members a cap on their liabilities?

I can understand what they are saying and feeling, but you can't bet the bank. You can't give them an open-ended check. That's why (capping liabilities) does not work.

I think we will put even more attention on NewCo. and the resolution of the old years because, within that, it may be possible to give much more finality to the names. But we don't have the information yet.

We might say that in making the offer now... it may have been too soon. It was the best we could do at the moment. More and better information in one year or 18 months

may mean that it may be possible to do something else. But we don't know that yet because we don't have the information.

Will the solvency of Lloyd's be affected if the offer fails?

I don't see that Lloyd's solvency will be threatened in any way.

It's been forecast that Lloyd's will report hefty losses when the 1991 results are announced under three-year accounting in June.

We've made it clear ourselves right back to last year's business plan that the pure-year 1991 loss would be in the order of 1 billion pounds (\$1.48 billion). With the deterioration on old years, there will clearly be a substantial loss.

But I have no reason to believe that the (1991) loss will be disastrous, although it will be serious.

What is the plan for Lloyd's, then, in 1994?

We are reviewing a large number of things, particularly relating to our capital structure. There are still unanswered questions. We've introduced corporate capital and Members Agency Pooling Arrangements. We've talked about members' pre-emption rights. We have to say what we mean by that (and) how members' pre-emption rights relate to MAPAs. Can those rights be assigned?

Pre-emption rights mean that if you get a place on a syndicate and the syndicate's capacity increases, you get right of first refusal (to increase your investment). How do we embody that into our constitution and what are the consequences of it? Do we ultimately create a market in syndicate places?

Until we get some better system, Lloyd's will always be open to allegations of insider preference because it works like a club.

In any other market, if syndicate 1234 was the best business, entrance to it would command a premium rating, and you would have to pay a price of entry. You'd pay more for shares in syndicate 1234 than in syndicate 5678; that overcomes insider preference because it's a publicly quoted stock.

The movement from where we are to that situation is clearly not at all simple to see through. I'm not saying that we can crack it.

If more and more of Lloyd's capital comes in as limited liability capital, are you going to have to change how you market yourself to policyholders?

The way we market ourselves to policyholders, I hope, will be the same and different in the sense that I want Lloyd's security to be the very best that's on offer in the world.

But I'm absolutely certain that will be by transparency and money paid upfront rather than by the mystique of (unlimited liability). The truth is that what's available is what we've got physically in this place. I want the ratios of that to be much higher. That's real security.

(The mystery of unlimited liability) is wonderful when people believe in it. But it's like the emperor's new clothes. Once you've been seen naked and you aren't terribly beautiful, they tend to remember what they've seen. That's the problem.

So, the only way we can go forward is to be a different, original market (where) the standards of disclosure, cash upfront (and) security are of the very highest order. There isn't a choice.

Mr. Middleton has suggested in jest that the Lloyd's building could be turned into a shopping mall. The London Underwriting Centre believes it can house both Lloyd's and the Institute of London Underwriters. Should all three markets merge into one building?

This states the blindingly obvious: that grown men of wisdom shouldn't have three physical underwriting sites in a market that is portraying itself as the "London Market" to the outside world.

We can provide accommodation here for all sorts of people and indeed we are. I have a very clear ambition, not related to a particular site, that London must espouse the cause of a coherence physically and electronically so that it's a market of easy access and extreme efficiency. Then the London market will be an extremely attractive and efficient low-cost place to do business, with very strong competitors within it.

Continued on next page



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FOCUS

Lloyd's 1991 loss over \$3 billion: Chatset

LONDON—Lloyd's of London will post more than \$3 billion in overall losses for the 1991 accounting year and up to \$1.5 billion in losses for 1992, predicts syndicate analyst Chatset Ltd.

However, by the 1993 accounting year, the market could pull itself out of its five-year loss slump and report banner profits, says Chatset analyst Charles Sturge.

Lloyd's Chairman David Rowland expects a loss of 1 billion pounds (\$1.48 billion) for the 1991 account, which closed at year-end 1993 under Lloyd's three-year accounting system. But that estimate does not include increased reserving for deteriorating losses on previous years (see related story, page 3).

Last year, for example, reserving for 1990 and prior years accounted for 1.13 billion pounds (\$1.71 billion) of a 2.92 billion pound (\$4.42 billion) loss in 1990 (*BI*, June 28, 1993).

Chatset predicts the overall loss for 1991 will be about 2.05 billion pounds (\$3.03 billion). This includes: 890 million pounds (\$1.32 billion) in pure-year losses excluding those from LMX syndicates; 950 million pounds (\$1.41 billion) for deterioration on old-year accounts; and 310 million pounds (\$458.8 million) for investment losses due to lower returns and cash flow problems.

Lloyd's 1991 losses, which the market will report in May, follow losses of about 5.5 billion pounds (\$8.33 billion) from 1988 to 1990 (*BI*, June 28, 1993).

Chatset also predicts that Lloyd's 1992 pure losses will be about 214 million pounds (\$324.2 million).

However, "if old years continue to ravage the figures," reserve additions will push up 1992 overall losses to about 1 billion pounds (\$1.52 billion), the analyst said.

"Solvency is going to be extremely difficult" for the market after 1991 and 1992 results are announced, said syndicate analyst John Rew. How-

ever, he believes Lloyd's will allow members to borrow from 1993 premium income to meet their losses, rather than use a levy to boost the Central Fund's ability to pay losses.

However, Lloyd's Mr. Rowland predicts there will not be a problem with solvency.

Meanwhile, Messrs. Rew and Sturge—both of whom have lost money at Lloyd's in recent years—were divided on how members should vote today on Lloyd's settlement offer.

Mr. Rew said he voted against the offer, though he believed between 50% and 60% of the affected names would accept it. To succeed, 70% of the names must accept the offer.

Mr. Sturge, though, voted in favor of the offer. "There seem to be an awful lot of nutters turning down a substantial offer... It's difficult to

see them getting a better deal through the courts," he said.

Many within the market last week debated whether to accept the 900 million pound (\$1.35 billion) offer.

But most of the members action groups last week remained adamant that they would reject the offer, particularly the Gooda Walker Action Group, whose members account for 23% of the vote. The Gooda Walker members' stance was strengthened last week by High Court Justice Peter Cresswell's decision not to adjourn their trial until next year.

"There can be no doubt that a judgment in our favor in the High Court this year will produce a more substantial offer" than the settlement, Gooda Walker Action Group Chairman Michael Deeny wrote to members last week.

—By Stacy Shapiro



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Rowland

Continued from previous page
Did American buyers run shy from Lloyd's during year-end renewals?

I can't answer that because I haven't got the information. Certainly, not just U.S. buyers, but a number of major buyers have questioned the situation. It would be ridiculous if they hadn't. But I think the reassurances we can give them and the personal contacts that have been established have caused the vast majority to continue to do business here—not least because the rest of the insurance world is not all that attractive, either. The rest of the insurance world certainly isn't trouble-free.

Yes, our problems are serious and it would be nice if we could have avoided some of them. But Lloyd's still is a very attractive place for a lot of people to do business.

While you are attempting to put Lloyd's right, how do you make sure that what's going on in the market now doesn't spell trouble in the future?

We have much more access (to syndicates) than executives did in the past. But I accept the question you are asking. I think the challenge is to see that we have a better feel about the market the whole time. What worries me about last year is that we had so much to do that some of the market knowledge one would like to have wasn't as great as it could be.

We are thinking about that and working on that this year. **BI**



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Piper

Continued from page 3

mined that an actuarially sound compensation plan for future claimants would mean that the company's unsecured creditors would receive little, if any, of their approximately \$30 million in claims, Mr. Parr said.

A draft report by consultant Milliman & Robertson Inc. estimated Piper would have to establish a \$100 million fund, which would cost about \$30 million to administer.

Pilatus had offered to buy Piper's assets for about \$36 million. An auction of Piper's assets scheduled for early May will start at about \$22 million, Mr. Parr said.

But, while the Pilatus offer was still on the table, U.S. Bankruptcy Judge Robert Mark appointed David Epstein of King & Spalding in Atlanta to represent future claimants.

Mr. Epstein likens Piper's future

claimants to those for whom A.H. Robins Co., which produced the Dalkon Shield intrauterine device, and asbestos producer Manville Corp. established trust funds.

But, Piper says the differences between the companies are marked.

Like the Robins and Manville trusts, the Piper plan would cover a class of individuals filing product liability claims after the company emerges from bankruptcy.

But, the Robins and Manville trust funds cover future claimants who already had been exposed to or were injured by those companies' products before the companies reorganized. In addition, the companies pulled their products off the market.

A compensation plan for future Piper claimants could conceivably cover individuals who have not yet been born but who eventually could be killed or injured in accidents involving the 50,000 to 95,000 Piper aircraft still in use worldwide.

Mr. Epstein is asking a U.S. District Court to reverse Judge Mark's Sept. 10, 1993, oral ruling, which the judge explained in a Jan. 14 memorandum.

Judge Mark acknowledged that Congress in 1978 made sweeping bankruptcy law changes to, among other things, expand the definition of a claim. The expanded definition under Section 101(5) says in part that a claim is a "right to payment" regardless of whether that right is "reduced to judgment," unliquidated, contingent, unmatured, disputed, legal, equitable or unsecured.

Congress expanded the definition so debtors' reorganization plans could address, among other things, contingent tort claims that were not "provable," which was a requirement under the previous definition. That definition often impeded reorganizations.

But, in ruling for Piper and its unsecured creditors, Judge Mark

agreed that the expanded definition of claimants "is not so broad as to include unidentified, and presently unidentifiable, individuals" who had no discernible relationship to Piper before the company sought to reorganize under bankruptcy laws.

Judge Mark said the design, manufacture and sale of Piper aircraft before the company entered bankruptcy does not establish a pre-bankruptcy relationship with future claimants, because future claimants have not been exposed "to a specific identifiable defective product." As a result, there is no way to identify a discrete class of future claimants, he ruled.

In his analysis, Judge Mark also rejects the notion that future plaintiffs' claims fall under the so-called conduct test. Under that test, which was used to sweep future claimants into Robins' and several asbestos companies' reorganizations, a right to payment occurs when the conduct

giving rise to liability occurs.

But, the conduct in the asbestos and Robins cases was the future claimants' exposure to those companies' known defective or dangerous products, not the manufacture of the products, Judge Mark explained.

He also noted that while the asbestos companies and Robins distributed products known to be harmful, Piper committed no such "great wrong," because only a fraction of Piper airplanes will be involved in crashes caused by manufacturing and design defects.

In addition, it cannot be determined "who will be exposed to the defective product in the future," Judge Mark wrote. "In effect, under the conduct test, everyone in the world would hold a claim against Piper simply by virtue of their potential future exposure to any plane in the existing fleet."

Judge Mark also rejected Mr. Epstein's argument that it is unfair to treat pre-and post-bankruptcy product liability claimants differently merely because of the fortuity of when a crash occurs.

Pointing to other provisions of the bankruptcy code, like the arbitrary date that determines which creditors can keep payments made by a debtor and which are subject to only a partial recovery, Judge Mark said: "In bankruptcy, as in life, timing is everything."

More than 200 Piper airplanes have crashed since Piper filed for reorganization, Mr. Epstein noted, though Piper's Mr. Parr said that most crashes are not caused by manufacturing and design defects.

In his appeal, Mr. Epstein argues that not only the expanded definition of a claim in the bankruptcy code but also Congress' intent shows that future claimants should be considered in Piper's reorganization.

Mr. Epstein cited a U.S. House and Senate report on the revised bankruptcy code that says "all legal obligations of the debtor, no matter how remote or contingent, will be able to be dealt with in the bankruptcy case."

No language in the bankruptcy code nor in legislative history supports the bankruptcy court's ruling that a pre-bankruptcy relationship must exist between Piper and future claimants for those individuals to hold a claim now, he argues. And, nothing in the law says a discrete class of future claimants must be established, he argues.

Judge Mark's concern that the future Piper claimants cannot be identified also is misplaced, according to Mr. Epstein. He noted that identifying the future Dalkon Shield and asbestos claimants was not possible nor necessary to determine the size of those companies' trust funds.

Mr. Epstein also notes that Judge Mark's concern that there is no way to determine who will be exposed to a defective Piper product overlooks an issue that bankruptcy courts faced when presiding over asbestos company cases: "The use of various asbestos products was so pervasive that virtually everyone in the United States was a future claimant."

Mr. Epstein also criticized Judge Mark's assertion that Piper committed no "great wrong." He contends there is no basis in the bankruptcy code for such a test. Even if there were, the extent of Piper's liability to future claimants as determined by Milliman & Robertson satisfies such a test, he said.

Piper Aircraft Corp., debtor, U.S. Bankruptcy Court Southern District of Florida; No. 91-31884-BKC-RAM; and David G. Epstein vs. The Official Committee of Unrestricted Creditors of the Estate of Piper Aircraft Corp., U.S. District Court for the Southern District of Florida; No. 948044.

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Injuries

Continued from page 3

are not intimidated about reporting their problems, said Dr. Stephen A. Dawkins, founder of Occupational Health International, an occupational health care provider in Atlanta.

Particularly in cases of carpal tunnel syndrome, which involves irreparable nerve damage, "people need to be comfortable presenting themselves earlier for care—before the point of no return," he said.

In addition, supervisors should be trained to spot signs of potential injury like employees rubbing and flicking their wrists.

One way companies can control their repetitive motion injury losses is by performing ergonomic reviews of workplace functions and equipment, Ms. Vallee said.

Using new, "ergonomically correct" equipment, like special computer keyboards and chairs, is one approach to preventing claims, but it is not the answer for everyone, Ms. Vallee said. "Keyboard design is only one of six to eight major factors" in repetitive motion injuries, she said. And, at \$600 to \$800 each, compared with about \$20 for a conventional keyboard, special ergonomic keyboards may be just too expensive for employers.

Another area that companies may overemphasize when performing workplace ergonomic reviews is

chairs, Ms. Vallee said.

Rather than buy equipment with a single worker in mind, companies should buy adjustable workstation components that can often fit 90% of a workforce.

Ergonomic adjustments should not be made across the board, Dr. Dawkins said. "Don't apply 'universal' solutions," he warned. "A wrist rest may not be for everyone. For some, it may cause special problems."

"One of the best investments you can make is to adequately train everyone," Ms. Vallee said.

Employees should be taught the things that can exacerbate repetitive motion injuries, including physical exertion, stress, vibration and cold.

Training new employees is even more critical—and generally more successful—as retraining current employees. "Supervisors should show people how to do a job right," Ms. Vallee said. "They should have no chance to learn bad habits. It's harder to change people."

Simple—and inexpensive—ergonomic changes include adjusting the height of chairs and computer monitors (which are often needlessly stacked on system units), providing wrist rests and foot rests (which can be as simple as three-ring binders) and adjusting lighting to prevent glare.

When claims do occur, Dr. Dawkins advocates a conservative initial approach. Repetitive work may need to be curtailed to give the hands and

wrists a chance to rest. Anti-inflammatory drugs and wrist splints can provide some relief. Surgery should be a last resort.

To be successful, any ergonomics program must have the support of senior management.

"You need to talk management's language," Ms. Vallee said. "A cost/benefit analysis is a good approach."

At Chubb, safety, human resources and operations approached management as a unified front.

Chubb recently finished the second year of an ergonomics program that is now 80% implemented, she said. In that time, the insurer has reduced new repetitive motion injury cases by 15%. Side benefits include a 20% gain in productivity and a 50% reduction in error rates.

Ergonomics efforts generally require three years to realize the benefits, Dr. Dawkins said.

"Fear of a deluge of cases frightens people from having an ergonomics program," he said. However, it is more likely that awareness has caused many already-affected employees to come in at the same time.

In the first year of an ergonomics program, companies may find that their cost per case and the number of cases go up. The next year, the number may level off.

"The third year is where you see the payoff," Dr. Dawkins said. "You have taken care of the severe cases." And, the new cases coming in are likely to be in the earlier stages and therefore less costly to treat. **B**

Tout your success to the top

ATLANTA—Corporate survival for risk managers means communicating to top management their contribution to the bottom line.

"The better they understand your goals, the more they will support you," said Gale G. Davis, vp and corporate risk manager of United Parcel Service of America Inc. in Atlanta.

"Look at management as your customers," advised David Adler, risk manager of The Portman Cos., an Atlanta-based real estate development and property management company. "To achieve customer satisfaction, you have to exceed their expectations."

In some companies, top managers make the actual insurance spending decisions, so they should be kept informed about market trends and products available, the two said during the annual educational conference of the Atlanta Chapter of RIMS.

"They may make the final decisions about limits, new purchases and risk retention levels," Mr. Davis said. "The risk manager can help them make informed decisions."

Another advantage is that if the risk manager talks to the board of directors, the board is more likely to talk to the risk manager.

"It creates reciprocal downward communication," Mr. Davis said.

At UPS, the risk management department communicates to upper levels of management through an

annual report to the chief financial officer and a presentation to the board, quarterly reports on developments in major lines of coverage and weekly reports to the risk manager's immediate supervisor, the asset manager.

All of those senior managers "need to know how risk management impacts the bottom line," Mr. Davis said.

At Portman, Mr. Adler focuses not on renewals and premiums but on strategic planning when he makes presentations before the board.

"We tell them what we accomplished this year that was good for the company, what crisis management was successful," he said.

He recommends presenting to the board short- and long-term risk management goals with specific target dates for completion.

Risk managers shouldn't wait until year end or until they are invited before the board to share their success stories. Instead, those should be shared with the chairman, president, chief operating officer, chief financial officer and others as they occur.

If they do share premium and rate information with senior management, risk managers must be careful not to take credit for market forces.

"We are in a protracted soft market," Mr. Adler said. "If you take the credit when the market is going down, you're going to take the ax when it is going up."

—By Sara Marley

Disasters cause personal trauma

By SARA MARLEY

ATLANTA—Employers that have survived catastrophes have learned a valuable lesson: When recovering from a hit from Mother Nature, don't overlook human nature.

The spate of disasters in the past two years has prompted many companies to develop crisis contingency plans. But they must not forget that "the people you need to carry out that plan may not be able to," said Bruce Blythe, president and chief executive officer of Crisis Management International Inc. in Atlanta.

Mr. Blythe spoke last month at the annual educational conference of the Atlanta Chapter of the Risk & Insurance Management Society Inc.

Employees may be too traumatized by an event to concentrate on the company's recovery, or they may be overwhelmed by personal losses.

Mr. Blythe recommends that companies appoint someone to their crisis management team who deals only with "the human side."

In large-scale natural disasters like the recent Los Angeles earthquake and 1992's Hurricane Andrew, that person may arrange for housing, food and clothing for employees and their families.

One employer called in Crisis Management after Hurricane Andrew destroyed or severely damaged 85% of its employees' homes.

"You can't concentrate on getting the workforce back together when you have no place to live," Mr. Blythe said.

Common traumatic stress reactions include lack of concentration, fatigue, headaches, intrusive thoughts or reliving the trauma and problems with appetite, relationships and sleep.

The symptoms may not be easy to spot. "People want to put their best face forward at work," he said. "They don't want to appear weak."

After any type of trauma, management should hold mandatory briefings and debriefings for employees, he added. In briefings, employees are given facts about what happened, what the company has done and what it is going to do.

"People are desperate for facts," Mr. Blythe said, noting that rumors are rampant after disasters. "Let them know that management is in control."

Mike Aldridge, director of operations at Teleport Communication Group, experienced catastrophe first-hand last year when a bomb

went off four stories above his office in New York's World Trade Center.

Operations for the company, which provides alternative access telecommunications via fiber-optic cables, were located in the sixth basement of the building. The bomb went off in the second basement (BI, March 8, 1993).

"It changed the way my company looks at our business and how we continue to build our business," Mr. Aldridge told attendees at the Atlanta conference.

Teleport did have a disaster plan because the WTC had received bomb threats a few weeks earlier. So while employees gathered and cleared restrooms, lunchrooms and offices, Mr. Aldridge called company headquarters. However, headquarters staff didn't believe him. "It took two phone calls for them to understand."

One of two stairwells had been blown away in the blast; the other was filled with smoke.

"We wet our shirts and started going up," he said. "It was our last way out."

Before the day was over, Mr. Aldridge made the trip three more times to remove and secure equipment.

Mr. Aldridge quickly learned that the Port Authority of New York & New Jersey had too many issues to deal with—including mourning the loss of four co-workers.

"We got a lot of bad information," he said. "At 6 p.m., we made the decision to bring in generators. We made our own plan." Teleport also had to pump out 14 inches of water from the 8-acre basement when it discovered the Port Authority's pumps could not be submerged.

For 48 hours after the disaster, the company had to provide its own security.

Mr. Aldridge didn't go home for two weeks after the disaster, working all day and catching two or three hours of sleep in the office each night. The nearest restrooms were six flights up.

Teleport lost only two days of operation, but better communication and planning could have mitigated that, Mr. Aldridge said. **B**

Survey

Continued from page 1

cause the consulting firm changed methodologies this year, including giving more weight to responses of small firms, which comprise the overwhelming majority of employers in the United States.

This change in methodology, though, doesn't affect broader trends of the past few years, including the slowing of health care inflation, which began to take hold about two years ago.

That slowdown in health care cost increases is the result of several factors, notes David Rahill, a Foster Higgins principal in New York. Those factors include:

- Employers are more aggressively pushing employees out of higher-cost traditional indemnity plans and into lower-cost managed care programs.

Last year, for example, the percentage of employees enrolled in traditional indemnity plans fell to 47% from 53% in 1992.

"The continuing, though gradual, migration of employees out of high-cost indemnity health plans into lower-cost managed care alternatives lowered employers' total health plan costs in 1993," the study said.

- Providers are more aggressively competing for market share and thus are tempering increases in the price of their services.

- Managed care plans themselves are becoming more adept at negotiating with providers and managing utilization.

"These plans are more efficient than they were just a few years ago and the movement of employees into these plans is just starting to pay dividends," the study noted.

- Employers continue to shift more costs to employees, such as through higher deductibles and co-insurance limits.

While Mr. Rahill said an 8% increase in total health plan costs amid a multiyear stretch of double-digit increases has to be viewed as "good news," health plan costs still outpace the general rate of inflation,

which increased 2.7% in 1993.

While no one is predicting that the difference between increases in the Consumer Price Index and employers' health care costs will entirely disappear soon, employers can expect single-digit increases in health plan costs to continue this year as enrollment in managed care plans grow and the plans operate more efficiently, he said.

Last year, average costs in the two largest types of managed care plans—health maintenance organizations and preferred provider organizations—were substantially lower than traditional indemnity plans.

HMO costs averaged \$3,276 per employee, up 6.5% from \$3,075 in 1992, while PPO costs increased 5.5% to \$3,317 from \$3,145.

By contrast, traditional indemnity plan costs rose 7.1%, boosting the

Continued on next page

400 attend Atlanta conference

ATLANTA—The 11th annual educational conference sponsored by the Atlanta chapter of the Risk & Insurance Management Society Inc. set an attendance record in spite of bad weather and bad luck.

More than 400 people attended the conference, but a few risk managers were called away to assess earthquake damage in Los Angeles, scheduled speakers were stranded in ice-bound Washington and conference organizers had to battle water damage to their own properties caused by frozen pipes in Atlanta.

More than 60 students from the University of Georgia and Georgia State University joined risk managers, brokers and insurers for the conference. Proceeds from the meeting support scholarships for students in risk management and insurance.

The conference raised between \$20,000 and \$25,000 for scholarships in 1994. Last year, the chapter awarded six \$1,000 scholarships to the University of Georgia and Georgia State, in addition to a \$12,500 donation to the Spencer Foundation (see story, page 17).

The 1995 conference will be held at Atlanta's Inforum Jan. 18-20. For more information, contact Chapter President David Adler of The Portman Cos. at 404-614-5267.

High-cost industries

1993 group health costs and % change from 1992

Manufacturing
\$3,991 7.0%

Wholesale/Retail
\$2,938 7.1%

Services
\$3,681 8.9%

Transportation/Communication/Utilities
\$4,639 9.6%

Health care
\$3,242 6.1%

Finance
\$4,067 10.1%

Government
\$4,219 9.0%

*Includes employer and employee contributions for indemnity plans, managed care plans, dental plans and vision/hearing plans

Source: A. Foster Higgins & Co. Inc.

GRAPHIC BY KIM HOME

Why do you still have a traditional plan?

Cannot find suitable managed care networks at all locations: 36%

Collective bargaining agreements require it: 15%

Are committed to unrestricted choice of providers: 15%

Believe it offers more value than managed care: 12%

Believe it is needed to attract and retain workers: 11%

Other: 11%

Source: A. Foster Higgins & Co., Inc.

GRAPHIC BY A. TRANCHITA

Survey

Continued from previous page
average cost per employee last year to \$3,500 per employee from \$3,268.

For point-of-service plans, Foster Higgins is only reporting cost figures for employers with at least 500 employees. For larger employers, the cost of POS plans increased 8.9% to \$3,516 per employee on average in 1993, up from \$3,229.

For large employers, the difference in costs between traditional indemnity plans and managed care plans was striking.

For example, among these employers, indemnity plans cost \$3,836 per employee on average last year, which was 14.9% higher than HMO costs of \$3,338 on average.

Traditional indemnity plan

costs among large employers were 9.1% higher than POS plans' \$3,516 average cost, and 5.9% higher than PPO costs, which averaged \$3,622 per employee.

While most health care reform initiatives have included provisions to establish group purchasing pools or alliances to give smaller firms more buying clout, small employers' total health plan cost increases were much lower than for larger employers.

Total health plan costs for employers with fewer than 500 employees increased 5.9% to an average of \$3,240 per employee last year from \$3,058 in 1992. However, among employers with 500 or more employees, total health plan costs leaped 9.1% to an average of \$4,117 per employee from \$3,775.

One reason small employers' health plan costs rose modestly is that smaller firms, like their

larger counterparts, are embracing managed care, Mr. Rahill said.

In fact, many small firms over the last year scrapped their traditional indemnity plan and replaced the costly plans with more cost-efficient PPOs.

"When a PPO is a total replacement for a traditional indemnity plan, you can have a pretty dramatic one-year swing in costs," Mr. Rahill added.

Thirty-three percent of workers at small employers were enrolled in PPOs in 1993, up from 28% a year earlier. PPO enrollment among larger employers grew at a slower rate: In 1993, 23% of employees were enrolled in a PPO, up from 21% in 1992.

Total health plan costs varied considerably by region, reflecting a variety of factors, including the penetration of managed care programs; the percentage of employees covered under collective bargaining agreements, which tend to offer richer benefits; and the average age of health plan participants.

Total health plan costs were highest in the Northeast, leaping 10.1% last year to an average of \$4,267 per employee from \$3,877.

While the Northeast no longer is a managed care desert, traditional indemnity plans remain strongly entrenched. Eighty-seven percent of large employers in the Northeast offered a traditional indemnity plan in 1993, compared with a national average of 67%.

"There aren't as many managed care choices in the Northeast as elsewhere. Employers there still depend heavily on traditional indemnity plans, which are the most expensive health plan alternative," Mr. Rahill said.

Employers in the Northeast also are much more likely—compared to employers in other parts of the country—to have employees enrolled in unions and covered by collectively bargained health plans.

On the other hand, the rise in total health plan costs was lowest for employers in the West—the nation's managed care stronghold—increasing 5.3% to an average of \$3,620 per employee from \$3,437.

By industry, employers in the transportation, communications and utilities industry—an industry characterized by a high degree of unionization and rich health care plans—had the highest health plan costs with per employee expenditures averaging \$4,639 last year, up 9.6% from \$4,234 in 1992.

Costs were lowest among employers in the wholesale/retail trade industry, where health care benefits are much less generous and where high-cost programs like retiree health plan coverage are rare. In the wholesale/retail industry, health plan costs averaged \$2,938 per employee in 1993, up 7.1% from \$2,743 a year earlier.

Other cost findings in the Foster Higgins survey include:

- Total health plan costs are directly related to the percentage of employees belonging to unions. Employers with more than 50% of employees in unions reported health plan costs averaging \$4,816 per employee, up 10.3% in 1993 from \$4,365 in 1992.

Among employers that had fewer than 50% of workers in unions, health plan costs averaged \$4,018 per employee in 1993, up 9% from \$3,685 in 1992.

Health plan costs for employers whose workforces are not unionized were the lowest, averaging \$3,325 per employee in 1993, up

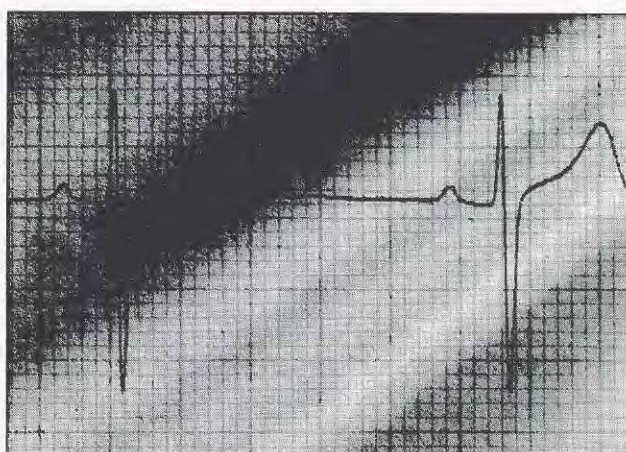
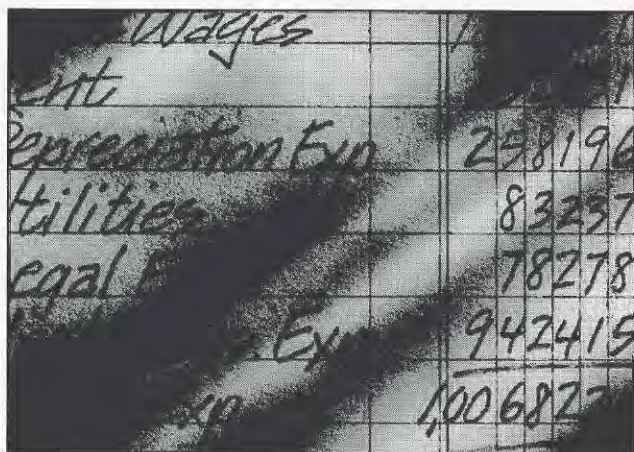
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Financial Services

Continued from previous page
6.8% from \$3,112 in 1992.

- Not surprisingly, employers offering retiree health care benefits had much higher overall health plan costs than employers without retiree plans.

Total health plan costs among employers offering retiree health care benefits averaged \$4,385 per employee in 1993, up 9.1% from \$4,018 in 1992. That was 35.3% higher compared with employers without retiree health plans, whose total health plan costs in 1993 averaged \$3,241 per employee, up 6.7% from \$3,036.

- Total health plan costs were highest for the country's corporate giants. Health plan costs averaged \$4,537 per employee in 1993 for employers with at least 20,000 employees, up 9.3% from \$4,150 per employee in 1992.

- Traditional indemnity plan costs were highest in the Midwest, where costs averaged \$3,997 per employee in 1993, up 9.1% from \$3,665 in 1992.

The lowest traditional indemnity plan costs were in the South,

where costs averaged \$2,775 per employee, up 4.8% from \$2,647.

- PPO costs were highest in the Northeast, where costs averaged \$4,158 per employee in 1993, up 13.4% from \$3,668. The lowest PPO costs were in the South, where costs averaged \$3,105 per employee, up 3.3% from \$3,007. PPO costs include both network and out-of-network expenditures.

- HMO costs were highest in the Midwest, where costs averaged \$3,607 per employee in 1993, up 6.4% from \$3,390. The lowest HMO costs were in the West, where costs averaged \$2,930, up 5.7% from \$2,772.

Copies of "The Foster Higgins National Survey of Employer Sponsored Health Plans" are available from Annemarie Harte, A. Foster Higgins & Co. Inc., 125 Broad St., New York, N.Y. 10004; 212-574-9025. The cost is \$500.

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POS plan option catches on

While point-of-service plans are a relatively small part of the group health care market, their popularity is increasing among employers and employees.

Fifteen percent of large employers—those with 500 or more employees—offered a POS plan in 1993, up from 10% in 1992. And 7% of large employers say they intend to offer a POS plan within the next year, according to the Foster Higgins study.

Among employers of all sizes, POS enrollment climbed to 9% of all employees in 1993 from 6% in 1992.

POS plans are making big inroads among large employers in the West. The number of large employers in that region offering a POS plan to some or all of their employees rose to 22% in 1993 from 9% in 1992.

And the recent decision by the nation's largest HMO—Oakland, Calif.-based Kaiser Permanente, which has 6.6 million members—to offer a POS plan in many regions of the country will give a further boost to POS plans (BI Jan. 31).

POS plans combine features of health maintenance organizations and PPOs. Like an HMO, each employee has a primary care physician who acts as a gatekeeper and helps to coordinate care for the employee. But, like a PPO, the employee can receive services outside the network of providers at a higher out-of-pocket cost.

While employees typically use network providers for most medical services, they enjoy the comfort of knowing they have the option—unlike a traditional HMO—of receiving services from providers who may not be in the network.

—By Jerry Geisel

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Employers confident of PPO savings

Employers overwhelmingly believe that preferred provider organizations are effective in controlling health care costs.

Eighty-three percent of employers with PPOs either agreed or strongly agreed that PPOs were effective in controlling their health care costs, according to the Foster Higgins survey. Just 7% either disagreed or strongly disagreed that PPOs were effective; the remaining 10% neither agreed nor disagreed.

Employers have good reason to believe in the ability of PPOs to control health care costs: In 1993, PPO costs rose 5.5% to an average of \$3,317 per employee from \$3,145 in 1992, according to the survey. That was the lowest cost

If current trends continue, the percentage of large employers offering PPOs could soon approach that of health maintenance organizations. Last year, 36% of large employers... offered a PPO, compared with 46% of large employers that offered an HMO.

increase of the three major types of health care plans.

If current trends continue, the percentage of large employers offering PPOs could soon approach that of health maintenance organizations. Last year, 36% of large employers—those with at least 500 employees—said they offered a PPO, compared with 46% of

large employers that offered an HMO.

Nine percent of large employers that do not currently offer a PPO to employees say they intend to offer one within the next two years. Just 3% of employers that do not currently offer an HMO intend to offer one to employees within the next two years.

While employers in all parts of the country offer PPOs, the plans are most prevalent among employers in the West.

Fifty-six percent of large employers in that region offered a PPO in 1993. That's almost three times greater than in the Northeast, where just 20% of employers offered a PPO in 1993.

And employers with PPOs report that most health claim dollars spent through the plans flow through network providers. Fifty-two percent of employers with PPOs said between 80% and 90% of claim dollars go to network providers, while 23% of employers said between 60% and 79% of claim dollars go to network providers.

On the other hand, just 13% of employers with PPOs said less than 40% of money spent through the plans goes to providers outside the network.

Employers incorporate financial incentives—like lower coinsurance requirements—to encourage employees to use PPO network providers.

Thirty-four percent of employers with PPOs said there was a 20-percentage-point difference in the coinsurance requirement for physician office visits inside and outside the network. Twenty-one percent of employers reported a 30-percentage-point difference.

Similarly, 42% of employers said there was a difference of 20 percentage points in coinsurance for inpatient hospital charges inside and outside the network, while 13% reported a differential of 30 percentage points.

—By Jerry Geisel

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Few firms push HMO enrollment

Even though health maintenance organization premium rates are lower than indemnity plan rates for nearly half of all employers, most do not actively encourage their employees to enroll in HMOs.

Forty-eight percent of employers reported that their indemnity plan rates in 1993 were higher than their HMO rates, while 22% of employers said HMO rates were higher, according to the Foster Higgins survey. Seventeen percent reported that rates charged by the two types of plans were about the same, while 12% of employers did not offer an indemnity plan last year.

But 70% of employers said they neither encourage nor discourage enrollment in HMOs, while 25% encourage enrollment in HMOs and 5% discourage enrollment, the survey found.

While a federal law that requires certain employers to offer an HMO to employees is due to expire in 1995, most employers say they will continue to offer HMOs even if no longer required to do so.

Eighty-six percent of employers said they will continue to offer HMOs even if they are not required to, while just 5% said they would stop offering HMOs if no longer required. Nine percent reported they would consider dropping HMOs.

Most employers—53%—said the experience of their own employees is used by HMOs when calculating premiums, rather than other types of rating like community rating, in which rates are set based on the experience of an entire group of people served by the HMOs.

Experience rating is most common for employers in the West, Midwest and South: More than 60% of employers in those states say at least one of their HMOs uses experience rating in setting premiums.

On the other hand, only 36% of employers in the Northeast say at least one of their HMOs uses experience rating.

A federal law passed in 1988 gave federally qualified HMOs the authority to use experience rating.

—By Jerry Geisel

INTERNATIONAL

German buyers protest rating system

By DON LEWIS KIRK

BONN, Germany—German corporations are fighting to change the consortium approach to setting primary insurance rates for very large property risks.

Underwriting committees of insurers and reinsurers make final rate determinations on individual risks with insured values of at least 1 billion deutsche marks (\$567.9 million). The committees last year raised rates as much as 300% on these large commercial property and business interruption risks, known as *spitzenrisiken*, which constitute one-third of all German commercial property risks.

In contrast, rates for smaller property risks rose an average of only

14% last year.

Risk managers for large industrial companies insist they deserve representation on the rate-setting committees, called consortial commissions or KOKOs. They say proposed rates negotiated their insurers before a KOKO meets to review the risk are often different than the rates set by the committee. The reason for that difference, policyholders contend, is that reinsurers want to harden a soft market at policyholders' expense.

Wilhelm Zeller, a member of Cologne Re Group's executive board, denied that charge. However, he added, policyholders shouldn't expect to participate on the KOKOs. "Would industry do the same? I know of no industry that would in-

vite a client to a meeting where it works out the client's bid."

But risk managers are adamant.

"There are basically two possibilities," said Fritz-Jurgen Cremer, risk manager of Frankfurt-based Hoechst A.G., Europe's largest chemical manufacturer. Either the consortiums voluntarily allow risk managers to take part in KOKO meetings or Germany's Federal Cartel Office must decide if the consortiums should be banned, said Mr. Cremer, who also sits on the insurance board of the Federation of German Industries.

Authorities last year began investigating allegations that property insurers had violated laws prohibiting market manipulation through the KOKOs.

After years of enormous underwriting losses, the lowest property rates in Europe and large claims, German commercial insurers began to push for higher property insurance rates in 1992. But, in the opinion of many policyholders, the rate increases have unfairly burdened companies with large risks.

"We want solvent insurance companies. But we also want adequate and fair premiums. That was the case in the past. It is no longer the case," said Wolfram Rohde-Liebenau, executive director of Risicom, Siemens A.G.'s risk management subsidiary and reinsurance captive, and VVK, its in-house broker.

KOKOs are not the first type of insurance rating consortium to come

under scrutiny in Germany.

Tariff commissions were established by reinsurers in 1970 to boost commercial property insurance pricing levels, which were regarded as overly soft. Reinsurers used the commissions them to set rates for the insurers of *spitzenrisiken* until that process was questioned by the Federal Cartel Office.

That office determined in 1989 that tariff commissions abused the process. Following allegations of illegal price manipulation by reinsurers, tariff commissions were banned and replaced by the KOKOs.

KOKOs are led by the principal insurer of a large property risk and include midsize and smaller insurers that participate on the risk. In addition,

Continued on next page



Housing London's three major insurance markets in the London Underwriting Centre is a logical move, Victor Blake says.

LUC makes a bid to be the hub of London market

By STACY SHAPIRO

LONDON—London's three major insurance markets could easily be housed in the new London Underwriting Centre, says the building association's chairman.

But, LUC Chairman Victor Blake admits he's biased. The newest underwriting center, which opened last autumn, is only half-full, with more than enough remaining room to accommodate the three markets, he said.

Logic suggests that the London Insurance & Reinsurance Market Assn., the Institute of London Underwriters and Lloyd's all be housed in the LUC, said Mr. Blake, chairman of CNA International Reinsurance Co. Ltd. LIRMA is already housed in the LUC.

Lloyd's Chairman David Rowland agrees there should be a way of accommodating the "London market" under one roof. But, Mr. Rowland said the Lloyd's building is the logical choice (see story, page 3).

Some people would say that it's inevitable to merge the ILU and LIRMA into the LUC, Mr. Blake said. The marine and non-marine insurer associations had considered moving into the LUC before it opened, but chose not to do so.

Since then, the ILU has lost more than 40 company members and is considering its future (BI, Jan. 31). Mr. Blake believes that more marine underwriters—who usually are based at the ILU—will be sitting next to their non-marine underwriting colleagues in the LUC in the next few months.

Although the LUC seems quiet compared with Lloyd's,

Continued on next page

New directions for NewCo?

Lloyd's may use the reinsurer for post-1986 open years

By STACY SHAPIRO

LONDON—Lloyd's of London's proposed runoff reinsurer—currently dubbed NewCo.—could possibly cap all Lloyd's members' losses and, thus, heighten the chances for a future settlement between the market and litigating names, one of its architects says.

Lloyd's is setting up a working group to examine whether NewCo. should reinsure all open syndicate accounts from 1986 onward, NewCo. project director Heidi Hutter announced last week.

The initial mandate given to NewCo. in Lloyd's April 1993 business plan is to reinsure all syndicates' pre-1986 liabilities, which are primarily U.S. long-tail liability losses for asbestos, pollution and other health hazards. The original cutoff date coincided with the introduction of U.S. claims-made commercial general liability policies.

Lloyd's business plan suggested that any syndicates with open years of account from 1986 and later should have the option of closing their accounts into Lloyd's existing runoff reinsurance company, Cen-

treWrite Ltd. (BI, Aug. 30, 1993).

However, "we've had a look at the situation, and it makes sense for 1986 and post open years to be put into NewCo.," said Robin Jackson, chairman of CentreWrite. As a result, CentreWrite has stopped giving quotations to reinsure open syndicate accounts.

If Lloyd's takes this approach, all open London market excess-of-loss reinsurance syndicates, like those formerly managed by Gooda Walker Ltd. and Feltrim Underwriting Agencies Ltd., would be reinsured into NewCo.

This means that most of the 22,500 members of LMX syndicates who were offered 900 million pounds (\$1.31 billion) to settle litigation against members and managing agents could cap their losses if their syndicates' losses are reinsured with NewCo. Many members rejected Lloyd's offer because it didn't include a cap on their liabilities.

If NewCo. caps their liabilities for a price, then a future settlement offer could be more successful, Lloyd's Chairman David Rowland agreed.

Members were to decide today whether

to accept Lloyd's offer (see stories, pages 3 and 15).

"If (the offer) doesn't work because the members think they'd be better off in litigation—well, then, put that to one side," said Mr. Rowland. "We watch to see what happens. We go flat out on NewCo., and you're absolutely right... All sorts of things might then happen."

If NewCo. actually makes its Dec. 31, 1995, deadline to be licensed by the British Department of Trade and Industry, it would become one of the largest limited liability insurers in the world.

The NewCo. project, officially known as "old and open years project," is headed by Lloyd's Deputy Chairman Richard Keeling and a Supervisory Board that includes Ms. Hutter and Lloyd's Chief Executive Peter Middleton.

Ms. Hutter, a math major who graduated in 1979 from Cornell University, arrived at Lloyd's in October to head the project for two years. After that, she said in a recent interview, "I want a long vacation."

She got the job after approaching

Continued on next page

Lengthy Cowen case raises call for disciplinary reform at Lloyd's

By STACY SHAPIRO

LONDON—It's easy to feel sorry for Edward Cowen, who earlier this month was censured by Lloyd's of London for conduct detrimental to members as the former underwriter of syndicate 529, managed by Sterling Underwriting Agencies Ltd.

Even the deputy president of Lloyd's Appeal Tribunal, Richard Southwell, seemed sympathetic to Mr. Cowen, who couldn't afford legal representation for much of the five-year disciplinary proceedings.

But what is clear from Mr. Cowen's case are problems with Lloyd's disciplinary procedures.

Mr. Southwell recommended that future disciplinary proceedings be less onerous, cheaper and shorter.

Indeed, Mr. Cowen maintains that Lloyd's proceedings were "an incredible breach of natural justice. For Lloyd's to spend 1 million to 3 million pounds (\$1.48 million to \$4.4 million) to pursue me is beyond belief," considering the number of underwriters who have caused massive losses for their members.

Lloyd's would not say how much it spent in the proceeding.

Mr. Cowen maintains he did nothing improper in placing catastrophe reinsurance contracts to offset LMX losses incurred by his syndicate. Syndicate 529 is still operating and showed a profit in 1987, 1988 and 1990 and a small loss in 1989.

Nevertheless, the Appeal Tribunal upheld a Disciplinary Committee's finding that Mr. Cowen was guilty of charges of improper conduct involving three reinsurance contracts pur-

chased for the syndicate between December 1987 and December 1988. The contracts allegedly benefited the members of syndicate 529's 1985 account, but provided little relief to members in future years as losses from 1985 and earlier years deteriorated.

One of the contracts also was not considered by Lloyd's to be reinsurance at all because it allegedly did not transfer any risk.

Mr. Cowen argued the contract was similar to the controversial time-and-distance policies used by many Lloyd's underwriters. But Mr. Southwell concluded it was not reinsurance.

"It may well be that some time-and-distance policies entered into by Lloyd's syndicates are not genuine reinsurance," said Mr. Southwell. "If so, no doubt the Lloyd's authorities will wish to re-examine this matter."

Because Mr. Cowen has been suspended from the market since 1989, when Lloyd's investigation began and was only censured following the proceedings, he has already fulfilled his three-year suspension sentence. Mr. Cowen said he would like to return to Lloyd's as an underwriter.

His case, however, shows how onerous Lloyd's disciplinary proceedings can be.

Mr. Cowen was fired by Sterling Underwriting Agencies in January 1989 for reasons not necessarily related to the charges, but those reasons have not been disclosed.

Three months later, Lloyd's told Mr. Cowen it would likely investigate his conduct as syndicate 529's underwriter and he

Continued on next page

INTERNATIONAL

KOKOs

Continued from previous page

tion, each KOKO invites one reinsurer official to serve as a "guest" on the commission. In the vast majority of cases, one of Germany's three largest reinsurers are represented.

The current cartel investigation is an indication that not all is well with Germany's KOKOs. In light of significant rate hikes, policyholders have renewed a longstanding demand for representation.

"We'd like to be at the KOKO meeting to clearly define our risk and our situation," says Karl-Heinz Jaeger, risk manager of BASF A.G. in Ludwigshafen, Germany. "The danger of a false assessment is great."

"While KOKOs push through 100% of tariff rates (for some policyholders), other companies under the *spitzenrisiken* pay only 15%-30% of tariff rates."

Risk managers fear reinsurers are dominating the KOKOs.

"We have the impression insurers lack the power to defend our interests," said Mr. Jaeger. "After KOKO meetings, we're told insurers would

Have liked to help but couldn't."

But reinsurers say policyholders exaggerate reinsurers' role.

"When guidelines for premiums are set, they are calculated based on existing industrial insurance tariffs," said Cologne Re's Mr. Zeller. "If the rates are proper, reinsurance companies give their approval. We don't say 80% of premium is enough or 115%. The moment an insurer in the KOKO says this is 100% of premium guidelines, then it's OK."

Policyholders, however, claim the tariffs are less frequently used as a gauge.

"I have colleagues who confront rates that are above the official tariff rates for *spitzenrisiken*," said one risk manager. "In reality, KOKOs go beyond tariff guidelines."

Karlfried Tesch, a director at Gerling-Konzern Allgemeine Versicherungs A.G., acknowledges problems between policyholders and insurers over the rates set by the commissions. "KOKOs are less willing to fulfill the individual wishes of the policyholder than in the past. The perspective of the reinsurer dominates."

However, Mr. Tesch added, German commercial property insurers

have lived with "catastrophic" underwriting losses for years and need to raise rates.

"Attempts to harden the market are understandable. In many respects, insurers are grateful. But it's a dilemma," he said. On the one hand, reinsurers are putting pressure on insurers to raise rates; on the other hand, insurers risk alienating policyholders with steep rate hikes.

Hoechst's Mr. Cremer said he understands that "insurance companies want to return to profitability. It's legitimate and we support it. We just feel they're doing it at our expense."

Theoretically, there are alternatives. The single European market should allow German companies to escape the KOKOs and find competitively priced coverage from insurers in other European Union countries like France, Great Britain and the Netherlands.

But, "as long as the worldwide capacity remains tight, German reinsurance companies can more or less dictate rates (for German companies) in the KOKOs. The moment the market softens, KOKOs will lose importance and reinsurers will have

to back off when setting rates," said Gerling's Mr. Tesch.

For most non-cumulative per risk business, Cologne Re's Mr. Zeller insists there are alternatives and that the position of Germany's reinsurers is not as strong as it is made out to be.

"Bottlenecks in capacity occur with some very large risks," he said. A jumbo risk with a possible maximum loss of 6 billion deutsche marks (\$3.41 billion), like German automaker Daimler-Benz A.G., requires much more capacity than could be provided by German reinsurers alone, said Mr. Zeller.

Large German industrial companies, which initiated the investigation of KOKOs by the cartel office, fear that by the time the office acts, insurers will have long returned to underwriting profitability and steep rate hikes will have moderated.

"Calling the cartel office is the wrong way to handle this," said Hoechst's Mr. Cremer. "I'm not in favor of using the cartel office. It only causes bad blood. But we have reached a point where a consensus is needed if insurers don't want to completely sour their relationship to industry." **BI**

LUC

Continued from previous page

2,000 brokers a day visit the building and make use of its facilities. The facilities include the New Yorker Bar, a food court and special dining rooms that are all catered by the Roux Brothers, famous chefs and restaurateurs in Europe.

Computer terminals dot the building with software, known as "LUCID," that tells visitors where to locate company offices, the names of the underwriters and whether there's a line of brokers already waiting to see the underwriter.

The broker areas on several floors of the building feature free telephones, seating and televisions showing Cable News Network, Mr. Blake said. About 120 brokers gathered around one of the sets when the Los Angeles earthquake struck, because CNN provided far more coverage of the quake than British television. **BI**

Cowen

Continued from previous page

was suspended from the market in May 1989. In September 1990, Lloyd's served Mr. Cowen with 16 charges, most of which were later dropped.

By November 1990, Mr. Cowen had tallied a legal bill of 40,000 pounds (\$77,200) defending himself, which Lloyd's agreed to pay. By March 1991, his costs had risen to 365,000 pounds (\$682,550) and Lloyd's refused to pay. As a result, Mr. Cowen had to represent himself during most of the public hearing.

The hearing, which began on Sept. 23, 1991, took 72 days. In September 1992, the Disciplinary Committee delivered its 358-page decision, which Mr. Cowen appealed.

Mr. Southwell upheld one charge of detrimental conduct and reduced two other charges of discreditable conduct to detrimental conduct. **BI**

Hutter

Continued from previous page

Lloyd's last year to see whether Atrium Corp., where she was executive vp, could help set up NewCo. The Swiss Reinsurance Co. unit had done work for Mr. Rowland when he was chairman of broker Stewart Wrightson Holdings P.L.C.

The structure of the NewCo. project was laid out by Mr. Keeling before Ms. Hutter arrived. Under the NewCo. supervisory board is the Core Reserving Group, which has seven working groups under it.

Four of these are examining the level of reserving and capital that NewCo. needs. Analysts at Tillinghast, Bacon & Woodrow, Coopers & Lybrand and Ernst & Young are involved in the projects.

A fifth group is looking at syndicates' current reinsurance available to pay losses, and another is looking

at legal issues. The seventh is looking at post-1986 open syndicate accounts.

NewCo.'s biggest critic, syndicate analyst Chatset Ltd., has said that a total of 7.35 billion pounds (\$10.73 billion) of additional reserves will be required to run off the 1985 and prior open years, and another 1.3 billion pounds (\$1.9 billion) will be needed for the 1986 and subsequent open years (*BI*, Dec. 20, 1993).

Mr. Keeling and Ms. Hutter have spoken to Chatset analysts about these projections.

"What we've determined is that we need to do exactly what it is that we're setting out to do, which is to gather information and do an analysis that's more detailed than anyone's done it before," said Ms. Hutter. "Only then will we have our arms around it and find our way forward. I'm convinced that we are going to find a way to do something very positive for this market for

1985 and prior liabilities."

Another way to reduce any gap in NewCo.'s reserves is to work on commutations with Lloyd's policyholders. Ms. Hutter is currently looking to recruit a "facilitator" to develop a commutations strategy.

Under a commutation, a policyholder and insurer agree to a lump-sum payment to settle all pending and future obligations of the insurer under the policy. Normally, the deal is attractive to policyholders concerned about the future solvency of an insurer.

However, "I don't see commutations (for NewCo.) as us going to the market and saying 'OK, look fellas. Here's your offer for 20 pence on the pound. Take it or leave it,'" said Ms. Hutter. "That's not our strategy."

"But there are situations where we are in dispute (in litigation) with our policyholder or reinsured. That's where commutations start to have a lot more possibility. . . . The last thing

I would want to signal to the market is that (NewCo.) is not going to pay in full."

"I think commutations are difficult to do at the moment because of the uncertainty of pollution losses," Mr. Jackson said.

But, he acknowledged, two or three commutations have been completed recently at Lloyd's, and it has been common practice when ceding companies think a reinsurer won't be around much longer.

Meanwhile, the NewCo. project is moving fast.

One item of concern: replacing the generic name, NewCo. Whoever comes up with the best name stands to win a very good bottle of champagne, courtesy of Mr. Middleton.

Project executives also are trying to decide whether NewCo. will be one company of 18,000 people or a smaller administrative firm that subcontracts all of its work to licensed runoff managers. **BI**

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Capital

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differentiate between insurers that write highly volatile coverage, like workers compensation, and those that write more "plain vanilla" lines.

Among the ways risk-based capital standards could affect property/casualty insurers are:

- By requiring them to maintain more capital to support long-tail liability lines, in particular workers comp. This could lead to higher workers comp rates.

- By requiring them to maintain capital in support of reinsurance recoverables, which would make the use of reinsurance more expensive. Critics charge that the formula unfairly fails to distinguish between top-quality and poor reinsurers.

- By encouraging them to invest more heavily in lower-yielding, but theoretically less risky, bonds rather than equities.

- By encouraging more mergers and acquisitions of weaker, poorly capitalized insurers.

- By giving non-U.S. insurers, which do not have to comply with the guidelines, a potential competitive advantage.

The formula applies to four different categories of an insurer's "risk": asset risks, like stocks and bonds; credit risks, including the risk of losses from unrecoverable reinsurance; underwriting risks, which reflect the risk of errors in pricing and reserves; and off-balance sheet risks, like the risks created by excessive growth.

Under the formula, line items in each category in the annual statement are multiplied by a formula to determine the amount of capital that will be required, with riskier areas requiring greater levels of capital.

The required capital for each category is then combined in accordance with actuarial principles to yield a total risk-based capital amount the insurer should meet.

Under the risk-based capital model law, regulators could take action against an insurer based on its level of risk-based capital. That action could range from requiring a financial plan with remedies for specific problems to seizing the insurer. Even states that have not approved the model law could use powers they already have when risk-based capital is low.

However, risk-based capital may not have the dramatic effect on insurers that many in the industry initially thought it would.

"It's really kind of hard to say with absolute certainty, but I don't believe it will have a significant impact," said Vincent Laurenzano, assistant deputy superintendent for the New York Insurance Department and chairman of the NAIC's risk-based capital task force.

Insurers with capital at or below the threshold may be motivated to act, he said. "But most of the companies have capital well above their RBC requirements."

Others agree. "Fundamentally, we think that the impact of risk-based capital on the industry will not be quite as dramatic as once feared," said Robert Zeman, assistant general counsel for the National Assn. of Independent Insurers in Des Plaines, Ill.

It will take several years before insurers can assess how the rules work and how regulators will react.

"At this point, it's probably too early for any company that does not think it's going to have a problem to do very much," added Doug Hodes, vp and corporate actuary for Liberty Mutual Insurance Co. in Boston, who includes Liberty Mutual in this category. If an insurer believes its level of risk-based capital position is "reasonable," the next step is setting up

computer programs that can estimate and track that capital. "It's more of a housekeeping stage than anything else."

Insurers have had plenty of time to prepare.

"The property/casualty industry has been waiting for this," said Robert Hogue, an analyst with RAS Securities in New York. "They've built up their capital positions almost to an historically high point, so they're not going to come up short except for an exception here and an exception there."

"It's not like the industry's waking up to this issue," agreed Arthur Chandler, vp-capital management for CIGNA Corp. in Philadelphia. Insurers have "always recognized there are different elements of risk" and have invested different amounts of capital commensurate with those risks.

"For us, I don't think it's going to mean we're going to change the way we do things," said Mr. Chandler.

Still, while insurers always have theoretically kept an eye on their capital costs, "it's never been as explicit," said William J. Murray, vp and assistant general counsel for Chubb & Son Inc. in Warren, N.J. Risk-based capital standards are expected, though, to create problems for some smaller or marginal insurers.

"It is going to be a bit more of a barrier to entry to someone who's trying to get into the game," said Ken Frohlich, corporate senior vp and chief actuary for Reliance Insurance Group in Philadelphia. "It's going to make it more difficult for a start-up operation to write heavy commercial lines, for example."

"I think it's going to penalize those people that are writing a lot of long-tail business, but basically we agree that some of those lines should require more capital," said Dan McLean, president of SAFECO Corp.'s property/casualty units in Seattle.

And if the companies that write long-tail liability business are small and geographically diverse, "they could find it particularly tough to live with risk-based capital," observed Michael Fringuelli, an analyst with Salomon Bros. Inc. in New York.

Whether risk-based capital will affect rates remains unclear.

"We're going to have a lot of money out there that will be dead money," said RAS Securities' Mr. Hogue, adding that the formula could prompt some rate hikes. "We're going to create a huge, permanent pool of unemployed capital, and the cost of holding that is larger than the interest that is earned, and that will have to be made up from the rates on the policies."

Other experts say the effects on pricing will be much more limited.

"Unfortunately, (the risk-based capital standard) falls far short of what is needed to even begin to foster some realism in pricing in the industry," said Myron M. Picoult, managing director and senior insurance analyst with Oppenheimer & Co. in New York.

And Peter Jokiel, senior vp and chief financial officer of CNA Financial Corp. in Chicago, cautioned that, "It's going to be very company-specific."

Beyond rates, risk-based capital could have other effects on the market.

Workers comp insurers costs, for example, will be increased by the risk charge on workers comp. Some insurers will just absorb that cost, said Liberty Mutual's Mr. Hodes. But others, with risk-based capital levels a "little too close to marginal," may feel workers comp is too expensive to continue writing, causing a "bit of contraction in that market."

Risk-based capital could be a factor in encouraging insurers to leave

certain lines of business, agreed William O'Neill, senior vp at Standard & Poor's Corp. in New York. They may have left anyway, but "it's clear that risk-based capital will indeed accelerate that process."

Ironically, by adopting the standards, state regulators—who usually try to keep insurers in markets—are providing insurers with powerful arguments that they should get out, Mr. O'Neill said.

It may be premature to predict an exodus from long-tail liability business, said Chubb's Mr. Murray, but "one reasonable interpretation might be that some of that business is going to get a lot more expensive."

Reinsurance programs also will be affected by risk-based capital.

Insurers with risk-based capital problems should be able to buy legitimate reinsurance to reduce their risk, maintains Mr. Hodes.

But, "the risk capital formula doesn't give credit for the reduction of the company's risk by ceding reinsurance," he explained. "The risk charge for reinsurance is fairly high and therefore even though you may actually have reduced risk, you can't reduce your risk-based capital appreciably by doing this. It's sort of perplexing."

Conceivably, some insurers may avoid buying reinsurance and, instead, write smaller lines on a net basis, said Reliance's Mr. Frohlich. That would require policyholders and brokers to assemble many insurers to write a program that previously had been insured by one company.

All reinsurers are treated equally under the risk-based capital rules.

"If your reinsurance is with Gen Re or Flowerpot Mutual, it doesn't make any difference in terms of the risk-based capital formula," said Chubb's Mr. Murray. "My position has always been there needed to be some distinction between quality reinsurance and the rest of the pack," he said, adding this may be one of the issues the NAIC examines.

However, making those distinctions would put the NAIC in the business of ranking or rating reinsurers, which is inappropriate, said Mr. Laurenzano, who said he does not believe risk-based capital will reduce reinsurance volume. The risk-based capital charge for reinsurance is lower than if the insurer retained the business, he added.

Risk-based capital could cut into investment income as insurers try to improve their ratios by investing in safer, but lower-yielding bonds.

From an operating perspective, that "might hurt a little," said Joseph L. Petrelli, president of Columbus, Ohio-based Demotech Inc., which rates insurers.

Risk-based capital also could en-

courage merger and acquisition activity, as well as corporate restructuring.

"Marginally capitalized companies are going to have to re-evaluate their growth strategies because of risk-based capital constraints," possibly causing such companies to sell non-core businesses, said Eric Simpson, vp in A.M. Best Co.'s property/casualty division in Oldwick, N.J. On the flip side, well-capitalized companies may be able to buy new blocks of business, "so it might represent an opportunity for some."

The standards could also influence insurers' corporate structures. Because of the "hefty" charge required for investments in affiliated companies, the formula encourages a hori-

zontal, rather than a vertical, ownership structure, said Mr. Simpson. So, instead of a holding company owning a property/casualty insurer, which itself owns a life/health insurer, both insurers would be owned by the holding company.

Another fallout from risk-based capital is that domestic insurers could be put at a disadvantage compared with non-U.S. insurers, which are not subject to the formula.

Already, "many non-U.S. insurers... are not subject to the same sort of tax problems, reserving constraints, etc., that indeed the U.S. insurers are," said Mr. O'Neill. "Here's one more instance where there is" potential to hurt the global competitiveness of a U.S. industry. **[B]**

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Blumeyer

Continued from page 2

Bel-Aire in 1987 by falsely claiming that the insurer had \$900,000 in initial capital.

In fact, \$500,000 of the money was borrowed from Royal Banks of Missouri in St. Louis and repaid after the license was issued, depleting Bel-Aire's surplus. The other \$400,000 was borrowed from the now-defunct Insurance Corp. of America, a Boca Raton, Fla., insurer headed by Al Johnson, a Blumeyer associate (BI, June 1, 1987).

Mr. Blumeyer produced a series of false financial statements for Bel-Aire between 1987 and 1990,

Bel-Aire reported assets that included worthless penny stock and overvalued real estate.

reporting assets that included worthless penny stock, overvalued real estate and a \$2 million loan from Atlantic General Insurance Co. of Anguilla, a company that Mr. Blumeyer secretly controlled and that was formed with little or no initial capital, prosecutors charged.

Bel-Aire took in about \$40 million in premiums before the Missouri Insurance Department placed it in receivership in October 1990.

Ordered into liquidation last July, Bel-Aire had year-end 1993 assets of about \$2 million and liabilities estimated at approximately \$10 million, according to Dana L. Frese, a lawyer with Carson & Coil in Jefferson City, Mo., representing the liquidator.

The assets, however, include about \$470,000 in a bank account held jointly by the insurer and another of Mr. Blumeyer's companies, and the estate is fighting Mr. Blumeyer's claim that the money is his, Mr. Frese said.

Mr. Blumeyer declared personal bankruptcy last November after he was hit with an \$8.9 million fine by the New Jersey Insurance Department for selling unauthorized or fraudulent insurance in the state.

Meanwhile, the Bel-Aire estate is trying to recover other potential assets, including a \$1 million Bel-Aire directors and officers liability policy written by London market insurers, including the now insolvent Walbrook Insurance Co. Ltd., Mr. Frese said.

As Bel-Aire became a target of increasing regulatory scrutiny, Mr. Blumeyer shifted business to Atlantic General, for which he and others had produced a phony financial statement listing non-existent assets, the indictment charged.

Between 1989 and 1990, Atlantic General policies generated \$3.5 million in premiums.

In December 1990, as regulators began questioning Atlantic General, Mr. Blumeyer and others formed another new company, Atlantic General & Specialty Insurance Co. of Anguilla.

This company soon after changed its name to Marigot Casualty Co. Ltd., and Mr. Blumeyer and others again produced a fraudulent financial statement for the insurer showing bogus assets, prosecutors charged.

The March 1993 indictment capped a federal investigation that began in September 1990. The trial of Mr. Blumeyer and the other defendants began Jan. 4, and the jury returned its verdicts on Feb. 4 after

six days of deliberation.

Although not mentioned in the indictment, Evergreen Management, Mr. Blumeyer's current company, ran into its own regulatory problems last year in its attempts to generate business for offshore insurers through American Assn. of Parents & Children, a group that Evergreen managed (BI, March 1, 1993).

Several of the companies Evergreen used to insure AAPC members—including Marigot, Tiberian Insurance Co. Ltd. of Anguilla and Olympian Insurance Co. Ltd. of Antigua—have been barred by regulators in various states.

AAPC last year advertised for business that had previously been written by other offshore insurers controlled by convicted insurance con man Alan Teale. At the time, Mr. Blumeyer described the advertisements as a "fact-finding" exercise.

Mr. Teale was sentenced to more than 17 years in prison in December for defrauding thousands of policyholders with a network of shell insurance companies (BI, Dec. 6, 1993).

Future risk managers helped by Spencer scholarship fund

By RODD ZOLKOS

Recognizing the importance of capital investment in advancing an industry, the Spencer Educational Foundation Inc. is working to move risk management forward by investing in one of its most important assets—future generations of risk managers.

Now in its 15th year, the foundation plans to award ten \$10,000 scholarships in May to full-time risk management and insurance students. Applications are due by the end of February; so far, 60 have been received.

Named for the late Robert S. Spencer, a former president of the Risk & Insurance Management Society Inc., the foundation is based in RIMS headquarters in New York.

"It's very pure," said Anita Benedetti, president of the foundation and deputy executive director of

RIMS. "We give out scholarships. We're trying to build the endowment and give out meaningful scholarships."

Since 1980, the foundation has awarded 143 scholarships, including 86 general fund awards.

Candidates must be full-time students, either undergraduate juniors or seniors, master's degree candidates or teaching-oriented Ph.D. candidates.

Candidates must have exceptional grades and typically major in risk management, property/casualty insurance, actuarial science or employee benefits, or minor in one of those fields with a major in finance, accounting, economics, business, health and safety, environmental studies, decision analysis or public administration.

Scholarship winners are selected by the foundation's Education Committee.

The committee's tough standards give the scholarship award particular significance, a previous recipient says.

"The Spencer Educational Foundation is clearly the most recognized and prestigious scholarship that a college student planning a career in risk management and insurance can merit," said Maryann E. Amici, former winner who graduated with honors from Temple University in 1993 and now is an account assistant at Sedgwick James Inc. in New York.

"The respect is due to the thorough process by which recipients are chosen and commitment to recipients after scholarships are awarded," she said.

To further promote awareness of risk management as a career opportunity, the foundation started a high school outreach program in 1991.

Continued on next page

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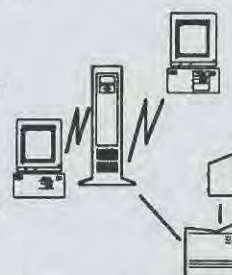
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Continued from previous page

Each year, grants totaling \$5,000 are available to RIMS chapters that submit winning proposals for introducing the concepts of risk management and insurance to high school students and fostering awareness of the field.

"We're beginning to branch out and be able to do more than the ten \$10,000 scholarships," said Anne M. Zug, chairwoman of the Foundation's board and associate vp-insurance and risk management with Main Line Health Inc. in Radnor, Pa.

Over the past two years, the foundation also has started a mentoring program. Ms. Zug, for example, mentors a master's student in Philadelphia.

"I try to keep her posted as to what the market's looking like," said Ms. Zug, who has been on the Spencer board for nine years. She said it's been "very gratifying" to watch students whom the foundation has helped move on to careers in risk management.

The foundation aims to raise \$200,000 in its 1993-1994 fund-raising year. Fund raisers will include its second annual raffle, which will have a \$10,000 grand prize and a \$2,500 second prize. Tickets are \$25 each or five for \$100, and all proceeds benefit the program's endowment fund. The drawing is May 5. Tickets may be purchased by check from the Spencer Educational Foundation.

The other major fund raiser will be a golf tournament at the RIMS conference this spring in New Orleans. For more information about the tournament, call Phil Kerrigan at Arthur J. Gallagher & Co., 714-756-8500.

For more information about the Spencer foundation, contact Ms. Benedetti at 212-286-9292. **[B]**

Prenatal care effectiveness evaluated

Prenatal care at leading health maintenance organizations has dropped their percentage of low birthweight babies below the national average, a recent study finds.

A recent Rand Corp./HMO Quality of Care Consortium study found that 87% of pregnant women covered by six leading HMOs received initial prenatal care during the first trimester, compared with the national average of 76%. As a result of this early care, only about 5% of the babies born to women included in the study had low birthweights. The national average is 7%.

The study focused on 600 randomly selected medical records out of 24,170 live births. The plans studied had a combined enrollment of more than 1.3 million members.

The HMO Quality of Care Consortium consists of 11 managed care plans. The study was based on six randomly selected plans: CIGNA HealthCare of Arizona Inc.; Harvard Community Health Plan; Health Plan of America in Orange County, Calif.; MedCenters Health Plan in Minneapolis; and the Colorado and Northwest Region plans of Kaiser Permanente.

While the study found that average rates of compliance for routine prenatal testing and the provision of routine prenatal services was 80% or more at all six plans, adherence less routine processes varied among the plans. **[B]**

Superfund

Continued from page 1
(BI, Feb. 7).

PRPs that accept their allocation of liability could not be sued by other PRPs. Those that reject the allocation, which would be determined by an independent party, could be held jointly and severally liable for the total cost of cleaning a site. The non-binding allocation process would start over if a PRP were to win its case in court after rejecting an allocation.

The process is further complicated because the EPA does not have to accept any allocation agreements.

PRPs that accept the allocation would be able to tap a trust fund financed by a proposed tax on domestic and foreign liability insurers and reinsurers. PRPs could recover 20%, 40% or 60% of their cleanup costs, up to \$15 million in most cases. The allowable recovery would depend on how favorable case law is for policyholders in the state whose law governs a PRP's case.

Thirty states would fall into the 40% coverage category, and 10 each would fall into the 20% and 60% coverage categories.

The non-binding allocation proposal makes the current liability problem worse because it adds a second layer of litigation to the current system, contends

Lawrence A. Salibra II, senior counsel for Alcan Aluminum Corp.

Alcan is appealing recent federal appeals court decisions that punch a hole in Superfund's strict liability standard, because those rulings do not go far enough in shielding dumpers of innocuous substances from liability (BI, April 26, 1993).

"I really think what they're proposing could do more damage than what they have now," said Mr. Salibra, who favors dumping the current "polluter pays" system.

Other businesses, like chemical manufacturers, also oppose the non-binding allocation proposal. But they want to keep the current liability system because they figure it will be cheaper in the long run.

"We're going to pay for it anyway," explained Pat Kenworthy, director-regulatory affairs for Monsanto Co. in Washington. Citing wasteful efforts by the EPA at sites where the agency has taken charge of cleanup efforts, she said: "The private sector knows how to do things more effectively."

Monsanto and others, including the Business Roundtable, want a binding liability allocation system like the one proposed in another Superfund reform bill, H.R. 3625, introduced in the House last fall.

A binding liability allocation system would prevent the EPA

and PRPs that are unhappy with an allocation from killing a cleanup arrangement, which would waste time and money, Ms. Kenworthy said.

She said the EPA, Rep. Swift's staff and the Justice Department have indicated they will be flexible on this issue.

A non-binding liability allocation system would be more palatable if the EPA were "forced to accept the allocation, unless something is really askew," said Gaylord Bridegan, a member of the Risk & Insurance Management Society Inc.'s Environmental Committee and risk manager for the Decatur, Ill., Park District.

That way, the EPA cannot "screw up everyone's agreement." The RIMS committee, though, has not issued a formal opinion of the administration's proposal.

However, sources say a binding liability allocation arrangement troubles the Justice Department. A non-binding allocation arrangement would, among other things, let the government challenge allocations that would dump too much of a site's cleanup costs on the government.

The proposed insurer-financed trust fund also would not reduce coverage litigation as the administration hopes, said policyholder attorney Nicholas J. Zoogman, a partner with Anderson Kill Olick & Oshinsky of New York.

Noting that policyholders won 13 of 14 major pollution insurance

coverage disputes in 1993 by his firm's reckoning, Mr. Zoogman does not see why many companies would accept an allocation agreement under which they would receive coverage for only 40% or less of their cleanup costs.

The trust fund would be a "tremendous bailout for insurers" because even the billion of dollars they would contribute to it would fall far short of the cleanup costs for which policyholders are covered, he said.

But, the American Insurance Assn. sees "the opposite problem" with the trust fund formula, said Senior Counsel John Arlington in Washington. The AIA argues that the formula does not take into account policyholders' coverage limits, which could allow policyholders to recover more than their limits from insurers.

But, other portions of the administration's proposal appeal to businesses because of their potential for lowering cleanup costs.

For example, the proposal would eliminate what many call ridiculous worst-case assumptions the EPA currently considers when determining how aggressively to clean up a waste site to protect the public's health. Typical assumptions are that an individual will stand naked at the site or that a child will eat dirt on the site for 70 years.

Under the administration's proposal, "the EPA and the public will talk through those crazy as-

sumptions and find ways to do it more realistically," said Monsanto's Ms. Kenworthy.

Hand in hand with that proposed change, the administration would impose less stringent cleanup requirements at sites that would be used for industrial or commercial purposes.

But, the national cleanup standards the administration proposes are vague, business representatives say. As a result, business would not be able to accurately predict its cleanup costs from site to site, said Monsanto's Ms. Kenworthy.

The Chemical Manufacturers Assn. wants national cleanup standards replaced with site-specific standards. Otherwise, "you're going to have to make worst-case assumptions again to make sure you protect everybody," said Dell Perelman, senior assistant general counsel in Washington.

The Business Roundtable and Mr. Bridegan of RIMS also support a provision that caps a municipality's cleanup liability at any given site at 10% of the total cost. Ten percent was the minimum recommended by the business group.

"That's something a municipality can plan on and handle," Mr. Bridegan said.

"I don't think it does any good to put a municipality out of business" by holding it jointly and severally liable for a site's cleanup costs, he said. **[B]**

Superfund rationale

Ruling kills EPA regulation limiting liability

Administration defends retroactive liability provision

By MARK A. HOFMANN

WASHINGTON—Eliminating retroactive liability from the federal Superfund program would result in more litigation than exists under the current law, Clinton administration officials say.

Representatives of the Environmental Protection Agency and the Justice Department defended the liability components of the administration's Superfund reauthorization bill—H.R. 3800—before the House Energy and Commerce Committee's Subcommittee on Transportation and Hazardous Materials last Thursday.

EPA Administrator Carol Browner unveiled the proposal before the same panel on Feb. 3 (BI, Feb. 7).

Last week's hearing was the first of several that the subcommittee is scheduling to examine specific aspects of the Superfund Reform Act of 1994.

In his opening remarks, Subcommittee Chairman Al Swift, D-Wash., said he intends to complete all of the hearings by early March and to begin marking up the measure before Easter.

Rep. Swift is the chief House sponsor of the administration's bill.

Subcommittee members also grilled the witnesses on whether a binding allocation of liability at Superfund sites would not be superior to the non-binding allocation called for in H.R. 3800.

Rep. Swift asked his first witness to explain exactly why the administration had insisted on maintaining the doctrine of "polluter pays," or retroactive liability, in its proposal, even though the provision has been blamed for much of the litigation that has stemmed from Superfund.

Fear of Superfund liability "has drastically changed" the way that corporate America deals with hazardous wastes, causing dumpers of hazardous waste to be much more careful, replied Elliot Laws, assistant administrator in the EPA's Office of Solid Waste and Emergency Response.

Getting rid of retroactive liability now

would disrupt the existing Superfund system and open the way for "a new wave of litigation" as litigants attempted to determine exactly when a certain substance had been dumped, he said.

"The deterrent effect that the current system provides would also disappear," said Mr. Laws. That would in turn lead to increased transaction costs, he said.

Rep. Swift asked how the Clinton approach addresses complaints about the inherent unfairness of retroactive liability. Mr. Laws described a series of breaks for small potentially responsible parties, such as letting certain PRPs escape liability if they were found responsible for dumping less than 10 pounds of hazardous waste at a site.

Turning to the administration's other witness, Deputy Assistant Attorney General

Getting rid of retroactive liability now would disrupt the existing Superfund system and open the way for 'a new wave of litigation,' says Elliot Laws, assistant administrator in the EPA's Office of Solid Waste and Emergency Response.

Myles E. Flynt, Rep. Swift asked if the Justice Department had examined the constitutional questions about creating a binding system of allocation rather than a non-binding one.

Mr. Flynt said that while the issue hadn't been addressed as such, a system of binding allocation would require creating a "mirror image" of the current litigation-based system, with all of its procedural safeguards. Allocating liability could become an even slower process than it is now, he said.

Rep. Swift then noted that H.R. 3800 relies on private allocators rather than federal officials to apportion responsibility among the major PRPs at a given site. He asked why administrative justices could not be used.

To handle the Superfund caseload, the EPA would have to hire between 40 and 60 new administrative law judges, plus clerks and other support personnel, Mr. Laws estimated.

Mr. Flynt added that because the federal government is often named as a PRP, and because administrative law judges work for the government, they might give the appearance of being an interested party.

Rep. Rick Boucher, D-Va., pressed the issue of non-binding vs. binding allocation in his opening remarks and during questioning. Rep. Boucher and Rep. Fred Upton, R-Mich., introduced a bill—H.R. 3624—last fall that would create a system of binding allocation dependent on administrative law judges.

Rep. Boucher asked Mr. Laws if a PRP dissatisfied with a non-binding allocation couldn't simply walk away. Mr. Laws said it was possible but added that PRPs that refuse to accept an allocation can be held jointly and severally for all the unallocated costs of cleaning up a site.

The congressman also asked whether creating a need for more administrative law judges at the EPA wouldn't decrease the demand for them at the Justice Department, a question for which Mr. Flynt had no answer.

Various business representatives presented their cases against the liability system in the Clinton proposal. In his testimony on behalf of the Chemical Manufacturers Assn., Bernard J. Reilly, corporate counsel of E.I. du Pont de Nemours & Co., said the non-binding allocation system provides "a loophole the lawyers can drive a fleet of luxury cars through."

A hint of what to expect at a future hearing regarding the creation of an Environmental Insurance Trust Fund financed by new taxes on property/casualty insurers came in the testimony of Mike McGavick, director of the American Insurance Assn.'s Superfund Improvement Project.

Although the insurance trust fund is designed to help settle disputes between insurers and policyholders for environmental damage caused before Jan. 1, 1986, no one would be forced to draw upon the fund. Policyholders unhappy with what they might recover could continue to sue their insurers.

"The current formula for resolving insurance litigation will not work," he said. **[B]**

WASHINGTON—Financial institutions are "basically acting in the dark" about their Superfund liability after a recent appeals court decision killed a 1992 federal regulation that limited the institutions' pollution liability, a banking industry representative says.

But President Clinton's Superfund reauthorization proposal would restore that protection.

If the proposal is not enacted this year, banks likely will severely cut back on loans, said John Byrne, senior counsel for the American Bankers Assn. in Washington.

The U.S. Environmental Protection Agency in 1992 issued a rule that lenders cannot be held liable for environmental damage caused by borrowers if the lenders were not involved in operating the borrowers' businesses. The rule also extended the protection to trustees of foreclosed property (BI, May 4, 1992).

The EPA's rule was prompted by a 1990 11th U.S. Circuit Court of Appeals ruling that lenders lose their Superfund liability exemption if they make any financial decision connected to borrowers' polluted property (BI, June 4, 1990).

But, the state of Michigan and the Chemical Manufacturers Assn. objected to the rule. They did not want to be prevented from suing lenders.

On Feb. 4, a day after the Clinton proposal was unveiled, the U.S. Circuit Court of Appeals for the District of Columbia said in a 2-1 decision that the EPA acted beyond its authority in drafting the rule.

The court said that only courts may determine a party's Superfund liability. The EPA's authority is limited to ordering parties, which can later appeal, to clean up a Superfund site, according to the court.

The appellate court also rejected the EPA's argument that it was merely interpreting the Superfund law, saying the agency devised—rather than defined—statutory terms.

—By Dave Lenckus

CBO report

Continued from page 3
\$5 billion, the CBO said.

In the CBO's view, "the administration cut itself every favor it could in its costs and revenue estimates," said Sylvester Schieber, director of The Wyatt Co.'s Research and Information Center in Washington.

CBO Director Robert Reischauer was quick to point out that the differences between the administration and CBO estimates are relatively small given that the nation spends about \$1 trillion annually on health care.

But some Washington observers say that any proposal that increases the federal deficit has no chance of passage.

"Anything that adds to the federal deficit is a non-starter," said Rick Smith, director of health care policy at the Assn. of Private Pension & Welfare Plans in Washington.

The CBO report is "the single largest hit the administration has taken on health care reform," said Joel Wood, vp-government affairs for the Council of Insurance Agents & Brokers in Washington.

House Republican Whip Newt Gingrich, R-Ga., said the CBO report makes the Clinton proposal "dead on arrival."

But some Senate Democrats viewed things differently. Sen. Edward Kennedy, D-Mass., suggested that revenue shortfalls might be made up by boosting the proposed excise tax on cigarettes to \$1 a pack from 75 cents.

While it is difficult to gauge how much of a setback the CBO report is for the administration, the timing could not have been worse.

Within days of one another, three major business groups—the Business Roundtable, the U.S. Chamber of Commerce and the National Assn. of Manufacturers—all rejected the administration's health care plan (BI, Feb. 7).

While their specific reasons varied, the groups all said the proposal would give the government

Clinton plan to cost more: HIAA

WASHINGTON—Health insurers assert that health care coverage under President Clinton's reform plan would cost about 33% more on average than the administration's estimates.

The Health Insurance Assn. of America analyzed the total premium that employers and covered individuals and families would have to pay for the Clinton proposal's high cost-sharing standard benefit plan, which resembles a traditional fee-for-service insurance plan.

The HIAA asserts that annual premiums for individual and family coverage would average \$2,509 and \$7,278, respectively. Those figures are about 30% and 67% more, respectively, than the administration's estimates of \$1,932 and \$4,360.

The HIAA's analysis follows on the heels of similar findings by two benefit consultants and a research firm (BI, Jan. 31; Dec. 13, 1993).

—By Dave Lenckus

too much control over health care.

When employers examine the Clinton bill, they see it as "too much government intervention" and control, said Himanshu Patel, vp-marketing support at CNA Insurance Cos. in Chicago.

Indeed, the CBO suggested that the new state-run or -affiliated alliances that are the centerpiece of the Clinton proposal may prove inadequate to the task.

According to the CBO, more than \$750 billion each year—nearly three times the current Department of Defense budget—would flow into the regional alliances, mainly in the form of premium payments from employers and individuals.

Handling such a huge amount of money could be too great a burden for regional alliances, all of which would have to be created from scratch. "Some regional alliances might succeed very well; others might be overwhelmed by these tasks, especially in their early years of operation," the CBO report said.

The report is the "death blow" to regional alliances as proposed by the Clinton administration, said Frank McArdle, a consultant with Hewitt Associates in Washington.

"There was little support on Capitol Hill for the administration's regional alliance structure. They were seen as too big, too bureaucratic and too big a change. The CBO report has confirmed

those fears and concerns," Mr. McArdle said.

Senators last week at a hearing on the CBO report publicly voiced their concerns about regional alliances.

Sen. Kent Conrad, D-N.D., questioned whether regional alliances would have the expertise to manage health care programs.

"I don't think we need these alliances," said Sen. Robert Packwood, R-Ore.

Under the administration proposal, employers with fewer than 5,000 employees would be required to buy coverage from regional alliances. Larger employers could set up their own alliances but would face penalties, including a 1% payroll tax, for doing so.

With three business lobbies rejecting its plan, and now the CBO concluding that it is underfinanced, the administration may have to try new compromises to regain lost momentum.

President Clinton himself recently said he was willing to compromise on all elements of his plan, except its requirement of universal coverage.

Some observers remain skeptical. "In the past, administration officials in private meetings have said, 'We're open to change,' but then nothing happens," said Wyatt's Mr. Schieber.

Mark A. Hofmann contributed to this report.

Reform expected to clear hurdles

WASHINGTON—A "major" health care reform bill will pass during the 103rd Congress, but passage is likely to go right down to the wire as lawmakers prepare to face the voters in November.

That was the message from a diverse group of speakers at the Council of Insurance Agents & Brokers' legislative conference last week.

Rep. John D. Dingell, D-Mich., predicted that the fight over health care reform would continue at least into the summer and possibly into October before lawmakers hit the hustings.

Universal coverage "is a great campaign issue," said Rep. Dingell, a longtime advocate of a single-payer system who is now one of President Clinton's strongest supporters on universal coverage.

The powerful chairman of the Energy and Commerce Committee dismissed the recent criticisms of the Clinton plan by high-profile

business groups. "These are simply skirmishes," he said.

Congress will be under intense pressure to act, said Willis Gradison, president of the Health Insurance

What the final bill will look like is far from certain, says Mr. Gradison. The whole thing is up for grabs.

Assn. of America and a former GOP representative from Ohio.

He predicts that the key House subcommittees will act on health care reform legislation by the middle of next month, with a final bill going to the House floor before the Memorial Day recess.

"It seems quite certain" that the Senate won't move until the House

has finished, said Mr. Gradison. And what the final product will look like is, of course, far from certain. "I think the whole thing is up for grabs," he said.

In the meantime, House Ways and Means Chairman Dan Rostenkowski, D-Ill., will spend a few weeks caucusing with committee members before moving the bill, said Pat Kery, legislative director for Rep. Barbara Kennelly, D-Conn.

"Whatever comes out of the Ways and Means Committee will be called Clinton," even if it doesn't look like the president's current bill, she said. The key question facing the committee is whether its GOP members "are going to play or not," she said.

Ms. Kery added that while "health care reform will die several deaths" during the session, it will be revived because nobody wants to be the lawmaker who killed reform.

—By Mark A. Hofmann

TakeCare/FHP

Continued from page 2

says potential suitors may include Foundation Health Corp. of Rancho Cordova, Calif., PacificCare Health Systems of Cypress, Calif., and United HealthCare Corp. of Minneapolis.

FHP remains ready and willing to sign the agreement with TakeCare, a spokeswoman said.

TakeCare's announcement that it will not sign a definitive agreement with FHP comes three weeks after a group of TakeCare shareholders filed suit to block the acquisition. The disgruntled shareholders claim, among other things, that offers of management bonuses were used to induce TakeCare President R. Judd Jessup to vote for the FHP offer instead of a competing offer. But TakeCare insists that management bonuses were recommended regardless of the ultimate purchaser and that shareholders approved such bonuses.

Updates

Surgeons back single-payer

Continued from page 2

The group's preference for a single-payer system is surprising because most surgeons' salaries would undoubtedly decrease under a government-operated health care system. But the group says the trade-off is worth it, as long as physicians can maintain their autonomy in making medical decisions.

In a statement, the American Medical Assn. opposed a single-payer system, saying it would result in delays in needed medical care.

Aetna downgrade follows loss

HARTFORD, Conn.—Ratings for Aetna Casualty & Surety Co.'s property/casualty units could be downgraded unless operating costs are cut, Standard & Poor's Corp. warned after Aetna reported a \$674 million loss for 1993.

That loss, by far Aetna's worst, followed an \$84 million loss in 1992. Included in the 1993 loss is a \$1.13 billion fourth-quarter loss primarily attributable to \$1.3 billion in charges the company took to add to workers compensation reserves and discontinue guaranteed investment contracts and single-premium annuities.

S&P last week downgraded the claims-paying rating of Aetna Life Insurance Co. to A+ from AA-, citing inadequate reserves to pay losses from the discontinued products. S&P also said the life unit's profit outlook is clouded by federal health care reform proposals.

S&P did affirm the AA- claims-paying ability of Aetna Casualty & Surety despite the \$574 million charge to bolster workers comp reserves. "However, maintenance of the rating will depend on Aetna's ability to improve earnings by bringing down costs to a more competitive level," S&P said.

Clinton backs OSHA bill

WASHINGTON—The Clinton administration will support workplace safety reform legislation backed by organized labor.

Labor Secretary Robert Reich told the Senate Labor and Human Resources Committee last week that the administration backs most provisions of the Comprehensive Occupational Safety and Health Reform Act, S. 575. The bill is opposed by most employer groups, which contend it would unnecessarily raise their costs through mandates like a requirement that all employers with at least 11 employees set up joint labor-management safety committees.

Mr. Reich said that while workplace fatalities have decreased significantly since the Occupational Safety and Health Act was passed in 1970, work-related injury and illness rates have changed little.

"If you can get control of workplace injuries and illnesses, you can get some control of health care costs. Businesses are suffering because of these costs as well as individuals," he said.

Briefly noted

The U.S. Olympic Committee has both general liability and directors and officers liability insurance that would respond to any judgments in a \$25 million lawsuit filed last week by figure skater Tonya Harding, said David Mair, USOC risk manager. The suit, filed Wednesday in federal court in Portland, Ore., alleges that the USOC is interfering with Ms. Harding's right to prepare for the Winter Olympics by giving her only eight days to respond to charges related to the attack on skating rival Nancy Kerrigan. The U.S. Figure Skating Assn. has given Ms. Harding 30 days to respond to similar charges. . . . C. Richard Peterson has been named CEO of Minet Inc., the U.S. unit of Minet Group P.L.C. He had been executive vp of Sedgwick James Inc. . . . A New York insurance broker has settled federal Labor Department charges that he violated ERISA while acting as a trustee of Consolidated Local 867, a purported union formed by con man William Loeb (BI, Dec. 13, 1993). Burton Goldstein and his companies, American Benefits Corp. and Business Marketing Consultants, have been permanently barred from serving an ERISA benefit plan. Mr. Goldstein was also ordered to pay \$25,000 in restitution. . . . A federal judge fined Douglas S. Cruet, former president of the defunct Physicians National Risk Retention Group Inc., \$10,000 for filing a frivolous defamation lawsuit against Louisiana Insurance Commissioner Jim Brown. The Louisiana Insurance Department is pursuing a \$20 million fraud suit against Mr. Cruet and others involved in the insurer's collapse (BI, May 17, 1993). . . . Bermuda-based Chesapeake Insurance Co. Ltd. has agreed to pay \$12 million to the rehabilitator of Mutual Fire, Marine & Inland Insurance Co. to settle litigation over reinsurance claims allegedly owed by Chesapeake. . . . Guardian Royal Exchange P.L.C., one of the U.K.'s biggest multiline insurers, has appointed John Robins, currently finance director of Willis Corroon Group P.L.C., as chief executive designate. Current Guardian Royal CEO Sidney Hopkins will resign June 30. Mr. Robins' replacement at Willis will be Richard Dalzell. . . . Lloyd's of London underwriting group Sturge Holdings P.L.C. is looking for its first group chief executive now that Chairman David Coleridge, former Lloyd's chairman, has decided to retire in June. Mr. Coleridge will become non-executive chairman. After shutting down its flagship syndicates 206 and 210 last year, the Sturge group's remaining syndicates increased its capacity to 665 million pounds this year (\$983.9 million) from 520 million pounds (\$787.5 million) last year. Nine percent of the 1994 capacity is from corporate capital. . . . Merrett Holdings P.L.C. has restructured its once-powerful and now defunct underwriting division into a comprehensive runoff services operation. Chairman Stephen Merrett will be responsible for servicing the runoff of the marine syndicates of Merrett Underwriting Agency Management Ltd. . . . Airline Mutual Insurance Ltd. is entering runoff. The London mutual, which currently insures 90 airlines with a combined fleet value of just under \$90 billion, will stop writing new and renewal business after April 1.

Jump in broker profits seen for '94

By LEONARD M. WILSON

Special to Business Insurance

1993 WAS MEMORABLE in one respect: Pricing failed to turn in commercial lines. Except for the spike in property catastrophe reinsurance and firming in selected lines like aviation and marine, property/casualty pricing was a keen disappointment to investors. Hurricane Andrew had raised high hopes that were dashed by the middle of the year.

Now, insurance brokers face another year of uncertainty for pricing as they formulate profit plans for this year. Risk Averse, a fictional composite representation of the publicly owned insurance brokers, is also faced with the necessity of completing its profit plan for 1994.

Last year's forecast guessed right on economic growth, short-term interest rates and inflation. Having been caught up in the general euphoria that followed Hurricane Andrew, the forecast foundered on the rock of stubbornly competitive premium rates. With continued softness in pricing, revenue growth for the publicly owned insurance brokers was anemic, profit margins remained under pressure and earnings progress was uninspiring.

So now for 1994's projections. First, the tough forecast: premium rates. The Risk Averse budget thinks the unthinkable, another year of competitive rates in liability, with stability in most property lines. Why aren't the profit planners more optimistic? After all, interest rates are low, and underwriters' investment income is now advancing slowly, if at all.

Yet, despite reduced investment yields and underwriting losses, profitability for most companies is pretty solid. Look no further than the fourth-quarter and full-year results of Chubb, AIG and St. Paul, for starters. Look no further than an industry surplus of \$180 billion, a record. Industry distress is the needed ingredient for a turn in pricing, and 1994 won't deliver the requisite degree of discomfort.

The Risk Averse budget thus contemplates a negative impact from premium rates of 3% to 4%, down nominally but mitigated by the firmness in some property sectors and specialty lines like aviation and marine. The question of rates will be re-examined later in the year, in case pricing is not conforming to this forecast.

The economy, in contrast, should be more cooperative. Inventories, payrolls and capital in-

vestment are on the rise. These are the ingredients of higher insurable values. The budget incorporates real economic growth of 3.5% to 4%. Inflation, the other ingredient of insurable values, is now running at an annual rate of 3%. Notwithstanding a brisk economy, the forecast allows for containment of inflation at the same pace for the full year. The combination of real economic growth and inflation should bolster retail premium volume and brokers' commissions by 4% to 5%, conservatively somewhat less than the sum of the two variables.

New business, the bedrock of revenue growth in the extended soft market, is estimated to continue at 9% of the base commission volume, slightly off the pace of recent years, reflecting the duration of the soft market and a rather subdued climate for new business. With lost business projected at 5% of base commissions, new business is calculated to contribute an incremental 4% to commission growth.

Economic variables contribute 4% to 5% to the top line and new business generates 4%. Premium rates are negative at an estimated 3% to 4%. Aggregate commission growth for retail brokerage, therefore, is projected at 5% to 6%.

Short-term interest rates did not budge from a level of about 3% for all of 1993. The economic expansion seems to be gathering steam, and short rates are likely to rise by year end. The budget recognizes a 60-basis-point advance in rates by year end. As a result of a possible rise in interest rates and a 5% to 6% increase in premium throughput, investment income could advance as much as 15% this year.

Consulting revenues were hurt in 1993 by uncertainty over health care reform and the recession. The economy should abate as a negative factor, but clients are in no hurry to conduct large-scale reviews until the shape of the future is revealed. Therefore, consulting is slated for another flat year and possibly slight slippage in profit margins.

Reinsurance brokerage is a relatively bright spot. Pricing is mixed and overall offers little impetus, but more capacity should enable brokers to increase placements and post growth in commissions. Risk Averse expects reinsurance brokerage to achieve a 12% gain in 1994.

Total revenues are the product of the weighted average rise in each of the revenue components. Performing the arithmetic, the profit planners anticipate 1994 revenue growth

of 6% to 7%. A gain of that magnitude appears to be ambitious in light of brokers' revenue growth in the fourth quarter. The forecast relies heavily upon strength in the economy in the absence of firming in commercial insurance prices and perhaps accelerating momentum in operations as the year progresses.

Expenses are driven by headcount, general inflation, bonuses and merit raises. Other operating expenses tend to be semi-variable, rising or falling at a lesser rate than revenues. Risk Averse recognizes the need for disciplined expense control in an uncertain market. Headcount will rise only when there is a clearly evident functional need. The budget allows for a 2% rise in staff numbers over the course of the year. Inflation, bonuses and merit raises add another 3% to the expansion of personnel expenses. In the aggregate, including other operating expenses, costs are pegged at an increase of 5% for the year as a whole.

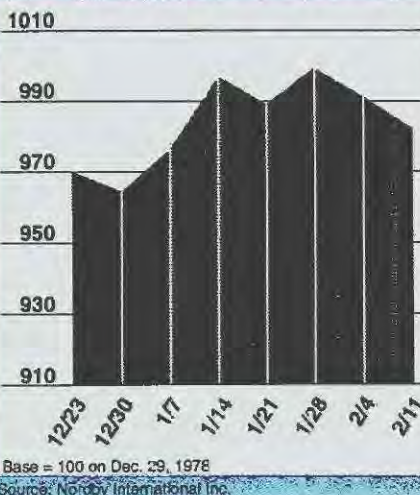
Based on growth of 6% to 7% in revenues and 5% in costs, Risk Averse believes that it can increase earnings at a 12% pace in 1994. This performance would be gratifying in the face of an unchanged insurance market and the strength in the economy as a whole.

Profit plans are management tools and vehicles for codifying organizational goals. As such, they reflect managements' best assessments. For investors, who have watched brokerage stocks underperform lately, an acceleration in earnings progress would provide the catalyst for intensified interest in the stocks. If the Risk Averse profit plan proves to be representative of performance on the part of the public brokers, we would not be surprised to see a marked improvement in the tempo of interest in the stocks. For now, though, skepticism among investors appears to be the prevailing sentiment.



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BI Insurance Index



Insurance stocks fell last week, as the *Business Insurance Index* lost 8.8 points to 982.4 Feb. 11 from 991.2 on Feb. 4. Advancing issues were led by: Acordia Inc., up 9.6%; Guaranty National Corp., up 7.2%; and TakeCare Inc., up 5.5%. Declining issues followed: Navigators Group, down 17.5%; United Fire & Casualty, down 6.4%; and U.S. Healthcare, down 6.1%. The most active issue was U.S. Healthcare, 16.0 million shares traded. The *BI* Index fell 0.9%; the Dow Jones 30 Industrials rose 0.6%; the NYSE Composite rose 0.04%; and the Standard & Poor's 500 rose 0.04%.

British Issues

Feb. 10 Companies	Price pence	P/E	Div. pence	Yield %	1 week	
					High	Low
Comm Union	643	21.4	30.6	4.8	669	643
Genl Accident	370	13.7	24.4	5.1	690	670
Gdn Royal Exch	223	13.3	9.4	4.1	232	223
Royal	313	12.7	8.8	2.8	324	318
Sun Alliance	385	24.1	18.1	4.7	394	385

Brokers		Price	P/E	Div.	Yield	1 week	
						High	Low
Bradstock	454	17.3	6.9	4.5	154	154	154
CE Heath	442	17.3	20.5	4.6	445	439	439
Hogg Group	133	23.2	7.1	5.1	139	137	137
JIB Group	183	16.4	9.5	5.0	189	185	185
Lloyd Thompson	299	20.2	8.4	2.9	299	290	290
Lowndes Lmbt	462	14.4	18.8	4.1	463	461	461
PWS Holdings	77	1.3	5.0	6.5	77	75	75
Sedgwick Grp	18	20.3	7.5	4.0	190	187	187
Steel Bri Jones	117	N/M	11.3	9.7	118	117	117
Willis Corroon	221	21.0	8.3	3.8	223	217	217

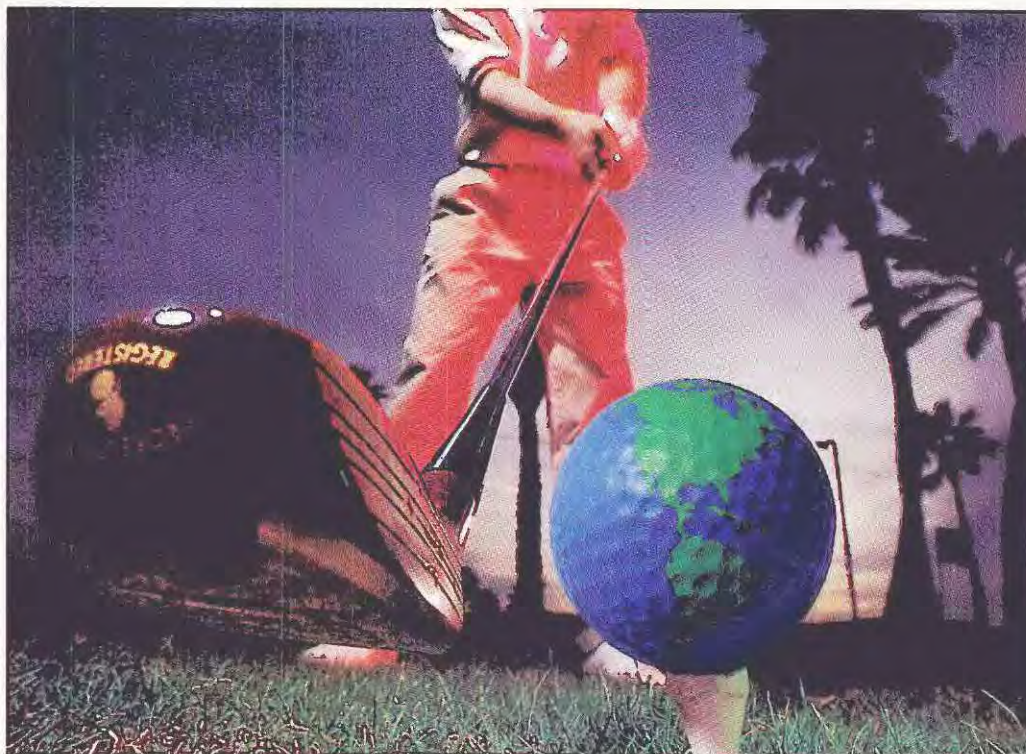
Source: Philip Olsen, London * 1993 figure; others estimated

BI Industry Stock Report

FEB. 7, 1994 THROUGH FEB. 11, 1994

BROKERS													INSURERS/REINSURERS												
		Price	Weekly % change	Year to date % change	High	Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value		Price	Weekly % change	Year to date % change	High	Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value	
Acordia Inc.	NYS	25.75	9.57	4.57	27.63	18.38	205	0.44	1.71	13	10.22	2.52	Mutual Risk Mgmt. Ltd.	NYS	26.63	-1.84	-11.25	32.75	21.16	222	0.23	1.5	19	5.71	4.66
Alexander & Alexander	NYS	20.75	-0.60	4.40	28.00	17.63	273	1.00	4.82	38	6.73	3.08	NAC Re Corp.	OTC	29.75	-2.46	2.15	43.75	27.50	117	0.15	0.54	13	19.24	1.55
E.W. Blanch Holdings Inc.	NYS	17.50	-1.41	0.72	23.50	16.50	2	0.32	1.83	18	4.10	4.27	National Re Corp.	NYS	27.25	-0.46	-11.02	39.63	27.25	156	0.16	0.59	8	16.89	1.61
Gallagher Arthur J. & Co.	NYS	31.50	4.13	-11.89	37.38	25.50	132	0.72	2.29	16	7.52	4.19	Navigators Group	OTC	23.50	-17.54	-32.86	39.00	23.50	86	0.00	0.00	13	16.99	1.38
Hibb, Rogal & Hamilton	NYS	11.75	-1.05	-10.48	16.88	11.38	61	0.48	4.09	18	4.51	2.61	Nobel Insurance LTD.	OTC	7.94	-0.78	4.10	8.44	6.25	57	0.00	0.00	3	6.84	1.16
Marsh & McLennan	NYS	82.13	1.23	0.92	96.00	77.00	732	2.68	3.26	18	16.76	4.90	NWNL Companies	NYS	30.13	-0.82	-7.31	38.75	26.50	787	0.00	2.66	11	23.97	1.26
Poe & Brown	OTC	17.75	-1.39	-1.39	21.25	16.25	42	0.40	2.25	31	3.02	5.88	Ohio Casualty Corp.	OTC	63.50	0.40	-0.78	72.00	57.63	157	2.64	4.7	13	47.88	1.33
BROKERS AVERAGE			1.5	-1.9					2.9	22			Old Republic Int'l	NYS	22.63	1.12	0.56	27.63	21.50	716	0.44	1.4	8	23.57	0.96
													Orion Capital Corp.	NYS	33.00	0.00	6.88	37.50	28.63	43	0.72	2.8	10	25.56	1.29
													Phoenix RE Corp.	OTC	23.50	-6.00	-14.55	38.25	21.50	297	0.28	1.9	14	19.99	1.18
ACE Ltd.	NYS	28.25	1.80	-7.38	36.00	25.50	697	0.40	1.42	5	28.74	0.98	Provident Life	NYS	31.00	0.81	-1.98	31.88	25.63	212	1.04	3.25	-11	26.38	1.18
Acceptance Insurance Cos.	NYS	13.13	2.94	12.90	15.63	9.75	10	0.00	0.00	15	9.85	1.36	Re Capital Corp.	OTC	14.13	0.89	3.67	16.25	13.25	127	0.23	1.88	12	16.88	0.84
AEGON N.V.	NYS	52.00	-2.80	-5.02	58.50	43.25	28	1.22	2.35	11	34.71	1.50	Reliance Group Holdings	NYS	6.75	-1.82	-12.90	10.38	5.83	660	0.32	4.74	14	4.22	1.60
Aetna Life & Casualty	NYS	62.75	2.66	4.15	66.25	43.38	1310	2.76	4.40	22	71.84	0.87	RLI Corp.	NYS	24.63	2.60	-7.94	28.63	23.25	24	0.55	2.7	10	22.91	1.07
Allied Group Inc.	OTC	25.25	3.06	1.00	32.75	21.34	164	0.52	2.06	7	10.45	2.42	St. Paul Companies	NYS	81.25	-5.11	-9.47	98.00	75.00	815	3.00	3.69	8	57.84	1.40
Allmerica Prop. & Casualty	NYS	19.50	-3.11	-9.48	22.16	17.16	172	0.16	0.82	5	56.97	0.34	SAFECO Corp.	OTC	56.38	-1.96	3.20	66.75	51.88	2374	1.63	3.9	10	41.59	1.36
Alstate Corp.	NYS	26.63	-1.84	-10.50	34.25	26.50	2436	0.72	2.70	9	18.43	1.44	SCOR U.S. Corp.	NYS	12.13	1.04	-3.96	20.75	11.50	79	0.32	2.64	9	16.08	0.75
American General	NYS	26.63	0.00	-6.58	36.50	26.25	2357	1.08	4.06	23	22.09	1.21	Seibels Bruce Group	OTC	1.38	0.00	-21.43	2.06	0.31	81	0.00	0.60	0	1.90	0.72
American Heritage Life Ins.	NYS	18.63	3.47	0.00	25.34	17.25	16	0.60	3.22	12	12.42	1.50	Selective Ins. Group	OTC	28.00	-2.61	-7.44	31.00	20.50	37	1.12	4.00	17	23.11	1.21
American Indemnity/Fin'l	OTC	14.00	1.82	7.69	16.25	7.75	12	0.12	0.86	5	16.18	0.87	Sphere Drake Holdings	NYS	16.63	-0.75	0.75	21.63	15.50	61	0.12	0.2	17	12.17	1.37
American International	NYS	88.88	0.85	0.85	100.25	73.41	1970	0.40	0.45	15	45.25	1.96	Statesman Group Inc.	NYS	12.63	2.02	1.00	15.72	9.75	158	0.10	0.79	5	8.65	1.48
American Re Corp.	NYS	29.88	-2.45	5.75	40.25	25.75	230	0.00	0.00	14	14.80	2.02	TIG Holdings	NYS	21.88	2.34	-3.31	28.00	20.25	402	0.20	0.51	-11	18.49	1.18
Aon Corp.	NYS	47.50	0.80	-1.55	58.50	45.00	283	1.80	3.79	11	33.10	1.44	Tokio Marine & Fire	OTC	61.00	2.74	12.96	67.00	46.88	8	0.57	0.61	40	57.72	1.06
Argonaut Group	OTC	30.25	-0.82	-0.82	35.50	28.75	27	1.00	3.31	9	27.65	1.09	Torchmark Corp.	NYS	45.88	-5.90	2.51	64.00	41.13	1045	1.12	2.44	12	17.35	2.64
AYEMCO Corp.	NYS	15.88	-3.05	-15.33	25.50	15.88	179	0.44	2.77	12	8.13	1.95	Transatlantic Holdings	NYS	50.63	-2.64	-5.15	61.50	49.00	41	0.38	0.71	13	29.60	1.71
Baldwin & Lyons Inc.	OTC	15.75	0.00	5.88	16.25	11.16	1	0.20	1.27	10	12.59	1.25	Travelers Corp.	NYS	39.63	1.93	1.93	49.50	26.00	5593	0.48	1.1	10	33.35	1.19
Berkley W.R. Corp.	OTC	35.50	-0.70	8.40	50.25	32.00	909	0.40	1.13	13	28.12	1.26	Trenwick Group Inc.	OTC	35.00	-3.45	-9.68	48.75	35.00	235	0.68	2.11	11	26.00	1.35
Berkshire Hathaway Inc.	NYS	16000.00	0.95	-1.99	17800.00	11800.00	0	0.00	0.00	42	8115.28	1.97	United Fire & Casualty	OTC	36.50	-6.41	1.39	41.00	34.75	3	1.03	2.96	20	26.96	1.26
Chandler Insurance	OTC	6.13	-3.92	11.36	6.63	3.50	9	0.00	0.00	15	8.87	0.69	Unitrin	OTC	41.25	-1.79	-2.94	46.75	39.00	970	1.40	3.29	18	36.90	1.06
Chubb Corp.	NYS	75.88	-2.25	-3.50	96.38	75.13	1486	1.72	2.27	19	46.59	1.63	UNUM Corp.	NYS	51.75	3.24	-1.43	60.13	47.75	1506	0.00	1.55	14	27.55	1.88
CIGNA Corp.	NYS	66.63	0.76	5.34	70.50	56.50	683	3.04	4.56	53	73.85	0.85	US Facilities Corp.	OTC	10.50	0.00	-11.58	14.00	6.50	227	0.00	0.00	10	10.48	1.00
CNA Financial Corp.	NYS	77.75	-0.32	-1.27	100.63	74.25	75	0.00	0.00	-7	77.92	1.00	USF&G Corp.	NYS	15.00	-0.83	-0.83	19.63	12.38	1513	0.20	1.33	16	10.60	1.42
Continental Corp.	NYS	26.75	-0.93	-3.17	34.63	24.38	376	1.00	3.74	11	38.99	0.69	USLICO Corp.	NYS	16.75	-3.88	1.52	19.00	15.50	81	0.24	1.43	-6	25.22	0.66
EDEL Ltd.	NYS	42.75	-1.72	-5.00	52.25	42.25	618	1.20	2.81	6	33.81	1.26	USLIFE Corp.	NYS	39.75	-1.55	2.58	45.75	35.75	127	1.04	3.12	11	41.73	0.95
Fremont General Corp.	NYS	23.38	-0.53	-3.11	28.75	21.00	67	0.72	3.08	8	23.40	1.00	Washington National	NYS	24.00	1.05	-1.03	28.00	21.75	83	1.68	4.50	10	26.40	0.85
Frontier Insurance Group	NYS	42																							

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