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Update

Underwriters refuse to pay Maxwell personal accident claim

LONDON—Insurers are refusing to pay a claim on a personal accident policy covering Robert Maxwell following a report by loss adjusters that the publishing magnate likely committed suicide.

Underwriters already have told Maxwell Communications Corp. P.L.C. that they will not likely pay a claim the company filed against a 20 million pound ($35 million) personal accident policy covering Mr. Maxwell. But, underwriters will meet with Willis Corroon P.L.C., which placed the

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Members predict Lloyd's cash crunch

Refusal to pay cash calls could cause some syndicates to run out of funds

By STACY SHAPIRO

LONDON—Disgruntled Lloyd's of London members contend several syndicates will be unable to pay losses, will exhaust the Central Fund and will need help from the Bank of England this year in light of the refusal by many members to pay cash calls.

The members expect the syndicates will be about 1 billion pounds ($1.76 billion) short of the amount needed to pay the losses, which are owed primarily to other Lloyd's syndicates and London market insurance companies on London market excess-of-loss reinsurance business.

If even one syndicate defaults on a legitimate claim because members won't pay, it would be the first time in history a Lloyd's syndicate did not pay a valid claim.

The members' allegations come as at least 600 members sought injunctions in London's High Court last week to stop Lloyd's from drawing down on members' deposits to pay losses that they have refused to pay.

As of late last week, the court had not ruled on the requests.

Lloyd's Chairman David Coleridge says that under Lloyd's rules, the members must pay their losses. Any refusal to do so will be "fought vigorously," he said. "We can't operate if members don't pay."

- **Members of Parliament continue to bombard Lloyd's with accusations. Page 31**
- **Task force chairman pitches reform proposals. Page 35**
- **Critics seek investigation of LMX losses. Page 36**

Lloyd's will "strongly" oppose the request for injunctions, he said.

Meanwhile, Lloyd's denies that it is talking with the Bank of England to ease a possible liquidity crunch later in the year.

"As the bank itself has confirmed, Lloyd's centrally is not and has not been involved in any discussion with the bank nor has any request been made for assistance from the bank or from government ministers," a Lloyd's statement said.

A Lloyd's spokesman says Lloyd's knows of no individual who has spoken to the Bank of England about a need for cash.

"The Corporation of Lloyd's is free from debt," the statement continued. "It has firm and committed lines of credit in place to deal with any unforeseen eventuality."

Lloyd's has arranged two lines of credit to ensure that Lloyd's meets the premium deposit requirements imposed by certain non-North American governments, the spokesman explained.

The total declared resources behind Lloyd's policies amount to 18 billion pounds ($31.6 billion), but this includes all members' personal assets. This amount includes members' deposits, personal reserves and special reserves totaling around 4.4 billion pounds ($7.73

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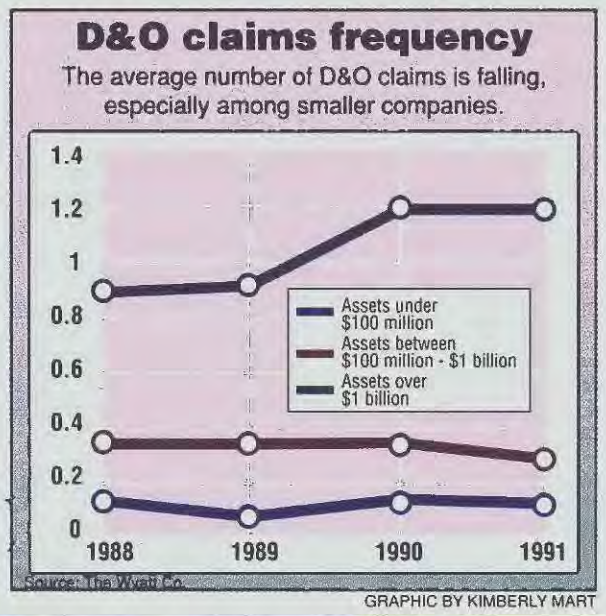
D&O claims severity still rising

But frequency of D&O suits shows signs of leveling off, says latest Wyatt survey



GRAPHIC BY KIMBERLY MART

By MARK A. HOFMANN

Directors and officers liability claims frequency may be leveling off, but the severity of these claims continues to grow, according to a new survey.

And while D&O premium increases outnumbered premium cuts by more than a 2-to-1 margin among respondents renewing their coverage, the size of those increases was modest, typically ranging from 5% to 8%, the survey from The Wyatt Co. says.

Wyatt also reported that mergers and acquisitions remain the most common source of D&O claims, though there was an increase in the number of claims generated both by poor financial performance and by inadequate or inaccurate financial disclosure.

"With the exception of large banks, and a few other industry niches which registered double-digit increases in premium, the market was fairly soft. Many large, standard risks were renewed with no change in premium. Expectations for

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Insurers may pay $100 million share of Drexel settlement

By MICHAEL BRADFORD

NEW YORK—Several insurers are negotiating to pay part of a $900 million settlement of civil suits against junk bond financier Michael Milken and other former officials of failed Drexel Burnham Lambert Inc.

Mr. Milken

Contributions from directors and officers insurers and possibly other insurers—said to be $100 million—are part of the tentative settlement that includes $500 million from Mr. Milken and $300 million from other former Drexel officials. Mr. Milken already has paid $400 million to government regulators in the wake of the scandal that led to his arrest and forced Drexel into bankruptcy in 1990.

Mr. Milken now is serving a 10-year sentence in a California prison following his con-

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Tax proposal includes 401(k) changes

By JERRY GEISEL

WASHINGTON—The House of Representatives could consider as early as this week a new tax package that includes changes in the non-discrimination tests for 401(k) plans as well as other pension and benefits changes.

However, the package is not expected to include a series of reforms proposed by the Bush administration to improve pension plan funding and to make the Pension Benefit Guaranty Corp. less vulnerable to big losses from the termination of underfunded plans.

Late last week, House Democrats still were making last-minute changes to the package; complete details were not available.

However, the package does include a provision—first proposed in 1990 by Rep. Rod Chandler, R-Wash., and Sen. David Pryor, D-Ark.—that would establish two new safe harbors for 401(k) plans. Plans qualifying for either of the safe harbors would not be subject to non-discrimination tests, which are run to determine whether contributions by high-paid employees exceed contributions by lower-paid employees by legally prescribed amounts.

The safe harbors would help 'a small minority of employers,' says Hewitt's Mr. McArdle.

Under the proposed safe harbors, an employer would have to either:

- Provide matching contributions equal to 100% of employee elective contributions, up to 3% of employee compensation. It also would have to provide matching contributions equal to 50% of employee contributions between 3% and 5% of employee compensation.
- Automatically make contributions equal to at least 3% of employee compensation regardless of whether employees actually contributed to the plan.

Employer contributions would have to be immediately vested under either safe harbor.

While the safe harbors are well-intentioned, they would be of little use to most employers unless companies beefed up their 401(k) matching contributions, benefit experts say.

For example, employers typically match only 50% of employee contributions to 401(k) plans, up to a maximum 6% of compensation. As a result, to qualify for either safe harbor, employers would have to significantly increase their contributions to their 401(k) plans.

"The bottom line is that for a

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Update

Maxwell accident claim denied

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coverage, to discuss the claim and study any new evidence.

The report was prepared by loss adjuster Rich Wheeler & Co. of London. It concludes that there are "reasonable grounds" to believe that Mr. Maxwell took his own life to avoid ignominy over the anticipated collapse of his publishing empire which occurred shortly after his death, confirmed lead underwriter Patrick Slade, underwriter for syndicate 782, managed by Oxford Underwriting Agencies Ltd.

Central to the loss adjuster's argument was the fact that Mr. Maxwell's room on the yacht was found locked after he was discovered missing. Mr. Maxwell did not usually lock his door and would probably not have done so if he had just stepped out for some air, the loss adjuster said.

The adjuster's report also said that Mr. Maxwell was unusually civil to the crew on the night preceding his death.

Cap punitive damages: Bush

WASHINGTON—The Bush administration is calling for states to cap punitive damage awards as part of its ongoing campaign for civil justice reforms to enhance the nation's economic performance.

A model state punitive damages statute recently unveiled by Vice President Dan Quayle would limit punitive damages to no more than the total compensatory damages awarded. The model law is part of the administration's larger package of proposed state and federal tort reforms (*BI*, Feb. 17; Feb. 10).

"The current common law approach of unlimited punitive damages leads to indiscriminate awards," says the President's Council on Competitiveness, which Mr. Quayle chairs. "If punitive damages are to be an effective deterrent, they must be imposed in a rational and effective manner."

The model law also would require plaintiffs to inform defendants at least 30 days before filing suit that they will seek punitive damages; forbid requests for specified punitive damages; require plaintiffs to prove that defendants acted with malice; mandate bifurcated trials in cases potentially involving punitive damages, with the jury deciding whether to impose punitive damages in a separate proceeding after determining liability; and that judges, rather than juries, determine the amount of punitive damages.

The U.S. Supreme Court last year ruled that the due process clause of the 14th Amendment does not mandate restrictions on jury awards of punitive damages (*BI*, March 11, 1991).

Lloyd's LMX loss probe

LONDON—The chairman of the U.K. Securities and Investments Board will oversee two internal investigations into the huge losses that some Lloyd's of London syndicates face from London market excess-of-loss reinsurance.

Lloyd's announced Friday that Sir David Walker, a non-Lloyd's member who sits on the Council of Lloyd's, will oversee the review of huge losses suffered by a small number of LMX syndicates in 1988 and 1989. He also will investigate allegations that the so-called LMX spiral benefitted brokers and underwriters unfairly at the expense of Lloyd's members who do not work in the market.

Members of Parliament and some Lloyd's members this week are expected to demand an investigation of the LMX market by an independent accounting firm (see earlier story, page 36).

Meanwhile, a new members' action group was set up last week to seek up to 6 million pounds ($10.5 million) in compensation for losses in 1985 from syndicate 384, managed by Aragorn Agencies Ltd.

Pollution study not covered

SAN MATEO, Calif.—Aerojet-General Corp. lost another round in its battle to win coverage for a massive pollution cleanup.

In one of the first verdicts of its kind, a San Mateo County Court jury ruled Feb. 11 that the defense contractor cannot recoup $28.6 million in costs for wells drilled to investigate groundwater pollution at its Sacramento facility. The jury ruled that these costs are not legal defense costs within the meaning of Aerojet's comprehensive general liability insurance policies.

"This is just an attempt by the policyholder to take a second bite of the apple," said insurer attorney Richard Seabolt of Hancock, Rothert & Bunshoft in San Francisco. "Lawyers don't drill 1,400 groundwater-monitoring wells in order to prove that their clients have contaminated 8 trillion gallons of groundwater."

La Jolla, Calif.-based Aerojet says it will appeal this ruling along with an earlier ruling that the company knew it was polluting the environment and, therefore, cannot tap its liability policies (*BI*, Jan. 20).

California warning law tested

NAPA, Calif.—In the first case to go to trial under California's Proposition 65, a garment manufacturer that exposed workers to the toxic chemical perchloroethylene was found not to have violated the law because the exposure was not intentional.

Sawyer of Napa Inc. could have been liable for "billions" of dollars in penalties had it lost the case, said Kurt Weissmuller, an attorney for Sawyer with Heller, Ehrman, White & McAuliffe in Los Angeles.

The plaintiffs, Citizens for a Better Environment and the International Ladies Garment Workers Union, may appeal the judge's ruling, which could be "discouraging" to plaintiffs bringing other Proposition 65 actions, said Roger Beers, a San Francisco attorney who represents CBE.

The judge used "very restrictive standards" in applying the law, even though Proposition 65 is "fairly straightforward" in requiring companies to warn employees and the public about exposure to hazardous substances, Mr. Beers said.

Proposition 65 requires all California businesses with 10 or more employees to issue "clear and reasonable" warnings if they expose their employees or the public to more than 350 substances that pose a significant risk of cancer or birth defects (*BI*, April 4, 1988; Feb. 29, 1988).

Updates continued on page 38

Maine work comp market facing uncertain future

By MEG FLETCHER

AUGUSTA, Maine—The future of Maine's beleaguered workers compensation system is uncertain as a capacity shortfall in the state's residual market looms.

One of the state's three servicing insurers for the residual market—in which about 90% of the state's workers comp risks are written—already has reached its self-imposed cap.

And, the other two servicing companies are close behind, said William Vieweg, assistant vp with the National Council on Compensation Insurance, which manages the state's residual market pool.

The insurers are allowed to set those caps to ensure their solvency.

State insurance officials are taking steps to keep the system operating, but several legislators and groups are proposing significant changes or alternatives to the current system.

"The future is definitely vague, uncertain and unchartered," said Joel Russ, vp and general counsel of the Maine Chamber of Commerce and Industry in Augusta.

"Most employers are waiting and watching. There is not much they think they can do or, in fact, can do," he said.

"The state of Maine just keeps plodding along," said Joseph A. DiGiovanni Jr., vp of the New England region for the American Insurance Assn. in Boston.

The most pressing problem is the evaporation of capacity for new risks underwritten in the state's residual market.

Hanover Insurance Co. of Worcester, Mass., is no longer accepting new business after reaching its $85 million cap last month. At the same time, Commercial Union Insurance Co. is closing in on its $60 million cap, and Maine Bonding & Casualty Co. of Portland, a Maryland Casualty Co. unit, is nearing its $30 million cap.

The trio of insurers was lured back to the state after a new 90-day emergency rule changed the way deficits in Maine's workers comp residual market for the 1992 policy year will be allocated among insurers.

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Antitrust review opposed

Attorneys general say reinstatement of case follows precedent

By JUDY GREENWALD

WASHINGTON—An appellate court's reinstatement of the massive insurance industry antitrust litigation does not raise issues of "exceptional legal and practical importance" that would warrant U.S. Supreme Court review, state attorneys general say.

In their brief filed Feb. 14, the attorneys general—who brought the antitrust action—argue the decision by the 9th U.S. Circuit Court of Appeals to reinstate the case is "faithful" to previous Supreme Court decisions.

"In no respect does the case present questions of exceptional legal and practical importance," the brief states. "Defendants cannot seriously contend that the egregious conduct described in plaintiffs' complaints must be countenanced to assure the survival of the insurance industry."

However, five amicus curiae briefs urging Supreme Court review of the case warn that the appellate decision could seriously disrupt the insurance industry (see story, page 37).

In addition, domestic defendants on Wednesday filed their own sharply worded response to the attorneys general. "Long on conclusory rhetoric, but short on substantive legal analysis" is how the defendants described the attorneys general's brief.

The brief filed by the attorneys general responded to several petitions filed in January by insurance industry defendants that asked the high court to review the 9th Circuit's decision (*BI*, Jan. 20; Jan. 13).

The Supreme Court could decide whether to hear the case by early March, said Mark I. Levy, an attorney with Mayer, Brown & Platt in Chicago, whose firm submitted a brief on behalf of the domestic defendants.

Mr. Levy noted there is a small possibility that the Supreme Court, before deciding whether to hear the case, will ask the U.S. Solicitor general to submit a brief outlining

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Municipal liability reinsurer enters rehabilitation in Ohio

By DOUGLAS McLEOD

COLUMBUS, Ohio—A municipal liability reinsurer controlled by insurance executive Wade R. Waterman has entered rehabilitation after Ohio regulators declared it insolvent by $2.3 million as of Sept. 30.

Governmental Casualty Insurance Co. of Dublin, Ohio, agreed to a rehabilitation order Feb. 10 after examiners found more than half its $8 million in assets had either been transferred to affiliated companies and individuals or were of questionable value.

The rehabilitation order is the latest in a series of regulatory and legal setbacks for Mr. Waterman and companies he has controlled.

American Commercial Liability Insurance Co., a Grand Rapids insurer Mr. Waterman owns, was placed under Michigan Insurance Bureau supervision last year. Regulators later petitioned to place it in rehabilitation (*BI*, July 8, 1991).

The petition still was pending last week; a hearing was scheduled for Friday.

The Michigan attorney general also filed criminal charges against Mr. Waterman last October, accusing him of illegally borrowing $5 million from ACLIC (*BI*, Oct. 21, 1991).

Mr. Waterman has pleaded not guilty. A trial scheduled to begin March 11 may be postponed until May, a spokesman for the attorney general said.

Mr. Waterman also headed Governmental Risk Managers Inc. of Livonia, Mich., which provided underwriting and risk control services to the Michigan Municipal Risk Management Authority (*BI*, Feb. 16, 1987).

That contract was canceled after the charges against Mr. Waterman were filed.

GCIC, formed in 1986, was

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Administration defends health package

By JERRY GEISEL

WASHINGTON—Administration officials are defending President Bush's health care reform proposals amid Democratic charges that the package does not go nearly far enough to expand coverage to the uninsured.

Health and Human Services Secretary Louis W. Sullivan told a Senate panel last week that nearly 90 million Americans would benefit from the administration's plan to provide expanded tax credits and tax deductions to help lower- and middle-income individuals purchase health insurance.

The maximum tax credit of $3,750—available to a family earning up to 100% of the federal poverty level—would be sufficient to purchase a basic health care plan for a family, Dr. Sullivan told the Senate Finance Committee.

The administration estimates that its package would reduce the number of Americans without any health insurance to about 5 million from the current 35.7 million. With the expansion of coverage, there will be a significant reduction in hospital cost shifting to patients covered under employer-sponsored health care plans, he said.

In addition, improving access to coverage would mean individuals would receive better care at lower costs, he said, noting that hospital emergency room care can be about five times more expensive than care provided in a doctor's office.

"If you have influenza, it is better to get care in the doctor's office than an emergency room," he said.

At the same time, Dr. Sullivan warned against radical changes to the nation's health care delivery system, which he described as the world's finest and most innovative.

Health and Human Services Secretary Louis W. Sullivan told a Senate panel that nearly 90 million Americans would benefit from the administration's health care reform plan.

"We want change, but not at the expense of endangering our system," he said.

But congressional Democrats said at the hearing that the administration's health care reform package does not go far enough.

To describe the administration's package as comprehensive "strains credulity," said Sen. John D. Rockefeller IV, D-W.Va., adding that even with tax credits and tax deductions the cost of health insurance still would be out of reach for many workers.

"I fear we are headed for the wrong solution. We need something bold," said Sen. Thomas Daschle, D-S.D., adding that he doesn't believe the administration's package would do much to help the 100,000 uninsured South Dakotans.

Last week's Finance Committee hearing was yet another in the dozens of congressional hearings during the current session on health care reform. But it was the first, with many more likely to follow, on the administration's reform package.

Key elements of the package, unveiled Feb. 6 in Cleveland by President Bush (*BI*, Feb. 10), include:

- New tax credits and deductions to help the poor and middle-class purchase health insurance.

The credit also could take the form of a certificate that could be transferred to an insurer to purchase coverage. The credit could

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How Garamendi's proposal would work

- All state residents guaranteed health care coverage
- All health care, including treatment of workplace injuries and auto accident injuries, to be provided by single plan
- Employers to pay 6.75% payroll tax; employees to pay 1% tax on wages
- Tax breaks for small employers and low-wage workers
- Employer health care plans and commercial health insurance severely restricted
- All citizens to be assigned to regional health insurance purchasing corporations, which would purchase basic care from HMOs
- Citizens or employers could purchase broader coverage from certified health care plans

California health proposal

Garamendi's 24-hour coverage plan gets mixed reviews

By LOUISE KERTESZ

SACRAMENTO, Calif.—A 24-hour universal health care plan proposed by Insurance Commissioner John Garamendi would shave California employers' health care costs and trim $1 billion in workers compensation costs annually, its proponents say.

But some employers and insurers are skeptical about what they say is a sketchy 46-page proposal to provide health care to all Californians.

Some fear that the plan would not deliver promised savings, but would put California companies at a competitive disadvantage by adding an unneeded layer of bureaucracy.

Others are concerned that employers would rather relocate than deal with such a radically new system, which would eliminate most employer-provided health plans and impose copayment requirements on workers injured on the job.

And, the proposal would severely restrict commercial health insurance operations in California.

The plan is expected to be formalized and introduced as a bill during this session of the Legislature, said Walter Zelman, special deputy commissioner for health insurance with the Insurance Department. As of late last week, no sponsor had been lined up for the plan, which the department estimates would cost employers and workers $34 billion annually.

The commissioner's Health Care Advisory Committee rejected incremental reforms—like those proposed by President Bush (*BI*, Feb. 17; Feb. 10)—unless they are part of "a defined goal of systemic reform," according to the proposal.

Under Mr. Garamendi's 24-hour universal health care plan, all individuals—regardless of age or sex—would be covered without waiting periods or exclusions for pre-existing conditions. Californians would be covered regardless of whether they sustained injuries or illnesses on or off their jobs or in automobile accidents.

The universal care plan would establish so-called regional health insurance purchasing corporations that would collect a 6.75% payroll tax from all employers and a 1% tax on employees' wages. This funding mechanism would avoid running afoul of the Employee Retirement Income Security Act of 1974 by taxing self-funded employers' payrolls, not their health plans.

Small employers and low-income workers would be taxed somewhat less.

It is not clear how multistate employers with operations in California and their workers would be treated.

The HIPCs would use the tax funds to purchase basic health insurance from health maintenance

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Lawyers, judges support limited tort reform: Study

By STACY GORDON

CHICAGO—Most defense lawyers, plaintiffs' lawyers and judges support reforming the civil justice system, which they perceive as only working "somewhat well," according to a study.

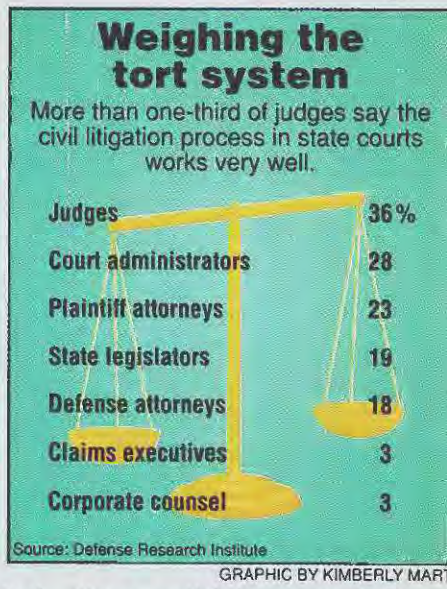
"The depth of the discontent with the civil justice system is remarkable," said Lou Potter, executive director of the Defense Research Institute in Chicago, which conducted the survey. "But there is still a belief that the system is worth saving."

In the first effort of its kind, attorneys, state court judges, court administrators, insurance claims executives, corporate legal counsel and state legislators were interviewed for the study titled "Civil Litigation in State Courts: Perspectives on the Process and Preferences for Reform."

The study was commissioned by the DRI, the nation's largest defense bar group with 18,000 members. The study was conducted by Research & Forecasts Inc., a research firm based in New York.

While the study purports to be an unbiased sampling, defense attorneys outnumbered plaintiffs' attorneys 2 to 1 in the sampling. The results of the survey are based on 803 telephone interviews.

Most of those responding—59%—say the civil justice system is working only "somewhat well," vs. 18% who believe the system works "very well." The remaining respondents expressed negative feelings about the overall process.



GRAPHIC BY KIMBERLY MART

The main criticisms leveled against the system relate to issues of "efficiency" rather than "quality," according to the survey.

Some 69% of the respondents cited delays, heavy case loads, crowded court dockets, frivolous claims and the jury selection system as factors contributing to the inefficiency of the judicial system.

In contrast, only 25% criticized the "quality" of the system, including the quality of judges and preparedness of lawyers.

Some 23% of the respondents faulted "rules/procedures" such as

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Nothing but bad news for U.S. brokers

By LORI BLOCK

There were few silver linings in the 1991 results of the publicly traded insurance brokers, and 1992's forecast is just as dreary.

Lackluster, even poor, results were the norm as U.S. brokers continued to struggle with a soft insurance market, the recession and low interest rates.

Indeed, the latter factor was the year's "crowning indignity" for brokers, observed Michael A. Smith, a vp with Lehman Brothers in New York.

The 1991 fourth-quarter and year-end results for six of the top seven publicly traded brokers reflect that property/casualty insurance rates remained flat throughout 1991, while the recession took a bite out of insurance services and consulting revenues, and lower short-term interest rates depressed investment income.

This year, the property/casualty insurance market "is still as competitive and challenging as ever," observed Arthur Quern, chairman and chief executive officer of Chicago-based Rollins Burdick Hunter Co., the retail brokerage unit of Rollins Burdick Hunter Group Inc.

"And the economic factors in 1991 produced even more of a challenge," he said.

Revenue gains among the publicly held brokers ranged from a high of 5.1% for RBH Group to a low of 2.1% for Marsh & McLennan Cos. Inc.

The best bottom-line performers during 1991 were Poe & Associates Inc. and Hilb, Rogal & Hamilton Co., which posted net income gains of 12% and 4.5%, respectively. The other brokers' profits were flat or down.

As of late last week, Frank B. Hall & Co. Inc. had not released its fourth-quarter or year-end results.

However, securities analysts are not critical of brokers' results, observing that there is little the companies can do to improve their situation.

"Insurance brokers are clearly hostage to the insurance cycle, and they are not immune to the recession," said Vanessa Wilson, an equity researcher with The First Boston Corp. in New York. These results "are exactly in line with what everybody expects. It's a soft market, and interest rates are down."

And, while few of the brokers were able to keep expenses from rising faster than revenues, analysts credit them for doing a good job in controlling costs.

"They're not doing a bad job, by any means," of controlling expenses, said Lehman's Mr. Smith. "The trouble is their revenues have been hit very hard. You can't fault the brokers for their expenses."

Sam Liss, director of research for Salomon Brothers Inc. in New York, concurs.

After a few years of holding the line on employee compensation, "brokers are obliged to pass through 3% to 5% increases," he said.

"I'm just not sure you can get expense (increases) down to zero," added Ms. Wilson of First Boston.

"The biggest problem is top line growth," she said, referring to the lack of revenue gains.

Unfortunately for brokers, there was little opportunity for such growth last year. Not only were consulting revenues kept in check by the recession and investment income dramatically off because of the sharp decline in short-term interest rates, commissions also were held nearly flat because of soft insurance rates.

"The combination of those three

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Maine work comp

Continued from page 2

The new allocation formula was designed to reduce the burden of residual market assessments on large writers of workers comp insurance and increase the burden on casualty insurers that write little or no workers comp insurance in the state (*BI*, Jan. 13).

The emergency rule is set to expire March 6. Richard Johnson, acting superintendent of Maine's Bureau of Insurance, said he expects to file a permanent version of the rule by Friday with the Secretary of State to meet a seven-day notice requirement.

The final version of the rule will be substantially similar to the emergency rule. Only slight modifications have been made, said Mr. Johnson, who declined to provide details.

But, while the rule attracted the three servicing carriers, it likely will not attract additional insurers to underwrite residual market risks, insurers say.

"The carriers are concerned about the residual market burden," said John Casner, the NCCI's regional director of government, consumer and industry affairs.

In addition, insurers are waiting to see how the state bureau responds to the NCCI request for a 32.2% average rate increase for both the voluntary and involuntary market beginning May 1.

The NCCI has promised to provide the Insurance Bureau as much notice as possible of an imminent capacity cutoff. While the Boca Raton, Fla.-based organization formally notified Mr. Johnson earlier this month that no new capacity was anticipated, capacity had not evaporated as of late last week, Mr. Vieweg said.

Once that point is reached, Maine's insurance law gives Mr. Johnson two primary ways to keep the system operating:

- Award service contracts through a bidding process.

Companies could compete on factors like servicing fee and operational capabilities.

The contracts could be awarded to a company that is not an insurer, like a third-party administrator. A TPA would have to have at least a working relationship with an insurer that can issue policies, Mr. Johnson said.

- Order the NCCI to make servicing assignments to all insurers licensed to write workers comp and employers liability insurance in the state.

"Our intent at this time would be to use carriers that could service employers—that is, carriers that have written comp," Mr. Johnson said. "It doesn't do any good to assign policies to a carrier that doesn't write comp."

However, he said the Insurance Bureau's plans may change because of insurer "resistance" and other factors.

The NCCI's Mr. Casner said an important factor in the state is the "fluid" political situation.

For example, a few legislators are expected to propose funding and implementing a competitive state fund that the Democratic-controlled Legislature authorized earlier this year.

Gov. John R. McKernan Jr., a Republican, opposes appropriating state money at this time to implement the fund, Mr. Johnson said. The governor plans to introduce a workers comp reform package later, he added.

A handful of other legislators have introduced workers comp reform bills, including one that proposes 24-hour coverage.

It remains to be seen, though, whether the Democratic leadership has the will to consider the reform bills, Mr. DiGiovanni said.

Meanwhile, legislators are facing a threat to their authority to deal with the situation. A citizen initiative would reform the state's workers comp system by closing loopholes that require workers comp coverage to pay for employee medical problems that have little or no connection to the workplace.

The Secretary of State's office is now verifying the more than 53,000 signatures that the Maine Citizens for Justice in the Workplace collected to put a reform proposal on the November election ballot.

Essentially, the proposal would change Maine law "to limit workers compensation benefits to work-related injuries and to limit benefits to only the portion of incapacity or treatment caused by the work-related injury."

Maine Citizens for Justice explains: "Maine's current workers compensation law specifies that an injury was 'more likely than not' caused by work. As a result, a host of issues fall under workers compensation coverage. Loopholes allow unrelated or casually connected problems to be compensated, essentially making workers compensation a catch-all health insurance program and human services system."

Chairing the coalition is Steven Tremblay, executive director of Alpha One, an independent living center in Portland for people with disabilities. Mr. Tremblay blames the loopholes in Maine's workers comp law for employers' reluctance to hire disabled persons.

Also, other parties are taking steps to usher in workers comp reform.

Currently, a group of seven employer and seven labor union representatives are researching other states' workers comp systems. They are seeking a good system Maine can adopt as a model.

A local newspaper is calling for the establishment of a "blue ribbon" commission to study the state's workers comp problems and propose solutions. ■

Comp insurer must pay claim from beer breaks at Stroh brewery

DETROIT—Stroh Brewery Co.'s workers compensation insurer will pay $85,000 in workers comp benefits to the widow of a former employee whose alcoholism was fostered by the brewer's policy of serving employees unlimited beer during breaks.

The 15-year-old case concluded last week when the Michigan Supreme Court refused to review it. Stroh had appealed a Michigan Court of Appeals ruling that upheld a state workers compensation appeals board decision that alcoholism is compensable if a corporate policy contributes to the condition.

"This ruling confirms that alcoholism is a disease just like other diseases. And, if it can be proven that the condition is related to employment, then it's compensable under the state's workers compensation laws," said Norton Cohen of Miller, Cohen, Martens & Ice in Southfield, Mich., the attorney for the family of Casimer A. Gacioch.

The brewer fired Mr. Gacioch in late 1974 after it concluded that Mr. Gacioch's drinking habits were hampering his work performance (*BI*, Nov. 5, 1990). In early 1977, Mr. Gacioch filed a claim seeking two years of workers comp benefits.

Because of the state high court's refusal to review the case, Michigan Mutual Insurance Co. of Detroit, which insured Stroh's workers comp risks through 1982, will pay the full amount of the claim.

Mr. Gacioch died in 1982 after accidentally setting himself on fire while smoking during inpatient treatment for an alcohol-related disease.

—By Michael Schachner

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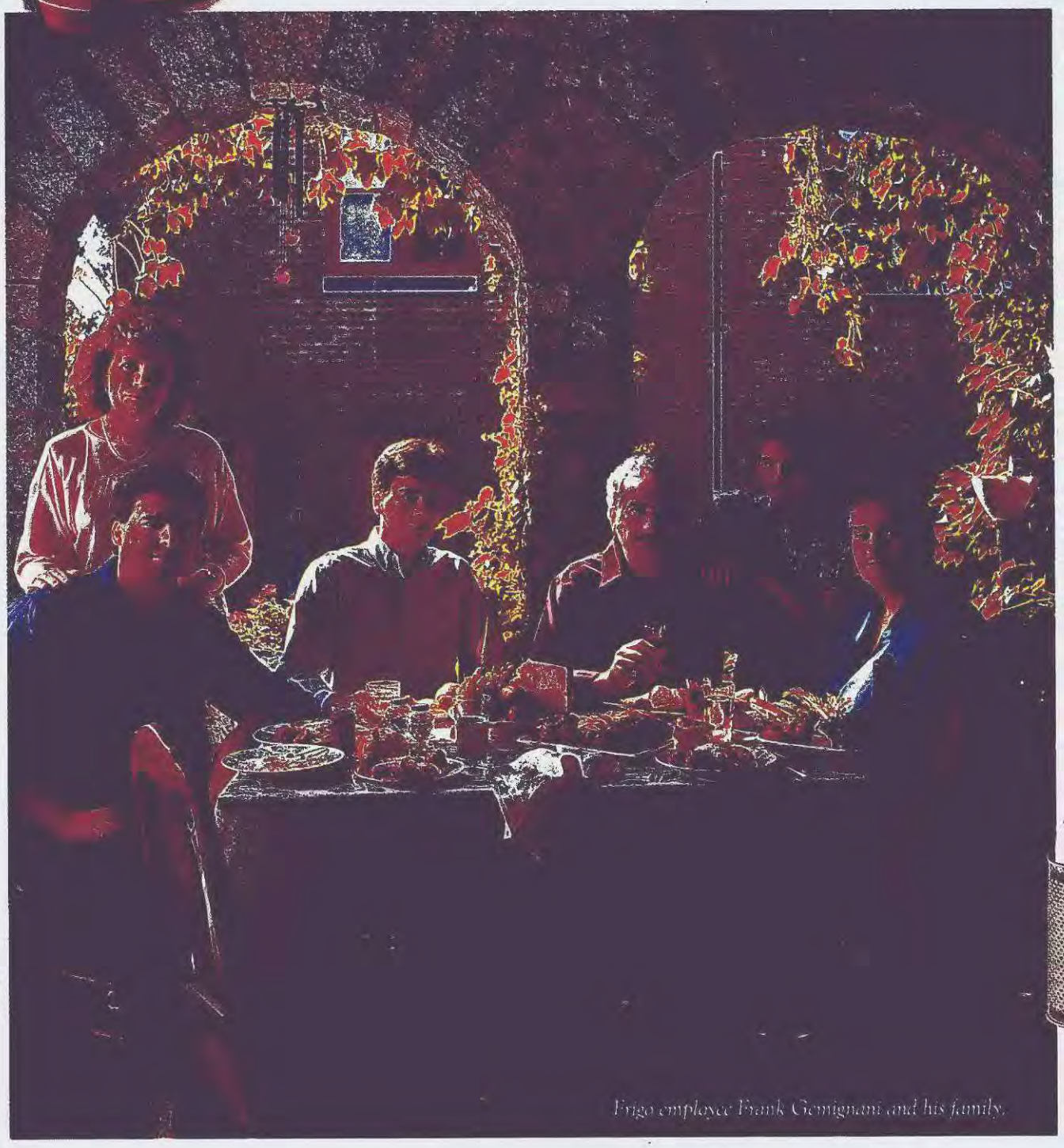
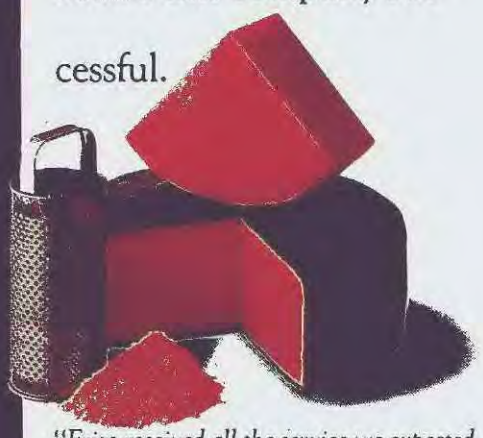
"People make a difference at Frigo. So does Wausau."

Frigo Cheese has a unique way of viewing the cheese making process. While they have high-tech computers and automated production lines, their authentic Italian cheeses are still made by authentic cheese makers.



Frigo employee Frank Genignani and his family.

"People make this company work," says David Leonhardt, President of this Green Bay, Wisconsin, company. "And, it's the quality of these people — how they feel about themselves, their sense of accomplishment — that makes this company successful.



"Frigo received all the service we expected with a Wausau 401(k); our earnings were even better than expected": David Leonhardt, President, Frigo Cheese Corp.

"To offer our people the best possible employee benefit plans, we look to Wausau Insurance as a provider of personal service. Our employees have people to talk to at Wausau — people they know.

"And there's an intangible, too. When our employees hear 'Wausau', they're reassured. It's Wausau's image, their service reputation, that gives our employees a good, comfortable feeling."

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School district targets mental health costs

The Los Angeles Unified School District expects to save about $1.8 million in the first year of a three-year managed mental health and substance abuse treatment plan—and even more in subsequent years—though the plan substantially improves mental health benefits.

By requiring its 75,000 active employees and retirees and their dependents to receive all mental health care through a network of Los Angeles-area mental health care providers, the school district expects to substantially reduce overutilization, said David Koch, division administrator-business services with the school district.

The plan, which became effective Jan. 1, also requires beneficiaries to be assessed three times by an existing employee assistance program before being referred to a mental health specialist.

However, the plan also improves coverage for both inpatient and outpatient services.

"Without trying to throw out buzzwords, it really is the ultimate win-win situation for the district and our employees and retirees," Mr. Koch said.

Health care costs for the district have been rising 8% to 14% over the past several years. So the district's benefit department last year established a joint labor/management benefits committee to identify areas that needed additional cost control. The committee targeted mental health and chemical dependency treatment, among other areas.

"Through our self-insured indemnity plan, to which about 54% of our active employees belong, we were paying an average of $9,000 per person to treat psychosis and about $37 per visit on 73,000 annual visits for neurosis treatment," Mr. Koch said.

"About 9% of total health care costs were attributable to mental health treatment. Obviously, it was a candidate to be looked at seriously," he said.

To reduce mental health-related costs, the school district first considered eliminating its EAP, which is provided by Los Angeles-based Managed Health Network Inc. But, "that didn't receive a very warm welcome from our employee group," Mr. Koch said.

Instead, the managed care firm analyzed the school district's mental health care utilization trends and showed that it could save money by carving out mental health and substance abuse treatment benefits from its indemnity plan and implementing a stand-alone managed plan. Those services had not previously been subject to managed care.

Under the new plan, employees must visit the MHN-run employee assistance program at least three times.

If staffers believe that further mental health or chemical dependency treatment is required, employees are then referred to one of 900 behavioral health care providers in the Los Angeles and Orange County areas.

For outpatient mental health and chemical dependency services, employees pay no deductibles under the new plan, and the first five visits are covered in full. The next five visits are subject to a $10 employee copayment, sessions 11-15 require a $20 copayment, and sessions 16-50 require a $30 copayment.

Employees have until June 30 to conclude their care with their non-network providers. Employees will receive mental health and chemical dependency treatment benefits as provided under the indemnity plan until that time. The indemnity plan had covered up to $40 of the cost of each visit, with a $3,000 annual maximum per person.

Benefit beat

After June 30, all services will require pre-certification through the EAP to be covered.

There also are no deductibles for inpatient mental health and chemical dependency treatment services under the new network plan.

Mental health services are covered at 80% for up to 30 days annually.

There also is a 90-day lifetime maximum on inpatient mental health benefits.

The plan also covers 80% of inpatient chemical dependency treatment, up to $10,000 per episode. The plan covers two episodes per lifetime.

There are no inpatient mental health or chemical dependency benefits for care received outside of the network.

Mr. Koch said benefit levels and MHN contract fees are set for three years.

—By Michael Schachner

Defined benefit plans

Far more defined benefit pension plans are being terminated than set up, Internal Revenue Service statistics show.

During the fiscal year ending Sept. 30, 1991, 10,064 defined benefit plans sought permission from the IRS to terminate. Only 370 plans sought start-up permission.

For defined contribution plans, formation ran slightly ahead of termination, with 11,853 plans filing initial applications and 11,629 plans filing termination applications.

"It's clear to me that defined benefit plans are the canary in the coal mine," said Howard Weizmann, executive director of the Assn. of Private Pension & Welfare Plans in Washington, D.C. "They are far more complicated and more expensive to administer" than defined contribution plans.

Defined contribution plans are "far more predictable, much simpler to run and more easily understood by employees," he said. "Actually, they are more expensive in terms of the benefits provided, but you don't need a bevy of experts to calculate accrued benefits for you."

—By Deborah Shalowitz

Health plan extended

Allied-Signal Corp. is extending its managed health care contract with CIGNA Corp. until the end of 1992, with an option to extend through 1993.

Under the contract, Philadelphia-based CIGNA agrees to hold health care cost increases to an unspecified percentage each year. Beyond that percentage, the insurer must absorb the additional costs.

"We continue to feel that the program is saving a substantial sum over what our indemnity costs would have been," noted Gary Yeaw, director of group insurance for Allied-Signal, a manufacturing concern based in Morristown, N.J. The original three-year program was extended for 10 months last year (*BI*, April 8, 1991).

The managed care program, called Health Care Connection, covers about 150,000 employees and dependents.

—By Deborah Shalowitz

At issue

Will the Americans with Disabilities Act cause risk management problems?

Mary E. Wheeler
Risk Manager
Albuquerque Public Schools
Albuquerque, N.M.

The ADA will have a profound effect on employers both financially and in how they do business—hiring and accommodation. Just meeting physical access requirements will cost megamillions for a school district our size. Precise, physical, specific job descriptions will be essential to containing workers compensation costs and avoiding lawsuits.

Hal K. Luttschwager
Risk Manager
Missoula County,
Missoula, Mont.

Yes. We can expect a significant amount of litigation, which will ultimately define the requirements of the ADA. Potential employment practices and facility accommodation problems, among other things, will need to be addressed promptly and reviewed as case law develops. A training program is strongly recommended.

Mark Wilson
Corporate Risk Manager
First Mississippi Corp.,
Jackson, Miss.

How will we define "reasonable accommodation"? Someone less mobile may have more difficulty evacuating our chemical plant, presenting special concerns. Also, there is no established relationship between the ADA and work comp. What costs will work comp be responsible for when an employee is injured on the job? I expect the answers to come through litigation.

John D. Veale
Director of Risk Management
Shriners Hospitals for Crippled Children,
Tampa, Fla.

The ADA may affect light-duty programs. Light duty is an effective tool for rehabilitating injured employees and reducing workers comp and disability claims costs. While the ADA reinforces incentives to use light duty, employers must be careful not to create opportunities for ADA-based discrimination claims. The key is to make light duty actual work rather than make work.

Compiled by Sara Harty

Alabama firms sue 17 writers of work comp

By LORI BLOCK

BIRMINGHAM, Ala.—A group of small Alabama businesses are suing 17 workers compensation insurers, charging that the insurers forced them and other Alabama employers to purchase unnecessary employers liability coverage as part of their workers comp coverage.

Among other things, the group's lawsuit seeks at least $200 million in damages for alleged violations of the Alabama Deceptive Trade Practices Act.

The lawsuit, filed last month in Jefferson County Circuit Court in Birmingham, also seeks class-action status.

Alabama employers were told "that the law requires them to buy both (workers comp and employers liability) coverage, when the law actually doesn't require them to" purchase employers liability coverage, according to plaintiffs' attorney Edward L. Hardin Jr., a senior partner in Hardin Tucker & Martin in Birmingham.

Mr. Hardin said all of the insurers named in the suit used a standard policy form that included both workers comp and employers liability coverage.

Because employers liability coverage was included, employers' premiums were 5% to 8% higher than necessary, Mr. Hardin alleged.

"We're going to contend that this should be a class action on behalf of all Alabama employers who purchased workers compensation policies from the private sector" over the past six years, Mr. Hardin said.

If a class action is approved, actual damages—including both the alleged 5% to 8% premium overcharge and the interest insurers earned on those funds—could be much higher than $200 million, Mr. Hardin said.

The lawsuit seeks injunctive relief and compensatory and punitive damages for fraud and deceit; civil conspiracy; or breach of contract.

However, an official with the National Council on Compensation Insurance disputes Mr. Hardin's notions and is uncertain how the plaintiffs and their attorney could estimate that employers liability coverage accounted for 5% to 8% of policy premiums.

The plaintiffs do not understand that their premium would be the same even if workers comp coverage could be purchased alone, said Robert Maxwell, the director of government, consumer and industry affairs for the NCCI in Birmingham.

"There is no way to divide the rate," he said.

Insurers use a state-approved standard policy form that includes coverage for both workers comp and employers liability, Mr. Maxwell said. He added that the workers comp rates are reviewed and approved by Alabama's Insurance Department.

A spokesman with Liberty Mutual Insurance Co., a named defendant, concurred.

Officials of several of the insurers named in the suit declined to comment because the litigation is pending.

The other named defendants are Aetna Life & Casualty Co.; American Liberty Insurance Co.; American States Insurance Co.; CIGNA Corp.; Cincinnati Casualty Insurance Co.; Commercial Union Insurance Co.; John Deere Insurance Co.; Employers Insurance Co. of Alabama; The Home Insurance Co.; ITT Hartford Group Inc.; Nationwide Mutual Insurance Co.; New Hampshire Insurance Co.; St. Paul Fire & Marine Insurance Co.; Southern Guaranty Insurance Co.; United States Fidelity & Guaranty Insurance Co.; and Wausau Business Insurance Co. ■

Opinions

Stay open to suggestions

WHAT DOES Lloyd's of London have to fear from government regulation?

Perhaps nothing.

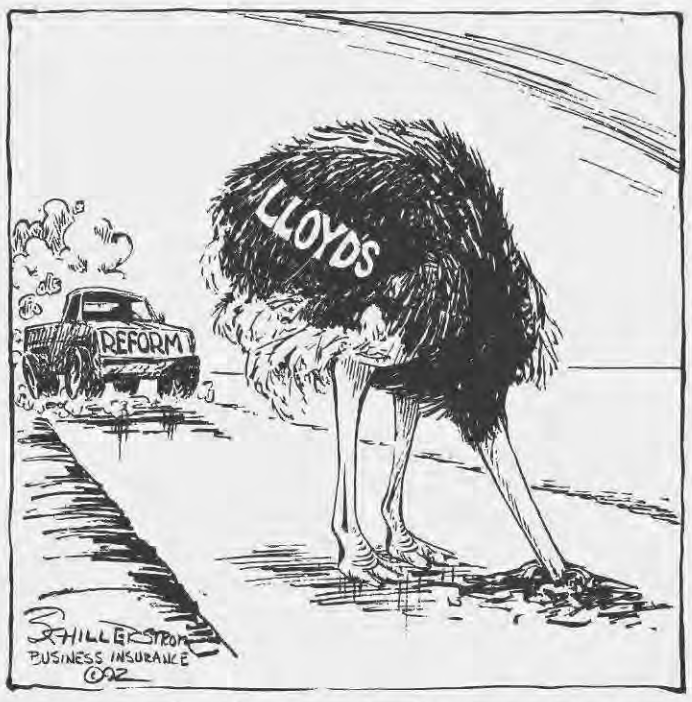
That's why leaders at Lloyd's should not reject out of hand calls that 304 years of self-regulation at Lloyd's come to an end.

We do not mean that Lloyd's necessarily should be regulated by the government. Just as poorly drafted federal regulation of insurer solvency in the United States would not be an improvement over current state regulation, government regulation alone won't cure Lloyd's many ills. And, a poorly designed system of government regulation of Lloyd's would only make them worse.

But the Council of Lloyd's and others in the marketplace should remember that Lloyd's has more than its share of problems. If it did not, a task force report released last month would not have suggested radical changes (*BI*, Jan. 27; Jan. 20).

While many of Lloyd's problems undoubtedly stem from insurance market cycles, not from wrongdoing, there's always room for regulatory improvement. The task force noted that when it recommended that Lloyd's establish two regulatory bodies: one that would govern business operations and another that would oversee regulation.

Unfortunately, the Council at first refused to even consider this suggestion. While it later agreed to review the recommendation, its immediate, knee-jerk reaction likely prodded those now calling for government regulation of Lloyd's.



However, we certainly do not believe the British government should step in just because some members of Parliament happened to lose money in the market and are now crying about it. These MPs were not suggesting government regulation when they collected record-shattering profits several years ago.

During these tumultuous times at Lloyd's, the Council should remain open to all responsible suggestions; after all, Lloyd's always has prided itself on its flexibility. Lloyd's and Parliament should study regulation at Lloyd's before either side says or does anything hasty.

Letters

Bush offering two significant health care reforms

To the editor: Widespread criticism of President Bush's health care plan would lead one to believe it has no redeeming value (*BI*, Feb. 17; Feb. 10).

Yet, lost in the political rhetoric about what is wrong with the president's plan are two major breakthroughs. For the first time, an American president has presented a plan that would:

- Use public funds to help finance health care coverage for those not on welfare but who cannot otherwise afford coverage. One might fault the method or the amount, but the principle is significant.
- Require insurance market reform to ensure availability of coverage to employees of small companies and to employees who are between jobs. Again, the method might be criticized, but the principle represents a major step toward overall health care reform.

Further, President Bush has come out in support of the principle of managed care and is encouraging networks for more efficient purchase of coverage by small groups. This specific approach is open to challenge, but the principles give us something with which to work. And, since this has not been presented in the form of a bill, we seem to have time to work with it.

The principles present significant opportunities to opponents who really are concerned with the health care system to show they support reform while still having a lot to criticize. Instead, presidential candidates generally have been quite dishonest in trashing the whole program in favor of demanding total reform, like national health insurance and even long-term care insurance, which they know cannot be achieved at this time.

The tax credit of $3,750 for families also is under attack, with some politicians quoting a wild range of costs for family coverage. Using exaggerated figures is at best playful and at worst misleading to a public that is struggling to understand. This again distracts from the principle that government is now willing to support those unable to afford coverage, even if we still need thoughtful debate to find the right figure.

President Bush also is roundly criticized for appearing to defend the health insurance industry, which has been presented as an ogre if not as the sole cause for our health care dilemma. This is not to defend the handful of shifty insurance companies that capitalize on an unsuspecting public and that should be drummed out of business. Rather, that charge takes our eye off the fact that costs are driven by doctors, hospitals, malpractice claims and inefficient delivery of a host of services, which are affecting the costs of both government programs and responsible private insurance programs and which must be the main target of any health care reform program.

Most congressmen who have seriously studied health care reform acknowledge that a shift to a national health care program or socialized medicine will take years, even if one accepts that concept philosophically. Those who attack immediate efforts to address our most urgent problems in favor of demanding total reform are quite dishonest, and their attacks further delay help to those who need it now.

Carson E. Beadle
Managing Director
William M. Mercer Inc.
New York

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

Individuals should pay for cost of health care

To the editor: One of the underlying assumptions of the "play-or-pay" health care proposal and several other health care proposals must be that employers have an inherent obligation to fund health care for their employees and dependents of their employees. Considering the amount of funding required for employer-sponsored health plans and the impact that these costs have had on the health of American companies, it is astounding that this premise has not been a focal point of debate.

Only individuals use health care. We have already taken substantial steps toward government-sponsored health care for individuals in the Medicare and Medicaid programs. If we are going to continue down this path through any of the federal health care proposals, we should take the opportunity to create some accountability by letting all the beneficiaries of the plan fund it out of their own pockets. Medicare participants certainly demanded accountability when faced with funding prescription drug benefits in the Medicare program.

Taxing corporations or mandating coverage deceives voters by hiding the true cost of the benefits. It also perpetuates the "my insurance will pay for it" mentality that encourages excessive utilization of services and technology.

If every year each of us had to contribute, in relation to the risk we present, to cover the cost of health care for all of us, it is likely that we would demand efficient design, delivery and administration of health care benefits. Exceptions would only be necessary for those who are unemployed, unable to work or who do not have sufficient income to fully contribute to the program.

Funding health care for all Americans solely through individual contributions could be accomplished without displacing the private initiatives and jobs involved in health care delivery and administration of benefits. It also would create a more prudent consumer mentality among voters who would be the financiers and beneficiaries of the system.

Ronald M. Chaffin
President
Utilization Management Systems Inc.
Omaha, Neb.

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Civil justice study

Continued from page 3

the "excess use of discovery" as a problem. And 20% cited excessive costs as a problem.

Totals exceed 100% because respondents were able to select more than one answer.

Beyond these broad categories, those surveyed also honed in on several specific problems contributing to overall inefficiency of the state civil justice system.

An overwhelming majority—77%—said, "The media sensationalize settlements and jury awards." Virtually all—93%—of the insurance claims executives agreed with this statement.

Similarly, 72% of those surveyed said "the court process is too slow," and 91% said the pace of litigation is sluggish.

Among the reasons cited for the slow pace of justice were inefficient resources for the courts, 69%; too much litigation, 61%; and litigation becoming too complex, 61%.

Predictably, only 35% of the plaintiffs' attorneys said there is too much litigation.

Two-thirds of those surveyed believe the delays have increased in the past decade. Insurance executives and corporate counsel were the groups most likely to believe delays have increased in the past 10 years, while defense attorneys and court administrators were the least likely to hold that belief.

Respondents were asked to estimate the average time it takes to bring a civil case to trial. The nationwide average computed from their estimates is 22 months.

Despite the long delays in civil litigation, respondents still expressed a strong belief that a fault-based compensation system is preferable to a compensation-based system, like workers compensation.

About 59% of all of the respondents work in with fault-based personal injury laws, 15% work in compensation-based personal injury systems and 15% work in both systems. The rest of the respondents did not provide an appropriate answer to this question.

Nonetheless, only 18% of the respondents prefer compensation-based systems to a fault-based system.

One of the reasons cited for preferring a fault-based system is that plaintiffs are "only entitled to compensation if someone causes injury and if there is negligence proven," cited by 46%. And, 44% said a fault-based system "is the fairest way, it's more equitable."

Among those who expressed a preference for a compensation-based system, the main reasons cited are that this system is the "fairest way/more equitable/objective," cited by 45%; "the purpose is to compensate, not blame," cited by 21%; "awards what is lost/restores plaintiff," cited by 20%; and "is quicker/simpler/works best," cited by 18%.

Respondents were also asked to identify which areas of civil litigation are likely to increase faster than others in the next 10 years.

Nearly everyone surveyed—91%—expects to see an increase in hazardous waste and environmental liability litigation.

Some 81% expect an increase in wrongful-termination litigation, 66% expect an increase in mass toxic tort litigation and 62% expect an increase in product liability litigation.

Also expected to increase are business litigation, cited by 43%; medical malpractice litigation, citied by 42%; mass latent injury cases such as asbestos, cited by 41%; and contract litigation, cited by 30%.

The high cost of bringing these types of cases to trial was consistently identified as a problem plaguing the civil justice system.

Some 52% of those surveyed said transaction costs, which comprise the costs incurred in litigation excluding monetary awards, have "increased greatly" over and above inflation in the past 10 years.

Although there are many reasons cited for increased transaction costs, "high attorneys' fees/too many lawyers" was cited by 26%, the cost of expert witnesses was cited by 24%, higher discovery costs was cited by 18% and higher court/filing costs was cited by 18%.

When asked about transaction costs in different types of litigation, 70% of the respondents said transaction costs are excessive in product liability cases, 65% find them excessive in medical malpractice cases, 62% find them excessive in environmental cases and 55% find them excessive in mass latent injury cases, like asbestos cases.

When asked who was responsible for these high transaction costs, the respondents all pointed the finger at each other.

Eighty percent of insurance claims executives and 68% of corporate counsel blamed plaintiffs' attorneys for the high transaction costs. Specifically, 81% of insurance executives and 64% of corporate counsel said that plaintiffs' attorneys bring too many lawsuits.

Conversely, 58% of plaintiffs' attorneys blamed insurance claims executives, while 54% of plaintiffs' attorneys blamed defense attorneys for the high transaction costs. Some 53% of the plaintiffs' attorneys blamed defense attorneys for keeping cases alive as long as possible to maximize billings.

Only a small minority of those surveyed—16%—were either somewhat familiar or very familiar with Vice President Dan Quayle's proposals to reform the civil justice system summarized in the "1991 Agenda for Civil Justice Reform" (*BI*, Feb. 10; Aug. 19, 1991).

Mr. Potter says one reason for that lack of familiarity was that the media failed to focus on the specifics of the proposal, which was unveiled at the American Bar Assn. annual meeting last August.

Rather, the media focused on what they called "lawyer bashing" by the vice president, said Mr. Potter.

The proposal identifies six areas of reform and then makes 50 specific recommendations.

Respondents generally favored all six areas of reform targeted by Mr. Quayle.

Some 88% favor voluntary dispute resolution, 87% favor reform of the discovery process and more efficient trial procedures, 78% favor reform of the use of expert evidence, and 70% favor reforms that would enhance incentives for meritorious litigation and limit punitive damages.

Among the specific reforms suggested by the Bush administration, 75% of the survey respondents favored "multidoor courthouses" that would permit parties to choose between several methods of alternative dispute resolution.

In addition, 72% said compliance with government standards should be considered a strong defense in a lawsuit and a guarantee against punitive damages.

And, 66% said courts should have greater ability to authorize class-action lawsuits to handle claims arising from mass disasters.

One of the DRI's goals in commissioning the study was to open a dialogue on the issues, said Mr. Potter.

To further that aim, the DRI sent copies of the survey to various legal groups as well as Mr. Quayle and Solicitor General Kenneth W. Starr.

To date, there has not been a response from any of these groups to the survey, which was released earlier this month, he said.

Nonetheless, Mr. Potter says he welcomes letters from the public in response to the survey.

•

Copies of the survey, "Civil Litigation in State Courts: Perspectives on the Process and Preferences for Reform" can be obtained without charge from the Defense Research Institute, 750 N. Lake Shore Drive, Chicago, Ill. 60611; 312-944-0575. Comments on the survey may be sent to the same address.

California plan

Continued from page 3

organizations that are certified by the HIPCs to deliver care to all California residents, including the 6 million who are now uninsured. Citizens would be assigned to a particular HIPC based upon where they live.

The HIPCs would be managed by employers and consumers who probably would be appointed "by elected authorities," Mr. Zelman said. A special state commission would oversee the corporations.

Large employers that offer health care services directly to employees could apply for certification as an approved health care plan for their own workers. One such company is Southern California Edison Co., which operates many medical clinics and first-aid stations for employees throughout Southern California (*BI*, March 5, 1990).

However, these employers and their workers still would be subject to the payroll and wage tax to fund the program.

All Californians would be guaranteed access to certified health plans delivering care "equivalent to that offered by most health maintenance organizations," the department said.

"The details of the benefit package would be defined on an ongoing basis by the State Health Commission, which would act in the context of the dollars raised by the employer/employee payroll contributions," the proposal says.

"The benefits package would be based on those services provided under a comprehensive HMO plan. It would cover a broad range of medically necessary care," the report said, without providing details. But, it also noted that "existing state mandated benefits would be considered as part of the design of the guaranteed benefits package and included where appropriate."

No deductibles would be charged, but small copayments would be set on many services: a $10 maximum copayment per physician office visit; a $3 copayment per lab and radiology test; a $10 copayment per outpatient drug prescription; a $25 copayment per emergency room visit, which would be waived if the patient is admitted to the hospital; and a $15 copayment per outpatient mental health treatment with some limits on the number of covered visits.

"Routine dental and vision care would not be covered. Certain high-cost vision and dental procedures would be covered with moderate copays," the report says.

There would be no copayment requirement for "medically necessary and appropriate inpatient hospital care" or for preventive care, including prenatal and well-baby care.

Californians seeking broader coverage could opt to pay more to competing HIPC-certified health care plans, including those operated by private health insurers, that would provide more generous benefits packages.

The plan's $34 billion price tag is "based. . .on existing HMO rates," Mr. Zelman explained.

But that calculation "does not take into account any of the plan's many cost-saving factors" for employers, he said.

For example, employers' health care costs as a percentage of payroll would be reduced to 6.75%—the proposed payroll tax—from an estimated 8%, the department said.

In addition, employers' workers comp costs would be reduced $1 billion annually under this plan, Mr. Zelman said.

Employers pay a total of $11 billion in workers comp costs annually, according to Californians for Compensation Reform in San Francisco.

Auto insurance premiums would also be reduced 15% under the plan, the department says.

Some employers and insurers are lauding the insurance commissioner's entry into the health care reform debate, though they may not support his proposal.

"He deserves a lot of credit for putting forward a very ambitious proposal" that affects "multiple constituencies," said Dr. Jacque J. Sokolov, vp and medical director at Southern California Edison and a member of the commissioner's Health Care Advisory Committee.

His "creative and somewhat nontraditional" proposals "are put forth as sounding boards, so the different constituencies can sound them out," said Dr. Sokolov.

The plan "is surprisingly well-written and thought-through, considering the incendiary rhetoric that usually comes out of" the Insurance Department," said Kathleen Eyre, director of health policy and advocacy at Blue Cross of California in Woodland Hills.

"We're very encouraged that the commissioner has stepped into this issue," said a spokeswoman for the California Medical Assn. in Sacramento.

The doctors group is hoping to place an initiative on the November ballot that would require all employers in the state to provide health insurance.

And, others cheer the proposal's focus on managed care and its inclusion of the private sector.

The California AFL-CIO in San Francisco has not taken an official position on the plan.

However, while the labor organization likes universal care, it has a problem with the 24-hour coverage concept because of the copayments that would be imposed on injured workers for some medical services. "We don't want to see the cost shifted to the employee," said Tom Rankin, research director.

And, some employers and insurers, saying they need to see more details about the plan, pointed out what they called other inherent flaws in the plan.

Among the most noteworthy, they claim, are cost estimates that are too low.

"Our major concern is that the proposal is too simple and may raise false hopes among consumers that putting all health care plans together under a government-controlled system will in fact lower their costs over time," said Thomas F. Conneely, president of the Assn. of California Insurance Cos. of Sacramento.

The ACIC is studying the proposal and is reserving judgment until the plan is formally introduced in the Legislature.

"A basic fallacy" in the proposal is the assumption that HMOs are less expensive and should provide the basic benefit package to state residents, said Richard Toral, chairman and chief executive officer of Admar Corp. of Santa Ana, Calif. Admar is a large managed care company that operates preferred provider organizations and provides utilization management and third-party administration services.

"Don't throw out the baby with the bathwater," he said. "Instead of dictating that HMOs will provide the coverage, just state what the coverage will be and allow whoever can best do the job to do it."

The Health Insurance Assn. of America is reserving comment on the proposal until it is introduced as legislation.

Russ Walker, an official for the National Assn. of Health Underwriters and president of Walker Health Insurance Services in Santa Ana, noted, however, that the plan would appear to limit the system to a "very small number" of large health insurers that run health care networks.

"There seems to be a feeling that we will cut (the HIPCs') administrative overhead if we reduce the number of companies. But in any industry we can eliminate overhead if we eliminate choice," which is not what most Americans want, Mr. Walker said.

In addition, like other critics of the proposal, Ms. Eyre of Blue Cross said she does not agree "with the need for a new bureaucracy" that the plan would set up to "funnel all

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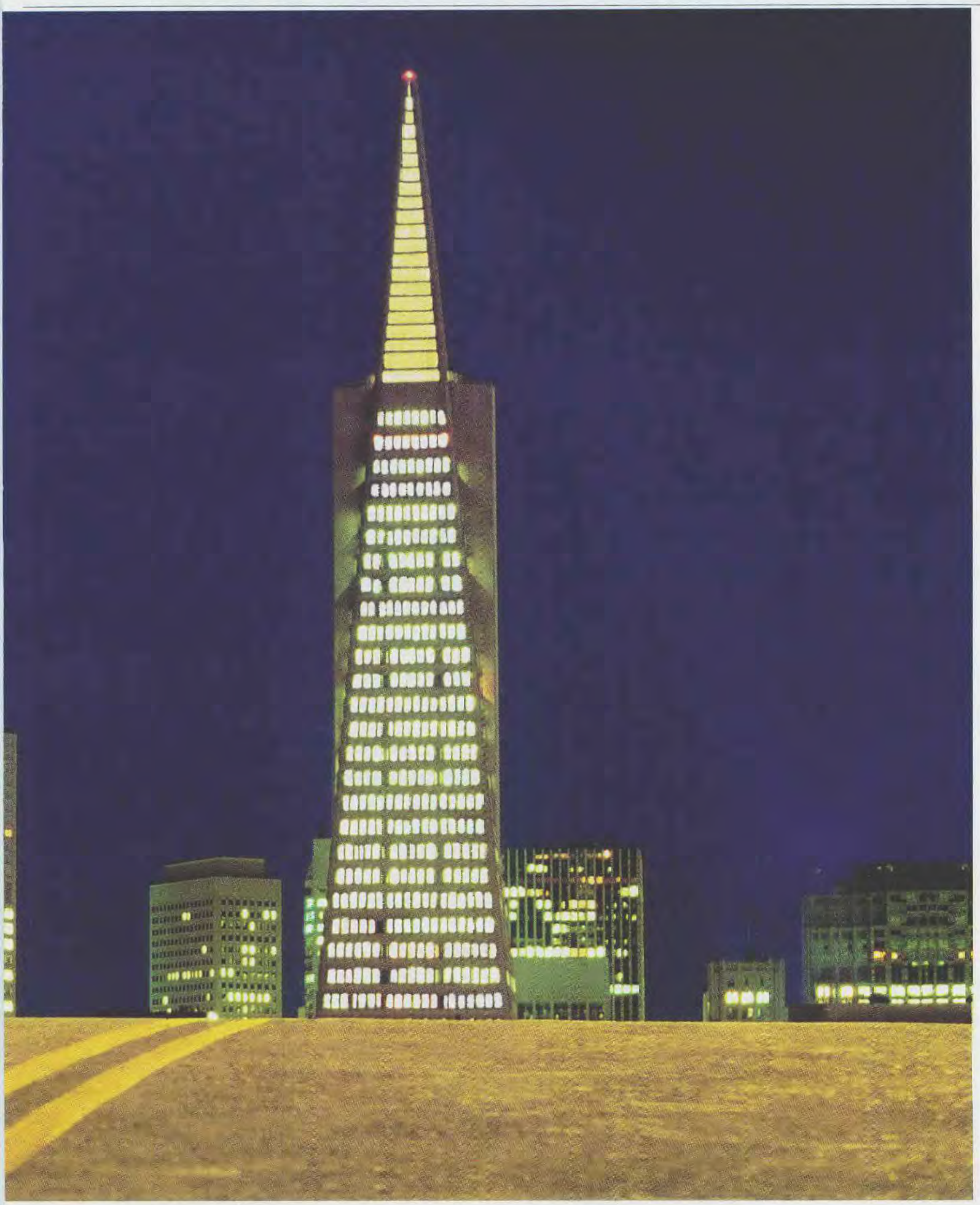

California plan

Continued from previous page
funds through the public sector."

"You'd be creating a huge bureaucracy in order to do all those things" that a large self-insured employer may already be doing, Admar's Mr. Toral agreed.

And, it is not clear that "a bureaucratic person on a fixed salary" will provide better service in dealing with claims and health care delivery problems than "an independent agent you can hire and fire," Mr. Walker said.

Several employers also balk at the disincentive for self-funded employer-sponsored health plans under Mr. Garamendi's proposal.

"I would not favor any plan that eliminates self-insurance," said Joseph Markey, president of the California Self-Insurers Assn. of Sacramento.

"That's one thing that we want additional clarification and support on—that innovative health care systems will be allowed to continue to function," Dr. Sokolov said. "The real question is, 'How much competition is going to be allowed and how much regulation?' "

But, Mr. Zelman replied: "From all that we can tell (eliminating self-insurance) is a plus. The state has no control over self-insured plans, and some of them are not run with the best of standards," leaving employees without benefits, he said.

Another concern is "the issue of equity that runs through this whole report," Mr. Zelman said.

"We cannot allow the largest employers to go their own route" and cover their own employees while not paying into the pool that covers all residents, or the burden on the rest of the system will be too great, he said.

"On a more positive note, we want and need their leadership to make this work. I want Arco, Pac Bell and Bank of America on the board of directors of these purchasing corporations," said Mr. Zelman.

All things considered, the question remains whether California "can truly have a single health care program that does not put California employers at a disadvantage," Dr. Sokolov said.

"The concern would be that California would lose jobs to places like Nevada and Mexico," he said.

There is "a lot of concern in this very touchy environment that businesses might relocate," concurred Julia Thomas, chairman and CEO of Bobrow, Thomas & Associates, an architectural firm in Los Angeles. She also is the health issues committee chairman and a director of the Los Angeles Chamber of Commerce. ■

Health proposal

Continued from page 3
not be used for other purposes or taken as cash.

The maximum amount of the credit or deduction would be $1,250 for a single person, $2,500 for married couples and $3,750 for families of three or more.

Individuals with incomes below the federal poverty level would receive the maximum tax credits. Those earning more than the federal poverty level would receive a smaller tax credit, with the credit decreasing to 10% of the maximum for those with incomes equal to 150% of the federal poverty level.

The poverty level is now about $7,000 for individuals and about $14,000 for families of four.

Those with incomes exceeding 150% of the poverty level generally would receive a tax deduction for their health insurance expenses.

No tax deductions or credits would be available to individuals with incomes of more than $50,000, couples with incomes exceeding $65,000 or families of three or more with incomes exceeding $80,000.

- Small employers could band together in new "Health Insurance Networks" to either purchase insurance on a group basis from insurers or self-fund. These employer networks would be exempt from state laws that now require policies sold by insurers to offer certain benefits.
- State laws that interfere with the delivery of managed care would be pre-empted.
- Employers and insurers could not exclude coverage for pre-existing medical conditions.

In addition, the administration package calls for an increase to 100% from 25% in the tax deduction the self-employed can take for health insurance premiums. It also "encourages" the states to adopt a series of medical malpractice reforms, including elimination of joint and several liability for non-economic damages.

Sen. John Chafee, R-R.I., who said he doubted that comprehensive changes are possible in an election year, asked if Republicans and Democrats could at least agree on a scaled-back package. Such a package could include medical malpractice reform, higher tax deductions for the self-employed and reforms of the insurance market, like the administration's proposed ban on exclusions for pre-existing medical conditions, he said.

Such a package would "not be a great reform. But at least we could make a start," Sen. Chafee said.

But Sen. John Danforth, R-Mo., questioned whether medical malpractice reforms have any chance of passage. Such reforms would be strongly resisted by the plaintiffs' bar, he said, adding that he would not "hold my breath" waiting for such tort reforms.

Other committee members said the time has come for Republicans and Democrats to put politics aside and try to agree on a health care reform package. "Let's not take pot shots at one another," advised Sen. Max Baucus, D-Mont.

But Sen. Baucus' plea didn't prevent Sen. Steve Symms, R-Idaho, and Senate Majority Leader George Mitchell, D-Maine, from an angry exchange on the best way to overhaul the health care system.

Sen. Symms charged that Democratic proposals to create a single-payer national health insurance system amount to "socialized medicine," while so-called "play or pay" proposals to require employers to offer a health insurance plan or pay new taxes would lead to a big new public health plan.

Sen. Mitchell answered that none of the Democratic proposals could be called socialized medicine and that Republicans were using the term to frighten the public.

All of the major Democratic proposals would continue to give Americans the freedom to choose their own physician, Sen. Mitchell said, adding that no one would call Medicare—the federal program that provides health care coverage for the elderly and disabled—"socialized medicine."

Sen. Danforth asked Secretary Sullivan why the Bush administration didn't recommend proposals, under consideration earlier, that would have taxed employees on employer-paid health insurance premiums exceeding certain levels.

Dr. Sullivan candidly replied that any proposal to alter the tax-favored status of employer-provided health care benefits would have triggered opposition that would have eliminated any chance of the administration's health package receiving serious congressional consideration. ■

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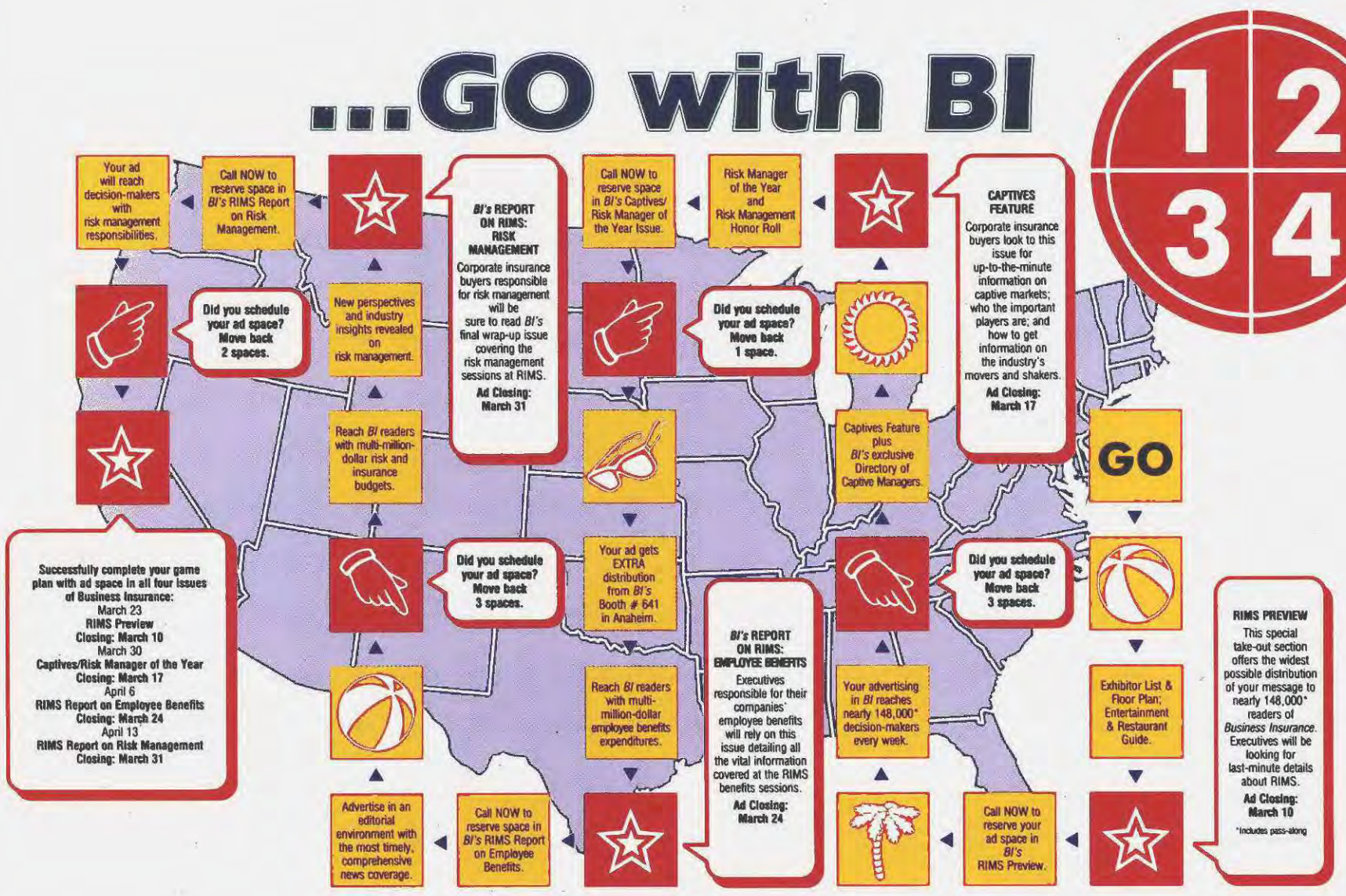

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Business Insurance
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D&O study

Continued from page 1

1992 are for continued gradual and controlled firming of the market for the majority of corporations," Phillip N. Norton, author of the survey and a consultant in Wyatt's Chicago office, wrote in the survey's summary.

He added that this D&O survey is the first in which the banking industry has been divided into two business classes: large banks and middle-market banks. Large banks are defined as those with assets of more than $1 billion, while middle-market are those with assets of between $100 million and $1 billion.

"The 1991 Wyatt Directors & Officers Liability Survey," which is scheduled to be released today, also found that new insurers are showing increased interest in the D&O market, which only a few years ago was shunned by all but a handful of underwriters.

Although the study shows that American International Group Inc. and Chubb Corp. together continue to write more than half of the primary D&O market's premium volume, new entrants to the market include such established insurers as Fireman's Fund Insurance Co., Mr. Norton said.

The 1991 survey examined the D&O experience of 1,501 corporations from the third quarter of 1990 through the third quarter of 1991.

This year's survey found the frequency of D&O claims for companies with assets of $1 billion or more to be 1.20, unchanged from the 1990 survey (*BI*, Jan. 14, 1991). Wyatt calculates claims frequency as the average number of claims per participant.

This marks the first time the frequency of D&O claims has not climbed since 1982, when the frequency was only 0.6022 for companies of this size.

For companies with assets of less than $100 million, claims frequency decreased to 0.107, from 0.117 in 1990. That is the lowest frequency measured for this group since 0.087 in 1982.

Claims frequency also dropped for companies with between $100 million and $1 billion in assets. Their 1991 claims frequency stood at 0.266, down from 0.334 a year earlier. The 1991 frequency was the lowest for these companies since 0.220 in 1984.

Mr. Norton cautioned against characterizing one year of lower frequencies as a trend.

He also noted that the mix of survey participants changes every year. Although about 60% of the participants in any given survey participate the following year, he said the change in the other 40% probably has an impact on the frequency of claims cited in the survey.

Wyatt found the average payment for all D&O claims closed during the survey period—excluding those closed with no payment—was $3.02 million, significantly higher than the average $1.94 million reported in the 1990 survey. The 1989 survey's average payment for closed claims was $1.71 million.

Mr. Norton said, however, that the averages could be misleading. "I don't believe that the average severity is a true picture" of the 1991 participants' claim experience because a few very large awards can knock the average off kilter, he said.

Two sources of claims showed a marked increase in frequency between the 1990 and 1991 surveys, Wyatt reported.

Claims stemming from a company's financial performance or bankruptcy jumped to 4% of claims in 1991, from 2.8% of the 1990 claims, the study said.

"I think that's a recessionary effect," Mr. Norton said of the increase.

Claims arising from inadequate or inaccurate financial disclosure rose to 7.7% of the 1991 claims, up from 6% in 1990, Wyatt found.

The increase in claims related to financial statements appears "due to the fact that corporate statements and disclosures are being scrutinized at a higher level than ever before," Mr. Norton said.

"Many of these newer disclosure claims are due to alleged violations of rule 10b(5) of the 1934 Securities Exchange Act; such claims relate to securities trading decisions that led to financial loss, which were made on the basis of inadequate or inaccurate disclosure from the corporation," he wrote in the report.

The single issue most frequently cited as the source of a D&O claim was wrongful employee termination, accounting for 11.7% of the claims reported in the 1991 report, compared with 11.9% of claims the previous year.

However, the broad area of mergers and acquisitions, comprising several related types of claims, accounted for 15.4% of all claims in the 1991 survey, down from 19.2% of claims in the 1990 survey, when it also was the leading source of claims.

Wyatt also found a slow but steady increase in D&O premiums throughout the five fiscal quarters covered by the 1991 report.

For participants who renewed policies during the survey period, more than half—56%—reported increased premiums, while 22% each reported either lower premiums or a level premium. In the 1990 survey, only 39% of respondents saw D&O premiums increase, while 32% experienced a decrease and 29% had no change.

A quarter-by-quarter breakdown of premiums paid at renewal shows D&O premiums grew steadily during the survey period:

- During the third quarter of 1990, 54% of all renewing respondents reported increased premiums, 19% saw premiums decrease, 26% had the same premium and the remaining 1% had no prior D&O coverage.
- In the fourth quarter of 1990, 55% reported increased premiums, 23% reported lower premiums and 21% reported level premiums, with 1% having no prior coverage.
- During the first quarter of 1991, 55% reported an increased premium, but only 20% reported a premium decrease, with 22% reporting no change and 3% having had no prior coverage.
- In the second quarter of 1991, 57% of the participants reported an increase, 21% a decrease, 20% no change and 2% no prior coverage.
- During the third quarter of 1991, 57% of the participants saw a premium increase, 22% a decrease, 20% level premiums and 1% no previous coverage.

Large banks were the most likely industry to report increased D&O premiums, the study found. Nearly three-quarters, 74%, of the large banks reported increased premiums, while only 19% reported lower premiums. The remaining 7% reported no change.

Large banks also had the highest median premium—$366,000—of any business class in the D&O report.

Middle-market banks reported the next highest rate of increased premiums, with 60% of the participants citing increases, 17% decreases, 22% no change and 1% no prior coverage.

But middle-market banks also enjoyed the lowest median premium of any class of business surveyed. The median premium for middle-market banks was $38,000, which was far below the next lowest median premium of $100,000 for personal and business services firms.

The class of business reporting the lowest incidence of premium increases was utilities. Forty-one percent of the utilities in the survey reported an increase, while another 41% reported a decrease and the remaining 18% reported no change.

Utilities, however, paid the second-highest median premium: $351,000.

Utilities were also the business class most likely to carry D&O coverage, Wyatt found. Ninety-three percent of the utilities responding to the survey had D&O coverage, followed by large banks, 91%; nonbank financial services companies, 84%; and middle-market banks, electronics and computer firms, and non-durable goods manufacturers, each with 83%.

Claims stemming from a company's financial performance or bankruptcy jumped to 4% of claims in 1991, from 2.8% of the 1990 claims, the study finds. 'I think that's a recessionary effect,' Mr. Norton says of the increase.

Construction and real estate firms were the least likely to carry D&O insurance, the survey found, with only 52% of the respondents in each of these business classes reporting having coverage.

While D&O premiums climbed, limits on average dropped slightly, Wyatt reported.

The aggregate D&O policy limits purchased by the survey respondents ranged from $250,000 to $210 million, Wyatt found. The average coverage limits for all companies of all sizes was $25.4 million in 1991, down 4.5% from $26.6 million in the 1990 survey.

However, only 4% of the respondents with prior coverage reported decreased limits at renewals. A majority of respondents—82%—reported retaining the same limits at renewal, while 14% purchased increased limits. That experience was about even with 1990 respondents.

Mr. Norton said average limits decreased even though most respondent reported purchasing the same amount of coverage because of a "slight change in the mix of respondents."

He noted that the 1991 survey contains more middle-market banks than earlier surveys, which lumped all banks into a single category.

Middle-market banks reported the lowest average primary and excess limits at $3.18 million and $4.6 million, respectively. Utilities had the highest average primary and excess limits, $21.16 million and $49.69 million, respectively.

Nearly 20% of the survey respondents said they had no D&O coverage. The most common reason for going without coverage—cited by 56% of these respondents—was that it cost too much. The second most common response was that the scope of coverage was too limited, offered by 31%.

Only 48% of the 1990 respondents without coverage had cited cost as a reason for going without D&O insurance and only 23% had said the coverage available was too limited.

Only 5% of the respondents without coverage last year said they could not obtain it, unchanged from the 1990 survey.

The lack of D&O coverage among some survey respondents was certainly not owing to a lack of insurers willing to write the coverage.

Three insurers appeared on Wyatt's list of D&O insurers for the first time—Fireman's Fund, RLI Insurance Co. and Zurich Insurance Co. None of the newcomers, however, accounted for more than four accounts among survey participants.

The primary D&O market continued to be dominated in 1991 by two insurers: AIG and Chubb.

AIG continued to rank first among primary D&O insurers in terms of premium volume, accounting for 37.4%—or $108.6 million—of the $290.3 million in primary D&O premiums paid by 1991 survey participants. AIG wrote 38.3% of the primary D&O premium reported by the participants in the 1990 survey.

Chubb maintained its second-place ranking with 20.1%—or $58.3 million—of the primary D&O premiums. Chubb held 19.5% of the primary D&O market in 1990.

The London market, which includes Lloyd's of London underwriters, moved into third place, accounting for 11.2%, or $32.4 million, of the primary D&O premium volume in 1991. That was a significant jump from 1990, when it ranked fourth with 8.2% of the primary market.

Associated Electric & Gas Insurance Services Ltd., a Bermuda-based group captive for utilities, was the only other primary insurer to account for at least 10% of the primary premium volume, with 10.4%—$30.9 million—of total primary volume. AEGIS had a 13.6% share of the 1990 premiums.

AIG and Chubb were in a virtual dead heat for the number of primary D&O policies written for survey participants. AIG held first place with 321 policies, or 27.3% of the total. Chubb ranked second with 318, or 27% of the total. No other insurer broke the 10% barrier, although CNA Financial Corp. came close with its third-place showing of 113 policies, or 9.6% of the total number.

Three insurers each held at least 10% of the nearly $189.5 million in excess D&O premiums reported in the 1991 survey.

A.C.E Insurance Co. Ltd. ranked first—as it has for several years—with 15.9%, or $30.1 million, of the excess D&O premium volume.

AIG ranked second, as in 1990, with 15.3%, or $28.9 million, of the excess premium volume. And Chubb maintained its 1990 third place showing with 12.6%, or $23.9 million, of 1991 excess premiums.

The standings were turned around for the top three in terms of the number of excess D&O policies among survey respondents. Chubb ranked first with 154 policies, or 15.2% of the 1,012 excess policies reported. AIG held on to second place, with 136, or 13.4% of the excess policies, and A.C.E. ranked third with 101, or 10% of the excess policies.

The relative rankings of the top three excess D&O insurers were the same as last year in terms of both share of total premium volume and percentage of policy count.

A separate Wyatt D&O report covering health care organizations, educational institutions and nonprofit organizations will be released next month.

●

The "1991 Wyatt Directors and Officers Liability Survey" is available for $250 from Kenned MacIver or Mary Maze, The Wyatt Co., Risk Management Services, 303 W. Madison St., Suite 2400, Chicago, Ill. 60606-3308. Ms. MacIver can be reached at 312-704-2719 and Ms. Maze at 312-704-2483.

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Broker results

Continued from page 3

things for an insurance broker is very, very difficult," said Frank Wieczynski, corporate secretary for Alexander & Alexander Services Inc.

"We're all struggling because of the soft insurance market," said Robert H. Hilb, president of HRH. "Then, we get a double smash with the economy."

And, those challenges are likely to continue to suppress broker revenues for at least the first half of 1992, broker executives and analysts predict.

All of the brokers said they do not plan to change their operating strategies. Thus, controlling expenses will continue to draw much attention.

"We're going to grind it out," said J. Michael Bischoff, vp of corporate development for M&M.

In the long term, this strategy could have dramatic payoffs for these brokers and their investors.

For instance, one of the factors contributing to A&A's $12.6 million loss in 1991 was a major restructuring that necessitated a $75.6 million charge in the fourth quarter.

But, the restructuring puts the company in a better operating position in the long run, and it will reduce expenses by $18 million in 1992, Mr. Wieczynski said.

The "bright note" in brokers' 1991 results is the fact that the brokers "are really positioning themselves to have good operating leverages when the market turns," said First Boston's Ms. Wilson.

Individual results for the fourth quarter and the year for publicly held brokers follow:

Marsh & McLennan

Gross revenue growth for the world's largest insurance broker slid to just 2.1% for the year, as revenues fell in the last two quarters of 1991.

For all of 1991, the New York-based broker's revenues increased to $2.78 billion from $2.72 billion in 1990.

Revenues during the fourth quarter slipped to $665.9 million from $668.5 million during the closing quarter of 1990.

Despite the overall revenue pressures, M&M's net income increased 0.5% for the year to $305.5 million from $304.1 million.

M&M managed its slim gain in net income even though fourth-quarter income fell to $54.2 million from $54.5 million for the year-earlier period because of a one-time realignment and consolidation charge of $34 million. This charge is associated with M&M's reorganization of its London operation, Mr. Bischoff explained.

Breaking down its fourth-quarter and year-end results into major business segments, M&M reported:

- Insurance services revenues fell 2% during the fourth quarter, slowing revenue growth within the broker's largest segment to just 2.2% for the year. Insurance services revenues were $357 million for the quarter and $1.57 billion for the year.
- Revenues from consulting continued to tumble, falling 6.3% during the fourth quarter to $220.1 million and nearly 1.8% for the year to $894 million.
- The investment management segment generated the most substantive revenue growth, with a 28% gain to $88.8 million during the fourth quarter and a 13.8% gain to $314.2 million for the year.

"Generally, the operating environment we faced in the fourth quarter of 1991 was really no different than the third quarter of 1991," said Mr. Bischoff, who made a similar observation three months ago when comparing third- and second-quarter results.

The key factor in the broker's fourth quarter and year-end performance is the decline in insurance services revenues, he said. That decline reflects the fact that fiduciary investment income fell $10.2 million in the quarter compared with the same quarter in 1990, as a result of lower short-term interest rates.

Nevertheless, "if you take that out, you'll still be looking at less than 1% growth" during the quarter, an indication that the soft market has not changed materially, Mr. Bischoff noted.

M&M's consulting revenues, largely generated by William M. Mercer Cos. Inc., were hurt by fluctuations in foreign currency exchange rates and a slowdown in general management, environmental and economic consulting.

Regarding the foreign currency exchange rate fluctuations, Mr. Bischoff said: "The dollar was fairly neutral to Mercer for the year, but it was actually stronger in the third and fourth quarters." Thus, when converted into dollars, revenues from foreign consulting dropped during the last two quarters of 1991.

That explains the 6.5% and 6.3% declines in consulting revenues during the third and fourth quarters, respectively.

But, revenues from foreign consulting also were off for the year by nearly 1.8%. Mr. Bischoff explained that the recession reduced demand for most consulting services.

The one partial exception is employee benefit consulting, "which is less sensitive to a decline in economic activity," he said.

Still, even benefit consulting struggled, posting an estimated 1.7% gain (*BI*, Dec. 16, 1991).

A bright note for M&M was the performance of The Putnam Cos. Inc., the unit that generates all of M&M's investment management revenues. Putnam had a banner year as "investors reacted to current economic conditions" and sought out the equity markets and long-term investments, Mr. Bischoff said.

"People are more willing to invest in fixed-income and security markets than money market funds, certificates of deposit" and other short-term vehicles at this time, he said. The escalation in the value of the equity markets also helped.

The 13.8% gain in investment management revenues was supported by a 23.4% rise in assets under management to $52.2 billion at year-end 1991 from $42.3 billion at the beginning of the year.

Another key factor in M&M's results was a $44 million pretax gain from the sale of its 30% interest in Dutch broker Hudig-Langeveldt Group bv (*BI*, July 1, 1991).

"M&M had to do some gymnastics to keep its (net income) up there," said Lehman's Mr. Smith, referring to the Hudig sale. "When you get beyond that, it wasn't really pretty."

However, Mr. Smith credits M&M—and other brokers—with doing a reasonable job of managing expenses. M&M has been particularly successful at this feat, Mr. Bischoff said.

"Our revenues were up 2% and our expenses attributed to '91 were up 2%. Obviously, we feel comfortable that we've been able to manage expenses in this environment," he said. "From our planning standpoint, we've adapted to this level of economic activity."

Mr. Bischoff added that M&M will continue to manage "as if (conditions) are not going to change."

Alexander & Alexander

Even though revenues increased 1.5% in the fourth quarter and 2.3% for all of 1991, New York-based A&A could not keep itself in the black.

A&A's 1991 revenues increased to $1.37 billion from $1.34 billion in 1990. In the fourth quarter of 1991, revenues rose to $360.3 million from $354.9 million in the year-earlier period.

Still, A&A reported a net loss of $12.6 million in 1991, compared with a net profit of $54.9 million in 1990. During the fourth quarter, A&A posted a net loss of $35.2 million, compared with a net gain of $20 million during the same period in 1990.

A special $75.6 million charge partly associated with the restructuring of brokering operations, increased expenses, a change in accounting standards, the soft market and low interest rates all contributed to the loss.

According to Mr. Wieczynski, the $75.6 million charge consists of three primary factors.

First, the broker had to account for severance payments, employee relocation costs and lease writeoffs associated with corporate restructuring, like the closing of an office in Albany, N.Y. This restructuring accounted for $48 million of the $75.6 million charge.

Of the remainder, roughly half is due to A&A's decision to sell or "wind down" its property tax consulting business and to revalue the worth of certain intangible assets and goodwill of past acquisitions.

The rest of the charge reflects a boost in the broker's litigation and other reserves, Mr. Wieczynski said.

But, if A&A's results are viewed without these charges, which after taxes amounted to $48.1 million, the broker would have reported $12.9 million in net income in the fourth quarter, still down 35% from $20 million for the year-earlier period.

For the year, if the $75.6 million special charge and a $2.2 million charge to recognize retiree health care liabilities under Financial Accounting Standard 106 are excluded, A&A would have reported $37.8 million in net income, a 31% drop from $54.9 million the previous year.

Mr. Wieczynski noted that the quarterly decline narrows further if 1990's results also are adjusted for special one-time charges. Viewed this way, earnings per share for the fourth quarter of 1991 fell 25.6% percent to 32 cents from 43 cents in 1990. It would be "still a down quarter, but it was in line with what we expected," he said.

An 18.4% decline in A&A's investment income also contributed to the drag in both revenues and earnings.

Mr. Wieczynski agrees with analysts who say A&A is a commission-driven broker, more sensitive to a soft market than others.

"I'd rather have our book of business when the market hardens, but we do take it on the chin when the market turns soft, because of our dependence on premium levels," he said.

He added that the restructuring "puts us in a better position in terms of the way the company is being run."

"We're taking our lumps now," but the restructuring will reduce expenses by $18 million in 1992, he said.

Rollins Burdick Hunter

Chicago-based Rollins Burdick Hunter Group Inc. reported gross revenues of $399.9 million during 1991, up 5.1% from $380.6 million in 1990.

During the fourth quarter of 1991, revenues rose 12.2% to $98.7 million from $88 million in the fourth quarter of 1990.

The brokerage group's 1991 pretax income fell 7.9% to $33.7 million from $36.6 million in 1990.

However, excluding a $4.7 million one-time charge, the group would have reported a 4.9% rise in pretax income for the year to $38.4 million.

Mr. Quern said the charge primarily reflects the consolidation or closing of some offices, including some offices of acquired operations.

In the fourth quarter, pretax income rose 28.6% to $5.4 million from $4.2 million in 1990's fourth quarter.

RBH Group's pretax income figures are broken out from the results of its parent company, Aon Corp. However, Aon does not give specific net income figures for the brokerage unit.

"For us, we feel good about 1991, particularly the fourth quarter" when revenues rose 12.2%, Mr. Quern said.

The fastest growing segment of RBH Group in 1991 was its employee benefit consulting operation, Miller, Mason & Dickenson. Revenues from this operation grew 20.7% during the fourth quarter and 12.3% for the year.

Like other RBH Group units, Miller, Mason & Dickenson grew both internally and through acquisitions, Mr. Quern explained.

Mr. Quern said RBH Group will not try to predict when the market will turn. Instead, it will concentrate on its own management. "We've got to continue to control expenses," service existing clients and "look for strategic acquisitions that fit," he said.

Arthur J. Gallagher

Gallagher's gross revenues rose 3.6% to $231.7 million during 1991, from a restated $223.6 million in 1990.

But, net income for the year fell 13.4% to $18.8 million from a restated $21.7 million in 1990.

For the quarter, the Itasca, Ill.-based broker reported that revenues increased 8.4% to $62.6 million from a restated $57.7 million. But, net income fell 2.2% to $5.8 million in the fourth quarter from a restated $5.9 million in the final quarter of 1990.

Gallagher restated its 1990 figures to reflect a pooling of interests from acquisitions (*BI*, Nov. 25, 1991).

Expenses grew at a faster clip

Continued on next page

1991 broker results

In thousands of dollars

Broker	Gross revenues	% change	Net income	% change
Marsh & McLennan	$2,779,200	2.1%	$305,500	0.5%
Alexander & Alexander	1,369,400	2.3	-12,600	NM
Rollins Burdick Hunter	399,900	5.1	33,700[1]	-7.9
Arthur J. Gallagher	231,679	3.6	18,790	-13.4
Hilb, Rogal & Hamilton	115,157	4.4	6,203	4.5
Poe & Associates	48,538	3.9	4,595	12.0

[1] Pretax NM-Not meaningful

Source: Company reports

GRAPHIC BY KIMBERLY MART

Broker results

Continued from previous page
than revenues during both the year and the fourth quarter.

But, Michael J. Cloherty, vp of finance, said that a 6.7% increase in expenses is quite moderate in the brokerage business, which historically reports double-digit expense increases, he said.

"Overall, as a company we are extremely pleased with our results based on the market today," Mr. Cloherty said.

Gallagher also established a $4 million reserve during the third quarter to cover declines in its investment portfolio and other costs, he noted. Without this reserve, Gallagher's earnings per share would have been flat instead of down 20 cents.

"All things considered, that isn't too bad," Mr. Cloherty said. Despite the recession, "we've put a great deal of new business on the books."

One bright spot for the broker is its risk management consulting business, which led to a 14.8% annual gain and a 17.7% fourth-quarter gain in fee-based revenues.

Looking ahead, Mr. Cloherty anticipates that the broker will continue struggling to improve commission gains, which, boosted by new business, rose just 2% in 1991.

And, investment income will continue to be hit by lower interest rates. "I don't look for much to be different in '92," he said.

As a result, the broker's cost containment efforts "are still in effect" and Gallagher will concentrate on client retention and attracting new business.

Hilb, Rogal & Hamilton

The Glen Allen, Va.-based broker ranked second among the leading brokers in both revenue and net income gains.

For the year, HRH's revenues grew 4.4% to $115.2 million from a restated $110.3 million in 1990. Net income rose 4.5% to $6.2 million from a restated $5.9 million the year before.

During the fourth quarter of 1991, revenues grew 2.6% to $27.6 million from just under $27 million a year ago. And net income nearly quadrupled to $833,468 from $211,742.

However, the company's revenue gains came largely from "miscellaneous" factors, while commissions and fees were flat and investment income was down more than 25%, Mr. Hilb noted.

A key factor in HRH's bottom-line results was its continued commitment to expense control. Expenses rose just 3.8% in 1991, less than the brokerage's 4.4% gain in revenues.

Mr. Hilb believes that expenses can be controlled further, but he said such efforts must not hurt customer service. Furthermore, the decentralized structure at HRH makes further expense control difficult, he said.

"This is a difficult time in the industry," Mr. Hilb said. "We all need to find ways to improve our services and control costs."

Poe & Associates

The Tampa, Fla.-based broker turned a 3.9% gain in gross revenues into nearly a 12% gain in net income during 1991.

Poe & Associates' revenues rose to $48.5 million in 1991 from $46.7 million in 1990, while net income increased to $4.6 million from $4.1 million.

During the fourth quarter, gross revenues rose 3.6% to $12.7 million from $12.3 million, while net income increased 13.2% to $1 million from $901,000.

The broker did not provide specific expense figures.

But Robert P. Cuthbert, Poe's new senior vp and chief financial officer, said that the majority of the broker's operating expenses have decreased. For example, Poe has consolidated office space and negotiated more favorable leases, he noted. But, mainly because of acquisitions, expenses rose roughly 2%, he said.

This expense control, part of the company's overall expense management program, enabled Poe to turn modest revenue gains into solid income gains, Mr. Cuthbert said.

Roughly three-fourths of Poe's growth has been fueled by acquisitions made in 1990 and 1991, Mr. Cuthbert said. These acquisitions also were responsible for what gains in expenses the broker experienced last year.

Looking ahead, Mr. Cuthbert said Poe is "confident it will be able to achieve year-over-year increases in '92" following its record-setting results of 1991.

"Our budget is designed to operate in this environment. If the market turns, we'll reap the benefits," he said. ■

Warning: Look before you litigate

Courts may be avoidable in coverage disputes

By STACY ADLER GORDON

NEW YORK—There is a pervasive—albeit erroneous—belief that complex insurance coverage disputes for hazardous waste cleanup costs cannot be handled through alternative dispute resolution, says a group that advocates litigation alternatives.

However, members of the Center for Public Resources Inc. gathered in New York last month to demonstrate how a hazardous waste coverage dispute could be handled without resorting to expensive and time-consuming litigation.

The hypothetical dispute centered on a Fortune 100 company that has been in business for more than 50 years and has generally followed prevailing environmental laws and regulations.

Nonetheless, the company has been named as a potentially responsible party for cleanup at 15 of its own manufacturing facilities and landfills in 10 states, where its waste products were deposited. The U.S. Environmental Protection Agency is seeking to hold it liable under the Comprehensive Environmental Response, Compensation & Liability Act, better known as the Superfund Act.

Throughout the period that the company owned and operated these manufacturing facilities and used these landfills, it purchased comprehensive general liability policies from 20 primary and excess insurers. The company now has requested that these insurers defend and indemnify it against the EPA's claims. The insurers have refused.

In what many feel has become almost a knee-jerk response, the company filed a lawsuit in federal court seeking a declaration that the insurers, which provided coverage over a 30-year period, owe a duty to defend and indemnify the company for its cleanup costs.

However, it is possible that instead of litigating with its insurers, the company could use a form of alternative dispute resolution.

Continuing this hypothetical scenario, two attorneys used role-playing to demonstrate how the policyholder might use ADR mechanisms to handle this dispute.

Scott Gilbert, a policyholder attorney with Covington & Burling in Washington, D.C., played the role of the attorney representing the policyholder.

Elizabeth Badger of Morrison & Hecker in Kansas City, Mo., took the role of the policyholder executive.

Initially, Mr. Gilbert informed Ms. Badger about the complexities of coverage disputes like this one. Among the difficult legal issues that must be decided, he said, are:

- Which state's law should apply?
- Is a letter from the EPA naming a policyholder as potentially responsible for cleanup costs sufficiently similar to a lawsuit to trigger an insurer's duty to defend?
- Do cleanup costs constitute "damages" as that term is used in the CGL policy?
- Did the company "expect or intend" the environmental damages?
- Will the pollution exclusion clause—which bars coverage for all pollution that is not "sudden and accidental"—bar coverage?

In addition to these difficult legal questions, the lawsuit will also raise complex factual questions regarding the policyholder's activities during the past 30 years, Mr. Gilbert told Ms. Badger. Document production and discovery costs could be enormous.

'Furthermore, the insurance industry as a whole has been supportive of ADR,' says Scott Gilbert.

Listening to the complexities of this lawsuit, Ms. Badger immediately expressed concern about the cost of litigating.

"The budget for this type of lawsuit is about $1 million a year for at least five years," replied Mr. Gilbert.

Mr. Gilbert also warned Ms. Badger that her company could face significant liability if it does not win the coverage dispute.

"What choice do I have" besides litigating? asked Ms. Badger.

Mr. Gilbert suggested that perhaps many of the legal issues in the case could be negotiated with the company's insurers.

He hinted that insurers might be willing to make certain concessions in private negotiations that they are not willing to make in litigation that would precedent for other policyholders.

But Ms. Badger was suspicious of attempting to negotiate the legal issues with the insurers.

"If we try to settle, won't the insurers think we believe this case isn't worth much?" she asked.

Mr. Gilbert said this is unlikely in a case such as this one "where each side is spending millions of dollars in legal fees."

"Furthermore, the insurance industry as a whole has been supportive of ADR," he said.

Ms. Badger was also concerned that negotiations with the insurers could cause the insurers to learn about other hazardous waste sites not mentioned in the lawsuit.

Mr. Gilbert said in all likelihood the company would need to disclose information about all of its waste sites to its insurers.

"The EPA has been blissfully ignorant of most of these settlement negotiations," he said, relieving Ms. Badger of her other concern that the government might require her company to clean up these other sites.

Still, even if the policyholder could negotiate many of the legal issues in this case, ultimately the question of coverage will turn on factual issues, he said.

"My view is that this ultimately comes down to a fact case," said Mr. Gilbert. "Insurers will try to make your company out to be a deliberate polluter."

One way to handle disputes over factual issues would be through a minitrial, he suggested.

A minitrial is a non-binding settlement process during which representatives of both parties listen to a short presentation of the case by attorneys. The hearing is informal, with no witnesses and relaxed rules of evidence and procedure. A judge, magistrate or special master presides over the proceedings, which often last one to two days.

After the minitrial is concluded, the client representatives attempt to negotiate a settlement based on what they have just heard.

Ms. Badger asked Mr. Gilbert what a minitrial might cost.

"A minitrial would be less expensive than half a year's litigation," he replied.

"In addition, we could negotiate that the loser pays all of the costs of the minitrial," he suggested.

Ms. Badger said she would consider all of the alternatives raised by Mr. Gilbert.

"Remember you have nothing to lose by at least initiating a dialogue with your insurers," said Mr. Gilbert.

The hypothetical dialogue was part of a two-day program that examined a variety of litigation alternatives, including arbitration, mediation and summary jury trials, which are similar to minitrials.

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For more information about alternative dispute resolution, contact the Center for Public Resources, 366 Madison Ave., New York, N.Y. 10017-3122; 212-949-6940.

M&M realigns U.S. brokerage operations

NEW YORK—Marsh & McLennan Inc. is reorganizing its U.S. brokerage operations and realigning its top management.

As of March 1, M&M Inc., the retail brokerage unit of Marsh & McLennan Cos. Inc., will split its U.S. operations into a risk management division, handling larger accounts with diverse risk management needs, and an insurance brokerage division to handle smaller, less complex accounts.

Where M&M Inc. previously divided U.S. operations into eight regions—with the largest offices maintaining a variety of industry-specific and other general departments—the firm will now have four risk management regions and five insurance brokerage regions.

Philip L. Wroughton, formerly M&M Inc.'s deputy chairman, will become chairman, succeeding Robert Clements, who will remain vice chairman of M&M Cos. Inc. John T. Sinnott and David D. Holbrook, meanwhile, have been named co-chief executive officers of M&M Inc..

Mr. Sinnott will be responsible for U.S. risk management, London-based C.T. Bowring & Co. Ltd.'s wholesale and specialty operations, the Asia/Pacific region, and international specialty operations and brokerage support.

Mr. Holbrook will be responsible for U.S. insurance brokerage, Canada, Europe and Latin America.

The four risk management regions will report to Executive Vp Timothy J. Mahoney, while the five brokerage regions will report to Executive Vp Ralph O. Hanley.

Markets

Health Net privatizes

Health Net, one of California's largest health maintenance organizations, will contribute more than $300 million over the next 15 years to a foundation to provide preventive health care services. The move is part of Health Net's conversion to for-profit status.

Under state law, non-profit HMOs converting to for-profit status must contribute their fair market value to a successor charity engaged in similar activity.

In this case, Woodland Hills, Calif.-based Health Net created the California Wellness Foundation to support statewide programs providing childhood immunizations, disease screening, substance abuse treatment for pregnant women and prenatal care for teenagers. The foundation board will consist of seven members, six with no ties to Health Net.

In its original application for conversion, Health Net estimated its fair market value as $104 million.

But, under the terms of conversion approved by the State Department of Corporations, the HMO will pay the foundation $75 million in cash up front and issue $225 million in 15-year interest-bearing notes.

In addition to the cash contribution, 80% of Health Net's stock was given to the foundation. Health Net's management and directors own the remaining 20% of the converted HMO.

Health Net, which has more than 800,000 enrollees statewide, had sought conversion to for-profit status since early 1991.

Its efforts were stymied by consumer advocates who, based on similar conversions by other HMOs, claimed that management was seriously undervaluing the assets.

During the delay, Health Net received and rejected several unsolicited takeover bids.

Health Net estimates its 1991 gross revenues at $1.2 billion, compared with $886 million in 1990.

Mutual Benefit venture

NEWARK, N.J.—Under a tentative agreement that relies on Congress rejecting proposed tax changes, Hartford Life Insurance Co. will assume Mutual Benefit Life Insurance Co.'s $44 billion book of corporate-owned life insurance policies.

The agreement reached this month calls for Hartford Life, a subsidiary of ITT Hartford Group Inc., to assume all of Mutual Benefit's existing COLI business, with Mutual Benefit then reinsuring a "substantial" portion of that business.

Also, the agreement would establish a joint venture between the insurers to underwrite future COLI business. Hartford would be the majority owner, of the venture, while Mutual Benefit would have an interest in future profits, said a Hartford spokesman.

Currently, Mutual Benefit has 55 outstanding COLI policies with a face value of $44 billion and cash value of $4 billion.

COLI policies are life insurance policies bought by employers—and payable to the employer—as corporate investments. Companies can borrow against the cash value of the policies to fund benefit programs and can deduct the interest paid on those loans.

However, the Treasury Department has asked Congress to bar these deductions. If such a measure passes, it would kill the Hartford deal, the spokesman said. ■

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Costlier organ transplants

Rising costs and frequency of transplants increases risk for health plans

By Donna Peterson and Bob Carey

THE FIRST SUCCESSFUL HUMAN organ transplant operation was performed fewer than 30 years ago. In 1990, more than 15,000 organ transplants were performed in the United States alone, and the number is expected to grow about 27% annually. The frequency of certain organ and tissue transplant procedures is increasing at significantly higher rates.

Many of these high-growth procedures could be labeled catastrophic because of cost. The impact on a health care plan of even one high-cost claim could be devastating. The average expenses for a liver transplant operation and one year of follow-up care now total more than $275,000.

Carve-out reinsurance is an important safeguard. It protects self-insured employers, insurers, health maintenance organizations and medical risk pools by covering unpredictable, high-cost procedures like heart, heart-lung, liver, pancreas and bone marrow transplants.

A detailed look at some of the factors behind the rising frequency of specific transplants and the volatility of costs shows why insurance providers are taking a hard look at their risks.

The growth in the frequency of transplants is driven by compound factors of increased availability of organs and tissues, as well as expanded applications of transplantation.

Several factors are contributing to this growth in frequency. Donor requests and matching programs are more established, effective and visible.

The United Network for Organ Sharing, which contracts with the federal government to coordinate organ procurement, had 24,664 registrants as of Jan. 8, up from 19,169 at year-end 1989. The National Marrow Donor Program had 467,934 volunteer donors as of Dec. 15, 1991; currently, 17,000 new donor files are added monthly. At any one time, about 2,000 active searches are being conducted, and in an average month, 35 allogeneic transplants—in which the donor and recipient are not genetically identical but are closely matched—are matched and facilitated.

The success and publicity surrounding living-donor procedures, especially for liver and bone marrow, means greater availability of organs and tissue. More than 100,000 live-donor organ transplants have been recorded. And all bone marrow grafts are living-donor procedures. The number of living organ donors rose to 1,788 in 1990, up 15% from 1989. While most donors donated a kidney, nine donors provided portions of the liver (which regenerates fully in the donor within weeks). Six others gave away healthy hearts when they received heart-lung transplant packages.

More hospitals are performing transplants. More than 300 transplantation centers are currently registered with the United Network for Organ Sharing; 48 are registered with the National Marrow Donor Program.

Both technology and drug therapies have expanded and improved the capabilities of tissue harvesting, which is the removal of an organ or a portion of an organ or other tissues for transplantation.

Also, technology has improved for purging, which is the removal of diseased cells from bone marrow after harvesting, and for rescue, which is the infusion of the donated marrow into the patient. Organ procurement, storage and transplantation, as well as anti-rejection management, also have been expanded and improved.

In addition, organ and bone marrow transplantation are being used as treatments for more and more diseases. What is perhaps most dramatic about this is the application of autologous bone marrow transplants—in which the patient's own healthy bone marrow is extracted, stored frozen and later replanted—in the treatment of solid-tumor cancers, including some forms of breast cancer; Hodgkin's disease; non-Hodgkin's lymphoma; adrenal tumors; and acute leukemia.

In addition, denial of coverage for organ or bone marrow transplant services on the basis that they are "experimental" often results in legal or regulatory challenges, which create additional risks and expenses. Perhaps the most highly publicized decision was a 1990 ruling in favor of a Blue Cross & Blue Shield of Virginia policyholder who had a bone marrow transplant for breast cancer.

Medical inflation, especially its impact on the more complex hospital-based procedures, is the other major force driving overall costs upward.

While improved efficiency has reduced the costs of portions of some procedures, most organ transplants and all bone marrow transplants remain acute treatments and high-cost procedures. In addition to sophisticated medical treatment, long hospital stays and intensive drug therapies also are expensive "givens."

Even one high-cost claim could be devastating to a health plan. The average expenses for a liver transplant operation and one year of follow-up now total more than $275,000.

There are few shortcuts in treatment or major savings in outpatient services or home treatment. Organ transplant networks and specialized transplant facilities can help reduce average transplant expenses, but capitated programs still run risks due to utilization, inflation and atypical cases with extraordinarily high costs.

Two categories of transplantation—pancreas and bone marrow—are currently the most volatile both from the standpoints of potential utilization and high cost.

Pancreas transplants are increasing at a rate of 70% annually; more than 1,200 procedures were projected for 1991, compared with 418 in 1989. The increase is due to improved patient and graft survival rates. The one-year pancreas transplantation patient survival rate is 92%, according to the most recent data from the United Network for Organ Sharing. Graft survival for this procedure is 72%. This level of success encourages more doctors and patients to consider this procedure.

One factor in the improved success of pancreas transplants is an increase in the number of simultaneous pancreas and kidney transplants, which reduces post-operative hyperglycemia, or elevated blood sugar, in recipients. Over the United Network for Organ Sharing's 1987-1990 reporting period, these grafts accounted for 82% of all pancreas transplants. On July 31, 1991, 575 patients were waiting for pancreas transplants at 86 pancreas transplant centers nationwide.

Bone marrow transplants, especially autologous tissue transplants, also are increasing. These procedures involve intensive preparation and care for the recipient both before and after the rescue process.

During the transplantation procedure, the recipient's own immune system and bone marrow are destroyed with high-dose chemotherapy before the new marrow is implanted.

As the new marrow is rebuilding throughout the body, rejection must be carefully monitored. Unlike in a single organ transplant, in which site rejection can be more specifically monitored, the graft rejection in bone marrow procedures can appear anywhere in the body at this time. Hospitalization stays for bone marrow transplant patients vary, but most are a minimum of 40 to 45 days.

Currently, the most common form of bone marrow transplant is the allogeneic transplant. Almost 3,000 allogeneic transplants were projected in the United States for 1991. Autologous procedures were projected at 1,700 for 1991. The average cost for either allogeneic or autologous transplants, including transplantation and first-year follow-up, was projected to be $214,000 for 1991.

The growth in autologous utilization will continue to outpace allogeneic utilization. With the autologous procedure, donor source and genetic match are not an issue. And graft vs. host disease—the most serious concern when the patient's entire immune system has been suppressed—is reduced, although about 10% of autologous transplant patients die from transplant complications.

Bone marrow procedures are rapidly expanding into the treatment of more diseases. Currently, the effectiveness of bone marrow transplants with AIDS patients is only in the earliest stages of testing. Research into procedures to cure sickle cell anemia also is under way.

Transplant costs are volatile—we've seen a liver transplant hit $1 million—and occurrence is unpredictable. That's why carve-out reinsureance is an important tool for self-insurers and insurers, alike. An organ and tissue transplant carve-out, for example, enables an insurance provider to avoid the "spikes" and catastrophic claims from such heart, heart-lung, liver, pancreas and bone marrow transplantation.

A good reinsurance program will match the underlying medical benefits program. Reinsurance can be structured as quota-share or coinsured first-dollar coverage excess of a deductible, a specified number of transplants per year or a variety of other combinations.

Standard coverage includes medical expenses within five days, prior and up to 52 weeks after a covered procedure; surgical, storage and transportation expenses related to organ or tissue procurement; and recipient expenses directly related to the procedure. Common options are private-duty nursing, extension of coverage to 78 weeks and family transportation and lodging benefits.

This is a very dynamic period for organ and tissue transplants. Employers should be aware that new developments, like a discovery by a research hospital or a precedent-setting court decision, could have a profound impact on the transplant environment—and their costs. ■

Ms. Peterson

Mr. Carey

Donna Peterson is assistant vice president-special risk underwriting at CIGNA Re Corp. in Philadelphia. Bob Carey is director-special risk underwriting, also at CIGNA Re.

Ergonomics to the rescue

Protecting typesetters' productive health potential

By The Insurance Institute of America

The following question and answer are drawn from the curriculum for the Associate in Risk Management designation awarded by the Insurance Institute of America. They represent the type of question asked—and the possible answers—in one of the three examinations for the A.R.M. designation.

The Institutes have begun presenting brief cases in the ARM examinations as a basis for asking interrelated examination questions. The case presented this month, taken from a recent national examination in ARM 55—Essentials of Risk Control, focuses on several facets of protecting employees' productive health and safety. This particular case applies to typesetters.

Q: For 120 years, East Book Co. has been a major publisher of medical texts for students and physicians. East Book recently hired its first risk manager. The company formerly employed an insurance buyer, who had purchased adequate traditional coverage for property, business interruption and routine liability exposures. However, this buyer apparently overlooked many opportunities for controlling readily preventable losses.

The risk manager sees a need for an ergonomic evaluation of word processing activities. There are 150 typesetters who sit at banks of computer keyboards and screens, spending their days entering or editing text copy. The typesetters face several ergonomic hazards that are characteristic of work at computerized workstations. These hazards can be managed through numerous controls, some of which relate to modern concepts of workplace design and some to more traditional procedural controls developed by industrial hygienists and safety engineers.

In reviewing some of the former insurance buyer's records, the risk manager finds that often when some typesetters' output has fallen significantly below daily volume quotas, the company has urged them to take early retirement and accept quite generous pensions. Clearly one of the risk manager's challenges will be to awaken management to the importance of protecting the productive health potential of these employees.

- East Book's management needs to understand the importance of the practical steps the company can take to preserve its employees' productive health potential. Explain the concept of employees' productive health potential and its value to an organization like this company. Other than preventing worksite injuries and providing rehabilitation, describe four specific actions the company could take to safeguard the productive health potential of its typesetters.
- East Book's president believes the company's long-term prosperity depends more on protecting its building and equipment from damage than on safeguarding the productive health potential of its typesetters. Explain whether you agree with him, giving two reasons to support your position.
- Would it be in East Book's interest to provide physical and vocational rehabilitation, rather than generous early retirement benefits, to any of its typesetters whose output has declined significantly? Give three reasons to justify your answer.
- Identify four ergonomic hazards that are characteristic of work at computerized workstations. Describe the physiological effects of each of the hazards identified in your answer to the above question.
- For any three of the ergonomic hazards identified in your answer to the above question, and without repeating any answers, describe one control suggested by modern workplace design, and one procedural (not engineering) control suggested by more traditional industrial hygiene and safety engineering.

A.R.M. exercises

A: • A key risk management responsibility for East Book is to protect the productive health potential of its employees, one of the company's most valuable assets.

The productive health potential of one or more employees is the value to the employer of the maximum potential future production of the employees, often discounted to a present value. This potential represents the most these employee could produce if fully trained, kept healthy and productive, and retained by the employer throughout the remainder of their careers.

The productive health potential of employees is essential to every organization, for it is employees' knowledge, skill, energy and dedication that provide the driving force to generate value throughout the organization's other assets and activities.

Among East Book's many opportunities to safeguard the productive health potential of its present typesetters, four of the most significant would be to institute a preventive health maintenance program to reduce the frequency and severity of illnesses these maturing employees may otherwise suffer; educate these employees in better working methods at appropriately designed workstations so that their routine activities do not place excessive physical or mental stresses on them; strive to prevent off-the-job injuries or other disabilities of these employees; and deter the retirement of any typesetters who, although approaching normal retirement age, continue to produce output at a value that exceeds the wages and benefits these employees receive.

- It is highly likely that the president is incorrect in believing that protecting employees' productive health potential is more important than protecting the company's building and equipment. Two of several possible reasons for this are that buildings and equipment are more easily replaced than are skilled and loyal employees; and failure to safeguard its employees may subject East Book to much more significant liability claims and other exposures than would failure to protect its buildings, equipment and other physical assets. However, under very special circumstances, the president could be correct.

Buildings and equipment could be more important than people to East Book's success if, for example, the company's publishing activities were fully automated or if the present typesetters could quickly and easily be replaced by new employees. (Note that two plausible reasons are given here for either a "yes" or "no" response. On the national examination, a student should take and defend one answer or the other, not both.)

- Rehabilitation would be preferable to early retirement for those impaired typesetters who were still quite young, or when rehabilitation could restore all (or virtually all) of their past ability, and whose morale and attitude toward East Book would be much more enhanced by rehabilitation than by early retirement. Difficulties in finding suitable replacements or training them also would tend to point to rehabilitation rather than early retirement, as would the strong commitment of East Book's senior management team to humanitarian rather than purely economic goals. However, for each of these factors, differing assumptions could favor early retirement rather than rehabilitation. (Once again, full credit was given for either answer with appropriate support.)
- Ergonomic hazards arise when employees must work under conditions that place excessive physical or psychological demands on them. These demands eventually cause both injuries or illnesses and reduced or defective employee output.

Four ergonomic hazards that characterize work at computerized stations are—among other possibilities—repetitive finger and wrist motions by computer operators, poor lighting, improper seating for computer operators and workstations that are not fully adjustable to the individual characteristics of operators.

Each of these conditions increases the likelihood or the severity of specific physical harm to operators.

Repetitive hand motions may bring about wrist pain, swelling, weakness and stiffness. Improper lighting (whether excessive, inadequate, or poorly directed) is likely to cause blurred vision and eye strain. Improper seating causes operators to suffer low back pain and in time damaged vertebrae and spinal disks. Non-adjustable features of workstations may well cause similar skeletal and muscular harm to operators, not only in their necks, shoulders and arms, but also in their lower extremities.

- Modern workplace design counters ergonomic hazards by altering the physical workplace to better accommodate individual employees so that they may function more safely and effectively without laboring under unnecessary physical demands. Thus, to control excessive repetitive motion, workplace design attempts to reduce wrist movements both horizontally and vertically, enabling computer operators to keep their wrists as straight as possible.

Improper lighting often must be fully redesigned and made more adjustable to the particular physical and vision characteristics of each operator.

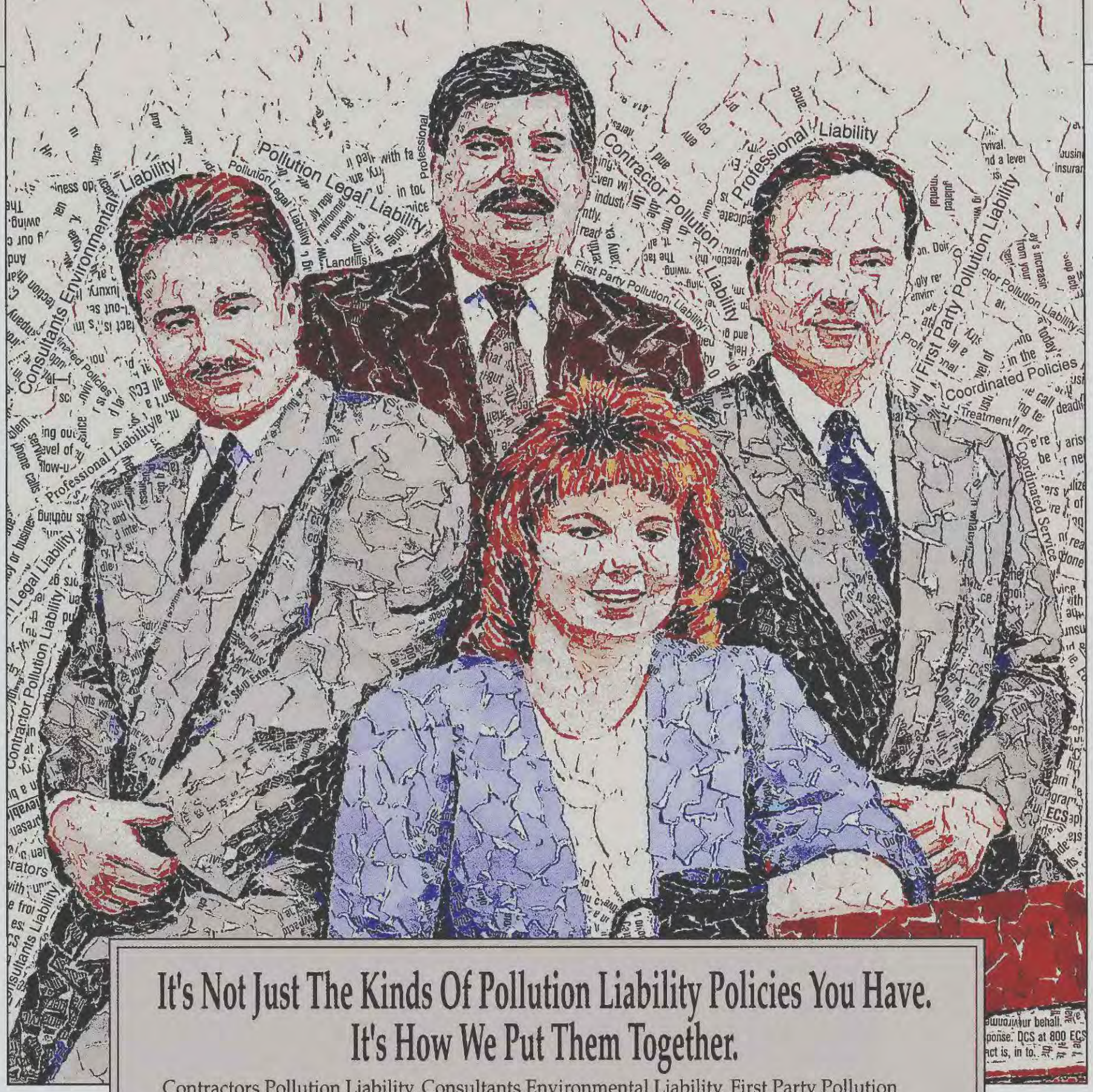
Similarly, inflexible seating must be made more fully adjustable to the physical characteristics of each operator and also may allow operators to choose a variety of seated and/or standing positions in which to work. Similarly, the entire workstation may be made more flexible by allowing each operator to set work surface and terminal screen heights and distances at positions that each operator finds most accommodating on any particular day.

A number of different procedural controls may change employees' exposures to any one of these ergonomic hazards. For example, periodic job rotation of a given employee to a number of tasks on a regular daily or weekly basis may allow needed breaks from otherwise destructively repetitive wrist motions.

Similarly, regularly scheduled rest periods may provide some recuperative relief from improper lighting conditions. Pre-placement screening of employees applying for computerized workstation positions may identify and excuse those applicants who would be particularly vulnerable to skeletal or muscular damage from improper seating.

Finally, a computer operator indirectly placed in a workstation that cannot be adjusted to his or her particular ergonomic requirements may be reassigned to another job.

The sample questions and answers used in this column are taken from the Associate in Risk Management designation curriculum of the IIA. For more information on the content of the A.R.M. program, write Dr. G.L. Head, Vp, Insurance Institute of America, P.O. Box 314, Malvern, Pa. 19355.



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Illinois Chamber launches work comp offensive

By MEG FLETCHER

SPRINGFIELD, Ill.—The Illinois State Chamber of Commerce is launching a three-prong attack to help its member companies reduce soaring workers compensation costs.

"Controlling workers compensation costs and remaining competitive always rank high on the list of concerns from our members," said Chamber President Lester W. Brann Jr.

The Chamber, which represents 6,000 businesses statewide, plans to:

- Unveil the results of a membership survey that shows what most of the 460 respondents believe to be the causes of increasing workers comp costs and what they are doing about them.

The Chamber's aim in surveying its membership was to establish a statistical data base to use in drafting and supporting its legislative agenda, Mr. Brann said.

"But the survey also found that effective cost management techniques are not being used by employers to lower their costs," the Chamber said in a statement.

- Support legislation expected to be introduced on Wednesday that would authorize disciplinary action against health care providers that repeatedly use irregular billing practices to inflate charges paid by employers.
- Develop a campaign to increase communication between a company's workers comp administrators and employee benefits managers, so they can work together to reduce employee health care costs.

The campaign—called "Can We Talk?"—will kick off with an April conference and will be followed by periodic meetings to identify common management objectives and legislative proposals.

Two Chamber members that are regional offices of national companies are donating their services to the group's workers compensation project: The Chicago office of risk management consultant Tillinghast, which helped develop the survey and interpret its results; and the Lisle, Ill., office of Intracorp, a health care cost containment and disability management firm, which helped design and plan the communications campaign.

"Almost 90% of the employers responding to the survey report that workers compensation affects their financial results. And, another 53% of those responding now categorize their workers compensation costs as 'somewhat' or 'totally' out of control," according to the Chamber.

Respondents to the survey identified 11 of 20 potential concerns as "major." While rapidly increasing medical costs were singled out as the most important, other concerns included: "fee differentiation/discrimination," in which health care providers charge more for a workers comp case than they charge for the same treatment received outside the system; laws that prohibit using health care cost containment measures for workers comp cases; and various abuses of the system by attorneys and employees.

The survey also asked Chamber members to evaluate possible workers comp reforms. Their top three choices were: impose harsher penalties for filing false claims; tighten the definition of what constitutes a work-related injury or illness; and prohibit irregular medical billing.

However, an analysis of the results indicates that "there is a lot of untapped potential for employers" to reduce the scope of the problem, said Michael R. Levin, manager of Tillinghast's Chicago office.

While more than 90% of respondents believe rapidly increasing medical expense costs are a concern, only half the respondents had implemented three key cost management methods: safety programs, pre-employment screening and proactive communication to employees.

The Chamber's survey was inspired by a national workers comp study Tillinghast conducted in 1990 (*BI,* Dec. 17, 1990).

The second prong in the Chamber's attack plan is to support legislation to be introduced this week by state Rep. Margaret R. Parcells, R-Glenview.

The bill will target "discriminatory" practices by health care providers who charge more for health care services based solely on the identity or classification of third-party payers, said Carol Hughes, the Chamber's director of workers compensation policy.

In addition, the proposed bill "can be interpreted to prohibit 'unbundling,' whereby health care providers enhance their charges to third-party payers by fragmenting a comprehensive medical service into separate components and charging individually for each component of the service, procedure, product or test," said Pamela D. Mitroff, the Chamber's director of health policy.

Specifically, Rep. Parcells' measure would extend billing standards established in the Illinois Dental Practice Act to other, older licensing acts that regulate seven other classes of health care providers: optometrists, pharmacies, doctors, podiatrists, hospitals, ambulatory surgical centers and clinical laboratories.

The Chamber's "Can We Talk?" campaign, which aims to foster communication between a company's employee benefits manager and workers comp administrator, will begin with a forum, including a panel discussion and luncheon speaker, to be held April 14 in Bloomingdale, Ill.

"Here in Illinois, some of our major employers already are taking a hard look and asking why corporate efforts to better manage employee health costs should not also encompass workers compensation costs," said Maddy Bowling, Intracorp's regional vp for the Midwest.

The fee for the forum is $70 for Chamber members and $100 for nonmembers. For program details, contact the Chamber at 217-522-5512.

●

Copies of the survey are available for $25 from the Illinois State Chamber of Commerce, Capital City Office, 215 E. Adams St., Springfield, Ill. 62701.

Hawaii matures as captive domicile

Flexible regulation key to success: Campaniano

By LOUISE KERTESZ

Hawaii Captive Forum

HONOLULU —Captive insurance regulation in Hawaii has evolved as a flexible mechanism to facilitate successful captive operations, a former insurance commissioner says.

"It was exhilarating to watch the growth and maturation of captives (in Hawaii)," said Robin Campaniano, who is now president of AIG Hawaii Insurance Co. Inc. in Honolulu.

Mr. Campaniano, who resigned as insurance commissioner last year, presented a history of captive development in Hawaii during the 1992 Hawaii Captive Insurance Forum. The forum, sponsored by the state and organized by the Tillinghast division of Towers, Perrin, Forster & Crosby Inc., was held last month in Honolulu.

The state captive law was passed in 1986, at the height of the hard market, though it did not take effect until the following year.

"Our Legislature wanted to make sure that the captive animal, whatever it was, had all the bugs worked out of it before we did anything relative to captives," he said.

The "apparent intent" of the Legislature was to "pass a law enabling small businesses to form associations to perhaps rid themselves" of the problems they had obtaining insurance, Mr. Campaniano explained.

"So they copied verbatim the Vermont captive law, even including two typographical errors," he noted.

However, the Legislature did not foresee the great interest on the part of companies outside the state to form captives in Hawaii.

By June 1987, regulators had been approached by many companies, many on the West Coast, some on the East Coast and some with foreign captives, interested in moving them to Hawaii.

For example, several partners in a large West Coast law firm wanted to move their Cayman captive closer to home, said Mr. Campaniano. "But in the spring of 1987 we had no infrastructure and no idea what to do with captives."

So the lawyers went "to sunny Colorado, where they found the infrastructure was not very good and the philosophy was awful and they should have come to Hawaii," Mr. Campaniano quipped. "But in the spring of 1987, no one could blame them.

"Over the next 18 months, the (Insurance) Division made a very concerted effort to get captives off the ground. We hired a consultant to help put together captive regulations and subsequently we modified our laws to adjust them to what we thought would be a good array of potential applicants to Hawaii," Mr. Campaniano said.

And Hawaii has since fine-tuned its law, which permits single-parent and association captives to write all lines of property/casualty insurance (*BI*, April 29, 1991).

Hawaii officials at first believed the state had many disadvantages compared with other captive domicile. "We were way behind the curve," Mr. Campaniano said. Domiciles like Vermont, Colorado, Bermuda, Cayman and Luxembourg "were far ahead of us in terms of established captives and infrastructure. Our attorneys, bankers and accountants knew nothing about captives."

Besides, "we were geographically separated. Hawaii is one of the most isolated land masses in the world. . . .We thought that would be a disadvantage to us," he said.

But they found starting late could also be advantageous. "We could build on the experience of other jurisdictions," Mr. Campaniano said, quipping that Hawaiian regulators "took all the bugs out" of the Vermont law.

Also, "geography has turned out to be an advantage for us. We're seated right in the middle of the Pacific Basin, and we think that in the next 20 to 30 years we are going to be one of the best situated states for captive development," he said.

"We've got a good array of services and a very competent regulatory staff, and we found this is very important for companies looking for a captive domicile," he added.

Hawaii's emphasis has been on attracting West Coast and Pacific Rim companies. "We can even accommodate mega-captives, though we're not specifically going after them. We're looking for solid captives that will stick around for a long time, not the real cheap and easy dime-a-dozen type of captives just to get up our numbers," Mr. Campaniano said.

He emphasized that the state's regulations "and the philosophy of the regulatory staff are very flexible and geared to the needs of the captive, as opposed to an arbitrary, bureaucratic regulatory rule cast in concrete.

"The division believes the more flexible approach is extremely necessary, provided of course that the ultimate goal of financial solvency of the captive is well taken care of," he said.

"We're looking for captives that are going to stick around for the long term, not for captives looking for a quick fix," he added.

Continued on next page

Hawaii's outlook: bullish

Officials predict steady increase for local captives

By LOUISE KERTESZ

HONOLULU—Because captive insurers are an integral part of Hawaii's economic development goals, the captive industry will grow steadily in the state, just as it continues to grow worldwide.

That assessment comes from state officials and consultants, who attribute their bullish outlook to Hawaii's "proactive" stance toward captives. That approach, they say, is reflected in its flexible regulatory environment.

And local captive managers stress Hawaii's "intangible" advantages and its ideal location for dealing with the growing interest in captives from nations of the Pacific Rim.

"Hawaii is not trying to become another industrial state," said Robert Alm, director of the state's Department of Commerce and Consumer Affairs. "We are committed to developing a few key areas of activity"—like captive insurance companies—"that we will nurture and manage and work with."

Mr. Alm spoke at the 1992 Hawaii Captive Insurance Forum in Honolulu last month, sponsored by the state government and organized by the Tillinghast division of Towers, Perrin, Forster & Crosby Inc.

When Hawaii focuses on a key area, "every resource we have will go to battle for it. The governor will be behind it all the way," he emphasized.

In fact, Gov. John D. Waihee III specifically mentioned the importance of the captive insurance industry in his State of the State speech last month, Mr. Alm observed.

"We're very serious about the growth of this captive industry," agreed Insurance Commissioner Linda Takayama, who also spoke at the conference. Hawaii has licensed 22 captives and currently is considering three applications, she noted.

"We want the respect of the nation and the world in terms of what we intend to do with" the captive insurance industry, said Ms. Takayama.

"I think that's beginning to happen. We intend to continue the commitment. We intend to make Hawaii a paradise for captives as it is in other areas," she commented.

Hawaii stands to benefit from an area of "potentially explosive new growth" for captives: group health insurance, observed Hugh Rosenbaum, a principal with Tillinghast in Stamford, Conn.

Hawaii law allows captives to write property/casualty and group health care coverages.

Companies will be seeking less expensive funding alternatives for employee benefits-related coverages "with specific urgency" in the wake of Financial Accounting Standard 106, he said. FAS 106 will require companies to accrue retiree health care benefit liabilities as an expense against earnings (*BI*, April 1, 1991).

At least one company is already planning to take advantage of a Hawaii law allowing captives to write group health care coverages, said Ward Ching, a senior consultant at Tillinghast in Irvine, Calif.

"I would submit that Hawaii is growing proportionately much quicker than any other U.S. domicile, certainly faster than Vermont," said Michael Murphy, principal and founder of captive manager RISKCAP in Denver, formerly called Risk Consultants Inc.

"Hawaii is somewhat unique in several respects. It is a proactive environment in that it wants captives to become part of its financial services community," Mr. Murphy said.

"If we were honest, we'd have to say that other domiciles have come to a point where they're not nearly as proactive. I think the future is incredibly bright for Hawaii, particularly when the market turns," he said.

"The big-picture issue relative to captive growth is that the conventional insurance market has proven that it cannot do niche underwriting in large commercial casualty lines," Mr. Murphy added. In the future, there will be very few alternatives to captives for parents with very specialized insurance needs, he said.

Three Hawaii captive managers who spoke at the conference sang the praises of Hawaii.

"Insurance is consistency and reliability, and we are all those things," said Sherman S. Hee, an attorney and president of Hawaii Captive Insurance Management Inc. in Honolulu, which manages the first captive insurer established in Hawaii and serves as counsel to several other captives.

And, he added in an interview, professionals in the state exhibit a mixture of the Asian values of loyalty and the American passion "to try something new."

Other domiciles can easily enough duplicate the state's flexible captive law, said Mr. Hee. But Hawaii, he said, offers "intangibles": Hawaiians "transcend ethnic bounds" and can "cut through red tape" in doing business in Pacific Rim countries.

"Anybody with any foresight who intends to bring a company into the 21st century must come to the Pacific Rim," he added. For example, "consider the potential insurance needs of China, with its 1.25 billion people."

"Watch China," agreed Craig Watanabe, assistant vp with captive manager Johnson & Higgins Services Inc.

Predicting that Southeast Asia and countries in the South Pacific will be "the next areas to develop globally," Mr. Watanabe called Hawaii a "unique bridge."

Apart from offering comprehensive captive management services, J&H's captive management office is completely separate from J&H's brokerage operations in Honolulu, Mr. Watanabe noted.

The domicile's newest captive manager, M&M Insurance Management Services Inc. in Honolulu, also offers comprehensive captive management services separate from parent Marsh & McLennan Inc.

Peter Lowe, M&M's resident captive manager, believes that Hawaii's well-developed infrastructure ideally prepares it to serve captives doing international business.

Mr. Lowe was instrumental in establishing a Hawaii captive for Telecom Corp. of New Zealand last year, the first Hawaiian captive—and possibly the first U.S.-domiciled captive—owned by a non-U.S. parent primarily to insure non-U.S. exposures (*BI*, Feb. 3). ■

Hawaii captive forum attracts 125 participants

HONOLULU—The 1992 Hawaii Captive Insurance Forum, sponsored by the state of Hawaii and organized by the consulting firm Tillinghast, was held Jan. 22-24 in Honolulu.

About 125 people participated in the forum. They were joined by representatives of the Insurance Division and other state agencies, including Hawaii's new insurance commissioner, Linda Takayama.

Highlights of the state's second captive insurance forum included the blessing by a Hawaiian priest of Johnson & Higgins Services Inc.'s new captive management office in Honolulu, which is headed by Craig Watanabe, an assistant vp.

Ms. Takayama

The opening of another new captive management office—that of Becher & Carlson Risk Management Inc.—was celebrated at a cocktail reception hosted by Vp and Manager Wanda L. Jong and other Becher officials.

Robin Campaniano, the former state insurance commissioner who was instrumental in the rapid growth of the captive insurance industry in Hawaii, was a featured speaker at the conference.

Mr. Campaniano is now president of AIG Hawaii Insurance Co. Inc. in Honolulu, which writes mostly personal auto coverages in the state.

Mr. Campaniano said he is responsible for developing AIG's commercial book of business in Hawaii. He also expects to continue his involvement with captive insurance company development.

The Hawaii captive conference produced "very solid expressions of very sincere interest by a half-dozen individual businesses," said Paul Pinckney, vp at Tillinghast in Irvine, Calif.

The first Hawaii Captive Insurance Forum was held four years ago in Honolulu. Such conferences should be held no more than every two or three years, because "the basics of Hawaii captives can get stale," Mr. Pinckney said.

But members of the newly formed Captive Insurance Council, a marketing and advisory group, expect to travel to major U.S. cities to promote the Hawaii captive program.

And last week the captive council was finishing plans to hold a reception on March 29 at the Risk & Insurance Management Society Inc. convention in Anaheim, Calif.

For more information on Hawaii's captive industry, contact Linda Takayama, Insurance Commissioner, 250 S. King St., P.O. Box 3614, Honolulu, Hawaii 96811; 808-586-2790.

Campaniano

Continued from previous page

But even more important, Mr. Campaniano said, "the state's strategy is not looking for a quick fix. The development of captives comes under the rubric of economic development. A state's typical ploy is to spend a lot of money to get a very good return to re-elect politicians. Hawaii has chosen a different tactic; that is, to build for the long term."

Hawaii is "a leader in solvency protection," said the former insurance commissioner. "We quite often know of the financial difficulties of an insurance company before other states do. We have been able to sit on top of our companies a lot quicker than many other states."

Hawaii currently is seeking certification of its solvency regulation program from the National Assn. of Insurance Commissioners, he said.

Mr. Campaniano cited several aspects of Hawaii's captive law that are designed to facilitate captive operations:

- The state has "one of the lowest premium taxes"—0.25% of premiums for single-parent captives and 1% for association captives and risk retention groups.
- There are no fees other than a $1,000 license fee and an annual $300 registration fee.
- Unlike some jurisdictions, there is no fixed employment requirement specifying that a certain number of the captive's employees must work in Hawaii.

"We do require one annual meeting of the captive's board of directors to be held in the state, and we have to twist some arms to have people come down from cold climes in February or March," Mr. Campaniano quipped.

Hawaii does not require captives to deposit the money they generate in local institutions, he added. But Hawaii's banks, which Mr. Campaniano called among the strongest in the nation, "have been very successful" in obtaining "their share of the business."

"We want to establish Hawaii as the financial center of the Pacific," he said. Mr. Campaniano called his successor as commissioner, Linda Takayama, "a very quick study" who will maintain the state's momentum in captive operations.

Other panelists highlighted aspects of Hawaii's captive law favorable to companies wishing to form captives.

Gerald C. Yoshida, an attorney with Char, Hamilton, Campbell & Thom in Honolulu, who represents most captives in Hawaii, praised the flexibility of the state's captive law.

Although other domiciles require specific capital and surplus amounts, Hawaii's regulations provide guidelines only, he noted. And with flexible investment requirements for captives, several single-parent captives "have come up with unique programs for better returns," Mr. Yoshida said.

He expects "very few changes coming up" in the law, which is "geared to creating a stable environment for captives."

Mr. Yoshida noted that several companies have taken advantage of the provision in the state's captive law that permits captives to write surety coverage, which is not allowed in all U.S. domiciles.

Two Hawaii-based companies are also taking advantage of a regulation that allows them to write workers compensation coverage directly through their captive, without a fronting insurer, he said.

Since Hawaii's law permits captives to write group health coverage, the division "is happy to consider applications from captives wishing to write employee benefit (coverages)," said Theresa Fitzgerald, insurance law analyst at the Insurance Division. ■

Experts weigh captive domiciles' strengths

By LOUISE KERTESZ

HONOLULU—Choosing a captive domicile may be more of an art than a science.

Hawaii Captive Forum

There are "many more similarities in domiciles rather than differences," observed Arthur Koritzinsky, a senior vp at Johnson & Higgins in New York.

And personal preference seems to play an important role in the selection of a domicile, Mr. Koritzinsky said. "It may be impressions left by regulators or service providers you've talked to, the amount and editorial content of media coverage, (or) industry trends," he said.

"Or maybe the boss has a condo in Maui," he quipped at the Hawaii Captive Insurance Forum, held last month in Honolulu.

Comparing offshore domiciles to U.S. domiciles, Mr. Koritzinsky noted that most domiciles in the Caribbean and Atlantic, like Bermuda and Cayman, permit captives to write third-party business. U.S. domiciles may permit third-party underwriting to some extent, but unrelated business cannot be the sole reason for forming a captive in a U.S. domicile, he pointed out.

In offshore domiciles, there may also be "somewhat less regulation," according to Mr. Koritzinsky. For instance, business plans are required in Bermuda as in Hawaii and other domiciles, but once a Bermuda captive is established, there's a more liberal attitude towards writing additional types of coverages or changing limits, Mr. Koritzinsky said.

One disadvantage of non-U.S. domiciles is that underwriting local risks "is typically not permitted in a Caribbean captive, as opposed to Hawaii where it is encouraged," he said.

U.S. domiciles also allow for "capital mobility," Mr. Koritzinsky said. "With offshores, it's much more difficult to effect intercompany loans because of investment restrictions and tax issues."

And insurance policies issued by a U.S.-based captive "may be more acceptable to the insured's customers and vendors" than policies issued from an offshore company, Mr. Koritzinsky added.

Turning to specific U.S. domiciles, Gregory Myers, vp at Becher & Carlson Risk Management Inc., a consulting firm in Woodland Hills, Calif., recalled that Colorado was a leader in the captive movement in the 1970s. But since then, Colorado "has gone through some cycles as to how interested it was in promoting captives," he said. As a result, some Colorado captives have shut down while others have moved to competing domiciles.

A 1988 law made Colorado "more competitive with other U.S. domiciles" and has been revised to further enhance the state's competitiveness, Mr. Myers observed. "They recently lowered their premium tax to be competitive with other domiciles like Hawaii and Vermont."

Still, Colorado's captive law is stricter than either Hawaii's or Vermont's. For example, Colorado requires a captive management affidavit, which is a filing with the state that shows how much of the captive's work is done within the state, he explained.

And in Colorado, the required minimum capital of $300,000—which can be in the form of securities or letters of credit—must be placed in a safe deposit box, and a key must be provided to regulators. Both those requirements make Colorado less attractive than other domiciles, Mr. Myers said.

But Colorado feels "international access" will give it an advantage. The state expects a new airport now under construction near Denver "will help make Colorado a center for captives because they're halfway between the East and West coasts or Europe and the Pacific Rim," Mr. Myers said.

Georgia, another domicile, "received a lot of fanfare when it set up a captive law in 1988," Mr. Myers continued. But the state has attracted only two captives. Its infrastructure is not developed and Georgia "is not actively promoting itself as a domicile," he said.

"Illinois is a large insurance center with some unique capitalization opportunities and a substantial amount of flexibility," Mr. Myers continued. But Illinois regulators focus their attention on the state's 470 insurance companies, not its eight captives.

The "strongest promoter" for Illinois' captive law is an independent attorney, rather than a state official, Mr. Myers observed.

On the other hand, the flexibility of Illinois' minimum capitalization requirement of $2 million is attractive: 80% can be represented by a letter of credit or two-thirds "can come as debt to be paid off in three annual installments," Mr. Myers said. "You can take a loan out for the full $2 million, to be paid off in three years. That may be a way for an association group to form a captive."

Illinois law is also flexible in several other areas, he said. For example, no physical presence within the state is required of the captive's manager and staff, not even an annual meeting. Only the captive's books and records must be kept in the state.

Looking at Vermont, by far the largest U.S. captive domicile, Mr. Myers noted that the state established its captive law in 1981 and boasts a well-developed infrastructure. Vermont is "the most common U.S. domicile," with 234 captives writing $1 billion in annual premiums.

The captive industry is also "a major business for the state" because Vermont derives 1% of its total revenues from captive premium taxes, he said.

But that may prove a problem for Vermont. Proponents of Vermont captives "want to remain competitive with other U.S. domiciles as they revise their laws, but they also have to look at how that affects their state revenues," Mr. Myers said.

A lower premium tax is good reason to look to Hawaii as a potential domicile, urged Jerome Aparton, senior vp at Sedgwick James of California Inc. in San Francisco. Since the premium tax rate for a Hawaii-based single-parent captive is only 0.25%—and that applied only to Hawaiian risks—"the state of Hawaii gets virtually nothing in the way of premium tax out of a captive," he said. "It's not designed to generate revenue" like Vermont's captive industry.

Many other features make Hawaii an attractive domicile, Mr. Aparton said. Fifty percent of its 1.1 million residents are employed, and its unemployment rate is 2.7%, he noted. Hawaiians also enjoy universal health care, he added.

"What do these things have to do

Continued on next page

Some assembly required for new captives

By LOUISE KERTESZ

HONOLULU—When designing a captive insurer, companies should plan to contract with providers for roughly 15 services needed to operate a captive, according to a risk management consultant.

Hawaii Captive Forum

But parents should hold down the actual number of service providers as much as possible in order to control expenses, said Michael Murphy, principal and founder of Denver captive manager RISK-CAP, formerly Risk Consultants Inc.

Forming and operating a captive requires a different mindset and different relationships with service providers, Mr. Murphy explained at the Hawaii Captive Insurance Forum held here last month. Companies that have gone from conventional commercial insurance to captive programs have experienced enormous "future shock," he said.

"About 25 to 30 years into the captive movement, captive service providers are still sort of an emerging industry, and their roles are not clearly defined from one jurisdiction to another, or from one provider to another," he said.

All the service providers should be viewed as forming the captive task force team, he said.

"What you initially want to do is come up with a project manager, someone who can pull all these different providers together, a team leader," the consultant explained.

This person could be a consultant, a broker, a captive manager or someone that combines those functions. The project manager is involved in the design and setup of the captive, including the application process and assistance in assembling the task force.

Because providers come from "absolutely divergent disciplines," it's difficult to find a project manager familiar with all the functions, Mr. Murphy said. "If you find one person that says they're an expert in all areas, you've found the wrong person. If you find a person that has a working knowledge of maybe seven of these areas, you've probably found an outstanding (project manager)."

Next, a company will designate a captive manager, perhaps even the captive's project manager. Captive managers perform a range of functions, which vary from one captive to another.

"Some captive managers do nothing but statutory accounting and maybe some interfacing with the insurance division. On the other end is a firm that brings a lot of services together into a captive management concept," Mr. Murphy explained.

If the captive manager is based in the domicile, that firm provides the captive's home office and keeps the books and records. If the manager is based elsewhere, the captive's counsel would keep its books and records.

Generally the captive manager provides ongoing accounting for the captive and regulators in the domicile, including preparing financial statements.

The captive manager is also responsible for premium collection, oversight and payment of service providers, completion of necessary filings, payment of state premium taxes and other functions required by regulation. If the captive is a risk retention group, the captive manager's duties extend to all the states in which the group does business, Mr. Murphy explained.

Companies changing to a captive program can experience 'future shock,' says Mr. Murphy.

The captive manager can also be responsible for reinsurance contract negotiations and can provide ongoing risk management consultation for the parent.

While establishing a captive, captive managers typically are paid for their time and expenses. In Hawaii, they later charge a fee based on a percentage of premium —typically 3% to 15%—depending on the services they perform. But they can also charge a flat fee to manage a captive, Mr. Murphy said.

The next important service provider is the domicile counsel, who should be "very actively involved" in designing the captive.

The domicile counsel's primary function is to represent the captive before local regulators, and he or she must ensure that the captive is complying with all relevant laws. "He's the one guy on the team that tends to be the real expert relative to Hawaii enabling laws and insurance regulations," Mr. Murphy said.

The domicile counsel also is involved in what the consultant described as another critical role: preparing the articles of incorporation. "There's literally a whole science in terms of structuring the captive's ownership, and the preparation of bylaws," said Mr. Murphy. Counsel also provides ongoing legal assistance in the state.

In Hawaii, the domicile counsel will also meet the requirement that the captive have a resident director, Mr. Murphy said.

Some captives also require a separate tax counsel for assistance with issues such as deductibility of premiums and "incredibly complex" income tax issues, he said.

Another important member of the captive team is the claims administrator. This person must "provide accurate and timely loss runs to the captive manager for reconciliation and reporting to the client" and make reports to the reinsurer in accordance with policy requirements, Mr. Murphy said.

If third-party claims are involved, the "administrator is the one function that can send your program south in a hurry, if you're not really tuned in to the quality of service as well as the reinsurance" that should respond to claims, Mr. Murphy cautioned.

Reinsurers also play "a very critical role" for the captive.

"You may find you also want to use a reinsurance intermediary, because it is physically impossible to access maybe 70 reinsurance markets in the United States as well as overseas," he added.

A captive also needs an actuary, an independent certified public accountant and bankers to maintain checking accounts and investments. A risk management consultant or a loss control consultant also may be necessary, Mr. Murphy said.

Group captives may want to secure an insurance broker or another mechanism to allow the captive "to go out and write new policies," he said.

Finally, Mr. Murphy asserted, "You need the regulator and may need an approved adviser. It's a mistake to think of those people on the other side of the table in an adversarial relationship. You really need them on your task force team, because you have to go through the whole process with them." ■

Infrastructure for captives

Continued from previous page

with captives?" he asked. "They are an index of how (Hawaiians) treat their people, how they conduct their business, how industrious they are."

Hawaii's infrastructure for captives is "way ahead of the learning curve of even places like Vermont," Mr. Aparton continued.

Vermont was in its fifth year as a domicile before the state attracted more than two captive managers, compared with the four captive managers already with offices in Hawaii, he said.

"So why are there only 22 captives in Hawaii?" Mr. Aparton asked.

"Beneath that Aloha shirt is a white-collar, buttoned-down mentality," he explained.

"They're very conservative people. The examiners have probably looked at perhaps twice that many and rejected them. They've seen some of the worst dogs that are possible."

Hawaii officials insist "they're not going to have a fallout like Bermuda in the early days," when some captives didn't survive, Mr. Aparton said.

He also cited the quick turnaround of applications as another factor to consider in the selection of Hawaii as a captive domicile. Applications properly filed will be approved—or disapproved—within a month.

And why choose Hawaii instead of an Asian domicile like Singapore, Malaysia or Hong Kong? Mr. Aparton asked. "It's the only one that's fun to come to. And you don't risk going to jail if you drop your chewing gum on the street."

However, the domicile selection process should not be "the tail that wags the dog," Mr. Koritzinsky warned. It is first important "to find out if the captive is feasible, if it makes sense, if the plan is going to work. If so, then analyze which domicile is going to have advantages or disadvantages for the company's plan."

If the captive doesn't work in one domicile, "it's very easy to move, either through redomestication or liquidating"—and forming a captive elsewhere, J&H's Mr. Koritzinsky added. ■

Rehabilitation order

Continued from page 2

headed by Mr. Waterman and owned by Governmental Risk Managers of Ohio, which acted as the insurer's manager. The insurer wrote $6 million in premiums in 1989.

A large part of GCIC's business was reinsuring general liability and property risks of three municipal insurance programs: the Michigan Township Participating Plan, the Ohio Government Risk Management Plan and the Ohio Fair Participating Plan.

This business was transferred to ACLIC in 1990, when GCIC started experiencing financial problems.

The Ohio Insurance Department issued a directive in August 1990 requiring GCIC to obtain prior regulatory approval for a variety of transactions, including transfers or investment of its funds. The directive was based on regulators' determination that GCIC's surplus had dipped below the $2.5 million statutory minimum three times in the previous 18 months.

Ohio regulators placed GCIC under supervision in August 1991, and petitioned to place the insurer in rehabilitation earlier this month after Mr. Waterman, GCIC's president, agreed to the action.

An examination of GCIC as of last Sept. 30 found the insurer insolvent by $2.3 million. Examiners disallowed $4.9 million of GCIC's reported $8 million in assets, including assets the insurer transferred to affiliates without the Ohio department's approval.

Disallowed assets included:

- $2.7 million in cash that had been transferred to ACLIC, GRM of Ohio and an unidentified former shareholder of GRM of Ohio.
- $850,000 in common stock of Waterman Investments Inc., the parent company of ACLIC. GCIC had transferred this stock to GRM of Ohio, examiners found.
- $328,000 representing two mortgage loans, one of which was forgiven and the other transferred to GRM of Ohio. Neither borrower is identified in the exam report.
- $265,972 representing anticipated federal tax refunds. The recoverable was assigned to GRM of Ohio, then to Midwest Intermediaries Inc.—another affiliated company—and finally to ACLIC. However, the tax return supposedly creating the recoverable was never filed with the Internal Revenue Service, according to the report.

Mr. Waterman could not be reached for comment. ■

INTERNATIONAL

Lloyd's rebuts charges leveled in Parliament

By CAROLYN ALDRED

LONDON—Members of Parliament continue to bombard Lloyd's of London with accusations of insider trading, incompetence and malpractice.

Following a meeting with Lloyd's Chairman David Coleridge and Chief Executive Alan Lord last week, a number of both Conservative and Labor Party MPs continued to call for government regulation of Lloyd's and to allege that members of Lloyd's who work in the market received favorable treatment over non-working members.

Those claims are described as ludicrous and naive by underwriting executives. And the executives charge that the MPs are abusing their power to try to ameliorate any losses they may have sustained as members of Lloyd's.

More than 40 of the 366 Conservative MPs are Lloyd's members, and some belong to various members' action groups that are litigating to avoid paying losses.

"We are talking about politicians who are losing a lot of money," said Ralph Bailey, underwriter for syndicate 138, managed by R.F. Bailey (Underwriting Agencies) Ltd.

"I think they are using their position of power and influence for their own benefit," he said, echoing a view expressed by many in the London insurance market.

Last Monday, at a luncheon with about 25 MPs, Messrs. Coleridge and Lord outlined initiatives Lloyd's is taking in response to reform recommendations released last month by a Lloyd's task force.

The report lists more than 60 recommendations designed to increase Lloyd's capital base to 17 billion pounds ($29.75 billion at current exchange rates) by 1997. Among other things, the task force suggests changing how Lloyd's is governed and introducing cor-

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New SCOR unit writing 'shared risk' coverage

By ROGER SCOTTON

HAMILTON, Bermuda—A specialty insurance and reinsurance unit of SCOR S.A. opened for business in Bermuda last week with $50 million in capital and a product concept it says represents the next stage of evolution for financial and finite risk programs.

The company, Commercial Risk Partners Ltd., is 75% owned by Societe Commerciale de Reassurance S.A. of Paris, the world's seventh-largest reinsurer. Commercial Risk is a holding company, with insurance and reinsurance transactions being written by operating units in Bermuda and Vermont.

With one application for an excess/surplus lines license in the works in Connecticut, the Vermont company hopes eventually to do business in all 50 states.

Besides SCOR S.A., other shareholders are SCOR U.S. Corp., with 20%, and Banque Nationale de Paris, with 5%.

Daniel G. Marren, Commercial Risk's president and chief executive, says every Commercial Risk transaction will have an element of "real" underwriting risk transfer built into it.

Based on this operating philosophy, the company has coined the term "shared risk" for its products.

"Shared risk is the next step beyond finite risk," says Mr. Marren, who in 1988 helped establish Bermuda's largest finite risk insurer, Centre Reinsurance Holdings Ltd.

"Insurance buyers are increasingly seeking true risk-taking partners, which is why we will be taking on a greater percentage of risk than finite risk carriers," he said. "The shared risk concept provides true insurance and reinsurance underwriting protection while continuing to offer clients a mechanism by which they may benefit from a long-term interest in favorable loss experience."

Commercial Risk programs will have an aggregate limit of liability with profit-sharing or premium return features. Typical insurance and reinsurance policyholders will include those with casualty, product liability or environmental exposures.

"Our view is that sophisticated buyers of insurance are increasingly going to be retaining greater amounts of predictable losses," says Mr. Marren. "With shared risk, we'll be sharing with them in their medium layers of, say, $20 million to $30 million—below the catastrophe level, but above their pure retention which may be in the area of $10 million.

"We'll probably focus on the $5 million to $10 million premium accounts, but we don't want to get pigeonholed. We're not saying that we'll only write business that will give us a $5 million premium. Every transaction will be priced on a risk/return basis," he said.

Operating subsidiaries of the

Continued on next page

Finding opportunities in Eastern Europe

Poland is darling of London brokers

By WILLIAM PITT

LONDON—London insurance brokers are flocking to Eastern Europe.

Far from being in the baggage train of merchant bankers who have been advising Eastern Europeans on the transition to a market-based economy, insurance brokers have found themselves in the vanguard.

Even some brokers have been surprised by the growing demand for insurance in the East. But recognizing that need, London brokers say they are ready and willing to tap these markets.

Poland is the most popular target for brokers eager to gain a foothold in the region.

Two of the largest brokers—Sedgwick Group P.L.C. and Willis Corroon P.L.C., both headquartered in London—have offices in Warsaw, and New York-based Marsh & McLennan Cos. Inc. is in the process of establishing one.

Two smaller brokerages—PWS Holdings P.L.C., based in London, and French family-owned Gras Savoye S.A.—also are open for business in the Polish capital.

This flurry of activity is a little surprising given that the Poles spend less on insurance than almost any other nation in the former Soviet bloc. In fact, according to Alexander & Alexander Services Inc., insurance as a percentage of Poland's gross domestic

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Russian insurance group

New trade association aims to improve domestic market

By MARIA KIELMAS

LONDON—A new association, the Union of Insurance Companies of Russia, aims to develop and regulate the Russian insurance market, promote training and professional standards, and represent the market abroad.

Only officially licensed insurers will be accepted as members.

The union's president is Mikhail Safronov, who is also chairman of Ingosstrakh, the Russian insurer and reinsurer that writes international business.

Mr. Safronov said the impetus behind the union came from the three largest companies in the market: Ingosstrakh; Gosstrakh Rossiya (formerly Gosstrakh), the largest domestic insurer; and Rossiya, a domestic insurer set up three years ago by several Russian commercial banks and Colonia Versicherung A.G. The German insurer is no longer a partner.

Insurers began discussing such a union at a January conference in Moscow. Of the 181 Russian insurers represented, 144 voted in favor of the union.

"We knew that not all of them had licenses. About 77 have a li-

cense, and some 40 or 50 companies have had confirmed (by the authorities) that a license is to be issued," said Mr. Safronov.

Presiding over the insurer union will be an 11-member committee. In addition to Mr. Safronov as president, it will include Yuri Bagaev, the chairman of Gosstrakh Rossiya, as first deputy chairman; and Ivan Klemetyev, a senior executive at Ingosstrakh, as secretary.

"We are now trying to expedite this union," said Mr. Safronov. "The priorities are insurance legislation, the introduction of insurance supervisory control, training, and certainly the representation of the Russian insurance market at various international conferences."

The Ingosstrakh chairman says he was elected president of the union because of his company's wide professional experience. "From the professional point of view and the classes of business which we run, we are slightly unique in this country," he said.

Regarding training of insurance professionals, he said Ingosstrakh is actively negotiating with companies that are "some of the big names in the West." He said it was too early to identify them.

A final decision on the new Russian insurance law is "expected soon," said Mr. Safronov.

The law will follow general international practices in insurance legislation and will set capitalization requirements for insurers depending on the class of business that they intend to write. Mr. Safronov was unable to quote exact figures, but said foreign and domestic insurers would face the same requirements.

But the draft law as it is now being discussed allows foreigners to acquire stakes of up to only 49%

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French insurer sues AMB over voting rights

By WILLIAM PITT

LONDON—The long-simmering battle between French insurer Assurances Generales de France Group and Germany's AMB Aachener & Muenchener Beteiligungs A.G. is heating up now that AGF has filed suit against AMB in a German court.

But an AMB executive contends the dispute over voting rights may be settled before trial.

The lawsuit alleges "an abuse of the legal rights of the management of AMB" in refusing to grant AGF voting rights in the German company, the state-controlled French insurer said last week.

Paris-based AGF has built up a stake of 25% plus one share in AMB and has been pressing AMB's board to register an equivalent percentage of the company's voting rights in AGF's name.

But Aachen, Germany-based AMB has steadfastly refused to register AGF's shares, arguing that under the German insurer's bylaws, management has the freedom to grant voting rights to whomever it wishes. That company policy will be tested in the county court in Aachen, where AGF filed suit.

However, the dispute may not reach that point. AMB Director Peter Matthiesen said that negotiations were continuing between AMB and AGF, despite the legal threat. He suggested that there were "good signs" that an amicable solution could be reached before the court case had gone far.

AMB has told AGF that it may be more willing to register the disputed shares if AGF can help relieve the German insurer of troubled subsidiary Bank fuer Gemeinwirtschaft, which AMB acquired in 1987. AGF has suggested that the state-owned French bank Credit Lyonnais might be willing to buy into the bank (*BI*, Feb. 17).

Mr. Matthiesen said he had yet to hear from Credit Lyonnais, but added that he expected a response "within weeks." By contrast, he said the lawsuit just filed by AGF might take six months to a year to be resolved.

In its formal statement alluding to the opening of legal proceedings, AGF stressed that the negotiations to "reach a durable solution for BfG" were still in progress.

Meanwhile, AMB last Tuesday unveiled its alternative to the form of international cooperation sought by AGF. A new Luxembourg-based joint venture called European Partners for Insurance Cooperation unites AMB with its two longstanding European partners: Fondiaria S.p.A. of Florence, Italy, and Royal Insurance Holdings P.L.C. of London (*BI*, Jan. 13).

Each of the three partners is committing 59 million pounds ($103.2 million at current exchange rates) to EPIC's initial capital.

In addition, the company plans to raise 34 million pounds ($59.5 million) of debt capital itself.

EPIC's official aim is to expand "the three partners' presence in European markets outside their home countries."

When asked whether AGF might be invited to join EPIC as a fourth member at some point, AMB's Mr. Matthiesen replied that EPIC is "open for other partners" providing the three founding members agree. However, he stressed that the fact that EPIC would not participate in members' home markets is "one of the important rules" of the partnership.

AGF has made no secret of the fact that it feels under-represented in AMB's home market of Germany, which would not be remedied by participation in EPIC. ■

INTERNATIONAL

New SCOR unit

Continued from previous page
Bermuda holding company are Commercial Risk Reinsurance Co. Ltd. in Bermuda and Commercial Risk Re-Insurance Co. in Vermont. Mr. Marren is president and CEO of the Vermont company as well as the parent firm.

The operating units are based in two major captive insurance company domiciles to be close to these targeted customers, Mr. Marren noted. "We're targeting corporate insurance buyers and their captives," he said.

"The Bermuda company will be responsible for underwriting pretty much all Commercial Risk's worldwide business, with the exclusion of prospective covers in the United States," said Mr. Pewter, who adds that the Vermont company will reinsure some business with the Bermuda company.

"But we're not interested in writing time-and-distance-type products, which we feel are uneconomical and have no future," he said. "These products are already under pressure in the United Kingdom and cannot be written at all in the United States because of statutory accounting problems. The future of financial products generally lies in the direction of the shared risk concept."

Bermuda offers 'tremendous scope for shared risk opportunities for captives,' says Mr. Marren. 'The financial insurance and reinsurance market is saturated, but there's not nearly enough capacity for those who want real risk-bearing products.'

Earlier plans to capitalize Commercial Risk with $100 million were scrapped (*BI*, Aug. 1, 1991). "It was decided $50 million was enough and that we didn't need to have the money sitting there doing nothing," he said.

Other partners were not sought, as originally intended, to allow the company more underwriting freedom, noted SCOR S.A. President of Operations Jacques Blondeau. He noted other partners could be sought in the future if additional capacity is needed.

The Vermont company, which is a subsidiary of the Bermuda reinsurer capitalized at $20 million, will concentrate on shared risk insurance and reinsurance transactions for U.S. companies, captive insurers and other insurance companies.

Managed from the offices of Yankee Captive Management Co. in Vermont, the Vermont company will open an administration and marketing office in Stamford, Conn. "This would put us in a greater metropolitan area and closer" to SCOR U.S., SCOR's U.S. affiliate which is based in New York, Mr. Marren said.

SCOR U.S. will be available to reinsure programs written by the Vermont company when additional capacity is needed, said Jerome Karter, president of SCOR Reinsurance Co.

Graham C. Pewter, formerly president of Edmond de Rothschild Insurance Services, an intermediary and finite risk consultant based in Bermuda, has been appointed president of the Bermuda operating unit. The Bermuda company will concentrate on shared risk insurance and reinsurance products for European entities and Bermuda-based captives.

The Bermuda company also will underwrite retrospective insurance and reinsurance transactions for U.S.-based entities.

Mr. Marren said Bermuda offers "tremendous scope for shared risk opportunities for captives."

"That's why we're there," he says. "The financial insurance and reinsurance market is saturated, but there's not nearly enough capacity for those who want real risk-bearing products."

Mr. Marren also sees strong potential for the company in the European Community through SCOR, which hired him as a consultant in 1990.

SCOR Chairman Patrick Peugeot also is chairman of Commercial Risk Partners.

"The integration of shared risk products into SCOR gives us a tremendous competitive advantage," said Mr. Marren.

He adds that Commercial Risk has been receiving submissions since it opened. Initial projections are for it to write net retained premiums of $50 million in its first year. ■

Russian group

Continued from previous page
in Russian insurance companies, Mr. Safronov said.

In areas other than insurance, there is no cap on foreign ownership.

The restriction on insurance company holdings may be lifted, he said. "It remains to be settled; the question is still unclear and open."

Russia's political and economic turmoil is not having much of a direct effect on Ingosstrakh, he said, but the indirect impact is very significant. "A lot of clients do not have enough funds to buy insurance because the economy is in such a bad state. They have difficulties in settling their premiums, there is a real delay in payments and documents are not always 100% clear." ■

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INTERNATIONAL

Eastern Europe

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product has shrunk in recent years to 1.3% from 2.5%.

But Ben Habib, finance director at PWS, said Poland was chosen as the most attractive Eastern European market because of the "dynamism" the Polish people had shown in casting off the shackles of communism. "We perceive the Poles as very well educated and very advanced in their thinking," he commented.

Of all the Eastern Europeans, Poles appear to have the greatest understanding of risk and seem to be moving most quickly toward a Western system of tort law.

Mr. Habib added that PWS's chairman, Lord Pearson, had close personal contacts in Poland and that a PWS non-executive director had helped organize the delivery of Western medical supplies to the country in the 1980s.

PWS's office in Poland officially opened Sept. 19. It is run by Tim Beecham, with the assistance of a former employee of Warta Insurance & Reinsurance Co. Ltd., the state-owned foreign trade insurer. Mr. Habib said the office would concentrate on large-scale insurance and reinsurance brokerage.

PWS has a rather original plan for exploiting the untapped riches —if riches there are—of Eastern Europe. Along with three insurers —one Spanish, one British and one Japanese—it has created a jointly owned company, PMC Eastern Europe Ltd.

Poland was chosen as the most attractive market because of the 'dynamism' the people had shown in casting off the shackles of communism, says Ben Habib. 'We perceive the Poles as very well educated and very advanced in their thinking.'

The firm's name derives from the initial letters of its shareholders: PWS, which holds 51%; Group Mapfre International of Spain and Municipal General Insurance Co. Ltd. of the United Kingdom; and Chiyoda Mutual Life Insurance Co. of Tokyo. PMC provides its insurer shareholders with what Mr. Habib calls a "listening post" in Eastern Europe, at low cost.

He also is hopeful that the insurance companies' clients may be encouraged to use PMC's Polish brokerage office if they have plans to invest in Poland.

This base of business is important for a medium-sized reinsurance brokerage like PWS. Mr. Habib pointed out that the firm cannot simply set up an office in Warsaw or Budapest, Hungary, and rake in business from its Western multinational clients, like international giants such as Marsh & McLennan might do.

PMC will face competition that grows stiffer by the day. In November, Sedgwick Group, the world's third-largest brokerage, opened a Warsaw office, marking a further step in the most ambitious expansion program in Eastern Europe undertaken by any brokerage house.

Adrian Platt, Sedgwick board director responsible for Central and Eastern Europe, said that with the help of brokers, "insurance could help to set the framework of change in Eastern Europe much more than it has elsewhere."

He alluded to the "traditional" view of insurance as the "last thing you think about" as an industrialist, and argued that this might not prove the case in Eastern Europe.

"You cannot make an enterprise self-financing," he said, "until it is fully costed as an enterprise." He argued that the cost of insurance has to be taken into account at the planning stage of privatizations.

Mr. Platt identified "about 40 so-called brokers" operating in the Polish market. Most of these really are direct agents, working with just one insurance company, he said.

Both Mr. Platt and Mr. Habib argued that the proliferation of direct agents calling themselves "brokers" places a premium on the services of true brokers, who can offer their clients a choice of markets. But they also expressed concern that with only minimal official regulation of brokers, unprofessional outfits may tarnish the reputations of other firms.

"That's always a risk in developing countries," said Mr. Habib. "Intermediaries are always suspect." He suggested that this could be due to brokerages' capital not being measured in the way insurers' capital is measured. Brokers' true capital consists of intangibles like "knowledge and expertise," he said.

Sedgwick steadily is building a comprehensive network of offices in Eastern Europe. In addition to Warsaw, it currently has offices in Budapest and Moscow. The Moscow office is slightly different from the offices in Poland and Hungary, which are empowered to accept premiums and pay claims, because it refers inquiries back to London.

The strength of Sedgwick's reputation as a broker of energy risks landed the company a major account as risk management consultant to the government of Kazakhstan for its oil and gas separation plant at Tengiz. Mr. Platt recently said the Kazakhs are negotiating with Chevron Corp. to invest in the plant.

If Sedgwick leads the pack in Eastern Europe, Willis Corroon is hot on its tail. Now severed from its old UNISON brokerage partners in Western Europe, Willis Corroon has moved quickly to build its own network in the East.

In mid-1991, Willis Corroon became the first Western brokerage to obtain accreditation from the Soviets to open an office in Moscow, said Mike White, managing director at Willis Faber & Dumas responsible for Central and Eastern Europe. It also is gradually buying into a Polish brokerage and has an office in Prague, Czechoslovakia, which "should be in a position to operate very soon."

Willis Corroon's office in Moscow is run by Andrei Sazonov, a former marine underwriter for the Black Sea & Baltic General Insurance Co., the London-based subsidiary of state-owned Ingosstrakh. Mr. Sazonov's former boss, Ingosstrakh Chairman Mikhail Safronov, was not happy about the defection, Mr. White recalls. Sedgwick's man in Moscow also was previously with Ingosstrakh.

The demise of the Soviet Union, however, will change the way business is done in the republics. Previously, brokerages that established a Moscow office could do business throughout the Soviet Union. Now, they may need offices in the individual republics in which they choose to do business.

Indeed, the flood of Western brokers into Eastern Europe is creating a demand for local insurance skills that employees of the old state-owned insurance companies seem only too glad to satisfy. ■

INTERNATIONAL

Three interim CEOs named for Lloyd's

By GAVIN SOUTER

LONDON

LONDON—A triumvirate of Lloyd's of London executives will temporarily take over as chief executive when Alan Lord retires from the post in June.

That measure will bridge the up to 12-month gap between Mr. Lord's retirement and the implementation of any governance reforms recommended by a Lloyd's task force last month (*BI*, Jan. 20).

During that time, day-to-day operations will be directed by three Lloyd's executives, led by John Gaynor, head of finance. The other directors will be Andrew Duiguid, head of market services, and Bob Hewes, head of regulatory services.

A member nominated by the Council of Lloyd's will be appointed deputy chairman with special responsibility for regulatory matters and the interests of members upon Mr. Lord's retirement. Mr. Lord, 62, has been Lloyd's chief executive and deputy chairman since 1986.

The council initially rejected a task force proposal to separate the marketing and regulatory functions at Lloyd's. But protests from the market forced the council to back down, and a working party is now studying the proposal (*BI*, Jan. 27). Mr. Lord said he expects a report from the working party later this year but adds that any reforms may take until June 1993 to implement.

Meanwhile, Lloyd's has set up six working parties to consider seven recommendations the task force advised implementing beginning with the 1993 accounting year.

The working parties are expected to report to the council between April and June.

Computer standards

U.S. insurance and reinsurance groups and European computer network organizations have agreed to set up a joint task force to explore electronic data interchange standards.

The process eventually will lead to claims settlements and reinsurance placements being handled worldwide via computer, they say.

The New York-based Brokers & Reinsurance Market Assn. and the Reinsurance Assn. of America in Washington, D.C., will establish a task force with the London Insurance Market Network in Britain and the Reinsurance and Insurance Network in Brussels, Belgium.

"This development is of major significance because it will optimize and accelerate the progress of international electronic communications networking in the areas of reinsurance and insurance, based on a set of standards and standard messages which can be accessed by reinsurers, insurers and intermediaries throughout the world," said a joint statement from the groups.

The initial task force agreement will run until January 1993, but is expected to be extended.

The impetus for the task force came from a January 1991 visit to the United States by RINET and LIMNET representatives, said Mike Seddon, information technology executive at the London Insurance & Reinsurance Market Assn.

"We found that we were approaching the same problem from different angles so we arrived at different standards. We said this is crazy; we should try and harmonize and not compete on what computer messages should look like," he said.

The task force should agree on standard claims messages this year and standards for placement and claims payment messages may follow in 1993, Mr. Seddon said.

U.K. firm in Hungary

Croyden, England-based Noble Lowndes, the world's fifth-largest employee benefits consultant, has acquired a majority stake in a Hungarian benefits consulting firm.

Px Human Risk Management Ltd. of Budapest, which advises the Hungarian government on the establishment of health insurance and pension systems, was established in 1989. Its 10 shareholders include the Hungarian Ministry of Welfare and the state insurer, Allami Biztosito.

Adam Gere, a native of Hungary, will serve as president of the renamed Noble Lowndes/Px Ltd.

Mr. Gere previously was an independent consultant to Western companies opening businesses in Hungary.

Noble Lowndes reported $255 million in gross revenues in 1991, 75% of which came from employee benefits consulting (*BI*, Dec. 16, 1991).

—By Sara Marley

The Professional Marketplace

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MPs' complaints

Continued from page 31

porate membership (*BI*, Jan. 20).

Many of the changes would require an act of Parliament, which wouldn't be introduced for at least two to three years, said Mr. Lord.

The meeting featured presentations by the task force chairman, David Rowland, who is chairman of Sedgwick Group P.L.C., and Paul Archard, chairman of Lloyd's Underwriting Agencies Assn. The meeting had been arranged before the current political storm (*BI*, Feb. 17).

Although several MPs tried to voice their own dissatisfaction with Lloyd's at the beginning of the meeting, other MPs criticized them for being impolite to their hosts.

Afterward, at a swiftly called press conference, Mr. Lord described the meeting as "constructive."

"I am in no doubt that the facility provided today has helped considerably to increase understanding of the pivotal role played by Lloyd's at the heart of the London insurance market," Mr. Coleridge added in a statement. "It also provided an opportunity for senior figures within the market to set in context some of the wild and misconceived assertions which have been made recently about the way in which the market is regulated and, importantly, how it conducts its business."

"It went very well," added the LUAA's Mr. Archard after the meeting. Most of the MPs' questions were positive and sensible, and misconceptions were explained, such as those surrounding the London market excess-of-loss spiral, he said (see story, page 36).

Despite the meeting, Lloyd's continued to fare poorly in Parliament.

Continuing the flood of Lloyd's-related motions delivered in the past few weeks, MPs last week called for Mr. Coleridge's resignation and alleged that working members protect their assets from unlimited liability by placing them offshore.

Attention from the MPs also kept Lloyd's problems on the front pages of many daily newspapers and on television screens.

Several MPs believe Lloyd's should be regulated by the British government rather than allowed to regulate itself through the Council of Lloyd's. This suggestion was made in some of the 290 submissions to the task force, and the suggestion was mentioned in the report. However, the task force concluded that regulation of Lloyd's wouldn't cost any less if it were in the hands of the government.

Mr. Coleridge said that Lloyd's was no closer to being regulated by the government than before the recent flurry of parliamentary activity. He also noted that the MPs he met with did not discuss the issue of government regulation.

Mr. Lord added that a government-ordered study of Lloyd's led by Sir Patrick Neill in the mid-1980s had already confirmed the effectiveness of Lloyd's self-regulation, though report produced by this study included 70 recommendations for improving regulation.

'There is no substance' in the MPs' allegations, says Mr. Bailey, a Lloyd's underwriter.

All were later implemented.

That reminder did not assuage the concerns of some MPs at Monday's luncheon meeting. They remain skeptical about the market's ability to police itself and to improve underwriting conditions.

"We were given a lucid representation of the task force report, but 10 out of the force's 13 members are insiders and the report will be implemented by insiders," said one Conservative MP.

The MP, who has suffered losses at Lloyd's, would talk to *Business Insurance* only on Parliamentary Lobby terms. This is a system used frequently in British politics whereby politicians speak candidly to journalists on the understanding they will not be quoted by name.

"The Cromer report was kept secret for 21 years and only selected bits from the Fisher and Neill reports were implemented by Lloyd's. So what hope is there for Rowland's report?" he said, referring to earlier task force reports from the 1970s and 1980s on regulation at Lloyd's.

In addition to government oversight, MPs are proposing that an accounting firm from outside London should be appointed to examine the Lloyd's recent losses and the allegations of wrongdoing in the market.

"We are most anxious that there should be an outside regulatory body set up to check the appalling allegations of insider dealing and claims that the bulk of Lloyd's Council members have protected their exposure to unlimited liability through the use of trust funds set up in offshore islands, such as the Cayman Islands," the Conservative MP told *Business Insurance*.

"At the moment all regulation at Lloyd's is done by insiders. We want to see Lloyd's appoint a firm of accountants from somewhere like Manchester to investigate," he said.

MPs from both the governing Conservative Party and the opposition Labor Party contend that working names have greater access to profitable syndicates than external members of Lloyd's. Earlier this month a list of alleged "insider" syndicates that are reputed to contain a high percentage of working names was released by the MPs (*BI*, Feb. 17).

Lloyd's executives representing those syndicates, though, dispute the allegations of any wrongdoing.

"We are not aware that anything this syndicate does is illegal or improper," said one members agency director who asked not to be named.

The director claimed that his agency represented few non-working members only because its executives "know very few rich people" and, therefore, were unable to make contacts with as many potential external Lloyd's members as other members agencies.

Besides, working members "have always tried to get on syndicates they have done business with, in the same way that employees often buy shares in companies they have worked for or with," he said. "It's not insider dealing; it's knowledgeable dealing."

"There is no substance" in the allegations, agreed Mr. Bailey of R.F. Bailey (Underwriting Agencies) Ltd., whose syndicate 138 was one of those identified by the MPs to have a high proportion of working names as underwriters. "I am astounded to be mentioned. We have about the market average" in terms of working members.

According to Mr. Bailey, the syndicate's 1992 account is 16% underwritten by working members.

Mr. Bailey believes syndicate 138 may have been singled out by MPs because in recent years it has refused any additional members due to a desire to reduce its capacity.

"I reduced the syndicate's size purposely between 1987 and 1991, because we were only underwriting about 25% of our stamp capacity," he said.

For 1992, the syndicate increased its stamp capacity by 5 million pounds ($9.3 million at year-end 1991 exchange rates) with "the vast majority of additional capacity coming from outside names," he added.

Mr. Bailey claims the MPs' allegations are "coming from a total lack of understanding" of the market. "They are bred from naivete and desperation," he said, adding that the complaining members fail to mention "how much (money) they have made in the past."

The MPs are using their prominence to highlight their personal plight, he said, referring to the daily coverage of Lloyd's last week in British newspapers and on television news programs.

"They can sing from the rooftops and get massive attention," said Mr. Bailey.

Moreover, "they can say what they like in the House and not be sued," he said, referring to the immunity of MPs from libel actions over what they say in the House of Commons debating chamber.

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International Editor Stacy Shapiro contributed to this story.

Suggestions for reform detailed

Rowland argues for changes

LONDON—While the political storm rages outside, Lloyd's of London is trying to put its own house in order on the inside.

Last week, David Rowland, chairman of Sedgwick Group P.L.C., outlined before the Insurance Institute of London the reform proposals made by a Lloyd's task force. Since the report was released last month, he has been giving similar speeches (*BI*, Jan. 20).

"This society is full of strengths: the independence of the underwriters, the competing nature of the market, the entrepreneurial units each trying to outdo the other. . . .It's unlike any other market in the world, and we must seek to preserve that," he said.

"If we lose it, Lloyd's will change into just another insurance company, and that's not much fun for anyone," said Mr. Rowland.

But he reiterated that while he believes the best of Lloyd's is the best in the insurance world, the worst "is positively dreadful."

In arguing for the proposed reforms, the task force chairman said, "it's an extraordinarily difficult task to manage a free entrepreneurial society like Lloyd's and keep the essential qualities of it, and yet take the key decisions that have to be taken for our competitive strength."

Mr. Rowland highlighted the key proposals, which include dividing governance between a "marketing board" to oversee Lloyd's business operations and and a "regulatory council" to oversee regulation.

Amid widespread criticism, the Council of Lloyd's, the market's current ruling body, was forced to withdraw its immediate rejection of that suggestion (*BI*, Jan. 27).

"The events in recent weeks make me regret that we didn't take this attitude to begin with," said Mr. Rowland. "Look at how much easier it would be today to deal with (Parliament) if only the Council had said, 'What a good idea. We should look at the way we govern ourselves. (We're) not sure that the task force has it wholly right, but this strikes a chord.' "

After his speech, Mr. Rowland was asked what the market can do about the "low ebb" of Lloyd's relations with members of Parliament and the media.

"We have got to be extremely brave and tough during the next year or two years because we shall have replayed to us continually a whole lot of the old issues," he answered. "We have to demonstrate to the outside world that we have belief in ourselves. . .and we have the guts and leadership to get ourselves through."

Another questioner criticized the task force for basing its recommendations on only 290 submissions. He believed that the council was now "clutching" to the report without any further discussion, even though the young people at Lloyd's think that "it's no answer" to Lloyd's problems.

"I'm sad if you think that (the report) doesn't provide Lloyd's with a future," said Mr. Rowland. The submissions were made by groups of people, and Mr. Rowland said he intentionally put people in their early 40s, on the panel.

Another questioner suggested that the task force proposals would be easier to implement if they didn't depend on a new act of Parliament.

Mr. Rowland responded there was no way to make some of the changes needed at Lloyd's without a new Lloyd's Act. But, he added, "if you can see other answers. . .for goodness sake tell us."

—By Stacy Shapiro

Member losses

Continued from page 1

billion).

But if the 600 members succeed in stopping Lloyd's from drawing down on their deposits, Lloyd's could not tap the deposits or reserves of other members unless it receives approval from its entire membership.

Losses not paid by members can be paid from Lloyd's Central Fund, which now stands at 500 million pounds ($878.5 million). Lloyd's, though, will not say how much of that fund already has been earmarked for non-paying members.

Lloyd's will be able to continue operating even if members are granted the injunctions, Mr. Coleridge said.

"There is no chance" that Lloyd's would shut down, he said. "Otherwise, Lloyd's would be completely destroyed."

Lloyd's will continue operating because it will be solvent even if the members do not pay the cash calls, disgruntled members agree.

Eventually Lloyd's will "run into a liquidity problem, not a solvency problem, and will have to go to the Bank of England" for a temporary loan to pay losses, predicted Alfred Doll-Steinberg, chairman of the Gooda Walker Action Group, which represents members of four defunct syndicates managed by now-liquidated Gooda Walker Ltd.

Lloyd's faces overall losses of about 1.3 billion pounds ($2.43 billion at appropriate exchange rates) for the 1989 underwriting year, which closed at the end of 1991 and is only now being audited under Lloyd's three-year accounting system. Losses for the 1988 year were a record 509.7 million pounds ($983.7 million at appropriate exchange rates).

Mr. Doll-Steinberg thinks the market by the end of the year will be about 1 billion pounds short to pay primarily LMX reinsurance claims to other Lloyd's syndicates and London market insurance companies. Most of the members refusing to pay losses were members of now-defunct LMX syndicates.

"Any government would be crazy to allow an institution like Lloyd's to go down the plug; it brings a lot of taxes and jobs," said Mr. Doll-Steinberg. Besides, Lloyd's isn't insolvent, just short of cash, he said.

Gooda Walker members owe a total of 238 million pounds ($418.2 million) in cash calls, including 101 million pounds ($193.6 million) due March 31 to repay a loan from the Lloyd's American Trust Fund.

Ralph Sharp, chairman of G.W. Run-Off Ltd., confirmed that most of the Gooda Walker claims result from LMX losses owed to other Lloyd's syndicates and London market insurance companies.

But the Gooda Walker names argue that many of the LMX policies are not valid and should be voided, which would negate the claims (see related story).

The members are willing to pay legitimate claims, but not those resulting from the LMX spiral, Mr. Doll-Steinberg said.

So far, Gooda Walker names have paid 116.3 million pounds ($204.7 million) of the 137.3 million pounds ($241.6 million) in cash calls ordered last year for 1989 and 1990 losses, according to Mr. Sharp.

However, "we have indications that names will not respond" to the latest cash call due at the end of March, he said. If names don't pay the call, G.W. Run-Off will have to discuss how to pay the losses with Lloyd's, he said. He wouldn't comment on whether the cash call was to pay back the loan on the Lloyd's American Trust Fund.

"We need cash," said Mr. Sharp. "We'll have to sit down with Lloyd's (executives) if the cash is not forthcoming. I have (legal) advice that the cash calls are perfectly legal and comply with Lloyd's regulations."

Meanwhile, the Gooda Walker Action Group has contributed about 10,000 pounds ($17,600) to a 120,000 pound ($211,200) fighting fund set up by London law firm Michael Freeman & Co. The fund was established to finance legal costs involved in seeking the injunctions last week against at least 10 members' agencies to prevent them from drawing down on members' deposits to pay cash calls.

Senior partner Michael Freeman first touted this idea at a January seminar (*BI*, Feb. 3).

At the end of January, he sent a letter to all members of the loss-riddled syndicates that are now being reviewed by Lloyd's-appointed panels because their losses exceeded 100% of the premium volume they wrote. These syndicates include syndicates once managed by Gooda Walker, Feltrim Underwriting Agencies Ltd., Devonshire Underwriting Agency (Holdings) Ltd. and Rose Thompson Young (Underwriting) Ltd.

Mr. Freeman said in letters to members that 600 members were needed to donate 200 pounds ($352) each to initiate the legal action. By Feb. 14, only 450 members had signed on. But with Lloyd's continuing to receive extensive British press coverage, Mr. Freeman hit his goal and began seeking the injunctions in High Court on Wednesday.

The members have a case for preventing Lloyd's members' agencies from drawing down on the deposits, Mr. Freeman contends. His arguments include:

- Members' agents have not made sufficient investigations on behalf of their clients about the facts and circumstances leading to the cash calls. He did note, though, that Elborne Mitchell, the London law firm representing members' agents, told him "that names have received all documents to which they are entitled."
- It is "wholly inappropriate" for members' agents to make the cash calls until the loss review committees appointed by Lloyd's have reported. The first report, dealing with a study conducted by Sir Patrick Neill of the Feltrim syndicate, will not be issued for at least another six to eight weeks, sources say.
- Members have received no information regarding how much of the cash calls relates to expenses and how much to legitimate claims, and whether "those expenses are necessary or reasonable or proper."
- It is not legally possible for members' agents to ask for "mixed calls" that combine requests for funds for both the 1989 and 1990 underwriting years.

"Names have a strongly arguable case to initiate applications for injunctions preventing members' agents from enforcing the calls which have been made, either against the premium trust fund or against security held at Lloyd's," said Mr. Freeman.

'Names have a strongly arguable case. . .for injunctions preventing members' agents from enforcing the calls which have been made, either against the premium trust fund or against security held at Lloyd's,' says attorney Michael Freeman.

Support for Mr. Freeman is far from unanimous. Even some representatives of litigating members do not believe he will actually stop Lloyd's from drawing down on deposits or that his action benefits all members facing huge losses.

The Gooda Walker Action Group donated some funds because Mr. Freeman's "energy and impetuosity should be rewarded," said Mr. Doll-Steinberg. "We have no view if he will succeed."

Meanwhile, Lloyd's hasn't yet drawn down on members' deposits, "though it is inevitable," he said.

"I have it on the best legal authority that he hasn't got a prayer," said Paul Archard, chairman of the Lloyd's Underwriting Agency Assn. Members are bound by the Lloyd's members' agency agreement governing the cash calls that they signed when they joined Lloyd's, he said.

"Talk about ambulance-chasing," said Mr. Archard, referring to the Freeman action.

Also, the Feltrim Names Assn.—said to be the largest action group with more than 1,000 members—has refused to back Mr. Freeman's attempt to win injunctions, confirmed its chairman, Colin Hook.

Feltrim's own law firm, Richards Butler, does not believe that any injunction will hold up for very long, Mr. Hook said.

Some of the arguments made by Mr. Freeman already have been considered by the Feltrim action group for four or five months, said Mr. Hook. "We are seeking advice and we didn't feel we should duplicate research costs" by supporting the Freeman action, he said.

The Feltrim association also is concerned that the Freeman action will postpone the release of the Neill report into the Feltrim syndicate losses, said Mr. Hook, who believes that Feltrim members may be able to negotiate a settlement with Lloyd's once the Neill report is published.

Besides, Lloyd's is not drawing down on deposits even though members are refusing to pay, Mr. Hook said. The members "will pay legitimate claims as and when they become due but do not want to pay for future losses that are not due or any additional expenses," he said.

"There is a mood that Lloyd's has a very limited future unless the back years are sorted out," added Mr. Hook. "So I tell members to be stout-hearted (because) eventually there will be a settlement."

The defunct Feltrim syndicates 540/542 and 847 face a maximum of 380 million pounds ($668.8 million) in losses over a four-year period, Mr. Hook said.

Although most of the losses are related to LMX risks, the Feltrim syndicates also wrote a significant portion of the errors and omissions coverage for the Gooda Walker underwriting agency, *Business Insurance* has learned. The E&O coverage was placed by LMX broker Walsham Brothers, sources say. ■

Members, MPs demand probe of Lloyd's

By STACY SHAPIRO

LONDON—Four members of Parliament and representatives of three Lloyd's of London members' action groups will meet with Lloyd's Chairman David Coleridge this week to demand an independent investigation of losses created by London market excess-of-loss reinsurance.

The MPs and Lloyd's members will "insist" on the investigation to provide "anti-conspiratorial proof" that the LMX reinsurance market was a game that allowed brokers to reap commissions, underwriters to falsely increase their capacity and members to incur nothing but losses, says Alfred Doll-Steinberg, chairman of the Gooda Walker Action Group.

As part of that game, LMX policies are voidable and Lloyd's members' losses stemming from those policies should not be paid, Mr. Doll-Steinberg contends.

The LMX market, which boomed during the 1980s, allowed London underwriters to reinsure the same risk over and over again, which created giant capacity for catastrophe risks. Although a legitimate and well-known form of reinsurance, the LMX market has been criticized for creating "artificial" capacity (*BI*, Nov. 4, 1991).

LMX reinsurance was profitable until 1988, the first of three consecutive years of catastrophes that caused an unprecedented $32 billion in insured damages, according to estimates by Swiss Reinsurance Co. These included the Piper Alpha oil platform disaster in 1988, which cost $1.4 billion in insured loss but created at least $11 billion in claims notifications because of the LMX spiral.

Lloyd's, in particular, has been hit hard by catastrophes because of its huge role in the LMX market.

More than a third of the 11.65 million claims notifications made to Lloyd's annually—4.1 million—are for excess-of-loss reinsurance. Of this, 2.9 million are for LMX reinsurance claims. Lloyd's officials have said that 30% of Lloyd's members are paying 70% of the catastrophe-related losses because of the heavy hits taken by syndicates specializing in excess-of-loss reinsurance (*BI*, Sept. 2, 1991).

The Lloyd's members who will meet with Mr. Coleridge this week represent members' action groups, which are litigating over the huge losses their specialized LMX syndicates incurred between 1988 and 1990. The syndicates were managed by Gooda Walker Ltd., Rose Thompson Young (Underwriting) Ltd. and Devonshire Underwriting Agencies Ltd.

Estimates of the combined losses incurred by just the Gooda Walker syndicates and loss-riddled syndicates managed by Feltrim Underwriting Agencies Ltd. reach 750 million pounds ($1.31 billion at current exchange rates).

The 3,000 Gooda Walker members alone have been asked so far to pay 238.9 million pounds ($418 million) for losses on four syndicates in the 1989 and 1990 underwriting years (*BI*, Jan. 27).

Last week, several members of Parliament alleged that working members of Lloyd's used the LMX market to pass potential losses to non-working members belonging to "victim syndicates."

'Insiders knew. . .the "dustbin" syndicates, and external names were placed on them,' says one MP.

They have also alleged that specialist LMX brokers have siphoned off premium by way of commissions, leaving LMX syndicates with very little premium to pay for losses.

On Feb. 13, Bob Cryer, a Labor MP, called for "an inquiry to examine why Lloyd's failed to learn from the scandals of the late 1970s and early 1980s, when fraud became custom and practice."

Mr. Cryer also called for "an inquiry to ask Lloyd's to explain why they refused to regulate the LMX spiral when they were apparently asked to do so earlier in the 1980s by underwriters."

Mr. Cryer wonders "if the LMX reinsurance spiral was used as a device to ensure that any potential losses on the insiders' syndicates were borne by the ordinary members on the victim LMX syndicates for ridiculously small premiums."

In an earlier motion, Labor MP Brian Sedgemore also suggested that Lloyd's arrange "a pooling of the LMX losses dumped on external members."

"Every time a separate (LMX) reinsurance was placed, the people who placed it receive 10% commission," said a Conservative MP who asked not to be identified. "How was that in the interests of external names?"

In addition, "insiders knew which were the 'dustbin' syndicates, and the external names were placed on them," the Conservative MP alleged.

Responding to these allegations, Lloyd's Mr. Coleridge last week pointed out that non-working members were encouraged to join LMX syndicates because prior to 1989 these syndicates had made significant profits.

In 1986, for example, there were no catastrophes, and LMX syndicates had a "bonanza" year, according to syndicate analysts Chatset Ltd. In 1987, too, the LMX syndicates produced above-average profits.

As a result, more external members than working members lined up to join the LMX syndicates, said Mr. Coleridge.

These syndicates "produced far better results and they thought that this could continue forever," he said.

According to the Lloyd's task force report, external names on average made as much or slightly more money from Lloyd's than working members between 1985 and 1987, and lost 1% more than working members in 1988.

Other market executives also challenged the allegations made in Parliament.

"There has been no deliberate attempt to put external names at a disadvantage," said a Lloyd's members agency executive.

LMX syndicates were regarded as high risk and tended to attract those names with a greater underwriting capacity and ability to spread their risk among more syndicates, he explained. There are far more external names with that sort of wealth, the executive noted.

In addition, he said, from the mid-1970s until the late 1980s LMX syndicates tended to be among the most profitable and attracted more names.

Although some members agents have more clout and are better able to get members on attractive syndicates, each member "always has a choice about which members' agent to join," he said. Members agents would not deliberately discriminate against external names in syndicate placement, he contended.

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Carolyn Aldred contributed to this story.

Antitrust action

Continued from page 2

the Justice Department's view of the case.

The Justice Department in 1990 submitted a brief to U.S. District Judge William Schwarzer in support of the attorneys general (*BI*, May 21, 1990). Judge Schwarzer later dismissed the case, but it was reinstated last year by the 9th Circuit (*BI*, June 24, 1991).

In its brief filed with Judge Schwarzer, the Justice Department conceded it was unsure whether the case made by the attorneys general "would persuade a jury." However, the department said it "has an interest in assuring that the federal antitrust laws and exemptions from them are construed in a manner that advances their objectives."

Thomas Greene, deputy attorney general for California, one of the 20 plaintiff states, said the Justice Department was "actively discouraged" from submitting a brief to the U.S. Supreme Court supporting the attorneys general's opposition to review of the case.

The general policy, he explained, is to "load up" on amicus curiae briefs when seeking Supreme Court review, but not when opposing review, Mr. Greene explained.

The high court agrees to hear only a small percentage of the cases that come before it, and observers are divided on whether the court will accept the antitrust litigation for review.

In their original lawsuit in 1988, the state attorneys general allege that 32 defendants engaged in a boycott to manipulate the U.S. liability insurance market. The defendants include major U.S. insurers and reinsurers, the Insurance Services Office Inc. and the Reinsurance Assn. of America, as well as several London underwriters.

The boycott forced ISO to rewrite its commercial general liability policy form to exclude coverage for pollution incidents and include a retroactive date in the claims-made version of the form, the suit alleges.

The antitrust immunity granted to insurers under the McCarran-Ferguson Act does not extend to boycotts or coercion.

The attorneys general argue in their brief that the case does not present the Supreme Court with the opportunity to "clarify the reaches" of McCarran-Ferguson.

The appellate court's "holdings on the McCarran-Ferguson Act defenses are unsuited to review by this court," the brief says. "They present numerous issues, each of which this court would need to resolve in defendants' favor before the outcome of these cases would change.

"Grasping at straws, defendants claim that a McCarran-Ferguson boycott does not exist unless 'competing insurance companies (are) absolutely excluded from the market' or there is a 'total refusal to deal on any terms,' " the brief argues. However, the Supreme Court "has never required such a finding," it says.

The brief notes the appellate court also held that the McCarran-Ferguson antitrust exemptions do not extend to U.S. defendants' participation in unregulated agreements with the foreign defendants. "The present record fails to indicate in any way that the insurance industry will become less efficient if this court fails to expand the McCarran exemption to include insurer conspiracies involving unregulated foreign reinsurance activity."

The brief also addresses the issue of the state action doctrine, which provides immunity from antitrust laws if an anticompetitive act reflects a state's policy and if a state supervises the anticompetitive practices. The 9th Circuit overturned Judge Schwarzer's dismissal of the case on the grounds of the state action doctrine.

"Contrary to defendants' hyperbole, the decision of the court of appeals will not create a crisis in federalism," the brief states. "Nowhere do the complaints attack or even question the regulatory acts of state officials.

"What plaintiffs do challenge are back-room deals, unknown and unapproved by regulators, to force unwilling companies to toe a line drawn by a handful of powerful firms."

The brief also supports the appellate court's refusal to dismiss the case on the grounds of comity, which is a reciprocal respect for foreign law.

"The conduct challenged in this case has its principal effects in the United States," says the attorneys general's brief. "The complaints allege a complex and overlapping pattern of conspiratorial activity engaged in by both foreign and domestic actors that targeted United States markets.

"Only by ignoring the overarching American focus of the complaints can defendants represent that their motion to dismiss on comity grounds involves solely British actors in British markets," the brief states.

The response brief submitted by U.S. defendants states that the attorneys general's arguments "are insufficient as a matter of law to sustain the 9th Circuit's rejection of the domestic defendants' McCarran-Ferguson and state action defenses."

Plaintiffs say the case is not an opportunity to 'clarify the reaches' of McCarran-Ferguson.

"Moreover, apart from their mischaracterization of the legal issues involved, plaintiffs do not deny the public importance of this case or of the questions presented for review," the defendants' brief adds. This is underscored by the amicus briefs, the defendants' say.

Furthermore, they contend, a full trial on the issues is unnecessary.

Plaintiffs "nowhere point to any factual issue material to the proper analysis of the controlling legal issues that would be illuminated by a full trial—a trial that plaintiffs do not dispute would be extremely costly and time-consuming for both sides and for the judicial system itself," the brief states.

Even if the plaintiffs' factual allegations are accepted as true, their theories do not "state a cognizable antitrust claim," the defendants' brief says.

The appellate court decision poses "disruptive consequences" to the business of insurance, the brief states. The decision "has thrown into doubt the most basic legal principles governing the business of insurance on which the entire industry has relied since the enactment of the McCarran Act, and nothing at trial can alleviate that disruption."

Other arguments made in the defense brief include:

- U.S. insurers and reinsurers did not forfeit their McCarran-Ferguson immunity because of the involvement of foreign reinsurers, and the appellate court's interpretation of this issue would render the McCarran-Ferguson "nonsensical and self-defeating."
- Insurers' agreements over coverage and terms of insurance are not a boycott under McCarran-Ferguson. This issue "plainly deserves this court's review."
- The state action doctrine applies to the plaintiffs' allegations dealing with the development of the CGL form. ■

Briefs support defendants

U.K. government, others favor review

By JUDY GREENWALD

WASHINGTON—The insurance industry could be seriously disrupted if the U.S. Supreme Court fails to review an appellate decision reinstating the massive insurance antitrust litigation, say a host of parties within and outside the industry.

Amicus curiae briefs supporting insurance industry defendants' request that the high court review the case have been filed:

- By the British government.
- Jointly by the American Insurance Assn., the National Assn. of Independent Insurers and the Surety Assn. of America.
- Jointly by the Independent Insurance Agents of America Inc., the National Assn. of Professional Insurance Agents and the National Assn. of Casualty & Surety Agents.
- By the Brokers & Reinsurance Markets Assn., a trade association which represents domestic reinsurance brokers and professional reinsurers.
- By the National Conference of Insurance Legislators, a group of state legislators.

Defendants and plaintiffs disagree whether the briefs will be a factor in whether the high court reviews the antitrust case.

"I think they will be very persuasive to the court," said Mark I. Levy, an attorney with Mayer, Brown & Platt in Chicago, which filed the petition seeking Supreme Court review on behalf of the U.S.-based defendants in the litigation.

According to Mr. Levy, the chances of a Supreme Court review "go up dramatically" if amicus curiae briefs are filed, reaching their maximum effectiveness with the filing of three to four briefs.

The fact that parties have made the effort to file briefs is important, as is the fact that they have been filed by "significant, responsible and reputable" organizations, he said. The persuasiveness of these briefs is further strengthened by the arguments they make, he said.

Thomas Greene, deputy attorney general for California, one of the states pursuing the case, said the substance of amicus briefs generally is less important than the fact that they were filed and who filed them. He said the amicus briefs he has read are " 'me too' kinds of briefs" that take the defendants' arguments as given "and assume the sky is falling."

"My assumption is (the briefs) will probably have little impact," he said. He noted that amicus briefs generally are not filed in support of parties, like the attorneys general, who object to a Supreme Court review.

The brief filed by the British government is the second the government has filed in the antitrust litigation. It previously filed an amicus brief with the 9th U.S. Circuit Court of Appeals, which later reinstated the litigation (*BI*, Aug. 13, 1990).

"Conduct in the London reinsurance market is for the British government to regulate," the British government says in its latest brief. "The decision of the (9th Circuit) constitutes an interference with the sovereign rights and interests of the British government and is, with all due respect, both erroneous and damaging to the principles of international law and comity to which this court has accorded great significance in the past."

The AIA/NAII/SAA brief states that the appellate decision could have a disruptive effect on the industry. Since 1945, the brief states, the McCarran-Ferguson Act "has afforded the amici's members an antitrust exemption permitting them to comply with state regulatory policies favoring joint action without fear of federal antitrust sanctions."

"The decision below, however, creates substantial uncertainty as to when that protection will continue to be available. The resulting threat of federal antitrust enforcement actions and treble damage claims will deter insurers from continuing to develop the standardized insurance coverages upon which state regulators and insurance markets now depend."

The 9th Circuit ruling also "will permit the federal antitrust laws to be used to challenge state-approved insurance rates and coverages—but without federal courts being able to consider, as state regulators must, the effect on insurer solvency or insurance availability," the insurer groups state.

The agents groups' brief says the case is important "because the appellate ruling "threatens the ability of advisory organizations, such as petitioner Insurance Services Office Inc., to freely gather information for ultimate use by state regulators."

"The danger caused by the 9th Circuit interpretation (of McCarran-Ferguson) is obvious. Advisory organizations would be effectively barred from consulting with foreign reinsurers. Moreover, advisory organizations might become wary of dealing with other unregulated entities," the brief says.

The Brokers & Reinsurance Markets Assn. in its brief says that the appellate decision threatens routine reinsurance placements for two reasons.

First, traditional reinsurance agreements, which necessarily involve coordinated action by competing reinsurers, "may be deemed 'boycotts' which are not entitled to antitrust immunity," BRMA contends. Secondly, "many treaties involve at least one foreign reinsurer, and, under the court of appeal's ruling, such foreign participation forfeits McCarran-Ferguson protection for all parties to the reinsurance placement."

The NCOIL brief notes that states have traditionally regulated competition in the insurance industry in accord with their "first priority" of preserving insurer solvency. The appellate decision "imperceptibly diminishes that authority," the group says in its brief.

With this decision, the appellate court "has redrawn the lines of federal antitrust liability. The court's decision forces state officials to surrender regulatory authority to an overburdened federal judiciary and to juries unfamiliar with the insurance industry and the means to maintain its solvency," NCOIL says.

"If not reversed, the ruling effectively will jeopardize the states' power to regulate the business of insurance and protect the public," the brief argues. ■

Milken settlement

Continued from page 1

viction on six securities-related felonies.

If the settlement is finalized, it will dispose of lawsuits by both individual investors who attribute their losses to Mr. Milken's illegal activities and by the Federal Deposit Insurance Corp. The FDIC contends that Mr. Milken coerced savings and loan executives into purchasing junk bonds, leading to S&L failures.

Although press reports put the insurer contribution to the settlement at $100 million, talks continued last week over the exact amount.

Court documents confirm that two Bermuda policyholder-owned facilities—ACE Ltd. and Corporate Officers & Directors Assurance Ltd.—are negotiating to fund part of the settlement, along with American International Group Inc. AIG's National Union Fire Insurance Co. of Pittsburgh, Pa., was a Drexel D&O insurer.

Also involved are Lloyd's of London syndicates and London insurance companies. At least seven London D&O policies—three from 1988-1989 and four from 1989-1990—are at issue in the talks, according to the court documents.

Further details of each insurer's participation were not available.

Whether the settlement is finalized may depend in part on whether "global releases" can be secured to ensure that if the settlement is paid, the D&O insurers and individuals covered by the policies won't be liable for future claims, said Bradford W. Rich, senior vp of claims and general counsel at ACE.

Mr. Rich said ACE and CODA are participating because the policyholders—Drexel directors and officers—decided to settle. "The insureds want to do it."

Bowring (Bermuda) Ltd. was the broker for the D&O coverage underwritten by ACE and CODA. Drexel's broker in London for its D&O coverage is Gibbs Hartley Cooper Ltd.

The D&O coverage is led at Lloyd's by underwriter Alec Sharp.

Although Mr. Rich did not reveal the amount of coverage provided by ACE or CODA, ACE currently writes D&O limits of $50 million excess of $25 million. CODA, which is managed by ACE Insurance Management Ltd., writes $25 million of primary or excess D&O coverage.

One issue to be decided before a final settlement is which policies will cover which activities.

ACE began in 1985 offering D&O limits of $50 million excess of $50 million or an amount equaling underlying D&O coverage with a minimum attachment point of $25 million.

ACE revised its D&O limits in 1987 when it began offering a minimum $10 million limit with additional limits available in $5 million increments up to $50 million. The minimum attachment point was set at $25 million.

CODA wrote its first policy in 1986, offering limits of $25 million for primary or excess coverage.

The London market has provided between $10 million and $25 million in D&O capacity between 1984 and 1991, according to a just-released D&O survey by The Wyatt Co. National Union generally has offered up to $25 million in D&O capacity during the same years, Wyatt reported.

It was unclear last week whether a tailored financial institutions bond purchased by Drexel played any role in the settlement negotiations. Such bonds are designed to protect the policyholder from employee fraud, crime and infidelity. They normally are not designed to pay third parties.

This coverage was led at Lloyd's by Stephen Burnhope, underwriter for a non-marine syndicate managed by Merrett Underwriting Agencies Management Ltd. National Union also wrote a portion of this coverage, sources say. ■

International Editor Stacy Shapiro in London contributed to this report.

Tax proposal

Continued from page 1

small minority of employers, the safe harbors would be helpful. But for the vast majority of employers, qualifying for the safe harbors would require a substantial increase in contributions and costs. Incurring new costs is not something many employers would want to do in the current economic climate," said Frank McArdle, a consultant with Hewitt Associates in Washington, D.C.

For many employers, the cost of increasing contributions would far outweigh any savings gained by not having to run the 401(k) nondiscrimination tests, Mr. McArdle added.

One change that would help employers with 401(k) plans also is included in the tax package the House will consider, benefit lobbyists say.

Under this change, employers would compare the salary deferrals made by lower-paid employees during the previous year with those contributions made by high-paid employees in the current year.

By contrast, Internal Revenue Service regulations now require employers to compare the current-year contributions of the two groups. This requires employers to constantly monitor the 401(k) contributions made by members of the two groups.

If lower-paid employees do not contribute as much as expected, employers in midyear may have to cut back the maximum contributions that can be made by high-paid workers or return excess contributions to these workers, a messy administrative task.

By comparing prior-year contributions by lower-paid employees to high-paid employees' current-year contributions, employers would know at the start of a plan year how much high-paid employees could contribute to the plan without failing the non-discrimination tests, said Henry Saveth, a principal with A. Foster Higgins & Co. Inc. in New York.

Meanwhile, the tax package likely will not include changes to the basic 401(k) non-discrimination test, which is known as the "200% or two percentage points" test.

Various changes to the basic non-discrimination test were proposed earlier by House Ways and Means Committee Chairman Daniel Rostenkowski, D-Ill., and the Bush administration (*BI,* Feb. 3; July 1, 1991).

However, the tax package is expected to include provisions that would eliminate a favorable method of taxation—known as five-year forward averaging—for employees who take lump-sum distributions from pension and savings plans. Instead, lump-sum distributions would be treated as regular income.

A provision in the package would let employers know at the start of a plan year how much high-paid employees could contribute to a 401(k) plan without failing the non-discrimination tests, says Foster Higgins' Mr. Saveth.

Such a change would be unfair to employees who, for example planned to retire and take their lump-sum distributions to pay off a mortgage or use the lump sum as a down payment on a retirement home, according to Mark Ugoretz, president of the ERISA Industry Committee, a Washington, D.C.-based benefits lobbying organization representing large employers.

The fate of several other pension provisions that were included in earlier versions of the tax package also wasn't certain last week. Those provisions include:

- Eliminating certain "half-year" provisions that govern the age at which employees must make certain benefit decisions.

For example, employees generally now must be at least age 59½ to receive lump-sum pension distributions without being hit with special taxes; the measure would round off this age requirement to 59.

- Giving employers earlier notice concerning the increase in the maximum annual benefits that can be funded through a defined benefit plan and the annual contributions that can be made to defined contribution plans, like 401(k) plans.

Currently, the IRS announces increases in the so-called 415 limit and 401(k) deferral limit in late January. These increases match the rise in the Consumer Price Index during the previous year.

Employees who want to contribute the maximum amount to their 401(k) plan now often must adjust their contribution levels after the IRS announces the maximum in January.

Under the proposal in the earlier tax package, the cost-of-living adjustment would have to be announced well before the end of the year.

The tax package is expected to include a provision that would make permanent Section 127 of the Internal Revenue Code, which allows employers to reimburse an employee on a tax-free basis for up to $5,250 in qualified educational expenses annually. Section 127 now is set to expire on July 1.

In previous years, Congress has allowed Section 127 to expire and then retroactively restored it.

A permanent extension would eliminate what has been the constant uncertainty for employers and employees on whether educational assistance benefits will remain tax-free, Mr. Ugoretz commented. ■

Termination losses amount to $1.05 billion for 1991

PBGC's deficit increases

WASHINGTON—The Pension Benefit Guaranty Corp.'s losses from terminations of underfunded pension plans continue to widen, resulting in a big net loss for fiscal 1991 and a sharp rise in the agency's deficit.

Termination losses, which include the termination of pension plans sponsored by Eastern Airlines Inc. and Pan American World Airways, both of which ceased operations last year, climbed to $1.05 billion in the year ending Sept. 30, 1991, up 12% from $938 million in fiscal 1990, according to the PBGC's annual report.

The three Pan Am plans alone have about $700 million in unfunded benefits, while the seven Eastern plans have about $575 million in unfunded benefits.

The PBGC, though, expects to recover a significant portion of the Eastern pension liability from its parent, Continental Air Holdings Inc., though Continental is in Chapter 11 bankruptcy proceedings (*BI,* Dec. 10, 1990). The PBGC has filed $752 million in claims against Continental in connection with the terminated Eastern plans.

The PBGC has been less sanguine about the prospects for recovery from Pan Am, which also filed for Chapter 11 reorganization but is now liquidating.

The PBGC in 1990 actually booked losses from Eastern and Pan Am as probable terminations. Last year, the PBGC revised downward by several hundred million dollars what the agency expected to recover after the two airlines ceased operations.

In all, the PBGC reported a net loss of $542 million in fiscal 1991, an improvement over fiscal 1990's $780 million net loss. PBGC's losses last year would have been greater except for a huge gain in investment income. Investment income last year surged to $945 million, compared with investment losses of $90 million in fiscal 1990.

The PBGC is 'increasingly vulnerable to large losses,' according to Mr. Lockhart.

The agency's accumulated deficit —the difference between benefits it has guaranteed to participants of terminated underfunded plans and total assets—widened to $2.32 billion as of Sept. 30, up from $1.78 billion a year earlier.

"Despite aggressive efforts to prevent losses and build a financially sound insurance program, PBGC is increasingly vulnerable to large losses and its exposure is growing," said PBGC Executive Director James B. Lockhart III.

The annual report notes that about 80 companies in various degrees of financial difficulty now sponsor pension plans with about $13 billion in unfunded benefits, representing a serious risk of loss to the PBGC.

During fiscal 1991, the PBGC paid $512 million in benefits to 142,000 retirees covered by underfunded terminated plans the agency has taken over. That's up 38% from fiscal 1990, when the PBGC paid $371 million in benefits to about 112,500 retirees.

And, the PBGC expects to eventually pay benefits to 183,000 individuals who have not yet reached retirement age but were participants in plans the PBGC has taken over. The agency also estimates it eventually will pay benefits to another 47,000 participants in plans the agency projects will terminate.

Meanwhile, in another PBGC-related development, LTV Corp., which has been waging a 5½-year legal battle with the PBGC over the custody of its three massively underfunded pension plans, has filed a new reorganization plan that calls for a substantial initial cash payment to its pension plans.

Under the reorganization plan, LTV, which filed under Chapter 11 in 1986, would make an initial cash payment of $1.5 billion to the plans. LTV then would make annual contributions of at least $50 million, with additional annual contributions tied to cash flow over the next 30 years.

The LTV plans now are underfunded by more than $3 billion.

The plan still must be approved by LTV creditors and a U.S. Bankruptcy Court in New York.

—By Jerry Geisel

Update

Superfund action group formed

WASHINGTON—A new business group is working to eliminate the retroactive liability provision of the federal Superfund act.

The Superfund Action Coalition wants the provision dropped when Congress reauthorizes the Comprehensive Environmental Response, Compensation & Liability Act in 1994.

The business-backed lobbying group favors eliminating liability for any non-willful release of potentially hazardous materials before 1986, said Anne Ligon, assistant general counsel of the Washington, D.C.-based group. The group advocates levying a broad-based industrial tax to pay for cleanups, if necessary, said Ms. Ligon, who is with William H. Bode & Associates, a Washington, D.C.-based law firm.

It also favors creating a Superfund oversight board of scientists to ensure that cleanups are performed cost-effectively.

"The assessment of liability for blameless industrial activity that occurred 20, 50 or even 100 years ago has mired down Superfund in massive litigation that drains resources that should be spent on cleanup," the coalition says in its goals statement.

While the group now only represents businesses, Ms. Ligon said the group hopes to attract municipal and state governments, trade associations and labor unions.

New safety standard published

WASHINGTON—The Occupational Safety and Health Administration expects its new safety standard for hazardous chemicals to prevent about 264 deaths and 1,534 injuries annually at a cost of $888.7 million in each of the first five years of implementation.

The process management safety standard, which was published last week and will take effect in mid-May, covers nearly 140 specific chemicals. The standard requires employers to undertake a systematic review of potential mishaps during processes that involve the identified substances and to determine what safeguards are necessary to prevent the release of hazardous chemicals.

The rule also requires employee participation in the hazard analysis process, written operating procedures, employee training, pre-startup safety reviews, compliance audits and investigations within 48 hours of incidents that result in release of the chemicals covered by the standard.

According to OSHA, the new standard primarily will affect manufacturers of chemicals, transportation equipment and fabricated metal products; as well as electric, gas and sanitary services; warehouses that store farm products; and certain segments of the retail market. OSHA estimates that compliance will cost an average of $888.7 million during each of the first five years of implementation and $405.8 million during each of the next five years.

These costs would be at least partially offset by reductions in accidents and increases in productivity, said Dorothy L. Strunk, the acting assistant secretary of labor who heads OSHA.

Briefly noted

The High Court in London will decide Wednesday whether to place four insolvent insurers owned by **London United Investments P.L.C.** into provisional liquidation. Separately, a trial begins in the High Court today to decide whether a British guaranty fund must pay 90% of the claims filed by North American accountants and lawyers that the four companies cannot pay. . . .A state-appointed panel studying **workers compensation rates in California** may advise state lawmakers to eliminate the standard expense ratio from the rate insurers can charge. Insurance Commissioner John Garamendi already has made a similar proposal (*BI,* Feb. 10). Basing the rate on only average lost costs would create a more competitive market by forcing insurers to keep their expenses down, say members of the panel, which is to make its final recommendations on April 1. . . .Employers can advance additional contributions to **defined contribution pension plans**—without violating Internal Revenue Service rules—to make up for losses resulting when regulators take over insurers that sold the plans guaranteed investment contracts. However, an employer first must receive special permission from the Labor Department, the IRS says. . . .California Gov. Pete Wilson has overruled the state administrative law agency's rejection of new regulations to implement **Proposition 103**'s insurance "charge" rollback provision. The governor's action clears the way for a hearing scheduled to resume today on Commissioner John Garamendi's order that 20th Century Insurance Co. refund $106 million to its policyholders. . . .Wind, hail and flooding, **this year's first catastrophe**, caused an estimated $35 million of insured property damage Feb. 9-12 to portions of California and Texas, reports the Property Claim Services division of the American Insurance Services Group. . . .Los Angeles Superior Court Judge Kurt Lewin has given final approval for the purchase of **Executive Life Insurance Co.** by Altus Finance and Mutuelle Assurances des Artisanale de France. The judge's action permits immediate transfer of most of ELIC's junk bond portfolio to the French group for a cash payment of $3.25 billion and also paves the way for policyholder liabilities to be transferred to the new Aurora National Life Assurance Co. Hearings to approve details of the transfer plan begin Tuesday in Los Angeles. . . .A U.S. Food and Drug Administration advisory panel has recommended that **silicone gel breast implants** remain available without restriction to breast cancer patients. But, it has recommended unspecified limitations on the use of implants for purely cosmetic purposes. . . .The U.S. Environmental Protection Agency says it will release by April 28 a regulatory proposal amending the Resource Conservation and Recovery Act's **definition of hazardous waste**, which currently includes any waste mixed with or derived from a substance that is officially classified as hazardous. . . .Coopers & Lybrand and other defendants have settled with former bondholders of failed MiniScribe Corp. after a state district court judge last week set aside a jury verdict and a $550.5 million damage award (*BI,* Feb. 10). . . .The **American Insurance Assn.** has created a special committee to review the AIA's workers compensation reform efforts. . . .**The National Organization of Life & Health Guaranty Assns.** has named Jack Blaine as acting president, succeeding President Eden Sarfaty, who resigned. Mr. Blaine, a former president of the Reinsurance Assn. of America and vp/general counsel of the American Council of Life Insurance, will serve until next January while NOLHGA searches for a permanent president.

1992 won't be vintage year for insurance brokerages

By LEONARD M. WILSON

Special to Business Insurance

BUDGETS FOR THE PUBLICLY owned insurance brokers for 1992 are now in place.

Risk Adverse, our fictitious composite insurance broker, has also completed its thinking about 1992. Stressful might be an apt description of the budgeting process in the toils of a soft market that won't go away.

Before jumping into our budget assumptions for 1992, we have gingerly cast a backward look at our forecast for 1991. We were on the mark with expectations of a continuing competitive market. The 1991 profit plan presciently allowed for a modest slowing in net new business and an easing in investment income due to declining short-term interest rates. We did, however, underestimate the negative effect of the recession on brokerage commissions (see story, page 3).

A struggling but gradually improving economy frames the budget for 1992. The first half of the year should witness sluggish gross national product growth of around 1%. By the second half of the year, GNP gains of 3% to 4% on an annualized basis are possible. Inflation has eased, and should run at 3.5% as measured by the Consumer Price Index. Short-term interest rates currently reflect a policy of monetary stimulus and, therefore, averaged over the year could be below the level of 1991.

The Risk Adverse budget envisions no end to the competitive insurance market in 1992. Premium rates across the book of business may decline something like 5%, despite firming in selective lines like workers compensation, aviation and marine insurance.

There are few optimists about the outlook for 1992. Many analysts point to robust surplus growth for the property/casualty insurance industry as a force for ongoing rate pressures. Thus, Risk Adverse's budget is conditioned by the prevailing spirit of caution.

New business for 1992 is projected at 10% of commissions. This figure holds up under the scrutiny of last year's performance. Broker-of-record letters and prospects in the pipeline also lend confidence to the estimate.

Lost business should be maintained at 4% to 5% of commissions. Closer attention to keeping existing clients proved effective during the past year. In addition, modest erosion of pricing has diminished the incentive for clients to shift allegiance, in contrast to the first three years of the competitive market when prices were dropping more steeply. As a consequence, net new business —defined as gross new business less lost business—should amount to 5% to 6% of commissions.

Reinsurance brokerage is not a large profit center for Risk Adverse, but in the past it has contributed nicely to operating results. Reinsurance pricing currently displays stability, based on discussions with industry contacts. Primary company retentions exhibit no evidence of movement downward. As a result, reinsurance brokerage commissions are likely to be flat or up no more than a few percentage points.

Benefit consulting fell prey to the recession late in 1991. Growth in revenues continued, but at a diminished rate. For 1992, the budget anticipates a 7% to 8% rise in benefit consulting billings. Corporate America is currently on a binge of cost cutting. Some benefit projects are eminently postponable, but the steep rise in health care expenses and such thorny cost problems as post-retirement medical benefits could provide upside surprises for benefits activity.

Investment income is being hurt by the low level of short-term interest rates, with small help from feebly rising premium volume. Year-over-year, Risk Adverse expects appreciably reduced investment income in the first half of the year and flattish investment income in the second half. On balance, for the full year, investment income could decline by as much as 10%.

International insurance brokerage should grow faster than domestic brokerage, but not by much. Premium rates outside the United States are not especially robust, with a few exceptions. International commission income may increase 5% to 6% for the year, assuming a stable dollar. However, the dollar could strengthen in the second half of the year as U.S. interest rates edge up and the economy gathers momentum. Under this scenario, international revenues might fall short of the budget.

Assembling the varying components of top-line growth, we incorporate a revenue gain of 3% to 4% for 1992. Risk Adverse's managers fervently covet a faster rate of growth but, unlike past years, there are virtually no business activities that compensate for the soft market or provide a cyclical counterweight.

Profit center managers have their feet to the fire, given another year of unprepossessing revenue growth. Managing costs in a setting of tepid momentum is difficult at best. Head counts will not move up, and top management intends to scrutinize very carefully major staff additions. Other operating expenses will be restrained as well. Notwithstanding, inflation creep and merit raises should result in a 4% to 5% advance in total expenses.

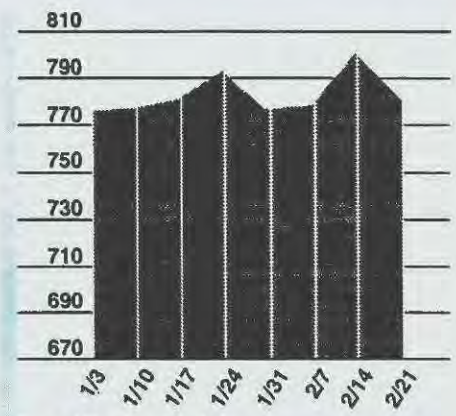
Pretax margins can be expected to narrow slightly again in 1992, and remain well below the level potentially attainable in a better operating climate. Net income, a function of weak top-line gains and the rise in expenses, should be flat or up no more than a smidgeon.

The budget does not view 1992 as a vintage year for the brokerage. The relevant theme seems to be "keep an eye on the horizon." We hope the horizon will not recede.

Maintaining underlying momentum against the tough competition should put the firm in a solid position to reap the higher profits inherent in a hard market when it arrives. Cash flow remains strong, morale is still upbeat and technical skills are honed to a fine edge by the more difficult operating environment. ■

Leonard M. Wilson is a senior vp with Lazard Asset Management Inc. He is a member of the New York Society of Security Analysts.

BI Insurance Index



Base = 100 on Dec. 29, 1978
Source: Nordby International Inc.

Insurance industry stocks stumbled last week as the *Business Insurance* Index fell 21.1 points to 780.8 on Feb. 21 from 801.9 on Feb. 14. Advancing issues were led by Poe & Associates, up 7.4%; USLICO Corp., up 5.7%; and Reliance Group Holdings, up 5.6%. Declining issues followed United Healthcare Corp., down 10.6%; Nobel Insurance Ltd., down 10.3%; and NAC Re Corp., down 8.6%. The most active issue for the period was U.S. Healthcare, with 4.1 million shares traded. The *BI* Index was down 2.6%; the New York Stock Exchange Composite was down 0.3%; the Standard & Poor's 500 was down 0.3%; and the Dow Jones 30 Industrials was up 1.1%.

British Issues

Feb. 20 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	446	N/M	30.7	6.9	451	441
Genl Accident	428	N/M	35.7	8.3	428	420
Gdn Royal Exch	123	N/M	15.9	12.9	123	120
Royal	226	N/M	34.7	15.3	232	226
Sun Alliance	273	N/M	18.7	6.8	276	273
Brokers						
Bradstock	166	18.7	6.3	3.8	166	165
CE Heath	448	15.7	34.5	7.7	448	445
Hogg Group	175	10.4	10.7	6.1	176	175
JIB Group	189	15.7	10.0	5.3	189	189
Lloyd Thompson	242	24.3	6.0	2.5	244	242
Lowndes Lmbrt	352	17.4	15.3	4.3	352	345
PWS Holdings	68	7.4	5.3	7.8	68	68
Sedgwick Grp	215	20.4	16.0	7.4	218	215
Steel Brrl Jones	298	15.8	16.3	5.5	298	298
Willis Corroon	244	12.9	17.6	7.2	251	244

Source: Philip Olsen, Insurance Industry Analyst, London

BI Industry Stock Report

FEBRUARY 18, 1992 THROUGH FEBRUARY 21, 1992

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt Bk. value
BROKERS												
Alexander & Alexander	NYS	20.75	-3.49	1.22	27.50	18.00	663	1.00	4.82	-83	9.77	2.12
Gallagher Arthur J. & Co	NYS	24.00	0.52	7.26	28.38	19.00	23	0.64	2.67	18	5.88	4.08
Frank B. Hall	NYS	3.63	-3.33	-14.71	5.50	3.13	57	0.00	0.00	-5	-5.24	-0.69
Hilb, Rogal & Hamilton	OTC	13.13	0.96	-0.94	17.50	11.25	163	0.40	3.05	22	3.56	3.69
Marsh & McLennan	NYS	75.00	-0.99	-7.83	87.25	70.00	482	2.60	3.47	18	14.77	5.08
Poe & Associates	OTC	14.50	7.41	20.83	14.50	6.88	48	0.40	2.76	16	2.52	5.75
BROKERS	AVERAGE		0.2	1.0					2.4	-2		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp	OTC	35.75	0.70	17.21	36.25	23.50	129	0.32	0.90	15	23.89	1.50
Berkshire Hathaway Inc	NYS	8700.00	-0.57	-3.87	8700.00	242.50	0	0.00	0.00	-37	4612.00	1.89
ITT (Hartford Group)	NYS	61.38	2.72	6.28	63.00	50.00	1405	1.84	3.00	10	64.01	0.96
Sears (Allstate)	NYS	43.88	-0.28	15.84	45.13	30.25	3911	2.00	4.56	13	37.38	1.17
CONGLOMERATES	AVERAGE		0.6	8.9					2.1	0		
INSURERS/REINSURERS												
AEGON N.V.	NYS	68.38	-0.73	-2.32	71.75	54.75	2	2.30	3.36	7	N/A	N/A
Aetna Life & Casualty	NYS	44.75	-2.98	1.70	49.13	31.88	1385	2.76	6.17	10	64.23	0.70
Allied Group Inc	OTC	20.25	5.19	19.12	21.50	13.25	498	0.56	2.77	8	11.50	1.76
American General	NYS	41.00	-0.30	-7.87	44.75	36.00	845	2.08	5.07	10	37.14	1.10
American Indemnity/Fin'l	OTC	6.63	-5.36	39.47	9.25	4.50	1	0.08	1.21	6	12.93	0.51
American International	NYS	87.63	-1.54	-10.93	102.00	78.63	1352	0.48	0.55	12	45.34	1.93
Aon Corp	NYS	44.00	2.33	11.04	44.38	33.50	331	1.60	3.64	12	18.50	2.38
Argonaut Group	OTC	26.00	-5.45	9.47	33.38	21.75	109	0.68	2.62	8	48.26	0.54
AVEMCO Corp	NYS	27.25	-1.36	9.00	27.63	18.50	26	0.40	1.47	20	9.55	2.85
Baldwin & Lyons Inc	OTC	26.50	-0.93	2.91	27.50	21.25	9	0.28	1.06	7	24.29	1.09
Belvedere Corp	ASE	4.50	2.86	38.46	5.38	2.63	29	0.04	0.89	13	7.65	0.59
Chandler Insurance	OTC	3.88	-6.06	19.23	4.75	2.13	100	0.00	0.00	-2	5.95	0.65
Chubb Corp	NYS	68.13	2.06	-11.53	78.00	60.75	908	1.48	2.17	11	35.19	1.94
CIGNA Corp	NYS	56.00	2.75	-8.38	61.75	41.25	1117	3.04	5.43	11	73.15	0.77
CNA Financial Corp	NYS	80.25	-0.31	-18.11	104.50	75.50	86	0.00	0.00	8	70.23	1.14
Continental Corp	NYS	26.88	-3.15	-2.71	30.50	23.25	485	2.60	9.67	27	37.83	0.71
EXEL Ltd	NYS	34.00	-2.16	-9.33	40.25	27.38	602	0.90	2.65	7	N/A	N/A
Fund American Corp	NYS	67.00	-2.90	-4.11	70.25	57.75	89	0.68	1.01	18	36.11	1.86
Fremont General Corp.	OTC	23.25	2.20	-4.62	26.00	15.50	346	1.00	4.30	6	19.13	1.22
Frontier Insurance Group	NYS	29.63	-1.66	9.72	30.50	18.19	48	0.00	0.00	11	11.20	2.65
Gainsco Inc	ASE	14.63	0.86	4.46	15.00	5.88	11	0.04	0.27	18	3.37	4.34
General RE Corp	NYS	91.75	-3.55	-9.94	104.75	85.00	513	1.80	1.96	12	37.50	2.45
Guaranty National Corp	NYS	15.00	0.84	3.45	17.00	12.63	139	0.48	3.20	11	N/A	N/A
Hanover Insurance Co	OTC	37.75	-0.66	5.59	42.75	27.13	6	0.44	1.17	16	37.44	1.01
Harleysville Group	OTC	20.75	0.00	-2.35	23.25	16.75	27	0.64	3.08	10	22.99	0.90
Hartford Steam Boiler	NYS	48.25	-0.77	-16.09	63.75	47.25	98	2.00	4.15	14	17.05	2.83
Kemper Corp	NYS	33.50	-4.96	-12.13	46.13	28.50	694	0.92	2.75	8	34.20	0.98
Lawrence Insurance Group	ASE	10.00	-1.23	-10.11	11.13	6.75	5	0.48	4.80	16	4.71	2.12
Liberty Corp	NYS	22.00	-3.30	-0.56	23.75	19.50	17	0.48	2.18	12	23.86	0.92
Lincoln National	NYS	55.88	-1.76	2.05	61.00	45.38	234	2.92	5.23	12	45.16	1.24
Markel Corp	OTC	26.13	-1.42	18.75	28.00	13.75	173	0.00	0.00	12	3.22	8.11
Mutual Risk Mgmt. Ltd.	NYS	37.13	3.13	5.69	37.50	17.00	206	0.12	0.32	31		
NAC Re Corp	OTC	26.50	-8.62	-15.87	33.00	21.75	175	0.16	0.60	12	18.90	1.40
Navigators Group	OTC	46.00	-2.13	12.20	48.25	26.00	12	0.00	0.00	25	13.52	3.40
Nobel Insurance LTD	OTC	4.38	-10.26	9.38	5.25	3.00	6	0.00	0.00	6	7.76	0.56
NWNL Companies	NYS	29.88	-0.83	-4.02	38.50	18.63	82	1.40	4.69	8	42.73	0.70
Ohio Casualty Corp	OTC	55.75	1.13	12.63	58.25	40.00	135	2.48	4.45	9	36.38	1.53
Old Republic Int'l	NYS	39.38	0.96	10.92	40.50	23.63	88	0.72	1.83	8	33.09	1.19
Orion Capital Corp	NYS	32.38	0.39	2.37	34.00	18.75	36	0.92	2.84	9	20.42	1.59
Phoenix RE Corp.	OTC	10.25	-2.38	-2.38	11.75	8.50	18	0.20	1.95	41	13.30	0.77
Provident Life	OTC	21.50	-2.27	-7.53	24.50	16.75	238	1.00	4.65	8	25.88	0.83
Re Capital Corp	ASE	13.50	-1.82	-6.09	18.63	13.50	24	0.20	1.48	11	15.05	0.90
Reliance Group Holdings	NYS	4.75	5.56	15.15	7.13	3.50	14	0.32	6.74	3	5.61	0.85
RLI Insurance Corp	NYS	19.63	-0.63	18.94	19.88	11.88	18	0.48	2.45	9	14.41	1.36
St. Paul Companies	NYS	72.00	-0.86	-1.20	75.75	57.13	194	2.72	3.78	8	52.00	1.38
SAFECO Corp	OTC	47.75	-1.04	-2.05	50.00	35.50	705	1.48	3.10	12	31.50	1.52
SCOR U.S. Corp	NYS	17.88	-2.05	16.26	18.88	11.63	5	0.24	1.34	10	11.19	1.60
Seibels Bruce Group	OTC	4.50	-5.26	-18.18	8.88	4.38	104	0.36	8.00	-2	7.35	0.61
Selective Ins. Group	OTC	19.00	2.70	13.43	19.00	13.75	410	1.04	5.47	9	18.91	1.00
Statesman Group Inc	OTC	5.88	-4.08	2.17	6.88	2.13	445	0.00	0.00	4	2.48	2.37
Tokio Marine & Fire	OTC	42.38	-3.14	-17.72	55.25	40.50	17	0.00	0.00	-	70.93	0.60
Torchmark Corp	NYS	56.75	-0.66	-1.94	61.50	46.50	279	1.60	2.82	12	16.70	3.40
Transamerica	NYS	40.00	-5.04	0.31	42.88	31.25	622	2.00	5.00	16	36.56	1.09
Transatlantic Holdings	NYS	37.38	-0.66	-3.86	39.63	29.00	13	0.24	0.64	12	18.38	2.03
Travelers Corp	NYS	21.25	-3.95	-1.73	25.38	17.25	1573	1.60	7.53	7	41.44	0.51
Trenwick Group Inc	OTC	30.50	0.83	7.02	30.75	23.00	28	0.72	2.36	11	21.71	1.40
United Fire & Casualty	OTC	49.38	3.95	9.72	58.00	40.00	2	1.32	2.67	10	35.39	1.40
USF&G Corp.	NYS	9.38	-3.85	29.31	12.50	5.63	1064	0.20	2.13	-4	11.96	0.78
UNUM Corp	NYS	73.88	0.00	-8.80	81.25	55.00	436	1.04	1.41	12	37.25	1.98
USLIFE Corp	NYS	42.50	-3.95	-11.23	47.88	33.50	121	1.64	3.86	9	60.34	0.70
Unitrin	OTC	33.88	-1.81	-5.24	41.50	31.00	149	1.00	2.95	13	30.70	1.10
USLICO Corp	NYS	18.50	5.71	0.00	21.00	17.00	41	1.00	5.41	-88	29.44	0.63
Washington National	NYS	17.63	-6.00	11.02	19.25	13.25	25	1.08	6.13	-8	26.86	0.66
Zenith National Ins.	NYS	15.00	-4.76	-11.11	18.50	13.75	58	1.00	6.67	7	13.14	1.14
INSURERS/REINSURERS	AVERAGE		-1.3	1.9					3.3	10.2		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	15.25	-8.27	7.02	29.75	9.88	1026	0.00	0.00	14	5.44	2.80
HMO America Inc	OTC	21.00	-8.20	25.37	24.88	7.50	715	0.00	0.00	22	0.61	34.43
Pacificare Health Sys	OTC	54.50	-6.84	37.97	62.50	21.50	1305	0.00	0.00	21	6.55	8.32
Safeguard Health Enter	OTC	12.38	2.06	32.00	12.38	4.63	209	0.00	0.00	21	3.53	3.51
Sierra Health Services	ASE	23.75	0.53	28.38	29.50	12.38	154	0.00	0.00	13	1.78	13.34
United Healthcare Corp	NYS	79.13	-10.59	6.21	93.00	29.38	936	0.06	0.08	33	3.76	21.04
United Medical Corp	ASE	7.25	0.00	3.57	10.88	5.88	23	0.20	2.76	23	8.79	0.82
U.S. Healthcare	OTC	49.50	-7.04	19.28	57.75	21.25	4094	0.56	1.13	24	3.38	14.64
HMOs	AVERAGE		-4.8	20.0					0.5	21		
ALL COMPANIES	AVERAGE		-1.3	7.9					2.8	9		

System design: Nordby International Inc.

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Protecting business and home. property and possessions.
A worldwide symbol of an organization with a rich history as legacy. And a bright future as promise.
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