

Business Insurance

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

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Navigators buys cat coverage following earthquake losses

NEW YORK—Navigators Group Inc. hopes \$45 million of new temporary catastrophe reinsurance will reassure skittish investors and bolster a reinsurance program battered by an estimated \$20 million to \$25 million in Los Angeles earthquake losses.

Only two months before its April 1 renewals, Navigators bought the coverage from an unidentified Bermuda firm.

Navigators Insurance Co. writes marine, aviation and property insurance and reinsurance. A.M. Best Co. reports that California
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McCarran compromise polarizes insurers

By MARK A. HOFMANN

WASHINGTON—A proposed compromise on overhaul of the McCarran-Ferguson Act may ultimately break a deadlock on Capitol Hill, but it has done nothing to heal serious rifts within the insurance industry.

In fact, the proposal may have widened those rifts as industry trade associations are sharply divided in their assessment of the compromise, which would allow insurers to retain only a few of the

limited exemptions from federal antitrust law that they currently enjoy under the McCarran-Ferguson Act.

The American Insurance Assn., which had a hand in drafting the compromise legislation, last week approved the draft during a quarterly meeting of its board of directors. The AIA's membership is made up mostly of large commercial insurers.

"We've got unanimous authority from our board to finalize this draft" with House Judiciary Com-

mittee Chairman Jack Brooks, D-Texas, and the Justice Department, said David Pratt, senior vp-federal affairs for the AIA. He said the draft compromise was the product of "long and oftentimes arduous talks" between the AIA and Rep. Brooks, who introduced his first version of a McCarran reform bill, now known as H.R. 9, in the mid-1980s.

Rep. Brooks' legislation currently would strip insurers of all immunity from antitrust laws.

The AIA first offered to work

with Rep. Brooks in early 1991 to forge a compromise suitable to both sides, but talks repeatedly broke off as the two sides failed to agree on what exemptions insurers would be allowed to retain.

The most recent discussions on a compromise have been taking place over the past several months.

The compromise would differ from Rep. Brooks' current version of H.R. 9 on a number of key points. Among the most significant changes, the compromise

would:

- Permit insurers to develop and use common policy forms. The current bill would provide no safe harbor for such activity.

- Phase out McCarran protection for collective trending of data by industry-affiliated organizations like the Insurance Services Office Inc.

However, the draft states that trending provided by non-affiliated sources would be "presumed not to violate the antitrust laws."

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Clinton's mandatory purchasing alliances imperiled

By JERRY GEISEL

WASHINGTON—The centerpiece of President Clinton's health care reform proposal—mandatory health care purchasing alliances—is languishing in critical condition as the president's package nears its first legislative test this week.

The House Ways and Means Health Subcommittee this week hopes to begin drafting health care reform legislation, the first of many congressional panels that will decide the fate of the Clinton package.

But Subcommittee Chairman Pete Stark, D-Calif., said last week that "zero" members of his panel favor the alliances proposed by the administration, which would force most of the nation's non-elderly population into state-run or affiliated purchasing pools.

Moreover, the subcommittee will not use the president's proposal as a starting point when it begins crafting health care reform legislation.

Instead, Rep. Stark is trying to reach a consensus with other panel members on alternative approaches, a Stark aide said. In the past, Rep. Stark has favored an expanded role for Medicare, which currently covers retirees over 65 and some disabled individuals.

Other lawmakers agree that health care alliances, as proposed by the administration, are dead.

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Earthquake fallout continues

A tale of two companies:
Bank, retailer affected
much differently by quake

By LOUISE KERTESZ

LOS ANGELES—Two Southern California companies experienced the same terrifying quake at the same early morning hour on Jan. 17, but with vastly and ironically different results.

One, Great Western Bank, has a 14-building headquarters complex—including its central computer facility, a concrete parking garage and a 10-story office building—only two miles from the epicenter. Although it buys earthquake insurance, Great Western carries no business interruption coverage.

The other company, Carter Hawley Hale Stores Inc., has department stores throughout the Los Angeles area, many of them miles from Northridge. It bought extensive earthquake and business interruption coverages from about 25 insurers only after carefully screening them and only after commissioning a brokerage to do a detailed study of its potential quake exposure.

So which company emerged from the earthquake relatively unscathed? And which is filing claims with insurers for an estimated \$90 million in losses?

"Roof supports gave way and had to be shored up," explained Richard L. Evans, vp of insurance and risk management at Great Western. "That was the only thing that required extensive modification." Though two of its buildings remain closed, the bank suffered only minimal business interruption losses.

Things couldn't be more different at Carter Hawley. Four of its Broadway stores sustained structural damage and remain closed a month after the quake. Another store was closed for 12 days.

Inside the stores, pillars and shear walls have collapsed, ceilings have fallen and water from sprinklers has combined with falling plaster to cause "tremendous inventory damage," said Susan Welch, the retail chain's risk manager.

Many Great Western employees would have had bad news in store for them even if the temblor had not struck. The bank had just acquired 119 branches of another bank

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Richard Evans, risk manager for Great Western Bank, reports minimal property and business interruption losses from the earthquake. At the other extreme, Susan Welch, risk manager for Carter Hawley Hale Stores Inc., says stores incurred widespread damage and several remain closed.



Photos by Tim Petros

Spreading disaster risk FEMA criticizes federal reinsurance proposal

By MARK A. HOFMANN

WASHINGTON—A proposal to create a federal reinsurance facility to minimize insurers' exposure to catastrophic events could saddle the government with unlimited liability, the Federal Emergency Management Agency warns.

However, congressional proponents of H.R. 2873, the Natural Disaster Protection Act, say that FEMA should come up with a counterproposal of its own—soon—rather than criticize the current bill.

A representative of FEMA received considerable criticism from legislators during a Feb. 23 hearing on the proposal before the House Public Works Committee's Subcommittee on Water Resources and Environment.

"I delayed this meeting at the request of FEMA for nearly 30 days," said Subcommittee Chairman Doug Applegate, D-Ohio. Even so, FEMA's testimony on H.R. 2873 wasn't made available to subcommittee members until the evening before the Feb. 23 hearing, the congressman said.

Jane Bullock, assistant to the director of FEMA, apologized for the delay and braced herself for more criticism as she fielded questions from panel members.

H.R. 2873 was co-sponsored by Public Works Chairman Norman Mineta, D-Calif., and Rep. Sherwood Boehlert, R-N.Y. The bill, which was introduced last year, would among other things create a new federally guaranteed disaster reinsurance pool prefunded by insurers (BI, Feb. 21).

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Updates

Navigators buys cat cover

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to A.M. Best Co., California is by far its largest market, accounting for 35% of direct premiums in 1992.

"We now have three times the protection we had on Jan. 1," said Allen Barnett, group chief financial officer. "The purchase was costly but was reasonable, particularly in light of what we believe is a profitable book of business."

Navigators will maintain the new level of coverage when it renews. Mr. Barnett said the added coverage should scotch rumors that higher-than-expected quake losses would bankrupt the company.

Navigators shares closed at \$20.63 Thursday, down from \$35 the week before the earthquake.

Cambridge Re final dividend

LONDON—Liquidators of Bermuda-based Cambridge Reinsurance Ltd. will distribute the company's sixth and final dividend to creditors next month, nine years after the company was shut down.

The liquidation may be one of the shortest in history and the first to apply Bermuda's Bankruptcy Act of 1876, which allowed liquidators to estimate an insolvent company's contingent liabilities rather than wait years for claims to be filed (*BI*, April 3, 1989; March 16, 1987).

Including the final dividend, creditors will have received 21.2% of their total claims, or \$21 million, said Philip Singer, assistant liquidator at Coopers & Lybrand. Total expenses were about \$10 million, including \$5 million in runoff fees and \$2 million in legal fees.

Meanwhile, the KWELM group of companies—the largest insurance insolvency ever—is expected to declare its first dividend to creditors in June and pay it by September, according to accounting firm Cork Gully, which is running off the former members of the H.S. Weavers (Underwriting) Agencies Ltd. line slip. The first KWELM dividend is expected to range from 3% to 12% of creditors' claims.

Chicago flood suits up in air

CHICAGO—A jurisdictional question now before the U.S. Supreme Court could dramatically affect liability for damages from Chicago's 1992 downtown underground flood.

The court will determine whether Illinois tort law or federal admiralty law applies to lawsuits stemming from the flood, which occurred when a wall was breached in an abandoned freight tunnel system beneath the Chicago River (*BI*, Dec. 14, 1992; April 20, 1992).

City officials claim Great Lakes Dredge & Dock Co. of Oak Brook, Ill., damaged the tunnel by negligently driving pilings into the river bed. The contractor counters that the city either failed to notify it of the tunnel's presence or failed to adequately maintain the tunnel.

Flood-related claims, most of them part of a class-action suit against both Great Lakes and the city, stand at about \$400 million.

Citing the federal Admiralty Extension Act, Great Lakes claimed the suits belong in federal court, where its liability could be limited to the value of the vessels involved in the incident—less than \$650,000.

Last year, the 7th U.S. Circuit Court of Appeals agreed.

Chicago officials contend the case belongs in state courts, as does a plaintiff in the class action, where the city may have immunity and Great Lakes' liability could be greater.

The court will hear the case after its new term begins in October, with a ruling not expected until late this year or early 1995.

Lloyd's funds questioned

NEW YORK—A New York court in April will begin hearings to assess whether the Lloyd's of London's American Trust Fund offers adequate security to American policyholders.

The question arose in a dispute over asbestos claims paid by Travelers Insurance Co. and reinsured by underwriters at Lloyd's. Justice Beatrice Shainswit of the Supreme Court for New County earlier this month ordered a judicial hearing officer to hear testimony April 4 on whether the trust funds that Lloyd's underwriters keep in New York would be sufficient to satisfy any judgment in this case.

Lloyd's defendants, led by Deputy Chairman Richard Keeling, argued last month that the court should waive the posting of a bond because Lloyd's maintains sufficient assets in the country, including the \$8.7 billion Lloyd's American Trust Fund, to meet any judgment.

But the judge said she could not tell whether that was true, "given the enormity of the claims involved, the fact that these figures are not current (and considering) Lloyd's deteriorated financial condition."

Travelers is suing for \$33 million in damages and \$500 million in punitive damages over a dispute involving asbestos-related claims reinsured by Lloyd's underwriters between 1947 and 1969. Justice Shainswit decided this dispute should be arbitrated.

Tort reform provision struck

MONTGOMERY, Ala.—The Alabama Supreme Court has struck down yet another provision of that state's 1987 tort reform package.

This time, however, the court ruled a judge can lower the amount of punitive damages awarded by a jury but cannot increase them.

In contrast, previous rulings by the high court have eliminated sections of the tort reform law that limited awards.

In a 5-2 decision Feb. 11, the court ruled that allowing a judge to increase jury-awarded punitive damages violates a defendant's constitutional right not to be deprived of property without due process.

In its earlier rulings, the court in June 1993 struck down a provision that capped punitive damages at \$250,000, while in 1991 it rejected a \$400,000 cap on non-economic damages in medical malpractice cases and a requirement that judgments of \$150,000 or more be structured over time (*BI*, July 26, 1993).

Updates continued on page 22

Federal agency may reduce health care data requirement

By JERRY GEISEL

WASHINGTON—Employers may get temporary relief from portions of a federal law that requires them to compile and report huge amounts of health care coverage information to the government.

Under that law, employers next year will be required to tell the Health Care Financing Administration the names and Social Security numbers of employees and dependents, as well as the specific

health care plans in which those individuals were enrolled during the year. The information will then be input into a Medicare data bank, which government officials will use to spot claims that should be paid by employer health plans, not Medicare.

HCFA officials said last week they may delay by one year the provision in the law that is causing the most problems for employers: providing dependents' Social Security numbers.

Many employers never have col-

lected that information because they have had no reason to do so.

HCFA officials acknowledge that without formal guidelines from the agency, which are not expected until next month, it could be difficult to comply with the requirement.

Under the law, employers are required to report by Feb. 28, 1995, health care coverage information, including all plan members' Social Security numbers, for the 1994 plan year. Employers

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FBI fraud investigation

Role of California regulators in offshore scams questioned

By LOUISE KERTESZ

LOS ANGELES—The FBI is investigating whether certain California Department of Insurance officials gave special treatment to fraudulent offshore insurers, according to a newspaper report.

FBI officials would not comment on reports last week in the Sacramento Bee that both the bureau's public corruption unit in Sacramento and an insurance fraud task force in Mobile, Ala.,

are investigating how offshore insurance scams have thrived in California in recent years.

The bureau "can neither confirm nor deny" those reports, said John Brennan, acting supervisor/special agent in Mobile who was involved in the arrest of convicted insurance con man Alan Teale (*BI*, Dec. 6, 1993).

Spokesmen for Insurance Commissioner John Garamendi said the commissioner knows of no federal investigation. Others in

the insurance industry and state government said they had only learned of an investigation in the newspaper reports.

Only one insurance industry source contacted said he knew directly of the investigation. He would not speak on the record.

The Bee also reported that the Insurance Department's conservation and liquidation division had misappropriated millions of dollars—sometimes illegally—from

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But more repetitive injury lawsuits likely

Computer maker wins verdict

By JOANNE WOJCIK

HOUSTON—Compaq Computer Corp. may have won its first battle with computer users attempting to link keyboard use to repetitive strain injuries, but the personal computer industry has not yet won the war, attorneys and ergonomics experts say.

Thousands of similar product liability suits have been filed around the country as more and

more people attribute crippling wrist and hand injuries to prolonged computer use.

And attorneys predict that employers and their workers compensation insurers will eventually enter the fray as they try to recoup some of the disability payments paid to workers suffering from a host of debilitating injuries.

Meanwhile, Patsy Heard Woodcock, a legal secretary who sued Compaq for more than \$800,000 in

damages and lost wages due to disabling wrist injuries, is appealing last week's jury verdict vindicating the Houston-based PC maker.

After hearing expert testimony that there was no scientific evidence linking keyboard use alone with repetitive strain injuries, the jury found that Compaq didn't know that its computers could cause injury and therefore wasn't

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Purchasing alliance OK'd

By JOANNE WOJCIK

SAN FRANCISCO—Nineteen employers in the San Francisco area can band together to purchase health care coverage as long as their efforts don't impede competition in the local health care market, the U.S. Justice Department has ruled.

In a Feb. 18 letter ruling, the department told the Bay Area Business Group on Health that it

Justice Department approves employer plan

won't challenge the group's plan to form a purchasing group that will collectively buy coverage from health maintenance organizations.

The group, whose members include 19 public and private San Francisco-area employers representing some 2.5 million employees, retirees and their dependents, was the first to be granted Justice

Department clearance to form a purchasing cooperative similar to that proposed in the president's health care reform blueprint. That aspect of the Clinton plan, though, has come under fire (see story, page 1).

In fact, one member of the group—the California Public Employees' Retirement System, or

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Vol. 28, No. 9—Business Insurance (ISSN 0007-6864) is published weekly by Crain Communications Inc., 740 N. Rush St., Chicago, Ill. 60611-2590. Second-class postage is paid at Chicago, Ill., and at additional mailing offices. Canadian Post International Publications Mail Product (Canadian Distribution) Sales Agreement No. 0293512, GST No. 136760444. Printed in U.S.A. Postmaster: Send address changes to Business Insurance, Circulation Department, 965 E. Jefferson Ave., Detroit, Mich. 48207-3185; 800-678-9595 or 313-446-1611. Copyright 1994 by Crain Communications Inc.

Florida health reforms

By DAVE LENCKUS

TALLAHASSEE, Fla.—Some health insurers and health maintenance organizations in Florida are cutting rates as the state gears up its health insurance reform plan.

But it is uncertain whether the cuts are in response to the reforms, which are based on the managed competition concept, or if wider use of managed care in general deserves the credit.

The Florida agency responsible for implementing the state's 1993 health care reforms is giving the plan high marks for helping suppress health insurance costs for small firms, the target of the state's experiment.

"It far exceeded our initial expectations," said Douglas M. Cook, director of the state's Agency for Health Care Administration in Tallahassee.

Others, though, say the AHCA is grabbing credit for market forces that have been shaped by years of managed care. And, they add, the lower rates are not significant enough to attract many small

Did experimental plan or market forces prompt some insurers to reduce rates?

firms to the voluntary system.

Of the state's 2.5 million uninsured residents, nearly 1.9 million are workers or their dependents. Nearly two-thirds of the uninsured work for firms with 100 or fewer employees; about 47% of Florida firms with fewer than 50 employees do not offer health insurance.

Florida's reform plan offers businesses with 50 or fewer employees the opportunity to join "Community Health Purchasing Alliances" to obtain health care coverage. The alliances cannot negotiate rates with state-certified health plans; they only can gather data on the health plans (BI, April 12, 1993).

Health plans must offer a minimum benefits package to all small firms seeking coverage through the alliances, and the plans cannot cancel coverage. The Legislature is still considering a minimum benefits proposal offered by

Gov. Lawton Chiles.

Under a modified community rating system, health plans can factor only age, gender, family composition, tobacco usage and location into their rates. The plans can adjust their alliance rates quarterly.

To prevent job lock, pre-existing condition exclusions—which can last one or two years, depending on the size of the firm—are permitted only when a person first obtains coverage through an alliance.

Washington state's 1993 health care reform law, which includes an employer mandate and price controls, more closely resembles President Clinton's reform plan than Florida's (BI, Oct. 4, 1993). But, Florida is much further ahead in implementing its reforms.

Indeed, the rates that 50 health plans submitted to the 11 commu-

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D&O rates holding stable

But some firms do report significant premium hikes: Wyatt

By MARK A. HOFMANN

The market for directors and officers liability insurance remains relatively stable, with a median premium increase of only 2% during 1993, a new survey shows.

"The two best words to briefly describe the D&O marketplace as measured by our 1993 survey would probably be 'competition' and 'stability,'" reported The Wyatt Co. in its annual survey of the D&O insurance market, which is being released today. "Premium increases did outpace decreases by a small margin, but a significant and possibly growing segment of the market increased limits, lowered personal deductibles, and eliminated some exclusions

and restrictive endorsements."

Wyatt, of course, found exceptions to that rule. Companies in the high-tech, construction and real estate, and personal and business services sectors "registered double-digit increases in premium" last year, Wyatt reported.

For companies in these categories, as well as those involved in initial public offerings or those experiencing "even some degree of financial distress, the D&O market in 1993 was anything but soft. These companies may again be treated harshly in 1994, even though some of these firms are actually good risks and merit better treatment," the survey said.

Shareholders in high-tech companies are banking on the success

of future products, explained Phillip N. Norton, the Chicago-based Wyatt consultant who wrote the report. If a company's earnings projections prove unrealistic and the company's stock price plummets, the company can find itself the target of a shareholder suit. Such suits are increasingly based on allegations of improper or inaccurate financial disclosure, he said (see story, page 10).

The increase in D&O premiums for high-tech companies, which saw the greatest increases on average, reflects D&O underwriters' "fear of shareholder suits," even for established companies that operate more like a typical manu-

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Rock 'n' Roll or the blues?

Industry practices cheated musicians of benefits: Suit

By MICHAEL SCHACHNER

ATLANTA—While a ditty like "Yakety Yak, Don't Talk Back" helped put Carl Gardner and the Coasters in the Rock 'n' Roll Hall of Fame, he says it did not necessarily guarantee adequate health care and pension benefits.

Some 30 years after immortalizing tunes like "Yakety Yak" and "Charlie Brown," Mr. Gardner—and about a dozen other pioneers of modern music—are suing their former record companies and trade union, seeking as much as \$750 million in overdue pension and health benefits.

Mr. Gardner and other legendary musicians, including Sam Moore of the duo Sam and Dave and Felix Cavaliere of the Young Rascals, contend they have been the victims of about 35 years of systematic pension fraud in which billion-dollar record companies have refused to contribute toward the artists' retirement benefits.

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Sam Moore, left, of Sam and Dave, is among those seeking benefits.

RIMS brings 'real life' to classrooms for future risk managers

By MICHAEL SCHACHNER

When many of today's students of risk management take their first job in the field, they will sit down at their desks with a very good idea of what a risk manager actually does each day.

Thanks to a special program coordinated by the Risk & Insurance Management Society Inc., today's college students are learning the ins and outs of the profession from sources other than textbooks and professors.

Members of the Risk Managers Speaker Network, a core group of about 60 deputy members of RIMS, for the past 18 months have lectured in graduate and undergraduate insurance classes throughout the country. Topics of discussion have included almost everything from how to get a job in risk management to analyzing loss exposures for motor speedways.

So far, the program has received very high grades from students, professors and the risk managers who have given the lectures, and all signs point to the program continuing and growing for many more semesters.

"We have a strong, viable insurance industry out there and we need to tap into it. It's always beneficial to have people from the working community come into our classrooms because it shows students that the industry cares and it gives them an opportunity to interact with someone in the field," said Phyllis Myers, director of insurance studies at Virginia Commonwealth University in Richmond.

Ms. Myers' class received a visit last year from Karen Fleming, manager-risk management with Bell Atlantic Corp. in Arlington, Va.

Ms. Fleming said her trip to VCU opened her eyes to how much

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Embezzled health premiums alleged

Federal investigation targets leasing firm

By DOUGLAS McLEOD

SAN FRANCISCO—Federal authorities are sorting through dozens of boxes of documents seized from an employee leasing company suspected of embezzling employee health care premiums.

Agents of the FBI and federal Office of Labor Racketeering earlier this month raided the offices of Hazar Inc., an employee leasing firm in San Francisco that operates through 24 subsidiaries and claims to be the largest employee leasing firm in the country.

No charges have yet been filed against Hazar or its employees.

However, an FBI affidavit filed in U.S. District Court in San Francisco says the firm is suspected of diverting employee health insurance premiums that should have been paid to Provident Life & Accident Insurance Co. of Chattanooga, Tenn., and failing to pay about \$1 million in payroll taxes and disability insurance premiums.

The raid was part of a larger, 18-month undercover operation in which the FBI and the Office of Labor Racketeering have targeted suspected fraudulent employee health benefit plans.

The operation, dubbed

"Goodhands," has separately led to the conviction of two principals of Sexton & Sexton Inc., an unrelated labor leasing firm in Clanton, Ala.

Investigations in several other cities are continuing, according to Office of Labor Racketeering officials.

Under an employee leasing arrangement, a company's workers become employees of the leasing firm, which then leases them back to the company while retaining responsibility for payroll, benefit plans and other administrative functions.

Hazar, formed in 1992, acquired a number of employee leasing firms in various states and claims to employ more than 30,000 workers for more than 1,700 client companies, court filings say.

According to court files, Hazar's principals include: Robert J. "Skip" Anderson and Donald K. Jorgensen, identified as Hazar's owners; and Bert Danzig and James R. Paille, Hazar officers.

Mr. Anderson is currently on parole from an unrelated fraud conviction and was indicted by a federal grand jury in Los Angeles in December on mail fraud charges stemming from his opera-

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Antitrust

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The current H.R. 9 would phase out all McCarran protection for trending of data, regardless of source.

- Create a safe harbor for "historic" industry pools and residual market pools.

The Justice Department would have to inform new pools within 90 days of a request whether they presented antitrust problems. The current bill would offer no safe harbor.

- Allow insurers to jointly inspect commercial structures for fire hazards, provided that they are permitted to do so by state law. The current bill would provide no safe harbor for joint inspections.

- Allow insurers to agree to collect, classify and disseminate historical loss data. The current bill would restrict such activities.

The limited exemptions contained in the McCarran-Ferguson Act currently allow insurers to engage in all of these activities without fear of antitrust action. And, that's the way at least two of the largest insurer trade associations want it to stay.

"There's no question we have a competitive industry and we've always maintained and believed that the McCarran act permits the insurance industry to be competitive. I don't really see anything of great merit that the modifications give us," said Rodger Lawson, president of the Alliance of American Insurers in Schaumburg, Ill. The Alliance's membership consists primarily of small and medium-sized mutual insurance companies.

Mr. Lawson predicted that passage of H.R. 9 in either form would create more uncertainty in the market, "provide an opportunity for some enterprising members of the bar to start shooting at those so-called safe harbors" and open the door for dual state/federal regulation of the insurance industry.

"We certainly are opposed to it. If we thought it was a step forward for the industry, we'd certainly join forces and promote it, but we just don't see where the benefit is for the industry," he said.

"We stand firm with the bulk of the insurance industry in opposing these changes. While a small segment of the industry has accepted modification in the name of political expediency, our belief is if it's not broken, don't fix it," said Lowell Beck, president of the National Assn. of Independent Insurers in Des Plaines, Ill. The NAII represents primarily small and medium-sized property/casualty insurers.

"H.R. 9 was a bad bill when it was introduced in the last Congress and despite the amended

language that one insurance company trade group has apparently signed off on, it remains a bad bill," he said.

"We are looking at it. We continue to support McCarran-Ferguson as drafted. We always have reservations concerning changes to it and those reservations stem

"I think the compromise looks very good and we have sent out the language to our executive committee and federal affairs committee and we're hoping they will endorse it," said Barbara Haugen, director of federal affairs for the National Assn. of Insurance Brokers.

'I don't really see anything of great merit that the modifications give us.'

Rodger Lawson



from the inequitable effect that these proposals have on different participants in the marketplace," said Pat Borowski, senior vp-industry and government affairs for the National Assn. of Professional Insurance Agents in Alexandria, Va.

She noted that regional insurance companies, which would be among the hardest hit by McCarran reform, are a mainstay of PIA's members.

Although the Independent Insurance Agents of America will not take a position on the compromise until its executive committee meets later this week, the producer group is concerned about several items, said Bob Rusbult, vp-federal affairs in Washington. In particular, the IIAA is concerned about the lack of a safe harbor for manuals that agents use to classify risks and to quote prices from a variety of insurers, he said.

But, the IIAA regards the compromise as "much better" than H.R. 9, he added.

The compromise fails to "continue protection for all of ISO's essential competitive services," said Fred Marcon, president of the Insurance Services Office in New York. "To the extent we negotiate away these economies of scale," costs will rise for insurers of all sizes, but would fall disproportionately on small and medium-sized companies, he said.

"As far as I can see, it's nothing more than a sacrifice of the smaller companies to appease the powers that be," Jack Ramirez, executive vp and chief operating officer of the NAII, said of the compromise measure.

The AIA disagrees, though, with the contention that the compromise would put smaller insurers at a competitive disadvantage.

"The general framework that we're pursuing is something under which efficient and well-managed companies, regardless of size, who are familiar with their markets and their customers will be able to prosper," said the AIA's Mr. Pratt.

The AIA's approach is not universally opposed by other insurance industry groups.

"We believe that the continuing debate over McCarran is unproductive and distracting to the industry, and the Council would welcome a solution that preserves the crucial activities of the industry but also quiets the ongoing congressional assaults on the industry," said Joel Wood, vp-federal affairs for the Council of Insurance Agents & Brokers in Washington. He noted that the Council has not endorsed the compromise.

Mr. Wood said that while he had "no doubt" that the insurance in-

dustry could maintain McCarran-Ferguson in its current form this year or maybe even for a couple of years, no one can predict what the congressional mood will be five or 10 years hence.

"If we relive the hard market of the mid-1980s, the industry could be in very deep trouble."

The compromise is drawing praise from other quarters, as well.

"If this compromise legislation assures the availability and affordability of insurance for consumers and protects the specific interests of insurers that appear to be vital to their business, RIMS would definitely consider supporting the measure. But at this point, we'll have to study the proposal more carefully before we take that step," said Paul Brown, vp and general counsel for the Risk & Insurance Management Society Inc. in New York.

"I think this is a real breakthrough," said Linda Lipsen, legislative director in Consumers Union's Washington office.

"I think the AIA should be applauded for working this out," she said. "The McCarran-Ferguson Act is a law that's long outlived its usefulness, and this is a very important step toward relegating this law into the trash heap of his-

tory," Ms. Lipsen said.

Although she said she thought the bill had a "great chance" of passing this year, other observers weren't so sure.

"From the standpoint of proceeding as a stand-alone bill, the probability is that it would not get through the whole process this Congress," said the NAII's Mr. Ramirez. He predicted a "battle royal" over the compromise.

Mr. Beck added that the NAII is "concerned that Chairman Brooks' ultimate goal" is to add the compromise McCarran language to the Clinton administration's health care reform package. The Clinton reform bill already calls for repeal of McCarran protections for health insurers, and leaves unclear how multiline insurers would be treated.

The IIAA's Mr. Rusbult offered a different forecast. He said the compromise has close to a 100% chance of winning Judiciary Committee approval if Rep. Brooks pushes it, but probably a 50% chance at best of making it to the House floor during this session of Congress. Because there's no movement in the Senate, even if the measure wins House approval, the proposal only has about a 5% chance of ever "seeing the light of day" in that chamber, he said. **BI**

California

Continued from page 2

the estates of some of the insurers it supervised. The Bee based those reports on public records and information from insurance company employees.

Gary Hernandez, the deputy commissioner in charge of enforcement, said those conclusions were "completely without merit."

"Unfortunately we provided documentation to the Bee, and they chose to ignore it," he said.

Mr. Garamendi, though, concedes that his department illegally took money from the estates of some insurers in conservation, but defends his actions. In a recent letter to state legislators, he said that the money was used to fund enforcement actions against other companies.

Since this practice "was inconsistent with the Insurance Code," he wrote, "I have taken the necessary steps to have the Insurance Fund properly repay all funds that were improperly charged and to ensure that it does not happen again."

The recent newspaper reports were not the first signs of trouble at the conservation and liquidation division. Last year Mr. Garamendi dismissed two division officials after learning of unauthorized payments to division employees and other wrongdoing (*BI*, Dec. 6, 1993).

The newspaper articles center on the throngs of offshore insurers, many from exotic Caribbean locales, that have done a land-office business in California in recent years, mainly selling auto and health policies.

That much everyone agrees on. What is less clear is who is to blame.

California regulators have been criticized in some quarters for moving too slowly against phony companies.

Until a recent regulation that set financial standards for non-admitted companies was promulgated, "the Department didn't do a damn thing," contends Richard Barger, a Los Angeles attorney who was insurance commissioner from 1968-72.

At a 1991 hearing on the regula-

tion, which is known as Section 2174, Mr. Barger argued that regulators had failed to enforce laws already in place and instead drew up new rules (*BI*, Feb. 11, 1991).

"It was like a lot of bureaucracies," said Mr. Barger, now with Barger & Wolen. "In all fairness to the commissioner, he was new on the job, and he didn't understand what was going on. You can't govern by press release. He was so busy trying to enforce Proposition 103, he forgot to look over his shoulder to see that there was a large group of companies taking advantage" of the turmoil in the market caused by Prop 103.

Regulators "did nothing," charges Raymond Greenberg, a Calabasas attorney representing non-admitted insurers.

In other quarters, though, Mr. Garamendi's anti-fraud efforts are praised.

"The commissioner has tried to clear out the bad actors. It's a slow process," said Sen. Pat Johnston, D-Stockton, a member of the Senate Committee on Insurance, Claims and Corporations.

"I think Commissioner Garamendi has moved aggressively to shut down fraudulent offshore insurance operations, and he is the sponsor of legislation (S.B. 959) that I'm carrying to require a 'white list,'" said Sen. Johnston in an interview. White listing refers to a preapproval process for non-admitted insurers.

"Are all the cheats gone? Probably not. But did he take it seriously and work at it more than prior commissioners? The answer is yes," he said.

Mr. Garamendi is defending his record on shutting down fraudulent insurers and his move to tighten procedures at the conservation and liquidation division.

In a letter to Sen. Johnston and another legislator, Mr. Garamendi said since the passage of Section 2174 (*BI*, Dec. 7, 1992), which established financial standards for non-admitted insurers, the number of non-admitted insurers in the state has dropped to about 140 from about 500. The department has also revoked or has issued accusations to revoke the licenses of 20 surplus lines brokers, he said.

Ironically, some in the insurance industry say, it was Proposi-

tion 103—championed by Mr. Garamendi and other consumer advocates—that prompted better-quality insurers to leave the California market, paving the way for less stable, offshore companies to step in.

"Demand for affordable insurance as a result of Proposition 103" was one reason so many unstable or fraudulent insurers did well in California, said Frederick J. Fisher, president of The Fisher Associates, an adjusting company based in Torrance.

Mr. Fisher says he was one of the first "vendor victims" of the phony companies. He lost about \$160,000 in fees that were not paid by companies operated by Alan Teale.

Another factor in the widespread fraud, he asserts, was "lack of financial review (of non-U.S.-based insurers) by the Surplus Line Assn. and the Insurance Department."

It indeed appears that for a number of years, no one was minding the store.

Until the early 1980s, under an informal arrangement, U.S. insurers based outside California were screened by the Insurance Department. Non-U.S. companies were screened by the Surplus Line Assn., a group formed in the 1930s to approve surplus lines insurers for use by surplus lines brokers.

But in the early 1980s, the SLA grew concerned with its potential exposure in screening companies without statutory or regulatory guidelines. So it told the department it could not continue to do the screening, explains broker Gerald Sullivan, president of Gerald L. Sullivan & Associates Inc. in Los Angeles and chair of the SLA legislative committee.

"It was a simple antitrust problem. There are people who will sue you" for not allowing business to be placed with them, he said.

"There was no problem until 1989" he said, when Proposition 103 encouraged many unstable insurers to enter the California market. "Criteria were established for foreign insurers, but not for (non-U.S.-based) insurers. I can't really tell you why."

Recently, Section 2174 "closed the door" on unstable non-admitted insurers, he said. **BI**

Dent joins Business Insurance

CHICAGO—Ovie M. Dent has joined the *Business Insurance* staff in Chicago as editorial assistant.



Ms. Dent

As part of her duties, Ms. Dent will solicit and compile the information that appears in the 21 directories that *BI* publishes.

Ms. Dent, 30, most recently worked at WSBT-TV, the CBS affiliate in South Bend, Ind., as a photojournalist and editor. Before that, she worked for the American Hospital Assn. in Chicago and its subsidiary, American Hospital Publishing Inc., as, among other things, a production assistant for the association's teleconferences.

She received a bachelor of arts degree in journalism from Columbia College in Chicago.

Ms. Dent can be reached at 312-649-5398.

Rockers

Continued from page 3

The recording artists also are singing the blues about their own union, the American Federation of Television & Radio Artists, charging that it failed to prod the record companies to make the contributions as promised.

In the lawsuit, pending in federal court in Atlanta as it awaits certification as a class action, 14 former musical greats allege, among other things, that 55 record companies have intentionally and systematically failed to make proper contributions to the musicians' union health and retirement funds since 1958.

The suit also charges AFTRA, the AFTRA Health and Retirement Funds, and fund trustees with negligence and breach of fiduciary duties. The suit contends the union failed to collect money the recording artists were owed by record companies under terms of National Code of Fair Practice for Phonographic Recordings, and also alleges the union made interest-free loans to the record companies.

Richard Perlman, an Augusta, Ga.-based attorney for the musicians, said the conduct of the record companies and the union adds up to "35 years of pension fraud, which under federal law needs to be counted up and paid" to the artists, many of whom badly need financial assistance and health care benefits.

Meanwhile, AFTRA is seeking to have the musicians' lawsuit and an accompanying motion seeking immediate relief from the funds dismissed on the grounds that the union did nothing wrong.

A lawyer for the union funds said audits of the funds performed in the 1980s and early 1990s that showed many record companies to be many millions of dollars behind health and welfare payments were overstated.

In response, new auditors have been hired by the musicians' union funds in an effort to determine if the record companies actually owe any amount and, if so, how much they owe.

Under the so-called Phono Code, the union funds are supposed to receive about 10% of an artist's compensation from the record company; that money was then to be earmarked for the artist's retirement benefits. This, according to the musicians' suit, has not happened.

But the AFTRA funds are not responsible for seeing that an artist is paid royalties, the union's attorney said.

"It was never our responsibility to enforce payment. If a record company doesn't pay an artist his or her royalties, that's a totally different story. All we ever had to go on was the twice-annual compensation reports we received from the record companies," said Edward Brill of Proskauer, Rose, Goetz & Mendelsohn in New York, who represents the union funds.

Nevertheless, the lawsuit seeks to hold AFTRA and the AFTRA fund responsible for the fact that someone like Carl Gardner was credited by the union fund with only \$121,000 in lifetime earnings, despite the fact that more than 16 million Coasters records have been sold under various record labels.

Based on that level of earnings, Mr. Gardner's entire pension account is valued at only about \$3,300.

"It's clearly the record companies that have failed the artists off

whom they have profited," according to Mr. Perlman.

"But that doesn't minimize the culpability of the funds. I can't believe the funds would disown their original audits and now claim their records are accurate. The recording industry is sick and needs to cure itself. This is a case of someone finally paying attention to federal law," he said.

The lawsuit charges that the AFTRA fund trustees have, among other things, failed to enforce the Phono Code, failed to take affirmative action on behalf of the artists, failed to follow generally accepted accounting principles and ultimately failed to provide eligible artists with the benefits to which they are entitled.

If the lawsuit is certified as a class action, 15,000 to 70,000 former recording artists could be included in the litigation, Mr. Perlman said.

If the case goes to trial, one person who will likely testify on behalf of the plaintiffs is Frederick Wilhelms III, a former fund administrator from 1989 to 1992. Mr. Wilhelms recently supplied an affidavit in support of the plaintiffs' motion for immediate relief from the fund.

"There's nearly \$1 billion in fund assets. Surely a Carl Gardner is due more than the \$3,000 he says is in his account. But there are a number of reasons why the fund balance is incomplete," Mr. Wilhelms explained.

"The payment practices of the record companies is a prominent one, but indifference within the funds, greed and a modicum of administrative incompetence played a part, too. Basically, everyone in the industry, including the fund trustees and the record companies, have failed to keep their promises to these singers,"

Mr. Wilhelms said.

Before the plaintiffs receive any money, "there will have to be a significant recovery of back payments from the record companies. They're the ones who failed to make contributions according to the code. My fear is that it will end up being nothing more than 80 lawyers, auditors and trustees pointing at each other while the people that need the money grow older and older. Probably the saddest thing of all is that if this were 15 plumbers, you wouldn't hear a word about it," he said.

While Mr. Wilhelms concedes that during his tenure there was some sloppy bookkeeping at the union funds, he stands by the audits that showed several major record companies to be millions of dollars behind in contributions.

According to Mr. Wilhelms, those audits showed that: M.C.A. owed more than \$13 million; Sony

Records, \$6.2 million; Polygram Records, \$5.7 million; and A&M Records, \$4.4 million.

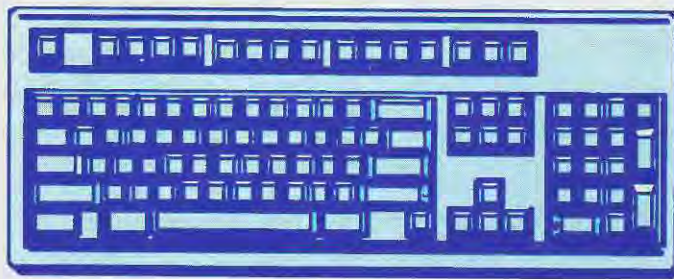
"The record industry has treated these musicians like serfs. They are, in fact, the music czars," said Mr. Perlman.

Record companies wouldn't comment.

In the meantime, Sam Moore, 58, and Carl Gardner, 65, maintain they have accrued only a few thousand dollars in their AFTRA health and retirement accounts, yet their songs continue to be heard on radios, stereos and jukeboxes across the country.

"Hopefully some money will be awarded and it'll go back into the funds for distribution under a defined benefit formula," said Mr. Wilhelms. "These old performers deserve it. Some serious errors, some intentional and others unintentional, have been made for a long time."

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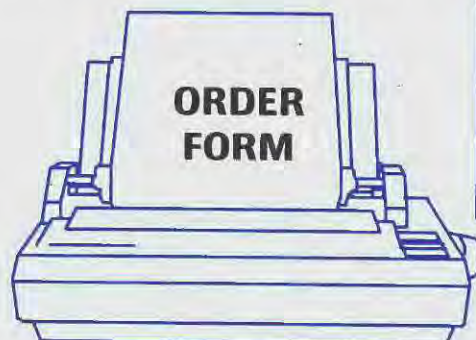
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Utility offering early retirement

CHICAGO—Electric utility Commonwealth Edison Co. is offering enhanced early retirement pension benefits to 1,000 managerial and union employees between the age of 55 and 60.

Com Ed has not estimated how many employees, who must have at least 10 years of service to be eligible for the offer, will accept it. However, when the same deal was offered to 625 management employees in 1992, 80%, or 500, retired early, a spokesman said.

The utility is trying to increase productivity in the face of increased competition from cogeneration firms, which help businesses cogenerate their own power, he said.

Under the offer, which is open until March 31, 1995, the utility will adjust its normal early retirement pension formula to reduce, and in some cases eliminate, the penalty for retiring early.

First, the utility will add two years to an early retiree's age in figuring the pension formula. Normally, the sliding-scale pension benefit penalty for early retirees begins at 16% for 55-year-olds and drops by four percentage points each year through age 58. The penalty drops by two percentage points each of the next two years.

For example, the benefit penalty for a 55-year-old early retiree, whose penalty under the offer would be figured as though the retiree were 57, would be cut to 8% from 16%.

Second, the utility will reduce the remaining pension benefit penalty by a percentage that is determined by adding the early retiree's actual age and years of service and multiplying that sum by 10%.

Under this formula, a 55-year-old early retiree with 25 years of service would receive a full pension benefit, because the 8% penalty would be eliminated by the sum of 55 and 25, or 80, multiplied by 0.1, or eight.

Some early retirees with decades of service would receive more than the full pension benefit they would receive if they did not retire early, because their early retiree pension benefit penalty offset is bigger than their penalty. This would occur with a 57-year-old early retiree with 25 years of service, for example, because the 2% penalty would be offset by the sum of the retiree's age and years of service, or 82, multiplied by 0.1, or 8.2.

Early retirees also will receive the health care benefits that all retirees receive. However, continuation of retiree health care benefits is subject to change under a reservation of rights, the spokesman said.

—By Dave Lenckus

Investment knowledge

Despite increased educational efforts by 401(k) plan sponsors, participants' investment knowledge has not improved, a recent study says.

The Department of Labor's voluntary 404(c) regulations, which exempt plan sponsors from potential liability for participants' investment choices, have resulted in increased investment educational efforts by plan sponsors (BI, Oct. 12, 1992).

According to the survey, sponsored by John Hancock Financial Services, 44% of the 813 plan participants surveyed said that their employer increased the quantity of educational or communication materials they received for their retirement savings plan in the past year. In addition, 49% said their employer had increased the quality of information materials.

Indeed, most of the plan participants have recognized those efforts. Sixty percent considered themselves

Benefit Beat

to be more knowledgeable investors today than they were a year or two ago, while 63% said they now focus more attention on the money in their retirement savings plan.

However, 51% of the participants said they still did not have sufficient knowledge and information to effectively manage their retirement savings, the survey said. In particular, participants are not very familiar with and do not understand how basic investment options work.

For example, 50% of the participants thought money market funds consist of stocks and bonds, when these funds typically include short-term financial instruments, like treasury bills and commercial paper. Forty percent did not know what investments are included in a bal-

anced fund, and only 26% knew that the best time to transfer into a bond fund is when interest rates are expected to decrease.

Thirty-four percent of the respondents believed it was their employer's responsibility to provide them with specific investment advice, such as how much to invest in stocks and bonds, while 66% said they did not think it was their employer's responsibility to provide such advice, the survey said.

Twenty-four percent of the respondents said they relied on materials provided by their employer to make 401(k) investment decisions, and 23% said they relied on the advice of family, friends and business associates. The survey also said another 15% relied on newspaper and magazine articles, and 11% cited a financial planner as a source of information.

For a free copy of the "Third An-

nual Defined Contribution Plan Survey," call John Hancock Financial Services at 800-294-7734.

—By Sally Roberts

Pac Bell restructuring

SAN FRANCISCO—As part of a corporate restructuring program, managers at Pacific Bell will be required to contribute to their health care plans for the first time, beginning in 1995.

Individuals will be expected to pay \$15 a month, while employees with two or more dependents will pay about \$45 a month. The charge will be the same regardless of the type of health coverage the employee has, a spokesman said.

The charges are part of a program that calls for a reduction of 10,000 employees by 1997, including 3,000 this year. Pacific Bell's parent, Pacific Telesis Group, which employs

more than 68,000 workers, has taken a \$576 million reserve and an additional \$89 million in charges to pay for the cost of the restructuring.

—By Judy Greenwald

Chase stock options

NEW YORK—Chase Manhattan Corp. is offering its 33,500 full-and part-time employees a stock option program that is based on the company's stock market performance.

Full-time Chase employees will each receive 400 stock options they can exercise in three years if Chase common stock trades at an average price of at least \$60 a share over a defined period of time.

They will be able to exercise half the options in three years if the stock has traded at an average price of \$52. If the stock performs below that level, they can exercise the options after nine years.

Chase's part-time employees will receive 200 stock options, said a spokesman.

—By Judy Greenwald

Hazar

Continued from page 3

leasing of UMC Inc., another employee leasing firm.

He is also named in a lawsuit filed last year by the Texas attorney general involving another employee leasing firm in that state.

Hazar officials couldn't be reached. No employees were denied benefits, the firm's lawyer says.

The FBI obtained search warrants earlier this month for the San Francisco offices of Hazar and the Chapel Hill, N.C., office of Preferred Staffing, one of Hazar's 24 employee leasing subsidiaries.

In an affidavit filed with the San Francisco search warrant application, FBI Special Agent Willard Hatcher said the Hazar investigation involved suspected embezzlement from an employee benefit plan, mail fraud, wire fraud and money laundering.

According to the affidavit, Mr. Anderson and other Hazar officials negotiated the March 1993 acquisition of International Resource Man-

agement Co., a Columbia, S.C., labor leasing firm, by Foothills Employee Leasing, a Hazar unit.

IRM had a health insurance contract with Provident that, after the buyout, was allegedly renegotiated to include most of the employees of Hazar's other operations.

However, Hazar significantly underreported the number of employees to Provident, according to the deposition.

For example, Labor Management Services Inc., a San Francisco-based Hazar unit, reported only about 2,000 of its 8,000 employees, the affidavit says, citing information from an unidentified Hazar employee described as a confidential source.

"This left approximately 6,000 LMS employees that believed they were insured through Provident but in fact had no health insurance," the affidavit says, adding that "this misrepresentation resulted in a substantial number of unpaid health insurance claims."

A Provident officer separately told the FBI that Hazar had reported only about 1,200 covered employees. Provident terminated its

policy as of Nov. 1, 1993, after Hazar failed to pay October 1993 premiums and post an \$800,000 letter of credit guaranteeing future payments, the affidavit says.

Nevertheless, Hazar officials continued to name Provident as their insurer after effectively cancelling coverage, the affidavit says.

Provident has received about 175 claims totaling about \$250,000 since the cancellation, which it is refusing to pay, the court document says.

The affidavit alleges that Hazar diverted premiums collected from clients and employees for the alleged Provident coverage, though an FBI spokesman said authorities were not yet certain how much money was siphoned.

The Hazar employee identified as a confidential source told the FBI that Mr. Anderson said he had "busted out" eight employee leasing companies in California before starting Hazar and that he needed to "move money and hide it" to protect himself from a possible civil judgment, according to the affidavit.

Mr. Paille, Hazar's chief financial officer, told undercover agents that

Hazar controls more than 70 bank accounts nationwide and that money collected by Hazar subsidiaries was wired into Hazar accounts.

Along with the alleged health insurance scheme, Hazar and its employees are also suspected of diverting payroll taxes and disability insurance premiums deducted from employees' checks, the deposition says.

For example, LMS reported paying California wages of \$20.4 million for the third quarter of 1993. While it owed \$1.4 million in payroll taxes on this amount, it had paid only \$204,266 as of last Dec. 6, according to the affidavit.

LMS later agreed to pay the state \$100,000 a week starting in December and had made two of these payments by early January, the court filing says.

The California Employment Development Department is also holding Mr. Anderson personally liable for \$333,783 in payroll taxes and disability premiums still owed by UMC, his previous employee leasing firm, for tax periods from 1989 to 1991, the affidavit says. ■

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Students

Continued from page 3

more today's students already know about the profession compared with what she knew as a college student.

"People my age mostly entered this field through the back door, but these kids already know so much, they're front-door material. I went there prepared to give a simple overview of what risk management is and ended up answering questions about how to get into the profession, salaries and so forth."

Other risk managers also found that leaving the office to lecture college students turned out to be an educational experience for themselves.

"It sent me back to theory for the first time in a while," said Benny Bumpers, risk manager with Vulcan Materials Co. in Birmingham, Ala. "Instead of dealing with the everyday practicality of the job, I was forced to think about risk management theory."

At the same time, Mr. Bumpers said his trip last spring to Mississippi State University allowed him to stress the importance of separating the world of theory from the world of reality. "I tried to teach them something about the world they'll be dealing with. Things are more complex these days, and if they can leave school with more knowledge about real life, they should be better off."

Hearing real-life anecdotes from risk managers is the true value of the lecture circuit, said David Nye, who teaches a corporate risk management class at the University of Florida in Gainesville.

"Students are learning about the job from someone in the trenches as opposed to an academic. They're getting a perspective on the hows, whys and with whoms that we can't offer. Anything that connects what they read in their books with real life is good."

Mr. Nye's class was visited last year by David Holcomb, risk manager with International

Speedway Corp., the company that owns raceways like Daytona and Talladega, as well as for NASCAR, the sanctioning body for the stock car races that run on those tracks.

"It was an extremely interesting day for me. Too often, we look at things from a paper perspective. This reconfirmed in my mind that risk management is a live profession with opportunities for everyone. It also gave me a chance to dispel the belief that all risk managers are bean counters with pocket protectors," Mr. Holcomb said.

While some of the lectures are very general in substance, others

Students should know 'risk management isn't some detached theoretical field,' says Moshe Porat.

are more specific.

Kenneth Maher, risk manager with Minet Group in Philadelphia, visited both graduate and undergraduate insurance classes at Philadelphia's Temple University to discuss crisis management. Mr. Maher is a good source: He is the former risk manager of Meridian Bancorp Inc., the largest tenant in Philadelphia's Meridian Plaza, which suffered a major fire in 1991 (BI, March 4, 1991).

"Basically, I gave a presentation that recounted exactly what happened after the fire. I tried to underscore the importance of pre-loss planning and contingency planning. My message was that failing to plan is planning to fail."

Beyond that, "I wanted to let them know that they're entering a field that's more than just risk financing. There's security, asset protection and planning involved. There's potential diversity beyond just purchasing insurance."

Moshe Porat, Temple's chairman of risk management, insurance and actuarial science, said lectures like the one provided by

Mr. Maher are at the core of Temple's curriculum.

"When students see someone who was once like themselves who has made it in the field, it gives them a dimension teachers can't provide. It's important to show them risk management isn't some detached theoretical field," Mr. Porat said.

In addition to giving students valuable information about what risk managers are called upon to do at their jobs, having working professionals in the classroom also assuages some of the fears students have about finding jobs.

"Students today are very concerned about getting a job and this helps them with tips on how to break in. The more they know, the better off they'll be when the leave campus," said Mark Browne, an assistant professor of insurance at the University of Wisconsin at Madison.

Rose Vena Berk, risk manager with Helene Curtis Industries Inc. in Chicago, visited Mr. Browne's mid-level commercial property insurance course last year. While part of her lecture revolved around the intricacies of property insurance and loss control, "students were most concerned about how to get a job and what kind of money they'll be making," she said.

"It was very interesting to see what's being taught in the schools and what interests young people. I was taught risk management on the job, but these kids are better prepared to enter the field because they're getting a solid theoretical framework. Still, I advised them that they're unlikely to get jobs as risk managers right out of school. My advice was to hook on with a brokerage to get started," she said.

Because feedback on the program has been overwhelmingly positive, the Risk Managers Speakers Network should continue to grow, participants said.

"Universities are always trying to build bridges with the professional community. This type of program adds a dimension to the classroom that we can't provide," said Mr. Browne. **BI**

Compaq

Continued from page 2

obligated to warn users, said Donald McFall, Compaq's attorney. He is with the firm McFall & Sartwelle in Houston.

In post-trial interviews, the plaintiff's attorney learned that the jury based its decision primarily on the year in which the word processor used by Ms. Woodcock was introduced.

"They decided that in 1988 there was not sufficient evidence for Compaq to know enough to put a warning on the product," explained Ms. Woodcock's attorney, Mark Collmer of Houston. "If the case were tried based on what we know today, it could have a very different result."

Indeed, many ergonomics experts predict this verdict—the first by a jury in a trial involving computer keyboard product liability claims—comes in only the first case in what will soon become mass tort litigation.

NCR Corp. won a similar case in New York that involved a grocery store scanner, according to Robert Dieterich, managing editor of New York-based VDT News, a bi-monthly newsletter that focuses on computer health and safety issues.

Many similar cases have either been settled out of court or dismissed at the trial court level, he said.

It's common for early suits in mass tort litigation to fail, said Steven Phillips, a partner with Levy, Phillips & Konigsberg in New York who is representing more than 2,000 keyboard users in similar product liability cases.

"At the beginning of these cases, the defendants usually win because they know where the bodies are buried and how to keep them hidden," he said. "With time, as the plaintiffs' counsel learns what's in the defendants' files, we'll undoubtedly be able to prevail."

And with more than 100,000 repetitive strain injuries per year being reported to the Bureau of Labor Statistics, "this has the po-

tential of becoming another mass tort case like asbestos, Dalkon Shield and breast implants," Mr. Phillips said.

While most of the suits filed so far cite the manufacturers' failure to warn of potential harm from prolonged use, "the hope is they'll eventually start building better keyboards," according to Mr. Phillips.

Indeed, studies have found that the slant of the personal computer keyboards tends to put the users hands in a "dorsal flexion" position that can lead to pinched nerves, carpal tunnel syndrome and other crippling hand injuries, according to Dr. Emil Pascarelli, a New York physician and author of "RSI: A Computer User's Guide."

A study by the National Institute of Occupational Safety and Health found 41% of 923 randomly selected video display users at the Los Angeles Times were suffering from upper extremity musculoskeletal work-related injuries.

Thirty-six percent of these users had seen a health care provider, and 12% missed at least one day of work.

"Based on those findings, anywhere from 5% to 15% of the total population of workers would have qualified as having an injury" compensable under workers comp, said Neal Taslitz, president of Chicago-based BackCare Corp., who has been conducting keyboard research with Northwestern University.

Because of this growing body of research, "it will be more difficult for manufacturers to use ignorance as a defense," said Mr. Taslitz. "So we'll start seeing more warnings accompanying keyboards."

Chicony America Inc. in Irvine, Calif., which makes keyboards for several major computer manufacturers, already warns users against prolonged use.

Chicony's warning was added in response to the recent spate of product liability lawsuits linking crippling hand disorders to prolonged keyboard use, according to Michael Rakiety, national OEM sales manager for the firm.

"Nearly every major PC maker has been named in a lawsuit," he said.

Chicony's warning states: "Caution: Avoid prolonged use of the keyboard without breaks. Take regular breaks and keep a good posture. Consult your physician promptly if you notice any loss of motion or pain in your wrist when using the keyboard."

But even warnings may not be enough to protect manufacturers and distributors from litigation, according to Mr. Collmer.

Eventually employers and their workers compensation insurance companies, facing an increasing number of claims for repetitive strain injuries stemming from keyboard use, "will sue computer makers and marketers for failing to advise them about proper setup and use" to recoup lost their disability payments, Mr. Collmer predicted.

And with more than 75 million computer users nationwide, "this will make asbestos look small," Mr. Taslitz predicted.

Mr. McFall, Compaq's attorney, agreed that this is only the beginning. "The plaintiffs attorneys have done their deal on asbestos, the breast cases have run out of steam, so now they're looking for something else."

"We're just at the beginning stages of what is going to be around for awhile," Mr. Taslitz said. "This is much worse than people had imagined." **BI**

carrier takes a big hit **TICK**.....**TICK**.....**TICK**.....**TICK**



General Accident Insurance Company of America; General Star National Insurance Company; The Home Insurance Company; Insurance Company of North America; NAC Reinsurance Corporation; The Travelers Indemnity Company; Zurich Insurance Company, U.S. Branch.



**American Excess
Insurance Association**

Opinions

Please, HCFA, ease up

While admittedly a final decision has not been made, we are encouraged that federal officials may temporarily relax a provision in a new law that requires employers to report health care plan enrollment information to the government.

Under that law, enacted last year, an employer must file annual reports with the Health Care Financing Administration that list the names and Social Security numbers of all employees and dependents covered by all of an employer's health care plans. The information is to be used by HCFA to recover payments for claims, chiefly those of older workers and their dependents, that employer plans—not Medicare—should have paid. It also will be used to prevent improper payments in the future.

As we report this week, HCFA, the federal agency that administers Medicare, now is considering a one-year delay of one of the most difficult provisions in the law for an employer: reporting the Social Security numbers of dependents covered by its health care plans.

On the surface, this requirement would seem to be a minor task. But for many employers, it's not. Many employers never have attempted to collect dependents' Social Security numbers because there was never a reason to do so. Indeed, some employers do not even know the names of dependents covered by their plans.

For big, national employers, obtaining Social Security numbers will be a long, drawn-out and expensive process.

And, there is no certainty that employers will be able to obtain the information for all dependents. How can an employer, for example, obtain the Social Security numbers for dependents of employees that have quit and moved away? Under the law, that would be necessary. And, if an employer does not comply, it could be fined up to \$1,000 per employee and dependent.

Over the long run, the problems the law will cause



"DARN! I'VE GOT A SCHEDULING CONFLICT... IF IT'S OK. WITH YOU, WE'LL JUST TRY AGAIN NEXT YEAR."

employers likely can be reduced or even eliminated. However, a bigger question remains: What logical purpose does this health care coverage reporting law serve?

We have no quarrel with the goal of the law: ensuring that employer plans, not Medicare, are the primary payers of health care bills for workers staying on the job after age 65. However, we see no purpose in requiring an employer to file a mountain of reports for health plan members nowhere near 65.

For now, we hope HCFA does everything it can within its authority to ease employers' reporting burdens. Over the long run, though, Congress needs to pare back the law to require employers to file information that is truly needed, not compile data that serves no useful purpose.

Letters

State laws determine the type of riverboat casinos

To the editor: The Jan. 17 article on riverboat casinos was researched very well. However, a clarification is needed: The exposure to dockside gaming vs. riverboats that cruise varies due to the gaming law of each state.

Currently in Illinois, Indiana and Iowa, the laws require boats to navigate when either the pilot and/or the Coast Guard judges navigation to be safe. Missouri law

keeps changing, but eventually we will see dockside casinos there, as well as vessels that will cruise. Mississippi allows dockside gaming, while Louisiana, like Missouri, will see both types.

The jurisdiction issue is an element that affects the exposure: Does maritime law or state law apply? Another issue is the boat's location and the exposure to wind, floods, etc. The size of the riverboat is another

variable. All of these issues are being met with a cautious but willing-to-listen attitude by underwriters.

The risk management programs of gaming boat operators are maturing with the insurance market. It is certain that less predictable and catastrophic losses will be insured, while predictable losses can be financed through alternatives.

The insurance industry is ready and willing to accept the gaming boat industry's exposures. Brokers must work harder to search, create, convince and help our riverboat gaming clients to seek the right balance between insurance and other risk financing methods.

This balance is somewhat dictated by a cautious but emerging insurance marketplace. Those gaming boat operators that now have one or two years of experience are making more informed decisions based on empirical data.

Robert E. Ruebsam

Executive VP

Sedgwick James of Missouri Inc.
Clayton, Mo.

ocrats alike expressing their concerns with the president's and Mrs. Clinton's health care plan. Are Americans ready to sacrifice their ability to choose their own health care options, doctors and hospitals? Are they ready to create another large government bureaucracy to administer the Clinton plan? I think not.

As an afterthought: Does your headquarters location on Rush Street have any significance?

Donald E. Fouraker
Orlando, Fla.

Lloyd's should have home of its own

To the editor: I read with interest your Feb. 14 article, "LUC Makes a Bid to Be the Hub of London Market." Fortunately, I know Lloyd's of London Chairman David Rowland to have a keen sense of humor, so he is unlikely to have been unduly alarmed by your headline. I would, however, like to amend one of the statements I made.

I was quoted as saying that "logic suggests" that the London Insurance & Reinsurance Market Assn, the Institute of London Underwriters and Lloyd's "all be housed" in the London Underwriting

Centre. What I intended to convey is that, while it would be physically possible to house Lloyd's, the ILU and the existing LUC tenants (which include LIRMA) all in one building, it would not necessarily be advisable. Indeed, to do so would leave no room for new companies attracted to the London market. I believe that a logical rationalization would be to have all the insurance companies in one building and Lloyd's in another.

The number of market buildings is academic and temporary compared with

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Survey

Continued from page 3

facturing firm than a start-up concern, Mr. Norton said.

Overall, though, the survey found that D&O pricing may be moderating for an increasing number of companies.

"By the third quarter of 1993, increases are still outpacing decreases, but only by a small margin as opposed to the third quarter of 1992," when three times as many companies reported premium increases as decreases, Mr. Norton said.

Of the respondents who renewed their D&O coverage in the third quarter of 1993, 41% saw premiums increase; 32% saw premiums decrease; 25% said they remained the same; and 2% had no prior coverage for comparison.

During the third quarter of 1992, though, 54% of the participants reported higher premiums, while only 17% said their premiums had fallen and 28% said they remained the same.

Mr. Norton said that D&O underwriters have become increasingly sophisticated in assessing risk and pricing coverage. Owing to increased information and improved analytical tools, pricing more accurately reflects exposure than in the past, he said.

Wyatt tallied the responses of 1,203 U.S. corporations with a median asset size of about \$600 million for its 1993 survey.

A majority of the respondents—59%—are publicly traded companies. Eighty-four percent of the respondents reported carrying D&O coverage.

Limits ranged from \$1 million to \$210 million, with the average D&O coverage limit being \$30.7 million. That average limit represents an increase of 8.1% over the \$28.4 million average limit reported by participants in Wyatt's 1992 survey (BI, Feb. 15, 1993).

Stability in the D&O marketplace was evident in that most respondents with prior coverage reported the same limits, deductibles and coverage exclusions at renewals in 1993.

The majority of respondents—83%—retained the same limits in 1993. Fourteen percent increased their limits, while 3% had lower limits.

Middle-market banks were the industry category most likely to increase D&O limits last year, with 25% of the respondents reporting higher limits.

Petroleum, mining and agricultural firms were the least likely to increase limits, with only 8% of the respondents in each industry saying they had higher limits in 1993.

Eighty-three percent of the respondents reported having maintained the same deductible or retention levels at renewals last year. Only 9% said they had increased their deductibles, while 8% said they decreased them.

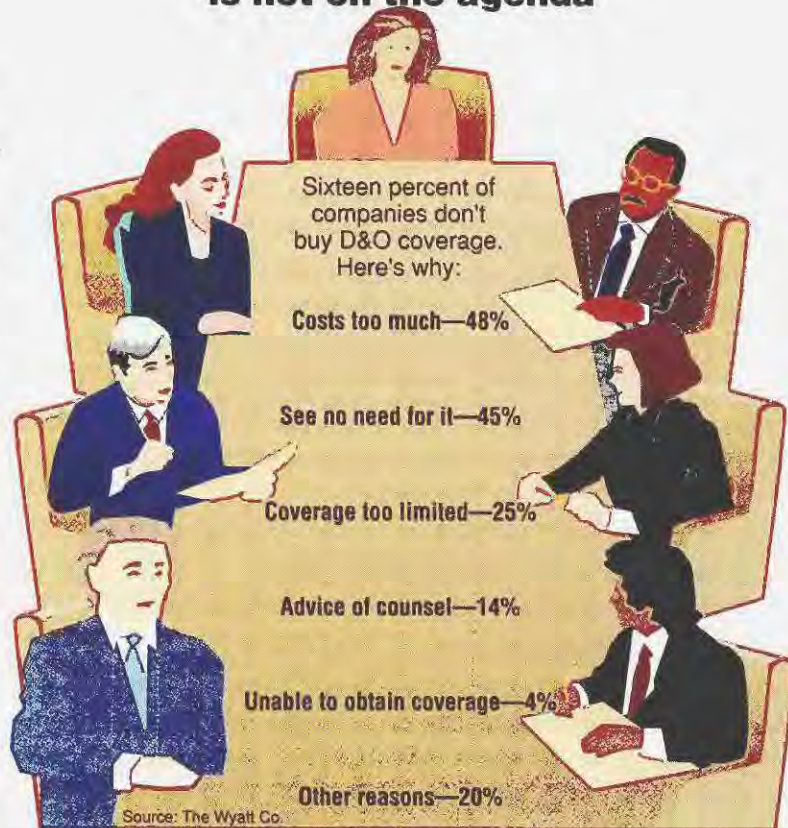
Respondents in the high-tech field of electronics and computers were the most likely to have increased deductibles, with 20% of these respondents reporting increases.

Construction and real estate firms were the most likely to reduce their deductibles, with 19% of the respondents in this sector reporting lower deductibles in 1993.

Wyatt found that respondents in the construction and real estate sector also were the most likely to secure fewer exclusions at renewals, with 35% reporting fewer exclusions.

Personal and business services firms were the most likely to report tougher terms at renewals, with 10% reporting more exclusions in 1993.

Why D&O cover is not on the agenda



GRAPHIC BY KIM ROME

"Most of the participants reported that exclusions did not change on renewal of their D&O insurance. Among those that did report a change, 75% indicated exclusions

had decreased and 25% indicated that exclusions had increased—a favorable trend," Mr. Norton commented.

A further indication that the D&O

market may be more favorable for buyers is a steady decline in the percentage of firms going without the coverage.

Only 16% of the respondents said they carried no D&O coverage in 1993, down from 19% in 1992 and 23% in 1990.

Forty-eight percent of the 1993 respondents without D&O coverage said the cost was too high, 45% said they saw no need for it; 25% complained that the coverage was too limited; and 14% said they went without D&O coverage on the advice of counsel. Those reasons were roughly the same as those given by 1992 survey participants.

Only 4% of the 1993 participants without coverage said they couldn't obtain it, compared with 5% a year earlier.

Another area in which there was little change between 1992 and 1993 was in individual D&O insurers' share of the market. The survey respondents accounted for 1,007 primary D&O policies with a total premium volume of nearly \$256.5 million in 1993.

The top three D&O insurers remained unchanged last year.

American International Group Inc. again had the largest share of the primary D&O market, accounting for 42.8% of the respondents' premium volume in 1993, compared with a 37.4% share in 1992.

Chubb Corp. again ranked second, with 21.8% of the premiums in 1993, compared with 21% a year

earlier.

Associated Electric & Gas Insurance Services Ltd., a group captive for U.S. utility companies, again ranked third with 9.2% of the premiums in 1993, compared with 10.1% a year earlier.

No other D&O insurer wrote more than 7% of the respondents' primary premiums in 1993.

The survey respondents also accounted for 1,136 excess D&O policies that generated a premium volume of almost \$191.4 million in 1993.

ACE Ltd. led in excess premium volume both years, accounting for 15.5% of respondents' excess premiums in 1993, compared with 16.4% a year earlier.

Chubb ranked second, with 11.9% of the 1993 premiums, compared with 11.6% and a third-place standing a year earlier. AIG followed right behind, garnering 9.9% of the 1993 premiums, compared with 14.3% and second place a year earlier.

In terms of sheer numbers, AIG and Chubb were virtually tied, writing 29.5% and 29% of the respondents' primary D&O policies, respectively. Lloyd's of London underwriters came in a distant third with 6.2% of the primary policies.

There was no change in the rankings of excess D&O insurers in terms of policy count: Chubb was first with 13.6%, followed by AIG with 9.7% and ACE ranking third with 9.4%. **BI**

Financial disclosure tops list of D&O claims

By MARK A. HOFMANN

Changes in the financial landscape of corporate America were evident in the nature of directors and officers liability claims activity last year.

As merger and acquisition activity has slackened from the pace of the late 1980s, its importance as a source of D&O claims has fallen accordingly, reports the "1993 Wyatt Directors and Officers Liability Survey" released today.

But D&O claims related to allegations of inadequate financial disclosure and reporting are becoming the most frequently mentioned general issue in claims, the survey found.

Merger and acquisition activity generally was cited as the main claimant issue in only about one in 10 D&O claims in 1993. That 10.1% rate was sharply lower than in 1992, when such activity accounted for 16.5% of claims, and in 1990, when it was cited in nearly 20% of claims.

By contrast, "inadequate (or) inaccurate disclosure was named the single most important issue in 10% of claims this year vs. 7.7% two years ago and 6% the year before that," Wyatt said. Last year's 10% rate was unchanged from 1992.

But "if we included claims relating to stock offerings (possibly our fastest-growing source of new claims) in our disclosure claim tally (as would almost always be appropriate), we would have a total of 17% of all D&O claims reported as due to general disclosure issues," the

report points out.

The 1993 survey examined 713 claims made against 302 participants. The claims themselves were filed over the nine-year period 1984 through 1992, and about two-thirds were closed by the time the participants filled out the survey.

Shareholders were the most common source of D&O claims, accounting for 47% of the claims reported in the survey. That was a slight drop from the 1992 survey, when 52% of the claims were related to shareholder actions.

Employees brought 22% of the claims noted in the 1993 survey, compared with 20% in the previous year's study. Customers and clients accounted for 19% of the 1993 survey's claims, up from their 16% share in 1992; competitors accounted for 4% of the 1993 claims, down from 6%; government-initiated claims accounted for 3% in both years; and other third-party claims represented 5% of the claims in 1993, up from 3% a year earlier.

While shareholder actions were the most prevalent source of D&O claims for the survey respondents on average, some industries reported other leading sources of claims.

For example, transportation and communications companies reported that shareholders and employees were equally frequent sources of claims, with each category accounting for about 37% of claims.

For non-banking financial companies, employee issues were the most common source of claims at 38%,

compared with 33% from shareholders and 21% from customers.

And for banking respondents, nearly half the claims—49%—came from customers, as opposed to only 18% from shareholders and 16% from employees.

Class-action suits accounted for more than one-third—36.5%—of all claims against all types of industries. That is in line with 39% during 1992.

The average payment to claimants whose claims resulted in a monetary settlement was \$3.25 million in 1993, virtually unchanged from 1992's \$3.26 million average.

The report notes that these figures

"do not reflect the possibility that the open claims reported (in 1993) may eventually close for greater amounts, on average."

The survey found wide disparity among the average amounts for which claims were settled.

The average shareholder claim settled at \$5.4 million in 1993, compared with an average settlement of \$536,461 for employee claims and \$106,779 for customer-generated claims. The average settlement in claims brought by competitors was \$2.5 million, and the average for claims brought by government agencies or other third parties was \$3.3 million. **BI**

L.A. quake

Continued from page 1

and officials were preoccupied with restructuring.

The bank on Jan. 18, the day after the quake, went ahead with plans to begin eliminating 500 of the 3,900 headquarters positions and institute a hiring freeze for California.

At Great Western headquarters, most of the dropped ceilings came down, but there was very little structural damage, Mr. Evans said at a recent meeting of the Los Angeles Chapter of the Risk & Insurance Management Society Inc.

"It looked worse than it was."

Several of the bank buildings, including a daycare center and the parking garage, were built in 1992, and "those came through pretty much unscathed," he said.

Built of poured, not precast, concrete, the \$4 million parking garage remained standing, though pictures of the collapsed Northridge Fashion Center garage only blocks away were seen by millions.

Also in the headquarters complex, the data center was back in operation several hours after the quake and even employee workstations held up pretty well.

"Those people that had their drawers closed and locked did not suffer any damage. The drawers that were not locked flew open and

tilted the whole workstation. So...if you suggest locking things up at night, that would prevent some damage," he said.

Planning and quick action prevented all but minimal business interruption losses. A facility had been set up in Florida for wire transfers, "and that went without a hitch," said Mr. Evans. Three branches were closed temporarily, but the business was transacted at other branches.

Maybe it's best that the bank didn't buy any business interruption coverage, Mr. Evans said. "The fact that we laid off almost one-third of our staff in this restructuring would not lend itself well to any business interruption claim."

A big concern for the bank is its earthquake coverage renewals, which were scheduled for February. "Needless to say, this earthquake did not help my renewal process," he quipped.

"My renewal is not complete. There is a moratorium in certain areas and a reluctance among a lot of underwriters to even write quake insurance."

With property valued at more than \$200 million, Great Western previously had \$75 million in aggregate earthquake limits. Its deductible is 5% of combined property and contents damage. But now, with capacity diminished and prices sure to

Continued on next page

How the survey was conducted

Participants in The Wyatt Co.'s 1993 directors and officers liability survey submitted detailed questionnaires to Wyatt's Chicago office in late summer and early fall of last year.

Information provided by the participants covers the period from the third quarter of 1992 through the third quarter of 1993, and is based on 1,203 usable responses. Wyatt conducted the survey with assistance from the Risk & Insurance Management Society Inc.

The survey is the 16th in a series of studies on D&O claims and insurance purchasing patterns.

Copies of the survey are available for \$270 each from Mary Maze, The Wyatt Co., D&O Liability Services, 303 W. Madison St., Suite 2400, Chicago, Ill. 60606-3308; 312-704-2719.

Continued from previous page
climb, the bank is considering buying limits of only \$50 million.

One reason, said Mr. Evans, is that the major concentration of value is in the data center, which held up very well.

Renegotiating renewals will be easier because its earthquake coverage is separate from its all-risk property policy, which is written by Arkwright Mutual Insurance Co., said Richard T. Lyons Jr., assistant vp and regional sales manager in Long Beach.

Great Western, Mr. Evans said, only started buying quake coverage seven or eight years ago and then only because its lease agreements required it. Now, all the bank's buildings are covered, with 19 insurers participating in various layers.

Carter Hawley, too, only started buying quake coverage recently.

"We've gone through and done a lot of soul searching on that," said Ms. Welch.

Like other companies, Carter Hawley was concerned with the price. So, two years ago it commissioned broker Johnson & Higgins to conduct a detailed study, including a computer simulation of potential losses. What the company learned was that a quake of 5.9 on the Richter scale could produce \$90 million in losses on certain risks in Southern California.

Although final damages are not yet known, "it is going to be probably fairly close to that," Ms. Welch said. On Feb. 4, the company notified its insurer that the loss will exceed \$60 million, she said.

But Carter Hawley was prepared. "We looked at what we had in terms of exposures and we bought the insurance for that," she said. "As you know, Carter Hawley Hale was in

bankruptcy a couple of years ago, and I would hate to say what our position would be today if we hadn't (bought coverage)."

Cautiously, Carter Hawley studied insurers' concentration of Los Angeles-area and Southern California risks and carefully examined its own policies.

Among the useful things it learned was that water damage as a result of sprinklers is covered by its all-risk policy, said Ms. Welch. "That will help if you're trying to refresh your limits; it will put your (water damage) loss over into another area."

Knowledge of the business interruption coverage may also help the retailer retain enough key people. To reopen quickly, "we believe we should have a substantial number of

our sales force maintained on staff," she said. "And we will propose that this should be covered."

And it is essential to know the relationship between business interruption coverage and the way inventories are valued under its property coverage. Because Carter Hawley's inventory coverage is based on retail value rather than cost, the company's business interruption expense will be mitigated, she explained.

The planning involved not only reading policies carefully but also setting up an internal claims team, including staff familiar with how to value a claim for structure, inventory and payroll.

"I was out of town in New York when this happened, and people stepped in and called the insurance

companies immediately, without me even being there. That makes me feel good—that I'm not the key person that would cause the destruction of the organization" by being away, she said.

Setting up an external claims team was also critical, and one important member is the auditor, who is assisting in claims filing, Ms. Welch said.

She advised risk managers to get both internal and external claims teams to the scene as soon as possible. "Get out there as soon as the accident happens and begin to establish evidence, take pictures, take items out of the stores, if needed, the sooner the better."

And, most importantly, the risk manager should "visit, visit, visit" damaged sites. "I spent two weeks

out in the stores, with the adjusters and the staff. They need to have someone there to answer questions for them. If I do nothing other than say, 'Let me think about it and get back to you,' that is helpful to staff at stricken sites, she said.

Planning helped Carter Hawley accumulate its costs immediately and present a claim by Feb. 4. It has already recovered a few million dollars of that claim and is expecting another few million within the next three weeks, for a total of an estimated 25% of the loss, she said.

Planning also allowed Carter Hawley and its insurers to agree upon one adjuster for its primary layer and one for all other layers. "With 25 carriers, you can imagine what would have happened if we had 25 different adjusters." **[B]**

FEMA

Continued from page 1

If the cost of a catastrophe exceeded 15% of the property/casualty insurance industry's surplus, insurers could make claims against the pool, which they would eventually have to repay with interest. FEMA would essentially oversee the pool.

Ms. Bullock called the reinsurance provision "the most difficult part of the bill" from FEMA's perspective.

"First, we are concerned that there are no limits to the federal outlay in the event of an earthquake or other natural disaster. Second, we believe that the program could become a federal government guarantee of the solvency of complex financial institutions whose finances, practices and risk management are subject to state rather than federal regulation."

Based on projected insurer contributions of \$1 billion per year, a major catastrophe that cost insurers and reinsurers \$80 billion or so would require federal outlays that wouldn't be recovered in a lifetime, if at all, Ms. Bullock said.

She also questioned the bill's primary insurance assumptions. She noted that earthquake coverage currently is available to homeowners and businesses but that many choose not to buy it.

Without a mandate in the bill, FEMA does not expect homeowners in earthquake-prone areas to buy the coverage, even if H.R. 2873 passed. As a result, a big portion of earthquake losses will continue to be uninsured.

Rep. Applegate was not impressed with Ms. Bullock's assessment of the bill. After chastising her about getting the testimony to the subcommittee so slowly, he asked her

whether the Clinton administration has a plan of its own.

"It's obvious you're not too crazy about the legislation before us," he said.

Ms. Bullock replied that the White House has assembled an interagency task force to study the question of disaster response. She assured the subcommittee that the matter was on the "fast track," although she could not say when the task force would make a recommendation.

The subcommittee chairman complained that, as a federal agency, FEMA ought to have done better. He added that the bill's co-authors had managed to put together their recommendations in a relatively short time, though he did not mention that legislation to create such a facility has been repeatedly introduced in Congress since the mid-1980s.

Ms. Bullock replied that FEMA is

a small agency, the problem is complex and that FEMA delayed its response because its first duty was to provide assistance to victims of last month's Los Angeles earthquake.

Rep. Boehlert said that the bill he and Rep. Mineta introduced should have given FEMA a head start. "It seems to me it's a hell of a lot easier for you to go forward" with a bill on the table than to start from scratch, he said.

In later questioning, Ms. Bullock said the bill as currently drafted would "probably make us the world's largest reinsurer." She said that FEMA would have to examine the books of every insurer that participated in the reinsurance pool.

Rep. Boehlert did not seem moved by her concerns.

"I'm really unhappy with the response today," he said, as several of his colleagues looked on in agreement. **[B]**

Raising Insurance Company Capital in a Turbulent Market: Cutting-Edge Strategies for Insurers to Tap Into New Funding Sources

May 23-24, 1994 • The Grand Hyatt • New York, New York

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The key questions to be addressed include:

- Risk based capital: has a diagnostic tool become a bludgeon?
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- Demutualization: what can the insurance industry learn from mutual savings and loans?
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- Are insurance company leveraged buy-outs dead?
- Do federal and state securities regulators really understand insurance company issues?
- What tax deductions are available to help pay for insurance company acquisitions?
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- How do recent regulatory developments restrict surplus notes?

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Captives soften impact of earthquakes

By LOUISE KERTESZ

HONOLULU—Two telecommunications companies have found that financing property risks through a captive insurer doesn't eliminate the shock of earthquake exposures, but it can cushion the blow.

Shortly after launching its Hawaiian captive, Pacific Telesis Group was hit by big losses from the 1989 Loma Prieta quake. Based on that initial experience with the captive, PacTel now is re-evaluating its strategy for using that facility.

Telecom Corp. of New Zealand has found that its captive has held down the cost of earthquake coverage. But, the Wellington-based company's Hawaiian captive faces the possibility of higher reinsurance costs in the wake of last month's earthquake in Los Angeles, even though the company has not incurred any major losses.

At the Hawaii Captive Insurance Forum in Honolulu last month, Virginia Tormey-Lawson, risk manager of Pacific Telesis in San Francisco, outlined the company's reasons for using a captive to insure its property exposures.

PacTel property in California is exposed to between \$300 million and \$400 million of potential earthquake-related losses. "This is what drives the availability of earthquake coverage, this is what drives the premium and this is what the problem is for us," Ms. Tormey-Lawson said.

Although PacTel found availability low and premiums high for earthquake insurance for its properties, "the losses we experienced never exceeded \$2 million to \$3 million," Ms. Tormey-Lawson said. For example, the Whittier quake in 1987 resulted in a \$3 million loss to the Pacific Bell subsidiary.

"We were paying very large premiums and were seeing losses at very low levels. (And) our retention was \$10 million for each and every loss. So, you can see, it was far above what we were dealing with," she said.

On top of that, "we had experienced great fluctuations in limits" available from the commercial insurance marketplace, she said. "A peak in premium along with a low in availability—I think we all remember that market," she quipped.

PacTel's goal in establishing its Hawaiian captive—PacTel Re Insurance Co.—was to help stabilize its property/casualty insurance premiums, Ms. Tormey-Lawson said.

Unfortunately, "the program went into effect in October 1989, 17 days before the (Loma Prieta) earthquake, which produced a very large loss for us," she said.

Ms. Tormey-Lawson would not reveal the amount of the loss, since it is "still in mediation" with reinsurers. But she confirmed that it was greater than the \$25 million loss PacTel sustained in last month's Los Angeles earthquake.

In establishing the captive insurance program, PacTel also hoped to gain more flexible coverage terms.

"The program... added a new dimension to our renewal negotiations. We have had long-term underwriter relationships (because) there are only a certain number of underwriters in the world in the first place that have the capacity to write this kind of a cover," Ms. Tormey-Lawson said.

However, negotiations with those underwriters were "becoming unproductive from year to year, (hav-

ing to) cut a little here, cut a little there" to maintain level pricing.

The captive was the key to a new risk-sharing program with commercial underwriters that was structured as "a win-win kind of thing for us and the underwriters both. We wanted a long-term, stable program, and that meant it had to be something that was advantageous to both sides," she said.

Under this program, the company agreed to gradually increase its \$10 million self-insured retention by a minimum of \$500,000 per year.

"We also said that if we could afford to (through use of the) captive, we would increase it more than that. Unfortunately we had a loss 17 days into the program," Ms. Tormey-Lawson said.

The company also established a

formula that allowed for 5% increases every three years in the premiums paid to the underwriters sharing the risk. If there were no losses, the captive retained a portion of the premium: It retained 35% of the premium for the primary layers above PacTel's retention and 50% of the premium for the first excess layer. Those amounts went into the captive's surplus account, Ms. Tormey-Lawson said.

The program also included a "retro penalty formula" whereby the company would pay the insurers an additional amount in the event of a sizable loss.

"The plan was not only to increase the premium but to allow the insurers to get further and further away from the loss," Ms. Tormey-Lawson explained.

"As you can see, we set this up so that in the event of a loss, while the insurer would not be made whole for the loss, which would sort of defeat our purpose, they would have a reasonably big payment," she said.

The premium reserve financed the captive's retention, "allowed us to buy reinsurance and gave us a lot more flexibility than we would have had otherwise," she said.

The money was also earmarked "to pay penalties in the event of a loss and to be able to add capacity as time went on."

"We took many many looks at this" before starting the program, Ms. Tormey-Lawson said. "There are a lot of pluses to this program, but one of the downsides was the complexity of recordkeeping involved," she conceded.

Ultimately, though, the losses from the 1989 quake and the hardening of the commercial property market made the risk-sharing program less attractive to the commercial market and to PacTel.

As of last October's renewals, PacTel phased out the retained premiums and retro penalties from its captive insurance program.

The company is now seeing its captive insurance program get "closer and closer to the standard way" of using a captive, typified by Telecom's Hawaiian captive, Ms. Tormey-Lawson said.

Telecom established its captive—Teleco Insurance Inc.—in September 1991, making it the first foreign company to form a captive in Hawaii to insure non-U.S. risks (BI, Continued on next page

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Continued from previous page
Feb. 3, 1992).

The captive was formed to insure the company's property damage and business interruption risks because "it was recognized that the market was likely to harden again in the near future, and the effects of this could be tempered by the captive," said Ray J. Good, insurance manager.

The alternative, raising its deductibles in the conventional market, would have increased the company's exposure to retained losses and could have affected its profitability, he said.

Telecom's property insurance deductibles at the time were "substantial"—a six-figure amount in New Zealand dollars for each event, he said.

Telecom wanted to form a captive to help reduce the effects of cyclical insurance markets, fund the company's retention in the most cost-effective

way and gain direct access to reinsurance markets, he said.

According to Mr. Good, other potential benefits included:

- Avoiding the purchase of unwanted services from direct insurers.
- Providing coverage for earthquake exposures in anticipation of the demise of a mandatory government-run program this year.
- Improving the claims handling process.
- Providing broader policy wording and coverage.
- Improving market leverage and cash flow.

Teleco's 1991 debut was promising. Its formation allowed Telecom to double its retention level, with reinsurance placed in London, Europe and New Zealand markets, Mr. Good said. Underwriters "oversubscribed the initial six-month policy period and then again the next 12 months," he said.

But at renewals in March 1993,

"the attitude of some underwriters did change" as a result of "the multitude and magnitude of disasters they had suffered" in 1992, Mr. Good said.

Teleco—which has not yet suffered a major loss—felt comfortable reducing the limits of its catastrophe reinsurance and coinsuring 10% of the first few layers of coverage above the captive to temper premium increases. That required a capital injection to boost the captive's surplus.

"Part of the reason for the price increase and the limited capacity was underwriters' perception of New Zealand's (and particularly Wellington's) earthquake exposure," Mr. Good said.

Nevertheless, "given the spread of risk, the engineering for diversity, the loss prevention mechanisms and recovery plans in place, Telecom considers itself a quality risk," he asserted.

And the captive did exactly what it was meant to do: "Without Teleco operating in this way, Telecom would have been more adversely affected by market conditions and the final market premium could have been considerably higher than those finally settled," Mr. Good observed.

With the use of Teleco, "building up of a panel of loyal underwriters, the quality risk it is insuring and the history of no losses, renewal premium stability was a reasonable expectation before the California earthquake" in January, Mr. Good said.

Now, reinsurance premiums are expected to increase in reaction to concerns about earthquake exposures.

"Telecom is satisfied that it took the sensible option to create the captive and the hardening market conditions currently being experienced are proving its value to shareholders," Mr. Good said. **BI**

Hawaii taking off as most recent captive alternative

By LOUISE KERTESZ

HONOLULU—Hawaii is expected to continue to see steady growth as a captive domicile.

A recent change in Hawaii's captive statutes that allows redomestication of captives from other domiciles has won Hawaii its largest captive, participants learned during the 1994 Hawaii Captive Insurance Forum held last month.

Los Angeles-based Occidental Petroleum Corp. in 1993 moved its captive to Hawaii from Bermuda, renaming it Piper Indemnity of Hawaii.

"Those of you contemplating moving captives here will find a refreshing change," said T. Michael Shelton, assistant treasurer and director of risk management, referring to the flexibility and efficiency of the domicile's application and regulatory process.

Piper writes \$37 million in annual premiums. It is used "mainly on the lower ends of our programs as a primary layer," he said.

Piper writes both property and casualty coverages, including workers compensation. It also writes marine, aviation and surety coverages and may one day write directors' and officers liability coverages.

"We weren't unhappy in Bermuda," Mr. Shelton said. Occidental decided to move its captive "for tax and other reasons," he said, declining to elaborate.

The conference drew 157 participants—many of them associated with Hawaii's 34 captives as owners, managers or service providers—as well as state officials.

Participants also included risk managers contemplating forming captives in Hawaii as well as service providers seeking to swell the domicile's infrastructure.

"This is a good time for us," Insurance Commissioner Linda Chu Takayama told participants. "It looks like we're headed for a hard-market cycle." Companies with good loss experience "ought to reap the benefits" of forming captives, she said.

Captives in Hawaii now contribute \$15 million a year to the state's economy, she said.

The Hawaii captive industry "has gotten so big... the Insurance Division is not able to handle it all, and we have had to turn to the captive industry itself to develop resources in Hawaii," she said.

"They did a good job," she asserted. There are 25 support employees, including bankers and attorneys, now working in the state's captive industry in Hawaii.

"We have broken down a lot of the entry barriers for doing business in Hawaii, not just for captives but for admitted markets," she noted.

Hawaii is working to achieve accreditation from the National Association of Insurance Commissioners and sees an advantage to following the NAIC's "stringent financial criteria," she said.

"We have a long way to catch up with Vermont (in the total number of captives) and are very anxious to close that gap," she added.

However, Ms. Takayama and other captive officials stressed that the domicile seeks only "top quality" companies with "financial security." **BI**

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The case for Vermont

By Dick Heydinger

RISK MANAGERS AND OPERATORS of risk retention groups were heartened when the newly elected leadership of the National Assn. of Insurance Commissioners signaled a desire to de-escalate the battle over Vermont's accreditation. The suggestion was that perhaps there was a middle ground that would permit the NAIC actually to evaluate how Vermont regulates risk retention groups, rather than merely insisting that Vermont change its practices to apply all of the NAIC model acts verbatim.

Before this development, the Vermont captive community had given up virtually all hope of working out differences with the NAIC, and a suit was being prepared challenging the entire accreditation process based on the NAIC's conduct to date.

A decision was made by the leadership of the Vermont Captive Insurance Assn. and the National Risk Retention Assn. to forbear in order to give the new NAIC leadership time to find a way to defuse the crisis. This forbearance extended to maintaining silence in the face of what the Coalition of Alternative Risk Funding Mechanisms considers a provocative and factually incorrect Perspective article by William McCartney, former NAIC president and chair of its accreditation committee (BI, Jan. 3).

CARFM remains convinced that Insurance Director David Walsh of Alaska, the new NAIC president, and Iowa Insurance Commissioner David Lyons, the new vp, are proceeding in good faith to try to resolve the dispute. We will continue to cooperate with their efforts unless and until it becomes clear that this approach has no chance to succeed. But we cannot let the record stand without correction in the face of another public pronouncement by Mr. McCartney (BI, Feb. 7).

First, we question the propriety of Mr. McCartney's running public commentary on an issue he was charged with addressing as chair of the accreditation committee. He personally has directed that committee in what should be a fair and impartial, almost judicial, process of deciding whether Vermont should be accredited. His conduct can be likened to a jurist engaging in a debate in the Op-Ed pages over a case pending before him. Due process demands a higher standard of conduct.

But even more disturbing are the flawed legal, factual and logical premises that form the basis for Mr. McCartney's views, and his actions as committee chairman. It is not our intent to debate the legal issues here. That will come later if other efforts fail. But it is true that nowhere in Mr. McCartney's written record is there the slightest acknowledgment that federal law grants Vermont a certain degree of judgment and latitude in its regulation of RRGs. This seems to reflect a growing certitude in the NAIC, as evidenced by the pending changes to its Risk Retention Handbook, that the federal statute is merely a nuisance to be worked around and that the federal court decisions are not entitled to any deference. The NAIC will not be able to sustain that position forever.

The major factual problem with Mr. McCartney's position is his assertion that Vermont has not been treated differently than any other state. That simply isn't true. Illinois, acknowledged by most to be perhaps the strongest regulator in the country, also gives risk retention groups the option to form under its captive law. It similarly exempts them from a number of the NAIC models. It permits them to use GAAP accounting, as Vermont does. It allows the use of letters of credit for capitalization, as Vermont does. Illinois is accredited. Vermont is not.

The fact is that when it came time last summer for Vermont's accreditation exam, Mr. McCartney's committee very clearly and deliberately changed the rules to include for the very first time a new standard that had not been applied to Illinois or to any other state that went before Vermont. It is part of the public record, or will be, that the examination team members

NAIC is wrong to insist Vermont must comply with all model laws

Speaking Out

were instructed to determine whether Vermont regulated RRGs according to all of the required model acts, and if not, to pack their bags and come home. That the rules changed specifically for Vermont can be demonstrated as well by the clean bill of health Vermont received in its preliminary exam. And while NAIC staff has been consulted repeatedly by Vermont on its RRG regulation, there was never a suggestion that its accreditation would be jeopardized if it adhered to its own standards. In fact, Vermont received assurance to the contrary.

So let's move beyond whether Vermont was "treated differently."

Mr. McCartney has finally acknowledged that Vermont has an excellent track record on its regulation of captives. In fact, NAIC personnel are apparently beginning to absorb the fact that Vermont has a virtually unblemished record in regulating scores of risk retention groups, while all of the failed RRGs are domiciled in accredited states that have regulated them as traditional companies. But acknowledging the facts is not the same thing as following where they lead.

Vermont has a virtually unblemished record in regulating scores of RRGs, while all of the failed RRGs are domiciled in accredited states that have regulated them as traditional companies.

Mr. McCartney now takes the position that while Vermont has an exemplary record, some other state might come along and try to follow Vermont's approach, with less success. What this fails to take into account is that even Vermont might have less success if it is forced to abandon its proven approach, developed over a dozen years, to embrace all of the mandatory model acts, some of which are still rolling off the press.

Mr. McCartney's logic appears to proceed as follows:

- Vermont has an excellent record of regulating RRGs.
- Some other states, including accredited ones, do not.
- Therefore, Vermont should be denied accreditation until it agrees to regulate RRGs as the other states do.

Mr. McCartney and the committee he chaired focused only on Vermont's exemption of RRGs from certain models, without inquiring into what Vermont does that has worked so well. Had they done so, they would have seen that in many respects Vermont is a more strict regulator than it would be if it conformed to the committee's demands. Indeed, Vermont has developed a regulatory structure that could be a model for all states to follow in dealing with consumer-owned insurers.

Vermont captives are regulated around their business plans. Before a charter is received, a plan of operations and feasibility study must be submitted. It

must be supported by a separate actuarial opinion, and it is then subjected to scrutiny by the Insurance Department and by a separate outside actuary brought in by the department. So each application must be approved by three sets of independent evaluations. If one of the three does not approve, then the company simply fails to receive a charter. (At least from Vermont; some applicants have gone to other states, even accredited ones, and gone into business with the plan Vermont rejected.)

From this point on, Vermont's regulatory scheme is elegantly simple and, at the same time, comprehensive. Once the business plan is approved, prior approval is required for any material change. And even without changes, a company is monitored closely for conformance to the business plan. If it does not perform as projected, early intervention often fixes things.

Of course, there must be outside monitoring as well, which is provided through annual loss reserve certifications and CPA audits. Many captives, particularly groups, are also subjected to audits of their claims, underwriting and loss prevention programs.

All of this is combined with constant communication among the regulators, the companies and their managers and other service providers. The regulators insist on being kept informed, and they are. There is simply no checklist or model act that can replace the communication, awareness and judgment that now goes into regulating Vermont RRGs.

Something needs to be said as well about the notion of "entrepreneurial RRGs." In his Perspective, Mr. McCartney said that "for every legitimate RRG there appears to be a dozen entrepreneurial ones." This is obviously hyperbole, because Vermont has chartered about half of all RRGs and it does not permit entrepreneurial ones, if by that phrase one is referring to a company that is not owned and controlled by its policyholders. But this phrase and its exaggerated use really appear to mask an antipathy for RRGs themselves.

The federal act indeed requires policyholder control. Attempts to make that requirement even more clear, which have been supported by the National Risk Retention Assn., have not been supported by the NAIC.

In the past, the NAIC has shown no more interest in addressing real issues affecting RRGs by working with Congress than it showed last summer in arbitrarily punishing the state in which most RRGs are domiciled. Ironically, wouldn't Mr. McCartney's concerns about entrepreneurial RRGs be better addressed under the Vermont captive regulatory framework, which is restricted to member-owned and controlled insurance facilities, than under traditional insurance regulation geared to the formation and operation of for-profit insurers?

Vermont's unparalleled results are not accidental. They are a direct consequence of its regulatory structure. Vermont is in its 14th year of regulating captives, and it will probably issue the 300th charter this year. The NAIC has nothing to gain and everything to lose in punishing this sort of success story.

On the other hand, it has much to gain in making an objective inquiry into just what it is that Vermont does, and why it works so well. We hope that under fresh leadership, the NAIC will be able at last to follow where the evidence leads. BI



Dick Heydinger is director of risk management services for Hallmark Cards Inc. He is president of the Coalition of Alternative Risk & Funding Mechanisms and past president of the Vermont Captive Insurance Assn.

ASK A CASUALTY ACTUARY

Self-insurance may work better with multiple coverages

Q

If it only makes marginal sense for our company to self-insure either workers compensation or liability or property, would it make more or less sense to self-insure all of these types of claims?

A

The only short answer I can give is: it depends. There are six (or more) keys to the successful retention of risk. In making the decision of whether or not to self-insure, each of these key areas needs to be considered. Clearly, the decision of whether or not to

self-insure is a complex one.

First, let's accept as fact your assessment that your company falls in the gray area where it is unclear for each type of claim whether or not you should self-insure.

Everything else being equal, does it help to self-insure several coverages or not?

If we can truly say that everything else is equal and that your company is financially strong, then I believe it is most likely advantageous to self-insure several coverages rather than only one or two.

This assumes that your company will be diligent in maintaining the quality of your loss prevention and claims management services (the first two key areas). These areas must not suffer by trying to do too much all at once.

In looking at the six keys to successful retention of risk, it becomes clear that each of the last four are more likely to be satisfied when several coverages are self-insured.

Let's look at those key areas:

- Dedication to preventing losses.

Much of the success or failure of a self-insured program hinges on the quality of the loss prevention and safety programs that are in place.

On the one hand, your company actually might do a better job at these programs if it has made the serious

The intriguing thing is that the amount of capital at risk for all self-insured coverages is usually not much greater than what it is for each self-insured coverage.

commitment of self-insuring several different types of claims.

On the other hand, your company might do a worse job if it isn't realistic about devoting the necessary resources to operate and maintain quality programs in each area.

It might make more sense for some companies to phase in the move to self-insurance over a few years in order to be sure that each new program is properly managed, rather than jumping into self-insurance with several programs all at once.

- Professional claims management.

What was said above for loss prevention and safety programs also holds for the quality of claims management. Moving to self-insurance without making sure that claims are handled professionally could prove to be a major mistake.

- Predictability of loss experience.

Having a sufficient volume of claims experience to make your total self-insured losses fairly predictable is important.

If your losses vary wildly from one year to the next because you only have a few claims, it is unlikely that self-insurance would be a good choice. By self-insuring several coverages, a significantly greater number of claims are involved—and that means that your total self-insured losses should be much more predictable.

Another factor works in the favor of the company that self-insures several coverages. Different types of claims often behave differently in any given year. You may have a bad year in terms of your workers compensation losses but an outstanding year for property or liability claims, and vice versa. As long as the magnitude of total losses for each type of claim is largely independent of what is happening with other types of claims, your total loss experience will most likely become more stable and predictable if you self-insure several coverages.

- Contingency planning.

An important part of operating a viable

is, how much of your capital are you risking to gain the benefits of these savings?

In the accompanying table, we see that expected savings from self-insuring workers comp is about \$30,000 per year. However, to realize those savings, you must risk \$500,000 of your capital when you self-insure.

That's a rate of return of only 6%, which is not terribly attractive. The rates of return for self-insuring the other coverages are even lower at 5% and 3%.

Given these low returns, it would not make much economic sense to self-insure all of these coverages individually.

However, if we self-insure all of these coverages, the rate of return rises to 11%, which is a reasonably attractive use of capital.

What has happened is that we can add the expected savings for each coverage while the total capital at risk does not change nearly as much. (Technically, the

Deciding to self-insure

Type of claim	SIR or deductible	Expected savings from self-insuring	Capital at risk	Rate of return (savings/capital at risk)	Should claims be self-insured?
Workers Comp	\$200,000	\$30,000	\$500,000	6%	?
General Liability	\$50,000	\$10,000	\$300,000	3%	No
Auto Liability	\$100,000	\$15,000	\$300,000	5%	??
Property	\$250,000	\$25,000	\$500,000	5%	??
Health	\$100,000	\$20,000	\$400,000	5%	??
All		\$100,000	\$900,000	11%	Yes

GRAPHIC BY MIKE GARVEY

self-insurance program is reasonably estimating how much capital you are risking by self-insuring and determining whether or not you are willing and able to accept that level of risk.

Capital at risk is typically defined as the largest reasonably foreseeable total losses you might have to retain minus the insurance premiums you would have paid to insure the coverage. It is the amount you could lose in a given year by self-insuring. Often it is defined at a level where total losses would not be greater during 99 out of 100 years (the 99% confidence level). Sometimes, the 95% or 97.5% confidence levels are used.

The table included with this article shows a typical example. The amount of capital at risk varies somewhat by coverage, but is in the range of \$300,000 to \$500,000 for each type of claim.

The intriguing thing is that the amount of capital at risk for all self-insured coverages is usually not much greater than what it is for each self-insured coverage. In other words, the level of risk you are assuming may not be much larger from self-insuring several coverages than it is for self-insuring only one coverage.

- Possessing the financial resources to absorb a major loss.

While the level of risk assumed by self-insuring may not rise dramatically when you self-insure more coverages, the financial resources of your company that have been committed to self-insurance increase directly with each new coverage you self-insure; that is, as long as the premiums you no longer are paying to insurers are "set aside" for the self-insurance programs.

- Realistically comparing the rate of return on the capital you are risking by self-insuring with other uses of your company's capital.

Normally, it can be expected that, on the average, you would save money by self-insuring. The real issue

total capital at risk increases roughly like the square root of the sum of the squares of the capital at risk of each coverage.)

As a result, the ratio of savings to capital at risk increases.

In conclusion, we can see that what may not make sense when considering only one type of claim may make good sense when all types of claims are considered.

It goes without saying, however, that your company should be adequately capitalized to accept the risk of self-insuring several coverages in order for that decision to be a wise one. **B1**

Would you like advice from an experienced colleague on a risk management, benefit management or actuarial problem? Four quarterly features in the Perspective section of Business Insurance can give you some answers. Ask A Casualty Actuary, Ask A Benefit Actuary, Ask A Benefit Manager and Ask A Risk Manager answer written questions from readers on risk and benefit management issues and actuarial problems.



Mr. Sherman

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

Continental Bank Corp. in Chicago, answers questions on employee benefit plans.

Mr. Sherman's next column will appear in May.

Address your questions to ASK, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. Please give us your name, title and employer; however, Business Insurance will consider unsigned letters.

INTERNATIONAL

Lloyd's looks at idea of trading in syndicate participation

By STACY SHAPIRO

LONDON—In another step toward reshaping its capital structure to meet future demands, Lloyd's of London is investigating whether syndicate participation has a value and can be traded like stock.

But critics question the motive behind this next step. Some wonder whether it's a way to curb Lloyd's 1995 capacity, while others think it may be a move toward Lloyd's syndicates becoming incorporated vehicles and members becoming shareholders.

Lloyd's announced earlier this month that Lloyd's Deputy Chairman Robert Hiscox would chair the Value Group, a working group that will investigate how to accomplish the following objectives over the next three years:

- Attract fresh capital to support Lloyd's growth strategy.
- Fulfill commitments made to 1994 members about pre-emption rights. Pre-emption rights allow current syndicate members to have first refusal to increase their capacity before it is offered to new members (BI, Feb. 14).
- Provide a transition path for those individual members who wish to participate through corporate membership bodies in the future.
- Manage capacity to the best advantage of members.

While examining these objectives, the Value Group also "will examine the scope for creating a market in syndicate participations, so that existing members might be able to realize value from their current participations," Lloyd's Chairman David Rowland wrote.

Lloyd's first proposed placing a value on syndicate participations in the 1992 report by a task force chaired by David Rowland, but indicated that it shouldn't be examined until at least 1995 (BI, Jan. 20, 1992).

The task force suggested that if investors bought into a syndicate directly rather than through members and managing agencies, then supply and demand of capacity would be controlled by market price, "unlike the current discretionary system."

"If the society abandoned the current basis of trading and moved to incorporation, it would inevitably have to accept a system of value... The incorporated insuring entities would be limited companies whose shares could be bought and sold," the task force said.

The task force noted that there were legal difficulties in establishing what was being bought and sold, particularly because a syndicate has no existence in law. But the task

Continued on next page

Dispute lost in the translation

By ALINE SULLIVAN

PARIS—A recent appeals court decision may force foreign insurers writing coverage in France to comply with a previously unenforced law that requires all policies sold there to be translated into French.

The Cour de Cassation earlier this month upheld a lower court ruling that Allianz Versicherungs A.G. cannot enforce a coverage exclusion against a French policyholder because it was not written in French.

The ruling concerns a helicopter pilot seeking coverage under an aviation liability policy written by the German insurer for the cost of injuries to a passenger.

Allianz argued that it was not liable to indemnify pilot Francois Duplenne because its policy contained a standard exclusion stipulating that policyholders must

conduct adequate safety checks before flying.

Allianz had argued that the helicopter pilot violated the policy's conditions by not verifying that the helicopter was in satisfactory working order. His alleged failure to conduct the checks prior to the Feb. 14, 1985, flight was exacerbated by the effect of heavy snowfall that caused the helicopter's rotary blades to stop functioning.

While the court agreed with Allianz's contention that the pilot had failed to perform adequate safety checks, it ruled the insurer still must indemnify Mr. Duplenne because the policy's supporting documents, which included the exclusion, had not been translated into French.

Patrick Devine, an attorney at London law firm Clyde & Co. who specializes in European insurance

law, said the case has potentially wide-ranging implications for unwary insurance buyers and for insurers issuing policies in France.

"It could be a real problem for companies with global insurance programs," said Mr. Devine, explaining that insurers may not want to be responsible for translating policies in the language of every country the policy covers. "Companies buying their global insurance policies in the U.S., for example, may be vulnerable if all the documentation isn't translated into the languages of the countries it operates in."

The court's decision was based on a provision in the French Insurance Code that requires that all policies issued in France and all relevant exclusions be translated into French.

Whether the provision runs

afoul of the European Union's efforts to create a single insurance market remains to be seen. In fact, lawyers following the Allianz case believe the German insurer may appeal the ruling to the European Court of Justice.

"The French language rule favors domestic French insurance companies and may represent a barrier to trade in France by insurers from other E.U. member states," said Mr. Devine.

The only other members of the European Union to have similar laws are Spain, whose law has not been challenged in the courts, and Ireland, where people who fill out life insurance policy applications in Irish must receive policies printed in Irish.

Barring an appeal by Allianz, the courts now must decide how much to award the pilot. **BI**

Merrett group looks at world beyond Lloyd's

By STACY SHAPIRO
and ADRIAN LADBURY

LONDON—Merrett Holdings P.L.C. has partially confirmed months of speculation that former Lloyd's of London Deputy Chairman Stephen Merrett could become active in the insurance industry outside Lloyd's after the shutdown or sale of his company's syndicates (BI, Dec. 13, 1993; Dec. 6, 1993).

"The Merrett Group states that it has been considering various opportunities for a new insurance underwriting entity since it became clear that its managing agency would not have sufficient capacity to operate lead syndicates in the Lloyd's market from 1 January 1994," the company said last week.

"However, while the strategy is firm, the structure and constitution of any new Merrett-linked insurance vehicle remain under discussion, and at this stage, it is not possible to release any further details."

Meanwhile, Merrett Group continues to streamline the runoff of its underwriting operations.

LONDON

Construction cover

The contractors all-risks coverage and third-party liability insurance for London's massive subway extension project have been placed with a British unit of German-owned Allianz Versicherungs A.G.

Last week, a division of Cornhill Insurance P.L.C., which is owned by Allianz, announced that it will be the sole underwriter for the contractors all-risks policy on the "Jubilee Extension Project" being undertaken by London Underground Ltd.

Allianz Cornhill International will write coverage for 13 separate contracts for the 10-mile construction project, valued at 1.9 billion pounds (\$2.81 billion), which will link the far west end of London with the far east end. The project, which will be carried out in 10 phases and employ 22,000 workers, will begin this year with the digging of a two-mile tunnel underneath London.

Allianz Cornhill also will write

5 million pounds (\$7.4 million) in third-party liability coverage for London Underground Ltd.

Both coverages are placed by Minet Holdings P.L.C.

Suicide toll denied

When a London evening newspaper declared on its front page that more than 30 people have committed suicide because of their Lloyd's of London losses, the market protested.

The truth is that there is no evidence supporting the allegation that 30 people have taken their own lives because of their Lloyd's debts, a Lloyd's statement said.

However, Lloyd's said, "The public record shows that seven deaths in the past few years have been attributed by others, in whole or in part, to the deceased's membership of Lloyd's. Lloyd's deeply regrets any such personal tragedies."

Charter Re runoff

Charter Reinsurance Co. Ltd., a London market reinsurer that stopped underwriting last year, intends to carry out its own runoff

through a self-administered scheme of arrangement.

Charter Re, established in June 1986, mainly wrote London market excess-of-loss property catastrophe business. It also underwrote catastrophe reinsurance for U.S. ceding companies.

The scheme of arrangement is expected to be ready this fall.

Alan Prince, financial controller and secretary of Charter Re, said it is too early to calculate an accurate estimate of the final payout for creditors but said he believes "it will be a high percentage" of liabilities.

There are no "significant single U.S. creditors," Mr. Prince said, but it's too early to tell how many of the creditors will be U.S.-based companies.

The reinsurer's last financial report, produced in September, showed liabilities of about 300 million pounds (\$443.9 million), and a deficit of about 4.5 million pounds (\$6.7 million).

The reinsurance company decided to use a self-administered scheme instead of appointing provisional liquidators, to limit the costs to creditors.

"In reaching this decision, the

Continued on next page

Report sees reserve shortfall at Spanish insurer

GLOBAL BRIEFS

MADRID—A Spanish regulator's investigation of troubled insurer La Union y el Fenix Espanol contends the insurer is under-reserved by nearly \$200 million.

However, the probe has not dampened plans by French insurer Assurances Generales de France to acquire a majority stake in the Spanish insurer. AGF continues to believe that UFE and the Spanish insurance market hold significant growth potential.

The investigation by the Direccion General de Seguros, an arm of Spain's Ministry of Finance that regulates insurance, produced an 800-page report into UFE's affairs. The DGS began its probe of UFE after the government seized the insurer and its parent, Banco Espanol de Credito, in December to prevent their collapse (BI, Jan. 24, Jan. 10).

Although the report has not been made public, DGS Director Eduardo Aguilar revealed some of its details.

The total of 27.66 billion pesetas (\$196.4 million) missing from UFE reserves is divided into a deficit in non-life reserves of 22.72 billion pesetas (\$161.3 million) and a deficit in life reserves of 4.94 billion pesetas (\$35.1 million).

The DGS report criticized the insurer's organization, charging a lack of coordination between the insurer's investment and treasury departments, inadequate accounting procedures and numerous uncashed checks, some dating back to 1989.

The DGS report also charged that UFE's investments were too highly concentrated in the stock of its parent, Banesto. Nearly 38% of UFE's portfolio, or 41.19 billion pesetas (\$292.5 million), was invested in Banesto stock.

Capital gains from the sale of assets dating back to 1990 were

not accounted for, provisions for tax liabilities were not made and the financial records of various subsidiaries were inaccurate, the report said.

A spokesman for the Ministry of Finance refused to comment on allegations in the Spanish press that Banesto may have paid kickbacks to outsiders following the bank's sale of 50.81% of UFE shares in 1991.

Spanish press reports have alleged that profits from this sale were transferred through a labyrinthine network of offshore bank accounts controlled by Mario Conde, the bank's former president.

The Bank of Spain, the country's central bank, currently is investigating the actions of Mr. Conde. "Until it is complete, we are not saying one single word," a Bank of Spain spokesman said.

Despite the takeover of UFE and Banesto, Paris-based AGF still plans to acquire a majority

stake in UFE and merge it with its Spanish subsidiary, AGF Seguros.

AGF President Antoine Jean-court Galignani visited Madrid on Feb. 15 to discuss the proposed merger with Alfredo Saenz, who was appointed by the government to head Banesto.

Talks between the two sides concluded last week, with an agreement for AGF to hold two-thirds of the merged Spanish company, an AGF spokeswoman said. The remaining one-third is expected to be held by a variety of small investors, with Banesto retaining only a very small stake, she said.

UFE's net losses for 1992 were estimated earlier this year at 12.8 billion pesetas (\$111.5 million), but that figure could rise. Banking sources have estimated that UFE's parent, Banesto, will declare losses for 1993 of 53 billion pesetas (\$371 million).

—By Maria Kielmas
Continued on next page

PacifiCare, Liberty Mutual in work comp venture

Products & Services

CYPRESS, Calif.—A new, comprehensive managed care program for workers compensation claimants using capitated payments to a network of health maintenance organizations will be available to California employers beginning this spring.

The new program is the result of a partnership between PacifiCare Health Systems Inc. in Cypress, Calif., a leading national managed care organization, and Liberty Mutual Insurance Group in Boston, the nation's largest workers compensation insurer.

Other managed care organizations often buy or become an insurer, rather than form a partnership with one, observed Alan Hoops, PacifiCare's president and chief executive officer.

The partnership draws on the expertise of both entities: PacifiCare will manage medical care and provide incentives for health care practitioners to provide only necessary—but quality—care. Liberty Mutual provides rehabilitation case management, workplace safety and indemnity benefit actuarial expertise.

The primary vehicle for delivering medical services is COMPREMIER, PacifiCare's HMO product for workers comp medical care. That product will be changed slightly for the joint program.

Specifically, the joint program requires Liberty Mutual, on behalf of an employer/client, to pay a PacifiCare HMO a fixed, monthly

amount for each employee, whether the employee becomes injured on the job or not.

In return, the HMO will provide all needed medical treatment to any employee who files a workers comp claim.

Under the joint program, the HMO's responsibility for treatment of the claimant ends one year after the date of his or her injury. After that, Liberty Mutual retains the long-term responsibility for the employee's medical care, said Richard Eskow, vp in Liberty Mutual's managed care group.

The arrangement also is designed to cope with California's rules on physician choice.

In most cases under current California law, an employer can choose a physician on behalf of an employee injured on the job for the first 30 days following an injury. If that employee later chooses to receive care from a physician outside the COMPREMIER network, those services are covered through Columbia General Life Insurance Co., a PacifiCare affiliate.

One unusual feature of the plan is the incentive bonus Liberty Mutual plans to pay the treating HMO to encourage physicians to release injured employees for work as early as possible.

"We are trying to align the incentives of employers, providers and

the patient to encourage full and speedy recovery," pointed out COMPREMIER President Vicki Merrill.

Specifically, the incentive program requires comparing estimated and actual return-to-work dates for workers with similar injuries. Liberty Mutual will pay the HMO a nominal incentive bonus, which is shared with the physician, for each day the employee returns ahead of schedule, Mr. Eskow said.

He declined to specify the amount of the bonus, adding that it may vary with the employer.

Liberty Mutual plans to carefully monitor the incentive program to make sure that injured workers are not being sent back to work too soon, Mr. Eskow added. For example, the bonus would be voided if an injured employee goes back to work but then goes off work again for the same disability, which might indicate that the worker was sent back too early, he added.

For additional information, contact Liberty Mutual's Mr. Eskow at 800-225-2390, ext. 43797.

Health software

NEW HAVEN, Conn.—Corporate Health Strategies Inc. of New Haven, Conn., has introduced a new health care information system for "managing health care in a rapidly

changing environment."

Called Parallax, the new system is intended for use by employers, health care providers and public-sector entities that deal with health care cost, quality and access issues.

Parallax is designed to run within the Windows operating system.

CHS says Parallax offers reporting capabilities on two levels. First, the system serves the end-user whose job requires analysis of health care claims data and preparation of reports for management evaluation.

Second, the viewing interface is designed for the "executive-level" information consumer who needs quick and easy access to health care data customized to meet specific needs.

For more information on the program, whose cost varies by user, contact Corporate Health Strategies at 2 Whitney Ave., New Haven, Conn. 06510; 203-781-5123.

NAIC insurer stats

KANSAS CITY, Mo.—The National Assn. of Insurance Commissioners has released two new publications providing statistics on the nation's insurers.

Data in the two volumes was taken directly from the 1992 annual statements that insurance companies filed with their state insurance departments and the NAIC. Those statements form the basis of the NAIC's insurance regulatory data bases.

"Statistical Compilation of Annual Statement Information for Life/Health Insurance Companies in 1992" contains data from nearly 1,800 companies.

"Statistical Compilation of Annual Statement Information for Property/Casualty Insurance Companies in 1992" includes data from more than 2,600 insurers.

The two new publications are available on computer disk or as bound volumes.

They can be ordered at a cost of \$150 per volume from the NAIC Publications Department by calling 816-374-7259.

New transit policy

HARTFORD, Conn.—With the opening of new trade markets creating international opportunities for many U.S. companies, ITT Hartford Insurance Group has created a new Global Transportation Policy to handle the needs of companies that have international transportation exposures.

The GTP policy covers a policyholder's domestic and international transit exposures, including warehousing risks.

The new coverage replaces on an all-risks basis both ITT Hartford's ocean cargo policy and combined transit policy.

GTP can be written on a standalone basis or as an attachment to an ITT Hartford special multiperil or property policy.

For more information, contact ITT Hartford Insurance Group at Hartford Plaza, Hartford, Conn. 06115; 203-547-5000. **BI**

GLOBAL BRIEFS

Continued from previous page

Munich Re offering

MUNICH, Germany—Munich Reinsurance Co. plans to bolster its capital via a rights offering of registered stock to existing shareholders.

The reinsurer says funds from the rights offering of 850,000 registered shares will help strengthen its financial position in the wake of anticipated underwriting losses in fiscal 1993-1994. Based on a nominal value of 100 deutsche marks (\$57.80) per share, the reinsurer expects to raise its share capital by 85 million deutsche marks (\$49.13 million). The overall offering is expected to raise about 700 million deutsche marks (\$404.6 million).

Munich Re said it still expects profits, though, to be above fiscal 1992-1993 levels.

"The company's motive in substantially increasing its shareholders' funds is to further extend the competitive advantage it derives from its great financial strength," according to a statement from the reinsurers' board of management.

The rights issue is structured to offer shareholders one new share at a discounted price for every eight now held. While the shares will have a nominal value of 100 deutsche marks, the offering price will be 800 deutsche marks (\$462.4), or about 75% of the current value of publicly traded shares.

Munich Re stock was trading last week at about 3,020 deutsche marks (\$1,746) per share.

To make the offer even more attractive, the new shares will be accompanied by a warrant for future new Munich Re shares. Four warrants will entitle the bearer to one additional registered share at

an exercise price of 2,650 deutsche marks (\$1,532) for a specified period of time.

—By Don Lewis Kirk

Austria eases rules

VIENNA, Austria—To prepare for entry into the European Union, Austria has relaxed some of its insurance market regulations.

The Austrian government removed the heavy penalty tax it levies against "large" domestic companies that buy insurance outside Austria, if the coverage is purchased within the European Union.

Until this year, the penalty for purchasing coverage from foreign insurers amounted to five times the Austrian premium tax, to a maximum of 50% of net premium. The tax on property/casualty insurance was recently raised to 11% of premium from 10%.

According to German broker C. Wuppesahl & Co. Assekuranzmakler, which has offices in Austria, the penalty tax still applies to insurance obtained from non-admitted insurers outside the European Union. The broker outlined the new regulations, which went into effect Jan. 1, in an information bulletin to its clients.

Under the regulations, a large domestic company is one that meets two of the following criteria: a minimal capitalization of 6.2 million ECUs (\$7 million), revenues of at least 18.2 million ECUs (\$20.4 million) and a minimum of 250 employees.

Under Austria's new Freedom of Services regulations, large companies may purchase, without penalty, aviation liability, auto liability, general third-party liability and property insurance from E.U. insurers not resident in Austria.

Prior to the new law, E.U. insurers without offices in Austria

could compete only for hull and cargo insurance.

E.U. insurers without offices in Austria are not permitted to solicit business for other lines of insurance or market themselves to small companies. However, an E.U. insurer may offer all lines except life insurance to any Austrian company that seeks coverage outside Austria.

—By Carolyn Aldred

INTERNATIONAL

Ross joins Assurex

SYDNEY, Australia—Sydney-based J.M.D. Ross Insurance Brokers Pty. Ltd. has joined the international broker network, Assurex International.

Affiliating with a brokerage network gives J.M.D. Ross clients access to information from brokers worldwide and makes it easier to arrange coverage for clients

with overseas offices, said A.D. "Sandy" Ross, deputy chairman of the Australian broker. The Assurex network also enables J.M.D. Ross, a small broker with 20 employees, to compete more effectively with the Australian arms of the international brokers.

Assurex, based in Columbus, Ohio, has about 60 brokerage members.

—By Kate McIlwaine

LONDON

Continued from previous page

board was mindful of the fact that the comparative youth of Charter Re, coupled with the very basic nature of its business, would enable it to avoid many of the difficulties which bedeviled other companies recently promoting schemes of arrangement," the company said.

Conference agenda

The Ninth Annual Airline Insurance Conference in London, to be held March 10-11, can boast a

major coup in securing the elusive John Brennan, chairman and chief executive officer of U.S. Aviation Insurance Group, as one of the speakers.

The two-day conference, sponsored by DYP Insurance & Reinsurance Research Group Ltd., has become one of the main events on major airline risk managers' calendars. This year's program, however, is one of the most impressive.

Mr. Brennan will be speaking only days after he chairs a meeting of aviation underwriters in-

volved in 1988's Pan American World Airways Flight 103 disaster (BI, Feb. 21).

Also speaking are: Lloyd's leading aviation underwriter Brian Beagley; Jacques Mercier, managing director of Assurance France Aviation; Tomoo Abe, manager of legal affairs at Japan Airlines; and Lawrence M. Nagin, executive vp-corporate affairs and general counsel for United Airlines Inc.

For more information, contact DYP Insurance & Reinsurance Research Group Ltd. at 71-236-2175; fax: 71-489-1487. **BI**

Syndicates

Continued from previous page

force made some suggestions to overcome this "complex issue," such as introducing bylaws that allow one member's rights to be transferred to another.

There are other problems, observers say.

"A lot of people think Lloyd's won't be able to pull it off," said a stock analyst. "They've been looking at it for years and haven't come up with a system yet. But they're worried that 1995 capacity will mushroom."

The capacity influx from corporate capital could be curbed if the contributors of the capital had to

pay an entry fee to join each syndicate, said the analyst.

One of the problems is how to value the syndicate, noted Oliver Laughton-Scott, director of consultant De Lisle Jessup Scott. Goodwill at Lloyd's rests with the individual underwriter, not the managing agency, and it's difficult to put a value on an individual rather than a company, he said.

A value could be based on the historical results of a syndicate, but a member would be selling his seat on a future underwriting year that doesn't yet exist and whose value would be difficult to calculate in advance, said Mr. Laughton-Scott.

If values were put on syndicate

participations, however, members facing losses could sell their seats to cover those liabilities, another consultant noted.

One members agent suggested that Lloyd's could opt for "fundamental reform" by introducing prices for seats on syndicates. In this way, Lloyd's could evolve into a market of "incorporated vehicles and members would become shareholders," said the agent.

But the security of the Lloyd's insurance policy would have to be retained, including some kind of central guarantee fund to pay for losses arising from syndicates that had been turned into limited liability companies, the agent agreed. **BI**

HCFA

Continued from page 2

that don't comply face stiff financial penalties, including a \$1,000 fine for each employee or dependent not included in the report.

While HCFA may temporarily delay this one aspect of the law, the agency intends to make clear next month that employers will have to provide more detailed information under other provisions of the law than had been expected.

Specifically, some employers have interpreted the law as requiring them to inform HCFA whether employees and dependents were covered under a group health plan at any time during the year. Next month's guidelines, though, will clarify that employers will also have to state exactly when during the year employees and dependents were covered under the health plan.

HCFA officials say that without specifying when beneficiaries' cover-

age began and ended during the year, the other information would be largely useless to the agency.

Benefit lobbyists welcome the news that HCFA is at least considering a one-year delay in requiring employers to provide dependents' Social Security numbers.

"This shows some sensitivity on the part of HCFA to the problems employers were facing," said Curtis Rooney, counsel for the Assn. of Private Pension & Welfare Plans in Washington.

Benefit managers point out that they not only lack dependents' Social Security numbers, but they have no way of forcing employees to supply the information.

"What legal authority do we have to compel employees to respond? What can we do about it?" asked Fred Hamacher, vp of compensation and benefits at Dayton-Hudson Corp. in Minneapolis.

Rubbing salt in the wound, said the APPWP's Mr. Rooney, is that employers could be fined for events,

like the inability to collect dependents' Social Security numbers, that are beyond their control.

Obtaining dependents' Social Security numbers isn't the only problem employers face in complying.

Hartmarx Corp., a Chicago-based apparel firm, says that its information system simply cannot track certain coverage changes during a plan year, such as the number of dependents for which a worker has elected coverage, said Michael Pikely, benefits consultant and corporate actuary.

Other employers have an even more basic problem: They lack the names of dependents that are covered under their health care plans. Some employers don't receive dependents' names until a claim is actually filed, said Janet Shepherd, a consultant with Hewitt Associates in Lincolnshire, Ill.

Employers say the law itself is ill-conceived and will impose a massive administrative burden on employers, while providing very little

gain for the government.

"This is an out-and-out waste. Ninety-five percent of information that will be collected will be absolutely useless. The law should be substantially modified or gotten rid of," said Mr. Hamacher.

The data bank is the latest government effort to reap Medicare savings that legislators thought would be generated by a series of laws passed in the early 1980s that made employer plans the primary payer of health care bills for certain individuals, especially workers who stay on the job after age 65. The law made Medicare the secondary payer.

A good chunk—no one knows exactly how much—of the savings has not materialized. In some cases, hospitals double-billed Medicare and employer plans. In other cases, older workers' health claims were never sent to the employer; they were submitted to and paid by Medicare.

But employers contend the Medicare data bank is government overkill. They say it makes no sense for

employers to file coverage information on all employees when the problem of Medicare overpayments chiefly involves older employees.

"There is no need for a lot of the information. We are being hit with another administrative burden, but for very little public gain," said Dennis Nirtaut, manager of employee benefits at Continental Bank in Chicago.

Before undertaking a massive data collection effort, many employers are waiting for HCFA's final guidelines or for Congress to answer their cries for relief.

It remains to be seen, though, what—if any—action Congress will take to amend or repeal the reporting requirements.

Sen. Joseph Lieberman, D-Conn., is trying to have the law delayed or repealed, but he only recently began to line up co-sponsors.

Meanwhile, a number of employer groups have joined forces to lobby Congress to delay or repeal the law (BI, Nov. 23, 1993). **BI**

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NOTICE IS HEREBY GIVEN that Anthony James McMahon and Roger Smith, as Joint Provisional Liquidators of English & American Insurance Company Limited (the "Company"), have obtained an Order from the United States Bankruptcy Court for the Southern District of New York (the "Order") affecting certain actions against Slater Walker Life Insurance Company ("Slater Walker"), Arrow Life Insurance Company Limited, and Providence Capitol Life Insurance Company Limited. Thus, all persons are enjoined and restrained from (a) commencing or continuing any judicial, administrative, or regulatory action or proceeding in the United States against Slater Walker Life Insurance Company, Arrow Life Insurance Company Limited, or Providence Capitol Life Insurance Company Limited with respect to insurance policies issued by Slater Walker during the years 1972 through 1976 (the "Providence Capitol Liabilities"); and (b) enforcing any judicial, administrative or regulatory judgment, assessment or order in the United States on the Providence Capitol Liabilities. Copies of the Order may be obtained by contacting counsel for the Joint Provisional Liquidators at the following address:

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Outlook good for muni-bond insurers

By MICHAEL SCHACHNER

NEW YORK—Leading municipal bond insurers rode record-high bond volume to excellent results in 1993 and the outlook for this year is nearly as bright, officials with the two largest municipal bond insurers say.

While executives with Municipal Bond Investors Assurance Corp. and AMBAC Indemnity Corp. predict that municipal bond volume in 1994 will be down from 1993's record-breaking pace, bond volume this year will remain relatively high and the percentage of municipal bond issues that are insured could top 40% for the first time.

Last year, MBIA and AMBAC each boosted net income by about

37% and increased net premiums written by between 25% and 30%. This year may prove to be equally rewarding.

"Looking down the road, the prospects for municipal financing are very favorable because the only way state and local governments can get the fabric of America back in shape is by issuing long-term, tax-exempt debt," said David H. Elliott, president and chief executive officer of Armonk, N.Y.-based MBIA.

Speaking at the company's annual Municipal Outlook conference, Mr. Elliott forecast that municipal bond volume will be about \$240 billion in 1994, down about 17% from \$290 billion in 1993.

Meanwhile, Philip B. Lassiter, president and CEO with New

York-based AMBAC, predicted during a press luncheon earlier this month that 1994 bond volume will approach \$210 million, with about 38% to 40% of those issues being insured.

"A continued upward movement in the economy combined with unlikely inflation leaves us pretty darn bullish. We believe that municipal bonds as an investor tool will outperform taxable instruments" for the foreseeable future, he said.

Both executives said financial guarantee insurers will not be hurt by a 15% to 20% dip in bond volume this year.

"Because of the unique nature of the municipal bond insurance business and the way premiums and investment income are earned, a financial guarantor's earnings would not be adversely affected by a downturn in a given year," Mr. Elliott said.

Even if bond volume does dip this year, bond insurers will still profit from insuring municipal debt.

"The financial state of our cities on average has improved or stabilized. Municipalities now have the

flexibility to allow for infrastructural spending. We can expect new money issues over the second half of 1994," said Mr. Lassiter.

Adding to the bright immediate future of the municipal bond market and bond insurers is the belief that interest rates will remain comparatively low this year.

"If low interest rates remain—and we believe they will—state and local governments should be active in the market for new money issues as well as refundings," said Mr. Elliott. "The heavy wave of refundings last year actually crowded out some of the new money issues we believe will emerge this year."

Indeed, Mr. Lassiter pointed out that interest rates were so attractive in 1993 that refundings dominated the market. With many municipalities having refinanced existing issues in 1993, the volume of refundings should drop this year. "Last year, we saw a record \$190 billion in refunds. It'll be more like \$100 billion this year," he said.

Lastly, both executives said urban and rural infrastructural needs are so great that govern-

ment entities will continue to seek capital for improvements.

"Forty percent of our highways are below engineering standards. More than half of the 575,000 bridges monitored by the Department of Transportation are structurally in bad shape and the numbers are equally alarming for our nation's airports and water and waste systems," Mr. Elliott said.

The strong bond market in 1993 was reflected in the financial results of AMBAC and MBIA.

MBIA posted net income of \$259 million last year, up 37% from \$188.7 million in 1992. Core earnings, which exclude the effects on net income of accounting changes, capital gains and premiums earned on refunded issues, rose 24% to \$190 million. It insured \$39 billion in par value bonds, up 48% from 1992. Gross premiums written were \$479.3 million, up 30% from \$368.7 million in 1992.

AMBAC had net income of \$179.3 million, up 38% from \$130.2 million in 1992, and core earnings of \$112.9 million, an increase of 24% from \$90.9 million in 1992. AMBAC insured \$33 billion in par value bonds last year, up 19% from \$27.7 billion in 1992. Its gross premiums written were \$318.3 million, up 25% from \$255.1 million in 1992. **B**

Letters

Continued from page 8

the effort all of us in London are making to maintain as well as to some extent regain the pre-emi-

Self-funding health benefits can have big payoff

To the editor: The Feb. 7 article, "Large Companies Still See Self-funding as Health Care Cure," deserves further comment. As Minnesota Power's health plan administrator, I can state that our plan is a good example of what such an approach can do to control costs while ensuring health care quality. MP has self-funded and self-administered its health care plan since 1962 with excellent results.

Our plan is directed by a board of governors representing all employee groups (union, non-union, management and retirees) and provides sound health care coverage for workers and dependents while protecting them from catastrophic expenses. We've also been innovative by participating in a broad array of managed care approaches. Consequently, MP's expenditures for its 2,267 participants are well below those of most other organizations. Costs per participant were \$2,059 in 1993 and \$2,029 in 1992, a 1.5% increase. Total plan expenses increased only 3.5% in 1993 over 1992.

We believe our plans, with the cooperation of their union and non-union participants, have provided through the years quality health care at an affordable price. Self-funding and self-administering the plan is the other key to our success. Minnesota Power certainly hopes the self-funded approach continues to be a viable one as our country goes through the painful process of health care reform because it would be most unfortunate if options that have proved successful were lost.

Roger G. Krantz
Health Plans Administrator
Minnesota Power
Duluth, Minn.

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44RSA

Politics isn't helping health care: Ellwood

By CHRISTINE WOOLSEY

CHICAGO—Politics has had nothing to do with the private sector's recent progress in tempering health care cost increases, the leader of the Jackson Hole Group says.

In fact, "the past 30 days, during which there was a chance to reach a political consensus, have been disastrous," Dr. Paul Ellwood, president and chief executive officer of InterStudy, a Minneapolis-based research firm, said earlier this month at a conference in Chicago. He also heads the Jackson Hole Group, a group of academics, physicians and others interested in shaping national health system reform.

"There is no process to resolve the differences between the administra-

tion and the various congressional (health reform) plans," Dr. Ellwood said. "The administration knows it has to reach a compromise with the barons in Congress, but I can't see that happening at all."

Republicans' suggestion that there is no health care crisis isn't helping matters, Dr. Ellwood observed. Key GOP members are spreading that message "because they recognize that the success of the Clinton administration depends on the passage of health care legislation."

There is some good news about private-sector health care costs, but that alone doesn't eliminate the need for health care reform, he said.

"It's remarkable what happened in the third quarter of 1993. Health care costs increased at the lowest rate ever since 1973, when prices were artificially low because of President Nixon's price controls," he said during a speech to the Case Management Society of America, which met in Chicago Feb. 16-19.

Group health plan costs rose 8% on average in 1993, ending five consecutive years of double-digit increases, according to a recent A. Foster Higgins & Co. survey (BI, Feb. 14).

But the slowdown in health care cost increases "does not imply that the cost of health care is rising at a satisfactory rate," Dr. Ellwood noted. He attributes the slowdown to sophistication among large health care buyers and the private sector's progress in managing the cost and quality of health care.

"Most organizations now delivering health care recognize the basic device for cost containment is likely to be health maintenance organizations," he said. During the last decade, HMO premium increases have been flat or lower than premium hikes for preferred provider arrangements or indemnity plans. "The consequence of that trend is the premium differences among the three different forms of coverage are growing wider." And, HMO enrollment is accelerating now, after a period of flat growth in the early '90s, he said.

As their popularity grows, HMOs will increasingly have to justify that they are providing quality care and value. Outcomes measurement systems will become a key tool for HMOs in the years to come, particularly if individuals are forced to receive treatment from a select group of providers.

"As people get the feeling that the government or their employer is forcing them to go to a certain health care organization, they'll say, 'I'm being sent here because of low cost,' not (because of) quality," he said. **BI**

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Alliances

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Sen. Robert Packwood, R-Ore., who met with President Clinton last week along with about two dozen senators, said the Senate will pass legislation this year establishing universal health care coverage, but that bill will not include mandatory alliances.

Administration officials now appear to see the writing on the wall. Deputy Treasury Secretary Roger Altman told a small political gathering last week that the administration is willing to compromise on both the size and structure of alliances, according to a hospital lobbyist who attended the meeting.

"After I heard that, I said to myself, 'What's left?'" the lobbyist noted.

Rep. Stark says there is no support for the administration's alliances among his subcommittee, and support elsewhere in Congress is skimpy at best. For example, among the 20-member Senate Finance Committee, only three members—John D. Rockefeller IV, D-W.Va.; Tom Daschle, D-S.D.; and George Mitchell, D-Maine—are viewed as strong supporters of the administration's alliance provision.

Another sign of the weak Finance Committee support for alliances, as envisioned by the administration, came last week. Prior to testifying before the committee, a lobbyist for a business group was implored by Democratic committee staffers not to spend much time on the alliance proposal.

According to the lobbyist, committee staffers essentially said: "We know the alliance provision is all screwed up."

Indeed, some Finance Committee members appeared to go out of their way at last week's hearing to trash the Clinton alliance provision.

"We would have chaos if we had alliances" as proposed by the administration, said Sen. Kent Conrad, D-N.D.

"It would be a repeat of the RTC—one of the biggest mistakes we ever made," said Sen. Conrad, referring to the Resolution Trust Corp., which was established to sell off the assets of bankrupt savings and loans associations. Some

have charged that RTC practices have wasted billions of dollars.

Republican members of the Finance Committee showed their discomfort with alliances, raising a number of issues that the administration has not addressed.

Noting that health care alliances could control a pool of money far bigger than some state budgets, Sen. William Roth, R-Del., wondered to whom alliance officials would be accountable.

"Who will make appointments? Can alliances run themselves?" Sen. Roth asked.

Sen. Bill Bradley, a moderate Democrat from New Jersey who could play a key role in the Finance

'We would have chaos if we had alliances' as proposed, says Sen. Kent Conrad, D-N.D.

Committee's alliance debate, asked if individuals who live in geographic areas that abut two or more state borders might face problems dealing with health care alliances.

By the end of the hearing, no member of the committee—besides Sens. Rockefeller and Daschle—offered overt support for the administration's alliances.

Some observers say that as members of Congress and their staffs dig into the guts of the alliance proposal, they realize that the alliances would be far more than simply a conduit for premium collection or a means of giving more buying clout to small employers and individuals. However, legislators are wary that the alliances would be ready to handle wide-ranging health care responsibilities.

"There was a growing suspicion that a governmental or quasi-governmental enterprise" couldn't handle all these functions, said Terry Brooks, an attorney with Dykema Gossett in Washington who represents a number of Michigan hospitals.

Some regulatory functions, like setting up fee schedules, would simply be too much for new agen-

cies, concluded Sen. John Breux, D-La.

"We have to come to grips with what the function of an alliance is. Is it regulatory or a purchasing co-op?" asked Sen. Breux, who clearly favors the latter.

Meanwhile, in the face of this opposition, the administration's strategy to defend its proposed alliances, such as it has one, is puzzling to many.

When critics, most notably the Health Insurance Assn. of America, began to assail the alliances as vehicles that would lead to another big government bureaucracy, the administration didn't rush to defend its own proposal. Instead, it focused on attacking the critics, arguing that insurers and others oppose any kind of meaningful reform. That gave more attention to the critics' charges without bolstering support for the administration's own proposal.

The administration and its allies only belatedly have begun to defend its alliances—but some think they waited too long.

At a press briefing last week, Sen. Rockefeller defended large, mandatory alliances as vehicles that would give consumers power they never had before. "There has been nothing devised by mankind that is more efficient...and brings down costs."

Sen. Edward Kennedy, D-Mass., said health care alliances are as American as apple pie, adding that the concept is no different than farmers joining together to form cooperatives.

Others, though, say that by devising the alliances as giant organizations that would act as monopolistic buying entities in specified geographic areas, the administration was bound to come up empty-handed when trying to gain broad support for its proposal.

Moderate and conservative members of Congress viewed the alliance structure as one that would stifle competition, noted James Klein, executive director of the Assn. of Private Pension & Welfare Plans in Washington.

On the other hand, the concept of numerous health care alliances nationwide was anathema to those who favor a single-payer health care system as the simplest way to achieve universal health care cov-

erage and control costs.

With health care reform only now entering its most decisive stage—the period during which congressional panels will debate and vote on specific proposals—it is much too soon to label the Clinton administration proposal, or any other proposal, as dead or alive.

But lobbyists agree the administration has made a number of critical mistakes that have hurt the chances that its reform package will be approved.

The first mistake, some maintain, came within days of President Clinton's inauguration, when he set up what became a 511-member task force on health care reform.

The task force deliberations slowed down the administration's reform effort by several months with little to show for the delay, critics say. The bill that President Clinton sent to Congress in November probably was not much different than what would have been proposed had the task force not been established.

Timing problems also have hurt the administration. After President Clinton promised—in a special address to Congress in September—to soon present sweeping health care reform legislation, nothing happened for weeks. Not only did that cause a legislative letdown, it also opened the door for opponents to criticize the proposal with little opportunity for the administration to rebut those charges.

Because of a number of mistakes, the administration lost the confidence of the business community (BI, Feb. 21).

"We heard about a willingness to compromise, but we never received any concrete examples of where they were willing to compromise. It became very frustrating," said the APPWP's Mr. Klein.

More fundamentally, the administration put together a health care reform bill that only would appeal to what Mr. Klein describes as a "political fringe."

As a result, unless major changes are made, the administration proposal may be doomed. "No major piece of social legislation has ever been passed whose appeal is limited. Politically, it is a bad bill," Mr. Klein said. **BI**

AFL-CIO to spend \$10 million to push for Clinton reforms

WASHINGTON—Organized labor groups say they will spend at least \$10 million in cash, resources and staff time to promote President Clinton's health care reform proposal.

By contrast, the AFL-CIO spent \$3.3 million in its unsuccessful campaign to defeat the North American Free Trade Agreement.

The AFL-CIO and affiliates support the president's plan to overhaul the nation's health care system because the administration has promised to ensure universal coverage for all Americans. Labor groups favor a single-payer approach above all other proposals but acknowledge that the Clinton plan is more politically feasible, an AFL-CIO spokeswoman said. Labor groups are insisting, however, that President Clinton retain a provision in his bill that would permit states to adopt their own single-payer systems.

Business groups, on the other hand, have denounced the Clinton reform plan in general and states' freedom to design single-payer systems in particular. For now, some employer groups favor a plan sponsored by Rep. Jim Cooper, D-Tenn., as a starting point for reform. The Cooper plan does not mandate employer contributions to health care plans or provide for universal coverage.

Meanwhile, the American Assn. of Retired Persons announced that it would not endorse the Clinton reform plan, though it supports the goal of universal health care coverage, among other reforms.

—By Christine Woolsey

Washington fund sued for shortfall of Mutual Benefit

SEATTLE—Two policyholders of Mutual Benefit Life Insurance Co. have filed a class-action suit to force the Washington Life & Disability Guaranty Assn. to make policyholders whole.

Under a rehabilitation plan approved last month by a New Jersey court, Mutual Benefit policyholders may either remain with the insurer when it emerges from rehabilitation or opt out and receive a cash payment of 55% of their policies' current cash value.

The rehabilitation plan also restructures Mutual Benefit's life and disability insurance contracts and retirement annuity contracts and restricts access to policy funds for seven years.

However, the lawsuit, filed Feb. 9 in King County Superior Court, claims the state guaranty fund is obligated to pay the insolvent insurer's obligations to Washington residents in full.

The guaranty association is "is required by statute to create a fund to protect state residents from the failure of out-of-state insurance companies," said plaintiffs' attorney Steve Berman, of Hagens & Berman in Seattle. Its liability to Mutual Benefit policyholders will likely exceed \$50 million, he said.

The suit, which seeks class-action status, was filed by Mr. Berman on behalf of Brian C. McCullough, a benefit consultant and former insurance commissioner candidate, and Sarajane Evans, a Seattle resident. Mr. McCullough purchased a disability income policy from Mutual Benefit in 1974, and Ms. Evans purchased a whole life policy in 1971.

—By Joanne Wojcik

Opportunities and risks seen in Latin America

By GAVIN SOUTER

NEW YORK—U.S. companies anxious to tap Latin America's liberalizing economies should temper their enthusiasm with caution when they buy insurance coverage for operations there, an insurance executive says.

As insurers in Latin America are privatized and pricing restrictions are abolished, poorly managed companies will be forced out of the market, leaving policyholders high and dry, he cautions.

And the surviving insurers will increase prices to ensure that they don't go bust, said Gary Petrosino, vp at Chubb & Son Inc. in Miami.

But that is not the only risk, added Kathleen B. Smith, a vp at Marsh & McLennan Inc. in Coral Gables, Fla.

The liberalization of the economies in most Latin America nations will create many opportunities for companies in the United States, but business executives should be wary because risk management is rudimentary at best in many industries in Latin America, Ms. Smith said.

Insurers, brokers and clients

will have to work together to cultivate a risk management culture in the region, she said.

Mr. Petrosino and Ms. Smith spoke earlier this month in New York at the Roundtable on Insurance Conditions in the Americas, sponsored by the International Insurance Council.

"Insurance regulation varies from country to country in Latin America, but virtually every country there is going through some level of liberalization or deregulation," said Mr. Petrosino.

In particular, Argentina, Chile, Colombia, Mexico and Peru have all introduced some degree of free competition to their insurance markets, while Brazil and Venezuela are expected to follow suit, he said.

Insurance buyers will benefit from the increased competition among insurers that will inevitably follow the liberalization of these markets, Mr. Petrosino said. "It will lead to lower rates, customer needs will be met with better service and insurers will become more efficient."

But not all of the existing insurers will be able to survive in that competitive environment, and re-

duced rates will drive some out of business, Mr. Petrosino said.

Consequently, insurance buyers should examine the financial strength of the insurers they use in Latin America to ensure that they do not find themselves stranded without coverage, he said.

Also, risk managers should expect the sharp fall in rates that will follow liberalization to be at least partially reversed as the remaining companies eventually push rates up, Mr. Petrosino said.

"There will be a second stage when, due to the reduced capacity in the marketplace, rating levels will be increased as insurers try to improve their results," he said.

This second stage is already occurring in Colombia and Chile, he added.

The newly liberalized economies in Latin America present great opportunities for foreign investors, said M&M's Ms. Smith.

Many companies have already realized this, as foreign investment in Latin America jumped to about \$9 billion in 1992 from \$100 million in 1985, she said.

"In addition to this, Latin American firms (also) are making

purchases within the region," Ms. Smith said.

The change in the commercial environment will have a direct impact on the region's insurance industry, she said.

Although insurance is not new to Latin America, up until the last five years it has always been characterized by strict regulation, minimal competition and predictable prices.

And insurance products have not been as innovative as in other industrialized nations, she said.

"The more industrially advanced the region becomes, the more sophisticated the insurance products will have to be," Ms. Smith said.

Risk management techniques also will need attention. Brokers and insurers should work together to develop seminars to teach risk management techniques to local managers, she said.

"The risk management approach is an evolutionary process that will have to be cultivated over time," Ms. Smith said. "Brokers will have to focus on the entire risk management cost and not just the insurance premium alone." **BI**

Florida

Continued from page 3

nity alliances become effective in May, pending Insurance Department approval. Those rates are based on the state's existing insurance and HMO benefit requirements.

To give the public a sense of how health plans would rate groups that purchase coverage through the alliances, the AHCA asked health plans to submit rates for two sample firms within each alliance.

The sample bids were unsealed Feb. 10, and the AHCA immediately asserted that the reforms are helping drive down insurance rates.

At least three—and often many more health plans—submitted rates that are 5% to 35% lower than the rates they would apply if the firms did not buy coverage through the alliances. Some health plans also submitted non-alliance rates that are lower than their year-end 1993 rates.

According to the AHCA, the health plans that cut rates the most for alliance business were: Time Insurance Co. and subsidiary Fortis Benefits Insurance Co.; Humana Health Care Plans; John Alden Life Insurance Co.; The Prudential Insurance Co. of America; and TMG Life Insurance Co., a unit of The Mutual Life Assurance Co. of Canada.

The sample alliance rates submitted by many other health plans—including Aetna Life & Casualty Co., Blue Cross & Blue Shield, CIGNA Corp. and Travelers Corp.—generally were either just slightly lower or higher than their non-alliance rates. Some of the plans, though, did offer significant savings in isolated cases.

Overall, the results were "great," said the AHCA's Mr. Cook.

Referring to the number of health plans that submitted reduced alliance rates for the sample companies, he said, "I don't think anyone expected health reform in a voluntary market setting would do that."

He expected that initially only one or two health plans in each alliance would aggressively cut rates.

A small-business representative thinks the progress of the state reforms so far has been "a major achievement."

But, the lower rates still are not affordable for many small firms, said Bill Herrle, state director of the National Federation of Independent Business in Tallahassee. Many small firms can afford to

contribute only \$50 or \$60 a month to the cost of coverage for each worker, he said.

Employer costs would be about double that under the lowest of the recently submitted rates, said the AHCA's Mr. Cook. Only a subsidy could further reduce employers' insurance costs, he said.

Gov. Chiles on Feb. 9 proposed subsidizing up to 82% of the cost of coverage for individuals and families with incomes of up to 250% of the federal poverty level, using savings the state is obtaining by directing Medicaid recipients into managed care. The Medicaid effort has generated \$100 million of savings during the past two years, an AHCA spokesman said.

The state Legislature and the federal Health Care Financing Administration, which would have to waive federal Medicaid regulations for the state to use those savings, are reviewing the plan. HCFA's decision is expected within a few months.

Another problem in assessing the significance of the rate submissions is that some health plans did not exactly follow the state's request for rate proposals for the sample companies, said John Erb, executive vp of the Community Health Purchasing Alliance of Broward County.

The rate cuts do not impress Arthur Dickerson, a principal in the Tampa office of benefit consultant William M. Mercer Inc.

A 1993 Mercer study showed the state's annual health insurance cost increases have nosedived since 1990. Mercer projected a drop in costs this year without the reforms.

Mercer estimates that the alliance rates the health plans filed will save small firms about 5% or 6%. But, those savings will be cut to 1% to 3%—which Florida employers could have expected without the reforms—after the alliances bill their members for administrative costs, Mr. Dickerson said. "I'm still waiting to see evidence the mechanism is reducing costs more than we were seeing without it."

Mr. Dickerson also said the small rate cuts will not be enough to induce many small firms to buy coverage through the alliances. He cited a marketing principle that states "15% is the difference that makes a difference that people can see."

Steve Hoffman, vp and manager of employee benefits services for Johnson & Higgins of Florida Inc. in Tampa, also does not believe the reforms are helping bring down insurance costs.

"My personal opinion is that it's

just another layer of government," he said. "It's pretty much business as usual for insurers, with a little extra work to qualify for CHPAs."

But, "without the CHPAs, there would be no incentive to lower costs inside vs. outside the CHPAs," Mr. Cook rebutted.

Whatever has spawned the lower rates, holding them down in a voluntary system will be difficult because individuals will be moving in and out of the system, said John D. Cuny, president of Anthem Health Plan of Florida Inc. in Jacksonville, a subsidiary of Associated Insurance Cos. Inc.

An employer mandate, which small firms vehemently oppose, is necessary for insurers to hold down costs, Mr. Cuny said. He expects the Legislature will impose one, perhaps as early as next year.

But, "you have to deal with the issue of affordability before you can deal with a mandate" so that the cost of health care does not force firms to close, Mr. Cook asserted.

Craig Thomas, director of state business for Blue Cross & Blue Shield of Florida Inc., agrees. Costs, like administrative expenditures, can be controlled without a mandate if most of the alliances select the same third-party administrator, he said.

So far, Dun & Bradstreet Plan Services has been chosen as TPA by six of the state's 11 alliances, though they still have to negotiate contracts with the TPA, a spokeswoman said.

The further development of managed care programs and the ultimate level of alliance bureaucracy also will help health plans control costs, Mr. Thomas said.

Time Insurance Co. felt comfortable cutting its alliance rates because its alliance coverage costs would be reduced in several ways. For example, the alliances' TPAs will be responsible for billing and collecting premiums, said Senior Vp James Oatman.

In addition, Time and its Fortis Benefits subsidiary have experienced only slight medical cost increases in other states, like Vermont and Connecticut, with guaranteed-issue requirements, Mr. Oatman said.

The reforms have to be given time to work or fail before the system is changed further, Mr. Thomas said.

However, other health plans were reluctant to cut rates because they could not determine whether the alliances would attract adverse risks.

"If the plan is voluntary, who does it attract?" asked Anthem's Mr. Cuny. **[B]**

BBGH

Continued from page 2

CalPERS—is frequently cited by the Clinton administration as a model for the bargaining power of regional purchasing alliances.

Other purchasing cooperatives have been unable to obtain the Justice Department green light since they began operating before seeking such approval, according to Maureen Corcoran, an attorney with Pillsbury, Madison & Sutro, who represents the BBGH.

However, the fact that the federal government gave its OK to the BBGH, whose members' health care market penetration is as high as 24% in some areas of the state, "should give other employer groups trying to purchase coverage collectively some comfort," she said. "This really follows the managed competition model."

Not all BBGH member employers

will participate in the purchasing group during its first year of operation since some, like CalPERS, have already contracted for the 1995 coverage year, explained Patricia Powers, the group's executive director.

CalPERS, in fact, has been able to hold down HMO cost increases for the past three years because of its bargaining power (BI, Feb. 14).

BBGH will be able to negotiate lower base premiums for the two basic benefit plans that employers will offer under the plan. The amount each will actually pay, however, will vary based on the actuarial risk of each company's employee population.

In addition, the employers will continue to offer an indemnity plan option, which each company funds separately.

To ensure that the HMOs that participate in the purchasing group provide quality service, the BBGH will also conduct a satisfaction survey of 80,000 randomly selected em-

ployees using performance measures created by the National Committee for Quality Assurance.

"We want to make sure we're not just looking at cost, but the value of our health care dollar," Ms. Powers explained.

Member employers can then use findings from the survey, to be completed sometime in July, to select the high-quality HMOs, she said.

Under the plan submitted to the Justice Department, the BBGH purchasing group will offer the 15 HMOs currently under contract with member employers as well as any other plans that request to be included in the request for proposal, she said.

BBGH members—which in addition to CalPERS include Bank of America, Pacific Telesis Group, Chevron Corp., Fireman's Fund Insurance Co. and Transamerica Corp.—will meet in March to discuss participation in the purchasing group. **[B]**

Updates

Insurer's parent settles action

HONOLULU—Hawaii regulators have reached a \$32 million settlement with Hawaiian Electric Industries in a lawsuit over its withdrawal from the insurance business when its insurer subsidiary became insolvent after Hurricane Iniki.

Subject to court approval, Hawaiian Electric will pay \$32 million in cash and has an option to purchase the workers compensation book of the insolvent company, Hawaiian Insurance & Guaranty Ltd. As a result, the state guaranty fund will not add a surcharge to insurance premiums in 1994 for the \$23 million assessed to insurers to pay for HIG claims, the Insurance Division said.

Hawaiian Electric withdrew from the insurance business in December 1992. HIG, which formerly held a major market share in the state in virtually every property and casualty line, has been reorganized as a company with few outstanding liabilities and downsized to emphasize homeowners and auto insurance. "We still plan to sell HIG at the end of this year. The profit will further help the estate pay off creditors," said Insurance Commissioner Linda Chu Takayama.

Complaint filed in settlement

PHILADELPHIA—As fairness hearings commenced last week on the Center for Claims Resolution's proposed \$1.3 billion class-action settlement of future asbestos personal injury claims, parties to the proposal alleged that attorneys have used misleading information to persuade many class members to pursue their claims in court.

In a motion filed Thursday before U.S. District Judge Lowell Reed, plaintiffs' attorneys Ron Motley and Gene Locks, as well as the CCR, said objectors to the settlement, including plaintiffs' lawyers Frederick Baron and Thomas Henderson, have engaged in a "massive disinformation campaign" that resulted in more than 250,000 individuals opting out of the settlement offer (BI, Jan. 25, 1993).

Meanwhile, Mr. Baron said the settlement, which seeks to provide up to \$1.3 billion over 10 years, will ultimately pay individual claimants much less on average than past claimants have settled for since the CCR became operative in 1988.

New Hampshire comp reforms

CONCORD, N.H.—New Hampshire Gov. Stephen Merrill has signed a workers compensation reform bill that will cut insurance rates and limit benefits.

The bill, signed into law earlier this month, cuts premiums 10% for employers in the voluntary workers comp insurance market that have managed care programs. The law mandates managed care programs for employers in the residual market that pay more than \$2,500 in annual workers comp premiums and cuts their premiums by 10% if they maintain workplace safety programs.

The maximum benefit payable to injured workers also has been reduced to 60% of salary from 66%, and the duration of partial disability payments has been limited to five years, down from seven, according to Douglas Scamman, state budget director.

The law also requires employers to include injury management facilitators in their managed care programs; develop temporary alternative work opportunities for injured employees; and reinstate injured employees to their former positions under certain conditions.

Briefly noted

Moody's Investors Service is reviewing CIGNA Corp.'s property/casualty and life insurance units for a possible downgrade. Last year, CIGNA withdrew from Standard & Poor's ratings after the agency downgraded the insurer. . . . The U.S. Chamber of Commerce said last week it will survey its 220,000 members for their views on health care reform. . . . Moody's Investors Service upgraded the USF&G Corp.'s senior debt rating to Ba1 from Ba2. The upgrade reflects the insurer's improved core earnings, strengthened balance sheet and decreased financial leverage. . . . The Senate Banking Committee unanimously approved an interstate banking bill last week that would neither expand nor limit banks' insurance powers. Sen. Christopher Dodd, D-Conn., dropped plans to introduce an amendment to limit banks' powers after agent groups disagreed how far the limitations should go. . . . Assemblyman Chuck Quackenbush of San Jose is the first Republican to announce his candidacy for California insurance commissioner. . . . Reversing a trial court decision in *Titan Corp. vs. Aetna Casualty & Surety Co.*, the California 4th District Court of Appeal ruled Feb. 10 that personal injury coverage does not apply to environmental cleanup costs. . . . The City University of New York has settled its dispute with USF&G Corp. over coverage for lead paint claims. The settlement, whose terms were not disclosed, allows the precedent set by the New York Court of Claims in *Oates vs. State of New York* in 1993 to stand, thus denying landlords coverage for lead paint claims filed by tenants. . . . Lockheed Corp. says it will receive payment from at least two of its D&O insurers to offset a portion of \$27 million it agreed to pay NL Industries Inc. to settle litigation arising from NL's failed acquisition of Lockheed. . . . A special Vermont House committee has rejected a single-payer health care reform proposal for the state. The panel favors a plan based on managed competition, similar to a plan Gov. Howard Dean supports (BI, Dec. 13, 1993). . . . Insurance Co. of North America and Gold Cities Insurance Agency must pay more than \$7 million to a Domino's pizza franchise owner whose business burned in the 1992 Los Angeles riots after a Los Angeles jury last week found the two liable for bad faith. . . . Alexander & Alexander Services Inc. reported \$26.9 million in net income in 1993, compared with a \$88 million net loss in 1992. Revenues dropped 2% to \$1.34 billion from \$1.37 billion. . . . Mid Ocean Ltd. reported a net operating income of \$16.6 million for the first quarter of fiscal 1994 ending Jan. 31, compared with \$5.9 million a year earlier. Results include a \$37 million provision for the Los Angeles earthquake.

Credibility is wearing thin

Investors appear indifferent to insurance industry's 'doublespeak'

By MYRON PICOULT

Special to Business Insurance

I HAVE BEEN FOLLOWING insurance stocks for about 28 years and I have never seen them so susceptible to interest rate movement—real or perceived. In fact, the performance of the group started to roll over almost coincidentally with the peaking of the 30-year bond at a 5.73% yield several months ago. The obvious question is why has there been such a marked increase in sensitivity?

To be sure, part of the change relates to the increased emphasis that portfolio managers have placed on momentum and group rotation. This is another way of saying that a relative shift in valuations has been occurring due to the improved earnings expectations for cyclical stocks vs. the deteriorating fundamentals for the property/casualty industry. The industry's "foreign" nomenclature and unusual accounting adds a modicum of unease.

Neither of these elements is new, but doubletalk and the use of financial gimmickry seem to have reached new heights that have

clearly tainted investor perspectives of the industry.

Untangling the presentation of the third- and fourth-quarter earnings reports requires a degree in decipherization. Some insurers have sought to be helpful by breaking out various restructuring charges, reserve adjustments (increases, not decreases), FASB adjustments and the impact of the 1993 Omnibus Tax Bill. This has given rise to a matrix of columns and lines. Hence, we are left with a situation of pick a column, pick a line, pick a number.

As an add-on, in numerous instances, fourth-quarter written and verbal commentaries have come down to the "but for" phrase. For example: "...but for the reserve for toxic exposures, restructuring adjustments and the unusually high level of catastrophe losses, we would have earned \$X per share as opposed to our reported loss of \$Y per share."

This is ludicrous, for it is like saying Hurricane Andrew never occurred. This latest rash of numerical fantasia and slick doubletalk has virtually eliminated what little credibility the industry had.

Notwithstanding ongoing public comments about pricing deficiencies in the sizable standard commercial lines market, the long-awaited turn in the property/casualty pricing cycle remains an apparition.

Indeed, operating earnings for 1994 are likely to fall below current prognostications and, in some instances, could be below 1993 results, given sluggish net investment income trends, questionable underwriting trends exacerbated by poor pricing in 1993 and this year's remarkable jump start on catastrophe losses. January alone has turned 1994 into the fourth-worst catastrophe year on record. Overall, the current operating environment reminds us of cash-flow underwriting without the investment yield kicker.

All of these factors have contributed to what can best be described as a raging indifference among investors for property/casualty equities.

We view this lack of interest as more of a positive than a negative sign, but only for those insurers that can clearly differentiate themselves from the rest of the pack via their operating superiority. In these cases in which a company's spots have changed, it is incumbent upon the new managers to definitively show what has changed and why it will impact future performance.

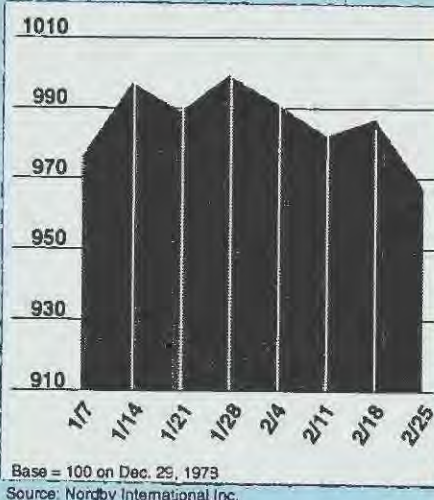
A change at the helm may just be window dressing—most companies need wholesale changes in the corporate cultures, which take years to accomplish.

It remains to be seen just how many passers-by will be willing to pick up broken umbrellas. As we said earlier, this is now an industry virtually devoid of credibility. **BI**



Myron M. Picoult is managing director and senior insurance analyst with Oppenheimer & Co. in New York. He is the past president of the Assn. of Insurance & Financial Analysts and a member of the New York Society of Security Analysts.

BI Insurance Index



Insurance stocks tumbled last week, as the Business Insurance Index lost 19.7 points to 967.1 Feb. 25 from 986.8 on Feb. 18. Advancing issues were led by: Seibels Bruce Group, up 17.4%; Chandler Insurance, up 10.2%; and HCC Insurance Holdings, up 6.5%. Declining issues followed: CNA Financial Corp., down 11.0%; Home Holdings Inc., down 8.6%; and Provident Life, down 7.8%. The most active issue was Travelers Corp., 3.1 million shares traded. The BI Index fell 2.0%; the Dow Jones 30 Industrials lost 1.3%; the NYSE Composite fell 0.5%; and the Standard & Poor's 500 fell 0.4%.

British Issues

Feb. 24 Companies	Price pence	P/E	Div. pence	Yield %	1 week High-Low pence
Comml Union	603	19.2*	31.0*	5.1*	633-603
Genl Accident	637	13.0	34.4	5.4	377-637
Gdn Royal Exch	208	13.4*	9.5*	4.5*	232-208
Royal	278	12.1*	9.4*	3.4*	306-278
Sun Alliance	339	21.2	15.1	5.3	374-339

Brokers	Price	P/E	Div. pence	Yield %	1 week High-Low pence
Bradstock	142	16.0*	6.3*	4.8*	149-142
CE Heath	398	15.3	20.5	5.1	414-398
Hogg Group	145	24.2*	7.1	4.9	145-145
JIB Group	184	16.0	9.5	5.2	185-184
Lloyd Thompson	295	19.9*	8.4*	2.5*	295-295
Lowndes Lmbt	448	14.0	18.8	4.2	453-448
PWS Holdings	80	11.7*	5.0*	6.2*	81-80
Sedgwick Grp	195	21.7*	7.5*	3.8*	195-183
Steel Bri Jones	109	N/M	11.3	10.4	114-109
Willis Corroon	217	20.7	8.3	3.8	217-208

Source: Philip Olsen, London * 1993 figure; others estimated

Aetna denies wrongful discharge

HARTFORD, Conn.—A former employee of Aetna Life & Casualty Co. is suing the insurer, alleging she was fired for asking for flexible working arrangements to care for her son in spite of Aetna's self-proclaimed family-oriented personnel policy.

Aetna denies the charge and says Virginia L. Daley was dismissed last year as a design project manager for "business reasons."

But, in a suit filed in Connecticut Superior Court in January, Ms. Daley alleges that Aetna "wrongfully, tortiously and abusively" discharged her, violating state law barring discrimination against employees who choose to have children. She is seeking compensatory damages in excess of \$15,000 and punitive damages.

Ms. Daley gave birth to a son in July 1991 and asked permission to work from home one day a week so she could care for the

baby. After the request was twice denied, she sent a written complaint to Aetna Chairman Ronald Compton in November 1992.

In February 1993, she was dismissed due to poor performance at work, court papers say.

Ms. Daley claims she was dismissed in retaliation for her memo to Mr. Compton.

An Aetna spokesman said the dismissal was in no way connected to the memo. Aetna, which was named one of the top 100 U.S. companies for working mothers for the past five years by Working Mothers magazine (BI, Sept. 27, 1993), has more than 2,000 employees in alternative working arrangements.

"We just said that we didn't think that it will work for this particular job," the spokesman said.

—By Gavin Souter

BI Industry Stock Report

FEB. 22, 1994, THROUGH FEB. 25, 1994

BROKERS																													
		Price	Weekly % change	Year to date % change	Annual High	Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt./Bk. value			Price	Weekly % change	Year to date % change	Annual High	Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt./Bk. value				
Accordia Inc.	NYS	26.63	2.90	8.12	27.63	18.38	41	0.44	1.65	13	10.22	2.61	Mutual Risk Mgmt. Ltd.	NYS	27.63	-0.45	-7.92	32.75	21.16	91	0.28	1.01	18	5.71	4.84				
Alexander & Alexander	NYS	20.13	-4.17	1.26	28.00	17.63	635	1.00	4.97	37	6.73	2.99	NAC Re Corp.	OTC	29.25	-3.31	0.43	43.25	27.50	379	0.16	0.55	13	19.24	1.52				
E.W. Blanch Holdings Inc.	NYS	17.13	-2.14	-1.44	23.50	16.50	41	0.32	1.87	18	4.10	4.18	National Re Corp.	NYS	29.00	-0.85	-5.31	39.63	27.13	51	0.16	0.55	8	16.89	1.72				
Gallagher Arthur J. & Co.	NYS	29.50	-4.07	-17.48	37.38	29.38	104	0.88	2.98	15	7.52	3.92	Navigators Group	OTC	20.25	-5.81	-42.14	39.00	16.50	427	0.00	0.00	11	16.99	1.19				
Hibb, Rogal & Hamilton	NYS	11.63	-2.11	-11.43	16.88	11.38	81	0.48	4.13	19	4.51	2.58	Nobel Insurance LTD.	OTC	8.13	3.17	6.56	8.44	6.25	16	0.00	0.00	3	6.84	1.19				
Marsh & McLennan	NYS	82.75	0.30	1.69	96.00	77.00	346	2.68	3.24	18	16.76	4.94	NWNL Companies	NYS	27.50	-2.22	-15.38	38.75	26.50	379	0.80	2.91	10	23.97	1.15				
Poe & Brown	OTC	17.50	-5.41	-2.78	21.25	16.25	18	0.40	2.29	19	3.02	5.79	Ohio Casualty Corp.	OTC	63.00	-1.18	-1.56	72.00	57.63	158	2.92	4.63	13	47.68	1.32				
BROKERS	AVERAGE		-2.1	-3.2					3.0	20			Old Republic Int'l	NYS	23.75	-0.52	5.56	27.63	21.50	137	0.44	1.85	8	23.57	1.21				
INSURERS/REINSURERS																													
ACE Ltd.	NYS	27.25	-3.54	-10.66	36.00	25.50	687	0.40	1.47	5	28.74	0.95	Orion Capital Corp.	NYS	32.25	-0.39	4.45	37.50	28.63	28	0.72	2.23	9	25.56	1.26				
Acceptance Insurance Cos.	NYS	12.13	-4.90	4.30	15.63	10.25	54	0.00	0.00	13	9.65	1.26	Phoenix RE Corp.	OTC	24.88	0.00	-9.55	38.25	22.75	233	0.28	1.13	8	19.59	1.24				
AEGON N.V.	NYS	51.25	-6.39	-6.39	58.50	43.25	79	1.22	2.38	11	34.71	1.48	Provident Life	NYS	28.25	-7.76	-10.67	31.88	25.63	159	1.04	3.68	10	26.38	1.07				
Aetna Life & Casualty	NYS	62.13	-2.36	3.11	66.25	46.13	1503	2.76	4.44	-11	71.84	0.86	Re Capital Corp.	OTC	13.75	-3.51	0.92	15.75	13.25	85	0.28	2.04	2	16.68	0.81				
Allied Group Inc.	OTC	24.75	-1.00	-1.00	32.75	21.34	313	0.52	2.10	7	10.45	2.37	Reliance Group Holdings	NYS	5.88	0.00	-24.19	10.38	5.63	1046	0.32	5.45	6	4.22	1.39				
Allmerica Prop. & Casualty	NYS	18.75	-2.60	-12.96	22.16	18.00	212	0.16	0.85	5	56.97	0.33	RLI Corp.	NYS	24.50	-0.51	-8.41	27.75	23.25	28	0.56	3.29	10	22.91	1.07				
Allstate Corp.	NYS	26.25	0.00	-11.76	34.25	25.00	1085	0.72	2.74	9	18.43	1.42	SAFECO Corp.	OTC	57.25	-1.08	4.81	66.75	51.88	963	1.80	3.14	11	41.53	1.38				
American General	NYS	26.75	0.94	-6.14	36.50	25.50	1626	1.16	4.34	23	22.09	1.21	SCOR U.S. Corp.	NYS	11.25	-3.23	-10.89	20.75	11.25	25	0.32	3.84	8	6.09	0.70				
American Heritage Life Ins.	NYS	19.00	0.66	2.01	25.34	17.25	29	0.60	3.16	12	12.42	1.53	Selbels Bruce Group	OTC	1.69	17.39	-3.54	2.00	0.31	73	0.00	0.00	-1	1.90	0.69				
American Indemnity/Fin'l	OTC	13.50	0.00	3.85	16.25	7.75	13	0.12	0.89	5	16.18	0.83	Selective Ins. Group	OTC	29.25	1.74	-3.31	31.00	20.50	42	1.12	3.83	19	23.11	1.27				
American International	NYS	88.25	-0.28	0.14	100.25	78.41	1530	0.40	0.45	15	45.25	1.95	Sohere Drake Holdings	NYS	15.88	-3.05	-3.79	21.63	15.50	44	0.12	0.76	17	2.17	1.50				
American Re Corp.	NYS	27.63	-3.07	-2.21	40.25	25.75	86	0.00	0.00	13	14.80	1.87	Statesman Group Inc.	NYS	12.00	-1.03	-4.00	15.72	9.75	94	0.10	0.83	5	8.65	1.39				
Aon Corp.	NYS	49.88	0.76	3.37	58.50	45.00	321	1.80	3.61	12	33.10	1.51	TIG Holdings	NYS	20.75	-4.05	-8.29	28.00	20.25	497	0.20	0.96	-13	18.49	1.12				
Argonaut Group	OTC	30.75	0.41	0.82	35.50	29.00	85	1.00	3.25	9	27.65	1.11	Tokio Marine & Fire	OTC	64.00	4.49	18.52	67.00	47.38	7	0.37	0.58	42	57.72	1.11				
AVEMCO Corp.	NYS	15.13	-3.97	-19.33	25.50	15.00	69	0.44	2.91	11	8.13	1.86	Torchmark Corp.	NYS	43.00	-3.91	-3.91	62.25	41.13	453	1.12	2.60	11	17.35	2.43				
Baldwin & Lyons Inc.	OTC	15.75	3.28	5.88	16.25	11.16	14	0.20	1.27	10	12.59	1.25	Transatlantic Holdings	NYS	47.88	-3.28	-10.30	61.50	47.88	65	0.36	2.75	12	29.60	1.62				
Berkley W.R. Corp.	OTC	36.00	-0.69	9.92	48.25	32.00	890	0.40	1.11	13	28.12	1.28	Travelers Corp.	NYS	37.50	-0.99	-3.54	49.50	27.28	3081	0.48	1.28	13	23.35	1.12				
Berkshire Hathaway Inc.	NYS	15450.00	0.49	-5.36	17800.00	11800.00	0	0.00	0.00	-	8115.28	1.90	Trenwick Group Inc.	OTC	33.88	-2.17	-12.58	49.75	33.88	65	0.88	2.60	10	26.00	1.30				
Chandler Insurance	OTC	6.75	10.20	22.73	6.75	3.50	35	0.00	0.00	13	8.67	0.76	United Fire & Casualty	OTC	37.00	-3.90	2.78	40.00	34.75	2	1.08	3.92	24	23.96	1.23				
Chubb Corp.	NYS	73.88	-3.11	-6.04	96.38	73.63	1291	1.72	2.33	19	46.99	1.59	Unilin	OTC	41.00	-1.20	-3.53	46.75	39.00	117	1.40	3.41	18	38.96	1.05				
CIGNA Corp.	NYS	65.63	-1.32	3.75	70.50	56.50	755	3.04	4.63	20	78.23	0.84	UNUM Corp.	NYS	53.38	0.23	1.67	60.13	47.75	525	0.80	1.50	12	27.55	1.94				
CNA Financial Corp.	NYS	69.00	-10.97	-12.38	100.63	69.00	314	0.00	0.00	16	77.92	0.89	US Facilities Corp.	OTC	9.25	-2.63	-22.11	14.00	7.50	73	0.00	0.00	12	13.48	0.88				
Continental Corp.	NYS	25.38	-4.69	-8.14	34.63	24.38	365	1.00	3.94	9	38.99	0.85	USF&G Corp.	NYS	14.25	-1.72	-5.79	19.63	12.38	2071	0.20	1.40	12	10.60	1.34				
EXEL Ltd.	NYS	43.13	-1.15	-4.17	52.25	41.88	621	1.20	2.78	6	33.81	1.28	USLICO Corp.	NYS	17.25	2.99	4.55	19.00	15.50	60	0.24	3.9	-6	25.22	0.86				
Fremont General Corp.	NYS	23.88	1.06	-1.04	28.75	21.00	146	0.72	3.02	8	23.40	1.02	USLIFE Corp.	NYS	39.00	0.32	0.65	45.75	35.75	294	1.24	3.18	3	4.73	0.93				
Frontier Insurance Group	NYS	42.38	-3.97	-3.42	50.00	36.72	29	0.60	1.42	14	16.33	2.59	Washington National	NYS	23.88	-2.05	-1.55	28.00	21.75	95	1.08	4.52	3	28.40	0.84				
Gaisco Inc.	ASE	9.75	-1.27	8.33	17.22	8.25	228	0.04	0.41	13	3.49	2.79	Zenith National Ins.	NYS	23.00	-2.13	3.95	29.25	21.25	53	1.00	4.35	3	17.71	1.30				
General RE Corp.	NYS	107.13	-0.81	0.82	133.38	102.50	935	1.92	1.79	13	55.54	1.93	Zurich Reinsurance Centr.	NYS	26.13	-1.42	-7.52	36.38	26.13	37	0.00	0.00	34	24.41	1.07				
Guaranty National Corp.	NYS	14.38	-4.17	-17.66	24.75	13.75	124	0.48	3.34	9	11.81	1.22	INSURERS/REINSURERS	AVERAGE		-1.0	-3.0					2.0	10.9						
Harleysville Group	OTC	25.50	0.99	-10.53	31.50	22.63	48	0.84	2.51	10	18.35	1.39																	
Hartford Steam Boiler	NYS	49.13	-2.72	10.39	59.88	42.63	180	2.12	4.32	78	15.80	3.11	FHP International	OTC	29.00	4.50	11.54	30.00	18.25	697	0.00	0.00	18	11.43	2.54				
HCC Insurance Holdings	OTC	28.50	6.54	-5.79	35.75	18.00	149	0.00	0.00	17	14.94	1.91	Pacificare Health Sys.	OTC	53.00	-4.93	40.40	57.25	30.50	243	0.00	0.00	22	11.15	4.75				
Home Holdings Inc.	NYS	16.00	-8.57	-7.25	18.50	16.00	88	0.00	0.00	-	19.96	0.80	Safeguard Health Enter.	OTC	14.25	-0.87	14.00	15.25	7.75	5	0.00	0.60	17	5.71	2.50				
ITT (Hartford Group)	NYS	95.75	-2.54	4.36	104.25	75.88	991	1.96	2.05	13	57.11	1.68	Sierra Health Services	ASE	26.75	-8.55	20.22	30.38	11.50	203	0.00	0.00	19	4.60	5.82				
Kemper Corp.	NYS	40.75	0.00	13.59	43.00	28.75	436	0.92	2.26	-17	38.98	1.05	TakeCare Inc.	OTC	67.00	0.00	22.94	67.75	27.50	173	0.00	0.00	22	18.69	3.58				
Lawrence Insurance Group	ASE	3.38	-3.57	-6.90	7.75	3.25	11	0.00	0.00	-8	4.26	0.79	United Healthcare Corp.	NYS	81.13	-2.99	8.53	87.25	44.50	1429	0.03	0.04	33	13.64	7.62				
Liberty Corp.	NYS	26.25	2.44	6.06	34.75	23.75	74	0.60	2.29	10	21.44	1.22	U.S. Healthcare	OTC	62.75	-1.18	9.13	68.25	36.75	2373	0.80	1.27	23	8.21	10.10				
Lincoln National	NYS	40.63	0.82	-5.52	48.25	36.50	582	1.64	4.04	10	32.53	1.25	Wellpoint Health Networks	NYS	34.50	-1.43	11.74	35.00	24.00	367	0.00	0.00	20	19.94	3.15				
Merkel Corp.	OTC	43.25	-1.14	12.34	44.50	32.25	60	0.00	0.00	10	24.68	1.75	HMOs	AVERAGE		-1.7	17.3					0.1	19						
Mid Ocean Ltd.	OTC	25.75	-2.37	-8.85	34.75	25.00	158	0.00	0.00	13	20.24	1.27	ALL COMPANIES	AVERAGE		-1.6	3.7					2.2	14						
Insurers/Reinsurers																													



Each year, in late October, Canada Geese sense the onset of winter and begin their seasonal migration southward. This journey takes some of the geese over 2,000 miles in search of the warm marshes that will sustain them through the winter.

Knowing That Change Is Coming Is One Thing. Doing Something About It Is Another.

Reacting to change as it happens isn't enough. To survive and flourish, the successful company must be able to see change coming and be ready to deal with it.

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We offer customized, individualized programs and administrative support that help our group clients prepare for and deal with change — not just react to it.

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