

Business Insurance

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

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Updates

Transit authority becomes first to use New York-based captive

NEW YORK—A captive formed by the Metropolitan Transportation Authority is the first licensed in New York under that state's new captive insurance law, which took effect late last year.

The MTA initially is using its new captive, First Mutual Transportation Co., to provide station liability coverage and the railroad workforce account portion of Federal Employment Liability Act coverage for the MTA's Long Island Rail Road and Metro-North Commuter Railroad lines.

See Updates on next page

EMLICO fight heats up

Massachusetts presses for control; Bermuda seeks settlement talks

By DOUGLAS McLEOD

BOSTON—In its strongest attack to date on Electric Mutual Liability Insurance Co., the Massachusetts Insurance Division is charging that EMLICO managers may have known the insurer was insolvent before its 1995 move to Bermuda and may have defrauded regulators in winning approval for the move.

In court filings Friday, Insurance Commissioner Linda Ruthardt noted that both she and a Bermuda judge "have expressed serious concerns that the redomestication to Bermuda was part of a scheme by EMLICO and its principal insured, General Electric

Co., to avoid liquidation of EMLICO in Massachusetts by misrepresenting and concealing the financial condition of the company until it could redomesticate."

The Insurance Division's filing came in response to efforts by EMLICO's joint liquidators—partners of Coopers & Lybrand in Bermuda and London—to halt a Massachusetts receivership petition against the insurer.

In an escalating fight over who will oversee the huge EMLICO insolvency, the joint liquidators are arguing that they are immune from any action in a U.S. court.

The Massachusetts filing capped a week in which:

- Ms. Ruthardt sent an angry letter to Bermuda Finance Minister Grant Gibbons condemning the joint liquidators' actions as "unseemly."

- Mr. Gibbons asked the joint liquidators—David E.W. Lines, Peter C.B. Mitchell and Christopher J. Hughes—to seek a negotiated settlement with Massachusetts over EMLICO's liquidation.

- Bermuda Chief Justice L. Austin Ward, acting at the request of Mr. Gibbons and the liquidators, wrote to a U.S. federal judge to ask that he order Ms. Ruthardt to begin settlement talks.

EMLICO, a longtime GE liability
See EMLICO on page 23

COLI plans targeted in budget

By JERRY GEISEL

WASHINGTON—Benefit experts digging deeper into the Clinton administration's proposed federal budget are uncovering some potentially nasty surprises for employee benefit programs.

Those provisions would:

- Reduce the effectiveness of corporate-owned life insurance as a funding vehicle by barring employers with COLI policies from fully deducting interest they pay on debt. COLI is a popular insurance product that employers buy to fund future obligations, such as supplemental pension benefits and retiree health care benefits.

- Make it more expensive for employers to qualify for a safe harbor that would exempt them from running non-discrimination tests on their 401(k) plans.

- Take away an alternative definition of highly compensated employees for 401(k) plan non-discrimination testing. This change could significantly reduce salary deferrals by higher-paid employees at small companies, such as investment banks, with a high percentage of employees earning top compensation.

The budget package also could have a significant impact on property/casualty insurers. A provision in the package would make investing in tax-exempt bonds less attractive, a change that could force insurers to rejigger their investment mix.

But not all provisions in the budget would hurt benefit programs. Certain provisions that would allow retirees to purchase Medicare coverage before they are 65 could cut employers' early retiree health care costs. Other provisions would give tax credits to employers developing child care programs.

Benefit experts now, though, are warning of the impact on employers of the COLI provision. Over the past decade or so, COLI has emerged as a popular way to tax-effectively build assets to pay for future obligations, especially for financially sophisticated companies.

"For Fortune 500 companies, it is not unusual to see COLI programs in the \$100 million to \$1 billion range," said Chris George, a consultant in the Wellesley Hills, Mass., office of WatsonWyatt Worldwide.

See Budget on page 10

U.S. battered on both coasts by series of winter storms

By MICHAEL BRADFORD

Severe winter storms caused flooding in Northern California, left, while on the East Coast, storms washed out roads in coastal communities such as Virginia Beach, Va., below.

FREEWAY
ENTRANCE



PHOTOS: ASSOCIATED PRESS



Insurers likely face a flurry of claims after a series of El Nino-fueled storms left property owners across the country with damage expected to total well in excess of \$100 million.

Those losses are expected to continue to pile up as South Florida and Northern California braced for a second round of storms last weekend.

Elsewhere, businesses and residents in the Ohio valley region are digging out from heavy snows that fell in parts of Ohio, Kentucky, West Virginia and Indiana. The snowstorm buckled roofs and downed power lines in the affected region, and communities from Tennessee to Connecticut suffered storm-related power outages.

Along the East Coast, many residential and commercial buildings were shuttered against a fierce nor'easter that caused extensive flooding in coastal areas from Florida to the mid-Atlantic states. The nor'easter sent the ocean surging across streets and boardwalks in the mid-Atlantic states and caused water damage to homes and businesses.

Flooding washed away a section of railroad track near Glasgow, Va., and state officials feared more damage from

See Storms on page 22

'Prior acts' ruling favors coverage

Ambiguity in exclusion means policyholder must benefit, judge says

By GAVIN SOUTER

ST. PAUL, Minn.—A commonly used "known prior acts" exclusion in claims-made professional liability policies is ambiguous when applied to claims at newly acquired subsidiaries, a federal judge has ruled.

As a result of the ambiguity, insurers should indemnify policyholders against the liability claims, said U.S. District Judge Richard H. Kyle.

The Jan. 26 decision will help stymie insurers' attempts to exclude claims because of prior knowledge of events, said William G. Passannante, a partner at Anderson Kill & Olick P.C. in New York who represented the policyholder.

"It'll help prevent retroactive underwriting," he said.

The case was brought by St. Paul Fire & Marine Insurance Co., which sought a declaratory judgment that it was not required to defend or indemnify policyholder MetPath Inc., which owns medical laboratories nationwide, for claims brought against Maryland Medical Laboratory. MetPath acquired MML in 1994.

St. Paul had issued a series of claims-made medical professional liability policies to Teterboro, N.J.-based MetPath from April 1, 1989, to April 1, 1995.

The final policy in the series had two layers. The first layer provided \$1 million excess of a \$1 million per person self-insured retention, up to a maximum retention of \$3 million, according to court papers.

A second layer had provided a \$5 million per person limit
See Prior acts on page 16

In the balance

President Clinton's balanced budget proposal won't



- Make 401(k) plan safe harbors costlier
- Redefine highly compensated employees for 401(k) plans
- Increase taxes on interest income of property/casualty insurers

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Updates

First New York captive running

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That coverage, with limits of \$6 million per occurrence, will be written by New York-based Reliance National Indemnity Co., which will then "reinsure a great deal of that back to the captive," according to Mario Vitale, an executive vp in the Casualty Risk Services Division of Reliance National.

As part of its arrangement with the MTA, Reliance National also will provide stop-loss, excess coverage and claims management for the captive, "as well as some other risk management services," Mr. Vitale said.

The MTA had indicated late last summer that it was working with Willis Corroon Corp. to conduct a captive feasibility study (*BI*, Sept. 15, 1997). Willis Corroon now is serving as manager of First Mutual, which may ultimately be used to insure other MTA operating agencies and provide other coverage lines.

New York Insurance Department officials indicated they have licensed a second captive as well, New York-based manufacturer Columbus-McKinnon Inc.'s CM Insurance Co. Inc. CM had been domiciled in Tennessee but has redomesticated to New York.

Insurers win pollution ruling

TALLAHASSEE, Fla.—In a loss for policyholders, the Supreme Court of Florida has joined 15 other states in ruling that the absolute pollution exclusion is unambiguous.

"We, too, agree that the pollution exclusion clause is clear and unambiguous," the court ruling says.

The ruling last month covered two unrelated pollution cases where the policyholders sought indemnity under their commercial general liability policies.

In one case, Deni Associates sought coverage from State Farm Fire & Casualty Insurance Co. after, in the course of moving equipment in its offices, ammonia was spilled from a blueprint machine and claims were made against the company for injuries sustained from inhaling ammonia fumes.

In the second case, E.C. Fogg, a fruit grower, sought coverage from Florida Farm Bureau Mutual Insurance Co. The policyholder had contracted with an insecticide sprayer to spray citrus groves, and in the course of the spraying, the insecticide was splashed on two men on an adjacent property.

The Supreme Court affirmed the decision of the appeals court that heard the cases and rejected the policyholders' argument that the exclusion should be limited to "environmental or industrial" pollution.

Exchange buys cover from ACE

CHICAGO—The INEX Insurance Exchange has purchased insurance from ACE Insurance Co. Ltd. of Bermuda to indemnify its guaranty fund obligations stemming from the insolvencies of three syndicates.

"I think this is another major step for us in terms of reducing uncertainties about dealing with the exchange and allowing us to refocus our attention on the future," said James E. Tait, president and chief executive officer of the Chicago-based INEX, which formerly was named the Illinois Insurance Exchange. He declined to discuss policy limits.

Exchange rules call for the guaranty fund to pay a maximum of \$300,000 per claim up to an aggregate cap of \$15 million per insolvency. But the exchange board probably will not decide until 1999 whether to follow an internal rule that may allow it to combine two insolvencies that occurred in a short time span. That would reduce the amount of money available to pay claims (*BI*, March 10, 1997).

The Illinois Insurance Department, which is overseeing liquidation of the three syndicates, declined to comment on the transaction because it had not seen the contract, said Richard Darling, chief operating officer of the department's Office of the Special Deputy Receiver.

The three insolvent syndicates are Geneva Assurance Syndicate Inc., First Oak Brook Syndicate Inc. and Resure Inc. Syndicate.

Bills to change tort reform die

SACRAMENTO, Calif.—The so-called "Royal Globe bill" and at least three other measures that would have curtailed tort reforms in California died last week after sponsors failed to resurrect them before a Jan. 31 deadline.

A.B. 1109, which would have permitted third-party bad-faith lawsuits against insurers, failed to obtain the required votes for full Assembly approval for two-year bills to pass out of their house of origin. The bill, known as the Royal Globe bill because it would restore a 1970s court ruling permitting third parties to sue insurers, was introduced by Assemblywoman Martha M. Escutia, D-Huntington Park, in March 1997 (*BI*, March 17).

Also failing to be resurrected:

- A.B. 250, which would have eliminated the \$250,000 cap on pain-and-suffering damages in medical malpractice cases. The cap, instituted by the Medical Injury Compensation Reform Act, has been in place for nearly 20 years.

- A.B. 1324, which would have weakened a judge's ability to dismiss frivolous lawsuits at an early stage.

- Companion measures A.B. 1486 and A.B. 1487, which would have given lawyers larger fees in lawsuits brought under the Consumer Legal Remedies Act.

Aon to buy Spanish broker

CHICAGO—Aon Corp. will significantly expand its presence in Spain with its proposed acquisition of broker Gil y Carvajal Group.

Aon Corp. announced it has entered into an agreement to acquire the Madrid, Spain-based retail and reinsurance broker last week. Terms were not disclosed.

Gil y Carvajal, with 21 offices throughout Spain and offices in the Uni-

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Plans still primary in ESRD

Judge makes permanent a ruling that employers pay first

By JERRY GEISEL

WASHINGTON—A long-running controversy on whether employers or Medicare have to pay the big health care bills of retirees with end-stage renal disease so far is going against employers.

Senior U.S. District Judge William Bryant in Washington ruled last month that the Health Care Financing Administration cannot enforce a rule—at least covering a limited period of time—under which Medicare is the primary payer of medical bills for retirees with ESRD, an expensive kidney ailment whose annual

treatment costs run in the \$30,000 to \$50,000 range.

The controversy involves an obscure health care cost-shifting provision in a 1993 budget law. Regulators at HCFA, the federal agency that administers Medicare, initially interpreted the 1993 law as requiring employers with retiree health care plans to be the primary payer for up to 18 months for retired workers over 65 who are covered by Medicare and then develop ESRD.

But regulators in 1995 reversed that position amid employer and insurer lobbying and said Medicare would continue to provide

primary coverage for workers who develop ESRD after they turn 65 and are covered by Medicare.

That interpretation was quickly challenged by National Medical Care Inc., the nation's largest operator of kidney dialysis centers. It sued to block regulators from "retroactively" enforcing its second interpretation of the cost-shifting provision in the 1993 law.

Shortly after the NMC suit was filed, Judge Bryant issued a preliminary injunction to temporarily bar HCFA from retroactively enforcing the new interpretation that had shifted liability for

See ESRD on page 21

Rejection of appeal means Lloyd's faces first U.S. trial

By GAVIN SOUTER

LLOYD'S

LOS ANGELES—The California Supreme Court's refusal to hear Lloyd's of London's appeal of a ruling allowing U.S. members to sue the market in state court appears to set the stage for the first trial against Lloyd's in the United States.

A trial in Superior Court in Los Angeles would enable the three members to take advantage of the extensive U.S. discovery rules and be heard in front of a jury, in contrast to the more limited discovery allowed in the non-jury commercial trials in England.

"The Wests will finally have

their day in court," said Eugene Goldman, a partner at McDermott, Will & Emery in Washington who represented the members David West and daughters Susan and Deborah.

However, Lloyd's lawyer Dean Hansell, a partner at LeBoeuf, Lamb, Greene & MacRae L.L.P. in Los Angeles, said, "We are still an awful long way from a trial."

Shortly after the state Supreme Court on Jan. 31 issued notice of its decision not to hear Lloyd's

appeal, however, the federal appeals court in San Francisco ruled in a separate case that Lloyd's members are required under their members agreements to bring any grievances against Lloyd's in England.

The Feb. 3 ruling by the 9th U.S. Circuit Court of Appeals is in line with six other federal appeals courts that have determined that members of Lloyd's gave up their right to sue in the United States under the agreements they signed when they first became Lloyd's members.

The apparently contradictory rulings in California should not

See Lloyd's on page 21

Blues will return \$10 million in deal

Massachusetts plan settles suit

By ROBERT KAZEL

BOSTON—About 500 health plan sponsors and thousands of current and former employees will share in a \$10 million settlement of a federal lawsuit announced last week.

The settlement resolves a U.S. Department of Labor suit filed more than two years ago against Boston-based Blue Cross & Blue Shield of Massachusetts. The government accused the insurer of violating the Employment Retirement Income Security Act by failing to pass on hospital savings to plan sponsors and beneficiaries (*BI*, Dec. 4, 1995).

At the time of the suit, filed in U.S. District Court in Boston, Labor Department officials said BC/BS of Massachusetts owed some \$180 million in refunds. But the actual amount in question probably was closer to \$50 million, because that figure represents self-insured plans covered by ERISA, said Stacey E. Elias, trial attorney with the Labor Department. Only these plans are eligible for refunds.

The hospitalizations occurred between 1988 and 1992. During this time, state law limited how much hospitals could charge BC/BS of Massachusetts in an effort to prevent cost-shifting that would harm the insurer.

See Settle on page 16

Deadline approaches for EBIS directory

Business Insurance will publish its annual Directory of Benefit Information and Claims Systems in the March 2 issue, which also will feature a Spotlight report on Benefits Administration and Online Resources.

The directory is published as an editorial service, and there is no charge to be included. Companies simply must submit a completed questionnaire by the extended deadline of Feb. 16.

If your company provides employee benefit information and claims systems and has not yet received a questionnaire, please request one by calling Assistant Directory Editor Matt Scroggins at 312-649-5483.

Inside

- The Clinton administration should hold off on modifying a safe harbor law for 401(k) plans until it has seen the effects of the law, this week's editorial says. **PAGE 8**

- The first scheme of arrangement for a solvent insurance company that will pay creditors in full has won the approval of the London High Court. **PAGE 17**

- Business interruption and loss-of-earnings claims are expected as a result of an accident in northern Italy that killed 20 people in a cable car when a U.S. military plane hit a cable. **PAGE 17**

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Transplant costs remain high, but savings are negotiable

By JUDY GREENWALD

Employers that negotiate in advance with networks of organ transplant specialists can significantly lower their health care costs for these high-cost, low-frequency procedures.

Organ transplants, which have largely become a standard part of large employers' benefit plans, always will be an extremely expensive medical procedure. But negotiated arrangements with transplant networks dubbed "centers of excellence" can cut employers' costs by as much as 30% to 40%, making even costly transplants an item that

can be budgeted, benefit experts say.

Many self-insured employers and most managed care plans and other health care providers today have arrangements with these centers for their group programs.

"We require that (employees) use one of our centers that we list or we provide no benefit. That's how seriously we take into consideration the cost of transplant care," said Darren Horndasch, chief executive officer of Milwaukee-based Wisconsin Health Fund, which funds coverage for 500 employers in the state and works with the Minneapolis-based United Resource Network. The fund provides benefits for about

one transplant per month, he said. "The advantage... is it is a budgetable item once we know our occurrence rate and the types of transplants that we incur," he said.

An increasing number of transplant cases, however, may end up in the workers compensation system, where effective cost controls and coverage caps are less likely to be applied (see story, page 4).

As of January, 53,640 people were waiting for transplants, according to the Richmond, Va.-based United Network for Organ Sharing's national patient waiting list.

"The waiting lists are growing faster than
See Transplants on next page

Transplant costs

Employers using centers of excellence can significantly reduce the standard cost of providing transplant coverage.

Average non-negotiated billings for surgery and first year of care.

Liver	\$314,500
Heart-lung	271,400
Lung	265,900
Heart	253,200
Bone marrow	217,000
Kidney-pancreas	141,300
Pancreas	125,800
Kidney	116,100

Source: Milliman & Robertson Inc.

Streamlining regs top goal for Pomeroy as NAIC president

By MEG FLETCHER

BISMARCK, N.D.—Streamlining regulation of commercial insurance to make the market more efficient is a top priority for Glenn Pomeroy as president of the National Assn. of Insurance Commissioners.

"It's consistent with what my theme is, which is: Make the multistate regulation of insurance work better through common-sense solutions," said Mr. Pomeroy, who is also the new chair of the NAIC's Special Committee on Regulatory Re-engineering.

The 41-year-old attorney and North Dakota Insurance Commissioner uses "State Regulation 2000" to describe that initiative, which he announced in December when he was elected to a one-year term as NAIC president.

His goal is to reduce multistate approval barriers and increase uniformity and consistency in the processing and regulation of rate and form filing, financial reporting and company licensing.

Those goals are reflected in some of the proposals outlined in a 23-page white paper from the regulatory re-engineering committee. The committee is seeking public comment on the paper.

The proposals include a list of criteria that would identify large insurance buyers deemed sophisticated enough to be exempt from many state regulatory protections (BI, Dec. 15, 1997).

Risk managers and insurance industry representatives generally support the committee's proposals so far.

Now, with Mr. Pomeroy at the helm, "I think we can continue to see good progress," said Anne Flanagan, director of state affairs for the National Assn. of Insurance Brokers in Washington.

Mr. Pomeroy also is expected to build on the joint regulator-industry efforts he spearheaded to streamline state insurance regulation by adopting efficient procedures for regulating producers. Those procedures are similar to those used in the securities industry.

See Pomeroy on page 20



Mr. Pomeroy

Employer groups divided on OSHA auditor idea

By MARK A. HOFMANN

WASHINGTON—The employer community has split over a proposal to give third-party safety auditors the authority to exempt workplaces from federal fines for two years.

The division was evident during a hearing on the Safety Advancement for Employees Act—better known as the SAFE Act—late last month before the House Small Business Committee.

Chairman James Talent, R-Mo., who co-sponsored the bill, opened the hearing with a swipe at the Occupational Safety and Health

Administration's current inspection system, which he branded "ineffective and adversarial," adding that OSHA has the ability to visit each work site in the country only once every 167 years.

"To improve the safety of America's workers, we must abandon this adversarial approach with decent and honest employers who are trying to do what is right. It's clear that most businesses will not be brought into compliance by an OSHA inspection in the foreseeable future. Nor is the mere threat of monetary fine enough to bring good-faith employers into compliance when they don't know how

to comply," he said.

Rep. Talent said the SAFE Act's third-party audit provision "embodies a true partnership approach that encourages employers to voluntarily hire third-party consultants to audit their workplaces for compliance with OSHA and safety in general."

Although all the witnesses praised the idea of using third-party safety auditors to enhance workplace safety, one took exception to the act's proposal that work sites that undergo inspection by qualified outside auditors be exempt for two years from
See Auditors on page 16

Sides spar over American Bankers AIG suit accuses Cendant of misleading shareholders

MIAMI—American International Group Inc. has filed a suit in federal court accusing Cendant Corp., its rival bidder for American Bankers Insurance Group, of misleading American Bankers' shareholders.

The suit, filed in U.S. District Court in Miami, seeks to prevent Cendant from discussing its takeover offer for American Bankers until it files registration documents with the federal Securities and Exchange Commission.

The complaint alleges that Cendant has "embarked upon a campaign of misinformation by disseminating numerous false and misleading statements to American Bankers' shareholders," in violation of federal securities laws.

For example, the complaint alleges that Cendant, a travel and real estate conglomerate based in Parsippany, N.J., and Stamford, Conn., misled shareholders about the value of its bid because it fluctuates with Cendant's "volatile" stock price.

The suit also claims that Cendant's president and chief executive officer, Henry Silverman, made "knowingly false and misleading" statements when he told analysts that regulatory approval for the two bids was comparable.

The bidding war over Miami-based American Bankers erupted when Cendant announced Jan. 27 a cash tender offer valued at \$2.7 billion for

51% of American Bankers' stock. It said it would acquire the rest of ABIG later for Cendant stock.

The bid came two weeks after AIG and American Bankers signed an agreement under which the New York-based insurance holding company would buy American Bankers for \$2.2 billion. (BI, Feb. 2).

In a statement, Cendant called the suit "baseless." The company added that it would file the registration documents with the federal securities regulators "in a timely fashion, when appropriate."

Meanwhile, American Bankers' board announced it is unable to take a position regarding the Cendant offer.

—By Michael Prince

Casualties of open rating

Diminishing profitability of California workers comp drives insurer from state

By JOANNE WOJCIK

ANAHEIM, Calif.—Great States Insurance Co. is leaving the California market after seeing its profits erode steadily since workers compensation rates were deregulated in 1995.

The insurer, formed in 1989 as a monoline workers comp underwriter principally doing business in California, becomes the second casualty of open rating. The first was Golden Eagle Insurance Co., seized last year when regulators determined the company was financially unstable and control of which was ultimately transferred by regulators to Liberty Mutual Insurance Co.

At least two other insurers also may withdraw from the cutthroat workers comp market competition: Argonaut In-

surance Co. of Menlo Park, Calif., and UniCare Insurance Co., a unit of Well-Point Health Systems Inc. of Woodland Hills, Calif., both are rumored to be up for sale.

Neither insurer would comment on the rumors, which have been circulating in the California workers comp industry for several weeks.

The fallout from open rating is expected to continue, with more insurers cutting back their California writings or merging with multilines and/or multistate insurers for a spread of risks.

For example, writings were down 6.9% in 1996 at State Compensation Insurance Fund, the state's largest workers comp underwriter with \$978.3 million in 1996 direct written premiums, according to a bulletin from the San Francisco-based

California Workers Compensation Institute.

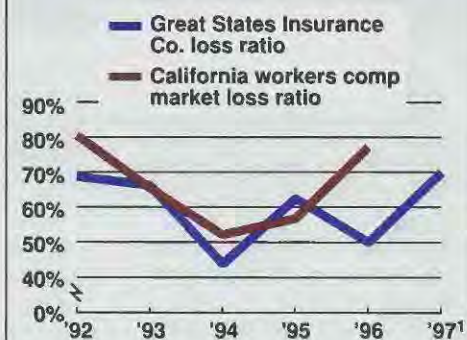
The largest reductions in workers comp premium volume in 1996—the most recent year for which statistics are available—were posted by American Financial Group, whose premiums dropped 25.3% to \$211.7 million in 1996, and Fremont General Group, which while still digesting its acquisitions of Citation Insurance Co. and Industrial Indemnity Co., saw its workers comp premium volume fall 39.2% to \$154.1 million in 1996.

California's workers comp market has shrunk to \$6 billion in direct premiums written, from nearly \$12 billion at the beginning of the decade.

"This wasn't unexpected," said Lori Kammerer, executive director of Califor-
See California on page 20

Leaving behind open rating

Widening workers comp losses are prompting Great States Insurance Co. to leave the California market.



Ratios are pure loss ratios
1 Great States estimate
Source: A.M. Best Co. and the California Workers Compensation Insurance Rating Bureau
GRAPHIC BY JOHN HALL

Transplants

Continued from previous page
the supply of organs," said Dr. David Epstein, senior consultant with Towers Perrin Integrated Health Systems Consulting in Atlanta.

But, thanks in part to better efforts to obtain available organs, the number of transplants still is rising. A 1996 report by benefit consultant Milliman & Robertson Inc. found the number of heart transplants in 1996 rose 47% to an estimated 2,507 from 1,705 in 1989.

Of the 19,410 transplants of "solid" organs in 1996, kidneys were the most common, followed by liver, heart, lung, pancreas, intestine and heart-lung procedures, UNOS said.

Not counted in these statistics are bone marrow transplants, including autologous transplants, which use a patient's own bone marrow and are viewed in some cases as experimental.

The survival rates for organ transplants vary widely. According to UNOS, four-year survival rates range from 92.8% for recipients of kidneys received from living donors to 45.4% for heart-lung recipients.

The cost of transplants, though they

may be a dying employee's only option, can be daunting for employers.

The Milliman & Robertson survey found that, as of 1993, a billed, non-negotiated heart transplant cost an average of \$253,200 for the surgery and first year of post-operative care.

This reflects \$11,000 for evaluation; monthly \$10,600 candidacy-related charges; \$25,200 for organ procurement; \$155,800 in hospital charges; \$21,800 for physicians; \$18,500 in follow-up charges; and \$10,300 for immunosuppressants. This excludes the estimated \$21,200 annual cost for follow-up exams and immunosuppressants in subsequent years.

"It's probably costing the employers more just because it's being done more often," said Richard Hauboldt, a consulting actuary at Milliman & Robertson in Milwaukee and author of its study. He estimated that organ transplants account for 1.5% to 3% of employers' total health care costs.

He also noted that kidney transplants could grow more costly for employers. Legislation signed into law by President Clinton last year provides that employers become the primary payer for a 30-month period—up from the previous 18 months—for

end-stage renal disease, a kidney impairment that could create the need for an transplant (BI, Aug. 11, 1997). Afterward, Medicare becomes the primary payer.

While transplant costs are steep, employers can negotiate discounts of up to 30% to 40% of the standard cost of care with "centers of excellence."

These are medical centers experienced in transplants that have been approved by managed care organizations, insurers and other health care providers based on their experience and success rate in transplant procedures. Centers of excellence also can focus on other areas, such as cancer care, burns and rehabilitation.

"A lot of health plans have gone this route" for organ transplants, though some of them "may be more sophisticated than others in their selection criteria," said Eileen Settineri, a consultant at Watson Wyatt in New York.

In some cases, "people have created their own (networks) through direct contracting," said Joseph Marlowe, senior vp in Aon Consulting's Philadelphia office. "Then there are some independent centers of excellence which offer their services directly to self-funded employers, or to

managed care organizations," he said.

Mr. Marlowe said large employers are likely to use a "pay-as-you-go approach," where it pays the center a percentage of its savings, while managed care organizations are more likely to pay on a per-month, per-member basis. "Much of the difference has to do with the predictability of volume," he said. "For an individual employer, it's hard to predict how many transplants you may have in a given year, depending upon the employer's size."

A total of 275 U.S. medical institutions operate organ transplant programs, according to UNOS.

But, only about 25 to 40 of these appear repeatedly on the best networks' "centers of excellence" lists, said Edmund Goodhue, president of Lynwood, Wash.-based Avandel Healthcare Inc., which underwrites group coverage for catastrophic care cases.

Prudential Health Care's Institutes for Quality program, based in Roseland, N.J., for instance, works with about 40 institutions, to which it annually sends a survey to collect prior years' results. "From there, we virtually always have a dialogue with them about their results," said Director Debbie Grinnell-Miller.

If a lead surgeon leaves a particular transplant program, leading to a lower volume of cases, or if a series of particularly difficult cases hurts its one-year survival rate, a program could be suspended at least temporarily, said a spokeswoman for another network, LifeTrac, operated by Minneapolis-based Allianz Life Insurance Co. of North America. LifeTrac works with 32 centers operating 170 programs.

"The whole basis of centers of excellence is the clinical outcomes are much more positive if a facility does a volume amount of transplants, and it makes sense that they should be much more adept at a transplant than if you went to a facility that only did it once in a while," said Jack Doerr, national

group benefits practices leader with Sedgwick Noble Lowndes in Chicago.

He noted that virtually all managed care organizations have adopted this preferred network approach.

Aon's Mr. Marlowe said this approach gives an employer "some degree of comfort that the institution has been screened for the quality of their care and, in particular, the survival rates and complications issues are well-researched, coupled with competitive pricing."

"Centers of excellence can keep expenses in line from a price standpoint and a cost standpoint, because we have a better likelihood for a better outcome," said Steve Peters, manager of health and welfare plans at Becton Dickinson & Co., a health care products maker in Franklin Lakes, N.J.

It means "less employee time away from work, a quicker, earlier return to a maximum level of productivity and less distraction if it's a family member receiving a transplant," he said.

Many centers of excellence also offer negotiated all-inclusive packages, "so there are fewer small bills that follow," said Mr. Peters, who estimated that transplants account for 3% to 5% of the company's health care costs.

Centers of excellence typically will have one person managing the various services involved, said Vicky King, director of compensation and benefits for New York-based Mosby Matthew Bender, a health science and legal publishing company. Unless organ transplants are centrally managed, "the cost can be double or triple what you ordinarily expect," she said.

The cost per transplant has "leveled off and probably actually declined over the last five years as a result of the national transplant networks, and also improvement in terms of getting people out of the hospital a little bit quicker, and just efficiencies in terms of delivering the transplant services," said Towers Perrin's Dr. Epstein. **BI**

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Comp system permits transplant claims

More organ transplant claims could end up in the workers compensation system, some experts say.

Although claimants must overcome the formidable barrier of proving their illnesses can be traced to their occupations, because the workers comp system is less subject to cost control measures than benefit plans, it could attract future claims.

Right now, "it's just kind of a steady trickle of new transplant cases coming into the workers comp system," though it could increase, said Mark Solomons, an attorney with Arter & Hadden in Washington. Others, though, say they have not yet seen any workers comp transplant claims.

Claimants may try to turn to the workers comp system because "compared to group health, it is still a more generous system of reimbursement. It's the last bastion of fee-for-service medicine out there," said Dr. David Epstein, senior consultant with Towers Perrin Integrated Health Systems Consulting in Atlanta.

Lung diseases probably are the most likely problem calling for a transplant that could be traced to an employee's occupation, said Mr. Solomons. "It's just not very common you would find an appropriate heart transplant patient that has a clear-cut claim or condition that caused the need for transplantation," he said.

Vicky King, director of compensation and benefits for New York-based Mosby Matthew Bender, a health science and legal publishing company that is a division of the Times-Mirror Co., said some workers could try to argue organ damage was due to the work environment, but it would "probably be very difficult to prove."

Michael LeFever, executive director of the South Carolina Workers Compensation Commission in Columbia and past president of the International Assn. of Industrial Accident Boards & Commissions, which represents state workers comp administrators, said while no such claim has crossed his desk, "I think our law certainly would allow such a situation if the medical conditions could be met."

But, he disagreed with some observers' assertion that the workers comp system, through its judges, is more prone to be swayed by emotion than would be the benefits side.

In South Carolina, for instance, there are four levels of possible judicial review for workers comp, "so if one judge happens to be too out of whack on the emotional end, the decision is going to get straightened out by a more objective panel of judges up the line someplace," said Mr. LeFever. "I think the final decision would have to be considered very reasonable."

Steve Peters, manager of health and welfare plans at Franklin Lakes, N.J.-based Becton Dickinson & Co., said, "We haven't seen many requests for organ transplants that are tied to occupational exposure," which is attributable at least in part to the richness of the company's group health benefit plan.

Mr. Peters also pointed to efforts to integrate the principles of managed health care and workers comp programs. Effective March 1, he noted, his company will have an integrated workers comp program in Nebraska, where 20% of the company's workforce is based, "so our exposure to these kinds of claims... is minimized."

—By Judy Greenwald



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Opinions

Keep 'safe harbors' safe

IF POLICYMAKERS EVER needed an example of why employers so distrust government pension policy, a Clinton administration proposal dealing with 401(k) plans is it.

Back in 1996, Congress passed legislation—with the enthusiastic support of employers—that began to peel away some of the rules, many of which were unnecessary, that have made pension plan administration so complex and expensive.

One of the provisions in that legislative package involved 401(k) plans and the tests employers must run to prove their plans don't discriminate in favor of highly compensated employees.

In order for a plan to pass those tests, contributions made by highly compensated employees can't exceed, on average, those of the rank and file by more than a specific percentage.

Running these tests is not easy. Employers have to monitor contributions throughout the year. And if it turns out that higher-paid employees put in too much, their contributions have to be returned, a messy administrative task.

Legislators came up with a great idea for employers to avoid the problems inherent in 401(k) plan non-discrimination testing: safe harbors.

Simply put, if an employer agrees to offer a 401(k) plan that fits certain criteria or safe harbors, the employer doesn't have to run the non-discrimination tests. Its 401(k) plan automatically will be considered non-discriminatory if it fits one of two safe harbors.

To qualify for the first safe harbor, each year an employer would have to contribute to the plan 3% of compensation for each eligible non-highly compensated employee. Alternatively, under the second safe harbor, an employer would have to match 100% of employees' deferrals, up to the first 3% of compensation and 50% of employees' contributions up to the next 2% of compensation. These new safe harbors are scheduled to go into effect next Jan. 1.

We think the safe harbor idea is a win for employers and employees. Employers can get out of the hassle of non-discrimination testing and employees can get generous employer contributions.

But now, before the safe harbors take effect, the administration wants to modify one of them. To qualify for the second safe harbor, the employer would have to make a contribution equal to 1% of compensation for each rank-and-file employee eligible to participate in the plan.

The administration says that without an automatic 1% employer contribution, lower-wage employees might not contribute to the plans.

Frankly, we think the proposal doesn't make much sense. The safe harbors haven't even gone into effect, and the administration wants to change them. We think that gives a terrible message to employers, especially those that now don't have a 401(k) plan because they don't want to go through the time and expense of non-discrimination testing.

An employer justifiably might ask: If the administration wants to change the safe harbors before they take effect, what assurance is there that the rules won't change year after year?

Indeed, employer distrust and perhaps disgust with government pension policy is that regulators



and legislators constantly change the rules. Changing a safe harbor before it even goes into effect exacerbates that distrust.

Aside from creating uncertainty, we don't like the proposal for another reason. Many employers believe saving for retirement is a dual responsibility they share with their employees. Toward that end, employers match—by varying percentages—employee contributions to the 401(k) plan.

By mandating that employers must contribute to the plan even if employees do not make their own contributions, the 401(k) plan becomes an entitlement program, something that goes against the corporate grain.

Perhaps, as the administration seems to think, employers—in the absence of non-discrimination tests—might not do enough to educate employees about the importance of contributing to 401(k) plans. The administration believes an automatic 1% contribution will help employees understand the value of tax-deferred compounding of contributions.

But how, in the absence of any experience with the safe harbors, can the administration be so sure? Indeed, many employers do everything possible through communication campaigns to get all their employees to contribute to their 401(k) plans. We don't think it is just non-discrimination tests that motivate employers to do this.

To be sure, the Clinton administration's track record on pension policy is impressive. For example, it led the successful drive for legislation that has shored up the financial base of the Pension Benefit Guaranty Corp. And the administration backed other initiatives to simplify pension rules.

But on the 401(k) safe harbor issue, the administration would be well-advised to withdraw a proposal that at best is premature and at worst is misguided.

If it fails to do so, Congress should let the safe harbors go into effect, as scheduled, next year. If the safe harbors do lead to a drop-off in employee contributions, legislators—after the evidence is in—can take appropriate steps to correct the problem.

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LEXINGTON INSURANCE COMPANY PIONEERS IN REVOLUTIONARY COVERAGE

Budget

Continued from page 1

"The use of corporate-owned life insurance has become a well-accepted funding practice," added David Sugar, a consultant with Hewitt Associates L.L.C. in Lincolnshire, Ill.

The popularity of COLI is due to how the plans can be used to build assets to pay for future obligations. Under a COLI program, an employer purchases life insurance for employees, but the employer owns the policies. Employers are not taxed on the so-called inside buildup—the increase in value of the policies due to investment earnings.

When an insured employee dies, the policy can be cashed in, and employers are not taxed on the proceeds. In addition, as long as they follow certain Internal Revenue Service rules, employers can borrow from the policies and not be taxed on what they borrow.

Under the administration proposal, though, buying COLI would carry a new price: partial loss of corporate deductions for interest they pay on debt.

Specifically, employers would compare the cash value of COLI policies to corporate assets. Their tax deduction for interest expenses would be reduced by the ratio of COLI policies' cash values to total assets.

For example, if the cash value of an employer's COLI policies was equal to 10% of total assets, an employer could only deduct as a business expense 90% of the interest it pays on outstanding debt; currently employers can fully deduct interest paid on debt.

With companies losing some of their ability to take interest deductions on debt, COLI will become less attractive, especially for highly leveraged companies.

"The effectiveness of COLI will depend on a corporation's level of

debt," said Mr. Sugar.

"This does not kill COLI, but it could make COLI less appealing," added Jim Hess, a vp with ASA Inc. in Somerset, N.J.

With COLI's new price tag—the potential loss of tax deductions for interest expense—employers would have to be especially careful that they are getting the best deals when they buy COLI policies.

"It will be critical to get cost-effective, low-margin policies," said Watson Wyatt's Mr. George.

The 401(k) plan provisions would amend legislation Congress passed in 1996 designed to make 401(k) plan non-discrimination testing easier for employers. That 1996 law exempts employers—effective next year—from running non-discrimination tests on the plans if they qualify for either of two safe harbors.

Under one of those safe harbors, an employer would have to contribute to the plan each year 3% of compensation for each non-highly compensated employee. Or, under the second safe harbor, an employer would have match 100% of employee contributions, up to the first 3% of compensation, and 50% of employees' contributions, up to the next 2% of compensation.

The administration proposal would make qualifying for the second safe harbor more expensive: it is proposing that employers make a contribution equal to 1% of compensation for lower-paid employees.

So far, there has been only limited corporate interest in the safe harbors, especially among large companies.

That is because employers typically put into the plans much less than they would have to contribute under the safe harbors. As a result, any administrative savings from not having to run non-discrimination tests would be more than offset by the cost of the

additional contributions.

"Clients have expressed an interest in the safe harbors. But when they realize how expensive the safe harbors would be to qualify for, the interest goes away quickly. A mandatory 1% contribution would reduce interest even further," said Pam Scott, a principal with The Kwasha Lipton Group in Fort Lee, N.J.

Still, the safe harbors are attractive to some small employers that have a handful of highly compensated employees and are concerned that the lower-paid employees won't contribute enough for the plans to pass the non-discrimination tests. When that happens, the amount of money highly compensated employees can contribute has to be cut back significantly.

In such situations, qualifying for either safe harbor—even with a mandatory 1% employer contribution for the second safe harbor—might allow highly compensated employees to put in more than they now could if the plans had to meet the non-discrimination tests, noted Gary Blank, a retirement plan consultant in San Francisco.

On the other hand, notes Mr. Blank, employers—fearful that the proposed change to the 401(k) safe harbors would be the first of others yet to come—might be apprehensive of setting up plans to qualify for the safe harbors.

"What this industry needs is a little benign neglect," he said.

The other 401(k) plan change involves changing the definition of highly compensated employees for non-discrimination testing purposes. Under current law, highly compensated employees are defined as 5% shareholders or employees earning more than \$80,000. Employers can opt for a rule under which highly compensated employees are those earning more than \$80,000 a year as long as those employees are among the

top-paid 20% of the workforce.

Under the proposed change, highly compensated employees would be only 5% shareholders or employees earning \$80,000, regardless of how their compensation compared with others in the company.

That change would hurt higher-paid employees, such as those earning between \$80,000 and \$100,000 working at companies such as investment banks. They now might be considered non-highly compensated employees if they don't fall in the top 20% of compensation category.

As non-highly compensated employees, those higher-paid—but not highest-paid—employees can contribute as much as the plan allows without being limited by how much the lower-paid contribute to a plan.

The proposed budget also would amend a provision in a 1986 tax law affecting tax deductions that property/casualty insurers can take for contributions to loss reserves.

Under the 1986 law, insurers must reduce deductions for reserves by 15% of income earned on tax-exempt bonds.

For example, if an insurer

earned \$10 million in interest on tax-exempt bonds and intended to take a \$100 million deduction for reserves, its deduction for the contributions to reserves would be reduced by \$1.5 million. Under the administration proposal, the so-called proration percentage would be increased to 30%, a change—depending on insurers' investment strategy—that could boost industry taxes by \$400 million over the next five years.

Such a change would result in a "significant tax hit to an industry that's already paying its fair share of taxes," said Steve Broadie, vp-tax and finance for the Alliance of American Insurers in Schaumburg, Ill.

Still, in light of the competitive market, some experts question if higher taxes would mean insurers would try to pass those costs on to buyers.

Instead, insurers might look at other investments to maximize their yields, said Joseph Jordan, national director of insurance and tax services at KPMG Peat Marwick L.L.P. in New York.

Washington Editor Mark A. Hofmann contributed to this story.

Superfund reform unlikely in '98: Lott

By MARK A. HOFMANN

WASHINGTON—The Senate is not likely to pass Superfund reform legislation this year, according to a lawmaker who ought to know: Senate Majority Leader Trent Lott, R-Miss.

The outlook also is doubtful for approval of the \$368.5 billion global settlement between cigarette makers and state attorneys general seeking compensation for smoking-related Medicaid costs in return for granting tobacco companies immunity from class-action lawsuits, said Sen. Lott. Sen. Lott offered his assessment of the legislative outlook to the annual legislative conference of the Council of Insurance Agents & Brokers last week in Washington.

But tort reform should not be written off as lost, he said. The senator said he and other tort reform advocates have learned something from President Clinton, who failed to push comprehensive health care reform through Congress in 1994 but who has since been successful in achieving incremental reforms by taking the matter "one salami slice at a time."

Tort reform advocates will do the same by tackling such matters as a countrywide no-fault auto insurance system and progressing to other aspects of legal reform, said Sen. Lott. Reform advocates will try to enact as much product liability legislation as they can, said Sen. Lott, though he did not put a timetable on that matter. He also expressed support for instituting some sort of "loser-pays" rule to deter frivolous lawsuits.

"It's an idea whose time has come," he said.

But the senator made clear that Superfund reform, as much as he would like to see it enacted, appears unlikely during the current congressional session. Although the current Superfund system "has become a cookie jar for lawyers," there does not appear to be enough support in the Senate for significant reform before Congress recesses for the year in early October, he said.

However, hours after making that comment, Sen. Lott sent a letter clarifying his Superfund position to Sen. Robert Smith, R-N.H. Sen. Smith is chief architect of the Republican leadership's Superfund reform bill, S.8.

Sen. Lott said in his letter: "I remain committed to Superfund reform, and will continue to support your efforts to bring the bill to legislative closure. My comments today before the Council of Insurance Agents & Brokers reflected

my frustration with the administration's unwillingness to hold a serious discussion on this issue. Without the administration's engagement,



Sen. Lott

Congress' ability to enact Superfund reform will be very difficult. However, no one should doubt my desire and dedication to finding a solution to this impasse."

The proposed tobacco settlement also appears unlikely to be enacted this year, he said. Sen. Lott says he personally thinks the settlement is "in the best interests of the country," but added, "if you go down a list," anyone can find several things about the proposal that he or she doesn't like. As a result, the political center ground necessary for the proposal's enactment into law has grown very narrow, he said.

"Maybe it will happen, but the president has to get down under the radar" and sit down with Congress to push the matter forward, he said.

Regarding the Patient Access to Responsible Care Act, or PARCA, Sen. Lott said that while managed care companies should address questions such as making medical decisions based on cost and other matters, he opposes the sweeping changes that PARCA would make and supports market-oriented reform instead. **BI**

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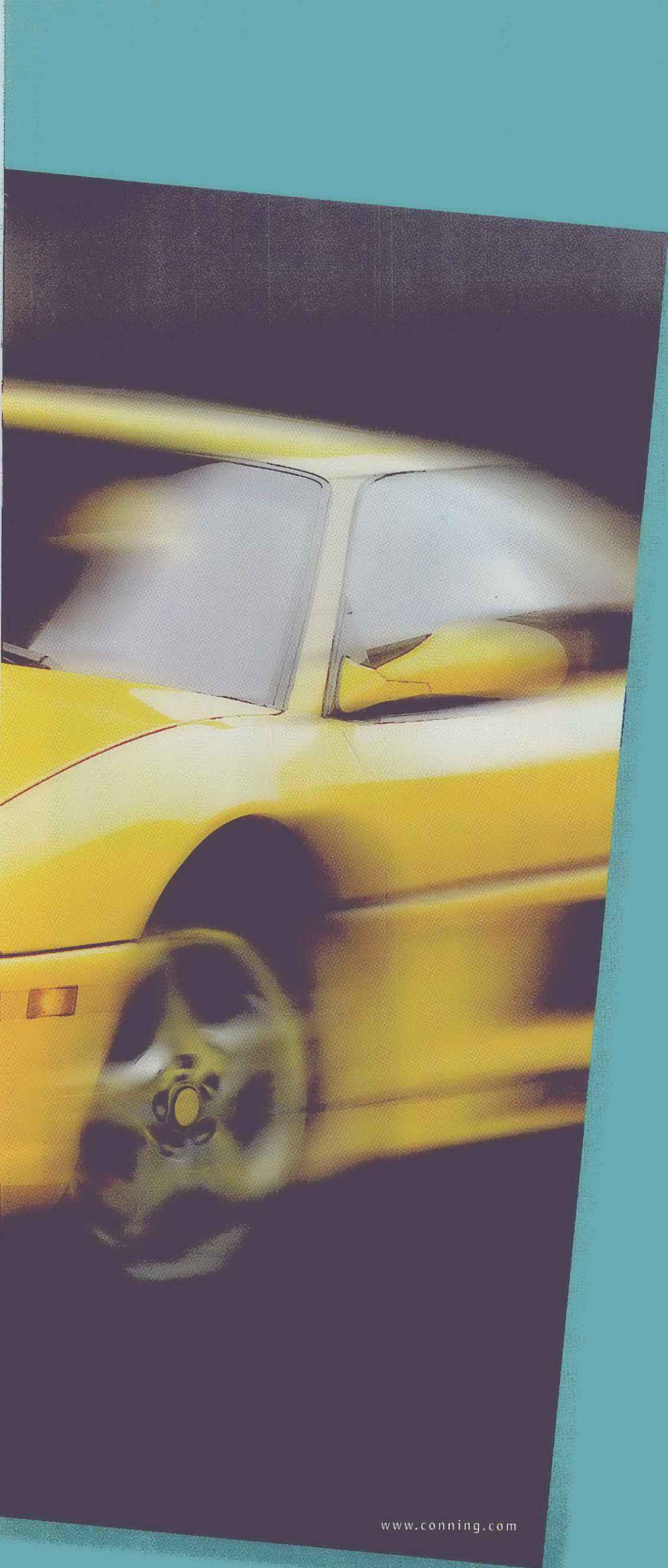
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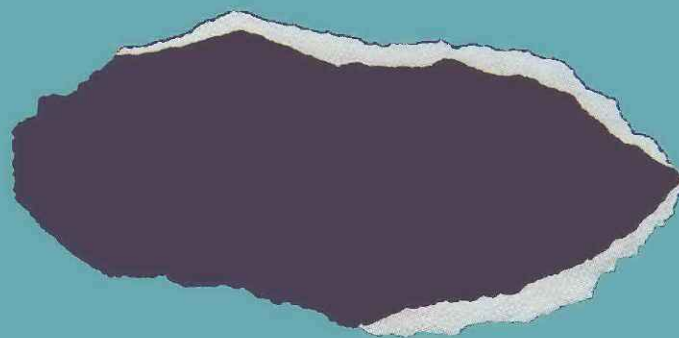




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ASK A CASUALTY ACTUARY

Q

Is there any reasonably priced software available that could enable us to perform a risk analysis?

A

Yes. I use two spreadsheet add-in programs to analyze risk: @RISK, with its companion, Best Fit, and Crystal Ball. In my opinion, both are outstanding products. They are powerful, efficient and fun to use. And their cost is reasonable.

Spreadsheets have two serious

limitations:

- Only one spreadsheet cell can be changed at a time. This makes determining the full range of possible outcomes difficult, if not impossible.
- Any "what-if" analysis ends up with single-point estimates that don't indicate the chances of any given outcome occurring. While such estimates might tell you what is possible, they won't tell you what is probable.

What these two spreadsheet programs do is fairly revolutionary—for those whose purpose is to assess risk. First, they enable the user to change any cell in an Excel or Lotus 1-2-3 spreadsheet into one of a wide range of probability distributions. Instead of a single value or a formula, you have a bell-shaped, i.e., normal, curve or some other distribution that summarizes what you believe are the chances that any one of a range of values will occur.

Second, they enable the user to change any cell or any number of cells into forecast or outcome cells, each of which will contain the results of a computer simulation. These results appear as a histogram, or a bar graph showing the probability that outcomes will fall within various ranges.

Let's take a simple example. Suppose you want to estimate the likelihood that total losses for 1998 will fall within various ranges.

You set up a simple model where 1998 losses are the product of losses per \$100 of payroll and of projected payroll. In your spreadsheet you designate cell D5 for the forecast loss rate, D6 for projected payroll and D7 for total 1998 losses. Obviously, the formula, $D5 \times D6$ goes into cell D7. The primitive approach to estimating how much 1998 losses might vary is to successively enter different values into D5 and D6 and note how much D7 changes and where most of the outcomes fall. This approach leaves a lot to be desired.

Let's look at how we would tackle this problem with one of these risk analysis spreadsheet add-ins. First, we gather past data on how much loss rates have varied over the last 10 years. We conclude that these rates appear to conform to a bell-shaped curve with a mean of \$4.10 per \$100 of payroll and a standard deviation of \$0.43. We query the key people regarding the range of possible values for 1998 payroll and conclude that it is equally likely that payroll could be any value between \$102 million and \$104 million.

What you want to know is the likelihood of occurrence of the full range of possible values for total losses for the next fiscal year. With a few mouse clicks and number entries using one of these add-ins, you insert a bell-shaped curve into the loss rate cell (D5) and a uniform probability distribution into the payroll cell (D6). You tell the add-in that you want D7 to be a forecast cell. It then uses a process called Monte Carlo simulation to generate a series of possible outcomes for 1998 losses. It also compiles the likelihood of each of these outcomes occurring and presents this in a histogram.

What has happened is that you have moved beyond

what-if analysis and have a statistical picture of the range of possibilities resulting from your assumptions. Either add-in also gives a wide variety of additional information, such as some esoteric statistics and tables that indicate how likely it is that 1998 losses will be less than \$4 million or \$4.5 million or \$5 million.

For most people, the latter will be the most helpful. You now have a better fix on what the chances are that 1998 losses will be more than \$5 million. If that probability is too high—e.g., 5%—you might want to try to obtain some aggregate stop-loss coverage. If you want to pursue this, with a bit more work with your add-in you can estimate what expected losses exceeding \$5 million would be and so get an idea of whether your premium quotation is reasonable.

In performing a Monte Carlo simulation, the add-in works within its spreadsheet environment to generate, for example, 1,000 estimates of what 1998 losses might be. In coming up with each estimate, the add-in first generates a random number between zero and

While estimates from a 'what-if' spreadsheet analysis might tell you what is possible, they won't tell you what is probable.

one and translates that into a specific value for the loss rate based on the bell-shaped curve you specified. It does the same thing, with an entirely different random number, for the payroll cell. It then stores the resulting product as one forecast of 1998 losses. It does this 1,000 times and then ranks the forecasts.

These ranked forecasts form the basis for the histogram and the table of values at different probabilities or confidence levels. The above example is very simplistic, but it does illustrate the kinds of things that can be done with risk analysis software.

Much of the work needed to make the above model more realistic will have to do with making the input assumptions more realistic. For example, it would be more accurate to have fit a bell-shaped curve to the logs of the loss rates, rather than to the loss rates themselves. You can do this easily by having the add-in fit a log-normal distribution to historical loss rates. This is a more accurate approach because the size of casualty claims is such that the logs of their sizes tend to fit a bell-shaped curve. This means there is a lingering chance of very large claims occurring. Further investigation might also suggest a better assumption for 1998 payroll. With either of these add-ins, it is easy to insert more complicated assumptions. Analysis of the range of forecasts is done just as easily as if very simple assumptions had been input.

What I have described is only the beginning of what can be done with risk analysis software. Here are some more advanced things that can be done:

Efficient assistance in defining cell assumptions. They will enable the user, when trying to define the parameters for the probability distribution of any cell, to first review fits of a wide range of probability distributions to a given range of data points elsewhere in the workbook. These distributions are presented in order of how well they fit the data. They will quickly display the proximity of the fit of each probability distribution to the original data in terms of differences between the cumulative distributions or individual differences between density functions.

Correlated distributions. They permit the user to define the parameters of any cell's probability distribution by a specified correlation to the values in any other specified cell. EXCEL and Lotus 1-2-3 already have custom functions that will measure the correlation between different data sets.

Custom or general distributions. They facilitate

defining a wide range of custom or general distributions. Such distributions can be defined as a series of discrete values and associated probabilities that can be entered one by one or all at once by referencing a range within a spreadsheet.

Copying distributions to other cells. They let the user copy any cell's probability distribution into any number of other cells.

Dynamic linking. They will allow the user to link the parameters of any cell's probability distribution to the values in another cell, which can also be a probability distribution. This enables the user to deal with uncertainty about the parameters of each assumed probability distribution.

Storing of simulated values. They create a separate worksheet with all of the values of the aggregate distribution, ranked from smallest to largest.

Allowing outcomes to define a custom distribution. The discrete, ranked results of a simulation can be fed quickly into a custom distribution by referencing the range of cells containing those simulated outcomes. This would be useful in determining the combined bottom-line impacts of several different types of claims.

Availability of macro programs to streamline simulations. @RISK permits direct use of Excel macros to control most of its operations. Crystal Ball sells a separate product, the Advanced Macro Interface, which allows the same uses of macros in running simulations.

Proper usage of these add-ins in deriving reasonable forecasts can often require a significant level of knowledge in probability and statistics. In developing forecasts of total losses, it is also important to have a thorough knowledge of the behavior of claim size distributions and claim frequency distributions.

If you do not have this kind of expertise, one approach is to set up a basic model of what you are trying to forecast and have an experienced statistician/risk analyst or actuary who is also proficient in one of these add-ins to review your model and specify refinements. With the ability today to send spreadsheet files via electronic mail, this kind of review can be performed almost as easily long-distance as it can in person.

If you want more information about these spreadsheet add-ins, I suggest calling Palisade Corp., 800-432-7475, regarding @RISK and Best Fit, and Decisioneering, 800-289-2550, regarding Crystal Ball. **BI**

Would you like advice from an experienced colleague on a risk management, benefits management or actuarial problem? Four quarterly features in the Perspective section of Business Insurance can give you some answers.

Ask A Benefit Manager, Ask A Risk Manager, Ask A Benefit Actuary and Ask A Casualty Actuary answer written questions from readers on risk and benefits management issues and actuarial problems.

This month's column on actuarial issues in the casualty



Mr. Sherman

field was written by Richard E. Sherman, president of Richard E. Sherman & Associates Inc. in Ashland, Ore. Dennis J. Nirtaut, managing director of compensation and benefits for Andersen Worldwide S.C. in Chicago, answers questions for benefit managers. Christopher E. Mandel, director of risk management at PepsiCo Restaurant Services Group in Louisville, Ky., answers

questions on risk management issues. William J. Miner, an actuary with Watson Wyatt Worldwide in Chicago, answers actuarial questions on benefits issues.

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.

Auditors

Continued from page 3
civil fines levied by OSHA (BI, Oct. 6, 1997).

Salvatore Bonfiglio, manager-environmental, health and safety audit program for Warren, N.J.-based Hoechst Corp., offered a half dozen objections to that facet of the SAFE Act as he testified on behalf of the Voluntary Protection Programs Participants Assn. The Falls Church, Va.-based group represents employers and employees of companies that participate in OSHA's Voluntary Protection Program.

Companies participating in the OSHA program are removed from the agency's programmed inspection list. Those companies have to undergo an extensive evaluation by OSHA and have written health and safety programs and widespread employee involvement, among other things.

In his written testimony, Mr. Bonfiglio noted that VPP sites report accident and illness rates on average 50% below industry norms. Yet even VPP participants still face civil penalties for violations.

Mr. Bonfiglio praised third-party consultants and noted that he has acted in that capacity in the past. The VPPPA, however, opposes giving third-party consultants the authority

to exempt facilities from civil fines, he said.

He said the VPPPA's concerns are: The system would create a clear conflict of interest; some people eligible to conduct audits would not necessarily have expertise in all necessary areas and would not be required to bring in other specialists as necessary; the system could have a detrimental impact on existing in-house safety programs; the bill would allow a site to become exempt from civil penalties even before the violations had been corrected; there would be no requirement that facilities would have to address imminent hazards; and that small businesses would balk at the price of hiring a safety consultant.

Mr. Bonfiglio's concerns were not shared by other witnesses, the bulk of whom praised the idea of using third-party auditors as more efficient and effective in promoting workplace safety than relying solely on OSHA inspectors, who may never visit a particular workplace in decades or—if the federal government's own estimates are correct—almost two centuries.

One witness credited a third-party auditor with saving his company thousands of dollars annually in workers compensation costs. Bob Cornell, director-dealer operations and environmental regulations for McKeesport, Pa.-based Mon Valley

Petroleum Inc., said a comprehensive audit by Pittsburgh-based Three Rivers Health and Safety in 1995 pinpointed hazards that Mon Valley began addressing immediately.

Mr. Cornell, appearing on behalf of the National Assn. of Manufacturers, noted that from 1992 to 1994, Mon Valley had filed 19 workers compensation claims and suffered 70 lost workdays among its approximately 100 employees. From 1995 through last year, Mon Valley recorded no lost workdays and only 13 workers comp claims. The company's workers comp premiums dropped to \$31,000 in 1998 from more than \$37,000 in 1994, he said.

"One very good way to encourage especially small companies to focus on their employees' safety is to provide incentives for them to use a third-party safety professional, who can provide needed direction and leadership," he said.

But insurers and risk managers, while supportive of the general thrust of the SAFE Act, have questions about the third-party audit provision.

"Our concern is the type of liability it may expose our companies to," said Tamera R. Velasquez, counsel in the Washington office of the Alliance of American Insurers, a Schaumburg, Ill.-based trade group that represents many workers comp insurers. The Alliance did not testify before the Small

Business Committee.

"As we see the third-party audit provisions, we see it as an attempt to avoid the threatened expense of unreasonable OSHA inspections by reaching out to the private market. Our member companies consult with business every day in addressing workplace safety problems. To the extent that third-party safety consultants advance that process, we would support the measure. But we see a number of hurdles with regard to the third-party audit, including litigation issues," she said.

Litigation issues could arise if businesses rely more heavily on insurers' consultants under the third-party auditor provisions.

Ms. Velasquez said Alliance member companies also feel some concern over what type of follow-up the third-party audit provision would entail. "We definitely don't want to be in a certification capacity," she said.

David Farmer, senior vp-federal affairs in the Alliance's Washington office, recently noted during a Washington press briefing that insurers always are considered potential "deep pockets" targets in civil litigation.

The Risk & Insurance Management Society Inc. shares some of the Alliance's concerns, said Lance Ewing, chairman of the RIMS health and safety committee and loss control administrator for the Philadelphia

School District.

"The RIMS health and safety committee discussed this a couple of weeks ago. One of the concerns that was raised was the issue that was raised by the Alliance of American Insurers, which is audit privilege. Most risk managers and safety managers have a concern about who will be able to access the findings," he said.

"Overall, at first blush, it appears like a good idea. It will get companies focused on safety, but like with all governmental programs, there are strings attached. And one of the questions that was raised is what criteria would be set for certifying these third-party auditors."

Mr. Ewing said the provision also raises a cost issue for medium and small companies: first the cost of hiring consultants, and then the cost of rectifying problems.

To the risk manager of a small or medium-sized organization, "where priorities are placed will be dictated by cost," he said.

Mr. Ewing said he personally would "like to see OSHA increase its efforts to enhance the VPP program as well as to expand the consultation program, both of which have proven to be extremely successful."

He added that RIMS is setting up a meeting with OSHA Administrator Charles Jeffress for later this year to discuss a variety of issues. **BI**

Prior acts

Continued from page 1
up to a total limit of \$15 million above the \$3 million.

The policy's known prior acts exclusion barred coverage for acts known "prior to the effective date of this agreement. And if this agreement is a renewal, the effective date is that of the earliest preceding agreement from which we have continuously provided the protection provided by this agreement," court papers show.

MetPath, now known as Quest

Diagnostics, had as many as 74 companies covered under the policies.

MML was added to the coverage June 8, 1994, when MetPath acquired it.

Prior to the purchase, MML had been aware that it had failed to diagnose three patients with cancer, and it had been approached by their attorneys seeking documentation on the testing MML had performed, court papers say.

MML informed MetPath of one potential claim during due diligence prior to the purchase. MetPath informed St. Paul of all three poten-

tial claims shortly after the purchase of MML.

In July 1995, St. Paul wrote to MetPath, issuing a reservation of rights to withdraw from the defense of the three claims based upon evidence of MML's knowledge of the claims prior to the purchase. In August 1996, St. Paul did withdraw from the defense.

In court, MetPath argued that the known prior acts exclusion should only apply to claims if they were known about prior to April 1, 1989, when St. Paul first issued coverage for MetPath.

"They could not have known about the three underlying claims before April 1, 1989, the defendants maintain, because the misdiagnosis had not yet occurred," MetPath said in court filings.

St. Paul argued that the final policy could not be construed as a renewal policy in relation to MML, which was not included on the policy until June 1994.

"The court finds that each side has advanced a reasonable interpretation of the known prior acts exclusion, and therefore, it is ambiguous. Neither the language in the exclusion itself nor in the policy as a whole precludes either interpretation, and neither interpretation strains the plain meaning of the words in the exclusion," Judge Kyle wrote.

If St. Paul had wanted to ensure that the effective date for purposes of the exclusion was the date MML was added to the policy, it should have clearly worded the policy to say that, the judge wrote.

"Because the known prior acts exclusion is ambiguous, the court must give it the meaning that favors finding coverage," he wrote.

St. Paul said it is reviewing the ruling and has not decided whether to appeal. The insurer would not comment on whether it would change the wording of its exclusion based on the ruling, as it considers the matter still under legal review.

St. Paul Fire & Marine Insurance Co. and St. Paul Mercury Insurance Co. vs. MetPath Inc., Maryland Medical Laboratory Inc. and Corning Clinical Laboratories Inc., as the successor of Maryland Medical Laboratory Inc., U.S. District Court, District of Minnesota, Third Division; Civil No. 3-96-703/ RHK/JMM.

Settle

Continued from page 2

Toward this end, the state required hospitals and BC/BS of Massachusetts annually to analyze whether they owed one another money, as calculated by a state-mandated formula.

The Blues plan for four years received payments from hospitals but deposited them in its reserves instead of sharing them with plan sponsors.

According to the Department of Labor, BC/BS of Massachusetts was obliged to refund a "proportionate share" of these bonuses to every ERISA-covered plan for which it had an administrative service contract or cost reimbursement contract.

The company also failed to reduce members' copayments to match the plan's actual costs. Copayments were based on a fixed percentage of non-discounted hospital charges instead of the discounted rate the Blues plan actually paid, officials said.

The federal government sued in 1995 because the company refused to give rebates to health plans voluntarily, officials said.

Although about 1,000 health plans are self-insured and ERISA-covered, probably only 500 or so will get refunds, Ms. Elias said. The settlement between the insurer and the Labor Department specifies that only plans entitled to \$1,000 or more in reimbursements will get them. The amount of refund money a plan gets will be proportional to its hospital claims.

To receive their money, plans must agree not to sue the Blues plan themselves.

Plan participants also will benefit from the settlement, at least in a modest way. The agreement mandates that 5% of total refunds to plan sponsors, or \$500,000, must be set aside to directly benefit either those who were members of the plan during the years in question or, if they cannot be found, present plan members. The consent decree suggests that "acceptable distribution methods" could include reductions in member employee payroll contribution, either once or over a period of time, or improvement in plan benefits.

Failure to distribute the refunds could lead to federal investigation or BC/BS of Massachusetts' vulnerability to claims by plan participants, the agreement states.

The settlement is "fair and reasonable under the circumstances," said Ms. Elias. Federal authorities, since starting a major probe five years ago of whether money was being withheld in the form of provider discounts from self-insured health plans, have completed 118 investigations and recovered more than \$35 million, according to the Labor Department. Ms. Elias would not comment on whether any other Blues plans are under investigation.

Calling the agreement "a fair and equitable settlement," a spokeswoman for BC/BS of Massachusetts said the plan set aside a specific reserve to cover the refund in 1995.

The only other Blues plan sued by the Department of Labor over hospital discounts was Memphis, Tenn.-based Blue Cross & Blue Shield of Memphis. In that case, the insurer signed a consent order to refund \$2 million to between 14 and 17 plan sponsors in 1994, Ms. Elias said.

The number of employers in that instance was low enough that the Blues plan was permitted to negotiate refunds individually with each plan and had the option of requesting binding arbitration.

Various non-Blues plans recently have paid plan sponsors money in circumstances similar to that of the Massachusetts plan, some of them to head off potential litigation.

Newark, N.J.-based Prudential Insurance Co. in 1996 determined it had shortchanged about 450 administrative services clients money that Prudential had received through capitation and negotiated fee arrangements with providers, a Prudential spokesman said. The period during which the accounts failed to be reconciled, and money was not refunded to employers, was 1990 to 1996, he said.

The insurer has refunded or credited the great majority of the money voluntarily, with the knowledge of the Labor Department and with auditing assistance from New York-based Coopers & Lybrand L.L.P., he said. He declined to say how much has been paid to plan sponsors. **BI**

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INTERNATIONAL

Global Briefs

Runoff to pay claims in full

By EDWIN UNSWORTH

LONDON—The London High Court has approved the insurance market's first scheme of arrangement for winding up a solvent insurer that will pay all creditors in full.

HIR (UK) Ltd. now has a year from the Feb. 2 ruling to meet all creditors' claims. HIR is a London-based, non-marine direct and facultative underwriter, writing business worldwide, excluding the United States. It has been in runoff since July 1990.

Ian Marshall, a director of London-based reinsurance consultants Chilington Intermediaries Ltd., has been managing the orderly runoff of HIR's

debts since the end of 1990.

Speaking the day after the High Court gave the final go-ahead for HIR's scheme of arrangement for a solvent company, he said that while the number of insurance companies becoming insolvent and going into runoff has multiplied over the past decade, it has been a long-term process up until now. "In the absence of a mechanism such as the solvent scheme of arrangement, it's very difficult to know when you've paid your last claim and can close your doors. HIR is the first company to find the way out the other end," Mr. Marshall said.

Under the terms of the scheme of arrangement, HIR's creditors will be paid in full but

first must submit final claims and agree on settlements over the coming year. Chilington has appointed two major loss adjusters to arbitrate disputed cases.

Many parties involved in insurance insolvency believe voluntary schemes of arrangement will be used more often in the future.

Mr. Marshall said Chilington is involved in research on other schemes, though it doesn't have any ready for creditors' approval.

Last week, the Scottish & Commonwealth Insurance Co. of Bermuda was arranging such a scheme.

Joe Bannister, a business restructuring partner at London-

based law firm Lovell White Durrant, said he thinks schemes of arrangement for solvent companies are "an innovative and exciting development." He said a number of major accounting and law firms, including Lovell White Durrant, are actively considering the concept for dealing with the runoff of non-life insurance companies.

Mr. Bannister expects to see more such schemes "coming through the pipeline," though he emphasizes they are not going to be appropriate in all cases. Among the two main criteria that must be met are, first, that the company being run off does not have too many long-tail

See Solvency on next page

Eye capital markets carefully: Experts

By MARIA KIELMAS

LYON, France—The development of capital market solutions has given risk managers more options for financing global political and commercial risks, but they must consider each product carefully, banking and insurance industry experts say.

A panel of speakers at a workshop during the Rencontres AMRAE 1998 in Lyon by the French risk management association, Assn. pour le Management des Risques et des Assurances de l'Entreprise, discussed examples of how risk securitization and other products combining traditional insurance may be used to cover potential losses.

While some capital market products enable companies to hedge risks for which no insurance is available, risk managers must weigh those products' cost

and other considerations, the speakers advised.

Luc Gagnon, senior vp at Centre Re Solutions in Dublin, Ireland, a unit of Zurich Insurance Group, spoke on the development of hybrid products and policies with double and triple coverage triggers.

For example, a double-trigger policy may link property insurance for an oil drilling platform with a guarantee on the oil price. This is based on the thinking that the oil price and platform damage are independent risks, said Mr. Gagnon, whose company offers such products. While property damage and a drop in the oil price below a stipulated level would trigger coverage, no guarantee would apply if the oil price remained above that level.

This mechanism reduces insurance costs, provides optimal

See AMRAE on page 19

U.K. report favors self-governance

By MATTHEW MacDERMOTT

LONDON—A new report on corporate governance favors self-regulation and is not expected to affect the U.K. directors and officers liability market.

However, any new laws that might arise from an upcoming government review could create more D&O exposures, underwriters say.

The Hampel Committee on Corporate Governance, established in November 1995, released its final report last month. The report follows previous U.K. corporate governance reports by the Cadbury Committee in December 1992 and the Greenbury Committee in July 1995. The committees were established by the Financial Reporting Council, which is jointly funded by the U.K. government and private sector to review accounting and reporting standards, as a response to corporate failures and financial scandals in the early 1990s.

The Hampel Committee was chaired by Sir Ronald Hampel, chairman of Imperial Chemical Industries P.L.C. of London, and included attorneys, consultants and directors from British companies.

The new report says there is "no need for a permanent committee on corporate governance" and says directors should improve their accountability to shareholders by applying the "broad principles of corporate governance" outlined in the previous reports.

Hampel recommendations, which are non-binding, include narrative accounts in company annual reports of how corporate governance principles are applied, and readiness by directors to explain their governance policies, including justifying departure

See D&O on next page

Ski lift accident may spur claims

CAVALESE, Italy—Some insurance coverage is expected to respond to claims from a fatal cable car accident at an Italian ski resort involving a U.S. military plane.

The accident occurred Feb. 3 when a low-flying EA-6B Grumman Prowler surveillance aircraft severed a cable on Mount Cermis near Cavalese in northern Italy. A cable car carrying 20 people plummeted several hundred feet, killing all 20. The plane, carrying a crew of four, landed safely at the U.S. Air Force Base in Aviano, Italy, 15 minutes after the accident.

Although the extent of commercial losses is unknown, an insurance executive said Italian insurers can expect business interruption and loss-of-earnings claims as a result of the accident.

U.S. Air Force authorities said a total of \$100,000 in initial compensation will go to the 20 victims' families. Of the 20 victims, eight were German, five Belgian, three Italian, two Polish, one Dutch and one Austrian.

Benito Pagnanelli, deputy manager of Trieste, Italy-based

Assicurazioni Generali S.p.A., said he thinks the compensation will come in two parts: first for the victims families and then for business interruption and loss of earnings of the cable car company and other businesses in the tourist region. The ski lift is owned jointly by the municipality of Cavalese and private businesses in the area, Mr. Pagnanelli said.

Local officials could not be reached for comment on insurance arrangements late last week.

Mr. Pagnanelli said he thinks the eventual settlement of compensation both for the victims and the businesses will come through negotiations between the two governments.

"There will be negotiations between the U.S. and Italian governments. Then we have claims for business interruption in an area with many tourists. We don't know how many indirect claims there will be," Mr. Pagnanelli said.

A military investigation is being conducted. U.S. military authorities were unable to say why the plane was flying below the level of the cable.

—By Maria Kielmas



Business interruption and loss-of-earnings claims are expected following an accident in which 20 people in a cable car in Italy died when a U.S. military plane severed a cable.

AP/WIDE WORLD PHOTOS

Solvency

Continued from previous page
liabilities, making it difficult to quantify outstanding claims. And second, it has to be demonstrable that the company has enough money, from the company's owners or reinsurance recoveries, to meet anticipated claims.

Mr. Marshall is confident HIR has adequately demonstrated it meets these criteria. The capital of the company well exceeds the known losses, he says.

HIR was set up in 1979 by Germany's Volksfuersorge Group. Over 11 years of active underwriting, it wrote slightly more than 13,000 policies, covering property and fire business, bloodstock, personal accident and travel. In 1991, while still in runoff, German insurer Hamburger Internationale Ruckversicherungs A.G. acquired it.

With £10 million (\$16.5 million) of authorized share capital locked in an unproductive investment and runoff costs proportionately increasing in significance as claims tailed off, the new owners were eager to resolve the situation rather than keep HIR in runoff indefinitely. In 1996 only five new claims, totaling less than £3,500 (\$5,763), were made.

So Chilington, accounting firm Robson

Rhodes and law firm Davies Arnold Cooper were asked to work together to consider the insurance, accounting and legal sides to find a way to wind up HIR. Together they came up with the scheme of arrangement, which under the U.K. Companies Act 1985 constitutes a binding agreement between a company and at least 75% of its creditors by value, and that has been approved by the High Court. In HIR's case, it was to be unique in becoming the country's first scheme of arrangement for a solvent company promising 100% payment to claimants.

Last month, HIR creditors representing more than 92% of estimated sums owed, voted to accept the scheme of arrangement. The Department of Trade and Industry, which regulated the insurance industry, also approved the scheme. Beginning this year, however, the U.K. Treasury has taken over the DTT's insurance regulatory duties. Any future schemes must be approved by the Treasury and the High Court.

Mr. Marshall remarked that it is a satisfactory solution because "it's a good way to make sure we can say at some point we can pay the last claim."

The Assn. of British Insurers would not comment on an individual solvency case, but referring to the scheme of arrangement, a spokesman said, "Obviously, anything that protects policyholders is good news." **B**

D&O

Continued from previous page
from best practice.

Only hours after the publication of the Hampel report, Britain's Trade and Industry secretary, Margaret Beckett, said she would be making a formal response to the report by including corporate governance in a consultative paper on U.K. company law due for release this spring.

Ms. Beckett has not indicated whether legislation will be introduced.

The Assn. of British Insurers, the National Assn. of Pension Funds and the U.K. Institute of Directors welcomed the Hampel report's self-regulatory approach as further encouraging good corporate governance practice.

But Harold Izzard, director of the U.K. Institute of Internal Auditors, said the Hampel report has "nothing substantial in it" and said directors would see it as a message to "carry on as you are."

The IIA promotes and develops the practice of internal auditing. Mr. Izzard favors tougher regulation on companies' internal reporting procedures, particularly regarding the reporting line between auditors and audit committees.

David Stevenson, a corporate law attorney in the Birmingham office of London-based law firm Eversheds, said he thinks the report's "broad and

flexible approach" had "ironically diluted corporate governance principles, leaving greater scope for companies to shirk disclosure responsibilities." Mr. Stevenson said greater accountability would only arise from stricter legal guidelines.

But Mark Watson, Institute of Directors corporate governance executive, said "too much prescription can become too much of a burden."

He said it is now up to company directors to "sensibly interpret" the broad thrust of the report as the British government is keeping a "watching brief" on corporate governance regulation.

Alan Telford, D&O underwriting manager for London-based Royal & Sun Alliance Insurance Group P.L.C., said it is significant that the government is "looking at the whole aspect of corporate governance."

"If they introduce statutory requirements, we could pick up some claims," he said.

Mr. Telford said the Hampel report will have little effect on the D&O market, as it is based on voluntary guidelines.

Reg Brown, underwriter of Lloyd's of London syndicate 782, which specializes in D&O cover and is managed by Octavian Syndicate Management Ltd., said the Hampel report caused no market reaction. Mr. Brown said statutory guidelines could potentially create more risk for directors. "The more regulations there are, the more likely you are to catch people out," he said. **B**

The Professional Marketplace

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May 26, 1997 Issue, as
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BPA Publisher's Statement

INTERNATIONAL

AMRAE

Continued from page 17

coverage and leaves the value of company assets intact after a loss, he said. The policy could be included within any oil company's existing oil price-hedging program, Mr. Gagnon said.

While products such as Chicago Board of Trade options and multiyear, multiline policies and credit derivatives are becoming common in the U.S. market, they are only debuting in Europe, Mr. Gagnon noted.

The advantage of derivatives, he said, is that maturities can range between a few months and several years for those risks deemed uninsurable in the conventional insurance market, such as certain liability exposures.

Credit derivatives, such as default swaps, spread options and credit-linked notes, allow the insured to benefit from a global capital market with \$200 billion to \$300 billion in capacity for those types of instruments.

In addition, companies that buy

credit risk derivatives can decrease their credit risk without affecting their cash flow, Mr. Gagnon explained.

Thierry Pierson, head of studies at the Securitization Markets Directorate in the Paris-based bank Credit Lyonnais, spoke on how a company may issue bonds as an insurance tool to cover potential losses on an investment portfolio, for example.

Investors in such a bond are exposed to two risks of the issuer: the credit risk, or ability to pay the interest, and the performance risk inherent in the company's business.

However, a European company must strive to issue an AAA-rated bond, as it is difficult, if not impossible, to place a BBB-rated bond on the European market. While the U.S. market for cat bonds and other such instruments has grown to \$2 billion, "Europe is far behind the U.S. in this sector," Mr. Pierson said.

But, "what if the interest paid (on the bond) is insufficient" to pay any losses? Mr. Pierson asked. The in-

vestor loses. The securitization process means that the insured—or bond issuer—will pay investors less if the underwriting result falls, though the issuer promises to pay a bonus if underwriting results are good.

The costs of this are substantially higher than conventional insurance. The policyholder also is dependent on the rating agency perception of the investment. The higher a company is rated above the Paris Interbank Offering Rate, the greater the credit risk.

Session moderator Mireille Darrhort, head of the Financial Risks Insurance department at Paris-based telecommunications and energy company Alcatel Alsthom S.A., said, "For exporters, this (securitization) is a system like any other to cover risks which you can't cover on the insurance market."

Finding political risk coverage can be difficult, as Marie-Gemma Dequae, risk manager at Belgian wire and steel products manufacturer Groupe Bekaert S.A., found out. The risk has increased given globalization

of assets, opening of world markets and more international treaties and commercial agreements, she said.

Bekaert has investments in China, Japan, Turkey, Europe and Latin America. The company reported 1996 consolidated profits of 2.27 billion Belgian francs (\$60.4 million) on sales of 61.8 billion Belgian francs (\$1.64 billion). Instead of a country-by-country political risk cover, the company wanted a global policy. Due to the need for corporate confidentiality, Ms. Dequae gave only an outline of what was offered. She did not speak on Bekaert's coverage arrangements.

The conventional insurance market offered a five-year coverage in layers excess of \$10 million. But there was a problem with insufficient capacity for certain countries, she explained.

The next move was a hybrid solution involving a default swap with a call option, or an option to buy back the product, in case of a loss.

A second alternative was a mixed solution to securitize the risk through issuing a BBB bond, with an element

of reinsurance through a special-purpose reinsurer in Dublin, Ireland, for example. Bekaert would keep a \$100 million retention. The costs of this were nearly double that of the conventional insurance.

The issue here is to know when to pay a higher price to cover the whole portfolio for a longer period or to stay with an incomplete coverage for a shorter period. "This problem is not yet solved," said Ms. Dequae.

Alcatel's Ms. Darrhort, who spends much of her time seeking political risk coverage, said, "It is not a problem with products but a problem with capacity."

"This is a great frustration for a user of the political risk market," she said.

Referring to the higher costs risk managers face when using the capital markets to cover political risks, Ms. Darrhort said: "But the insurance market does not give you such a guarantee, and this is the problem you face. You are left with part of your portfolio uninsured." **BI**

Risk, finance should work together: Exec

By MARIA KIELMAS

LYON, France—Companies that want secure futures should integrate the risk management functions of risk managers and financial officers, an executive said.

"Only a limited number of the risks which companies face are covered in the traditional insurance market," said Thomas Wellauer, chief executive officer of Winterthur Insurance Co., a part of the Credit Suisse Group. He spoke at the sixth annual meeting of the Assn. pour le Management des Risques et des Assurances de l'Entreprises Jan. 14-16 in Lyon.

Mr. Wellauer said insurance companies have developed an integrated system for managing risk, assets and administration. But in the future, he said, these systems will include insurance risks, asset management by banks and administration system of insurers and brokers. This global risk management will come in two main forms:

- Mixed banking-insurance products.
- Securitization of insurance risks.

These risks are limited principally to risks connected with project development. Banks should be involved with risk managers to complete the integration, he said, as those institutions help manage risks connected with the company activities such as

commodity acquisitions, foreign exchange costs and interest charges through instruments such as options, forward sales or swaps.

"The risks which we could qualify as external risks or those risks independent of the company's activity are generally not part of any insurance," Mr. Wellauer noted.

In the case of an Australian oil exploration company, such external risks are oil and gas prices and exchange rates. Such a company would be exposed to fluctuations in commodity prices, which are not covered under conventional insurance.

The financial, insurance and reinsurance markets are converging for three main reasons, noted Mr. Wellauer.

- The rapid integration of capital markets and the creation of new stock market products. This has increased available capital as institu-

tional investors seek new attractive products while efforts continue toward more insurance risk securitization and competition to service the market increases.

- The deregulation of insurance and reinsurance markets. Nevertheless, risks have increased faster than available capacity. Insurance prices fluctuate sharply as do tax advantages of insurance or reinsurance as taxation systems in markets such as Europe change.

- Market players have become more competent and are perfecting their skills on a global scale. While traditional insurance and reinsurance offers some financial options, banks have been creative and are structured to provide innovative new products.

These products range from traditional property/casualty insurance to a unified insurance policy encompassing the risk, tapping the tax advantages of a greater retention on the part of the insured and captive location, to finite structures and protecting liquidity through capital market solutions.

During the same session, Dick Verbeek, chairman of Aon Risk Services Worldwide, said he thinks brokers need to be large enough to capture the global risk markets. **BI**

Risk managers told to embrace technology

By MARIA KIELMAS

LYON, France—Grasping and using technology will be essential to the future success of French risk managers, observers say.

"After the agrarian revolution, the industrial revolution, welcome to the communication revolution," said Thierry Van Santen, director of risk

management at Paris-based food conglomerate Groupe Danone and the outgoing president of the French risk management association, l'Assn. pour le Management des Risques et des

Assurances de l'Entreprises. He spoke at AMRAE's sixth annual meeting Jan. 14-16 in Lyon.

Mr. Van Santen acknowledged AMRAE has been criticized in the past for tackling themes apparently quite removed from a risk manager's everyday worries. But he emphasized, "I don't think it is possible for us to work without taking heed of the great developments in the world around us."

Communication has become the essence of the risk manager's business: data and statistics administration and managing information flow among offices, among different services, with partners, insurers, consultants and brokers, he said. It is also about the corporate risk, security of networks, financial flows and "savoir-faire."

Globalization of production, brand names and capital has spurred a profound change in companies. "After any local accident, the media can alter instantly (financial) institutions' judgment of a company's fundamentals, with consequences of which you are all aware: an attack in image, stock price, management, even civil or criminal lawsuits," he said.

The risk manager's mission is to protect the company's assets globally without hindering the risk-taking strategy that is the essential element of competition.

The difficulties in that are greater for French risk managers because French companies are far behind

their U.S. counterparts in information technology investments.

Mr. Van Santen said France's educational systems is partly to blame, saying it produces a political and business elite opposed to new technology.

In his valedictory speech as AMRAE president, Mr. Van Santen explained how AMRAE's approach has developed since its first conference in 1992 in Bordeaux, a conference that called for greater exchange between French risk managers and their U.S. and U.K. counterparts.

"We have moved from a situation where (risk management) is a question of knowing if a sprinkler is necessary in such and such a location. Tomorrow's issue will be to know if the wealth destruction by some event will have an impact on the judgment of an American pension fund, a Singapore trader or a shareholder association. This mission means that above all we have to develop the means of communication," he said.

Jacques Stern, honorary president of electronics group Bull S.A., expressed concern over whether French companies are prepared for the information revolution. "Only 5% of French companies are prepared for the changes of tomorrow," he said.

Although France has pioneered earlier information technology that is universally available, such as the Minitel information system, which is transmitted via the telephone system, the country lags behind the rest of the world in using the Internet.

Companies also have a problem in training their personnel. "Information technology is one thing; education is another," Mr. Stern said. Mastering the technology requires time. "The price is terms of time is very important," he said.

Above all, companies will have a hard time finding people qualified to understand all aspects of the new information world, he said. The United States dominates the world of information technology, but only several dozen people could honestly be described as the real experts in this field. "The number in France is much, much smaller," Mr. Stern added.

"With these great changes, one needs the capacity to manage the change. The company and society are equally important," he concluded. **BI**

Weaknesses cited in French industry

LYON, France—High costs and low profits are two weaknesses that restrict the French insurance industry's competitiveness internationally, a French insurance association official says.

"French insurance has many winning cards: its technical expertise, professionalism, creativity, the diversity of its distribution networks. It has high solvency margins in sectors such as life insurance. But it also has high costs and inadequate profitability," said Jean Arvis, president of the Federation Francaise des Societes d'Assurances. Mr. Arvis spoke recently at the sixth annual meeting of the Assn. pour le Management des Risques et des Assurances de l'Entreprises in Lyon.

Mergers and acquisitions have stalled French companies' expansion into international markets, Mr. Arvis said.

Provisional results for the financial year 1997 indicate a slowing down in the growth of non-life premiums, reflecting rate cuts and falling underwriting results, Mr. Arvis said.

To compete against global insurance groups, French insurers have to become stronger at home. This is one reason the FFSA opposes a move by the French postal service to sell non-life personal lines insurance, which would compete with many insurers.

The demand for insurance coverage has become the subject of a global negotiation, Mr. Arvis said. Reinsurers are competing with insurers for the same services while new players, such as banks, are entering the market.

But he cautioned insurers against acting as bankers.

—By Maria Kielmas

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Pomeroy

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His ideas stem from lessons he learned as state commissioner of securities, which he regulated four years before being elected as North Dakota's Democratic insurance commis-

sioner in 1992 and 1996.

A major vehicle for improving state regulation of producers is the Insurance Regulatory Information Network, a nonprofit NAIC affiliate that is developing a producer database. It now includes information from 19 states and about 1 million producers, or about 70% of the U.S. total.

Sandler O'Neill & Partners, L.P.

is pleased to announce that

Douglas J. Elliott

has joined the firm as a
Managing Director

and

**Head of Insurance
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Sandler O'Neill

January 1998

A nine-member, joint industry-regulator board headed by Mr. Pomeroy oversees IRIN's activities. Ms. Flanagan is board vp.

However, there is some concern about whether the NAIC is moving fast enough.

Some supporters of a federal financial services modernization bill are urging creation of a National Assn. of Registered Agents & Brokers, which would be controlled by state regulators but would be able to pre-empt individual state regulation that didn't conform with NARAB's uniform licensing rules.

Mr. Pomeroy sees NARAB's creation as "a threat" that duplicates the NAIC's efforts. He plans to work to defeat the measure.

The Washington-based Council of Insurance Agents & Brokers, which wrote the NARAB proposal, "supports the NAIC's efforts to fast-track the producer licensing reform, which would make NARAB unnecessary," said Coletta Kemper, the council's director of industry affairs. However, any proposal must provide full reciprocity for non-resident producers, she said.

Enhancing efficiency is not the only regulatory issue Mr. Pomeroy cares about. He is "guardedly optimistic" that new insurer accounting rules will

become a reality.

In addition, he supports the NAIC's plan to again reverse the order of Executive Committee and Plenary meetings so a proposal could move through both groups and be formally adopted at a single quarterly meeting. He favors the plan to eliminate delays while increasing disclosure requirements.

Mr. Pomeroy is taking a wait-and-see attitude about recent findings that the money states spend on insurance regulation by state insurance departments has essentially stopped increasing this year after 10 years of steady growth.

Mr. Pomeroy graduated from the University of North Dakota with a bachelor's degree in political science the same year he was elected to the North Dakota Legislature. After serving three terms and practicing law for county and state governments and in the private sector, he was appointed state securities commissioner.

When Earl, his older brother, left the post of insurance commissioner to run for Congress, Glenn was elected to succeed him.

Glenn Pomeroy's stature among insurance industry representatives stems from five years of work in forging consensus on NAIC technology and health issues, using skills he honed as a legislator and administra-

tor. He also served as the NAIC's secretary/treasurer and vp.

Plain speaking has helped make him popular. He still quotes a Boy Scout camping motto to explain his goal in whatever public post he has held: "Leave the campsite cleaner than when you found it."

"People in North Dakota understand that Glenn is his own man. He is strong in his beliefs and his ability to run a regulatory agency," said his brother Earl, a three-term U.S. Representative.

"He's extremely pro-active in seeking to improve the archaic, multistate licensing of insurance," said David Turner, vp of state government affairs for the Independent Insurance Agents of America in Alexandria, Va. Also, "he seeks consensus in a very inclusive yet non-political manner."

"I think Glenn is a terrific person and insurance commissioner," despite his opposition to the NARAB proposal, said Ms. Kemper of the Council.

"I think his strongest point is his eternal optimism that he can help make things better," said the NAIB's Ms. Flanagan. "His willingness to listen and try and forge a compromise is another strong point."

Glenn Pomeroy and his wife reside in Bismarck, N.D., and have three children. **BI**

California

Continued from page 3

nians for Compensation Reform, an employer coalition in Sacramento that has led the charge for legislative reforms, including repeal of the minimum rate law.

"Once we deregulated the insurance market, much of the profit and incentive for writing workers comp in California was taken away," she said.

As a result of deregulation, "there will be more carrier consolidation," agreed Roger Moseley, president of Great States, which announced last month that it was

pulling up stakes in California.

The exit of workers comp insurers from the state could lead to fewer competitors and ultimately higher prices for employers, said John Wilson, executive director of the Schools Excess Liability Fund in Sacramento.

"They told us this would happen," he said. "In Oregon, there were 40 markets before open rating, and afterward, there were two."

Instead of California, Great States will focus its marketing efforts on Colorado, Arizona and Texas—the other states in which the insurer is licensed. Its second-largest presence is in Arizona, where it wrote \$21.1 million, or 48.6% of its 1996 premium volume.

Since the repeal of California's minimum rate law in 1995, "workers compensation premiums have been greatly reduced," Mr. Moseley said. "This has led to unacceptable loss ratios and poor underwriting results for our company."

Indeed, Great States' 1997 loss ratio will be "in the 70s" he said, compared with 49.7% in 1996.

That puts Great States on par with the California workers comp industry as a whole. According to the California Workers Compensation Insurance Rating Bureau, the pure loss ratio for all of the state's comp insurers averaged 76.8% in 1996, compared with 56.7% in 1995. Last year's loss ratio has not yet been calculated.

Great States, a unit of Pacific Health Systems Inc. of Cypress, Calif., was a pioneer in applying managed care principles to workers compensation. It was one of the first insurers in the state to establish a health care organization, or HCO, to provide managed workers comp care.

Under the 1993 workers compensation reform law, employers that contract with HCOs licensed by the state can direct the treatment of injured workers for up to 180 days, while those without managed care can direct treatment only for the first 30 days.

Great States also was one of the first insurers in the state to offer its employer policyholders integrated disability management in conjunction with its HMO parent.

Unfortunately, this attempt at so-called "24-hour care" wasn't successful, Mr. Moseley said.

"Some of the purported benefits

of 24-hour never materialized," he said.

For example, few employers were interested in having their workers comp and health insurance bills combined, because their health care premiums often varied with changes in employees' marital status, he explained.

In addition, "primary care doctors aren't equipped to handle emergency or trauma care," Mr. Moseley pointed out. "That's why we developed our own occupational network," he said, referring to the Great States HCO, which includes more than 1,000 providers statewide.

The business abandoned by Great States, which wrote about 0.4% of the California workers compensation market, is expected to be quickly absorbed by the state's other hungry workers comp insurers.

"We're not renewing any policies. But the business is going away pretty fast. Our Jan. 1 renewal business was replaced within 24 hours" by other insurers, Mr. Moseley remarked.

Great States already had lost about half of its California business in April 1997, when it tried to institute a rate increase to improve its underwriting results, he added.

Great States began 1997 with about \$28 million in California workers comp premiums but ended the year with just \$14 million, according to Mr. Moseley.

"We basically cut our book of business in half by trying to raise rates just 5% to 7%," he recounted.

As a result of its exodus from California, Great States will reduce its staff to 41 positions from its current roster of 87, said Mr. Moseley, who will remain president of the company and work from its Anaheim, Calif., headquarters.

He said the company and its parent also are "exploring the option" of marketing its HCO on a stand-alone basis to other workers comp insurers and to self-insured employers in the state.

"We have one of the largest HCOs in California, but in the past we were reluctant to sell it to our competitors," he explained.

The company, which sold coverage primarily to small and mid-sized employers, has about 2,000 outstanding workers comp claims in runoff. **BI**

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Commentary

Industry shows it's College bound

The insurance industry is making a smart investment in its future.

As The College of Insurance recently paid tribute to its 1997 insurance leader of the year, it also was clear that the insurance industry was honoring the college.

Patrick G. Ryan, chairman and chief executive officer of Aon Corp., received the college's annual award Jan. 29 in New York.

The award, established in 1995 and given to two recipients before Mr. Ryan, goes to a person who has either demonstrated outstanding leadership over the course of his or her professional career in insurance and financial services, or who has accomplished something truly outstanding in the current year.

As was noted by Robert Clements, chairman of Risk Capital Reinsurance Inc. and chairman of the college's board of trustees, Mr. Ryan was "an especially appropriate honoree" as he satisfies both requirements.

The awards dinner—a leading source of funding for the college's programs, and which raised \$1.12 million this year—attracted more than 750 people. It was not just the number in attendance that was impressive, but also the caliber of attendees: Numerous CEOs and prominent insurance and reinsurance industry executives were on hand.

It became clear they were there not only to honor Mr. Ryan for his accomplishments but also to cast their support for the college.

The rapid consolidation within the insurance industry in recent years—of which Mr. Ryan has been a catalyst and participant—caused some to question whether financial support for the college would diminish in proportion to the number of players in the market.

However, Mr. Ryan and others sought to allay those fears. As Aon has grown, he noted, it has come to depend even more on The College of Insurance for supplying individuals with a broad range of risk management, financial and information technology skills.

"Even if companies are fewer in number, it doesn't mean a diminution of support. Indeed, a better-capitalized company is in a better position to offer more support for the college," Mr. Ryan said.

Mr. Ryan and others also noted that the industry depends more than ever on the college to provide the intellectual capital needed to effectively compete in the future. That need becomes more acute as the insurance industry faces competition from other financial services sectors to meet buyers' risk management needs.

"As an industry, insurance has not done as well in attracting new talent as other financial services," Mr. Ryan said. "Investment banks, consultants and others are all saying they can help the client manage risk."

To succeed against these competitors, the industry must assure that the college has the resources necessary to provide the sort of training and research that will help the insurance industry keep its edge in a world of increasing convergence among financial services.

In return, the college offers a wide range of educational opportunities. In addition to undergraduate education in risk management, insurance actuarial science and finance, The College of Insurance also offers a master of business administration program, a joint program with Bermuda College and continuing education programs delivered at the college and onsite at some New York businesses, among other programs.

In addition to the skills the college delivers, another benefit of the symbiotic relationship the college and insurance industry enjoy is that the insurance industry is bound to become more diverse as it employs graduates of the college. The college reports that 31% of its students are minorities, 53% are women, and 10% come from countries other than the United States.

Those are numbers currently not found in the executive ranks of the U.S. insurance industry. But, with the industry's continued support, that will surely change.

The College of Insurance clearly is positioned to meet the needs of the insurance industry on several levels. With continued investment from the insurance community, this important educational institution should pay handsome dividends for years to come.

Editor Paul D. Winston and Publisher and Editorial Director Kathryn J. McIntyre write columns on alternate weeks.



Paul D. Winston

ESRD

Continued from page 2
retirees with ESRD back to Medicare.

That initial injunction applied for services delivered between Aug. 10, 1993, the date the budget's law ESRD provision took effect, and April 24, 1995, the date HCFA formally reversed its earlier interpretation.

In last month's ruling, Judge Bryant made his earlier injunction permanent. "In April 1995, along with the HCFA reinterpretation was an attempt to apply it to all actions taken since August 1993. This was clearly an effort to retroactively repeal a rule that it previously promulgated and retroactively alter the rights plaintiffs possessed," Judge Bryant wrote.

A HCFA attorney said the government has not decided whether it will appeal Judge Bryant's ruling. It has until March 8 to decide.

Judge Bryant's order could set the stage for a broader court ruling that NMC is seeking: that the second HCFA interpretation is incorrect and cannot be enforced. That issue still is before the court.

"Potentially, this becomes a much bigger deal in terms of a cost issue and an administrative nightmare," said Robert Roth, a former HCFA attorney and now a principal with Michaels, Wishner & Bonner in Washington.

Indeed, technically, Judge Bryant's ruling only applies to NMC and the issue of retroactivity. But other parties could join the suit, while a future ruling could go beyond the issue of retroactivity and whether or not HCFA's second interpretation is correct.

"This is a very confusing situation with interpretations of law going back and forth," said Henry Saveth, an attorney with William M. Mercer Inc. in Washington.

While the legal maneuverings are going on, employers, kidney dialysis centers and Medicare have to decide who is responsible for retirees' medical bills.

However the controversy is resolved, the outcome for employers is significant. At issue is whether

"This is a very confusing situation with interpretations of law going back and forth," says Henry Saveth.

employers will be the primary payers of the tens of millions of dollars incurred by retirees who develop ESRD after they become eligible for Medicare.

The issue of whether Medicare or employers are the primary payer of ESRD patients' medical bills also is vital for dialysis centers. That is because the centers typically impose higher charges for patients covered by employer plans than those covered by Medicare. An earlier study by the General Accounting Office found that employer plans paid dialysis providers \$690 per week on average, 80% more than the \$383 paid by Medicare.

In 1994, the latest year for which statistics are available, Medicare spent \$8.4 billion on ESRD services, up from \$7.6 billion in 1993. Enrollment in the program has been increasing at about 10% a

year, with a total enrollment of almost 280,000 beneficiaries in 1994. Of the more than 62,000 new enrollees in 1994, more than 27,000 were at least age 65.

The controversy over who should pay the health care bills of retired workers who develop ESRD after turning 65 began with the enactment of Omnibus Budget Reconciliation Act of 1993. HCFA initially interpreted an OBRA provision as requiring employers' retiree health care plans to be the primary payer for 18 months for retired workers who developed ESRD after they turned 65 and were already covered by Medicare.

That meant a retiree could have bounced from Medicare to the employer's retiree health care plan and then, after 18 months, back to Medicare.

Later, after hearing protests from employers and insurers, HCFA in 1995 reversed its earlier interpretation and said Medicare would remain the primary payer.

That policy shift, NMC earlier charged in court papers, came in the wake of pressure from individual congressmen and others. But the Justice Department said the change in position was the result of a "careful and reasoned analysis."

The earlier interpretation, the Justice Department said, would have "wrought havoc."

Benefit experts note the litigation and confusion on interpreting a provision in a budget law could have been avoided if, at the time the legislation was being put together, there had been more open discussion with the private sector.

"This may well be an example of how imprecise legislation can lead to significant uncertainty down the road," Mr. Saveth said. **BI**

Lloyd's

Continued from page 2
affect each other, as the two cases allege fraud by Lloyd's under different federal and state securities laws, said Mr. Goldman.

However, the federal court's finding may influence the ruling of the state trial court in further, as yet undetermined, technical issues that Lloyd's will raise prior to the trial, Mr. Hansell said.

The Wests' case comes after a long line of Lloyd's cases in the United States have failed to get to trial as Lloyd's has successfully argued that the forum selection clause in the membership agreements bar members from bringing suits anywhere other than England.

One of those previous cases in 1996 nearly felled Lloyd's reconstruction and renewal plan.

Days before the plan was to be voted on by the market's members, a federal court in Richmond, Va., slapped an injunction barring Lloyd's from promoting the plan to members in the United States until Lloyd's met requirements under U.S. securities laws to reveal more details of the plan (*BI*, Aug. 26, 1996).

That decision was overturned by a last-minute appeals court decision that ruled that the forum selection clause barred the members' case from being heard in the United States (*BI*, Sept. 2, 1996).

The Wests' suit alleges that Lloyd's breached California securities laws. They argue that membership in Lloyd's is the same as a security and that Lloyd's violated the laws by promoting membership in the United States without state authorization.

They also allege Lloyd's committed fraud by concealing information about huge asbestos exposures that would have deterred potential

members from joining Lloyd's in the 1980s.

The Superior Court of Los Angeles County ruled in favor of Lloyd's in July 1995, but the Court of Appeals of California, Second Appellate District, reversed that decision in October 1997. Lloyd's appealed to the California Supreme Court, but the Supreme Court ultimately refused to hear the case. The case is now slated to go back to the Superior Court for trial.

In the state appeals court ruling, a three-judge panel said Lloyd's had not refuted any allegations, in-

Despite the California ruling, Lloyd's still may avoid a U.S. trial, says attorney Dean Hansell, who represents Lloyd's.

cluding whether membership in Lloyd's was a security, but had simply argued that the forum selection clause meant the case should be heard in England.

However, California law "renders void any provision purporting to waive or evade the Corporate Securities Law," court papers say.

Despite the ruling, Lloyd's still may avoid a U.S. trial, according to Lloyd's lawyer Mr. Hansell.

"We never even got to the issue of the validity of the complaint," he said.

Lloyd's is considering its options but will likely file objections to the complaint. Possible objections could include the validity of filing a commercial suit under consumer protection laws, Mr. Hansell said.

Also, Lloyd's is reviewing whether the suit could be barred under statutes of limitation, he said.

Mr. Hansell also said the state appeals court did not determine that membership of Lloyd's was a security, as alleged by the Wests.

However, the Wests have documentary proof of a former Lloyd's official in the late 1970s admitting that membership of Lloyd's could be likened to a security, said Mr. Goldman.

Meanwhile, the 9th Circuit's decision followed other federal appeals court rulings that Lloyd's cases should not be heard in the United States. The 9th Circuit, sitting en banc, reconsidered an October 1997 ruling by a three-judge panel that the case could be heard in the United States.

The full court followed the precedent of six other federal appeals courts ruling that the case should be brought in England.

The federal ruling—which came three days after the California Supreme Court's notice—could influence the state trial court, as the original appeals court ruling was influenced by the prior federal appeals panel ruling that favored the members, said Mr. Hansell.

However, the two cases will have no bearing on each other, asserted Mr. Goldman.

"The Wests' case is based on state law, and the other case was an interpretation of federal statutes," he said.

The federal case could influence the state court but ultimately the state court need not acknowledge federal precedents other than the U.S. Supreme court, said Alan Kaufman, a partner at Kaufman & Payton in Farmington Hills, Mich., an insurer attorney who is not involved in the case.

"Sure the federal court can have an influence on the state court but the real issue is does the state court have an obligation to follow the federal precedent and the answer is no," he said. **BI**

Storms

Continued from page 1

swollen rivers would occur over the weekend.

South Florida also was assaulted last week by tornadoes that tore through part of the Miami area and nearby cities. Airports in the area were turning in some of the largest losses from the storms, which tossed around small planes and severely damaged several facilities.

City officials in Hialeah, Fla., counted 600 homes, businesses and public facilities damaged when a twister swiped a line of destruction through the town.

"It runs the entire length of the city," said Dan Deloach, city clerk of Hialeah, which is self-insured for property losses. Miraculously, he added, no one was hurt.

Damage to business and personal structures in the city will total \$15 million to \$20 million, estimated Mr. Deloach, who said that damage to contents and business interruption likely will push that total higher.

A spokesman for the Hialeah mayor's office said the mayor believes the total for damages to the city could reach \$50 million.

Miami-Dade Aviation Department said 140 aircraft and 18 buildings, including four World War II-era hangars, were damaged at Opa-locka Airport. Losses were estimated at \$10 million to \$15 million. The aviation facility is self-insured, though the planes would be covered by owners'

private insurance.

Twelve small planes also were damaged at Miami International Airport, and North Perry Airport in Pembroke Pines also reported damaged aircraft.

United Parcel Service of America Inc.'s regional distribution facility in Hialeah took a hit from the twister, losing a portion of its roof and side panels. The structural steel building "looks like somebody took a can opener and opened it," Mr. Deloach said.

Atlanta-based UPS could not comment on its coverage for the losses.

Hialeah's Chamber of Commerce building was badly damaged from debris that flew off other structures.

A spokeswoman for the City of Opa-locka, Fla., said damage to city property likely will reach \$2.5 million, with the total damage to personal and commercial property in the city estimated at around \$10 million. The city is covered by a self-insurance pool operated by the Florida League of Cities.

In Northern California, residents and businesses are tallying losses from winter storms that caused widespread flooding and damaged roads, bridges, piers and other structures.

Gov. Pete Wilson declared a state of emergency in 10 counties in the Bay Area.

Thousands of Californians were evacuated as rain created mudslides and washed away part of Highway 1 near Big Sur, Calif.

Preliminary estimates from the Western Insurance Information Service in San Ramon, Calif., were that insurers would incur about 15,000

claims totaling approximately \$20 million in California.

The Property Claim Services division of American Insurance Services Group had no estimates of insured storm losses as of last week.

The latest round of bad weather arrived shortly after parts of New England and Canada were blasted by ice storms in January. Preliminary estimates from those ice storms have put insured damages at \$600 million Canadian (\$418.9 million) and \$75 million to \$125 million in the United States (BI, Jan. 19).



In San Francisco, a worker struggles to climb a mudflow.

TIG posts fourth-quarter loss

By JUDY GREENWALD

NEW YORK—TIG Holdings Inc. said a pretax loss reserve charge of \$145 million at TIG Reinsurance Co. led to a \$62.7 million fourth-quarter loss for the holding company.

This compares with a \$38.9 million profit for the comparable quarter in 1996. TIG Holdings reported \$52.3 million in net income for 1997, a 33.7% decline from 1996.

The reserve additions were made in connection with a "limited number of large accounts," all of which have been restructured or non-renewed, according to the company.

According to Louis G. Paglia, senior vp and treasurer at TIG Holdings, most of the reserve additions were for professional liability.

TIG said an actuarial review of TIG Re's loss reserves based on December 1996 data that had been conducted during 1997's second quarter had concluded reserves were adequate. The latest study was conducted during the fourth quarter based on data through September.

TIG said it will contribute \$70 million to TIG Re's surplus, effective Dec. 31, 1997, which will boost its statutory surplus to \$508 million.

Jon Rotenstreich, TIG Holdings chairman and chief executive officer, said in a statement, "The reunderwriting of our book of business at TIG Re that occurred during the past year has strengthened the company."

"Many refinements have been made to our underwriting process which will further improve our de-

cision-making and client service," he said.

Ken Zuckerberg, vp at Moody's Investors Service Inc. in New York, said, "On balance, while reserve strengthening is positive in terms of improving balance sheet quality, one could be concerned that the business written shouldn't have been on their books to begin with."

"Furthermore, management may have a credibility problem near term given that they essentially signed off on the organization's reserve strength earlier in 1997," Mr. Zuckerberg said.

Additional reserve strengthening over the next 12 to 18 months by insurers and reinsurers in light of the soft market is possible, he added. "We are increasingly concerned with reserve adequacy in the P/C industry overall." (BI)

AIG may drop its appeal

SAN FRANCISCO—American International Group Inc. will drop its appeal of the sale of Golden Eagle Insurance Co. to rival Liberty Mutual Insurance Group if Golden Eagle's estate reimburses it for its expenses in competing for the failed insurer, lawyers told regulators.

The California Insurance Department not only supports the move but also is asking the court overseeing Golden Eagle's rehabilitation to use Golden Eagle assets to pay at least two other parties involved in last year's bidding war.

In a declaration filed in San Francisco Superior Court, the department is seeking \$6 million in compensation for reinsurance broker E.W. Blanch Co. and \$300,000 for Zurich Centre Re. Both acted as consultants to the Insurance Department.

The department also supports paying AIG "as long as the amount is reasonable," said William Palmer, the department's general

counsel.

While New York-based AIG believes its appeal has a good chance to succeed, it "understands that pursuing the appeal to a successful conclusion would unwind the rehabilitation plan already in place and it understands the department desires not to risk such a result," said Richard de Saint Phalle, an attorney with Barger & Wolen in San Francisco, in a letter to the department offering to withdraw its appeal in exchange for compensation.

Furthermore, "AIG added substantial value to Golden Eagle's rehabilitation," the letter states. "AIG's April 4, 1997, bid created the economic baseline against which Liberty Mutual overbid. If AIG had not submitted its \$1.79 billion reinsurance bid, Liberty Mutual's original \$1.44 billion bid likely would have been accepted, resulting in hundreds of millions less in reinsurance for policyholders' benefit."

AIG is seeking reimbursement of \$2.3 million in fees and expenses.

Golden Eagle attorney James Lyons has expressed concern in court documents that the assets in the insurer's estate would be "quickly and greatly diminished" if every failed bidder and its consultants were to be paid.

However, "we recommend" reimbursement, said Mr. Palmer.

Former Golden Eagle owner John Mabee "will get the residue of what's left over at the end" of the rehabilitation, Mr. Palmer said.

San Francisco Superior Court Judge William Cahill must rule on the settlement proposal and reimbursement requests.

Meanwhile, Judge Cahill has appointed three deputy trustees to preside over the liquidation: Deputy Conservator Karl Rubinstein, former Gov. George Deukmejian and San Diego businessman Philip A. Ward.

—By Joanne Wojcik

Updates

Aon to buy Spanish broker

Continued from page 2

ted Kingdom, Portugal and Colombia, reported \$51 million in 1997 revenues and has roughly 600 employees. Subject to regulatory approval, Gil y Carvajal will be merged with Aon's existing Madrid brokerage operation, Aon Iberia.

The combined operation will be called Aon Gil y Carvajal and have total annual revenues of about \$61 million and 750 employees. Santiago Gil de Biedma, president of Gil y Carvajal, will become president of the merged operation.

Gil y Carvajal was the last major member of the UNISON network that had not affiliated itself with a new international partner. The 14-member UNISON network took a hit when its largest member, Johnson & Higgins, was acquired by Marsh & McLennan Cos. Inc. early last year. While J&H Marsh & McLennan has since acquired several UNISON members, Willis Corroon Group P.L.C. was quick to acquire one-third state in Paris-based Gras-Savoye S.A., and Aon acquired Hamburg, Germany-based Jauch & Huebener KGaA last fall.

St. Paul outlines exec structure

ST. PAUL, Minn.—The St. Paul Cos. Inc. is announcing a new leadership structure in anticipation of the completion of its proposed \$2.8 billion merger with USF&G Corp.

Several St. Paul executives will assume new responsibilities with St. Paul Fire & Marine Insurance Co., effective immediately: Joseph B. Nardi, who will continue as president-Medical Services until a successor is named, has been named executive vp and president-Specialty Commercial; James A. Schulte, previously President-Commercial, has been named executive vp and president-General Commercial; and T. Michael Miller, previously vp-Financial and Professional Services, has been named president of that unit and senior vp of St. Paul Fire & Marine.

The company said Mr. Schulte and Kim B. Rich, president of USF&G's Family and Business Insurance Group, will be co-leaders of the insurance integration team, which will develop an overall plan for merging the organizations. They will report to Patrick A. Thiele, executive vp of St. Paul and CEO of the Worldwide Insurance Operations.

Douglas W. Leatherdale will continue to serve as chairman, president and chief executive officer of the combined companies. A number of other St. Paul execs also will continue in their present posts.

Among USF&G executives, those who will be named to new posts at St. Paul Fire & Marine include Robert J. Lamendola, now president of USF&G's Surety Group, who will be named senior vp and president-Surety; Kenneth E. Cihy, now executive vp of claims for USF&G, who will be named senior vp-claim; and Stephen W. Lienthal, now USF&G's executive vp and chief underwriting officer of the Commercial Insurance Group, who will be named senior vp-operations.

John R. Berger, president of F&G Re, USF&G's Morristown, N.J.-based reinsurance operation, will continue in that position. Mr. Berger will report to St. Paul Re President James F. Duffy, who also will oversee USF&G's Discover Re Managers Inc. unit.

Doctors seek Oxford payments

NEW YORK—Oxford Health Plans Inc., still struggling to recover after a tumultuous stock decline last year, became the target of two arbitration claims last week when a group of New York physicians accused the plan of dragging its feet on the payment of \$140 million in fees.

The New York County Medical Society, which represents 5,000 Manhattan doctors, asked the American Arbitration Assn. to oversee payment of the fees, some of which date to mid-1996. In the second arbitration claim, the doctors are requesting that Oxford sign a fixed schedule for the future processing of provider claims.

The society is asking thousands of doctors to sign statements to join the arbitration effort against Norwalk, Conn.-based Oxford.

Oxford called the \$140 million figure "a substantial overstatement" and said it has agreed to pay interest on late payments.

A spokeswoman for Oxford declined to comment on a report last week in The Wall Street Journal that Oxford is looking to find financing to beef up its capital base and that the company might sell a minority stake to investors to increase shareholder equity.

Briefly noted

A New Jersey Superior Court judge ruled Jan. 28 that the dozens of primary and excess general liability policies covering CIBA-Geigy Corp. from 1952 until 1984 must respond to the approximately \$525 million of pollution cleanup costs that CIBA faces at its chemical plant site in Toms River, N.J. Citing the company's aggressive 32-year effort to properly dispose of the hazardous wastes that its plant generated, the judge ruled that CIBA did not intend to pollute nearby ground water and that the company could not have foreseen that its waste disposal methods would likely cause the contamination. . . . Louisiana's 4th Circuit Court of Appeals last week rejected plaintiffs' request to review and reverse a state district court judge's Dec. 1, 1997, ruling decertifying the class in what was the nation's first class-action **silicone breast implant lawsuit** to be tried against Dow Chemical Co., *Spitzfaden vs. Dow*. . . . Lawrence Doyle is heading up a new **Bermuda life reinsurer**, Annuity & Life Re (Holdings) Ltd., which plans to raise about \$230 million in capital, according to filings with the Securities and Exchange Committee. Mr. Doyle formerly headed Bermuda catastrophe Global Capital Re Ltd. prior to its purchase by EXEL Ltd. last year. . . . **Oracle Re**, a new Bermuda employee benefits reinsurer and rent-a-captive facility, is up and running with \$40 million in capital. Oracle is headed by Colin O'Connor, the former chief executive officer of Belvedere Insurance Co. Ltd., which is in runoff. . . . Frontier Insurance Group Inc. Chairman, President and CEO **Walter Rhulen** died Jan. 31. Mr. Rhulen will be succeeded by his son, Harry W. Rhulen, who had been named president and acting CEO during his father's declining health, last week was elected chairman of the Rock Hill, N.Y.-based insurer.

EMLICO

Continued from page 1
insurer, won approval from Massachusetts regulators in 1995 to move to Bermuda after spinning off its non-GE liability business to a former subsidiary. A few months after redomesticating, it declared itself hugely underreserved for decades of GE pollution and asbestos claims and insolvent by more than \$500 million.

The collapse sparked an international legal fight in which several EMLICO reinsurers—including Lloyd's of London underwriters and Kemper Reinsurance Co.—charged that the move was part of a conspiracy to take advantage of Bermuda liquidation laws more favorable to GE than those in Massachusetts.

After briefly investigating the charges, the Massachusetts division last year proposed a settlement in which it would become ancillary receiver to EMLICO's Bermuda liquidators.

The settlement required court approval, though, and Massachusetts' highest court last month threw out the deal, ruling that Ms. Ruthardt had no authority to allow the EMLICO redomestication in the first place and that EMLICO remains a Massachusetts insurer (*BI*, Jan. 12).

Ms. Ruthardt then filed a petition in state court to place EMLICO in receivership, and the Bermuda liquidators countered by removing the petition to federal court in Boston and asking U.S. District Judge Douglas P. Woodlock to dismiss it.

Supporting their effort to halt a U.S. receivership, the liquidators argue that they are "agencies... of a foreign state" under U.S. law and are not subject to state court proceedings. They also say the receivership petition should be thrown out on grounds of comity, a doctrine requiring that U.S. courts respect existing Bermuda court orders in the EMLICO liquidation.

The liquidators also note that they have already taken major steps in the winding-up, including taking control of \$370 million in EMLICO cash and securities, along with other assets, books and records of the estate; reviewing more than \$170 million in non-contingent claims; and generating more than \$100 million in settlements with EMLICO reinsurers.

Ms. Ruthardt, who has asked Judge Woodlock to return the case to state court, last week denounced the Bermuda liquidators' actions in a strongly worded letter to Mr. Gibbons, Bermuda's finance minister.

"I have... directly informed the joint liquidators of my disappointment with their action," she said in the Feb. 2 letter.

"I ask that Bermuda government officials publicly object to the removal of my petition by

the joint liquidators and strongly encourage them to withdraw their (action) and not further obstruct entry of the proposed receivership order by the Massachusetts court.

"I believe it is particularly unseemly for individuals, claiming to be agencies of the Bermuda government, to seek to preclude Massachusetts from acting under these extremely unfortunate circumstances in relation to a company which our highest court has determined to be a Massachusetts insurer," Ms. Ruthardt wrote.

On Friday, the Insurance Division filed papers supporting its plea that Judge Woodlock send the case back to state court. The division contends that the joint liquidators are not immune to U.S. court action; that the state's highest court has found EMLICO to be a Massachusetts company; and that Ms. Ruthardt, if appointed as EMLICO's receiver, would go to court in Bermuda for an order turning over management of the estate to her and satisfying concerns about comity.

Ms. Ruthardt then argues that Massachusetts is the appropriate site for the receivership because her "approval of the redomestication may have been obtained by fraud."

The filing cites several pieces of "evidence suggesting that management knew that EMLICO was insolvent by late 1994 or early 1995 but failed to inform the commissioner." This evidence, the filing says, includes:

- EMLICO financial statements showing the company was solvent in 1994 and 1995 and management projections that it would maintain surplus of at least \$260 million through 1999. Less than four months after the move to Bermuda, the same EMLICO managers concluded the insurer's reserves were deficient by \$679 million.

- A December 1994 memo prepared for EMLICO by London law firm Clifford Chance & Co. evaluating possible sites for a winding-up, including Bermuda. Also in 1994, the law firm Chadbourne & Parke gave EMLICO an "insolvency flow chart" tracing what would happen if EMLICO posted reserves for GE claims and was declared insolvent in Massachusetts.

- Documents showing EMLICO officials were in contact with Coopers & Lybrand before the redomestication regarding the "feasibility of redomestication option" and a "proposed action plan for EMLICO restructuring."

Reinsurers have cited these documents in charging that the redomestication was a fraud, and Ms. Ruthardt acknowledged them in deciding in 1996 not to reopen the redomestication (*BI*, July 8, 1996).

Meanwhile, a week before last Friday's filing—and before Ms. Ruthardt's letter arrived in Bermuda—Bermuda Finance Minister Mr. Gibbons had himself written to Coopers & Lybrand noting the jurisdictional conflict and expressing

concern about "the impact such a conflict could have on future relations between insurance regulators in Massachusetts and Bermuda."

In the Jan. 30 letter, Mr. Gibbons said he would "be grateful if you would give serious consideration to the possibility of making an application to the Supreme Court of Bermuda, and subsequently to the courts of Massachusetts, requesting the assistance of those courts in enabling a negotiated settlement to be reached, perhaps through the appointment of a mediator."

Last Monday, the joint liquidators did just that, and Chief Justice Ward issued an order that requires the liquidators to:

- Try negotiating a "protocol" with Ms. Ruthardt within 30 days that would define the respective functions of the joint liquidators and Massachusetts division.

- Meet with Ms. Ruthardt and a mediator to again try to work out a protocol for the liquidation if no agreement is reached in 30 days.

- Report back to Chief Justice Ward for further instructions if no protocol is negotiated within 90 days.

On the same day he entered the order, Chief Justice Ward also sent a "request for international judicial assistance" to Judge Woodlock asking for his help in pushing for a settlement.

"In the interests of avoiding the considerable potential for conflict, which would unnecessarily consume the time of our respective courts, I... request Your Honour to consider assisting this court, as an interim step, by giving directions to (Ms. Ruthardt) in similar terms to those which I have given to the joint liquidators," Chief Justice Ward wrote.

It is unclear whether Judge Woodlock could comply with this request before ruling on Ms. Ruthardt's motion to remand the case to state court for lack of federal jurisdiction.

It is also unclear what form a negotiated settlement between the two sides could take, given that the Massachusetts high court already has thrown out a joint liquidation proposal on the grounds that EMLICO's original redomestication was invalid.

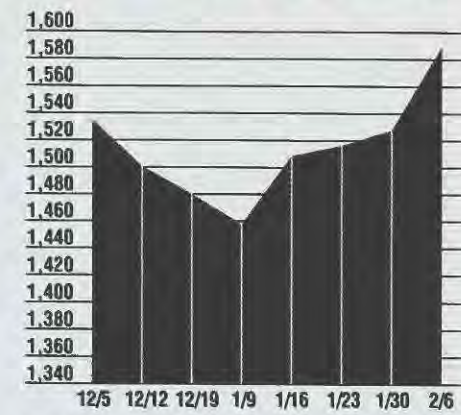
Still, while Ms. Ruthardt and the liquidators vie for the upper hand, some observers say a settlement is the only way to proceed with the winding-up.

"They are going to have to have some working deal," said a lawyer familiar with the case. "The records are in Bermuda, the assets are in Bermuda. They're going to have to sit down and talk."

Both sides "are kind of looking for a silver bullet right now, and I don't think there is a silver bullet," an industry official observed.

"Every time you think nothing more is going to happen in this case, something more pops up," he added.

BI Insurance Index



Base=100 on Dec. 29, 1978
Source: Nordby International Inc. (nordby.com) Boulder, Colo.

PCS catastrophe options

As of Feb. 6			
Call spread	Price bid/ask	Call spread	Price bid/ask
National Annual 1998		California Annual 1998	
40/60	9.8/12.0	40/60	—2.3
60/80	7.0/8.3	150C	—3.0
80/100	5.0/6.0		
Eastern September 1998		Western Annual 1998	
20/40	3.5/5.5	40/60	1.4/2.5
40/60	3.0/3.5	80/100	—1.8
		150C	2.2/3.0
Southeastern September 1998		Florida September 1998	
40/60	2.2/3.0	40/60	1.4/2.4
Northeastern September 1998			
100/150	.8/1.4		

Total volume: 41 Total open interest: 18,233
For information on PCS cat options, call the Chicago Board of Trade at 312-435-3674.
Source: Chicago Board of Trade

British Issues

Companies	Price pence	P/E	Div. %	Yield %	52-week high—low
Comml Union	1045	15.7	35.8	3.5	1045—630
Genl Accident	1305	8.7	35.4	3.4	1326—772
Gdn Royal Exch	407	5.8	12.2	3.0	416—257
Legal & Gen	670	17.0	11.6	2.2	694—377
Royal & Sun	695	23.9	19.7	3.5	730—429

Brokers

Lmbt Fenchurch	105	7.5	8.4	9.9	138—101
Lloyd Thompson	167	14.1	10.8	8.0	206—151
Sedgwick Grp	143	11.6	7.4	5.2	171—115
Willis Corroon	136	15.6	6.6	6.0	165—116

Note: Prices are Feb. 6 closings; other numbers from Feb. 5.
Source: Nordby International Inc. (nordby.com) Boulder, Colo.

BI Industry Stock Report FEB. 2, 1998, THROUGH FEB. 6, 1998

BROKERS																									
		Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)			Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)			Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)		
Aon Corp.	NYS	56.31	0.90	-3.94	58.88	40.25	562	ESG Re Limited	NDO	25.50	4.08	8.51	25.50	20.88	461	RLI Corp.	NYS	47.75	-3.66	-4.14	50.38	30.50	51		
E.W. Blanch Holdings Inc.	NYS	35.00	3.51	1.63	36.00	21.25	171	Enhance Financial Services	NYS	58.38	-4.94	-1.89	62.13	34.25	158	St. Paul Companies	NYS	88.00	1.11	7.24	88.19	62.63	2353		
Gallagher Arthur J. & Co.	NYS	38.50	4.05	11.80	39.50	30.38	506	Everest Reinsurance	NYS	37.38	-1.32	-9.39	43.00	26.75	1050	SCOR	NYS	53.13	4.17	11.26	53.13	35.25	5		
Hibb, Royal & Hamilton	NYS	17.81	1.06	-7.77	19.63	12.50	153	Executive Risk Inc.	NYS	73.06	2.54	4.66	74.19	37.00	321	SAFECO Corp.	NDO	51.66	3.44	5.96	55.38	37.88	1874		
Kaye Group Inc.	NDO	6.88	5.77	3.77	9.00	4.38	3	EXEL Ltd.	NYS	60.00	-1.64	-5.33	65.19	39.00	733	SCPIE Holdings Inc.	NYS	29.00	1.75	0.22	32.13	19.13	NA		
Marsh & McLennan	NYS	75.13	1.69	0.75	80.00	55.00	1161	Fremont General Corp.	NYS	51.94	1.96	-5.14	55.50	26.38	339	Seibels Bruce Group	NDO	7.31	2.63	-2.50	9.25	5.88	70		
Poe & Brown	NDO	46.38	-1.98	3.92	48.56	25.50	5	Frontier Insurance Group	NYS	26.00	8.90	13.66	39.25	19.13	1584	Selective Ins. Group	NDO	26.44	1.68	-2.08	28.63	19.75	138		
Sedgwick Group PLC	NYS	12.19	1.56	-1.02	13.25	9.38	109	Gainsco Inc.	NYS	8.13	1.56	-4.41	10.19	7.88	190	Terra Nova Insurance Co. Ltd.	NYS	26.38	4.46	0.48	30.00	18.00	715		
Willis Corroon Corp.	NYS	11.50	1.66	-6.60	13.50	9.75	155	General RE Corp.	NYS	210.00	0.90	-0.94	221.25	151.50	864	TIG Holdings	NYS	24.63	-8.16	-25.80	38.00	24.63	6666		
BROKERS AVERAGE																									
INSURERS/REINSURERS																									
		Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)			Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)			Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)		
ACE Ltd.	NYS	98.25	5.57	1.81	101.06	57.63	403	Hartford Steam Boiler	NDO	25.00	-1.48	4.17	27.50	14.94	265	Tokio Marine & Fire	NDO	58.00	4.50	0.43	66.00	41.25	59		
Acceptance Insurance Cos.	NYS	23.31	-1.32	-3.62	28.63	17.75	288	HCC Insurance Holdings	NYS	59.63	0.85	8.04	60.13	44.00	408	Torchmark Corp.	NYS	42.06	0.75	-0.30	44.25	26.00	1600		
AEGON N.V.	NYS	98.00	3.43	9.34	98.94	61.88	132	ING Groep N.V.	NYS	19.63	5.37	-7.65	32.69	15.63	1151	Transatlantic Holdings	NYS	73.81	3.14	3.23	76.56	51.88	80		
Aetna Life & Casualty	NYS	80.38	9.35	13.91	118.13	66.31	4266	IPC Holdings Ltd.	NDO	47.94	5.07	13.29	53.00	38.88	740	Travelers Property/Casualty	NYS	40.63	-2.69	-7.57	46.06	31.38	2068		
AFLAC Inc.	NYS	61.31	12.63	19.93	61.31	37.50	3102	Hartford Financial Services	NYS	31.38	5.02	-2.52	32.88	22.38	333	Travelers Corp.	NYS	52.94	6.68	-1.74	57.38	30.88	16797		
Allied Group Inc.	NYS	28.88	5.00	0.87	35.75	21.38	447	LaSalle Re Holdings Ltd.	NYS	91.13	1.25	-2.61	94.56	68.13	2341	Trenwick Group Inc.	NDO	37.00	6.47	-1.66	39.63	31.88	84		
Allstate Corp.	NYS	91.00	2.82	0.55	94.38	58.63	5745	Life Re Corp.	NYS	32.06	-5.35	-9.36	36.13	27.25	140	Unico American Corp.	NDO	12.00	0.00	-2.04	14.13	9.83	6		
AMBAC Indemnity Corp.	NYS	53.63	12.75	16.58	53.63	31.00	1429	Lincoln National	NYS	42.25	-1.17	-4.52	47.00	30.00	32	United Fire & Casualty	NDO	42.25	-1.17	-4.52	47.00	30.00	32		
American Bankers Ins.	NDO	55.38	0.23	20.54	56.38	24.38	4533	Life Re Corp.	NYS	63.69	3.56	-2.30	65.38	37.38	103	Unitrin	NDO	65.13	4.41	0.77	68.50	48.50	109		
American Financial Group	NYS	39.56	4.98	-1.86	49.25	32.38	565	Lincoln National	NYS	77.19	1.40	-1.20	78.88	49.00	613	UNUM Corp.	NYS	49.94	2.70	-8.16	54.63	33.63	2031		
American General	NYS	57.06	1.22	5.55	57.19	36.50	2372	MAIC Holdings Inc.	NYS	29.19	12.26	8.97	29.19	14.56	83	USF&G Corp.	NYS	24.19	1.31	9.63	25.50	15.63	5860		
American Heritage Life Ins.	NYS	39.44	6.05	9.55	40.50	23.50	190	Market Corp.	NYS	167.00	2.65	6.97	168.31	97.00	21	Vesta Insurance Co.	NYS	55.50	-1.77	-6.53	64.75	32.75	1616		
American International/Finl	NDO	13.00	4.00	-6.31	15.50	11.25	13	MBA Insurance Group	NYS	69.38	7.14	3.84	69.38	45.44	2245	Zenith National Ins.	NYS	25.44	1.50	-1.21	28.75	24.50	105		
American Internatl.	NYS	113.88	3.23	4.71	114.19	75.13	4133	Meadowbrook Insur. Group	NYS	28.56	-1.30	9.59	29.50	21.25	21	INSURERS/REINSURERS AVERAGE								2.37	1.55
Argonaut Group	NDO	35.06	-2.60	3.51	38.13	26.75	926	Mid Ocean Ltd.	NYS	59.56	9.54	9.79	66.75	44.13	534	HEALTH MAINTENANCE ORGANIZATIONS									
AXA-UAP Group	NYS	43.38	5.31	11.22	43.44	29.25	573	MMI Cos. Inc.	NYS	24.94	2.05	-0.75	30.63	20.75	86	Humana Inc.	NYS	21.00	4.67	1.20	25.31	17.63	2963		
Baldwin & Lyons Inc.	NDO	22.50	-1.37	-6.74	28.75	17.38	1	Mutual Risk Mgmt. Ltd.	NYS	29.75	-0.21	-0.63	30.50	16.75	391	Oxford Health Plans	NDO	19.25	10.00	23.69	89.00	13.75	30730		
Berkley W.R. Corp.	NDO	44.00	6.99	0.28	46.38	31.19	442	NAC Re Corp.	NYS	50.56	1.13	3.59	52.88	35.38	228	Pacificare Health Sys.	NDO	58.75	4.68	16.92	85.63	46.75	234		
Berkshire Hathaway Inc.	NYS	53400.00	6.16	16.09	53400.00	30000.00	1	Navigator Group	NDO	18.38	5.00	-2.16	22.50	15.75	66	Safeguard Health Enter.	NDO	11.13	34.85	-17.59	17.00	6.13	44		
Capital RE Corporation	NYS	59.56	0.00	-4.03	62.88	38.75	180	Nobel Insurance Ltd.	NDO	13.31	0.47	1.43	15.38	11.88	73	Sierra Health Services	NYS	34.38	5.97	2.23	41.63	23.75	180		
Capitol Transamerica Corp.	NAS	20.25	-6.90	-4.99	28.13	19.25	86	NYMagic Inc.	NYS	25.75	-6.36	-6.58	29.81	18.38	29	United Healthcare Corp.	NYS	52.25	1.95	5.16	60.13	42.44	4005		
CapMac Holdings Ltd.	NYS	32.00	4.07	-7.91	35.75	22.50	774	Ohio Casualty Corp.	NDO	47.00	3.72	5.32	51.00	35.50	274	Wellpoint Health Networks	NYS	50.50	3.06	19.53	61.13	33.00	633		
Centris Group Inc.	NYS	25.31	15.06	13.45	25.31	17.88	167	Old Republic Int'l	NYS	40.94	4.47	10.08	40.94	24.63	1516	HMOs AVERAGE								9.31	7.31
Charwell Re	NYS	31.25	-7.75	-7.41	36.25	24.50	85	Orion Capital Corp.	NYS	46.00	3.23	-0.94	51.00	30.88	323	ALL COMPANIES AVERAGE								4.62	3.22
Chubb Corp.	NYS	79.69	4.94	5.37	79.69	51.13	2441	Partner Re Ltd.	NYS	46.13	-0.81	-0.54	48.13	30.75	310										
CIGNA Corp.	NYS	179.25	5.71	3.99	200.75	136.94	1425	Penn-America Group Inc.	NDO	19.63	-0.63	-4.27	21.75	11.25	16										
CNA Financial Corp.	NYS	134.44	0.61	5.23	135.94	96.38	137	Philadelphia Cons. Holding	NDO	19.63	3.29	10.56	23.25	12.75	215										
CNA Surety	NYS	15.38	-3.15	-0.40	16.50	12.88	138	PXRE Corp.	NYS	32.13	-5.17	-3.20	35.25	24.75	116										
EMC Insurance Group Inc.	NDO	12.88	-3.74	-2.83	15.00	10.75	66	Reliance Group Holdings	NYS	14.50	3.57	2.65	15.13	9.13	836										
								Reliastar Financial Corp.	NYS	41.88	0.90	1.67	42.38	27.50	1156										
								RenaissanceRe Holdings Ltd.	NYS	42.56	1.85	-3.54	50.00	34.13	238										
								Risk Capital Holdings	NDO	23.25	4.49	4.49	24.00	16.00	74										

*We taught shipping clerk Joe Mattingly
the safest ways to lift packages.
[Especially one that's quite a handful.]*



Liberty Mutual is committed to reducing the impact of low back pain, so someone like Joe won't miss work, or the occasional piggyback ride with daughter Lisa. At our research center we analyze how variations in bending habits can affect the risk of low back pain. Our research has led to innovative products like Computask[™], a software program we use to evaluate workplace tasks and help recommend ways to ensure that Joe and daughter Lisa live safer, more secure lives.

➤ *There's more information we'd like to share. So please call John Ryan
at (617) 574-5842 or visit our website at <http://www.libertymutual.com>*

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