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Update

Long-awaited Lloyd's report to be released this week

LONDON—Lloyd's of London this week will release a long-awaited task force report that includes suggestions for unprecedented ways to improve the market's capital base.

The Council of Lloyd's received the 280-page report, along with a 10-page executive summary, last week and discussed it over the weekend. Lloyd's will announce the report's contents early this week and is scheduled to formally unveil its proposals at a press conference on Wednesday. All Lloyd's members are expected to receive a copy of

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'Play-or-pay' proposals hit

Plans to increase access to health care would cause firms to drop benefits: Study

By JERRY GEISEL

WASHINGTON—Proposals to require employers to offer group health care plans or be hit with new payroll taxes would lead to a gargantuan new public health care plan nearly four times larger than Medicare, according to a new study commissioned by the Bush administration.

The play-or-pay approach would ensure coverage for the nation's 34 million uninsured Americans, but it would sock employers and other taxpayers with tens of billions of dollars in new taxes, the study finds.

Such a proposal, now under consideration in Congress, would radically change the way most Americans receive coverage, according to the study released last week.

If employers were given a choice of offering a health care plan or paying a new 7% payroll tax, many would find it cheaper to pay the tax and then terminate their health care plans, shifting millions of workers and dependents into the new public plan that would be created to cover the uninsured, the study concluded.

In fact, it said, if a 7% payroll tax was set, the number of employees and dependents covered by employer-sponsored plans would plummet to 104.7 million from the current 142.2 million.

The study projects the new public plan would cover about 112 million people, comprising workers and dependents from employers terminating health care plans, tens of millions of Americans now covered by Medicaid and other government programs, as well as people who now buy individual insurance or are uninsured. That would make it nearly four times the size of the federal Medicare program.

In all, the study said more non-elderly Americans—a projected 52%—would receive coverage through the public plan than from employers.

If the tax were set at 9% of payroll, the public plan would be smaller, though still large, according to the study. With a 9% tax, 84.8 million Americans, including 57.1 million workers and dependents, would receive coverage through the public plan.

Aside from shifting tens of millions of workers and dependents to a public program, a play-or-pay mandate also would hit employers—chiefly those without health care plans—with billions of dollars in new taxes.

According to the study, a play-or-pay proposal with a 7% payroll tax would directly raise employers' annual costs by about $29.7 billion, compared with $44.3 billion with a 9% tax.

However, because the payroll taxes would not cover the full costs of the public plan, the federal government would have to find new revenues—presumably through higher taxes—to fund the public plan, according to the study. For

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Punitive damage problem is exaggerated: Report

By STACY ADLER GORDON

BOSTON—A study funded by an organization linked to plaintiffs' lawyers that suggests punitive damages are not a major societal problem is drawing stinging criticism from defense attorneys and tort reform advocates.

The frequency of punitive damage awards in non-asbestos cases is decreasing, according to the study. And even when punitive damages are awarded by juries, they are often reduced or reversed on appeal, the study points out.

"This study shows the exaggerated importance given to punitive damages in the legal landscape," said study author Michael Rustad, a professor at Suffolk University Law School in Boston.

"Punitive damages are rarely imposed, so it is surprising they are a national policy issue," said Mr. Rustad, who received a grant to conduct the study from the Roscoe Pound Foundation, which is largely financed by members of the Washington, D.C.-based Assn. of Trial Lawyers of America. The foundation, which is named after a former dean of the Harvard Law School, studies how the law influences society.

Critics of Mr. Rustad's conclusions say the fact that punitive damage awards are frequently reduced or overturned by appellate courts shows that juries are not being properly instructed by judges in cases involving punitive damages.

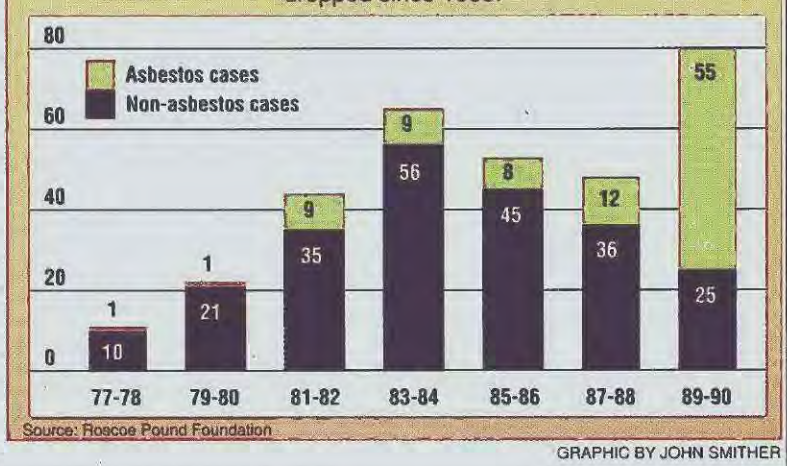
"This study supports the need for reform," said product liability defense attorney Malcolm Wheeler of Parcel, Mauro, Hultin & Spaanstra in Denver. "It shows that juries are often influenced by passion or prejudice."

In his study titled "Demystifying Punitive Damages in Product Liability Cases: A Survey of a Quarter Century of Trial Verdicts," Mr. Rustad found that punitive damages have been awarded in only 355 product liability cases in all U.S. courts between 1965 and 1990.

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Punitive damages awarded in asbestos vs. non-asbestos cases

The number of asbestos cases in which punitive damages were awarded has increased since 1985, while the number of punitive damage awards in non-asbestos product liability cases has dropped since 1983.



Source: Roscoe Pound Foundation

GRAPHIC BY JOHN SMITHER

Medicare seeks repayment from employers

By MARK A. HOFMANN and JERRY GEISEL

WASHINGTON—A federal agency this month will begin mailing bills to recover hundreds of millions of dollars that employer health care plans—not the Medicare program—should have paid on behalf of older workers and other beneficiaries.

The Health Care Financing Administration, the federal agency that administers Medicare, acknowledges that in many cases the amounts it is seeking will be overstated. In these cases, plan administrators will have to demonstrate that the health care plan would have paid a lower benefit or would not have covered some medical care at all.

HCFA soon will begin sending bills to third-party claims administrators, insurers and, in some cases, to employers to recover payments Medicare improperly made to hospitals and physicians.

These notices are part of the last phase of a massive HCFA project to ensure the government reaps the savings Congress intended when legislators passed a series of laws in the 1980s to shift to employer plans some health care costs that Medicare previously paid.

Under those laws, employer plans became the primary payer of health care bills for employees who stayed on the job when reaching age 65. Medicare then became the secondary payer.

In addition, those laws made employer plans the primary payer for some non-elderly employees with permanent kidney failure and for employees with certain other disabilities for whom Medicare previously was the primary payer.

Congress intended to shift billions of dollars in costs from the financially ailing Medicare program to employer plans.

But, hundreds of millions of dollars in potential savings have not been realized by HCFA because Medicare continued to pay claims for beneficiaries—generally workers older than 65 and their spouses—who were covered by employer health plans. The Medicare program was not always aware that the beneficiaries were covered under an employer health plan that should have been the primary payer of the beneficiaries' health care bills.

Concerned that the anticipated savings were not being realized, Congress in 1989 gave HCFA authority—in cooperation with the Internal Revenue Service and the Social Security Administration—to comb payroll records after 1986 to identify individuals with employment-related income after they turned 65. HCFA then asked employers if and when those individuals had group health insurance (*BI*, Feb. 4, 1991).

With that portion of the project drawing to a close, HCFA now is examining Medicare records to see how much Medicare paid on behalf of beneficiaries covered under employer health plans.

After examining the Medicare records, HCFA will send out bills, typically to an employer's current TPA, to recover payments the employer's health care plan should have made.

But HCFA officials acknowledge the bills often will be overstated because they will reflect the payment Medicare actually paid, not the amount an employer would have paid if its health plan had been the primary payer. The bills will not reflect the amount that employers' plans should have paid in light of provisions like deductibles and coinsurance.

For example, assume Medicare erroneously paid a $10,000 claim for hospital services incurred in 1989 for a 66-year-old employee. HCFA will now send out a $10,000 bill.

But, in 1989, the employer's group health plan may have covered only 80% of employees' hospital expenses. As a result, HCFA only would be entitled to $8,000

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Update

Lloyd's task force report due

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the report within three days of its public release.

Although the report was not available last week, the market was rife with rumors about its recommendations, which may include:

- Raising external capital, possibly through corporate membership rather than individual membership.
- Retaining unlimited liability, but on a syndicate level rather than on individual member level. Members' losses would be capped, and losses above that cap would be paid by a levy on all Lloyd's members. Or, the report may suggest that members retain unlimited liability but be offered stop-loss insurance funded by a levy on all members.
- Prohibiting managing agents from owing members' agents, though brokers could continue to own members' agents.

It is unlikely that the panel will recommend one-year accounting to replace the three-year system syndicates now use.

The 14-person task force has met for the past year to "identify the framework within which the society should, ideally, be trading five to seven years hence," Lloyd's said when the group was formed. In particular, the group's goal has been to "examine and assess the advantages and disadvantages of the present basis on which capital is provided to support underwriting at Lloyd's."

The task force was formed before the market unveiled its record 509.7 million pound ($983.7 million at appropriate exchange rates) loss for the 1988 underwriting year (*BI*, July 1, 1991).

Lincoln National to sell units

FORT WAYNE, Ind.—Lincoln National Corp. agreed late last week to sell its managed care divisions and most of its group life and health operations. Terms were not disclosed.

TakeCare Inc., a Concord, Calif.-based health maintenance organization, will purchase Lincoln National's 22 HMOs—with about 300,000 members—and its network of 24 preferred provider organizations. TakeCare currently serves about 2,100 employer groups and covers 233,000 members.

Great-West Life & Annuity Insurance Co. of Englewood, Colo., will assume almost all of Lincoln National's group life and health business, including the 335,000 members of Lincoln National's PPOs. Great-West, a unit of investment firm Power Corp. of Canada, has more than 4,000 group life and health clients and wrote nearly $922.7 million in group life and health premiums in 1990. Lincoln National's 1990 group life and health book of business included about 2,200 group life and health clients covering about 800,000 lives, with most plans covering 50 to 2,000 lives. Its group life and health premiums totaled $724.7 million, according to A.M. Best Co.

Few details of the deals were released. But, the insurer said it expects to take a $60 million to $90 million charge against fourth-quarter net income to cover expenses related to the sale. And, it has said it hoped to receive more than $250 million (*BI* Sept. 30, 1991).

Lincoln National said in September that despite "dramatic" improvement over the last two years, it is unsure of the future of group life and health business and does not want to make further investments. Lincoln National also sold its network of 16 third-party administrators recently to a consortium that included its management. The company is not selling its small Employers Health Insurance Co. unit.

OSHA warns N.C. safety plan

WASHINGTON—U.S. Labor Secretary Lynn Martin last week gave the North Carolina Department of Labor 90 days to bring its state workplace safety program up to federal standards.

If the state's Occupational Safety and Health Plan, which is responsible for workplace safety inspections, does not comply, it could be decertified and its activities taken over by federal authorities.

The state OSHA plan has come under intense criticism for failing to inspect a poultry processing plant at which 25 workers died in a Sept. 3 fire (*BI*, Oct. 7, 1991; Sept. 9, 1991).

More breast implant suits filed

HOUSTON—Forty-eight suits were filed in three Texas county courts against the manufacturers of silicone breast implants immediately following last week's move by the U.S. Food and Drug Administration to discontinue the implants.

FDA Commissioner David Kessler on Jan. 6 asked all doctors to stop performing silicone breast implant procedures and all manufacturers to stop supplying them until the agency reviews new information concerning their safety that arose from a recent product liability case against a Dow Corning Corp. subsidiary. In that case, a federal court jury in San Francisco awarded $7.3 million in damages to a California woman who contracted a severe immune system disease after her silicone breast implants ruptured (*BI*, Dec. 23).

The 48 new lawsuits, filed Jan. 6 in state courts in three Texas counties by attorney Richard Laminack of O'Quinn, Kerensky & McAninch in Houston, brings to nearly 400 the total number of suits pending against the silicone breast implant manufacturers, says Public Citizen Health Research Group, a consumer group tracking the litigation.

In addition to Dow Corning, other silicone manufacturers named in the 400 suits include Bristol-Myers Squibb Co., McGahn Medical Co., and Minnesota Mining & Manufacturing Co., said Jeff Steidley, a partner with Olivier & Steidley in Houston, who represents 50 other women seeking compensation for injuries related to breast implants.

More than 1 million women have received silicone breast implants since 1961, the FDA estimates.

Felony charges filed in oil spill

LOS ANGELES—The Los Angeles County District Attorney has filed the first criminal charges under California's 1990 Oil Spill Prevention and Response Act, which makes it a felony to discharge oil into state waters.

The complaint, filed in Los Angeles County Municipal Court last week, names Pan Ocean Shipping Co. Ltd. of Seoul, South Korea,

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Court rules for Intel in pollution dispute

By STACY ADLER GORDON

SAN FRANCISCO—Ten years after first seeking coverage for pollution cleanup costs, Intel Corp. has won its battle with Hartford Accident & Indemnity Co.

The 9th U.S. Circuit Court of Appeals ruled Dec. 24 that the computer company's cleanup costs were covered "damages" as that term is used in the comprehensive general liability policy. And the court found that the pollution exclusion, which bars coverage for all pollution that is not "sudden and accidental," did not bar coverage.

Many courts have found that policyholders are insured when they are required by the government to clean polluted property. But the Intel decision is one of the few to find that there is coverage when a policyholder enters voluntarily into a consent decree with the U.S. Environmental Protection Agency to clean polluted property.

As a result, the decision could be important for other policyholders in the 9th Circuit, which includes Alaska, Arizona, California, Hawaii, Idaho, Montana, Nevada, Oregon, Washington and Guam.

The most immediate impact of the decision will be to provide Intel with coverage for its costs to clean pollution on third-party property that resulted when underground storage tanks at its Mountain View, Calif., facility leaked toxic chemicals into the soil and groundwater. On remand, Intel will have to differentiate between money spent to clean its own property, which is not covered, and that spent to clean third-party property, which is covered.

Intel, which is based in Santa Clara, Calif., manufactured semiconductors at the plant from 1968 through 1980. Solvents containing a variety of hazardous chemicals

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Health care conference

April meeting to examine managed care, cost containment

NEW YORK—More than two dozen experts from the managed care, group health insurance and benefit consulting fields highlight the agenda of the first annual Health Care Management and Cost Containment Conference, to be held April 27-28 in New York.

The conference, co-sponsored by *Business Insurance* and The International Business Forum Inc., will be held at the Grand Hyatt Hotel in midtown Manhattan.

With the theme "Managed Care, a Changing Industry," the Health Care Management and Cost Containment Conference will feature speakers representing employers, health care providers and managed care companies, and employee benefit consultants.

The speakers will address the problem of skyrocketing health care costs and offer solutions to help control costs. The latest innovations in managed care also will be discussed.

"*Business Insurance* is co-sponsoring this conference because we recognize that managed care is an important tool for corporate America to control rising health care costs," said Kathryn J. McIntyre, publisher/editorial director of *Business Insurance* and conference chairwoman.

"Because managed care as a concept is relatively new and is constantly changing, we believe it should be explored in a forum like this," she said.

Panel discussions will get under way Monday morning when three experts will discuss current models of managed care, trends that are changing managed care and the next generation of managed care. The panelists will be Dr. Roger S. Taylor, national leader of health care at The Wyatt Co. in Washington, D.C.; Charles Jacobs, president of InterQual Inc., a medical consulting firm in Marlboro,

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BI's directory of UR providers set for February

The Feb. 17 issue of *Business Insurance* will contain the annual directory of utilization review providers. The issue also will feature a spotlight report on health care cost control.

The directory is published as an editorial service; there is no charge for companies to be included. To be listed, companies must fill out and return a questionnaire provided by *BI*.

If your company provides utilization review services directly to employers and you have not yet received a questionnaire, please request one by calling Karen Armaganian at 312-280-3195.

The extended deadline for returning completed questionnaires is Jan. 18.

Industry defendants ask justices to review antitrust decision

By JUDY GREENWALD

WASHINGTON—The property/casualty insurance industry would be left "in a state of paralyzing uncertainty for many years" if the U.S. Supreme Court refuses to review an appellate decision reinstating the massive antitrust litigation against the industry, says a petition filed last week.

The petition, filed by domestic insurance and reinsurance entities named in the antitrust litigation, asks the Supreme Court to review the June 1991 ruling by a three-judge panel of the 9th U.S. Circuit Court of Appeals that unanimously overturned an earlier dismissal of the suit (*BI*, June 24, 1991; Sept. 25, 1989).

The appellate court subsequently refused the defendants' request for either a rehearing or a review by an 11-member panel of the 9th Circuit (*BI*, Oct. 21, 1991).

Additional petitions seeking Supreme Court review are expected to be filed today by London defendants and by defendant Winterthur Reinsurance Corp. of America, says Mark I. Levy, an attorney with Mayer, Brown & Platt of Chicago, who worked on the domestic defendants' petition.

In their original lawsuit in 1988, state attorneys general alleged that 32 defendants—including major U.S. insurers and reinsurers, the Insurance Services Office Inc. and the Reinsurance Assn. of America,

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Reviving Maine's work comp system

Emergency rule lures 3 major insurers to return, but angers other underwriters

By MEG FLETCHER

AUGUSTA, Maine—A new emergency rule that changes the way deficits in Maine's workers compensation assigned risk plan are allocated among the state's casualty insurers has lured back enough insurers to revive Maine's faltering workers comp market for up to a year.

But, the Bureau of Insurance's actions have created a split between insurers that write a large amount of workers comp business and those casualty insurers that write little or no workers comp coverage in Maine.

The new allocation formula is designed to reduce the burden of residual market assessments on large worker comp insurers and increase the burden on casualty insurers that write little or no workers comp insurance in Maine.

In addition, the stopgap measure does not address the nagging problems—including a projected but unspecified shortfall in residual market capacity—that still plague the system despite legislative reforms last year (*BI*, July 22, 1991). Those problems prompted the National Council on Compensation Insurance recently to request a 32.2% rate increase effective on May 1.

Maine's Bureau of Insurance adopted the rule and related amendments last month on a 90-day emergency basis.

The emergency rule was enough to lure three of the largest insurers of workers comp coverage in Maine back to the market. They rescinded their plans to withdraw last month and agreed to resume accepting assignments as servicing carriers for coverage written in the state's assigned risk plan.

The residual market writes at least 89% of the $300 million in total workers comp premium volume in Maine (*BI*, Nov. 18, 1991).

Those three insurers are: Commercial Union Insurance Co. of Boston, which wrote 17.1% of the residual market in 1990; Hanover Insurance Cos. of Worcester, Mass., which wrote 21.8% of the residual market; and Maine Bonding & Casualty Co. of Portland, a Maryland Casualty Co. unit that wrote 9.5% of the residual market.

"At least these three will keep the system afloat," said Peter Burton, vp of the NCCI's Northern region.

"The emergency rule is perhaps a Band-Aid for another year," said Joseph A. DiGiovanni Jr., vp of the New England region for the American Insurance Assn.

The collapse of the state's fragile workers comp system "seems to be averted for at least another year," said Joel Russ, vp and general counsel of the Maine Chamber of Commerce & Industry in Augusta.

In addition, Peerless Insurance Co. of Keene, N.H., which writes a small amount of voluntary market coverage, also rescinded its withdrawal notice.

Altogether, there are 140 insurers or insurer groups that the bureau considers licensed to write workers comp coverage in the state, said Acting Insurance Superintendent Richard Johnson.

But several workers comp insurers are following through with their plans to reduce or to curtail their workers comp writings in the state, which the bureau has approved. They are: American Fidelity Co. of Montpelier, Vt.; most insurers affiliated with Royal Insurance Co. of America of Charlotte, N.C.; Travelers Corp. of Hartford, Conn.; and United States Fidelity & Guaranty Co. of Baltimore.

The withdrawing insurers—

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GRAPHIC BY CYNTHIA WATSON

Health insurer sues union for fraudulent enrollment

By LORI BLOCK

NEW YORK—State Mutual Life Assurance Co. of America is suing a labor union local, claiming the local padded its membership rolls and misled the insurer to secure health insurance for thousands of people with no traditional ties to the union.

The suit, filed last month in U.S. District Court in Manhattan, alleges that Local 906 of the Retail, Drug, Cigar, Soda & Luncheonette Employees Union enrolled thousands of people who, as "associate" members, had no other ties to the union so that the associate members could take advantage of the group rates under a policy issued in June.

State Mutual, which is based in Worcester, Mass., seeks either a declaratory judgment that the contract never existed or a judgment rescinding it.

Several officials of the New York local are named as defendants.

Also named as defendants are five privately held corporations and two individuals, one of whom is believed to be an officer or principal of those five companies. All five are New York corporations run from the same Brooklyn address. The suit indicates that they assisted the union in administering the health plan and enrolling members, often through employers not aligned with the union but with a local business group.

State Mutual alleges that the union local enrolled thousands of people who, as 'associate' members, had no other ties to the union so that the associate members could take advantage of the group rates.

Associate members paid monthly union dues of $12 but had no voting rights. Union bylaws were changed to allow associate member status for "any person who is employed or was at one time previously employed." An associate member's current or former employer did not have to be covered under a collective bargaining agreement with the union.

This union status enabled associate members to join the health plan. Either members or their employers were charged monthly premiums of $160 for individual coverage and $396 for family coverage, according to Richard R. Lutz, a lawyer representing State Mutual.

When the contract was entered into in June, the number of associate members was misrepresented to State Mutual, the insurer alleges. State Mutual claims that it only later discovered that "nearly all" the people who were covered by the plan were associate members. Both sides estimate plan enrollment at 6,500 to 8,000.

Mr. Lutz, with the New York law firm of Townley & Updike, added that associate members paid the corporate defendants a fee based on a percentage of the premiums paid.

Lawyers for the defendants maintain that State Mutual knew about the associate members and knew that they would be a significant part of the covered pool.

As this case begins, another suit

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Higher limits, deductibles are urged for police liability

$1 million in coverage 'doesn't do it'

By JUDY GREENWALD

Local governments could make better use of their law enforcement liability insurance premiums by purchasing higher coverage limits with larger deductibles, according to a recent survey.

Public entities could reduce their exposure by placing greater stress on police education and training, the survey said.

In addition, local governments should not rely on sovereign immunity to protect them from lawsuits because many suits are filed in federal court, where the doctrine does not apply.

These are among the findings of a recently released study of 1,151 jurisdictions conducted by The Wyatt Co. and the International City/County Management Assn., a professional and educational group of city and county administrators. It was conducted between October 1990 and January 1991.

Public entities commonly purchase just $1 million of police professional liability insurance, the survey found.

"While some entities purchase significantly higher or lower limits, a $1 million limit was by far the most common across all entities and even across all subgroups by size, geographic (area) and type of coverage provider (pool vs. commercial insurer)," says the survey. The only exception was among Pacific Coast jurisdictions, which were evenly split between $500,000 and $2 million limits.

The mean limit purchased by governments insured by public entity pools was $2.1 million, while the mean limit purchased by those with commercial insurance was $1.1 million.

However, $1 million in coverage limits "doesn't do it," contends Paul Buse, a Washington, D.C.-based Wyatt consultant who worked on the survey. "The upside to loss is much larger than that."

Among the surveyed local governments, the largest reported settlement since 1985 was $2.5 million, far exceeding the police professional liability limits most public entities purchase.

The survey also found that 75% of settlements are below $10,000. But, many jurisdictions—particularly small ones—reported setting their deductibles at just $5,000.

Doubling the amount of the deductible would allow governments to use their insurance more efficiently, focusing on less frequent but more severe losses, the survey

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MBIA predicts bond market growth will top record year

Bullish on muni bond cover

By MICHAEL SCHACHNER

NEW YORK—Financial guarantee insurance volume this year will top its record 1991 performance as the municipal bond market is expected to grow by about 7%, forecasts an executive with a leading financial guarantee insurer.

Records will be set both for the volume of new municipal bonds and financial guarantee insurance written, according to David Elliott, president and chief executive officer of MBIA Corp. of Armonk, N.Y.

The nation's deteriorating infrastructure and reduced federal support of state and local governments will push new-issue, long-term, tax-exempt municipal bond volume to about $180 billion in 1992, up 7.1% from approximately $168 billion last year, Mr. Elliott said last week at MBIA's fifth annual forum on the municipal bond market.

He expects the insured portion of the municipal bond market to reach 33% to 35% in 1992, up from about 31% last year. Total insured bond volume likely will exceed $60 billion this year, he said.

"We're very optimistic about the prospects of the municipal bond market in 1992, and with the economic pressures facing municipalities, credit enhancement will be pursued more than ever," he said.

"Credit quality is a growing concern for retail investors, which are the predominant buyers of tax-exempt municipal bonds. In light of the economic crunch hitting many municipalities, the importance of bond security is currently at its highest level," Mr. Elliott said.

Despite the recession and widespread state and local budget deficits, MBIA says it remains optimistic about the 1992 bond market.

Mr. Elliott highlighted three reasons for his bullish outlook:

- The U.S. infrastructure badly needs improvement. Approximately 25% of the nation's highways are in poor condition; about 500 million hours are wasted annually in urban and suburban traffic because roads cannot efficiently handle the traffic volume; and about one-third of the water supply in some cities is lost because of the dilapidated public water transport system.

"Public works are tired and aging, and nearly all public facilities are deteriorating," Mr. Elliott said. "However, local governments are struggling along without much help from anyone. Thus, municipal bonds are the engine to finance rehabilitation projects."

- As federal financial support continues to decline, state, county and city governments are being forced to float bonds to fund public works.
- Interest rates will remain low in 1992, making it easier for many municipalities to pay off old debts and reissue bonds at lower rates.

Mr. Elliott pointed out that 30% of the 1991 municipal bond volume consisted of reissues of old bonds, compared with 25% in 1990.

Long-term, tax-exempt bonds

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NWNL Cos. to sell Chartwell Re

By DOUGLAS McLEOD

MINNEAPOLIS—The NWNL Cos. Inc. is selling reinsurer subsidiary Chartwell Re Corp. to an investor group that includes Chartwell's management and led by an affiliate of London-based investment bank S.G. Warburg & Co. Ltd.

NWNL, the parent of Northwestern National Life Insurance Co., said the sale will allow it to concentrate on its life, health and annuity operations.

The sale, announced last week, is expected to be completed early this year, following approval from Minnesota insurance regulators.

Although NWNL did not disclose the sale price, it is believed to be about $66 million, which is equal to Chartwell's 1990 net worth using generally accepted accounting principles. NWNL said the sale will not materially affect its earnings and will increase its statutory surplus.

Chartwell Reinsurance Co., Chartwell's Stamford, Conn.-based property/casualty reinsurance underwriting unit, estimates gross written premium volume of $31 million for 1991, an increase from $18 million in 1990, said Chartwell President Richard E. Cole.

The reinsurance unit's policyholder surplus is estimated to be $51 million as of year-end 1991, a slight erosion from $54 million at the end of 1990, according to Mr. Cole.

Chartwell is being sold to a group led by Wand Partners Inc., a New York-based affiliate of S.G. Warburg, which will be Chartwell's majority shareholder, according to Bruce W. Schnitzer, chairman of Wand and a former president of Marsh & McLennan Inc.

Other investors are Michigan Mutual Insurance Co. of Detroit and Chartwell's management. The company's management will hold a roughly 5% equity stake with the opportunity to increase its ownership if the company performs well.

'This buyer group has very much bought into our philosophy,' Mr. Cole observes.

Chartwell also is seeking to raise additional capital through private placements of shares with other investors, Mr. Cole said.

The company hopes to soon boost its surplus to about $75 million and to increase it to more than $100 million when the property/casualty reinsurance market shows signs of tightening, according to Mr. Cole.

No major changes in Chartwell's business are expected. The reinsurer will continue restrained underwriting in the soft market, Mr. Cole said, explaining that last year's big jump in gross volume resulted from the formation of a new specialty casualty unit and new catastrophe retrocessional contracts.

Chartwell will continue to focus on traditional and specialty casualty treaty business and "will increase our writings dramatically when the market turns," Mr. Cole commented.

The sale "is not changing our philosophy. This buyer group has very much bought into our philosophy," Mr. Cole observed.

Separately, New York-based Piedmont Management Co. Inc. announced two acquisitions by its reinsurance subsidiary Reinsurance Corp. of New York.

RECO last month acquired 75% of United Reinsurance Corp. of New York from Pohjola Insurance Co. Ltd., based in Helsinki, Finland, and A.G. Belges of Belgium for $23.2 million, or about 75% of United Re's book value.

RECO owned the other 25% of United Re and served as the company's underwriting manager. United Re—which wrote about $9 million in net premiums last year—will cease underwriting and its business will be taken over by RECO, Piedmont announced.

Meanwhile, RECO also acquired a 55% interest in Continental National Corp., the parent of Continental National Indemnity Co. of Cincinnati, an insurer specializing in trucking and other commercial casualty risks. The remaining 45% of CNI is owned by CNI's management.

RECO paid $3 million for its equity stake and loaned CNI $846,000 to help buy out other non-management shareholders.

CNI wrote net premiums of about $17 million last year and reported surplus of about $10 million, Piedmont said. ■

When the patient requires special attention, so does the case management.

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Editorial staff at *BI* grows

CHICAGO—*Business Insurance* has added two new editorial staff members in its Chicago office.

Sara Marley has joined *BI* as a staff reporter, while Cynthia Bloom has joined the staff as editorial assistant.

Ms. Marley, 23, has worked as a free-lance writer for the South Bend, Ind., Tribune, where she interned while earning a bachelor of arts degree in English and German from the University of Notre Dame in Notre Dame, Ind. She holds a master of science degree in journalism from The Medill School of Journalism at Northwestern University in Evanston, Ill.

As part of her graduate studies,



Ms. Marley



Ms. Bloom

Ms. Marley worked as the Washington correspondent for the Michigan City, Ind., News Dispatch.

She can be reached at 312-649-5313.

Ms. Bloom, 23, worked as a marketing director for a Chicago eye care center before joining *BI*. In addition, she was a journalism intern with the Michigan Dance Assn. in East Lansing, Mich., and a fund raising intern with the Michigan Children's Trust Fund in Lansing, Mich.

She holds a bachelor of arts degree in advertising from Michigan State University in East Lansing.

Ms. Bloom may be reached at 312-280-5398. ■

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Rationing needed to cut health tab: Researcher

Health care rationing is the only realistic way by which the U.S. can gain control of skyrocketing health care costs, according to a leading medical researcher.

America's policymakers must abandon the idea that current forms of health care cost control—like managed care, streamlining administration and promoting healthy competition among providers—will succeed in getting annual health care inflation below double digits, he says.

These methods focus almost entirely on eliminating inefficiency in the health care delivery system, says Dr. William B. Schwartz, a professor of medicine at Tufts University in Boston.

And, while these techniques have succeeded in reducing unnecessary treatments and lowering the average length of a hospital stay, they no longer are capable of curbing health care inflation on their own, he adds.

Benefit beat

"There's no magic, painless solution. We have to preserve the high-cost, high-yield procedures that save lives and do away with coverage for the high-cost, low-yield exploratory procedures," said Dr. Schwartz.

Through a two-year study partially funded by a $200,000 grant from the Washington, D.C.-based Robert Wood Johnson Foundation, Dr. Schwartz will attempt to prove that some form of health care rationing is needed to bring costs under control before the year 2000.

The study, which began this month, will focus on the financial dynamics of nearly every sector of the health care system and will dispel widely held myths that cost control can be achieved without sacrifice, said Dr. Schwartz, whose writings on the U.S. health care system have been published in several major newspapers and medical journals.

"Denying certain medical services and rationing care is the only reasonable method we have to control costs. Managed care, while it has reduced hospital days by some 30% since its inception, has. . .gone as far as it can go," Dr. Schwartz said.

Any savings achieved by managed care and streamlining of health care administration are being eroded by mammoth increases in costs associated with medical technology.

"Today we're spending billions of dollars on bone marrow transplant work, various forms of cancer treatment and the development of new diagnostic devices. And, I believe we're on the threshold of a new wave of biomedical inflation. There's nothing in sight that indicates that costs will come down," he said.

Dr. Schwartz said that his study also will show that a single-payer, national health care plan patterned after the Canadian system would only hold down costs for a limited time, after which savings would be swallowed up by increases in technology-related costs.

"We estimate that a one-payer system would eliminate the insurance industry and would save $75 billion over two years. But it, too, would run its course," he said.

In his research, Dr. Schwartz plans to examine costs associated with virtually all elements of the health care system: hospitals, physicians, dentists, pharmaceuticals, medical and pathology research, home care and nursing homes.

For each area, he'll calculate the rate of cost increases over the past 15 years, identify the forces that may influence future inflation and make projections of how costs will change over the next decade.

"We've wrung most of the inefficiencies out of the medical system that can be wrung out. Health care inflation is already regathering momentum. We need to work in a larger context and that's rationing," he said.

—By Michael Schachner

Hospital stays shorter

The lengths of hospital stays in the United States has steadily declined since 1981, recent research shows.

The average length of stay for patients in short-term, general hospitals in 1990 was 5.5 days, down 17.9% from an average stay of 6.7 days in 1981, according to data in the "1990 Length of Stay by Diagnosis and Operation" series published by Healthcare Knowledge Resources. HKR is the information distribution arm of the Commission on Professional & Hospital Activities, a non-profit center for health services research and education in Ann Arbor, Mich.

From 1989 to 1990 alone, the average short-term, general hospital stay dropped 1.8% from 5.6 days.

The downward trend is more evident when lengths of stays for specific diagnoses and procedures are evaluated.

For instance, the length of stay for a normal delivery declined 36.7% to 1.9 days on average in 1990 from 3.0 days on average in 1981. While attributing this drop to improved prenatal education, the introduction of labor-delivery rooms and pressure from third-party payers, the report says experts do not expect the average length of stay to fall much more.

The data in the report is drawn from the Commission on Professional & Hospital Activities' data base and includes information on more than 4 million discharge records from short-term, general hospital stays.

For more information on the "Length of Stay" data, contact Healthcare Knowledge Resources, P.O. Box 303, Ann Arbor, Mich. 48106-0303; 313-930-7830.

—By Sara J. Harty

Cost sharing

Brokers and consultants report that employers in the St. Louis area are asking their employees to pay more of their health care costs, according to a recent survey.

In addition, almost four out of five brokers and consultants surveyed report that employers increasingly are relying on managed care.

"St. Louis HealthWatch," a quarterly publication of Group Health Plan, a St. Louis-based health maintenance organization, surveyed 100 brokers and consultants associated with 82 St. Louis-area employers about health care issues.

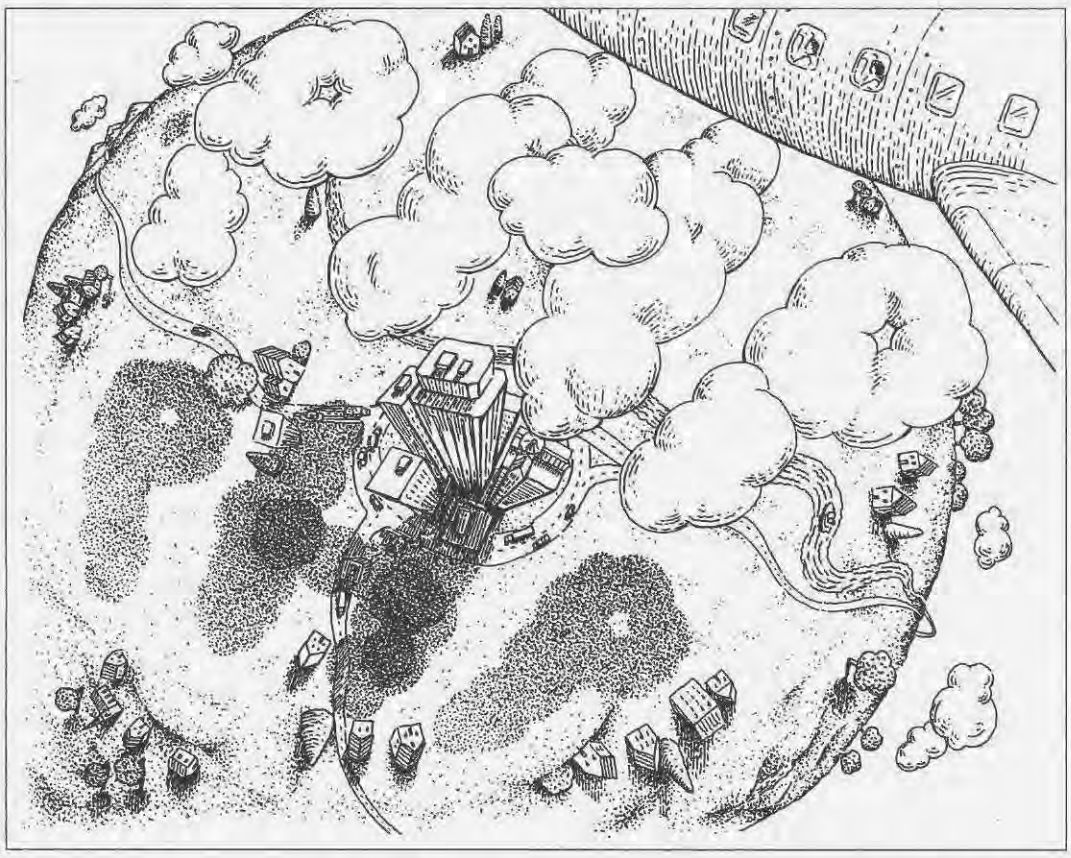
Almost all of the brokers and consultants—99%—reported that their clients have increased deductibles for health care coverage in the last two years. Increases in coinsurance levels were reported by 91% of the respondents, while 80% report that clients have "reduced specific benefits."

Nine out of 10 brokers and consultants report advising their employer-clients to move more of their employees into managed care "to a great" extent or "to some extent."

Asked to name the types of managed care programs they recommend most often, 60% of the respondents included point-of-service health maintenance organizations, while 90% of the respondents included preferred provider organizations.

Copies of "HealthWatch" are available from Steven L. Williams, Group Health Plan, 940 W. Port Plaza, Suite 300, St. Louis, Mo. 63146; 314-453-1700.

—By Sara J. Harty



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Opinions

Gazing into the crystal ball

AS IS OUR CUSTOM at the start of a new year, here is our fifth annual set of predictions on what will be "in" and "out" in the world of risk management, employee benefits and commercial insurance.

We were on the mark about two-thirds of the time last year. For example, we correctly forecast that legislative proposals for federal insurer solvency regulation would be introduced in 1991; we were on target when we predicted the continued growth of open-ended health maintenance organizations; and there was one more "mega-broker" merger as we suggested: the combination of Rollins Burdick Hunter Co. and Hudig Langeveldt Group bv.

However, we'll concede some clunkers. We predicted higher property/casualty insurance costs, and except for some isolated lines of coverage, rates are still going down or are holding steady. And while we predicted a new surge in captive insurance company growth, it never occurred.

Even though our crystal ball sometimes may be clouded (or even cracked), we refuse to give up. For better or worse, here's our look ahead at 1992:

In: New insurance company rating agencies.

Out: Blind trust by risk managers in insurer ratings.

In: Health care reform as a presidential campaign issue.

Out: Refusal to admit there is a health care crisis.

In: Risk managers increasingly worried about the end of the soft property/casualty market.

Out: Renewals with twice the coverage limits at half the price.

In: Pension simplification legislation.

Out: More IRS pension non-discrimination rules.

In: Increased availability of pollution liability insurance.

Out: Agreement among courts on how to interpret coverage for cleanup costs.

In: Completing financial reinsurance deals.

Out: Talking about financial reinsurance deals.

In: More legislative proposals for federal oversight of insurer solvency regulation.

Out: Proposals for a national property/casualty guaranty fund.

In: Continued turmoil at Lloyd's of London.

Out: Lloyd's members' unlimited liability.

In: Tight risk management budgets.

Out: New captive insurer formations.

In: "Living benefits" provisions in group life insurance policies.

Out: Employer ignorance of the AIDS epidemic.



In: Insurance fraud prosecutions.

Out: Offshore reinsurers capitalized entirely with gold certificates and penny stocks doing business in the United States.

In: Concern about the quality of life insurers' investments.

Out: Investing in junk bonds and real estate.

In: Defined contribution pension plans.

Out: Defined benefit pension plans.

In: Renewed negotiations between the insurance industry and McCarran-Ferguson opponents.

Out: Absolute repeal of McCarran-Ferguson.

In: Expanded Medicaid program.

Out: National health insurance.

In: Medical malpractice reform proposals.

Out: Product liability reform legislation.

In: Reduced health care inflation.

Out: Unmanaged medical indemnity plans.

In: More OSHA crackdowns on employers.

Out: Lax state workplace safety regulation.

In: Concern by property/casualty insurer executives over the state of the market.

Out: Property/casualty insurer profits.

In: Adding long-term care plans to employer-provided benefit packages.

Out: Taxing health insurance benefits.

In: Tabulating retiree health plan liabilities.

Out: Unlimited retiree medical benefits.

In: The Continental European insurance industry.

Out: The London market.

Letters

Reconciling one insurer's woes with others' gains

To the editor: The gist of a page 1 article in the Nov. 18 issue, "Hartford Reinsurance Cost Grabs Attention," is that Hartford Group Inc. will pay 50% more for its catastrophe reinsurance next year, provided that capacity is available. The implication was that this may be the tip of the iceberg.

The gist of a page 1 article in the Dec. 9 issue, "P/C Insurers' Profit Gains Spell Further Rate Cutting," is that despite all kinds of negative patterns at property/casualty insurers—underwriting losses increased from the previous year, net premium volume fell, cash flows declined, interest rates fell, reserve levels weakened—net income for major property/casualty insurers jumped 28.6% and policyholder surplus increased 16.4%.

The consensus seems to be that despite all the signs of trouble ahead, there will be further rate cutting. I'm not an actuary, so maybe that's why I don't understand what I am reading.

Even though I have been in this business for more than 35 years, it makes no more sense to me than to my clients. Their attitude is: "Don't believe any numbers coming from the insurance companies because it can't be bad if they keep reducing their prices." No company sells their product for less than it costs to produce. Who can argue with that?

R.L. Fisher
Property/Casualty Insurance Consultant
McNeary Insurance Consulting Services Inc.
Richmond, Va.

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

No relation to exec arrested in Germany

To the editor: I would like to make it clear that the Norman Howard and Sterling Insurance Corp. that are mentioned in the Dec. 16, 1991, *Business Insurance* article, "Fugitive Insurer Exec Arrested in Germany," are in no way related to John Howard and Sterling Risk Placement Inc., which until recently placed surplus lines business and operated from Chicago.

John R. Howard
Vp
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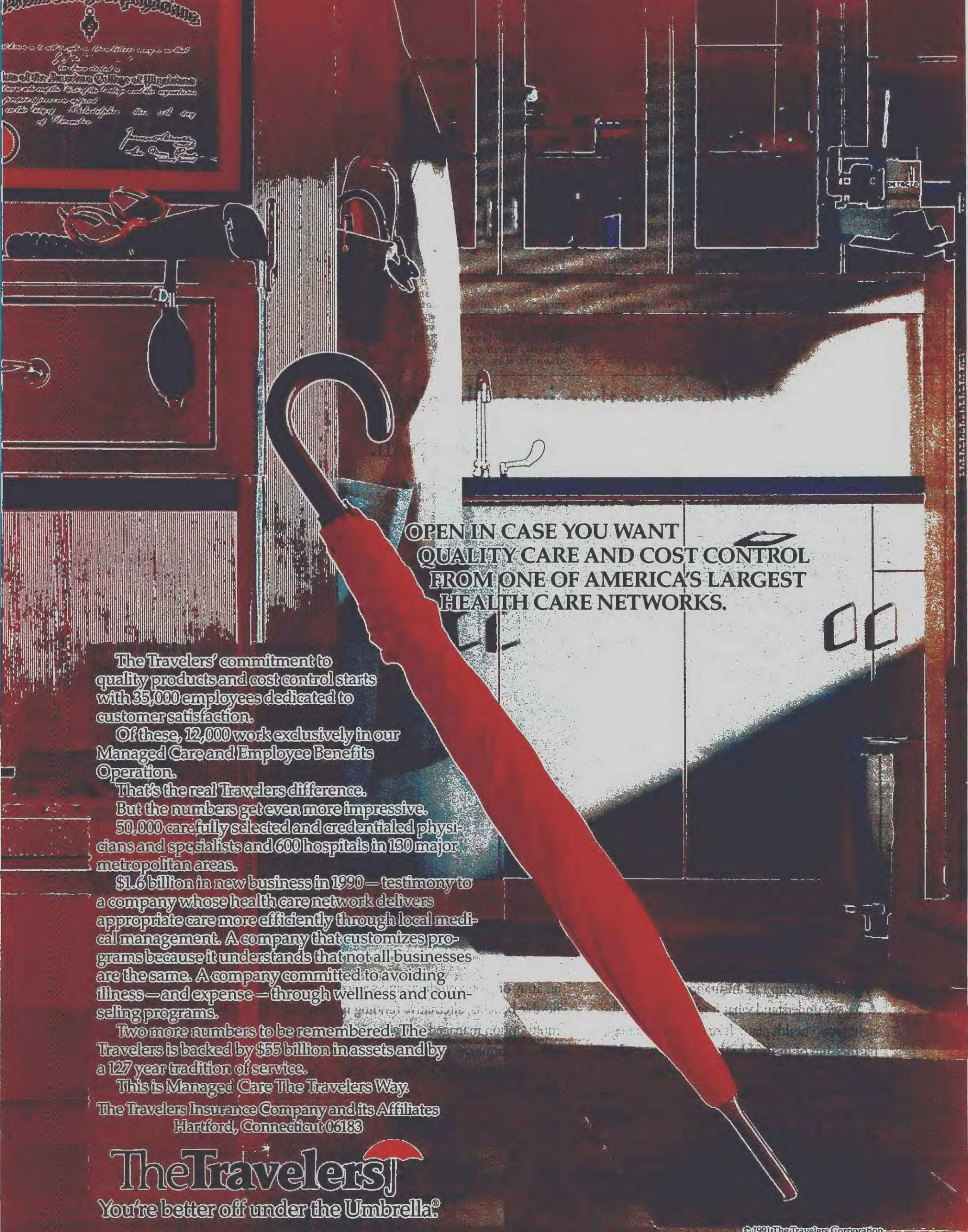
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Law enforcement

Continued from page 3

says. "The savings realized from raising deductibles will be well spent on purchasing higher limits."

The low-frequency/high-severity nature of law enforcement claims also is cited in the survey as an argument against self-insuring. According to the survey, 69.5% of localities with populations of less than 100,000 buy commercial insurance, compared with only 25.3% of larger entities.

And of all those that do not purchase insurance, 67.5% said it is because they choose to self-insure. The survey, though, warns that "most insurance and risk management practitioners would not consider police professional liability a candidate for self-insurance. . . .This kind of insurance is not an ideal risk to self-insure, as it is a low-frequency/high-severity loss exposure above the $10,000 loss level."

The other factor cited most frequently by respondents that do not purchase police liability coverage is that they contract out for law enforcement officers. Most—54%—of the jurisdictions giving this reason have populations of 10,000 to 24,999.

Sources of claims also were analyzed by the survey. It found that the three most frequently cited causes of claims were undue use of force, false arrest and failure to follow due process.

All are problems that are "very much influenced" by police education and training, said Mr. Buse. "Good training and education is a major key to lowering your liability."

The survey also notes that jails traditionally have been considered a source of police professional liability claims, and the results of the study substantiate this to a degree.

According to a breakout of claims resolved between 1985 and 1990, almost 33% of the responding local governments with jails had resolved at least one claim since 1985, while only 25% of entities without jails had resolved at least one claim since then.

"The difference between 33% and 25%, while far from decisive, seems to indicate a higher claims frequency for those entities with jails," the survey said.

The median settlement cost for a claim was $1,000, the survey found, while the median defense cost was double that, at $2,000, and the median claim demand was $50,000.

"Clearly, police professional liability cases are seen as having big award potential," observes the survey.

Mr. Buse noted also that this survey was conducted before the videotaped beating of Rodney King by Los Angeles police officers, and his subsequent lawsuit for $56 million (*BI*, March 25, 1991). Claims amounts may have risen even higher due to publicity surrounding the King case, noted Mr. Buse.

Among the survey's other major recommendations is a warning against overreliance on sovereign immunity.

"Public entities should be extremely cautious in relying on sovereign immunity statutes in justifying carrying low or no police professional liability insurance limits," the authors say. "About half of all claims are brought in federal, not state courts. Federal courts, unlike state courts, are not subject to state sovereign immunity claims."

The survey also found that 61.6% of all police professional liability coverage is written on an occurrence basis. But of the jurisdictions that have claims-made coverage, only about half purchase insurance that would cover claims stemming from prior years, according to the survey.

Public entities also were asked about the types of insurers that write their coverage.

The survey found that 44.3% purchase coverage from a public entity pool, with little variation on the basis of a government entity's size. The most frequently named commercial insurer was National Casualty Co. of St. Louis, cited by 15.4% of the respondents, followed by Scottsdale Insurance Co. of Scottsdale, Ariz., which was cited by 14.9%. Both are Nationwide Mutual Insurance Co. units.

"The survey results show that public entity risk-sharing pools are on the verge of becoming the dominant insurance coverage provider, displacing commercially provided coverage," says the survey.

"While the pooling movement is readily recognized to have started and grown the most rapidly on the West Coast, all areas of the country now have public entity pools providing police professional liability coverage," it adds.

A total of 26.2% of public entities also obtain excess liability protection above their primary limits, according to the survey. While the most common excess limit is $1 million, $5 million is also popular and some have $10 million or more in excess coverage.

Meanwhile, the survey found that non-renewals and cancellations of police professional liability insurance are minimal among the responding public entities, though "in a hard market, many more cancellations and non-renewals can be expected."

•

Copies of the survey, which cost $32, can be obtained by calling ICMA's distribution center at 800-745-8780 and asking for document number 40644.

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Trucking firm insurer settles car crash claim

DALLAS—A Dallas trucking firm's insurer will pay the majority of a $3.5 million settlement stemming from a car crash that killed one teen-ager and left another teen partially paralyzed.

The 1989 accident, which left Kristina Hope Rutledge without the use of the left side of her body, occurred when the car in which she and the other teen were riding struck an 18-wheeler owned by National Freight Inc. that was illegally parked beside a freeway service road. The car's driver sustained minor injuries.

National Continental Insurance Co., a Melville, N.Y.-based unit of The Progressive Corp., agreed to settle for $3.5 million rather than risk a large jury award, according to Clyde Bracken, a Dallas attorney representing National Freight and the truck's driver. National Continental wrote $5 million of trucking liability insurance for National Freight excess of the company's $1 million self-insured retention.

A Texas district court judge approved the settlement on Dec. 16.

Mr. Bracken said the judge determined the truck was illegally parked even though the driver had received permission from a police officer to park it on the concrete space adjacent to the road.

Mr. Bracken maintains that the cause of the accident was the teen-aged driver's "teasing" of the car's passengers.

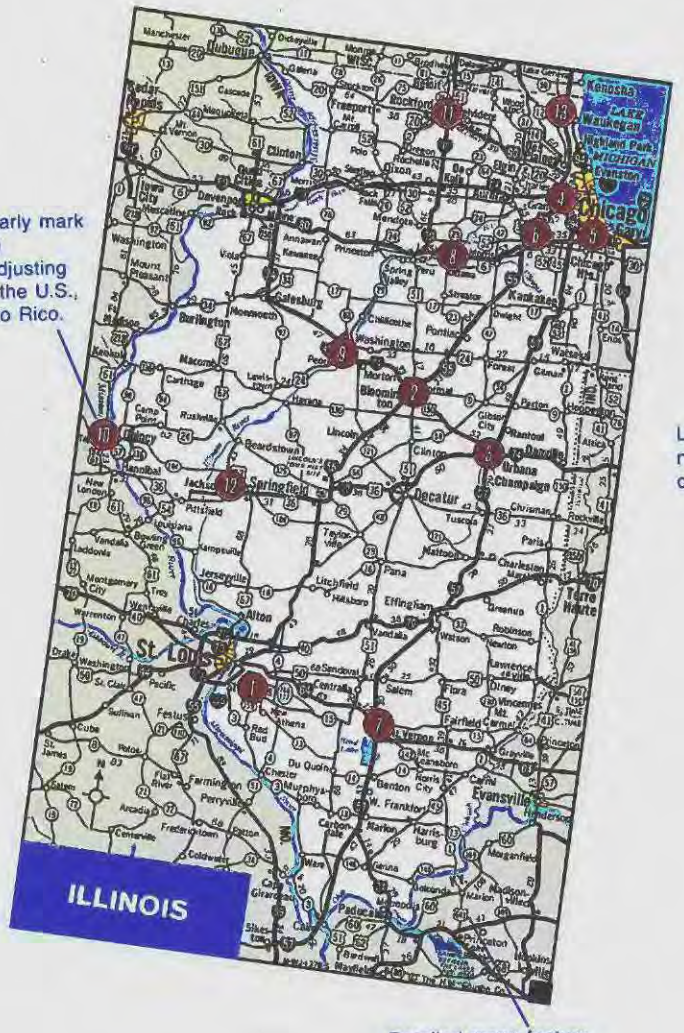
Ms. Rutledge received a $775,000 settlement last year from the parents of the car's driver. The settlement was paid under the terms of an Aetna Life & Casualty Co. personal auto policy with $1 million in limits, said attorney Robert Vial of Vial, Hamilton, Koch & Knox in Dallas.

Aetna also paid a $225,000 settlement to the parents of the teen killed in the accident, Mr. Vial said.

—By Michael Bradford

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Claims Services



Large red dots clearly mark the more than 500 Crawford claims adjusting office locations in the U.S., Canada and Puerto Rico.

Detailed maps feature highways and towns of 5,000 or more.

Midwestern Region
Claims Services

Directory listings include the names of the manager of each office.

Listings include FAX numbers for fast case referrals.

Handy "Refer to" section makes case referrals for small towns easy.

1 Belleville, IL 62222
521 W. Main, Ste. 130
P.O. Box 8200
FAX (618) 233-4568
Jerry M. Green, Mgr.
Phone: (618) 233-3363

2 Bloomington, IL 61701
2416 E. Washington, Ste. D
P.O. Box 61
Robert C. Schollenberger, AIC
Phone: (309) 663-8881

3 Champaign, IL 61824-0397
4 Henson Place
P.O. Box 397
Les St. Peter, AIC
Phone: (217) 356-1334

4 Chicago, IL
Three Woodfield Lake, Ste.100C
900 National Parkway
P.O. Box 681519
Schaumburg, IL 60173
FAX (708) 517-4181
Charles A. Brownson, Gen. Mgr.
Phone: (708) 517-4175

5 Chicago Hts., IL
4343 Lincoln Hwy.
Ste. 120, 1st Fl.
Mailing Address:
P.O. Box 1929
Matteson, IL 60443-1929
FAX (708) 481-4560
John Dyer, Mgr.
Phone: (708) 481-4011

6 Joliet, IL 60435
3033 W. Jefferson St., Ste. 107
FAX (815) 729-1219
Dennis Randina, Mgr.
Phone: (815) 729-1210

7 Mt. Vernon, IL 62864
4114 N. Water St., #A
P.O. Box 516
Joe F. Nation, AIC
Phone: (618) 242-5656

8 Ottawa, IL 61350
807 LaSalle St., Ste. 105
P.O. Box 948
Tom Burkhart, AIC
Phone: (815) 434-3182

9 Peoria, IL 61614
7820 N. University, Ste. 106A
FAX (309) 692-5524
Gordon Daniel, Mgr.
Phone: (309) 693-0121

10 Quincy, IL 62306
200 N. 8th St., Ste. 105
P.O. Box 1212
Herb Wellman, AIC
Phone: (217) 224-7272

11 Rockford, IL 61110
Fairview Bldg., Rm. 222
3600 E. State St.
P.O. Box 4352
FAX (815) 226-0449
D.J. Swendrowski, Mgr.
Phone: (815) 398-3440

12 Springfield, IL 62704
2904 Greenbriar Dr., Ste. B
P.O. Box 9170
FAX (217) 793-2841
Pete G. VanGieson, Mgr.
Phone: (217) 793-1850

13 Waukegan, IL 60085
2835 Belvidere St., Ste. 106
Larry L. Johnson, AIC
Phone: (708) 623-9600

Refer to:

City	
Addison	Branch
Adeline	Chicago
Albion	Rockford
Algonquin	Vincennes, IN
Alsip	Rockford
Alton	Chicago Hts.
Anna	Belleville
Arlington Hts.	Cape Girardeau, MO
Aurora	Chicago
Barrington	Joliet
Bartlett	Chicago
Bartonville	Chicago
Batavia	Peoria
Beardstown	Chicago
Belleville	Springfield
Bellwood	Belleville
Belvidere	Chicago
Bensenville	Rockford
Berkeley	Chicago
Berwyn	Chicago
Bethalto	Chicago
Bloomingdale	Belleville
Bloomington	Chicago
Blue Island	Bloomington
Bollingbrook	Chicago Hts.
Bourbonnais	Joliet
Bradley	Joliet
Bridge View	Chicago
Broadview	Chicago
Brookfield	Chicago
Brookport	Chicago
Buffalo Gr.	Paducah, KY
Burbank	Chicago
Burlington	Chicago
Byron	Rockford
Cahokia	Belleville
Cairo	Paducah, KY
Caledonia	Rockford
Calumet City	Chicago Hts.
Calumet Park	Chicago Hts.
Canton	Peoria

Refer to:

City	
Carlinville	Springfield
Carmi	Evansville, IN
Carol Stream	Chicago
Carpentersville	Rockford
Carthage	Quincy
Cary	Rockford
Centralia	Mt. Vernon
Champaign	Champaign
Charleston	Champaign
Chatham	Springfield
Chester	Belleville
Chicago	Chicago
Chicago Hts.	Chicago Hts.
Chicago Ridge	Chicago Hts.
Chillicothe	Peoria
Cicero	Chicago
Clarendon Hills	Chicago
Clinton	Champaign
Collinsville	Belleville
Cortland	Rockford
Country Club Hills	Chicago Hts.
Countryside	Chicago
Crest Hill	Joliet
Crestwood	Chicago Hts.
Crete	Chicago Hts.
Creve Coeur	Peoria
Crystal Lake	Rockford
Dakota	Rockford
Danville	Champaign
Darien	Chicago
DeKalb	Rockford
Decatur	Springfield
Deerfield	Waukegan
Des Plaines	Chicago
Dixon	Rockford
Dolton	Chicago Hts.
Downers Gr.	Chicago
Du Quoin	Mt. Vernon
E. Alton	Belleville
E. Chicago Hts.	Chicago Hts.
E. Dundee	Rockford
E. Moline	Davenport, IA
E. Peoria	Peoria
E. St. Louis	Belleville
Edwardsville	Belleville
Effingham	Champaign
Eldorado	Evansville, IN
Elgin	Chicago
Elk Gr. Vil.	Chicago
Elmhurst	Chicago
Elmwood Park	Chicago
Evanston	Chicago
Evergreen Park	Chicago
Fairfield	Mt. Vernon
Fairview Hts.	Belleville
Flora	Vincennes, IN
Flossmoor	Chicago Hts.
Forest Park	Chicago
Forreston	Rockford
Fox Lake	Waukegan
Franklin Park	Chicago
Freeport	Rockford
Galesburg	Peoria
Geneva	Chicago
Genoa	Rockford
German Valley	Rockford
Glen Carbon	Belleville
Glen Ellyn	Chicago

The New 1992 Crawford Directory Is Now Available.

(All international Graham Miller loss adjusting offices included)

Crawford & Company, a complete provider of claims services for more than 50 years, is pleased to offer our new 1992 Directory. It's a comprehensive listing of Crawford offices with . . .

- An updated listing of all of Crawford & Company HealthCare Management offices
- A new selection with all Crawford's branch offices listed in numerical order
- An index of Crawford Risk Control offices, including the FPE Group
- All Crawford Property and Casualty General Adjusters and Heavy Equipment Appraisers



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Title _____ Phone (____) _____

Company _____

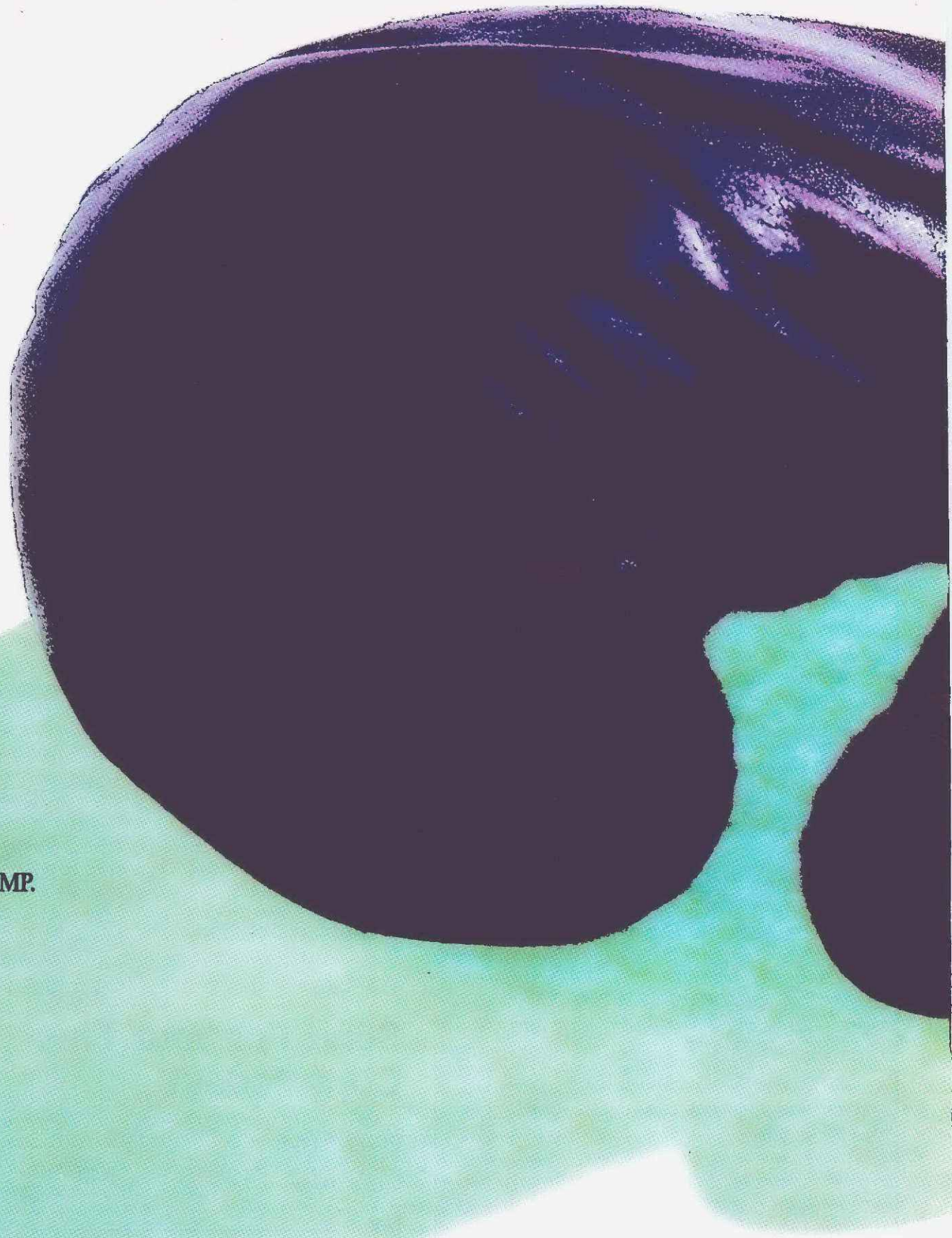
Street Address _____

City _____ State _____ Zip _____

Mail to:
Crawford & Company, Market Communications
P.O. Box 5047, Atlanta, GA 30302

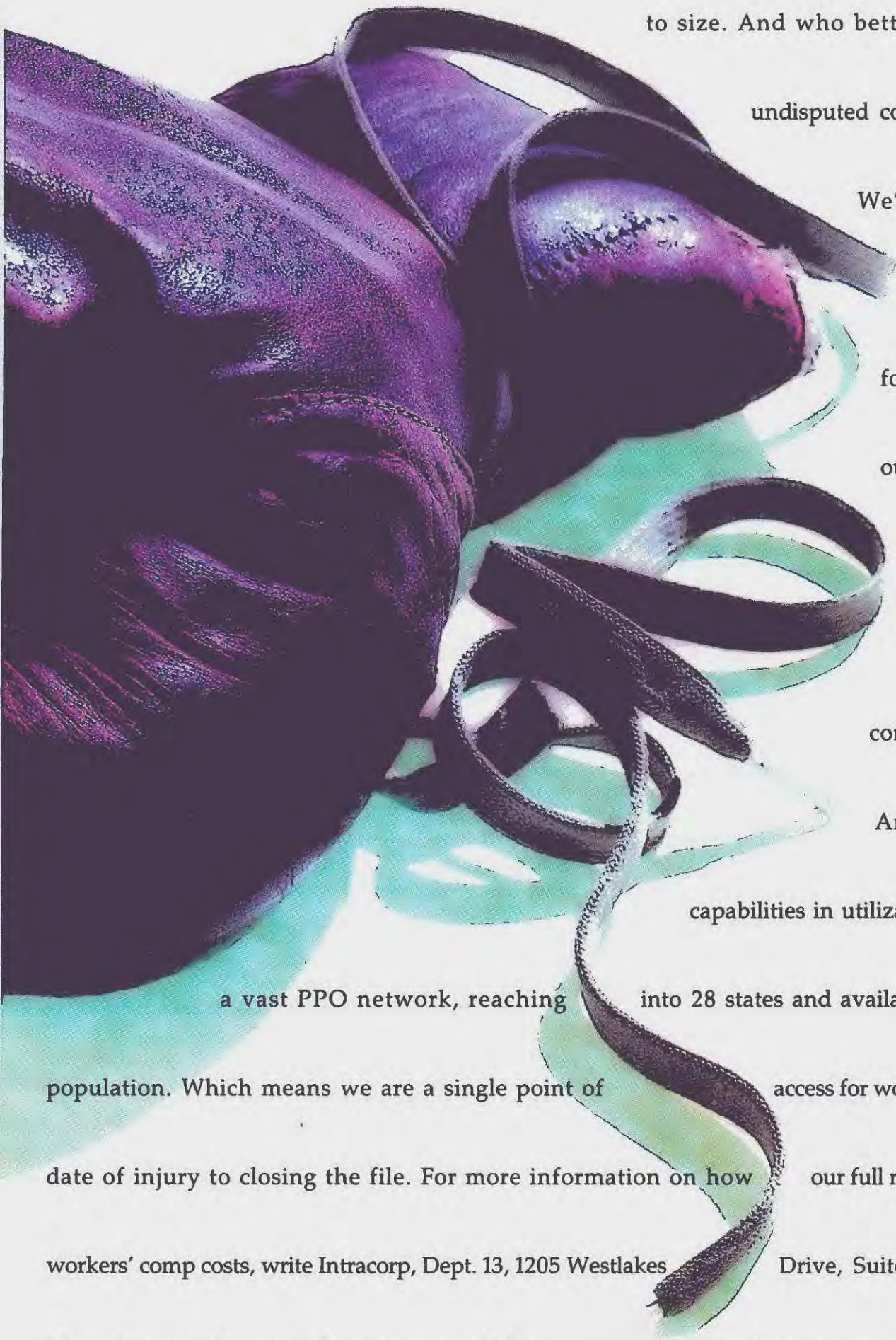
Crawford
CRAWFORD & COMPANY

BI



BRING ON WORKERS' COMP.

We'll admit we're up against a very formidable opponent. One look at the figures will bear us out. Since 1985, workers' comp spending has leaped a staggering 83%. Last year alone it topped $53 billion. But now it's time to cut it down to size. And who better to take on the fight than the undisputed cost containment leader—Intracorp.



We've been battling rising workers' comp and other health care costs for more than twenty years. Saving our clients in excess of $1.5 billion in claims payments in 1990 alone. (No wonder so many blue chip companies want us in their corner.)

And now, adding to our extensive capabilities in utilization and disability management is a vast PPO network, reaching into 28 states and available to more than 72% of the U.S. population. Which means we are a single point of access for workers' comp case management, from date of injury to closing the file. For more information on how our full range of services can help you control workers' comp costs, write Intracorp, Dept. 13, 1205 Westlakes Drive, Suite 300, Berwyn, PA 19312. Because it's going to take more than one punch for this adversary to go down.

INTRACORP

Employee benefit informational material

AUTOMATED SYSTEMS AND SOFTWARE FOR AGENTS AND BROKERS

■ The Insurance Institute of America's three-course **associate in automation management designation** program, designed specifically for insurance professionals who use computers in their work or supervise automated jobs, is described in a flier. Request item 101.

■ A brochure from Pentabs describes the company's government-forms system which produces **fully formatted and completed mandatory government forms**. Request item 102.

■ A quick and easy reference system offered by Information Learning Systems **answers employee benefit questions** in less than 60 seconds. Request item 103.

■ A system from Continental Software Inc. provides **tracking and marketing tools for the group insurance professional**. Group life, weekly income, long-term disability, health, PPO, excess risk and other product types may be managed to suit each user's purposes. Request item 104.

■ A **marketing guide for insurance agents/brokers** selling various products and services is available from Benefit Software Inc. Tips on using employee benefit statements as a door-opener, census-information gatherer and profit center are included. Request item 105.

■ A fact sheet offered by Information Learning Systems gives information on **a customer-service product which allows access to information about any of your clients' benefit plans.** Request item 106.

■ Pentabs offers a brochure about its professional proposal system designed to generate an unlimited number of **retirement plan studies and proposals** with minimum data. All types of plans are handled. Request item 107.

■ A guide provided by Pentabs describes software that **automates retirement plan proposals and administration**. The systems can generate required government forms, manage data and provide trust accounting. Request item 108.

AUTOMATED SYSTEMS AND SOFTWARE FOR INSURERS

■ A booklet from Electronic Data Systems describes an easy-to-use **reporting and analysis tool that enables insurance and benefits professionals to gain access to data** and create customized information quickly. Request item 201.

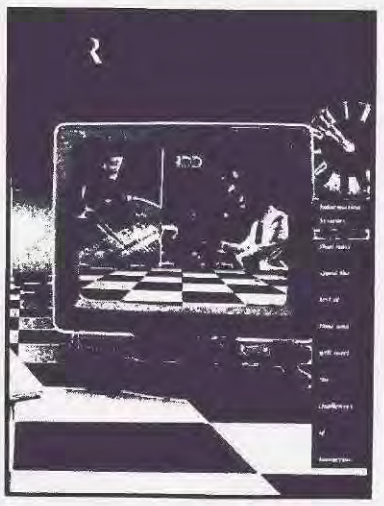
■ A brochure provided by Genelco explains its software applications and system support, which **reduces data processing costs, cuts staff and controls group coverage and claim costs.** Request item 202.

■ Electronic Data Systems' **software that supports multiple cost-containment programs** is described in an informational folder. Programs for precertification, case management and concurrent review are all supported by the system. Request item 203.

■ A packet of information from Shared Financial Systems explains the **technology that electronically processes claims.** Drug utilization review and on-line adjudication support are also addressed. Request item 204.

■ A booklet from Electronic Data Systems discusses **electronic claims capture and clearing services, claim adjudication, eligibility and referrals,** among other things. Request item 205.

■ A description of **managed care information systems and services** available to insurers, third-party administrators, self-insured employers and managed care plans is available from Reilly-Dike-Dosher Corp. Request item 206.



■ "Image Processing Technology in Health Care," a guide from Electronic Data Systems, describes the **full integration of processing systems to automating data entry with form-independent character recognition.** Request item 207.

■ Continental Software Inc. offers a personal computer-based system that deals with **life, health, disability and dental coverages.**

Continued on page 16

Business Insurance **Information Resource**

NOTE: THIS COUPON WILL NOT BE SERVICED AFTER MARCH 23, 1992
All questions must be answered in order to have your inquiry processed.

Please check one item for each category:

1. My organization is best described as:
   A ☐ Mfg/Svcs F ☐ Ins Agent K ☐ Adj/Apprs
   B ☐ Association G ☐ Ins Broker L ☐ TPA
   C ☐ Union H ☐ Ins/Reins Co M ☐ Healthcare Inst
   D ☐ Government I ☐ Actry/Consit
   E ☐ Educational Inst J ☐ Attorney N ☐ Other
2. Number of employees:
   1 ☐ 150 or less 2 ☐ 151-499 3 ☐ 500-999
   4 ☐ 1,000-4,999 5 ☐ 5,000 or more 6 ☐ Unknown
3. My title is best defined as:
   A ☐ Administrative Mgt D ☐ Benefits Mgt
   B ☐ Financial Mgt E ☐ Loss Prevention Mgt
   C ☐ Risk Mgt F ☐ Other
4. My purchasing involvement for the requested products is to:
   1 ☐ recommend only 2 ☐ specify 3 ☐ approve
5. Do you now receive a personally addressed copy of Business Insurance?
   A ☐ Yes B ☐ No C ☐ Please send Business Insurance subscription information

To obtain copies of literature and information about products and services listed in the Jan. 13 info section, simply indicate the key numbers for the items you want and mail the coupon to:
Business Insurance Reader Service Center
650 S. Clark St., 6th Floor
Chicago, IL 60605-1702

Please print clearly

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Title_____

Company_____

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City_____ State_____ Zip_____

Phone ( ) _____

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Anaheim

Focus on **Employee Benefits** at
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MARCH 29 - APRIL 3



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Wellness—Do health incentives really work?
Privacy—Should high risk individuals be identified?
Non-Traditional Families—How far should benefits be extended?
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Headliners:

- Management guru **Peter Drucker** views today's global economy
- **Insurance Company CEOs** periscope the industry

International Trade Exhibit—with 300 RM/EB service suppliers.

Risk and Insurance Management Society, Inc.®

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Conference and **Exhibitors'** brochures available on request.

Guide to information listings

The Employee Benefits Information Resource section is an editorial compilation of current informational and educational materials on topics of interest to employee benefits, financial and insurance executives.

The listings are published as an editorial service by *Business Insurance*; there is no charge to list material in the section.

The materials, all of which may be obtained free of charge by *Business Insurance* readers, are organized under these headings: automated systems and software for agents and brokers; automated systems and software for insurers; employee benefits; employee benefit management information systems; international; self-insurance services.

Risk Management Information Resource listings will appear in the Jan. 20 issue of *Business Insurance*.

To receive any of the free materials listed in this special section, please write the key numbers of the items you want on the reader service coupons that are printed throughout the section. Fill out the remainder of the coupon and mail it to: *Business Insurance* Reader Service Center, 605 S. Clark St., Sixth Floor, Chicago, Ill., 60605-1702.

All requests for free material must be received before March 23 to be processed.



Strength, Security, The Best Of Both Worlds Joined Hands.

Thomas Howell Group And Gay & Taylor, Inc. Announce Integration Of Services.

John A. Stitch, Chairman of Thomas Howell Group, London, England, and T. Bruce Tilley, President and CEO of Gay & Taylor, Inc., Winston-Salem, NC, have jointly announced plans to integrate the services of their companies.

The Thomas Howell Group dates back to some of the world's oldest loss adjusting companies, the first of which was established in 1785. Together with Gay & Taylor, founded in 1928, a combined worldwide office network of over 350 locations is offered, providing a comprehensive range of insurance claims and risk related services. Through the greater resources created by the integrated operations, services are tailored to individual client needs and each account is assured of professional and expert attention.

With over 200 locations in the United States and a single telephone number for reporting claims outside the U.S., the network provides close contact with clients ensuring the responsive and efficient handling of all claims.

A combined Management Company will direct operations in the Americas. This Management Company maintains the values held by both companies... integrity, unparalleled service and professional excellence.

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THOMAS HOWELL KIEWIT (USA)
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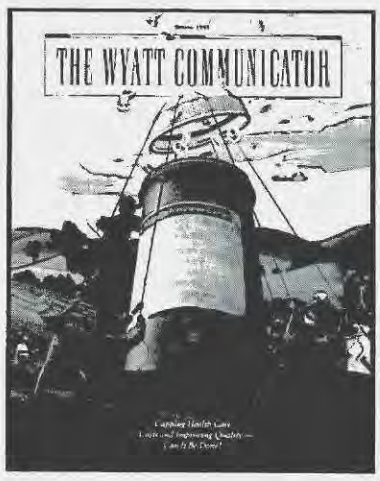
THOMAS HOWELL GROUP

Continued from previous page
Census entry, rate and factor updating, proposal analysis, client management and text updating are streamlined. Request item 208.

■ A fully integrated administrative system for managed care organizations is described in a brochure from Electronic Data Systems. **Automated solutions for claims and membership processing, authorization and referral tracking, and coordination of benefits** are discussed. Request item 209.

EMPLOYEE BENEFITS

■ The Wyatt Communicator, a magazine published three times a year by The Wyatt Co., addresses major issues in **human resources, communication and organizational design**. Request item 501.



■ An informational newsletter produced by the Alexander Consulting Group Inc. supplies **updates on legislative actions and in-depth reviews of government/industry trends**. For a sample of the semimonthly publication, request item 502.

■ RLI Corp. offers a pamphlet on its **XS Executive Medical Insurance Plan**. Coverages, premiums, limitations and exclusions are discussed. Request item 503.

■ A booklet produced by the American Council of Life Insurance deals with **questions and answers about life insurance**, including the industry's investment strategy and state regulations. Request item 504.

■ The Martin E. Segal Co. produces a five-page bulletin describing **FAS 106's implications for employers**. The Securities and Exchange Commission's reporting standards for publicly traded companies on disclosing the impact of FAS 106 are also noted. Request item 505.

■ An article reprint offered by Minnesota Mutual Life Insurance Co. discusses **how an allocated, daily valued annuity contract works** and the benefits of the contract to plan sponsors, retirement plan participants and plan administrators. Request item 506.

■ United Healthcare Corp. supplies a special issue of the periodical, "Business & Health," with a report on **integrating managed health care services.** The issue discusses what some vendors and employers are doing to achieve this goal. Request item 507.

■ An employee travel plan brochure is published by International Accident Facilities Inc. and outlines tips on how to develop **travel accident insurance plans, from business travel to 24-hour protection**. Request item 508.

■ A bulletin describing **benefits and human resource considerations for military reservists and National Guard members returning from active duty** is offered by the Martin E. Segal Co. Request item 509.

■ A bimonthly publication of The Wyatt Co., Wyatt Comparison, presents current **comparative and analytical employee benefit plan information** concerning group, health/medical, retirement and capital accumulation benefits. Request item 510.

■ An article reprint provided by Beech Street of California Inc. deals with the **benefits of providing quality services to corporate health care plan** clients. Request item 511.

■ An informational report written by La Petite Academy Inc. looks into the facts and statistics surrounding **child care and companies that take the initiative to create work/family solutions**. Request item 512.

■ The Martin E. Segal Co. offers a **survey of multiemployer plans that are fully funded** for their vested obligations. Request item 513.

■ A brochure explaining the legal services, features and costs of **group legal plans for employee benefit programs** is offered by Hyatt Legal Plans Inc. Plans funded by the employer and those funded by payroll deduction are reviewed. Request item 514.

■ "Controlling Your Prescription Drug Benefit Costs," a booklet offered by Prescription Health Services Inc. describes **cost containment strategies for management of prescription drug benefit costs**. Statistical charts are included. Request item 515.

■ American Drug Stores Inc. has developed an integrated **drug store/mail order prescription drug program.** This Scriptplan/RX America Information Packet describes the benefits of using a single supplier instead of multiple sources. Request item 516.

■ A 1991 survey of state employee health benefit plans from the Martin E. Segal Co. includes the number of **employees and retirees covered by state government employee health care plans** and their monthly contributions. State health maintenance organization offerings are also summarized. Request item 517.

■ Beech Street of California Inc. offers a newsletter on health care cost control, which has in the past discussed issues like **controlling workers compensation medical costs, accountability in outpatient care and information systems**. Request item 518.

■ A quarterly newsletter published by La Petite Academy Inc. focuses on **child care trends and issues.** "Partners" covers new laws and regulations, creative developments and workable solutions. Request item 519.

■ A description of the **background and impact of FAS 106 and some options for employers** is provided by the Alexander Con-

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This policy needs four forms, three rate sheets, two reports, and it's due in one hour.

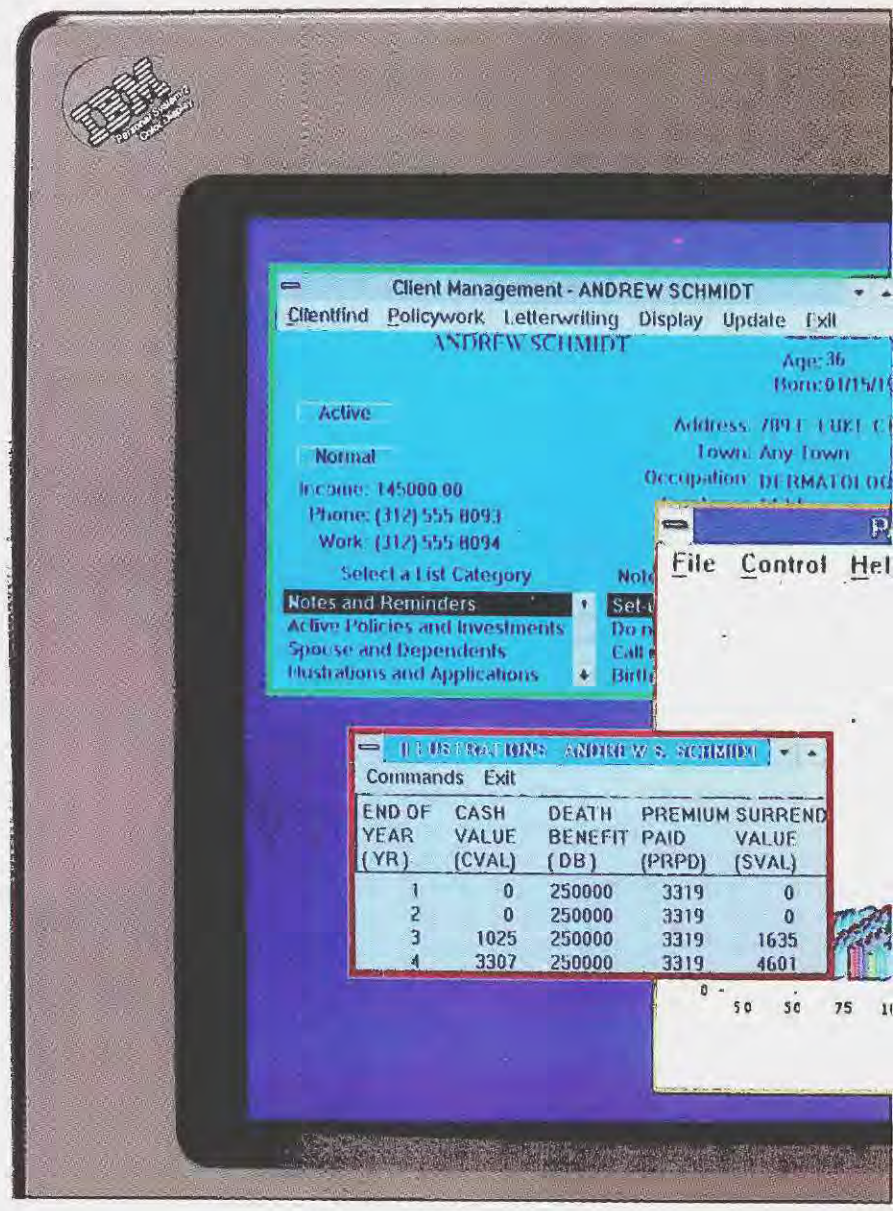
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IVANlink, a product of IBM's Business Partner, Insurance Value Added Network Services, connects both agents and carriers to a wealth of industry data: marketing leads, daily industry news and events, even motor vehicle reports. Carriers can use bulletin board and electronic mail services to transmit proprietary information to their agents. IVANlink can help agents and carriers increase sales, cut underwriting time and service customers more efficiently.



Continued from previous page
sulting Group Inc. A calculator for estimating retiree health care liabilities and annual expenses is included. Request item 520.

■ "My Baby and Me—A Prenatal Care Record Book," supplied by PM Group Life Insurance Co., provides **an opportunity for expectant mothers to keep a pregnancy record**. The booklet is written in Spanish and English. Request item 521.

■ A newsletter providing a brief overview of **current issues in compensation, qualified plans, welfare plans and personnel practices** is supplied by the Alexander Consulting Group Inc. Request item 522.



■ "Forum," a quarterly magazine produced by Intracorp, focuses on **issues, trends and legislation impacting the health care cost control and disability management industry.** The target audience includes employee benefits decision makers, claims managers, third-party administrators and consultants. Request item 523.

■ The HealthPath Questionnaire, provided by Staywell Health Management Systems Inc., can be used as part of a health care cost management strategy. The questionnaire, which **identifies high-risk employees**, is followed by education suggestions for changing unhealthy lifestyles and can be followed up to track progress. Request item 524.

■ A reference guide from Coopers & Lybrand reviews the **general health care environment, general managed care strategies,** the range of managed care health plan designs and provides a glossary of common health care and health benefits terminology. Request item 525.

■ A 1991 survey conducted by The Pace Group Inc. of state regulators overseeing health maintenance organizations provides **information on point-of-service plans, HMO penetration and growth by region,** and other issues. Request item 526.

■ Ameritas Life Insurance Corp. provides a thorough guide to **Section 125 plans**, including reporting and notification requirements, a glossary of terms and answers to commonly asked questions. Request item 527.

■ "Postemployment Welfare Benefits: The Current Environment" is a 32-page paper published by Alexander Consulting Group Inc. that explores the **impact of retiree medical benefits programs on the financial well-being of many U.S. companies.** Request item 528.

■ A bulletin from Martin E. Segal Co. outlines the American Institute of Certified Public Accountant's **proposed application of FAS 106 to multiemployer plans.** Request item 529.

■ An information sheet produced by Applied Benefits Research Inc. illustrates a work flow chart diagramming the steps necessary to **comply with the Consolidation Omnibus Budget Reconciliation Act (COBRA).** Request item 530.

■ Information about Section 125 **"Premium Only Plans"** is available from Ameritas Life Insurance Corp. The kit describes how premiums for employer-sponsored insurance benefits can be deducted from paychecks on a pretax basis. Request item 531.

■ Progressive Health Management Inc. offers a brochure containing an overview of its **medical cost management programs,** including fact sheets about utilization management, case management, hospital and provider bill audits, wellness programs and maternity/newborn programs. Request item 532.

■ William M. Mercer Inc. provides an informational booklet that explains **how accounting rules will affect employers that sponsor post-retirement medical plans** and shows what type of alternative plan designs can lessen the financial impact on employers while still keeping the retirees secure. Request item 533.

■ Results of a 1991 national survey of **employees' knowledge, attitudes and concerns about mental health benefits** are available from the National Assn. of Private Psychiatric Hospitals. Graphs and charts are included. Request item 534.

■ A bulletin from Martin E. Segal Co. describes the Health Care Financing Administration's **attempts to recover money from group health plans for claims that Medicare mistakenly paid as the primary payer.** Request item 535.

■ The Wyatt Co.'s monthly newsletter, "The Wyatt Insider," reports on U.S. and global activities in the regulatory, legislative, judicial and other areas that affect clients' operations in **employee benefits, compensation and asset/risk management.** Request item 536.

■ The **"Employee Benefits Satisfaction" survey** of 112,000 employees covered under medical, dental, life insurance, disability, pension, savings plan and other benefits is provided by Alexander Consulting Group Inc. The survey reveals that one out of two employees are dissatisfied with employer-provided benefits. Graphs and charts are included. Request item 537.

■ A fact sheet written by Empire Medical Management Ltd. reviews concerns about **pre-employment testing under the Americans with Disabilities Act**, which will go into effect for most employers on July 26. Request item 538.

■ Crawford & Co. offers a brochure that describes its **program for expectant mothers**, which provides information on maternity support services that can reduce the unexpected costs of high-risk

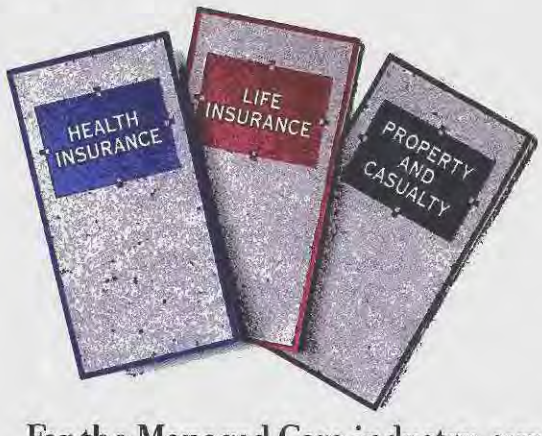
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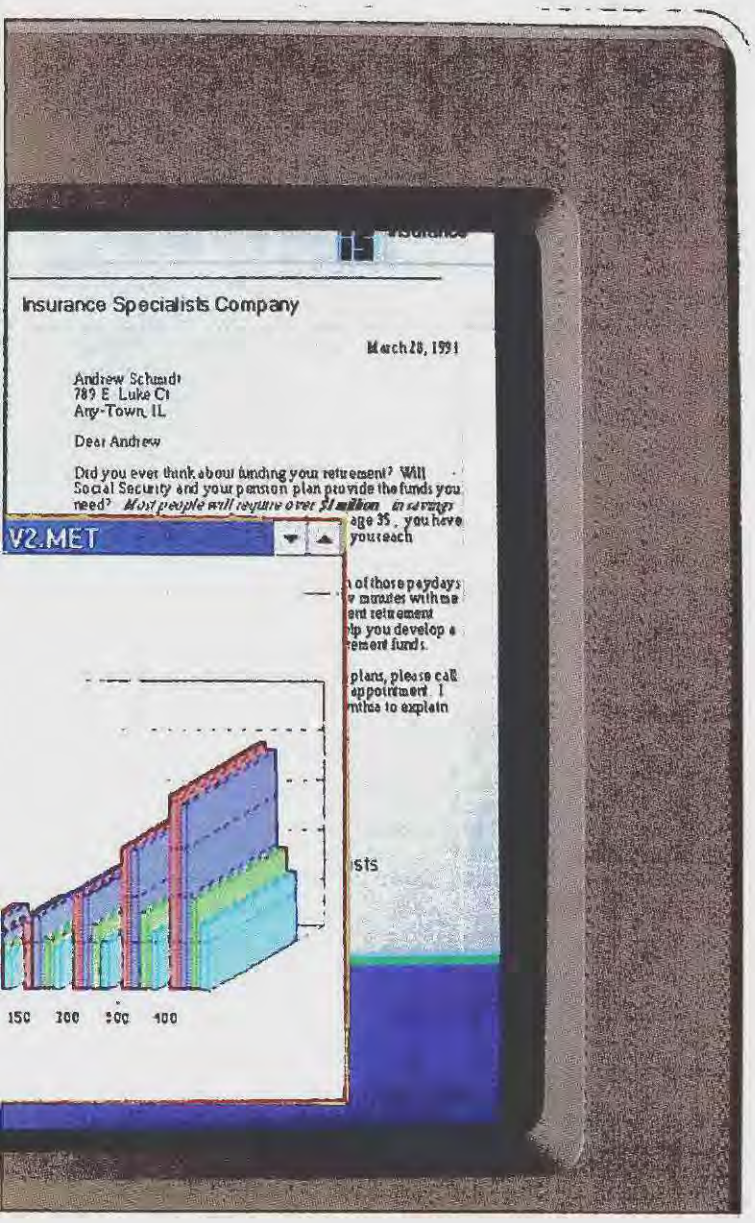


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IBM®

Continued from previous page
pregnancy and low birth weight babies. Request item 539.

■ Coopers & Lybrand conducted a **survey of company-sponsored wellness programs in the U.S.** The lengthy report includes general program design, number and types of activities offered, employee participation, level of employee contributions and program development and assessment. Request item 540.

■ The Alexander Consulting Group Inc. explains in a nine-page report the **symptoms of the health care crisis** and discusses proposed legislative remedies and options available in the interim. Request item 541.

■ A brochure from Dental Benefit Providers Inc. explains the company's corporate capabilities and discusses **various delivery systems and managed dental care goals.** Request item 542.

■ CIGNA Special Benefits has developed a report from its data base on **death claims of employees and their families,** including: leading causes of accidental deaths, areas of greatest risk in the business community, and safety and accident prevention programs. Request item 543.

■ The National Assn. of Private Psychiatric Hospitals is offering aflier with an overview of **ethical psychiatric hospital practices** in nine critical areas, including patient and family rights and admissions. Request item 544.

■ An overview of **qualified domestic relations orders,** including key terms and a summary of many rules affecting pension plan administration, is provided in a paper from the Alexander Consulting Group Inc. Request item 545.

■ A handbook from Kwasha Lipton's seminar examines **post-retirement medical benefits.** Request item 546.

■ A report from William M. Mercer Inc. looks at **the balance of work and families and the changing role of the workplace.** It provides guidelines on determining which employee programs might be most needed. Request item 547.

■ The "Utilization Review Survey: 1991 Results," conducted by the National Assn. of Private Psychiatric Hospitals, surveys NAPPH member hospitals' utilization review personnel to determine **providers' perspective on working with managed care firms.** Request item 548.

■ A comprehensive seminar handbook on **the relationship between health care plan design and cost control** is available from Kwasha Lipton. Request item 549.

■ The American Dental Assn. created a brochure to guide **employees faced with a choice between a traditional dental benefits plan and an alternative care model.** Request item 550.

■ "Alternatives to Traditional Methods of Physician Reimbursement" is a lengthy report from benefit consultant Martin E. Segal Co. addressing **the rising cost of physician services** and the Medicare program's new fee schedule for physicians. Request item 551.

■ **A glossary of flex terms** to introduce personnel, human resource specialists and management to flexible compensation may be obtained from the Alexander Consulting Group Inc. Request item 552.

■ A report on the benefits of **long-term care insurance**, what features to include in the policy, how much policies cost and how to design a plan that meets your employees' needs is available from William M. Mercer Inc. The report includes tips on preparing requests for proposals and choosing insurers. Request item 553.

■ A guide from the National Assn. of Private Psychiatric Hospitals overviews **the inpatient psychiatric delivery system**, including private psychiatric hospitals, general hospital units and "scatter" beds and public hospitals. Request item 554.

■ A brochure from Coopers & Lybrand outlines a six-step analytical process for **managing health care benefit utilization and costs** that, over time, enables employers to measure the program's performance. Request item 555.

■ A 20-page booklet to assist business owners in **selecting the best type of deferred compensation plan** is available from Practice Development Institute. Request item 556.

■ An explanation of **vision care needs and PPO delivery systems** is supplied by Spectrum Vision Systems Inc. in an information folder. Request item 557.

■ A folder from Midwest Vision Service Plan outlines its **vision plan**, including frequency of services, member benefits, schedule of allowances and more. Request item 558.

■ **"Trends in Mental Health Coverage"** examines insurance for mental illness, the prevalence of mental illness, its impact on the workplace and techniques for cost control. This report is produced by the National Assn. of Private Psychiatric Hospitals. Request item 559.

■ Crawford & Co. discusses how its health care management programs fight to **control health benefit costs with utilization reviews, large case management, maternity review programs and other systems** in its information packet. Request item 560.

■ Information on the integration of Social Security disability insurance benefits with long-term disability plans, the Medicare primary/secondary payer and other **Social Security consulting and claims services issues** is provided in a bimonthly magazine from Allsup Inc. Request item 561.

■ IPRO-Corporate Planning & Development provides a guide to help **Medicare beneficiaries in New York exercise and protect their Medicare rights pertaining to in-hospital care.** Request item 562.

■ CIGNA Special Benefits offers a reference brochure for benefit managers and advisers who want to know how to **control costs associated with the disability claims process**. Request item 563.

■ **"A Seminar on Flexible Benefit Plans for Active and Retired Employees"** is the title of a handbook that supports the Kwasha Lipton seminar on this topic. Request item 564.

■ The "Healthcost Monitor" provides information to employers about **workers compensation and health insurance** cost containment **issues**. This quarterly newsletter is published by Crawford & Co. Request item 565.

■ A William M. Mercer Inc. special report on called-up reservists focuses on **employers' rights and obligations toward employees who are called to military duty.** The issue looks into contributions and allocations to retirement plans and other wage and benefit issues. Request item 566.

■ The National Assn. of Private Psychiatric Hospitals provides a booklet describing the group's **data system to improve psychiatric quality assurance.** Request item 567.

■ Kwasha Lipton offers a handbook on the flexible, practical approach to **daily valuations for savings plans,** which supports their seminar on this topic. Request item 568.

■ A newsletter written by CIGNA Special Benefits for benefitmanagers contains articles on the **expense and administrative impact on employers caused by disabilities in the workplace.** It also outlines disability management. Request item 569.

■ **The advantages of offering a dental benefits plan, the inherent difference between dental care and medical care and the cost of offering dental benefits** are discussed in a leaflet produced by the American Dental Assn. Request item 570.

■ An article produced by Crawford & Co. describes **magnetic resonance imaging**, its benefits and costs, and current use including joint ventures by self-referring physicians. Request item 571.

■ A report from American Specialty Underwriters discusses **the uninsured disability risks of senior-level corporate executives.** It explores the likelihood of disability of a key person and the risk of financial loss faced by the individual and the company. Request item 572.

■ A newsletter produced by Kwasha Lipton discusses the need for individuals to make **long-range retirement plans and how management can help create and execute these plans.** Request item 573.

■ **Avoiding hidden costs within employee assistance programs** is the subject of an article

Continued on next page

Business Insurance **Information Resource**

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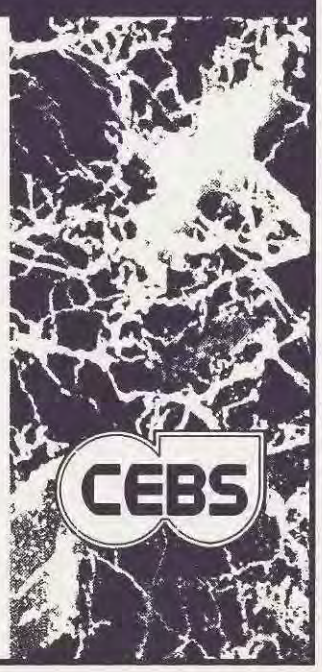
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Continued from previous page
from Buck Consultants Inc. The piece illustrates how to set out objectives and appropriate plan design. Request item 574.

■ A 1991 **directory of members of the National Assn. of Private Psychiatric Hospitals** includes name, address, phone number, chief executive officer, medical director, administrator and number of beds for each hospital. Request item 575.

■ A catalog from the International Foundation of Employee Benefit Plans provides information and forms for enrolling in the **Certified Employee Benefit Specialist (CEBS) program, a 10-course program.** To receive the CEBS designation, individuals must pass a national examination and subscribe to a code of ethics for business and professional conduct. Request item 576.

■ The **unexpected costs of prenatal care**, analyzing your potential for unexpected prenatal benefit costs and identifying elements of a successful management program are discussed in a Crawford & Co. 12-page report. Request item 577.

■ "In the Eye of the Storm," an article reprint from CIGNA Special Benefits, covers **disability management** and its four components: integration of products and services, cost reduction, prevention, management information and reporting needs. Request item 578.

■ A 1992 survey of the **benefits offered to various staff groups (non-legal staff, paralegals, associates) at the top 100 law firms** based on gross annual income is offered by the Martin E. Segal Co. Request item 579.

■ **Aspects of cash balance pension plans** are reviewed in Kwasha Lipton's comprehensive handbook from the seminar on this topic. Request item 580.

■ A comprehensive review of **dental insurance trends and a line of cost-management products** is provided in a brochure from Delta Dental Plans Assn. Request item 581.

■ CIGNA has developed a **seat belt safety awareness program** in conjunction with an accidental death and dismemberment package. Samples of the program materials are available. Request item 582.

■ "Perspectives" is a quarterly newsletter published by Erisco Inc. aimed at informing and educating its readers about **issues in the employee benefits industry.** Request item 583.

■ **Leveraged employee stock option plans (ESOPs)** and key issues in examining the feasibility of a leveraged ESOP transaction are discussed in a Coopers & Lybrand informational book. ESOP tax incentives, assessing non-tax issues and financial reporting issues are included. Request item 584.

■ A catalog providing a listing and a synopsis of the newest and best-selling **employee benefit books, research reports and reference materials** published by the International Foundation of Employee Benefit Plans is available. Request item 585.

■ "Managing Healthcare Cost and Quality: Programs, Performance and Promise" is a conference brochure from the West Coast Healthcare Coalition discussing **topics of interest to employers, the insurance industry and health care providers** that will be reviewed at an annual conference in January. Request item 586.

■ An article from American Specialty Underwriters discusses voluntary **long-term disability plans.** Request item 587.

■ Hay/Huggins Company Inc. provides a special bulletin that gives **frequent, quick-response analyses of breaking developments in benefits management.** Request item 588.

■ The "Employee Benefits Infosource Journals List" **lists more than 350 journals containing comprehensive information on U.S., Canadian and international employee benefits.** The list, compiled by the International Foundation of Employee Benefit Plans, also explains how to access the data base. Request item 589.

■ **Legislation, trends, benefits**
Continued on page 25

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ASK A CASUALTY ACTUARY

Calculating IBNR reserves with two different formulas

Q **How does the Bornhuetter-Ferguson method differ from the incurred loss development method for calculating IBNR reserves?**

A In my Nov. 4, 1991, column, the Bornhuetter-Ferguson method was boiled down to the following formula: IBNR Reserve = (Expected Losses) × (Proportion of Ultimate Losses Yet to be Developed).

This method was applied separately to each accident year or policy year. We looked at a very simple example: During 1990, earned premium for general liability coverage was $10 million, and the expected loss ratio is 80%. This means that expected losses will be $8 million. A study of recent patterns of the development of incurred losses for this coverage indicates that the proportion of ultimate losses yet to be developed as of 24 months (year-end 1991) is 40%. According to the Bornhuetter-Ferguson method, the IBNR reserve should then be $3.2 million: IBNR reserve = ($8 million) × (40%).

We noted that the simplicity of this often gets buried within a dizzying exhibit of numbers, but that the Bornhuetter-Ferguson method is actually that straightforward. The basic philosophy of the method is simple. Independent of losses reported to date, the IBNR reserve can be estimated by applying a percentage to a predetermined estimate of ultimate losses for each given accident year or policy year. Understandably, the method is only as good as the percentage unreported and the predetermined estimate of ultimate losses on which the method relies.

To understand the difference between the Bornhuetter-Ferguson method and the standard incurred loss development method and how they are often related, we'll consider a simplified casualty example.

Table 1 provides a history of the development of incurred losses for each of the latest three accident years. For example, for the accident year 1989, total incurred losses were $1.23 million as of year-end 1989 (12 months of development), $2.4 million as of year-end 1990 (24 months) and $3.6 million as of year-end 1991 (36 months).

After studying these patterns of loss development for older years (such as 1979), we estimate that 75% of ultimate losses are unreported as of 12 months, 50% as of 24 months, and 25% as of 36 months.

Table 2 illustrates the application of the incurred development method using the percentages unreported from the bottom of Table 1. For each accident year, the latest reported incurred losses (A) are divided by 1 minus the percentage of ultimate losses unreported (from B) to derive an estimate of ultimate losses (C), from which reported losses (A) are subtracted to derive an estimate of IBNR (D). When the projections in (C) are divided by earned premium (E), estimates of the ultimate loss ratios (F) are obtained. These ratios are approximately 0.75 for the two oldest accident years, but the ratio for 1991 is greater than 1.0.

By contrast, Table 3 details the estimation of the IBNR reserve using the Bornhuetter-Ferguson method. Because rate changes have been keeping track with inflation in this example, it is believed that the loss ratios should be about the same for each of the most recent three years. Because we are more certain of the ultimate loss ratios for the two oldest accident years, we conclude that a 75% loss ratio should be expected for each of these three accident years. Therefore, for each year, the percentage of unreported losses (C) is multiplied by the ultimate losses equivalent to a 75% loss ratio (B) to estimate the IBNR reserve.

It is worth noting that the 75% loss ratio is only assumed for the unreported portion of losses and, quite reasonably, actual reported losses to date are accepted without modification. The Bornhuetter-Ferguson method then assumes that the 75% of ultimate losses that are yet to be reported for accident year 1991 will be consistent with an ultimate loss ratio of 75%, even though reported losses to date ($2.35 million) are worse than expected ($1.744 million or 25% of 75% of earned premium). In this case, the Bornhuetter-Ferguson method results in an ultimate loss ratio of 81.5%. This can be obtained by adding the IBNR estimate of $5.231 million in Table 3 to the reported losses of $2.35 million from Table 1 and dividing this total by the earned premium of $9.3 million. By contrast, the incurred loss development method produced an estimated loss ratio of 101% as shown in Table 2.

Which method is more accurate? It depends. Any development factor method can tend to be oversensitive to reported losses to date for the more recent year. After all, in this example, reported losses through 12 months are quadrupled to obtain an estimate of ultimate losses.

The real questions to ask are:

- How indicative will be the experience through year-end as a predictor of how the remaining claims will be settled?
- And, how reasonable is it to assume that the latest year will conform to the same 75% loss ratio as the previous year, at least with respect to losses yet to be reported?

If we know that one or two unusually large claims already have been reported, we might conclude that the Bornhuetter-Ferguson method provides an excellent estimate of ultimate losses. In this case, the method includes claims adjusters' estimates of the cost of those large claims, while it does not assume that such adverse occurrences will be repeated threefold before the year is played out (which the incurred development method would assume).

This difference largely accounts for why the IBNR estimated by the incurred development method ($11.4 million) is 20% higher than that based on the Bornhuetter-Ferguson method ($9.5 million).

As might be expected, reality is often much more complicated than the simple example presented here. Normally, however, expected losses for the Bornhuetter-Ferguson method are obtained by applying a loss ratio to earned premiums for the year.

Several variations on this are not unusual. Sometimes expected losses are estimated using pure premiums (ultimate losses per unit of exposure) multiplied by the number of exposure units. In other instances, expected losses are estimated as the product of the ultimate number of claims times a forecast of ultimate claim severity.

Regardless of the variation used, however, the Bornhuetter-Ferguson method usually uses "percentages unreported" derived from a review of the history of changes in incurred losses, which also serves as the basis for the incurred loss development method. ■

Table 1

Incurred losses in thousands of dollars

Accident year	12 months	24 months	36 months	Ultimate
1989	$1,230	$2,400	$3,600	$4,800
1990	1,550	3,200		
1991	2,350			
Percentage unreported	75%	50%	25%	0%

GRAPHIC BY JOHN SMITHER

Table 2

Estimate of ultimate losses by incurred development in thousands of dollars

Accident year	(A) Reported incurred losses	(B) Percentage of ultimate losses unreported	(C) Estimated ultimate incurred losses (A) ÷ (1 - B))	(D) Development estimate of IBNR (C) - (A)	(E) Earned premium	(F) Ultimate loss ratio (C) ÷ (E)
1989	$3,600	25%	$4,800	$1,200	$6,600	0.73
1990	3,200	50	6,400	3,200	8,500	0.75
1991	2,350	75	9,400	7,050	9,300	1.01

GRAPHIC BY JOHN SMITHER

Table 3

Estimate of IBNR reserve by Bornhuetter-Ferguson method in thousands of dollars

Accident year	(A) Earned premium	(B) Ultimate loss at 75% loss ratio .75 x (A)	(C) Percentage of ultimate losses unreported	(D) B-F estimate of IBNR (B) x (C)	(E) Incurred development estimate of IBNR
1989	$6,600	$4,950	25%	$1,238	$1,200
1990	8,100	6,075	50	3,038	3,200
1991	9,300	6,975	75	5,231	7,050
Total				$9,506	$11,450

GRAPHIC BY CYNTHIA WATSON

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

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



Mr. Sherman

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

Ms. Werner's and Mr. Nirtaut's columns appear on the second Monday of alternate months. Mr. Miner's and Mr. Sherman's columns normally appear alternately on the first Monday of each month.

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

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.

ASK A BENEFITS MANAGER

More tips to control growing health costs

Q **As 1991 ended, I noted that my company's health care costs will again exceed original projections with a trend of about 20%. How can I better control costs this year?**

A This question was first presented in the Nov. 11, 1991, issue. In that issue, I discussed cost containment and cost shifting, two elements of plan design change that can help reduce employee health plan costs.

In this week's column, I'll address two other areas of cost containment: alternative delivery systems and administrative issues.

- **Preferred provider organizations.**

The use of PPOs in medical plans has increased dramatically in recent years. A PPO is a network of providers, including hospitals and physicians, that have agreed to provide a discount for members utilizing the network. Employers use these networks to lower utilization, such as the average length of stay in the hospital, and to provide discounted fees by both doctors and hospitals. The average discount from normal fees is about 20% for PPOs using fee discounts.

If you are currently using a PPO or are considering implementing one, carefully review how the discount arrangements are structured. The most common approach for hospitals is to have a straight discounted charge.

Other structures include a per diem amount paid to the hospital based on the diagnosis. In other cases, a flat dollar amount is paid to the hospital for each admission, based on the diagnosis and regardless of the number of days hospitalized. Probably the most cost-efficient discount arrangement is the diagnostic related group-based approach.

Another type of PPO arrangement is the gatekeeper or primary care physician approach. The physician, who is chosen by the employee, is the director of services for that employee and will provide most services to the employee. The gatekeeper PPO approach is very much like a health maintenance organization, but the employee still has the option to go outside of the gatekeeper and the PPO.

In a non-gatekeeper PPO, there is usually a difference in reimbursement between the PPO and the non-PPO provider. The incentive for the employee to utilize the PPO provider is a discounted fee and a higher reimbursement under the plan.

A gatekeeper-type PPO may have a similar copayment arrangement as the non-gatekeeper PPO. However, there is a trend toward even smaller copayments. Some plans may provide up to 100% reimbursement for use of the PPO network. Another approach is to require small-dollar copayments for PPO program usage, such as a $10 office visit copayment or a $200 hospital admission copayment.

- **Other alternative delivery services.**

A well-designed plan should ensure that the appropriate level of health care is being provided in the most appropriate setting. There should be an incentive to move individuals out of the hospital setting—which should be used for only the most intense required treatments—into a non-hospital setting. Some non-hospital settings include services provided at home or a post-hospital convalescent center. Check to see that alternative care, like home health services, post-hospital convalescent care and hospice care, is provided and reimbursed under your plan.

Also, there is a trend in mental health/substance abuse treatment of providing more treatment outside of the hospital. These facilities include outpatient treatment centers and halfway houses. Make sure that such outpatient treatments are reimbursed under your plan.

- **Coordination of benefits.**

Although the majority of companies use the "birthday rule" for coordination of benefits, the "gender rule" can be used in most cases under a self-insured plan. The gender rule provides that in cases in which a husband and wife both have group coverage, the husband's employer's plan is primary for covered dependents. This approach was the norm until some companies began using the birthday rule, which determines the primary plan by the birth dates of the spouses. The birth date that falls earlier in the year is considered, not the year of birth.

Keep in mind that there are some restrictions regarding the type of coordination method used. For example, under rules set out by the National Assn. of Insurance Commissioners, if there is a conflict of coordination between two plans, the gender rule predominates.

The approaches taken must be consistent with the organization's culture. Part of the challenge is to educate management and employees on. . .the need for change.

Other rules regarding coordination of benefits vary by state and may be different for insured plans as opposed to self-insured plans.

Another approach to coordination of benefits that has become very common is non-duplication coordination of benefits. Take, for example, an employee and spouse who are covered under identical plans: The plans call for a $200 deductible and coinsurance at 80%. Assume there is a claim for $4,200.

Under standard coordination of benefits, if your employee's spouse's plan is the primary plan, the $200 deductible would be subtracted from the $4,200 claim, leaving $4,000. After applying the 80% coinsurance, the remaining $3,200 is paid by the plan. Then your employee's plan would pay the remaining $1,000 of the bill.

Under non-duplication coordination of benefits, on the other hand, the spouse's plan would pay $3,200. Your employee's plan would not pay anything, because the plan would only pay up to the amount that normally would have been paid. In this example, if the spouse's plan paid $2,800, your employee's plan with the non-duplication coordination of benefits would pay $400 (the difference between $3,200 and $2,800) or up to the amount the plan would have paid if your employee's plan were primary.

Non-duplication coordination of benefits is initially somewhat subtle, but it is significant and may have a double impact. The direct savings are obvious, but this method also may reduce the number of covered lives under your plan. This method ensures that expenses are no longer paid at 100%. Once employees realize this, they will need to make decisions regarding their coverage. Coverage for spouses and possibly dependents may be dropped, and with fewer covered lives under your plan, there should be lower expenses. However, if your plan is very attractive—with low employee contribution rates, small deductibles, low maximum out-of-pocket expenses—employees may drop out of their spouses' plans, and all family members would switch to your plan exclusively.

- **Administrative service fees.**

If your plan is self-insured and you have implemented managed care programs, your plan is paying numerous administrative fees. Under a self-insured plan, either an insurance company or third-party administrator is charging a fee to process claims.

Administrative services only fees are difficult to compare from plan to plan and from one administrator to another. This is because of the differences in plan design and in covered lives (employees as opposed to retirees), which has an effect on the volume of claims. Benefit administrators should establish performance standards to ensure the quality of the services provided. Standards typically include claims turnaround time, financial error rate, administrative error rate and customer service.

Precertification fees vary from vendor to vendor, based mainly on the vendors' staffing levels and the type of staff they provide, like the ratio of nurses to doctors. The level of fees also will be affected by the intensity of the services provided. Here, too, benefit managers should establish performance standards with the utilization review vendor.

PPO access fees generally are charged on a per capita basis for access to the network. At a minimum, the PPO access fee should be paid for by the savings from PPO usage. If the PPO is doing its job, savings should be at least two to five times the access fee. Performance standards would include a guaranteed savings level, usually a multiple of the PPO access fee.

I've only scratched the surface on controlling health care costs. Because these costs are escalating rapidly, employee benefit professionals have the responsibility to use all methods that are possible and appropriate. But keep in mind that the approaches taken must be consistent with the organization's culture. For example, managed care through a gatekeeper PPO may be appropriate for some organizations, but not for others. Part of the challenge is to educate management and employees on the health care crisis and the need for change. ■

Would you like advice from an experienced colleague on a risk management, benefits management or actuarial problem? Four 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 employee benefit management issues is written by Dennis J. Nirtaut, manager of employee benefits at Continental Bank Corp. in Chicago. Susan M. Werner, director of risk management at Hardee's Food Systems Inc. in Rocky Mount, N.C., answers questions on risk management issues. William J. Miner, an actuary with The Wyatt Co. in Chicago, answers actuarial questions on benefits issues. And, Richard E. Sherman, president of Pacific Actuarial Resources (PAR) Excellence in Ashland, Ore., answers actuarial questions in the casualty field.



Mr. Nirtaut

Mr. Nirtaut's and Ms. Werner's columns appear on the second Monday of alternate months. Mr. Miner's and Mr. Sherman's columns normally appear alternately on the first Monday of each month.

Mr. Nirtaut's next column will appear in March.

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.

Business Insurance **Information Resource**

NOTE: THIS COUPON WILL NOT BE SERVICED AFTER MARCH 23, 1992
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Continued from page 19

events and timely announcements pertinent to benefits are covered in the quarterly bulletin published by Hay/Huggins Co. Inc. Request item 590.

■ A booklet designed by the International Foundation of Employee Benefit Plans lists educational **programs and conferences for corporations trust funds, associations, public employee groups and Canadian benefits personnel.** The booklet describes each program and gives its location. Request item 591.

■ A manual from Dental Benefit Providers Inc. describe its newest point-of-service delivery system, which offers a **network of contracting dental providers with a fee-for-service component.** Request item 592.

■ Getting employees to see **benefit packages as financial planning tools** is the subject of an article from Buck Consultants Inc. Doing so can help sponsors manage the rising cost of benefits and get employees involved in planning their financial security, Buck says. Request item 593.

■ Hay/Huggins Co. Inc. is offering a reference guide to answer questions in specific benefits areas like **reporting and disclosure rules and coordination of benefits guidelines.** Request item 594.

■ The fall 1991 issue of "PensionMaker Edge," published by EBG & Associates Inc., features an overview of the **final 401(k) regulations**, including their impact on plan restructuring. Request item 595.

■ A brochure from the International Foundation of Employee Benefit Plans describes the organization's **two-year summer internship program for college sophomores** and what it offers employers and students. Request item 596.

■ Buck Consultants Inc. is offering an article which discusses **FAS 106**, the new accounting standard for post-retirement benefits other than pensions. Request item 597.

■ Features that have made **401(k) plans popular with employees** are compared in surveys from 1984, 1986 and 1991 by Buck Consultants Inc. Request item 598.

■ A brochure describing a range of **services for self-funded employers**—including self-funded plan design, cost control through claims management, comprehensive reporting, managed care alternatives, cost management programs and Section 125 flexible spending accounts—is available from the National Assn. of Employee Benefit Administrators. Request item 599.

■ "Prescription Medicine Benefit Programs," a booklet from the Upjohn Co., is designed to demonstrate the value of **drug therapy** as part of a cost-effective health care plan. Request item 600.

■ Articles discussing the need for **employee benefit statements**, their content and whether they should be produced in-house are available from Benefit Software Inc. Request item 601.

■ A publication of EBG & Associates Inc., "PensionMaker Edge," discusses **age-weighted profit-sharing plans**, including methods of calculating age-based allocations. Request item 602.

■ An informational report on how **health testing and wellness programs** can improve the current state of your corporate health while safeguarding the bottom line is available from Corporate Health Planning Inc. Request item 603.

■ An executive summary from Dental Benefit Providers Inc. explains the company's delivery systems and **the spectrum of managed dental care goals** Request item 604.

■ A brochure from National Health Services Inc./CareReview details the medical screening criteria it uses in **automated evaluation for pre-certification reviews.** Request item 605.

■ **Prepaid legal benefits and the advantages of owning a legal expense plan** are described in a brochure from Pre-Paid Legal Services Inc Request item 606.

■ ARUP Inc. offers background information on the history of **employee drug-testing**, explains how to establish a sound drug-testing program and describes its services in a detailed folder. Request item 607.

EMPLOYEE BENEFIT MANAGEMENT INFORMATION SYSTEMS

■ Software designed to cut administrative costs and **increase employer control over pension, profit-sharing, 401(k) and ESOP plans** is explained in a brochure from EBG & Associates Inc. The software options are designed to improve communication of plan benefits to employees and to cost-effectively calculate benefit amounts. Request item 651

■ Cyborg Systems Inc. offers materials explaining the benefits administration module of its human resources management software. The module simplifies **record keeping for flexible benefit plans, flexible spending accounts and complete COBRA administration, among other things.** Request item 652.

Continued on next page

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Continued from previous page

■ GENESYS Software Systems Inc.'s **human resources program** allows users to immediately access information on employees and stay on top of constantly changing information requirements. The online, menu-driven system covers executive compensation, labor relations and complete government compliance reporting. Request item 653.

■ DATAIR Employee Benefit Systems Inc.'s flier explains the need to **keep software up to date to meet ever-changing government requirements** and suggests questions to ask when looking for employee benefit software. Request item 654.

■ A brochure from GENESYS Software Systems Inc. describes its **defined benefits system**, a pension plan administration system that supports record keeping, calculations, pre-retirement counseling, benefit statements and more. Request item 655.

■ The "Networker" newsletter, available from MEDSTAT Systems Inc., covers such topics as MEDSTAT clients' use of **health claims data for strategic employee benefits management**. Request item 656.

■ Information on GENESYS Software Systems Inc.'s **defined contribution software system,** which is designed to handle all plan administration requirements, is available in a brochure. The software package features eligibility determination, automation of enrollment, fund transfers, forfeitures and investment purchases. Request item 657.

■ National Health Services Inc. offers a flier detailing its CareReview **utilization review program**, which is available for purchase as an in-house licensee. The complete turnkey program, covering personnel recruiting to medical panel support, allows claim payers to increase client service and reduce UR cost. Request item 658.

■ A demonstration disk and printed materials illustrate the features of three **human resources information management programs** from Abra Cadabra Software Inc.: the payroll system; human resource system, which includes employee benefit plan administration; and job applicant tracking system. Request item 659.

■ A human resource planning system designed to **help manage the integration of human resource and strategic business planning** has been developed by GENESYS Software Systems Inc. Features include succession planning, performance tracking and requisition control. For information, request item 660.

■ A pamphlet from National Health Services Inc./CareReview provides information on DataReview, a computer system linked to its **utilization review program**, comprehensive reporting systems and other cost containment programs. Request item 661.

■ The **flexible benefits administration system** from GENESYS Software Systems Inc. provides eligibility and enrollment processing, confirmation statements and FSA payments, among other things. For a descriptive brochure, request item 662.

INTERNATIONAL

■ A brochure from National Travelers Corp. describes a **worldwide travel assistance and emergency medical service** for employees who travel or are in high-risk occupations. The brochure details benefits that most insurers or corporate charge cards do not cover. Request item 901.

SELF-INSURANCE SERVICES

■ A flier from SIEX Inc. describes a **self-insurance referral service**. The service is offered to companies with self-funded programs that are trying to locate pre-screened vendors for property/casualty and group employee benefit claims and other services. Request item 1601.

■ Self-Insurance Marketing Service offers a brochure detailing its **full-service professional marketing-support program** designed to help vendors reach the self-insurance market. Request item 1602.

■ DAVID Corp.'s demonstration diskette highlights its **claims management system** for workers compensation, property/liability and incident tracking. Requires IBM-compatible personal computer. Specify disk size. Request item 1603.

■ A booklet available from WLT Software of Florida Inc. includes information on the company's **health claims administration and billing system**. Request item 1604.

Continued on next page

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Continued from previous page

■ A pamphlet from SBPA Systems Inc. describes its systems for benefit plan administrators. Functions include **integrated eligibility tracking and adjudication of medical, dental, vision and standard claims.** COBRA and Section 125 administration are also handled. Request item 1605.

■ A brochure from PRO Systems Inc. explains its **health administration software package** for claims including medical, dental, vision and disability. Request item 1606.

■ **"Strategic Solutions for Health Benefits Management,"** a Business & Health special report, covers a variety of health care cost issues and is available from Erisco Inc. Request item 1607.



■ A summary sheet from Lexington Insurance Co. covers its various **medical stop-loss products** including specific stop-loss protection for individual claimants, aggregate stop-loss protection and HMO/hospital capitation program. Request item 1608.

■ Information related to **automating benefit and claims administration** is provided by SW Systems Inc. Claims processing, COBRA administration, management reporting, cost containment and managed care are among the issues covered. Request item 1609.

■ A folder from Telos Computing Inc. outlines its **automated benefit and claims administration system.** The information addresses claims processing, COBRA administration and group premium billing and gives management report samples. Request item 1610.

Around the states

Big liability costs lead to rental car surcharges

PARK RIDGE, N.J.—Huge losses from liability claims are prompting Hertz Corp. to add surcharges of up to $56 per day for individuals living in four New York City boroughs.

Corporate customers, though, will not have to pay the surcharges, a Hertz spokesman said.

Residents of the Bronx, Brooklyn, Manhattan and Queens have faced the surcharges since Jan. 2 when they rent Hertz cars in New York, Connecticut, New Jersey or Pennsylvania. Bronx residents fare the worst, paying an additional $56 per day. Residents of Brooklyn are charged an extra $34, residents of Queens $15 and residents of Manhattan $3. Staten Island residents are not affected.

Renters from other parts of the country will not pay the surcharge when renting in New York, nor will New York City residents renting cars outside the four-state area.

The spokesman said Hertz paid $45 million in third-party liability claims that exceeded $25,000 per claim from 1988 to 1990 in New York City. Hertz is self-insured for liability losses.

"For every dollar we get from a Bronx resident, we pay out $1.28," he said. "It was unprofitable business."

Hertz and other rental car companies blame New York state's vicarious liability law for the losses. The law holds a vehicle's owner liable for damage caused by any driver of the car, regardless of fault.

Vicarious liability laws also are on the books in Florida, Iowa, Michigan and the District of Columbia. In Connecticut, a vicarious liability law applies only to car rental companies.

Hertz said it does not now assess surcharges in these states because claims there are much lower than in New York.

States without vicarious liability laws cap car owners' liability, typically at between $10,000 and $50,000, said Thomas Santorelli, president of claims management at Hertz.

Avis Inc. of Garden City, N.J., Budget Rent a Car Corp. of Chicago and National Car Rental System Inc. of Minneapolis said they have no plans to impose surcharges, but are fighting the New York law in other ways.

"We are lobbying the state Legislature to get the law changed," an Avis spokesman said.

Hertz has come under fire from consumers and government officials in New York over the fee, with charges ranging from consumer fraud to racism. Hertz representatives were scheduled to meet with the New York Attorney General on Jan. 9 to document the liability losses.

"We might consider legal action" if Hertz is found to violate contract law or the state's General Business Law, which limits the use of surcharges, said a spokeswoman for Attorney General Robert Abrams.

—By Sara Marley

Uninsured motorists

AUSTIN, Texas—Regulators and insurers have settled their dispute over the cost of auto coverage for previously uninsured motorists.

The State Board of Insurance on Dec. 20 adopted a rule requiring insurers to charge the same rates for drivers who have had bought coverage and those who have not. However, insurers will have a chance to argue that previously uninsured motorists should pay higher rates.

Regulators adopted the rule as an alternative to an earlier proposal that would have denied insurers the opportunity to prove that previously uninsured motorists are bad risks. Insurers contend that proposal would have forced good drivers to subsidize those who had gone without coverage in violation of the state's mandatory insurance law (*BI*, Dec. 23, 1991; Oct. 7, 1991).

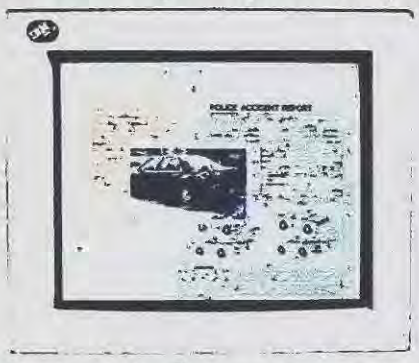
Under the new rule, insurers may present data on accident rates for previously uninsured motorists. If the board determines higher premiums are justified, surcharges will be allowed.

"It's acceptable," said a spokeswoman for State Farm Mutual Automobile Insurance Co. in Austin.

—By Michael Bradford

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Reichard new president of Seibels Bruce

W. Thomas Reichard has been elected president and chief operating officer of Seibels Bruce Group Inc. of Columbia, S.C., replacing **Jack S. Hupp**, who is retiring.

Mr. Reichard joined Seibels Bruce in 1984 and was most recently the executive vp in charge of all underwriting, actuarial, marketing, reinsurance and branch office activities.

Also at Seibels Bruce, **F. Michael Klopp** promoted to senior vp-underwriting.

Other insurer changes:

Bruce F. Friedberg named senior vp and chief financial officer for the commercial insurance division of Fireman's Fund Insurance Co., an Allianz A.G. Holding subsidiary in Novato, Calif. He had been underwriting and marketing executive for national accounts.

Comings & goings: industry

Patrick A. Thiele elected executive vp and will continue as chief financial officer with The St. Paul Cos. Inc. of St. Paul, Minn.

Niesa Brateman Halpern promoted to senior vp of strategic planning and development for the College Construction Loan Insurance Assn. in Washington, D.C. She had been vp-finance.

At Arkwright Mutual Insurance Co. of Waltham, Mass., **Allen D. Alexander**, who is senior vp and Western area manager, is now responsible for overseeing the corporate engineering function, and **Thomas G. Kaiser**, who is senior vp and Eastern area manager, is responsible for the corporate marketing function.

Security Life Insurance Co. of Denver named Keith Glover as executive vp-operations and Dr. Richard Don King as vp/chief medical director. Both men formerly were executives at Mutual Benefit Life Insurance Co.

Agent/Brokers

Robert Needle named director for the East and **Denis H. Langhans** director for the West with a new Alexander & Alexander Inc. unit, the Global Network Offices group, comprising A&A offices in 16 large cities. Other U.S. offices are now designated Corporate Specialty Offices, overseen by National Director **Robert C. Nevins**. Regional directors of those smaller-city offices are: **Robert J. Murphy** in New York; **J. Ray Taylor** in Dallas; and **Richard M. Chappell** in Phoenix.

Also at A&A: **Robert J. Kestenbaum**, formerly managing vp of the Greenwich, Conn., office, appointed managing vp of the Melville, N.Y., office; replacing Mr. Kestenbaum in Greenwich is **Richard H. Pierpont**; and **Michael Stankard** hired as vp and senior regional marketing specialist in Cleveland.

A. Michael Hewins named head of the Space and TeleCom Group unit of Johnson & Higgins in Washington, D.C. Mr. Hewins, who left his job as a manager in the J&H space unit in 1986, has been a risk manager for European space agency Arianespace and an executive with specialty insurer International Technology Underwriters.

Also at J&H, new vps were named in the New York office: **Nancy L. Kalbfell**, **John C. Raskin** and **Michael R. Viso** in the casualty department; **William M. Clardy**, **Robert L. Peterson** and **Kenneth J. Ross** in casualty loss control services; **Steven R. Liguori** in the international department; **Matthew P. Eckmayer** and **Cathleen M. Fitzpatrick** of the middle market department; **David J. Finnis** and **Rudolph Mastrocinque** of the property department; **Glenn D. Buser** of property loss control services; and **Vincent T. Moy** of the surety department.

Willis Corroon P.L.C. announced several changes. **Jennifer B. Cartmell**, who had been corporate treasurer and chief development officer of Willis Corroon Corp., named executive vp and chief operating officer of Willis Corroon Corp. of New York Inc. She succeeds **William Quinn**, who has been named corporate senior vp and national director of marketing. At Willis Corroon Corp. of Minnesota, **Richard G. Donovan**, formerly a risk manager at construction company M.A. Mortenson Co., named executive vp and branch manager in charge of developing the construction industry division in Minneapolis. And **Katja Andersen**, formerly with Alexander & Alexander Services Inc., named vp and international account executive in San Jose, Calif.

Other suppliers

Richard A. Simon, who is president and CEO of GAB Business Services Inc., named president and chief executive officer of its immediate parent, SGS North America Inc., a Fort Lee, N.J., holding company. Both firms are owned by Societe Generale de Surveillance, a Swiss concern.

Alexander Consulting Group Inc., an Alexander & Alexander Services Inc. unit in Lyndhurst, N.J., announced these recent appointments: **Brian E. Kennedy**, formerly president and CEO of ACG Ltd. of Canada, has taken the same post with ACG Ltd. of the United Kingdom in London; his predecessor in the U.K., **R. Allan Durward**, is retiring. Succeedng Mr. Kennedy in Canada is **Robert K. Burden**, who had been executive vp and Western division manager with Alexander & Alexander Benefits Services, A&A's U.S. benefits brokerage. And, **John L. Goodyear**, who had been executive vp and Eastern division manager, appointed president and chief operating officer of Alexander & Alexander Benefits Services.

Dale S. Douglas, formerly a risk manager with trucking company Jones Motor Co. Inc., joins Richard J. Mills & Associates, a Pittsburgh law firm, as an associate specializng in transportation law and insurance practice and defense. ■

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CAPITAL RE

CenTrust workers settle 401(k) suit

By JOANNE WOJCIK

MIAMI—A fiduciary liability insurance policy will cover the settlement of a suit filed last year by former employees of failed CenTrust Savings Bank of Miami against the trustees of their 401(k) plan.

The suit, filed last May in U.S. District Court in Miami, charged that CenTrust Chairman David L. Paul and other trustees of the plan had imprudently invested most of the plan's assets in junk bonds and highly speculative CenTrust securities, explained Neal R. Hagglund, president of American Pension Management Inc.

The Miami pension management firm filed the lawsuit on the employees' behalf.

Upon seizing the failed thrift in February, the Resolution Trust Corp. appointed American Pension Management to take over the 401(k) plan.

According to the suit, nearly $9 million in plan assets—which included employees' pretax contributions and 50% matching contribution made by CenTrust for 1986 to 1996 against employee contributions and anticipated contributions—were invested in CenTrust securities. Those securities became worthless when the S&L was declared insolvent.

But, under the settlement, the 2,000 plan participants will receive a 15% annual return on their plan investments, Mr. Hagglund said.

Part of the settlement—$1.7 million—will be covered by the trustees' fiduciary liability policy written by Aetna Life & Casualty Co. The remaining $300,000 of the $2 million of policy limits will be applied to legal fees and court costs.

Also as part of the settlement, CenTrust forgave the $4.2 million "loan" the bank made to the plan to fund future matching contributions, Mr. Hagglund explained.

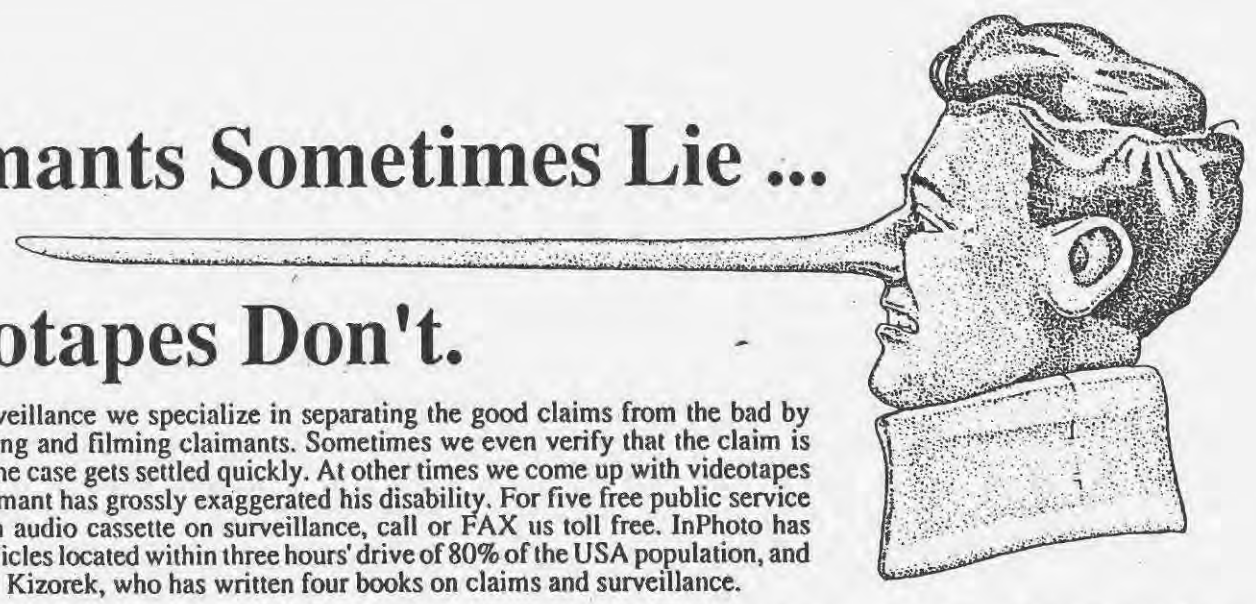
In addition, $2.9 million in plan assets were invested more conservatively, and Centrust made a $2.3 million cash infusion into the plan just before the thrift was seized, according to Mr. Hagglund.

These $5.2 million in assets—coupled with the $1.7 million settlement and the elimination of the $4.2 million loan—will more than make up CenTrust employees' losses, Mr. Hagglund said.

"We currently project that, after the settlement proceeds have been distributed, all losses will be eliminated and the participants will receive an annual rate of return of approximately 15% on all moneys —including both employee contributions and employer matching funds," he said.

Federal regulators say the CenTrust failure could end up costing taxpayers $2 billion. ■

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Former CEO of TPF&C Re dies at age 62

Bernard D. Berry, who retired in 1987 after six years as chief executive officer of TPF&C Reinsurance in Philadelphia, died late last year after a long illness. He was 62.

Mr. Berry joined the Towers, Perrin, Forster & Crosby Inc. reinsurance brokerage unit in 1956 and was named vp in 1968. Six years later, he became a board member, and in 1981, he was elected vice chairman and CEO.

Mr. Berry is survived by his wife, Katherine, and four children.

INTERNATIONAL

KELM creditors try to prevent liquidation

By STACY SHAPIRO and GAVIN SOUTER

LONDON

LONDON—Creditors and other concerned parties are meeting this week in New York to hammer out schemes of arrangement for four insolvent U.S. casualty insurance subsidiaries of London United Investments P.L.C.

However, should agreement on those schemes—which are similar to reorganization plans—continue to be stalled as it has for the last 18 months, the four insurers could be placed in liquidation as early as next month. A liquidation would delay payouts to creditors, mainly U.S. policyholders, for years.

The High Court in London last month allowed another extension of applications to liquidate the companies until Feb. 26. Creditors agreed to this delay, even though the Policyholders Protection Board, the U.K. guaranty fund, had recommended liquidation if no agreement on proposed schemes of arrangement was reached by Dec. 18 (*BI*, Dec. 2, 1991).

Liquidation is possible if LUI subsidiary H.S. Weavers (Underwriting) Agencies Ltd. and the four insolvent subsidiaries are unable to settle a dispute over who should control the money in a premium trust fund.

Weavers and the 20-odd stamp companies on its line slip, which include Walbrook Insurance Co. Ltd. and the four insolvent "KELM" insurers—Kingscroft Insurance Co. Ltd., El Paso Insurance Co. Ltd., Lime Street Insurance Co. Ltd. and Mutual Reinsurance Co. Ltd. of Bermuda—dispute the ownership of some of the $30 million to $100 million that Weavers held in trust for the companies.

Weavers claims it is entitled to some of the money, said Paul Evans, assistant to the administrator of LUI. The disagreement may have to be resolved through court proceedings, he added.

The London law firm Freshfields is trying to negotiate a settlement between the parties to avoid lengthy litigation and improve the chances of a scheme of arrangement, creditors say. Freshfields had no comment on the talks.

But Mr. Evans thinks that the schemes of arrangement for the KELM companies are viable even without a settlement of the trust fund dispute.

"The dispute has given rise to some delay, but we hope that the schemes of arrangement will go out (to creditors for approval) soon," he said.

Meanwhile, the Assn. of British Insurers last month warned its members that the Policyholder Protection Board may soon assess all British-based property/casualty insurers to pay for KELM losses, said Vic Rance, manager-general insurance and international affairs for the ABI.

The letter was an informal reminder and not a request for payment, he said. Any such request would ultimately come from the PPB.

The PPB will pay up to 90% of claims unpaid by insolvent British insurers if the the policyholder is an individual with a British insurance policy. The claims are paid by a levy on all British property/casualty insurers. That levy is capped at 1% of net property/casualty premium volume in any one year.

The ABI, though, thinks the PPB may seek a smaller assessment, perhaps 0.5% of premium volume. This means that the British insur-

Continued on next page

Australia adopts new standards for cargo liability

By KATE McILWAINE

CANBERRA, Australia—New marine cargo liability laws passed by the Australian Parliament increasing cargo carriers' liability will eventually require carriers to assume more responsibility for cargo lost or damaged at sea.

Sen. Bob Collins, minister for shipping, said the new law is patterned after international standards known as the Visby and Special Drawing Rights protocols, which increase liability limits. The new law—The Carriage of Goods by Sea Act 1991—updates a 1924 law that—according to shippers, shipowners and insurers—put Australian shippers at a competitive disadvantage (*BI*, Oct. 8, 1990).

Though a bill had been before the Parliament since September 1990, it did not pass all stages and become law until Nov. 1.

Under the old law, shipowners had little legal responsibility to ensure cargo was delivered in good condition and exporters and cargo owners had to bear the major burden of insuring against loss, damage or theft during the sea voyage, Sen. Collins said

He said the new laws bring Australia in line with international standards. The Visby/SDR protocols increase the liability limits from 100 pounds sterling ($187 at current exchange rates) to 666.67 SDRs ($954) per package. They also change the definition of packages to account for containerization, or putting a quantity of materials into a single container for shipping.

The SDR is an imaginary unit of currency based on the currencies of Britain, France, Germany, Japan and the United States. Before using the SDR as the currency unit, the gold standard was used.

According to Sen. Collins, the new law also foreshadows Australia's eventual adoption of the Hamburg Rules—formally known as the United Nations Convention on the Carriage of Goods by Sea—

Continued on page 31

Making up past losses

French reinsurers hike rates for natural catastrophe cover

By WILLIAM PITT

PARIS—French reinsurers are reporting a sharp upswing in rates for natural perils catastrophe reinsurance and some hardening of rates for industrial fire reinsurance.

But "it's hard to say whether it's enough," said Patrick Peugeot, chairman of the nation's largest reinsurer, Paris-based Societe Commerciale de Reassurance S.A.

Catastrophe coverages for storm damage have risen in price by about 30%, according to Philippe Coignard, deputy general manager at Paris-based Societe Anonyme Francaise de Reassurances.

Ceding companies have increased their retentions and "there is now a better sharing of the risks" between reinsurers and the direct insurance market, according to Mr. Peugeot. SCOR has advocated this for some time, claiming that reinsurers had borne a disproportionate share of the burden for the winter storms that buffeted the coast of northern France in 1990.

The message is now at least getting through, and reinsurers are generally willing to write catastrophe coverage at the higher rates, Mr. Peugeot said.

But the market for industrial fire risks is more problematic. Reinsurers agree that rates are rising, but say the increases are difficult to quantify because many of the bigger ceding companies' programs are not yet fully placed.

Mr. Coignard of SAFR added that rate increases vary widely with the claims experience of the cedant, making generalization difficult.

Rates for the lower and middle layers of excess-of-loss reinsurance programs have hardened most dramatically, "because this was where reinsurers sustained the heaviest losses last year," said Jacques Pierre, a director at reinsurance broker Gras Savoye Willis Faber S.A. in Paris.

However, there still is a wide diversity of terms available in the market which suggests a degree of uncertainty, with reinsurers still "seeking the right price" for industrial fire business.

Gras Savoye Willis Faber places reinsurance mostly for small and medium-sized French insurers, which, according to Mr. Pierre, often show a "lack of innovation" in identifying their exposures.

French insurers still are failing to scrutinize their reinsurance programs as a whole, he said. They are simply seeking to renew their programs on the same terms as last year. "If you look at their (reinsurance) coverage class by class, it seems adequate, but if you look at it as a whole, they are under-reinsured," he said.

French insurers, Mr. Pierre contends, all too often lack the sophisticated computer systems necessary to evaluate the need for "clash" coverage, or excess-of-loss reinsurance that covers losses from two or more policies caused by the same event. And,

Continued on next page

Kenneth V. Grob dead at age 70

Played key part in scandal that rocked Lloyd's

LONDON—Insurance brokerage executive Kenneth V. Grob, a key figure in a major scandal that rocked Lloyd's of London in the early 1980s, is dead at the age of 70.

The former chairman of Alexander Howden Group Ltd. died of cancer Jan. 3.

His ill health first came to light during a lengthy 1989 criminal trial. Both he and former Lloyd's underwriter Ian Posgate were found innocent of criminal charges connected with the misappropriation of $55 million from Howden (*BI*, Aug. 21, 1989).

A second criminal trial involving the allegedly stolen money was dropped because of Mr. Grob's poor health.

Recently, Mr. Grob was expected to be asked to testify in a civil trial in London's High Court, but the court was told he was sick, possibly suffering from cancer of the kidneys.



Kenneth Grob

Mr. Grob, a Swiss citizen born

Continued on page 31

'Enough is enough'

Reinsurers are standing firm, Munich Re official says

By CAROLYN ALDRED

MUNICH, Germany—Capacity is falling and rates are rising for most property reinsurance renewals, according to a Munich Reinsurance Co. manager.

The most dramatic rate increases are for catastrophe excess-of-loss reinsurance, with rates escalating between 25% and 50% for U.S. business, said Karl Wittmann, an executive manager for Munich Re, the world's largest reinsurer.

Tougher attitudes among European reinsurers are leading to higher rates and reduced ceding commissions for proportional and excess-of-loss property reinsurance generally, he said.

"This year, reinsurers are saying, 'Enough is enough.' They cannot wait for direct increases. We need significant improvements," said Mr. Wittmann.

"It is not a dramatic turnaround, but there is a clear reduction in capacity," he noted last month.

"Prices are going up because of reduced supply and because everyone realizes that prices have to go up," he said, adding that reductions of 5% to 10% in reinsurance commissions were being accepted by cedants.

Although Europe, particularly the United Kingdom, is generally seeing small increases in direct property insurance prices after the huge underwriting losses of the past few years, reinsurers are pushing ahead with greater increases, he noted.

"Reinsurers have lost a lot of money the last few years," Mr. Wittmann said.

Many large individual losses hit reinsurers' books in 1989, and 1990's European windstorms struck a further blow, he noted. Losses also were heavy in 1991, with various European industrial fire markets—particularly Germany—heavily hit.

Also now hurting reinsurers' accounts are losses from the Japanese typhoons, which will cost insurers and reinsurers an estimated $2 billion, and the $450 million Canadian ($387.9 million) hailstorm in Calgary, Canada's worst natural catastrophe, said Mr. Wittmann.

These two losses have brought home to cedants just how global the insurance and reinsurance marketplace is, he added.

Only last year, Canadian and Japanese insurers were refusing to pay increased reinsurance costs to cover reinsurers' losses stemming from the United States and Europe, noted Mr. Wittmann.

"This year more than ever before it has been proved that worldwide reinsurance is only possible on the basis of worldwide solidarity—and no one can claim to be outside the solidarity," said Mr. Wittmann.

Also, the lack of high-layer reinsurance cover by many Japanese reinsurers has demonstrated the need for many insurers to purchase additional cover, he said.

Not until about April, when renewals typically

Continued on next page

INTERNATIONAL

LONDON

Continued from previous page
ers may be assessed 75 million pounds to 150 million pounds ($141 million to $282 million at current exchange rates), according to Mr. Rance.

Negotiations between the KELM companies and the Policyholder Protection Board have been the biggest stumbling block for the schemes of arrangement, parties involved agree.

Part of the impasse was resolved late last month when former Weavers Chairman Roger Borley resigned as a director of the KELM companies and Walbrook. He remains a director of Weavers.

Another source close to the situation, however, says that the amount the PPB will ultimately be responsible for paying is "a moving target." The High Court must first define "individual" and "British policy" to see whether U.S. partners in law, accounting and medical practices are covered by the Policyholder Protection Act, the source said.

The net cost to the board is expected to be about $300 million, assuming all U.S. individual policyholders are covered and the schemes of arrangement go according to plan, the source said.

Lloyd's testimony

Lloyd's of London Chairman David Coleridge and three former chairmen are expected to take the stand in the readjournment of the trial that pits members of loss-riddled syndicates formerly managed by Oakeley Vaughan Underwriting Ltd. against Lloyd's.

The trial of the members' charges of negligence is recommencing this week after a long adjournment. During that time, both sides argued over whether a preliminary hearing should be held to decide whether Lloyd's owed a duty of care to the members and, if so, whether the market was immune from members' suits under the 1982 Lloyd's Act.

Justice Gatehouse in June ordered a preliminary hearing to resolve this issue. But a Court of Appeal later overruled him, ordering the full trial to continue (*BI*, Sept. 23, 1991).

In December, the Court of Appeal denied Lloyd's request for a hearing by the House of Lords, Britain's highest court.

Nevertheless, Lloyd's still plans to directly petition the House of Lords to consider the appeal, which is allowed under British law, according to a Lloyd's spokesman.

Royal sells AMB stock

London-based Royal Insurance Holdings P.L.C. has raised 250 million pounds ($470.5 million) through the sale of shares it holds in a German ally.

The sale of Royal's 18.8% stake in AMB Aachener & Munchener Beteiligungs-A.G. of Aachener, Germany, took place last month. The stock was sold to merchant bank Credit Suisse First Boston.

The sale coincided with a decision by Royal to link up with AMB & Fondiaria S.p.A. of Florence, Italy, to form a holding company for their European business.

Fondiaria also has an option to buy some or all of the AMB shares from Royal.

"We will decide during the next few weeks what we will do with the option," a spokeswoman for the Italian insurer said.

The stock sale came a month after Royal posted its worst-ever nine-month results. Royal reported a loss of 214 million pounds ($379.4 million at appropriate exchange rate) for the first nine months of 1991 (*BI*, Nov. 25).

Royal's current debt was not revealed, but a spokesman for the insurer said that speculation that its debt was about 700 million pounds ($1.32 billion) "was not far wrong." Royal's debt stood at 600 million pounds ($1.13 billion) at the beginning of 1991.

Royal had discussed with AMB & Fondiaria the sale of 15% of Royal's own stock for about 300 million pounds ($564.6 million) as part of the pan-European agreement.

Rather than form cross-shareholdings, the three companies decided to form a holding company to handle all European business outside of their home markets, the Royal spokesman said.

The three insurers probably will have equal stakes in the new company, the spokesman said. The holding company should be set up early this year, "but we will have to move at the pace of the slowest lawyer," he said.

The preferred location for the holding company's domicile is the Netherlands, the spokesman said.

Meanwhile, French state-owned insurer Assurance Generales de France has increased its stake in AMB to 25% in the past few months. AGF is eager to establish a partnership with AMB.

However, a partnership between the two companies would be incompatible, said an AMB spokesman.

AMB, meanwhile, has bought 70% of Fondiaria's 25% stake in Volksfursorge Group in Hamburg.

Lloyd's posts filled

John Greig, chairman of Lloyd's broker Greig Fester Group Ltd., has become Lloyd's of London senior deputy chairman this year.

In addition, Richard Hazell, underwriter for syndicate 190, managed by Three Quays Underwriting Management Ltd., is now junior deputy chairman.

David Coleridge remains chairman.

Mr. Hazell will retire from his syndicate later this year and will be replaced by John Wetherell, its leading non-marine underwriter.

Meanwhile, Lloyd's has set up a plan that would help fund the "orderly runoff" of a Lloyd's broker in the future. Up to 4 million pounds ($7.5 million) could be raised through a levy on all 218 Lloyd's brokers if necessary.

No brokers are expected to be running off their business soon, said a Lloyd's spokesman.

Hearing to resume

The first-ever public hearings of a Lloyd's disciplinary committee are to resume this month with former underwriter Edward Cowen delivering his own defense.

Mr. Cowen, formerly an underwriter for syndicate 529, managed by Sterling Underwriting Agencies Ltd., is accused of arranging "a number of reinsurance contracts which could give rise to inequity between years of account and names," a Lloyd's spokesman said.

Lloyd's, which is bringing two charges, alleges that the contracts "are banking contracts with no real risk transfer. Therefore, they are not an insurance policy and, therefore, you are not allowed to place them," said Simon Kemp, a lawyer who is advising Mr. Cowen but not representing him before the committee.

Those contracts—arranged in 1988 and 1989—allegedly allowed Mr. Cowen to manipulate syndicate results and require members in 1986 to 1988 to pay higher premiums for the same or lower amounts of coverage than members of the 1985 year.

When details of the reinsurance emerged, Mr. Cowen was dismissed as underwriter of the syndicate. He left the syndicate on Jan. 12, 1989.

Comings & goings

David Rowland has agreed to continue as chairman and chief executive officer of Sedgwick Group P.L.C. until December 1995, two years beyond his normal retirement date.

Also at Sedgwick, **Saxon Riley**, vice chairman of the group and chairman of Sedgwick Broking Services Ltd., has been appointed to the new position of group managing director. He will be responsible for the operation of the group's worldwide insurance broking and risk management services.

John Swinglehurst has retired as a director of the Sedgwick Group board but will continue to be a director of Sedgwick Group Development Council Ltd. and a consultant to the company. And Richard Titley, chairman of Sedgwick Energy Ltd., has been appointed to the group board.

In other comings and goings:

John Mallinson has been appointed solicitor to the Corporation of Lloyd's effective Jan. 1, following the retirement of **William Beckett**. Mr. Mallinson currently is general manager in the solicitors department.

James Rossi named a director and a member of the management advisory board of Terra Nova Insurance Co. Ltd. Mr. Rossi is director of marine and aviation underwriting at Terra Nova.

David Sturt retired as chief executive of the London Insurance & Reinsurance Market Assn. on Dec. 31. **Bill Braid**, currently director of finance and administration, will serve as acting chief executive. ■

French reinsurers

Continued from previous page
with reinsurance budgets tightening, chances are slim for their making the investment in the near future.

French reinsurers say they had little difficulty arranging their own retrocession protections in preparation for the renewal season, notwithstanding the shakeout in the London excess-of-loss market.

SCOR has purchased a little less retrocessional cover than last year, but not much, according to Mr. Peugeot. SCOR, which is a market leader in facultative reinsurance, retrocedes very little of its business to the London market.

However, the retrocessional markets for French reinsurers have tightened markedly since last year, according to James Denniston, a director at reinsurance brokerage Muir Beddall Mise & Cie. in Paris.

Excess-of-loss coverage for facultative risks is now much more difficult to obtain than it had been last year, he says.

Despite the rate increases, there is new competition among French reinsurers, French brokers agree. "There is a new generation of reinsurers in France with a much more supple (underwriting) policy than the big companies," said Mr. Pierre of Gras Savoye Willis Faber.

Despite the rate increases, brokers report a new competition among French reinsurers.

French reinsurers now are retaining a larger proportion of reinsurance cessions within the country, notwithstanding reductions in capacity through events like the recent merger of reinsurers Assurances Generales de France Re and SAFR. The merged company is currently writing less French business than the two parent firms did before because of the adoption of SAFR's "more conservative" underwriting policy for the group as a whole, said Mr. Coignard of SAFR.

Younger reinsurers such as Sorema and AXA Reassurance have the means to expand rapidly in the French market, if they decide to do so, as a result of heavy capital injections from their parents, the agricultural mutual insurer Groupama and AXA Group, respectively.

At the same time that rates are rising, French reinsurers have been able to insert claims participation clauses into proportional treaties and shave ceding commissions, Mr. Coignard said.

Still, some observers are skeptical about the strength of the market upturn and the speed with which it will affect reinsurers' bottom line.

In London, securities analysts at Banque Nationale de Paris marked SCOR's stock as a "short-term sell" in December on the grounds that the company's results were "unlikely to improve significantly before 1993." ■

Property reinsurance

Continued from previous page
start for Japanese insurers, will the insurance and reinsurance markets feel the full impact of the typhoon losses.

Even in mid-December, Mr. Wittmann said it was too early to accurately gauge the state of the catastrophe excess-of-loss market for January renewals.

"There has been an exodus of Lloyd's syndicates, and the withdrawal of several Japanese, U.S. and Finnish companies writing catastrophe excess-of-loss business," inevitably leading to reduced capacity and higher prices, noted Mr. Wittmann.

When he spoke, however, the replacement for most catastrophe reinsurance programs had not yet started, and Munich Re had not been inundated with additional requests for cover.

Munich Re's capacity for excess-of-loss business remains unchanged, but Mr. Wittmann added that the reinsurer "would not hesitate in reducing capacity if pricing was not right."

He also noted that reinsurance buyers are not shopping around this year.

"There seems to be a consensus between clients and reinsurers. Now is not the time to shop around. That is the spirit (during) this renewal season," said Mr. Wittmann. ■

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Correspondents at Lloyd's of London

INTERNATIONAL

Grob dies

Continued from page 29

Sept. 15, 1921, joined Lloyd's broker Swann & Everett in 1937 at age 16 and became chairman in 1956. He and former Howden executive Ronald Comery at one time had acquired up to 90% of the brokerage through family trusts, but owned only 60% to 70% when it merged with publicly traded Howden in 1966.

In 1970, Mr. Grob became executive chairman of Howden. By the mid-1970s he had also set up trusts in Liechtenstein to handle his personal investments, particularly his stock portfolio. His financial affairs were handled by the Banque du Rhone et de la Tamise S.A. in Geneva, Switzerland, a Howden subsidiary.

Mr. Grob and Howden executives Allan Page, Jack Carpenter and Mr. Comery—who were later described in the London press as the "Gang of Four"—secretly bought the bank in 1979 with funds paid for quota-share reinsurance purchased by Lloyd's syndicates underwritten by Ian Posgate, who was chairman of Howden's underwriting unit.

Through his trusts, Mr. Grob also made "black-box payments" that allowed him to buy works of art and a villa in the South of France.

When Howden's new owner, Alexander & Alexander Services Inc., in 1982 accused Mr. Grob and the other members of the "Gang of Four" of misappropriating $55 million for their own benefit, he and the others left their offices, never to return.

The executives returned $41.8 million to Howden by August 1982. A&A filed suit against them on Sept. 20 of the same year.

A&A eventually settled with the four and with Mr. Posgate for an undisclosed sum. Market reports over the years have stated that many assets were returned to Howden, including: Mr. Grob's villa, which he eventually bought back from A&A; some works of art; one of London's finest wine cellars, which was used to entertain Howden guests; and silver goblets that Mr. Grob used to drink from at company lunches.

In February 1985, Messrs. Grob, Comery and Carpenter were expelled from Lloyd's for their part in the misappropriation of assets from Howden, and Mr. Posgate was suspended for six months.

Messrs. Grob, Posgate, Page and Carpenter were arrested in July 1987 during simultaneous police raids in Britain and France in connection with the allegedly stolen money (*BI*, July 20, 1987). Although Mr. Grob could have fought extradition from France, where he was living, he decided to return immediately to England.

Although Mr. Grob was found innocent on 16 charges of theft by a jury at Southwark Crown Court in 1989, the judge refused Mr. Grob's request that his legal costs be paid by the prosecution.

In a 1990 report on the Howden affair, the British Department of Trade and Industry condemned the actions of Messrs. Grob, Comery, Carpenter and Page (*BI*, Sept. 10, 1990).

With Mr. Grob's death, only one of the "Gang of Four" is alive.

Mr. Comery died in a car crash in 1987, and Mr. Page—who did not stand trial because he was terminally ill—died in early 1991. Mr. Carpenter is still alive, but was dismissed from the criminal trial in 1989 due to his ill health.

—By Stacy Shapiro

Cargo liability

Continued from page 29

which he said make shipowners "substantially more liable for loss or damage to cargo in their charge."

The Hamburg Rules extend liability to reflect the different categories of cargo carried, new technology and loading methods, and practical problems incurred by shippers, like delivery delays. Carrier liability also is extended while goods sit on a wharf.

Because they have not been adopted internationally, the Hamburg Rules are not "a viable alternative marine cargo liability regime at this stage," said Sen. Collins.

Zambia agreed to adopt the rules in October, making it the 20th* signatory. That is the level of support required for international adoption, which is expected in November 1992.

Unless adopted earlier, the Hamburg Rules would come into effect automatically in Australia in 1994, unless the Parliament specifically passes a resolution rejecting them.

The Hamburg Rules would not be automatically implemented without consultation with shippers, cargo owners, insurers and shipowners, Sen. Collins said. And, he said, they would not be implemented unless a significant number of Australia's

Continued on next page

1991 1992

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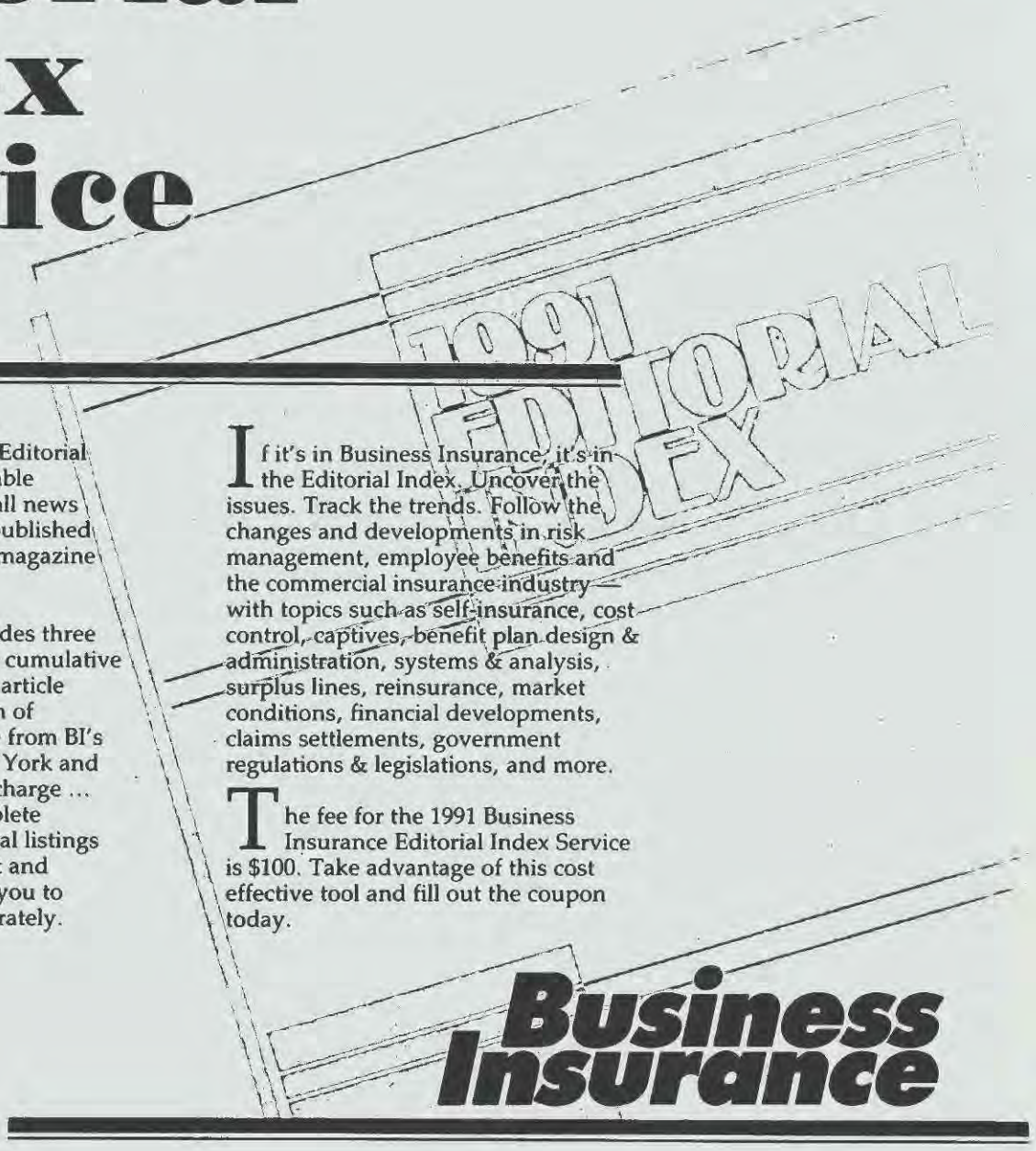
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INTERNATIONAL

Cargo liability

Continued from previous page
trading partners also plan to adopt them.

John Levingston, a Sydney-based solicitor who specializes in marine issues, observed that shippers are keen to see the Hamburg Rules implemented, while insurers and shipowners oppose them.

"Those who own ships don't want them (the rules) because it increases their liability, but others do," he said.

U.S. shipping groups are lobbying to have the rules adopted by Congress, pointed out Mr. Levingston. "Carriers must accept liability in this modern world," he commented.

Passage of the rules in Australia will require a "big battle," but is inevitable, he predicted. "Those insurers who position themselves well and plan for it, putting products on the market in anticipation, will benefit; the others will be caught cold."

Australian insurers welcome the adoption of the Visby/SDR protocols but still oppose the Hamburg Rules, said Chris D. Henri, marine manager for the Insurance Council of Australia in Sydney.

Were the Hamburg Rules adopted, insurers claim, more cargo insurance would be underwritten by protection and indemnity clubs and other non-Australian underwriters. Currently, 60% of cargo exported from Australia is insured offshore and only 40% is placed onshore.

"The government has at last seen fit to update the laws to keep us in line with our trading partners," said Mr. Henri. Visby/SDR are "tried and tested" protocols and their worth has been demonstrated internationally by other countries that already have adopted them, he said.

But the Hamburg Rules, which none of Australia's major trading partners has adopted, are "an academic compromise" that does not take "commercial reality into account," Mr. Henri argued. "We will continue to lobby the federal government not to move with any undue haste to adopt the Hamburg Rules."

Shippers' organizations will probably join the ICA in any lobbying, said Mr. Henri. It is more economical for cargo owners to arrange insurance in Australia and then let the insurance company take action against a carrier or shipowner if the cargo is damaged.

"That's more economical than shifting the responsibility to the carrier and then trying to get compensation," he said. "Cargo does get damaged; it's a fact of life."

Implementing the Hamburg Rules would be "foolhardy in the extreme," he argued, because the increased liability limits would result in "a dissipation of marine cargo insurance." ■

Winds whip up claims along Norwegian coast

By GAVIN SOUTER

BERGEN, Norway—Insurers in Norway face large claims after hurricane-force winds hit the country's western coast over the New Year's holiday.

But energy insurers in London escaped virtually scot-free despite winds of 197 m.p.h. scathing the North Sea oil fields, according to brokers.

It was the worst storm in a hundred years, said a spokesman for Vesta General Insurance Co., which is based here.

"The damage is terrible; it's like war zone. It's miraculous that no one was killed," he said.

One family that sought shelter in their basement watched their farmhouse blown away overhead, the spokesman said.

About 340 miles of coastline stretching from Sognefjord to Namsos were hit by the storm. Farms, houses and fish farms, he said, suffered a total of about 750 million krona ($125.3 million at current exchange rates) in insured losses.

Building claims will be met by the individual catastrophe funds insurers are required to establish through a premium surcharge of 0.01% of insured value, the Vesta spokesman said.

Fishing vessels and cars in the area were also damaged, but the insured losses have not yet been assessed.

Insurers will also compensate fish farmers for the 1 million salmon that escaped when the fish farms were damaged.

Vesta, which insures about one-third of the nation's fish farms, says it expects to pay 22 million krona ($3.7 million) for salmon losses.

Energy insurers have not received any claims so far despite the high winds that began Dec. 31, which brokers had feared would cause substantial damage to energy installations.

"Although the winds were high, the sea remained flat so there does not appear to be any claims," explained Philip Hallett, executive director in the energy department of C.T. Bowring & Co. Ltd. in London.

Two production platforms operated by Shell U.K. Ltd. had to be shut down, but the company does not carry business interruption insurance for its North Sea installations, Shell U.K.'s insurance department confirmed.

The North Cormorant and Eider production platforms were shut down on Jan. 2 after fire-resistant covering on housing units was damaged, a Shell U.K. spokesman said. The combined production of both platforms is 80,000 barrels a day, he said.

Late last week the platforms were still inoperative. ■

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Maine work comp

Continued from page 3

which, except for Royal, were residual market servicing carriers—are keeping existing policies in force until they expire, Mr. Johnson said.

And, the bureau has not acted on withdrawal requests from about a half-dozen other insurers, which the bureau received after the Nov. 1 withdrawal deadline, he said.

The emergency rule establishes an allocation procedure for the distribution of the portion of any workers comp residual market deficit that is found under state law "to be the responsibility of insurers due to their failure to depopulate the residual market."

Since early 1988, employers in Maine have been responsible for paying all residual market deficits unless insurers do not make a good-faith effort to write voluntary market business.

The Insurance Bureau determined that insurers did not meet the state's standard for making a good-faith effort to write in the voluntary market, so, under the law, the residual market deficit must be split equally between employers and insurers.

In addition, since 1988, insurers' share of residual market losses had been divided so that insurers designated as servicing carriers as of Oct. ', 1986, and authorized to write workers comp insurance in any year for which a deficit existed were responsible for 90% of any resulting assessment on insurers on an equal-share basis. All other casualty insurers—including insurers that did not write workers comp coverage—were responsible for the remaining 10%, according the Insurance Bureau.

"As a result, a small number of insurers (or groups) have been responsible for 90% of any assessment based on failure to depopulate the residual market, under circumstances where the residual market continues to be far larger than normal," the bureau says.

Most of the insurers that filed withdrawal plans late last year, which threatened to cause the collapse of the entire Maine workers comp market, were those responsible for 90% of the assessments (*BI*, Nov. 18, 1991). They cited the assessments as a major reason for their decision to withdraw.

The emergency rule approved last month establishes a new, complex assessment procedure to allocate the 1992 residual market deficit between "major carriers," or those with direct written premium of at least 2% of the state workers comp market from 1988 to 1990, and "all other carriers," or those with less than a 2% market share during that period.

Under the rule, the small workers comp insurers must now pay 40%—rather than 10%—of the insurers' share of the deficit, subject to certain caps. Assessments on the small workers comp insurers are based on their policyholder surplus rather than their workers comp premium volume.

The rule "may shift more of the burden on a company that is licensed but had not written much—or any—workers compensation in recent years," the bureau's Mr. Johnson said.

The emergency rule also establishes new credits against assessments that insurers can receive for voluntary workers comp writings, caps on assessments for both large and small workers comp insurers and a procedure for allocating any deficit remaining after caps are reached by both categories of insurers.

The major workers comp insurers' residual market assessments are initially capped at between $1 million and $2 million based on their share of the workers comp market from 1988 to 1990.

In addition, the smaller workers comp insurers' assessments are initially capped at between $7,000 and $1 million based on their policyholder surplus.

However, any deficit remaining after these initial caps are reached will be allocated equally among all casualty insurers, though an individual insurer's additional assessment cannot exceed 0.1% of its policyholder surplus.

The emergency rule "may not be perfect or address problems in the system, but it allows us and other carriers more equitableness and predictability in the way deficits will be distributed for the 1992 year," a Maine Bonding spokesman said.

The new assessment formula is "much more favorable," agreed Rick Sawyer, president of Hanover of Maine Inc., a Scarborough, Maine, management company that manages Hanover Insurance's operations in the state. "The biggest concern has been the assessments that insurance companies have to pay," he said.

For example, he estimated that Hanover would have to pay $6.1 million of the estimated $150 million deficit for the assigned risk plan in 1989, which is the most current estimate available, due to the lag time in claim development.

"Employers are happy there is a work comp market for 1992," Acting Superintendent Johnson said. However, state statutes still hold policyholders responsible for paying 50% of any residual market deficit through policy surcharges.

The bureau's actions are a concern to some large national insurers and small Maine-based insurers that write little or no workers comp business, because the emergency rule could increase those insurers' residual market assessments, according to spokesmen for State Farm Fire & Casualty Co., Allstate Insurance Co. and the Maine Assn. of Insurance Companies.

All three are reviewing the emergency rule and its potential effect on insurers' operations and considering what steps, if any, to take.

The emergency rule causes State Farm "grave concern," because it disregards protections set by state law and exceeds the bureau's authority, said insurer attorney John W. Ashenfelter.

The emergency rule is "inequitable and confiscatory" and violates the company's constitutional right to a fair rate of return and to hold property, he said in a letter to Mr. Johnson last month.

Under the new rule, State Farm, which wrote $440,000 in workers comp premiums in Maine in 1991, could be liable for at least $1 million in 1992 residual market assessments up front and perhaps several million dollars more if a second assessment is made after insurers reach their caps, Mr. Ashenfelter explained.

And, "it's a very, very serious matter for small domestic companies," said Beverly Gammon, president of the 16-member Maine Assn. of Insurance Companies and executive vp of York Mutual Insurance Co. in Westbrook, Maine.

Many small casualty insurers only recently realized that the bureau since 1988 has maintained that it can assess them for workers comp residual market deficits because they hold casualty insurance licenses, even though several MAIC members have never written workers comp insurance, she said.

As a result, these smaller companies are "seriously" contemplating legal action challenging the bureau's interpretation that all casualty insurers fall under the rule's provisions because they are assumed to be authorized to write workers comp insurance, she said.

Ms. Gammon pointed out that executives from at least two small insurers queried Insurance Bureau personnel about writing workers comp coverage a few years ago and were told that the insurers had insufficient surplus to write the coverage.

Although the bureau responded to small domestic insurers' concerns by giving the superintendent the authority to exempt or defer assessments against any insurer if it would jeopardize its solvency, that is not enough, Ms. Gammon said.

The rule is "a last-ditch effort" to save a market "desperately" in need of reform, said Web Templeton, a workers comp manager for Allstate, which writes less than $1 million in workers comp premiums in Maine.

Even Maine's Bureau of Insurance views the rule as a stopgap measure that is not likely to keep insurers in the workers comp market next year, Mr. Johnson said.

Even with the three large insurers returning to the market, an unspecified shortfall in workers comp market capacity is expected to occur before year end, he added.

That and the myriad of other problems facing the state will be discussed at upcoming meetings and hearings, he said. ■

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Secretaries, Treasurers, controllers and other Financial Personnel	4,405
Risk/Employee Benefits:	
Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations	10,976
Sub-total	**24,117**
Associations	458
Government, Unions and Educational Institutions	1,234
Commercial Consumers	
Sub-total	**26,809**
Insurance Agents and Brokers	9,430
Insurance Companies	8,045
Accountants, Actuaries, Attorneys & Consultants	3,405
Adjusters, Appraisers, TPA's, Captive Managers & Health Care Providers	1,392
Others Allied to the Field	1,518
TOTAL	**50,599**

★ Source Business/Occupational breakdown of qualified circulation, May 27, 1991 issue, as submitted to BPA for June 1991 BPA Publisher's Statement.

HCFA billing

Continued from page 1
from the employer plan.

For an employer to prove that it owes Medicare an amount less than it has been billed, the employer's TPA should send an explanation of the company's benefits. This typically would be a one-page statement that lists the size of the claim, the applicable deductibles and coinsurance, and the final amount that is owed.

In some cases, an employer might not provide any coverage for a particular treatment, like chiropractic services. In those situations, Medicare would not be entitled to any refund.

"It is up to the group health plan to show that it did not cover the service or that its payment for the service is less than the amount Medicare paid. If the group health plan satisfactorily documents that a lesser amount or no amount is due for the service, the amount that must be refunded is adjusted," HCFA says.

An employer also wouldn't have to reimburse Medicare if the employer can show it acted as the primary payer for the beneficiary. If a provider billed both the employer's plan and Medicare for a beneficiary's treatment, Medicare will seek recovery from the providers.

HCFA officials say they do not know how many claims will involve double billing.

However, Fred Hunt, president of the Society of Professional Benefit Administrators, a Chevy Chase, Md.-based TPA trade group, said double billing could be involved in as many one-third of the bills that HCFA will send out.

Plan administrators "should be very careful and cautious" before paying the HCFA bills, he advised.

Payment is due within 60 days of the initial request for payment.

HCFA can refer cases in which bills are not paid to the Justice Department for legal action. Under law, the Justice Department can seek damages double the size of the claim from TPAs, insurers or employers.

The parties that U.S. attorneys could sue will vary according to the facts of an individual case, the HCFA spokesman said.

But, some benefit experts question whether courts would find TPAs liable in cases where the TPA essentially only processed claims.

"Ultimately, the liability may rest with employers," warned Mary Lynn Eubanks, a consultant with Hewitt Associates in Lincolnshire, Ill.

In addition, HCFA can refer unpaid bills to the IRS for tax penalties against employers whose health plans did not pay claims as required on a primary basis. Under law, the IRS can impose a penalty equal to 25% of an organization's health care expenses.

But, HCFA says that it does not plan to refer employers to the IRS in cases where the employer can demonstrate that it relied on erroneous advice from an insurer or TPA and where Medicare is reimbursed.

HCFA officials emphasize that only in rare cases will bills for reimbursement go to employers. In most cases, bills will go to TPAs or insurers, a HCFA spokesman said. He explained that a TPA would have plan records and be responsible for claim payments.

However, HCFA will send bills directly to self-insured employers that self-administer their health care programs.

Squabbles could emerge between employers and insurers over whether current insurance would cover bills for services that were incurred years ago, noted Rick Raup, president of Business Administrators & Consultants Inc. in Reynoldsburg, Ohio.

While contractual requirements vary considerably, some stop-loss policies, for example, require that requests for reimbursement from the insurer be made no later than one year after the close of the policy year in which an employer paid a claim, said Susan DeGregorio, a Hewitt consultant in Lincolnshire.

Meanwhile, some employers say the earlier phase of the HCFA project —in which HCFA asked employers whether certain employees for which Medicare paid bills were covered under the company's health plan— has been time-consuming and difficult.

"We're probably talking 8,000 or 9,000 people that we'll have to check on," said Ruth Mill, supervisor-health resources for Dayton Hudson Corp., the Minneapolis-based retailer. "For retailers with a high turnover, it can be a real nightmare," Ms. Mill said.

Cathy Wooster, benefits planning manager at Barnett Banks Inc. in Jacksonville, Fla., also cited the difficulty of gathering information on past and current employees as a headache for benefit managers. "Unfortunately, the records aren't all in one place," she said. While current employee information is stored electronically, some of the bank's previous records exist on paper in warehouses, she said.

Even when the necessary records are at a central location and the number of people affected is small, the task still is time-consuming.

For example, Kemper National Insurance Cos. in Long Grove, Ill., might have only 70 people affected by the Medicare Secondary Payer program, said Sally Bullen, director of compensation and benefits. But, Ms. Bullen estimated that it would take at least 30 minutes to retrieve the information required on each person.

However, Kemper's payroll department has not yet received any specific requests for information.

According to HCFA, about 88% of the 983,152 employers affected by the data request—or 865,173 employers —will have to supply information about 10 or fewer employees. Ten percent—or 98,312—must provide information about between 11 and 100 employees. Less than 1% of those employers—9,105—must provide information about more than 100 employees. Roughly 0.1%—or 576 employers, must provide information about more than 1,000 employees. ■

Intel pollution ruling

Continued from page 1
were used in the manufacturing process. These chemicals were stored temporarily in underground storage tanks that leaked.

In accordance with the Comprehensive Environmental Response, Compensation and Liability Act, better known as the Superfund Act, Intel entered into a consent decree with the EPA to perform a multimillion-dollar cleanup at the site.

The coverage dispute began in 1981, when Intel first contacted Hartford for reimbursement of its cleanup costs, which Hartford denied.

Intel purchased primary CGL coverage from Hartford from April 1976 to April 1983 with a $1 million per-occurrence limit.

Intel also has a "significant amount" of excess insurance, said Intel attorney John A. Skelton Jr. of Williams, Kelly, Romanski, Polverari & Skelton in Redwood City, Calif. The excess insurers "are aware of the claims, but there have been no discussions" about coverage, he said.

In 1988, attempting to predict how the California Supreme Court would rule in Intel's dispute with Hartford, U.S. District Judge Robert P. Aguilar ruled that under California law, cleanup costs are "damages" under the CGL policy; therefore, Hartford must provide coverage to Intel (*BI*, June 27, 1988).

Two years later, the California Supreme Court did, in fact, issue a sweeping pro-policyholder ruling finding that cleanup costs are "damages" under the CGL policy in a case involving FMC Corp. of Chicago (*BI*, Nov. 26, 1990).

The CGL policy states that the insurer "will pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages."

Hartford argued in the Intel case that the term "damages" only encompasses monetary amounts awarded in a court of law, not amounts paid pursuant to a consent decree.

The 9th Circuit, relying on the FMC ruling, disagreed.

Under the FMC ruling, "costs incurred to comply with an injunction mandating cleanup or to reimburse a government agency for cleanup expenses are 'damages' within the meaning of the insurance policy," said the 9th Circuit.

The court then went on to extend this ruling to apply when the policyholder enters into a consent decree with the government, volunteering to clean up polluted property.

"Consent decrees are an alternative means of government agencies to ensure that cleanup takes place," said the court. "They are a favored method, as they provide for more rapid and less costly cleanup than does full-scale litigation."

"Faced with an obligation that it will have to meet sooner or later, an insured would reasonably expect that if it acts responsibly and cooperates with government agencies, it will not forego coverage to which it would be entitled if it forced the agencies to expend their resources in filing suit, particularly where cooperation will probably result in compliance at a lower costs to the insured—and thus the insurer," said the court.

"Coverage of cleanup costs should not turn on the fortuity of form in which the offending company fulfills its cleanup responsibilities," concluded the court.

This is the most significant portion of the ruling, according to Mr. Skelton.

"The court takes (the FMC ruling) one step further and applies it to consent decrees," said Mr. Skelton. "This is a logical and fair extension."

Policyholder attorney Tom Freeman said securing coverage for a consent decree "ought not to be a serious issue for policyholders.

"Insurance often applies to a settled claim in the same manner as a fully litigated claim," said Mr. Freeman of Brobeck, Phleger & Harrison in San Francisco.

Attorneys for Hartford could not be reached.

Insurer attorney Mitchell Lathrop called the 9th Circuit's ruling "predictable."

Mr. Lathrop of Adams, Duque & Hazeltine in San Diego emphasized that the 9th Circuit was merely following the California Supreme Court ruling in the FMC case.

In addition to its ruling on damages, the 9th Circuit also ruled that the pollution exclusion did not bar coverage.

Reversing the lower court, the 9th Circuit said that Hartford did not waive the right to argue that the pollution exclusion bars coverage. But the court nonetheless found that Hartford failed to prove that the pollution exclusion should bar coverage.

Mr. Lathrop criticized this portion of the ruling.

"I don't think Hartford had a fair opportunity to show the applicability of the pollution exclusion," he said, noting there was no factual discovery in the case. "The 9th Circuit knew what decision they wanted to reach and that's where they went."

●

Intel Corp. v. Hartford Accident & Indemnity Co., U.S. Court of Appeals for the 9th Circuit, No. 89-15165.

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Health conference

Continued from page 2

Mass.; and Warren L. Moser, president of Advanced Benefit Concepts, a consulting firm in Pasadena, Md.

New approaches to containing health care costs will be addressed by John. J. Hague, corporate director of benefits for Campbell Soup Co. of Camden, N.J., and Jim Norton, a managing consultant with A. Foster Higgins & Co. Inc. of New York.

The final Monday morning session will offer advice on direct contracting with health care providers, including customizing plan design and leasing existing managed care networks. Speakers include Leesa J. Key, a partner with Coopers & Lybrand in Chicago, and Paul McAuliffe, director of compensation and benefits for Becton, Dickinson & Co., a health care product manufacturer based in Franklin Lakes, N.J.

William E. Caulfield, senior vp-group benefit operations for John Hancock Mutual Life Insurance Co. of Boston, will address attendees at the Monday lunch.

Preventive care will be the focus of the first panel discussion on Monday afternoon, with a discussion of the financial incentives to promote healthy behavior, successful wellness programs and effective employee communications. The speakers are Lynn Gilfillan, community wellness development coordinator for Coors Brewing Co. in Golden, Colo.; John Moses, a consultant with Hewitt Associates in Lincolnshire, Ill.; and Sonia Muchnick-Baku, director of the National Resource Center on Worksite Health Promotion for the Washington Business Group on Health, an employer coalition in Washington, D.C.

Registrants then can select one of two concurrent sessions later Monday afternoon. "The Top Risk Management Issue of the 1990s: Workers Compensation" will examine how to apply managed care techniques to containing workers comp costs. Speakers include David Figurelli, treasurer for Esstar Inc., a holding company in New Haven, Conn.; Douglas Rinaldi, risk manager for the City of Waterbury, Conn.; and Michele Wilber, chief executive officer of Healthnet Corp., a managed care company in Oakland, N.J.

"Flexible Benefits: Have They Proven Effective in Containing Health Care Costs?" is the subject of the other concurrent session. John Hickey, a partner with consultant Kwasha Lipton of Fort Lee, N.J., and Andrea L. Schutz, vp and director of human resources for Educational Testing Services of Princeton, N.J., will address this topic.

The final session of the day will offer advice on managing mental health and substance abuse benefits while improving quality and containing costs. Donald Longnecker, manager of finance and planning-health care group insurance at Chrysler Corp. in Highland Park, Mich., will discuss how Chrysler succeeded in integrating its managed mental health program with its employee assistance program. David McDonnell, president and chief executive officer of Preferred Health Care, a managed care company in Wilton, Conn., also will speak, and Sara Bilik, vp of marketing for Preferred Health Care, will moderate the session.

Registrants may attend a cocktail reception Monday evening.

At the top of Tuesday's schedule is a working breakfast that will offer employers advice for cost-effective mental health and substance abuse plan design as well as vendor selection, management and evaluation. Ms. Bilik of Preferred Health Care and David Stone, corporate vp of marketing for Preferred Health Care, will address the topics, followed by remarks from conference chairwoman, Ms. McIntyre.

Kicking off the day's sessions is a panel entitled "Health Care Reform: What Is on the Horizon?" moderated by Jerry Geisel, *BI*'s editor-at-large in Washington. Panel members include Dr. William Custer, research director for the Employee Benefit Research Institute in Washington; Ellen Goldstein, director of health policy and communications for the Assn. for Private Pension & Welfare Plans in Washington; and Frank McArdle, partner and research consultant with Hewitt Associates in Washington.

Techniques for monitoring a provider's quality of care and other topics will be discussed in the next session by John George, executive vp of InterGroup Services Corp., a PPO based in Pittsburgh, and Donna Lynne, first deputy commissioner for the city of New York's Office of Labor Relations. Joseph Metz, director of governmental legal services for Buck Consultants Inc. of New York, will moderate the panel.

An update on developments in health maintenance and preferred provider organizations, including information on exclusive provider organizations and open-ended HMOs, will be offered by Art Drechsler, vp at Martin E. Segal Co. of New York, and Larry Goelman, president and chief executive officer of Cost Care Inc., a Huntington Beach, Calif.-based unit of John Hancock.

The Tuesday luncheon speaker will be Gerry Goodrich, deputy commissioner of health for the state of New Jersey.

Registrants can attend one of two concurrent sessions Tuesday afternoon.

"Efficient and Cost-Effective Uses of Technology in Managing Health Care Costs" will provide advice on evaluating the claims process and monitoring physician costs. Jack Romeo, director of health care systems for Bethlehem Steel Corp. of Bethlehem, Pa., and Dr. David Rullo, medical director for Health Payment Review, a claims administration firm in Boston, are scheduled to speak.

"Understanding and Implementing FAS 106" is the subject of the second concurrent session, which features Lee Launer, partner with Coopers & Lybrand in New York, and Neela K. Ranade, vp-welfare benefits consulting for Actuarial Sciences Associates, a subsidiary of American Telephone & Telegraph Co. in Piscataway, N.J.

The conference will conclude with a session concerning health care coalitions and how employers have banded together to reach common goals. Debra Hubers, director of marketing for The Alliance, a health care purchasing coalition in Denver, and Dorothee Maynard, president of the Good Neighbor Alliance in Cranston, R.I., are the scheduled speakers.

The conference will include a table-top exhibit area where publications will be displayed and software will be demonstrated.

The conference fee for those who register before March 2 is $695. After March 2, the registration fee will be $795.

Registrants can enclose payment along with completed registration forms, choose to be billed or pay with the American Express card.

For registration information, including group registration, contact Theresa Amenta, The International Business Forum Inc., 50 Charles Lindbergh Blvd., Suite 400, Uniondale, Long Island, N.Y. 11553; 516-229-2375; fax: 516-229-2386.

For exhibit space reservations, contact Kim Mascolo of IBF at the same number. ■

Experts to advise meeting

NEW YORK—Members of the advisory board for the first annual Health Care Management and Cost Containment Conference include:

- Kathryn J. McIntyre, publisher and editorial director of *Business Insurance* in Chicago, and conference chairwoman.
- Jacqueline C. Berkelhamer, executive director of the American Assn. of Preferred Provider Organizations in Chicago.
- William E. Caulfield, senior vp-group benefit operations for John Hancock Mutual Life Insurance Co. in Boston.
- William Custer, director of research for the Washington, D.C.-based Employee Benefit Research Institute.
- John Hickey, partner with benefit consultant Kwasha Lipton in Fort Lee, N.J.
- Dr. Anthony Masso, director of managed care and insurance products for Health Insurance Assn. of America in Washington, D.C.
- Joseph Metz, director of governmental legal services with Buck Consultants Inc. in New York.
- Sonia Muchnick-Baku, director of the National Resource Center on Worksite Health Promotion for the Washington Business Group on Health in Washington, D.C.
- Louise Probst, president of The Alliance, a health care purchasing coalition in Denver.
- Glenn Shively, chairman-health care industry for Coopers & Lybrand in Philadelphia.
- Kenneth Sperling, consultant with Hewitt Associates in Rowayton, Conn.
- Dr. Roger S. Taylor, national leader-health care for The Wyatt Co. in Washington, D.C.
- Howard Weizmann, executive director of the Assn. of Private Pension & Welfare Plans in Washington, D.C.
- Michele Wilber, chief executive officer of Healthnet Corp., a managed care company in Oakland, N.J.

Financial guarantee insurance

Continued from page 3

are the "best and only" way to finance the building and rebuilding of infrastructure, especially considering that most investors are seeking tax-exempt investment vehicles, according to Mr. Elliott.

The financial guarantee insurance industry will improve on the record year it had in 1991, he predicted.

"Retail investors are placing a high value on security, especially because many individual buyers can't tell a good bond from a bad one. This is where Triple-A bond insurance steps in and provides the Good Housekeeping seal of approval," Mr. Elliott said.

With insurance, he pointed out, buyers can be found even for the bonds of low-rated governments like California, Massachusetts, Pennsylvania, Washington state, New York City, Philadelphia and Bridgeport, Conn., which last year filed for bankruptcy.

In addition, New York state also may find it easier to issue bonds backed with financial guarantee insurance than to issue uninsured bonds. Moody's Investors Service Inc. last week lowered New York's appropriation-backed bond rating to Baal from A.

Regardless of whether the recession continues, public entities' budget deficits persist and major rating agencies continue to lower municipal bond ratings, investors and insurers should not fear a rash of bond defaults, according to Mr. Elliott.

"You won't read about many municipal defaults in our portfolio in 1992, because the bonds we insure are for bread and butter, essential services. It's important to remember that a deficit is to a default what a sneeze is to pneumonia" Mr. Elliott explained.

"Cities and states will be doing everything possible not to default on an issue to avoid the stigma it causes. Eventually, they'll have to come back and tap those capital markets."

And if insured bonds do go into default, companies like MBIA are there to pay the principal and interest, he said.

Mr. Elliott also stressed that the holders of insured bonds usually find it easier and less costly to complete a sale before maturity than holders of uninsured bonds. This is especially true if the bond being sold was issued by an entity in questionable financial condition.

"While our product doesn't guarantee market value," recent cases in which issuers were downgraded —but investors were still found— prove that, "in practicality, insurance does add value," Mr. Elliott commented.

Mr. Elliott, who has been president of MBIA since it was formed in 1986, recently assumed the additional title of chief executive officer, succeeding William O. Bailey, who will remain chairman of the board.

Mr. Bailey had been chairman and CEO since 1986.

Also speaking at the meeting were: New York state Lt. Gov. Stan Lundine, and Rep. Beryl Anthony, D-Ark. ■

JANUARY CLOSINGS

SET YOUR DATES

issue:	January 20
closing:	**January 7** — Reader Service
editorial feature:	Risk Management: Information Resource
demographic section:	Insurer Topics: Consumer/Customer Relations
issue:	January 27
closing:	**January 14**
editorial feature:	Self-Insurance: Employee Benefits & Property/Casualty
	Directory: Third-Party Administrators
issue:	February 3
closing:	**January 22**
demographic section:	Agent/Broker Topics: Controlling Costs
issue:	February 10
closing:	**January 29**

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Play or pay

Continued from page 1

example, under a play-or-pay approach with a 7% payroll tax, the federal government would have to raise an additional $36.4 billion to help fund the plan, the study says.

The new study was commissioned by the Labor Department's Pension and Welfare and Benefits Administration and conducted by The Urban Institute, a research organization in Washington, D.C. It is the first detailed examination of the ramifications of play or pay, one of the most widely discussed proposals for bringing health insurance to the nation's 34 million uninsured.

Last June, for example, legislation introduced by the Senate Democratic leadership included a play-or-pay provision. While the payroll tax rate would be set by the secretary of health and human services under that bill, the measure's sponsors suggested that the tax would be about 7.5% (*BI*, June 10, 1991).

Later, House Ways and Means Committee Chairman Daniel Rostenkowski, D-Ill., introduced comprehensive health care reform legislation that included a play-or-pay provision with a 9% payroll tax (*BI*, Aug. 19, 1991).

In addition, the National Leadership Coalition for Health Care Reform, which is dominated by large companies including Chrysler Corp., Bethlehem Steel Corp. and Dayton Hudson Corp., recommended a 7% payroll tax as part of its play-or-pay provision.

Play or pay, which was first suggested at the federal level in 1990 by the Pepper Commission (*BI*, March 12, 1990), is seen by proponents as more politically acceptable than a single-payer national health insurance.

Play or pay, advocates maintain, would build on the current employment-based health care delivery system, in which most Americans receive coverage from employers.

But Bush administration officials, who staunchly oppose play or pay, say the new study proves how play or pay would undermine employment-based coverage.

"Since most employers now spend more than 7% of their payroll costs for health insurance for their workers, many of them would stop offering insurance and just pay the 7% tax," contends Labor Secretary Lynn Martin.

"Millions of workers who now have employer-sponsored plans would be thrown into the public plan, losing both their freedom to choose the type of coverage they want to have and their access to private health insurance," Ms. Martin said.

Workers and dependents covered by the new public plan would have to deal with "all the red tape, bureaucracy, uncertainty and delay of large government bureaucracies," she said.

Play or pay "is backdoor national health insurance. It reduces choice. It is a health plan managed by politicians and it means fewer jobs," Ms. Martin said. "This doesn't mean today's system is adequate. But play or pay is no answer to our problems in health care."

Play or pay 'is backdoor national health insurance. It reduces choice. It is a health plan managed by politicians and it means fewer jobs,' says Labor Secretary Lynn Martin, who adds that 'play or pay is no answer to our problems in health care.'

However, the authors of the The Urban Institute study said the study did not examine the effects of play or pay on employment.

Some business lobbyists agree that play or pay would be a step toward national health insurance and less freedom of choice for employers and employees.

"Play or pay really is an interim step toward national health insurance and taking over the health care of Americans, which we oppose. We like private enterprise. We think individual employers and employees make better health care decisions than bureaucrats," said Carolynn Miller Kane, Washington legislative representative for the National Federation of Independent Business, a small-business lobbying organization.

Other business lobbyists say the costs of the new public plan embodied in a play-or-pay approach would be difficult to control, because politicians would constantly try to enrich the benefit package, especially near election time.

"Business is concerned that government would keep adding benefits, which would lead to higher costs," said Mark Ugoretz, president of the ERISA Industry Committee, a Washington, D.C.-based benefits lobbying organization representing large employers.

But proponents of play or pay say The Urban Institute study is incomplete because it doesn't measure the effects of other provisions in the various play-or-pay legislative packages.

Walter B. Maher, director of federal relations and human resources in Chrysler Corp.'s Washington, D.C., office, notes that the study examined play or pay without assuming that any mechanisms would be built in to control health care costs.

Virtually all the major play-or-pay proposals, including those from Rep. Rostenkowski as well as the National Leadership Coalition, incorporate tough controls on health care spending, Mr. Maher noted. In fact, the health care reform package proposed by the National Leadership Coalition would cut health care costs by $1.8 trillion by the end of the decade, he said.

In addition, Mr. Maher disputes whether a new public plan would mean fewer choices in how workers would receive health care.

Opponents of play or pay confuse "tax-financed with government-run," he said. For example, while the government would collect tax revenues to pay for a public plan, the government in turn could use the money to buy coverage from many different types of providers, like health maintenance organizations or commercial insurers.

In addition, even if a public plan were established, employers still could offer additional benefits to meet the needs of individual workforces, said Karen Ignagni, director of the AFL-CIO's Department of Employee Benefits in Washington, D.C.

Some observers say the study could force advocates of play or pay to modify their proposals to reduce the size of the public plan.

To keep down the size of the public plan, other reform proposals include a higher payroll tax or requiring employers with health plans to maintain the level of benefits they now offer, according to Frank McArdle, a consultant with Hewitt Associates in Washington, D.C.

"Without refinements to better control the size of the public program, play or pay becomes much harder to enact," Mr. McArdle said.

The Urban Institute study is based on an economic model and uses certain assumptions. For example, it assumes that an employer would either offer a health care plan meeting the federal standards or pay a payroll tax.

If they chose to offer a health care plan, employers generally would have to pay 80% of the premiums. Deductibles could not exceed $200 for individual coverage and $500 for family coverage with 20% coinsurance.

Individuals who obtain coverage through the public plan, which would offer the same benefits as employers, also would pay 20% of the premium. However, the government would pick up a greater share of the premium for low-income individuals.

The study also assumes that the annual premium for coverage in a plan meeting the federal standards would vary by size of employer. For example, it assumes that single coverage, expressed in 1989 dollars, would be:

- $1,435 for employers with fewer than 25 employees.
- $1,380 for employers with between 25 employees and 99 employees.
- $1,260 for employers with between 100 and 499, as well as for employers with 500 to 999 employees.
- $1,230 for employers with more than 1,000 employees.

The study assumes premium costs for smaller employers would be higher than for bigger ones because "insurers' marketing costs are higher and insurers do not realize the same economies of scale for small firms as they do for large firms."

In addition, the study assumes average payroll costs at smaller firms are much lower than at larger firms. For example, the study assumes employers at firms employing fewer than 25 employees pay workers, expressed in 1989 dollars, an average of $17,500 per employee, compared with an average of $30,080 per employee at companies with more than 1,000 workers.

Because small employers would pay higher health care costs but have lower payroll costs, they would most likely find the payroll tax option more attractive than the cost of offering a health care plan.

For example, assuming a play-or-pay provision with a 7% payroll tax, the study estimates that 81% of workers at companies with fewer than 25 employees would receive coverage through the public plan, compared with 64% at firms with between 25 and 99 employees, 60% at employers with between 100 and 499 employees, and 42% at firms with more than 500 employees.

Because so many small employers do not now offer health insurance, the total costs of this category of employers under play or pay—including both health insurance premiums and the new payroll tax—would be much higher than today.

For example, employers with fewer than 25 employees paid $15.5 billion in health insurance premiums in 1989. Under a play-or-pay approach with a 7% payroll tax, small firms—many of whom would drop coverage—would have paid $9.2 billion in premiums, but $17.3 billion in new taxes for a total cost of $26.5 billion, a 71% increase from 1989 costs.

For larger employers, the cost impact of play or pay would not be as severe.

For example, employers with between 25 and 99 employees would pay $19.8 billion, including $11.3 billion in premiums and $8.5 billion in taxes, up 37% from $14.5 billion in premiums.

In addition if a play-or-pay provision with a 7% payroll tax had been in effect in 1989:

- Employers with between 100 and 499 employees would have paid $24 billion, including $15.9 billion in premiums and $8.1 billion in taxes, up 15% from $20.8 billion without a play-or-pay system.
- Employers with between 500 and 999 employees would have paid $10.2 billion, including $7 billion in premiums and $3.2 billion in taxes, up 11% from premiums of $9 billion.
- Employers with more than 1,000 employees would have paid $78.1 billion, including $66.9 billion in premiums and $11.2 billion in taxes, up 13% from premiums of $69 billion. ■

Antitrust petition

Continued from page 2

several London underwriters and assorted others—engaged in a boycott to manipulate the U.S. liability insurance market.

That boycott forced ISO to rewrite its commercial general liability policy form to exclude coverage for pollution incidents and to include a retroactive date in the claims-made version of the form, the suit alleges.

The antitrust immunity granted to insurers under the McCarran-Ferguson Act does not extend to boycotts or coercion.

The focus of the petition to the Supreme Court is to persuade the court to hear the case, noted Bartlett H. McGuire, an attorney with Davis Polk & Wardell in Washington, D.C., which represents ISO. The petition stresses the importance of the litigation to the industry, the legal importance of the issues involved and the appellate ruling's conflict with precedents.

"I think the fundamental arguments on the merits are similar to ones we've made before," he said.

The petition states that "this case presents questions of exceptional legal and practical importance. The 9th Circuit's decision is both unprecedented and manifestly incorrect. By opening the door to federal antitrust oversight of accepted insurance practices within the regulatory purview of state insurance departments, the decision. . .will irreparably upset the careful accommodation between federal and state law that Congress deliberately embodied in the McCarran-Ferguson Act."

The defendants argue the Supreme Court should review the appellate ruling because:

- Domestic insurers and their reinsurers do not forfeit their antitrust immunities by participating with foreign reinsurers in the business of insurance.

The appellate court held that the domestic insurance industry defendants forfeited any immunity under McCarran-Ferguson by engaging in joint activities with foreign reinsurers that, the court concluded, were not subject to state regulation and thus were not immune under McCarran-Ferguson.

The defendants ask the high court to reject this reasoning because "communication and agreement among primary insurers and reinsurers, including foreign reinsurers, are a necessity in the business of insurance."

The appellate court "fundamentally erred by ignoring the express text of (McCarran-Ferguson), which provides antitrust immunity for the regulated 'business of insurance' rather than for particular regulated entities," the petition states.

- Agreements among insurers and reinsurers on policy terms do not constitute a "boycott."

The appellate court ruled that the defendants had engaged in a boycott "based on nothing more than collective agreements among insurers and reinsurers as to the coverage. . .they would be willing to accept," the petition says.

The Supreme Court is expected to decide whether to review the case by the spring.

However, the defendants argue that the lawsuit never claimed that these agreements were not based on business judgment and the economic self-interest of each of the defendants. The suit also failed to charge that the defendants refused "to deal on any terms."

"Rather than being a prohibited boycott, the alleged agreements on terms and coverage are at the heart of (McCarran-Ferguson's) antitrust immunity for the business of insurance," the petition states.

- The 9th Circuit's refusal to dismiss the suit on the grounds of the state action doctrine "defeats principles of federalism by allowing federal antitrust courts to second-guess the state regulatory process."

The state action doctrine provides immunity from antitrust laws if an anticompetitive act reflects a state's policy and if a state supervises the anticompetitive practice.

The 9th Circuit's rejection of the state action doctrine "allows a federal antitrust lawsuit to become the vehicle for overturning state officials' approval of insurance forms," the petition argues, noting that 42 states—including 16 that filed the antitrust suit—approved ISO's revised CGL forms.

Mr. McGuire, the ISO attorney, noted that the Supreme Court only accepts about 150 of the several thousand petitions it receives each year. Nevertheless, he is optimistic the high court will agree to review the antitrust litigation.

"I think we have a very powerful argument," he said. Given the importance of the case, its adverse impact on insurers and the fact that the appellate decision runs contrary to precedents set by both the Supreme Court and other appellate courts, "I think as things go we have a very good shot."

The states that brought the antitrust action will be given 30 days to respond to the brief, although this period is often extended another 30 days, Mr. Levy said. The industry defendants will then have the opportunity to respond, and amicus curiae briefs on behalf of the defendants also are expected to be filed, he said.

The Supreme Court has several options: It can agree to hear the case, refuse to hear it or ask the U.S. Solicitor General, who represents the federal government before the court, to submit a brief. Such a brief is sometimes requested by the court in cases in which the federal government has an interest, Mr. Levy explained.

Noting that the Justice Department filed a brief with the appellate court, Mr. Levy—who previously worked in the Solicitor General's office—said he believes there is a "reasonably good" chance the Supreme Court will request such a brief in this case (*BI*, May 21, 1990).

The Justice brief supported some of the attorneys general's arguments.

The Supreme Court is expected to decide whether to review the case by the spring. ■

Update

Felony charges filed in oil spill

Continued from page 2

owner and operator of the freighter Sammi Superstars; Panobulk America Inc. of Long Beach, Calif., Pan Ocean's U.S. representative; and Links Marine Inc. of Long Beach, a barge owner and operator. The charges were filed in connection with an oil spill of at least 1,600 gallons, according to prosecutors, in the Los Angeles harbor last January. Part of the harbor had to be closed for a day.

If convicted, each company could face fines of up to $500,000.

Barge operators were attempting to load fuel oil onto the freighter when the spill occurred. Deputy District Attorney William W. Carter said the crews of both vessels "failed to properly monitor the fueling operation, which resulted in the oil overflowing from the ship's tanks" and into the water.

Sidney Kanazawa, a lawyer representing Pan Ocean and Panobulk, argued that cleanup costs, not criminal prosecution, deter oil spills. And, the fear of criminal prosecution could inhibit cleanup efforts because it may cause vessel crews—fearing criminal liability—to become guarded with investigators, said Mr. Kanazawa, a partner with Pillsbury, Madison & Sutro in Los Angeles. Pan Ocean and Panobulk spent about three months cleaning up the spill and have made restitution for property damage, Mr. Kanazawa said.

Scannell resigns OSHA post

WASHINGTON—Gerard F. Scannell is resigning as head of the Occupational Safety & Health Administration at the end of this week.

Mr. Scannell, who President Bush nominated as assistant secretary of labor in charge of OSHA in 1989, will return to Johnson & Johnson as vp-safety and health (*BI*, Jan. 15, 1990; July 10, 1989). He previously was the company's director of corporate safety/fire/environmental safety with worldwide responsibility. Mr. Scannell said the J&J post is "a unique opportunity to return to the private sector."

Dorothy Strunk, deputy assistant labor secretary, was named acting OSHA head.

New insurance fraud hot line

PALOS HILLS, Ill.—A new group formed to fight crime and fraud against property/casualty insurers is operating a toll-free hot line to handle reports of possible fraud.

Rewards of up to $1,000 will be offered for tips leading to convictions, according to Arnold Schlossberg Jr., president and chief executive officer of the insurer-funded National Insurance Crime Bureau. The NICB, based in Palos Hills, Ill., has an annual budget of about $30 million. It was created this year by the merger of the National Automobile Theft Bureau and the Insurance Crime Prevention Institute.

Mr. Schlossberg says that fraud costs insurers about $17 billion annually, with vehicle theft costing another $8 billion annually.

The hot line number is 800-TEL-NICB, or 800-835-6422.

Briefly noted

Transamerica Corp. will take a one-time $50 million aftertax charge against 1991 earnings to recognize its **retiree health care obligations** to comply with Financial Accounting Standard 106. . . .The Lloyd's of London Underwriting Agents Regulatory Committee has turned down a proposed management buy-out of the ongoing business of **R.H.M. Outhwaite (Underwriting Agencies) Ltd.** because of liabilities arising from the Outhwaite 1982 underwriting year. The managers are appealing. . . .A federal grand jury in Newark, N.J., has added Kent E. Conshafter, former secretary of **Preferred Indemnity Insurance Co.** of Old Bridge, N.J., as a defendant in a fraud, money laundering and conspiracy indictment relating to Preferred's operations. The indictment also names Warren H. Berkle Jr. and brothers Martin Bramson and Leonard Allen Bramson (*BI*, Sept. 16, 1991; Nov. 4, 1991). . . .The Iowa Insurance Department has approved a 6.7% **workers compensation rate increase**, effective Jan. 1. The National Council on Compensation Insurance sought a 17% rate hike. . . .The NCCI requested and the Indiana Insurance Department has approved a 13.4% **workers comp rate increase**, effective Jan. 1. . . .The **New York Insurance Exchange** has shut down most of its remaining runoff operations and terminated its five remaining employees with severance. All but five of the exchange's syndicates have formally withdrawn and had their business assumed by other insurers. The exchange also has asked the New York Insurance Department to take over the exchange's remaining functions before March 31. . . .Markel Corp. is negotiating to sell its **Governmental Programs Division** to Aon Corp. subsidiary Rollins Specialty Group Inc. The division specializes in placing police professional and public officers errors and omissions liability coverages. . . .The liquidators of **Cambridge Reinsurance Ltd.** later this month expect to pay its fourth interim dividend to creditors of 3% of the amount owed. . . .The U.S. Supreme Court is being asked to review an appeals court ruling that **pension excise tax penalties** imposed by the Internal Revenue Service against the estate of a bankrupt employer that failed to meet its minimum pension funding requirements deserve priority treatment over other estate creditors. . . .Membership dues for the **Alliance of American Insurers** fell an average of 30% on Jan. 1 as a result of the trade association's recent reorganization (*BI*, Oct. 21, 1991). . . .Underwriting profits at **EXEL Ltd.**, the Cayman Islands-based parent of excess liability insurer X.L. Insurance Co. Ltd., dropped 19.4% to $25 million for the year ending Nov. 30, 1991. Despite the decrease in underwriting income, EXEL's net income climbed by more than 51% to $267 million in fiscal 1991, spurred by a huge increase in realized investment gains. . . .A federal judge in Tucson, Ariz., denied a motion by large accounting firms to decertify a racketeering class-action suit that charges them and former American Continental Corp. Chairman **Charles H. Keating Jr.** with defrauding American Continental bondholders. The civil suit, which names Ernst & Young, Arthur Andersen & Co. and Deloitte & Touche, seeks more than $1.2 billion, including treble damages (*BI*, June 25, 1990). . . .**Equitable Life Assurance Society of the United States**, which was a pioneer in the guaranteed investment contract business, is no longer writing new contracts. Equitable, which is planning to convert from a mutual to a stock company, has suffered GIC losses of about $1 billion (*BI*, Dec. 9, 1991).

Punitive awards

Continued from page 1

He found seven punitive awards in product liability cases during the 1960s, while 17 such awards were handed down between 1971 and 1975. The number swelled to 41 between 1976 and 1980, and tripled to 139 between 1981 and 1985. Finally, between 1986 and 1990, 151 such awards were assessed.

Although the total number of punitive damage awards in product liability cases has increased steadily, the number actually decreased to 25 in 1989-1990 from 56 in 1983-84 if asbestos-related awards are not included (see chart, page 1).

"The rarity of punitive damages awards, when compared with potential plaintiffs, is staggering," according to the study.

According to a 1988 U.S. Product Safety Commission publication, consumer products are involved in an estimated 29,000 deaths and 33 million injuries annually, the survey notes. "Yet the overwhelming majority of U.S. manufacturers did not have a single punitive damages award rendered against them in the last 25 years," the study says.

The study also revealed that even when juries do award punitive damages in product liability cases, appellate courts often reverse the decision or reduce the awards.

The compensatory damage portion of jury verdicts was affirmed in 73% of the cases studied, while the punitive award was affirmed in only 55%.

"This suggests great appellate scrutiny for punitive damages in particular," the study found. "The fact that trial verdicts are so frequently reduced, reversed or never collected casts serious doubt on the anecdotal tales of jury-made millionaires."

The study's other findings include:

- Punitive damage awards exceeded compensatory damage awards in 59% of the cases in which punitive awards were assessed; they were double the size of the compensatory award in 38% of these cases.
- The median punitive damage award in all 355 cases studied was $625,000, not adjusted for inflation. The median compensatory award in these cases was $500,100.

After appellate review, the median punitive damage award was $135,000, or only about 22% of the amount awarded by the trial court. The median compensatory award following review was $212,783, or about 42% of the original award.

Also, 37% of the punitive damage verdicts reached by trial courts were later thrown out on appeal. Only 14% of compensatory awards were rescinded on appeal.

- The vast majority—74%—of punitive verdicts were awarded in state, not federal, courts.
- Most plaintiffs' attorneys interviewed by Mr. Rustad said they are reluctant to handle product liability lawsuits because they are perceived as risky and expensive.

Mr. Rustad says the small number of punitive damage awards in product liability cases—only 355 over 25 years—shows that punitive damages are not the large societal problem they are perceived to be.

"This shows the unimportance of punitive damages," he said.

Robert Habush, president of the Roscoe Pound Foundation, agreed: "This is another piece of evidence that completely deflates Vice President Quayle and his Council on Competitiveness that punitive damage awards are having any significant effect on American business or competitiveness" (*BI*, Aug. 19, 1991).

"Hopefully this will have an impact on thinking lawmakers interested in truth and not myth," said Mr. Habush, a plaintiffs' attorney with Habush, Habush & Davis in Milwaukee.

Defense attorneys and tort reform advocates have a sharply different—and negative—view of the study.

Regardless of the frequency of punitive damage awards, "if you impose them without guidelines, they are unconstitutional," said product liability defense attorney Victor Schwartz of Crowell & Moring in Washington, D.C.

"Furthermore, the mere threat of punitive damages is a vehicle to increase settlements," he said.

"ATLA is an organ of the plaintiffs' bar and anything with that label should be looked at carefully," cautioned Mr. Schwartz, who predicted that most lawmakers will view the study as an advocacy effort.

Martin Connor, president of the American Tort Reform Assn., agreed: "It's an advocacy piece, even though it purports to be a scholarly study."

Furthermore, "the point the study ignores is that punitive damages are as random as lightening and when they hit they are devasting," said Mr. Connor. "The number of punitive damage awards is not significant."

Defense attorney Andrew Frey of Mayer, Brown & Platt in Washington, D.C., noted: "The study doesn't take into account the impact of punitive damages on settlements or the impact on business operations that are forced to engage in liability-avoiding behavior."

The specter of punitive damages is one factor that forces many manufacturers to withhold valuable products to avoid potential liability, he contended.

Regardless of the frequency of punitive damage awards, their "freakish nature" and unpredictability causes companies to behave in antisocial ways, Mr. Frey said.

Mr. Wheeler, a defense attorney, says the study also reveals other problems caused by punitive damage awards.

The tendency of appellate courts to reverse or remand punitive damage awards means that defendants hit with a punitive award will almost always appeal, he said.

If appellate courts are reversing or reducing punitive damage awards in nearly half of the cases, "juries are being badly instructed and controlled," he pointed out.

In addition, the study fails to address the problem of multiple punitive damage awards leveled against the same manufacturer for identical conduct, Mr. Wheeler said.

Eugene Anderson of Anderson, Kill, Olick & Oshinsky in New York, who represents policyholders in coverage disputes, concluded that if "punitive damages are not having the impact that they are perceived to be having, (that's) all the more reason to get rid of the problem."

Responding to these criticisms, Mr. Rustad noted that regardless of their frequency, punitive damages have a strong deterrent effect.

"You don't need many public hangings to send a message," he said.

Furthermore, he noted that the frequency of non-asbestos punitive damage awards has declined because 37 states in the past several years have enacted tort reforms that limit the use of punitive damages.

Mr. Rustad also questioned "what would replace" punitive damages if they were eliminated. He suggested that a system of criminal penalties administered by government agencies would likely be the replacement.

"If we have a remedy that doesn't require the funding of a new governmental agency, we shouldn't eliminate it," Mr. Rustad said.

While Mr. Rustad favors the use of punitive damages, he says the current system is imperfect. Among tort reforms that he supports are:

- Increasing the burden of proof for punitive damages to "clear and convincing evidence" from "a preponderance of evidence."
- Compulsory bifurcation of punitive damage trials from compensatory damages proceedings.
- More uniform state laws governing punitive damages.

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Copies of "Demystifying Punitive Damages in Product Liability Cases: A Survey of a Quarter Century of Trial Verdicts" cost $25 prepaid. Contact The Roscoe Pound Foundation, 1050 31st St. N.W., Washington, D.C., 20007; 202-965-3500 ext. 380 or 202-965-0355.

Union suit

Continued from page 3

involving Local 906, its membership rolls and an insurer is pending. Empire Blue Cross/Blue Shield, which canceled the local's coverage before State Mutual took it over, is being sued by the union for more than $3 billion for that termination. State Mutual says it was unaware of this suit when it wrote the union's policy.

The insurer claims that documents relating to that BC/BS contract and other documents it received from the union were forged. And those documents formed the basis of its decision to write the group policy, said Mr. Lutz, the insurer's attorney. "We think that's a legitimate basis to rescind the contract."

"Secondarily, this group, not being a true group but people brought in from all over the place," had worse loss experience than expected, Mr. Lutz said.

Had the insurer known that the group would include "massive numbers of persons wholly unconnected to the collective bargaining agreement, or even the retail industry," it would not have insured the local, the suit alleges.

So far, State Mutual has received premiums "somewhat in excess of the claims actually paid," Mr. Lutz said. But more than 18,000 claims have not been paid, and "new claims continue to be received in substantial numbers. There are not and will not be sufficient premiums to pay such claims."

Max Goldweber, a lawyer for the union, insists that State Mutual "knew at the inception of the contract that a good percentage of the people would be associate members."

He argued that the suit "is a fight over money," brought on by rising health care costs. "We know as lawyers that a lot of carriers don't believe in paying claims; they only want to collect premiums," said Mr. Goldweber, who is with Goldweber & Hershowitz in Mineola, N.Y.

State Mutual said it would give the remaining premiums it has collected under this plan to the court to cover unpaid claims.

The State Mutual suit also charges that the corporate defendants and the union have received "substantial unwarranted fees, charges and dues paid by the persons to whom the insurance was promoted."

Mr. Lutz was unable to cite the exact amount purportedly collected, though the suit put the total at "several million dollars."

In its suit, State Mutual argues that if it is found to be responsible for pending claims that exceed its available premiums, that responsibility should pass to the defendants, "by reason of their fraud."

Solomon Sprei, who according to the suit is believed to be an officer or principal of the group of corporate defendants, "disavows or refutes any allegations of wrongdoing," according to his attorney.

Gerry Feinberg of the New York firm of Bower & Gardner, agrees with Mr. Goldweber that State Mutual knew of the group's makeup.

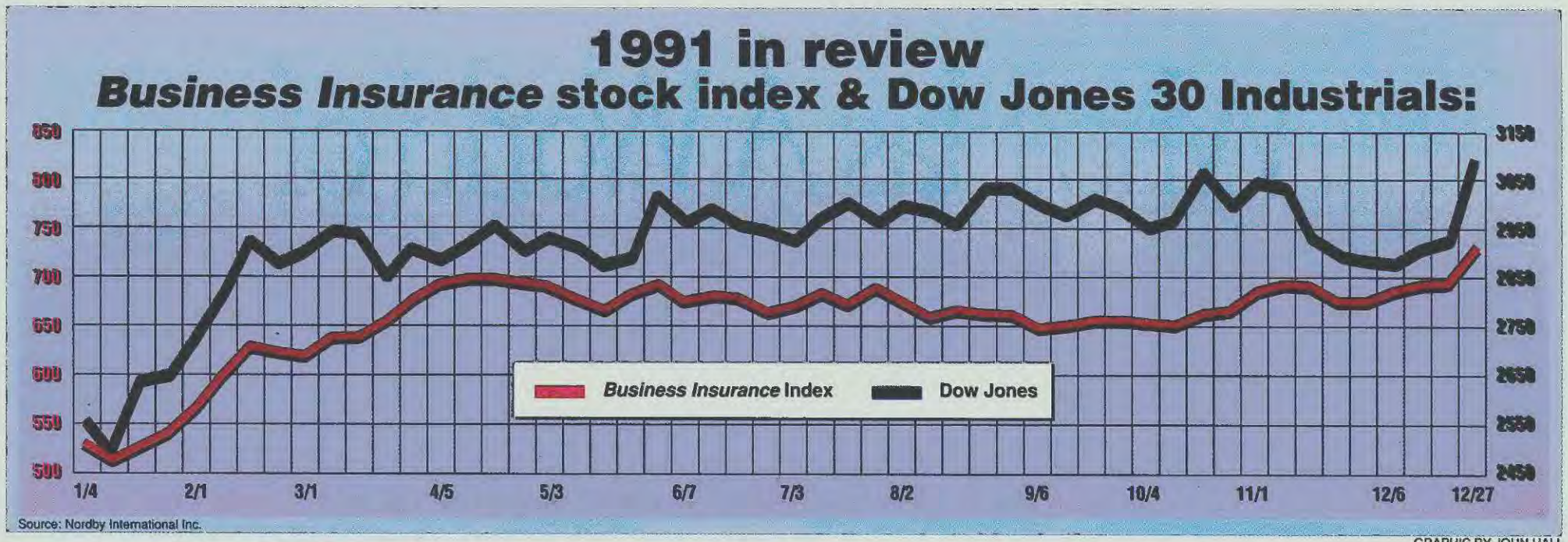
"Our contention is that maybe (State Mutual) didn't do its homework," Mr. Feinberg said.

Mr. Goldweber indicated that the suit may be settled soon, and Mr. Feinberg added that the defendants are "doing everything in their power to see to it that the misunderstanding is resolved so that none of the insureds go without coverage."

For his part, Mr. Lutz said it was "premature" to discuss a settlement.

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State Mutual Life Assurance Co. of America vs. Retail Local 906 AFL-CIO Welfare Fund et al.



GRAPHIC BY JOHN HALL

Insurance stocks gain in soft market

Starting and ending the year with a flourish, overall gains made by insurance industry stocks outpaced the Dow Jones Industrial Average in 1991.

The *Business Insurance* Index posted a 37.7% gain during the year, rising to its high point of 733.4 on Dec. 27 from 532.5 on Jan. 4. The Dow Jones 30 Industrials posted only a 20.9% gain during the same period, rising to 3101.5 from 2566.1.

The *BI* Index tracks gains in 82 commercial insurance industry stocks (see below).

The *BI* index's low point of the year was 516.3 on Jan. 11. From there it gained steadily, including a seven-week string of increases in March and April, reaching its high point, 733.4, in the final week of 1991.

Last week, insurance industry stocks continued to climb as the *Business Insurance* Index rose 16.7 points to 775.1 on Jan. 10 from to 758.4 on Jan. 3. Advancing issues for the week were led by Chandler Insurance Co., up 30.8%; Sierra Health Services, up 24.7%; and Nobel Insurance Ltd., up 21.2%. Declining insurance issues for the week followed SAFECO Corp., down 7.3%; Hartford Steam Boiler, down 6.7%; and Chubb Corp., down 6.0%. The most active issue for the period was U.S. Healthcare, with 4.4 million shares traded. The *BI* Index was up 2.2%; the New York Stock Exchange Composite was down 0.6%; the Standard & Poor's 500 was down 1.0; and the Dow Jones 30 Industrials was up 0.1%. ■

'Premium Dollar Today' sets program schedule

"The Premium Dollar Today," a 1992 television series on insurance topics, begins Jan. 15 on cable television's USA Network.

The 30-minute program, which airs at 6 a.m. Eastern and Pacific Standard Time and 5 a.m. Central Standard Time, features experts discussing insurance issues in a roundtable format.

The guests on the first program, which will deal with the McCarran-Ferguson Act, include Mavis A. Walters, executive vp of the Insurance Services Office Inc.; Theodore C. Whitehouse, partner with Willkie Farr & Gallagher; and Andrew S. Wright, senior counsel of the American Insurance Assn.

"The Premium Dollar Today" is sponsored by Reliance National Insurance Co., a unit of Reliance Group Holdings Inc., the Society of Chartered Property & Casualty Underwriters and KPMG Peat Marwick. Herbert E. Goodfriend, director of insurance analysis in the management consulting division of KPMG Peat Marwick, is host.

Beginning with the 1992 series, *Business Insurance* will provide special editorial assistance to the series.

Reliance National launched the program in 1990 in an effort to "demystify" the insurance business. It is designed to deliver information, but not to promote the insurance industry. Industry critics, as well as industry representatives, appear on the programs.

The second 1992 program, to air Jan. 29, will focus on national health care. Guests will include Claudia Bradbury, policy associate in the employee benefits department of the AFL-CIO; Ellen Goldstein, director of health policy and communications for the Assn. of Private Pension & Welfare Plans; and Stephen Young, director in the New York office of the Health Insurance Assn. of America.

The third 1992 program, to air Feb. 12, will deal with "Tracking the Premium Dollar (The Property/Casualty Industry)." Guests will include Edward F. Bader, a partner with Arthur Anderson & Co.; Charles Johanns, senior vp-public affairs and communications with Kemper National Insurance Cos.; and Sean Mooney, senior vp and economist with the Insurance Information Institute.

USA Network is the third-largest cable network, reaching approximately 58 million homes. ■

British Issues

Jan. 9 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence pence
Commi Union	478	N/M	30.7	6.4	500—476
Genl Accident	458	N/M	35.7	7.8	481—458
Gdn Royal Exch	122	N/M	15.9	13.0	124—121
Royal	249	N/M	34.7	13.9	263—249
Sun Alliance	285	N/M	18.7	6.6	303—285
Brokers					
Bradstock	153	17.2	6.3	4.1	153—153
CE Heath	459	16.0	34.5	7.5	459—459
Hogg Group	183	10.9	10.7	5.8	183—179
JIB Group	198	16.5	10.0	5.0	198—198
Lloyd Thompson	240	24.1	6.0	2.5	240—240
Lowndes Lmbrt	325	16.2	15.3	4.7	325—325
PWS Holdings	80	9.4	4.7	5.9	80—80
Sedgwick Grp	204	19.4	16.0	7.8	213—203
Steel Brrl Jones	306	16.2	16.3	5.3	306—301
Willis Corroon	237	12.3	17.6	7.4	237—233

Source: Philip Olsen, Insurance Industry Analyst, London

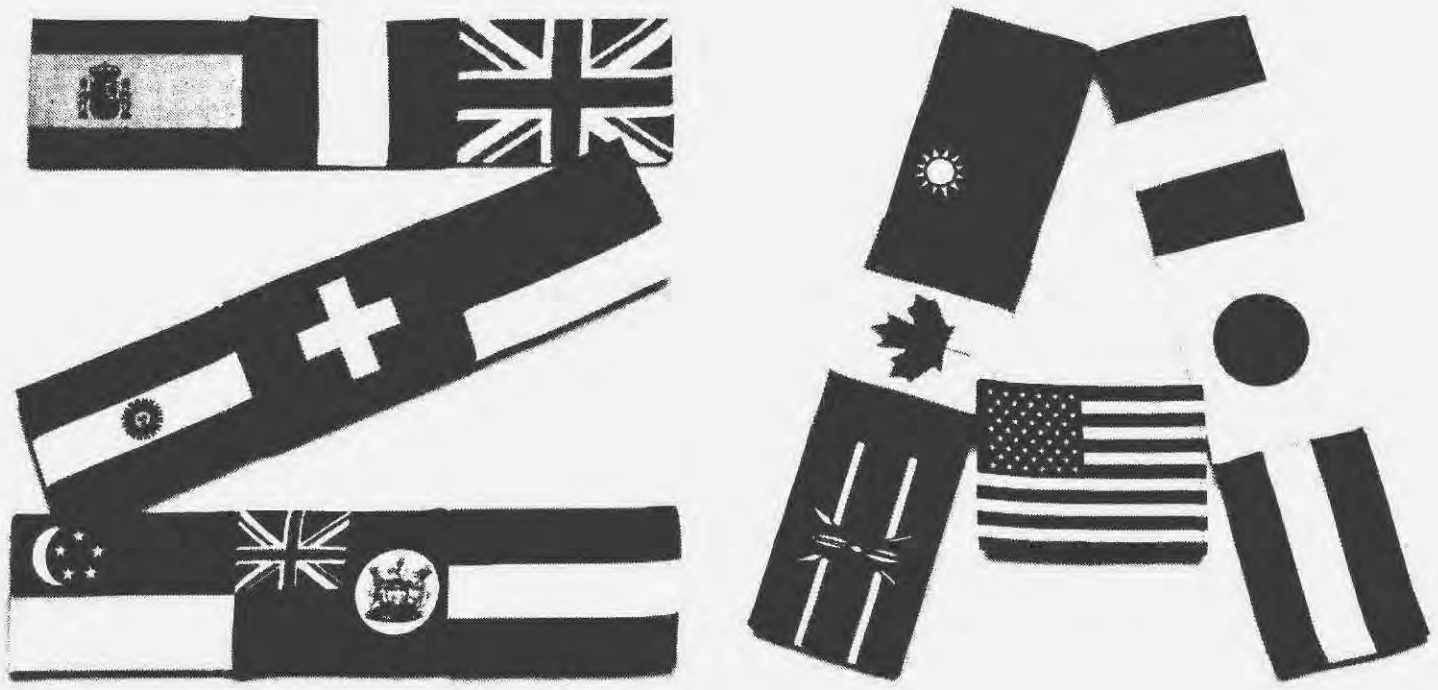
BI Industry Stock Report

JANUARY 6, 1992 THROUGH JANUARY 10, 1992

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander	NYS	20.38	2.52	-0.61	27.63	18.00	794	1.00	4.91	19	9.77	2.09
Gallagher Arthur J. & Co.	NYS	22.50	0.56	0.56	28.38	19.00	126	0.64	2.84	19	5.88	3.83
Frank B. Hall	NYS	4.25	6.25	0.00	5.50	2.88	132	0.00	0.00	-6	-5.24	-0.81
Hilb, Rogal & Hamilton	OTC	13.00	0.00	-1.89	17.50	11.25	122	0.40	3.08	22	3.56	3.65
Marsh & McLennan	NYS	79.50	-2.15	-2.30	87.25	69.13	524	2.60	3.27	19	14.77	5.38
Poe & Associates	OTC	11.88	-1.04	-1.04	12.50	6.50	55	0.32	2.69	13	2.52	4.71
BROKERS	AVERAGE		1.0	-0.9					2.4	12		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	31.88	1.19	4.51	32.25	23.00	550	0.32	1.00	13	23.89	1.33
Berkshire Hathaway Inc.	NYS	8800.00	0.00	-2.76	8800.00	204.69	0	0.00	0.00	-37	4612.00	1.91
ITT (Hartford Group)	NYS	56.25	0.90	-2.60	63.00	46.00	1920	1.72	3.06	9	64.01	0.88
Sears (Allstate)	NYS	39.25	1.95	3.63	43.50	24.38	4399	2.00	5.10	14	37.38	1.05
CONGLOMERATES	AVERAGE		1.0	0.7					2.3	0		
INSURERS/REINSURERS												
AEGON N.V.	NYS	70.38	-0.71	0.54	71.00	54.75	36	2.30	3.27	7	N/A	N/A
Aetna Life & Casualty	NYS	43.88	2.03	-0.28	49.13	31.88	1850	2.76	6.29	9	64.23	0.68
Allied Group Inc.	OTC	17.25	-0.72	1.47	21.50	12.25	182	0.56	3.25	6	11.50	1.50
American General	NYS	44.25	0.85	-0.56	45.63	28.00	740	2.00	4.52	11	37.14	1.19
American Indemnity/Fin'l	OTC	4.75	-5.00	0.00	7.75	3.75	2	0.08	1.68	14	12.93	0.37
American International	NYS	96.00	-1.92	-2.41	102.00	72.25	1944	0.48	0.50	13	45.34	2.12
Aon Corp.	NYS	41.38	5.08	4.42	41.75	29.75	545	1.60	3.87	11	18.50	2.24
Argonaut Group	OTC	25.00	4.17	5.26	33.38	21.75	151	0.68	2.72	8	48.26	0.52
AVEMCO Corp.	NYS	25.00	-1.48	0.00	27.25	16.00	159	0.40	1.60	19	9.55	2.62
Baldwin & Lyons Inc.	OTC	25.00	-1.96	-2.91	27.50	17.00	1	0.28	1.12	7	24.29	1.03
Belvedere Corp.	ASE	3.75	15.38	15.38	3.88	2.63	14	0.04	1.07	15	7.65	0.49
Chandler Insurance	OTC	4.25	30.77	30.77	7.00	2.13	63	0.00	0.00	-2	5.95	0.71
Chubb Corp.	NYS	72.00	-6.04	-6.49	78.00	51.13	1106	1.48	2.06	11	35.19	2.05
CIGNA Corp.	NYS	59.75	-0.42	-2.25	61.75	36.50	865	3.04	5.09	11	73.15	0.82
CNA Financial Corp.	NYS	101.88	1.75	3.95	101.88	62.75	131	0.00	0.00	15	70.23	1.45
Continental Corp.	NYS	28.13	-0.88	1.81	30.63	22.88	816	2.60	9.24	13	37.83	0.74
EXEL Ltd.	NYS	37.88	-0.66	1.00	40.25	27.38	616	0.90	2.38	8	N/A	N/A
Fund American Corp.	NYS	69.00	-0.72	-1.25	70.25	50.38	210	0.68	0.99	11	36.11	1.91
Fremont General Corp.	OTC	24.50	2.08	0.51	25.50	14.00	331	1.00	4.08	7	19.13	1.28
Frontier Insurance Group	NYS	26.88	0.47	-0.46	27.88	16.03	47	0.00	0.00	11	11.20	2.40
Gainsco Inc.	ASE	14.00	-1.75	0.00	14.63	4.63	40	0.04	0.29	18	3.37	4.15
General RE Corp.	NYS	98.63	-4.59	-3.19	104.75	85.00	933	1.68	1.70	14	37.50	2.63
Guaranty National Corp.	NYS	15.38	6.03	6.03	15.38	12.63	462	0.00	0.00	16	N/A	N/A
Hanover Insurance Co.	OTC	36.75	2.80	2.80	42.75	25.50	208	0.44	1.20	15	37.44	0.98
Harleysville Group	OTC	21.50	-4.44	1.18	23.25	13.84	94	0.64	2.98	10	22.99	0.94
Hartford Steam Boiler	NYS	50.25	-6.73	-12.61	63.75	46.13	204	2.00	3.98	13	17.05	2.95
Kemper Corp.	NYS	44.25	9.60	16.07	44.25	19.75	2391	0.92	2.08	10	34.20	1.29
Lawrence Insurance Group	ASE	10.38	-3.49	-6.74	11.13	6.38	6	0.48	4.63	16	4.71	2.20
Liberty Corp.	NYS	22.88	7.02	3.39	24.00	19.50	55	0.48	2.10	14	23.86	0.96
Lincoln National	NYS	57.88	6.44	5.71	57.88	38.00	445	2.92	5.05	10	45.16	1.28
Markel Corp.	OTC	20.75	-3.49	-5.68	22.00	10.25	163	0.00	0.00	9	3.22	6.44
Mutual Risk Mgmt. Ltd.	NYS	36.00	6.27	2.49	36.00	17.00	64	0.20	0.56	31	-	-
NAC Re Corp.	OTC	32.50	6.12	3.17	32.50	19.34	280	0.16	0.49	16	18.90	1.72
Navigators Group	OTC	39.50	0.00	-3.66	42.00	21.88	6	0.00	0.00	21	13.52	2.92
Nobel Insurance LTD.	OTC	5.00	21.21	25.00	5.13	2.75	53	0.00	0.00	7	7.76	0.64
NWNL Companies	NYS	36.38	12.36	16.87	37.25	17.13	660	1.40	3.85	9	42.73	0.85
Ohio Casualty Corp.	OTC	52.00	6.12	5.05	52.00	40.00	313	2.48	4.77	10	36.38	1.43
Old Republic Int'l	NYS	35.75	-1.38	0.70	36.88	20.38	168	0.72	2.01	8	33.09	1.08
Orion Capital Corp.	NYS	32.38	1.17	2.37	33.50	16.38	126	0.92	2.84	9	20.42	1.59
Phoenix RE Corp.	OTC	9.50	-5.00	-9.52	11.25	7.63	32	0.20	2.11	14	13.30	0.71
Provident Life	OTC	23.50	2.17	1.08	24.50	14.38	207	1.00	4.26	8	25.88	0.91
Re Capital Corp.	ASE	14.38	0.00	0.00	18.63	12.63	16	0.20	1.39	11	15.05	0.96
Reliance Group Holdings	NYS	4.13	0.00	0.00	7.50	3.75	131	0.32	7.76	3	5.61	0.74
RLI Insurance Corp.	NYS	16.63	3.91	0.76	16.88	11.88	34	0.48	2.89	8	14.41	1.15
St. Paul Companies	NYS	71.63	-3.21	-1.72	75.25	57.13	339	2.60	3.63	8	52.00	1.38
SAFECO Corp.	OTC	45.88	-7.32	-5.90	50.00	31.25	796	1.48	3.23	11	31.50	1.46
SCOR U.S. Corp.	NYS	16.75	8.06	8.94	16.75	11.50	23	0.24	1.43	10	11.19	1.50
Seibels Bruce Group	OTC	5.63	0.00	2.27	8.88	4.75	58	0.36	6.40	-80	7.35	0.77
Selective Ins. Group	OTC	16.25	-1.52	-2.99	18.00	13.00	97	1.04	6.40	8	18.91	0.86
Statesman Group Inc.	OTC	5.56	-1.10	-3.25	6.38	1.56	342	0.00	0.00	17	2.48	2.24
Tokio Marine & Fire	OTC	50.25	-3.83	-2.43	56.50	40.50	19	0.00	0.00	-	70.93	0.71
Torchmark Corp.	NYS	59.75	4.37	3.24	59.75	46.38	395	1.60	2.68	14	16.70	3.58
Transamerica	NYS	37.63	-3.53	-5.64	40.00	29.63	585	2.00	5.32	15	36.56	1.03
Transatlantic Holdings	NYS	38.75	0.98	-0.32	39.38	25.63	148	0.24	0.62	13	18.38	2.11
Travelers Corp.	NYS	22.25	1.71	2.89	25.38	16.50	2318	1.60	7.19	6	41.44	0.54
Trenwick Group Inc.	OTC	29.75	6.25	4.39	30.50	21.75	118	0.72	2.42	11	21.71	1.37
United Fire & Casualty	OTC	47.00	4.44	4.44	58.00	33.75	2	1.32	2.81	10	35.39	1.33
USF&G Corp.	NYS	8.13	10.17	12.07	12.50	5.63	3233	0.20	2.46	-1	11.96	0.68
UNUM Corp.	NYS	80.13	1.10	-1.08	81.00	41.50	759	1.04	1.30	13	37.25	2.15
USLIFE Corp.	NYS	46.63	-0.27	-2.61	47.88	27.00	259	1.64	3.52	10	60.34	0.77
Unitrin	OTC	34.75	-2.80	-2.80	41.50	29.75	668	1.00	2.88	13	30.70	1.13
Washington National	NYS	17.38	6.11	9.45	17.50	9.38	120	1.08	6.22	-8	26.86	0.65
USLICO Corp.	NYS	19.50	6.12	5.41	21.00	15.38	73	1.00	5.13	-93	29.44	0.66
Zenith National Ins.	NYS	16.00	-0.78	-5.19	18.50	12.00	251	1.00	6.25	133	13.14	1.22
INSURERS/REINSURERS	AVERAGE		2.0	1.9					3.2	10.8		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	15.75	14.55	10.53	29.75	9.88	1907	0.00	0.00	13	5.44	2.90
HMO America Inc.	OTC	21.50	18.62	28.36	21.50	5.38	3930	0.00	0.00	23	0.61	35.25
Pacificare Health Sys.	OTC	40.75	3.82	3.16	42.50	14.50	1047	0.00	0.00	19	6.55	6.22
Safeguard Health Enter.	OTC	10.50	16.67	12.00	10.50	4.13	438	0.00	0.00	24	3.53	2.97
Sierra Health Services	ASE	24.00	24.68	29.73	29.50	12.25	773	0.00	0.00	12	1.78	13.48
United Healthcare Corp.	NYS	82.88	4.74	11.24	82.88	21.13	674	0.06	0.07	40	3.76	22.04
United Medical Corp.	ASE	7.88	12.50	12.50	10.88	5.88	35	0.20	2.54	13	8.79	0.90
U.S. Healthcare	OTC	47.50	8.57	14.46	47.50	16.25	4422	0.44	0.93	25	3.38	14.05
HMOs	AVERAGE			13.0	15.2				0.4	21		
ALL COMPANIES	AVERAGE			4.3	4.2				2.7	11		

System design: Nordby International Inc.

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