

JANUARY 31, 1994

Updates

Business Insurance

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Lloyd's makes another effort to win support for settlement

LONDON—Lloyd's of London Chairman David Rowland made a last-ditch effort on Friday—even stressing the confidentiality of the votes—to convince Lloyd's members litigating over losses to accept the market's settlement offer of 900 million pounds (\$1.35 billion).

A settlement can only be reached if more than 70% of 22,500 members accept the offer by Feb. 14. The offer looks doomed after public rejection by the Gooda Walker Action Group and the Feltrim Names Assn.,

Continued on next page



AP/Wide World Photo

Allstate and other insurers took steps to field claims last week.

L.A. businesses still grappling with quake losses

By JOANNE WOJCIK

LOS ANGELES—Commercial property losses from the Los Angeles earthquake continue to mount as risk managers assess the extent of damage to their companies.

Insured losses expected to hit at least \$3 billion

By JUDY GREENWALD

LOS ANGELES—Insured losses from the Los Angeles earthquake could exceed \$3 billion, up considerably from initial estimates of \$1.5 billion to \$2.5 billion in insured damage, a prominent loss-adjusting firm says.

London-based Thomas Howell Group, which is adjusting earthquake claims for insurers via its U.S. subsidiaries, believes the initial estimates will prove too low, largely because the most affected areas are more heavily insured for earthquake losses than statewide averages.

An Insurance Information Institute spokesman last week agreed that insured quake losses would probably exceed \$1.5 billion but cautioned that "we won't know until the middle of next week how much higher the loss figure will be."

As of late last week, few insurance companies were releasing loss estimates.

THG based its higher aggregate projections on the popularity of earthquake coverage in the San Fernando Valley area, the quake's epicenter. Statewide, an estimated 20% to 25% of homeowners and 40% to 45% of busi-

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It seemed no type of business was spared from some damage in the Jan. 17 temblor and the more than 1,500 aftershocks that are still shuddering throughout Southern California.

The extent of damage ranged from having to relocate entire companies due to structural damage, to stock damaged by collapsed shelving in retail stores, to mostly cosmetic damages.

Insured losses are expected to climb to \$3 billion or more—up from initial estimates (BI, Jan. 24)—largely due to a greater percentage of area residents and businesses buying earthquake coverage than in other areas of the state (see related story).

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Clinton says reform open to negotiation

Employers welcome flexibility on provisions

By MARK A. HOFMANN and JERRY GEISEL

WASHINGTON—Reading the political tea leaves, the Clinton administration is opening the door to sweeping revisions to its health care reform package.

Following virtually non-stop attacks on his proposal since he unveiled it last fall, President Clinton said last week he was open to suggestions for overhauling his package.

"I have no special brief for any specific approach, even in our own bill," he said in his State of the Union address before Congress last Tuesday.

The only non-negotiable point, President Clinton said, is that health reform legislation must ensure universal coverage.

If Congress passes health reform legislation without such a guarantee, President Clinton said he would veto the bill and tell Congress to start all over again.

President Clinton's stated will-

'You think the 5,000-employee threshold is too high for joining regional alliances. . . . We hear you. We're willing to discuss this,' says Lloyd Bentsen.

ingness to compromise in order to win a consensus on health care reform legislation was quickly backed up with action.

One day after President's Clinton address, Treasury Secretary Lloyd Bentsen told business groups that the administration is not wedded to a controversial proposal to require all employers with fewer than 5,000 employees to buy coverage through regional health care alliances. Under the administra-

tion's plan, larger employers could opt out of the alliances and establish their own corporate alliances, though there would be a number of financial penalties for doing so.

"You think the 5,000-employee threshold is too high for joining regional alliances. . . . We hear you. We're willing to discuss this and other details of our plan," Mr. Bentsen told a conference in Washington jointly sponsored by the Assn. of Private Pension & Welfare Plans and the National Assn. of Manufacturers.

Almost simultaneously with Secretary Bentsen's speech, White House officials said at a press briefing that the administration wanted to make corporate alliances a more attractive option for employers. They did not elaborate.

There were other signs of a new openness and willingness to compromise on health reform legislation from an administration that many have criticized for its arrogance on the issue.

For example, top officials of the

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Satellite loss sets record

\$356 million claim may propel insurance rates skyward

By STACY SHAPIRO

LONDON—Just when things were looking up for satellite owners, two commercial orbiters with a combined insured value of \$356 million were destroyed last week during the failed launch of an Ariane rocket.

The losses, the largest ever during a single take-off, are likely to curtail possible launch insurance rate reductions that satellite owners had anticipated this year.

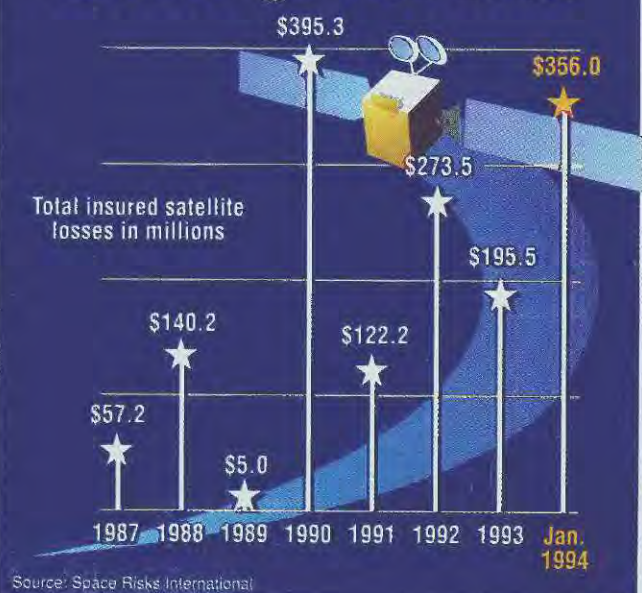
Arianespace's Flight 63 failed last week when its third-stage engine prematurely shut down. A panel has been established by Arianespace, the European Space Agency and Centre National d'Etudes Spatiales to look into the cause of the shutdown. The panel is expected to file a report by mid-February.

Two commercial satellites with a combined insured value of \$356 million were on board the rocket, confirmed Jean Fournier, head of space insurance for the satellite owners' broker, Paris-based Faugere & Jutheau S.A. The satellites were ditched into the Atlantic Ocean when the flight failed and cannot be recovered.

A total of \$320 million of the coverage was written by London, U.S. and French satellite insurers, said Mr. Fournier. Because it was difficult to place all of the coverage for the two satellites, the remaining \$36 million was written by Arianespace's French captive, Space Related Risks Reinsurance Co.

Mr. Fournier would not give details of the satellites' coverage. However, sources in Europe say that the European Telecommunications Satellite Organization's

Losses go into orbit



GRAPHIC BY CHRIS ROY

Eutelsat II-F5 satellite was insured for 170 million European Currency Units (\$188.9 million), while the Turkish communications satellite Turksat 1 was insured for \$168 million.

The coverage for both satellites was placed by

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Updates

Rowland presses case for offer

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whose members would receive more than 40% of the total amount being offered (BI, Jan. 24).

In a letter to Lloyd's members, Mr. Rowland reiterated that "the offer will not be increased in value, and if it is not accepted (by Feb. 14), then the substantial contribution from Lloyd's Central Fund will be withdrawn."

Mr. Rowland also enclosed a letter from the Steering Group of the Lloyd's Agents' Errors & Omissions line slips, explaining there is no more money to offer than what's on the table. Rejecting the offer could mean years of litigation, and insurance funds will be "well short" of the 900 million pounds in the offer, the E&O underwriters warned.

"If the offer is withdrawn because of lack of sufficient support, I shall regret it. I do not believe that the alternative for members is other than a very lengthy, costly and uncertain prospect leading to an ultimate figure little different from that now proposed," Mr. Rowland said.

Kaiser to offer POS programs

OAKLAND, Calif.—Kaiser Permanente, the nation's largest health maintenance organization with 6.6 million members, will introduce point-of-service products during the next year in most of the markets in which it operates.

Competition and customer demand have led Kaiser to add POS programs, which have grown rapidly at other HMOs, Kaiser says.

"Employers want simplicity and ease of administration, and consumers want as wide a range of options as possible," said Hugh Jones, executive vp and regional manager-Southern California.

Kaiser says it will establish arrangements with insurers and other vendors to provide out-of-network coverage and certain administrative functions, like claims processing. In some regions, Kaiser will handle those functions.

Premiums and benefit differentials between using providers in and outside of networks will vary by region, Kaiser says.

Montgomery & Collins sold

BOSTON—CIGNA Corp. has sold its Montgomery & Collins Inc. surplus lines brokerage unit to Arbor Acquisition Corp., a holding company formed by a Boston-based investor group.

Terms of the transaction were not disclosed.

"It was not a strategic fit for us, and we found a buyer for whom it was a better fit," a CIGNA spokesman said.

Los Angeles-based Montgomery & Collins, one of the largest U.S. wholesalers with \$13.3 million in 1992 revenues, will continue to operate under its own name.

Sanford D. Elsass, an Arbor principal, has been named the company's new chairman and chief executive. Mr. Elsass and other Arbor principals have experience in insurance agencies and insurance investment operations.

Other principals include Thomas F. Goode, Christopher D. Van Curran and Jane A. Frank.

Robert P. Keul, formerly Montgomery & Collins' president, will remain a CIGNA officer, a CIGNA spokesman said.

ISO data base approved

WASHINGTON—The U.S. Justice Department's antitrust division has given permission for the Insurance Services Office Inc. to develop a computerized data base that would enable insurers and others to compare premiums for personal auto and homeowners insurance.

Before proceeding with the project, ISO had asked the Justice Department whether it would challenge the proposed information service on antitrust grounds.

In a Jan. 25 letter to ISO's attorneys, Anne K. Bingham, assistant attorney general in charge of the antitrust division, said the proposed service appears to fall under provisions of the McCarran-Ferguson Act, which grants insurers a limited antitrust exemption.

She cautioned that "the department reserves the right, however, to bring an enforcement action in the future with regard to any aspect of ISO's proposed product or the conduct of its membership that is found to be anti-competitive in purpose or effect and that is determined to be not subject to the limited antitrust exemption provided by the McCarran-Ferguson Act."

New post for M&M's Clements

NEW YORK—Robert Clements has stepped down as president of Marsh & McLennan Cos. Inc. to become chairman and chief executive of Marsh & McLennan Risk Capital Corp.

A.J.C. Smith, M&M's chairman, has assumed the additional title of president.

M&M Risk Capital was formed in 1992 to manage the broker's market-development efforts, which have included the formations of ACE Ltd., EXEL Ltd. and Mid Ocean Reinsurance Co. Ltd.

Mr. Clements, 61, headed M&M's worldwide brokering operations for many years. Since 1980, he has served as president and chairman of Marsh & McLennan Inc., the company's retail brokerage unit, and vice chairman of Marsh & McLennan Cos. Inc.

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Errors & omissions

• Due to a production error, two charts were omitted from a Jan. 24 Perspective article by Alice Rosenblatt on risk adjustment methods. An illustration of risk adjustment and the charts appear on page 20.

Chase searches for cover after veto by regulators

By DOUGLAS McLEOD

NEW YORK—Buying property insurance in the Caribbean hasn't been easy since Hurricane Andrew, but few companies have had the kind of trouble Chase Manhattan Corp. is having.

The New York-based banking giant last year struggled to find insurers to cover U.S. Virgin Islands properties on which it had made more than \$80 million in mortgage loans.

Now, Chase is struggling to recover from two failed attempts to win Virgin Islands regulatory approval for property programs that included a shifting cast of off-

shore insurers and reinsurers.

Two of these companies—Commercial Indemnity Assurance Co. of the Dominican Republic and Provident Capital Indemnity Ltd. of Costa Rica—previously were barred by U.S. regulators for reporting phony or unverifiable assets.

In addition, Commercial Indemnity and another Chase insurer—La Fenix Boliviana S.A. of Bolivia—were represented by Ferrell Travis Riley, a Kansas City, Mo.-based consultant who himself has a history of regulatory problems, say sources familiar with the Chase placement.

Mr. Riley lost his Texas agent's

licenses in 1989 for allegedly defrauding policyholders and insurers. The company for which he now works, M&M Management Corp., also was implicated in a 1991 effort to bribe Missouri insurance regulators to issue a license to Meadowlark Insurance Co., which M&M Management represented (see story, page 16).

Meadowlark, itself barred in more than a half-dozen states, changed its name to Commercial Indemnity in 1992.

Virgin Islands regulators last year rejected Chase property insurance proposals involving these insurers. Chase has since submit-

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P/C issues not forgotten

Legislators study Superfund, cat reinsurance and redlining

By MARK A. HOFMANN

WASHINGTON—Health care reform may be the biggest insurance game in town, but it's by no means the only insurance game as far as Capitol Hill is concerned.

In fact, lawmakers in the 103rd Congress face a full slate of property/casualty insurance-related issues this year.

One of the most pressing items on the Congressional agenda is Superfund reauthorization, and President Clinton's proposal may be unveiled as early as today.

While waiting for that bill, Congress has begun tackling the question of whether the federal government should establish a national reinsurance facility that would respond to catastrophic natural disasters. The Senate held hearings on S. 1350, the Natural Disaster Protection Act, late last year. The House is scheduled to hold hearings on companion legislation, H.R. 2873, on Wednesday. Both bills have been gaining support outside Congress in the aftermath of the Los Angeles earthquake (BI, Jan. 24).

The next property/casualty issue Congress is likely to confront is that of alleged insurer "redlining," or illegally denying property insurance coverage to inner-city residents, said David Farmer, senior vp-federal affairs of the Alliance of American Insurers in Washington.

The House Rules Committee must decide which of two bills addressing the subject should go to the full House. Mr. Farmer noted that most insurers can "accept" H.R. 1188, sponsored by Rep.

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Hogg Group profits decline in 1993

LONDON—Hogg Group P.L.C.'s share price fell sharply last week after the world's 12th-largest brokerage announced that pretax profits fell more than 50% from 1992 levels, mostly due to the U.S. unit.

Hogg shares dropped nearly 15%—or 22 pence (33 cents)—to a low of 130 pence (\$1.94) after the company announced that pretax profits declined to 6 million pounds (\$8.9 million) from 13.4 million pounds (\$20.3 million) in 1992.

Much of the blame was placed

on U.S. unit Hogg Robinson Inc. In recent years Hogg Robinson has overhauled its property/casualty business, including modifying products and cutting staff to 740 as of last September from 950 in 1992.

New property/casualty business was "not sufficient to offset the effect of rate reductions in the renewable portfolio, reduced contingency commissions and lost business," Hogg Group said last week.

Revenues also are down in Hogg's third-party administration

division. Revenue from continuing operations is expected to be 7.3 million pounds (\$10.9 million). Losses from discontinued operations—namely Downes & Burke, Hogg's fine arts and jewelry division that is now in runoff—are expected to be 1.3 million pounds (\$1.9 million).

In addition, the company lost revenue because it divested Lloyd's managing agencies and Hobbs & Partners, its French wholesale broker, which it sold in October 1993.

—By Adrian Ladbury

Risk management consulting directory nears

Business Insurance will publish its annual directory of risk management consultants in the March 7 issue. Accompanying the directory will be a Spotlight Report on trends in risk management consulting.

To be included in the directory, consultants must fill out and return a questionnaire provided by BI. The directory is published as an editorial

service; there is no charge to be included.

If your company generates at least 50% or \$500,000 of its gross revenues from risk management consulting and you have not yet received a questionnaire, please request one by calling Director Editor Kathy Welyki at 312-649-5279.

The extended deadline for returning completed questionnaires to *Business Insurance* is Feb. 11.

Inside

• Denying there is a health care crisis is not a solution, this week's editorial says. **PAGE 8**

• U.K. and European employers were thrown a curve in a recent pension ruling. **PAGE 17**

• Defrauded Maxwell pensioners appear ready to settle their litigation. **PAGE 17**

• The slowdown in medical inflation will be just a historic blip without health reform, a Clinton administration official says. **PAGE 22**

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AP/Wide World Photo

Lillehammer's ice pavilion is one of several new facilities constructed by the organizers of the 1994 Winter Olympic Games.

Lillehammer's Olympic coverage in place and ready

By MICHAEL SCHACHNER

LILLEHAMMER, Norway—As Norway readies itself to host its first Winter Olympic Games since 1952, comprehensive insurance is in place to cover virtually every risk imaginable.

The insurance staff of the Lillehammer Olympic Organizing Committee has faced greater time pressures than its predecessors. When the International Olympic Committee decided to stagger Summer and Winter Games, it cut the time span between the last Winter Games and next month's event to two years from the traditional four.

Despite the tight schedule, the LOOC placed some 20 different property/casualty programs. When the XVII Winter Olympic Games take place Feb. 12-27 in and around this quaint town about 120 miles north of Oslo, the LOOC and the Olympians will be very well protected.

Some 1,800 athletes from 65 countries are expected to take part in 55 events in 12 winter sports. About 6,200 IOC officials, event judges, VIPs and others are also expected. Add to that an expected 1.5 million spectators, and liability and property insurance

become all the more important.

"The LOOC spent more than \$230 million building new (sports, administration and lodging) facilities, including a brand-new ice pavilion. Thus, risk management on this project really has evolved. When we secured the bid in 1985, we expected total costs of putting on the Games to be about \$243 million U.S. The costs have grown 600% since then," said Morten Wang, acting risk manager for the Games and director of non-marine insurance with Oslo brokerage Grieg Insurance A/S, which placed most of the LOOC cover.

Total premium for the 20 insurance programs is about 45 million Norwegian kroner (\$6 million). Most of that, said Mr. Wang, comes in three areas: television rights coverage, general liability coverage, and travel protection and health coverage for the 8,000-member "Olympic family" of athletes, IOC representatives and LOOC officials.

Gjensidige General Insurance Co. of Oslo, a major sponsor of the Games, leads virtually all the programs, except the two-layered TV rights package, which is written both in London and throughout the continental European market.

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Freeze claims add up to big catastrophe loss

By MICHAEL SCHACHNER

Property insurers are hoping the groundhog won't see its shadow this week and trigger another six weeks of winter-related losses.

The brutal cold, snow and ice that has blanketed the Midwest and East for much of January is responsible for thousands of minor, mostly personal lines claims and scattered commercial losses.

Industrywide loss estimates still are unavailable, but ultimately the claims likely will add up to hundreds of millions of dollars.

With already large numbers of claims growing daily, the severe winter weather and subzero temperatures may produce insured losses on a par with a December

1989 cold snap that caused \$500 million in insured damage.

"It seems as though the property/casualty industry is under siege with a string of annoying storms that produce many claims that settle for small amounts," said John H. Snyder, senior vp with A.M. Best & Co. in Oldwick, N.J. "It's having a real corrosive effect on the industry. It's death by 1,000 pin pricks."

"In current dollars, one could expect (the freeze) to be comparable to past freezes," said Mr. Snyder. "It's not like houses are insulated any differently now, and they're certainly worth more."

The Property Claims Services division of the American Insurance Services Group designated the

deep freeze Catastrophe No. 77 (BI, Jan. 24).

Numerous weather-related losses in the past year are prompting insurers to rework their reinsurance contracts, said Best's Mr. Snyder.

"Generally, these types of losses don't pierce traditional reinsurance programs because individual claims are too small," he said. "In addition, the aggregate of these storms often isn't large enough to get to the attachment point for catastrophe reinsurance. It has forced companies to explore programs that resemble stop-loss coverage or loss ratio programs."

The most common types of storm-related claims reported by insurers are for frozen and burst

Continued on next page

Clinton plan premiums underestimated: Study

By JERRY GEISEL

The Clinton administration is substantially underestimating the amount of premiums regional alliances would need to charge under its health care reform proposal, according to a new study.

The Wyatt Co. says premiums on average would actually need to be more than 18% higher than administration estimates.

Assuming the reform package went into effect this year, Wyatt estimated the average annual premium charged by a regional alliance for single coverage would be \$2,285, or 18.3% greater than the administration's estimate of \$1,932. Wyatt says the premium for a family with two adults would be \$5,155, 18.2% more than the administration's estimate of \$4,360.

There were similar differences between the administration and Wyatt estimates of premiums for coverage for couples as well as for families headed by one adult.

The Wyatt study, based on a microeconomic model developed by the Washington-based benefit consulting firm, is the third study in recent months to find that administration estimates of premiums that would be charged by regional alliances are unrealistically low.

Lewin-VHI Inc., a Fairfax, Va., research firm, said last month that its estimates of regional alliance premiums were, on average, 17% higher than those of the administration (BI, Dec. 13, 1993). And Hewitt Associates earlier estimated that premiums could be

What the Clinton plan would cost

Estimated premiums

Highest cost states	Single	Family*
District of Columbia	\$2,917	\$6,584
Michigan	2,881	6,502
California	2,831	6,389
New York	2,731	6,163
Florida	2,702	6,098
National average	\$2,917	\$5,155
Lowest cost states		
Nebraska	\$1,472	\$3,322
Idaho	1,501	3,387
South Dakota	1,534	3,462
South Carolina	1,557	3,514
Vermont	1,624	3,666

* Two adults
Source: The Wyatt Co.

GRAPHIC BY CHRIS ROY

between 19% and 59% higher than the administration estimates (BI, Nov. 29, 1993).

The latest estimates confirm what employers thought last year when the administration first revealed its own premium estimates, said Sylvester Schieber, director of The Wyatt Co.'s Research and Information Center in Washington.

"From the very beginning, there has been a healthy

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Benefit decisions fraught with risk

ADA language leaves room for more coverage claims

Gray areas cloud decisions on experimental treatment

By JERRY GEISEL

SAN DIEGO—There's good and bad news for employers concerned about the impact of the Americans with Disabilities Act on their employee benefit programs.

First, the good news: In the first full year that the act has been in effect, just 3.6% of claims filed with the Equal Employment Opportunity Commission involve charges of improper denial of benefits or discriminatory benefits, said Michael Lotito, a managing partner with San Francisco law firm Jackson, Lewis, Schnitzler & Krupman.

The bad news: This percentage is almost certain to rise as more plaintiffs attorneys see the potential for big awards in employee benefit discrimination and denial

cases, he said.

"Where is the pot of gold under ADA? It is in denial of benefits," Mr. Lotito said at *Business Insurance's* Second Annual Winter Health Care Management and Cost Containment Conference, held Jan. 19-21 at Loews Coronado Bay Hotel in San Diego.

Denial of benefits or discriminatory benefits cases could lead to big awards because actual damages—such as big health care bills that an individual

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By CHRISTINE WOOLSEY

THE SECOND ANNUAL

Business Insurance

WINTER HEALTH CARE MANAGEMENT & COST CONTAINMENT CONFERENCE

SAN DIEGO—Sometimes marketing and emotions, rather than science, dictate whether a health insurer will pay for experimental or investigational medical treatment.

Most health insurers have a specific process to determine whether a medical procedure or use of a particular technology is experimental and, therefore, not insured.

For example, Metropolitan Life Insurance Co. of New York accumulates

data from regulatory agencies like the Food and Drug Administration, as well as from research bodies like the National Institutes of Health, said Dr. Kenneth Krause, vp of the technology review unit of MetLife.

The technology review committee studies data on medical devices and procedures to see if there is agreement about the safety and efficiency of the treatment and whether it is an improvement over existing treatments, Dr. Krause said.

"But in real life it differs," said Dr. Terry Rogers, senior vp of medical affairs for King County Medical Blue Shield in Seattle. "If a client is large enough and wants to provide" an experimental treatment like high-dose chemotherapy for

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Freeze

Continued from page 3

pipes and roof damage on homeowners policies. Personal auto claims also are mounting.

But, commercial claims are few and far between. In fact, brokers and risk managers in the affected areas say major commercial losses are virtually non-existent.

One exception was a series of fires at an Amoco Oil Co. refinery in Whiting, Ind., that normally processes 400,000 barrels of fuel a day.

When temperatures in Whiting finally warmed to above freezing on Jan. 22, fuel pipes that contained water and boiling crude oil burst, igniting three separate serious fires. Each took several hours to put out.

Since then, the refinery, the largest in the Midwest and the fourth-largest in the country, has been operating far below capacity.

"These were major fires, but we expect the damaged units to be up within a few weeks," said a spokesman for Chicago-based Amoco. "By no means have these units been destroyed."

Amoco is self-insured for the "millions of dollars" in physical damage and extra costs associated with meeting orders, he said.

Graduate Health System, a Philadelphia health care company, is insured for at least portions of the loss it sustained when a frozen water pipe ruptured and flooded the basement of its Parkview Hospital on Jan. 20. "The flood knocked out our transformer causing us to lose heat and power. We had to relocate all 125 of our patients to other area hospitals," said a spokesman. Parkview did not get full power back until last Thursday, at which time it began transferring patients back.

Parkview has insurance to respond, said Denise Barger, corpo-

rate director of risk management with Graduate Health. "We're looking at our coverage to see exactly what we have. It's our belief that we are covered for the loss of business and the costs of moving patients."

Few insurers last week were willing to estimate their monetary losses from winter's wrath as the freeze claims kept pouring in.

State Farm Group, which carries no commercial reinsurance, reported late last week that it already had received 40,300 claims for about \$66 million.

"The only good thing is that it looks like we may not approach the \$183 million we paid in 1989 or the \$147 million in freeze-related claims we paid in 1983," said a spokesman for the Bloomington, Ill.-based insurer. "Those were two of our 10 largest catastrophe payouts ever."

Nationwide Mutual Insurance Co. is projecting 20,000 claims from the deep freeze. A spokesman for the

company said Nationwide expects its gross losses to fall between \$30 million and \$35 million. He said roughly half of the claims, with a value of \$16 million to \$20 million, came from Pennsylvania.

Allstate Insurance Co., which carries no catastrophe reinsurance, received nearly 17,000 personal lines claims as of last week. Most were homeowners claims. Commercial claims had not yet been counted.

Ohio Casualty Corp. last week estimated that it would pay at least \$5 million in claims.

As of late last week, a spokesman said the Hamilton, Ohio, company had fielded more than 2,000 freeze-related claims, primarily from eastern Pennsylvania, southern New Jersey and the Louisville, Ky., area.

Personal lines insurer GEICO Corp. of Washington reported 1,250 claims as of Thursday. "They're typically busted pipes and shingle backup. The costs run \$1,200 to

\$1,500 per claim and they're coming in every day," said Vp Bill Griswold.

Travelers Corp., meanwhile, is looking at about 3,000 homeowners and auto claims as well as another 1,100 commercial claims. "The vast majority are related to minor auto accidents," said a spokesman for the Hartford, Conn., insurer.

Aetna Casualty & Surety Co. has received approximately 3,500 homeowners claims and about 900 small commercial claims.

As of Jan. 21, Liberty Mutual Insurance Co. had received 948 claims totaling an estimated \$2.2 million for freeze-related losses in nine states, a spokeswoman said. **BI**

Staff changes and additions announced at BI

A reporter has joined the *Business Insurance* staff, while another editorial staffer has been promoted. In addition, an advertising sales representative also has joined BI.

Rodd Zolkos, 38, has joined the staff as an associate editor in Chicago, where he will report on both risk management and employee benefit topics.

For the past nine years, Mr. Zolkos has been a reporter for City & State magazine, which had been published by Crain Communications Inc., the publisher of BI. Before joining City & State, Mr. Zolkos was a managing editor and staff writer at Pioneer Press Inc., a group of suburban Chicago newspapers. Prior to that, he was city editor of the Daily Herald-Journal in Monticello, Ind.

He received a bachelors of arts degree in mass communication from Purdue University in West Lafayette, Ind.

Mr. Zolkos can be reached at 312-649-7784.

Kerry Dziubek, 24, has been promoted to associate directory editor in the Chicago office. Ms. Dziubek



Mr. Zolkos



Ms. Dziubek

joined *Business Insurance* in 1992 as editorial assistant.

Ms. Dziubek received a bachelor of arts degree in communication/rhetorical studies and Spanish from Marquette University in Milwaukee. In addition, she currently is pursuing a law degree at Loyola University Law School in Chicago.

She can be reached at 280-3195.

Barrie Harmelin, 28, has joined BI's advertising sales staff in New York as a district manager. She will be responsible for accounts in the Mid-Atlantic region.

Ms. Harmelin most recently was an account executive at the Philadelphia Business Journal. She also had been an account executive at WFLN, a Philadelphia radio station, and a media planner at Weightman Advertising, also in Philadelphia.

She received a bachelor of arts degree in advertising from Pennsylvania State University in State College.

Ms. Harmelin can be reached at 212-210-0135. **BI**

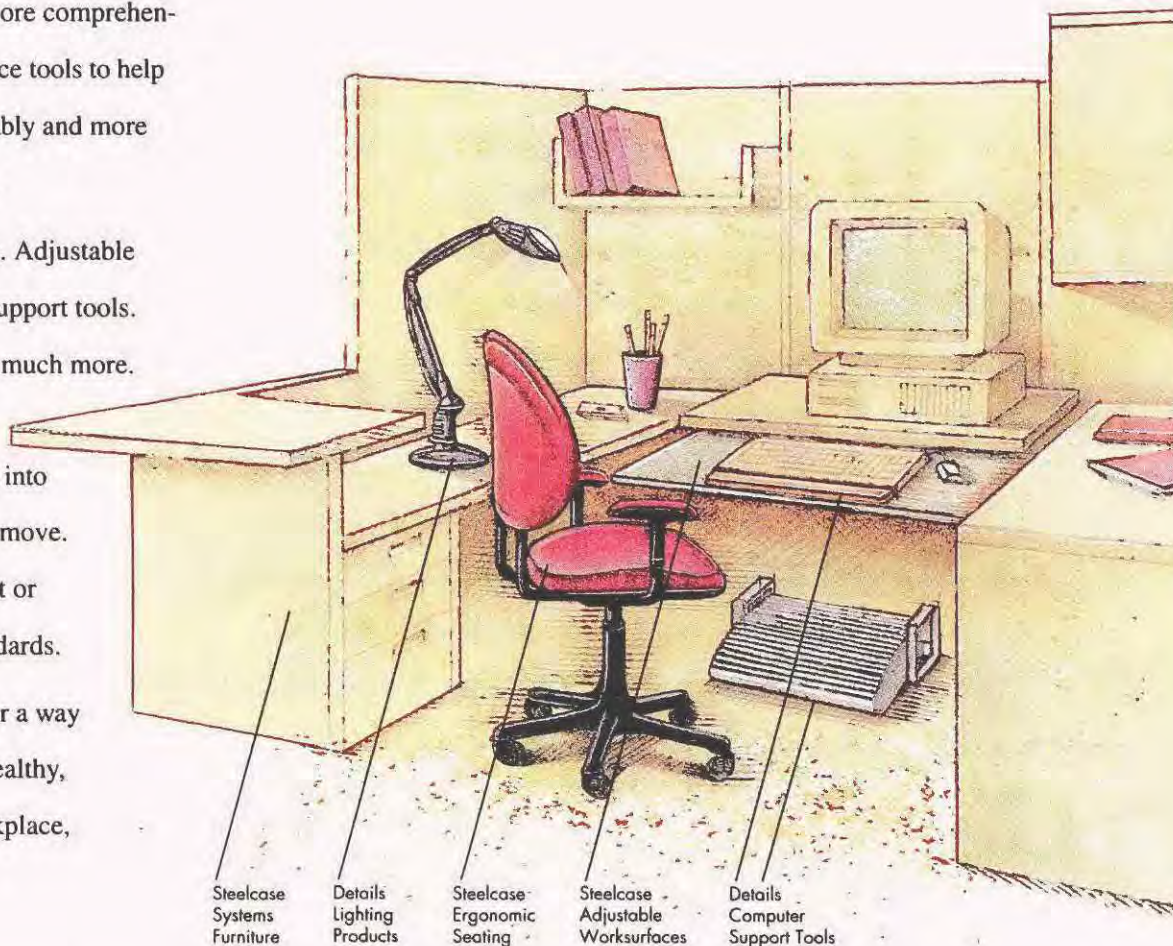
So what's new?

Prescriptions for a healthier office.

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Details
Lighting
Products

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Seating

Steelcase
Adjustable
Worksurfaces

Details
Computer
Support Tools

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Measuring quality of care

By CHRISTINE WOOLSEY

SAN DIEGO—Relying on patient satisfaction data to measure health outcomes is bad science, according to an independent health care planning and policy consultant.

Most patients are so grateful to get out of the hospital that they answer any questions about their treatment or their health status with a positive view, which may not always be accurate, she said.

Yet, employers increasingly are turning to such patient outcomes data in an effort to identify the best hospitals and physicians.

"As a negotiator for self-insured employers using outcomes data to select network providers, I have three major concerns," said Lucy Johns, an independent health care planning and policy consultant in San Francisco. Those concerns are: preserving patient access by finding enough doctors and hospitals located near a patient's home or work; negotiating affordable provider pricing; and ensuring quality, said Ms. Johns, who took part in a panel discussion on the value of outcomes measurement during the *Business Insurance* health care conference.

But, she asked, "How do you know (that just because) a hospital is well-located and offers a great deal that employees will come out of it alive?"

Employers should try to find out the mortality rates at various hospitals for the conditions and procedures that typically impact their employees. For starters, Ms. Johns said, "Look at procedures that are most frequent or that cost the most." Once those conditions and procedures are identified, there

must be a mechanism to balance a hospital's mortality rates with the severity of the patients it treats.

Severity-adjusted outcomes take into account the patient case mix for a certain procedure, including all patients' ages, sex and any underlying risk factors or complications that make it more likely that the patient will suffer a bad outcome.

Employers also should scrutinize a hospital's length-of-stay data to determine if patients stay in the facility longer than normal given their condition, she said.

Employers also should evaluate patients' functional status after they leave the hospital, including whether their health problems improved and whether they are able to return to their normal routines.

Unfortunately, "for years in most of the United States there were no measures to calculate these indicators," Ms. Johns said.

That is changing as more employers demand health care outcomes data. Some states, including California, Pennsylvania and New York, have mandated hospitals to provide outcomes data, according to Ms. Johns. Outcomes studies that include data from all hospitals within the state, rather than a few, is the most statistically useful, she noted.

Four Cincinnati employers are reaping the benefits of gathering severity-adjusted outcomes data from local hospitals. Procter & Gamble Co., General Electric Aircraft Engines, The Kroger Co. and Cincinnati Bell Telephone Co. have combined forces to collect and use outcomes data to identify high quality/cost effective hospitals (*BI*, April 12, 1993).

Fourteen hospitals participated in

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the initiative, which began in 1991, said William O'Neil, director of health care and wellness programs for Procter & Gamble Co. and a session panelist. Using a severity-adjustment system marketed by San Mateo, Calif.-based Iameter Inc., the hospitals were able to pinpoint physician practice patterns that deviated from practice patterns of physicians with the best outcomes.

"You as payers need to know the order of magnitude of variation in severity-adjusted outcomes" among different physicians and hospitals, as well as differences in their charges, said Lawrence Frye, president of Iameter and another panelist. For example, using Iameter's system, Cincinnati payers found out there can be as much as a \$10,000 per case variation and an eight-day length-of-stay variation among hospitals treating certain circulatory disorders.

"This information is what you need to have a constructive dialogue with hospitals and physicians within individual medical departments," Mr. Frye said.

The Cincinnati hospitals are now in the process of improving their outcomes based on the information gleaned from the Iameter process.

As a result of the project, all payers in Cincinnati were able to keep their health care cost increases to 6.8% between 1991 and 1992, Mr. O'Neil said. For 1993, the community expects no increase in health care costs, he said. **BI**

Treatment

Continued from page 3

breast cancer "and agrees to pay a higher premium, it adds an entirely different dimension to the scientific issue."

Drs. Krause and Rogers participated in a panel discussion on how insurers determine what medical procedures are experimental during *Business Insurance's* Second Annual Winter Health Care Management and Cost Containment Conference, held in San Diego Jan. 19-21.

If an insurer wants to follow the directive of a major client, it will pay for procedures or treatments that may have been deemed experimental, Dr. Rogers said.

Coverage for high-dose chemotherapy/autologous bone marrow transplants to treat breast cancer has become a hot issue for insurers in recent years.

Some insurers have decided to pay for such treatments despite the fact, they say, that there is no scientific evidence the treatment improves patient mortality.

However, there is evidence the procedure may prolong life, so many patients—and the employers that sponsor their group benefit plan—are insisting that the treatment be covered.

And, insurers or other health plans that deny such treatment often find themselves in court over this issue.

Many times the insurers prevail, based on specific contract language pertaining to experimental treatment coverage and the testimony of medical experts.

But not always. A California jury recently ordered HealthNet, a health maintenance organization, to pay \$89 million to the estate of a woman who died from breast cancer. The

HMO had denied payment for a bone marrow transplant (*BI*, Jan. 3).

Insurers fear emotions rather than scientific evidence will become the litmus test to determine whether they should cover certain procedures.

"Conflict arises when an individual says, 'Even though the treatment is no improvement and may be futile, I want to try it anyway.' That's why court cases don't go so well. You parade by a mother of three and she says this is her last chance," Dr. Krause said.

The advancement of medical science also is contributing to the problem, said Dr. Lawrence Schneiderman, a professor of family and preventive medicine at the University of California-San Diego. It is easy for patients to find medical professionals who will perform experimental procedures in violation of standard medical practice, he said.

"We can do lots of things, one is replace bone marrow. And it's become a goal to replace marrow because we can, not because it will improve the outcome for the patient," Dr. Schneiderman said. Until medical providers see the latter as their primary goal, the problem will continue.

"Naturally insurance companies are concerned about the cost" of covering experimental treatments, he added. "But it bothers people because they think if you won't pay, it's because they aren't worthy. That's an emotional issue and that's why it's important for the medical profession to distinguish the difference between futile treatments and rationing."

Rationing beneficial treatments is a political issue, Dr. Schneiderman said. "But rationing futile treatments shouldn't be an issue at all," he said. **BI**

ADA suits

Continued from page 3

could incur when his or her group policy doesn't cover a claim—could be substantial.

"When the plaintiffs bar figures this out, (nearly) every ADA claim will have a benefits component because there is where the money is," Mr. Lotito said.

And there's more bad news, he said: The ADA contains ambiguities and uncertainty, which make it difficult for employers hoping to avoid benefits-related suits by complying with the law.

When legislators drafted the ADA, they "committed congressional malpractice. They totally screwed things up," Mr. Lotito said.

For example, the ADA says that nothing in the law should be interpreted as preventing insurers from classifying or underwriting risks based on factors that are not inconsistent with state law.

On the other hand, another section of the ADA says nothing in the law shall permit employers to engage in practices that are a "subterfuge" to evade the purposes of the law.

"What in God's name does that mean?" Mr. Lotito asked.

Interpretation of the ADA is likely to evolve through litigation, he said.

For example, a key case pending in a federal court in New York involves the Mason Tenders District Council Welfare Fund, a multiemployer welfare plan that denied a union member coverage for HIV and AIDS treatment.

The fund contended that it eliminated coverage for HIV and AIDS treatment as part of an effort to "stem the economic hemorrhaging" of fund assets. It also eliminated a wide range of other benefits, includ-

ing organ transplants and well-baby care.

The HIV and AIDS coverage restriction violated the ADA, an EEOC official concluded in a non-binding ruling last year.

The multiemployer plan then filed suit seeking to block further action by the EEOC and two other plan members who have the human immunodeficiency virus (*BI*, March 8,

1993; Feb. 15, 1993).

Under interim guidance issued last year by the EEOC, employers may reduce specific benefits if such actions are, among other things, actuarially justified or are necessary to prevent plan insolvency or "unacceptable" increases in premiums (*BI*, June 14, 1993).

The outcome of the Mason Tenders case, Mr. Lotito said, could be

enormously significant. The case "is going to begin to define the relationship of ADA and benefits. You are going to have to watch it closely," he said.

If the EEOC's position prevails, the cost argument—that an employer limited or reduced a benefit to prevent an unacceptable cost increase—may not prove to be an acceptable defense, he said.

But the facts of the case show the Mason Tender plan was in financial difficulty, he added.

"If the EEOC prevails, read out the cost argument as a defense under the interim guidance. Based on the facts, this plan was in trouble. The (HIV and AIDS) cap was not implemented for purposes of any kind of discrimination," Mr. Lotito said. **BI**

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Getting with the program

Employers find wellness programs are a healthy idea

By JOANNE WOJCIK

SAN DIEGO—Health promotion will be given a higher priority in employee benefit plans in the next decade because there's finally enough evidence to prove that it works, wellness experts predict.

And wellness will soon become part of corporate culture as managers realize that healthy employees are more productive, experts say.

"Our senior management buys into the idea of wellness because they understand that health is very important to productivity," said William B. Baun, manager of health and fitness for Houston-based Tenneco Inc.

The American Journal of Health

Promotion has published some 48 case studies documenting the effectiveness of employer-provided wellness programs, according to William E. Hembree, director of the Health Research Institute in Walnut Creek, Calif., and moderator of a panel discussion on wellness during the *Business Insurance* health care conference earlier this month.

With the advent of health reform, "we're in the midst of a paradigm shift from an illness care system to a wellness care system," Mr. Hembree said. "And I believe one day that wellness will take the forefront."

The panelists reviewed three wellness programs that have won the C. Everett Koop National Health Award, which recognizes companies

for health promotion and disease prevention programs with demonstrated savings from improving health behaviors.

Tenneco was one of the first major employers to embrace wellness, launching a worksite health promotion program in 1981.

Because of the program's maturity, the company has been able to produce reliable data proving the value of wellness as a management tool to increase productivity, reduce absenteeism, and reduce medical and workers comp costs, said Mr. Baun.

The program reduces the number of employees who leave their jobs and encourages them to stay with the company longer before leaving,

he said. In addition, employees "who participate in programs like this are injured less than those who don't participate," he said.

In the 13 years since Tenneco's program was launched, the percentage of workers who smoke has shrunk to less than 10% from about 32% in 1981. And 40% of Tenneco employees now exercise regularly, compared with just 25% at the program's inception.

Southern California Edison Co.'s Good Health Rebate and Preventive Health Account have been equally successful.

Since 1989, about 48,000 employees and dependents—or 45% of those eligible—have been screened for high blood pressure, blood sugar, blood cholesterol, body weight and smoking status. The company rebates up to \$10 per month on the health plan contributions of employees who pass the screening or enter into a risk reduction program for

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one or more elevated risk factors, said Kurt P. Hobbs, supervisor of preventive health education for the utility in Rosemead, Calif.

Approximately 78% of those screened actually received the rebate, he said, and more than half of the employees who filed the highest-cost health claims participate in the program.

Participation also has been good in the Preventive Health Account program, in which employees and dependents can receive up to \$150 in financial assistance toward the cost of preventive health programs like weight management, smoking cessation, consultation with a registered dietitian or participating in an approved exercise program.

So far, "the trends that we've seen have been very positive," Mr. Hobbs said. For example, most of the participants who have made improvements were those who smoked, were overweight and/or had high blood pressure, he explained.

An integrated health data management system was developed to help CalEdison keep track of employees' progress. As part of his continuing analysis of the programs' effectiveness, Mr. Hobbs will cross-reference personnel, health plan enrollment and eligibility data with Good Health Rebate and screening data, claims made for preventive health care as well as health and workers comp claims experience.

Ventura County, Calif., has already crunched the numbers to prove that its wellness program has reduced the public entity's overall health plan costs, said Ronald W. Komers, personnel director.

The program was initiated by a joint labor-management committee in 1985 after the county's medical claims surged 71% in one year, he recounted.

Initially, money was used as an incentive for employees to participate, and those employees who demonstrated through a point system a positive change in their lifestyles were given a \$300 annual bonus at Christmastime.

About 60% of the county's workforce took part, and the county gave out \$2 million in bonuses.

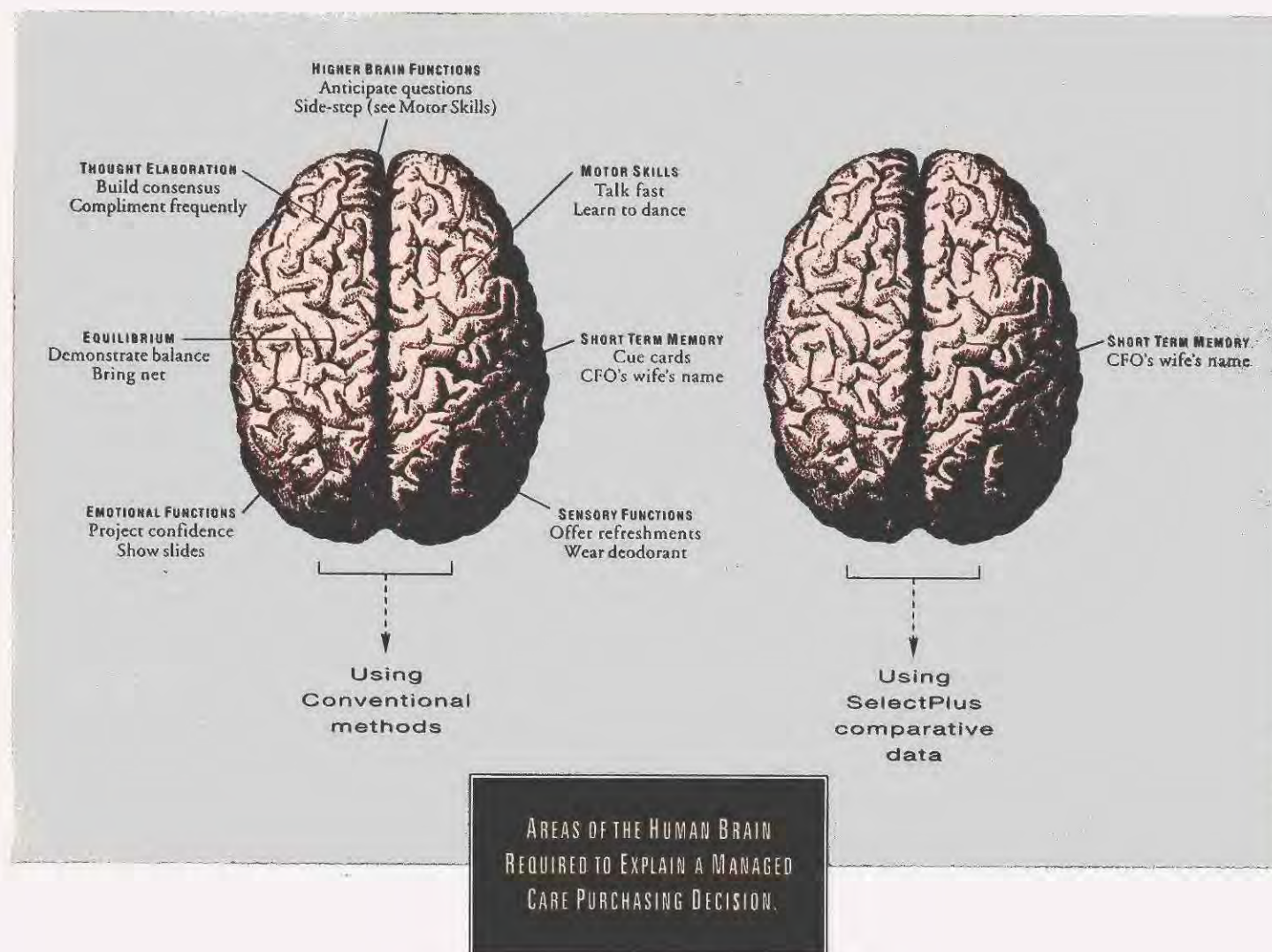
"But because of the financial struggle that public agencies in California have undergone, our program currently exists in a managed care environment where we provide health risk profiles for our employees and are focusing our efforts on employees with three or more risk factors," Mr. Komers explained.

This is because "we determined that 5% of our employees were causing 56% of our costs, and those costs were primarily in the area of cancer and cardiovascular-related diseases," he said.

Under the county's current program, any employee or dependent with three or more risk factors can get counseling and follow-up care.

Results have been significant: Participants generate an average of \$212 less per year in health claims than non-participants, and the average participant's risk factors fell to 3.5 from 4.7 before joining.

In tallying self-reported changes by employees, Mr. Komers has found that: 80% increased aerobic exercise; 61% lost weight; 82% increased seat belt usage; 51% reduced or quit smoking; 69% reduced blood pressure; and 86% reduced fat intake. **[B]**



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Opinions

Health care crisis is real

A YEAR AGO, EVERYONE was talking about the health care crisis. Today, most everyone still is talking about the health care crisis—with the notable exception of Sen. Bob Dole and a pack of Republicans.

"Our country has health care problems, but no health care crisis," the Senate GOP leader said in his response last week to President Clinton's State of the Union address.

We would like to think that Sen. Dole, whose political cunning usually cannot be questioned, doesn't really believe the health care crisis is fiction. Instead, we think the good senator would like to lead the American people to believe that the crisis does not exist and, thus, the massive changes to the health care system that would result from President Clinton's proposal are not necessary.

We agree with Sen. Dole that there's a lot wrong with the Clinton reform proposal, but ignoring the facts is not the way to defeat it.

Yes, health care inflation has moderated in the past year. Some of that is due at long last to managed care and other cost control mechanisms that employers and other payers have adopted over the past decade. But we believe that a lot of the slowdown in health care inflation is due to the "Hillary effect": The Clintons' emphasis on health care reform has caused providers and others, like drug companies, to hold the line on price increases, so that a champion—like Sen. Dole—can proclaim the crisis is over.

And, as a Health and Human Services Department official noted last week, health care cost increases usually moderate when the focus is on health reform. Health care inflation slackened in the early 1970s, when President Nixon advocated a national health plan, and later in the decade, when President Carter suggested hospital price controls. In both cases, costs zoomed when the presidential proposals died.

Yes, there still is a health care crisis. Ask insurers, ask benefit managers, ask those without access to affordable health care coverage.

While we disagree with a lot of President Clinton's proposals to reform our troubled health care system, we do agree with his pledge during the State of the Union address to stand firm for universal coverage. There is no way that health care costs can truly be brought under control—and there is no way a "level playing field" can be established for the employers that already offer health care coverage—until all Americans have access to coverage. The best way to assure universal coverage is through an employer mandate, as President Clinton has proposed.



While there is much to admire in the managed competition-based reform proposal sponsored by Reps. Jim Cooper and Fred Grandy, it contains a flaw more fatal than any in the Clinton reform plan: It does not assure universal coverage. Encouraging employers and individuals to purchase coverage is simply not enough; that will not get the job done.

While an employer mandate will pinch the pocketbooks of some small businesses, as well as some large ones, nearly all businesses would agree that employer-based universal coverage is much preferable to a single-payer health plan.

And, if the Clinton administration is truly willing to negotiate many details of its reform proposal, especially reducing the threshold below which employers must join regional health alliances, an employer mandate is indeed workable.

President Clinton's assertion that universal coverage is the only portion of his plan that is not negotiable sends a signal to Congress that the administration is ready to make major, but sensible, changes in 1994 to reform the health care system.

We believe the administration must make many modifications to its reform plan before it can be adopted. In fact, we believe that much of the Cooper-Grandy bill can be substituted.

However, we are glad the administration is willing to suggest bold changes, rather than take Sen. Dole's lead and ignore the problems in the health care system. That's how the crisis got started in the first place.

Letters

Time for straight talk on health reform plan

To the editor: Bravo on your Jan. 10 editorial, "Health Care Hypocrisy." I hope we will continue to see more hardhitting reviews of the Clinton proposal from your publication and from the insurance industry in general. While the industry's cautious reaction to date appears designed to deflect criticism that we will stonewall any attempts to reform the system, it's now time to take the gloves off and expose this sham for what it is.

The broad goals of health care reform—full participation, portability and affordability—are not served by a plan that is inherently anti-competitive, relies on a massive federal bureaucracy to administer and severely restricts both employer and employee choice. Despite overwhelming contemporary and historical evidence to the contrary, the administration and (judging from recent opinion polls) a majority of the American public continue to live in a fan-

tasy world where federal government paternalism is the solution to this and all other problems that afflict our society. In this debate, the insurance industry needs to be a strong voice, a voice that emphasizes more (rather than less) competition as the only proven road to quality, accessibil-

ity and affordability. Under the Clinton plan, we'll get less care and it will cost everybody more. It'll be equal—equally bad for everybody.

Brad Evans
CIGNA Special Risk Facilities
Los Angeles

CAJPA not sole pool accreditation source

To the editor: The program sponsored by the California Assn. of Joint Powers Authorities featured in the Jan. 3 issue is not the only voluntary accreditation program for intergovernmental pools. Demotech Inc. had the first voluntary accreditation program, initiated in the fall of 1988 (BI, Sept. 11, 1989).

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and Pennsylvania have availed themselves of our program.

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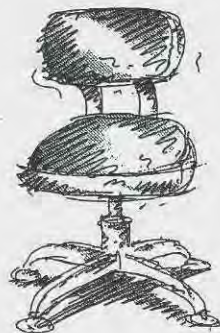
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Health care 'food chain' to be disrupted by reform, says marketplace futurist

By CHRISTINE WOOLSEY

SAN DIEGO—The future relationships between U.S. health care providers can be explained in terms of a simple food chain, according to a health care market futurist.

The role and dominance of the major players, represented as fish, will change under a reformed health care system, he predicted.

"The primary care medical group will be the biggest fish," explained Russell Coile Jr., president of The Health Forecasting Group in Santa Clarita, Calif. Mr. Coile was a keynote speaker at the

Business Insurance health care conference.

Groups of primary care physicians will provide the majority of preventive and general health care services, which will be stressed in the reformed health care system.

Further down the chain will be specialists—highly trained doctors organized into specialty networks, Mr. Coile said.

With all physician groups trying to control inpatient costs, hospitals will exist even further down the food chain. Those that survive reform will be "small and quick-swimming," Mr. Coile predicted.

Solo practitioners, including radiologists, pathologists and anesthesiologists, as well as university and public hospitals, will become "sushi," he said. Those providers won't survive

because of their high costs and perceived "attitude problem" toward capitated payment arrangements, Mr. Coile predicted.

With a less fragmented health care system, the focus will switch to care management and clinical efficiency. "We will have shorter lengths of stay in the hospital, appropriate utilization, clinical paths and protocols for treatment and real-time data," Mr. Coile said.

In addition, providers will be able to identify the group of patients that drives the majority of the costs, then manage them through cost-effective use of technology and lifestyle improvement, Mr. Coile said.

"The future of health care finance and delivery is in health maintenance organizations, even though there are still places in the country where they can't spell HMO," Mr. Coile said. Capitation, rather than fee-for-service medicine, will help the country control costs.

Among other developments Mr. Coile sees as health reform unfolds is a system for evaluating so-called "superdrugs," so that only those with proven benefits are developed.

And, rationing of high-cost therapies will take place, but primarily through benefit plan design, he said.

If the country can achieve these goals, among others, universal health care coverage could become a reality by the end of the decade, Mr. Coile said. If all goes well, health care inflation will slow to a rate of 2% or 3% above the Consumer Price Index. And, he said, health care as a percentage of gross domestic product could fall to 10%, if the economy springs back.

The evolution toward this scenario has a long way to go, and no one is exactly sure what specific events will lead up to it, Mr. Coile said. One thing is certain, though: the utter lack of confidence employers have in President Clinton's ability to solve their health care cost management problems. However, "If employers work with health insurers and health maintenance organizations to get around the problem, perhaps we can do something," Mr. Coile said.

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Reform support is split

Panelists see little agreement on best course for reform

By CHRISTINE WOOLSEY

SAN DIEGO—The lack of a clear vision for health care reform from the Clinton administration's health care task force has resulted in a proposal that is vulnerable to attack, warns a health care consultant.

The task force struggled to come up with a workable health reform plan "because we lack a national vision for health care reform," said G. Rodney Wolford, an independent consultant who worked with the task force and who is the former president and chief executive officer of California Healthcare System, a holding company for four California hospitals. "That's why the task force failed—because there were so many individual visions."

Employers, insurers, providers and politicians agree the U.S. health care system is in dire need of change. Unfortunately, that's where the agreement ends.

Many are quick to find fault with the president's plan, but few have been able to fashion an alternative.

And, many players insist that real health care system reform is occurring right now, on the local and state level. They don't want a national health care plan to jeopardize

coverage, which President Clinton has suggested, employers will see increased cost-shifting from providers.

Some observers say the 7.9% cap is a lure, a phony number to attract the business community to the president's plan. "It doesn't add up," said Mr. Langenus.

Others are questioning the fate of managed competition, a health care reform model embraced early on by the president and Hillary Rodham Clinton but seemingly abandoned by the task force assigned by the president to develop a cure for the nation's health care ills.

"The term 'managed competition' is not in the dictionary. It's an evolutionary term and has been cast out and used loosely by a lot of po-

litical bodies," said Mr. Wolford.

"I believe what happened in the task force is, when they first looked at the health care crisis, they came up with very simplistic answers. But when you start bringing all the constituencies together, you start deviating from simplistic answers," Mr. Wolford said. There wasn't a "departure from managed competition, it was just a translation issue" for the task force, he said.

Yet, with or without the task force or federal legislation, health care reform is taking place, the panelists agreed. "Reform is happening now, without legislation," Mr. Wolford said, noting the rapid consolidation occurring in the health care industry.

Rockwell's Mr. Milroy agreed that health care reform is taking place but said the Clinton plan is a "natural catalyst" for change. "And that's how it should be seen, as a guiding light."

CIGNA's Mr. Langenus disagreed, saying the president's plan is much more than a "debate initiator." The scope of the proposal and "the stridency with which they are launching their attack" on other reform plans, means President Clinton is serious about health care reform, he said. "They are doing much more than launching a discussion. This will go down much harder than NAFTA or the budget bill."

The size and powers of the quasi-governmental health alliances proposed in President Clinton's plan have become one of the most contentious issues for employers and insurers. Large employers with 5,000 or more workers can opt out of these alliances to form their own

corporate alliance, but few see that as a real choice given some of the penalties for doing so.

"As an insurer, I'm concerned about dealing with alliances," Mr. Langenus said. "Alliances make sense if they are designed to give unrepresented groups buying leverage, but I don't like the 5,000-employee opt-out level."

However, that level is less of an issue for insurers than "the power of the alliance to regulate price, quality and professional standards" of the health plans, he said.

If the alliances grow too large and have too much authority, the U.S. health system may begin to look more like Canada's single-payer system, Mr. Wolford warned. "It will evolve to single-payer because of the large bureaucracy created. And it will be costly to create, so we may not see the administrative cost reductions" President Clinton is promising, he said.

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and national accounts for CIGNA Corp. "Any employer who pays for health benefits is in a cost crisis, and any individual between jobs is in an access crisis."

But Mr. Langenus joins critics who say President Clinton's reform plan is nothing more than a single-payer system in disguise.

"The administration really wants the Canadian single-payer system," said Mr. Langenus. "This (Clinton) program is single-payer in drag."

Mr. Langenus and Mr. Wolford took part in a discussion of health care reform at the *Business Insurance* health care conference.

Portions of the Clinton plan appear to offer some cost relief for big business, but surprisingly many large employers do not support the plan.

For example, President Clinton's proposal, among other things, would cap employer contributions for basic group health care coverage at 7.9% of payroll. In addition, the federal government would assume 80% of the cost of health care coverage for workers who retire between age 55 and 64. Yet, many employers remain skeptical.

"The problem with the process is that our largest driver of cost increases is cost shifting," explained Larry Milroy, director of benefit management/health services at Rockwell International Corp. in Cedar Rapids, Iowa. "Unless we level the playing field for all payers, we can't deal with the cost problem."

Mr. Milroy said that modified community rating is the only way to avoid cost shifting from large employers that manage care to smaller employers that do not, and to the private sector from the public sector.

"The problem with the payroll cap is it's a moving target, and we have no confidence that it will stay at 7.9%," Mr. Milroy said. And, if the government reduces Medicare

the strides they've made.

"The most current topic of conversation is the health care crisis—and I think there is one," said John Langenus, senior vp of sales

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Drug makers want to deal directly with employers

SAN DIEGO—As a sign of a new aggressiveness and competitiveness sweeping the industry, drug manufacturers increasingly are interested in dealing directly with employers, an industry official says.

"We are just starting to call on employers," said Dale Martin, director of managed care for the western division of The Upjohn Co. in Denver.

Speaking at the *Business Insurance* health care conference, Mr. Martin acknowledged that direct dealings with employers, as well as managed care plans, are a change in direction for an industry known for its hidebound ways.

"It is unusual for me to say: 'Are there better ways to do things?'" he conceded.

The potential for direct employer and drug manufacturer arrangements are limited by the small percentage of employers that have in-house pharmacies.

Still, Mr. Martin says, manufacturers are open to employer input. "Tell us what you would like," he said.

The pharmaceutical industry has come under increased scrutiny over the last year as the Clinton administration has charged the industry with racking up excessive profits. "There is no question we (the pharmaceutical industry) are on a target," he said.

But he noted that drug manufacturers incur enormous costs in developing new products. The cost of developing a new drug can amount to \$300 million, he said.

He acknowledged that the cost of a drug may be higher in the United States than in another country where the identical product may be available. That's because much of the research costs associated with developing the product are incurred in the United States, he said.

In some cases, though, drug manufacturers are putting out new products that may have only a slight therapeutic advantage but cost much more than the products they are replacing, said Dennis Nirtaut, manager of employee benefits at Continental Bank in Chicago.

Another speaker on the panel recommends that employers undertake a "targeted intervention" approach to bring their prescription drug costs under control.

Under that approach, individual prescriptions would be carefully analyzed by managed care vendors to determine cost trends, said Diane Giaquinta, vp and general manager at Wellpoint Pharmacy Management in Calabasas Hills, Calif.

Ms. Giaquinta said individual physicians might be contacted to ask them why they are writing more prescriptions than other physicians.

In addition, a targeted approach could examine claims data to see whether a significant percentage of prescriptions involve generic products rather than more costly brand-name drugs, she said.

—By Jerry Geisel

Lactation programs yield multiple benefits

By JERRY GEISEL

SAN DIEGO—An onsite lactation program is helping the Los Angeles Department of Water and Power reduce employee absenteeism and cut health care costs.

The department provides double-action breast pumps at 35 worksites. Nursing mothers can use the devices at the worksite free of charge and also can take the pumps home for a subsidized monthly fee of \$14.50. The department pays \$30 a month to rent each pump.

Speaking at the *Business Insurance* health care conference, Beverly King, director of human resources at the Los Angeles Department of Water and Power, outlined several benefits of the department's lactation program.

A study of the department's employees who have infants indicated that breast-fed babies were sick less frequently than bottle-fed bottles.

Over a one-year period, 93% of bottle-fed babies were sick enough to require treatment by a doctor, compared with 50% of breast-fed babies.

At the same time, when breast-fed babies did get sick, illnesses were less severe compared with bottle-fed babies, the department's internal studies indicated.

Because breast-fed babies were healthier, their parents required less time off from work to care for the infants than parents of bottle-fed babies. In fact, parents of bottle-fed babies had an absenteeism rate seven times higher than parents of breast-fed infants.

"I can get real motivated" by that statistic, Ms. King said. "This is a high-payback program."

By reducing employee absenteeism, more departmental employees are able to service customers.

The rate of absenteeism makes a big difference, "especially at times like this," Ms. King said, referring to the earthquake that rocked the Los Angeles area three days before the conference.

The lactation program is one of a number of work/family programs offered by the Department of Water and Power, the nation's largest public utility, with 11,500 employees (*BI*, Sept. 27, 1993).

Kathi Marshall, a national spokeswoman for the March of Dimes and president of Conmar Publishing Inc. in Citrus Heights, Calif., said big

savings on health care costs could be racked up if more efforts were made in health education and preventive health care.

"We tend to engage in back-end heroics rather than front-end education and prevention, which is where the smart money is," said Ms. Marshall, adding that most unhealthy birth outcomes, like premature births and low-weight babies, are preventable.

"We can do a lot better than we have been doing," she said.

Dr. Larry Platt also spoke at the session. He recently retired from the maternal and child health care bureau at the Institute for Health Policy Studies at the University of California's medical school in San Francisco and is now a health care consultant in Berkeley, Calif. **BI**



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Capping mental health benefits ill-advised

By JOANNE WOJCIK

SAN DIEGO—Arbitrary limits on mental health care benefits are often counterproductive since the treatment of psychiatric disorders varies so much from patient to patient, experts say.

Limited mental health care benefits can also backfire since mental disorders and substance abuse can be extremely costly if left untreated, the experts point out.

Instead, employers should use managed care to ensure that treatment is tailored to employee needs, agreed a group of mental health care experts in a panel discussion at the *Business Insurance* health care conference.

"Mental illness can really affect profits and margins and productivity," said Dr. William M. Glazer, as-

sociate professor of psychiatry at Yale University School of Medicine in Stony Creek, Conn.

Unfortunately, mental health care benefits vary by company and by region, said Joan M. Pearson, a principal at benefit consultant Towers Perrin in Seattle.

New Yorkers might be more inclined to seek out the analyst's couch, whereas "people in Washington believe a walk in the woods can cure just about everything," said Ms. Pearson, who moderated the panel.

"There is no clinical rationale for lifetime benefit limits," said Stephen B. Connor, medical director for Life-Link, the Van Nuys, Calif.-based behavioral health care unit of Pacific-Care Inc.

For example, "alcoholism is a chronic relapsing disease," so one or two confinements per lifetime is not

adequate, Mr. Connor said.

However, many employers limit mental health care benefits to avoid contributing to a third or fourth confinement, said Ann M. Collins, director of employee benefits for Philip Morris Management Corp.'s North American operations in New York.

While Dr. Glazer acknowledged that some providers have abused the system, he said it is partly because rigid benefit plan designs have limited their ability to tailor treatment to individual patients.

"The cynical view of mental health I hear from benefit managers is that utilization is tied to benefits...so that utilization becomes independent of the illness or the epidemiology. Our profession has to take responsibility for that," he said.

But "there are ways to take re-

sponsibility, and that's in the decision-making, by making psychiatric decisions in fair and objective ways, just as in medical and surgical areas," he suggested.

For example, recent studies have shown that outpatient detoxification can be effective in treating some substance abuse patients, yet few plan designs permit this option even though it is less expensive, Dr. Glazer said.

To encourage the use of patient-specific treatment, or managed care, Dr. Glazer said he is developing a scale based on a person's behavior to determine whether a patient should be admitted or can be treated on an outpatient basis.

Copayments also are antithetical to treatment objectives because they discourage patients from seeking long-term care when necessary, Towers Perrin's Ms. Pearson said.

"If there's going to be cost-sharing, let it happen once and then get

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out of the way," she said, suggesting that employees be subject only to one-time up-front deductibles for each diagnosis to encourage them to remain in treatment until they are cured.

Limited mental health benefits also can lead to cost-shifting to the medical plan or workers compensation, the panelists noted.

For example, the average panic disorder patient has 31 medical visits before being properly diagnosed with a behavioral disorder, according to Dr. Glazer.

And the costs can add up: One angiogram—a test often administered to panic disorder patients complaining of chest pain—can cost as much as \$3,000, he said.

Depression also can be masked by numerous physical ailments, Dr. Glazer said.

Philip Morris has commissioned a study to determine how much the company's mental health care benefit program, launched in 1991, has affected its other benefit costs, according to Ms. Collins.

The study is being conducted by MCC Cos. of Minneapolis, a unit of CIGNA Corp. **BI**

Patients doctored by nurses often come out ahead

By JERRY GEISEL

SAN DIEGO—Barriers must be removed to provide a greater role for nurses as part of a restructured health care delivery system, a nurse advocate says.

"Nurses are part of the solution. They are not the problem," said Ellen Sanders, first vp of the American Nurses Assn.

Speaking at the *Business Insurance* health care conference, Ms. Sanders said advanced practice nurses can perform many services now provided by physicians—at a much lower cost. Advanced practice nurses are those with nursing degrees and additional graduate nursing training.

Nurses are "qualified to handle a wide range of health care problems," she said. For example, nurses can monitor patients with ongoing problems, like high-blood pressure; provide care in corporate health departments; treat minor illnesses; and administer immunizations.

And nurses provide treatment at a cost about 20% to 40% less than physicians, while freeing up physicians for other, more specialized services.

According to Ms. Sanders, research has shown that nurses and nurse midwives can provide prenatal care and handle normal pregnancies as well as, if not better than, physicians.

"Obviously, part of the solution to our health care cost and access problem is to more effectively utilize advanced practice nurses as primary care providers," she said.

But, before that can happen, several barriers that limit nurses' role as care providers must be removed, said Ms. Sanders, who also is a partner with Innovative Health Care Services Inc. in Boca Raton, Fla.

Those barriers include:

- State laws that either limit or bar nurses from writing prescrip-

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Nursing

Continued from previous page

• The refusal of some health care plans to provide reimbursement if care is provided by nurses rather than by physicians.

• The unwillingness of some managed care organizations to use nurses in gatekeeper functions, a practice that Ms. Sanders calls especially illogical.

"Nurses are uniquely qualified to conduct assessments, manage care and refer patients to appropriate providers," she contended.

Unless these and other barriers are removed, "we will continue to underutilize cost-effective providers," Ms. Sanders said.

The move to expand the role of nurses as care providers comes at a time when there is a growing recognition that health care ser-

vices aren't effectively delivered in the United States.

Health care costs this year will top \$1 trillion and will equal more than 14% of the gross domestic product.

Yet, more than 38 million people are uninsured for medical expenses, she pointed out.

One answer to that problem is to ensure all Americans access to health care coverage, Ms. Sanders said.

If everyone had health insurance, individuals would be less likely to seek treatment in emergency rooms, the most expensive form of treatment, she said.

In addition, Ms. Sanders said, greater emphasis must be placed on disease prevention and primary care services. "Prevention, education, early treatment, ongoing management" of care can reduce expenditures, according to Ms. Sanders. **BI**

Help employees be assertive patients

SAN DIEGO—Employers must train their employees to be more assertive and challenge physician decisions, a medical director advises.

Employees should be asking their physicians, "Are you sure?" said Dr. Joel Levin, regional medical director in the Itasca, Ill., office of health care cost management firm Intracorp.

Speaking at the *Business Insurance* health care conference, Dr. Levin said employees haven't taken an active role in their health care decisions.

Some actions, though, are being taken to help employees become equal partners in decisions regarding medical procedures.

For example, Dr. John Wennberg, a professor of epidemiology at Dartmouth Medical College in Hanover, N.H., has pioneered a drive in which older men are shown videotapes in

which the pros and cons of prostate operations are discussed by men who have undergone the operations. The videos have been used by various managed care organizations.

"Employees have to be trained to be more assertive. Employees have to understand the benefits and risks of medicine" and of certain procedures, Dr. Levin said.

But, before employees can be more assertive, employers must overcome employee misconceptions about the health care system.

Many employees, for example, distrust managed care or don't understand the role of the primary care physician, said Paula Roe, vp and director of compensation and employee benefits at Norwest Corp., a Minneapolis-based financial services firm. In addition, employees often feel they do not have enough information to be good consumers

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of health care services, she said.

And the demand for health care services could be cut sharply if employers do more to encourage health promotion and wellness, said Carson Beadle, a managing director with benefit consultant William M. Mercer Inc. in New York.

While much of the health care reform debate has focused on the supply of health care services, more attention should be given to reducing the demand by encouraging healthier lifestyles, Mr. Beadle said.

Healthier lifestyles and disease prevention could cut the nation's health care bill by \$200 billion, or 20% of this year's estimated \$1 trillion tab, he said.

—By Jerry Geisel

Health specialties vital: Professor

SAN DIEGO—A health care reform policy encouraging medical students to become primary care physicians rather than specialists could put the nation's status as a leader in health research at risk, warns a medical school professor.

Some health care reformers are calling for an increase in primary care physicians to serve as patients' main health care providers. Meanwhile, they say, the number of specialists—high-cost doctors who provide more complicated medical services—should be reduced to get costs under control.

"Many academic physicians, myself included, are very concerned by elements of health care reform that intend to reshape the landscape of American medical residencies by mandating that a higher percentage of aspiring physicians pursue careers in primary care," said Dr. Jerry Gardner, professor of internal medicine at St. Louis University Health Sciences Center.

There is a growing assumption that the nation would be better off if more doctors were trained to provide general and preventive medical services, he said during a luncheon speech at the *Business Insurance* health care conference.

Many people believe that health care costs have been inflated by the number of specialists, Dr. Gardner said. These doctors are viewed as "high-priced specialists who grow rich doing procedures, or researchers who cannibalize millions of dollars of the taxpayers' money studying esoteric subjects," he added.

Indeed, the ratio of specialists to generalists in the United States is 68-to-32, compared with a 50-50 ratio in other industrialized countries, he pointed out.

However, discouraging specialty medicine would jeopardize America's position as the world's leader in medical science, argued Dr. Gardner. "In terms of medical science, the way that we have become a world leader is through laboratory and clinical research in specialty medicine, not by promoting primary care, Dr. Gardner said.

"Primary care doctors don't do research," he explained. "They deliver the highest-quality medical care in the world by using diagnostic tools, applying procedures and administering drugs developed through the myriad of specialty areas in medicine—the very areas that current (reform) proposals would significantly reduce."

—By Christine Woolsey

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Olympics

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"Gjensidige, because it is a sponsor, competed very hard for the coverage. Because the LOOC is a semi-state-owned entity, it didn't want to pay too much, and Gjensidige met our prices. On every coverage, Gjensidige was cheapest," Mr. Wang said.

One major portion of the total package is coverage protecting the \$400 million in worldwide TV rights for the Games, said Patrick Vajda, liability manager with broker Gras Savoye S.A. The Paris brokerage placed all the coverage for the 1992 Winter Games in Albertville, France, (BI, Feb. 3, 1992) and helped Grieg, a co-member of the UNISON network, craft programs for Lillehammer.

The \$150 million, no-deductible TV rights program covers the LOOC against revenues lost from the complete or partial cancellation of TV broadcasting contracts, including the largest one, CBS Inc.'s \$300 million contract.

Other major broadcasting companies have bought rights, said Mr. Vajda, including: Japan's NHK International Inc., which paid \$36 million; the European Broadcasting Union, \$25 million; the Canadian Broadcasting Corp., about \$6 million; and major networks in Australia, New Zealand and South Africa, about \$6 million combined.

Worldwide, about 2 billion people are expected to tune in to the Games.

The TV rights program pays up to \$150 million if the LOOC has to make any full or partial refunds to any broadcaster. Coverage is subject to proof that a claimant lost money and ultimately paid the LOOC less than its contract called for. For example, if consecutive days of heavy snow forced repeated postponements of the men's downhill and CBS ultimately wasn't able to show it—and therefore withheld part of its payment—the LOOC would be covered.

The LOOC would also be covered for any broadcast rights losses resulting from the unexpected pullout of a major participant like Germany, Italy or the United States.

"The program is all-risk and is patterned after the program we placed for the '92 Albertville Games, which produced no claims," said Gras Savoye's Mr.

Vajda. He would not disclose the premium.

The program carries limits of \$150 million in two \$75 million layers. Lloyd's of London syndicates write 32%, or \$24 million, of the first \$75 million layer, with other London insurers responsible for 16%, or \$12 million. Continental European insurers provide the remaining 52%, or \$39 million, with Abeille-Paix/Group Victoire, Colonia Versicherung A.G. and Allianz Versicherungs A.G. responsible for \$21 million of the layer.

On the second layer, Lloyd's syndicates are responsible for \$31.5 million, the London market about \$6.75 million and European insurers \$36.75 million combined.

The TV rights coverage carries several exclusions: Lloyd's of London's comprehensive war exclusion; radioactivity that directly or indirectly damages property and forces cancellation of the Games; the unilateral decision by the IOC or the LOOC to cancel the Games for any reason other than for the safety of spectators or participants; and lost television revenues due to a network not being able to broadcast beer and wine advertisements in its own country. "The beer and wine exclusion won't come into play, but it's the feeling at Lloyd's that, in the near future, some governments will

"If, for example, there's too much snow and an event is postponed at a cost, the coverage will pay," says the LOOC's Morten Wang. "Likewise, if there's not enough snow and a snowmaker has to be flown in from Italy, this coverage covers that cost."

forbid beer and wine advertising," Mr. Vajda explained.

The TV rights package also covers lost revenues from cancellation due to terrorist attacks, he added.

The LOOC's \$20 million general liability package is written by Gjensidige in two \$10 million layers, said Grieg's Mr. Wang. The first layer became effective in 1991 and runs through August of this year. The excess layer is in force only during the Games.

The liability coverage carries a \$13,300 deductible.

The LOOC paid 270,000 Norwegian kroner (\$35,800) for the first layer and 94,000 Norwegian kroner (\$12,500) for the excess layer.

CBS not switching channels for cover

NEW YORK—As it did two years ago for the XVI Winter Olympics in Albertville, France, CBS Inc. has purchased some low-level liability coverages from local insurers, but most of its major risks will be covered by its existing global program.

"Event cancellation, physical damage, general liability, ocean cargo and just about everything else is covered under a comprehensive global policy that is written in layers by various insurers," said Dennis D'Oca, risk manager for CBS, which paid about \$300 million to broadcast the two-week event that kicks off Feb. 12 in Lillehammer, Norway.

Except for covering the loss of satellite transmission and some liability coverage for Norwegians hired by CBS to help produce the Games, "we're taken care of" through the global plan, he said.

The global program was arranged by Rollins

Hudig Hall Group Inc., while travel insurance for CBS employees covering the Games in Norway was placed by Kalvin-Miller International Inc. in New York.

"Unless we're talking about a very specific risk, the global package is as broad as you can imagine. Even non-owned aircraft that we'll be using for aerial shots and panoramas is covered."

CBS has not insured the risk of cancellation of the Games, though its exclusive TV rights would be refunded by the Lillehammer Olympic Organizing Committee if something unforeseen causes cancellation. The LOOC is insured for a portion of that exposure (see story, page 3).

If employees are injured on the job, they'll be covered by CBS' workers compensation coverage if they are U.S.-based and were brought over for the Games. "Otherwise, per diem employees and third-country nationals are insured locally."

—By Michael Schachner

The 8,000 members of the Olympic "family" are covered for accidents and medical care from the time they depart for Lillehammer until their first significant stop after leaving.

Gjensidige underwrites the comprehensive travel accident, illness and liability policy, for which the LOOC paid 1 million Norwegian kroner (\$132,700). Limits are \$2,000 for stolen items, \$40,000 for death or dismember-

ment we built."

Gjensidige is also providing 5 million kroner (\$663,500) in coverage for wear and tear to houses and hotels rented by LOOC for its employees and athletes as well as comprehensive automobile collision and liability insurance for LOOC's fleet of vehicles, which has been provided for free by another sponsor, Volvo International of Sweden.

Besides more traditional forms of insurance, the LOOC has purchased an extra-expense coverage program that would require Gjensidige to pay the LOOC up to 50 million kroner (\$6.6 million) for the costs associated with making sure events start on time.

"If, for example, there's too much snow and an event is postponed at a cost, the coverage will pay," he said. "Likewise, if there's not enough snow and a snowmaker has to be flown in from Italy, this coverage covers that cost. I don't think there was a claim against this policy in Albertville, but we expect something. Gjensidige is a little nervous about it, but they're writing it because we have backup plans for most things that could happen."

Along the same lines, the LOOC has a form of business interruption coverage that covers a spectator's cost of not being able to use a purchased ticket. For example, if the women's slalom finals are postponed due to weather, and rescheduled at the same time the U.S. and Canada are facing off in hockey, a ticketholder for both events would get a refund and the

coverage would offset those costs. The limit on this coverage is 80 million kroner (\$10.6 million). The premium was \$250,000.

In assessing the insurance needs for Lillehammer, Messrs. Wang and Vajda, along with other members of the LOOC insurance team, looked at claims from the Albertville Games, which had virtually the same types of coverage.

Gras Savoye's Mr. Vajda said the Albertville OOC received about 200 to 300 liability claims worth about 1 million French francs (\$181,000); one claim accounted for about half that amount.

Automobile claims were the biggest trouble area. The Albertville Olympics produced about 1,000 claims before, during and after the Games. "The cost was about 12 million francs (\$2.2 million)," he said, "which was exactly what the premium was."

So far, the LOOC has faced only one major loss, said Mr. Wang: a 4.5 million kroner (\$597,000) claim from damage during construction of the new ice pavilion.

When the Games begin, a team from Grieg and Gras Savoye will be on site to handle all insurance and risk management duties.

Mr. Wang will lead the team and will be assisted by fellow Grieg employees Kare Ulvin, Reider Larsen and Kristian Von Hirsch. Jan Paus will handle legal affairs. Mr. Vajda and Philippe Duplex will represent Gras Savoye.

The insurance team will report to Halvor Bru, the LOOC's divisional finance manager. **BI**

Reforms

Continued from page 3

skepticism in the business community about the (administration's) premium estimates. All along, many employers knew they would pay more" than the administration said they would, Mr. Schieber said.

The administration acknowledged that its initial set of premium estimates were too low and slightly increased them last fall as it was revising its health care reform proposal. Administration officials later said they would "scrub" all numbers in the package for accuracy, but that process has not been completed.

Wyatt said there are several reasons why its premium estimates are higher than those of the administration. For example, the administration underestimated both the cost of medical services and the demand for medical services, especially from individuals who now are covered by Medicaid, the consultant said.

Wyatt also found there would be considerable geographic variation in premiums charged by regional alliances. This variation would range from a low in Nebraska of \$1,472 for single coverage and \$3,322 for family coverage, to a high in the District of Columbia of \$2,917 for individual coverage and \$6,584 for family coverage (see chart, page 3).

Those variations are a reflection, among other things, of the considerable differences in the cost of health care throughout the country, Mr. Schieber said.

The administration has acknowledged that premiums charged by different alliances would vary.

Aside from underestimating premiums paid to regional alliances, the administration overestimated several revenue sources, according to the Wyatt study.

For example, Wyatt estimates that a proposed 1% payroll tax that employers would have to pay if they chose to opt out of regional alliances and set up their own corporate alliances would reap about

\$1 billion this year. The administration estimates the 1% payroll tax would generate more than \$4 billion.

The administration's revenue estimates for the 1% tax are too

The administration underestimated both the cost of and demand for medical services, Wyatt says.

high because it overestimated the number of employers that would establish corporate alliances, Mr. Schieber said.

Among other things, employers would be discouraged from setting up alliances because their buying power and clout with providers would be minute compared with the gigantic regional alliances, health experts say.

Under the administration proposal, all employers with more

than 5,000 employees would have to buy coverage through regional alliances. Last week, though, Treasury Secretary Lloyd Bentsen and other administration officials said they would consider lowering the 5,000 employee minimum for employers to opt out of regional alliances (see story, page 1).

The Wyatt study also found that many small employers would be eligible for special subsidies the administration has proposed to reduce the premiums they would pay to regional alliances.

For example, under the administration proposal, the premiums paid by employers with fewer than 25 employees and per capita salary costs of less than \$12,000 would be capped at 3.5% of payroll. The amount of this special subsidy would decrease as company size grows. Employers with more than 75 employees or payrolls averaging more than \$24,000 per employee would not be eligible for this subsidy.

Under another proposed subsidy, employers—regardless of size—that join regional alliances

would have their premiums capped at 7.9% of payroll for basic health care coverage.

In all, Wyatt estimates that 85% of employers with between two and nine employees would be eligible for the small, low-wage company subsidy. The average subsidy would be \$864 per employee.

A substantially smaller percentage of larger employers would benefit from the 7.9% premium cap. Wyatt estimates that 41% of employers with between 100 and 999 employees would benefit from the 7.9% cap, with the subsidy amounting to an average of \$185 per employee.

Twenty-two percent of employers with at least 1,000 employees would benefit from the 7.9% premium cap, with the subsidy equal to \$130 per employee.

Copies of "The Economics of Health Reform" are available for \$100 from The Wyatt Co., Research and Information Center, 601 13th St. N.W., Suite 1000, Washington, D.C. 20005; 202-508-4600.

Chase

Continued from page 2

ted a new program in which Lloyd's of London underwriters would provide the coverage over a self-insured retention, sources familiar with the program confirm.

However, the bank is still trying to recoup about \$900,000 of the approximately \$1.8 million in premium it already paid to La Fenix, a company whose trust account for U.S. policyholders includes a large block of stock in a bankrupt tire recycling company, sources involved in the program say.

The Florida Insurance Department also is investigating the placement and has subpoenaed records on La Fenix from the Coral Gables, Fla., office of Rollins Hudig Hall, Chase's broker.

A Chase spokesman confirmed that the bank terminated its relationship with La Fenix in December "for business reasons" but declined further comment. A spokeswoman for RHH also declined to comment, and Mr. Riley did not return phone calls.

The coverage that has created these troubles for Chase is a "forced placement" property program in which the bank buys insurance on behalf of borrowers who have not obtained insurance themselves, passing along the cost to the borrowers.

The program was intended to

cover U.S. Virgin Islands houses and apartments on which Chase has loaned about \$88 million, sources familiar with the risk say.

Last summer, Chase submitted a proposed insurance package to the U.S. Virgin Islands Division of Banking and Insurance, which had to approve the insurers and reinsurers participating in the program, said John McDonald, acting director of the division.

The program first called for Chase property risks to be divided between La Fenix and Commercial Indemnity. The two insurers would then reinsure most of the risk under treaties whose major participants included Gaelic Union Reinsurance Co. of Ireland. Other parts of the risk were reinsured by Lloyd's underwriters, Mr. McDonald said.

Dominique Testu, a Gaelic Union director in Nantes, France, confirmed that La Fenix was to insure up to \$500,000 per location, retaining \$50,000 and reinsuring the balance.

Mr. Testu and another Gaelic Union director, Georges O'Neill, are also directors of La Fenix, and Mr. Testu is a former managing director of Meadowlark, the predecessor of Commercial Indemnity.

A circuitous chain of intermediaries originally brought La Fenix and Commercial Indemnity to Chase. They included: The Donnelly Corp., a Mercer Island, Wash., firm headed by Patrick R.

Donnelly; Various Markets Inc., a broker based in Warren, Mich.; and ultimately Mr. Riley at M&M Management. M&M Management is not affiliated with broker Marsh & McLennan Cos. Inc.

Mark Dupuis, president of Various Markets, said he was introduced to La Fenix and Commercial Indemnity by Mr. Riley. Mr. Dupuis then brought the insurers to the attention of Mr. Donnelly,

consisted of accounts set up outside Bolivia for La Fenix's 1993 expansion into the international market. He also said that the accounts had "changed substantially" since year-end 1992 but that audited 1993 financial information is not yet available.

La Fenix maintains a trust account for U.S. policyholders at The Trust Co. of St. Joseph, Mo. As of Jan. 7 this year, the account was

John McDonald, acting director of the Virgin Islands Division of Banking and Insurance, says he rejected Chase's second coverage proposal after learning of PCI's regulatory problems. "That was enough for us."

who presented them to RHH and Chase, he said.

Mr. Donnelly could not be reached for comment.

La Fenix, based in La Paz, Bolivia, reported total assets of 23.4 million bolivianos (about \$5.7 million at the appropriate exchange rate) in a year-end 1992 financial statement.

The assets included 17 million bolivianos (\$4.1 million) in "documents collectible," which were not described in detail.

Responding to faxed questions, Orlando Nogales, a La Fenix executive vp, said the "documents"

valued at \$1.4 million, including cash in other La Fenix accounts and a "large block" of stock in Canton Industrial Corp. of Salt Lake City, according to Nancy Barnett, a trust officer at The Trust Co.

Canton, which filed for Chapter 11 bankruptcy protection in 1988, had no recent operations until it bought a tire recycling plant in February 1993. It recently petitioned the bankruptcy court to remove it from Chapter 11. However, the company reported shareholders equity of \$311,168 in a Sept. 30, 1993, financial statement, which also raised "substantial doubt" about Canton's ability to survive as a going concern.

Separately, Alabama insurance regulators last month rejected La Fenix as the proposed insurer of three risk purchasing groups, concluding it had not shown that its trust agreement and trust securities met National Assn. of Insurance Commissioners standards.

Chase's other proposed insurer, Commercial Indemnity, reported total assets of \$14.6 million in a Jan. 1, 1992, financial statement audited by Cliff Heffner, an Albuquerque, N.M., certified public accountant.

These assets included more than \$10 million in real estate loans, real estate investments and premiums in the course of collection.

The California Insurance Department, however, barred Commercial Indemnity last May, noting that the insurer:

- Was not actually licensed as an insurer in the Dominican Republic, its purported domicile.
- Failed to verify the ownership or valuation of most of its assets, leading regulators to conclude that its financial condition was "far too precarious" to allow it to write business in the state.
- Is the successor company to Meadowlark, which itself had been barred in California in 1989.

Mr. Heffner, Commercial Indemnity's auditor, said the insurer changed its name in January 1992. He submitted Meadowlark bank statements in an attempt to verify cash accounts reportedly held by Commercial Indemnity, California department documents say.

Virgin Islands regulators reviewing the Chase program rejected La Fenix and Commercial Indemnity because of unanswered questions about their reinsurance arrangements rather than because of objections to the companies themselves, Mr. McDonald said.

He added, though, that he had asked for additional information about Commercial Indemnity, which he had not received before the program was rejected.

Chase and RHH then submitted a revised program in which Commercial Indemnity was dropped and La Fenix was named as the

sole insurer. La Fenix's reinsurance protection was also changed, with Provident Capital Indemnity named as principal reinsurer, Mr. McDonald confirmed.

PCI, originally based in Dominica in the Caribbean, was barred by California regulators in 1992 for reporting \$75 million in allegedly bogus assets in its balance sheet. The assets—three certificates of deposit from a non-existent Hong Kong bank—comprised the majority of PCI's total reported assets of \$86.6 million (BI, Nov. 2, 1992).

Florida regulators shut down PCI's Delray Beach, Fla., office last year and leveled criminal charges against several PCI officials, including: President Robert C. Roy, Kathryn Elliott, Harold Charles Maridon and Grahame Sanders.

Mr. Roy pleaded no contest in September to a felony charge of selling insurance without a license and was sentenced to one year's probation. Messrs. Maridon and Sanders and Ms. Elliott fled to Costa Rica, where PCI has continued to operate.

A state judge appointed the Florida Insurance Department as PCI's liquidator Jan. 19.

Mr. Sanders was formerly vp of Dyna Span Corp., a purported risk retention group in Boca Raton, Fla., that was hit with cease and desist orders in several states in 1986 (BI, May 26, 1986; March 3, 1986).

Mr. McDonald said he rejected Chase's second proposal after learning of PCI's regulatory problems. "That was enough for us."

After the second rejection, La Fenix representatives in the United States scrambled to find replacement reinsurance coverage.

Mr. Riley and Ken Dolan, an official with Kansas City-based Prairie Star, an M&M Management affiliate, contacted Sedgwick Payne Co. in Seattle in November and obtained a preliminary quote for replacement coverage with Berkshire Hathaway Group, sources familiar with the placement say.

Mr. Dolan said he was brought in only to find replacement coverage after PCI was removed. He also blamed Chase representatives for the PCI debacle, maintaining that La Fenix had never wanted to deal with the reinsurer.

"I only go totally traditional routes," Mr. Dolan said.

"It's a good program. It's a solid program," he added of the Chase/La Fenix cover. "Otherwise, Berkshire would not have been interested in it."

No reinsurance deal was ever finalized between La Fenix and Berkshire, though, and Chase terminated the La Fenix cover in December.

Between July and December, Chase paid \$1.8 million in premiums to La Fenix and is now seeking about \$900,000 in return premiums, according to Various Markets' Mr. Dupuis and others familiar with the program.

However, Mr. McDonald, the U.S. Virgin Islands regulator, questioned whether the coverage was ever actually in place: Regulators never approved La Fenix, and Chase's U.S. Virgin Islands property risks could not be covered under a program without this approval, he said.

Chase also would not be able to pass along the costs of unapproved insurance coverage to mortgage borrowers, he said.

The bank has told Virgin Islands regulators that it has not tried to charge borrowers for the cost of the La Fenix program, Mr. McDonald said. **BI**

Intermediary named in bribe scheme

KANSAS CITY, Mo.—M&M Management Corp., representative of the former Meadowlark Insurance Co., has been implicated in alleged schemes to bribe Missouri and Maryland state officials on Meadowlark's behalf in 1991 and 1992.

A federal grand jury in Kansas City last year indicted two men on charges of pocketing \$300,000 they received from unidentified M&M Management and Meadowlark officials to bribe Missouri insurance regulators to secure a license for Meadowlark.

Meadowlark had been barred from Wyoming and New Mexico and received cease and desist orders from several other states when it applied for a Missouri license in April 1991. Missouri regulators denied the application and have also denied being approached with bribes.

Meadowlark, based in the Dominican Republic, later changed its name to Commercial Indemnity Assurance Co. (see story, page 2).

Kevin M. Hare, a Kansas City

attorney, was sentenced last week to three years and 10 months in prison after being convicted of pocketing money he told M&M Management and Meadowlark officials he needed to pay off Missouri regulators.

Raymond W. Sermon, described as an associate of M&M Management officials, received an identical sentence after pleading guilty last year to wire fraud and money-laundering charges connected with the scheme.

Separately, Austin W. Evans Jr., a former Maryland transportation official, was sentenced last month to four years and nine months in prison for accepting more than \$17,000 in bribes from M&M Management and Meadowlark to funnel business to the insurer.

Mr. Evans was indicted in Kansas City last year on charges that he took bribes in 1991 and 1992 to steer more than \$400,000 in surety bond business to Meadowlark. The bonds were required of school bus companies participating in the Maryland Motor Vehicle Ad-

ministration's self-insurance program, which Mr. Evans managed.

M&M Management and Meadowlark officials were not charged in either indictment. A spokesman for the U.S. Attorney in Kansas City declined to comment on whether the firms are targets of an ongoing investigation.

M&M is not related to New York-based broker Marsh & McLennan Cos. Inc.

Ferrell Travis Riley, a consultant who works for M&M Management, could not be reached.

Mr. Riley has a long history of regulatory trouble: The Texas Insurance Department revoked his agent's licenses in 1989 on a variety of charges, including that he misrepresented himself as an agent of the now-defunct Dexter Lloyds Insurance Co. of Houston; misrepresented Dexter Lloyds' financial condition; and pocketed premiums on policies he issued for St. Paul Fire & Marine Insurance Co. and United States Fidelity & Guaranty Co.

—By Douglas McLeod

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INTERNATIONAL

European court shifts course on pensions

By ALINE SULLIVAN

LONDON—Pension rulings issued by the European Court of Justice are making employers wonder how much they'll really save from the European Community's plans to raise the age at which women are eligible to receive their pensions to 65 from 60, actuaries and lawyers say.

The Luxembourg-based court has ruled on three of four pension cases—one each from Britain, Germany and the Netherlands. Each tackles a different aspect of the same problem: how to interpret the court's May 17, 1990, decision in the case of *Barber vs. Guardian Royal Exchange* that men's and women's pension benefits must be equal.

The fourth case, involving Colonn Group, a failed British wallpaper company, has yet to be decided. Many lawyers regard that case as the most important.

In its most recent pension decision, the court ruled Dec. 22 in *Neath vs. Steeper* that companies can continue to calculate retirement benefits on the basis of gender. It will remain legal for employers to pay different lump-sum benefits to men and women, based on actuarial tables that show women's average life span is five years longer than that of men.

"It seems a rather peculiar deci-

sion," said John Swabey, an attorney with the Wyatt Co. consulting firm in Brussels. "It overturns the earlier recommendation by the advocate-general."

"Certainly, we expected it to go the other way," he said. "The decision seems to fly in the face of the court's other recent decisions which were consistent in equalizing benefits between men and women. Until

now, we have been advising clients to use unisex actuarial tables. Now that doesn't seem necessary."

The *Neath* case was brought to the court by David Neath, a former employee of British artificial limb manufacturer Hugh Steeper. Mr. Neath had worked for the company for 17 years before his job was eliminated in a corporate downsizing in 1990. During his employment, he

contributed regularly to a private company pension plan.

The pension plan allowed male employees a full pension at age 65 and female employees at age 60. When Mr. Neath was forced to leave the company before he reached retirement age, he had the option of transferring his pension to another plan or waiting for a deferred pension when he reached age 65.

Mr. Neath objected that the value of his pension would be less than that of a female employee because the amount was based on actuarial tables illustrating different life expectancies for men and women. Hugh Steeper, like many British companies, paid a bigger lump sum to women on retirement than to men, to reflect women's greater life expectancy.

Mr. Neath's view is backed by the European Commission, which has argued that both lump-sum and periodic pension benefits should be regarded as pay. Under European Union equality laws, firms should therefore not be allowed to differentiate between men and women.

But the Court of Justice ruled against Mr. Neath, saying that company lump-sum pension benefits do not constitute pay and are therefore not incompatible with European Union equal-pay rules.

"The court seems to think that it is in the nature of a pension to be a periodic payment," said Mr. Swabey. "It is a bit worrying that (the court) doesn't seem to understand the retirement benefits industry."

Mr. Neath also argued that his pension benefits should be equalized retroactively to cover the 17 years of employment. This argument related to the court's 1990 *Barber vs.*

Continued on next page

Maxwell pensioners appear likely to settle

LONDON—A settlement between the former employees of the late publishing mogul Robert Maxwell and the investment managers that handled pension funds he stole from his companies appeared close late last week.

The U.K. Chancery Court twice last week postponed the 200 million pound (\$298.9 million) suit brought by Mirror Group Newspapers Pension Trustees Ltd. The defendants in the case are two U.K. fund managers, Invesco MIM and Capel-Cure Myers Capital Management, and New York investment firm Lehman Bros.

The second postponement, from last Wednesday until today, was granted because the Mirror Group trustees' attorney requested time to continue negotiations with the defendants. A spokeswoman for Lehman Bros. in London confirmed late last week that the parties are in "detailed discussions."

This latest settlement effort follows Lehman Bros. International's return of roughly \$40 million

in securities to Mirror Group pensioners and Bank of America's decision to pay \$37 million to settle the Mirror Group pensioners' claims (*BI* Jan. 17, Jan. 10).

The Mirror Group pension trustees still have an outstanding action filed against Zurich-based bank Credit Suisse to recover plan assets given to the Swiss bank as security for a 50 million pound (\$74.7 million) loan.

In a separate development, Rhobson Rhodes, the joint liquidators of Bishopsgate Investment Management Ltd., which was trustee of the Common Investment Fund set up to manage the Maxwell Co. pension funds, has filed suit against Credit Suisse.

BIM's liquidator is making a claim for more than 15 million pounds (\$22.4 million) worth of shares that were deposited with Credit Suisse in 1990 and 1991 and used as security for the same loan.

—By Adrian Ladbury

ILU may strengthen security

Market aims to reassure policyholders

By STACY SHAPIRO

LONDON—The Institute of London Underwriters is examining whether to implement tougher financial security measures to reassure its policyholders following the publication of an internal report on market changes.

As ILU members begin to map out the market's future course, the first-ever public release of ILU financial results show premium rates and deductibles on the rise.

The internal review was launched following the withdrawal of 40 London market insurance companies in recent years from the ILU, which is an association of marine underwriting offices. Two of those insurers now are in provisional liquidation and have stopped paying claims.

A total of 74 insurance companies still belong to the ILU. Underwriting capacity, currently estimated at 10 billion pounds (\$14.8 billion), has been only marginally affected by the withdrawals, said Peter

Evans, the ILU's immediate past chairman.

However, "these stark developments created concern, not only among policyholders who fear their claims not being paid but also among brokers, who for the first time felt that they had to question the security on offer," Mr. Evans stated at the market's annual meeting last week.

The ILU has worked hard to explain to policyholders and brokers that each member is a separate entity. "Security provided through the ILU will no longer be treated as a single entity with all members equal," he said.

If some of these problems are not solved, however, "there is a danger that the ILU will fragment itself as the stronger members seek to distance themselves from the weaker," Mr. Evans warned.

A strategy review group set up last September has privately published its preliminary report on what should be done to improve the 110-year-old market's reputation.

One of the issues discussed in the review is whether to improve the security of ILU policies by introducing a guaranty fund and policing the membership.

Another issue is whether the ILU should merge offices with the London Insurance & Reinsurance Market Assn., an association of non-marine underwriters in the London market. Last month, the ILU and LIRMA merged their claims and information bureaus to form the London Processing Center in suburban London.

"It's my opinion that we should maintain the independence of the marine market" that the ILU represents, said Mr. Evans. However, he warned, "It is likely that current and future circumstances will require a radical response."

Members now will begin discussion of a plan for the ILU's future.

Meanwhile, the ILU for the first time publicly released market statistics. Although ILU uses a three-year accounting period, the market provided 12-month results for 1991, 1992 and 1993. Net premiums for

Continued on next page

LONDON

Court approves backup plan for Municipal Mutual runoff

By ADRIAN LADBURY

LONDON—The British High Court has approved a contingent scheme of arrangement created to run off the liabilities of Municipal Mutual Insurance Ltd.

But the defunct insurer's managers believe that the scheme, which creditors overwhelmingly approved at a Jan. 5 meeting, will not be needed. The current management believes there is enough money reserved and due from reinsurers to pay its estimated 931 million pounds (\$1.39 billion) of liabilities with 45 million pounds (\$67.3 million) to spare, and they say the plan has been adopted only as a backup.

MMI, once the dominant insurer of municipalities in the United Kingdom, announced its intention to seek a transfer of its business to other insurers in May 1992, after it failed to satisfy the Department of Trade and Industry's solvency requirement. In September of that year, it ceased underwriting new or renewal business.

Since the announcement, MMI has disposed of the majority of its business and some liabilities to other insurers in 17 transactions. The biggest deal was signed with Zurich Insurance (U.K.) Ltd., the U.K. arm of the Swiss insurance and reinsurance giant that took over the municipal business.

In 1991, some 82% of MMI's 347 million pounds (\$648.7 million) of gross commercial insurance premiums came from local-government business, and it insured 90% of local U.K. authorities.

MMI suffered along with the rest of the U.K. general insurance sector between 1990 and 1992, but was hurt especially by the need to dra-

cally increase reserves for public and employers liability claims against local governments.

It was unable to raise outside funds because of its mutual status.

No time frame has been set for MMI's runoff.

Brokers merge

Lloyd's of London brokers Nicholson Chamberlain Colls Ltd. and Leslie & Godwin Ltd. have finally merged to create what they say is one of London's top six brokerages—Nicholson Leslie Group.

Alan Colls, chairman of NCC, is the new company's chairman, while Antony Pinsent, chairman of L&G, is deputy chairman. The new company expects to generate brokerage revenues of about 60 million pounds (\$89.7 million) in 1994, about 60% of which is wholesale and 40% is re-insurance business.

The merger has been in the cards since Chicago-based Aon Corp. bought Frank B. Hall & Co. Inc. in November 1992. L&G was acquired by Frank B. Hall in 1978; Aon has been a major shareholder in NCC since its creation in 1988. Last year, the remaining shareholders of NCC sold their stakes to Aon to make it 100% owner, which cleared the way for a merger.

The company's U.K. retail business, handled from L&G's 10 U.K. retail offices, has been split from the main group and will operate under Aon's global retail company, Rollins Hudig Hall Group.

IRISC London Ltd., the recently launched London arm of the runoff company jointly owned by Aon and Bermuda-based Centre Reinsurance Ltd., has picked up a number of the brokers' runoff accounts.

Suez may divest Groupe Victoire

PARIS—Cie. de Suez, the French financial and industrial conglomerate, may sell its Groupe Victoire insurance unit.

According to reports in the French press last week, Suez has reached an advanced stage in negotiations with three potential Victoire purchasers: Allianz A.G. Holding of Cologne, Germany; Assicurazioni Generali S.p.A. of Trieste, Italy; and B.A.T. Industries P.L.C. of London.

Suez declined to comment on the reports.

The reports quoted unidentified sources close to the negotiations as saying that Suez wants to sell Victoire for at least 20 billion French

francs (\$3.38 billion).

Groupe Victoire had been jointly owned by Suez and Union des Assurances de Paris. UAP's former chairman, Jean Peyrelevade, in November traded the insurer's Victoire stake for a controlling interest in Suez's German subsidiary, Colonia Versicherungs A.G., Germany's third-largest insurer. The German insurer had been controlled by Groupe Victoire (*BI*, Nov. 15, 1993).

Separately, UAP shares rose 7% early last week despite warnings by Chairman Jacques Friedmann that the insurer's 1993 profits will be about 1.5 billion francs (\$253.8 million), at the low end of market ex-

pectations. UAP's earnings have been adversely affected by claims from recent heavy flooding in France, he said (*BI*, Jan. 3).

Insurance analysts said they expect UAP to show strong profit growth this year, thanks to higher premium rates.

State-owned UAP, which is the largest insurer in France, will also benefit from its plans to offer a 3-1 stock split later this year. UAP is scheduled for privatization in the next few months, and the stock split will make shares more accessible to small investors, analysts said (*BI*, Dec. 20, 1993).

—By Aline Sullivan

INTERNATIONAL

ILU plans

Continued from previous page

hull, cargo and aviation rose 15% to 991 million pounds (\$1.47 billion) last year from 861.1 million pounds (\$1.30 billion) in 1992. Net premiums totaled 585.5 million pounds (\$1.09 billion) in 1991.

Hull premiums in particular rose 15% to 624.2 million pounds (\$923.5 million) from 541.7 million pounds (\$820.4 million) in 1992.

Marine hull underwriters are continuing to see higher premium rates and higher deductibles, added Stephen Redmond, deputy chairman of the Joint ILU and Lloyd's Hull Committee. But, the rates charged by insurers and policy conditions vary according to a shipowner's loss record.

So far, underwriters know of 121 vessels that were total losses last year, together producing insured claims in excess of \$590 million. That total is an improvement over 1992, when 134 vessels were lost at an approximate cost of \$590 million.

Net aviation premiums rose 21% in 1993 to 277.7 million pounds (\$410.9 million) from 229.2 million pounds (\$347.1 million) in 1992.

A total of 26 jetliners were total losses last year, with an estimated hull value of \$433 million, compared with 22 jetliners lost in 1992 with a total value of \$432 million. There were, 42 partial hull losses last year, costing \$302 million, compared with 26 in 1992 costing \$112 million.

Cargo net premiums remained about the same last year at 89.1 million pounds (\$131.8 million), compared with 90.2 million pounds (\$136.6 million) in 1992.

The ILU published total hull, cargo and aviation claims for 1991, 1992 and 1993, but these statistics are likely to change substantially when accounts are closed under the market's three-year accounting system. Total claims in 1993, for example, came to 150 million pounds (\$221.9 million), far less than 227.9 million pounds (\$345.2 million) in 1992, but nearly the same as 1991's level of 148.3 million pounds (\$318.5 million). **BI**

Pensions

Continued from previous page

Guardian Royal Exchange decision, which left several questions about pension equality unresolved, including the issue of retroactive payments.

In this aspect of his case, Mr. Neath was not supported by the European Commission. In the absence of a firm ruling from the court on the length of retroactive payments, the commission in 1992 added a provision to the Maastricht Treaties on European union that retroactive pension payments should apply only to service after May 1990.

Mr. Neath's hopes on that score were dashed on Oct. 7, 1993, when the court ruled in the Netherlands' *Ten Oever* case. In that suit, which involved pension payments to the widows and widowers of former window washers, the court ruled that employers are not required to pay equal pensions to men and women for work carried out before the Barber decision (*BI*, Oct. 18,

1993). The same reasoning was used in Mr. Neath's case.

The German case, *Meroni vs. Collor*, concerned the length of retroactive pension payments to men. The court had to decide whether retroactive equalization applied only to ac-

Most employers have already taken steps to equalize women's pensions with men,' says Bob Sperl.

tive employment after the Barber decision or to the total service of already retired employees. The court's decision on Dec. 14, 1993, reaffirmed the advocate-general's opinion that payments were retroactive only for active employment after the Barber vs. *Guardian Royal Exchange* decision.

Lawyers say the decision in *Meroni vs. Collor* and the *Ten Oever*

cases were more in line with the court's other rulings and with changes in European Union legislation. The *Neath* case has thrown a wrench in the works, though it is unlikely to boost companies' pension benefits costs significantly.

"Based on these earlier cases, most employers have already taken the actions necessary to equalize women's pensions with men," said Bob Sperl, international consultant with Wyatt in London. "Most of the bigger companies have decreased benefits for women. Now the situation is much more confused."

In *Coloroll*, the court must decide how annuity benefits should be equalized, given that women outlive men by an average of five years and more money is required to fund a comparable benefit.

Coloroll has dragged on longer than expected (*BI*, June 21, 1993; May 28, 1990). Lawyers following the cases say they anticipated a *Coloroll* decision by December and are now waiting for the court to make an announcement on when it will rule on the case. **BI**

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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 15,094

Sub-total 28,112

Associations 385
Government, unions and Educational Institutions 1,075

Commercial Consumers

Sub-total 29,572

Insurance Agents and Brokers 8,714
Insurance Companies 7,981
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Adjusters, Appraisers, TPA's, Captive Managers & Health Care Providers 1,936
Others Allied to the Field 1,081

TOTAL 52,816

* Source Business/Occupational breakdown of qualified circulation, May 31, 1993 issue, as submitted to BPA for June 1993 BPA Publisher's Statement.

Satellites

Continued from page 1

Faugere & Jutheau in Paris and its sister brokerage Bowring Space Projects in London, both of which are units of Marsh & McLennan Cos. Inc. The estimated 20% of the coverage that was placed in London for both satellites was led by the Ariel syndicate at Lloyd's. The new Marchant Space Consortium, a group of 20 syndicates at Lloyd's, also insured one of the satellites and wrote other launch-related reinsurance for a total of \$39.3 million in coverage.

In one fell swoop, the loss wipes out the \$350 million in profits generated by the world's satellite insurance market between 1987 and 1993, according to net premiums-to-claims statistics from Space Risks International, a joint subsidiary of brokers Rollins Hudig Hall Group Inc., Rollins Hudig

Hall Europe, Nicholson Leslie Group in London and C.E.C.A.R. in Paris.

It means that the overall satellite insurance market "will go into the red," said Mr. Fournier. "It's very detrimental to the market."

However, the loss is substantially less than the \$840 million in satellite insurance premiums generated during 27 Ariane flights since 1990, the last time an Ariane rocket failed, said Mr. Fournier. That disaster cost insurers \$189 million (BI, Feb. 26, 1990).

"For the overall market, the loss has a bad impact because it's the largest loss ever and the first one of the year," Mr. Fournier commented.

The loss "is a lot of money and the space market's going back into the red," added Benito Pagnanelli, deputy general manager for Assicurazioni Generali S.p.A. in Trieste, Italy, another major satellite underwriter involved in last week's loss.

The satellite insurance market has been recovering for the past four years following a succession of serious losses in the 1980s, and capacity was starting to grow, said Mr. Pagnanelli.

Indeed, before last week's disaster, Space Risks International said the satellite insurance market was

'With this big a loss, the market will react,' predicts Generali's Benito Pagnanelli.

in "as healthy a state as it has been in the last seven years."

For example, despite a \$188 million satellite loss in February 1993, the largest single satellite loss in history, space underwriters had a total net profit of \$100 mil-

lion, according to SRI's estimate in its Satellite Insurance Market Review.

Capacity this year also has grown to \$450 million per launch from \$350 million, SRI estimated, which is in line with other underwriters' estimates. That figure includes capacity offered by syndicates at Lloyd's, which has increased its satellite insurance capacity to \$120 million from \$65 million, according to SRI.

In particular, the consortium managed by Marham Consortium Management Ltd. and formed by Michael Marchant Underwriting Ltd. and underwriter Simon Clapham, has a total capacity of \$60 million. Mr. Clapham wrote \$27.5 million in premium in 1993.

SRI predicted before last week's disaster that "in the absence of major losses in the next few months, it would be reasonable to predict that rates might ease back to the 1991-1992 benchmark of 16.5%" of the insured value of

each satellite for launch coverage. Rates at the moment average about 17% to 18% of insured value. However, after last week's loss, it is unlikely that rate reductions are in the wind.

"With this big a loss, the market will react," predicted Mr. Pagnanelli. "There will be a reaction on the level of rates."

"The loss will have an effect, but what effect I don't know," added a Lloyd's underwriter.

"I imagine this large loss will have an impact (on rating), but it's unlikely to be focused just on the Ariane rocket (launches)," said Mr. Fournier.

Launch insurance rates have been dropping lately because, while there have been several losses, the market still has made profits over the past four years.

But now that the Ariane loss has wiped out those earnings, underwriters will probably question whether they should reduce rates, he said.

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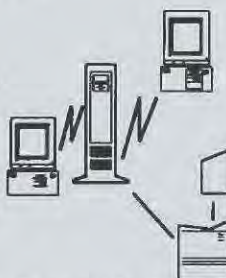
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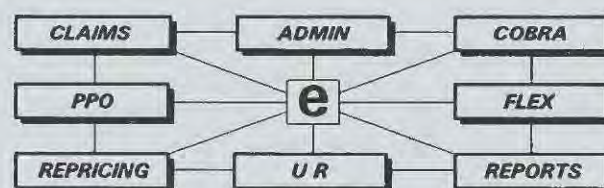


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Congress

Continued from page 2
Cardiss Collins, D-Ill., and backed by House Energy and Commerce Chairman John Dingell, D-Mich.

Although the bill requires insurers to submit underwriting data on certain urban areas for federal review, it is far less sweeping than a competing House Banking Committee bill, H.R. 1257, sponsored by Rep. Joseph Kennedy, D-Mass. The Kennedy bill would subject insurance companies to a degree of federal regulation and require considerably more data-gathering.

Although H.R. 1188 appears more likely to go to the floor, supporters of the Kennedy bill may try "to weigh (1188) down with some very costly amendments" to insurance companies before the full House votes, Mr. Farmer explained.

The Senate is not likely to act on redlining until the House passes a bill.

A bill creating a dual system of federal and state regulation of insurer solvency, H.R. 1290, could also move very quickly in the House if Rep. Dingell decides the time has come to push his bill.

"The driving force behind federal regulation may not be the insolvencies of major insurers but

cries from our major trading partners over 50-state regulation," said Joel Wood, vp-government affairs for the Council of Insurance Agents & Brokers in Washington.

"At any point at which (Rep. Dingell) chooses to move, I have no doubt that he could move it through his committee," said Mr. Wood.

He added that while the issue has been "somewhat moribund of late," there's evidence that pressure will continue to grow for a more streamlined regulatory structure.

David Pratt, senior vp-federal affairs for the American Insurance Assn., said he thinks action on the Dingell bill will depend on a variety of factors, not the least of which is moving the redlining bill to the House floor.

The Energy and Commerce Committee also is one of the key panels involved in the health care debate, which could hold up consideration of insurer solvency regulation.

Congressional assessment of the effectiveness of state regulation and the general stability of the property/casualty insurance market also could help determine whether the measure is acted on, Mr. Pratt said.

Tied closely to the question of a federal role in insurance regula-

tion is the fate of the 49-year-old McCarran-Ferguson Act, which grants states primary regulatory power over insurance and provides insurance companies with a limited exemption from federal antitrust law. H.R. 9, legislation introduced by House Judiciary Chairman Jack Brooks, D-Texas,

mobile insurers, said the Alliance's Mr. Farmer.

Rep. Brooks could also play a key role in determining the ultimate fate of a mild product liability reform bill—S. 687—that appears likely to win Senate approval if Senate Majority Leader George Mitchell, D-Maine, allows

its earlier—and more sweeping—incarnations.

The House and Senate are also likely to deal with labor-backed changes to the Occupational Safety and Health Act of 1970. Companion bills H.R. 1280 and S. 575 would require, among other things, the creation of worker/management safety committees at virtually all workplaces.

Businesses oppose the bills, but the House and Senate Labor committees, which must pass judgment on them, "can pass them any day they want to," said Tom O'Day, associate vp of the Alliance in Washington.

Mr. O'Day said the question remains whether there is any significant congressional support for sweeping OSHA reforms outside the committees and predicted that a standoff was possible in both chambers.

Insurers are also keeping a close watch on anti-crime bills being considered by the House and Senate.

The Senate crime package includes industry-supported measures that make certain types of insurance fraud federal offenses. But the House crime package has been separated into several pieces, with the insurance fraud provisions existing as a stand-alone bill sponsored by Reps. Brooks and Dingell. The ultimate fate of the measure is not clear yet, said AIA's Mr. Pratt.

'The driving force behind federal regulation may not be the insolvencies of major insurers but cries from our major trading partners over 50-state regulation,' says Joel Wood of the Council of Insurance Agents & Brokers in Washington.

would effectively gut the act. Insurers are uniformly opposed to H.R. 9.

Whether the bill moves out of committee could depend on how quickly Rep. Brooks dispenses with three other issues facing his panel: telecommunications law, health care reform and changes to federal criminal law, Mr. Pratt said.

The president's health care reform bill also threatens some provisions of McCarran. The bill abolishes McCarran exemptions for health insurers and leaves open whether McCarran would apply to health care-related insurance programs provided by workers compensation and auto-

a vote on the matter.

The Senate bill, which enjoys bipartisan support, won easy approval in the Commerce Committee last November and has enough sponsors to block a filibuster.

The first House hearings on product liability in several years are scheduled for this week, when an Energy and Commerce subcommittee examines H.R. 1910, the companion to the Senate measure.

However, even though the House bill also enjoys considerable bipartisan support led by Rep. Dingell, it must get through the Judiciary Committee. Rep. Brooks vehemently opposes the measure, as he has opposed all of

Errors & omissions

Due to a production error, two charts were inadvertently omitted from Alice Rosenblatt's Jan. 24 Perspective article, "Adjusting for Health Risks."

The missing charts illustrated a section of text, which follows, explaining the difference a risk adjustment mechanism can make for two health plans under the Clinton health care system reform plan.

Assume that two health plans, A and B, are offered by the regional alliance and that each plan offers the standard point-of-service plan design.

Plan A previously used medical underwriting to exclude individuals expected to have high medical claim costs, while Plan B insured everyone.

Plan A's costs are \$100 per month for individual coverage and \$250 per month for family coverage, using community rating. Plan B, an insurer that has been accepting all applicants for insurance, has community rates of \$120 per month for individual coverage and \$300 per month for family coverage, under an assumption that the provider cost structures are identical to those of Plan A. In other words, we are assuming Plan B needs to charge 20% more than Plan A due solely to the differences in the risk characteristics of the populations insured by the two insurance companies.

Plan B has been able to negotiate fees with in-network providers that are 10% less than the fees Plan A has been able to negotiate,

and 90% of usage is in-network for both insurers.

If the resulting 9% differential is applied to the premiums, we obtain the following premium rates (see top chart).

To the consumer purchasing insurance, it looks like Plan B has a higher cost structure than Plan A. However, we know from our assumptions that Plan B actually has the lower cost structure and that the higher rates reflect the combined impact of the lower cost structure with the higher relative risk characteristics. What we try to accomplish through risk adjustment is the removal of the value of these relative risk differentials from the premiums to be charged.

In the above example, we could require that Plan A pay to Plan B \$10 per individual and \$25.03 per family to adjust for the risk differential. The premiums we end up with if Plan A adds this payment to its premium and Plan B subtracts this amount from its premium are as follows (see bottom chart).

These adjusted monthly premi-

	Plan A	Plan B	Ratio of Plan B to Plan A
Individual Monthly Premium	\$100.00	\$109.20	1.092
Family Monthly Premium	\$250.00	\$273.00	1.092

	Plan A	Plan B	Ratio of Plan B to Plan A
Individual Adjusted Monthly Premium	\$110.00	\$99.20	.902
Family Adjusted Monthly Premium	\$275.03	\$247.97	.902

ums better reflect the relative costs of the two insurers and the consumer can now see the premium differential caused by the fact that Plan B pays in-network providers 10% less for services than Plan A.

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Losses

Continued from page 1

Among the companies relocated by quake damage was personal computer manufacturer Packard Bell Electronics Inc., which was displaced when its Chatsworth headquarters was rendered uninhabitable.

The company spent the majority of the last two weeks packing up and moving its equipment and 1,500 employees to a "permanent-temporary" headquarters in Westlake Village, about 15 miles west of the quake's epicenter.

Coverage details were unavailable. Packard Bell, the country's fourth-largest PC manufacturer, is moving into 160,000 square feet of space in the Eaton building in Thousand Oaks, sharing space with telecommunications giant GTE Corp.

About 400 workers in Packard Bell's technical support department have moved to Utah, a spokeswoman said.

GTE's customer service office in Granada Hills may be condemned, a spokesman said. However, the loss is not that great a blow since GTE had planned on eventually closing it as part of a restructuring, he explained.

The quake also caused two GTE telecommunications switches to temporarily shut off, but overall "there was no permanent damage, no facility damage, and no central office had to close," he said.

GTE's coverage information was unavailable.

Another communications giant, Pacific Bell, suffered \$25 million in property damage from the quake and subsequent aftershocks.

The subsidiary of San Francisco-based Pacific Telesis Group has a \$25 million self-insured retention above which it has coverage through its captive, Pac Tel Reinsurance Co. of Hawaii, said Virginia F. Tormey-Lawson, director of risk management.

United Parcel Service of America Inc.'s San Fernando sorting facility was severely damaged when the quake caused part of its roof to collapse and a wall to cave in, according to Risk Manager Gale Davis in Atlanta.

UPS' Van Nuys facility also suffered water damage, he said.

The shipping company has rerouted packages to some of its other Southern California facilities and has pulled out of storage double-wide trailers used at Christmastime to sort packages.

"We are obviously struggling," he said. "We think we will be back in full operation by the end of February."

Ironically, the San Fernando facility, built in 1986, was constructed "beyond the California building code," taking into account the possibility of an earthquake, according to Mr. Davis.

"They say if we hadn't, the building would have gone down completely," he said.

UPS has earthquake coverage from Allendale Insurance Co. that will provide coverage for the \$20 million structure and the shipping company's other losses above a 5% deductible.

"We think we're going to hit the deductible," he said. UPS doesn't purchase business interruption coverage "because it's not cost-effective in our business," he added. "We can always reroute."

That won't be too easy this time, though.

"The one thing nobody really thought about was the impact of losing major arteries," Mr. Davis said, referring to the numerous freeway closures that have affected many companies transporting goods in and around Southern California.

Tandy Corp. Risk Manager David

Lee said the Fort Worth, Texas-based electronics retailer has done a pretty good job of spreading its risks since only eight of its 90 area Radio Shack stores are still closed two weeks after the quake.

"We're fortunate to have a large number of stores widely scattered around the area," he said.

All of the Los Angeles-area retail outlets sustained some damage, ranging from mild to severe. Its most severely damaged store was in the Northridge Fashion Center near the quake's epicenter.

"The storage rack systems keep some shelving from falling over, but because of the display mode we operate in, we're always likely to have some damage," Mr. Lee explained.

Tandy doesn't purchase property insurance since it leases space for its stores. However, it has contents coverage and business interruption coverage from CIGNA Corp.

Great Western Bank was still assessing quake damage late last week.

Damage to its Northridge headquarters and various valley branches will cost between \$6 million and \$10 million, Risk Manager Dick Evans estimated.

Mr. Evans said Great Western purchases earthquake coverage through the Hobbs Group Inc., which is the brokerage arm of Arkwright Mutual Insurance Co.

Los Angeles' entertainment industry also was sent reeling by the quake.

Many production facilities—particularly those near the San Fernando Valley epicenter of the quake—suffered extensive damage that will disrupt regular activity for the near future.

Insurance

Continued from page 1

nesses buy the coverage. But in the valley area, those figures are estimated at 40% to 45% for homeowners and 60% for businesses, according to THG.

More than 100,000 residential claims are expected, and if they amount to only an average of \$15,000 per loss, the total would be \$1.5 billion, THG said. "There could be an equivalent loss on commercial risks."

Fully insured fire losses alone were expected to be \$134 million, according to projections by engineering consulting firm EQE International Inc. of San Francisco.

Several factors, though, may hold down the size of insured quake losses.

The standard 10% deductible on earthquake coverage, for example, may temper some potential losses. "There are a lot of people that fall into the category of having damage to their home but did not meet the deductible requirements," the III spokesman said.

And aggregate commercial losses are usually less than homeowners losses because office buildings tend to be more structurally sound, he said.

Many of the claims flooding into insurer offices are "precautionary submissions" that will not mean major payouts because there is either a significant deductible or there may not actually be any coverage, said Alan Levin, managing director at Standard & Poor's Rating Group in New York.

Also, there have been no reports in Los Angeles of widespread price-gouging, which boosted early loss estimates on Hurricane Andrew to record levels, he said.

Despite potentially large aggregate losses, "we really still don't think this is going to be such a major event" from an insurance perspective, said Mr. Levin. "As far as

For example, the administration building at CBS Studio Center in Studio City suffered water and other damage when a water main broke, according to Dennis D'Oca, risk manager for CBS Inc. in New York.

There also was structural damage to facilities at CBS-MTM Studios, where many independent producers like Linda Bloodworth-Thomason and Castle Rock Entertainment shoot television programs.

Some of the walls in stages that date back to 1918 "started to crumble" when the quake struck. Studio head Mike Klausman "did a hell of a job" mitigating the damage," said Mr. D'Oca.

CBS hired Horizon Public Adjusters of New York, which has a Los Angeles office, to set up a portable risk management department at the disaster site.

"What really pleases me is that I have a risk management department on the West Coast now," Mr. D'Oca said.

Among the loss control measures employed by Horizon Principal John Morrongiello was to use cherry-pickers to brace walls, he said.

In addition, the local CBS television station instituted its emergency disaster plan to ensure that news of the earthquake could be broadcast throughout the Los Angeles metropolitan area.

"We have an emergency disaster plan so we can set up a microwave dish and get the news vans out" should the transmitter atop Mount Wilson suffer damage, Mr. D'Oca said.

"But the studio is harder to protect" since many parts of sound stages are portable, such as lighting

the insured loss, this industry has the ability to handle very large numbers fairly well."

Insurers were still determining their own losses last week.

State Farm Group, California's largest earthquake insurer with nearly a quarter of the market, reported 60,000 quake claims as of last week. About 10% were commercial.

"We're still in the process of coming up with a figure for how great losses will be," said a spokesman for the Bloomington, Ill.-based insurer. "So much damage in earthquakes goes unseen at first. We're projecting 115,000 total claims when all is said and done, but we'll pay only a percentage of those."

Some 45% of affected State Farm policyholders carry earthquake insurance, compared with only 30% in the San Francisco Bay area at the time of the 1989 quake.

Allstate Insurance Co. had received more than 22,500 personal lines earthquake claims as of late last week but had not yet tabulated commercial claims, said a spokesman for the Northbrook, Ill.-based insurer. Allstate is not reinsured for quake losses.

Another major insurer in the area, Farmers Insurance Co., reported receiving 16,600 homeowners and 1,720 commercial claims, including businesses, apartments and condominiums, as of last Thursday.

Farmers has a risk excess reinsurance program for high-valued buildings (BI, Jan. 24).

One of the few insurers to venture a loss estimate was Liberty Mutual Insurance Co., which expects gross losses of \$34 million on the 1,100 claims it received as of last Thursday. The total includes 105 commercial property claims, eight commercial auto claims, 105 personal auto claims and 882 personal property claims, a spokeswoman for the Boston-based insurer said.

RLI Corp. of Peoria, Ill., projects a net aftertax cost from the quake of \$13 million to \$17 million, based on

that hangs loosely from the ceiling, Mr. D'Oca explained.

CBS is insured for the damage under a deductible program that is part of a manuscript global policy that covers losses from earthquake, property and contingent business interruption expenses. Underwriters include Phoenix Insurance Co. of Hartford, Conn., Navigators Insurance Co. of New York, Lexington Insurance Co. of Boston and the Home Insurance Co. of New York, he said.

MGM-UA Communications Co.'s Santa Monica offices suffered water damage when the quake set off sprinkler systems there.

While property damage is likely to exceed MGM's 5% earthquake deductible, no claim has been filed yet with its insurer, Continental Corp.

Water damage is one of the major causes of damage from an earthquake, explained Richard Freund, general manager of Munters Moisture Control Services, which has set up a catastrophe headquarters at its Irvine offices to help companies dry out.

"What happens is that sprinkler systems are activated—or water pipe breaks occur—as buildings are shaken by the quake. A building that might only suffer minor damage—such as broken glass—is suddenly flooded by sprinklers that damage walls, furniture, carpeting, ceiling tiles, computers and cabinets of irreplaceable files," he said.

Water damage was also sustained by Blue Cross of California in Woodland Hills, which is still assessing the extent of its damage. BC of California is insured by Liberty Mutual Insurance Co.

While quake damage was wide-

spread, many business escaped with only relatively minor damage.

Sanyo Fisher Electric Co. Ltd., which manufactures home audio/visual equipment in Chatsworth, Calif., suffered mostly cosmetic damage.

Comptroller Steve Kawakami estimated the firm's total loss at \$1 million and said the company was "well on the way to recovery."

While damage to the company's data processing equipment is covered under a commercial insurance program, it is self-insured for its property and earthquake exposures, he said.

Litton Industries Inc. also suffered relatively minor damage at its Canoga Park complex.

Initially "there was some concern" about Litton's Aero Products Division headquarters, but "the city building inspector and two outside engineers green-tagged the building," a spokesman said.

Litton purchases earthquake coverage from a consortium of underwriters, he said, declining to elaborate.

All around Los Angeles last week, buildings awaiting inspection were encircled by yellow plastic ribbons bearing the words "CAUTION." If the structure passes inspection by the city building department, it received a green tag notifying the public that it is safe to enter. If it did not, however, the building was "red-tagged," or "condemned."

So far some 1,000 buildings in the Los Angeles area have been condemned, according to local officials.

Louise Kertesz contributed to this report.

claims received and computer estimates, said Gerald D. Stephens, chairman and CEO.

Jonathan E. Michael, president and chief operating officer of RLI Insurance Co., RLI Corp.'s insurance unit, said that as of Wednesday, RLI had about 400 claims, of which 45% were commercial.

Mr. Stephens said RLI has total earthquake capacity—including its net retention, all working layers plus catastrophe reinsurance—of \$157 million, and gross losses will certainly not reach that total.

Despite the L.A. quake, earthquake coverage, which RLI writes through difference-in-conditions policies, remains profitable and RLI will continue to write it, Mr. Stephens said.

Among other insurers who provided claims information:

- Aetna Casualty & Surety Co. had received about 1,300 claims by midweek, of which about 1,000 were homeowners claims.

- About 800 of those claims were filed by people with earthquake riders. But the others haven't been formally denied yet because if fire caused damage, that would be insured," said a spokesman.

- "A problem with earthquake claims is that a lot of damage is hidden. We write checks to get claimants started, but more damage appears later once engineers are brought in. A wall crack that at first seems minor later becomes a serious structural problem that has to be fixed," he said.

- CNA Insurance Cos. reported 1,513 earthquake claims as of Thursday.

- Reliance Insurance Co. had 885 received claims as of Thursday, 10% of them commercial.

Dennis Busti, president of Reliance National Insurance Co. in New York, said because of reinsurance protection, the most the entire Reliance Insurance Group would have to pay would be \$15 million.

- TIG Holdings Inc. reported receiving 700 personal lines claims as

of Thursday but was not releasing commercial claims data.

- Travelers Corp., which labeled itself a "relatively small player in the California property/casualty market," said it had received 105 commercial claims and 19 personal lines claims as of Thursday.

- Another small player in California, GEICO Corp., reported 188 homeowners claims and 74 auto claims as of late Wednesday.

- Nationwide Insurance Cos.' Wausau Insurance Cos. affiliate reported 110 property claims stemming from the earthquake and was adjusting an additional 12 for Nationwide. By last Friday, Wausau had established a reserve in excess of \$4 million for the earthquake claims.

In addition, Nationwide had received about 175 personal lines claims by last Friday. The Columbus, Ohio-based insurer had no estimate of losses yet.

The Property Claim Services division of the American Insurance Services Group did not expect to have an estimate of industrywide insured property damage from the earthquake until later this week.

On the reinsurance end, Lloyd's of London could well be called upon to provide reinsurance for Woodland Hills, Calif.-based personal lines insurer 20th Century Insurance Co.

"I think there's a very good possibility of that, largely if you consider we've got over 20,000 claims," a 20th Century spokesman said. All but 3,100 automobile claims are residential property losses.

20th Century, which paid a \$13 million premium for its catastrophe reinsurance program, has a \$10 million retention, he said. It has co-reinsurance for 25% of all claims above its deductible, with Lloyd's underwriters obligated to pay a maximum of \$75 million.

Mark Hofmann, Adrian Ladbury, Michael Schachner, Douglas McLeod and Sara Marley contributed to this report.

Learning from history's lessons?

Medical cost slowdown temporary without reform: Official

By JERRY GEISEL

WASHINGTON—The current slowdown in health care cost increases will be only a temporary lull unless Congress passes comprehensive health care reform legislation, a Clinton administration official says.

The easing of medical inflation follows a pattern that has developed twice before, says Kenneth Thorpe, deputy assistant secretary for health policy at the Department of Health and Human Services.

Health care cost increases eased during the early 1970s, when Congress imposed wage and price controls and when legislators considered a Nixon administration health care reform proposal.

But as soon as price controls were lifted and the prospects of health care reform darkened due to the Watergate scandal, health care costs shot up, Mr. Thorpe said.

Then, in the late 1970s, when the Carter administration proposed price controls on hospitals, health care cost increases once again slowed. But costs leaped after it became clear the Carter proposal would not win congressional approval, he noted.

Speaking last week before a conference in Washington jointly sponsored by the Assn. of Private Pension & Welfare Plans and the Na-

tional Assn. of Manufacturers, Mr. Thorpe said that without comprehensive reform, health care costs will begin to increase.

"We will be back to the same problem," he said.

The medical care component of the Consumer Price Index rose 5.4% in 1993, the smallest increase since 1973. Many employers say their health plan costs rose by between 7% and 9%. Only a few years ago 15% to 20% annual increases were the norm.

Looking at historical trends, the lid on health plan cost increases will be lifted if comprehensive reforms are not enacted, Mr. Thorpe said.

Making a pitch for the administration's proposal, he said enactment of the program will lower employers' health care costs.

For example, total business spending on health care premiums is expected to rise to just more than \$300 billion in the year 2000, up from approximately \$180 billion this year, Mr. Thorpe said. But if the Clinton plan is passed, employers' spending would amount to approximately \$275 billion in 2000, he said.

But a study released in December by research firm Lewin VHI Inc. of Fairfax, Va., projected that enactment of the administration proposal would boost costs by at least \$100 per employee for more than 40% of

employers now offering health care programs (BI, Dec. 13, 1993).

Another speaker at the conference was skeptical about the administration's proposal holding down employer costs.

Under that proposal, employer premiums paid to state health care alliances would be capped at 7.9% of payroll.

But those caps, warned David Kendall, an aide to Rep. Michael Andrews, D-Texas, are subject to "congressional tinkering."

At the first hint of "queuing" for services, those caps and other cost control provisions likely would be lifted, Mr. Kendall said.

He made his own pitch for a managed competition bill that was introduced by Rep. Jim Cooper, D-Tenn., and is being co-sponsored by Rep. Andrews and other legislators.

In particular, Mr. Kendall stressed the importance of a provision in the Cooper bill that would limit employer tax deductions for health care coverage to the lowest-cost plan offered in specific regions.

Because employers now can completely deduct the cost of health care as a business expense, they do not have a strong economic incentive to offer cost-efficient programs.

The unlimited tax break "artificially inflates" the demand for services, he said. **BI**

For the Record

HIAA to continue ads critical of reform

WASHINGTON—The Health Insurance Assn. of America is resuming a controversial advertising campaign criticizing various aspects of the Clinton administration's health care reform proposal.

The latest campaign, which will cost about \$3.4 million, will include television and radio ads that will air in 14 states. The television ads began running Jan. 13 and will continue through Feb. 20. The radio ads began to air last month and will run through Feb. 18.

An earlier HIAA advertising campaign drew the ire of Hillary Rodham Clinton, who charged the ads were false and misleading. HIAA officials have defended the ads as accurate, adding that they may have helped influence the administration to change certain aspects of its proposal, including giving consumers greater choice of health care plans.

The latest ads in the so-called "Harry and Louise" series raise questions about the administration proposal to create giant state-run or state-affiliated health care purchasing alliances through which all employers—except the largest firms—would be required to buy coverage.

Florio signs fraud law in final days of tenure

TRENTON, N.J.—Before leaving office, New Jersey Gov. Jim Florio signed a pair of bills aimed at reducing health insurance fraud.

S. 1008 requires every health insurer in New Jersey to file plans for the prevention of health care fraud with the insurance commissioner's office. Failure to file a plan within 120 days after the law is adopted may carry a fine of up to \$5,000 per day.

S. 1732 makes it a crime to com-

mit fraud through the misuse of a patient's health care benefits. Fraud of this type exceeding \$75,000 would be punishable by a prison term of five to 10 years and a fine of up to \$100,000. If the fraud involves less than \$75,000, the prison term could be three to five years and the fine up to \$7,500.

Gov. Florio was defeated in November by Republican Christine Whitman, who took office Jan. 18.

Health insurers say reform won't hurt them

PHILADELPHIA—Although many health care market observers agree the health insurance industry may feel the impact of national health care reform more than any other sector, most health insurers are confident of their future, a recent survey says.

In a survey of 65 major health insurers, 47% of responding companies said if President Clinton's health care reform bill were to pass immediately, they would be prepared or that it would take less than a year to shift their business strategies to meet national health reform requirements.

Another 38% said they would have a business strategy to deal with national health care reform ramifications in place within one or two years, according to the survey conducted by Hay/Huggins, the benefit consulting division of the Hay Group of Philadelphia.

One business strategy—contemplated by 77% of insurers—is offering supplemental products not in the basic benefit package proposed by President Clinton. Fifty-two percent said they would offer services like administration and rate setting to health alliances and approved health plans, while 47% said they would offer health insurance to AHPs.

Insurers say their underwriting departments face the greatest jeopardy under health reform, the

survey found. Fifty-three percent acknowledge underwriters will be less important, and 30% say those departments may be eliminated entirely.

For more information about Hay/Huggins' Insurance Co. Survey on National Health Care Reform, call Doran Tower at 215-875-2337.

Information in brief

Indianapolis-based **Acordia Inc.** has bought the remaining 50% stake of McDonough Caperton Benefit Services Inc. that it did not already own from Greensboro, N.C.-based Jefferson-Pilot Life Insurance Co. McDonough Caperton Benefit Services owns and operates a managed health care network in West Virginia and is a third-party administrator. Terms of the deal were not disclosed. **ITT/Hartford Group Inc.** is purchasing Voluntary Plan Administrators Inc., a Calabasas, Calif.-based third-party administrator, for about \$7 million. Hartford says it plans to use VPA's experience as a specialist in the administration of self-insured disability plans to market fully integrated short- and long-term disability plans. **The California Workers Compensation Appeals Board** has ordered the owner of three unlicensed clinics in Southern California to reimburse State Compensation Insurance Fund \$347,957 in medical payments. The WCAB judgment involved about 100 claims for medical services which were filed by Unified Health Services, Valley Health Care and Valley Imaging. **Chrysler Corp.** will soon distribute profit-sharing checks averaging \$4,300 to 65,000 hourly and salary workers represented by the United Auto Workers. That amount, the largest ever paid by any U.S. auto company, will be distributed Feb. 11, the company said. Last year's profit sharing payments averaged \$421. **BI**

Updates

8 arrested in fraud probe

LOS ANGELES—California insurance regulators say they cracked a major workers compensation fraud ring last week with the arrest of eight people who are believed to have submitted hundreds of millions of dollars of phony claims.

The arrests of a lawyer, his employees, three doctors and the manager of a recruiting operation capped a state investigation begun in 1992 after complaints of unsolicited phone calls from a group that claimed to be the state government.

The California Employee Protection Agency offered to help unemployed workers file workers comp and state disability insurance claims. The agency then referred claimants to the law offices of Robert M. Ball, CEPA's owner.

Arrested last Thursday were: Mr. Ball and three employees; Reginald P. Mason, president of Drexel, Melton & Lynch, a patient-referral collection agency; Drs. Arthur L. Carlisle and Charles Murrel Valyan, chiropractors; and Dr. George P. Rowell, a psychologist.

Sexual harassment ruling

NEW YORK—The 2nd U.S. Circuit Court of Appeals last week made it easier for plaintiffs to bring sexual harassment suits against employers when it ruled that cases can go to trial without employees having to prove the alleged harassment caused economic loss.

The court also ruled that employers can be held liable for acts of sexual harassment even if they attempted to remedy those situations.

In reinstating a case dismissed last year on summary judgment by a district court judge, the appellate court ruled that an employer is liable for creating an abusive working environment when a supervisor uses "actual or apparent" authority to force a subordinate employee into having sex. But if the alleged harasser is an equal employee or a lower-level employee, employers are only liable if they knew about the harassment and did nothing.

The case at hand involves Sharon Karibian, a former employee of Columbia University, who alleged that between 1988 and 1990 a supervisor harassed her in the school's fund-raising office.

At the district court level, Columbia successfully argued the case should be dismissed because it discovered the harassment and fired the supervisor before the plaintiff in the case was laid off.

No right to sue liability insurer

NEW ORLEANS—Victims of an accident on the high seas cannot sue a vessel owner's liability insurer directly, a court has ruled.

Eagle Transport Ltd., owner of a ship that sank in international waters in 1984, was hit with a \$22 million jury award in a suit brought by surviving crew members and families of deceased crew members. When Eagle failed to pay, the plaintiffs said they would sue Eagle's protection and indemnity insurer, United Kingdom Mutual Steamship Assurance Assn., to recover.

The P&I club had separately won an arbitration judgment that it was not liable to Eagle for the award. In addition, it had won a declaratory judgment in federal court in Tyler, Texas, that it cannot be sued directly by the plaintiffs.

A panel of the 5th U.S. Circuit Court of Appeals affirmed that ruling Jan. 14. The appeals panel found that English law would require payment by Eagle before the P&I Club could be sued directly. And, the panel found, Texas law requires "a direct and close relationship" between the insurer and the party bringing suit. No such relationship exists in this case, the panel concluded.

Eagle Star policy valid

LONDON—Eagle Star Insurance Co. Ltd. must continue to honor its runoff reinsurance contract with defunct syndicate 640, the British Court of Appeal ruled last week, upholding a lower court decision.

The ruling could cost Eagle Star an additional 40 million pounds (\$60.3 million), said Paul Toomey, underwriter for the former syndicate. Eagle Star already paid the syndicate \$29 million during the 18 years the reinsurer honored the contract before it halted payments in June 1991 (BI, Dec. 14, 1992; Nov. 16, 1992).

An Eagle Star spokesman said the insurer will consider petitioning the House of Lords to overturn the recent decision. "We're fully reserved for the outcome," he added.

Briefly noted

Aetna Casualty & Surety Co. is taking a \$1.03 billion aftertax charge to 1993 operating earnings associated with its decision to stop writing GICs and certain single-premium annuities and to lay off 4,000 of its 43,000 employees. Aetna is also adding \$574 million to workers compensation reserves, which will result in an aftertax charge to operating earnings of \$259 million. **A group of shareholders of Concord, Calif.-based TakeCare Inc.** have filed suit to block the HMO's acquisition by **FHP International Corp.**, an HMO in Fountain Valley, Calif. (BI, Jan. 17). The shareholder group, which has a 22% stake in TakeCare, alleges that a majority of TakeCare's directors violated fiduciary obligations in agreeing to the buyout. **Arkwright International Ltd.**, a unit of Arkwright Mutual Insurance Co., has opened a new office in suburban London that will serve as its base for European expansion. **A secondary offering of 8 million common shares of ACE Ltd.** was priced last week at \$28.25 per share. The shares are being sold by existing ACE shareholders; 6.4 million of the shares are being sold in the United States, Canada and Bermuda and the remaining 1.6 million in other markets. **Union des Assurances de Paris** will cover insured losses stemming from a collapsed supermarket roof in Nice, France, last week, which killed four and injured more than 95 people. **House Education and Labor Committee Chairman William Ford, D-Mich.,** does not plan to seek a 16th term.

Negotiation

Continued from page 1

Health Insurance Assn. of America—whose ads criticizing the Clinton plan were lambasted by Hillary Rodham Clinton as inaccurate and misleading—met last week with several senior White House officials to try to find common ground on health care reform.

"Who would have thought this would happen," said an HIAA spokesman, referring to the 90-minute White House meeting, which House Ways and Means Committee Chairman Daniel Rostenkowski, D-Ill., helped to arrange.

This apparent willingness to compromise on health care reform signals a recognition by the administration that its massive proposal has no chance of passage without major changes, Washington observers say.

President Clinton "is bowing to political reality. A mega-bill is not acceptable to many people," according to Frank McArdle, a consultant with Hewitt Associates in Washington.

"Administration officials are realists. They understand that public opinion" was running against their proposal, said Dirk Van Dongen, president of the National Assn. of Wholesaler-Distributors, a small-employer trade group in Washington.

Of all the provisions in the Clinton health package, the provisions on regional and corporate alliances have drawn the most heat from the employer community.

Employers say the 5,000-employee threshold for opting out of regional alliance would be too high.

Those employers say medium-sized firms also should be allowed to opt out of the alliances, which many expect would be bureaucratic monsters.

Others say that regional alliances would be so large that corporate alliances set up by employers would have relatively little buying clout with providers.

Benefit experts welcome the sign from officials that the administration appears willing to set a new, lower threshold for employers to opt out of regional alliances.

"To my knowledge, this is the first time that the administration has indicated flexibility on the subject of alliances. It is a very welcome development for employers," said Thomas C. Billet, a principal in A. Foster Higgins & Co. Inc.'s Stamford, Conn., office.

Many companies have already shown that they can contain costs on their own and want to retain the ability to provide good service to

their employees, Mr. Billet added.

"We're delighted and encouraged to learn that (the administration is) flexible in negotiating the limit on the alliance threshold because that number is key to everything else that follows," said Anne Marie O'Keefe, director of public policy for the Washington Business Group on Health.

Some members of Congress also welcomed the willingness to compromise on the number of workers a company must have to opt out of the alliances.

"Alliances are one of the areas where there is a fair amount of room for movement," said Rep. John Dingell, D-Mich., chairman of the House Energy and Commerce Committee.

"Let's put it this way: I don't believe in alliances like I do in the Holy Trinity," Mr. Dingell said.

'Let's put it this way: I don't believe in alliances like I do in the Holy Trinity,' Rep. John Dingell says about the possibility for compromise.

While Mr. Bentsen did not specify the exact number of employees an employer could have and opt out of regional alliances, the Treasury secretary said he was troubled by suggestions that the threshold should be as low as 100 employees.

But some business lobbyists support a threshold as small as 50 employees to keep more health care buying power under the control of the private sector.

"I would argue for a (threshold) of 50 employees," said Sean Sullivan, president of the National Business Coalition on Health in Washington.

A threshold of 100 employees would split the number of people covered by corporate and regional alliances about evenly, Mr. Sullivan said.

"The need is to keep the majority of the purchasing power in the hands of private employers," he said.

Some benefit managers, though, say the administration should clarify its proposal to make clear that individual employers—acting on their own—should be able to band together to form purchasing alliances.

Fred Hamacher, vp of compensation and

employee benefits at Dayton-Hudson Corp. in Minneapolis, says the administration should allow employers with as few as 500 employees each to band together to form their own purchasing alliances rather than relying on government-run alliances.

"Government organizations don't understand cost containment. They understand access and taxing to fund access, but quality and cost containment are out of their league," Mr. Hamacher said.

Regional alliances should be a "last redoubt" for people without health care coverage, said Mark Ugoretz, president of the ERISA Industry Committee, a Washington-based benefits lobbying organization representing large employers.

But some benefit managers say too much attention is being paid to thresholds for opting out of regional alliances while other reform issues may be getting short-shrift.

"Alliances should be the final phase. The first phase should be reforming buying practices" and instituting certificate of need programs to contain the proliferation of unnecessary medical resources, said Bob Bonin, manager of benefits administration at First Chicago Corp. in Chicago.

"They need to deal with the fundamentals of the health care system first, then create health alliances," Mr. Bonin added.

The president's threat to veto any health care reform proposal that does not guarantee universal coverage surprised some benefit experts.

"It seems a bit soon to say what your bottom line is. It is very early in the political process to brandish such a threat," a business lobbyist said.

Other observers note, though, there is plenty of wiggle room in President Clinton's veto threat.

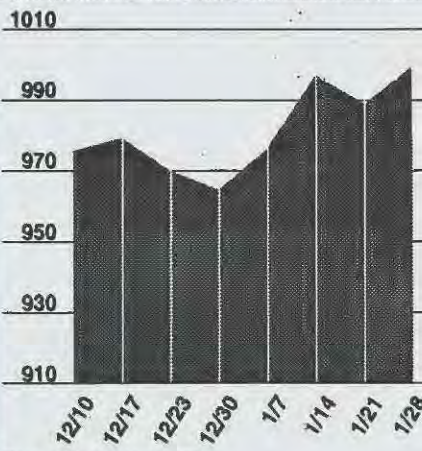
For example, President Clinton didn't say he would veto a bill that would extend the timetable for universal coverage well beyond the administration's proposed 1998 deadline, noted Hewitt's Mr. McArdle.

A veto threat might mean "that anything that promises universal coverage by a certain date would be acceptable," agreed Mr. Sullivan of the National Business Coalition on Health.

Indeed, rumors were flying last week in Washington that the administration could live with a timetable of 2000 or 2002 to achieve universal coverage.

Christine Woolsey contributed to this report.

BI Insurance Index



Base = 100 on Dec. 29, 1978

Source: Nordby International Inc.

Insurance stocks rose last week, as the Business Insurance Index gained 9.2 points to 999.1 Jan. 28 from 989.9 on Jan. 21. Advancing issues for the week were led by: American Indemnity/Financial, up 9.8%; Chandler Insurance, up 8.9%; and Seibels Bruce Group, up 7.7%. Declining issues followed: Lawrence Insurance Group, down 9.7%; RLI Insurance Holdings, down 8.9%; and HCC Insurance Holdings, down 6.6%. The most active issue was U.S. Healthcare, 4.1 million shares traded. The BI Index rose 0.9%; the Dow Jones 30 Industrials rose 0.8%; the NYSE Composite rose 0.9%; and the S&P 500 rose 0.8%.

British Issues

Jan. 27 Companies	Price	P/E	Div. %	1 week	
				High-Low	Value
Comm Union	674	N/M	29.8	4.4	709-674
Genl Accident	724	N/M	33.8	4.7	738-724
Gdn Royal Exch	232	N/M	9.0	3.9	239-232
Royal	330	N/M	8.0	2.4	341-327
Sun Alliance	402	N/M	17.8	4.4	406-400
Brokers					
Bradstock	158	17.7	6.9	4.4	158-155
CE Heath	430	20.7	20.0	4.7	435-430
Hogg Group	130	21.7	7.1	5.5	167-130
JIB Group	180	17.7	9.5	5.3	195-180
Lloyd Thompson	305	20.5	8.4	2.8	308-305
Lowndes Lmbt	465	16.8	16.8	3.6	465-459
PWS Holdings	82	12.0	5.0	6.1	82-81
Sedgwick Grp	195	23.4	7.5	3.8	200-195
Steel Bri Jones	125	N/M	15.0	12.0	126-125
Willia Corroon	232	21.7	8.3	3.6	237-229

Source: Philip Olsen, London

Estimated

BI Industry Stock Report

JAN. 24, 1994 THROUGH JAN. 28, 1994

BROKERS													INSURERS/REINSURERS													HEALTH MAINTENANCE ORGANIZATIONS																	
		Price	Weekly % change	Year to date % change	Annual High	Annual Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt./Bk. value			Price	Weekly % change	Year to date % change	Annual High	Annual Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt./Bk. value			Price	Weekly % change	Year to date % change	Annual High	Annual Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt./Bk. value					
Accordia Inc.	NYS	24.25	-1.52	-1.52	27.63	18.38	24	0.44	1.81	14	10.22	2.37	Mutual Risk Mgmt. Ltd.	NYS	26.75	-5.31	-10.83	32.75	21.16	65	0.28	1.05	19	5.71	4.66																		
Alexander & Alexander	NYS	21.00	0.00	5.66	28.88	17.63	726	1.00	4.76	38	6.73	3.12	NAC Re Corp.	OTC	31.25	4.60	7.30	44.75	27.50	1085	0.16	0.51	17	19.24	1.62																		
E.W. Blanch Holdings Inc.	NYS	18.75	1.35	7.91	23.50	16.50	11	0.32	1.71	18	4.10	4.57	National Re Corp.	NYS	29.50	3.51	-3.67	39.63	27.50	77	0.12	0.41	9	16.89	1.75																		
Gallagher Arthur J. & Co.	NYS	30.63	-1.21	-14.34	37.38	25.50	324	0.72	2.35	15	7.52	4.07	Navigator Group	OTC	29.50	-6.35	-15.71	39.00	28.50	20	0.00	0.00	16	16.99	1.74																		
Hibb, Rogal & Hamilton	NYS	12.25	-2.00	-6.67	16.88	11.38	33	0.48	3.92	19	4.51	2.72	Nobel Insurance LTD.	OTC	8.00	-0.78	4.92	8.44	6.25	25	0.00	0.00	3	6.64	1.17																		
Marsh & McLennan	NYS	81.75	0.77	0.46	97.63	77.00	736	2.68	3.28	18	16.76	4.88	NWNL Companies	NYS	31.88	-3.41	-1.92	38.75	26.50	390	0.80	2.51	13	23.6*	1.33																		
Poe & Brown	OTC	18.75	0.00	4.17	21.25	16.25	31	0.40	2.13	32	3.02	6.21	Ohio Casualty Corp.	OTC	63.50	-1.17	-0.78	72.00	57.63	282	2.84	4.47	11	47.63	1.33																		
BROKERS AVERAGE			-0.4	-0.6					2.9	22			Old Republic Int'l	NYS	22.13	-2.75	-1.67	27.63	21.50	766	0.44	1.99	8	23.5*	0.94																		
													Orion Capital Corp.	NYS	32.75	1.16	6.07	37.50	28.63	97	0.72	2.20	9	25.54	1.28																		
													Phoenix RE Corp.	OTC	25.75	-0.96	-6.36	38.25	20.25	215	0.28	1.09		9.89*	1.29																		
ACE Ltd.	NYS	28.50	-0.87	-6.56	36.00	25.50	3679	0.40	1.40	5	28.74	0.99	Provident Life	NYS	31.50	5.00	-0.40	31.88	25.63	90	1.04	3.30	-11	26.38	1.19																		
Acceptance Insurance Cos.	NYS	13.63	2.83	17.20	15.63	9.75	52	0.00	0.00	15	9.65	1.41	Re Capital Corp.	OTC	14.38	0.88	5.50	16.25	13.25	50	0.28	1.95	15	16.85	0.85																		
AEGON N.V.	NYS	55.00	0.46	0.46	58.50	43.25	24	1.22	2.22	11	34.71	1.58	Reliance Group Holdings	NYS	7.50	1.69	-3.23	10.38	5.63	639	0.32	4.27	3	4.2*	1.78																		
Aetna Life & Casualty	NYS	59.88	2.13	-0.62	66.25	43.38	1668	2.76	4.61	21	71.84	0.83	RLI Corp.	NYS	24.38	-8.88	-8.88	28.63	24.13	38	0.56	2.30	11	22.9*	1.06																		
Allied Group Inc.	OTC	25.75	0.98	3.00	32.75	21.00	395	0.52	2.02	7	10.45	2.46	St. Paul Companies	NYS	88.38	-0.42	-1.53	98.00	75.00	423	2.80	3.17	9	57.84	1.53																		
Allmerica Prop. & Casualty	NYS	20.25	-1.82	-6.00	22.16	17.16	281	0.16	0.79	5	56.97	0.36	SAFECO Corp.	OTC	59.13	6.05	8.24	66.75	51.88	2838	1.80	3.04	10	41.52	1.42																		
Allstate Corp.	NYS	28.50	-1.30	-4.20	34.25	27.13	1488	0.72	2.53	14	18.43	1.55	SCOR U.S. Corp.	NYS	11.75	-4.08	-6.93	20.75	11.75	68	0.32	2.72	18	16.05	0.73																		
American General	NYS	28.50	-3.39	0.00	36.50	26.25	1716	1.08	3.79	11	22.09	1.29	Seibels Bruce Group	OTC	1.75	7.69	0.00	2.13	0.31	279	0.00	0.00	-1	1.92	0.92																		
American Heritage Life Ins.	NYS	19.00	-3.18	2.01	25.34	17.25	19	0.60	3.16	12	12.42	1.53	Selective Ins. Group	OTC	27.75	-4.72	-8.26	31.00	20.50	109	1.12	4.04	19	23.11	1.20																		
American Indemnity/Finl	OTC	14.00	9.80	7.69	16.25	7.75	27	0.12	0.86	5	16.18	0.37	Sphere Drake Holdings	NYS	17.50	-2.78	6.06	21.63	15.50	29	0.12	0.69	18	N/A	N/A																		
American International	NYS	91.63	2.09	3.97	100.25	73.41	3512	0.40	0.44	16	45.25	2.02	Statesman Group Inc.	NYS	13.25	-4.50	6.00	15.72	9.75	577	0.10	0.75	6	3.66	1.53																		
American Re Corp.	NYS	30.63	2.94	8.41	41.75	25.75	112	0.00	0.00	26	14.80	2.07	TIG Holdings	NYS	21.88	-1.13	-3.31	28.00	20.25	474	0.20	0.91	-9	13.45	1.18																		
Aon Corp.	NYS	48.00	1.05	-0.52	58.50	46.00	318	1.80	3.75	15	33.10	1.45	Tokio Marine & Fire	OTC	58.63	5.87	8.56	67.00	46.88	30	0.37	0.83	38	57.72	1.02																		
Argonaut Group	OTC	30.50	-0.41	0.00	35.50	28.75	148	1.00	3.28	9	27.65	1.10	Torchmark Corp.	NYS	47.25	2.72	5.59	64.75	41.13	763	1.12	2.37	14	17.35	2.72																		
AVEMCO Corp.	NYS	18.25	-2.67	-2.67	25.50	16.75	8	0.44	2.41	15	8.13	2.24	Transatlantic Holdings	NYS	53.38	0.23	0.00	61.50	49.00	133	0.36	0.67	14	29.60	1.80																		
Baldwin & Lyons Inc.	OTC	15.13	4.31	1.68	16.25	11.16	91	0.20	1.32	11	12.59	1.20	Travelers Corp.	NYS	31.13	0.00	2.05	38.88	23.75	0	1.60	5.14	-8	33.35	0.93																		
Berkley W.R. Corp.	OTC	35.00	2.94	6.87	50.50	32.00	1101	0.40	1.14	13	28.12	1.24	Trenwick Group Inc.	OTC	36.50	-1.68	-5.81	49.75	35.00	154	0.88	2.41	11	26.00	1.40																		
Berkshire Hathaway Inc.	NYS	16050.00	-1.53	-1.68	17800.00	11800.00	1	0.00	0.00	42	8115.28	1.98	United Fire & Casualty	OTC	36.00	0.00	0.00	42.00	34.75	1	1.08	3.00	-	28.96	1.24																		
Chandler Insurance	OTC	6.13	8.89	11.36	6.25	3.50	57	0.00	0.00	15	8.87	0.69	Unilin	OTC	42.63	0.29	0.29	46.75	39.00	355	1.40	3.28	23	38.90	1.10																		
Chubb Corp.	NYS	81.88	0.61	4.13	96.38	75.13	1348	1.72	2.10	19	46.59	1.76	UNUM Corp.	NYS	50.00	-0.50	-4.76	60.13	47.75	1119	0.80	1.60	13	27.55	1.81																		
CIGNA Corp.	NYS	68.25	-0.73	7.91	69.38	56.50	1410	3.04	4.45	11	78.23	0.67	US Facilities Corp.	OTC	11.25	4.65	-5.26	14.00	6.50	141	0.00	0.00	10	10.46	1.07																		
CNA Financial Corp.	NYS	79.13	1.12	0.48	101.00	74.25	102	0.00	0.00	-15	77.92	1.02	USF&G Corp.	NYS	14.13	0.00	-6.61	19.63	12.38	1194	0.20	1.42	-	10.63	1.33																		
Continental Corp.	NYS	28.13	1.81	1.81	34.63	24.38	659	1.00	3.56	12	38.99	0.72	USLICO Corp.	NYS	16.63	0.00	0.76	19.00	15.50	43	0.24	1.44	-6	25.22	0.66																		
EXEL Ltd.	NYS	43.38	2.06	-3.61	52.25	42.25	754	1.20	2.77	6	33.81	1.28	USLIFE Corp.	NYS	39.63	3.59	2.26	45.75	35.75	254	1.24	3.13	11	41.73	0.95																		
Fremont General Corp.	NYS	23.25	-2.62	-3.63	28.75	21.00	167	0.72	3.10	8	23.40	0.99	Washington National	NYS	25.13	5.79	3.61	28.00	21.75	120	1.08	4.30	11	26.40	0.88																		
Frontier Insurance Group	NYS	42.38	-0.29	-3.42	50.00	36.72	83	0.60	1.42	14	16.33	2.59	Zenith National Ins.	NYS	22.50	-2.70	1.69	29.25	21.25	144	1.00	4.44	11	17.71	1.27																		
Gainco Inc.	ASE	10.00	2.56	11.11	17.47	8.25	83	0.04	0.40	13	3.49	2.87	Zurich Reinsurance Centr.	NYS	26.63	-0.47	-5.75	36.38	26.25	353	0.00	0.00		24.41	1.09																		
General RE Corp.	NYS	113.25	4.74	6.59	133.38	102.50	1301	1.88	1.66	15	55.54	2.04	INSURERS/REINSURERS AVERAGE																														
Guaranty National Corp.	NYS	17.63	-2.08	0.71	24.75	16.75	92	0.48	2.72	10	11.81	1.49																															
Harleysville Group	OTC	27.50	0.00	-3.51	32.75	22.63	14	0.64	2.33	14	18.35	1.50	HEALTH MAINTENANCE ORGANIZATIONS																														
Hartford Steam Boiler	NYS	51.25	5.94	15.17	59.88	42.63	191	2.12	4.14	81	15.80	3.24	FHP International	OTC	27.00	0.93	3.85	30.00	18.25	1926	0.00	0.00	18	11.43	2.36																		
HCC Insurance Holdings	OTC	28.50	-6.56	-5.79	35.75	16.50	104	0.00	0.00	20	14.94	1.91	Pacificare Health Sys.	OTC	45.25	3.43	19.87	57.50	25.50	375	0.00	0.00	20	11.15	4.26																		
Home Holdings Inc.	NYS	17.00	-2.16	-1																																							



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