JUNE 22, 1992

Business Insurance®

Reporting weekly for corporate risk, employee benefit and financial executives / $2.00 a copy; $80 a year

Update

Reliance rebuts M&M letter concerning insurer's '91 results

NEW YORK—Reliance Insurance Co. is downplaying a letter Marsh & McLennan Cos. Inc. sent to Reliance policyholders detailing its concerns about Reliance's 1991 results.

Several rating agencies apparently agree with Reliance, indicating they have no plans to change their current ratings.

In a letter dated May 28, Jack Foley, head of M&M's market information committee, expressed concerns over Philadelphia-based Reliance's liquidity, the payment of

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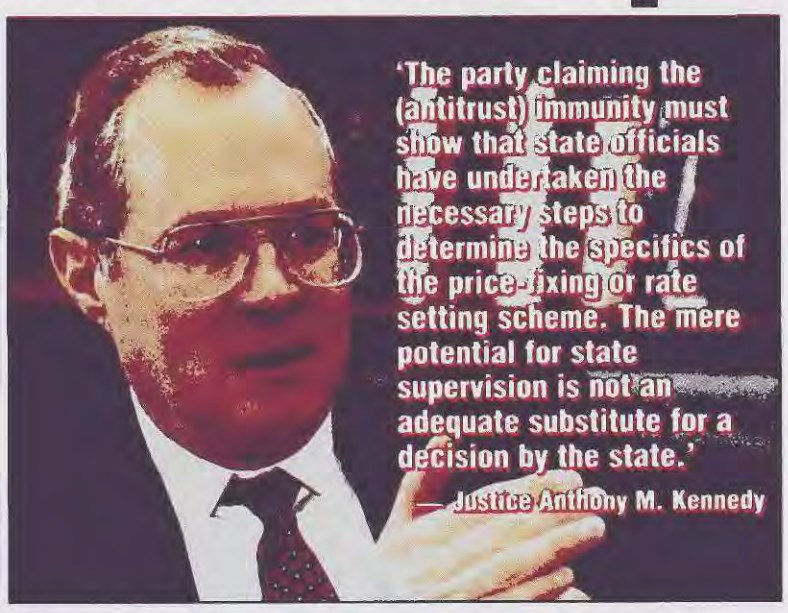
Antitrust protection under fire



Ruling could affect pending industry litigation

By STACY GORDON and JUDY GREENWALD

WASHINGTON—The U.S. Supreme Court is chipping away at insurers' protection from federal antitrust law as it considers whether to rule on the massive antitrust case pending against insurance industry defendants.

The high court ruled 6-3 on June 12 to restrict the ability of insurers to rely on a legal doctrine that provides businesses immunity from antitrust law for anti-competitive restraints of trade that are "actively supervised" by states.

The court—in a ruling by Justice Anthony M. Kennedy—found that Montana's and Wisconsin's insurance regulators had not done enough to "actively supervise" the amounts charged by title insurers for title searches and examinations.

As a result, Los Angeles-based Ticor Title Insurance Co. of California and other title insurers cannot rely on the so-called state action doctrine to protect them from antitrust laws in connection with litigation filed by the Federal Trade Commission.

The Ticor decision has attracted nationwide attention because the state action doctrine was cited by the federal judge who dismissed the massive antitrust litigation filed against 32 insurance industry defendants by 20 state attorneys general. The defendants include major U.S. insurers and reinsurers, the Insurance Services Office Inc. and the Reinsurance Assn. of America, several London underwriters and others.

The attorneys general allege that the defendants engaged in a boycott to manipulate the U.S. liability insurance market during the mid-1980s that forced ISO to rewrite its general liability policy to exclude coverage for pollution incidents and include a retroactive date in the claims-made version of the form.

But the insurance industry de-

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Reinsurer proposal outlined

M&M, J.P. Morgan shop for investors to fund property catastrophe facility

By DOUGLAS McLEOD

HAMILTON, Bermuda—Marsh & McLennan Cos. Inc. and J.P. Morgan & Co. Inc. are mounting an effort to raise at least $300 million in capital for a proposed new property catastrophe reinsurer based in Bermuda.

Mid Ocean Reinsurance Co. Ltd. would provide excess-of-loss catastrophe limits of up to $30 million per occurrence per reinsured, subject to an overall $250 million per occurrence limit in geographical zones to be defined by the company, according to a draft copy of a Mid Ocean offering memorandum that *Business Insurance* has obtained.

While specializing in catastrophe reinsurance, Mid Ocean also may write catastrophe retrocessional coverages, quota-share reinsurance of Lloyd's of London syndicates and other property/casualty business that appears attractive, the draft memorandum says.

It is unclear how widely M&M and Morgan have circulated the memorandum among potential investors or whether any have agreed to make the minimum $10 million investment called for in the draft.

An M&M spokeswoman said the memorandum is "preliminary" and "confidential" but declined further comment.

The draft memorandum, dated June 9, notes that heavy catastrophe losses in recent years have boosted the demand for catastrophe reinsurance at the same time that capacity has contracted.

"Current market conditions provide pricing levels which should result in an attractive return to investors, due in part to the small number of adequately capitalized competitors in the company's lines of business and due also to the company's efficient structure," according to the memo.

Mid Ocean would be incorporated and licensed in Bermuda but would not be licensed or operate directly anywhere in the United States.

This would free the reinsurer

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Policyholder awarded cover despite failure to disclose HIV

By MICHAEL BRADFORD

DALLAS—The wording of a health insurance policy application is tripping up an insurer seeking to revoke the coverage it wrote for a Dallas man who failed to disclose that he is infected with the virus that causes AIDS.

A federal judge in Dallas has upheld a March jury verdict that David T. Smith did not intend to deceive Golden Rule Insurance Co. when he did not indicate on an application for $1 million of health insurance that he had tested positive for the human immunodeficiency virus.

Mr. Smith argued that he did not disclose his medical condition because questions in the application pertaining to blood diseases were vague and did not explicitly ask whether he had tested positive for HIV, which causes acquired immune deficiency syndrome.

The insurer, which had asked the judge to overturn a jury verdict, is now appealing the ruling to the 5th U.S. Circuit Court of Appeals in New Orleans.

While the language of a policy application is more of a concern for individual health and life insurance underwriters, it could be a concern for employers and group health insurers if an employee fails to enroll in a health plan immediately after he or she is hired, noted a spokesman for the Health Insurance Association of America.

New hires generally have an allotted time during which to join a group health plan. But, if

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Democrats plan House vote on health reform

By JERRY GEISEL

WASHINGTON—House Democrats intend to push a sweeping new comprehensive health care reform bill along a fast track in an effort to force the first-ever House vote on such legislation by next month.

House Ways and Means Health Subcommittee Chairman Pete Stark, D-Calif., plans to introduce legislation this week that would give the federal government authority to set the maximum rates that hospitals and physicians could charge.

The legislation also would expand health care access for the nation's 36 million uninsured by significantly expanding both the Medicaid and Medicare programs.

The subcommittee plans to vote on the Stark bill next week, and the full Ways and Means Committee is set to begin action in early July, congressional committee staffers say. That would set the stage for a House floor vote later in July.

During the debate on the House floor, votes would be allowed on at least three alternatives to the Stark bill. Those alternatives include a single-payer health care system as well as an approach now being developed by several conservative House Democrats that would encourage employers to use managed care programs and establish health care purchasing cooperatives for small employers.

House Republicans also would be allowed to propose an alternative or substitute bill.

However, House Democrats do not intend to permit an amendment that would establish a "play-or-pay" approach to health care. That approach would require employers to either offer a health care plan or pay a new federal payroll tax.

House support for the play-or-pay concept has dwindled, according to congressional staffers.

These developments come after nearly two years, dozens of congressional hearings and thousands of hours of discussions on the myriad health care reform proposals that have been introduced during the 102nd Congress.

"This is the first serious step in the House to produce a bill that can pass," said Frank McArdle, a consultant with Hewitt

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Update

Reliance rejects M&M concerns

Continued from previous page
dividends to Reliance's parent, increased underwriting losses, and investments in subsidiaries and affiliates, among other things.

The letter focused on the $400.1 million in preferred and common stock Reliance holds in broker Frank B. Hall & Co. Inc., which currently is for sale (*BI*, March 30). These holdings represent 47.6% of Reliance's policyholder surplus, according to a chart that accompanied the letter, which also says that Reliance's total holdings in affiliated companies represent 143.3% of surplus.

Another element of M&M's "growing concern" with Reliance is the fact that underwriting losses increased by 50% to $217 million last year from $145 million in 1990. And these loss figures were augmented by an increase in discounts on workers compensation loss reserves of $180.4 million, the letter stated.

Also cited in the letter was the fact that between 1987 and 1991, Reliance paid a total of $723.5 million in dividends to its parent, Reliance Group Holdings Inc. of New York.

A Reliance spokesman dismissed the letter, saying it came out of a "normal annual review (M&M) does with all underwriters." He said the issues brought up in the letter "have been dealt with."

"We remain on their list of approved carriers and we continue to do business with (M&M)," said the spokesman.

M&M officials refused to comment.

A.M. Best Co., which in May affirmed Reliance's A− rating, said the M&M letter contained nothing new. "Our rating takes into account the positive steps Reliance management is taking in 1992 to reduce its ties to non-core business, especially Frank B. Hall," said Jack Snyder, a Best analyst.

Standard & Poor's Corp., which in March lowered the company's rating to BBB+ from A−, said Reliance's financial condition was still "adequate."

Mutual Benefit impropriety seen

NEW YORK—Mutual Benefit Life Insurance Co. paid more than $30 million in illegal subsidies to many of its agents, an audit by the New York Insurance Department says.

The bulk of the improper payments—more than $27.6 million—went to Mayer & Meyer Associates Inc. of New York, one of Mutual Benefit's largest producers, regulators said.

Among other things, Mutual Benefit improperly paid the salaries of agency personnel and the rent on agency offices, the department charges.

Because Newark, N.J.-based Mutual Benefit is in rehabilitation, the department said it will forego the $300,000 fine.

New York regulators say they are investigating whether Mayer & Meyer violated insurance law by accepting the Mutual Benefit payments. New Jersey regulators already have filed suit charging the agency received similar payments.

Mayer & Meyer officials could not be reached.

State safety laws pre-empted

WASHINGTON—States cannot enforce public safety laws that conflict with federal workplace safety regulations, the U.S. Supreme Court ruled.

The court ruled 5-4 in a challenge to two Illinois laws that set workplace safety requirements for solid waste handlers. The 1988 laws, designed to ensure public and workplace safety, are stricter than Occupational Safety and Health Administration standards.

The high court ruled that the OSHA standards pre-empt the state laws. The state "asserts that if the state Legislature articulates a purpose other than (or in addition to) workplace health and safety, then the OSH Act loses its pre-emptive force. We disagree," wrote Justice Sandra Day O'Connor.

Allowing states to set their own requirements would create a "conflicting patchwork that would frustrate OSHA's comprehensive standards," said Eugene J. Wingerter, executive director and chief executive officer of the National Solid Wastes Management Assn., which brought the original lawsuit.

However, states still can implement tougher rules as part of state workplace safety programs authorized by OSHA, the court said.

Huge toxic waste suit settled

HOUSTON—In what is believed to be the largest-ever settlement of personal injury claims stemming from a toxic waste site, eight companies have agreed to pay $207.5 million to some 1,700 people living near the Brio Refining site in Houston.

The residents said they were hurt by chemicals that leaked from the reclaiming plant, which closed in 1982 after being used by more than a half-dozen chemical companies since the 1950s.

Crum & Forster Inc. agreed to fund a $128 million settlement by Farm & Home Savings of Nevada, Mo., which financed the development of a subdivision near the site. Farm & Home has already paid $32 million. Crum & Forster agreed to advance the money to the S&L until its insurers make a final determination.

Monsanto Corp. agreed to pay $39 million. The St. Louis-based company says it is insured for the amount and is litigating with its liability insurers in state court in Delaware.

A Texas judge earlier ordered Crum & Forster, one of Monsanto's

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Errors & omissions

• Los Angeles-based Managed Health Network Inc. was misidentified as Mental Health Network Inc. in a June 8 article on employee assistance programs.

Lloyd's will not bail out members facing losses

By GAVIN SOUTER

LONDON—Lloyd's of London is refusing to bail out the approximately 6,000 members facing huge underwriting losses at the troubled insurance market.

Lloyd's is, however, taking steps to minimize members' future losses.

Lloyd's expects to partially alleviate any future losses by easing the terms of a marketwide stop-loss scheme to be funded by members beginning with the 1993 underwriting year.

Lloyd's also will pass the hat to brokers and underwriting agencies, asking them to help lighten the burden on members with losses who apply to the Lloyd's hardship committee.

However, Lloyd's decision did not sit well with members.

Members' action groups—which are challenging the huge losses passed on to members from various syndicates—warned that a wave of litigation is now inevitable. And one member has collected 100 signatures on a petition calling for an extraordinary general meeting of members to condemn the move by Lloyd's.

In a letter to members late last week, Lloyd's Chairman David Coleridge said a working group of the Council of Lloyd's had considered several plans to assist members facing large losses.

"Unfortunately, although a number of possible schemes were identified, the group felt unable to recommend any scheme to the council," Mr. Coleridge said.

Of the three principal plans

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MEWA proponents say Bush proposal on track

By MARK A. HOFMANN

WASHINGTON—The Bush administration's proposal for regulating multiple employer welfare arrangements is winning praise from supporters of the controversial health care benefit plans.

But those supporters still prefer an earlier bill—H.R. 2773, sponsored by Rep. Thomas Petri, R-Wis.—to "The Multiple Employer Welfare Arrangements Enforcement Improvements Act of 1992" proposed by the administration. The administration bill, introduced June 11 by Rep. Petri, is the latest of several bills focusing on MEWA regulation.

MEWA proponents also hold that the administration's plan, H.R. 5386, is far preferable to two Democratic bills, S. 2843 and H.R. 4919, which would give the states authority to regulate all MEWAs, meaning they could be prohibited altogether in some states.

"We're in an odd quandary," said Frederick D. Hunt, president of the Society of Professional Benefit Administrators in Chevy Chase, Md.

The administration proposal contains nearly everything the SPBA has been seeking since the enactment of the Employee Re-

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NCCI blasts rate hike denials

Hager says states removing incentive to improve safety

By MARK A. HOFMANN

WASHINGTON—State insurance regulators who deny workers compensation rate hike requests in effect grant subsidized coverage to employers that ignore safety, says a former state insurance commissioner.

Without rate suppression, insurers could charge rates based on loss experience and thereby provide an incentive for safer workplaces, according to William Hager, president of the Boca Raton, Fla.-based National Council on Compensation Insurance and a former Iowa insurance commissioner.

Regulators have approved rate hikes that generated only about half the total amount of additional premiums workers comp insurers have sought since 1988, he noted during a discussion of rate regulation held June 9 in Washington, sponsored by the regulatory and legislative section of the Society of Chartered Property & Casualty Underwriters.

This rate suppression has led to the explosive growth of residual markets, since many insurers have refused to voluntarily write workers comp coverage in certain states, he said.

These pools, which are funded by assessments on insurers, lost about $2.2 billion on $4.9 billion of net premium in 1991, according to Mr. Hager.

The existence of residual markets that provide coverage to

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Excess/surplus specialists listed

Business Insurance will publish two directories in the Aug. 17 issue, which also will contain a Spotlight Report on the surplus lines insurance market.

One directory will list underwriting managers, managing general agents and surplus lines brokers. The second will list surplus lines insurers and insurers that specialize in writing excess liability coverages.

To be listed in the directory of insurers, surplus lines insurers must write at least 50% of their gross premiums on a direct, nonadmitted basis; excess insurers must write at least 50% of their volume or $500,000 of gross premiums in excess liability insurance.

There is no charge to be included in the directories. Companies that wish to be listed must fill out and return a questionnaire provided by *Business Insurance*.

Companies eligible to be listed in either directory that have not yet received a questionnaire should request one from Editorial Assistant Cindy Bloom at 312-280-3195.

The extended deadline for returning questionnaires is July 6.

Inside

Vol.26, No.25—*Business Insurance* (ISSN 0007-6864) is published weekly by Crain Communications Inc., 740 N. Rush St., Chicago, Ill. 60611-2590. Second-class postage is paid at Chicago, Ill., and at additional mailing offices. Postmaster: Send address changes to *Business Insurance*, Circulation Department, 965 E. Jefferson Ave., Detroit, Mich. 48207-3185; 800-678-9595 or 313-446-1611.

Photo by Alvis Upitis/The Image Bank

Self-insured payers are advised to weigh the value of new medical technology like magnetic resonance imaging with its costs.

Medical care advances pose tough decisions for self-insurers

By CHRISTINE WOOLSEY

MINNEAPOLIS—Self-insured employers and group health insurers increasingly are being asked to pay for costly new medical technologies and experimental therapies.

GHAA

This type of care is adding significantly to the cost of the nation's health care system. Yet little guidance is available to help self-insured employers and commercial insurers decide which procedures and therapies to cover.

Most self-insurers and insurers are using their own judgment, pointed out Dr. Daniel Dragalin, a health care consultant with Towers Perrin in New York.

When faced with a request to cover an expensive new technology, payers must ask what additional value the new technology offers over existing treatments, suggested Dr. Christine W. Parker, assistant vp and medical director of Provident Life & Accident Insurance Co. in Chattanooga, Tenn.

Dr. Dragalin moderated a panel that included Dr. Parker and two other physicians at the 42nd annual Group Health Institute sponsored by the Group Health Assn. of America Inc., an HMO trade group.

The physicians discussed the types of new technologies, treatments and drugs patients are requesting employers or insurers to cover and the associated costs.

A second session on medical technology offered legal advice to self-insured employers and insurers that are increasingly finding themselves in court after denying coverage for procedures they deem experimental.

Part of the problem payers face when confronted with a request to pay for an expensive new treatment is patients' belief that if more money is spent on health care, the outcome will be better, Dr. Parker said. "But, more does not mean better in health care," she said. "People still get old and die. And, when

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Bush opposes role in insurer regulation

By MEG FLETCHER

WASHINGTON—The Bush administration opposes proposals pending in Congress that would give the federal government a role in regulating insurer solvency.

NAIC

The administration is particularly opposed to the concept of a national guaranty fund, because such a fund would eventually become a burden to taxpayers, a Treasury Department official contends.

Proposals for a federal role in solvency regulation are "premature," because the existing system of state regulation "appears to have adequately handled" the failures of several large life insurers last year, said John C. Dugan, assistant treasury secretary for domestic finance.

In addition, the National Assn. of Insurance Commissioners' "very aggressive" program of state insurance department accreditation should be given time to work before Congress considers changes, he said during a panel discussion at the NAIC's summer meeting earlier this month in Washington.

Thirteen states so far have received NAIC accreditation.

In the interim, the Treasury Department is supporting a bill, H.R. 4731, sponsored by Rep. Ben Erdreich, D-Ala., that calls for the department to study insurer insolvencies in light of the broad role insurance plays in the national economy and to submit recommendations to improve solvency regulations.

That legislation was approved last week by the House Banking, Finance and Urban Affairs Committee.

Mr. Dugan's statement at the

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COBRA notification ruling

Blues plan's effort to notify comatose beneficiary sufficient: Court

By MICHAEL SCHACHNER

OMAHA, Neb.—A group health plan administrator met its COBRA requirements by mailing a premium statement and benefits information to a woman even though she was comatose and did not personally receive the material, a federal appeals court has ruled.

Affirming a 1991 district court decision, a three-judge panel for the 8th U.S. Circuit Court of Appeals last month unanimously ruled that by sending the woman formal notice that she was a qualified COBRA beneficiary and requesting payment of overdue premiums, the administrator met its COBRA obligations.

As a result, Blue Cross & Blue Shield of Nebraska is not required to pay a $111,000 hospital bill incurred by the comatose woman. BC/BS cancelled her coverage because she did not continue to pay COBRA premiums after her ex-husband had registered her for the coverage.

The ruling stems from a lawsuit brought by Lincoln General Hospital. The Lincoln, Neb., hospital sought to force BC/BS of Nebraska, the administrator of the health plan offered by the Lincoln Public School System, to pay Delores Phillips' hospital bills.

Lawyers involved in the dispute say the strange string of events that led to a denial of benefits by BC/BS makes this case unlike most other disputes over notification required by the Consolidated Omnibus Budget Reconciliation Act of 1985.

The case began Feb. 1, 1988, nearly two months after Ms. Phillips divorced Roy Phillips, an employee of the Lincoln school system.

On that date, Ms. Phillips had

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Non-network hospitals sue over higher copayments

State's PPO under fire

By SALLY ROBERTS

RALEIGH, N.C.—A North Carolina health care plan is coming under fire for penalizing participants who use a hospital system that is not part of its preferred provider network.

The North Carolina Attorney General's office is appealing a Wake County Superior Court judge's decision to grant an injunction barring the state's self-funded health care plan from requiring plan participants who use the non-network facilities to pay a higher copayment.

The state last week won a temporary stay of the injunction pending its appeal.

The Superior Court judge found June 9 that Carolina Medicorp Inc., which operates two hospitals in Winston-Salem, N.C., is likely to suffer "immediate and irreparable harm" as a consequence of the state contracting only with nearby North Carolina Baptist Hospital, and not with Carolina Medicorp's Forsyth Memorial Hospital or Medical Park Hospital.

In addition, the judge said the state's health care plan would "impose significant financial penalties upon plan members who use the services of Forsyth and Medical Park."

Hospitals that participate in the PPO are required to give discounts of 5% on room charges, 8% on inpatient ancillary charges and 5% on outpatient services, according to David DeVries, executive administrator of the State of North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan in Raleigh.

The self-funded plan, which was established by the General

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Antitrust penalty uninsured

California court finds state law bars insurance for intentional act

By LOUISE KERTESZ

SAN FRANCISCO—Policyholders facing civil damages for violations of federal antitrust law are stinging from a federal judge's ruling that such damages are not insurable under California law, which precludes coverage for intentional acts.

Even if the act that violates antitrust law is not willful, policyholders cannot recover from insurers because harm is inherent in the act itself, ruled U.S. District Judge Charles A. Legge of San Francisco.

As a result of the decision, tugboat and barge operator Trailer Marine Transport Corp. of Jacksonville, Fla., will not be able to recover the $24.5 million it sought from excess liability insurer Chicago Insurance Co.

Trailer Marine is considering whether to appeal, said a spokesman for its parent, Crowley Maritime Corp. of Oakland, Calif.

Judge Legge's decision is the first interpreting how California law precluding coverage for willful acts applies to commercial insurance policies.

The decision also appears to be only the second ruling in the nation "directly on the question of whether antitrust liability is covered by a liability insurance policy," the judge said in his decision.

The other case is a 1979 ruling by the 5th U.S. Circuit Court of Appeals. Interpreting Alabama law, that court also denied coverage for court-awarded damages arising from antitrust violations. The 5th Circuit covered Alabama at that time.

Not many coverage disputes arising from antitrust cases proceed to trial because, as Judge Legge noted in his decision, most comprehensive general liability

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Photo by Michael A. Marcotte

Bulls euphoria costs city

Property damage in Chicago from burning and looting—like damage suffered by these Michigan Avenue shops—that followed the Chicago Bulls' NBA championship last week will total at least $10 million, predicts the local Chamber of Commerce. More than 200 stores were damaged. Most, but not all, of the businesses are insured, the Chamber believes.

M&M proposal

Continued from page 1

from U.S. insurance regulation and liability for U.S. income tax and branch profits tax. It still would be subject to a 1% excise tax on reinsurance premiums attributable to U.S. risks, according to the draft of the offering memorandum.

Mid Ocean also intends to structure itself to avoid being considered a controlled foreign corporation under U.S. tax law. This would relieve U.S. investors' of current taxation on their pro-rata shares of the company's insurance income.

Accepting business through "independent reinsurance intermediaries," Mid Ocean plans to write in three areas:

- All-risk excess-of-loss property catastrophe reinsurance, excluding war and nuclear contamination risks, with a maximum limit of $30 million per occurrence per reinsured.

Mid Ocean also would try to cap its aggregate exposure to any one catastrophe by imposing a $250 million per occurrence limit for each geographical zone, to be defined by the reinsurer.

Policy and zone limits would be subject to change based on inflation and the level of Mid Ocean's capital and surplus, the memorandum says.

- Proportional and excess-of-loss catastrophe retrocessional coverage, which Mid Ocean would write in limited amounts subject to a $50 million per occurrence limit for each geographical zone.
- Proportional reinsurance of Lloyd's syndicates on risks other than property catastrophe.

A Lloyd's task force recommended in January that syndicates be allowed to write 125% of their premium limits subject to a 25% quota share reinsurance placement with independent reinsurers (*BI*, Jan. 27). The recommendation, if adopted, would create an opportunity for Mid Ocean to reinsure Lloyd's syndicates, the draft notes.

The company 'will endeavor to reinsure syndicates with significant histories of success.'

The company "will endeavor to reinsure syndicates with significant histories of success and avoid syndicates which have had less than favorable results," the draft says.

Mid Ocean also might assume syndicate liabilities from occurrences prior to the binding date of the reinsurance contract, the draft adds.

In addition to these three lines, the reinsurer may also write other types of property/casualty business, though it would avoid working layer casualty risks and focus instead on high-layer excess casualty or clash coverages, the draft memorandum says.

M&M and Morgan—which previously teamed up to form A.C.E. Insurance Co. Ltd., X.L. Insurance Co. Ltd. and Centre Reinsurance Co. Ltd.—are hoping to raise at least $300 million for Mid Ocean, according to the draft memorandum.

M&M would receive an advisory fee equal to 1.2% of the gross proceeds of the share sales, along with options to buy non-voting shares in an amount equal to 7.2% of Mid Ocean's outstanding voting and non-voting common shares.

Morgan would receive a placement fee of 0.8% of the proceeds of the stock offering and options to buy non-voting stock equal to 4.8% of Mid Ocean's outstanding shares, according to the draft.

J.P. Morgan Investment Management Inc. and The Putnam Advisory Co. Inc., an M&M unit, would serve as Mid Ocean's investment advisors.

KPMG Peat Marwick in Bermuda would act as auditor, while Conyers, Dill & Pearman in Bermuda and Cahill, Gordon & Reindel in New York would be legal counsel.

Initial reaction to the potential new market was mixed.

"This is an extremely volatile deal," said one reinsurance broker who asked not to be identified. "They will either make a lot of money, or they are going to lose everything."

Mid Ocean would be writing catastrophe reinsurance and retrocessional limits totaling $300 million per zone, the broker pointed out. This one-to-one ratio of exposure to capital and surplus represents an "extremely aggressive business plan," especially since Mid Ocean's capacity would most likely attract large ceding insurers that are all exposed to the same losses, he observed.

In addition, while demand for catastrophe capacity is still high, pricing is already starting to slip in some areas and could decline rapidly over the next year if the market escapes new catastrophe losses, said one reinsurer official who requested anonymity.

The official added, though, that major catastrophe losses this year could also send rates rocketing upward again.

"It's a super-volatile class," he observed. ■

AIG units to assume custom reinsurance

NEW YORK—A new American International Group Inc. unit arranges custom-designed property/casualty and life/health reinsurance programs that are then assumed by AIG insurance companies.

AIG Reinsurance Advisors Inc., which was officially launched this month, is working with international reinsurance brokers to try to devise tailored stop-loss, shortfall and surplus relief reinsurance programs for ceding companies.

"It's not our intent to be a broker," said Joseph Umansky, president of AIG Re Advisors. "Our goal is to work with brokers to come up with unique reinsurance plans for ceding companies of all types. There's a growing demand for custom-structured reinsurance that's stable and long-lasting," he explained.

Business procured by AIG Re Advisors is then assumed by various AIG insurers, Mr. Umansky said.

Transatlantic Reinsurance Co., in which AIG holds a 47.2% stake, will not write the business, he said.

—By Michael Schachner

Will it cost your company your company?

Ready for one of the most difficult challenges ever to confront corporate America? One that's estimated to cost up to $400 billion.

New FASB regulations will force companies to measure and post as a debit their health expense obligation to current and *future* retirees.

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We can help. We offer actuarial, retirement and health benefits expertise.

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And help you better prepare for the future.

We will do everything from measuring your expense and liability to evaluating plan redesign alternatives and advance funding options.

The end result: we'll help you minimize the financial impact of these regulations and still enable you to remain responsive to the benefit needs of employees. Write or call Mark Lynch, CIGNA Employee Benefits Services, Dept. M-50, Hartford, CT 06152, (203) 725-2186.

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HMOs receive nod of respect from AMA

Benefit beat

After nearly a century of staunchly opposing the concept of prepaid group health care practices, the nation's largest medical association is beginning to publicly acknowledge the contributions HMOs and other managed care arrangements have made to the health care delivery system.

In a recent speech to a major HMO trade group, an American Medical Assn. official said HMOs and other types of prepaid programs have helped to hold down health care costs while simultaneously providing employers with more freedom of choice and physicians with more latitude in how they set up practices.

In his June 8 speech to the Group Health Assn. of America Inc., Dr. James S. Todd, executive vp with the AMA, said that organized medicine has for too long failed to recognize the legitimacy and benefits of HMOs and group practices.

Furthermore, Dr. Todd said the AMA is prepared to be a leading player in the health care debate.

"We have been slow in recognizing and accepting these modes of practice. This failure was based on traditional beliefs and conventional wisdom which, as we all know, is sometimes more conventional than wise," he said.

"Managed care is helping in the battle to hold down rising health care expenditures, and it allows employers to shop around for the most effective use of their health care dollars.

"Another obvious advantage of HMOs and other managed care arrangements is that they afford today's physicians a wider choice in how they can practice medicine," said Dr. Todd. With the advent of HMOs, physicians can choose either to enter private practice or to work directly for the HMO, he said.

Observers say Dr. Todd's remarks are a radical departure from the AMA's public positions since group-based medicine first began in the early 1900s.

"The AMA has for a long time held much animus against the idea of prepaid medical services. It opposed the HMO Act of 1975 and has been committed to the status quo in terms of fee-for-service medicine," said Jim Doherty, president of the GHAA in Washington. And, while Mr. Doherty hailed Dr. Todd's comments as positive and appropriate, he also labeled those comments "anti-climactic" in that they only confirm what the rest of the health care industry had known for some time.

Dr. Michael McGarvey, managing director of Alexander & Alexander Consulting Group Inc.'s Health Strategies Group in Lyndhurst, N.J., said Dr. Todd's speech indicates that the AMA has been forced to give reality its due. "With these comments, organized medicine is basically acknowledging the reality of the situation. A large number of patients are voluntarily selecting HMO coverage, and they're doing so without significant adverse effects," he said.

In a telephone interview, Dr. Todd admitted that his comments at the conference constituted an acknowledgment of reality and were not a "plowing of new ground."

"But more importantly, I'd like to emphasize that we have a huge problem to solve in our health care system, and it makes no sense for the AMA to continue holding to an ideological schism with the HMO industry," Dr. Todd said.

—By Michael Schachner

AIDS claim survey

AIDS claims are not taking a toll on U.S. health insurers, although the total claims cost for 1990 exceeded $1 billion, according to a survey by benefit consultant Milliman & Robertson Inc.

Seventy-two percent of 140 life, health and disability insurers surveyed early this year reported that acquired immune deficiency syndrome and AIDS-related medical claims accounted for less than 1% of total claims costs. And, more than 76% reported that AIDS-related disability claims accounted for less than 1% of total claims costs.

"The AIDS epidemic has not overwhelmed the private insurance system as predicted," said Timothy F. Harris, a consulting actuary with Milliman & Robertson in St. Louis. The number and size of AIDS-related claims have not increased as greatly as insurers had expected, said Mr. Harris.

For example, the American Council of Life Insurance had projected $1.8 billion in AIDS-related life, health and disability claims for 1990, but the group's 1990 survey of AIDS claims paid put the total at $1.2 billion.

Insurers reported that the average duration of an AIDS-related medical claim was 2.37 years in 1991; costs averaged an estimated $67,943. The average duration of AIDS-related disability claims was 2.07 years, with an average estimated cost of $20,017, they reported.

Only 14.3% of insurers surveyed reported a need to increase reserves in their 1991 statutory statements against future AIDS-related claims. The rest said reserves were conservative enough to cover the additional risks or that AIDS represented little or no risk in terms of the types of coverage offered.

At present, 3.7% of the insurers surveyed said they exclude medical coverage for AIDS, while 7.5% said they place coverage limitations on AIDS claims.

No insurer reported excluding AIDS under any type of disability policy and only 0.9% impose limitations on the amount paid for AIDS-related disability claims, the survey found.

However, Mr. Harris pointed out, "insurers have become more conservative in their underwriting" of AIDS cases. More than half of the insurers surveyed cited blood testing as an "effective means of reducing AIDS claims," he said.

And, insurers now require blood testing on individuals who have smaller amounts of medical and disability coverage, Mr. Harris noted. Many insurers never used to impose blood tests as an underwriting requirement or only tested individuals with very large coverage amounts, he explained.

The survey was mailed to 432 U.S. life/health insurers with at least $20 million in annual premiums.

Free copies of the survey are available from Milliman & Robertson Inc., Suite 2202, 720 Olive St., St. Louis, Mo. 63101.

—By Christine Woolsey

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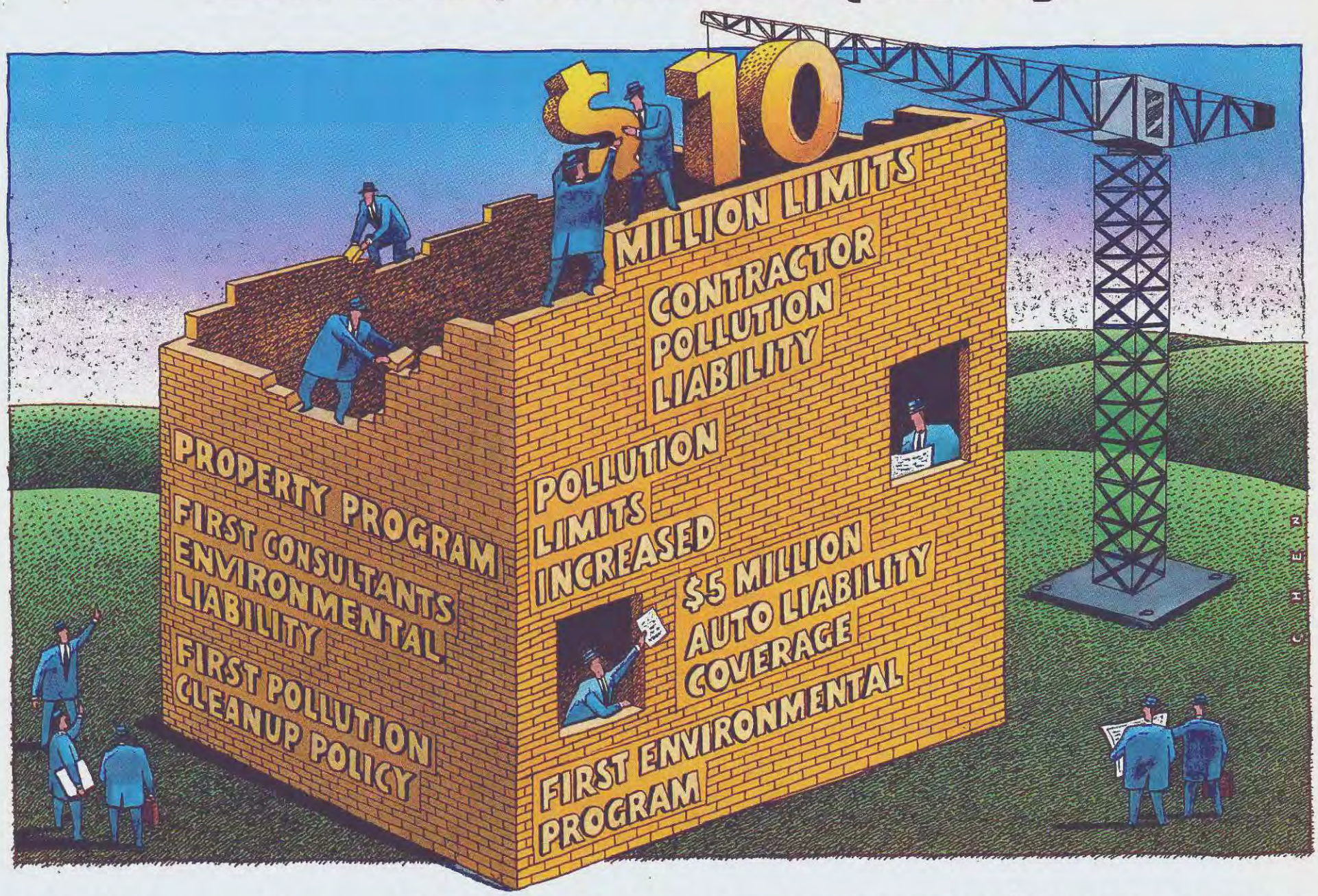

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Opinions

Let's make a deal. . .Not!

"TAKE THE MONEY AND RUN" was a great Woody Allen movie, but it's not the best way to resolve an insurance coverage dispute.

Yet that's just what a growing number of policyholders are doing, as New York Bureau Chief Stacy Gordon reported in last week's issue. They are agreeing to ask judges to vacate pro-policyholder rulings in coverage disputes in exchange for either a bit more money from the insurer than the court awarded or a promise that the insurer will not appeal.

In the majority of these cases, the judge has agreed to vacate his or her ruling.

On the surface, it appears that all sides win: The policyholder recovers more money than it would have under the court decision alone, and the insurance company rids itself—and other insurers—of a nasty, pro-policyholder precedent that could come back another day to haunt the insurance industry.

But, in reality, policyholders are losers when such deals are made. Policyholders litigating with their insurers over coverage issues depend on pro-policyholder judicial precedents to back their arguments. If these precedents are wiped off the books through so-called private settlements, it will be more difficult for policyholders to prove their arguments in court.

Even the policyholder that winds up settling for additional money could end up on the losing end of the deal. The company could find itself in a similar coverage dispute years later—without the help of the precedent in the earlier case.

If enough private settlements are made in a hotly disputed area of coverage litigation, like pollution cleanup coverage, the record will show an overwhelming number of insurer victories. In short, individual policyholders will have won many battles, but as a group they will have lost the war.

While some attorneys argue that courts exist for the benefit of litigants and, thus, the parties to a lawsuit should be able to resolve their dispute in any manner—

including wiping a ruling off the books—we steadfastly disagree. The U.S. justice system, which is based on case law, exists for the benefit of all Americans. Erasing judicial precedents to benefit a single policyholder—at the expense of many others—is not a correct use of the civil justice system.

In fact, businesses that are calling for civil justice reform are nothing more than hypocrites if they tie up a courtroom for weeks or months, only to discard the judge's ruling for a few additional bucks.

Of course, we are not so naive to think that companies will not act in their own best interest—and in many cases that means recovering the maximum amount of dollars. However, companies must weigh their decisions very carefully before they scheme with an insurer to toss pro-policyholder court decisions into the wastebasket.

Letters

'Attack' on RIMS chapters was unwarranted

To the editor: After reading the editorial, "Praise RIMS for Taking Stand" (*BI*, June 1), I felt compelled to write to express my disappointment with the non-professional journalistic attack on certain chapters of the Risk & Insurance Management Society Inc.

Granted, the press has the right to editorialize, but with that right also goes responsibility. The editorial appears to be a veiled attempt to suppress a member of a society from expressing an opinion or objection. You have taken an issue of debate among members of a society, RIMS, and ridiculed the members who speak out.

The editorial states: "If the executive council had to consult its 89 chapters every time it issued a policy statement, RIMS would never take a timely stand on issues important to risk managers."

The statement is in direct contrast to remarks that Paul S. Brown, RIMS' director of government and public affairs and general counsel, made to another publication. Mr. Brown stated that "RIMS' positions usually start at the level of the society's committees, which consist of member volunteers. The committees are designed to give the pulse of the membership." Then the position is typically submitted to the society's 20-member executive council, which is elected by the RIMS board of directors to run the society, Mr. Brown said. The position on federal solvency regulation proceeded in the opposite way than it usually does, Mr. Brown said. "Here the momentum came from the executive council and then got the full support of the governmental affairs committee," he said.

With these statements "to give the pulse of the membership" and "proceeded in the opposite direction" and with the haste in which this decision was taken, I would certainly think a RIMS member has a right to object without being criticized by an editorial and ridiculed by a cartoon. I might suggest that you research the entire series of events before you jump to a conclusion.

In the past I viewed *Business Insurance* as a very professional publication, but now I'm left with a doubt.

John R. Rath
Risk Manager
Milwaukee County, Wis.

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

Providers hold all the cards in health care system debate

To the editor: The discussion contained in the May 11 article "Free Market May Be Dead, But What Lay Ahead?" is based on the assumption that America's health care system is a free market. It is not.

Health care is an extremely subjective topic, and the providers hold all the cards when it comes to determining demand for their services. After all, when one is ill, the main concern is feeling better. Such an ill-defined result offers wide latitude to the provider in choosing and administering treatment.

To compound matters, the natural constraint on supply—a limit to what consumers are willing or able to pay—has been obviated by a third-party payer system that effectively isolates the consumer of health care from the cost of the services consumed.

The root cause of our health care system's major deficiency, spiraling costs, is the result of a market that has broken down. The first—and by no means only—step toward reforming our health care system is to reintroduce the consumer of health care to the provider of health care and, more importantly, to the provider's rate card.

David Albanese
Stamford, Conn.

Letters continued on next page

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Published weekly at 740 Rush St., Chicago, Ill. 60611-2590, Telex 6871241, Fax 312/280-3174, Cable CRAINCOM. Offices: 220 E. 42nd St., New York, N.Y. 10017-5806, Fax 212/210-0704, CRAIN COM NYK; 1 Northpark, East Suite 114, 8950 N. Central Expressway, Dallas, Texas, 75231-6415, Fax 214/696-1936; Suite 814, National Press Building, Washington, D.C. 20045-1801, Fax 202/638-3155; 6500 Wilshire Blvd., Suite 2300 Los Angeles, Calif. 90048-4947, Fax 213/655-8157; 540 Latimer Circle, Campbell, Calif. 95008, Fax 408/379-3257; Cowcross Court, 2nd Floor, 75-77 Cowcross St., London EC1M 6BP, England, Fax 71/608/1173. $2.00 a copy. $80 a year in U.S. Canada and all other foreign add $38 for surface mail. Europe and Middle East only add $116 for air delivery. First-class mail to U. S., add $95; to Canada add $105. Bermuda only, $200 per year expedited delivery; Australia only, $305 per year expedited delivery. SHEILA GORMLEY, circulation manager. Four weeks' notice required for change of address. Send subscription correspondence to Circulation Department, Business Insurance, 965 E. Jefferson Ave., Detroit, Mich., 48207-3185, or phone 800-678-9595 or 313-446-1611, Fax 313/446-1650. Microfilm copies are available from University Microfilms, 300 Zeeb Road, Ann Arbor, Mich. 48013. Microfiche copies available: Bell & Howell, Micro Photo Division, Old Mansfield Road, Wooster, Ohio 44691. Portions of the editorial content of this issue are available for reprint or reproduction in other media. For information and rates to reproduce in general circulation media, contact: ART MERTZ, The Crain Syndicate, 740 Rush St., Chicago, Ill. 60611-2590, 312-649-5303. For reprints or reprint permission contact: Reprint Department, Business Insurance, 220 E. 42nd St., New York, N.Y. 10017-5806, 212-210-0229, Fax 212/210-0704.

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Letters

Students need exposure to industry

To the editor: Kudos to Michael R. Hubbel for his June 8 letter encouraging risk management and insurance education on our college campuses. The Houston Chapter of the Risk & Insurance Management Society Inc., specifically its past presidents' council headed by Willa White of Tenneco Corp., has been actively involved with this issue.

Mrs. White and her committee have met with John Ivancevich, dean and Cullen professor at the College of Business Administration at the University of Houston. The purpose was to acquaint Mr. Ivancevich with RIMS and also to encourage the university to add insurance and risk management courses to its curriculum.

It is inconceivable that any college or university offering either baccalaureate or graduate degrees could award a business degree to an individual who has not had the most elementary or cursory exposure to our profession and industry.

Steven B. Steinberg
Vp-Risk Management Services
Sedgwick James of Houston
Houston

Agent prefers national license

To the editor: The May 25 article "Agent Regulation Reform Plan Fails," which concerns multistate licensing of agents, touched on a very delicate issue. I am sure insurers would rather deal with each state than be subject to national regulations. But multistate licensing puts agents in a very inconvenient situation.

One of my company's clients is a major national group health care account with employees in many states. If an employee contacts me in regard to obtaining individual medical insurance because of termination, I am required to become licensed in that state before I can offer the employee an individual policy.

Although life insurance regulations don't seem to be as specific as health regulations, I do not feel comfortable, when writing a life insurance application, stating that I met the terminated employee at the corporate headquarters in Connecticut in order to avoid the licensing requirement in the state in which the former employee lives.

My estimate is that my company maintains life, health and variable life licenses in about 10 states. Not only is this a time-consuming matter to keep track of all of these licenses, but it also is a tremendous expense. I feel an obligation to serve the needs of my clients and their employees, but often the cost of a license exceeds the amount of commission.

Although I may come to odds with insurers, a nationally recognized license would be preferable from an agent's standpoint.

Richard P. Duffy
Duffy Associates
Ridgefield, Conn.

Singapore changes don't affect captives

To the editor: The March 30 article on Singapore's captive insurance industry stated "the minimum solvency margin for offshore business, including captives, remains unchanged: $1 million Singapore or 20% of net premiums or loss reserves."

I would like to clarify that the solvency margin does not apply to captives. This new margin, which becomes effective Dec. 31, 1991, is applicable only to the offshore insurance fund of general insurers. Professional reinsurers and captives are not affected by the new enhanced solvency margin.

The solvency margin requirements for captives are unchanged: Captives are only required to maintain a solvency margin of $1 million Singapore and ensure assets equal liabilities.

Luz Foo
Insurance Commissioner's Department
Monetary Authority of Singapore
Singapore

City wins $23 million for asbestos removal

By EILEEN P. GUNN

BALTIMORE—U.S. Gypsum Corp. will appeal a jury verdict awarding the city of Baltimore $23.2 million from it and two other defendants for the costs of removing asbestos from city-owned buildings.

The June 5 state court verdict marks the first time a large city has been able to recover the costs of removing asbestos from numerous city-owned buildings, including police headquarters and several schools.

The verdict includes $17.2 million in compensatory damages and $6 million in punitive damages.

Chicago-based U.S. Gypsum's share of the damages amounts to $8.8 million in compensatory damages and $4 million in punitive damages.

A spokesman for U.S. Gypsum says the asbestos manufacturer is fully insured for the award, including the punitive damages portion. Maryland law allows coverage for punitive damages.

Insurer attorneys estimated last year that from the late '60s until 1971, U.S. Gypsum self-insured the first $1 million of its liability risk. The insurer attorneys also estimated that the company purchased between $50 million and $100 million in liability coverage each year during that period (*BI*, Jan. 21, 1991).

U.S. Gypsum is currently litigating with its insurers over coverage for asbestos property damage claims in state court in Illinois

In January 1991, a trial court held that asbestos in buildings constitutes property damage, but the court also limited liability coverage to the policy period during which the asbestos was discovered.

Both U.S. Gypsum and its insurers appealed the January 1991 decision. Both sides are currently submitting briefs to the Illinois Intermediate Appellate Court.

Asbestospray Corp., a now-defunct manufacturer of asbestos products formerly based in New Jersey, was hit with $8.3 million in compensatory damages and $2 million in punitive damages. The company stopped operating in 1973, and its attorneys could not be reached for comment.

Hampshire Industries Inc., a Baltimore-based company that installed the asbestos-containing products, was assessed $718,000 in compensatory damages. The company has sufficient liability insurance to cover the judgment, said Robert Lynott, lead counsel for Hampshire with Thomas, Libowitz in Baltimore.

However, Hampshire plans to ask the court to overrule a portion of the jury's verdict relating to it or to order a new trial. Mr. Lynott said it doesn't make sense to hold the installer of the asbestos-containing materials strictly liable for a defect in a product.

In its lawsuit, originally filed in 1984, the city of Baltimore argued that asbestos-containing materials used in its buildings, including plaster and ceiling tiles, would require continual monitoring because of their poor condition if they were left in place. And in several instances, the materials had to be removed by law. Federal legislation passed in 1979 requires asbestos-containing materials to be removed from school buildings.

In addition, the police department will need to relocate its headquarters because of chronic asbestos problems, according to the city.

U.S. Gypsum argued that 'the materials did not impose any harm in their current state,' a spokesman says.

However, U.S. Gypsum argued that "the materials did not impose any harm in their current state," according to a company spokesman.

Hampshire contended that when the products were installed in the late 1960s through 1971, it was no more aware than the city Health Department about the dangers of asbestos products.

"The nature of the hazard of asbestos was not perceived as it is now," said Hampshire's co-counsel Peter Talliafarro, also with Thomas, Libowitz.

Precautions were taken to protect workers and passersby while the products were being installed, "but it was generally believed that once (asbestos products) were in place, they were OK," he explained.

The Baltimore verdict is the first phase of a three-phase trial. In the second and third phases, issues concerning the cost of removing asbestos from boiler room equipment and floor tiles will be litigated.

U.S. Gypsum says it will appeal the Baltimore verdict, but it has to wait until after phase three is concluded, even though it is not involved in the second or third phases of the trial.

Hampshire is involved in phase three of the suit, but rather than waiting to file an appeal, it wants the issue of its liability settled immediately.

Hampshire also intends to file a countersuit against the asbestos manufacturers for "alleged failure to warn about design defect," Mr. Lynott said.

Mr. Talliafarro explained: "The manufacturer has access to the full range of scientific knowledge about a product, which the installer does not." ■

Pension protected in bankruptcy: Court

WASHINGTON—Creditors are not entitled to a bankrupt individual's pension benefits, a unanimous Supreme Court ruled last week.

The ruling is a victory for employers as well as beneficiaries because it eliminates a threat to the tax-favored status of pension plans.

"The court's conclusion in favor of plan participants is very much welcomed," said Mark Ugoretz, president of the ERISA Industry Committee, a Washington-based benefits lobbying group representing large employers.

"Before this decision, plans were forced to litigate against every bankruptcy trustee that demanded access to plan assets," he said.

The justices ruled that shielding pension benefits from creditors "gives full and appropriate effect to" the Employee Retirement Income Security Act's goal of protecting pension benefits.

The justices also said that pension benefits qualify for special treatment under Section 541 of the Bankruptcy Code. Under that section, assets protected under "applicable non-bankruptcy law" are not considered estate assets and are thus safe from creditors.

Several lower courts have interpreted applicable non-bankruptcy law to refer only to "spendthrift trusts" established under state law. Under that interpretation, only pension plans that qualify as spendthrift trusts under the relevant state law would be excluded from the property of a bankruptcy estate.

Spendthrift trusts are used to limit access to funds. Parents, for instance, might set one up for a child to limit the amount of money a child could withdraw from the trust.

But the high court said that nothing in Section 541 limits its scope exclusively to state law. "Plainly read, the provision encompasses any relevant non-bankruptcy law, including federal law such as ERISA."

At the same time, pension benefits qualify for protection from creditors if the plan includes a standard ERISA requirement that says a participant's benefits generally may not be attached or assigned to another party, the court said.

The court ruled in a case involving a $250,000 pension benefit promised to the former president of a Virginia furniture company who filed for personal bankruptcy.

—By Jerry Geisel

Quayle adviser decries litigation trends

By MICHAEL SCHACHNER

NEW YORK—Lawyers and accountants have become the target of excessive litigation because clients see them as deep pockets after business deals fail, according to a top adviser to Vice President Dan Quayle.

If the recent trend of multimillion-dollar damage awards against large firms continues unchecked, it is likely that at least a few large law and accounting firms may be forced to cease operations, said John Howard, counsel to Mr. Quayle.

Mr. Howard, speaking at a Manhattan Institute luncheon in New York earlier this month, said jilted clients and even the federal government more frequently are attempting to hold lawyers and accountants responsible for misguided business endeavors, because it is generally believed that these firms are the ones holding the bag of money when deals go up in smoke.

These suits generally stem from services or counsel provided by accounting or law firms, in the form of audits, assessments of financial health or advice on potential business deals.

"I think it's a case of following the money. People feel these consultants are the ones closest to the deal and thus have some liability. It's also a matter of public relations. There's a clear PR angle to winning a multimillion-dollar judgment from a big firm," said Mr. Howard.

Another reason for the increase in large verdicts against firms is that "accountants are perceived by most people to be the watchdogs of America, and their fiduciary duty is supposed to be to the public," said Philip Lacovara, managing director and general counsel with Morgan Stanley Group Inc. in New York, who also spoke as part of a panel discussion.

Similarly, Mr. Lacovara added, society generally equates lawyers with the police. "Even if a lawyer is acting just in an advisory role, the public believes they're supposed to come in with affirmative responses aimed at preventing damage."

According to Mr. Howard, these large jury awards eventually will lead to:

- A reduction in the overall number of practicing lawyers and certified public accountants.
- Higher fees for clients in order for lawyers and CPAs to offset their increasing professional liability costs.
- An unwillingness on the part of lawyers and accountants to accept certain types of high-risk clients, like financial institutions.
- Fewer new strategies being introduced by attorneys and CPAs due to the fear that innovative methods may fail and leave them susceptible to a lawsuit.

"The legal system has gone to the ludicrous extreme where all (lawyers and accountants) fall short and all must pay damages for these shortcomings," said Walter Olson, author of "The Litigation Explosion." The book discusses why major accountants and law firms like Price Waterhouse and Kaye, Scholer, Fierman, Hays & Handler are getting hit with jury verdicts in excess of $250 million for negligence.

Not only are disgruntled clients pulling the litigation trigger quickly, but the federal government, which never used to pursue such cases, also has jumped into the act.

"The government has 176 claims filed against lawyers and accountants" related to savings and loan failures "and even though there's little chance the government will recoup what it's putting into these cases, it's moving ahead," said Glenn Yago, a professor of economics at the State University of New York at Stony Brook.

'People feel these consultants are the ones closest to the deal and thus have some liability. It's also a matter of public relations. There's a clear PR angle to winning a multimillion-dollar judgment from a big firm,' says Mr. Howard.

"We have reached the point where plaintiffs don't even have to lose money to sue. For them to sue, it's sufficient if they didn't make as much as they thought they should," said Mr. Olson, who agreed with Mr. Howard that soon legal and accounting services will be harder to find and significantly more expensive.

"There's no comfort even for the innocent. Partners are being forced to pay damages out of pocket, and many times these suits originate from events that occurred before they even became partners," said Mr. Olson.

"It's this abrupt change of focus that can fuel the litigation frenzy," he added.

Mr. Howard agreed that government regulators are now coming after big firms with more resources and commitment.

"The administration feels that the old system of finding liable parties for the nation's financial disasters was moving along too slowly at too high a cost. But we're not out to get everyone. With Kaye Scholer, I think it is widely accepted that they were overzealous advocates," he said.

Kaye Scholer allegedly withheld information from Lincoln Savings & Loan Assn., encouraging it to enter into several bad real estate deals. The law firm had collected $13 million in fees related to these transactions. Government regulators sued the law firm for its alleged role in contributing to the failure. Without admitting wrongdoing, the law firm settled the case for $275 million.

To stem the overflow of lawsuits, Morgan Stanley's Mr. Lacovara suggested that the legal system adopt a principle under which the loser of a court case pays all fees. "This would certainly stop frivolous suits that have little to no chance of being won."

Mr. Lacovara also recommended that the theory of joint and several liability be abolished in the jurisdictions where it is accepted today.

Mr. Olson said an answer to the problem of uncontrolled litigation could be to establish standards of wrongfulness and to create guidelines that would govern who can sue over what issues. However, he predicted that such guidelines could only come about through a constitutional amendment.

Charles Morin, a senior partner with Dickstein, Shapiro & Morin in Washington, moderated the panel discussion. ■

Rate suppression

Continued from page 2

many employers at unrealistically low rates discourages some employers from taking adequate safety precautions, because they have no financial incentive to do so, he said.

"Unsafe employers are being subsidized to the tune of $2.2 billion as a result of rate suppression," Mr. Hager said.

"Doesn't this raise a question?" he asked. "How many lives in this country have been lost? How many quadriplegics? How many paraplegics?"

Another social cost of rate suppression is reduced capacity and availability of workers comp insurance, Mr. Hager said.

Orin S. Kramer, president of Princeton, N.J.-based Kramer Associates, a financial services industry consultant, also questioned the desirability of rate regulation.

Mr. Kramer pointed out the political dimension of rate regulation. "Political accountability can be deferred indefinitely" as long as voters do not draw a connection between insurance rates held artificially low by regulators and the availability problems that have occurred in some lines of insurance at various times.

Like Mr. Hager, Mr. Kramer listed the negative consequences of regulatory rate suppression. The lists had many items in common, not the least of which was removing incentives for safety in the workplace.

'Unsafe employers are being subsidized to the tune of $2.2 billion,' says Mr. Hager.

Mr. Kramer also noted the subsidization of high-risk policyholders by low-risk policyholders, calling attention to the subsidization of urban drivers by their suburban and rural counterparts.

Rate suppression also reduces the incentives for insurers to operate in a given state and causes a contraction in the types and number of products and services insurers offer, he said.

And, in a study of workers comp and private passenger auto insurers conducted last year for the insurer-supported Insurance Information Institute in New York, Mr. Kramer found that rate suppression has been a factor in some insurer insolvencies (*BI*, Nov. 25, 1991).

But, during a question-and-answer period, J. Robert Hunter, president of the National Insurance Consumer Organization in Alexandria, Va., challenged the notion that rate suppression was a key factor in numerous insurer insolvencies.

He asked the panelists to name three insurers that became insolvent as a result of rate suppression.

The only insurer the panelists could name as they adjourned was Employers Casualty Co. of Dallas, which Texas regulators ordered earlier this year to stop writing new business (*BI*, April 13, Feb. 17).

Rate regulation was defended by Martin M. Simons, chief property and casualty actuary and director of the property/casualty division of the South Carolina Department of Insurance.

He noted that regulators are not charged just with keeping rates low, but also with ensuring that rates are adequate and not "unfairly discriminatory."

Mr. Simons pointed out that regulators and insurers do not always use the same techniques to judge rates.

"It doesn't mean a regulator is a rate suppressor if he uses a different formula than the filer," he said.

Michael A. Walters, vp and principal at Tillinghast, a Towers Perrin unit in New York, spoke about the impact of regulation on the private passenger auto insurance market in selected states.

John S. Benton, director of government affairs for Woodland Hills, Calif.-based Transamerica Insurance Co., moderated the discussion. ■

Antitrust damages

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policies are not worded as broadly as Trailer Marine's.

Insurers also often settle before reaching that stage, said antitrust attorney Richard C. Weisberg with Latham & Watkins in New York.

But, since Judge Legge's decision, "we have had quite a few phone calls from attorneys around the country," said Kurt Micklow, a lawyer for Chicago Insurance.

There appears "to be a fairly large number of cases currently pending in which companies are trying to obtain liability coverage for antitrust judgments and settlements," said Mr. Micklow, a partner in San Francisco with Rice, Fowler, Kingsmill, Vance, Flint & Booth.

"There seems to be somewhat of a new trend for companies to attempt to obtain coverage" for damages resulting from antitrust violations with the help of "creative lawyers," he said.

But California and many other states bar coverage for intentional wrongdoing by policyholders.

"We find that Judge Legge's opinion should help settle the law in this area and make it clear to companies around the country that business torts such as antitrust violations are intentional and willful acts" that are not insurable, Mr. Micklow said.

The decision shows "a company must be very careful to have adequate, fully developed corporate (antitrust law) compliance programs, because if they don't, they may incur big damages which they will have to pay for themselves," Mr. Weisberg agreed.

The underlying antitrust action against Trailer Marine was filed in federal court in New Orleans in July 1986 by Zapata Gulf Marine Corp. The New Orleans subsidiary of Tidewater Inc. is a predecessor in interest to the now-defunct American Caribe Lines Inc.

Zapata charged that Trailer Marine, as well as SeaLand Service Inc. and the Puerto Rico Maritime Shipping Authority, violated the Sherman Act from 1983 through 1985 by engaging in predatory pricing in a conspiracy to drive American Caribe out of business. The defendants were involved in shipping cargo between Eastern Seaboard ports and Puerto Rico.

SeaLand paid $1 million to settle the charges, and a court ruled that the Puerto Rican shipping authority had governmental immunity.

In March 1990, a jury ordered Trailer Marine to pay Zapata $47 million, which included attorneys' fees and interest. Subsequently, Zapata settled for $45 million.

Trailer Marine wanted to appeal the judgment, but its outside counsel failed to file the appropriate appeal and the case could not proceed, said the Crowley Maritime spokesman. Trailer Marine sued its counsel for malpractice, and the attorneys settled for about half of the cost of the underlying settlement. Trailer Marine applied that settlement toward the antitrust damages.

Then Trailer Marine sued its primary liability insurers for 1983-85 and separately sued Chicago Insurance. Beacon Insurance Co., Crowley's Bermuda captive, wrote $1 million of primary limits in 1983-84. National Union Insurance Co. of Pittsburgh, Pa., an American International Group Inc. unit, wrote the same primary limits for 1984-85. Chicago, an Allianz A.G. Holding unit, wrote $19 million of coverage excess of $1 million in both years.

But shortly before Judge Legge's decision, a federal court in San Francisco ruled that Trailer Marine's primary policies did not cover claims for antitrust damages.

Trailer Marine based its coverage claim against Chicago Insurance on the fact that the antitrust judgment resulted in a loss of profits. Beacon's manuscript policy contained "broad insuring language" in which the insurer agreed to cover the " 'loss of or damage to property or other thing" and "loss of. . .profits,' " Judge Legge noted.

"Most printed forms of comprehensive general liability policies limit property damage coverage to physical loss or physical injury. The insuring agreements of these policies are obviously different, and the difference explains why the issue of insurance coverage for antitrust liability under comprehensive general liability policies arises in this case but has not arisen frequently in the past," Judge Legge wrote.

But, he noted: "The policies contain a relevant exclusion. They do not provide coverage for liability for property damage 'caused intentionally by or at the direction of the assured.' "

Chicago Insurance moved for summary judgment on the basis of that exclusion. The insurer noted the California insurance code prohibits coverage for losses caused by a policyholder's willful act. And, the state civil code states "all contracts which have for their object, directly or indirectly, to exempt anyone for responsibility for his own fraud, or willful injury to the person or property of another, or violation of law, whether willful or negligent, are against the policy of the law."

Trailer Marine argued that coverage is not excluded unless there is proof of intent to cause injury.

But Judge Legge followed a 1991 California Supreme Court ruling that the court "does not require a showing of specific intent to cause injury if the harm was inherent in the act itself."

However, even if Trailer Marine's "interpretation of California law was correct—that is, requiring a specific intent to injure—the verdict of the jury under the antitrust law established even that degree of intent," Judge Legge added.

There is a substantial body of case law interpreting both criminal and civil code provisions, but not in the context of business-related losses, the judge wrote.

"Typically, the issue comes up when you have a plaintiff who successfully prosecutes a civil action against a child molester and obtains a judgment and then proceeds against the home-owners insurer or other personal liability insurer of the defendant," Mr. Micklow said.

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Trailer Marine Transport Corp. vs. Chicago Insurance Co., U.S. District Court for the Northern District of California, No. C-91-3751-CAL

COBRA notice ruling

Continued from page 3
an accident that caused her to lapse into a coma. She was hospitalized at Lincoln General. Two days later, aware that his ex-wife had been hospitalized, Mr. Phillips notified the school system of his December divorce and requested COBRA forms for his ex-wife.

Mr. Phillips then elected COBRA coverage for Ms. Phillips and, without informing his comatose ex-wife's guardian, paid one month's premium on her behalf, which effectively made her eligible for benefits.

BC/BS was not told that she was hospitalized at Lincoln General. And 12 days later, BC/BS mailed to her home address an identification card, an explanation of benefits and a notice that her January premium was paid, but the next two payments were delinquent.

January was the first month covered because COBRA requires that benefits begin the month after previous coverage ended. Because Mr. and Mrs. Phillips were divorced in December, COBRA coverage began the following month.

In its suit, the hospital argued that simply sending this package of information did not constitute formal notification. However, the federal courts disagreed, ruling that by mailing these documents, BC/BS met its obligation to notify a qualified beneficiary.

"After Blue Cross mailed the ID card, benefits information and premium statement to Mrs. Phillips' residence, it was up to her guardians to receive it and act upon it," said Geoffrey Pohl, an attorney with McGrath, North, Mullin & Kratz in Omaha, which represents BC/BS.

Further compounding the situation was the fact that on the same day BC/BS sent its package to Ms. Phillips' house, Lincoln General called BC/BS to check the status of her insurance.

According to court papers, a BC/BS employee ran a computer check on Ms. Phillips and told the hospital that she was indeed covered.

However, the employee did not say that Ms. Phillips was in a "grace period" pending payment of her overdue February premium. The employee also didn't mention that Ms. Phillips' coverage was due to lapse at the end of February and that the premium already paid would be applied retroactively to coverage for January.

Lincoln General argued that BC/BS was equitably estopped from denying coverage because the hospital had relied to its detriment on what it now contends was a misstated fact. Lincoln General insisted that the BC/BS employee realized she was providing false information, and failed to correct it.

"Had the hospital known that Ms. Phillips' coverage was going to expire, it would have paid the premium itself and just tacked it onto the bill," said James Zalewski of Erickson & Sederstrom, the Lincoln law firm representing the hospital.

However, the court ruled that there was no proof that the BC/BS employee knew anything more than the fact that Ms. Phillips had coverage on that date.

In fact, the appellate court placed the onus on the hospital to obtain all possible information because it knew of Ms. Phillips' condition.

"Blue Cross did not know Ms. Phillips was in a coma, though the hospital of course did know it. The hospital could have inquired about the (payments), and perhaps it should have done so in view of the patient's incapacity," the court said.

"Equitable estoppel requires that one party be harmed by a blatant misstatement of fact. The Blue Cross employee simply said what she knew, which was that Ms. Phillips had (coverage)," said Mr. Pohl.

The hospital's attorney, Mr. Zalewski, said he has filed a motion to have the case reheard by the full 15-member 8th Circuit.

"We hope to get the ruling overturned because it contradicts an 11th Circuit ruling that is somewhat similar," he said.

Earlier this year, the 11th Circuit ruled that an insurer was prohibited from enforcing a coverage waiver because it failed to include in a COBRA notification package plan documents that were understandable enough to help guide a person to select coverage or not.

Regardless of any review of the 8th Circuit ruling, Ms. Phillips, who emerged from her coma about six weeks after entering the hospital, will not have to pay the $111,000 bill. She had assigned her legal cause of action to Lincoln General in exchange for a release from the charges she incurred.

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Lincoln General Hospital vs. Blue Cross & Blue Shield of Nebraska; 8th U.S. Circuit Court of Appeals; No. 91-1777NE.

New technology

Continued from page 3

you look at the relationship between health spending and medical outcome, many times you find the less you spend on simple procedures, the more value you get."

Dr. Parker said some of the new technologies patients are eager to try may not be safe or effective. "And the use or misuse of these services will increase costs and lead to bad outcomes."

But, "Medical care and technology is big business, and if there is a new technology available, we'll use it," Dr. Parker said.

When Provident is faced with a request to pay for a new technology or treatment, it looks at how far the new treatment has made it through the approval process, Dr. Parker explained. New technologies go through several stages before they are accepted by the medical community: experimental, investigative, promising and accepted.

The insurer also has identified some of the providers that are most likely to use costly new technologies, including imaging centers, cancer treatment centers, and rehabilitation and pain management centers.

When payers look at the enormous expense associated with certain diagnostic tests, it is easy to understand why they want to

Medical technology is 'big business, and if there is a new technology, we'll use it,' says Dr. Parker.

make sure the tests are absolutely necessary and will do more than less expensive treatments will, Dr. Parker said.

For example, the machine used for computerized axial tomography tests—or CAT scans—costs up to $1.2 million, while each test can run about $500, Dr. Parker said. Machines for magnetic resonance imaging—MRI—cost about $2.5 million, and each tests runs about $1,000. And machines used to perform positron emission transaxial tomography tests—or PETT scans—cost about $4.2 million, with each test running about $2,000.

"Does everyone need one of these test?" Dr. Parker asked. "We have places in the country where if you have a history of heart disease, (some facilities) will automatically tell you to come in to get one of these tests —without a doctor's suggestion to," she said. "Without medical guidelines about when to use these tests, they may be overused or misused."

Dr. Parker also noted that AIDS patients are increasingly requesting Provident to pay for experimental treatments, even though the treatments have not improved outcomes. Cancer patients also are requesting reimbursement for "clinical trials" performed by for-profit cancer treatment centers. Clinical trials typically involve procedures that have not been proven effective.

Rehabilitation and pain management centers also are eating a larger chunk of the health care dollar and should be scrutinized carefully, Dr. Parker said. "Our utilization review program found that 50% of rehab admissions were unnecessary, and 90% of the pain admissions were inappropriate."

Dr. Dragalin pointed out that reimbursement requests for new drugs also lead to controversy.

"New drugs are truly increasing the quality and quantity of life," said Dr. Henry Blissenbach, president of Diversified Pharmaceutical Services Inc., a Bloomington, Minn.-based provider of pharmacy service to health maintenance organizations. "But developing new drugs costs money, and this has payers throwing their hands up."

Dr. Blissenbach sees the controversy over drugs heating up in the future. "Payers are asking, 'How do I know if I'm getting value for my prescription drug dollar?' " And, they will increasingly be faced with questions about approved drugs being used for non-approved uses—espe-

Continued on next page

New technology

Continued from previous page
cially in connection with the AIDS epidemic.

Mental health therapies also are creating controversy, said Dr. Tracy Gordy, a neuropsychiatrist and medical director at Shoal Creek Hospital in Austin, Texas.

"The technology in mental health is really in the drug area for the moment. This is the area you as payers will have to look at carefully," Dr. Gordy said.

Many illnesses, like depression, are now considered organic illnesses and are being treated by drugs rather than psychotherapy, he explained.

And, some mental disorders can now be detected by diagnostic tests like electroencephalographies—or EEGs—so payers should not be alarmed if they see claims for these types of tests, he said.

An increasing number of lawsuits challenge payers' denial of coverage for treatments based on experimental and investigational exclusions, said Thomas E. Johnson, an insurer attorney with Baird, Holm, McEachen, Pedersen, Hamann & Strasheim in Omaha, Neb., during the second session.

Until recently, "the policy exclusion for experimental and investigational procedures was used primarily to protect third-party payers against the occasional odd-ball or maverick medical therapy," Mr. Johnson explained.

But, now "these suits are no longer about anti-neoplaston therapy to be delivered in a Bahamian clinic," the lawyer said. "More often they are about high-dose chemotherapy with autologous cell rescue to be provided by prestigious American universities and medical centers."

Mr. Johnson suggested, among other things, that payers keep the investigational exclusion in their policy contracts separate from the medical necessity clause, since some therapies are experimental and medically necessary and others are experimental but not medically necessary.

"Don't let the trial be a battle between expert witnesses," who will debate the medical necessity of experimental procedures, he said.

Instead, by keeping the language separate, the determining factor in deciding whether a procedure is excluded will be whether or not it has been scientifically approved.

In addition, Mr. Johnson said payers should clearly define what constitutes investigational or experimental therapy and list a set of criteria so that failure to meet one criterion means failure to qualify for coverage.

Jeff Lerner, vp of strategic planing for Emergency Care Research Institute, a private sector technology assessment center in Plymouth Meeting, Pa., discussed how new technologies are approved and the costs involved in the approval process. ■

Tort system assailed

Professor backs malpractice laws based on strict liability

By CHRISTINE WOOLSEY

MINNEAPOLIS—The current tort system does not effectively deter medical malpractice or compensate injured patients, a professor of medicine maintains.

Although the medical liability insurance market is stable, physicians are still bothered by frequent lawsuits and the accompanying hikes in malpractice insurance rates, he said.

And, the tort system—which requires patients to prove negligence to collect any damages—creates inequities. Many patients with injuries not caused by provider negligence suffer losses as great or greater than those of the victims of negligence, yet are entitled to nothing.

Now physicians are increasingly seeking to change medical malpractice law, said Dr. Howard H. Hiatt of Harvard Medical School.

Various groups, including the American Medical Assn., are seeking radical changes to the malpractice system, he pointed out at the recent 42nd annual Group Health Institute. The meeting was sponsored by the Group Health Assn. of America Inc., an HMO trade group.

The current fault-based system of liability, which focuses on the personal negligence of individual physicians, is unacceptable, Dr. Hiatt maintains. Risk of lawsuits is driving too many physicians out of certain practices, like obstetrics.

But, Dr. Hiatt said, a no-fault medical malpractice system—in which all patients are compensated but no one is held responsible for the injuries—is "unrealistic." And such a system would raise questions about how to encourage doctors to prevent injuries, he added.

Instead, Dr. Hiatt advocates a system based on strict liability. Strict liability, as now applied in the product liability context, makes manufacturers liable for all defective goods they produce without requiring users of those goods to show that the manufacturer was negligent.

Like no-fault, a system based on strict liability would compensate all injured patients, he said.

Dr. Hiatt and his colleagues also favor shifting legal and financial liability from individual physicians to the institutions with which they are affiliated. Such a system would aim to give institutions incentives to monitor themselves and to implement prevention programs.

And, like the workers compensation system, the strict liability medical malpractice system would require the patient to give up the right to sue in return for guaranteed compensation.

Dr. Hiatt, along with a lawyer and an economist, recently undertook a study to look at some of the basic questions policymakers need answered before deciding whether or how to change malpractice laws.

The Harvard Medical Practice Study attempted to quantify how many medical injuries take place and how many are the result of negligence; the relationship among injuries, malpractice claims and litigation; the costs of injuries to patients and society; and how those costs are affected by the malpractice system.

The study cost approximately $4 million, $3.6 million of which was provided by New York state. "The state's legislators agreed to hold back on any reform until our study results were released," Dr. Hiatt said.

The researchers found that 2.6 million people were hospitalized in 260 different acute care, nonpsychiatric hospitals in 1984. Almost 100,000 of those people experienced a "medical injury," and out of that group, 27,000 suffered from a "negligent medical injury," the study found.

Furthermore, of those with a medical injury, 9,000 suffered permanent or severe injuries, and more than 13,000 died, Dr. Hiatt pointed out. More than half of those deaths—6,985—were attributed to medical negligence.

More patients died during vascular surgery than during heart, neurosurgery or general operations, the researchers found. Typically, the more complicated the procedure, the greater the risk of injury, Dr. Hiatt explained. The study also found that almost 20% of all injuries were related to drug administration.

The Harvard study confirmed that medical care is a risky enterprise, Dr. Hiatt said. But he and the other researchers, in the May 6 issue of the Journal of the American Medical Assn., urged that the findings "be looked at in perspective. A major reason that today's care is so hazardous is that advances in medical science have made possible bolder interventions (and more favorable outcomes), often in more fragile patients. Therefore, the consequences of errors are likely to be far more serious."

Many doctors say patients bring too many malpractice suits, and that most are ill-founded. To test the validity of those beliefs, researchers collected all tort claims filed by New York patients in and after 1984 and matched them with findings of negligent injury during the same year, Dr. Hiatt explained.

When the researchers matched all patient claims against their hospital files, they found evidence of physician negligence in only 17% of the claims, Dr. Hiatt explained. And, in 60% of the claims "we couldn't find evidence of a medical injury at all."

Meanwhile, "We found that of about 3,800 claims opened in 1984, about 1,900 will be paid," he said. "But during that time, we saw 27,200 adverse events, 9,500 resulting from negligence. That means for every claim paid, 15 negligent injuries took place. And for every claim paid, five very serious injuries took place."

The researchers concluded, therefore, that "a small fraction of patients who are injured bring claims to the system and are compensated. And, a very small proportion of patients who bring claims to the system are injured at all."

The study also attempted to quantify the costs of medical injuries, including costs associated with lost wages, household expenses and patient care. "Overall costs totaled about $20 billion for all patients," Dr. Hiatt said. "About $3.5 billion was the result of adverse medical outcomes," he noted.

"The malpractice system is designed to deter negligent behavior and compensate injured patients," Dr. Hiatt said. "But it's not possible to measure how much deterrence takes place."

Clearly, the system is not preventing bad outcomes or large damage awards, he said. "We desperately need alternatives to the tort system, because it is not serving us well."

Dr. Hiatt and his colleagues recommend allowing hospitals and other health care organizations to offer patients compensation for medical injuries in return for a waiver of the common law tort liability of the hospital and its providers.

Such legislation would require that compensation cover full out-of-pocket medical expenses not covered by insurance, 80% of net lost earnings up to 200% of the state's average earnings level, plus specified payments for loss of enjoyment of life associated with different physical impairments.

The program would cover all injuries suffered by the hospital's patients, even those caused by non-employee physicians with admitting privileges. Hospitals could charge physicians on their staffs a fee in exchange for their being relieved of personal tort liability, Dr. Hiatt said. ■

National health could save billions in administration

By CHRISTINE WOOLSEY

MINNEAPOLIS—Proponents of Canada's health care system maintain that a similar single-payer program in the United States would be much less costly to operate than the current U.S. health care system.

The savings in administrative costs would be more than adequate to extend coverage to all Americans, they add.

Estimates of the U.S. health system's administration costs have been made by the Congressional Budget Office, the General Accounting Office and several independent research firms, but the figures vary widely.

A lot of confusion and debate surrounds the question of how much money is spent on health care administration and, more importantly, how much less would be spent if a single-payer system were adopted, said Marsha Gold, senior health researcher at Mathematica Policy Research Inc. in Washington.

Administrative costs have become the central issue in the debate over how the health care system should be reformed, said Ms. Gold, who also moderated the session of the Group Health Assn. of America Inc.'s 42nd annual Group Health Institute conference June 7-10 in Minneapolis.

"There is an assumption that there are a lot of unnecessary administrative costs" in the U.S. health system, Ms. Gold explained. "There is some effort to get rid of those costs without changing the system" through uniform billing systems, for example, she said.

Many people feel adopting a Canadian-style health system is the only way to achieve wide-scale savings.

Without question, administration adds greatly to the cost of running America's health care system, said Judith Arnold, project manager in the Fairfax, Va., office of Lewin/ICF, an independent policy research firm.

"The United States spends about 25 cents of every dollar on administration" according to Lewin/ICF's estimates, Ms. Arnold said. In addition, hospitals and physicians spend about one-third of their revenues on administration—mostly claims processing, she noted.

Although Lewin/ICF has not calculated the total amount U.S. employers spend to administer their health plans, "health insurance is much more costly to administer for small firms," accounting for as much as 12% of total health plan costs, she said.

"If the United States were to adopt a Canadian system—with its benefit package and no cost-sharing, deductibles or premiums—we would save a lot of money," Ms. Arnold said.

1991 savings estimates from both the public and private sectors vary greatly—ranging from $3 billion to $241 billion.

Lewin/ICF estimates that if the United States in 1991 had adopted a Canadian-style health care system—with no cost sharing—it would have saved about $46.5 billion, Ms. Arnold said. Costs associated with insurance administration would have dropped 65%, resulting in a net savings of $22.5 billion, while physician administrative costs would have decreased 25%, saving $11 billion, she explained. And, hospital administrative costs would have dropped 15%, saving about $13 billion, she said.

The U.S. health care system costs more than $700 billion annually, according to the Health Care Financing Administration.

However, Ms. Arnold pointed out, "If we move to a Canadian system, there will be increased utilization as the uninsured use more health services. And, if we eliminate cost sharing, we'd probably see increased utilization as well."

When Lewin/ICF combined an estimated $78.2 billion in increased utilization with an estimated $46.8 billion in administrative savings that a single-payer system would reap, the firm calculated the net cost of adopting a single-payer system to be about $31.4 billion, she said.

Fueling the debate over whether a Canadian-style health system is appropriate for the United States are observers who question whether all administrative costs are unnecessary or whether some of them actually add value to the health care system, Ms. Gold noted. Those individuals are asking, "To what extent would it be worth it to have certain administrative costs—particularly if they help decrease utilization and better manage the delivery of health care?" she said.

Managed care programs attempt to control utilization and to manage health care services, although they do increase administrative costs, Ms. Arnold explained. And, she said, almost "all recent health care reform proposals recommend expanding the role of managed care."

However, "Many of the proponents that want to adopt a Canadian system haven't looked at how managed care would fit in," she noted. "The Canadian system has very little managed care as we know it. They have limited retrospective review, few quality assurance mechanisms and first-dollar coverage to all, so there is little reason for people to join an HMO."

But, some reform proposals would incorporate managed care in a single-payer model, Ms. Arnold said.

For example, the Health USA Act, sponsored by Sen. Bob Kerrey, D-Neb., proposes a tax-financed system that allows people to choose among competing insurers and provider networks (*BI*, Dec. 23, 1991).

Another proposal, backed by the American Hospital Assn., recommends that providers be organized into networks that would compete in large metropolitan areas, Ms. Arnold explained.

Those networks would receive capitated payments adjusted according to a national budget and would be responsible for utilization management, among other things.

Ms. Arnold predicts that, in the short term, "Congress probably will not enact any reform that requires more spending. It is more likely to enact insurance market reforms for indemnity plans," which would restrict insurers from redlining unhealthy individuals or small employers and would shorten pre-existing condition clauses.

And, Congress will continue to impose cost controls through national budgets, Ms. Arnold said. Congress will cap spending and pay according to fee schedules, like the recently adopted Resource Based Relative Value Scale used by Medicare.

"None of these (congressional) insurance market reforms addresses the problem of the uninsured," however, Ms. Arnold pointed out. ■

1,600 attend health conference

MINNEAPOLIS—Nearly 1,600 managed health care professionals, physicians, benefit consultants and employee benefit managers attended the Group Health Assn. of America Inc.'s 42nd annual Group Health Institute June 7-10 in Minneapolis.

More than 54 sessions featured discussions about the administrative costs of the U.S. health care system, the impact of malpractice reforms on managed care organizations, medical technology assessment and how health care reform efforts will affect the managed care industry.

In addition, managed health care executives and researchers presented professional papers on a variety of topics: innovative developments and research in HMO management, product development, cost-containment and health care delivery.

More than 100 companies took part in the GHAA's 1992 exhibitor display forum, offering conference attendees information about their managed health care products and services.

The Washington-based trade association for HMOs was founded in 1959. Among other things, the GHAA provides continuing education programs for its members and collects data on HMO enrollment and the number of and costs of HMOs nationwide.

The 43rd Group Health Institute is scheduled for San Francisco next June. For more information, contact the Conference Office at the Group Health Assn. of America Inc., 1129 20th St. N.W., Suite 600, Washington, D.C. 20036.

Two reformers, one goal: Cut health costs

By CHRISTINE WOOLSEY

MINNEAPOLIS—The high cost of health insurance is not an insurance problem, but a medical system problem caused by poor productivity, a health care expert maintains.

"There isn't a person in this room who hasn't seen the future of health care in this country—and the future stinks," said Walter McClure, who spoke at a recent health care conference. Mr. McClure, chairman of the Center for Policy Studies, an independent policy research organization in Minneapolis, is nationally known for pioneering work on practical strategies to restructure the health care system.

To encourage systemwide reform, Mr. McClure advocates a purchasing strategy, called "Buy Right," in which health care consumers combine their purchasing leverage to improve the cost-efficiency of the health care system in their location. Purchasers should direct their resources to providers that keep costs low and quality high, he said.

But currently, health care is an unsound market in which provider behavior drives up costs, Mr. McClure said.

Unlike other markets, competition in health care tends to actually raise costs, rather than lower costs and improve services, he explained. That phenomenon occurs because when competition forces providers to lower their costs below market averages, they simply begin performing—and charging for—additional services, he said.

Mr. McClure was among well-known leaders in health care who spoke at the 42nd annual Group Health Institute, which was sponsored by the Group Health Assn. of America, an HMO trade group.

'Our health system is still characterized by cost-unconscious choice,' says Alain Enthoven.

His reform strategy is rooted in Adam Smith's principle that a market will function efficiently only in the presence of certain conditions, such as market competition that drives prices, an appropriate amount of regulation and educated consumers. Because not all of these conditions occur naturally in most markets, they must be "deliberately imposed and maintained by public policy," Mr. McClure said.

Consumers must be educated to think of what they are buying as "health results and patient satisfaction, not health services," he said.

Another conference keynoter, Alain Enthoven, professor of health research at Stanford University School of Medicine in Palo Alto, Calif., outlined his health system reform strategy, termed "managed care/managed competition."

Among other proposals, Mr. Enthoven and his colleagues—collectively known as the Jackson Hole group—favor eliminating a fee-for-service payment system in favor of a system of per capita pre-payment. "Much of the economic failure of the current system is due to the fee-for-service structure characterized by groups of specialty practitioners and remote third-party reimbursement," he said.

Another problem is that "our health system is still characterized by cost-unconscious choice," he said. Like Mr. McClure, Mr. Enthoven favors a "purchaser strategy based on cost-conscious consumer choice that is designed to reward the most efficient providers."

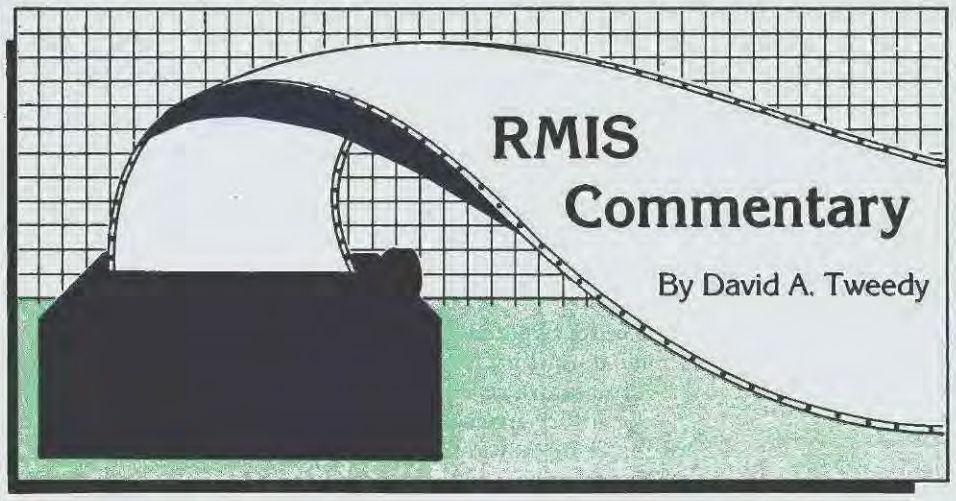
In addition, Mr. Enthoven suggests establishing "Health Insurance Purchasing Cooperatives" to provide coverage for workers at small firms, who often go without health insurance because their employers cannot afford it.

While risk pooling exists now, it often fails because "healthy" companies don't want to pool with "unhealthy" companies, Mr. Enthoven said. But, he said, "Employers have to take a longer view. Just because your experience is good today doesn't mean it will always be good. If you are hit with some expensive claims and your premiums go up, then other employers won't want to pool with you."

One way to guarantee participation in such cooperatives would be to bar employers of a minimum size from buying coverage outside the pool, Mr. Enthoven said. ■

Artificial intelligence

Knowledge-based comp claims system ready for U.S. market



APPLYING ARTIFICIAL intelligence—or expert systems—to the claims reserving function within the insurance industry is overdue.

In my Jan. 20 column on artificial intelligence in underwriting systems, I asked why the insurance industry had not more actively embraced expert systems in the two most prevalent and logical functions within insurance: underwriting and claims.

As a former claims adjuster/supervisor for Liberty Mutual Insurance Co., my initial reaction to artificial intelligence and case reserving was predictable and generally reflective of the claims industry's opinion: "Reserving is an art, not a science. . . .Computers will never be able to include all of the objective and subjective elements that go into setting future reserves in workers compensation or liability cases."

Unfortunately, neither does the claims industry—there is so much variance on how to set casualty reserves on a case basis within the industry itself! However, no one in the insurance industry seemed to be interested in providing a sophisticated reserving system to improve and streamline the process.

That has changed. In 1991, Risk Data Corp. introduced Micro Insurance Reserve Analysis to the insurance industry. MIRA provides on-line automatic reserve setting, drawing on a historical data base of 10 million claims from 14 insurers.

And now, Care Systems Corp.—an Australian company with offices in Dallas—in partnership with Perot Systems Corp. of Dallas is unveiling a comprehensive workers compensation claims management information system that includes computer-derived reserves. (Until recently, Perot Systems was headed by Ross Perot.) The system—Compensation And Rehabilitation Expertise, or CARE—is being introduced to the U.S. and Canadian workers comp market, hoping to parallel or even improve upon its performance in Australia.

Over a 3½-year trial period utilizing the CARE system, average claims costs in Australia were reduced to $384 from $2,300. Whereas the average industry loss ratio in Australia was 80%, Australian firms using the CARE system reduced the loss ratio of claims to premiums to 30%. Furthermore, CARE was able to reduce internal administration costs by more than 50%: For every $10 million of premium under the old system, 10 people would be required to maintain it. With the CARE system, that was cut to three.

Obviously, Care/Perot is looking to reach the same level of success in North America—the largest workers compensation marketplace in the world.

How can this system have results like this? Can it be transferred to the highly complex, combative and beleaguered U.S. workers comp system? Just how does a knowledge-based system reduce health claims and administrative costs? What about other emerging expert systems? Finally, how does CARE fit within the risk management information system industry?

These are some of the same questions that we were asking when Perot Systems asked us to review the CARE system last December. After all, entering a mature marketplace like the RMIS industry requires the product to clearly differentiate itself from its competition. Otherwise, it would get lost in the crowd.

Clearly, the advantages of a knowledge-based claims information system make it unique in comparison to any of the mainframe, minicomputer or microcomputer vendors available today. Many are quite sophisticated, using fourth-generation languages, image processing, computer-aided software engineering tools, and some quasi-artificial intelligence, especially in the more sophisticated case management modules on medical treatment. None, though, has designed a core system for claims management as a knowledge-based system.

Entering a mature market like the RMIS industry requires the product to clearly differentiate itself from its competition.

For illustrative purposes, I'd like to discuss just how CARE's knowledge-based claims management system works from an overview perspective:

✔ **Comprehensive data base.**

For any knowledge-based system, the construction of a comprehensive and detailed data base forms a crucial foundation. In fact, a sophisticated data base provides 80% of all the information needed to process a claim, whereas, according to Care, other workers comp systems only provide 30% of the necessary information.

The data base itself is a compilation of dozens of data elements crucial to the workers comp process: litigation, including comparative verdicts in different jurisdictions; an incapacity data base, including periods of hospitalization, total disability and partial disability; a medical data base, including the customary injury codes and classifications; a rehabilitation data base; and standard demographic information like occupation, age and sex. The MIRA system, for example, is able to analyze up to 66 individual claim characteristics.

In essence, necessary claims characteristics are captured as data and input into the master data base upon which the rest of the knowledge-based system's features depend.

✔ **Advanced claims management capabilities.**

A comprehensive, knowledge-based system, like CARE, has the following similarities to other advanced systems:

- Automatic processing of claims, minimizing manual input.
- Reduction of paper file dependence.
- Effective quality control of claims-managed decision.

Most RMIS workers comp systems can do these things.

Two distinctive features of the knowledge-based systems are automatic reserving and pro-active management reports.

Both the CARE and MIRA systems utilize an extensive data base to compute indemnity, medical, rehabilitation and expense reserves on incoming claims.

Using certain proprietary rule bases—a major foundation of a knowledge-based system—the CARE system evaluates each new claim, subjecting it to a number of complex tests to produce the reserve estimate.

How accurate is it? MIRA's accuracy has been computed at 98%, validated by Ernst & Young, based on tests performed at two leading insurers. CARE's accuracy rate is similar, based on its experience in Australia.

The obvious advantage is in saving time. If claims information is gathered and entered quickly, the system can generate an accurate reserve without some of the guesswork frequenting many claims organizations. The suggested reserve is not mandatory; the claim examiner has veto capability if he or she knows of some fact that has not been made part of the data base or the claim itself. The suggested reserves are guidelines and timesavers only.

Further, these reserves are constantly evaluated and changed over time. Obviously, the outstanding reserve is decreased as the claim advances in time and approaches its ultimate result. However, additional information as to medical, legal or liability status would affect the reserve as well, either up or down. It is, therefore, a dynamic reserving process.

Another advantage of the knowledge-based system is its creation of "action reports."

Given daily to claims personnel, these reports comprise a series of tests for all workers compensation claims in the CARE data base. An action report is produced for every claim identified by the CARE system as requiring reaction or other followup by claims personnel. It is not just a simple diary function. Each action report displays key data, like an accident/claims summary, an injury summary, current claims status, current reserve estimates and particular instructions to individual claims personnel for followup.

The action reports are a supplemental tool for the claims professional; they are not meant to supplant the human processes of devising tactics and strategy in investigation and resolution of a claim. They are intended to alert them beyond just a simple diary function, since the system can anticipate conditions and key action areas. A diary system would simply print out, upon instruction, a list of claims to be reviewed every 20 or 30 days. The CARE action report would take basic information contained within the claim itself and identify action steps to be taken at any time.

In next month's column, I will examine why a knowledge-based system can reduce the cost of the claims program to both the end user, whether self-insured or insured, and the provider of those services. ■

David A. Tweedy is a senior consultant for Betterley Risk Consultants Inc. in Worcester, Mass. He is the editor of Betterley Risk Management Commentary and the author of RMIS Update, a yearly publication analyzing major risk management information systems and vendors. Mr. Tweedy's column on risk management information systems appears the third Monday of the month.

Keeping liability losses at bay

During construction, hotel finds leaky tank that pollutes the soil and neighbors' wells

By The Insurance Institute of America

The following question and answer are drawn from the curriculum for the Associate in Risk Management designation awarded by the Insurance Institute of America. They represent the types of questions asked on, and possible answers to, the three examinations for the ARM designation.

The focus this month, based on material from a recent national examination in ARM 55—Essentials of Risk Control, is on actions a seaside hotel can take to reduce the frequency and severity of its liability losses from environmental pollution and from fires occurring on its premises.

Q: The Small Hotel, a shore resort hotel with 200 guest rooms that was built in 1920 by Orville Small, is separated from the Gulf of Mexico by 50 yards of beach which the hotel owns. To reduce hurricane damage, the hotel has erected a breakwater and a substantial protective wall.

The hotel is a five-story building of ordinary joisted masonry construction. Despite occasional violent storms and minor fires, the hotel building has remained in excellent condition, perhaps because it has been well maintained by the Small family.

The owners of the Small Hotel have decided to expand the resort by erecting a modern, four-story building with 175 rooms located 100 yards to the left of the original hotel. In excavating for the foundation of this new building, the general contractor hired by the Smalls has unearthed a large, empty metal storage tank that was installed during World War II to store reserve fuel oil for heating the building. The tank has corroded, and the residual oil from the tank has contaminated the surrounding earth.

The hotel employees have removed the

A.R.M. exercises

underground tank, but efforts to purge all the oil from the soil have been unsuccessful. Consequently, some remaining oil has polluted the wells that provide water to neighboring homes.

- Briefly describe two processes by which the hotel might reasonably attempt to remove the oil from the contaminated soil that surrounded the underground tank.
- Identify four actions the hotel might take, following the contamination of the neighbors' wells, to reduce the extent of the hotel's potential liability to these neighbors.
- Because of its remote location, the Small Hotel provides some dormitory living quarters for the hotel staff. From a fire risk control perspective, should the dormitory space remain in the large, old hotel building or be moved to the smaller, newer building? Give two reasons to support your recommendations.

A: • Under common law, the Small Hotel is liable to the owners of the neighboring properties both for the damages to their real estate and for the cost of cleaning up the hotel's and the neighbors' properties. Under federal statutes, the hotel and previous owners and occupants of the land are jointly and severally liable for environmental cleanup and other pollution damage.

Two of the several processes the hotel could use to cleanse contaminated soil are chemical treatment and biological treatment. Chemical treatment entails mixing chemicals with the soil to neutralize the pollutants in it. Biological treatment involves placing living enzymes and other microorganisms in the soil to consume the contaminating oil and transform it through their digestive processes into less harmful substances.

The first of several actions the Small Hotel could take to reduce the extent of its liability for contaminations of neighbors' wells would be to warn them of the danger and agree to help the neighbors reduce or avoid any resulting harm. Second, the hotel could agree to decontaminate these wells and to supply clean water until they are again usable. Third, the hotel could attempt to purchase neighboring properties so that the neighbors would no longer have claims for damage to their land. Fourth, the Small Hotel could seek other potential defendants, like previous owners or tenants of the hotel's property, to share the statutory liability to those harmed by the environmental pollution.

With the appropriate assumptions, good reasons can be made both for continuing to house employees in the old hotel building and for moving the dormitory space to the new building. Much depends on the relative fire safety of the two buildings, the abilities of guests and of employees to cope with fire emergencies, and the differences between the hotel's potential liability to injured or killed employees its potential liability to similarly harmed hotel guests.

In favor of leaving the employees' quarters in the older, presumably more fire-susceptible building is the fact that these employees may be more familiar with this building and, therefore, they may more readily exit the older building if it should catch fire.

Another reason for housing employees in the old building, and thus providing guest rooms in the newer, possibly safer building, is that such an arrangement would show that the Small Hotel took great care to protect its guests. This would make the hotel less vulnerable to fire-related negligence claims from any guests injured in a fire.

Making different assumptions leads to sound fire safety reasons for moving the employee dormitory to the new building. The construction of the old building may make it better able to resist fire than the new one and, therefore, a safer haven for the hotel's guests. Furthermore, some of the more veteran employees of the hotel may be less agile than the typical guest and, therefore, should have dormitory space available in the safer of the two buildings.

Adequate support of either position earned full national examination credit. ■

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

Court finds TPA liable for gross negligence

The Supreme Court of Mississippi ruled that while a group health insurance administrator could not be held liable for simple negligence in handling a claim, it could incur liability for gross negligence or reckless disregard for the rights of a policyholder.

As an employee of the city of Tupelo, Donna Bass was enrolled in the city's group health insurance plan in May 1984. In February 1985, California Life Insurance Co. replaced Dependable Life Insurance Co. as the group insurer. The California Life policy provided continuous coverage for city employees without changing their effective dates of insurance. California Life used Variable Protection Administrators Inc. to manage claims.

In September 1984, Ms. Bass consulted a physician because of foot problems. She was referred to a podiatrist who recommended orthopedic shoes. In March 1985, after obtaining a second opinion, she had surgery to correct her foot problems. Ms. Bass' first insurance claim for the

Legal briefs

orthopedist/podiatrist bills were put toward her deductible. The other claims were denied allegedly because it was a pre-existing condition. Variable continued to deny her claims, asserting her policy effective date was Feb. 1, 1985, rather than May 1, 1984; that the two medical claims were for different problems; and that her condition was "progressive" and, therefore, existed prior to the effective date of insurance. She sued but lost in the trial court.

On appeal, Ms. Bass argued that Variable's handling of the claim was done in a grossly negligent and wanton manner. Variable argued that since it was not a party to the insurance contract in question, it could not be held liable for bad faith. Agreeing that the plan administrator was not liable for simple negligence, the court said Variable could incur independent liability when its conduct constituted gross negligence, malice or reckless disregard for the rights of the policyholder. The case was returned to the trial court for further proceedings. *Bass vs. California Life Insurance Co.*, Supreme Court of Mississippi, May 29, 1991 (*BI*/01/A.-$10).

Mental stress comp claim

An employee's excessively increased workload constituted an unusual and extraordinary condition of employment that rendered his resulting nervous breakdown an accident compensable under workers compensation law, according to the Supreme Court of South Carolina.

Danny W. Stokes was employed as vp in charge of item processing at First National Bank, where he supervised 130 employees and four managers. In 1983, the bank initiated a merger with South Carolina National Bank. As a result of the merger activity and the resignation of one of his managers, Mr. Stokes' work increased from about 45 hours per week to 60 hours per week in January 1984 and then increased to workdays of 12 to 15 hours in July 1984, and 16 to 18 hours after November 1984. The merger was completed Dec. 1, 1984. He worked until Dec. 9, when he was hospitalized as the result of a nervous breakdown. He filed for and was awarded workers comp benefits.

On appeal, the employer argued that Mr. Stokes did not sustain an "injury by accident" under the workers comp law. But, the court said that the extreme prolonged increase in Mr. Stokes' work hours, combined with additional job responsibilities, constituted "unusual and extraordinary conditions of employment" which resulted in a compensable accidental injury. *Stokes vs. First National Bank*, Supreme Court of South Carolina, Oct. 14, 1991 (*BI*/02/Ju.-$10) ■

These abstracts were prepared by Mayo H. Stiegler. Copies of these decisions are available by sending a $10 check payable to Mayo H. Stiegler to Business Insurance, *740 N. Rush St., Chicago, Ill. 60611-2590. List the number for each opinion.*

INTERNATIONAL

Court may reverse guaranty fund ruling

By STACY SHAPIRO

LONDON—The Court of Appeal of England and Wales appears to be leaning toward a reversal of a controversial lower court decision that bars contingent liability claims from being paid by a British guaranty fund.

After an unusual intervention in the proceedings by the Secretary of State for Trade and Industry, the justices indicated they support overturning that portion of the lower court decision that limits coverage of claims for North American professionals insured by the insolvent KELM companies.

However, a final judgment will not be issued until at least July.

The interest of the government official may have reminded the Court of Appeal judges of the wide-ranging implications their decision will have on the protection of millions of policyholders of insolvent U.K. insurers.

In addition to the contingent claims issue, the court also must decide whether it agrees with the lower court ruling that North American individuals who bought policies from U.K. insurers can receive 90% of unpaid losses from the Policyholder Protection Board, which administers the guaranty funds. And, the court must decide if professionals are covered by the fund if they are in partnerships.

Regardless of its decision, the case is likely to go to the House of Lords, the country's highest court, all parties agree.

The Court of Appeal hearing last week involved four insolvent insurance companies that wrote coverage on the H.S. Weavers (Underwriting) Agencies Ltd. line slip. Known as the KELM companies, they are: Kingscroft Insurance Co. Ltd., El Paso Insurance Co. Ltd., Lime Street Insurance Co. Ltd. and Mutual Reinsurance Co. Ltd.

A group of North American lawyers, doctors and accountants is appealing a test case decision by Justice Webster in London's High Court that would stick the North American professionals with hundreds of millions of dollars in unpaid professional liability claims.

Opposing the North American professionals are:

- The Policyholder Protection Board, which is dominated by British insurer executives.

Under the Policyholder Protection Act of 1975, the board is required to pay "private policyholders" with "U.K. policies" 90% of all valid claims if an authorized U.K. insurer is liquidated. The board must pay 100% of claims on mandatory insurance policies, like third-party auto insurance.

- Royal Insurance (U.K.) Ltd., representing the Assn. of British Insurers. ABI member companies will have to pay a levy of up to 1% of the previous year's non-life net premium income to fund any claims payments the PPB makes to policyholders.

Parliament might have to in-

Continued on next page

Utility insurer creates rent-a-captive

By ROGER SCOTTON

HAMILTON, Bermuda—Electric and gas utility excess liability insurer Energy Insurance Mutual Ltd. is forming what has been described as a rent-a-captive-style subsidiary in Bermuda to underwrite the "various and sundry" risks of its 104 member utilities.

EIM, which is domiciled in Barbados, is capitalizing Energy Insurance (Bermuda) Ltd. at only $120,000.

"My intuition tells me this could soon become a very substantial company, but we'll build capital as we go forward," said Gene L. Weaver, president and chief operating officer of the parent company.

The Bermuda subsidiary will operate on mutual principles and is seeking powers to issue a wide range of policies, Mr. Weaver said.

According to its just-published articles of incorporation, the Bermuda company wants permission to issue "contracts of insurance, reinsurance and co-insurance of all kinds." It is also seeking permission to enter into risk-bearing or

BERMUDA

fully funded "financial guarantee insurance contracts; guaranteed investment contracts; annuities; and guaranty, surety and indemnity business of all kinds."

"We want to be licensed to write anything we consider it prudent to write," said Mr. Weaver. "This could be pure insurance, self-insurance or a combination of the two, with some reinsurance involved."

Mr. Weaver said that each program written by the Bermuda subsidiary will be "custom-designed to meet the needs of particular members."

Individual "cells" or self-contained units are to be set up within the new company to run specific programs, each with segregated assets and liabilities. One Bermuda source this week described the company's structure as being similar to a rent-a-captive facility with segregated member accounts.

The new subsidiary's aims are set out in a formal petition to Bermuda's British-style Parliament. The petition, called the Energy Insurance (Bermuda) Ltd. (Segregated Reserves) Act, requests legislation to establish "segregated reserves for the sole purpose of assuring the company's ability to meet the ultimate aggregate insurance liability under policies issued by the company."

And it provides that, in the event of a winding up, "the liquidator shall be bound to recognize the separate nature of each Mutual Business Program and shall not apply assets identified as the assets of any one (program) to pay claims by member insureds under policies issued under any other (program)."

Similarly, the profits and losses of each program are to be borne by the relevant member policyholders of any one mutual program.

Mr. Weaver said he could not predict the likely level of premi-

Continued on next page

Maxwell funds bolstered

U.K. government sets up temporary pension funding

By GAVIN SOUTER

LONDON—Amid a flurry of developments surrounding the late Robert Maxwell's empire, the British government will provide temporary funding of 2.5 million pounds ($4.6 million at current exchange rates) to meet the pension obligations of Maxwell companies.

Last Thursday, Robert Maxwell's sons, Kevin and Ian, as well as Larry Trachtenberg, a director of various Maxwell companies, were arrested in connection with various criminal allegations involving the Maxwell media empire and pension funds.

Also last week, Britain's prime minister denied allegations that the government had intelligence information about dishonest activities by Mr. Maxwell two years before his death, including the siphoning of pension funds.

Before these developments emerged last week, Peter Lilley, secretary of state for British Social Security, announced that the government would extend funds to the Maxwell pension plans. In addition, he said, the government will encourage financial institutions to contribute to a separate fund to assist retirees of Maxwell companies and also will institute a review of pension law.

Mr. Maxwell allegedly stole 426 million pounds ($779.6 million) from his companies' pension funds before his death (*BI*, Dec. 16, 1991). Currently, the liabilities of the Maxwell pension funds are estimated to exceed assets by 350 million pounds ($641.6 million), Mr. Lilley said, noting that not all of the money in the funds was stolen and that some of the money Mr. Maxwell allegedly took has been retrieved.

That shortfall has led to payments being stopped for some retirees and dependents.

The government will set up a temporary emergency fund of 2.5 million pounds in the form of grants that will eventually be repaid by the funds, Mr. Lilley said.

"The intention is that the grants

Continued on next page

U.S. Lloyd's members rebuffed

By GAVIN SOUTER

LONDON—Underwriters at Lloyd's of London have won the first round of a legal battle against 91 U.S. members seeking to recover their losses in the market.

A U.S. District Court judge in New York last week ruled that any suits brought against the 318 syndicates named in the members' complaint should be governed by English law.

Judge Morris Lasker also ruled that regardless of whether the syndicates were being sued under English, New York or federal law, they are not legal entities capable of being sued.

The judge found that the syndicates are groups of individuals brought together for administrative convenience rather than legal entities in themselves, explained Sheila Marshall, a lawyer at LeBoeuf, Lamb, Leiby & MacRae in New York, who represents Lloyd's in the case.

LONDON

The members are appealing the decision, according to members' lawyer Steve Feigenbaum with Proskauer, Rose, Goetz and Mendelsohn in New York.

E&O mandate gone

Lloyd's of London has withdrawn its requirement that managing agents purchase a minimum of 5 million pounds ($9.3 million) of errors and omissions coverage.

However, an agency's level of E&O coverage will still be taken into consideration when the market periodically judges whether it is fit and proper to underwrite at Lloyd's.

Compulsory E&O coverage for agents will end Jan. 1, 1993.

"Severe difficulties have been experienced in establishing a viable market for such insurance this year, and it seems likely that the situation may be even more uncertain next year," said Richard Hazell, a deputy chairman of Lloyd's in a letter to members and agents.

Earlier this year, the capacity of a line slip for managing agents' E&O coverage shrunk to 2 million pounds ($3.7 million) from 20 mil-

Continued on next page

London market executives oppose merger of Lloyd's, ILU and LIRMA

By STACY SHAPIRO

LONDON—Will Lloyd's of London merge with the two other major London market associations by the year 2000 to form a single, uniform association?

No.

At least, that was the prediction by the vast majority of guests voting at the third annual black tie dinner and debate hosted last month in London by Skandia U.K. Insurance P.L.C.

Nevertheless, interesting arguments were made in favor of merging Lloyd's, the London Insurance & Reinsurance Market Assn. and the Institute of London Underwriters. Among them:

- LIRMA and the ILU are already talking about a merger.
- Lloyd's is expected to introduce corporate membership, so it would eventually make sense for the three organizations with similar members to merge.
- All London underwriters could market themselves as one force.

It is certain that the worldwide insurance industry will be restructured by the turn of the century, said John Engestrom, chairman of the debate and chief operating officer of Skandia Reinsurance Co. in Stockholm, Sweden.

"I am a firm believer (in the London) market, that it will survive," said Mr. Engestrom. "I am also a firm believer that the ways of doing business will change drastically."

About 190 people attended the debate on the motion: "This house believes that by Dec. 31, 1999, Lloyd's, LIRMA and ILU should have combined in one body corporate."

In favor of the motion was John Arpel, managing director of SCOR U.K. Reinsurance Co. Ltd. To state the obvious, "The London market is going through difficult times," he said.

A single corporate body would not give the market what it needs—uniform rate increases—but it would "give us a single voice," said Mr. Arpel.

Part of the current problem centers around Lloyd's, which Mr. Arpel said has been London's "brightest beacon." Lloyd's and some London insurance companies have been getting a

Continued on page 21

The Professional Marketplace

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The West Virginia Public Employees Insurance Agency (PEIA) will release a Request for Proposal on or about June 25, 1992, for group administation system software and related installation, data conversion, training, technical support, and similar services. This new Employee Insurance Administration System (EIAS) will be installed within the State's IBM mainframe based computer center and will handle all enrollment, eligibility, billing and premium reconciliation processes for a variety of both self-funded and insured benefits programs covering approximately 100,000 active and retired public employees within over 500 agencies/employers throughout West Virginia.

A qualified vendor of the EIAS will have: 1) a proven track record of supplying packaged and well-documented eligibility, billing and premium handling system software to insurance carriers, Blues organizations, third party administrators, governmental agencies, associations, employers, and the like; 2) state-of-the-art eligibility, billing and premium handling systems technology; 3) sole rights as principal to license (not sublicense) and fully maintain and support its EIAS; 4) existing system product for the IBM mainframe environment; 5) capability to install the system, convert existing (automated) data and bring up fully operational enrollment and eligibility maintenance functions by January 1, 1993, and 6) capability to bring up fully operational billing and premium reconciliation functions by June 30, 1993.

Interested and qualified organizations may contact **Ann M. Stottlemyer, Deputy Director, PEIA; Building 5, Room 1001, 1900 Kanawha Boulevard, East; Charleston, West Virginia 25305 (FAX: 304-558-2516).**

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Ticor suit

Continued from page 1

fendants claim they are protected from federal antitrust law by the McCarran-Ferguson Act and the state action doctrine.

The federal judge hearing the case dismissed the lawsuit in September 1989, but the 9th U.S. Circuit Court of Appeals reinstated the lawsuit a year ago (*BI*, June 24, 1991; Sept. 25, 1989).

The defendants have asked the U.S. Supreme Court to review the case (*BI*, Jan. 20; Jan. 13).

The court is waiting for a brief it requested from the U.S. Solicitor General's office, part of the Justice Department, outlining its views on whether the court should hear the case (*BI*, March 30). The brief is expected to be filed within the next week or so.

In general, attorneys representing defendants in the industry antitrust litigation do not believe the Ticor decision is relevant to their case. While both cases deal with the state action doctrine, the specific issues in each case are different, they say.

But, some attorneys general believe the high court's restrictive interpretation of the state action doctrine will be helpful to their arguments.

The Ticor case also is significant in light of the congressional debate over whether to repeal the limited antitrust exemption provided to insurers by the McCarran-Ferguson Act.

Under the state action doctrine, joint pricing activity by an industry is exempt from federal antitrust law if:

- The activity is undertaken pursuant to a clearly articulated state policy to displace competition with regulation.
- The state "actively supervises" the conduct.

In the Ticor case, the FTC charged that insurance regulators in Arizona, Connecticut, Montana and Wisconsin did not "actively supervise" the rates set by title insurers for title searches and examinations.

Insurers named in the case are: Ticor and SAFECO Title Insurance Co., both of which have since merged with Chicago Title Insurance Co.; Lawyers Title Insurance Corp.; and Stewart Title Guaranty Co.

The insurers filed rates in the four states under file-and-use systems through rating bureaus, all of which have since been disbanded.

The Ticor case concerns only the rates set by title insurers for title searches and examination, not title insurance rates.

The FTC did not challenge the title insurers' cooperative setting of rates because the McCarran-Ferguson Act protects from antitrust scrutiny an activity that is the "business of insurance."

In his decision, Justice Kennedy concluded that regulators in Montana and Wisconsin did not sufficiently supervise the title insurers' rate setting for title searches and examinations.

"Where prices or rates are set as an initial matter by private parties, subject only to veto if the state chooses to exercise it, the party claiming the immunity must show that state officials have undertaken the necessary steps to determine the specifics of the price-fixing or rate setting scheme. The mere potential for state supervision is not an adequate substitute for a decision by the state," he wrote.

"The analysis asks whether the state has played a substantial role in determining the specifics of the economic policy," he said. "The question is not how well state regulation works but whether the anti-competitive scheme is the state's own."

In light of this standard, he concluded regulators in Montana and Wisconsin had not "played a substantial role" in the rates set by the title insurers.

For example, he noted that Wisconsin only checked the mathematical accuracy of the rate filing.

The court remanded the case to the 3rd U.S. Circuit Court of Appeals in Philadelphia for a further determination of whether Arizona and Connecticut regulators conducted sufficient review of the insurers' rate filings.

In his dissenting opinion, Chief Justice William Rehnquist, joined by Justices Sandra Day O'Connor and Clarence Thomas, criticized the majority for failing to set a clear standard that states and businesses can follow.

And, Justice Antonin Scalia, in a concurring opinion, said the court's vague standard would engender more antitrust litigation.

"This ruling places state-regulated businesses in a very difficult position," said Craig Berrington, senior vp and general counsel for the American Insurance Assn. in Washington.

"You can follow the state's regulations perfectly and later be subject to federal antitrust law because the federal court finds the state didn't do its job," he said.

"This decision is tantamount to requiring federal oversight of state regulatory activity," said attorney John C. Christie Jr., who represents the title insurers in the Ticor case.

The decision also places the burden on the regulated businesses to prove there was sufficient regulatory activity, said Mr. Christie of Bell, Boyd & Lloyd in Washington.

"The decision comes close, in practical terms," to wiping out the state action doctrine, said David Canton, an antitrust lawyer with Baker & McKenzie in Washington. "This opens the door for additional litigation on what constitutes active state regulation."

Although the Ticor case did not involve the McCarran-Ferguson Act, Mr. Christie says the title insurers will press this issue on remand. They will argue that title searches and examinations are part of the "business of insurance" because they are an integral part of underwriting risk.

David M. Farmer, vp-federal affairs for the Alliance of American Insurers in Washington, observed that one of the arguments used by those who advocate repeal of McCarran-Ferguson is that insurers also are protected by the state action doctrine. "If McCarran-Ferguson is taken away, then the Ticor decision will have substantial and far-reaching impact on the insurance industry," he said.

"This will force states and insurers to seek out more and more regulation and move away from competition in order to satisfy the requirements of the state action doctrine," he said.

"Insurers need less regulation —not more," Mr. Farmer argued. "The hidden tax of exhaustive regulation is unnecessary and should be avoided rather than encouraged. The Ticor decision is clearly one more argument for retention of McCarran-Ferguson in its present form."

In speculating on what impact the Ticor decision could have on the attorneys general's antitrust suit, defense attorneys stress that very different issues are involved in the two cases.

"The insurance antitrust litigation is independent from Ticor and raises a separate issue," said Mark Levy, an attorney with Mayer, Brown & Platt in Chicago, which prepared the Supreme Court review petition filed by most of the U.S. insurance industry defendants.

The issue in the Ticor case is that states did not actively supervise insurers' conduct. In the attorneys general case, "it's clear that the state engaged in extensive and detailed supervision," he said.

"I don't think that Ticor is relevant to us at all," agreed attorney Bartlett H. McGuire of Washington-based Davis Polk & Wardell, which represents ISO in the antitrust case.

In the Ticor case, there was no state supervision at all; in the insurance industry case, 35 different states held hearings on the changes in the policy form, Mr. McGwire said.

"There is no question in the insurance antitrust litigation that the insurance regulators reviewed the forms very extensively," said Roy T. Englert Jr. of Mayer, Brown & Platt in Washington. "As a result, the Ticor decision will have very little impact on the insurance antitrust litigation."

Despite the factual differences between the Ticor case and the insurance industry antitrust litigation, many of the attorneys general believe the Ticor ruling may help them.

The emphasis throughout the Ticor decision was that the state must look closely at the particular conduct it is approving, said Richard Schwartz, assistant attorney general for New York. "That general tendency helps us greatly."

If there was any doubt that the attorneys general would win their state action arguments, the Ticor decision removed it, Mr. Schwartz said.

But, he predicted the Ticor decision will have "no effect at all" on whether the Supreme Court agrees to hear the attorneys general case.

"We felt that the states had not actively supervised the conduct at issue," which was the alleged boycott, said Tom Alpert, assistant attorney general for Massachusetts. "What Ticor makes clear is that active supervision is a fairly stringent test to beat."

Attorneys for both sides said they generally could not discern from the Ticor ruling whether the Supreme Court is likely to review the insurance industry antitrust litigation.

But some attorneys observed an underlying pro-antitrust tone in the decision. This would indicate the Supreme Court is more likely to let the 9th Circuit's decision reinstating the litigation to stand.

The Ticor decision sends a signal that the court is concerned "with the states' regulatory process," said the AIA's Mr. Berrington. "There is an attitude that the state regulatory systems should not be presumed to be competent."

Mr. Englert agreed.

And, "it might be fair to conclude that the court is more anti-businesses than previously thought," he said.

"What the court decided is very, very consistent with the states' position in the insurance case," said Kathleen E. Foote, a deputy attorney general for California.

Furthermore, the major issue in the attorneys general litigation is the alleged boycott activity, not the state action doctrine, Ms. Foote said. If the 9th Circuit's decision to reinstate the case on the boycott issue is permitted to stand, there would be no reason to review the issue of the state action doctrine, she said.

However, according to Ms. Foote, the court's handling of the Ticor case could indicate that "the court has a particular interest in this area" and may decide to review the insurance industry litigation.

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Federal Trade Commission vs. Ticor Title Insurance Co. et al, U.S. Supreme Court; No. 91-72.

Illinois voters to consider national health

CHICAGO—Voters in Chicago and surrounding communities in Cook County, Ill., will get a chance to express their views on national health insurance in November.

An ordinance sponsored by John H. Stroger Jr., a member of the Cook County Board of Commissioners, and approved 11-4 by the board, puts on the Nov. 3 ballot an advisory referendum on whether a national health insurance system is needed.

The referendum will read as follows: "Should the State of Illinois urge the Congress and the President of the United States to enact a publicly funded national health insurance program that provides comprehensive health care for all citizens while giving everyone the right to choose their own hospital, doctor or other health care professional?"

It will be the first time an Illinois county has put the issue of national health insurance before its voters. Cook County reportedly spends $440 million annually on health insurance.

Explaining this action, the ordinance states that the board deems it "to be in the public interest to survey the opinion of the voters" regarding national health insurance.

—By Lori Block

Bank-insurer affiliations

Insurance products offered by banks pose regulatory challenge

By MEG FLETCHER

WASHINGTON—The integration of insurance and banking products is creating new challenges for regulators in the United States and other industrial nations, according to an international group of insurance regulatory officials.

"There is ample evidence that a process of 'convergence' between insurance services and other financial services is under way," said Andre Laboul, administrator of the Directorate for Financial, Fiscal and Enterprise Affairs of the Organization for Economic Co-operation and Development in Europe.

Industrial nations, especially those in Europe, have made great strides in integrating financial services, especially those involving life insurance products, according to spokesmen representing the OECD, Denmark and South Africa.

The international officials participated in a panel discussion at the Seventh International Conference of Insurance Regulatory Officials, held June 7-11 in Washington.

More than 90 regulators from 55 countries—a record attendance—participated in the conference, held in conjunction with the summer meeting of the National Assn. of Insurance Commissioners.

The integration of financial services worldwide was a major topic of discussion at the meeting.

NAIC

According to an OECD study prepared by Mr. Laboul—"Insurance and other Financial Services: Structural Trends"—15 of 24 industrial nations surveyed last summer allowed a bank to directly distribute some type of insurance product.

The trend is toward a "one-stop" financial supermarket, said Piet Badenhorst, executive director of South Africa's Financial Services Board.

"You have to have a rather liberal approach to a phenomenon like this," according to Eigil Molgaard, director general of the Danish Financial Supervisory Authority.

Fifteen of 24 industrial nations surveyed allow banks to distribute some insurance products.

In the United States, the Bush administration supports allowing insurance companies and banks to increase their affiliations, said John C. Dugan, deputy assistant secretary of the U.S. Treasury.

Currently, many states allow banks to engage in agent activities, he pointed out.

However, the administration has found it hard to persuade Congress to pass bills allowing this natural "evolution" to take place, he said.

Integration of banking and insurance provides new opportunities for consumers, the regulators say.

Consumers generally benefit through the increased number of product options as well as by their lower cost, Mr. Molgaard added.

However, consumers face some potential disadvantages, including the possibility of a bank engaging in "coercive selling," by requiring its loan recipients to also purchase insurance, Mr. Badenhorst said.

In addition, an integrated entity may not keep consumer information as confidential as separate banking and insurance entities would, Mr. Badenhorst said.

International regulators' high level of interest in the conference probably was due to ongoing talks about establishing a separate organization for international regulators, said David Walsh, Alaska insurance director and chairman of the NAIC's International Insurance Relations Task Force (*BI*, Oct. 7, 1991).

However, it may take another year for such an organization to establish itself, because international regulators are still discussing issues including which countries should be members, he said.

"The critical thing is to get a structure with which everyone agrees," Mr. Walsh said. In addition, it is important to define the purpose of the organization so would-be participants "are comfortable with it and do not feel that they have given up their autonomy," he added. ■

State Farm proposes new solvency program

WASHINGTON—State Farm Group is proposing a solvency protection program that would require property/casualty insurers to annually deposit enough high-quality assets with a bank trustee to cover their anticipated losses.

NAIC

The Solvency and Financial Enforcement Trust program, dubbed SAFE-T, is intended to enhance current solvency regulation requirements and ensure that substantial assets will be available in the event of insurer insolvencies, said two former regulators who endorse the proposal by the Bloomington, Ill.-based insurance group.

Zack Stamp and Philip R. O'Connor, both former directors of the Illinois Insurance Department, presented the proposal to the National Assn. of Insurance Commissioners during the group's recent meeting in Washington.

Under the SAFE-T plan, an insurer would be required annually to post an amount equal to the total of all reserves for losses and loss adjustment expenses as reflected in the company's most recent annual statement.

The insurer would retain control over trading activities within the account, but any withdrawal from the account would require approval from the insurance regulator in the insurer's home state.

Insurers would be required to eliminate any deficiencies in the account from year to year. If the account dropped to less than 80% of the amount required, the insurer would immediately have to cease writing new and renewal business.

A state's insurance guaranty fund would have a lien against the SAFE-T account if the insurer were declared insolvent.

"SAFE-T constitutes the next logical step in the progress of solvency regulation in an increasingly complex and risky insurance market," according to a statement by Messrs. Stamp and O'Connor.

"As an early warning device, SAFE-T would further mitigate the size of insurance failures," they say.

They contend the plan is appealing because it is:

- Flexible rather than rigid.
- Prospective rather than retrospective.
- Self-executing rather than intrusive.
- Reliant on computer-based surveillance.
- Targeted on reserve adequacy rather than numerous indirect financial indicators.
- Efficient in the use of limited regulatory resources, because it enlists the fiduciary role of banks.

—By Meg Fletcher

Pennsylvania Senate OKs comp reform

HARRISBURG, Pa.—The Republican-controlled Pennsylvania Senate has passed a workers compensation reform package aimed at controlling costs while ensuring quality care and workplace safety.

But Democrats in the state House of Representatives believe this amended version of a bill passed by the House in December weakens its cost containment provisions (*BI*, Feb. 3).

Key elements of H.B. 2140 are:

- A competitive rating system.
- A cap on medical benefits.
- Greater emphasis on workplace safety.

Both versions call for a competitive rating system based on filing of loss costs and individual insurer expenses. This rating system would replace uniform statewide rates.

One point of difference between the House and Senate proposals is the need for prior approval of loss cost adjustments and expenses.

The Senate version also aims to control costs by limiting medical benefits to 120% of Medicare reimbursements, an increase from 113% in the House bill. Currently, medical costs are not capped.

Proponents of the House package cite this change, among others, in arguing that the Senate's amendments benefit the insurance industry rather than businesses and workers.

"The bill as it reads now is a windfall for the insurance industry," says Rep. Dan Surra, D-Elk and Clearfield Counties, a leading proponent of the original House package. "It's not going to save the business community as much money as they (proponents of the amended bill) think it will."

Around the states

The Senate bill also arranges for medical benefit caps to be adjusted annually to parallel changes in the standard weekly wage across the state.

"Opponents of the bill want to make it sound like an automatic annual increase, but it's not," said Neil Malady, an aide to Sen. Robert J. Mellow, D-Lackawanna County, who co-sponsored the Senate bill. "It keeps the rates consistent with inflation. If the standard weekly wage does not go up, neither do Medicare rates."

Rep. Surra says adjustable caps undermine cost containment because whenever rates go up, the percentage insurers have to pay increases, which could lead to increased workers comp premiums.

Workplace safety provisions are another major point of contention. The amended bill requires insurers to provide "safety consultations" to policyholders upon request. But the bill provides no specific incentives to make or follow up on these requests. As a result, House Democrats believe the provision is too lax.

The House version included a proposal from the AFL-CIO which would give a 5% discount to corporations that set up "safety committees" at construction sites and in any workplace that maintains more than 26 workers. Safety committees would provide a means of getting workers and management together to discuss safety needs.

The two sides also disagree over the Senate's attempt to eliminate a state minimum benefits requirement in workers comp cases.

Injured workers off the job now receive a benefit equal to two-thirds of their wages, but cannot receive less than $144 per week.

"We believe if a person's workers comp is more than their salary, then there is no incentive to go back to work," Mr. Malady said.

Rep. Surra disagrees. "The person is making a little more, but he may have lost 30% of the use of his arm," he said.

Gov. Robert Casey introduced the workers comp legislation, the first in 22 years, to pre-empt a statewide 51.8% rate increase.

The House is expected to vote shortly on whether to concur with the Senate's amendments. If they do concur, the governor will veto the legislation, a spokesman in the governor's office said.

If the legislation is vetoed, it would clear the way for the rate hike to go into effect in August.

—By Eileen P. Gunn

N.J. eyes creditor list

TRENTON, N.J.—A bill passed by the New Jersey Senate would establish a priority creditors list in life/health insurer rehabilitations and liquidations.

Choosing to make no changes in a National Assn. of Insurance Commissioners' model law—known as the Life and Health Insurers Rehabilitation and Liquidation Act—the Senate passed S-719 on June 8.

Rehabilitators would be required first to pay operational expenses and employee salaries. Policyholders would be third in line for payment, followed by all other creditors, including reinsurers and banks.

New Jersey now has no priority creditors list; courts allocate assets of failed insurers on a case-by-case basis. Both banks and reinsurers favor the current method.

However, Insurance Commissioner Samuel Fortunato, told members of the Senate Commerce Committee earlier this month that individual policyholders deserve to be placed above institutional creditors "as a matter of social justice."

The NAIC bill may not be as well received in the State Assembly. The Assembly Insurance Committee is now considering changes proposed by reinsurers, which argue that the NAIC bill would too severely restrict offsets, through which reinsurers can subtract from the amount they owe a failed insurer the amount the insurer owes them.

The Insurance Committee, which is preparing to vote on the rehabilitation/liquidation bill, is considering an amendment that would permit a reinsurer to continue to use offsets unless it has a history of abuses.

"The way the NAIC is seeking to limit the offsetting of risk is overrestrictive and counterproductive. It interferes with legitimate transactions that have been allowed for many years," said Brad Kading, a vp with the Reinsurance Assn. of America in Washington.

The legislation being considered by the Assembly, A-1338, would apply retroactively to policyholders and creditors of Mutual Benefit Life Insurance Co., which was placed into rehabilitation in July 1991.

However, Mr. Kading said the offset amendment now being considered by the Assembly committee would not be implemented retroactively and thus wouldn't apply to the Mutual Benefit Life rehabilitation.

—By Michael Schachner

Advertiser Index

Issue of June 22

Business Insurance

Health care reform

Continued from page 1
Associates in Washington.

A serious move to push legislation first developed last month when Rep. Stark tried to forge a consensus from Ways and Means Committee Democrats on health care reform legislation he was drafting.

Rep. Stark acknowledged that several earlier efforts to reach a consensus failed at least in part because earlier proposals did not offer enough benefits to recipients.

The latest proposal won support after Rep. Stark agreed that he would not push for certain highly controversial provisions contained in earlier drafts of his bill that are not directly related to health care reform.

For example, the bill that Rep. Stark plans to introduce this week will not include a provision that calls for allowing employees in group health plans to seek punitive damages against insurers because of improperly denied claims, congressional staffers said.

Rep. Stark said his bill will be passed by his subcommittee, a prediction other benefit experts said is on target. The California Democrat also said he expects passage by the Ways and Means Committee, but he did not predict the bill's fate on the House floor.

The move by Rep. Stark and other House Democrats to bring a health care reform bill to the House floor carries with it the potential for political gains and losses.

The Democrats hope a bill is passed—at least in the House—to send a signal to voters that the Democratic Party is working for health care reform, benefit experts say.

"There is a political impetus here," Mr. McArdle said.

"The Democrats want to put themselves on record as having a program on health care reform," said Mark Ugoretz, president of the ERISA Industry Committee, a Washington-based benefits lobbying organization representing large employers on benefit issues.

But Democrats face a big political risk, too. At this point, it is not clear whether Democrats can win enough support to pass any type of health care reform legislation on the House floor.

"The Democrats might not get anything through and will be seen as unable to accomplish anything," observed Stuart J. Brahs, vp-federal government relations at The Principal Financial Group in Washington.

"It would be an embarrassment if the Democrats could not get a bill passed," said Ellen Goldstein, director of health care policy at the Assn. of Private Pension & Welfare Plans in Washington.

Ms. Goldstein said it would be a "Herculean" feat for Congress to pass significant health care reform legislation this session because of several factors. Most significantly, there is little time remaining in the session because of the election and the administration opposes most proposals advanced by congressional Democrats.

In addition, the unwillingness of House Democratic leaders to consider play-or-pay proposals puts them at odds with the Senate Democratic leadership, which is pushing for that approach, she said.

Still, congressional Democrats and Republicans, as well as the Bush administration, could become so concerned about anti-incumbency anger among voters that they could reach an agreement on some type of health care reform legislation in the waning weeks of the session, Ms. Goldstein said.

And, even if only the House passed a bill before the session ended, it could pave the way for action during the next congressional session, Mr. McArdle said.

Certain portions of the new Stark bill are borrowed or adapted from bills previously introduced by other members of the Ways and Means Committee.

For example, the Stark proposal would set national health care spending limits, as did a bill introduced almost a year ago by Ways and Means Committee Chairman Daniel Rostenkowski, D-Ill.

Under the Stark proposal, the total health care budget would be set by statute in 1994, the year the legislation would go into effect.

Total health care spending in 1994 would be allowed to increase by 9.1% from 1993. An 8.2% increase would be allowed in 1995 with somewhat smaller increases in succeeding years.

After health care spending limits are set, the Department of Health and Human Services would set specific payment rates for health care services so that expenditures would equal the national limits. While physicians and hospitals could charge less than these rates, they could not charge more.

These rates would be based on the same methodology that Medicare uses to reimburse hospitals and physicians.

But while rates paid by private payers, like insurers and employers, would be based on the same or similar methodologies that Medicare uses, the actual rates would be about 30% to 35% higher, congressional staffers estimate.

Hospitals now receive fixed fees from Medicare based on patient diagnosis.

The Health Care Financing Administration, which administers Medicare, currently is putting into place a new fee schedule, known as the Resource-Based Relative Value Scale, for physicians.

While employers have been hit with double-digit increases in health care costs, they are not yet ready to endorse federal rate setting and regulation.

"There is a concern it could drive out quality as well as a worry it could lead to price controls for other services," said ERIC's Mr. Ugoretz.

However, the cost savings resulting from capping health care spending and rates for providers would be so great that it would allow a major expansion of Medicaid and Medicare without an increase in federal taxes, Rep. Stark maintains.

Under his proposal, the Medicaid program, which is funded by the federal and state governments, would be expanded to offer coverage to individuals with incomes up to 200% of the federal poverty level.

For a family of four, the current federal poverty level is about $14,000 of income.

Eligibility for Medicaid now varies from state to state.

In addition, the federal Medicare program, which now provides health care benefits to the elderly and the disabled, would be expanded in several ways.

Individuals with incomes of more than 200% of the federal poverty level could buy Medicare coverage for children under 18 years of age. The premium for this so-called Medicare buy-in would be roughly $100 a month per covered individual, congressional staffers estimate.

Medicare also would be expanded to offer a new prescription drug benefit beginning in 1996. But, the deductible would be $800 in 1996, $850 in 1997 and $900 in 1998. A 20% copayment also would be required.

Also under the Stark proposal:

- Employers with fewer than 100 employees and multiple employer welfare arrangements would not be allowed to self-insure health care coverages.

While the proposal doesn't explain why small employers should not be allowed to self-fund, benefit experts say there is congressional concern as to whether small firms have the financial strength to self-insure. And, there have been many collapses of self-funded MEWAs.

- The self-employed could deduct up to 100% of their health insurance expenses, up from the current 25% limit.
- Employers and insurers could not deny coverage because of pre-existing medical conditions to new workers with less than a three-month break in employment-based health coverage.

In other situations, the maximum pre-existing medical exclusion would be six months.

- Insurers and employers could not deny coverage to any individual based on health status or medical condition.
- States could establish regional health insurance purchasing cooperatives for small employers. ■

Solvency regulation proposals

Continued from page 3
NAIC meeting—and during recent testimony on H.R. 4731—"is the administration's only indication of its position on the issue," noted Dennis Fitzgibbons, a staffer with the House Energy and Commerce Committee, which is chaired by Rep. John D. Dingell, D-Mich.

"This statement is the strongest thus far that I have seen of (administration) support for the continuation of the state system of regulation, or alternatively, its opposition to a federal role," said David M. Farmer, vp-federal affairs for the Alliance of American Insurers.

Previously, officials of the Risk & Insurance Management Society Inc. heard some "rumblings" that the administration would not accept a bill like that proposed in April by Rep. Dingell, but that was all, said Paul Brown, director of governmental and public affairs and general counsel for RIMS (*BI*, April 20; April 13).

Industry groups' reaction to the administration's stance varies according to where each group stands on a federal role in solvency regulation.

Proponents of the current state regulatory system welcomed the administration's support.

"We are pleased to have the administration's position favoring state regulation on the record," commented NAIC President William H. McCartney, who is the insurance director in Nebraska.

"We would certainly agree with the administration's assessment of current regulatory needs," said Mr. Farmer of the Alliance, which supports state regulation.

But, proponents of some form of a federal regulatory role criticized the administration's stance.

The Treasury Department is "somewhat misguided," said Mr. Brown of RIMS. It is "ludicrous" to say that because a state-based regulatory system has worked up until now in some areas, it should continue in all areas, he said.

"There are clearly some areas where state regulation is not working," Mr. Brown said.

For example, there is a need to better coordinate state guaranty fund activities and a need for special regulatory treatment for insurers that write coverage for large commercial policyholders, according to Mr. Brown.

"States are allocating their resources on the wrong things," said George K. Bernstein, an attorney in Washington and New York who represents the Insurance Solvency Coalition, a group of insurers, brokers and policyholders that advocates federal regulation of commercial insurers (*BI*, May 11).

Those "wrong things" include "Mickey Mouse" rate regulation, overregulation of commercial policyholders and requirements that discourage foreign insurers that want to establish U.S. subsidiaries, he explained.

Missing from the debate is that the current system encourages unauthorized insurers and creates competitive disadvantages for commercial insurers, he added.

Spurring the Treasury Department's concerns about a federal regulatory role are proposals for a federal guaranty fund, according to Andrew Wright, vp-federal affairs for the American Insurance Assn. in Washington.

Mr. Dingell's bill, H.R. 4900, calls for establishing a national guaranty fund for insurers that choose to be regulated by a new federal agency. The fund would be prefunded through insurer assessments and would not receive government backing.

"We do not think that now is the time to move forward with a federal legislative regulatory scheme, particularly one that involves a federal guaranty fund for policyholders," the Treasury Department's Mr. Dugan commented.

"We have seen only too well the consequence of a federal deposit insurance scheme for the banking and thrift industry, which many people do not know was not guaranteed by the U.S. government officially until just several years ago," Mr. Dugan explained.

"It started out as a fund that was supposed to be entirely funded by the industry with no government guarantees," just as the proposal for the most recent federal guaranty legislation attempts to do.

"But from our point of view, once you put that sign on the door that says. . .federal guarantee, sooner or later the American taxpayer will be called upon to fulfill that commitment," Mr. Dugan said.

"So, we are very, very skeptical of any move that would take us in that direction: to expand the liability of the U.S. taxpayer," he said.

The Treasury Department endorses the proposal calling for a Treasury Department study, because its experience with the savings and loan bailout taught it to be wary of the side effects of "well-intentioned" efforts that may dampen credit availability.

The insurance industry plays "a critical role" as "one of the principal financial intermediaries and sources of capital in our economic system," Mr. Dugan said in a statement.

In 1990, "total assets of life and property/casualty insurers approached $1.9 trillion, representing over 17% of the financial assets of all private sector financial intermediaries," he said.

"Insurance companies held 32% of all U.S. tax-exempt bonds, 52% of all corporate and U.S.-held foreign bonds, 15% of federal agency securities, 17% of U.S. Treasury securities and almost 16% of all corporate equities and mutual fund shares held by the private financial sector," he noted.

"In addition, insurance companies are a major source of long-term mortgage funds to finance commercial real estate projects after the initial construction and development are complete," Mr. Dugan continued.

Specifically, the Treasury Department wants to study the impact of any solvency regulation proposal on credit availability, monetary policy and other areas of the U.S. financial system.

While not objecting to a Treasury Department study, industry officials wonder whether it is necessary.

RIMS fears a study may be merely a delaying tactic, Mr. Brown said.

Even the Alliance, which strongly supports state regulation, is not sure another study is necessary in light of a study already conducted by the General Accounting Office and an informal study already under way by the Treasury Department (*BI*, May 27, 1991).

"Regulatory problems have been identified, and state regulators are on a clear course to correct them," Mr. Farmer pointed out.

Recommending a study instead of change is "an election year stance," said the AIA's Mr. Wright. In his opinion, the study's conclusions will not have any impact on Mr. Dingell's agenda.

Meanwhile, a jurisdictional squabble is emerging in the House.

Although the House Banking, Finance and Urban Affairs Committee last week approved H.R. 4731, which calls for the Treasury Department study, House Speaker Thomas Foley is considering Mr. Dingell's request that the bill be referred to his Energy and Commerce Committee before it goes to the House floor.

However, a previous request by Mr. Dingell for joint jurisdiction of H.R. 4731 was denied, noted William H. Phillips, staff director of the House Subcommittee on Policy Research and Insurance, which is under the aegis of the House Banking Committee.

In addition, legislators are reluctant to deal with non-essential matters just before an election, according to Mr. Farmer. ■

Bush aims to speed health claims

WASHINGTON—The Bush administration is proposing legislation that would speed up the electronic transmission of health care claims processing and payments, as well as to force hospitals to automate medical records.

In addition, the legislation eventually would give consumers more information about the quality and cost of health care services.

The legislation is intended to shave billions of dollars off the administration of health care claims by forcing insurers—if necessary—to scrap manual processing of a blizzard of paper claim forms in favor of electronic processing.

"Automating the insurance claims process will eliminate the enormous and needless paperwork burden of the system. Automation of health care records will result in quality improvements that will add value to each health care dollar spent," said Health and Human Services Secretary Louis W. Sullivan.

Electronic transmission and processing of claims would greatly improve the accuracy of data, said Lee Barrett, director of information systems-managed care and employee benefits at The Travelers Insurance Co. in Hartford, Conn.

Under the legislation, the HHS secretary would be given authority to develop standards for the electronic transmission of claims information if insurers have not made significant progress toward such standards by 1993.

Insurers already are making some progress in developing such standards through their participation in a special committee of the American National Standards Institute, said Elaine Waxman, director of environmental and strategic analysis at Blue Cross & Blue Shield Assn. in Chicago.

In addition, the legislation would require hospitals to computerize patient records. This could give, for instance, an emergency room doctor access to a patient's entire medical history. Without computerized records, such a doctor may lose valuable time in flipping through a 100-plus page hospital chart, Dr. Sullivan said.

Hospitals now are a long way from computerizing patient records and doing so would be costly, said Dr. Roger Taylor, national leader for health care at The Wyatt Co. in Washington.

Hospitals would have until Jan. 1, 1998, to develop computerized patient record systems.

The measure also would require the states to make publicly available the average prices for commonly provided health care services.

At the same time, all Medicare claims information—after the identity of the patient was removed—would be made publicly available. That would help employers and insurers with their evaluations in setting up provider networks, the administration said. ■

Lloyd's rejects bailout

Continued from page 2

considered by the group, one was found to be inequitable, one too costly and the third involved Lloyd's offering loans to members when it does not have the banking expertise to do so, said Alan Lord, Lloyd's chief executive.

The first proposal would have limited members' losses in the 1988 and 1989 accounting years to about 250% of their capacity on each syndicate.

The working group, headed by Lloyd's Deputy Chairman Richard Hazell, rejected this idea saying it would be inequitable to grant relief to members who suffered large losses on some syndicates but who earned profits on other syndicates, Mr. Lord said.

The second plan called for Lloyd's to pay the net losses of all members for the years 1986 to 1990 and then start fresh.

"The cost of this scheme would have been too high. . .and most people to whom the benefit would have been given are no longer active members of Lloyd's," the deputy chairman said.

The huge costs involved in this scheme would have significantly eroded the Central Fund and might jeopardize policyholders' confidence in the market, he said.

"The central objective of any insurance organization is to reassure policyholders that it will be in a position to meet any claims that arise," Mr. Lord said.

The third plan called for Lloyd's to make loans to members to help them meet their losses, he said.

"That would be mortgaging the future," Mr. Lord said.

Also, it would mean that Lloyd's would have to take on the role of a banker when it does not have the specialized knowledge to do this, according to Mr. Lord.

Although it rejected a central bailout for members' past losses, the council did agree to lower the level at which a marketwide stop-loss scheme would kick in for members' future losses.

The council lowered the loss threshold to 80% of a member's premium limit, the amount he or she agreed to write in a given year, down from the 100% that was originally proposed (*BI*, Jan. 20).

This would encourage wealthy people to join Lloyd's in the future, Mr. Lord said.

There are many people worth many millions of pounds who would not want to risk their whole wealth by joining Lloyd's but would be prepared to risk the maximum of 2.4 million pounds ($4.5 million) that they could lose under an 80% stop-loss threshold, he said.

The maximum premium members are allowed to underwrite at Lloyd's is 3 million pounds ($5.6 million).

The stop-loss plan would be funded by a levy on all Lloyd's members.

Lloyd's also is holding discussions with underwriting agents and brokers to seek contributions to help ease the terms imposed on members who apply to the Lloyd's hardship committee for help in paying their losses, Mr. Lord said.

The payment terms and living conditions currently imposed on members who apply to the hardship committee vary according to individual circumstances, he said.

However, the terms are quite uniform and well-known, argued Tom Benyon, chairman of the Society of Names, a members' group.

"They allow you to keep 9,000 pounds ($16,740) a year if you are single, 14,000 pounds ($26,040) a year for a couple and they let you live in a small house worth 50,000 pounds ($93,000). That's not a lot," Mr. Benyon said.

Unless Lloyd's reconsiders its rejection of a central bailout, such as imposing a levy on all members and market professionals, it will face "death by a thousand writs," Mr. Benyon said.

The change in the stop-loss scheme will not encourage anyone to join Lloyd's, he argued.

"It's difficult to see anybody this side of the funny farm joining Lloyd's until it sorts out its past," Mr. Benyon said.

"There will be a wave of litigation," said Christopher Stockwell, chairman of Lloyd's Names Assn. Working Party. "It's very difficult to see anyone considering joining Lloyd's in the future having any faith in the market after this decision."

Lloyd's should help members facing large losses by raising funds through a charge on all policies written at Lloyd's, recommended Charles Sturge, a syndicate analyst at Chatset Ltd., which earlier this month predicted Lloyd's 1989 loss will top 2 billion pounds ($3.72 billion) (*BI*, June 8).

Lloyd's is expected to announce its 1989 results this week.

Brokers and agents being asked for money to help hardship cases will have to dig deep into their pockets if the problems at Lloyd's are to be cleared up, said Mark Farrer, chairman of the Assn. of Lloyd's Members.

"The market must contribute—and contribute meaningfully—to the problems that it created. Significant sums must be placed upon the table," said Mr. Farrer.

Meanwhile, another Lloyd's member, Claud Gurney, late last week obtained the 100 members' signatures he needs to call an extraordinary general meeting of Lloyd's members. He expects the members to vote on a motion declaring, among other things, no confidence in the council. ■

Senate votes to keep bankrupt firms making payments to pension plans

WASHINGTON—Companies operating under Chapter 11 of the Federal Bankruptcy Act would be required to continue to make minimum contributions to defined benefit pension plans under legislation passed last week by the Senate.

At the request of creditors, though, a bankruptcy court could postpone the minimum contributions if it finds that the needs of the bankrupt company's estate warrant such a delay. But any such delayed contributions would have to be secured.

The legislation, S. 1985, also would give the Pension Benefit Guaranty Corp. the option of sitting on creditors' committees of companies in Chapter 11.

—By Jerry Geisel

Update

Huge toxic waste suit settled

Continued from page 2

insurers, to pay $71 million in bad faith damages to Monsanto. The chemical company alleged, among other things, that Crum & Forster had attempted to unfairly shift costs related to the Brio litigation to Monsanto (*BI*, May 4; April 16).

In addition, a group of chemical companies had previously agreed to pay a total $8.5 million to the Brio plaintiffs. These companies include units of Amoco Corp., Atlantic Richfield Co., Chevron Corp., Cos-Mar Co., Union Carbide Corp. and Hoechst A.G. Many of these companies are also litigating with their insurers.

Tobacco investigation begun

NEW YORK—The U.S. Attorney's Office in Brooklyn is conducting a criminal investigation into whether major tobacco companies misled the public about the dangers of smoking.

According to attorneys familiar with the probe, it could lead to criminal charges under the federal Racketeer Influenced & Corrupt Organizations law as well as mail fraud and wire fraud charges.

The investigation was launched recently in light of documents that the Council for Tobacco Research released earlier this year on the order of a federal district court in Newark, N.J.

Marc Z. Edell, the plaintiff's attorney in a case pending before the U.S. Supreme Court that seeks to hold cigarette manufacturers civilly liable to smokers, said the criminal investigation may turn up evidence that could provide the bases for lawsuits alleging fraud.

Mutual life insurers merge

NEW YORK—Phoenix Mutual Life Insurance Co. and Home Life Insurance Co. will join forces next month in what will be the largest merger in history among two mutual life insurers.

On July 1, Home Life and Phoenix will form Phoenix Home Life Mutual Insurance Co. The new company, which will be based in New York, will have assets of nearly $11 billion and capital and surplus of more than $600 million. It will rank as the 12th-largest mutual insurer in the country.

Officials at New York-based Home Life and Hartford, Conn.-based Phoenix say they are merging in order to strengthen their standing in the group and individual life/health markets and to save about $60 million per year through reduced overhead. They emphasize that neither company is engaging in the merger due to financial problems.

Ohio Casualty leaves California

HAMILTON, Ohio—Citing 10 years of underwriting losses, Ohio Casualty Insurance Co. is withdrawing from California, where it has written property/casualty insurance since the early 1940s.

"We have not made an underwriting profit in California in any line for the past 10 years," a spokeswoman said.

Other factors that contributed to the decision were an estimated $22 million loss from last year's Oakland fires; rates that Ohio Casualty said were too low; and litigation costs it said were too high.

Ohio Casualty wrote $225.3 million in premiums in California in 1991, or 15% of its total business, the spokeswoman said. By April 30, that share had dropped to 13%.

Ohio Casualty says it will run off its policies by the end of 1993.

Briefly noted

The California Supreme Court has let stand an appellate decision permitting the Legislature to siphon $1.9 billion in state employee pension fund assets to help reduce the state's $6.4 billion budget deficit. The **California Public Employee Retirement System** had $64.7 billion in assets at year end. . . .California Insurance Commissioner John Garamendi has filed suit seeking the enforcement of emergency **Proposition 103** rate rollback regulations that have been rejected three times by an administrative law judge. The rules were scheduled to expire last week but were extended for 30 days because of the suit (*BI*, June 15). . . .The California Supreme Court upheld an appellate decision that non-residents cannot file emotional distress suits in California against **heart valve manufacturer Shiley Inc.** simply because the states or countries in which they reside prohibit damages for mental distress caused by fear the valves might fail (*BI*, March 16). . . .Dow Corning Corp. estimates that the $45 million pretax charge it plans to take in the second quarter—on top of earlier charges totaling $49 million—will cover any non-insured liability costs associated with its now-discontinued **silicone breast implant** business. . . .Richard L. Rowe, the former owner of **Harbor Medical Administrators Inc.** of Boston, was sentenced to six years in jail and ordered to make restitution of $1.9 million after pleading guilty to kickback, embezzlement and fraud charges related to Harbor's administration of two bankrupt MEWAs (*BI*, May 14, 1990; Jan. 29, 1990). . . .**NAC Re Corp.** last week began a public offering of $100 million in notes. NAC Re will contribute about 80% of the proceeds to the surplus of NAC Reinsurance Corp. and use the other 20% for corporate purposes. . . .Talks have broken down between insurance and banking industry representatives on a compromise that would limit the **rights of regional banks to sell insurance**. . . .Financial Institutions Insurance Group Ltd. has rejected **Chartwell Reinsurance Co.**'s unsolicited offer of $20 per share to acquire 100% of the insurance holding company's outstanding shares. . . .About 16,000 agents have filed an antitrust suit in federal court in Austin, Texas, seeking $200 million in damages from **Farmers Group Inc.** The agents allege Farmers denied them access to pricing, marketing and policyholder data unless they purchased computer equipment at an inflated price from Farmers. . . .Blue Cross & Blue Shield of Massachusetts will take over ailing HMO **Bay State Health Care Inc.**

MEWA reform bill

Continued from page 2

tirement Income Security Act of 1974. But it relies on the Department of Labor to be "efficient, fair, fast and use good judgment," qualities that Mr. Hunt said the department hasn't always shown.

George Pantos, Washington counsel for the Self-Insurance Institute of America Inc. and an attorney with Vedder, Price, Kaufman, Kammholz & Day, called the Bush bill "a step in the right direction" because it includes federal standards for MEWAs.

Many MEWAs provide a legitimate source of health insurance, primarily to small employers. But the plans have come under intense congressional scrutiny in recent years as fraudulent operators repeatedly have used them to defraud employers and employees under the guise of providing health benefits.

Labor officials are now conducting 109 MEWA investigations, David George Ball, assistant secretary of labor for pension and welfare benefits, told the House Subcommittee on Labor-Management Relations last week. Twenty-one of those are criminal investigations.

The administration proposal, H.R. 5386, contains three major provisions:

- A MEWA would have to register each year with the Labor Department and send copies of the registration statement to all states where it offers or provides benefits.

Failure to register would be punished by a fine of up to $1,000 against those responsible for filing. Willful violations could draw an added fine of $5,000 and a year in jail.

- The labor secretary could under certain circumstances exempt from state regulation ERISA-covered MEWA plans that provide medical benefits and that are not fully insured.

Mr. Ball testified that the secretary of labor "could grant a three-year exemption to a MEWA after determining that the exemption is administratively feasible, is not adverse to the interest of the participants and beneficiaries, and is protective of the rights and benefits of the participants. All other MEWAS, including fully-insured MEWAs, non-ERISA-plan MEWAs and those non-fully insured ERISA-plan MEWAs which were not granted an exemption would remain subject to state regulation."

The administration bill contains explicit standards for exemption. "We are concerned that any pre-established, statutorily prescribed reserve, contribution or other requirements may not be appropriate now or in every instance," Mr. Ball explained.

"The most important consideration would be the financial stability of the plan, and its ability to provide the promised benefits at the time and in the future," said Mr. Ball.

- The Labor Department would have the power to obtain a court order to force a MEWA to stop operations immediately if it was not operating in accord with a department exemption or in compliance with state law.

From a philosophical viewpoint, many people would prefer state regulation, said Mr. Hunt of the benefit administrators group; states are closer to the people and actions they govern. But state regulation "just doesn't work" in employee benefits, he said. Contradictory regulations can frustrate employers with multiple locations and discourage them from offering benefit plans.

The Labor Department would be 'the weak link' in administering the administration's proposal, Mr. Hunt says.

The role of the Labor Department under the administration proposal worries Mr. Hunt. He says that the department already has the power to regulate MEWAs under ERISA, but has chosen not to get involved.

"Even if Congress said (the Bush proposal) is a great idea and here's 1,000 new people, the department hasn't in the past shown any desire to take on more work," said Mr. Hunt. The department would be "the weak link" in administering the administration's proposal, he said.

The Bush bill, the earlier Petri bill and H.R. 4919, sponsored by Rep. William Hughes, D-N.J., were all discussed at a hearing before the House Subcommittee on Labor-Management Relations last week. No date has been set on a vote on any of the measures.

Although he introduced the administration bill and praised it as "running along much the same lines" as his earlier bill, Rep. Petri kept his bill before the subcommittee. H.R. 2773, the "Multiple Employer Health Benefits Protection Act," creates federal certification for self-funded MEWAs that meet specific funding and reporting requirements (*BI*, March 16; July 22, 1991).

In an attempt to curtail fraud, one of the Democratic-sponsored measures, H.R. 4919, would allow new MEWAs to be certified by the Labor Department, but would leave most regulation in the hands of the states, including the right to shut down MEWAs. The bill also would make it a felony to misrepresent the financial viability or risks associated with a MEWA.

Another measure aimed at battling MEWA fraud was recently introduced by Sen. Sam Nunn, D-Ga. Its a simple bill, says Sen. Nunn, chairman of the Senate Subcommittee on Investigations. "Its intent is to make clear that a MEWA may be subjected to state insurance regulation, regardless of whether it is an employee welfare benefit plan under ERISA."

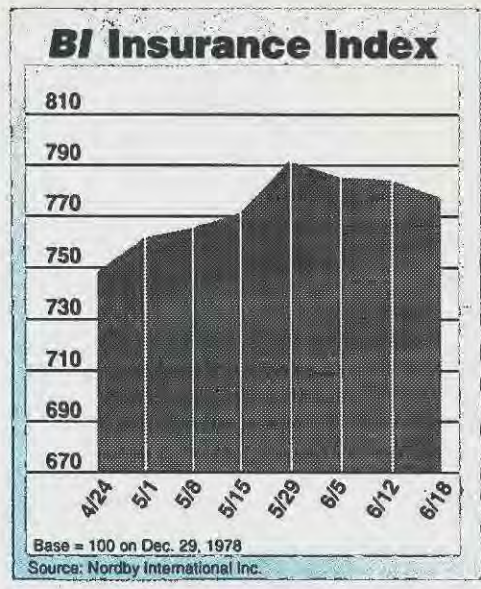
Besides establishing the primacy of state regulation, Sen. Nunn's bill would create fines of up to $5,000 and jail terms of up to one year for people who misrepresent an entity's status under ERISA.

"Quite frankly, it is inconceivable to me that Congress could ever have intended that a product that walks like insurance, talks like insurance and acts like insurance could somehow, by invoking the name of ERISA, avoid the safety and soundness protections of state insurance law," the senator said. "Yet, if it takes one more reiteration of this basic premise to help stop these abuses, then it is incumbent upon us to do so."

The SPBA's Mr. Hunt called both the Hughes and Nunn approaches "punitive."

"With the best of intentions, they have wrapped up (the operation of MEWAs) in so much red tape" that the arrangements would be killed off, he said.

Mr. Pantos agreed. "The bill introduced by Sen. Nunn only does half the job. It deals with the fraud aspect," Mr. Pantos said, explaining that under the Nunn bill, states would be able to regulate MEWAs out of existence. ■



Insurance industry stocks slid last week, as the *Business Insurance* Index fell 9.8 points to 776.5 on June 19 from 786.3 on June 12. Advancing issues for the week were led by HMO America Inc., up 13.0%; Hartford Steam Boiler, up 12.2%; and Lawrence Insurance Group, up 7.9%. Declining issues for the week followed NAC Re Corp., down 10.7%; Sierra Health Services, down 10.1%; and Chandler Insurance, down 9.1%. The most active issue was Sears, Roebuck (Allstate), 2.3 million shares traded. The *BI* Index was down 1.3%; the NYSE Composite fell 1.6%; the Standard & Poor's 500 was down 1.5%; and the Dow Jones 30 Industrials fell 2.1%.

British Issues

June 18 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Commi Union	491	N/M	31.5	6.4	499—	491
Genl Accident	473	N/M	35.7	7.5	473—	461
Gdn Royal Exch	146	N/M	10.0	6.8	156—	146
Royal	232	N/M	15.0	6.5	243—	232
Sun Alliance	312	N/M	19.0	6.1	319—	310
Brokers						
Bradstock	138	15.5	6.3	4.6	150—	138
CE Heath	369	21.3	34.5	9.3	380—	369
Hogg Group	161	9.8	10.7	6.8	163—	161
JIB Group	173	12.7	10.0	5.8	180—	173
Lloyd Thompson	223	22.3	6.0	2.7	240—	223
Lowndes Lmbrt	282	11.8	17.3	6.1	292—	282
PWS Holdings	47	5.1	5.3	11.3	48—	47
Sedgwick Grp	203	15.8	16.0	7.9	207—	203
Steel Brrl Jones	265	13.3	17.7	6.7	285—	265
Willis Corroon	232	14.7	17.6	7.6	246—	232

Source: Philip Olsen, Insurance Industry Analyst, London

BI Industry Stock Report

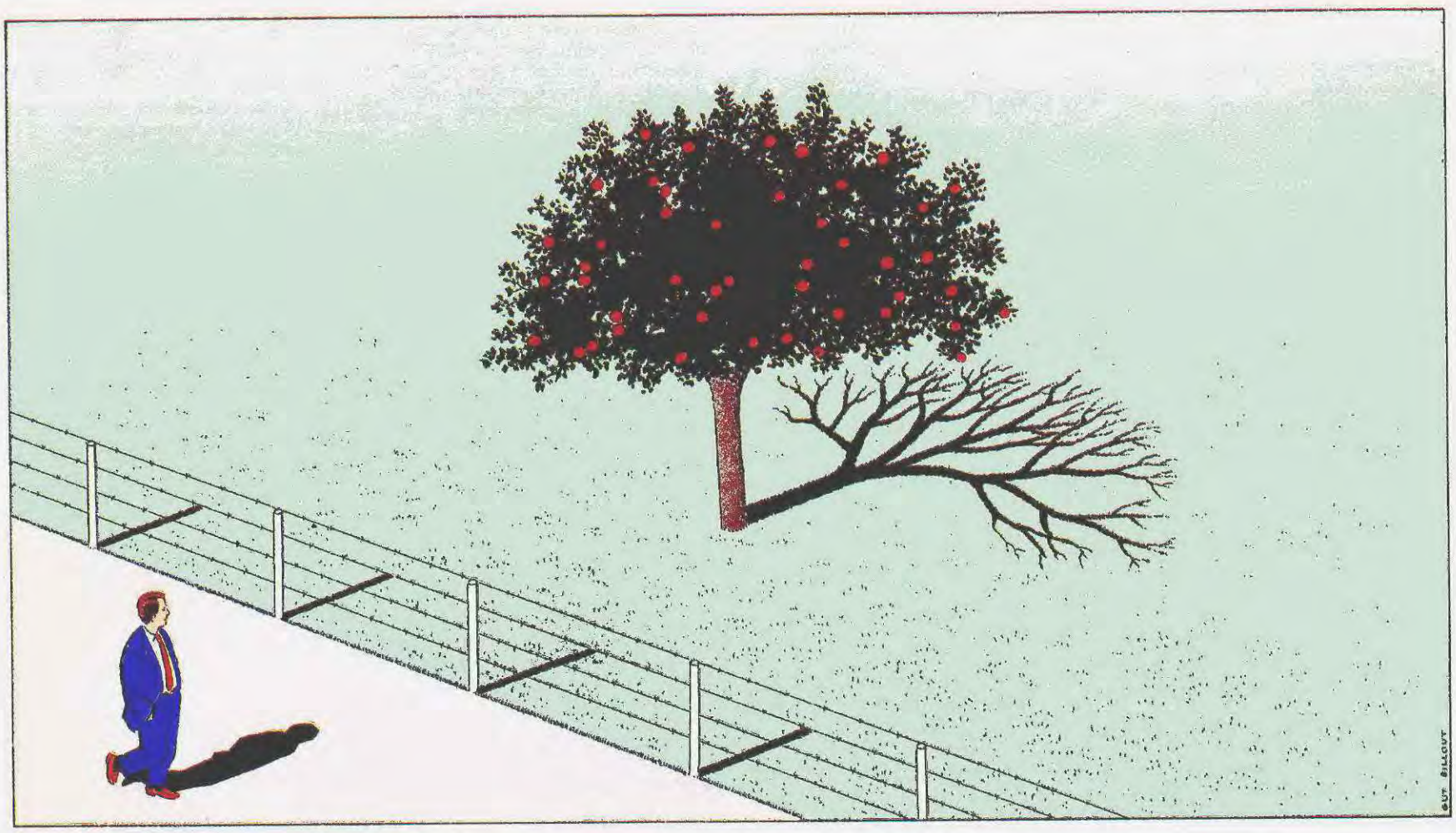
JUNE 15, 1992 THROUGH JUNE 19, 1992

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander	NYS	21.38	-2.84	4.27	23.38	18.00	150	1.00	4.68	134	13.10	1.63
Gallagher Arthur J. & Co.	NYS	22.25	-5.32	-0.56	25.25	19.00	111	0.64	2.88	18	5.88	3.78
Frank B. Hall	NYS	3.75	7.14	-11.76	5.50	3.13	75	0.00	0.00	-3	1.95	1.92
Hilb, Rogal & Hamilton	OTC	11.38	-3.19	-14.15	15.50	11.00	220	0.40	3.52	19	3.56	3.20
Marsh & McLennan	NYS	76.50	0.99	-5.99	83.75	70.00	316	2.68	3.50	18	28.00	2.73
Poe & Associates	OTC	13.50	-5.26	12.50	16.00	10.50	23	0.40	2.96	16	2.82	4.79
BROKERS	AVERAGE		-1.4	-2.6					2.5	29		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	32.88	0.38	7.79	36.25	23.50	299	0.36	1.10	12	36.95	0.89
Berkshire Hathaway Inc.	NYS	8950.00										
			-1.76	-1.10	9200.00	7150.00	0	0.00	0.00	28	7270.00	1.23
ITT (Hartford Group)	NYS	63.50	-0.78	9.96	70.63	50.00	1526	1.84	2.90	11	112.05	0.57
Sears (Allstate)	NYS	38.13	-5.86	0.66	48.00	32.50	4489	2.00	5.25	11	34.50	1.11
CONGLOMERATES	AVERAGE		-2.0	4.3					2.3	15		
INSURERS/REINSURERS												
AEGON N.V.	NYS	34.63	-0.72	-1.07	35.88	27.38	9	1.14	3.29	7	N/A	N/A
Aetna Life & Casualty	NYS	40.25	-0.62	-8.52	47.00	31.88	819	2.76	6.86	8	87.60	0.46
Allied Group Inc.	OTC	21.50	0.00	26.47	23.00	16.00	146	0.64	2.98	7	19.85	1.08
American General	NYS	46.50	-0.27	4.49	48.88	37.50	868	2.08	4.47	10	60.00	0.78
American Heritage Life Ins.	NYS	31.50	5.00	2.86	31.50	20.06	5	0.84	2.67	16	N/A	N/A
American Indemnity/Fin'l	OTC	7.00	0.00	47.37	9.25	4.50	11	0.08	1.14	5	12.93	0.54
American International	NYS	84.75	-3.83	-13.85	99.38	78.63	1641	0.56	0.66	11	99.30	0.85
Aon Corp.	NYS	42.50	2.41	7.26	45.25	34.75	224	1.68	3.95	11	39.70	1.07
Argonaut Group	OTC	26.25	-1.87	10.53	30.25	21.75	29	0.84	3.20	8	20.96	1.25
AVEMCO Corp.	NYS	25.25	-5.16	1.00	28.00	19.63	75	0.40	1.58	22	9.55	2.64
Baldwin & Lyons Inc.	OTC	31.00	0.00	20.39	31.75	22.75	9	0.28	0.90	8	24.29	1.28
Belvedere Corp.	ASE	6.13	0.00	88.46	6.25	2.88	0	0.04	0.65	17	7.65	0.80
Chandler Insurance	OTC	5.00	-9.09	53.85	6.00	2.13	128	0.00	0.00	45	5.95	0.84
Chubb Corp.	NYS	69.75	-0.53	-9.42	78.00	60.75	1305	1.60	2.29	11	72.95	0.96
CIGNA Corp.	NYS	56.00	3.23	-8.38	61.75	41.25	520	3.04	5.43	11	117.15	0.48
CNA Financial Corp.	NYS	85.50	0.74	-12.76	104.50	76.25	77	0.00	0.00	9	143.55	0.60
Continental Corp.	NYS	28.13	0.45	1.81	30.38	23.25	442	2.60	9.24	24	40.00	0.70
EXEL Ltd.	NYS	33.38	1.14	-11.00	40.25	27.38	208	0.92	2.76	7	N/A	N/A
Fund American Corp.	NYS	69.50	0.18	-0.54	70.50	62.00	125	0.68	0.98	30	36.11	1.92
Fremont General Corp.	OTC	21.50	1.18	-11.79	26.00	17.00	114	1.00	4.65	5	45.55	0.47
Frontier Insurance Group	NYS	36.13	-4.93	33.80	39.50	20.91	46	0.60	1.66	13	26.65	1.36
Gainsco Inc.	ASE	16.63	4.72	18.75	16.63	9.63	72	0.04	0.24	18	3.37	4.93
General RE Corp.	NYS	81.00	-0.61	-20.49	104.75	77.50	1071	1.80	2.22	11	78.65	1.03
Guaranty National Corp.	NYS	14.50	-2.52	0.00	17.00	12.63	31	0.48	3.31	10	N/A	N/A
Hanover Insurance Co.	OTC	35.00	-5.41	-2.10	42.75	27.13	56	0.44	1.26	9	37.44	0.93
Harleysville Group	OTC	18.75	-2.60	-11.76	23.25	16.75	78	0.64	3.41	8	22.99	0.82
Hartford Steam Boiler	NYS	56.00	7.95	-2.61	60.50	45.13	144	2.00	3.57	17	35.50	1.58
Kemper Corp.	NYS	23.88	-1.55	-37.38	46.13	23.25	311	0.92	3.85	6	50.00	0.48
Lawrence Insurance Group	ASE	8.50	7.94	-23.60	11.13	7.25	3	0.48	5.65	19	4.71	1.80
Liberty Corp.	NYS	29.50	0.43	33.33	31.38	19.50	67	0.48	1.63	14	29.35	1.01
Lincoln National	NYS	59.50	-1.24	8.68	61.50	45.38	366	2.92	4.91	10	81.00	0.73
Markel Corp.	OTC	24.75	-2.46	12.50	28.25	17.13	26	0.00	0.00	7	15.59	1.59
Mutual Risk Mgmt. Ltd.	NYS	29.75	-5.56	-15.30	37.75	17.00	40	0.12	0.40	20	-	-
NAC Re Corp.	OTC	23.00	-10.68	-26.98	33.00	21.75	669	0.16	0.70	10	18.90	1.22
National Re Holdings Corp.	NYS	19.25	4.76	N/A	23.63	17.00	58	0.12	0.62	10	N/A	N/A
Navigators Group	OTC	33.25	-2.21	-18.90	48.25	29.50	84	0.00	0.00	19	13.52	2.46
Nobel Insurance LTD.	OTC	5.00	2.56	25.00	6.00	3.38	111	0.00	0.00	3	7.76	0.64
NWNL Companies	NYS	35.00	-1.75	12.45	38.50	18.63	63	1.48	4.23	11	62.65	0.56
Ohio Casualty Corp.	OTC	53.00	-2.30	7.07	58.25	43.50	94	2.68	5.06	8	18.00	2.94
Old Republic Int'l	NYS	20.38	0.62	14.79	21.50	13.75	273	0.40	1.96	8	33.09	0.62
Orion Capital Corp.	NYS	34.50	3.76	9.09	35.50	27.00	223	0.92	2.67	6	43.50	0.79
Phoenix RE Corp.	OTC	10.25	-6.82	-2.38	11.75	8.50	24	0.20	1.95	25	13.30	0.77
Provident Life	OTC	22.25	0.56	-4.30	24.25	16.75	271	1.00	4.49	9	39.50	0.56
Re Capital Corp.	ASE	13.00	-6.31	-9.57	17.50	13.00	104	0.24	1.85	13	15.05	0.86
Reliance Group Holdings	NYS	4.88	-2.50	18.18	5.88	3.50	66	0.32	6.56	3	6.40	0.76
RLI Insurance Corp.	NYS	21.13	4.97	28.03	21.13	11.88	32	0.48	2.27	9	14.41	1.47
St. Paul Companies	NYS	70.00	0.00	-3.95	75.75	57.13	408	2.72	3.89	7	86.60	0.81
SAFECO Corp.	OTC	49.38	0.77	1.28	50.25	35.50	986	1.64	3.32	11	51.65	0.96
SCOR U.S. Corp.	NYS	16.50	-0.75	7.32	18.88	11.63	48	0.28	1.70	9	11.19	1.47
Seibels Bruce Group	OTC	5.75	0.00	4.55	8.75	4.00	144	0.36	6.26	-3	10.60	0.54
Selective Ins. Group	OTC	19.50	-3.70	16.42	20.25	13.75	67	1.12	5.74	8	30.75	0.63
Statesman Group Inc.	OTC	5.38	-2.27	-6.52	6.88	3.63	225	0.00	0.00	3	2.48	2.17
Tokio Marine & Fire	OTC	37.75	-3.82	-26.70	55.25	32.25	0	0.00	0.00	-	70.93	0.53
Torchmark Corp.	NYS	63.63	2.21	9.94	63.63	46.50	531	1.60	2.51	13	40.95	1.55
Transamerica	NYS	42.00	-2.33	5.33	46.75	31.25	300	2.00	4.76	28	55.00	0.76
Transatlantic Holdings	NYS	29.75	-2.46	-23.47	39.63	29.00	253	0.24	0.81	9	18.38	1.62
Traveler's Corp.	NYS	20.38	2.52	-5.78	23.75	17.25	725	1.60	7.85	8	59.00	0.35
Trenwick Group Inc.	OTC	26.25	0.00	-7.89	30.75	23.00	57	0.72	2.74	9	21.71	1.21
United Fire & Casualty	OTC	39.25	3.29	30.83	41.34	28.00	9	1.00	2.55	11	35.39	1.11
USF&G Corp.	NYS	13.13	6.06	81.03	13.13	5.63	2140	0.20	1.52	-8	12.30	1.07
UNUM Corp.	NYS	38.63	0.98	-4.63	40.88	28.81	564	0.64	1.66	12	37.70	1.02
USLIFE Corp.	NYS	48.75	-3.23	1.83	50.00	45.38	168	0.00	0.00	-	84.55	0.58
Unitrin	OTC	33.25	-3.62	-6.99	38.50	31.00	347	1.00	3.01	13	37.23	0.89
USLICO Corp.	NYS	17.63	-2.08	-4.73	21.00	17.00	21	1.00	5.67	-14	33.15	0.53
Washington National	NYS	19.50	-1.89	22.83	20.63	13.50	47	1.08	5.54	-34	33.50	0.58
Zenith National Ins.	NYS	18.00	0.70	6.67	18.38	13.75	25	1.00	5.56	8	13.14	1.37
INSURERS/REINSURERS	AVERAGE		-0.6	5.0					3.3	11.6		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	16.25	-3.70	14.04	27.00	9.88	1191	0.00	0.00	15	15.50	1.05
HMO America Inc.	OTC	10.88	12.99	-35.07	24.88	9.63	267	0.00	0.00	12	0.61	17.83
Pacificare Health Sys.	OTC	57.50	0.00	45.57	62.50	21.50	224	0.00	0.00	21	28.25	2.04
Safeguard Health Enter.	OTC	10.00	1.27	6.67	14.75	5.38	49	0.00	0.00	15	3.53	2.83
Sierra Health Services	ASE	16.75	-10.07	-9.46	27.50	12.38	71	0.00	0.00	9	1.78	9.41
United Healthcare Corp.	NYS	80.25	-4.46	7.72	93.00	40.25	734	0.03	0.04	31	43.60	1.84
United Medical Corp.	ASE	7.25	0.00	3.57	10.25	5.88	5	0.20	2.76	28	8.79	0.82
U.S. Healthcare	OTC	48.50	-3.48	16.87	52.00	45.00	2349	0.00	0.00	-	20.55	2.36
HMOs	AVERAGE		-0.9	6.2					0.3	16		

System design: Nordby International Inc.

Knowledge Without Action Is Wasted.

Every group insurance company promises the fruits of its knowledge and resources. But we put our knowledge and resources to work on practical ideas for employers and employees. ◆ For example, we identified early one of the great



emerging issues in employee benefits -- the provision of practical, economical group long-term care coverage -- and moved to implement it. Today, those we serve have this coverage available to them -- because our experience and the resources we command made it possible early. ◆ Clients who depend on your advice want to know how well group insurance companies know the industry. Now you can tell them how we make our experience and expertise work for them. For more information, call Patrick Moeschler, Director of National Accounts, at 1-800-877-1052.

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