

MARCH 13, 1995

Business Insurance

Updates

Airlines to discuss proposals to override Warsaw limits

MONTREAL—A meeting of the world's commercial airlines this summer will focus on proposals to voluntarily eliminate or increase international airlines' \$75,000 per passenger liability limitation established under the Warsaw Convention.

In the first international move to address this issue, the International Air Transport Assn. will invite all air carriers to meet in Washington in June, following permission by the U.S. Department of Transportation and the European Commission to hold such

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Highlights of the House bill

- Punitive damages would be capped in all civil actions and restricted to plaintiffs who prove defendants intended to cause harm or were consciously and flagrantly indifferent to the safety of others.
- Several liability would be abandoned for non-economic damages. Instead, civil defendants could be liable only for a proportionate share.
- Statute of repose would be set at 15 years for all goods, so manufacturers generally would be immune from suits filed 15 years or more after goods were delivered.
- Defenses would shield manufacturers from liability when an injured party was intoxicated and more than 50% responsible for harm and limit the liability of most product sellers.



GRAPHIC BY JOHN HALL

Tort reform measure approved by House could still face veto

By MARK A. HOFMANN

WASHINGTON—Uniform product liability standards still have a long way to go before becoming a reality, despite last Friday's House of Representatives overwhelming approval of a sweeping tort reform bill.

The House's 265-to-161 vote in favor of H.R. 956, the Common Sense Product Liability and Legal Reform Act of 1995, marked the first time either chamber of Congress has approved a comprehensive product liability reform bill. But the vote fell short of the two-thirds majority needed to override a presidential veto, which President Clinton has not ruled out.

In fact, Attorney General Janet Reno and White House Counsel Abner Mikva sent House Speaker Newt Gingrich, R-Ga., a March 6 letter that criticized many of the provisions of the product liability measure and related tort reform bills.

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High court shifts focus of benefit cutback suits

By DAVE LENCKUS

WASHINGTON—The U.S. Supreme Court's ruling in the closely watched Curtiss-Wright Corp. case probably will shift the focus of benefit takeaway lawsuits from whether the takeaways were permissible to whether plan sponsors followed their amendment rules.

Overruling two lower courts, the Supreme Court unanimously ruled on March 6 that Curtiss-Wright's simple reservation of its right to modify its health plan satisfies the plan amendment requirements in the Employee Retirement Income Security Act of 1974. Section 402(b)(3) of ERISA requires plan sponsors to provide

"a procedure for amending such plan and for identifying the persons who have authority to amend the plan."

If the court had required plan amendment procedures to be more specific, a majority of the nation's employers could have been stuck in a litigation quagmire.

Some benefit experts say that as many as 75% of employers rely on plan amendment language similar to Curtiss-Wright's. And retirees would have flooded the courts with litigation over recent cuts in retiree benefits and additions of managed care features, attorneys say.

"It is a very significant decision" for health plan sponsors,

said employer attorney Bill Boies, a partner with McDermott, Will & Emery of Chicago. "Otherwise, it causes lots of problems with thousands of plans."

The ruling gives employers "the assurance that their past amendments are valid," he added.

The Supreme Court, though, remanded the case to the 3rd U.S. Circuit Court of Appeals to determine whether authorized Curtiss-Wright officials approved a plan change that led to the termination of health benefits for about 520 retirees. The 3rd Circuit, in turn, could remand the case to a district court.

Although the Supreme Court

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Putting Barings on its feet

ING expected to seek coverage as part of recovery effort

By ADRIAN LADBURY

LONDON—Dutch banking and insurance giant Internationale Nederlanden Groep N.V., which has acquired most of Barings P.L.C., says it is too early to know whether it will make claims against the various insurance policies covering the failed investment bank and its subsidiaries.

Barings and its subsidiaries held bankers blanket bond, professional indemnity, and directors and officers liability insurance policies that may be worth more than £100 million (\$160.9 million) (BI, March 6).

The Hague-based ING acquired the collapsed British institution for about £660 million (\$1.1 billion) and has agreed to honor the bank's deposits.

"We are going through a unique process of getting this acquisition done and getting Barings to resume business. I simply cannot answer (whether claims will be filed against its coverage) at this moment in time," an ING spokesman said last week.

London financial institution insurance experts predict that ING will seek compensation from Barings' insurers to recoup some of the cash it has injected into the

moribund bank.

"I would be very surprised if they didn't try to get some of that investment back from the insurers," said one Lloyd's specialty broker.

Clients of subsidiary Baring Asset Management Ltd., which manages more than \$1 billion in captive insurance company assets and substantial investments on behalf of protection and indemnity clubs, are expected to breathe easier after ING's buyout. The ING spokesman said it is too early to judge how much, if any, of this business has left for alternative

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New pension 'guideposts'

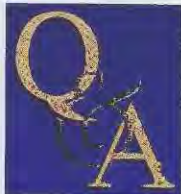
Labor Department's Berg explains new annuity standards

Even four years after the collapse of Executive Life Insurance Co., no one knows whether the failure was a once-in-a-lifetime event.

But Olena Berg, the federal government's top pension official, thinks regulators would be remiss if they assumed such a failure could not happen again.

Following the 1991 failure, the Labor Department began developing more detailed standards for employers to select the safest possible annuities to pay benefits. Having rejected the idea of a precise rule or formula employers should use to evaluate annuities, the department in a new bulletin gives employers what Ms. Berg calls "guideposts" to follow for evaluating annuity providers.

In an interview with Business Insurance Editor-at-Large Jerry Geisel, Ms. Berg, who is assistant secretary at the Department of Labor's Office of Pension and Welfare Benefits Administration, explains how and why those standards were developed and the implications for employers.



What do you hope to accomplish through the bulletin?

What we hope to accomplish is that employers indeed will go through the process of weighing the factors we have laid out to result in a decision that will be most protective of plan participants. This is an investment decision that is so important to plan participants that every element of care must be taken.

In view of the fact that the department has said in lawsuits just what steps it expects employers should take in evaluating an annuity provider, why was the bulletin needed?

The GAO looked at this issue and reached the conclusion that greater and more explicit guidance was desirable.

We were trying to respond to that congressional interest. In addition, we realized that people needed more information on what our position is.

Finally, since our legal position appeared, there were questions, such as what does "safest available" really mean. Does it mean just one? What do you have to look at (in eval-

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TOM REED

Olena Berg hopes the standards will make employers more careful, though they differ little from current practices. See story, page 14.

Updates**Airlines to discuss liability***Continued from preceding page*

talks with immunity from antitrust laws.

The Department of Transportation issued an order last week giving the IATA 120 days to hold such meetings, confirmed William Murnighan, director of legal services for the Montreal-based IATA.

In its order, the Transportation Department also recommends that any agreement by the airlines include strict and unlimited liability for passenger claims arising from international journeys ticketed to the United States, as well as for U.S. citizens and permanent residents traveling internationally on tickets not issued in the United States.

Executives at the DYP Group's 10th Airline Insurance Assn. Conference in London last week said they favor a 1993 initiative by Japanese airlines to simply remove the existing Warsaw liability limitation language from passenger tickets (*BI*, April 11, 1994). But the Transportation Department said that it doesn't believe that approach would work for all airlines.

Meanwhile, the Australian government and the European Civil Aviation Conference, which represents most European countries, have taken steps recently to increase the Warsaw Convention liability limit to 250,000 Special Drawing Rights (\$388,000).

"Many airlines have felt for a long time that the limits are low," said Mr. Murnighan of the IATA.

Feltrim members win ruling

LONDON—The Feltrim Names Assn. has won its negligence suit brought against underwriters of three Lloyd's of London syndicates and 53 members agents who placed the members on those syndicates, though the amount of damages they will recover has not been resolved.

High Court Justice Phillips handed down the ruling Friday in the suit involving syndicates 540, 542 and 847, which were managed by Feltrim Underwriting Agencies Ltd. before 1990. But, he had not scheduled a hearing to assess how much the award would be, or if the members would be eligible for an interim payment.

The members are seeking more than £500 million (\$805 million) in damages. Damon de Laszlo, chairman of the members group, predicted that members will get "substantially more" than the £240 million (\$386.4 million) they would have received under Lloyd's 1994 settlement offer.

Errors and omissions underwriters, by contrast, predict that the payout will be "significantly less" than the £240 million offer, according to a statement issued by London law firm Clyde & Co.

Some names hope that Friday's ruling will assist Lloyd's efforts to broker a second settlement deal, though they are unlikely to accept any offer that does not cap their future liabilities.

House considers LTC tax break

WASHINGTON—Tax legislation to be taken up today by the House Ways and Means Committee would give group long-term care coverage more favorable tax treatment and create a new type of individual retirement account.

Under the tax measure, unveiled last week by Committee Chairman Bill Archer, R-Texas, LTC policy premiums paid by employers to provide benefits of up to \$200 a day for long-term care would not be taxable to employees. That \$200 daily limit would be indexed for medical inflation after 1996.

The measure, on which the committee could complete action this week, also would allow employees to withdraw 401(k) funds tax-free to pay for LTC premiums for themselves or their spouses.

In addition, the proposal would create a new type of IRA known as American Dream Savings Accounts. Individuals—regardless of income or whether they were covered by a pension plan—could make annual \$2,000 non-tax-deductible contributions. Funds could be withdrawn tax-free after five years for any purpose for individuals over age 59½ or for "qualified special purposes"—defined as a downpayment on a first home, educational and medical expenses or LTC premiums. Funds withdrawn before five years for special purposes would be exempt from a 10% excise tax on early withdrawals, but regular income taxes would be due.

Separately, the committee approved legislation last week that includes provisions earlier proposed by President Clinton that would indefinitely extend the so-called Medicare Data Match program. Under that program, officials scour health, tax and payroll information to determine if Medicare paid medical bills—chiefly those of older workers—that employer health plans should have paid. The measure also would indefinitely extend another provision in which employer health plans are the primary payers—for the first 18 months—of medical bills for employees who develop end-stage renal disease.

Deloitte & Touche judgment

JACKSONVILLE, Fla.—Deloitte & Touche will appeal an \$81.3 million judgment in favor of Koger Properties Inc. shareholders, who charged that the accounting firm materially misrepresented the real estate firm's accounts in its audit reports.

Deloitte & Touche said it has insurance to cover the award if its appeals are unsuccessful. The firm would not provide coverage details.

In a class-action suit brought in the U.S. District Court in Jacksonville, Fla., Koger shareholders charged that Deloitte & Touche violated generally accepted accounting principles when it audited Koger's accounts.

*Continued on page 22***Errors & omissions**

Contrary to a report on page 20, WellPoint Health Networks Inc. and Health Systems International Inc. as of deadline would not confirm rumors that they are in talks about a possible merger.

Cost control paying off

Managed care forays boost life/health insurers' 1994 results

Membership gains help leading HMOs improve 1994 results

By SALLY ROBERTS

While health care reform is being re-engineered in Washington, D.C., major life/health insurers are re-engineering their operations to make money where the real reform is taking place—at the grass roots level.

Insurers say state legislative reforms and reforms driven by employer coalitions are more likely than federal efforts to affect their business.

Health insurance executives say group indemnity business dwindled further in 1994. As a result, health insurers invested more in managed care capabilities to keep pace as customers migrated into managed care plans.

Insurers also continued to benefit from a favorable medical cost inflation trend. Executives report slight medical cost increases in managed care plans during 1994. In some cases, medical costs actually decreased.

According to A. Foster Higgins & Co. Inc.'s recent group health care cost survey, 1994 HMO costs rose 6.4% to an average of \$3,485 per employee from \$3,276 in 1993, while indemnity plan costs rose 10% to an average \$3,850 per employee in 1994 from \$3,500 in 1993 (*BI*, Feb. 13).

"1994 was an excellent year for group health writ-

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By SALLY ROBERTS

As the nation's largest health maintenance organizations expand their membership rolls with the promise of cost-effective medical care, the HMOs themselves are boosting their profits by trimming operating expenses.

In addition to increased enrollment—through internal growth and acquisitions—HMO executives also point to cost control as a catalyst for their companies' gains for the year.

A 64% increase in enrollment at United HealthCare Corp., for example, helped boost revenues 21% to \$3.8 billion in 1994 from \$3.1 billion in 1993. Excluding a \$1.4 billion extraordinary gain during the second quarter from the sale of its Diversified Pharmaceutical Services subsidiary to Smith Kline Beecham (*BI*, May 16, 1994), profits were up 46.3% to \$310.4 million, compared with \$212.1 million in 1993. Net income figures also exclude non-operating pooling expenses associated with the acquisition of two HMOs during 1994—Complete Health Services Inc. of Birmingham, Ala., and Ramsay-HMO Inc. of Coral Gables, Fla.

Dave Koppe, chief financial officer for the Minneapolis-based HMO, said excluding acquisitions,

*Continued on page 20***Deadline nears for BI to list captive managers**

Business Insurance will publish its annual directory of captive insurance company management companies in the April 24 issue, which also will contain a spotlight report on domestic and foreign captive domiciles.

To be listed, organizations must complete the *BI* questionnaire. The questionnaire also includes a section that must be completed to be listed in the chart of policyholder-owned alternative risk financing facilities that will be published in the May 22 issue.

The alternative risk financing facility chart will be expanded to include a section on rent-a-captives this year. To be listed, organizations must complete *BI*'s rent-a-captive questionnaire.

If your company provides captive insurance company management services, manages an alternative risk financing facility or offers rent-a-captives, and you have not yet received a questionnaire but would like to be participate, please request one from Directory Editor Kathy Welyki at 312-649-5279.

State official rebuts allegations against Confed rehabilitator

By JUDY GREENWALD

LANSING, Mich.—Michigan's acting insurance commissioner is defending former commissioner David Dykhouse against charges that he did a poor job of overseeing Confederation Life Insurance Co. before it was put into rehabilitation last year and is now improperly profiting from its situation as principal special deputy rehabilitator.

Those charges were made by State Rep. Pat Gagliardi, D-Drummond Island, in letters last month to State Attorney General Frank Kelley and Michael Hayes Dettmer, the U.S. Attorney in Grand Rapids, Mich. In those letters, Rep. Gagliardi, who is the majority floor leader in the Michigan House, called for an investigation of Mr. Dykhouse, who resigned as commissioner at year-end and was appointed to his current job Jan. 30.

Acting Insurance Commissioner Patrick McQueen contends the charges are politically motivated. Rep. Gagliardi is a Democrat and Mr. Dykhouse a Republican.

In response, Rep. Gagliardi said, "Regardless of political party, I think it's unethical for anyone who stands watch with this kind of major collapse" to assume the position Mr. Dykhouse has.

Neither Mr. Dykhouse nor a fellow special deputy rehabilitator, Victor M. Palmieri, would comment. The state attorney general's office said no decision had been made on how to proceed. Citing office policy, Mr. Dettmer would neither confirm nor deny any federal investigation was under way.

Canada's Superintendent of Financial Institutions took over Confed and its Confederation Trust Co. unit in August amid concerns that losses in its real estate and mortgage portfolio had damaged its liquidity. Michigan regulators are involved because the state is Confed's entry point into the U.S. market (*BI*, Aug. 22, 1994).

In the United States, Confed wrote group and individual life and health insurance, as well as stop-loss coverage for self-insurers.

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• The tort reform debate calls for reason and factual evidence, not pandering to emotions, one of this week's editorials says. **PAGE 8**

• The U.S. Department of Labor's new standard on selecting a pension annuity provider generally follows current practices. **PAGE 14**

• U.K. insurers posted improved profits in 1994 thanks to low losses and more selective underwriting. **PAGE 17**

• The claim from the recent sinking of an Australian America's Cup yacht has already been paid. **PAGE 17**

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Regulatory upheaval

Louisiana Insurance Department faces resignation, charges

By DOUGLAS McLEOD

BATON ROUGE, La.—A management shake-up is under way at the Louisiana Insurance Department following the surprise resignation of a deputy commissioner and questions about the department's handling of receivership assets.

Winston Riddick, top deputy to Insurance Commissioner Jim Brown, resigned last month following allegations that he solicited a \$50 million loan from Blue Cross & Blue Shield of Louisiana.

No replacement has been named, a department spokesman said.

Meanwhile, James Higgins, director of the department's office of receiverships, is being reassigned to an as-yet-undetermined job and Charles Reichman, the division's chief financial officer, has been placed on "indefinite leave of absence," the department announced.

William O. Myrick, the Louisiana department's chief examiner, has been named acting director of the office of receiverships while



Commissioner Jim Brown has his hands full with turmoil in the insurance department.

the department searches for a permanent director.

The department spokesman said the changes are the result of an

ongoing review of the receivership division, which grew rapidly under Commissioner Brown and has come to resemble "a tent city for refugees."

However, the moves also follow a bitter legal battle between Mr. Brown and Sally A. Nungesser, the recently fired executive director of the Louisiana Insurance Guaranty Assn., over an accounting of receivership assets.

Mr. Brown also had to defend the receivership division's performance in a hearing last month before the Louisiana House Committee on Insurance.

Mr. Brown, considered a potential gubernatorial and U.S. Senate candidate, is planning to run for re-election as insurance commissioner this year.

Mr. Riddick, former deputy commissioner, resigned last month after P.J. Mills, CEO of BC/BS of Louisiana, charged that the regulator had asked for a \$50 million loan in April 1994 to cover a temporary cash shortfall at the insurance department.

BC/BS of Louisiana was briefly

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Willis Corroon's 1994 changes bring lower revenues, profits

By STACY SHAPIRO

LONDON—Willis Corroon P.L.C. capped a tumultuous 1994 last week by reporting gross revenues fell 6% to £713.9 million last year from £763.2 million in 1993, while pretax profits dropped 92.7% to just £5.6 million from £77.3 million.

Converted to dollars, gross revenues of \$1.093 billion will keep Willis Corroon in the No. 5 position among the world's largest brokerages.

On the same day it announced its 1994 results, Willis said that Donald Payne—once heir apparent to Executive Chairman Roger Elliott, and former chairman and chief executive officer of Willis Corroon Americas—had resigned his position effective immediately.

On news of the results, Willis' stock price remained unchanged at 141 pence (\$2.27) per share on the London Stock Exchange.

The brokerage's operating profit before exceptional items was £53.9 million (\$82.5 million). Those exceptional items, totaling £49.1 million (\$75.2 million)—which is 20% higher than analysts had been told to expect—consist of:

- Expenses associated with cutting more than 500 jobs, including 300 in the United States, costing £20.1 million (\$32.4 million). Another 300 job cuts are expected this year.
- Net lease expense for property no longer needed by the group, at a cost of £22 million (\$35.4 million). Willis is trying to sell its Nashville, Tenn., headquarters and then lease back some of the massive space, said Mr. Elliott.
- Staff relocations and office closures, accounting for £7 million (\$11.3 million). Two San Francisco offices have merged and an office in St. Louis is up for rent.

The brokerage said that it expects the cuts to save £26 million

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Muni bond insurers optimistic for 1995

By MICHAEL SCHACHNER

NEW YORK—Despite the slumping U.S. dollar, which could prompt the Federal Reserve Board to again raise interest rates, municipal bond insurers are hoping in 1995 to rebound from an off year.

With a Republican-led Congress expected to take a less active role in public works, state and local governments may try to make up for reduced federal funds through new municipal bond issues, say executives at the nation's two largest municipal bond insurers.

Municipal bond volume will only be \$150 billion to \$165 billion in 1995—compared with \$164 billion last year—predicted David H. Elliott, chairman of Municipal Bond Investors Assurance Corp. of Armonk, N.Y., and Phillip B. Lassiter, president and CEO at AMBAC Indemnity Corp. in New York.

However, other market observers contend those executives' estimates may be too high.

Anne Ross, vp and manager of research at Roosevelt & Cross Inc. in New York, said her firm estimates issuance will be \$130 billion to \$150 billion.

Richard A. Ciccarone, senior vp and director-fixed income research at Kemper Securities Group Inc. in Chicago, said that, based on bond issuance in the first two months of the year, he now estimates the total this year could be as low as \$140 billion.

Mr. Ciccarone noted new issues plunged by 57.4% for January and February to \$14.32 billion vs. \$33.57 billion for the comparable period a year ago. Factors that could be slowing growth, he said,

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Insurers adapting to changes

By JOANNE WOJCIK

SAN FRANCISCO—The growth of the alternative market is forcing insurers to become more flexible so they will still have something to offer their self-insured clients, says the CEO of what soon could be the nation's largest commercial insurer.

A declining number of fully insured clients also is triggering industry consolidation as insurers and brokers merge and streamline their operations to become more competitive, said Dennis Chookaszian, chairman and chief executive officer CNA Insurance Cos. in Chicago.

The insurance industry is undergoing "horizontal and vertical compression," Mr. Chookaszian said last week at the invitation-only National Insurance Symposium Leadership Conference,



which is sponsored by Russell Miller Inc.

"There is horizontal compression in that the number of insurance companies underwriting business has declined," Mr. Chookaszian said. "The industry is getting smaller in terms of the number of firms doing distribution, (and the) numbers of firms doing underwriting."

One prime example of this consolidation is CNA's pending purchase of Continental Corp. (BI, Dec. 12, 1994).

By creating economies of scale, CNA will be able to more cost-effectively compete in the package auto and homeowners market by increasing the volume it writes in each state, according to Mr. Chookaszian.

"Continental, which has about the same amount of personal lines business as us, will allow CNA to be more cost-effective in distribution," he said. "You don't have to

be No. 1 or No. 2, but you need to be of the magnitude of the larger competitors to be successful."

On the brokerage side, consolidation is evidenced by the continuing acquisition of indepen-

dent agencies by some national brokerages, and the formation of new national brokerages out of mergers of large regional brokerages, he said.

"Twenty years ago there were 60,000 independent agents, while



'Customer expectations are going to continue to drive us to operate more efficiently.'

Dennis Chookaszian

into larger and more competitive independent agents who will have stronger organizations better able to compete."

Mr. Chookaszian also said the

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Teaching workers to save pays off

By CHRISTINE WOOLSEY

NEW YORK—Until this summer, when the Labor Department is expected to issue guidelines on complying with savings plan investor education rules, many plan sponsors will look to other companies for ideas about how to improve workers' savings strategies.

One company that has successfully educated its workforce on the need to boost retirement savings is VNU Marketing Information Services Inc. VNU successfully encouraged younger employees to participate in its savings plans—and all employees to invest in funds with higher returns—without actually offering investment advice and, thus, avoiding fiduciary liability for its workers' investments.

The New York-based unit of a Dutch conglomerate began an aggressive education program in 1992, about the same time the De-



The Conference Board

partment of Labor published regulations to implement Internal Revenue Code Section 404(c). Those regulations exempt plan sponsors that offer participants enough information to make informed choices from any fiduciary liability should the investments go bad.

Beverly Mazze, vp of human resources at VNU, described her company's program earlier this month at a benefits conference sponsored by the Conference Board.

VNU may be the "typical American corporation of the 1990s," Ms. Mazze said, noting that it is foreign-owned, fast-moving and entrepreneurial. VNU has 10,000 employees worldwide, but the majority work at 30 U.S. locations.

"Since we are getting lean and

mean, right-sized and re-engineered, the total number of corporate human resource staff is two," she lamented. What's more, VNU's corporate human resource budget is modest and a mere 15% is allotted to implement benefit programs.

Issued in 1992, the Labor Department's voluntary 404(c) regulations pushed VNU to take several steps to evaluate and improve its savings plans.

VNU offers no defined benefit plans and its 401(k) plan asset match is light: 50% for the first 3% of employees' savings and 25% for the next 3% of savings.

"We are concerned that employees will not have enough money at retirement, particularly given the composition of our 401(k)-eligible workforce," Ms. Mazze said. Seventy-five percent of employees eligible to participate in VNU's 401(k) plan earn less than \$39,999 per year and, of those, 38% earn

less than \$20,000 per year. That doesn't leave a lot of disposable income to sock away for retirement, she noted.

That realization, combined with the fact that employees started saving too late and invested too cautiously, led VNU to begin making changes in 1991.

Among other things, VNU liquidated all its guaranteed investment contracts following well-publicized insurance company failures and began offering Fidelity Investments' mutual funds. The company also added an aggressive growth fund to the money market, bond, balanced, index and Europe funds it already offered.

Beginning in 1992, VNU prepared an employee education campaign that consisted of clearly written handouts on investment basics and understanding the relationship of risk and re-

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Barings

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asset managers. "Keeping the business is our No. 1 priority now," he said.

But not everyone associated with Barings will be covered under the ING deal. Bondholders of subordinated notes issued by two Barings subsidiaries—worth £100 million (\$160.9 million) and \$93 million, respectively—will be left out of pocket because ING is offering to pay only a fraction of their face value.

London underwriters say the Barings' insurance coverage triggered, if any, by the bank's collapse will not be known until the cause of the massive trading losses is established.

Much will depend on the story told by Nicholas Leeson, the Singapore-based Barings futures

trader directly blamed for the bank's collapse who currently is being held by German police in Frankfurt.

Stephen Pollard, a lawyer at London law firm Kingsley Napley who represents Mr. Leeson, said last week that his client hopes he will be extradited to the United Kingdom, rather than Singapore, where the alleged fraud occurred.

The U.K. Serious Fraud Office, which is conducting an investigation into the Barings collapse in conjunction with the City of London police, would not comment on whether it is preparing to seek Mr. Leeson's extradition.

"Our inquiries are at an early stage, and it is not possible to say at the moment whether or not we are planning to extradite Mr. Leeson," an SFO spokeswoman said. "We can seek extradition if we feel the need. . . . We are in contact with the German and Singapore

authorities," she said.

A spokesman for the Frankfurt public prosecutor said that Singapore authorities have not submitted any evidence of fraud in support of extraditing the trader to their jurisdiction, despite rumors last week to the contrary. The spokesman said that the U.K. or Singapore authorities must make an application for extradition by May 2, which would be two months after the German police first picked up Mr. Leeson.

"It's too early to say whether Mr. Leeson will come to the U.K. We believe that the SFO is preparing a case, but we will just have to wait and see the result of their inquiries. Mr. Leeson would rather face any legal investigation in a system which he understands and with the support of his family," said Mr. Pollard, the trader's attorney.

The U.K. High Court approved

the ING buyout late last Monday. The court-appointed administrators for Barings, Ernst & Young, formally signed the agreement to transfer "substantially all" the business of the merchant bank to ING last Wednesday.

ING Chairman Aad Jacobs said the bank has agreed to inject £660 million (\$1.06 billion) in cash immediately into Barings, which would supplement about £440 million (\$707.7 million) of assets that ING estimates now exists.

ING estimates that liabilities arising from speculative futures trading by Barings' Singapore office will total £860 million (\$1.4 billion). Therefore, the new Barings, which is being renamed Barings Bank Ltd. and Barings Securities International Ltd., commenced operations last week with roughly £240 million pounds (\$386.2 million).

ING has acquired the three profitable operations of the group: Baring Asset Management; Baring Brothers & Co. Ltd.; and Baring Securities Ltd.

Holding company Barings P.L.C. and the firm's Dutch subsidiary, Barings N.V., are not part of the acquisition because ING has decided not to fully honor bonds owed by Baring Brothers & Co. Ltd. to those two entities. The two firms will remain in administration.

Administrator Ernst & Young disclosed late last week that it has a £62 million (\$99.8 million) "buffer fund" available to cover future Barings liabilities.

ING has agreed to pay only \$7.5 million (\$12.1 million) for the £100 million (\$160.9 million) loan

to Barings P.L.C. and is still negotiating a "similar offer" for the \$93 million owed to the Barings N.V. unit.

As part of the deal, ING has acquired Baring Securities (Japan) Ltd. and Mr. Leeson's direct employer, Baring Futures (Singapore) Pte. Ltd., the two units blamed for the huge losses, but says that "a few technical issues" need to be resolved before the units resume trading.

Singapore monetary authorities have decided to prevent Baring Futures from trading until it has finished investigating the bank's collapse.

ING's Mr. Jacobs said during a press conference last week that he thought risk management controls at the bank were adequate. He refused to blame the collapse on senior Barings staff for failure to adhere to the controls.

The ING chairman also would not say whether senior Barings staff would be fired. He did reveal that bonuses to Barings directors worth £90 million (\$144.8 million) had been set aside to be paid by the Dutch company, which angered bondholders seeking additional amounts.

The bonus figure is down from the original £105 million (\$168.9 million) because six directors have voluntarily forfeited their bonuses, an ING spokeswoman said.

She said most Barings employees would be safe from layoffs or firing. She said that the lack of overlap between the two companies means that the only losses would be from attrition as people retire or quit. **BI**



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ING ratings under review, but analysts say it is strong

The financial strength ratings of three U.S. life insurers are under review for possible downgrade after their parent, Internationale Nederlanden Groep N.V., acquired failed British bank Barings P.L.C.

The three insurers, all rated Aa2 by Standard & Poor's Corp., are: Security Life of Denver Insurance Co. in Denver, Life Insurance Co. of Georgia, and Southland Life Insurance Co., both of Atlanta. Security Life and Life Insurance Co. of Georgia both write small amounts of group life and health business. Southland writes no group business.

In addition to those three, Moody's Investor Services Inc. is also reviewing the ratings of ING's main banking subsidiary, Internationale Nederlanden Bank N.V., and S&P has placed all ING units on CreditWatch with negative implications.

Moody's said it needs to examine the risks the Dutch financial giant assumed, the value of Barings assets and liabilities it assumes, and the impact of the acquisition on ING's capital structure.

S&P said that none of the banking or insurance units currently carry commercial paper or senior debt ratings below A-1+, and that "based on currently available information" no ratings are likely to fall below A-1.

Some securities analysts say that ING can readily afford the Barings takeover.

ING has committed £660 million (\$1.1 billion) to shore up the collapsed bank and pay losses from Barings' disastrous futures trading in Japan and Singapore. Those losses are estimated to be £860 million (\$1.38 billion) (see

story, page 1).

Analysts predict that the Barings investment will not hinder further growth for ING.

Created by the 1991 merger of Nationale-Nederlanden N.V., the Netherlands' largest insurer, and NMB Postbank, its third-largest bank, ING is now one of Europe's biggest financial services companies with \$212 billion in assets.

In relation to the Dutch group's overall size and capital, the Barings acquisition is "not too significant," said Tom Bennett, analyst with Paribas Capital Markets Group in London.

ING's net worth is about £13 billion (\$20.9 billion), Mr. Bennett noted. He also estimates the company has a "war chest" of cash available for acquisitions and development of £1.6 billion to £1.7 billion (\$2.57 billion to \$2.74 billion). "This means it still has about £1 billion left."

With a market capitalization of 20.6 billion guilders (\$13.16 billion), he said, ING may now be Europe's third-largest insurance company behind Allianz A.G. Holdings of Germany and Assicurazioni Generali S.p.A. of Italy.

The Barings acquisition will not hurt ING's balance sheet or future growth, agreed Simon Rudolph, an insurance analyst at Morgan Stanley & Co. in London.

Both analysts agree that the deal makes sense for ING. Chairman Aad Jacobs has helped ING develop a strategy that focuses on profits, not merely growth, Mr. Bennett said. He cited as proof ING's decision to shut down loss-making London market insurer Orion Insurance Co. P.L.C. last year, and reinsurer N.R.G. Victory Reinsurance Co. Ltd. in 1991.

—By Adrian Ladbury

Opinions

An appeal to reason

WE ARE DISMAYED at the level of exaggeration and stretching of truth taking place amid the debate over federal tort reform proposals.

The need for civil justice reform is real enough to U.S. businesses that proponents do not need to resort to hyperbole to make their case.

Both sides of the debate, in fact, seem to be appealing to the heart rather than the mind, when this is a cold cash, hard facts issue.

Take for example, a pro-reform ad prepared by the U.S. Chamber of Commerce. In the ad, a Girl Scout claimed that her local council in the District of Columbia had to sell 87,000 boxes of Girl Scout cookies to pay for its liability insurance. Shortly after the ads ran, the Girl Scouts of America requested that the ad be withdrawn, stating that it had no position on the issue.

No matter. Tort reformers quickly found another mom-and-apple-pie victim to step up to the plate: The Little League of America, which said that liability insurance for volunteers in the youth baseball program often costs more than bats and balls.

We think the arguments for tort reform could be made far more persuasive and concrete if they stuck to hard facts rather than trying to prey on emotions. In particular, the proponents should press their case with examples of manufacturers that have shelved



products to avoid the risk of being sued, of huge punitive awards that bore no relation to actual damages, and of insurance and legal costs increasing to defend frivolous lawsuits.

We think this important debate needs to be fought with reason rather than emotion.

Common sense prevails

THE HEALTH Care Financing Administration finally got it right.

As we reported, HCFA last month reversed its interpretation of an obscure and arcane provision in a 1993 law that lay down new rules for determining the primary payer of medical claims for retirees with end-stage renal disease, a kidney impairment for which there is no cure, only expensive dialysis treatments.

In the 1970s, Congress expanded the Medicare program to cover the disease for individuals under age 65. Later legislation made employer plans the primary payer of such claims for 18 months for employees and retirees under 65; after that period, or when an individual turned 65, Medicare would become the primary payer. For retirees who developed the disease after age 65, Medicare paid the bills.

But in 1993, legislators amended earlier laws to shift more costs to employer plans.

Initially, HCFA interpreted the changes as requiring

the following: For a retiree who developed ESRD after age 65, primary responsibility for paying the bills would shift to the retiree's former employer. After 18 months, though, Medicare again would become the primary payer.

Would this work in the real world? Not for a minute. Take, for example, the case of an 80-year-old who develops ESRD. Imagine the confusion and massive paperwork for that individual, the former employer, Medicare and kidney dialysis centers as the retiree bounced between Medicare and the employer's health plan.

Fortunately, HCFA has reconsidered and now says that Medicare will be the primary payer for retirees who develop the disease after 65.

We're aware that the issue may not yet be settled—With Medicare paying lower fees than employer plans, dialysis centers may challenge HCFA's new stance. But, for now, we're glad to see common sense prevail.

Letters

Remembering Louis Biegler's contributions

To the editor: Louis W. Biegler, founder and retired chairman and CEO of L.W. Biegler Inc. and International Surplus Lines Insurance Co., passed away on Feb. 5.

His accomplishments in the E&S industry are legendary. Perhaps not as well known is the profound effect that Lou Biegler had on young people fortunate enough to work for him.

Lou Biegler provided an environment for young people to learn the business, with responsibility doled out in proportion to ability, talent and willingness to work. To many, this environment provided not only the foundation but a springboard to successful careers within and outside the industry.

Many of us completed higher education while in Lou Biegler's employ, and with his assistance and encouragement. Members of the Biegler alumni are found in varied and successful positions.

To Lou Biegler: Thanks for the opportu-

nity, encouragement and memories.

Scott L. Carey
Matthew M. Murphy
Bates Meckler Bulger & Tilson
Chicago

To the editor: I noticed the brief mention of Lou Biegler's death in your Feb. 27 issue. Let me suggest that Lou's impact on the profession deserves more space.

Lou Biegler made a major impact on specialty lines insurance in the United States. When I first met him, L.W. Biegler Inc. and International Surplus Lines Insurance Co. were major players in a fast-growing portion of the industry. As if that weren't enough, he also was chairman of the Illinois Insurance Exchange for five years and was instrumental in making it a leading market for specialty lines.

Lou mentioned once to me that he got his start in fire protection. According to his listing in *Who's Who in Insurance*, he

graduated from the Illinois Institute of Technology with a degree in that and began his career in 1932 with the Oklahoma Inspection Bureau. His long and successful career moved into brokerage with three years at Fred S. James and 22 years at George S. Brown, among other positions.

After he retired as chairman of the IIE, he continued to serve as director emeritus. His knowledge and input were of particular value to the IIE. He had an encyclopedic knowledge of people in the business.

Lou Biegler was a talented individual who used his sixty-some years in the insurance business to influence major changes in the way insurance was and is transacted. He was also a thoughtful and considerate man who cared for family and friends and always found time to talk with others less accomplished than him.

Randall Kleinman
Partner
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Amendment

Continued from page 1

lays out a broad path that a lower court could follow to find Curtiss-Wright complied with its amendment procedures, the ruling is a warning to employers to follow their plans' amendment procedures, said Nancy G. Ross, another partner with McDermott.

Mr. Boies predicts that the decision will not trigger any additional lawsuits against plan sponsors. But, he expects that suits now will focus on whether plan sponsors complied with their own amendment procedures, rather than whether the procedures violated ERISA.

The decision also suggests that employers take the time to determine how specific they want their amendment procedures to be, given their own corporate culture and their ERISA goals, said Curtiss-

Wright attorney Laurence Reich, a partner with Carpenter, Bennett & Morrissey of Newark, N.J.

An attorney for the retirees, who sued the Lyndhurst, N.J.-based defense contractor more than a decade ago, said a settlement may be best for the group now. About half of the retirees have died during the course of the litigation, noted Nicholas Lewis, a partner with Lewis, Greenwald, Kennedy, Lewis, Clifton & Schwartz of New York.

The dispute is rooted in the language Curtiss-Wright added to its governing plan documents in 1983. The addition said that retirees' health coverage would cease if the plant from which they retired closes.

That year, Curtiss-Wright shut down its Wood-Ridge, N.J., facility and terminated the health benefits of the plant's retirees. An executive vp informed the retirees about their loss of benefits in writing.

The retirees sued, claiming that

the additional language was an invalid amendment. They argued that the plan did not specify how beneficiaries could determine which company representatives could make amendments and the procedures to be followed. Section 402(b)(3) of ERISA requires that plan documents contain that information, the retirees contended.

Curtiss-Wright contended that the new language was a clarification of its health plan, not an amendment.

Even if the addition was an amendment, Curtiss-Wright argued, it had long noted in plan documents that "the company" reserved its right to amend the plan.

But under corporate law, "the company" generally refers to the board of directors, which apparently played no role in drafting or approving the new plan language, the retirees contended. The company's benefits director and labor attorney drew up the new terms.

A federal district court ruled in 1990 and the 3rd Circuit agreed in 1993 that the new plan language was an amendment and that the plan did not contain a description of the amendment procedures required by section 402(b)(3). (*BI*, Jan. 10, 1994). Both the 3rd Circuit and the district court invalidated the amendment and ordered Curtiss-Wright to pay the retirees nearly \$2.7 million—their benefits' value over a nearly seven-year period.

Curtiss-Wright in 1990 adopted the plan amendment language that the district court held was required by Section 402(b)(3), and again adopted the retiree benefit termination language.

In ruling that Curtiss-Wright's simple reservation of its right to amend its plan was a valid statement of its amendment procedure, the Supreme Court rejected the retirees' argument that Congress intended that plan sponsors provide

amendment procedures that "convey enough detail to serve beneficiaries' interest in knowing their plans' terms."

"Section 402(b)(3)'s primary purpose is to ensure that every plan has a workable amendment procedure," while other portions of ERISA are designed to protect plan beneficiaries, Justice Sandra Day O'Connor wrote for the court.

Section 402(b)(3) is not a clear guideline for employers, Justice O'Connor acknowledged, saying that it "somewhat awkwardly" requires plan sponsors to provide a procedure that allows beneficiaries to discern who can change a plan.

Still, a plan sponsor like Curtiss-Wright that only identifies those who may amend a plan as "the company" also provides a procedure for identifying the responsible company officers, Justice O'Connor wrote. That procedure is to always look to the company rather than to outside parties like a union or a third-party trustee, she wrote.

The high court found that the tougher question was whether Curtiss-Wright's reservation of rights to amend its plan provided a valid procedure for amending the plan.

The court took an approach very similar to how it resolved the first issue. The court found that the reservation established a procedure that only the company—not a third-party trustee or a union, for example—may amend the plan.

"Certainly a plan that says it may be amended only by a unilateral company decision adequately sets forth 'a particular way' of making an amendment," Justice O'Connor wrote.

The court also said that it was reluctant to hand down a ruling that would jeopardize the many uncontested plan amendments that other employers have adopted.

On remand, a lower court will have to determine whether Curtiss-Wright complied with its own amendment procedure.

A "fact-intensive inquiry" will be necessary because there is no clear record that states which Curtiss-Wright officials or committees were expressly or impliedly authorized to make plan changes and whether those individuals approved the plan change, Justice O'Connor noted.

Even if the provision that terminated the retirees' health benefits was improperly adopted, a lower court would have to determine whether the company executive vp's letter to the retirees informing them of the plan change "served to ratify the provision *ex post*," Justice O'Connor wrote.

Mr. Lewis said that "it's hard to believe they meant that" employers have an opportunity to ratify invalid plan amendments.

But corporate law allows companies to ratify legally binding actions by the company either in advance or after the fact, according to Mr. Reich, Curtiss-Wright's attorney.

The court also noted that while plan sponsors are not obliged to spell out their amendment procedures more specifically than Curtiss-Wright did, doing so could avoid costly litigation with beneficiaries. The court quickly noted, though, that employers may lose some flexibility in whom they allow to amend their plans.

ERISA does not address that "dilemma," Justice O'Connor noted. "ERISA, rather, follows standard trust law principles in dictating only that whatever level of specificity a company ultimately chooses, in an amendment procedure or elsewhere, it is bound to that level," Justice O'Connor wrote.

Curtiss-Wright Corp. vs. Frank C. Schoonejongen, U.S. Supreme Court; No. 93-1935.

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Muni bond

Continued from page 3

are the situation in Orange County, Calif., and a "wait-and-see" attitude on the part of public officials who are waiting to see the impact of the Contract with America on federally mandated programs.

At separate press briefings held recently by MBIA and AMBAC, the insurers' top executives predicted that about 40% of bonds issued this year will be insured, up from 38% in 1994.

And, bond insurance rates are likely to increase this year, said Mr. Lassiter.

It turns out both executives last year were overly optimistic in their 1994 bond volume projections: Mr. Elliott projected \$240 billion and Mr. Lassiter estimated \$210 billion.

Their companies missed the mark, too, as an unexpected spike in interest rates slowed refundings and new issues.

Earnings in 1994 were flat, compared with record growth in 1993 at MBIA. At AMBAC, net income actually was down 21% last year.

Now Mr. Elliott is somewhat bullish on the muni bond market, even though interest rates remain high. Local governments' need for working capital, along with more stable interest rates, should both benefit bond insurers, he said.

"From a technical point of view, the relative level of interest rates is not inordinately high, and all it might take is rate stability to convince issuers that market access in 1995 makes good economic sense. I for one, believe we are at the dawn of this more stable era, and I will go out on a limb and suggest that rates may even decline somewhat between now and the end of the year," he said last month.

Regardless of whether interest rates fall or volume picks up in 1995, municipal bond insurers will be raising rates, said Mr. Lassiter. He gives three reasons for his projection that insurance rates will rise in 1995: depressed bond insurance rates in recent years; lower-than-expected bond volume in 1994; and the Orange

County bankruptcy debacle.

"Pricing was down in 1994 due to competition in a market that had lower levels than the previous year. The same could occur this year," Mr. Lassiter said. "Price increases will also be based on perceived increased value (of bond insurance) by municipalities and we are trying to recoup some of the price deterioration that occurred over the previous 15 to 18 months."

Ironically, the Orange County bankruptcy could be a boon for bond insurers because direct losses are not expected to be large and the bankruptcy is expected to

prompt others to buy insurance (BI, Dec. 19, 1994).

"Orange County is the largest, most pervasive, most surprising event in my memory. Insurance is an antibiotic against Orangitis," said Mr. Lassiter. "Orange County is a reminder of the importance of what we do."

Sounding a similar theme, Mr. Elliott said, "Bond insurance helps preserve portfolio liquidity in the face of financial crisis."

"Holders of insured bond issues by participants in the county's failed investment pool found that there were healthy bids in the secondary markets on their bonds,"

he said.

AMBAC insured the bond issues of many government entities that participated in the ill-fated Orange County investment pool. If all their bonds were to default, AMBAC would have to pay out \$17 million annually for the terms of the bonds they insured, said Mr. Lassiter.

Meanwhile, results tailed off for both insurance companies in 1994.

At MBIA, net income was flat—\$260.2 million compared with \$259 million in 1993. But, "core earnings," which exclude capital gains and premiums earned on refunded issues, rose

14.4% to \$221.6 million from \$193.7 million. The par value of bonds insured by MBIA fell 35.4% to \$25.2 billion from \$39 billion in 1993. And gross premiums written fell 24.7% to \$360.8 million last year from \$479.3 million in 1993.

At AMBAC, net income dropped 21.3% to \$141.1 million from \$179.3 million, though core earnings rose 16.2% to \$131.2 million from \$112.9 million in 1993. The par value of bonds AMBAC insured fell 44.6% to \$17.4 billion from \$31.4 billion in 1993. And its gross premiums written fell 40.3% to \$189.9 million from \$318.3 million in 1993.

Do rate wars hurt antifraud efforts?

SACRAMENTO, Calif.—Workers compensation insurers are cutting costs so much to compete under the new California open rating law that they may be sacrificing anti-fraud programs, Insurance Commissioner Chuck Quackenbush says.

Testifying recently at a legislative hearing on the open rating law, he said recent premium reductions are "good news." But, he added that he is concerned about "anecdotal evidence" that insurers are cutting back on their special investigative units.

"As open rating drives carriers to search for short-term cost reductions, the department will not tolerate reductions in the (units) that play a critical role in the fight against insurance fraud," he said.

Insurer officials told the Joint Committee on Workers Compensation that cutthroat pricing could jeopardize some companies' solvency.

Coverage in California is "underpriced" by as much as 20% to 25% because of the state's new open rating law, the Assn. of California Insurance Cos. contends.

—By Joanne Wojcik



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when the hard market returns, a capable wholesale broker will be your best friend.

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Curt Biersch, CPCU
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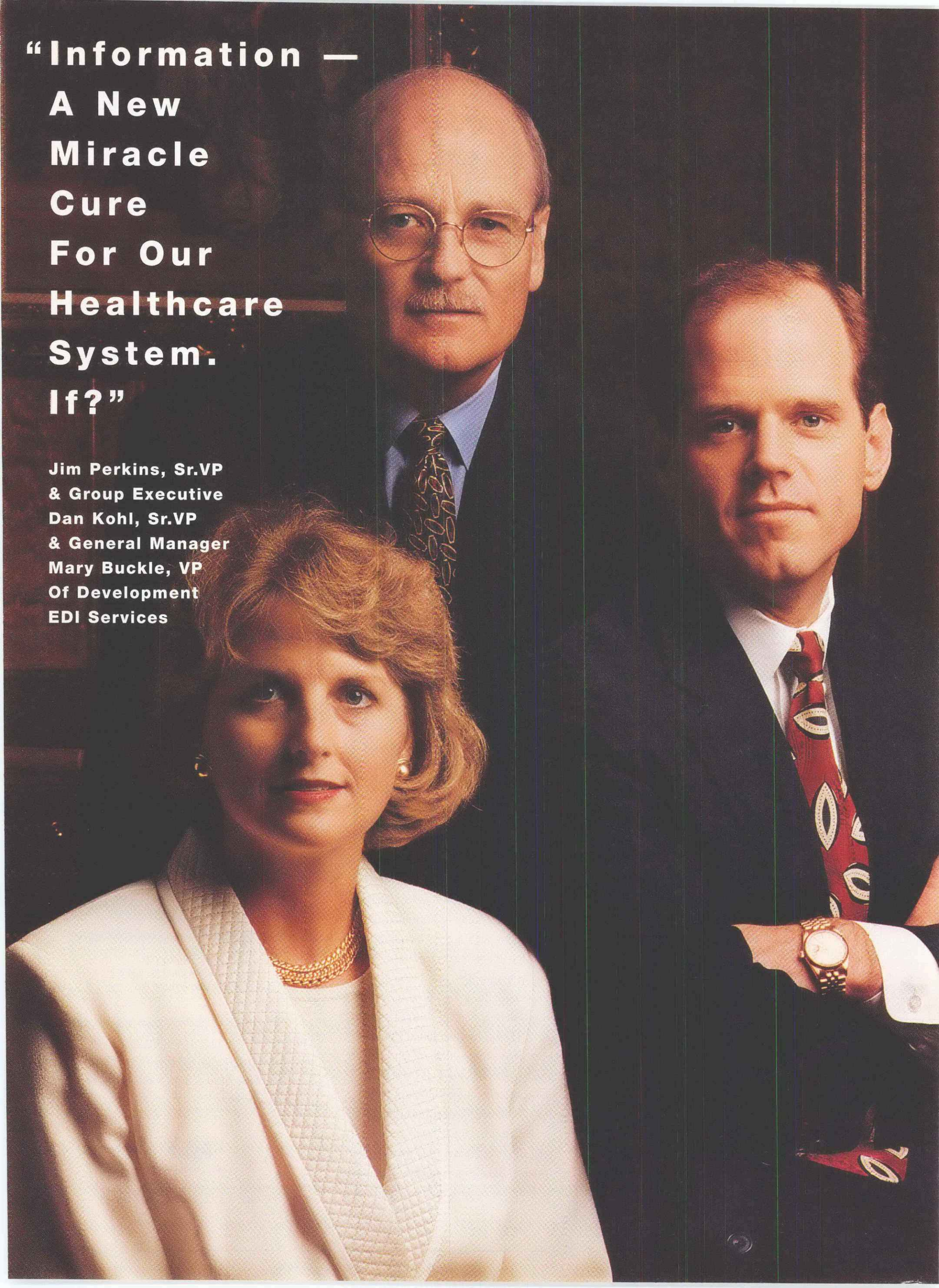
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Here's possibly the most important healthcare announcement this year: Equifax is ready to give medical information new healing power.

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As important as this information is — Equifax believes it can reduce the national healthcare bill by \$300 billion — what's more important is the team that is bringing it to the healthcare market. Every member of this team is measured by how much care he or she puts into healthcare.

"What makes Equifax different," says Jim Perkins, "is that we take a holistic approach to healthcare information. Total solutions, not partial symptoms. Data may be okay in capsule form, not information. Ours comes with a total guarantee."

Mary Buckle has a new term: informational medicine. "Other businesses say they work closely with clients to solve problems; we believe in joint ownership. Only together can we practice informational medicine better than individually we thought possible."

Team leader Dan Kohl knows information must stop traveling at the speed of paper. "We're working on total electronic delivery," he says. "If universal coverage is a national concern, then universal information is a must. It's going to take the best ideas, the best technology — integrated like never before. Just as importantly, we've got to cure the system without breaching the privacy of the patient."

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Most employers exceed new annuity standard

By JERRY GEISEL

WASHINGTON—The U.S. Department of Labor's new standard on the factors that employers must evaluate in selecting a pension annuity provider is expected to have little effect on company buying practices.

In that standard—known as an interpretative bulletin and published in the March 6 issue of the Federal Register—the department says that selecting the "safest available" annuity provider requires employers to do more than rely on insurance rating agencies.

In conducting an "objective, thorough and analytical" search for providers, employers must evaluate a number of factors that could affect an insurer's creditworthiness and ability to pay claims. Those factors include:

- Its size relative to the size of the proposed contract.
- Its level of capital and surplus.
- Its lines of business and other indications of exposure to liability.
- The quality and diversification of its investment portfolio.
- The structure of the annuity contract and the guarantees supporting the annuities.

"The department is saying that ratings are useful, but you can't only rely on them," said Steve Kraus, chief counsel-pensions at the American Council of Life Insurance in Washington.

Employers have been moving in that direction since the 1991 collapse of Executive Life Insurance Co., a major annuity provider that had been highly rated. Companies now retain consulting firms be-

fore buying annuities and do more of the sort of analysis the Labor Department says is necessary.

"Instead of just looking at the ratings, there has been examination of providers' assets and other financial results," said Dick Joss, a consultant with The Wyatt Co.'s Research and Information Center in Washington.

"Over the last few years, more employers have retained organizations to assess the relative creditworthiness of bidding annuity carriers," said Bill Templeton, director of insurance consulting in Towers Perrin's asset consulting group in Atlanta.

The impact of the bulletin also is less than what it would have been a few years ago because the annuity market has charged.

In the mid- and late 1980s, hundreds of employers each year terminated pension plans to recover the surplus assets and then purchased annuities to cover benefits to retirees and employees in those plans. In 1985, at the peak of pension reversions, employers terminated 582 overfunded plans, gaining access to \$6.1 billion in surplus assets, according to the Pension Benefit Guaranty Corp.

Now such reversions are rare. Several recent laws virtually eliminate the financial incentive to terminate an overfunded pension plan. Last year, just four overfunded pension plans were terminated with the sponsoring employers recovering just \$12.4 million in surplus assets.

But another part of the annuity

business remains substantial: employers that purchase annuities after terminating pension plans for a variety of other reasons, including mergers and acquisitions, going out of business or because the companies no longer want to offer a defined benefit plan.

In 1993, the last year for which information is available, the PBGC received more than 5,000 notices from employers that intended to terminate their pension plans.

Benefit experts welcome the Labor Department decision not to impose a "bright line test," a precise formula for determining the safest available annuity provider.

"Plan fiduciaries are not placed in a straitjacket. They and their advisers have some latitude (in evaluating providers)," said Pamela Scott, a principal with Kwasha Lipton in Fort Lee, N.J.

Experts also applaud the department for recognizing that employers may conclude, after evaluating insurers, that more than one provider may be able to offer the safest available annuity.

Still, the bulletin's inexactitude could pose problems for some employers in deciding which insurers can provide the safest available annuity.

"Is insurer size, for example, more important than diversity of assets?" asks Wyatt's Mr. Joss.

Labor Department officials say the answer will depend on the situation (see story, page one).

Other benefit experts, though, question whether an interpreta-

tive bulletin is necessary. They say Labor Department lawsuits against employers that purchased Executive Life annuities have made employers more aware of the steps they must take in selecting annuity providers.

"The regulatory process has worked without this bulletin. The enforcement actions speak for themselves. There was no need for further action," said Phil Suess, a principal with William M. Mercer Inc. in Chicago.

Mr. Suess also views as "redundant" employer analysis of an annuity provider's creditworthiness and claims-paying ability. That type of analysis already is reflected in the ratings the insurers receive from rating agencies, he said.

Others say the suggestion that it is possible to identify the "safest available" provider is flawed.

"The failure over the last few years of well-known, top-rated carriers, coupled with the recent collapse of Barings, suggests that predictions of the financial destiny of any investment organization may be somewhat problematic," said Towers Perrin's Mr. Templeton.

On the other hand, the publication of the Labor Department bulletin focuses employer attention on an issue—the selection of annuity providers—that needs more attention.

"We are supportive of that," said Ned Burmeister, director of pensions at The Principal Financial Group in Des Moines. **BI**

Q&A

Continued from page 1

uating annuity providers)? Are ratings enough? We took this as an opportunity to answer some of those questions.

What additional information have you provided?

We tried to provide more detail to take care of concerns that were raised with us. Let me give you one example. There was a fear that the standard "safest available" on the face of it meant there was only one insurance company you could go to to purchase an annuity. We made explicitly clear in the bulletin that you can go through the process we've set out and reach the conclusion that there may be more than one company that meets that standard of safest available.

Rating agencies perform the five major steps you say should be taken in evaluating annuity providers. In view of that, why is it necessary for plan fiduciaries to undertake the same steps. Isn't it redundant?

Rating agencies don't do it all. One of the things Executive Life demonstrated was the potential danger of relying on just one source of information.

The selection of an annuity provider is of enormous importance to participants. You are making one investment decision that is going to ensure whether or not they are going to get the money to which they are entitled for the rest of their lives. That calls for a procedure that will provide as much information as possible.

The interpretive bulletin provides a kind of checklist—these are the things that the Labor Department says an employer must consider when evaluating an annuity provider. But there is no weighting of factors. For example, the bulletin says employers must consider diversification of assets. How diverse is diverse? How is an employer to know what is enough?

There is no one way to answer that.

These are, after all, matters of judgment. There is no way we in regulation or in an interpretive bulletin can set out an exact weighting that is right in all circumstances.

If you will, we've tried to provide the guideposts, and it is the individual plans that have to go through the assessments.

In providing these guideposts, are

you saying one factor is more important than another?

It will depend on the plan and the circumstances.

A potential annuity provider may have, for example, more non-performing loans than a second provider. But the first provider may have more capital and surplus. Which is a better annuity provider?

The employer will have to go through that process of laying out the things it has considered and on balance (decide) who it considers the safest and the reasons for that. That is all we are looking for.

Do employers have the expertise to evaluate potential annuity providers?

Some employers do and some employers probably don't. If you don't have that expertise, ERISA requires you to get that expertise.

What kind of documentation do you expect employers to maintain to prove they did that sort of research?

I don't want to suggest that this is exhaustive or required in every case.

But I think the kinds of things that would be reasonable to expect them to keep would be a record of the individuals who were involved in the discussions. Certainly, if they hired someone for their outside expertise, the reports they produced.

Some sort of documentation of the process they went through to consider the factors that we laid out in the bulletin. Records of any meetings they held to discuss these issues. And any other documentation so that if we or anyone else went through could see they went through a process.

Legislation is working its way through Congress that would impose a retroactive moratorium on regulations. Would the bulletin be affected by the moratorium?

If one of the two bills were to pass in its present form, our interpretation is that interpretive bulletins would be covered and therefore be subject to the moratorium.

As a practical matter, we don't think it would have much effect. After all, what is an IB except a statement of the Department of Labor's position on a fiduciary's obligations? We have stated (the position) in lawsuits. It is now out there in print. The purpose is to give guidance to fiduciaries. As a practical matter, the moratorium would have little effect. **BI**

For the Record

Texas ruling restricts punitive damages

AUSTIN, Texas—Punitive damages cannot be awarded in wrongful death suits if the plaintiff would not be entitled to compensatory damages, Texas' highest court has ruled.

In its Feb. 16 ruling, the state Supreme Court held that the state Workers Compensation Act—which exempts insurers from liability for accidents caused by, or that could have been prevented by, a loss control program—did not violate the right of surviving family members to receive damages in cases of gross negligence.

The case involved Regina Fuller, who sued Travelers Indemnity Co., alleging that the workers compensation insurer was grossly negligent in failing to protect her father from safety hazards at an American Petrofina Holding Co. oil and gas refinery. Ms. Fuller attributed his death from cancer to hazardous emissions at the refinery. As part of its services, Travelers did safety audits and industrial hygiene surveys at the refinery.

The Texas Constitution modifies the state's Wrongful Death Act in entitling surviving family members to "exemplary damages"—damages above their actual losses—when wrongful deaths are caused by gross negligence. An appeals court had found that the workers compensation law violated that right in restricting the liability of insurers.

But in reversing, the high court held that the state constitution permits wrongful-death beneficiaries to receive punitive damages only when they would also have a cause of action for compensatory relief.

"The reason for adoption of the constitutional provision was to allow for exemplary damages under the Wrongful Death Act... It did

not abrogate the common law requirement of actual damages and extend the remedy to those with no cause of action under the Act," Justice Jack Hightower wrote.

The ruling reinstates a summary judgment granted the insurers by the trial court.

Travelers Indemnity Co. of Illinois and Travelers Insurance Co. vs. Regina Fuller, Supreme Court of Texas; No. 94-0648.

Investor suing Denver over airport delays

DENVER—As the delay-plagued Denver International Airport opened March 1, an investor filed suit in U.S. District Court in Denver, alleging that the city misled investors in the facility.

In a 44-page lawsuit that seeks class-action status and unspecified damages, Bonnie Sonnenfeld accuses Denver of misleading the purchasers of \$3.3 billion in revenue bonds used to finance the \$4 billion airport project by withholding information about opening delays. Ms. Sonnenfeld, of Tampa, Fla., had bought airport bonds with a face value totaling \$25,000.

The Securities and Exchange Commission launched an investigation late last year into whether bondholders were misled, but the agency would not comment.

The DIA, under construction since 1989, originally was scheduled to open Oct. 31, 1993. But the opening was postponed four times by construction delays and problems with its automated baggage system.

Under an agreement with contractor BAE Automated Systems of Carrollton, Texas, the city agreed to pay an additional \$35 million for modifications to the baggage system—originally priced at \$193 million—if the system was working for the new air-

port's principal tenant, United Airlines, by Feb. 28.

BAE now has until Aug. 31 to complete the system for the airport's other tenants, including American Airlines, which had threatened to sue to have access to it.

So far, none of the overrun costs has been covered under the DIA's owner-controlled insurance program, which provides aggregate liability limits of \$200 million (*BI*, Nov. 7, 1994).

Regulator criticizes Empire Blues' actions

NEW YORK—Empire Blue Cross & Blue Shield must improve its service, cut costs, introduce managed care and generate more premiums from its large group business, New York Superintendent of Insurance Edward J. Muhl says.

He also limited Empire's weighted average rate increase to 15.7% instead of the 28% it had requested.

Mr. Muhl severely criticized the Blues plan's management. "We will no longer tolerate excuses by Empire's management in failing to reach acceptable service levels, achieve savings in administrative expenses and increase efforts to detect fraud. Empire must simply do a better job in addressing these serious areas of concern."

Empire has had large losses in recent years, and last year its managers were accused of misfiling information (*BI*, March 21, 1994; Nov. 15, 1993).

Empire should also provide a managed care plan with a point-of-service option and limited prescription drug benefits, Mr. Muhl said. It should cut administrative costs in 1995 to 7% of gross premiums from 9.4% in 1994 and raise rates for large group contracts in its experience-rated business, he said. **BI**

A more immediate solution

By William Whitehead

A HEATED DEBATE IS currently raging through the group health benefits and workers compensation industries about how to best achieve insurance nirvana: 24-hour coverage.

While there is a need to explore this approach as a possible long-term solution, too much attention is focused on 24-hour coverage—defined as one insurance policy providing complete disability and medical coverage regardless of the occupational or non-occupational nature of the injury—at the expense of other opportunities. Benefit and risk managers need immediate solutions. A thirsty man doesn't need a theoretical discussion of how to drill a well; he needs a drink.

"Joint administration" is emerging as an effective cost management tool. Joint administration unites medical benefit cost containment strategies—networks, bill review and precertification—with workers compensation indemnity cost containment strategies—case management and return-to-work programs. It provides a single system that seamlessly applies these tools to employers' group health, workers compensation and disability policies. Effective cost management requires addressing both the medical and indemnity components of each coverage type.

This approach yields savings by providing a single administrative system, enhanced ability to identify fraud, the opportunity to reduce disability length, and the most appropriate medical care at the most favorable rates. It also provides employers and employees with easy claim submission—the TPA or insurer determines whether the injury is a workers compensation or a group health claim.

Employers should evaluate the effectiveness of a joint administration program in light of these six central building blocks:

- **Unity of purpose.** All internal and external parties developing and implementing an employers' joint administration approach must work toward the same goal—to better contain group health, workers comp and disability costs. It is essential that all parties help to define the common objectives of the program, the steps necessary to achieve these, and the milestones used to measure the program's effectiveness.
- **Information technology.** Technology is the key to maximizing joint administration's potential savings, for it enables reduced administrative costs and the

Managing costs of group health and work comp

systematic application of cost containment and management tools, such as utilization review, case management and medical bill review. A series of integrated databases allows greater communication between all parties involved in managing, monitoring and processing claims. The same cost management tools are performed on each type of claim, but since benefit and risk managers use that information differently, the information system must be capable of producing reports that meet their specific needs. Such an information system makes possible the timely analysis of medical provider quality issues, injury trends and return-to-work results so that the program can be modified as needed.

- **Culture.** The historic divisions between group health benefits and workers comp must be dissolved among employers, insurers and TPAs. An open flow of information between group health benefits and workers comp managers is needed. Each has a role to play and joint administration should be viewed as a strategic tool to help the organization's short- and long-term profitability, rather than threatening traditional responsibilities.

- **Broad experience.** This is the flip side of the "culture" issue. While the boundaries between benefits and risk managers become blurred as each contributes to controlling the company's bottom line, joint administration requires extensive experience with each insurance type. Health benefits and workers comp each face many state and federal regulations, and effective joint administration requires a detailed understanding of the complexities of each insurance type. In addition, joint administration may provide synergies by applying cost containment tools developed for one insurance type to another.

For example, an aggressive return-to-work philosophy is a vital part of effective workers comp programs. But such a philosophy also has merits for group health as well as short- and long-term disability claims. Broad experience is needed to capitalize on these opportunities.

- **Communications.** While most employees understand their group health benefits, few are aware of those available through workers comp. Many companies have been leery of detailing the medical and disability coverage provided by workers comp. However, controlling these costs requires empowering employees to minimize a claim's impact on the employer. Joint administration applies cost containment tools to these cases, but it also stresses the importance of establishing accident-reporting systems and regular contact between the injured worker and the employer. The goal is to provide the highest quality medical care within a context which stresses returning injured employees to productive lifestyles.

- **Negotiating ability.** The greater the ability to manage medical costs, the greater the savings on both group health and workers comp claims. Accordingly, insurers and TPAs should demonstrate experience negotiating discounted fee structures with local health care providers, as well as quickly appointing and maintaining open communications with such providers. Joint administration's goal is to make available the most appropriate care through the most cost-effective means. The quality of the medical care is part of the equation. Equally important, and a major cost-driver, is the need to focus on returning injured individuals to a productive lifestyle. Maximizing joint administration's savings will depend on the ability to negotiate fee discounts with local health care providers who share this outlook.

Better managing group health benefits and workers compensation costs is a critical issue facing employers today. While there is a need to study all potential longer-term solutions, including 24-hour coverage, benefits and risk managers should not overlook the solution available today by jointly administering current group health benefits, workers compensation and disability policies.

Let's give that man a drink.

BI



William Whitehead is vp-operations of Worcester, Mass.-based Sterling Risk Management, which provides third-party administration services to employers that self-insure workers compensation. It is a unit of State Mutual Life Assurance Co. of America.

Workers comp payout offsets pension benefits

The 7th U.S. Circuit Court of Appeals ruled that the anti-forfeiture provision of the Employee Retirement Income Security Act did not preclude a pension plan provision requiring the reduction of a retiree's pension benefits by the amount he received in workers compensation.

Robert Huppeler worked for Oscar Mayer Foods Corp. for more than 25 years when his doctors told him he had suffered a substantial permanent partial bilateral hearing loss. His duties had required him to work alongside noisy machinery. Mr. Huppeler took early retirement in January 1982. He was awarded about \$6,500 in workers compensation benefits.

The benefits manager of his retirement plan then advised him that under the plan provisions adopted by a collective bargaining agreement, every dollar he received in workers compensation benefits would be subtracted from his pension. Mr. Huppeler sued the employer, claiming that the offset clause in the pension plan represented a forfeiture and, therefore, was forbidden under the anti-forfeiture

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provision of ERISA. The trial court ruled for the employer.

The appellate court concluded that the provision in the employer's pension plan, under which Huppeler's pension benefits are reduced a dollar for every dollar he received under workers comp, does not represent an impermissible forfeiture. The court acknowledged that this was a very harsh result, especially as Mr. Huppeler had suffered a permanent hearing loss and had no remedy. But, the court said the result did give effect to the agreement reached between the company and the union in the collective bargaining process. The trial court decision was affirmed.

Huppeler vs. Oscar Mayer Corp., U.S. Court of Appeals for the Seventh Circuit, Aug. 8, 1994 (BI/01/M.-\$10).

Pension plan created

The U.S. Circuit Court of Appeals for the District of Columbia ruled that a

contractor's actions created a "benefits plan," even if the contractor never placed employees' withheld wages in a pension plan.

The ruling stems from a suit in which an employee sued the contractor for alleged deliberate and tortious retention of employees' fringe benefits in violation of the fiduciary duties under the Employee Retirement Income Security Act.

Between July 1990 and January 1991, John Kenney worked for Roland Parson Contracting Corp. on two construction projects subject to the prevailing wage laws. Parson informed its employees that it intended to satisfy the federal law by paying the difference between their wage and the prevailing wage into a pension fund for their benefit. Parson also contacted a pension administrator about participating in its plan and obtained a number of brochures that described the pension plan. Parson never actually paid any money into any pension plan.

Mr. Kenney sued alleging breach of fiduciary duty imposed on Parson by

ERISA. The trial court dismissed the suit.

The appellate court said federal law makes clear that a plan need not be formalized and that a plaintiff can prevail if the existence of a plan can be inferred. The appellate court said several factors led it to conclude Parson established a plan, such as the distribution of documents, oral representations, deliberate failure to correct known perceptions of the plan's existence and the reasonable understanding of the employees.

Mr. Kenney's claim was reinstated.

Kenney vs. Roland Parson Contracting Corp., U.S. Court of Appeals for the District of Columbia, July 15, 1994 (BI/03/F.-\$10).

BI

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.

Retirement savings often 'too little, too late'

By CHRISTINE WOOLSEY

NEW YORK—Employers must take steps to prevent the financial shortfalls that many workers currently appear destined to experience at retirement, consultants and benefits executives say.

When viewed collectively, trends in U.S. demographics and economic conditions foretell a bleak future for retirees' financial security, said Jeffrey Newman, a partner in the Parsippany, N.J., office of Coopers & Lybrand L.L.P.

During the next 20 years, many Americans may have to work longer before retiring because they are delaying saving for retirement until their 40s and 50s and, as a result, their nest egg has less time to accumulate interest, explained Mr. Newman, who moderated a retirement planning session earlier this month at a benefits conference sponsored by the Conference Board.

In addition, people are living much longer following retirement, so their savings will have to be spread over a longer period of time, he said.

Other factors could have an impact on retirement savings, as well.

For example, college tuition increased at double-digit rates during the 1980s and could erode a large portion of many American families' retirement savings. And, the flat housing market may mean the windfall many Americans ex-



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pect from selling their homes at retirement will not materialize.

In addition, medical care will become a major cost for retirees as more employers cut back or eliminate retiree medical benefits for active employees to save costs.

Indeed, business conditions are also putting increased pressure on traditional employer-sponsored retirement plans.

As a result of significant downsizing and merger and acquisition activity over the last decade, one of every six U.S. workers has been displaced from his or her job. "In terms of retirement benefits, that has a negative impact on the buildup of defined benefit plans, particularly final pay pension plans," Mr. Newman said.

Employers have responded to those trends by taking a shorter-term focus on retirement plans—specifically moving away from defined benefit plans in favor of defined contribution, cash balance and pension equity plans.

But that shift is not promoting adequate savings rates among U.S. employees, who on average save about 3% of earnings annually, much less than workers in other countries. Japanese workers save an average of 23% of earnings annually, and German workers save an average of 14%.

Several employers are taking

steps now to address the need for more effective retirement savings programs, particularly in light of these looming factors. The overlying theme of such efforts makes it clear that employers and employees share the responsibility for retirement security.

RJR Nabisco Inc., which came together after a well-publicized leveraged buy-out in 1989, is a prime example of a company that has undergone vast changes, followed by the need to revamp its employee benefit programs.

Facing retiree medical liabilities of \$1.2 billion in 1992, the company desperately needed to alter its retiree benefit programs.

"We needed to change our plans but we didn't want to eliminate or cut benefits severely," said Gerald Angowitz, vp of human resources at the New York-based tobacco and food conglomerate.

The firm undertook a series of plan design changes aimed at making retiree benefits more flexible and allowing employees to choose among various benefit levels and pricing, he said.

The firm replaced most employees' rich retiree medical plans with a new retiree medical plan called MedChoice that gives retirees indemnity, catastrophic and managed care options. The company's contribution is now based on employees' years of service.

The company also established a cap for retiree medical spending equal to 1.5 times its 1991 average

retiree medical expenditures. To help retirees save for medical costs they might face in the future as a result of the cap, RJR Nabisco created MedSave, a program that will match 50 cents on each dollar of pretax savings of employees over age 40. The money accumulates in a trust fund that retirees can access when they incur medical expenses not paid for under the MedChoice plan.

In addition, the company combined R.J. Reynolds' and Nabisco's 401(k) savings plans and implemented daily valuation and automatic voice-response technology. The company also increased the number of investment options available to employees. And, the firm introduced a scholastic savings plan for employees with children entering college, as well as an employee-paid long-term care benefit.

After holding several focus group meetings with employees, RJR Nabisco also introduced a financial education program. "Employees said they were not looking for hand-holding but wanted education to make their own decisions," Mr. Angowitz said. Employees expressed an interest in broad "financial planning and wanted to determine how best to invest and how to make their money stretch" effectively throughout their retirement.

Helping employees become better financial planners was also a key strategy for Engelhard Corp., said John Hess, director of human resource policies, plans and services for the Iselin, N.J., chemical company.

"We examined our pensions and savings plans and found they were financially and competitively sound," Mr. Hess said. "But, we found employees have been less than diligent in their lead role in the retirement planning process and Engelhard had not clearly articulated that role or provided the resources to help them."

The company therefore undertook a restructuring of its retiree benefit packages that focused on "engaging employees in the process" rather than redesigning the plans themselves. The changes were more psychological than "financial," Mr. Hess said.

Among other things, Engelhard introduced an interactive computer system that featured modeling software to help employees bring together multiple aspects of retirement—apart from the company's pension and savings plans and Social Security. "We want the tools to be used in conjunction with financial seminars, newsletters and the like. There is a lot of information out there. As employers, we need to bring it together for employees," he said. **BI**

Education

Continued from page 3

turn, Ms. Mazze said. VNU distributed materials from Fidelity's annual investment review during presentations to eligible employees and also mailed "user-friendly" investment communications to employees' homes.

"In 1993, we expanded the educational campaign by producing brochures designed to answer the kinds of questions employees asked most often," she added. Those questions included when to start saving for retirement and how to save for specific needs such as educational expenses or a house.

The brochures also addressed more complex concepts, like the advantages and disadvantages to investing in higher risk funds. Graphs and charts were designed to help employees understand the risks and returns associated with the various funds the company offered.

In 1994, VNU held seminars to be sure employees were getting the message. "It's good to distribute written materials, but when you verbalize and add interaction, the message really sinks in," Ms. Mazze explained. Attendance was excellent for the meetings, which were held at company locations, on company time.

"Onsite seminars work better and are usually better-attended," noted Michael Rosenthal, a managing consultant with A. Foster Higgins & Co. Inc., the New York-based consultant that worked with VNU, and the session moderator.

In 1994, VNU assessed the results of its first series of educational efforts and determined its future education needs.

"We were surprised to learn that participants were not twenty-something," said Ms. Mazze. For example, even in the compa-

ny's lower salary brackets, the median ages of participants were in the mid-30s.

To get younger employees involved, the company ran more financial planning seminars emphasizing how early one needs to start to accumulate adequate savings, volatility, earnings potential and erosion of value. The company also installed Fidelity's financial planning software at all U.S. offices so employees could do their own retirement modeling.

"Everyone used it; it was so hot," Ms. Mazze said.

VNU also studied the investment choices workers made and found that they often selected those with the lowest yields. To encourage them to opt for higher yields, the company added two new fund options: one at the high end of the medium-risk category and one at the low end of the high-risk category.

The company also distributed more information about the concept of risk and reward in summary fund descriptions. Also included were model portfolios that featured various asset allocations by investment type in an effort to teach employees how to get

greater returns on their investments.

In measuring the success of that educational campaign, Ms. Mazze said employees have moved away from low-risk, low-return investments and moved toward high-risk and potentially high return investments. The amount of existing 401(k) savings allocated to low, medium and high risk funds is about even, she noted. However, as of December 1994, 71% of the new money employees contributed to their 401(k) plans has been invested in high risk funds. "Overall the balance between money already allocated and new money is good," Ms. Mazze said.

Employers that embark on a similar course need to recognize that employees tend to look for the underlying messages—rather than the overt messages—contained in these types of benefit plan communications, she suggested.

"Our underlying message was we treat employees as responsible adults who are capable of making their own decisions about financial investments, just as they are capable of making other decisions." **BI**

Benefits conference attracts 200

NEW YORK—More than 200 corporate benefits executives and consultants attended the Conference Board's 15th Annual Employee Benefits Conference at the Waldorf-Astoria Hotel in New York March 1-2.

The theme of the two-day meeting was "How Benefit Programs Can Help Your Company Be an Employer of Choice."

Many of the 14 sessions covered retirement planning, including how to better prepare employees for a financially secure retirement and how to redesign retiree benefit programs to reduce costs. Other sessions discussed the future of flexible benefits programs and the increasing need for employers to implement programs that help employees balance work and family issues.

The conference also featured concurrent sessions about the successes and failures of specific benefit program changes.

For further information contact the Conference Board Customer Service Department, 845 Third Ave., New York, N.Y. 10022; 212-339-0345.

Employers told not to let up on efforts to contain costs

By CHRISTINE WOOLSEY



The Conference Board

NEW YORK—Employers need to keep pressuring the health care industry to cut costs and improve efficiency, says a prominent health care policy specialist.

Stuart Altman, a professor of health policy at Brandeis University in Waltham, Mass., and former health adviser to the Clinton, Ford and Nixon administrations, warned employers not to become complacent as cost increases moderate.

In the cyclical health care market, he said, employers and other payers must strive to control costs or else the increases will again become unbearable.

Mr. Altman, who chairs the Prospective Payment Assessment Commission—which advises Congress on how to improve the Medicare system—spoke earlier this month at a benefits conference sponsored by the Conference Board.

Mr. Altman chided employers for being "patsies" during the 1980s when Medicare payments to hospitals were cut significantly. "Business communities were the great tooth fairies of the health care system for a long time."

Like a "great Ponzi scheme," health care providers go after the deepest pockets, he asserted. At times those pockets belong to the government, at times to private payers.

When Medicare payments were cut, employers came to the rescue, paying out billions of dollars for employee medical benefits, Mr. Altman said.

Beginning in 1991, however, private payers began to cut back. "Employers finally figured out how to control health care spending."

Today, with neither Medicare nor employers prepared to "bail out" an industry, hospitals are facing tough business decisions,

said Mr. Altman.

Many hospitals will close, while others align themselves with their competitors in an effort to stay in business. Teaching hospitals, which tend to be very expensive, face an uncertain future as both the government and private payers cut spending.

"The question is, who will worry about training the next generation of physicians? Who will pay for the research that is done by teaching hospitals?" Mr. Altman asked.

Employers "cannot afford to collectively ignore the impact of change on the health care delivery system," he warned. "We are in complicated waters when it comes to health care financing and the health care delivery system."

"You have to make a decision. You can do your best as an individual employer and not worry about the big picture. But, if you don't worry about it collectively, I don't know who will."

Employers also should not lose sight of the problem of the uninsured, he added. During the last two years, when health care cost hikes decreased for many employers, the number of uninsured continued to climb. In 1992, 38.9 million Americans were uninsured and in 1993, 41.2 million were uninsured. "That could reach 50 million very soon," Mr. Altman said.

"Right now we are caught up in the heyday of reduced government. But watch out. If the uninsured does go up to 50 million and the health care infrastructure collapses, we may end up with a single payer system."

"As you aggressively pursue better benefits management, you need to think about the health care delivery system. You are being given the ball." **BI**

INTERNATIONAL

Profits increase for U.K. insurers in 1994

By ADRIAN LADBURY

LONDON—Low losses and more selective underwriting resulted in vastly improved profits in 1994 for the United Kingdom's largest multiline insurers.

On average, the six largest U.K. multiline insurers—excluding Norwich Union Insurance Group which has not yet released results—reported that 1994 pre-tax profits rose 79% to £2.04 billion (\$3.19 billion) in 1994 from £1.17 billion (\$1.83 billion) in 1993.

London-based Commercial Union P.L.C. posted record profits of £413 million (\$646.3 million) compared

with £218 million (\$322.6 million) in 1993, and reported reduced claims in most classes of business. Its gross non-life premiums written rose 6.1% to £4.32 billion (\$6.76 billion) from £4.07 billion (\$6.02 billion).

At General Accident P.L.C., of Perth, Scotland, profits rose 45% to £428.3 million (\$670.3 million) from £294.9 million (\$436.5 million). Its gross non-life premiums written rose 1.4% to £4.25 billion (\$6.29 billion) from £4.19 billion (\$6.2 billion).

London-based Royal Insurance P.L.C. reported the biggest improvement in profits, which soared 180% to £401 million (\$627.6 million) from £143 million (\$211.6 million). Its

gross non-life written premiums fell 2.7% to £3.56 billion (\$5.57 billion) from £3.69 billion (\$5.46 billion).

As a result, Standard & Poor's Corp. raised the claims-paying ability ratings of Royal Insurance and its pooled companies in the United States to an A from an A-.

Guardian Royal Exchange P.L.C.'s profits improved 78% to £326 million from £183 million (to \$510.2 million from \$270.8 million) in 1993. The London-based multiline insurer also made a group underwriting profit of £15 million (\$23 million), its first since 1978. Its gross non-life premiums written rose 11.8% to £2.84 billion (\$4.44 billion) from

£2.54 billion (\$3.76 billion).

The six companies' shareholders benefited from steep rate increases in 1992 and 1993 in most classes, vastly improved claims experience and improved results in overseas business, which is becoming a larger part of the insurers' book.

Insurers also listed as key factors in the improvement closer cooperation with police, improved car anti-theft systems and increased deductibles, especially in commercial property policies. And, walking away from accounts that resisted rate and

deductible increases proved worthwhile, the insurers said.

Eagle Star Holdings, the insurance subsidiary of B.A.T. Industries P.L.C., said non-life premiums written fell last year "as the company continued its emphasis on writing profitable business in the face of increasingly competitive markets."

Eagle Star's non-life premiums written fell 1.7% to £2.39 billion (\$3.74 billion) last year from £2.43 billion (\$3.6 billion) in 1993. Pre-tax profits rose 41.4% to £157 million

Continued on page 19

Gooda Walker interim payout delayed

By STACY SHAPIRO

LONDON—The members of the Gooda Walker Action Group will not receive a £210 million (\$340.2 million) interim payment on their court award until at least the end of April, following the British Court of Appeal's decision this month to postpone the payout until other issues in the case are settled.

The interim damages, most recently scheduled to be paid on March 10, now cannot be paid until at least April 26, when the Court of Appeal will hear a challenge to a High Court ruling that members who are "first past the post" in litigation proceedings should receive damages before other members' actions are decided (*BI*, Feb. 20).

The Court of Appeal's stay on

LONDON

the interim payment and other litigation related to Gooda Walker also puts on hold a lawsuit filed in the High Court late last month by 17 members agents against their errors and omissions underwriters for coverage of damages, said Nicholas Pryor, partner at law firm Manches, which represents the members agents.

Underwriters contend only about £115 million (\$186.3 million) of the interim payment is insured, said Clyde & Co., the underwriters' attorneys.

U.K. cat reserves

British insurance companies are closer than ever to winning ap-

proval for tax-free catastrophe reserves following the passage of a private members bill in the House of Commons earlier this month.

In January, it appeared the catastrophe reserve proposal would be tabled when Labour MPs filibustered and time ran out for debate on the bill (*BI*, Feb. 6). The legislation, the Insurance Companies (Reserves) Bill, had been introduced by Conservative Member of Parliament Oliver Heald.

However, despite the filibuster, Mr. Heald's office contends that "the bill was never dead." Mr. Heald reintroduced the bill every Friday in an effort to get it passed.

The postponement of debate on the measure had more to do with MPs wanting other legislation to be considered first rather than direct opposition to this bill, Parliamentary sources say.

On March 3, the House of Commons passed the bill on a "begging to move all stages" motion, whereby the bill moved through three key stages in five minutes rather than several weeks. It now goes to the House of Lords, where there is expected to be little opposition.

If the bill becomes law this year, it will enable the British Department of Trade and Industry to set out rules and regulations for British companies to set up tax-free catastrophe reserves.

The DTI is scheduled to publish a consultation document detailing these requirements "shortly," said a DTI spokeswoman.

London continued on next page

International data offers a look at size of European market

BY STACY SHAPIRO

LONDON—For the first time, the insurance associations of 24 European countries have jointly published data on their markets to give a clearer picture of the European market's size.

The Comité Européen des Assurances, representing the 24 insurance associations, reported that gross premiums totaled 434 billion European Currency Units (\$484.17 billion) in 1993—the last year for which information was available—up 11% from 390.2 billion ECUs (\$470.62 billion) in 1992. Members of the European Union accounted for 88%, or 383 billion ECUs (\$427.27 billion), of 1993's volume.

Non-life premiums of 221 billion ECUs (\$246.55 billion) accounted for 51% of total gross premiums in 1993.

CEA did not calculate total claims across the 24 member countries participating, and only gave claims data for some classes of business.

Gross premium volume for fire/property insurance totaled 46.6 billion ECUs (\$51.99 billion) in 1993, the largest non-life sector outside of auto, which totaled 74.6 billion ECUs (\$83.22 billion). Gross premiums totaled 14.3 billion ECUs (\$15.95 billion) for the marine/aviation/transport line in 1993.

Property claims, meanwhile, amounted to 1.9 billion ECUs (\$2.12 billion). There was an upsurge in arson and robbery, losses from natural catastrophes and environmental claims in 1993, the CEA's 1993-1994 annual report shows. CEA is studying whether there should be a mandatory guaranty system across Europe to pay for losses caused by catastrophic events. Such a system is already used in several individual countries to pay for part or all catastrophic losses, but other countries leave such coverage entirely to their insurance markets.

CEA continues to work with European insurance organizations to establish international property loss control criteria. These include: participating in current initiatives to standardize certain fire prevention equipment; recommendations safely stocking hazardous products; and chairing the European Sector Committee for Intrusion & Fire.

Gross premiums written for liability insurance totaled 14.6 billion ECUs (\$16.29 billion) in 1993, and many European markets

Continued on next page



AP/Wide World

A rescue team saves the crew of oneAustralia, the America's Cup yacht that broke up and sank off San Diego March 5.

Insurer pays yacht claim

SYDNEY, Australia—Australian insurer MMI Ltd. has paid a \$3 million Australian (\$2.2 million) claim for the loss of oneAustralia, the Australian entry in the America's Cup, which sank during a race off the coast of San Diego earlier this month.

Sydney-based MMI had underwritten 100% of the cover and also was a sponsor of the 75-foot boat, which was owned by the oneAustralia syndicate, a group of Australian businesses that provide funding for the America's Cup challenge.

Sydney-based General Reinsurance Australasia Ltd. was the lead reinsurer. An MMI spokesman would not provide details of the reinsurance arrangements.

It's unlikely the yacht will be salvaged, according to Peter Morris, chief executive of the syndicate.

Clifton Love, MMI chairman, said the oneAustralia team was re-equipping its reserve yacht. Commenting on the fast claim payment, he said: "We don't want any uncertainty over insurance to affect (Skipper) John Bertrand."

The syndicate's broker is Heath Fielding Australia Ltd. in Sydney.

—By Kate Tilley

Insurers taken over by Mexico may be sold

MEXICO CITY—Several insurance companies, including foreign firms, are interested in buying two Mexican property/casualty insurers that the government took over following financial trouble at their parent company, says an insurance trade group official.

The government has notified the Asociación Mexicana de Instituciones de Seguros that several companies have contacted authorities about buying the two units of Grupo Financiero Asemex Banpais S.A. de C.V., said Jose Covarrubias, director general of the trade group.

Both units—Aseguradora Mexicana S.A., or Asemex, and Seguros Banpais—will continue to pay claims and write new business.

Asemex, which is by far the largest of the two units, writes

primarily auto, fire and marine coverages.

Combined, the two units had 1994 gross written premiums of 2.73 billion pesos (\$390.1 million).

Asemex established a branch office in Austin, Texas, last year to write trucking business, but it has not yet written any premiums.

The Mexican authorities replaced the management of Asemex Banpais earlier this month after the banking arm of the group ran into financial difficulties as a result of its investment policies.

The authorities have informed the Texas regulators that the two insurance companies had no part in the problems of the banking side of the group, said Gloria Leal, international regulatory counsel in the Texas Department of Insurance.

The Asemex branch office in Texas was established in May 1994. In the business plan submitted to the Texas regulators, Asemex said it would target trucking business between Mexico and the United States, according to Ms. Leal.

The insurer has not yet written any business in the United States, but even if it had policyholders, they would be protected by funds held in the United States, she said.

"The Texas branch is separately capitalized pursuant to a trust agreement which says that it must have at least \$2.5 million in a U.S. bank," Ms. Leal said.

According to the latest filings, Asemex has \$2.67 million in trust at the Texas Commerce bank in Austin, she said.

—By Gavin Souter

INTERNATIONAL

Europe

Continued from previous page
are expressing concern about that risk's stability, the CEA noted.

Several markets said legal developments in their countries were adversely affecting liability risks and making certain activities difficult to insure, according to the annual report.

Various categories of professional liability coverage—particularly medical malpractice—as well as environmental liability, fall under that difficult-to-insure category, the report says.

"These trends—which recall the unfortunate drift noted in the U.S. over the last few years—are apparent especially in Germany, Belgium, France and the Netherlands," the CEA stated.

And, some countries—like Belgium, Spain and France—have tied insurers' hands by making it illegal to sell claims-made insurance policies, which would limit the amount of time in which a policyholder could file a claim. The CEA advocates greater contractual freedom in this area.

Meanwhile, there is a "growing demand" in Europe for directors and officers liability coverage, so the CEA is conducting a study of D&O needs and coverage availability.

The association also is examining the insurability of new liabilities arising from the growing use of computerized transmission of data.

Accident and health insurance, with 1993 gross premium volume

of 43.5 billion ECUs (\$48.53 billion), is growing in all parts of Europe as governments reduce state benefits, the CEA's annual report says. Private disability coverage has become popular in the Netherlands, for example, following the government's decision to restrict state disability insurance benefits, the CEA noted.

The CEA collated the results of 24 of its 25 national insurance association members and associate members, from Cyprus to Sweden and the Czech Republic to Ireland.

The association also reported to members its major activities in 1993-1994, which included:

- Discussions with the European Commission about proposed rules on environmental liability.
- Examination of the E.C. discussion paper on liability and insurance in the construction field.
- Monitoring the formation of the single insurance market.
- Discussions with the E.U. and the Organization for Economic Cooperation & Development about uniform solvency regulations with both the European Union and the OECD.

Free copies of the 1993-1994 Annual Report are available in French and German; copies of "European Insurance in Figures 1993" are available in English, French and German for 130 French francs (\$26.59). Contact the Comité Européen des Assurances, Secrétariat Général, 3 Bis, Rue de la Chaussee d'Antin, F75009 Paris, France; 3314-483-1183; fax: 3314-770-0375.

Asbestos warning

As many as 1 in 40 of all British men now in their 50s who were exposed to asbestos dust while working in the building trades may be at risk of dying from mesothelioma, warns an English cancer specialist.

"Building workers—particularly plumbers, gas fitters, carpenters and electricians—will account for...these deaths," said Julian Peto, who is the Cancer Research Campaign professor of epidemiology at the Institute of Cancer Research at London University.

Mr. Peto and colleagues from the Health and Safety Executive wrote a paper published in the March 4 issue of the medical journal The Lancet on the reported increase in mesothelioma deaths in Britain.

The report said that asbestos use in the United Kingdom peaked in the 1960s and 1970s, before falling steeply.

"Many buildings, however, still contain asbestos materials, and substantial exposure may still be occurring in the building renovations and maintenance trades. Workers in these trades may therefore still be at risk," their paper said.

Asbestos exposure is responsible for more occupational deaths than any other single cause, killing about 3,000 people in Britain annually, which could peak as

high as 5,000 deaths in the next century, according to the researchers.

But, "the risk from asbestos is much less now than it was in the past, both because its use is now very strictly limited and the removal of asbestos insulation by licensed contractors is much better controlled," said Dr. Peter Graham, HSE's senior health policy official.

Although personal injury litigation

Asbestos exposure is responsible for more occupational deaths than any other single cause, the paper says.

tion is increasing in the United Kingdom, it is not clear if part of the reason behind that increase is the apparent rise in victims of asbestos-related diseases.

Claimants in Britain have generally sought compensation for asbestos-related illnesses directly from their employers or unions, said Stephen Moss, partner for London law firm Reid Minty, who has represented asbestos claimants.

In addition, he noted, some have sued for damages in U.S. courts to recover additional damages from the U.S. companies that produced

asbestos products.

The difficulty in suing in courts in the United Kingdom is that the claimant must prove negligence on the part of a defendant before recovering damages, Mr. Moss explained.

However, personal injury litigation in Britain is definitely on the rise, he added. "It's very much a '90s phenomena."

Occupational disease claims, including asbestos-related diseases, hit U.K. employers liability insurers hard in the 1980s, even though the insurance policies under which claims were filed may have been written between 10 and 40 years earlier, said David Thomas, technical director of liability for Willis Corroon Ltd., during a seminar to launch an occupational health management service.

There is now about £300 million to £400 million (\$486 million to \$648 million) worth of occupational disease claims annually paid by employers liability insurers, said Mr. Thomas.

The trend to pay compensation for occupational disease "is undoubtedly up," he said.

Compensation to workers who are totally disabled also is on the increase, noted Mr. Thomas.

In 1972, a worker who was totally disabled received about £50,000 (\$81,000) in compensation from his employer.

In 1992 the compensation rose to a whopping £750,000 (\$1.2 million). **BI**

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Persons applying for this position must have the following experience and training: Undergraduate degree required, with graduate degree in accounting or business preferred; CPA certificate or other evidence of professional development is desired; 8-10 years experience in financial operations with at least 5 years in a supervisory capacity. Ability to apply generally accepted accounting principles and practice through knowledge of office procedures and ability to hire, supervise, train and motivate employees.

Send resume to Chief Financial Officer, Local Government Insurance Trust, P.O. Box 2697, Columbia, Maryland 21045, by March 24, 1995. Applications received after that date will not be considered. EOE.

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Commercial Consumers

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Financial:

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Sub-total 30,001
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Government, Unions and Educational Institutions 950

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Sub-total 31,294
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Others Allied to the Field 1,028

Total Qualified 53,701
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TOTAL CIRCULATION 53,781
★ Source Business/Occupational breakdown of qualified circulation, November 28, 1994 Issue, as submitted to BPA for December 1994 BPA Publisher's Statement

INTERNATIONAL

Damaged natural gas platform finally operational

By KATE TILLEY

PERTH, Western Australia—A damaged offshore natural gas drilling and production platform, the subject of a \$320 million Australian (\$236.5 million) insurance claim, has finally begun producing gas after a 16-month delay.

The platform was recommissioned Feb. 4 and is now producing natural gas for domestic markets and export, according to Woodside Offshore Petroleum Pty. Ltd., the Perth, Western Australian-based managing partner of the facility.

It is the southern hemisphere's largest offshore facility and is part of the North-West Shelf Gas Pro-

ject, off the western coast of Australia.

The 55,000 ton, \$2 billion Australian (\$1.48 billion) platform, Goodwyn A, was severely damaged during construction (BI, May 31, 1993).

Insurers paid \$280 million Australian (\$206.9 million), after Woodside paid a \$40 million Australian (\$29.6 million) deductible, which was shared by the project's partners, confirmed a Woodside spokesman.

Mr. Atherton said the coverage, a contractors' all-risks policy, was placed by Sedgwick Ltd.'s Perth office. Lloyd's of London syndicates led the slip, with Australian,

Japanese and European insurers also on the risk. Mr. Atherton would not name the underwriters.

Despite the delay, no contracts have been lost and Mr. Atherton said there was no lost production, since the platform's operation was delayed, not interrupted.

Goodwyn A is now expected to reach full production in mid-1996.

The six equal partners in the North-West Shelf Gas Project include Woodside; BHP Petroleum (North West Shelf) Pty. Ltd., BP Developments Australia Ltd., Chevron Asiatic Ltd., Japan Australia LNG (MIMI) Pty. Ltd. and Shell Development (Australia) Pty. Ltd. **BI**

Results

Continued from page 17
(\$245.7 million) from £111 million (\$164.3 million).

But, clement weather conditions may have been the biggest reason for the reduction in claims in 1994. U.K. weather-related losses in commercial and personal lines coverage were especially low.

Subsidence, or shifting of the ground beneath buildings, has led to significant U.K. claims in recent years. But U.K. subsidence claims were down sharply in 1994 because of less severe weather. And, despite severe storms and floods in Northern Europe late last year, U.K. insurers with exposures in that region did not suffer significant losses.

CU estimates that its recently acquired French subsidiary Groupe Victoire will lose no more than £7 million (\$11 million) from the floods that ravaged parts of Northern France late last year (BI, Feb. 6).

U.K. flood damage in December 1994 will probably mainly be felt in the first quarter of 1995.

London-based Sun Alliance Group P.L.C. dampened its profit by strengthening reserves by £100 million (\$156 million) to cover domestic mortgage indemnity claims, which are made by homeowners if lenders repossess the properties. But Sun Alliance and all other insurers reported big decreases in the level of DMI claims as the U.K. housing market claws back to stability. A Sun Alliance spokesman said that it had decided to cap remaining losses "once and for all."

Sun Alliance boosted profits by 42% last year to £316 million from £222 million in 1993 (to \$494.5 million from \$328.6 million). Its gross non-life premiums written rose 0.5% to £3.41 billion (\$5.34 billion) from £3.39 billion (\$5.02 billion).

The insurers' decision to focus attention on claims reduction rather than rate increases is largely explained by the already softened rates in the major classes this year. To stay competitive in the U.K. market, rates must remain stable.

U.K. commercial auto rates have fallen by about 5%, personal auto by about 10% and homeowners about 5%. Commercial property rates increases finally petered out during January renewals and could fall this year. Liability was the only area where rates continued to rise.

The loss of reinsurance capacity for employers liability business and a growing number of industrial accident and illness claims are blamed for continued poor underwriting results in this line.

Insurers say rate increases will continue and reserves will be strengthened as far as the Department of Trade and Industry will allow to cope with rising liability claims.

The major U.K. insurers are trying to balance their portfolios and reduce their reliance on the United Kingdom by overseas expansion.

CU made the biggest move last year with its acquisition of Groupe Victoire. John Carter, chief executive, said overseas expansion would help the company smooth the effects of the underwriting cycle. He expects improved overseas profits to offset falling U.K. profits resulting from flattening rates.

Of the U.K. insurers, General Accident has the biggest presence in the United States. Its £1.2 billion (\$1.88 billion) in gross premiums written on U.S. business accounted for almost 30% of its global 1994 gross premium volume of £4.25 billion (\$6.65 billion). And, the insurer is optimistic about its U.S. business.

"In the United States, where underwriting losses for the year were down 20%, we produced our best fourth-quarter result since 1987, as the benefits of successful rating action begin to show through. We remain positive regarding our prospects," said Nelson Robertson, the insurer's group executive.

Insurance company shareholders got more good news last week as the Assn. of British Insurers published its annual statistical report for 1994.

The ABI calculated that: domestic and commercial claims from natural perils fell 30.2%, to £390 million from £559 million (to \$608 million from \$827 million); commercial and personal property theft claims dropped 14.8%, to £840 million from £980 million (to \$1.31 billion from \$1.45 billion); fire claims were down 6%, to £606 million from £647 million (to \$948.4 million from \$957.6 million); and the number of domestic subsidence claims fell to 27,000, down 20.6% from 34,000 in 1993.

The ABI reported a startling increase in business interruption claims, which rose 84% in the United Kingdom to £209 million last year from £111 million (to \$327 million from \$164 million) in 1993. Claims following fire damage rose to £191 million from £104 million (to \$298.9 million from \$153.9 million) and those following weather damage rose to £18 million from £7 million (to \$28 million from \$10.4 million).

The ABI gave no reason for the massive increase in claims. Most of the major insurers were stumped. A Royal Insurance spokesman suggested the claims could be due partly to the growth of just-in-time management systems in manufacturing, causing larger interruptions when catastrophes occur. **BI**

Louisiana

Continued from page 3

under state conservation in 1993. Mr. Mills, chief of staff for former Gov. Buddy Roemer, was named to head the Blues plan by a board of directors appointed by Mr. Brown at the time of the conservation order.

Neither Mr. Mills nor Mr. Riddick could be reached for comment.

At a press conference the week before his resignation, though, Mr. Riddick denied soliciting a loan for the department. He said he met with Mr. Mills to introduce a friend, Paul Ironmonger, who proposed a \$50 million investment for BC/BS of Louisiana.

"Mr. Mills misunderstood a 10-minute conversation," Mr. Riddick said at the press conference.

Mr. Ironmonger had earlier proposed the same investment plan to the insurance department's receivership office, but the department turned it down, the department spokesman said.

Mr. Ironmonger could not be reached for comment. Until recently, he headed Cedar Casualty Insurance Co., which was created from the assets of the now-liquidated Liberty Lloyd's, which is under insurance department control.

A state grand jury in East Baton Rouge Parish is investigating the alleged loan solicitation, and Mr. Mills and Mr. Ironmonger have reportedly been subpoenaed to testify.

The Louisiana department has voluntarily turned over information it has on Mr. Ironmonger's investment plan to the grand jury, according to the spokesman.

Mr. Riddick's wife, Patricia, remains the insurance department's general counsel, the spokesman said.

Meanwhile, Mr. Brown has had to defend the receivership division against criticism over its handling of the assets of companies in liquidation.

Ms. Nungesser, former LIGA di-

rector, charged that the department was not providing LIGA with money it needed to pay claims. She sued Mr. Brown in state court for allegedly failing to turn over records on receivership assets and won a Feb. 21 judgment requiring the department to turn over documents and pay a fine for violating state public records laws.

Days before the ruling, though, the LIGA board voted to fire Ms. Nungesser, a move she attributed to pressure from Mr. Brown. Lawrence Uter, a LIGA staff member, has been named interim executive director.

On Feb. 24, Mr. Brown also ap-

A state grand jury in East Baton Rouge Parish is investigating the alleged loan solicitation.

peared before the Louisiana House Insurance Committee to defend the receivership division's investment track record.

The division, which oversees 65 insurers in receivership, has posted an average gain of 5.5% on its investment portfolio over the last two years, according to the department.

However, Rep. Chuck McMains, R-Baton Rouge, has raised concerns about the department's investment practices, citing the LIGA dispute and the alleged Blues plan loan solicitation.

Rep. McMains this month wrote to Mr. Brown demanding copies of investment records for the department, the receivership office and Cedar Casualty.

How quick the response will be remains to be seen: After learning of the letter, Rep. Ted Haik Jr., D-New Iberia and chairman of the insurance committee, wrote to Mr. Brown suggesting that other committee requests should be given higher priority. **BI**

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Life/health

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ers, as has been the case since the early '90s," said Mark Pucci, a director in the insurance rating group at Standard & Poor's Corp. in New York. "The old adage of a six-year cycle—three years up and three years down—has been broadly extended."

Michael A. Lewis, senior vp at Dean Witter Reynolds Inc. in New York, viewed 1994 more as "a decent year, not sensational."

"I expect the pattern to continue in '95 as (insurers) continue to build up their managed care facilities and shift business (to them)," he said.

Insurance executives are now looking for incremental health care reform, rather than a complete overhaul.

"It's the first time in several

years I see as much or more opportunity from (health care) reform than I see threat," said Chris Doerr, senior vp and chief financial officer of CIGNA Health Care Inc. in Bloomfield, Conn.

Analysts and insurers note that increased managed care business coupled with lower costs buoyed 1994 results for many group life/health insurers.

At CIGNA Corp., operating income for group life and health lines rose 14.7% to \$531 million from \$463 million in 1993. Most of that gain is due to a 43.7% increase for HMO operations—to \$204 million from \$142 million in 1993. Indemnity operating income rose a modest 1.9% to \$327 million from \$321 million.

"We've had a shrinkage in our indemnity book of business for several years now," Mr. Doerr said.

While this hurts CIGNA on a

pure-revenue basis because clients are going from paying higher premiums to paying lower premiums, the end result is a "win/win situation," he said. Customers are getting better care at lower cost, and, in many cases, customers leaving the indemnity plans are "moving from one bucket to another" and joining CIGNA's managed care plans, he explained.

Gross revenues for CIGNA's group life and health operations were basically flat, rising 0.2% to \$18.32 billion in 1994 from \$18.28 billion in 1993.

Enrollment in CIGNA's HMO plans increased 23% over 1993 to 3.5 million members. CIGNA made no acquisitions in 1994. Enrollment in CIGNA's pure indemnity operations was down about 800,000, while 200,000 new members enrolled in CIGNA's preferred provider organization during 1994, added Mr. Doerr.

At Aetna Life & Casualty Co., 1994 net income from life and health insurance operations rose 26.7% to \$355.3 million from \$280.5 million in 1993. HMO earnings alone increased 180.6% to \$30.3 million from \$10.8 million.

Aetna's profitability can be attributed to strong migration into managed care and to lower health care inflation, said Charles Bell, senior vp of Aetna Health Plans in Hartford, Conn.

Indemnity enrollment fell 10.4% in 1994 to 8.6 million from 9.6 million in 1993. Enrollment in Aetna's HMO grew 7.1% to 1.5 million from 1.4 million in 1993. "Earnings are a reflection of continued development in the managed care business," he said. "We acquired or started in the neighborhood of 20 physician practices in 1994" and will continue to invest in those arrangements in 1995, Mr. Bell said.

With the intention of converting The Travelers Corp. and Metropolitan Life Insurance Co.'s predominantly indemnity-based business into a single managed care plan, the insurers combined their group health care business in January and formed MetraHealth Cos. Inc. of McLean, Va. (BI, June 20, 1994).

MetraHealth, which has been focusing on organization during the first quarter, estimates its combined HMO and point-of-service plan enrollment will exceed 2 million, a spokesman said.

"1994 was not a good year" for MetLife and Travelers, but "they have a bright future" together, S&P's Mr. Pucci said.

"Right now, MetraHealth is no major threat," CIGNA's Mr. Doerr said. In the future, though, "they will be a major player."

Individually, Hartford, Conn.-based Travelers report that its life insurance service segment posted \$7 billion in revenues for 1994. However, this segment includes revenues from Primerica Financial Services, Travelers life and annuities, as well as managed care and employee benefit revenues. 1993 figures are not relevant due

to the acquisition of Travelers by Primerica Corp. in 1993.

However, Travelers said new business in the group life and health areas was down in 1994 largely because of a focus on increasing margins to improve profitability and to reduce financial risk. Net written premiums for Travelers' health insurance business were down 5.2% to \$9.2 billion in 1994 from \$9.7 billion in 1993.

At Metropolitan Life Insurance Co. of New York, operating revenue was \$7.9 billion for group life operations and \$11.1 billion for group health operations. A spokesman said that due to changes in the way the company categorizes revenues, it could not provide comparisons for earlier years.

At Portland, Maine-based UNUM Corp., revenues rose 6.7% to \$3.6 billion in 1994 from \$3.4 billion in 1993. Net income plummeted 48.4% to \$154.7 million from \$299.9 million.

Excluding aftertax charges of \$134.5 million taken to restructure and to strengthen reserves in its non-cancelable individual disability business, net income would have been \$289.2 million.

UNUM's employee benefits segment, including group life, long-term disability and short-term disability, reported revenues of \$1.5 billion in 1994, a 6.5% increase from \$1.4 billion in 1993. Pretax operating income grew 7.8% to \$257.8 million from \$239.1 million in 1993.

"We would have liked to have had 12% to 15% growth" in this segment, said Kent Mohnkern, vp-investor relations for UNUM.

Group long-term disability claims at the end of the first quarter hurt the insurer's employee benefit business. When the claims—predominantly repetitive motion and stress claims—increased, UNUM "began aggressive rate increase actions," Mr. Mohnkern said. As a result, client retention levels for group long-term disability dropped to 84% for 1994 from 88.7% a year earlier. (BI)

HMOs

Continued from page 2

United HealthCare's internal enrollment grew 18%, or by 384,000 enrollees, during 1994.

Operating revenues at Cypress, Calif.-based PacifiCare Health Systems Inc. jumped 30.3% to \$2.9 billion for the fiscal year ending Sept. 30, compared with \$2.2 billion in 1993. Profits were up 44% to \$90.3 million, compared with \$62.7 million in 1993.

"The main driver behind our results was membership gains," said David K. Erickson, director of investment relations. Excluding acquisitions, commercial membership increased 17.6% to 949,124 members from 806,918 in 1993.

Mr. Erickson also mentioned that PacifiCare's investment in technology—specifically imaging technology programs—has helped the HMO to speed up enrollment and claims processing, resulting in reduced administrative costs for the company.

Acquisitions and expense controls generated the 14% boost in premium revenues for Louisville, Ky.-based Humana Inc. in 1994 to \$3.6 billion from \$3.1 billion in 1993. Net income soared 97.8% to \$176 million from \$89 million in 1993. 1994 profits include a \$17 million non-recurring gain due to a favorable tax settlement with the Internal Revenue Service.

Two acquisitions in 1994—including Washington-based Group Health Assn. and Milwaukee-based CareNetwork Inc.—added approximately \$340 million to revenues as well as 200,000 new

members, said Laurie G. Scarborough, director of investor relations.

Total membership in commercial and Medicare plans increased by 330,900 members, or 22%, in 1994. Excluding acquisitions, membership was up 9.2%, Ms. Scarborough said. Commercial membership alone in 1994 was up 25.9% to 1,528,300, compared with 1,214,000 a year earlier.

Ms. Scarborough said Humana's profitability in 1994 also can be attributed to managing its medical cost structure. Humana's medical cost ratio—medical costs as a percentage of premium revenue—decreased by five percentage points over the year to 81.6% from 83.8%, she said, specifically citing decreases in hospital utilization as the major contributor.

After a full year of operating as a merged company, Health Systems International Inc. reported a 17.8% increase in gross revenues to \$2.3 billion from \$2 billion in 1993. Net income nearly quadrupled, catapulting 270.2% to \$88.1 million from \$23.8 million in 1993.

The company's 1993 figures represent consolidated figures from Woodland Hills, Calif.-based Health Net and Pueblo, Colo.-based QualMed, which merged in 1993 to form Health Systems (BI, Sept. 6, 1993).

And it may grow even further: Health Systems last week confirmed it is in talks with Wellpoint Health Networks Inc. about a possible merger.

"We owe our success to a simple, clearly defined strategy" to sell and develop new products and

to expand the HMO's customer base, said Roger Greaves, co-chairman, co-president and co-chief executive officer of Health Systems.

Commercial membership was up 11.4%, or 141,950 enrollees, in 1994, bringing Health Systems' membership close to 1.4 million.

A modest increase in enrollment was consistent with modest revenue growth for the nation's largest HMO, Kaiser Foundation Health Plan Inc. Gross revenues at the not-for-profit HMO rose 3.4% to \$12.3 billion in 1994 from \$11.9 billion in 1993. Net income retained for capital requirements, however, fell 2.2% to \$816 million from \$834 million in 1993.

Total enrollment was 6.7 million at the end of 1994, compared with 6.6 million at the end of 1993—a 1.3% increase.

A Kaiser spokesman said the HMO lost members in Southern California and Ohio in 1994 and has not gained back the market share. "This is reflective of the intense competition we've encountered over the past couple of years. We've made a concerted effort to gain cost advantage."

For example, Kaiser "made significant progress in decreasing our basic cost structure, which is critical in bringing down rates," he continued, adding that the Oakland, Calif.-based HMO expects rates to be down 3% in 1995.

Most of Kaiser's cost reduction comes in the form of internal reorganization. "We're trying to find ways to consolidate management functions rather than duplicate it in 12 different regions," the spokesman said. (BI)

Single insurer for Missouri comp pool

By MEG FLETCHER

JEFFERSON CITY, Mo.—Missouri is adopting a single-insurer approach to running the state's workers compensation assigned risk pool in an effort to cut costs through better loss control and prevention.

The state chose The Travelers Insurance Co. and its Lynch, Ryan & Associates loss control subsidiary to replace—effective July 1—the 12 insurers that provide pool coverage under the direction of the National Council on Compensation Insurance.

Under the new program, manual rates will increase by an average of 5%, though premiums for the 32,000 employers in the pool will be increasing by only 0.4% overall.

Many employers will be able to offset most rate increases, however, by participating in loss management programs that offer premium credits, which vary with employer size.

Travelers, which will have a one-year contract to run the pool, will bear the risk for residual market pool losses up to 115% of the premium paid.

Insurance Director Jay Angoff said he hopes the new single-insurer program will help reduce regular market rates because those insurers will no longer have to cover assigned risk pool operat-

ing losses.

Separately, Hartford, Conn.-based Travelers announced last week that it will cut its Missouri voluntary market workers compensation rates by 8.4%, effective April 1.

Travelers cited better underwriting results and an improvement in the structure of the voluntary market. (BI)

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Liability

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But the details of the final reform bill won't be certain for some time, because the Senate version—expected to be more moderate than H.R. 956—has yet to be unveiled, though its sponsors may introduce it this week.

And, regardless of what happens to H.R. 956, no one expects any product liability reform bill to have an immediate impact on product liability insurance rates. Rep. Charles Schumer, D-N.Y., attempted to amend H.R. 956 to require that the law die if the secretary of commerce could not certify that insurance rates had dropped by at least 10% within five years of the law's enactment. His amendment was handily defeated, though, shortly before the final vote.

H.R. 956 incorporates features from two measures approved last month by the House Commerce and Judiciary committees. Among other things, the bill would:

- Cap punitive damages in "all civil actions" to \$250,000 or three times economic damages, whichever is greater.
- Replace joint liability with proportional liability for non-economic damages.
- Impose a 15-year statute of repose for all goods under most circumstances, with the exception of situations in which the plaintiffs do not have their medical expenses fully reimbursed from a collateral source.
- Limit the product liability of sellers under most circumstances.
- Create a defense against suits brought by people who were drunk or drugged when they were injured by a product they were using.
- Protect biomedical suppliers against "unfair liability."
- Allow either party to request a separate or bifurcated trial to determine punitive damages after the basic issue of liability is solved.

The law would not apply to suits that had been filed before it was enacted. Products that were more than 15 years old at the time of enactment would, however, be covered by the statute of repose.

Despite the attorney general's letter, reform advocates doubt that President Clinton could veto a bill that enjoys strong bipartisan support.

Tom O'Day, associate vp in the Alliance of American Insurers' Washington office, said the key to the president's decision will probably be provided in the Senate. For the Senate to consider product liability reform, reformers will have to have at least 60 votes to choke off any filibusters. Filibusters killed previous reform bills, notably a bipartisan measure that died last June (BI, July 4). But to get the 60 votes, the reformers will have to win the support of at least 20% of the Democratic membership, because not all Republicans support the measure, he said.

If a bill can win that much Democratic support, the president will find it "extremely difficult" to veto it, said Mr. O'Day. He stressed that the Alliance supports reform because its member companies' customers want reform.

If the final bill looks like previous Senate bills, which for example did not cap punitive damages, the president would take a "huge, huge risk" in vetoing such a measure, said Peter A. Lefkin, vp-federal affairs in Fireman's Fund Insurance Co.'s Washington office. "The public is certainly supportive of tort reform," said Mr. Lefkin. In addition, vetoing such a popular measure means the president would

"run the risk of looking like he's in the pocket of the trial bar," he said.

"It's unfortunate the president has come out the way he is," said Lawrence Fineran, assistant vp-resources, environment and regulation for the National Assn. of Manufacturers in Washington. But Mr. Fineran said that it's too early to talk about any compromises in the bill. In fact, NAM would like to see some of the measure's provisions extended, such as extending a proportional cap on punitive damages to non-economic damages like pain and suffering.

"It would be nice" to see caps or proportional limits on non-economic damages like those placed on punitive damages in the House bill, agreed Louis J. Drapeau, manager-insurance and risk management for The Budd Co., a Troy, Mich.-based automotive parts manufacturer. "But how do you legislate common sense?" he asked.

Mike Mayers, senior vp-risk management accounts for Employers Insurance of Wausau in Wausau, Wis.—which is among the largest product liability insurers in the country—said that any legislation limiting punitive damage exposure has to be viewed as an improvement over current law.

Some sort of limit on non-economic damage should cut costs as well, said Mr. Mayers, though he cautioned that such a limit would have to be weighed against social concerns. But enacting product liability reform will limit "runaway costs" associated with the exposure and, thus, eventually should have an impact on costs, he said.

The broad business community agrees on two points: The product liability bill is good public policy that the president would veto at his peril. And the measure's impact on product liability insurance rates won't be evident for quite some time.

"If the bill would warrant strong movement, it would be in steps," said Dave McDonald, senior vp-corporate underwriting from Royal Insurance Group in Charlotte, N.C., which is a leading product liability underwriter. He added that he doesn't foresee any rate decreases on the heels of reform.

Mr. McDonald noted that in the mid-1980s, insurers reacted "precipitously" to changing economic conditions and were blamed for causing a liability insurance crisis of insufficient capacity and high rates.

That experience will cause them to react cautiously to any product

liability law changes, he explained.

A spokeswoman for ITT Hartford Group Inc., another top product liability underwriter, said that the Hartford, Conn.-based insurer does not expect reform to have any immediate impact on rates. She added that the insurer's underwriters say that passage of a reform bill won't lead to any changes in terms or conditions, either. But rates might drop over time if the change in liability standards warrant it, she said.

"It's a long, long way" to the point where reforms will lead to lower insurance rates, agreed Harold Lang, director-insurance and risk management for Kohler Co., a manufacturer of plumbing fixtures and other products in Kohler, Wis. But enactment of a bill, should eventually give risk managers with good product liability track records more power to negotiate rates with their insurers, he said.

The bill's abolition of joint liability for non-economic damages

"It will take some time" for the law to have a favorable impact on insurance rates, notably because it doesn't apply to product liability suits filed before the bill becomes law, said Budd's Mr. Drapeau. He added, though, that "there's really not a crisis" in product liability insurance, because virtually all companies facing product liability exposures now carry large retentions.

The Risk & Insurance Management Society Inc. plans to release a list of recommendations on civil justice reform, including product liability, on March 20.

In related tort reform actions: The House last week approved a bill requiring the loser in certain federal civil cases to pay for a portion of the winner's legal costs in some circumstances.

The House also approved a separate bill making it more difficult for shareholders to sue companies in which they own stock. The bill also shields accountants, consultants and other third parties from being held jointly and severally lia-

Liability caps would aid doctors

Physicians and drug manufacturers would also get specific liability breaks under the final version of the House reform bill.

The bill was amended on the floor to cap non-economic damages in medical malpractice cases at \$250,000, a change the American Medical Assn. has sought aggressively. The amendment was offered by Rep. Christopher Cox, R-Calif.

The House also approved an amendment offered by Rep. Michael Oxley, R-Ohio, to shield pharmaceutical manufacturers from punitive damages in certain cases.

Drug manufacturers would be immune from punitive damages if their products had been approved by the Food and Drug Administration, unless it can be proved that the companies misrepresented their products or bribed officials to win approval. **BI**

Punitive damage awards bigger but less frequent

Punitive damage awards are getting rarer, but bigger, according to data from two large county court systems.

RAND Corp., the Santa Monica, Calif., think tank, has been tracking punitive awards in Cook County, Ill., and San Francisco County dating back to 1960.

RAND had given members of Congress some of its preliminary data as background for the current debate on legal reforms. Once an advocacy group published some of its figures, RAND released the information.

According to the survey, the median punitive damage award made in San Francisco County during the 1990-94 period reached \$97,000—up more than 24% from the median punitive award of \$78,000 from 1985-89. The increase in Cook County was even more spectacular, with the 1990-94 median rising to \$250,000 from \$29,000 in 1985-89.

The mean punitive damage award in Cook County in 1990-94 was nearly \$6.8 million, compared with slightly less than \$1.9 million during the previous period. In San Francisco, the mean increased to nearly \$1.7 million during the 1990-94 period from \$1.1 million during the previ-

ous period.

"The mean award shows the effect of a few extremely large punitive damage awards...The largest punitive damage award topped \$12 million in San Francisco in 1990-94, and \$128 million in Cook County in the same period," says the report.

But the number of punitive damage awards in the two jurisdictions has been declining, the research shows.

For example, punitive damages were awarded in only 29 civil cases studied in Cook County during the 1990-94 period, compared with 51 cases during the previous period. Only 11 cases in the San Francisco County survey entailed punitive damage awards, compared with 41 cases during the previous five years.

The percentage of all verdicts in which punitive damages were awarded dropped to 1% in Cook County during the 1990-94 period from 2% in 1985-89, and to 4% in San Francisco County from 7%.

In cases where plaintiffs triumphed, the percentage of verdicts with punitive damages stood at 2% in Cook County and 4% in San Francisco during the period 1990-94.

—By Mark A. Hofmann

could also help risk managers who can show that previous losses were due to their company being the "deep pocket" in product liability cases rather than the most liable party, he said. He added that enactment of the reform law would also help self-insured companies like Kohler reduce their projected losses.

ble if their clients are accused of fraud and go bankrupt. Under the bill, such professionals could be held liable only for the portion of damages attributable to their acts.

In addition, the Senate Governmental Affairs Committee approved its version of a regulatory moratorium last Thursday. S. 219, sponsored by the committee's

chairman—Sen. William Roth, R-Del.—would freeze most new federal regulations expected to have an impact of at least \$100 million on the U.S. economy until Dec. 31. Specific exceptions were made for five pending rules, including regulations dealing with lead in paint and water and a rule on commuter aircraft pilot training. **BI**

No escape from rhetoric in tort reform, product liability debate

WASHINGTON—If figures lie and liars figure, lawmakers considering product liability and tort reform legislation could certainly be forgiven for not being able to tell who was telling the truth in the weeks preceding Friday's vote.

Take, for example, a dispute over the costs associated with tort laws.

Howard Metzenbaum, a former stalwart opponent of probusiness tort laws in the Senate and current chairman of the Consumer Federation of America, last week criticized the National Assn. of Manufacturers, accusing the group of putting out an exaggerated estimate of annual product liability expenses of \$130 billion.

To bolster his point, former Texas Insurance Commissioner J. Robert Hunter released a study, drawn from A.M. Best Co. data, showing that insurers paid out \$2.6 billion in product liability claims in 1993, the last full year for which results are available. Even with self-insured payouts,

total product liability claims would fall far short of \$130 billion.

In response, NAM said its figure actually included expenses related to all tort claims, not just product liability claims.

The actual figure—which came from a 1992 study by Towers Perrin's Tillinghast unit (BI, Oct. 19, 1992)—included insured and self-insured claims payments, and administrative and legal fees related to all torts.

Meanwhile, opponents of product liability reform released a survey that purported to show that the majority of U.S. citizens opposed the tort reforms, while the American Tort Reform Assn. issued a survey purporting to show just the opposite. The contradictory results appeared to have more than a little to do with how the questions were framed.

As the battle of statistics heated up, anyone listening to Washington area radio was treated to commercial after commercial dealing

with the subject.

In a matter of minutes, appeals from the Product Liability Coordinating Committee, Citizen Action and the American Medical Assn. could be heard on the same radio station.

The PLCC ad featured a Briton pleased at the thought that the U.S. tort system cripples American competitiveness; Citizen Action's ad had a child complaining about "bad guys" who hurt kids with defective products; and the AMA had a real doctor telling why Congress should include medical malpractice reforms in a tort reform bill so that she could deliver babies in the District of Columbia.

A bit esoteric for radio ads? Of course. But this is the same city where listeners can also hear advertisements for Titan rockets and Apache helicopters designed to influence defense spending decisions.

It's also a town where you can see erstwhile Republican presi-

dential hopeful Jack Kemp and 1972 Democratic nominee George McGovern appearing together in an ad sponsored by the tort reform proponents. Although Mr. McGovern later distanced himself somewhat from the spot, this political odd couple made quite an impression for a few days.

Then there was a pro-reform ad campaign featuring a Girl Scout, saying that the Girl Scout Council had to sell 87,000 boxes of Girl Scout cookies to pay for its liability insurance. A council spokeswoman said the number was correct, but that liability insurance didn't account for much of its budget. "We are not taking sides in this debate," she stressed. The ad was quickly dropped.

But the thrust of the argument wasn't. Little League Baseball Inc. was quickly drafted to step up to bat for tort reform by telling how undue liability exposures were threatening its version of the national pastime.

—By Mark A. Hofmann

A small world after all

Technology helping insurers of all sizes compete globally

By JOANNE WOJCIK

SAN FRANCISCO—Smaller, regional players are beginning to give the global insurance giants a run for their money, thanks to advances in communications technology, says an executive with one of the giants.

"Communications technology is revolutionizing the way business is done on a multinational level," observed Jeffrey W. Greenberg, executive vp of American International Group Inc. in New York.

"Today there is vastly more accessible information about markets and competition," he said last week at the National Insurance Symposium Leadership Conference, which is sponsored by Russell Miller Inc.

"Local companies around the world are acquiring the technology and information needed to compete effectively with much larger global companies," he said. "The world is not only shrinking, but the playing field is becoming much more level."

As a result, "our competitors today are not only other Western multinational companies, but often smaller, adroit local companies in each country where we operate," Mr. Greenberg said.

AIG is even feeling competition in the United States, he said, where foreign insurers and reinsurers are gaining market share.

For example, 70% of the non-admitted insurance companies on the National Assn. of Insurance Commissioners' "white list" of pre-approved non-admitted insurers are from outside the United States, compared with just 40% 10 years ago, he said.

In addition, non-U.S. companies accounted for 40% of the entire surplus lines market in 1993, compared with just 15% in 1973, he said.

"This places a premium on our own managerial agility, product development, marketing skills, flexibility and our willingness to consider new ways of doing business in overseas markets," Mr. Greenberg said.

With increasing privatization in formerly communist countries, greater liberalization of world trade rules, and rapid growth in some emerging nations, "many of your own small and medium-sized corpo-

rate clients will be showing an interest in investing in overseas markets, if they haven't already," Mr. Greenberg said.

Trade pacts such as the North American Free Trade Agreement and the General Agreement on Tariffs and Trade will further encourage companies to venture outside of the U.S. marketplace, he predicted.

"Companies without the global sophistication of the Fortune 500 who seek to move overseas are go-

mean you can transplant that success overseas."

He credited much of AIG's international success to the global strategy mapped out by his father, Chairman Maurice R. Greenberg.

"Observers often credit the founding of the company in Shanghai in 1919 as really being the reason" for AIG's international longevity. "Of course, that set the cultural tone, but that really didn't assure future success," he said.

What makes AIG the multinational giant that it is today is management's commitment to overseas markets, "not just in the good times, but for the long term," he said.

The hiring, training and promotion of local nationals to work in AIG branches gives AIG an indigenous quality by giving these nationals "a real incentive to work for a foreign company rather than a local one," he explained.

"Moving when the climate is right—not too soon before the legal and economic infrastructures are in place, and not so late that opportunities have been grabbed by others" also helped AIG succeed, Mr. Greenberg said.

Last, but not least, AIG is continually "recognizing the differing needs of overseas markets, being adept at product adaptation, innovation, technology transfer and always bringing something to the market that hasn't been there before," he said.

"Changing laws, changing exposures, changing appetites for risk, volatility and greater involvement by financial officers in the risk management process" have all worked together to alter insurance consumers' needs," he said.

"So merely translating the form into a new language doesn't work," he said. "You have to do something for the client that they can't do themselves." ■

'The world is not only shrinking, but the playing field is becoming more level,' says Jeffrey Greenberg.

ing to be looking for insurance and for risk management expertise in these new markets," he said.

And foreign investment in U.S. insurers is "going to bring more competition in your own back yard," warned Mr. Greenberg.

Among the examples he cited were Munich, Germany-based Allianz A.G. Holding's purchase of Novato, Calif.-based Fireman's Fund Insurance Cos. (BI, Aug. 6, 1990) and London-based B.A.T Industries P.L.C.'s purchase of Farmers Group Inc. of Los Angeles (BI, Aug. 29, 1988).

To compete, he advised insurers to develop products and services tailored to the needs of multinational clients.

He also advised smaller industry players to form strategic partnerships with global insurance organizations to tap emerging markets.

"Complacency is simply not possible," he asserted. "Merely because you are successful at home does not

120 execs attend symposium

SAN FRANCISCO—Approximately 120 insurance industry executives attended the 1995 National Insurance Symposium Leadership Conference March 5-7 in San Francisco.

The conference is an invitation-only annual event sponsored by Russell Miller Inc., a San Francisco-based consulting firm that provides financial analysis, strategic planning and litigation support services to the insurance industry.

For information about next year's event, scheduled for March 3-5, contact Symposium Director Darlene Nelson at Russell Miller Inc., 300 Montgomery St., San Francisco, Calif. 94104; 415-956-7474.

able only as part of a package.

For example, 20 years ago it was unheard of for an insurer to offer unbundled services to a client that wanted to self-insure and do its own claims administration. Today insurers will do just about anything to maintain that business, he said.

"Today, virtually all of the major carriers in one form or another would do that. In fact, some are developing their own third-party administrators," he said.

That, he said, is precisely why CNA acquired Alexis Inc., a TPA formerly owned by Alexander & Alexander Services Inc. (BI, Jan. 23).

"Our strategy here is to attempt to have a dual offering," he explained. "One fully bundled offering, and one unbundled offering, so that we can provide to our distribution systems two alternatives."

"Another response is automation," Mr. Chookaszian said. While the insurance industry was one of the first industries to automate in the early days of computerization, it was mostly in backroom accounting and

policy issuance areas, he explained.

Insurers today increasingly are moving toward personal computer technology and away from mainframe technology because of the increased efficiency it affords.

Using CNA as an example, Mr. Chookaszian said that desktop automation—including personal computers and telephone voicemail—permitted the insurer to reduce its clerical workforce by two-thirds.

In fact, after years of dictating letters to secretaries, Mr. Chookaszian now types his own correspondence.

Laptop computers also help executives practice better time management by allowing them to work while traveling, he pointed out.

However, because of the huge investment insurers have made in their mainframe systems, Mr. Chookaszian predicts the industry's transition to PC-based technology won't be immediate.

"You can't just say, 'Shut it off and we'll switch to a new system,'" he said. "So what you'll see will be an evolution, not a revolution." ■

Updates

Deloitte & Touche judgment

Continued from page two

counts in 1989 and 1990, said Keith Fleishman, an associate at Milberg, Weiss, Bershad, Hynes & Lerach in New York, who represented the shareholders.

Koger cut its dividend in October 1990 and the company went bankrupt in 1991, he said. The shareholders charge that Deloitte & Touche knew the financial condition of Koger but withheld the information to retain a valued client, he said.

The judgment is in the face of evidence against the charge, Deloitte & Touche firm said in a statement. The firm, which remains convinced it performed its Koger audits properly, will ask the court to set aside the judgment, and will pursue other remedies, the statement said.

A Minet P.L.C. spokesman confirmed that Deloitte & Touche is a Minet client but would not comment further. The Minet professional liability line slip is placed with more than 100 underwriters.

Reinsurer results improve

WASHINGTON—U.S. reinsurers combined ratio improved to 106.2% in 1994 compared with 106.9% in 1993, according to the Reinsurance Assn. of America.

The 59 reinsurers participating in the 1994 survey reported \$17.2 billion in net reinsurance premiums written, a 12.4% increase from \$15.3 billion reported in 1993. The reinsurers reported net income of \$1.69 billion and policyholder surplus of \$17.96 billion, according to the report.

Captive manager charged

BATON ROUGE, La.—A Bahamas captive manager is facing criminal charges that he arranged fraudulent reinsurance covering policyholders of now-defunct Physicians National Risk Retention Group Inc.

Charles A. Donaldson, president of Nassau-based Captive Managers Ltd., was indicted by a federal grand jury earlier this year on mail and wire fraud charges related to the group's 1991 collapse.

Arrested in Fort Lauderdale, Fla., on March 1, Mr. Donaldson pleaded not guilty to the charges and was released on \$250,000 bond, according to Edward J. Gonzales, assistant U.S. Attorney.

Each of the two charges in the indictment carries a maximum sentence of five years in prison and \$250,000 in fines. Trial is scheduled for April 24, Mr. Gonzales said.

Neither Mr. Donaldson nor his lawyer could be reached.

Physicians National, a Louisiana-licensed medical malpractice risk retention group, was ordered into liquidation in 1991, a few months after it was placed in conservation and after it had been hit with cease and desist orders in about 14 of the 44 states where it did business.

The collapse triggered a barrage of lawsuits between the Louisiana Insurance Department and dozens of directors, officers and others involved with the insurer (BI, March 21, 1994; May 17, 1993).

Mr. Donaldson was indicted Jan. 31 for an allegedly fraudulent reinsurance scheme that was executed shortly before Physicians National went under and was described by state regulators in a 1994 civil suit.

According to the indictment, Mr. Donaldson claimed to have binding authority for Builders & Contractors Insurance Ltd., a dormant Bahamas reinsurer of which he was an officer. In mid-October 1991, shortly before Physicians National failed, Mr. Donaldson signed a reinsurance agreement under which BCI would continue the malpractice coverage of physicians whose policies would otherwise lapse because of the Physicians National liquidation, the indictment says.

In fact, Mr. Donaldson had no authority to bind BCI and concealed the agreement from BCI and its auditors, the indictment charges.

Mr. Donaldson personally received \$150,000 when the agreement was signed, prosecutors say.

IBM wins repetitive strain case

HASTINGS, Minn.—A Minnesota jury has ruled that International Business Machines Corp. has no liability in a case attempting to link computer keyboard use with repetitive strain injuries.

After deliberating only a few hours, the jury concluded that IBM had no obligation to provide a warning, despite evidence that the company knew that its own employees had been injured after using the keyboards. The jury also found that IBM did nothing wrong in designing the keyboard.

At least 300 other similar cases are pending.

The case was the second to go to trial out of thousands that blame keyboard makers for wrist, back and neck injuries. Houston computer manufacturer Compaq Computer Corp. won the first such case to go to trial (BI, Feb. 28, 1994). A settlement two weeks ago took Apple Computer Inc. out of the IBM case (BI, March 6).

Briefly noted

Malcolm Butterfield resigned as registrar of companies in Bermuda last week to take another position, said a spokesman for the Bermuda Insurance Institute. . . ACE Ltd. plans to begin offering aviation product liability insurance through a new division headed by Gary Cooke, a former Lloyd's of London underwriter for syndicates managed by Tower Underwriting Agents Ltd. Mr. Cooke will be named a senior vp of ACE in June. . . Linda S. Kaiser, a former lawyer for Reliance Insurance Co. in Philadelphia, was confirmed as the insurance commissioner of Pennsylvania last week. . . Illinois Gov. Jim Edgar last week signed into law a tort reform bill that limits non-economic damages to \$500,000 in personal injury cases, and limits punitive damages to three times actual damages, among other things. . . Lloyd's of London denied reports last week that it has been granted a license to accept business directly from Japan. A spokesman said its application is "still between ministries."

Leaders

Continued from page 3

industry is undergoing vertical compression, which he defined as increased pressure on agents and others in the distribution chain to eliminate duplication in an effort to cut expenses.

"As you see this vertical compression take place, you're also seeing significant pressure, for example, on the commission structure for independent agents, compensation for direct writers and underwriting costs as everyone tries to be more competitive," he said.

The industry also is in the process of reinventing itself as its customer base seeks lower-cost alternatives to traditional insurance, according to Mr. Chookaszian. "Customer expectations are going to continue to drive us to operate more efficiently."

Already, many insurers are developing innovative new products and services and offering some on an unbundled basis that used to be avail-

Dykhouse

Continued from page 2

Shortly after Canadian and U.S. regulators moved in, two insurers bought most of Confed's group business. The U.S. subsidiary of Great-West Life Assurance Co. of Toronto assumed most of the U.S. group life and health business (BI, Aug. 29, 1994). And Manufacturers Life Insurance Co. of Toronto bought the majority of the Canadian group business (BI, Sept. 1, 1994).

In his letter, Rep. Gagliardi charges Mr. Dykhouse "appears to have willfully ignored clear signs that Confederation Life was in serious financial trouble and willfully neglected to act, though under a clear duty to do so."

Among other issues, the legislator also faults Mr. Dykhouse for allegedly not taking any action when Confed's assets increased rapidly.

Confed's "assets" supposedly increased from \$3 billion to \$8 billion in just four years," he wrote. "By itself, 'growth' of that magnitude should have set off alarms at the bureau, which the commissioner could have hardly failed to hear. At a minimum, an immediate investigation should have taken place to determine if cease and desist orders, or orders of supervision or seizure should have been issued on this basis alone."

Pointing to Mr. Dykhouse's current position as a rehabilitator, Rep. Gagliardi wrote, "The potential this poses for the commissioner to personally profit from the

fruits of his own apparent willful neglect is appalling. Moreover, his continued involvement after resigning his post could make any investigation more difficult."

Mr. McQueen insisted that there is no evidence that the former commissioner neglected his duties while in office.

Once Confed was identified as a problem in January 1994, Mr. Dykhouse "worked fe-

David Dykhouse 'serves at my pleasure and his service can be terminated at any moment in time by me without notice,' says Patrick McQueen.

verishly" with Canadian regulators in an unsuccessful attempt to sell its assets to another company, Mr. McQueen said. "There is no indication whatsoever that Dykhouse was in any way willfully neglecting his duties."

Mr. McQueen pointed out that the Confederation Life rehabilitation involves Canadian regulators and life insurance companies, guaranty funds, the American Council of Life Insurance and numerous court actions, among other factors.

"It's a very, very complex situation," said Mr. McQueen, who also remains commissioner of Michigan's Financial Institutions Bureau. "Imagine how I felt coming out of the cold and walking into this office and

putting this in my lap."

"When you look at the two positions I'm holding, as well as acting as receiver for Confederation Life in the U.S., I felt I should use every tool available to me to assure that the policyholders are protected. Commissioner David Dykhouse's role has been defined by me."

"I take full responsibility for entering into an agreement with him, the purpose of which is to help me become fully acquainted with Confederation Life so there is a continuity in the receivership in that I don't go in there cold, so he has been that bridge for me to keep me up to speed on what's going on. I don't envision his role to be ongoing."

Mr. Dykhouse is expected to stay in his post for 60 to 90 days "on the outside," said Mr. McQueen.

The former commissioner will be paid \$100 an hour for the first 100 hours he works, \$200 for the next 100 and \$250 for the next 100 hours, which would amount to \$55,000 for 300 hours of work.

The pay for any additional time would be \$250 an hour. He now works about 20 hours a week.

"He serves at my pleasure and his service can be terminated at any moment in time by me without notice," said Mr. McQueen.

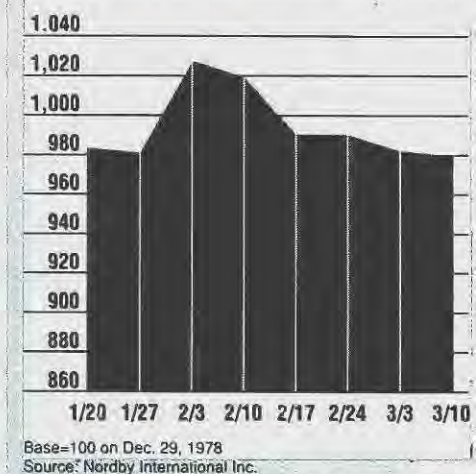
Outside the state, reaction to appointing a former regulator as a rehabilitator was varied.

"I could see where there are some appearance problems" but a former commissioner could also bring a mix of regulatory and insurance skills to the job, said Teresa Rankin, former Nevada insurance commissioner. "I can see why the current commissioner would feel he would have some expertise about the company."

Dale Stephenson, president and chief executive officer of the National Conference of Insurance Guaranty Funds, said, "There are situations where it can be very much to the benefit of the estate (of an insurance company) and the state, but at the same time we have a history in this country of cronyism."

Mr. Stephenson said he lacks the knowledge to have an opinion on the Michigan situation.

BI Insurance Index



Catastrophe insurance option call spreads

As of Mar. 10					
Call spread	Price bid/ask	Rate on line %	Call spread	Price bid/ask	Rate on line %
Eastern September 1995			Western Annual 1995		
45/65	5.8/6.5	29/30.5	20/30	0.5/3	5/30
50/70	5.3/5.6	26.5/28	30/40	0.3/1.8	3/1E
60/80	4/5.5	20/27.5	30/50	0.5/2.5	2.5/12.5
100c	8.5/12	8.5/12	50/70	0.6/1.8	3/9
150c	4/5	7/11	60/80	0.3/3.5	1.5/17.5
Total volume: 10		Total open interest: 5,106			
For quotes, call the CBOT trading floor at 312-341-3342. For general information, call 312-435-3674.					
Source: Chicago Board of Trade					

British Issues

Mar. 9	Price	P/E	Div.	Yield	1 week
Companies	pence		pence	%	high-low
Comml Union	520	10.4	33.0	6.3	520-505
Genl Accident	530	7.8	36.3	6.8	535-533
Gdn Royal Exch	169	N/M	10.3	6.1	173-169
Independent	275	7.6	1.9	4.3	280-275
Royal	271	5.1	15.0	5.5	274-268
Sun Alliance	313	10.5	19.7	6.3	313-308
Brokers					
Bradstock	86	9.7	7.1	8.2	89-86
Fenchurch	146	10.2	10.0	6.8	148-146
CE Heath	231	11.5	20.0	8.6	245-233
JIB Group	124	11.3	9.4	7.6	124-122
Lloyd Thompson	151	10.5	9.8	6.5	152-151
Lowndes Lmbrt	157	9.2	10.4	6.6	157-157
Nelson Hurst	172	13.5	8.3	4.8	172-172
PWS Holdings	15	N/M	0.8	5.3	17-15
Sedgwick Grp	155	14.1	8.1	5.2	155-155
Steel Bri Jones	115	11.5	11.3	9.8	116-115
Willis Corroon	141	N/M	8.3	5.9	143-141
Source: Philip Olsen, London * 1994 estimated data					

Willis Corroon

Continued from page 3

(\$41.9 million) in 1995 and £39 million (\$62.8 million) annually thereafter. No loss of revenue is expected from the staff cuts, said Chief Executive Max Taylor.

Meanwhile, operating expenses grew last year by 4% to £651.8 million (\$997.9 million).

The expenses include £21 million (\$32.2 million) mainly for the redevelopment of the North American retail and reinsurance operations. Of this, £4.2 million (\$6.7 million) was spent hiring a new construction team to replace 60 people who left to join Rollins

Hudig Hall Group Inc. in 1993.

Willis sued RHH over the defections, alleging a conspiracy to steal clients, employees, trade secrets and other information (BI, June 27, 1994). Willis revealed last week that the suit has been settled but would give no details. RHH could not comment on the settlement.

Meanwhile, the group already expects lower profits from its U.S. wholesale company Professional Liability Underwriting Managers, which is switching its business from The Home Insurance Co. to Zurich American Insurance Group in the next few weeks. The unit lost some clients when The Home was downgraded by rating agencies, said Mr. Taylor.

BI Industry Stock Report MARCH 6, 1995, THROUGH MARCH 10, 1995

BROKERS												INSURERS/REINSURERS												
	Price	Weekly % change	Year to date % change	Annual High	Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt./Bk. value		Price	Weekly % change	Year to date % change	Annual High	Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt./Bk. value	
Accordia Inc.	NYS	33.13	-1.49	-1.12	34.50	24.63	20	0.72	2.17	16	13.24	NAC Re Corp.	NDQ	32.75	0.00	-2.24	34.00	24.00	197	0.16	0.49	16	19.75	1.6E
Alexander & Alexander	NYS	21.88	-0.57	18.24	22.50	14.00	149	0.10	0.46	-8	6.08	National Re Corp.	NYS	30.25	-0.41	15.24	31.75	22.25	40	0.16	0.53	19	17.31	1.7E
E.W. Blanch Holdings Inc.	NYS	20.75	-1.19	0.61	23.00	16.25	18	0.40	1.93	17	4.55	Navators Group	NDQ	17.06	-2.50	17.67	20.50	13.75	13	0.00	0.00	-5	10.21	1.67
Gallagher Arthur J. & Co.	NYS	34.25	-1.44	7.03	36.00	28.13	30	1.00	2.92	16	6.48	Nobel Insurance Ltd.	NDQ	9.13	0.00	10.61	9.13	7.63	9	0.20	2.19	5	6.84	1.33
Hill, Rogal & Hamilton	NYS	11.38	-1.09	-6.19	13.38	10.75	132	0.56	4.92	14	4.72	Ohio Casualty Corp.	NDQ	32.88	-0.38	16.37	34.00	26.50	421	1.52	4.62	13	24.68	1.33
Marsh & McLennan	NYS	82.88	1.69	4.57	88.75	71.25	450	2.90	3.50	16	19.40	Old Republic Int'l	NYS	24.13	-2.53	13.53	25.50	18.88	206	0.48	1.99	9	24.60	0.98
Poe & Brown	NDQ	21.50	0.00	-1.15	22.75	17.63	18	0.48	2.23	14	4.49	Orion Capital Corp.	NYS	35.13	-0.35	-0.35	37.88	28.13	79	0.80	2.28	9	25.86	1.36
BROKERS	AVERAGE		-0.6	3.1					2.6	12		Partner Re Holdings Ltd.	NDQ	21.00	-1.75	1.20	22.25	18.50	718	0.40	1.90	8	N.A.	N.A.
												Penn-America Group Inc.	NDQ	7.00	-6.67	-5.08	8.00	6.50	2	0.00	0.00	9	6.21	1.13
												Phoenix RE Corp.	NDQ	22.50	-1.10	-20.35	29.25	18.50	339	0.60	2.67	5	22.86	0.98
ACE Ltd.	NYS	23.75	-1.04	1.60	28.88	20.75	308	0.44	1.85	-8	22.45	Provident Life	NYS	22.88	-2.66	5.17	29.88	21.50	148	0.72	3.15	8	27.09	0.84
Acceptance Insurance Cos.	NYS	15.25	-0.81	1.67	18.00	11.13	29	0.00	0.00	11	9.83	Re Capital Corp.	NDQ	18.00	-0.35	46.94	18.13	12.00	24	0.32	1.78	16	17.63	1.02
AEGON N.V.	NYS	69.13	-0.18	8.86	70.63	49.38	15	2.92	4.22	12	43.84	Reliance Group Holdings	NYS	5.13	-2.38	-1.20	6.75	4.88	1088	0.32	6.24	3	3.48	1.47
Aetna Life & Casualty	NYS	55.00	1.38	16.71	58.25	42.25	1369	2.76	5.02	13	57.21	Reliastar Financial Corp.	NYS	34.00	-1.45	17.24	35.50	27.00	176	0.90	2.65	0	24.81	1.37
Allied Group Inc.	NDQ	26.88	0.47	8.59	31.00	22.00	77	0.68	2.53	6	23.43	RLL Corp.	NYS	22.75	-0.55	10.98	24.75	19.88	7	0.60	2.64	-37	20.51	1.11
Allmerica Prop. & Casualty	NYS	18.50	-4.52	9.63	20.13	14.25	205	0.16	0.86	11	19.45	St. Paul Companies	NYS	50.50	0.00	12.85	51.00	37.69	1024	1.60	3.17	0	31.88	1.58
Allstate Corp.	NYS	26.63	-0.47	12.11	27.50	22.63	1019	0.78	2.93	25	19.60	SAFECO Corp.	NDQ	55.00	-1.12	5.77	59.75	46.75	734	1.96	3.56	2	46.94	1.17
American General	NYS	30.75	-2.77	8.85	32.00	24.88	1550	1.24	4.03	13	20.39	SCOR U.S. Corp.	NYS	8.00	-3.03	-4.48	12.25	7.50	12	0.36	4.50	-7	13.80	3.59
American Heritage Life Ins.	NYS	19.00	-1.30	0.00	19.75	16.50	11	0.64	3.37	11	12.42	Seibels Bruce Group	NDQ	1.75	-9.68	-30.00	3.50	1.38	155	0.00	0.00	7	1.05	1.67
American Indemnity/Fin'l	NDQ	11.88	0.00	17.28	14.25	10.00	10	0.24	2.02	3	15.92	Selective Ins. Group	NDQ	28.50	2.24	12.87	29.25	23.00	42	1.12	3.93	0	23.36	1.22
American International	NYS	102.13	-0.49	4.21	106.88	82.38	3263	0.46	0.45	15	49.75	Sphere Drake Holdings	NYS	13.63	0.93	-1.80	17.88	10.75	10	0.16	1.17	6	13.15	1.04
American Re Corp.	NYS	33.63	-1.47	4.26	35.75	25.25	143	0.32	0.95	17	16.85	TIG Holdings	NYS	20.00	-0.62	6.67	21.75	17.00	723	0.20	1.00	-25	17.25	1.16
Aon Corp.	NYS	35.00	0.72	9.38	35.75	29.25	721	1.28	3.66	11	21.96	Titan Holdings, Inc.	NYS	10.00	2.56	2.56	11.38	7.75	101	0.28	2.80	8	9.31	1.07
Argonaut Group	NDQ	30.50	-1.61	7.96	31.25	26.25	758	1.16	3.80	10	29.80	Torchmark Corp.	NDQ	55.75	3.48	-8.23	66.00	49.88	17	0.40	0.72	-9	57.72	0.97
AVEMCO Corp.	NYS	14.88	-0.83	-3.25	17.38	13.38	22	0.44	2.96	12	6.30	Torckmark Corp.	NYS	42.13	2.12	22.10	44.50	32.38	544	1.12	2.66	-1	17.49	2.41
Baldwin & Lyons Inc.	NDQ	15.75	-4.55	6.78	17.63	13.75	38	0.24	1.52	11	13.56	Transatlantic Holdings	NYS	59.63	2.80	6.71	59.63	45.63	222	0.40	0.67	3	32.43	1.84
Berkley W.R. Corp.	NDQ	34.75	-1.42	-7.33	42.00	32.50	561	0.48	1.38	24	36.47	Transnational Re Corp.	NDQ	19.88	1.92	-15.43	25.50	17.25	25	0.00	0.00	7	N.A.	N.A.
Berkshire Hathaway Inc.	NYS	22200.00	-0.89	8.82	25200.00	15400.00	1	0.00	0.00	28	9157.79	Travelers Corp.	NYS	37.75	0.33	16.60	39.88	30.38	3030	0.80	2.12	-0	24.26	1.56
Capital RE Corporation	NYS	22.75	-1.09	-16.89	27.38	18.63	142	0.20	0.88	8	21.48	Trenwick Group Inc.	NDQ	43.75	0.00	3.24	44.25	33.50	5	1.12	2.56	-4	29.20	1.50
Capsure Holdings Corp.	NYS	13.00	-1.89	-11.11	16.13	12.13	427	0.00	0.00	14	13.72	United Fire & Casualty	NDQ	29.00	2.65	4.82	29.81	24.31	2	0.80	2.76	-9	28.96	1.00
Chubb Corp.	NYS	78.00	0.32	0.81	82.63	68.63	1160	1.96	2.51	13	48.40	Unifire	NDQ	49.75	1.02	15.70	51.50	38.50	553	2.00	4.02	-7	38.64	1.29
CIGNA Corp.	NYS	74.50	-1.16	17.09	76.00	57.00	526	3.04	4.08	10	80.98	UNIMUN Corp.	NYS	42.50	0.00	12.58	57.25	35.13	1119	0.96	2.26	-1	27.78	1.53
CNA Financial Corp.	NYS	73.13	-0.68	12.72	74.00	60.00	35	0.00	0.00	143	73.83	US Facilities Corp.	NDQ	13.75	3.77	37.50	14.83	8.25	429	0.20	1.45	3	11.07	1.24
Continental Corp.	NYS	19.50	0.65	2.63	24.00	12.00	1081	0.00	0.00	-2	29.69	USF&G Corp.	NYS	13.75	-2.65	1.85	15.63	11.69	1361	0.20	1.45	6	10.04	1.37
EMC Insurance Group Inc.	NDQ	10.25	-2.38	7.89	10.88	8.50	5	0.52	5.07	8	10.77	N.A.	NYS	36.25	-2.03	-3.94	41.38	30.88	210	1.32	3.64	9	40.82	0.89
Emphesys Financial Gr. Inc.	NYS	37.00	-1.33	16.54	38.88	21.25	266	0.50	1.62	10	N.A.	N.A.	NYS	18.88	2.03	-0.66	25.00	17.81	167	1.08	5.72	7	23.61	0.80
EXEL Ltd.	NYS	43.88	0.29	11.08	45.13	36.00	409	1.32	3.01	17	31.62	Washington National	NYS	20.88	-1.18	-8.24	27.38	20.63	28	1.00	4.79	10	17.54	1.19
Fremont General Corp.	NYS	20.50	0.61	-12.30	26.00	19.75	83	0.76	3.71	6	22.90	Zenith National Ins.	NYS	30.13	0.00	4.33	30.25	24.50	183	0.00	0.00	-25	22.26	1.35
Frontier Insurance Group	NYS	21.88	5.42	0.00	37.50	16.75	130	0.48	2.19	17	14.94	Zurich Reinsurance Centr.	NYS	1.46										
Gainco Inc.	ASE	9.00	-1.37	9.09	9.41	7.63	94	0.04	0.44	12	3.79	INSURERS/REINSURERS	AVERAGE		-0.4	5.4				2.3	13.3			
General RE Corp.	NYS	127.00	0.10	2.83	133.00	102.75	608	1.96	1.54	16	57.17													
Guaranty National Corp.	NYS	16.50	-2.94	-10.20	18.50	14.25	7	0.48	2.91	9	11.84	FHP International	NDQ	28.00	-0.88	8.74	31.00	20.25	645	0.00	0.00	15	12.22	2.29
Harleysville Group	NDQ	24.25	1.04	0.00	26.50	19.75	14	0.68	2.80	18	20.18	Humana Inc.	NYS	22.88	-4.69	1.10	25.75	15.88	3096	0.00	0.00	21	8.04	3.79
Hartford Steam Boiler	NYS	41.75	-0.60	4.70	52.88	35.88	148	2.20	5.27	16	14.62	Pacificare Health Sys.	NDQ	68.50	-2.49	5.18	79.50	44.25	265	0.00	0.00	23	14.21	4.82
HCC Insurance Holdings	NDQ	24.75	-2.94	17.86	25.75	15.00	509	0.00	0.00	16	10.75	Seafeguard Health Enter.	NDQ	8.75	1.45	-5.41	15.50	8.25	31	0.00	0.00	32	5.16	1.42
Home Holdings Inc.	NYS	8.63	-1.43	8.00	15.38	3.00	145	0.00	0.00	-3	22.36	Sierra Health Services	NYS	29.88	0.42	-5.53	33.50	21.25	215	0.00	0.00	17	6.04	4.95
ITT (Hartford Group)	NYS	98.25	3.15	10.86	99.75	77.00	1632	1.98	2.02	12	49.95	United Healthcare Corp.	NYS	42.88	-0.29	-4.99	55.38	27.25	5242	0.03	0.07	25	6.57	6.53
Kemper Corp.	NYS	41.38	0.61	9.24	85.00	35.75	2730	0.92	2.22	23	28.68	U.S. Healthcare	NDQ	41.25	1.85	0.00	49.00	33.75	15745	1.00	2.42	17	5.04	6.18
Lincoln National	NYS	40.75	1.24	16.43	43.88	34.63	647	1.72	4.22	12	31.99	Wellpoint Health Networks	NYS	31.13	-1.97	6.87	37.00	24.25	691	0.00	0.00	15	12.73	2.45
Markel Corp.	NDQ	45.00	1.12	8.43	46.00	37.50	37	0.00	0.00	13	25.15	HMOs	AVERAGE		-0.8	0.7				0.3	13			
Mid Ocean Ltd.	NDQ	29.00	11.54	6.42	30.50	22.25	577	0.00	0.00	12	20.24	ALL COMPANIES	AVERAGE		-0.6	3.1				2.5	13			
Mutual Risk Mgmt. Ltd.	NYS	27.88	-3.88	6.19	29.25	21.13	95	0.32	1.15	15	9.11													

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