

Business Insurance

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UNI Storebrand shutting down its international subsidiary

OSLO, Norway—UNI Storebrand New A/S is winding up its international reinsurance operations and subsidiary UNI Storebrand International Insurance will cease writing all new and renewal business.

Oslo-based UNI Storebrand New is the holding company formed in 1992 for the assets of UNI Storebrand A/S, which filed for bankruptcy after its expansion strategy failed (*BI*, Aug. 31, 1992).

Although the international unit is being shut down, non-life subsidiary UNI Store-
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Stark plan delivers blow to Clinton plan

By JERRY GEISEL
and MARK A. HOFMANN

WASHINGTON—A consensus between the Clinton administration and Congress appears even farther away after legislators threw up new roadblocks last week.

Carrying out an earlier vow, Rep. Pete Stark, D-Calif., formally junked the administration's health care reform bill in favor of his own proposal as his Ways and Means Health Subcommittee began the slow process of drafting legislation.

While requiring that employers offer coverage to workers, Rep.

Stark's proposal discards the centerpiece of the administration's proposal—mandatory state purchasing alliances—in favor of allowing small employers to purchase coverage through an expanded Medicare program. States could establish purchasing alliances, but participation would be voluntary.

In contrast to the administration's proposal, the Stark plan would not relieve employers of early retiree health care obligations, nor does it provide government subsidies to reduce employers' premium costs.

In a pointed reference to the ad-
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Clinton plan	Little common ground	Stark proposal
Mandatory for employers with fewer than 5,000 employees	☐ Alliances	☐ Generally voluntary
Generally 80%	☐ Employer premium contributions	☐ Generally 80%
Government would pay 80% of early retiree health premiums	☐ Retirees	☐ Employers now offering early retiree coverage would pay 80% of premiums
Allowed only for employers with more than 5,000 employees	☐ Self-insurance	☐ Allowed for employers with more than 1,000 employees
More generous than many current health plans	☐ Basic benefit package	☐ Similar to Medicare but with add ons like prescription drugs

GRAPHIC BY A. TRANCHITA

An ill wind still blowing

Hawaiian companies hit by hardening property market

By LOUISE KERTESZ

HONOLULU—Although Hurricane Iniki's winds, which caused \$1.6 billion of insured damage, have long since died down, the storm continues to batter Hawaii's insurance marketplace.

Risk managers at larger companies are being hit with sharply higher property insurance rates and unprecedented windstorm exclusions or large windstorm deductibles. And many insurers wary of their catastrophe exposure on the islands—where no property is located more than 50 miles from the coastline—have simply not renewed property policies for many smaller companies.

"It's a nightmare in Hawaii. On a commercial and homeowners insurance basis, it's out of control," said Judith Boyle, risk manager at C. Brewer & Co. Ltd. in Honolulu and president of the Hawaii chapter of the Risk & Insurance Management Society Inc.

Policyholders that had bought property cover-

age from an insurer for as many as 20 years "were just cut out, not because of their experience, but because insurers were trying to reduce their exposures," said Sam Slom, president and executive director of Small Business Hawaii, a trade group. "New companies are having an incredible time getting insurance at any price. A lot of businesses are going bare right now."

The failure of Hawaiian Insurance Group, which was taken over by regulators in 1992 as a result of Iniki losses (*BI*, Dec. 7, 1992), has had a domino effect on the market. HIG's parent, Hawaiian Electric Industries Inc., has settled a lawsuit brought by regulators over its alleged failure to support the insurer in the wake of Iniki losses (*BI*, Feb. 28).

"After the failure of a company that wrote about 12% of the (property/casualty) market, everyone else was faced with the re-evaluation of their exposure," said Paul Ables, chairman of the legislative committee of the Hawaii Insurers Council, which represents about 15 insurers.

"Then they also ran into the problem with the reinsurers of the world who decided that Hawaii wasn't a good place to write after all. All of a sudden carriers found themselves not able to buy the same amount of reinsurance and paying eight to 10 times what they were paying" before Iniki, he said.

"It was the first time a hurricane in Hawaii created \$1.6 billion in insurable damage—in a property market where the total of all property/casualty premiums is \$1.4 billion annually," Mr. Ables said.

To reduce their exposure, major insurers have cut back on their books of property business in the state and, in some cases, have laid

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Judith Boyle, risk manager at C. Brewer & Co. Ltd in Honolulu, saw property premiums triple after Iniki. Some smaller companies cannot get coverage.

Photo by Richard D. Wood

Policy in demand for reducing risk of big credit loss

By GAVIN SOUTER

Credit losses have long been a cost of doing business, but several recent bankruptcies are prompting some companies to consider excess-of-loss credit insurance to minimize their exposure to big losses.

Corporate credit control departments have traditionally guarded against the failure of customers to cover accounts receivable. But several loud wake-up calls in recent years have convinced some companies they may require extra protection for their catastrophic exposures.

One particularly loud alarm: The unexpected bankruptcy filing

of Phar-Mor Inc., a fast-growing discount drug chain, in 1992. Phar-Mor sought protection from creditors under Chapter 11 after massive fraud left the company with losses of \$1 billion.

"That was a shock to a lot of people and we know people who went out of business as a direct result of that," said H. Michael Cushinski, president and chief executive officer of American Credit Indemnity Inc. in Baltimore.

Jolted by the Phar-Mor bankruptcy and similar events during the recent recession, credit managers are thinking like risk managers. More credit managers are taking on the basic risk evalua-

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Texas gets reprieve; N.Y. protest continues

Accreditations up, but critics remain

By MEG FLETCHER

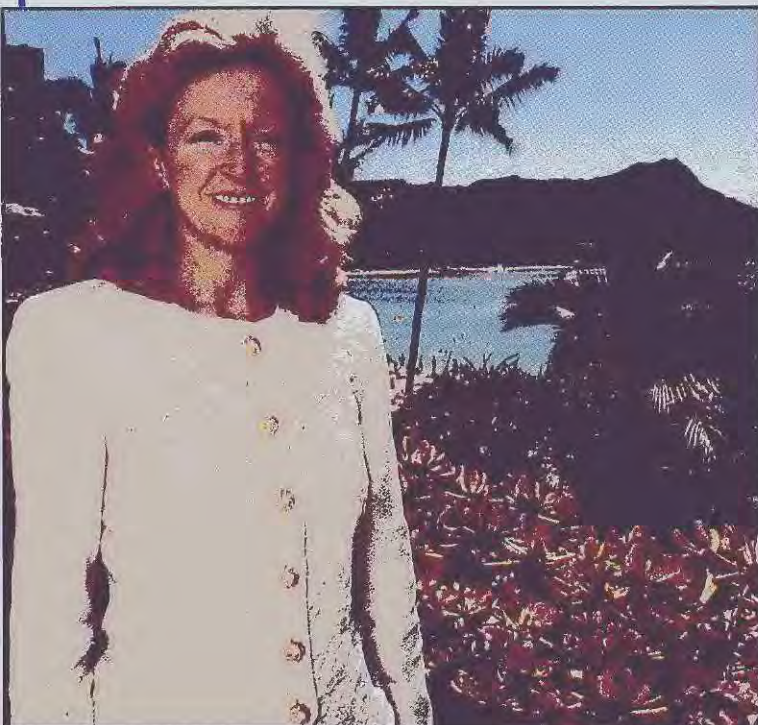
DENVER—Recent ups and downs in the National Assn. of Insurance Commissioners' accreditation program appear to be taking some state regulators on a roller coaster ride.

High points for the accreditation program include a last-minute compromise reached at the NAIC's meeting last week that allowed Texas to avoid a threatened revocation of its accreditation. Montana and Pennsylvania were

awarded accreditation certificates at the meeting.

In addition, progress is reported in efforts by Vermont to address NAIC concerns and gain accreditation (see story, page 14).

One of the lowest points for the accreditation program is ongoing saber-rattling by New York State Sen. Guy J. Velella, R-Bronx and Westchester counties, a vocal critic of the program since New
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Updates

UNI Storebrand winds up unit

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brand Skadeforsikring will continue writing some international business in sectors like marine, oil and satellite insurance.

UNI Storebrand International reported an operating loss of 357 million kroner (\$47.5 million) for 1993.

Reserves are adequate to meet future claims and expenses involved in winding up the reinsurance operation, said UNI Storebrand New.

UNI Storebrand International's office in Singapore will be closed, and its U.S. subsidiary, Christiania General Insurance Corp., will be merged into the non-life company.

UNI Storebrand Insurance Co. (U.K.) Ltd. in London will continue operations with the support of a liquidity guarantee from its parent.

The same day that it announced its departure from reinsurance, UNI Storebrand New announced record pretax profits of 5.97 billion Norwegian kroner (\$790 million) for 1993, compared with a loss of 1.74 billion kroner (\$250 million) for 1992.

Elsewhere in the Nordic market, Sweden's Skandia Insurance Co. Ltd. announced record operating profits of 2.01 billion Swedish kronor (\$240 million) in 1993, compared with a loss of 3.24 billion kronor (\$460 million) in 1992. Skandia also announced that it plans a 3 billion kronor (\$380 million) rights issue, its first since 1978, to develop insurance operations within the Nordic market.

Ex-hockey executive indicted

BOSTON—A federal grand jury has indicted the former executive director of the National Hockey League Players Assn. for allegedly defrauding players of pension fund contributions, disability benefits and other funds.

R. Alan Eagleson, a Toronto lawyer who headed the association from 1967 to 1991, was charged in a 32-count racketeering, fraud and embezzlement indictment unsealed March 3.

The indictment outlines a variety of schemes Mr. Eagleson allegedly used to defraud the association and its members. Among other things, the indictment charges that he induced players to participate in a Canadian tournament with the promise that revenues would go toward the players' pension plans, but he allegedly diverted the revenues to himself, members of his family and business associates.

The indictment also alleges that he defrauded two players on disability claims paid by Lloyd's of London underwriters. Prosecutors also charge that Mr. Eagleson tried to obstruct the grand jury investigation by destroying documents and intimidating a witness.

If found guilty, he faces prison terms ranging from three to 20 years and fines of \$250,000 on each count. Prosecutors are also seeking forfeiture of \$2 million.

However, Mr. Eagleson's lawyers said at a Friday press conference that he would not "submit himself to the jurisdiction of the United States courts."

Since the alleged wrongdoing took place mainly in Canada, any charges against Mr. Eagleson should be brought in Canada, according to his Toronto attorneys, Brian Greenspan and J. Edgar Sexton.

Mr. Eagleson "categorically denies any wrongdoing."

GTE Re moving to Vermont

HAMILTON, Bermuda—GTE Corp. is moving its captive insurance subsidiary, GTE Reinsurance Co. Ltd., to Vermont from Bermuda.

Among U.S. domiciles, "Vermont is the most attractive domicile at this point according to all the people in the know," said Fred Finley, president of GTE Re, which is asking Bermuda officials for approval to move.

GTE Reinsurance was licensed in Vermont March 3, and Mr. Finley said he expects the company to be domiciled in the state by early April. Despite the change in domicile, "nothing changes in the way that we've been doing things here for the past year," Mr. Finley said.

GTE Re writes property/casualty risks for its parent company. It ceased writing third-party business in 1989 and continues to runoff that book of business.

Panel OKs OSHA bill

WASHINGTON—The House of Representatives could vote on a labor-backed OSHA reform bill later this year following a key committee's approval of the measure last week.

The House Education and Labor Committee rejected Republican attempts to soften H.R. 1280, the Comprehensive Occupational Safety and Health Reform Act, before approving it last Thursday. The bill, which has generated considerable opposition from business groups, would require: the creation of joint labor-management safety committees at most workplaces, employer-drafted health and safety programs, and tougher criminal sanctions on employers that violate OSHA rules. The bill also would extend OSHA protections to state and municipal employees.

Committee Chairman William Ford, D-Mich., who will not seek reelection, has said that he wants the House to vote on the bill by this summer. The Clinton administration supports the measure.

Air crash losses insured

NEW DELHI, India—Losses stemming from last Tuesday's crash of an Indian airliner that killed eight people and damaged a Russian plane at New Delhi International Airport are insured.

Hull insurance for the Sahara India Boeing 737 was written by state-owned General Insurance Co. of India and was reinsured for \$8.6 million by the British Aviation Insurance Group, insurance sources say. Reinsurance coverage was placed through London broker Willis Corroon Group P.L.C.

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Integrating comp coverage will increase costs: WCRI

By MEG FLETCHER

CAMBRIDGE, Mass.—President Clinton's plan to integrate medical care for work-related injuries and general health care will increase employers' workers compensation costs overall, a research organization says.

Generally, the "effects of features that increase costs are likely to outweigh effects of features that reduce them," according to two top researchers from the Workers Compensation Research



Institute in Cambridge, Mass.

"The possible exception is the corporate alliance, which could provide a vehicle for large employers to counter some of the cost-increasing incentives created by the Clinton plan," said Thomas W. Grannemann, manager of the health policy program, and Richard A. Victor, executive director.

The WCRI's first assessment of the Clinton plan relies on an ex-

amination of research conducted by various sources, though that research is sometimes very limited. It is contained in a 26-page "health policy memorandum" rather than a WCRI research report, which undergoes more extensive review, they emphasized.

According to their analysis, features likely to increase costs include the following:

- Mixing fee-for-service and capitated payment could produce medical and income benefit cost

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D&O coverage denied

2 courts deny RTC, FDIC claims for banks' coverage

SAN FRANCISCO—The "regulatory exclusion" in directors and officers liability policies applies to the Resolution Trust Corp. even if the RTC did not exist when a policy was issued, the 9th U.S. Circuit Court of Appeals has ruled.

The RTC had attempted to recover from D&O policies written for now defunct Pacific Savings Bank by American Casualty Co., a unit of CNA Financial Corp.

While the exclusion excludes coverage for claims made by the Federal Deposit Insurance Corp., it does

not apply to the RTC, which had yet not been created, the agency argued.

Upholding a lower court, the 9th Circuit on March 8 rejected that argument: "It is unreasonable to protect the RTC from operation of the exclusion merely because CNA was unable to predict that Congress would restructure its regulatory framework of depository institutions and create a new federal agency."

Meanwhile, the 5th U.S. Circuit Court of Appeals dealt the FDIC a blow when it ruled March 10 against the agency regarding what

constituted a claim under a claims-made D&O policy.

The case involved a failed Louisiana bank that had purchased two D&O policies in the early 1980s from International Insurance Co. The FDIC took over the bank in 1986, and attempted to recover from the D&O policy. International argued that coverage didn't exist because no claim was made during the policy periods. The appeals court agreed and overturned a district court ruling in the FDIC's favor.

—By Mark A. Hoffmann

Insurer needed immediate cash, asset manager says

Exec Life bond sale defended

By LOUISE KERTESZ

SAN FRANCISCO—Long criticized for his handling of the spectacular Executive Life Insurance Co. failure, California Insurance Commissioner John Garamendi now has at least one well-placed defender.

George E. Bull, whose capital management firm was hired as asset manager of conserved Executive Life, last week took issue with reports that the California regulator



gave away billions of dollars in selling the insurer's junk bond portfolio.

Also last week, Mr. Garamendi said 92% of ELIC policyholders with traditional life insurance policies and annuities chose to participate in the court-approved rehabilitation plan. But holders of guaranteed investment contracts that backed municipal bond issues still contest the plan, which would give policyholders their original ac-

count values plus interest and restructure GIC holders' annuities.

Media reports since ELIC was seized in 1991—including a recent Forbes cover story and a detailed 1993 *Business Insurance* report—have argued that dealmaker Leon Black outfoxed regulators, buying at a low price a junk bond portfolio that quickly appreciated by billions of dollars (*BI*, April 26, 1993).

Mr. Bull, who has himself been criticized for undervaluing ELIC

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Stockholm Re to be run off

By GAVIN SOUTER

HAMILTON, Bermuda—Stockholm Re (Bermuda) Ltd. has been placed in run off, following failed attempts to find an investor to inject fresh capital.

Stockholm Re, which predominantly wrote excess-of-loss reinsurance, split its business between property and marine business. About half of its property business was for U.S. risks, with the

Parent decides to refocus its business

remainder spread worldwide.

Stockholm Re's parent company, Lansforsakringsbolagens A.B. of Stockholm, decided one year ago to withdraw from the reinsurance market and concentrate on its core business as a mutual insurer, said John C. Williams, president of Eastney Investments Ltd., which will oversee the run-off.

Stockholm Re's management subsidiary, Stockholm Management Ltd., will be merged with Eastney, while its brokerage subsidiary, HJF International, has been bought by its existing management.

The parent also considered that with capital and surplus of \$20.5 million at year-end 1992, Stock-

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Speaking out against killer

AIDS hits close to home for risk management community

By CHRISTINE WOOLSEY

CHARLOTTE, N.C.—When Ruth Vickery noticed her boss was taking frequent naps in his office, she wasn't alarmed.

"I figured he was just tired and needed a little rest," said the NationsBank Corp. assistant vp and insurance administrator.

After all, Frank Lubbers was constantly on the go. As the risk manager for NationsBank, he had his hands full with a \$20 million insurance program. And, when he wasn't ironing out the final details of yet another buyout by the rapidly expanding banking giant, he devoted his time to church projects and volunteer work or to hosting social events in his spacious home, Mammoth Oaks.

But it wasn't a stressful job or busy social schedule that caught up with Frank Lubbers.

It was AIDS.

In 1988, Mr. Lubbers got the news that changed his life: He had tested positive for the human immunodeficiency virus, which causes acquired immune deficiency syndrome. Five years later, "my energy level said stop," he said.

Last October, after an emotional retirement reception at the bank's Charlotte, N.C., headquarters, Mr. Lubbers stepped down as senior vp-risk management, ending a 21-year career with the powerful financial services firm.

Only 52, Mr. Lubbers could be starting a second career at another company. Or possibly entering the consulting field. Or starting a long, leisurely retirement, visiting his native Germany and tending the hundreds of varieties of annuals, perennials, shrubs and trees in his locally renowned garden.

None of these scenarios are likely.

Still relatively healthy, Mr. Lubbers tires easily. According to his most recent T-cell count—which indicates a person's immune system responsiveness—he should live another 30 months.

That news would make many people give up. But learning he has limited time seems to have motivated Mr. Lubbers, who is known for his giving nature and zeal for life.

"I want to spend my remaining time and energy getting the word out about AIDS," he said. "Most insurance people think that it only happens to those 'other' people. If they continue to think that, they are at risk. More importantly, our children and grandchildren are at risk."

The face of AIDS is changing. Heterosexual transmission accounted for the largest proportionate increase in AIDS cases reported in 1993, according to the Centers for Disease Control and Prevention. Heterosexual transmission now accounts for 9% of the total AIDS cases reported last year, up from 1.9% of total cases in 1985. The CDC

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Frank Lubbers holds a quilt panel made for him by his NationsBank coworkers. The panel will eventually be added to a quilt commemorating all those who have died of AIDS.



Photo by J. Wes Bobbitt

Perks may defeat managed drug plans: Study

By MICHAEL SCHACHNER

New research suggests that benefit managers and managed care companies need to be on the alert for doctors who try to override drug formularies after receiving financial favors from pharmaceutical manufacturers.

There is little evidence directly linking drug company largesse with doctors' prescribing habits,

but the findings by a pair of Cleveland doctors are causing concern among benefit managers and managed drug firms.

Doctors who request that specific types of drugs be added to hospital formularies are more likely to have received monetary benefits from the drug companies than doctors who do not request additions to formularies, the two doctors conclude in a study that

appeared March 2 in the Journal of the American Medical Assn.

Those benefits ranged from fees for appearing at drug company-sponsored educational seminars to money for personal travel and expenses, free meals with drug company employees and company-subsidized research.

Dr. Mary-Margaret Chren and Dr. C. Seth Landefeld examined the prescribing patterns of two

groups of doctors during a 22-month period from 1989-1990: one group of 40 who had recommended that certain drugs be added to a hospital's formulary and another group of 80 that had not requested additions.

Both physicians are affiliated with the University Hospital of Cleveland and with Case Western Reserve University School of Medicine in Cleveland.

Physician prescribing patterns have a major influence on drug company sales, the two doctors assert. One key way to aid drug company performance is to include its drugs on hospital formularies, which are the lists of drugs that doctors are allowed to prescribe for certain ailments.

"Many types of physician behavior relate to drugs. Not only do

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Railways prepare for claims from train derailments in South Africa, Switzerland

By MARIA KIELMAS
and DON LEWIS KIRK

South Africa's railway is insured for any claims arising from last week's derailment of a packed commuter train, while claims stemming from a freight train wreck in Zurich will be retained by the Swiss national railway.

The commuter train derailed near Durban, South Africa, last



AP/Wide World photo

Police search for bodies after last week's train crash in South Africa.

Although the driver of the train was arrested and charged with manslaughter following the accident, South African law does not allow a corpo-

Continued on next page

Also on Tuesday, a Swiss Railway freight train derailed in Zurich and caused a series of explosions, resulting in several million dollars damage to cars, buildings and railway equipment. If Swiss Railway is found liable for the accident, claims will be paid from a \$35 million self-insurance fund.

Despite the large number of deaths and injuries in the South African crash, claims are expected to be low unless negligence on the part of the railway company is proved.

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Managing retiree care

Retirees less likely to have a 'gatekeeper' type plan: Survey

By JUDY GREENWALD

Managed care today is less available to retirees than it is to active employees, but that may eventually change.

Those are among the conclusions of a recent survey on retiree managed care by the Washington Business Group on Health and Hewitt Associates.

The survey of 123 major U.S. companies, which was conducted last October and November, focused on so-called gatekeeper plans. These are plans under which primary care physicians monitor the types of care and dif-

ferent treatments that patients receive, explained Janet Shepherd, a Hewitt principal and manager of its research group. Under this category are point-of-service plans, point-of-service health maintenance organizations and standard HMOs.

"Almost all of the employers offer that kind of plan to employees as an option" but a lesser number offer such plans to their retirees, she said. The survey found that while 91% of companies offer gatekeeper plans to active employees, only 63% offer them to retirees younger than 65, and 51% offer these types of plans to retirees 65 and older.

Because it is one thing to offer a plan "and another to say, 'This is being used,'" the survey also tried to find out which plans people really use, said Ms. Shepherd. The survey determined that gatekeeper plans were more often used by active employees than by retirees.

According to the survey, 32% of companies reported that the largest number of their active employees were in gatekeeper-type plans. In contrast, only 10% of companies said their largest number of pre-65 retirees were in these

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Two-tier compensation

By DEBORAH
SHALOWITZ COWANS

ELK GROVE VILLAGE, Ill.—Non-union employees hired by United Airlines after Jan. 1 are receiving lower salaries for the same work and far fewer benefits than employees hired before the beginning of the year.

New hires do not receive company-paid medical or dental insurance, paid holidays, paid sick leave or paid time off for a death in the family or for jury duty, while employees hired before Jan. 1 receive all those benefits.

The temporary two-tier compensation arrangement, which affects all new non-union, salaried

New hires take less so ESOP gets more in UAL buyout

and management employees, is part of the concessions employees are making in return for acquiring a majority stake in the airline and its parent, UAL Corp. A new employee stock ownership plan would hold at least 53% of the company's stock.

United Airlines has hired fewer than 100 people since the beginning of the year, a spokesman said.

United Airlines has had several two-tier compensation programs

since 1983, according to another spokesman. He said the latest program is simply a modification of previous programs, though he declined to elaborate.

United's two-tier compensation program will likely be revamped after the employee buyout. Documents related to the ESOP must be completed by March 15, after which the buyout plan will be sent to shareholders for a vote. The buyout could be completed as early as June.

United's unions are in the process of negotiating new contracts, which also must be completed by March 15. Instead of eliminating benefits, the unions are expected

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Trains

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ration to be held liable for the negligence of an employee.

The train was coming around a curve at the time of the crash, according to Jakki Van Niekerk, finance general manager of SARCC in Johannesburg. The coach cars derailed and hit a rock wall next to the train tracks.

Damage to the coach cars will total 2 million to 4.5 million rand (\$576,200 to \$1.3 million), he estimated.

The SARCC owns all the fixed assets and rolling stock of the rail network, but a state-owned contractor, Transnet, manages the railway.

SARCC has 100 million rand (\$28.8 million) per loss in collision damage insurance, with a 1.25 million rand (\$360,125) deduct-

ible. The coverage was placed evenly with the South African Special Risks Insurance Assn. and London market underwriters.

The railway company also has liability coverage for 200 million rand (\$57.6 million) per occurrence, with a 250,000 rand (\$72,000) deductible, also placed with the South African Special Risks Insurance Assn. and London underwriters.

The government, SARCC and Transnet are each conducting inquiries into the crash.

Switzerland's national railway system is self-insured for any claims arising from the derailment and explosion in Zurich.

The freight train derailed in a suburb about four miles from downtown Zurich, caught fire and exploded. Some of its cargo of about 100,000 gallons of gasoline leaked into the sewers and ignited, causing massive explosions

and fires that damaged buildings and cars. Three people were injured, including two women struck by manhole covers that were sent flying by the explosions.

A spokesman for property insurer Zurich Gebaeudeversicherung estimated insured property damage to buildings of more than \$2 million.

Damage to railway facilities, including rails melted by the fires, will be significantly less than that amount, said Gregor Beuret, regional director of the government-owned Swiss Railway.

Investigators are still probing the cause of the accident.

Ulrich Rothhard, director of the transport insurance division of insurer Berner Versicherungen in Berne, said overall insured losses from the accident could exceed 10 million Swiss francs (\$6.9 million), with cargo losses of nearly 1 million Swiss francs (\$695,200).

"Several factors play a role—liability cover for damage to building and cars, personal injuries and contamination," he said.

One of the largest single losses likely will be damage to the city's water drainage system. Zurich Gebaeudeversicherung estimates

damage in excess of 1 million Swiss francs.

Swiss Railway is self-insured for any liability claims arising from the accident, Mr. Rothhard said. It has a 50 million Swiss franc (\$34.76 million) fund set aside for liability claims. **BI**

Exec Life

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assets, defended Mr. Garamendi in an address to about 135 executives at the sixth annual Russell Miller National Insurance Symposium and Leadership Conference.

Some say that when Mr. Garamendi seized the company, it "wasn't really insolvent, it was just sort of having a bad day," Mr. Bull quipped.

But the policyholder run on ELIC amounted to \$250 million a

week by early April 1991, he said. At the time, Mr. Bull, who is president of GB Capital Management, told Mr. Garamendi that ELIC was insolvent since it didn't have enough cash to meet its liabilities.

At the time of the takeover, Mr. Bull said, the bond portfolio resembled "Kuwait after the war." Eighty-three of the companies that issued the bonds were in bankruptcy and there was "an extreme lack of information" about the securities.

Making policyholders whole would have required recovering 75 cents on the dollar for every bond that went into default, he said. Analysts had placed the recovery value of junk bonds as low as 20 cents to the dollar.

The portfolio of defaulted securities was "eclectic," Mr. Bull said. Millions were invested in companies owning toy stores, eyeglass frames, motels, meatpacking plants and timeshares in Aruba properties that were "wiped out by a single hurricane."

Among the companies represented were over-leveraged firms, a bankrupt savings and loan and "my most favorite, \$50 million (of securities in) a company whose best product was an artificial Christmas tree with built-in lights," he said.

What's more, the insurer was head of the creditor committees for 55 major companies and was the entire creditors committee for about 15 others in bankruptcy.

"Would it be prudent to use policyholder dollars to find out if we could recover anything from this portfolio?" Mr. Bull asked. "Should the commissioner have held on to the bonds? Is it appropriate to have a public official using policyholder money to manage so many companies?"

Altus Finance, a merchant bank that led Mr. Black's investment group, had "real money, so we started talking to them."

Did Altus buy the bonds at a low in the marketplace? Mr. Bull asked rhetorically. "Maybe. Any bond purchase at that time would have made a lot of money. Nobody would have forecast a 5% decline in interest rates that helped (bankrupt) companies restructure themselves," he said.

But in 1991, a key question was, "Would it have been appropriate to have a publicly elected official using policyholder money to control the operations of so many companies? Reasonable people can answer the question themselves," he said.

Also discussed at the symposium were growth and change in the property catastrophe reinsurance market.

"The supply/demand imbalance (after Hurricane Andrew) was severe; it lasted five minutes," quipped Donald Kramer, chairman of Tempest Reinsurance Co. Ltd., a Bermuda-based catastrophe reinsurance facility.

The new Bermuda cat facilities, which attracted \$4 billion in capital late last year, "will lead to some moderation and probably reduction in rates," he said (BI, Nov. 1, 1993).

In fact, following the Los Angeles earthquake in January, the Bermuda cat facilities saw a number of insurers seeking additional property catastrophe cover. **BI**

Coffee, Tea or Duvet.



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BRITISH AIRWAYS

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AT BOEING, THE PROPERTY INSURANCE IS NEVER UP IN THE AIR.

When The Boeing Company of Seattle needed additional property insurance capacity for the largest building, by volume, in the world, they came to Wausau. Wausau is one of a few insurers with Highly Protected Risk (HPR) capability and the willingness to do Special Risk underwriting, including primary and excess programs. And, with Wausau's financial strength and A+ A.M. Best Rating, Wausau gives Boeing the ground support it needs.



PROPERTY • HPR • SPECIAL RISK

New plan is music to domestic partners

SEATTLE—After long negotiations, the Seattle Symphony Orchestra has a new contract covering the 1993-1994 season that includes domestic partner benefits for the first time.

The new health care coverage benefits, extended to same- and opposite-sex partners, are modeled after the city of Seattle's benefit plan, said Carla Johnson, artistic administrator.

As under the old contract with the Seattle Opera Players Organization—which expired Aug. 31, 1993 and has been in negotiation since then—management will cover 100% of health care premiums. The new contract, which expires Aug. 31, also calls for management to cover any increases in the plan's base premiums up to 15%.

"We're hoping there won't be any increase," said Ms. Johnson, who pointed out that the symphony has replaced its traditional indemnity plan with a preferred provider organization offered by Travelers Corp.

Under the PPO plan, in-network services are covered at 90% and out-of-network services at 80%, she said. Symphony musicians can also continue to choose an HMO, Seattle-based Group Health Cooperative.

The new agreement with the musicians' labor organization covers 41 weeks of employment, including six weeks of vacation—one week less than the previous contract. It includes a base weekly wage of \$800, pension increases and an increase in seniority pay for musicians with 25 or more years of employment.

—By Louise Kertesz

Benefit Beat

N.Y. workers' HMO

NEW YORK—New York City employees and retirees and their dependents will soon have access to a point-of-service health maintenance organization through U.S. Healthcare Inc. The plan will be made available to 480,000 active employees and retirees currently enrolled in any of the city's various health plans. The transfer period will begin April 18 and the plan will become effective July 1.

Under the plan, enrollees may seek benefits under U.S. Healthcare's standard HMO or seek primary-care physician approval to opt out of the HMO at the point of service and pay deductibles and coinsurance. U.S. Healthcare's traditional HMO has been available to New York City employees since 1987. Currently, 58,000 employees, retirees and dependents are enrolled in that plan.

—By Michael Schachner

Segal health study

NEW YORK—Most employers will experience an increase in overall medical plan costs if President Clinton's health system reform plan is adopted, according to a study by the Segal Co.

The New York-based benefit consulting firm developed a pricing model to project the financial impact of the Clinton plan on employers. Among its findings: The average

percentage increase in projected total medical plan costs to an employer would be 28%; the average annual dollar increase in employer costs would be \$911 per employee.

For a report copy, contact Mary L. Feldman, vp of public affairs, at the Segal Co., 1 Park Ave., New York, N.Y. 10016; 212-251-5029.

—By Christine Woolsey

Maternity benefits

HELENA, Mont.—Insurers that provide major medical coverage in Montana now must include maternity benefits at no extra charge.

State Insurance Commissioner Mark O'Keefe also said he is considering ordering insurers to pay claims and refund premiums for maternity coverage riders to those in the state who incurred such costs in the last eight years. Mr. O'Keefe said he chose the period of eight years because the statute of limitations for written contracts is eight years.

He based last month's order on a Dec. 28 Montana Supreme Court ruling that an insurance policy issued by Bankers Life & Casualty Co. that excluded maternity benefits is discriminatory on the basis of sex and violates the state's unisex insurance law.

—By Deborah Shalowitz Cowans

Employee study

For the first time, the majority of state and local government workers with health care benefits were covered by managed care plans, a new

Bureau of Labor Statistics study shows.

Fifty-seven percent of full-time workers employed by state and local governments in 1992 were covered by managed care provisions, including health maintenance organizations, preferred provider and exclusive provider networks, the BLS reports. By contrast, 43% of state and local government employees were covered by traditional fee-for-service plans. The fee-for-service plans, however, typically required workers to seek approval for certain types of health care services and more often than not required second surgical opinions, the survey said.

The previous BLS survey in 1990 found that 61% of state and local government employees were covered by traditional indemnity plans, 22% by HMOs and 17% by PPOs.

The BLS also found that 43% of full-time employees with health benefits were required to contribute toward individual coverage. Their monthly premium contributions for both managed care and indemnity plans averaged \$29. Seventy-two percent had to contribute an average of \$139 per month for family coverage in managed care or indemnity plans.

Annual deductibles for those employees enrolled in fee-for-service plans averaged \$173 per year in 1992, according to the BLS report. Out-of-pocket expenses for 80% of the individuals enrolled in these plans averaged \$908 per year. Family out-of-pocket expense, when applicable, averaged \$1,856 per year.

Twenty-nine percent of full-time workers with medical care benefits

received coverage under a PPO, while 27% were covered by HMOs, the survey found. Exclusive provider organizations, which are PPOs created for the employer, covered 1% of health plan participants.

The 1992 BLS survey provides information on benefit plans for about 14 million employees in state and local governments. For a free copy of "Payouts from Employee Benefit Plans" write the Bureau of Labor Statistics, Division of Information Services, Room 2850, 2 Massachusetts Ave. N.E., Washington, D.C. 20212; or call 202-606-5888.

—By Christine Woolsey

Time partner cover

NEW YORK—After studying the effects of a pilot program to extend medical benefits to some Time Warner Inc. employees' same-sex domestic partners, the media giant's Time Inc. unit says it will provide domestic partner coverage for its workers as well.

Two other units of Time Warner—Home Box Office and Warner Bros.—and the company's corporate staff were offered domestic partner coverage last summer.

The cost of providing domestic partner coverage to those employees has been "manageable," said an internal memo to employees of Time Inc. As a result, the magazine and book publishing arm will begin offering medical coverage to employees with same-sex partners July 1. The unit is the largest division of Time Warner, employing more than 10,000 workers.

—By Christine Woolsey

Five Years Ago, This Would Not Have Been Considered An Intensive Care Nursery.



On a warm afternoon in August, Jeremy Masters came home.

Jeremy, born six weeks premature, was expected to stay in the hospital at least five weeks. However, his insurance company asked a Special Alternatives nurse-consultant to review the case. By arranging for extracontractual benefits such as 24-hour nursing care, she made it possible for Jeremy to go home.

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NAIC

Continued from page 1

York lost its accreditation a year ago.

Sen. Velella, who chairs the state Senate's insurance committee, wrote to Gov. Mario Cuomo on March 2, urging him to prohibit the New York Insurance Department from spending any more money on NAIC-related expenses. The department has spent more than \$1 million of taxpayer money on such expenses in the past five years, the state senator charged.

In addition, he asked the governor to muster anti-NAIC sentiment among members of the National Governors Assn.

Sen. Velella said he resents "political blackmail" by the NAIC, which suspended the New York department's accreditation in March 1993 because the state Legislature failed to pass three new model laws required by the NAIC accreditation program (BI, March 15, 1993). Those model laws now are contained in two bills, S. 2601 and S. 2822, which have been passed by the Assembly and currently are before Sen. Velella's insurance committee.

Sen. Velella is urging passage of a bill, S. 6648, that would allow New York to retaliate against any states that impose sanctions against New York-based insurance companies (BI, Feb. 21).

The NAIC launched its Financial Regulation Standards and Accreditation Program in 1990 to elevate the quality of solvency regulation by the states. The standards required for accreditation include adoption of laws, regulations, practices and procedures deemed by the NAIC to be necessary for effective solvency regulation. An independent audit team makes an initial determination whether a state meets these standards, which is followed by annual compliance checks and an onsite review every five years.

The accreditation program has spurred states to enact more NAIC model laws in the past three years than at any other time in the organization's history.

Most state legislators are generally supportive of the aims of the NAIC's accreditation program, which include improving state-based regulation as a way to forestall federal intervention.

However, many states have grown increasingly weary of the NAIC's constant adoption of new and revised model law requirements for the program, because they create a constant stream of needed legislative enactments.

NAIC leaders say they plan to be more deliberative and sensitive to this concern in the future.

Thirty-four states are currently accredited, including Montana and Pennsylvania.

To encourage participation in the accreditation program, the NAIC began enforcing sanctions Jan. 1: Unaccredited states will not have their insurer examination reports accepted by accredited states unless an examiner from an accredited state significantly participates in the non-accredited state's exam (BI, Dec. 20, 1993).

The NAIC previously informed Texas Insurance Commissioner J. Robert Hunter that the state's accreditation was at risk because a Texas law regarding payment of extraordinary dividends by insurance companies is different from the NAIC standard, due to "an inadvertent error" in the last session of the Texas Legislature.

Because the Texas Legislature meets in odd-numbered years, the law cannot be changed until 1995. Efforts to change it in 1993 were

unsuccessful.

Mr. Hunter proposed a plan that would allow him to carry out the intent of NAIC standards administratively until the Legislature meets in 1995. He will issue a bulletin notifying all states in which an affected company does business about all dividend payments paid to stockholders or owners of insurance companies.

"We don't comply, but we can deliver the substance of what they want," Mr. Hunter said.

Texas Rep. John Smithee, R-Amarillo, and chairman of the House Insurance Committee, accompanied Mr. Hunter to the NAIC meeting in Denver last week and expressed his support for the plan during a closed-door meeting of the NAIC's Financial Standards and Accreditation Subcommittee. Rep. Smithee pledged to work during the 1995 legislative session to correct problems with the statute, though he

could not guarantee passage.

The subcommittee then voted 7-5 to give Texas until May 1, 1995, to adopt legislation that would bring its laws in line with NAIC requirements, Mr. Hunter said.

NAIC President David J. Walsh said he was "delighted" at the "extraordinary efforts" Texas is making to preserve NAIC accreditation standards until the Texas Legislature reconvenes in 1995.

However, the subcommittee will audit Texas's compliance with its bulletin and will suspend the state's accreditation if the plan is violated, he added.

The problem in Texas is similar to one experienced by Iowa, though Iowa was able to rectify it during a 1994 legislative session, said Mr. Walsh, who is Alaska's insurance commissioner. Because the NAIC keeps state accreditation proceedings confidential, details on Iowa's problem were not available.

Texas action shows that the NAIC's accreditation program is "successful" and that pushing back the deadline is "realistic," said Lenore S. Marema, vp-legal and regulatory affairs for the Alliance of American Insurers in Schaumburg, Ill.

However, Jon Harkavy, vp and general counsel of USA Risk Group in Arlington, Va., a captive services firm, disagreed. Making special exceptions for Texas is "absolutely a weakness," he said. It is "regulatorily incorrect" to make such allowances for Texas, which has a large industrial and premium base.

In New York's case, an Insurance Department spokesman took exception to Sen. Velella's specific charge that nearly \$1 million in taxpayer funds has been spent on NAIC-related expenses like dues and travel to meetings in the past five years.

"No taxpayer dollars are going to pay the department's NAIC-related expenditures, because the depart-

ment is funded by assessments on the insurance industry," the spokesman said.

The department's current budget is \$66.8 million.

The department plans to continue discussing the "technical suspension" of New York's accreditation with the NAIC in hopes of remedying it, he said.

"I hope we can sit down and work things out," said the NAIC's Mr. Walsh, who is meeting with Rep. Velella this week. New York is "an important member" of the NAIC and like all states gets more than it gives, Mr. Walsh said. **[B]**

Coverage of additional developments at the National Assn. of Insurance Commissioners' meeting in Denver last week will appear in the March 21 issue.

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Opinions

Time to start from scratch

IT'S OBVIOUS by now: The Clinton health care reform proposal is dead.

Despite a massive publicity campaign, public opinion has turned decidedly against the proposal. More Americans now oppose the plan than support it, a sharp reversal of fortunes since President Clinton unveiled the proposal in September.

In Congress, support for the proposal has dwindled to a tiny cadre of loyalists. If Congress acted today, we doubt if the president's bill—in its current form—would garner more than a dozen votes in the Senate and four or five dozen in the House.

This lack of support has little to do with insurance industry advertising, as some in the administration seem to think, and everything to do with the proposal itself. Simply put, the administration has produced a bill that the public and Congress increasingly fear could do more harm than good.

The biggest fear involves the heart of the administration proposal: a system of mandatory, state-established, monopolistic health care purchasing alliances. That fear is well-justified. Could government bureaucrats, many of whom would have no experience with health care plans, effectively manage health care programs covering at least half of the nation's population and generating hundreds of billions of dollars in premiums? And would the alliances, operating in a monopolistic environment, improve health care while reducing costs?

The Congressional Budget Office is absolutely on the mark in noting that some alliances could be overwhelmed.

Granted, today's system in which most Americans receive coverage through their employers is not perfect, but none of those flaws justifies risking it all in favor of the alliance structure.

Support for the Clinton proposal has eroded for other reasons as well. Legislators are concerned that if it is left to Congress to decide the scope of the basic benefit package to be offered to all Americans, provider pressure will force them to keep adding benefit after benefit—with spiraling costs the inevitable result.

While it is abundantly clear that the Clinton proposal is dead, it is just as clear that alternative proposals—like Rep. Jim Cooper's managed competition bill or a single-payer approach—lack enough support to pass Congress. Once again, the result on health care reform could be gridlock.

The administration can prevent that from happening, but only if it takes a radical step: It has to junk its health care proposal and work with Congress on a new proposal, one that can pass.

Certainly, the mandatory, monopolistic alliance structure has to go in favor of voluntary competing alliances. Also, the administration should drop its insistence that all health plans offer a specifically de-



fined benefit package, though it should spell out basic coverage guidelines like, for example, a ban on coverage exclusions for pre-existing medical conditions.

Realistically, requiring employers to pay for health care premiums is a tough sell, but the administration made it even tougher by setting the contribution level too high. Congress would never require employers to pay 80% of premiums. The administration has to recognize that and propose a lower percentage, perhaps 50%.

The employer mandate itself is highly controversial. To defuse some of the opposition, the administration would be wise to consider a longer phase-in period. However, the employer mandate is one point on which the administration should not compromise: Despite the objections from employer groups, we believe an employer mandate is the best way—and perhaps the only way short of a single-payer system—to guarantee universal coverage. An individual mandate is simply unworkable.

Above all, the administration has to recognize that with the congressional calendar winding down, the time to break the stalemate on health care reform is now.

As we noted months ago, health care reform is only possible with presidential leadership. The best leadership now would be to recognize past mistakes and work more closely with Congress and interest groups to develop a proposal that can and should be enacted.

If not, no meaningful health care reform will be enacted this year. While some say major reforms are no longer needed, this is a short-sighted view. The health care crisis is real and it must be addressed.

It's up to the president to make the next move.

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Letters

Effective data analysis affordable to most employers

To the editor: While we were pleased to see an article emphasizing the role of data analysts as an important tool for employers to use in their efforts to con-

tain health care costs (BI, Feb. 21), we were concerned about one statement in the article. It is not true that "employers interested in high-level data analysis must spend \$50,000 to \$200,000 each year." This statement may dissuade mid-size and smaller companies from taking advantage of an excellent opportunity to manage their health benefit plans.

For example, National Health Management Corp., which was mentioned in the article, charges \$25,000 to \$30,000 annually to provide comprehensive midyear and annual reports to an employer that wants to compare utilization in its indemnity plan, three or four HMOs and a

PPO. For that fee, we: collect data from each plan; conduct an in-depth analysis of utilization aided by physicians, actuaries, underwriters and managed care specialists; compare claims experience; and provide reports with specific recommendations.

There is no question that effective managers rely on good data to make important decisions and to monitor results. Your readers should know that almost all employers can afford that data.

Iris P. Masotti
President

National Health Management Corp.
Evanston, Ill.

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Drugs

Continued from page 3

physicians prescribe drugs that patients buy, but physicians who speak about drugs at medical symposia may influence their listeners' prescribing behavior, faculty physicians shape the prescribing behavior of their students, and physicians' research affects the availability of and indications of drugs," Drs. Chren and Landefeld wrote.

"And additional physician behavior—requesting that a drug be added to a hospital formulary—is also important to drug sales because the formulary regulates the drugs available for physicians to prescribe to patients. Furthermore, in teaching hospitals, the formulary determines which drugs are most easily prescribed by doctors in training, who are developing

prescribing styles likely to persist throughout their careers," the doctors wrote.

Despite such ethical concerns, the practices questioned in the article are far from uncommon and have not resulted in a plethora of incorrect prescriptions and increased costs, managed drug plan experts say.

"We often run into pharmacists who say doctors have strong ties to the drug companies," said Henry Blissenbach, president of Diversified Pharmaceutical Services Inc. in Bloomington, Minn. "I have no problem with physicians being on the therapeutic committees that select formularies or doing pharmaceutical research. But what you don't want is a physician with a financial interest in the drugs being prescribed. If physicians are bringing their private interests to the table, you confront the doctor and then bring the situation to the

attention of the person in charge of the health plan that is being affected."

Dennis Nirtaut, employee benefits manager at Continental Bank Corp. in Chicago, said the influence exerted by drug companies on doctors is simply part of the highly competitive pharmaceutical industry.

"The study's findings aren't surprising because this is something that has been going on for years. It makes sense that as a physician you're more likely to prescribe something you're familiar with than something you don't know," he said.

Still, knowing that doctors may be influencing formularies because they were invited to speak at a seminar or were treated to lunch isn't comforting to those who pay the cost of prescription drugs, Mr. Nirtaut admitted.

"Knowing that it's possible that

the best drugs may not be getting on formularies doesn't give me a great comfort level. Is the system perfect? No. But it's a very competitive market, and when doctors get free trips or an upgraded computer system for prescribing a high number of a certain company's products, formulary addition requests aren't surprising," he said.

To assuage benefit managers' fears that drug companies are winning and dining their drugs onto formularies, one managed drug plan official said a drug will not automatically be added to a formulary simply because a request is made. If additions are approved by therapeutic committees, it is because the drugs are worthwhile, even though they may be more expensive than drugs already on the formulary.

"The onus is on the pharmacy and therapeutic committees to not approve requests that can't be jus-

tified," said Jeff Herzfeld, director of business development with Prescription Solutions, a unit of PacificCare Health Services Inc. in Cypress, Calif.

"We get formulary addition requests all the time and sometimes the drugs being requested and the signature are in different colors of ink," he explained. "It's obvious the doctor just signed a piece of paper put in front of him by the drug company representative. I throw these out immediately. But, give me a good reason why the drug should be added and our pharmacy committee will consider it."

Drs. Chren and Landefeld, however, found something quite different. In their study, 46 out of 52 requests for additions to formularies were approved. This, they said, shows that additional scrutiny may be needed for formularies to be effective. **BI**

Small firms surveyed on reform

Small-business owners are generally satisfied with the nation's health care system and favor reforms that would emphasize individual choice and responsibility, a new survey shows.

The telephone survey of 623 members of the National Assn. for the Self-Employed, a Dallas-based trade group for primarily small employers, showed health care reform as only the third most important national concern of those polled, behind reducing the federal deficit and crime.

Survey participants said they are generally happy with the health care they receive, with 35% "very satisfied" and 39% "fairly satisfied" with their personal health care. Only 12% said they aren't happy at all with their own health care.

Asked to characterize their thoughts about health care reform, 68% said they believe the current U.S. health care system works overall, though some changes need to be made to fix what isn't working.

Only 22% of those polled said the health care system needs a complete overhaul, while 10% said there is no health care crisis and no changes are needed, according to the survey.

Those surveyed also prefer a health care reform plan that would emphasize personal choice, with 89% favoring a system that would allow individuals to choose from a variety of health plans with different benefits. In addition, 86% of survey participants oppose any system that would achieve cost control by limiting patients' choice of physicians, the survey found.

The survey group vigorously rejected any strong federal controls to rein in health care costs, with 78% of small employers opposed to letting the federal government set health care prices and 79% opposed to the notion of Washington setting annual limits on national health care spending.

The suggestion that costs should be controlled by allowing individuals to set aside money tax-free to meet medical expenses got a more favorable response from those surveyed, with 74% supporting the idea.

Free copies of the survey are available from the association by calling 1-800-414-2464.



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Reforms

Continued from page 2
increases "as large as \$13.5 billion."

That "very rough" estimate is based on a study of eight federal shipyards by Alan M. Ducatman, who found that the total workers comp cost per worker, based on 1983-1984 data, was "substantially higher" when workers obtained medical care from HMOs, the WCRI said. His work was summarized in a 1987 WCRI research brief.

That estimate was criticized during the WCRI's Health Care Reform Issues and Research Conference March 1-3 in Cambridge, Mass. Fred Siskind, an economist with the U.S. Department of Labor, said he did not think the shipyard study was strong enough to support that estimate.

- Disconnecting responsibility for managing medical treatment from responsibility for wage replacement costs, which may increase wage replacement payments.

- Using specialized workers comp providers outside the control of health plans and perhaps insurers and employers.

Use of those providers is "likely to increase costs relative to the current system even if they turn out to be less costly than care through health plans."

But, the WCRI researchers also found that the Clinton plan includes several controls and incentives that may reduce employers' workers comp costs:

- Using medical fee schedules,

which could save up to \$3.9 billion initially, if rates were set as low as Medicare rates.

- Increasing the use of capitated delivery systems like health maintenance organizations, which could have more cost-effective practice styles that would "spill over" to treatment of workers comp patients.

- Using medical treatment protocols. While such protocols potentially could save a lot of money, they are likely to save only a small amount because of the lack of incentives or controls for enforcement, the researchers say.

In addition to potential employer savings, corporate alliances could save money because they would have the added option of selectively contracting with health plans.

Contracting with the most cost-effective plans could give such alliances "a potentially important tool to control both medical and indemnity workers compensation costs," the two WCRI researchers said.

Several other speakers at the conference discussed other implications for workers comp in President Clinton's reform package.

"The proper relationship between the workers compensation health care system and the general health care system is the most controversial current issue in workers compensation," said John F. Burton Jr., director of the Institute of Management and Labor Relations at Rutgers University in New Brunswick, N.J., and editor of a newsletter on workers comp issues.

The Clinton plan—at least ini-

tially—calls for "partial integration" through a common delivery system for both workers comp and general health benefits but a separate financing mechanism, Mr. Burton said.

However, "the Health Security Act is not carved in stone," the Labor Department's Mr. Siskind emphasized. He urged interested parties to provide comments and suggestions on ways to improve the act.

For example, he said he would like to see the proposal changed to reflect the drafters' intent to preempt state laws on provider choice only for an injured worker's initial choice of a provider, not subsequent ones.

The drafters' intent was generally not to interfere with other state laws, including the few states that require employee co-

payments for some workers comp medical treatments, he added.

Also, the proposed act's intent is to require an injured employee to seek medical care from his or her own general health care provider, excluding point-of-service HMOs, Mr. Siskind said.

The proposal could be improved if drafters placed HMOs at financial risk for treatment of work-related injuries and illnesses, suggested Jon B. Christianson, a University of Minnesota professor. In addition, the HMOs should "offer a choice of plans, paying the same level dollar amount to whichever plan is chosen" and "consider risk-adjusting premiums as appropriate methods are developed."

Labor generally supports the workers comp aspects of the proposed act, though it would prefer

a totally integrated program, said James N. Ellenberger, assistant director of the AFL-CIO Department of Occupational Safety and Health in Washington.

The current draft of the health care plan asks a commission to explore the feasibility of total integration and, if feasible, to report on how to do it by 1995.

Early efforts by California Insurance Commissioner John Garamendi to push for a totally integrated system by estimating large potential savings are now considered by many to be "preposterous" and "a pipe dream," commented Rutgers' Mr. Burton.

However, "it's clear that merger is their ultimate goal," said Keith Bateman, vp of policy development-commercial lines of the Alliance of American Insurers in Schaumburg, Ill. **BI**

Trimming comp costs

By MEG FLETCHER

WCRI stresses success of managed care

CAMBRIDGE, Mass.—They have seen the future of workers compensation and it is managed care.

Various cost containment strategies can trim medical costs anywhere from 5% to 65%, according to speakers who discussed their research and experiences at a recent Workers Compensation Research Institute conference on health care.

Much of that research was on cost control techniques that have proved effective in holding down

group health care costs and may be transferable to the workers comp environment.

Fee schedules, for example, can cut employers' medical costs an estimated 10% to 54% while provider networks can save 14% to 50%, said Thomas W. Granemann, manager of the health policy program for the WCRI in Cambridge, Mass.

Estimated cost savings from other cost containment strategies, he said, include: utilization management, 5% to 15%; health maintenance organizations and capita-

tion, 10% to 60%; employee cost sharing, 15% to 25%; provider profiling, about 40%; and determining the most effective treatments and reducing practice variations from those standards, 40% to 65%.

Utilization management and provider-directed techniques like physician profiling, networks and use of practice guidelines are particularly important because they show that "quality and cost containment can go together," he said.

Although some aspects of managed care are not readily applicable to the more complex workers comp environment because of political and legal considerations, research indicates that savings can be achieved. Five cost control techniques discussed were:

- **Utilization review.**

UR can save an average of 6% on total medical expenditures, said Thomas Wickizer, an associate professor at the department of health services at the University of Washington who studied more than 200 groups insured by one health insurer, among others. UR led to fewer inpatient admissions, shorter hospital stays and lower routine and ancillary charges.

Preliminary studies have shown that UR also reduces workers comp costs, as well as outpatient expenditures. But Mr. Wickizer cautioned that this only works for frequent procedures or for groups that use a high volume of medical services. "If the volume is low, it may have little effect."

- **HMOs.**

HMOs achieve savings by restricting provider choice, reducing unnecessary utilization, using conservative providers, practice guidelines and a variety of UR techniques, among other things.

While their potential for savings is well established for group health plans, researchers are just starting to present data about HMOs' impact on workers comp costs.

First-year findings from a pilot project in Florida show that an HMO that has a financial incentive based on outcomes has potential for controlling workers comp medical costs (*BI*, Oct. 18, 1993).

Significant savings in the Florida program were attributable to managed care, said David Appel, a principal with Milliman & Robertson in New York. Price discounting netted savings of about 15% to 20% compared with a control group that received traditional fee-for-service care, while use of lower cost treatments saved 10%. Fewer provider/patient contacts and treatments per patient saved

Continued on next page

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Continued from previous page
15% to 30%, he said.

In Oregon, about 43% of all employers have arranged for employees to receive care for work-related accidents and illnesses through HMOs, said Sara T. Harmon, administrator of the Workers Compensation Division of the Oregon Department of Consumer and Business Services. Regulators are currently evaluating the effectiveness of the managed care plans at delivering care and holding down costs.

• Medical fee schedules.

A recent WCRI study found that workers comp medical fee schedules now in use are "irrational" because they vary widely and bear no relationship to the Medicare fee schedule, said Stacey M. Eccleston, a WCRI analyst.

Lowering fees to Medicare levels could reduce medical fees by 40% on average, she said. Actual workers comp medical costs, though, would be reduced only by 22%, after factoring in provider-driven cost increases caused by higher utilization and billing practices designed to recoup lost income.

WCRI has developed a computer model to help states evaluate their fee schedules and suggest changes.

• Controlling payments to providers.

The federal Medicare and Medicaid programs have taught researchers a lot about what happens when controls like fee schedules are placed on physician payments, said Janet B. Mitchell, president of the Center for Health Economics Research in Waltham, Mass.

"Lower fees and physicians will provide more services," she said. "At some point, fees become too low," and physicians will quit providing any services.

States that wish to follow the federal example, can take one of two main approaches to establishing a workers comp fee schedule, Ms. Mitchell said. They can adopt a "Medicare Plus" schedule, which consists of paying a fixed percentage above the Medicare fee schedule. Or, a state can calculate its own fee schedule based on a "resource-based relative value scale," she said. RBRVS reimbursement programs consider a physician's time, training and other factors.

States developing their own fee schedule must consider how to pay non-physician providers and how to treat services for which no relative

WCRI spotlights health reform

CAMBRIDGE, Mass.—The Workers Compensation Research Institute turned the spotlight on health care reform issues and research during a March 1-3 conference.

An economist from the Clinton administration was among several experts who discussed these issues before approximately 300 attendees.

The WCRI was established in 1983 by insurers and employers, and now has a broader membership. It seeks to improve state workers compensation systems by providing the public with objective research about important issues. It does not take formal positions on issues.

Each year, its team of economists and researchers collect, analyze and publish data on topics that affect workers compensation.

The institute also has developed computer models to help public officials analyze the impact of changing temporary disability benefit structures as well as workers comp fee schedules.

For more information, contact Richard A. Victor, Executive Director, Workers Compensation Research Institute, 101 Main St., Cambridge, Mass. 02142; 617-494-1240.

value unit has been calculated, among other things.

• PPOs.

Workers comp PPO rates in a non-fee schedule states during the first six months of 1993 saved 50% of hospital inpatient costs, 27% of hospital outpatient costs and 20% of non-hospital costs, compared with non-network care, said Erik J. Taylor, manager of analytic consulting at Healthcare COMPARE Corp. in Sacramento, Calif.

Workers comp PPO savings in states with fee schedules were lower; 31% of hospital inpatient costs, 16% of hospital outpatient costs and 14% of non-hospital costs, he added.

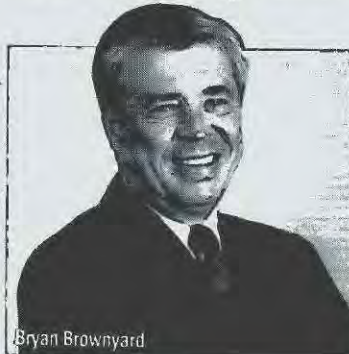
A nationwide workers comp PPO established by Liberty Mutual Insurance Cos. saved an average of \$2,283 in medical costs for an average lost time claim during the first six months of 1993, said James A. Hatherley, a vp at Liberty Mutual Insurance Cos. in Boston. **BI**

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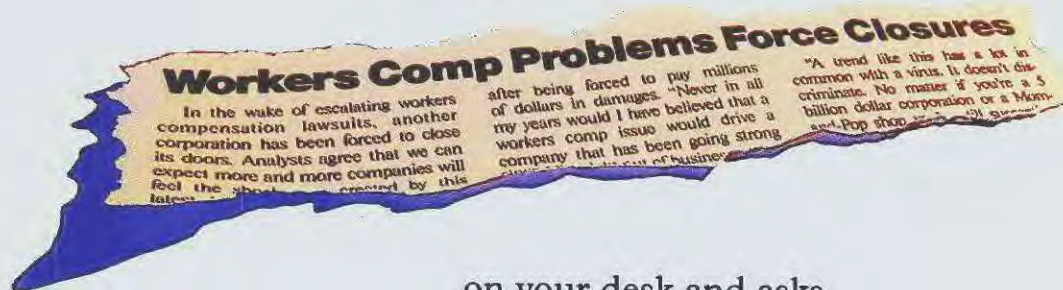
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Continued from page 3
plans. And just 6% of companies, or a total of five companies in the survey group, reported their largest number of post-65 retirees were in gatekeeper plans.

Part of that difference may be attributed to a time lag as employers implement managed care with one group at a time, Ms. Shepherd said.

Respondents were also asked about the barriers to offering managed care to retiree groups.

The barrier for Medicare-eligible retirees identified most frequently was geographic dispersal, which was cited by 56% of the companies.

Many retirees move after they quit working, noted Ms. Shepherd, so it is hard to set up programs that will work for them.

Three other barriers cited by almost one-third of the companies were: managed care is too complicated to communicate; a wait-and-see attitude in light of pending health care reform legislation, and a "feeling that the current plan design for the post-65 group already does an adequate job in addressing company cost and liability issues," the survey found.

The survey also examined specialty managed care services. "We found a growing number of employers that were definitely looking" at specialty prescription drug coverage, which could involve the use of mail-order programs as well as generic drugs, said Ms. Shepherd.

A total of 74% of employers offer these programs to active employees, while 63% offer them to their pre-65 retirees and 61% offer them to their post-65 retirees.

One of the surprises the survey uncovered is that fewer companies than expected are aware of HMO programs aimed at retirees, noted Sally Coberly, director of the Washington Business Group on Health's Institute on Aging, Work and Health, who also worked on the survey.

According to the survey, 49% of companies said they were unfamiliar with Medicare Risk HMO contract arrangements. These programs are offered to Medicare-eligible retirees in lieu of retiree coverage under the regular Medicare system.

It could be that those companies that were not familiar with these programs do not have them in their areas, Ms. Coberly suggested. Some parts of the country have not been penetrated by the Medicare Risk HMOs. Some HMOs have "decided not to participate because they do not find it financially viable given the reimbursement mechanisms."

Similarly, only 28% of participating companies said they were familiar with the Medicare Select alternative to regular Medicare coverage, which is a PPO arrangement offered through Medigap insurers.

The survey did find, however, that respondents with more than 10,000 employees were more aware of both of these types of programs, with 66% saying they were familiar with Medicare Risk contracts and 37% saying they were familiar with the Medicare Select program.

Those that do offer managed care programs to their retirees "reported cost savings and people appeared to be satisfied with it," said Ms. Shepherd. According to the survey, 97% of the companies reported that both pre- and post-65 retirees participating in managed care programs were "satisfied" or "extremely satisfied" with their health care programs.

Furthermore, 93% of the companies reported at least some cost savings for the use of managed care strategies for pre-65 retirees, while 71% reported at least some cost savings for post-65 retirees.

The future looks promising in terms of more companies offering gatekeeper programs to retirees. A total of 38% of companies said they expect to offer a POS plan to most or all pre-65 retirees and 52% expect to offer this group traditional HMO coverage.

As for the post-65 group, 28% expect to offer a POS plan to most or all of these retirees, while 38% expect to offer traditional HMO coverage.

"We think more companies will be looking at it," Ms. Shepherd said. "The main point is, there are just more issues to deal with" when working with a retiree population.

"You don't have the same kind of communication link with retirees

and particularly you don't have the geographical concentration all the time." But Ms. Shepherd also pointed out that those who have tried it are cutting costs while also satisfying retirees. It may be just a matter of time before they are more widely used.

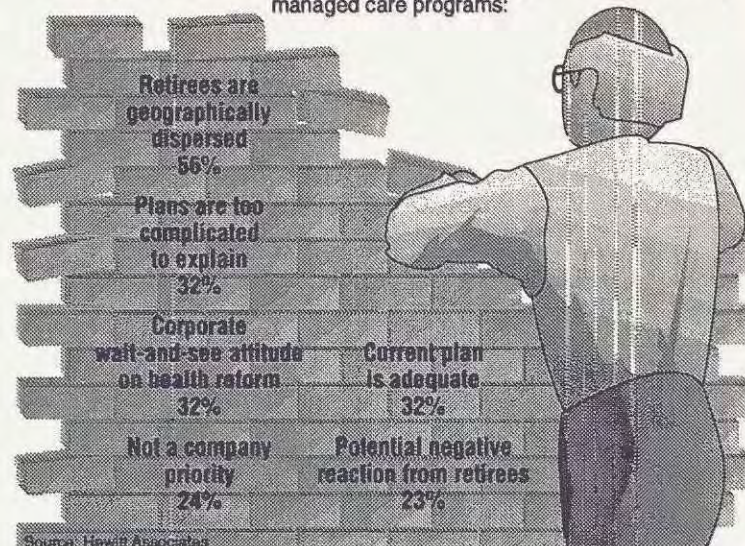
Much of the future also "will depend on what happens with health care system reform," Ms. Coberly said.

A second part of the survey asked employers their reaction to retiree provisions in President Clinton's health care reform proposal. Among other findings, 65% indicated moderate to strong support for provisions for pre-65 retirees.

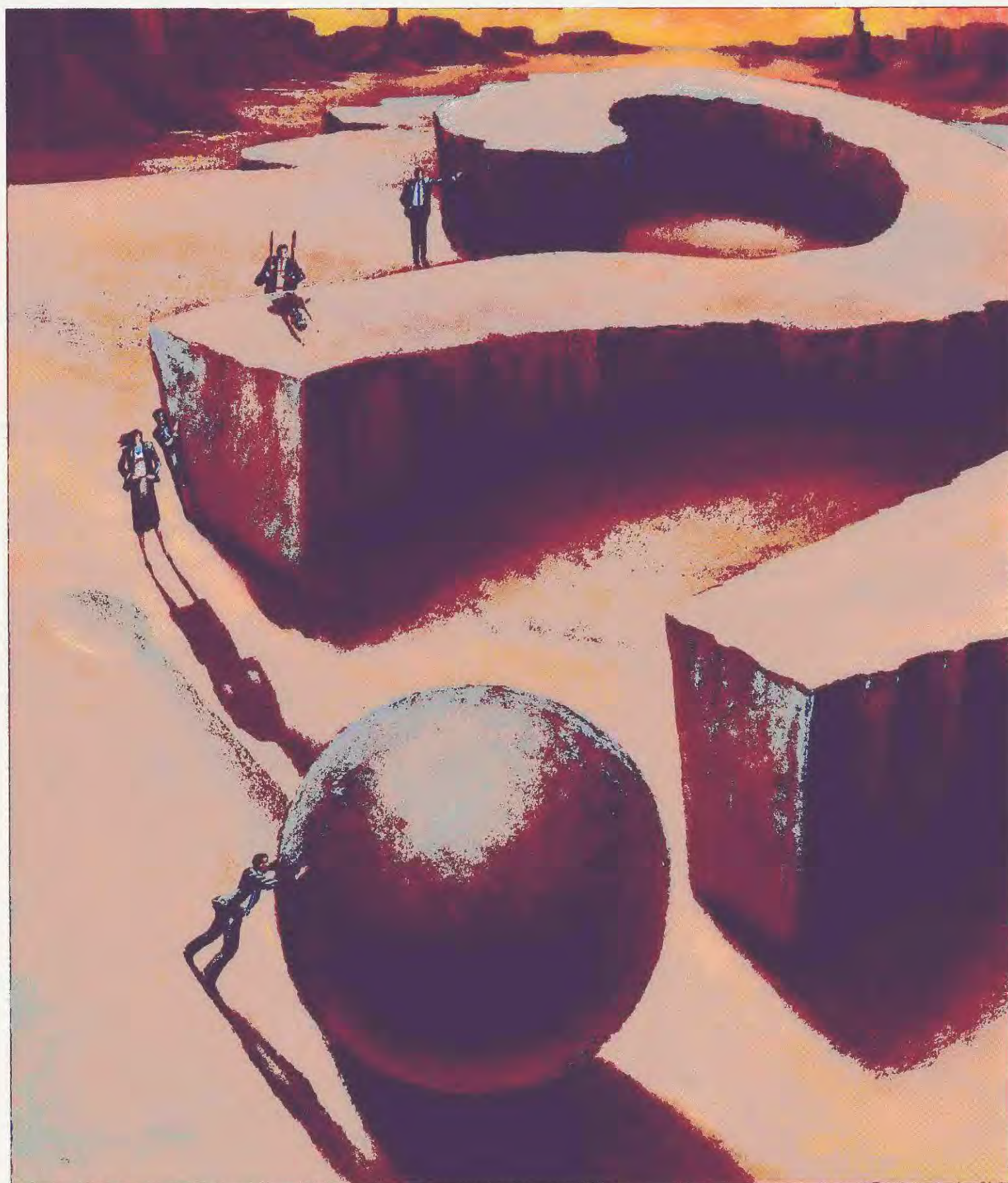
The Survey of Retiree Managed Care is available for \$50 from Diane Schuett, Hewitt Associates, 100 Half Day Road, Lincolnshire, Ill. 60069; 708-295-5000.

Barriers to managed care

Among the difficulties cited by employers in getting post-65 retirees into managed care programs:



GRAPHIC BY MIKE GARVEY



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Credit

Continued from page 1

tion duties of deciding whether a risk should be retained, shared or insured, Mr. Cushinski said.

Once the exposure to these types of losses is evaluated, many corporations that would not normally bother with credit insurance are considering buying excess-of-loss credit insurance, said Jack Willyard, director of specialty brokerage at Sedgwick Global in New York.

"Over the past few years one of the main products that has developed is excess-of-loss coverage for Fortune 1000 companies for their receivables. Before, receivables was about the only asset on the balance sheet that wasn't insured," he said.

Although the terms are generally quite flexible, excess-of-loss

credit coverage would normally have a retention of \$1 million or more, while the limits could range anywhere from \$10 million to \$25 million, Mr. Willyard said.

Originally, the coverage was popular with multinational companies trading with less-developed nations. But in recent years, the weak economy has prompted more U.S. and European companies to buy the policies to cover their domestic exposures.

Much of the coverage is written on a non-disclosure basis, which means that the policy is void if the policyholder reveals that it has the coverage. This is done so that financially strained companies are not tempted to pay-off uninsured creditors before those that carry credit coverage.

Even when insurers do not insist on non-disclosure, policyholders might. Many companies hesitate to reveal they have this coverage,

fearing that the information would make line managers less vigilant in avoiding bad debts, brokers say.

Few insurers offer the excess-of-loss coverage and the costs vary according to the risk and the size of the deductible. A typical rate on line would be 6% to 7%, according to Richard Hall, a broker with JIB Group P.L.C. in London.

"This kind of coverage is still in the developing stage and it doesn't come cheap," said one U.S. risk manager whose company is considering buying it.

Companies buy the coverage for three basic reasons:

- To help prevent catastrophic losses. Companies motivated by this risk usually have already suffered two or three catastrophic credit losses, said Sedgwick's Mr. Willyard. "Somebody in the company says, 'What happened here?'"

so somebody else looks at it and says, 'Why don't we flatten the risk out with insurance?'"

- To provide a way to efficiently account for bad debts. Having excess-of-loss coverage permits companies to ratchet down their reserves for doubtful accounts to the amount of the self-insured retention. This has provided several major companies with significant earnings benefits, Mr. Willyard said.

- To lend stability in a fast-changing industry. Some corporations involved in businesses that have changed radically and unexpectedly, like the computer industry, for example, are seeking this type of protection. Rapid changes might increase the risk of bankruptcy among a small customer base or may lead to a large number of buyers that are start-up companies that have no credit history, he said.

Excess-of-loss coverage is a significant departure from traditional credit insurance, which typically requires the credit insurer to closely monitor a policyholder's debtors. With excess-of-loss coverage, much of that job is left to the policyholder, with insurers taking only the risks of extraordinary exposures that cannot be foreseen.

"You don't have the almost daily exchanges of information between an underwriter and an insured on the creditworthiness of debtors," explained Paul Davidson, executive director of political risks at Willis Corroon Group P.L.C. in London. "The excess coverage is plainly the domain of medium-sized to large firms that have sophisticated in-house credit analysis."

The insurer is in effect underwriting the credit analysis of the corporation, he said.

American International Group Inc. is the largest provider of excess-of-loss credit insurance in the United States, brokers say. AIG has offered the coverage to multinationals with trading risks outside the United States since 1982, and for domestic risks since 1989.

Five years ago, brokerage sources say, AIG's premium volume for this line of coverage was less than \$5 million. Now its annual premium volume is \$50 million and brokers expect that to grow substantially this year.

John Salinger, president of the trade and political risk division at American International Underwriters, a unit of AIG, would not provide premium volume figures, but did say that hundreds of U.S. companies now buy the coverage.

Typical buyers are companies that sell products on short-credit terms, such as pulp and paper companies, consumer electronics firms and food producers, Mr. Salinger said.

AIG provides three levels of coverage. For companies selling products or services within the United States, the policy covers insolvency of a policyholder's buyer. Companies selling domestically and to customers in developed foreign countries are covered for protracted deferral or non-payment as well. And companies trading with developing foreign countries have additional coverage for non-payment for political reasons, Mr. Salinger said.

The coverage is provided above a large self-insured retention or above coverage written through a captive insurer, he said.

"We have some deductibles in the tens of millions of dollars range," Mr. Salinger said.

American Credit Indemnity—which signed up about a dozen clients during a recent trial of the coverage in Texas—will begin offering excess-of-loss credit coverage nationwide this year.

Its product is aimed at "upper middle-market companies"—those with \$50 million to \$100 million in annual sales, Mr. Cushinski said.

Self-insured retentions are usually in excess of \$1 million. ACI insists on individual risk approval if a policyholder has customers that individually account for more than \$1 million in sales.

Increasingly, corporations that would not buy traditional credit insurance coverage are taking out excess-of-loss credit coverage, Mr. Cushinski said.

"Credit management is becoming more sophisticated and CFOs are beginning to see the coverage as an adjunct rather than a substi-

Continued on next page



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Continued from previous page
 tute to credit control," he said.
 Trade Indemnity P.L.C. is one of the main providers of the coverage in Britain, brokers say.
 Most of its customers have annual sales volume of more than 20 million pounds (\$29.9 million).
 Unlike U.S. insurers writing the coverage, rather than rely on a policyholder's credit controls, Trade Indemnity insists on rigorous credit analysis of all of a policyholder's major buyers. This also often includes discussions with the buyers' bankers, a Trade Indemnity spokeswoman said. "In a sense, the credit insurance is a way of providing early warnings of trouble in a company," she said.
 Few U.S. risk managers will discuss whether or not their companies carry credit insurance because of

We have always felt we can manage credit risks without insurance, says Steven H. Lawrence.

the non-disclosure provision.
 One who asked not to be identified said recent insolvencies in his industry had prompted his company to seriously consider the coverage.
 "There is quite an exposure out there when you look at what might happen if one of our dealer channels collapsed and, while we are not looking for first-dollar coverage, we are considering taking out some catastrophe coverage," he said. "We are not looking to abdicate credit control but we do want coverage

against a catastrophe."
 Other risk managers remain unconvinced of the need for the coverage.
 "Like a lot of large companies we have considered it but we have always decided that it is a risk we can manage," said Steven H. Lawrence, director of risk management and insurance at PepsiCo Inc. in Purchase, N.Y.
 PepsiCo manages its credit risk by only supplying a fixed amount of goods to a retailer on credit, he said. "We think it is a perfect candidate for risk control."
 Large companies with in-house credit control departments should be able to control all of their credit risks, agreed Michael J. Dempsey, director of risk management at General Mills Inc. in Minneapolis.
 "We've looked at it but we concluded that the risk was not great because we are happy with our credit control," he said. **BI**

Vermont may be closing in on NAIC accreditation

By JERRY GEISEL

WASHINGTON—Vermont and the National Assn. of Insurance Commissioners are narrowing their differences over standards the state must meet to win NAIC accreditation, Vermont's top insurance regulator says.
 Still, it is too soon to predict if the NAIC will accredit Vermont, says Elizabeth Costle, commissioner of the Vermont Department of Banking, Insurance and Securities. "I think the NAIC is becoming more pragmatic and less rigid," she said last week at the annual National Risk Retention Assn. meeting in Washington.
 "We seem to be narrowing on a

lot of the issues. But I can't promise the outcome will be good," Ms. Costle told the trade group, which represents risk retention and purchasing groups as well as service providers.
 Differences between Vermont and the NAIC center on accounting standards that captives are allowed to follow, captives' use of letters of credit for capitalization and certain asset valuation procedures.
 During several months of what she called "shuttle diplomacy," Ms. Costle has been trying to convince NAIC officials that Vermont's regulatory system is effective—even though it doesn't follow all NAIC standards.
 "Maybe I'm starting to get through. The NAIC is starting to realize that it should look at the substance of regulation, not just the form," she said. "If we were to have a 'one size fits all' regulation, you would basically freeze innovation and competition."
 Ms. Costle encouraged the captive and risk retention group industry to make the public and regulators more aware of the benefits of the alternative risk financing market.
 "Captives need to educate more people on what you do, why you do it, why captives are an effective insurance mechanism" and on the public benefits some captives generate, she said.
 For example, some entities like public housing authorities received effective loss prevention programs for the first time after they joined risk retention groups. The result has been safer homes for residents of public housing, she said.
 Turning to another area, Ms. Costle said Vermont regulators this summer will examine whether to propose raising the minimum capitalization and surplus standards for captives. Those levels—which include \$250,000 for single-parent captives—were set by a 1981 captive law.
 While it is unlikely that the state would license a captive meeting only the minimum requirement, it may be time to formally raise the minimum, Ms. Costle said, noting the 13 years of inflation since the captive law was enacted.
 In addition, Vermont may formalize other standards and procedures, she said, a consequence of the tremendous growth of the state's captive industry.
 Vermont is far and away the largest domestic domicile, with about 250 captives. **BI**



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Employers paying VA too much

By David Stern

A LITTLE-KNOWN PROVISION IN THE Consolidated Omnibus Budget Reconciliation Act may be costing employers them many thousands of dollars.

Pursuant to COBRA, the Veterans Administration was given the right to bill certain health plans for care or services provided to veterans for disabilities not stemming from military service. The provision—U.S. Code Service, Title 38, Section 1729—provides the specifics of the VA's right to subrogate against health plans.

Prior to this law, many health plans excluded coverage for treatment provided by governmental facilities. It is clear that the intent of this law was to ensure that the VA was treated the same as non-government providers. Further, to avoid the inefficient transfer of funds between federal agencies, the VA is precluded from billing Medicare.

The problem arises when a retired individual who is age 65 or older is treated at a VA facility. In most cases, that retiree will also be covered by Medicare and, in accordance with Medicare Secondary Payer rules, Medicare should be the primary payer.

But Medicare won't pay because the VA cannot bill Medicare!

As a result, claims administrators for employer-sponsored group health plans typically have the employer plan drop down to act as primary payer.

Another approach should be considered, however.

Reduce payment to the amount that Medicare would pay

The law states that "the United States has the right to recover or collect the reasonable cost of such care or services (as determined by the Secretary) from a third party to the extent that the veteran (or the provider of the care or services) would be eligible to receive payment for such care or services from such third party if the care or services had not been furnished by a department or agency of the United States."

The law further states that:

"...the reasonable cost of care or services sought to be recovered or collected from a third party liable under a health plan contract may not exceed the amount that such third party demonstrates to the satisfaction of the Secretary it would pay for the care or services if provided by facilities (other than facilities of departments or agencies of the United States) in the same geographic area."

Many health plans require that retired plan members enroll in Medicare and, in some form or fashion, carve out those benefits available from Medicare. Many employers even pay the retiree's Medicare premiums when Medicare is primary payer.

So why should a health plan pay the full cost of the VA claim? To pay the full amount is to pay too much. If the member was treated at a non-government facility for which Medicare would have paid, the health plan's expense would be lower than if a VA facility provides treatment.

It appears that the health plan that is being billed may reduce the charges by the amount that Medicare would have paid had the care or services been provided by a non-government facility.

Supporting this argument is a March 22, 1993 ruling by the 4th U.S. Circuit Court of Appeals. In *United States vs. Blue Cross & Blue Shield of Maryland Inc.*, the court wrote: "The VA has replaced Medicare as the primary payer for services rendered to veterans, and BC/BS must make a determination regarding coverage for those expenses Medicare would not have reimbursed."

Employers should closely examine this provision in COBRA and review their own master plan document. Then a decision can be made as to whether a VA subrogation claim is paid in full or reduced by that amount that Medicare would have paid had the care or service been provided by a non-government facility.

BI



David Stern is risk manager for the Putnam/Northern Westchester Health Benefits Consortium in Yorktown Heights, N.Y.

Stress from workplace gossip not compensable

Stress caused by workplace rumors and innuendoes made by co-workers is not an occupational disease for purposes of workers compensation, according to the Washington Court of Appeals.

In 1979, Vickie Gast was employed by the Housing Authority of Grant County, Wash., as a receptionist and secretary. After a maternity leave in 1980, she returned as a maintenance dispatcher, supply clerk and general clerk.

Some personality conflicts developed between some staff in the office, but she continued in her position until the latter part of 1981. She was rehired in September 1982 as a member of the office staff. Personality conflicts continued. In June 1983, Ms. Gast was hired to work for the city of Moses Lake. She returned to work at the Housing Authority for one day a week commencing January 1984, and resumed full-time work there in April 1984.

Rumors developed concerning alleged relationships Ms. Gast was having with male co-workers. In 1987, she requested a change in her job classification from laborer to maintenance mechanic. Her request was denied.

Ms. Gast filed a claim for workers compensation alleging an occupational disease caused by stress arising out of her employment. Her claim was rejected. The Board of Industrial Insurance Appeals also denied benefits. She sued and lost in the trial court.

On appeal, Ms. Gast argued that rumors, innuendoes and inappropriate comments by co-workers are distinctive conditions of employment because they arise naturally and proximately out of employment. But the state argued that such factors only coincidentally exist in the workplace, because they occur in everyday life and are not distinctive conditions of employment.

Legal Briefs

The appellate court agreed with the state. "Such conditions are unfortunate conditions in everyday life or all employment in general," the court said. According to the court, their occurrence at a specific workplace was coincidental and not a natural consequence or incident of distinctive employment conditions. The lower court decision was affirmed.

Gast vs. Department of Labor and Industry, Washington Court of Appeals, June 8, 1993 (BI/01/M.-\$10).

Mental injuries compensable

Connecticut has joined the majority position among other jurisdictions in supporting workers compensation benefits for mental injuries, according to a recent decision by the Supreme Court of Connecticut.

Roderick Crochiere was a tenured music teacher at an elementary school. In June 1987, the parents of a female student at the school registered a complaint with the board of education alleging several instances of inappropriate touching of their daughter by Mr. Crochiere.

Reports of the accusations appeared on several local television and radio stations and also in many newspapers. He was suspended from his employment in June 1987 and never returned to work. In October 1987, Mr. Crochiere was terminated after a hearing. He then submitted a claim for workers comp benefits on the basis of the mental stress that he had experienced beginning in June 1987. He claimed the work-related stress resulted from false accusations that had been made against him and

caused him to suffer a nervous breakdown. The commission ruled in his favor. The board appealed.

On appeal, the board argued, in part, that mental injuries unaccompanied by a physical component are not compensable. The appellate court emphasized that "injury," as stated throughout the compensation act, was not defined exclusively as physical injury. The court also said that there is a growing majority position among other jurisdictions supporting compensability in such cases.

Accordingly, the court held that mental disorders, even if not accompanied by physical trauma to the body, constitute an injury under the Worker Compensation Act. The award of benefits was affirmed.

Crochiere vs. Board of Education, Supreme Court of Connecticut, Aug. 24, 1993 (BI/05/A.-\$10).

ERISA limited to reductions

The 5th U.S. Circuit Court of Appeals held that an employee cannot bring an Employee Retirement Income Security Act claim for benefits where the employee's termination did not result from a workforce reduction or a job elimination plan.

William R. Perdue was employed as a restaurant manager for Burger King Corp. In 1987, he was promoted to franchise area manager for the Houston office. A BKC reorganization in 1989 eliminated that position. Mr. Perdue was offered the position of franchise operations manager or cash severance benefits under a job elimination program. Mr. Perdue accepted the new position, which he performed until July 31, 1989, when he was terminated by BKC because it felt he was no longer

trustworthy. Upon termination, Mr. Perdue demanded payment of severance benefits under the job elimination program.

BKC determined that he was ineligible under the program because his termination did not result from either a reduction in workforce or a job elimination plan. Mr. Perdue sued BKC in state court, claiming an ERISA benefit due him under the program. The case was removed to federal court on the grounds that ERISA pre-empted the state law claims. The federal court ruled against Mr. Perdue.

The federal appellate court pointed out that ERISA provides a private right of action for persons alleging entitlement to benefits, or seeking to enforce or clarify rights, pursuant to the terms of an ERISA plan. The court emphasized that the plain language of the BKC program limited eligibility to employees involuntarily terminated in connection with either a workforce reduction or job elimination plan. Because Mr. Perdue did not allege that his termination as franchise operations manager occurred under either of those two circumstances, the court said, he failed to allege entitlement to benefits within the eligibility provision of the program. The trial court decision was affirmed.

Perdue vs. Burger King Corp., 5th U.S. Circuit Court of Appeals, Dec. 1, 1993 (BI/02/A.-\$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.

Hawaii

Continued from page 1
off staff.

Travelers Corp. recently closed its Honolulu marketing office and laid off about 15 people. Hawaiian business now will be handled by the insurer's Walnut Creek, Calif., office.

This is in line with Travelers' nationwide strategy of reducing its concentration of business in areas with a high windstorm risk, a spokesman said.

Travelers is "continuing to renew their book, but everybody is uncertain what they will do" now, said Mr. Ables.

Pacific Insurance Co. Ltd., a unit of ITT Hartford Group Inc., also laid off staff and its parent had considered selling the insurer. Former Hawaiian Insurance Commissioner Linda Takayama met with ITT Hartford officials in an attempt to allay their concerns about the Hawaiian market.

Ms. Takayama made a "pilgrimage" to Hartford, Conn., to persuade ITT Hartford Group not to sell Pacific Insurance Co., said Harvey King, president of Honolulu-based broker King & Neel Inc.

An ITT Hartford spokeswoman said, "We toyed with the idea (of selling Pacific) but never pursued it." Pacific has reduced premium volume in Hawaii "to manage our market share and balance our risk," she said.

The state's largest insurer of commercial property—First Insurance Co. of Hawaii Ltd., which is majority owned by New York-based Continental Corp.—generally stopped writing new and re-

tered at renewals last October when its property premiums tripled, said Ms. Boyle.

Brewer's windstorm deductibles also increased from \$100,000 to a minimum of \$1 million and a maximum of 5% of insured value.

"We had an increase when the hard market struck in 1985, but this is the most radical increase in property premiums" the company has ever experienced, Ms. Boyle said.

About 12 insurers currently participate in Brewer's property insurance program. "We had to break the layers down more than usual," she said. For example, "the first layer is \$5 million, rather than \$10 million or \$20 million (because) insurers are willing to take less exposure now."

While no other company polled by the Hawaii RIMS chapter has seen property premiums rise as steeply as Brewer, most big policyholders in the state have been hit by higher property insurance rates, Ms. Boyle said.

"Some of the major players had stability, but most had double-digit increases, anywhere from 10% to 50%," she said.

Fortunately "because the liability markets are still somewhat stable, if not soft, we experienced up to 50% savings in other areas" by restructuring liability coverage, she said.

At renewals last summer with Arkwright Mutual Insurance Co., Honolulu-based Outrigger Hotels Inc., Hawaii's largest hotel chain, faced a 50% increase in its property premiums "and a huge increase in the risk retention for ourselves," said Clyde Mark, director of risk management and in-

level. You can't have everything. I figure, what is the lesser of two evils? Kemper did step in to bat when we asked them to," Mr. Mark said. The policy also includes a separate deductible for hurricane damage, "which is not something we had before Iniki."

According to Mr. Mark, Arkwright's sister company in the Factory Mutual System, Allendale Mutual Insurance Co., suffered tremendous losses from damage to a hotel it insured on Kauai. This may account for the spiking of Outrigger's property premium, he said.

ues, which exceed \$1 billion, "no single carrier would be able to provide the capacity that (Factory Mutual) has given us up to this point in time."

Another Factory Mutual policyholder, Hawaiian Tug & Barge Corp., reports that "as a general rule" it is not having a problem with property coverage.

The company, which is a unit of Hawaiian Electric Industries, is covered by its parent's highly protected risk policies, which are not affected by the local market conditions, said Bruce McEwan, the unit's risk manager.

Small manufacturer Roscha Woodwork transferred its coverage to Island Insurance Co. after the insolvency of Hawaiian Insurance Group. Its property premium "went up, but not that drastically," said Margit Schafnitzel, vp.

"Maybe it's our construction—it's pretty sturdy concrete, and a hurricane wouldn't blow it away," she said. Location might also be a factor, Ms. Schafnitzel speculated. Roscha Woodwork, which manufactures store fixtures and cabinets, is located in the center of Oahu rather than along the coast.

Alexander & Baldwin Inc., a property management and development company, was able to negotiate limited windstorm coverage from Fireman's Fund Insurance Co. on property coverage for a non-profit museum A&B owns on Maui.

"At renewal, they were willing to renew but with absolutely no wind damage," said Debra Butler, supervisor of risk management with A&B in San Francisco. "For a variety of reasons, we could negotiate some windstorm coverage, but only because we do so much business" with Fireman's Fund, she said.

A&B was also affected by the crunch in homeowners insurance. After the company built 58 homes on Kauai, "we were about to transfer title on the first two on the day Iniki hit," Ms. Butler explained.

By the time the homes were re-

paired and ready for sale, the homeowners insurance market had dried up and buyers could no longer find coverage to close on their mortgages.

"It took homeowners quite a while to arrange" coverage, she said. "It was very frustrating for those people."

Hilton Hotels Corp. escaped the worst winds of Hurricane Iniki—and will likely emerge from post-Iniki renewals equally unscathed, said David Little, director of risk management for the Beverly Hills, Calif.-based hotel chain.

Hilton Hawaiian Village in Honolulu suffered between \$2 million and \$3 million in damage, including damage from water, sand and high winds that blew off roof shingles and uprooted shrubbery.

But because the property is included in a five-year blanket property policy, the hurricane's impact should be minimal, he said.

"Through the grapevine I hear that property on a standalone basis there is very difficult," Mr. Little said. "Underwriters are looking for a spread of risk."

Industry sources are hopeful that the state's new Hurricane Relief Fund, signed into law last August, will alleviate the property insurance problem by encouraging more insurers to write property coverage.

The program will give property insurers discretion to begin writing after March 15. Property insurers will write commercial and homeowners coverages with an exclusion for hurricane damage. Policyholders will be able to buy hurricane coverage from the fund through their property insurers.

The fund will limit insurers' liability for hurricane loss to the first \$500 million of the total loss, by percentage of market share.

Losses above that amount will be paid by the fund, which is expected to generate \$50 million to \$70 million in annual premium in about a year, said Craig Watanabe, vp with Johnson & Higgins in Honolulu.

The fund also will be supported by a 0.1% surcharge on all real estate and mortgage recordings in the state registration division. The Legislature also may approve a bond issue to support the fund. As of December 1993, the fund had \$6 million in it, according to Mr. Watanabe.

"I think it will help" expand the property insurance market, as well as "have ripple effects on our economy" by encouraging construction and borrowing, Mr. Watanabe said.

■

'After Iniki, the property market totally deteriorated. It took probably a six- to eight-month period for the full impact to be felt,' says Larry Busto, managing vp of broker Alexander of Hawaii, a unit of Alexander & Alexander Services Inc.

newal property coverage for a year to reduce its exposure to catastrophe losses in Hawaii.

The Hawaiian insurer announced March 3 that it is writing commercial property coverage again, but with a wind peril exclusion. The insurer will also resume writing homeowners coverage, but with a hurricane peril exclusion.

First Insurance believes the time is right to resume writing because policyholders now realize that premium increases are inevitable, said Linda Chinn, assistant vp.

"After Iniki, the property market totally deteriorated. It took probably a six- to eight-month period for the full impact to be felt," said Larry Busto, managing vp of broker Alexander of Hawaii, a unit of Alexander & Alexander Services Inc.

"Historically, only a handful of companies write 80% to 90% of the business." The thinking of those insurers is "why should we expose a billion of our surplus—virtually all of our surplus—where the returns have not been that great?" he said.

One of the companies hardest hit by the tightening market in Hawaii is C. Brewer & Co., an agriculture and food products conglomerate known for its Mauna Loa macadamia nuts.

Brewer, which sustained a \$20 million hurricane loss mostly due to damage at a sugar cane plantation on Kauai, was further bat-

terance.

Mr. Mark argued that Arkwright had made money on the Outrigger account over the past six years. "So I said, 'If you're going to increase premiums and risk retention across the board, your good accounts will walk.'"

Outrigger found a better deal with Kemper National Insurance Cos. "Kemper came back and offered us a little higher risk retention but the (previous) premium

HONOLULU—Property insurance woes may soon be the least of risk managers' problems in Hawaii.

"The problem on the horizon that we think is going to dwarf the property issue is workers compensation," said Linda Chinn, assistant vp at First Insurance Co. of Hawaii Ltd.

Workers comp insurers in Hawaii had a combined ratio of 136.1% for this line in 1992, which was the fifth-largest workers comp combined ratio nationwide, according to A.M. Best Co. "In the past two years, the cost of claims has been escalating at an alarming rate," said Linda Takayama, former insurance commissioner of Hawaii.

Regulators approved a 20.4% rate increase for workers comp insurance in 1994, though insurers had sought a 30.8% increase.

Following years of what it calls

inadequate rates, First Insurance stopped writing workers comp coverage entirely last December, sending most of its policyholders into the state's assigned risk pool, which now covers about 40% of Hawaii employers.

"It's a tremendous problem," said Bradley Oliver, senior vp at Marsh & McLennan Inc. in Honolulu. "The message from some of these larger companies is that Hawaii is not an attractive place to do business."

"Insurance companies don't have to make profits in every line as long as they perceive an environment where making a profit is possible; what they see now is hard times in too many lines," he said.

Although a workers comp reform bill, H.B. 3644, has been introduced this session, reform "is a two- or three-year, intense project," said Clyde Mark, director of

risk management and insurance for Outrigger Hotel Corp. in Honolulu.

Areas targeted for immediate reform will yield "immediate cost savings that can be translated directly into avoiding premium increases," said John McGuire, vp-governmental affairs at the Chamber of Commerce, which pushed for the reform measure.

For example, the bill would amend the law so that wage replacement benefits for part-time workers would be based on actual hours worked rather than on a 35-hour workweek, as the law currently allows.

Reform efforts will also target Hawaii's workers comp provider medical fee schedule, which is among the highest in the nation, Mr. McGuire said.

"We've already gotten infinitely further than we thought we ever would" with the reform bill, he

said. In the past seven years, reforms initiated by the Chamber "got absolutely no attention whatsoever."

The workers comp crisis also affects self-insured C. Brewer & Co. Ltd., "because the same cost drivers that require insurer premium increases are driving our costs as well," said Judith Boyle, risk manager for the Honolulu-based agricultural conglomerate.

The company has joined with other major employers in the Coalition to Reform Obsolete Workers' Compensation Design. CROWD's "purpose is to work with the Legislature, labor and the medical community to achieve fairness in the system," she said.

Coalition members, which represent about 60,000 jobs and combined have more than \$6 billion in revenues, support the reform bill now in the House.

—By Louise Kertesz

Who stood in Iniki's way

Largest property insurers in Hawaii

	1992 premium volume (\$mil.)
State Farm	\$10.4
Transamerica	10.5
Tradewind Insurance Co.	10.0
First Insurance	9.9
First Fire & Casualty	8.6
Allstate	8.0
United National	7.9
Pacific Insurance Co.	7.8
Hawaiian Insurance & Guaranty	7.4
Fireman's Fund	5.6

* In millions of dollars
Source: Hawaii Insurance Division

GRAPHIC BY KIM ROME

German tax may boost property premiums

By CAROLYN ALDRED

BONN, Germany—German industrial property insurance premiums likely will increase after the government raises a fire brigade premium tax to 8% from 5% on July 1.

The tax, which is based on insurers' net industrial property and homeowners insurance premiums, will generate increased revenue of about 125 million deutsche marks (\$73.2 million).

The tax funds local fire protection services.

The fire brigade tax is included in the German insurers' tariff calculations, which insurers use as rate guidelines. As a result, new tariffs will be introduced July 1, according to German broker C. Wuppesahl & Co. Assekuranzmakler, an affiliate of Willis Corroon Group P.L.C.

Insurers concerns about this tax increase are exacerbated by the fact that the fire brigade tax is in addition to the standard 10% tax on property insurance.

In a recent update on the German industrial property insurance market, Bremen-based Wuppesahl said the market already has hardened substantially.

"The stringent measures of German industrial property insurers, under pressure from their reinsurers to improve technical results, are now taking effect," the broker said.

German insurers are now looking to keep premiums close to tariff levels, and tariff levels are likely to rise later this year. Before 1991, German insurers had been offering up to 60% discounts off the published tariffs.

Dietmar Nowak, board member of Cologne-based Gerling Konzern Allgemeine Versicherungs A.G., explained that large industrial policyholders, which pay 100% of the tariff rate, represent about one-third of the industrial property insurance premiums. The remaining two-thirds of industrial property insurance premiums comes from smaller companies, which pay varying percentages of the tariff.

Because "there's more competition" for smaller risks, some policyholders pay as little as 70% of the tariff, while others pay 100%. The higher rates are "necessary for insurers to get out of disastrous results," he said.

Mr. Nowak said the era of deep discounts is long gone and he expects the property insurance market will continue to harden.

In response, commercial and industrial policyholders are increasing retentions, which insurers are welcoming, he said.

Some German companies also have formed captive insurers, though that may not signal an increased captive movement, Mr. Nowak said.

David Lewin, marketing and production manager in Wuppesahl's international department in Düsseldorf, said there is a growing interest in captives among German companies. For example, more than 100 companies sent representatives to a

Continued on next page

Removing obstacles to litigation

By ADRIAN LADBURY

LONDON—Justice will be swift for the parties involved in the massive litigation between Lloyd's of London members and their agents.

Efforts by members agents' attorneys last week to delay the litigation were rebuffed by the courts, which appear committed to expediting these cases.

Lord Justice Cresswell, the High Court judge in charge of Lloyd's litigation, rejected two separate attempts to postpone the April 26 trial of negligence charges brought by Gooda Walker Action Group members against Gooda Walker Ltd. and 71 members agents.

In addition, a few days before Justice Cresswell's move, the House

of Lords set a March 15 date—much sooner than anticipated—for hearing members agents' appeal of a lower court ruling that they could be held liable for the negligence of managing agents (BI, March 7).

Amid the litigation, rapid consolidation within the members agency community continues, with two more major acquisitions and a merger.

The number of members agents has been declining steadily due to consolidation over the last decade. This trend was hastened by the arrival of corporate capital, which generated demand for a new type of adviser.

The litigation against members

agents also may be driving the changes.

The representatives of Gooda Walker Ltd. and the members agents were told last week that they have no grounds to postpone the April 26 trial date. The agents are being sued by 3,000 Gooda Walker Action Group members seeking 553 million pounds (\$824 million).

Tim Ackeroyd, a partner with Elbourne Mitchell, which represents Gooda Walker Ltd., said the agents had moved for a delay because Derek Walker, a key defense witness and ex-chairman of Gooda Walker Ltd., refused to testify in the civil proceeding because he feared it could prejudice a criminal investiga-

tion into the demise of his former company (BI, Feb. 7).

But Mr. Walker now has been subpoenaed by Gooda Walker Ltd. and will appear at the trial. Nevertheless, he still may not cooperate with either the defendants or the plaintiffs.

The agents had hoped that the case could be combined with the second-largest Lloyd's case, brought by the Feltrim Names Assn. against Feltrim Underwriting Agencies Ltd. and many of the same members agents, Mr. Ackeroyd. Trial in that case is not expected to begin until October.

But Justice Cresswell rejected the

Continued on page 19

German reforms revive profits

Lower sickness fund premiums sought

By DON LEWIS KIRK

BONN—The German Health Care Minister is calling on the nation's sickness funds to reduce employer and employee contributions because of the funds' record profits in 1993.

Sickness funds are non-profit, self-administered health insurance funds supported primarily by employer and employee contributions. About 90% of German citizens are covered by these funds, most of which are sponsored by employers. The remaining 10% of German citizens are covered by private health insurance.

The sickness funds reported a 10.2 billion deutsche mark (\$5.87 billion at the appropriate exchange rate) profit in 1993, after a record deficit of 9.4 billion deutsche marks in 1992 (\$5.81 billion).

Despite the funds' improved earnings, the average premium for 1993 was reduced only slightly—to 13.35% of employee income from 13.5% in 1992. Employers pay half the premium and employees pay the other half. The average contribution paid by a family with monthly income of 5,000 deutsche marks (\$2,916) would be 650 deutsche marks (\$379). Half of that would be paid by the employer.

German Health Care Minister Horst Seehofer said the primary factor behind sickness fund profits was

health care reform measures that went into effect Jan. 1, 1993 (BI, March 26, 1993; Dec. 21, 1992). As a result of those measures, outlays by the sickness funds fell 1.3% in 1993, compared with a 9.4% increase in 1992.

Those reforms included developing a list of approved, low-cost drugs that physicians and dentists can prescribe. Drugs deemed too costly are not approved for coverage by the funds and, if they are prescribed, the costs must be borne by health care providers and pharmaceutical companies. The reforms also increased the patient copayment for prescription drugs. Copayments now are 2, 5 or 7 deutsche marks (\$1.16, \$2.91 or \$4.07), up from 2 deutsche marks.

Additionally, the reforms established global budgets for physicians, dentists and hospitals.

Dental care costs dropped 26.6% last year, and prescription drug costs dropped 19.3%. "These are areas which in the past have seen the largest increases," said Mr. Seehofer.

Government Health Ministry official Paul Hoffacker said a reduction in employer and employee contributions must follow. "Sickness funds have profited most from the health reform, now they should pass this on to their members."

The sickness funds are trying to

Continued on next page

Hartford unit leaves Australia

SYDNEY, Australia—Hartford Fire Insurance Co., a property/casualty unit of ITT Hartford Group Inc., is pulling out of the Australian market.

Hartford Fire's Australian portfolio, with annual premium volume of \$13 million Australian (\$9.3 million), will be acquired by Sydney-based QBE Insurance Ltd., said Neil G. Drabsch, QBE's chief financial officer.

QBE is Australia's eighth-largest non-life insurer, and the largest publicly traded insurer.

Peter Rogstad, general manager of Hartford's Australian operation, said the insurer wants to focus on its larger international markets in Asia and Europe.

Some of the 30 employees in Australia will be retained by Hartford,

some will join QBE, and others will be laid off, said Mr. Rogstad, who will return to Connecticut.

Hartford established its Australian operation in January 1986. It has branches in Sydney and Melbourne.

QBE's Mr. Drabsch said the agreement is dated Feb. 28, but is subject to insurance regulators' approval, which is expected by early April.

QBE has a runoff agreement with Hartford, which is indemnifying it against future claims. Mr. Drabsch said the portfolio is mainly short-tail business, including travel, health, engineering and homeowners insurance.

Mr. Drabsch would not reveal the purchase price.

—By Kate McIlwaine



AP/Wide World photo

The Sally Albatross lies stranded in the frozen Gulf of Finland after running aground late Friday, March 4. All passengers and crew were rescued.

Scandinavian cruise ship insured for hull damage

By MARIA KIELMAS

Ice blocking a navigational channel in the Baltic Sea may have contributed to the grounding of the Sally Albatross cruise ship last week.

Insurers say that the ship is not a total loss and will be repaired, but damages cannot be assessed until it is hauled into dry dock.

The Sally Albatross is owned by the Silja Line shipping company, a subsidiary of the Swedish/Finnish-owned Effjohn International.

Hull and machinery coverage for the ship was jointly written by: Pohjola Insurance Co. Ltd., which wrote 38% of the coverage; the Industrial Insurance Co. of Finland, 36%; Finnish shipowners' mutual insurer Redarnas Omsesidiga, 20%; and Sweden's Lansforsakringsbolagens A.B., 6%.

Sure Lindholm, marine insurance manager at Pohjola Insurance in Helsinki, Finland, says the insurers have agreed with the shipowners not to disclose the amount of coverage.

Mr. Lindholm said the Silja Line's business interruption insurance will cover all business interruption losses while the passenger vessel is inactive, though he did not give any figures.

Reinsurance has been placed in the Scandinavian, London and continental European markets.

The Finnish government has ordered a public inquiry into the accident, and the ship's master will give evidence next week in a separate investigation by the Finnish Board of Navigation.

The accident occurred when the ship was returning to Helsinki from a 24-hour cruise to Tallinn in Estonia. The Helsinki-Tallinn crossing normally takes four hours, but the 24-hour cruise was designed so that passengers could purchase duty free goods on board.

Mr. Lindholm said that the accident seems to have occurred when the ship was approaching an east-west navigational channel through the ice to Helsinki. The Baltic Sea is frozen in winter and shipping operations use channels cut by vessels called ice breakers. The normal passage into this channel was blocked by ice, and the ship appeared to have made a diversion from the normal route when it ran aground in shallow water off Helsinki.

The passengers were able to disembark quickly from the damaged ship onto a nearby ice breaker and another cruise ship, the

Continued on next page

INTERNATIONAL

Fire tax

Continued from previous page
German captive conference earlier this month.

Eberhard Knebel, risk and insurance manager for Munich-based automaker BMW A.G., said the higher taxes and the hardening market are prompting commercial policyholders to increase their retentions, and a captive is one way of doing that. BMW has two captives domiciled in Dublin, Ireland, one formed in 1989 and one in 1990. Those captives operate "on high levels of self-retention and on the basis of increasing self-retentions," he said.

He said the captive trend among

German companies is "a slow process, but a visible development."

According to, Bundes Verband Deutsche Versicherungs Makler, a trade association for German brokers, total industrial property premiums increased 13% to 4.1 billion deutsche marks (\$2.36 billion) in 1993 from 3.64 billion deutsche marks in 1992 (\$2.25 billion), compared with a 7.4% increase from 1991 to 1992.

Meanwhile, loss ratios improved to 88.3% in 1992 from 127.9% in 1991 and stand at 52% for the first half of 1993. However, from 1983 to 1992, an average loss ratio of 91.5%, plus 25% average expense ratio, has left the German industrial property insurers with a "severe deficit," Wuppesahl said. **B**

Reforms

Continued from previous page

overcome past deficits, however, and are not inclined to lower contributions, a recent survey found.

Mr. Seehofer said further caps on health care outlays are planned. For example, ambulance costs have increased 13.9%, he said. The government would step in to curb cost increases if other measures fail.

Mr. Seehofer sees further cuts in hospital costs. "Eighty percent of hospitals we polled see further room for cost reduction in organization and management without hurting quality," said Mr. Seehofer.

While reforms appear to be reducing some health care costs, new

costs are looming on another health care front.

Successful negotiations between Social Democrats and government coalition parties have cleared the way for Germany's controversial long-term nursing care bill to be passed and a law to go into effect Jan. 1, 1995 (BI, Sept. 27, 1993; July 26, 1993). The compromise calls for employers and employees to pay contributions for long-term nursing care for the aged or chronically ill. Employers would be compensated by the elimination of one paid holiday for German workers.

The original bill would have compensated employers by eliminating two paid holidays for workers.

The compromise in Bavaria and Saxony calls for employees to carry

the entire contribution rather than forfeiting a holiday.

Initially nursing care coverage was to go into effect in 1994. The later start date is part of the compromise. While contributions would begin Jan. 1, 1995, actual coverage would not start until April 1, 1995, for home nursing care and July 1, 1996, for hospital nursing care.

The law would help 2 million patients who get nursing care at home or in hospitals. Employers and employees each would pay half of a monthly contribution that initially would equal 1% of wages and would rise to 1.7% of wages in 1996, with a wage cap of 5,100 deutsche marks (\$2,935). Annual contributions are expected to total 24 billion deutsche marks (\$13.81 billion). **B**

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Litigation

Continued from page 17

application, stating that a combined trial would produce "a case of unmanageable proportions."

Justice Cresswell also gave the litigating members a boost and lawyers a warning last Monday when he published a summary of all cases to be heard in High Court, signaling his intent to get the whole process moving as soon as possible.

"The court wishes to emphasize the heavy responsibility on all solicitors and barristers concerned to assist the court to ensure that cases are conducted efficiently in accordance with best Commercial Court practice, costs to the parties are contained and unnecessary delay is avoided," he wrote.

The justice also told members that they run the risk of not recouping all their losses in this litigation, which could prompt some members to seek out-of-court settlements.

"There is a distinct possibility, even if the claims are sound in law, that there may be insufficient money to satisfy them all," he said.

Gooda Walker Action Group Chairman Michael Deeny said,

"The courts are showing a commendable and consistent determination to deal with all the Lloyd's litigation with dispatch and efficiency. What is deplorable are the efforts of the agents to use every legalistic, petty fogging device to delay the Gooda Walker action. If they believe that they have a good defense to our claims, why are they so desperate to avoid a judgment?" he said.

Mr. Ackeroyd said he believes there is a good chance that the lords will overturn the ruling and absolve the members agents of liability for the conduct of managing agents.

"The lords considered the appeal worthwhile... and so the outcome must be very uncertain," he said.

If the lords do overturn the lower court ruling, it would leave insolvent and underinsured Gooda Walker managing agency as the only source of compensation for the litigating members.

Meanwhile, members agents are responding to the need for bigger and better-capitalized agencies in this era of corporate capital at Lloyd's. In fact, the agents linked to corporate capital vehicles tend to be the ones expanding through mergers and acquisitions.

In 1984, there were 110 independent members agents at Lloyd's and 160 combined members and managing agencies. A decade later, the figures are 36 and 13, respectively.

London analyst De Lisle Jessup Scott predicted in a May 1993 survey of the Lloyd's adviser market that this number could well fall to as low as six independent members agents and 12 combined agents within the next two to three years.

That prediction looks likely.

Bankside Members Agency Ltd., the 11th-biggest Lloyd's members agency in 1993, with 259 million pounds (\$392.3 million) in capacity under management, is acquiring the active members of now-defunct London Wall Members Agency Ltd. London Wall was the sixth-biggest members agency last year, with 332 million pounds (\$502.8 million) under management.

BMA's 1994 capacity after the acquisition will be will 559 million pounds (\$827 million). BMA is a subsidiary of Bankside Underwriting Agencies Ltd.

BMA is also adviser to Abtrust Lloyd's Insurance Trust, a corporate investment vehicle with capacity of 38 million pounds (\$56.2 million).

In addition, members agent Willis Faber & Dumas (Agencies) Ltd. is

acquiring the members of combined agency Janson Green Ltd. Willis was Lloyd's fifth-biggest members agency last year, with 348 million pounds (\$514.9 million) of gross capacity under management. Willis also acts as an adviser to corporate capital vehicle Lomond Underwriting P.L.C., with 54 million pounds (\$79.9 million) of capacity for 1994.

Willis's 1994 capacity after the acquisition will be 473.5 million pounds (\$700.5 million), said Managing Director James Sinclair.

Peter Cowell, managing director of Janson Green, said that it decided to transfer the members agency to

'...There may be insufficient money to satisfy them all,' Justice Cresswell says of the claims.

Willis because of the recommendation in last year's Lloyd's business plan that combined agencies should be split up. He said the members will benefit in a bigger, better-capitalized agency.

Litigating Janson Green members' interests will not be impaired by the transfer, he stressed.

Sturge Holdings P.L.C. intends to merge R.W. Sturge Ltd., the second-biggest Lloyd's members agency in 1993 with 630 million pounds (\$954 million) of capacity under management, and Donner Underwriting Agencies Ltd., which Sturge acquired in 1990 (BI, Oct. 22, 1990). Donner was the 16th-biggest members agency last year with 223 million pounds of capacity (\$329.9 million).

Sturge Group Finance Director James Macdonald said the new, as-yet-unnamed agency will provide about 1,500 members with "economies of scale... improved syndicate analysis and monitoring... (and) better administrative services."

The previous agencies will remain intact to run off old years of account, keep their independent share capital and remain registered Lloyd's agencies after next year. The new company will be launched Jan. 1, 1995.

"Names' rights will not be prejudiced by the proposed changes," said Mr. Macdonald.

But the litigating Sturge and Donner members are unhappy.

Alan Porter, chairman of the Devonshire Names Action Group, which includes some members of the Donner agency, wrote to Lloyd's Chairman David Rowland last week, asking him to reassure members that they would not be "disadvantaged" and to ensure that sufficient assets are left with the old agencies to cover future liabilities.

John Rew, chairman of the Sturge Names Action Group, met with Sir Alan Hardcastle, Lloyd's new chairman of the regulatory board, to air his members' fears.

"The names are justifiably concerned about the restructuring of agency companies, and this case may have given rise to assets going in one direction and liabilities in the other," said Mr. Rew. **BI**

U.S. operations generate big gains for Willis Corroon

LONDON—Fueled by improved results from U.S. operations, Willis Corroon Group P.L.C. recorded double-digit gains in both revenues and profits during 1993.

Gross revenues, including discontinued operations, grew by 11.6% to 763.2 million pounds last year from 683.8 million pounds in 1992. In dollar terms, though, revenues slipped by 5.1% to \$1.14 billion from \$1.21 billion based on average exchange rates, reflecting the strength of the dollar against the pound in 1992.

Meanwhile, Willis Corroon's pretax profits jumped by 79.3% to 76.2 million pounds (\$114.3 million) in 1993 from 43.3 million pounds (\$76.4 million) in 1992.

The brokerage has restated some of its results from 1992 and the first quarter of 1993 to reflect its sale in December of 64% of Gryphon Holdings Inc., its insurance underwriting unit. Results from Gryphon are now treated as a discontinued operation.

Brokerage commissions and fee revenues increased by 15.4% last year to 664.3 million pounds (\$996.5 million) from 575.6 million pounds (\$1.02 billion) in 1992, while interest and investment income tumbled 11.3% to

39.1 million pounds (\$58.7 million) from 44.1 million pounds (\$77.8 million).

Added together, revenues from continuing operations grew 13.5% to 703.4 million pounds (\$1.05 billion) from 619.7 million pounds (\$1.09 billion).

The increase in revenues and profits were fueled by the broker's North American operations. Operating revenues in North America rose by 19.8% to 382 million pounds (\$573 million) in 1993, while U.K. operating revenues rose only by 4.9% to 293.6 million pounds (\$440.4 million). Operating revenues from all other nations rose 33% to 27.8 million pounds (\$41.7 million).

Likewise, profits from U.S. continuing operations rose by more than 375% in 1993 to 21.4 million pounds (\$32.1 million), while U.K. profits edged up only 0.8% to 48.6 million pounds (\$72.9 million) and profits from other nations jumped 66.7% to 6.5 million pounds (\$9.8 million).

Executive Chairman Roger Elliott noted that the brokerage was "delighted" with the results even though "the U.S. market is still not turning."

—By James M. Burcke

Grounding

Continued from previous page

Irish-owned St. Patrick II, which was cruising along the same Helsinki-Tallinn route.

None of the 1,100 passengers or

158 crew members were hurt in the grounding.

Mr. Lindholm said that damage noted so far includes hull punctures and 170 cabins and the engine room that are under water. The pre-fabricated cabins, engine and auxiliary engine could

be replaced.

But engine problems will only become apparent once the vessel is removed from water. The electrical system will have to be replaced, he said, though divers saw no damage to the rudder and propeller. **BI**

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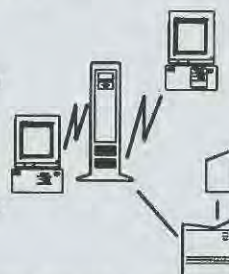
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MARCH 21-22. Ergonomics Control Programs to Reduce Injury and Illness in the Workplace seminar in Evanston, Ill., sponsored by Northwestern University's Continuing Professional Development department; \$795. McCormick Continu-

ing Professional Development, Northwestern University, 2145 Sheridan Road, Room 2823, Evanston, Ill. 60208-3124; 708-491-3365.

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MARCH 23-24. Measure and Ensure Patient Satisfaction in Managed Care seminar in Washington, sponsored by the Institute for International Research; \$1,195. Institute for International Research, 708 Third Ave., Fourth Floor, New York, N.Y. 10017-4103; 1-800-345-8016 or 212-661-8740.

MARCH 23-24. Wellness in the Workplace and Wellness Management seminar in Ann Arbor, Mich., sponsored by the University of Michigan's Fitness Re-

search Center; \$170. University of Michigan, Fitness Research Center, 401 Washtenaw Ave., Ann Arbor, Mich. 48109-2214; 313-763-2462.

MARCH 23-25. The California HMO Experience seminar in Monterey, Calif., sponsored by CAHMO; \$600 for members, \$700 for non-members. Lynn Morris, CAHMO Inc., 910 K St., Suite 350, Sacramento, Calif. 95814; 916-552-2910.

MARCH 23-25. Building Member Loyalty and Retention in Managed Care conference in New York, sponsored by Global Business Research; \$1195. Conference Administrator, Global Business Research Ltd., 151 W. 19th St., Eighth Floor, New York, N.Y. 10011; 1-800-868-7188 or 212-645-4226.

MARCH 24. A Life Cycle Approach to Employee Benefits luncheon meeting in New York, sponsored by WEB Network of Employee Benefits; \$40 for WEB

members, \$50 for non-members. Barry D. Podob, Vp, Director of Employee Benefits, Interpublic Group of Companies Inc., 1271 Ave. of the Americas, New York, N.Y. 10017; 212-399-8049.

MARCH 24-25. Fifth Annual Symposium on Excess and Reinsurance Coverage in Chicago, sponsored by Defense Research Institute; \$425 for DRI members, \$475 for non-members. Defense Research Institute Inc., 750 N. Lake Shore Drive, Suite 500, Chicago, Ill. 60611; 312-944-0575.

MARCH 24-25. Environmental Documentation conference in Chicago, sponsored by Executive Enterprises; \$1,195. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6990; 1-800-831-8333.

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44RSA

United

Continued from page 3

to make concessions in the form of work-rule changes like requiring pilots to fly additional flights for the same pay and not paying workers for lunch breaks, according to a spokesman.

"The prevalence of two-tier plans is not high but it's not unheard of," said Sandra O'Neal, national practice leader for employee pay in the St. Louis office of Towers Perrin. Ms. O'Neal estimated that 10% to 20% of companies nationwide use some kind of two-tier compensation program.

Two-tier compensation arrangements are "never sought after unless there's a real issue of survival involved," she added. "They're a phenomenon of the crash of the '80s."

However, two-tier compensation plans are fairly unusual in non-union environments, said Ken Abosch, a compensation con-

sultant with Hewitt Associates in Lincolnshire, Ill. "We don't see this practice used very often" on salaried employees.

Typically manufacturing companies and other heavily unionized industries would be most likely to use tiered compensation arrangements, Mr. Abosch said.

However, "it's not unusual to see a company that's not unionized follow approaches that are used in union environments," he added.

The problem with the approach is "it does result in some morale issues," he said. Two-tier compensation programs "create a class mentality within the organization."

But Towers Perrin's Ms. O'Neal pointed out that employers resorting to the programs are "protecting the earnings power of everyone who's currently on staff." Since companies are forthright about the programs, newly hired employees know what they are getting into, she added. **EB**

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Stark bill

Continued from page 1

ministration's proposed system of mandatory, monopolistic health care purchasing alliances, Rep. Stark said his proposal would achieve universal coverage without creating new bureaucracies.

Rep. Stark, who in the mid-1980s played a key role in the passage of COBRA health care continuation requirements, said he is under no illusions that his health care reform legislation will sail

smoothly through Congress.

"I believe that the health reform plan I have outlined offers numerous and powerful advantages, but perhaps the best thing I can say about it is that this bill will give everyone something to complain about," Rep. Stark said. "In fact, if there aren't any complaints, I will start thinking about changing the bill."

As the subcommittee began consideration of the Stark bill—a process that may continue for another week before voting begins—the administration faced

other challenges standing in the way of health care reform legislation.

In an eerie coincidence to the early 1970s, when the last serious congressional health care reform effort disintegrated during the Watergate scandal, the turmoil growing from President Clinton and Hillary Rodham Clinton's investment in an Arkansas land development project already is diverting administration attention from health care reform.

Two Clinton administration officials—New York labor attorney Harold Ickes, who joined the administration earlier this year to shore up support for the proposal, and Roger Altman, deputy secretary at the Treasury Department and a member of the administration health care strategy team—have received subpoenas from the special counsel investigating the Whitewater affair.

Besides distractions inside the administration, one of its most important congressional allies on health care reform has his own headaches: House Ways and Means Committee Chairman Rep. Daniel Rostenkowski, D-Ill., faces a tough race in this week's primary in his Chicago district.

These developments are taking place as the drive to enact health care reform legislation is now—to borrow a political term—entering

the early primary season.

As many as five congressional committees and several subcommittees, including Rep. Stark's, will have a crack at producing a bill.

While it may not be clear for several months what will be in the final bill, the Stark proposal is yet another sign that the Clinton proposal no longer is a front-runner.

The Stark bill, and its rejection of key administration provisions like purchasing alliances, "is a reality check for the Clinton administration. It says, 'You're not really the leader of the congressional pack,'" said Fred Hunt, president of the Society of Professional Benefit Administrators in Chevy Chase, Md., which represents third-party health care plan administrators.

With a number of proposals—including a managed competition bill introduced by Rep. Jim Cooper, D-Tenn., and a single-payer bill backed by Rep. Jim McDermott, D-Wash.—vying for but not yet winning commanding congressional support, a consensus approach to health care reform has yet to emerge, said Frank McArdle, a consultant with Hewitt Associates in Washington.

While Rep. Stark upstaged President Clinton last week, it isn't clear yet whether he has enough votes to get his bill out of

his own subcommittee.

In fact, subcommittee members last week raised questions about a number of provisions in the Stark bill.

Rep. Nancy Johnson, R-Conn., questioned whether there was any logic in a provision that would allow only employers with more than 1,000 employees to self-insure their health care programs.

Rep. Johnson also said the Stark bill would bar employers with low-deductible plans from adopting more cost-effective plans. She was referring to a provision that would prevent—for a five-year period—employers from cutting existing benefits that exceed the bill's mandated minimum basic benefit package.

Rep. Fred Grandy, R-Iowa, said he might propose an amendment to the Stark bill to eliminate the employer premium contribution requirement. Rep. Stark said if such an amendment were accepted, it would kill the bill.

Rep. Sander Levin, D-Mich., said small employers need special government subsidies to offset the cost of health care premiums.

But, such subsidies still wouldn't quash opposition from small employers, Rep. Stark said. "Maybe some of my colleagues would throw money at (small business), but that is like feeding dog biscuits to a pit bull." ■

'Stark' contrasts are seen in two health reform bills

WASHINGTON—The latest health care reform proposal to surface on Capitol Hill illustrates how wide the gulf is between the Clinton administration and the proposal's author, congressional heavyweight Rep. Pete Stark, D-Calif.

Among the differences between the proposals:

• Health care alliances.

Rep. Stark would give states the option of establishing voluntary health care purchasing alliances through which employers could buy coverage.

These alliances would be intended for employers with 1,000 or fewer employees. States, though, apparently would have the option of requiring that all employers purchase coverage through alliances.

Employers with 100 or fewer employees would have an additional purchasing option: They could buy coverage through the federal Medicare program, which would offer expanded benefits. This expanded Medicare program, offering so-called "nationally guaranteed benefits," would be known as Medicare Part C.

Under the Clinton proposal, all employers with fewer than 5,000 employees would be required to buy coverage through state-established alliances.

• Premium contributions.

Under the Stark bill, employers generally would have to pay 80% of the premium for a health plan offering a certain set of benefits.

If an employer does not currently pay for dependent coverage, it only would have to pay 80% of the single adult premium. The single adult premium would include coverage for children, but not for a spouse.

Under the Clinton plan, employers would have to pay for 80% of the premiums for individual and family coverage.

• Basic benefit package.

Under the Stark proposal, all individuals would be entitled to a basic benefit package. This package would be similar to benefits now provided through Medicare.

But unlike Medicare, which has significant cost-sharing requirements for hospitalization, the basic benefit package would cover 100% of hospital expenses. For non-hospital care, the annual deductible would be \$500 per individual coverage or \$1,000 per family.

The bill also calls for prescription drug benefits, subject to a \$500 deductible, 20% coinsurance and a \$1,000 out-of-pocket limit.

Certain preventive services like new and well-baby care, would be covered without any cost-sharing.

If health care coverage was offered through a managed care plan, different and lower cost-sharing levels would apply.

Under a maintenance of effort

provision, employers providing benefits that exceed the basic benefit plan would have to offer and pay for those benefits for five years.

Meanwhile, the Clinton bill would mandate a much richer set of benefits, including coverage for mental health expenses and children's dental care.

Deductibles in the Clinton bill—\$200 and \$400, respectively, for individual and family coverage—are less than half those proposed in the Stark plan.

• Retiree health care coverage.

The Stark proposal would require employers now paying for a "portion" of health care coverage for retirees age 55 to 64 to pay 80% of the premium for the basic benefit package. The proposal does not define "portion."

If an employer currently provides additional benefits beyond the basic benefit package, it would be required to continue those benefits under a maintenance of effort provision. The proposal does not indicate when—or if—this maintenance of effort provision would expire.

In sharp contrast, the Clinton bill would have the government pay 80% of early retiree health care premiums, a huge windfall to steel manufacturers, automakers and other smokestack industries whose retiree health care obligations run into the tens of billions of dollars.

• Self-insurance.

The Stark bill would bar employers with 1,000 or fewer employees from self-insuring.

Under the Clinton plan, employers with fewer than 5,000 employees would have to buy coverage through state alliances, ruling out self-insurance for these companies.

• Payroll tax.

The Stark bill would impose a 0.8% payroll tax on all employers. Revenues generated by this tax would be used to help subsidize coverage for low-income individuals.

Under the Clinton bill, employers that self-insure their health plans would have to pay a 1% payroll tax.

• Employer premium subsidies.

The Stark bill would not provide government subsidies to offset employers' health care premiums.

Under the Clinton bill, employers' premium payments would be capped at 7.9% of payroll. For very small, low-wage employers, premiums would be capped at 3.5% of payroll.

Both proposals, though, would bar employers from offering health care benefits through flexible benefit programs. Both would also prevent health care plans from denying coverage for pre-existing medical conditions.

—By Jerry Geisel

CIGNA to combine two units

Markets

PHILADELPHIA—CIGNA Corp. is merging its international property/casualty and employee benefits operations and has appointed a new head of its property/casualty reinsurance unit.

The combined CIGNA International Property & Casualty and CIGNA International Life & Employee Benefits units will be headed by H. Edward Hanway, who previously was president of the P/C operation.

"Each business has good prospects, with each having a significant geographic presence and an internationally experienced staff. Their combination will enable us to better capitalize on our international opportunities," said Wilson H. Taylor, CIGNA's chief executive.

The two units had combined 1993 revenues of \$2.2 billion and operate in 51 jurisdictions.

Separately, CIGNA named Thomas C. Jones president of CIGNA Property & Casualty Reinsurance. Mr. Jones, former executive vp and chief operating officer of NAC Re Corp., will take over July 1.

The CIGNA Re president's post has been vacant since Norman Wayne left the company last November, a spokesman said.

AIG in Argentina

NEW YORK—American International Group Inc. is moving into newly liberalized financial markets in Argentina.

AIG and the Bank of Boston will form a joint venture to provide insurance and pension fund management there, taking advantage of the privatization of the Argentine pension fund market.

Each company will own half of the joint venture, called Bank of Boston-AIG Co. Ltd.

Gustavo Covacevich will be general manager. He was a consultant during the initial stages of the joint venture project and has managed one of the largest pension fund administrators in Chile.

Argentina privatized its social security system in October, allowing private-sector companies to administer pension funds.

In addition, AIG subsidiary American Life Insurance Co. has formed

ALICO Compania de Seguros de Vida S.A. to market life insurance in Argentina.

The Buenos Aires-based company will sell to the middle-income market through agents.

Argentina's insurance superintendent recently permitted full foreign ownership of licensed insurers and removed certain limitations on foreign currency transactions and investments.

A&A serves Mexico

NEW YORK—Alexander & Alexander Services Inc. has established a risk management services unit in Mexico City to support the local risk management and insurance needs of global companies in the region.

A&A recently purchased 80% of Asesores Kennedy Agente de Seguros, a leading Mexican insurance broker.

Richard H. Atherton is the manager of the risk management services unit. He can be reached at Asesores Kennedy Agente de Seguros S.A., Presa Tepuxtepec No. 40, Col. Loma Hermosa, 11200, Mexico City, D.F.; 525-395-9666; fax: 525-395-0605.

Excess comp cover

HARTFORD, Conn.—Hartford Specialty Co., a subsidiary of IIT Hartford Insurance Group, has created a new unit to provide excess workers compensation insurance to self-insured and partially self-insured organizations.

Insurance written by the unit has a minimum attachment point of \$250,000 per occurrence.

The Excess Workers Compensation Unit provides statutory, specific and aggregate coverages focusing on manufacturing and retail operations.

The unit, headed by Joe Wiedemann, began writing on Feb. 1 in Arkansas, Florida, Georgia, Kansas, Kentucky, Mississippi, South Carolina and Tennessee.

It expects to write excess workers

comp coverage nationwide by the end of 1994.

New Blanch unit

MINNEAPOLIS—E.W. Blanch Holdings Inc. has formed a new wholly owned subsidiary, Paragon Reinsurance Risk Management Services Inc.

The company brings the reinsurance risk management services that were traditionally provided by E.W. Blanch to a broader base of clients, such as management consultants and financial analysts.

Those services include product development, financial reinsurance, catastrophe modeling, contract writing and runoff management.

Executive and other functions not directly related to reinsurance are conducted by E.W. Blanch Holdings.

In connection with the organizational change, Michael W. Cashman Sr. and Chris L. Walker were named chairman and president, respectively, of reinsurance broker E.W. Blanch Co. Inc.

Frank S. Wilkinson Jr. was named chairman and president of Paragon.

Safety consulting

BOSTON—Liberty Mutual Insurance Co. has opened an office in Mexico City to provide occupational health and safety services and products to Mexican companies, U.S. companies with subsidiaries in Mexico, and other multinationals.

The office is headed by Efrain Salazar, the former health and safety manager of Du Pont-Mexico, a Mexican unit of E.I. du Pont de Nemours & Co.

Servicios Liberty S.A. de C.V. offers products and services designed to increase productivity and reduce costs.

Those services include workplace safety audits, machinery safeguarding programs, transportation safety programs, ergonomics design programs, property inspections and industrial hygiene services.

The company is located at Ave. Cuauhtemoc, 1236 Eighth Floor, Col. Letran Valle, Mexico D.F., Mexico; 03560; 525-604-2358; fax: 525-604-0084. ■

Lubbers

Continued from page 3

says that the 9% is a conservative estimate.

The proportion of cases among women and heterosexual men who inject drugs also increased over that period, to 27.7% from 17.4%.

By contrast, from 1985 to 1993, the proportion of cases attributed to sex among gay men decreased from 66.5% to 46.6%.

In 1993, the CDC adopted a broader definition of AIDS, which led to a significant increase in the number of cases reported. The centers received reports of 103,500 AIDS cases among people 13 years and older in 1993, a 111% jump from 49,016 cases in 1992. The increase was far greater in women than men, the CDC reports.

The expanded definition makes it difficult to estimate the total number of HIV infections nationwide, but federal estimates range from 600,000 to 1 million.

One problem in using AIDS cases as a predictor of the epidemic's size is that they only reflect the status of the epidemic in the year individuals become ill. The numbers do not reflect the number of individuals who may be infected with the virus, which can remain dormant in adults for as long as 10 years.

In fact, Mr. Lubbers points out, "One of the biggest misconceptions about people with HIV is that they will get sick and die shortly."

Mr. Lubbers suspects he contracted the disease through unprotected sex in the 1970s. "If that's so, I've been living with this illness for 15 years."

Those were years of advancement for both NationsBank and Frank Lubbers.

He joined the firm in 1972 with responsibilities in areas like corporate reporting, international accounting, and mergers and acquisitions.

"When the risk manager left, I was asked to figure out what needed to be done in risk management," Mr. Lubbers recalled during a recent interview.

His first move was to hire Ms. Vickery, a statistical typist, whose duties now include handling the bank's property insurance program.

"He was a wonderful person to work for," said Ms. Vickery, who has known Mr. Lubbers for 12 years. "He is intelligent and was very conscientious about the bank and about getting things done. He just saw to it that things got done—period."

One of his many accomplishments was the development of an in-house risk management information system.

"My background in corporate reporting meant I had to be aware of everything in various departments," he explained. "One of my first tasks

as risk manager was to identify the bank's exposures and computerize them."

In those days, NationsBank contracted with a variety of property/casualty insurers. "There was a separate policy for almost everything. It was just a clerical nightmare to follow the program. So the first thing I decided to do was consolidate all of it," Mr. Lubbers said.

"We started with one personal computer left over from a merger," he remembered. That soon grew into a RMIS that was so efficient that several other banks adopted a prototype of it.

Colleagues are quick to praise his work.

"In order to be a good risk manager, you need to know where your losses are and you need to prevent them," said Senior Vp Norman "Reggie" Dickens, who succeeded Mr. Lubbers as risk manager. "The system (Frank developed) provided a good basis for identifying losses—where they were occurring and what type of losses they were."

Before the department developed its RMIS, this identification process had been nearly impossible because so many insurers were involved in the bank's programs.

The need for detailed analysis grew along with NationsBank. A series of Florida acquisitions that began in 1982 produced significant growth. Then in 1988, it acquired First Republic Bancorp Inc. and soon after that bought C&S/Sovran Corp. Today, NationsBank, with roughly \$118 billion in assets, has 1,700 branches in nine states and the District of Columbia.

"As a risk manager of a North Carolina bank, you have a gut feel for who your employees are. But once you have 50,000 employees, you can't do it anymore," Mr. Lubbers said.

His RMIS played an important role in helping top management identify the "hidden costs" of mergers and acquisitions.

Using the system, "We could plot and show in the year after a merger—when employees are wondering what is going to happen—that workers comp claims went up sky high." Armed with that insight, the bank stepped up educational efforts to try to avoid inappropriate claims.

"As luck would have it," these initial efforts coincided with the beginning of the soft property/casualty market, "so I was pretty much considered a hero," Mr. Lubbers said, in a rare moment of self-congratulation.

His early success certainly wasn't the result of formal training. "My risk management training was compliments of Johnson & Higgins; they held an all-day seminar just for me," he recalled.

But perhaps the most useful advice came from a property broker. "The best kind of risk management is to pretend there is no insurance

and to try to prevent something from happening."

That same theme runs through Mr. Lubbers' AIDS education efforts.

He is involved in various projects, including the Regional AIDS Interfaith Network, a group of volunteers who care for people with IV or AIDS. As part of this network, he has spoken to church groups about educating young people, and last March, he spoke to 50 personnel officers about AIDS in the workplace.

"Employers should adopt and publish an AIDS workplace policy. The employer needs to be prepared to manage HIV/AIDS when it occurs and not end up being overwhelmed with managing a crisis. It's good risk management to be prepared," Mr. Lubbers said.

Afraid of losing his job, Mr. Lubbers at first kept his HIV status secret. Then, in 1989, he told his supervisor, who had asked him to do something Mr. Lubbers knew he did not have the energy for. The supervisor reacted with concern and support.

"I started to tell friends on a need-to-know basis, and then it got too complicated because I couldn't remember who I had told and who I hadn't. I only told my co-workers two weeks before the official 'retirement' function," he said.

Everyone was shocked—and saddened—by the news.

"Let's face it. So many people think AIDS only affects other people, certainly not a senior vp at NationsBank," Mr. Dickens said.

"AIDS was far removed from me before," Ms. Vickery said. "I guess because it's not something you think about in the workplace, especially in the banking industry. I knew it was out there, but I didn't know anyone with AIDS personally. I figured I probably would, eventually."

But, "I certainly never suspected it would be my boss," she added. "Frank doesn't fit the mold or stereotype. That makes it all the more difficult to accept."

"We don't think AIDS will impact us because we are older," said Folger Gifford, risk manager for European American Bank in Long Island, N.Y.

"We think of it as something that affects the younger generation," said Mr. Gifford, who knows Mr. Lubbers through their work with Bankers Insurance Co. Ltd., a banking industry captive insurer.

Risk managers in particular may be less inclined to accept the view that HIV or AIDS can strike anyone who puts himself at risk, Ms. Vickery added. "We don't think it can happen to one of us because we are so focused on insurance and preventing things from happening."

Mr. Lubbers hopes to convince them otherwise by putting a face on this disease. "Most people still think they are safe and, sad to say, they are the ones most at risk." **B1**

In 1992, Stockholm Re paid out \$12 million in Hurricane Andrew claims. It also suffered sizable losses from Hurricane Hugo in 1989 and the European windstorms in 1990.

Stockholm Re wrote \$70 million in premiums in 1992

Most of the reinsurer's senior managers have resigned, including James G. Parkinson, president and CEO, and Senior Vps Peter Woolf and Paul Murray. About half the company's 50 employees are expected to be laid off.

Alain Wattiez, president of the Stockholm Management, said there are 12 accounts—including captives and underwriting companies—under management that will be transferred to Eastney.

One week before the runoff was announced, Lansforsakringsbols-

gens offered Mr. Wattiez the option of organizing a leveraged buyout of the firm. "We were interested in considering it, but 24 hours later the offer was withdrawn," Mr. Wattiez said, adding that no reason was given.

The option to buy the brokerage subsidiary, HJF International, was granted to its management. HJF is now wholly owned by two of its executive vps: Michael G. Foulger and Michael Jenkins.

"We are very happy with the buyout and it's business as usual," said Mr. Foulger.

HJF places liability coverage, financial reinsurance, captive reinsurance and property catastrophe reinsurance. About 50% of its revenues is generated by property catastrophe business, he said. **B1**

Updates

Air crash losses insured

Continued from page 2

Hull insurance for the Aeroflot Ilyushin 86 plane is believed to have been placed in the Russian domestic market.

The Indian aircraft was carrying a four-member crew on a training flight when it crashed on landing, sending debris onto the Russian plane, which was on the ground. All four Indian crew members, three Russian engineers and an Indian catering worker were killed.

Insurer to appeal award

EL CAJON, Calif.—Golden Eagle Insurance Co. says it will appeal a jury award of more than \$2.5 million to a San Diego accountant who claimed the insurer unfairly denied coverage under his professional liability policy.

The March 4 award reflected a \$1.95 million default judgment against Darryl Drummond in December 1991, as well as interest and \$250,000 for emotional distress, said attorney R. Craig Clark, of Clark & Morris in San Diego.

According to Mr. Clark, Mr. Drummond had been terminated as an accountant for grocery store owner Melvin Gorham in November 1988 and was instructed to return relevant documents to Mr. Gorham, which the accountant did not do. Mr. Drummond then obtained a \$50,000 insurance policy from Golden Eagle in 1990 that was retroactive to January 1989. Mr. Gorham subsequently went out of business and blamed Mr. Drummond's failure to turn over the business records. He then sued the accountant.

Golden Eagle denied the claim and refused to defend Mr. Drummond on the grounds that he had been fired before the policy period. The \$1.95 million default judgment was entered against Mr. Drummond, who could not afford an attorney.

Mr. Drummond argued that he was entitled to coverage because the policy provided errors and omissions coverage for anything he "did or should have done" during the policy period.

Golden Eagle is appealing the award.

Briefly noted

Deloitte & Touche, the Federal Deposit Insurance Corp. and the Resolution Trust Corp. are near agreement on a \$300 million settlement of claims from the Big Six firm's audits of failed savings and loans, the Wall Street Journal reported Friday. None of the parties would confirm the report. "Stay tuned," said an FDIC spokeswoman. . . . Ernst & Young has been appointed provisional liquidator for Pine Top Insurance Co. Ltd. Pine Top ceased underwriting in 1982 and has been managing its own runoff. But deteriorating losses indicate liabilities could now exceed recoveries by millions of dollars, Ernst & Young said. Separately, the accountant was named provisional liquidator for Municipal General Insurance Co., a unit of insolvent U.K. insurer Municipal Mutual Insurance Ltd., which stopped underwriting in April 1992. . . . The National Insurance Crime Bureau will appoint a committee to seek a successor to NICB President Arnold Schlossberg, who is leaving his post because of health reasons. Mr. Schlossberg, who has headed the NICB since its creation two years ago, has been on medical leave since October. David A. Frisco, NICB's vp-administration, has been acting president. . . . San Francisco-based United States Insurance Services has signed a letter of intent to acquire property/casualty broker TriWest Insurance Services of Sherman Oaks, Calif. Neither USI Chairman Bernard H. Mizel nor TriWest would disclose the broker's premium volume. This is the first step of USI's strategy to create a major brokerage by acquiring "fewer than 20" medium-sized to large agencies that serve middle-market commercial and industrial businesses (BI, Sept. 27, 1993). Also at USI, John Addeo, former chief financial officer of Preferred Health Care Ltd. and senior vp and treasurer of Frank B. Hall & Co. Inc., has been named executive vp-operations. . . . Standard & Poor's Corp. has raised the claims-paying ability rating of London & Edinburgh Insurance Co. Ltd., a unit of ITT Hartford Group Inc., to AA from AA-. Separately, S&P withdrew its rating of Trade Indemnity P.L.C. at the company's request after dropping the rating to BBB+ from A-. S&P cited deterioration of the commercial credit insurer's capital base relative to its exposure to losses. . . . The French government last week approved the privatization of Assurances Generales de France, which will happen later this year. The government owns a 57.1% stake in AGF. . . . Kemper Reinsurance Co.'s financial strength rating has been upgraded to A2 from A3 by Moody's Investors Service Inc. because its ownership structure was strengthened in 1993 when a Kemper National Insurance Cos. subsidiary acquired the reinsurer from Kemper Corp. (BI, March 22, 1993). The new parent boosted Kemper Re's reserves and capital by \$100 million. . . . Acordia Inc. is expected to complete by April 1 its acquisition of property/casualty brokerage Pettit-Morley Co. of Seattle, which had 1992 revenues of \$20.6 million. Terms were not disclosed. . . . Metropolitan Life Insurance Co. has agreed to pay a \$20 million fine that the Florida Insurance Department proposed on behalf of all states after determining that Met agents illegally marketed individual whole life insurance policies as retirement savings accounts to various professional groups. The fine is subject to the other states' approval. . . . California insurers are opposing redlining regulations that Commissioner John Garamendi sent to a state agency for approval. Among other things, the regulations would require insurers to submit data on policyholders' race and gender, and rejected applications for coverage. . . . National Medical Enterprises Inc. has agreed to settle suits filed by 23 former psychiatric patients alleging fraud and conspiracy at some of its psychiatric hospitals for \$2.5 million. Macon, Ga.-based Charter Medical Corp. has begun negotiations to buy 50 of NME's 61 psychiatric hospitals. . . . Medicare paid an average of \$3,940 per enrollee in claims during the 1993 fiscal year, up 8.7% from 1992. The rise was comparable to health care cost increases in the private sector last year.

Stockholm

Continued from page 2

holm Re was not large enough to compete in the current reinsurance market, he said.

"It was felt that Stockholm Re was not an ideal candidate for restructuring, such as a third-party investment," Mr. Williams said.

Stockholm Re also has suffered poor results for several years.

"Obviously, as a company that writes excess-of-loss business, it has suffered," Mr. Williams said.

The company made a profit of \$67,000 in 1992, the latest year for which figures are available. But it posted a combined loss of \$4.7 million in 1991, 1990 and 1989 (BI, April 26, 1993).

For the Record

'Harry and Louise' reach out to Bill and Hillary

WASHINGTON—Harry and Louise have invited their Pennsylvania Avenue neighbors, Bill and Hillary, to join them in a series of ads.

The Health Insurance Assn. of America, sponsor of a controversial \$13 million campaign attacking parts of the Clinton health plan, last week extended an olive branch—kind of—to the White House.

The HIAA, noting that it supports more of the Clinton plan than it opposes, in a letter proposed a joint ad campaign with the White House to highlight "shared goals and our willingness to work together to achieve them."

The HIAA also requested that President Clinton ask the Healthcare Reform Project—a coalition of business, labor and consumer groups—to end what the trade group called "misleading, inaccurate and inflammatory print and broadcast advertisements."

A reform project spokesman called the HIAA letter "a publicity stunt" and speculated that "maybe the HIAA is starting to feel like some of our ads are getting to them."

But the White House is legally prohibited from doing any paid advertising, said the administration's health care spokeswoman.

She added that the president had not yet seen the hand-delivered letter by March 11 and had no comment on its request for White House intervention against the reform project ads.

The HIAA ads ended last month and a spokesman said there are no plans to resume them "at this time."

Also on the health reform ad front, several unions representing health care workers, are planning a \$6 million ad campaign in support of health care reform.

Workers prefer cash, stock over pension benefits

American workers would prefer a fatter paycheck or company stock that can be cashed out when they leave the job to an employer-paid pension, according to a survey conducted by the Employee Benefit Research Institute and the Gallup Organization Inc.

The survey showed 52% of 1,000 workers

questioned favoring extra pay or company stock over employer-paid pension benefits after retirement. Given a choice, 29% said they'd opt for the stock, 23% for the larger paycheck and 46% for the pension.

The findings showed a definite age gap in employees' attitudes. Among those 18 to 34, 29% said they'd prefer the extra cash and 34% favored the stock, while 37% favored the pension benefits. Among those 55 and over, though, only 15% said they'd prefer the cash and 23% the stock, while 58% said they'd prefer the pension benefits.

Asked whether they would favor employers' being allowed to contribute stock to pension plans, 80% of all respondents said they'd prefer that their employer be allowed to contribute company stock to the retirement plan. Again age was a factor, with only 73% of those 55 and over favoring such an option.

Those surveyed also tended to have greater faith in their employers than the federal government to be there for them in retirement, with 52% saying they have more confidence in their employer to pay the pension benefits they had been promised and 40% saying they had more faith in the government.

Missouri considers health care reform bill

JEFFERSON CITY, Mo.—A bill that would make health care coverage more available and affordable for Missouri businesses and residents has been introduced in the Legislature.

H.B. 1622, which is endorsed by Gov. Mel Carnahan, would encourage insurers, hospitals and physicians to form "integrated service networks" and offer a comprehensive standard benefits package and optional supplemental coverage.

Basic insurance market reforms contained in the measure include: community rating, an annual 30-day open-enrollment period, portability of coverage, use of practice guidelines and consumer education.

The plan would place no new mandates on employers and would not raise taxes, an Insurance Department spokesman said.

Under the plan, an employer that paid 80% or more of the ISN premium would be able to pick which ISN covers its employees.

Small businesses are expected to benefit through improved bargaining ability, proponents say.

House Speaker Bob Griffin, D-Cameron, sponsored the bill.

California regulators sanction Cayman insurer

SAN FRANCISCO—The California Insurance Department has issued a cease and desist order against Cayman Islands-based Association Insurance Co. Ltd. and several others charged with illegally soliciting auto insurance in the state.

AIC, operated by Florida businessman Anthony J. Damoulis, had its Cayman license revoked last August. Mr. Damoulis was implicated in corruption charges brought against former Cayman Insurance Superintendent Gilbert C. Connolly this month (BI, Feb. 14; Sept. 20, 1993).

Also named in the California order are: Diamond Insurance Co. Ltd. of Antigua, which has allegedly written auto business illegally; American Vehicle Assn. Inc., National Vehicle Assn. Inc. and Assn. of Business Enterprises Inc., which held group policies from the insurers; Coast Marketing Services and Automobile & Commercial Managing General Agents, two Los Angeles agencies; and Royal V. Montrose, Ryan R. Martin and Steve Lee, who solicited business for the insurers.

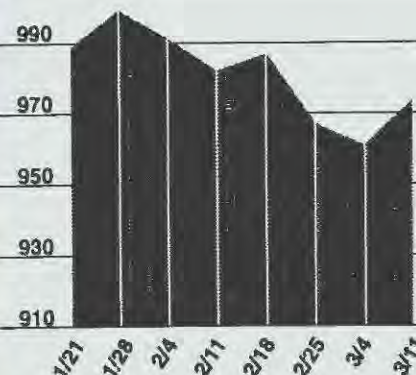
Neither Mr. Damoulis, who is not named in the order, nor any of those named in the order could be reached.

Information in brief

The National Assn. of Independent Insurers has filed a complaint in Florida over a regulation that limits the number of policyholders an insurer can drop in hurricane areas. . . . EXEL Ltd. is seeking approval for certain current shareholders and optionholders to sell 6.3 million common shares that were previously restricted. EXEL will not receive the proceeds of any such sales, and the sales will not affect the total number of shares outstanding. . . . Self-insured Connecticut Refining Co. agreed to drop a \$10,000 cap on treatments for HIV and AIDS and provide AIDS awareness training to most employees after the New York office of the Equal Opportunity Commission ruled the cap violated the Americans with Disabilities Act. . . . Harleyville Group Inc. will report a \$7.5 million first-quarter charge from January and February winter storms after taxes and reinsurance. . . . American Re Corp. estimates its pretax losses from the Los Angeles earthquake at between \$23 million and \$28 million. The reinsurer does not anticipate material losses from the East Coast storms. [BI]

BI Insurance Index

1010



Base = 100 on Dec. 29, 1978

Source: Nordby International Inc.

Insurance stocks rose last week, as the Business Insurance Index gained 13.1 points to 973.7 March 11 from 960.6 on March 4. Advancing issues for the week were led by: Take-Care Inc., up 11.6%; Sierra Health Services, up 9.8%; and NWNL Cos., up 9.1%. Declining issues for the week followed: ITT Hartford Group, down 10.1%; FHP International, down 9.9%; and Baldwin & Lyons Inc., down 9.5%. The most active issue was Allstate, 7.7 million shares traded. The BI Index increased 1.4%; the Dow Jones 30 Industrials gained 0.8%; the NYSE Composite rose 0.3%; and the Standard & Poor's 500 rose 0.4%.

British Issues

March 10 Companies	Price pence	P/E	Div. pence	Yield %	1 week	
					High	Low
Comm Union	585	18.6	31.0	5.3	601	535
Genl Accident	615	12.3	34.4	5.3	637	615
Gdn Royal Exch	97	12.7	9.5	4.3	197	195
Royal	274	11.9	9.4	3.1	234	27
Sun Alliance	318	19.9	18.1	5.7	345	318

Brokers	Price pence	P/E	Div. pence	Yield %	1 week	
					High	Low
Bradstock	37	15.4	6.9	5.3	137	13
CE Heath	396	15.2	20.5	5.2	338	390
Hogg Group	44	24.0	7.1	4.9	145	14
JIB Group	82	15.8	9.5	5.2	132	132
Lloyd Thompson	289	19.5	8.4	2.3	239	239
Lowndes Lomb	441	13.8	18.8	4.3	441	44
PWS Holdings	81	11.8	5.0	6.2	81	81
Sedgwick Grp	98	22.0	7.5	3.3	139	135
Steel Br Jones	19	N/M	11.3	9.5	119	119
Willis Corroon	223	20.5	8.3	3.7	223	22

Source: Philip Olsen, London • 1993 figure; others estimated

BI Industry Stock Report

MARCH 7, 1994, THROUGH MARCH 11, 1994

BROKERS												INSURERS/REINSURERS												HEALTH MAINTENANCE ORGANIZATIONS																
		Price	% change	Year to date % change	Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt./Bk. value			Price	% change	Year to date % change	Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt./Bk. value			Price	% change	Year to date % change	Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt./Bk. value		
					High	Low													High	Low												High	Low							
Accordia Inc.	NYS	27.75	4.23	12.69	27.88	18.38	26	0.60	2.16	14	10.22	2.72	Mutual Risk Mgmt. Ltd.	NYS	27.25	-1.36	-9.17	32.75	21.16	120	0.28	1.03	18	5.71	2.77								32.75	21.16	120	0.28	1.03	18	5.71	2.77
Alexander & Alexander	NYS	19.38	-3.73	-2.52	28.00	17.63	265	1.00	5.16	51	6.73	2.88	NAC Re Corp.	OTC	28.63	-2.14	-1.72	43.25	27.50	1182	0.16	0.56	13	19.24	2.43								43.25	27.50	1182	0.16	0.56	13	19.24	2.43
E.W. Blanch Holdings Inc.	NYS	16.25	-5.11	-6.47	23.50	16.25	502	0.32	1.97	17	4.10	3.96	National Re Group	NYS	27.75	-4.31	-9.39	39.63	27.13	116	0.16	0.58	8	16.89	2.64								39.63	27.13	116	0.16	0.58	8	16.89	2.64
Gallagher Arthur J. & Co.	NYS	28.88	-2.12	-19.23	37.38	28.88	194	0.88	3.05	14	7.52	3.84	Navigators Group	OTC	20.50	1.23	-41.43	39.00	16.50	404	0.00	0.00	11	16.99	2.51								39.00	16.50	404	0.00	0.00	11	16.99	2.51
Hill, Rogal & Hamilton	NYS	11.50	-1.08	-12.38	16.75	11.13	36	0.48	4.17	19	4.51	2.55	Nobel Insurance LTD.	OTC	8.25	1.54	8.20	8.44	6.25	24	0.00	0.00	3	6.84	2.51								8.44	6.25	24	0.00	0.00	3	6.84	2.51
Marsh & McLennan	NYS	82.25	-0.80	1.08	95.00	77.00	434	2.68	3.26	18	16.76	4.91	NWNL Companies	NYS	30.00	9.09	-7.69	38.75	26.50	726	0.80	2.67	11	23.97	2.55								38.75	26.50	726	0.80	2.67	11	23.97	2.55
Poe & Brown	OTC	17.63	0.71	-2.08	21.25	16.25	110	0.40	2.27	19	3.02	5.84	Ohio Casualty Corp.	OTC	63.00	0.00	-1.56	72.00	57.63	254	2.92	4.63	13	47.68	2.52								72.00	57.63	254	2.92	4.63	13	47.68	2.52
BROKERS	AVERAGE		-1.1	-4.1					3.1	22			Old Republic Int'l	NYS	23.88	0.53	6.11	27.63	21.50	323	0.44	1.84	8	23.57	2.61								27.63	21.50	323	0.44	1.84	8	23.57	2.61
													Orion Capital Corp.	NYS	32.13	-0.39	4.05	37.50	28.63	3	0.72	2.24	8	25.56	2.56								37.50	28.63	3	0.72	2.24	8	25.56	2.56
													Phoenix Re Corp.	OTC	23.75	-4.52	-13.64	38.25	19.75	425	0.28	1.18	7	19.99	2.53								38.25	19.75	425	0.28	1.18	7	19.99	2.53
ACE Ltd.	NYS	26.13	-4.13	-14.34	36.00	25.50	736	0.40	1.53	5	28.74	0.91	Provident Life	NYS	26.75	-5.31	-15.42	31.88	25.63	269	0.04	3.89	9	26.38	2.61								31.88	25.63	269	0.04	3.89	9	26.38	2.61
Acceptance Insurance Cos.	NYS	11.63	-4.12	0.00	15.63	10.88	49	0.00	0.00	13	9.65	1.20	Re Capital Corp.	OTC	13.50	-1.82	-0.92	15.75	13.25	42	0.28	2.07	11	16.88	0.93								15.75	13.25	42	0.28	2.07	11	16.88	0.93
AEGON N.V.	NYS	51.00	-0.49	-6.85	58.50	43.25	15	1.22	2.39	11	34.71	1.47	Reliance Group Holdings	NYS	6.00	2.13	-22.58	10.38	5.63	980	0.32	5.33	6	4.22	2.52								10.38	5.63	980	0.32	5.33	6	4.22	2.52
Aetna Life & Casualty	NYS	57.38	-7.65	-4.77	66.25	46.13	1322	2.76	4.81	11	71.84	0.80	RUI Corp.	NYS	24.75	1.02	-7.48	27.75	23.25	32	0.56	2.26	10	22.91	2.63								27.75	23.25	32	0.56	2.26	10	22.91	2.63
Allied Group Inc.	OTC	25.00	1.01	0.00	32.75	21.34	289	0.60	2.40	7	10.45	2.39	St. Paul Companies	OTC	55.38	-3.28	1.37	66.75	51.88	976	1.80	3.25	10	41.59	2.53								66.75	51.88	976	1.80	3.25	10	41.59	2.53
Allmerica Prop. & Casualty	NYS	18.00	-4.00	-16.44	22.16	18.00	85	0.16	0.89	4	56.97	0.32	SAFECO Corp.	OTC	11.25	0.00	-10.89	20.63	10.25	33	0.32	2.84	8	16.08	0.93								20.63	10.25	33	0.32	2.84	8	16.08	0.93
Allstate Corp.	NYS	24.75	-5.71	-16.81	34.25	24.38	7740	0.72	2.91	8	18.43	1.34	SCOR U.S. Corp.	NYS	11.25	0.00	-10.89	20.63	10.25	33	0.32	2.84	8	16.08	0.93								20.63	10.25	33	0.32	2.84	8	16.08	0.93
American General	NYS	26.50	-0.93	-7.02	36.50	25.50	1445	1.16	4.38	23	22.09	1.20	Seibels Bruce Group	OTC	1.81	7.41	3.60	2.13	0.31	206	0.00	0.00	-1	1.90	0.95								2.13	0.31	206	0.00	0.00	-1	1.90	0.95
American Heritage Life Ins.	NYS	18.13	-4.61	-2.68	25.34	17.25	58	0.60	3.31	11	12.42	1.46	Selective Ins. Group	OTC	28.50	-2.56	-5.79	31.00	20.50	37	1.12	3.93	17	23.11	2.53								31.00	20.50	37	1.12	3.93	17	23.11	2.53
American Indemnity/Fin'l	OTC	13.00	-3.70	0.00	16.25	7.75	7	0.12	0.92	4	16.18	0.80	Sphere Drake Holdings	NYS	15.25	-3.94	-7.58	21.63	15.00	117	0.12	0.79	16	12.17	2.53								21.63	15.00	117	0.12	0.79	16	12.17	2.53
American International	NYS	83.63	-5.11	-5.11	100.25	78.41	4038	0.40	0.48	14	45.25	1.85	Statesman Group Inc.	NYS	11.25	-6.25	-10.00	15.72	9.75	153	0.10	0.89	5	8.65	2.50								15.72	9.75	153	0.10	0.89	5	8.65	2.50
American Re Corp.	NYS	25.63	-7.24	-9.29	40.25	23.50	610	0.00	0.00	12	14.80	1.73	TIG Holdings	NYS	19.88	-4.22	-12.15	28.00	19.88	909	0.20	1.01	-10	18.49	2.67								28.00	19.88	909	0.20	1.01	-10	18.49	2.67
Aon Corp.	NYS	49.00	-1.75	1.55	58.50	45.00	778	1.80	3.67	12	33.10	1.48	Tokio Marine & Fire	OTC	61.25	-4.30	13.43	67.00	48.00	10	0.37	0.60	40	57.72	2.96								67.00	48.00	10	0.37	0.60	40	57.72	2.96
Argonaut Group	OTC	30.50	-0.81	0.00	35.50	29.50	344	1.00	3.28	9	27.65	1.10	Torchmark Corp.	NYS	41.88	-2.62	-6.42	61.88	41.13	41	1.12	2.67	11	17.35	2.41								61.88	41.13	41	1.12	2.67	11	17.35	2.41
AVEMCO Corp.	NYS	16.13	6.61	-14.00	24.38	14.50	31	0.44	2.73	12	8.13	1.98	Transatlantic Holdings	NYS	46.75	-2.35	-12.41	61.50	45.38	21	0.36	0.77	12	29.60	2.58								61.50	45.38	21	0.36	0.77	12	29.60	2.58
Baldwin & Lyons Inc.	OTC	14.25	-9.52	-4.20	16.25	11.16	50	0.20	1.40	9	12.59	1.13	Travelers Corp.	NYS	36.00	-4.00	-7.40	49.50	31.22	6205	0.48	1.33	9	33.35	2.98								49.50	31.22	6205	0.48	1.33	9	33.35	2.98
Berkley W.F. Corp.	OTC	37.88	5.21	15.65	48.00	32.00	125	0.40	1.06	13	28.12	1.35	Trenwick Group Inc.	OTC	34.00	0.37	-12.26	49.75	33.25	360	1.00	2.94	10	26.00	2.51								49.75	33.25	360	1.00	2.94	10	26.00	2.51
Berkshire Hathaway Inc.	NYS	15600.00	0.97	-4.44	17900.00	11800.00	0	0.00	0.00	41	8115.28	1.92	United Fire & Casualty	OTC	38.50	4.05	6.84	39.00	34.75	2	1.08	2.81	10	28.96	2.53								39.00	34.75	2	1.08	2.81	10	28.96	2.53
Chandler Insurance	OTC	6.75	0.00	22.73	7.06	3.50	71	0.00	0.00	13	8.87	0.76	Unitrin	OTC	40.25	-1.83	-5.29	46.75	39.00	172	1.40	3.48	18	38.90	2.93								46.75	39.00	172	1.40	3.48	18	38.90	2.93
Chubb Corp.	NYS	73.13	-1.02	-7.00	96.38	73.00	1154	1.72	2.35	19	46.59	1.57	UNUM Corp.	NYS	57.00	6.79	8.57	60.13	47.75	6275	0.80	1.40	14	27.55	2.97								60.13	47.75	6275	0.80	1.40	14	27.55	2.97
CIGNA Corp.	NYS	82.63	-4.57	-0.99	70.50	56.50	691	3.04	4.85	19	78.23	0.80	US Facilities Corp.	OTC	9.25	0.00	-22.11	14.00	8.25	70	0.00	0.00	8	10.48	0.98								14.00	8.25	70	0.00	0.00	8	10.48	0.98
CNA Financial Corp.	NYS	68.38	-0.91	-13.17	100.63	67.75	669	0.00	0.00	16	77.92	0.88	USF&G Corp.	NYS	14.63	2.63	-3.31	19.63	12.38	953	0.20	1.37	16	10.60	2.58								19.63	12.38	953	0.20	1.37	16	10.60	2.58
Continental Corp.	NYS	23.50	-7.39	-14.93	34.63	23.50	788	1.00	4.26	8	38.99	0.60	USLICO Corp.	NYS	17.00	-1.45	3.03	19.00	15.63	43	0.24	1.41	8	25.22	0.67								19.00	15.63	43	0.24	1.41	8	25.22	0.67
EXEL Ltd.	NYS	40.75	-5.51	-9.44	52.25	40.63	904	1.20	2.94	6	33.81	1.21	USLIFE Corp.	NYS	39.00	0.00	0.65	45.75	35.75	264	1.24	3.18	9	41.73	0.93								45.75	35.75	264	1.24	3.18	9	41.73	0.93
Fremont General Corp.	NYS	23.38	-2.09	-3.11	28.75	21.00	169	0.72	3.08	8	23.40	1.00	Washington National	NYS	24.13	1.05	-0.52	27.88	21.75	77	0.08	4.48	10	28.40	0.65								27.88	21.75	77	0.08	4.48	10	28.40	0.65
Frontier Insurance Group	NYS	39.50	-6.78	-9.97	50.00	36.72	118	0.60	1.52	13	16.33	2.42	Zenith National Ins.	NYS	22.13	-3.80	0.00	29.25	21.25	90	1.00	4.52	8	17.71	2.55								29.25	21.25	90	1.00	4.52	8	17.71	2.55
Gaisco Inc.	ASE	10.00	2.56	11.11	17.16	8.25	136	0.04	0.40	14																														

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