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Update

Reinsurers' combined ratio worsens to 117.4% in '92: RAA

WASHINGTON—U.S. reinsurers' combined ratio deteriorated dramatically to 117.4% in 1992 from 106.5% in 1991, according to the Reinsurance Assn. of America.

The 1992 combined ratio reflects an 85.8% loss ratio and a 31.6% expense ratio.

"The loss ratio reflects the fact that 1992 was the worst catastrophic year in history," said James Dwane, chairman of the Washington-based RAA and president of Prudential Reinsurance Co. of Newark, N.J.

Continued on next page

RICO ruling wins applause

High court decision will limit frivolous suits: Professionals

By DOUGLAS McLEOD

WASHINGTON—Accounting firms and defense lawyers are praising the U.S. Supreme Court's ruling that sharply limits the use of federal racketeering laws against professional firms.

In a 7-2 ruling, the Supreme Court earlier this month concluded that professionals like outside auditors cannot be held liable for treble damages under the federal Racketeer Influenced and Corrupt Organizations statute unless they participated in the operation or management of an organization (*BI*, March 8).

The ruling will effectively bar many civil RICO claims against professional firms that do work for failed companies like insurers and savings & loans. Previously, such claims had been relatively easy to bring under rules adopted by several federal courts, legal experts say.

Hundreds of pending suits could be affected by the ruling.

The ruling also represents a change for the high court, which previously has upheld broad interpretations of the sweeping RICO statute, lawyers say.

"It really is the first time the Supreme Court has interpreted RICO in a narrow rather than a broad way," said Edward Brodsky of Proskauer, Rose, Goetz & Mendelsohn in New York. "Up until now, the court has read that statute very, very broadly."

As a result, "you will not have these frivolous suits brought against professional people, or if they are brought, they won't be worth anything," Mr. Brodsky added.

The National Assn. of Insurance Commissioners and others had fought any narrowing of RICO, arguing that it would impede their ability to recover damages from professionals who contribute to the failure of insurance companies and other businesses.

"One is not liable under (RICO) unless one has participated in the operation or management of the enterprise itself."

Justice Harry Blackmun

The Supreme Court's March 3 ruling came in a case brought against Arthur Young & Co.—now part of Ernst & Young—by

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Fronting draft would burden more captives

By MEG FLETCHER

NASHVILLE, Tenn.—An extremely limited exemption for captive insurers in the latest version of a proposed model fronting law is expected to spur an outcry from businesses with captives.

NAIC

The latest draft was hammered out last week at the National Assn. of Insurance Commissioners' spring meeting.

The net result of the exemption is that an overwhelming majority of captives—including captives domiciled outside the United States as well as all association captives—would be subject to the disclosure and reporting requirements of the proposed model law.

Risk managers and captive representatives predict the new draft will cause a groundswell of criticism because it will make operating captives more expensive and require disclosure of data.

Members of the NAIC's Reinsurance Task Force last week unanimously agreed to release the much-edited March 3 draft for public comment, though two 7-4 votes during the drafting process illustrate the lack of consensus on the panel on different issues.

New York regulators, for example, continue to say that no captives should be exempted. Other opponents of parts of the draft include New Hampshire, North Carolina and Virginia regulators.

NAIC staff expect to have copies of the latest version of the model "Fronting Disclosure and Regulation Act" available soon.

Regulators say the model law is

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Benefits play role in IBM breakup

By LOUISE KERTESZ

PURCHASE, N.Y.—One little-noticed bit player in the breakup of Big Blue has been its corporate benefits department.

International Business Machines Corp. formerly employed 120 people to handle benefits work at its headquarters; another 221 people around the country spent part of their time on benefits.

Now, IBM's entire central benefits operation has only 61 employees, all working for Workforce Solutions Inc., a quasi-independent company that once was IBM's human resources operation and now is one of what IBM calls its "confederation of companies."

By making its human resources division quasi-independent and by making health care plan changes—such as increasing the use of case management and shifting some costs to employees—the ailing computer giant cut its per-capita health care costs by 5% in 1992.

IBM's per-employee health care costs of $3,904 in 1992, down from $4,274 a year earlier, were slightly less than the national average of $3,968 per employee in 1992 reported earlier this month by A. Foster Higgins & Co. Inc. (*BI*, March 1).

Still, even with the cuts, IBM's total health care bill approached $1 billion last year.

Dramatic reductions are not expected this year. In fact, per-capita costs are likely to grow 7% to 8% in 1993, said Michael Tarre, director of compensation and benefits at 9-month-old Workforce Solutions in Purchase, N.Y.

But IBM says it's confident that health care plan cuts and the overall restructuring that created WFS will continue to yield savings. Each of IBM's 13 "federation" companies has

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Mixed messages on benefits tax

Mrs. Clinton says tax not in cards; HHS chief says decision not final

By JERRY GEISEL

WASHINGTON—While President Clinton's health care reform package is not due until May 1, the pace of reform efforts is picking up.

Among the swirl of health care-related events last week:

- Hillary Rodham Clinton suggested the Task Force on National Health Care Reform, which she chairs, will not propose taxing workers on employer-paid health care premiums.

In an Associated Press interview, Mrs. Clinton said the task force would not—with one exception—propose any taxes that broadly hit the middle class to help pay for health care coverage for the nation's 36.3 million uninsured.

The one exception, she said, would be boosting cigarette taxes. Higher cigarette taxes would be an appropriate revenue source because so many health care problems and costs are related to smoking, Mrs. Clinton said, echoing comments made earlier by her husband.

However, Donna Shalala, secretary of health and human services and one of six cabinet members on the task force, said a final decision has not been made on benefit taxes.

In fact, Mrs. Clinton only was saying the task force will be "very careful" about adding a tax burden on the middle class, Ms. Shalala said in a television interview.

- Two more business groups proposed their own health care

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New York's accreditation suspended

By MEG FLETCHER

NASHVILLE, Tenn.—The New York Insurance Department is the first to have its accreditation suspended by the National Assn. of Insurance Commissioners.

NAIC

The NAIC suspended New York's accreditation last week, citing the state Legislature's failure to enact three model laws that the regulators consider essential to effective regulation.

Stricter sanctions may be applied by year end, but until then the suspension will have little practical effect.

Still, New York presented the first test of the NAIC's willingness to enforce rules that require accredited states to adopt—within two years—a growing stream of new model laws. Including New York's, 19 state insurance departments have been accredited (*BI*, Dec. 14, 1992).

On Capitol Hill, the accreditation program has come under fire as "often undemanding and, in some cases, inadequate" (*BI*, Dec. 9, 1991).

Critics of state insurer solvency regulation have noted that state legislatures often

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Update

Reinsurers' combined ratio up

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The 54 reinsurers surveyed by the RAA posted $11.97 billion in net written premiums last year, up 6.6% from $11.23 billion in 1991.

The companies surveyed had a net income of $1.05 billion. Policyholder surplus totaled $13.9 billion.

Court strikes COBRA eligibility

CHICAGO—An employer can deny COBRA benefits to a former employee discharged for stealing, a federal court has ruled.

Part-time grocery clerk Judith A. Burke was covered under American Stores Co.'s self-insured health plan when she was fired for retail theft. She was then receiving workers compensation benefits.

Jewel Food Stores Inc. in Joliet, Ill., a unit of American Stores, determined that Ms. Burke's discharge voided her health benefits and did not tell her she had a right to continue coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985.

Ms. Burke sustained another injury after her termination and ultimately filed $150,000 in medical bills. Jewel refused to pay on the ground that she had engaged in "gross misconduct."

Ms. Burke sued Jewel, claiming the store wrongfully denied her health benefits. She further alleged that she was discriminated against under the Employee Retirement Income Security Act because Jewel fired her while she had a workers comp claim pending.

In granting summary judgment March 2, Judge James F. Holderman said Ms. Burke's conduct constituted "gross misconduct" under COBRA and ERISA. He did not explicitly define the term, but instead deferred to the state law definition. He also rejected the discrimination claim, saying Jewel's knowledge of the workers comp claim and Ms. Burke's request for further health insurance did not constitute discrimination.

The case is significant because there are "very few decisions in the United States that define gross misconduct under COBRA or ERISA," said Gerald R. Maatman Jr., an attorney with Baker & McKenzie in Chicago, which represented Jewel.

X.L. hikes chemical firm rates

HAMILTON, Bermuda—X.L. Insurance Co. is raising excess liability rates at least 10% for policyholders in the chemical industry.

The increase, effective immediately, could be as high as 25% for accounts with poor loss records.

Brian O'Hara, X.L.'s president and CEO, said the increase will affect up to 80 policyholders "in an industry that has given us the majority of our large claims and losses." Chemical industry accounts represent the biggest single industry on X.L.'s general excess liability book, constituting 18% of total excess liability premiums written of $382.3 million last year.

"Paid and case reserves in this sector have exceeded premium income from our inception," he said.

The rate increase is the second of its kind at X.L., following an across-the-board increase of 6% on average in 1991 (*BI*, Jan. 7, 1991).

CIGNA debt downgraded

CHICAGO—Duff & Phelps Credit Rating Co. has lowered CIGNA Corp.'s senior debt rating to A+ from AA− and its subordinated debt rating to A from A−, reflecting deterioration in property/casualty operations.

That deterioration—aftertax operating losses ballooned to $485 million in 1992 from $43 million in 1991—has pushed the operating leverage of the property and casualty group "beyond prudent levels given its business mix," said Duff & Phelps.

Contributing to CIGNA's poor 1992 results were $223 million in pretax losses from hurricanes Andrew and Iniki, the December East Coast winter storm and the Los Angeles riots. The losses also reflect uncollectible reinsurance from the London reinsurance book of business, Duff & Phelps said.

More than $1 billion in debt is affected by the downgrades.

CIGNA's exposure in the World Trade Center explosion will not immediately affect its bond ratings, said Timothy A. Bienek, vp of Duff & Phelps.

CIGNA wrote $130 million of a $290 million excess of $10 million layer and $61 million of a $100 million layer above that for the Port Authority of New York & New Jersey. CIGNA also writes property insurance for the damaged Vista International Hotel (*BI*, March 8).

Meanwhile, CIGNA named Gerald A. Isom president of its domestic property/casualty operation. The former Transamerica Corp. executive replaces Caleb Fowler, who resigned (*BI*, March 1).

Clinton launches PBGC panel

WASHINGTON—The Clinton administration is launching a task force to examine problems facing the Pension Benefit Guaranty Corp.

The task force, being organized by Labor Secretary Robert Reich, will meet over the next six weeks to probe the PBGC's financial problems, evaluate current proposals intended to shore up the agency and consider new approaches, a Labor Department spokesman said.

The PBGC now has a $2.4 billion deficit, an amount agency officials have said could soar by tens of billions of dollars if more employers terminate large underfunded defined benefit plans.

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Errors & omissions

• In a March 8 Update, "Cap on AIDS Benefits Upheld," Richard L. Robbins was incorrectly identified as the plaintiff's attorney. Mr. Robbins represents defendant Storehouse Inc.

Prudential trying to sell reinsurance subsidiary

By DOUGLAS McLEOD

NEWARK, N.J.—Prudential Insurance Co. of America is seeking a buyer for its Prudential Reinsurance Co. subsidiary.

Prudential last week hired financial advisers J.P. Morgan & Co. and Prudential Securities Inc. to "evaluate strategic alternatives" for Pru Re, the fifth-largest U.S. reinsurer and the largest broker market company.

Noting that Prudential does not consider reinsurance a "core business," Prudential Chairman Robert C. Winters said that "given current investor interest in the reinsurance sector, we feel that now is an opportune time to explore alternatives with respect to the future of Prudential Re."

A Prudential spokesman said the company is aiming for a private sale of Pru Re and is not now considering a public offering or management buyout.

The spokesman also said Prudential would retain ownership of Pru Re if it doesn't receive an acceptable offer, though analysts expressed doubts that Prudential could continue operating the unit successfully after putting it on the block.

Prudential hopes to sell the reinsurer for at least $1.2 billion, the spokesman said. That would amount to more than twice Pru Re's year-end 1992 statutory surplus of $519 million and represents an optimistic estimate of the reinsurer's worth, especially given its heavy exposure to pro-rata property reinsurance, some analysts say.

Pre Re has been reducing that exposure since being hammered by losses from Hurricane Andrew last year, a spokesman said.

Standard & Poor's Corp. last week placed Pru Re's AA claims-paying ability rating on CreditWatch following the announcement. And Moody's Investors Service Inc. placed its Aa3 financial strength rating of Pru Re under review.

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'Greenmail' appeal

Reliance Group challenges ruling on D&O coverage

By DAVE LENCKUS

NEW YORK—Reliance Group Holdings Inc. will appeal a state appellate court ruling that its directors and officers liability insurance does not cover a $21.1 million settlement of litigation stemming from a "greenmail" payment it received from a corporate takeover target.

The 5-0 decision by the Appellate Division of the New York Supreme Court, which overturns a trial court ruling, "raises very broad policy questions," said Howard E. Steinberg, general counsel for the insurance holding company.

Those questions revolve around the court's finding on March 2 that the settlement amounted to a determination of wrongdoing by Reliance and that the settlement amount is not a loss because Reliance still made a profit when it abandoned its takeover attempt.

Language in the appellate court ruling also may point to future trouble for policyholders over the insurability of D&O defense costs, according to an attorney who specializes in D&O coverage disputes.

The litigation stems from Reliance's aborted hostile takeover attempt of Walt Disney Productions Inc. in 1984.

After several Reliance subsidiaries had purchased about 12% of Disney's common stock, Disney took various measures to make itself a less attractive tar-

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Retirees get taste of future

By SALLY ROBERTS

COLUMBUS, Ohio—Retired state workers in Ohio might be the first retirees to benefit from a managed competition model health care plan.

In an effort to give high-quality and cost-effective care to some of its retirees, four Ohio retirement programs that cover most state workers have banded together to form a large purchasing block.

The block, consisting of about 85,000 pre-Medicare-age retirees and their dependents, has contracted with Aetna Health Plan and Blue Cross & Blue Shield of Ohio.

Like the managed competition model the Clinton administration is contemplating, the two providers will compete for plan participants on the basis of quality, access, service and cost. According to the self-insured retirement plans' benefit consultant, The Wyatt Co., the estimated initial savings in the first two years of operation could be more than $100 million.

The retirement plans are: The Police & Firemen's Disability & Pension Fund; The Highway Patrol Retirement System; the Public Employees Retirement System; and the State Teachers Retirement System. Another

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IPO to raise capital for new reinsurer

By JUDY GREENWALD

NEW YORK—Newly formed Zurich Reinsurance Centre Holdings Inc.'s capital is expected to top $550 million following an initial public offering.

That would make the company the largest broker market reinsurer in the United States and the fifth-largest U.S. reinsurer overall based on surplus.

Both the IPO and the new reinsurer are expected to be received enthusiastically by the stock and insurance markets. The IPO is expected to be held during the second quarter.

Zurich Reinsurance Centre Holding's operating subsidiary, Zurich Reinsurance Centre Inc., will act principally as a lead writer of brokered, working-layer excess-of-loss and pro rata reinsurance treaties, according to a prospectus filed last week. ZRC will offer reinsurance primarily to commercial liability and personal lines insurers and, to a lesser extent, commercial property insurers.

Principal shareholders in the new firm are Centre Reinsurance Holdings Ltd. and Fund American Enterprises Holding Inc., which have already invested $300 million and $40 million, respectively.

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Is too much knowledge a bad thing for insurers?

By JOANNE WOJCIK

PHOENIX—Although policyholders need to be up front with their insurers when negotiating coverage, they should be less candid after a claim is filed, legal experts advise.

Sharing too much information with insurers after a lawsuit has been filed could come back to haunt policyholders when they later seek coverage for a claim, warned Jean A. O'Hare, corporate counsel for Pfizer Inc. in New York.

Policyholders also risk the possibility that any sensitive information they share with their insurers will end up in the hands of third-party claimants who are certain to use it in obtaining a settlement, according to Scott D. Gilbert, an attorney with Covington & Burling in Washington who specializes in insurance defense.

There is also the danger, particularly in the context of joint and several liability, that co-defendants will use the information to reduce their own exposure in a lawsuit, he added.

Ms. O'Hare and Mr. Gilbert spoke during a meeting of the Insurance Coverage Litigation Committee of the American Bar Assn.'s Tort & Insurance Practice Section held last month in Phoenix.

While information sharing can help defeat claims by third parties, determine the scope of insurance coverage, expedite discovery and forge settlements, policyholders must place significant controls and limits on sharing that information, both speakers agreed.

"Policyholders need to limit the information they provide, to protect themselves, and insurers need to respect that need," asserted Mr. Gilbert, who served as moderator of a session on information

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AP/Wide World photo

A survivor is carried from the 1985 crash of a Japan Air Lines flight, in which 501 people were killed. Japanese airlines' recent move to remove liability caps was prompted by the JAL disaster.

Debate rages on airline liability caps

By STACY SHAPIRO

LONDON—Airlines, insurers and regulators are debating passenger liability limits for international flights following Japanese airlines' decision last year to abolish the limits.

Supporters of the Japanese initiative contend that removing liability limits from international flights would reduce costly and time-consuming litigation to recover more than currently is allowed under the Warsaw Convention. In fact, a few nations—including the United States—already set no limit of liability for domestic flights.

But aviation underwriters believe that the removal of Warsaw limits governing international flights will actually be more costly, with higher awards being paid to plaintiffs. That's why some underwriters plan to impose additional premiums on airlines that say they will not cap their liability for accidents on international flights.

Meanwhile, the European Community does not favor removing the Warsaw liability limits for international flights. Instead, a recent European Commission document proposes increasing liability limits for passengers on flights crossing E.C. borders, although some observers say the limits would still be too low. Some individual airlines around the world favor waiving or at least increasing the Warsaw liability limit. However, U.S. airlines don't seem to be interested in raising the ceiling, observers say.

Hundreds of airline risk managers, underwriters and brokers addressed the complex issue of liability limits at two meetings in London earlier this month: the Eighth Annual International Airline Insurance conference sponsored by DYP Insurance & Reinsurance Research Group Ltd.; and a lunchtime seminar sponsored by the Insurance Institute of London.

These are "exciting new developments," said Peter Martin, a senior partner for London law firm Frere Cholmeley. Mr. Martin, who specializes in aviation defense, addressed the DYP conference.

"Hopefully it means a new beginning," added George N. Tompkins Jr., senior partner for New York law firm Condon & Forsyth, also an aviation defense lawyer. Mr. Tompkins spoke at both the DYP and IIL meetings. "What the Japanese have done is long overdue and should be done by all airlines around the world. . . .But U.S. carriers aren't in favor of doing it and no one knows why," he said.

The Warsaw Convention was adopted by most nations and became effective in 1929 for governing international air flights. Article 22(1) in the convention restricted airlines' liability on international flights for death or bodily injury of a passenger unless willful misconduct of the airline could be proved. The limit originally was about $8,300 per passenger. Aircraft manu-

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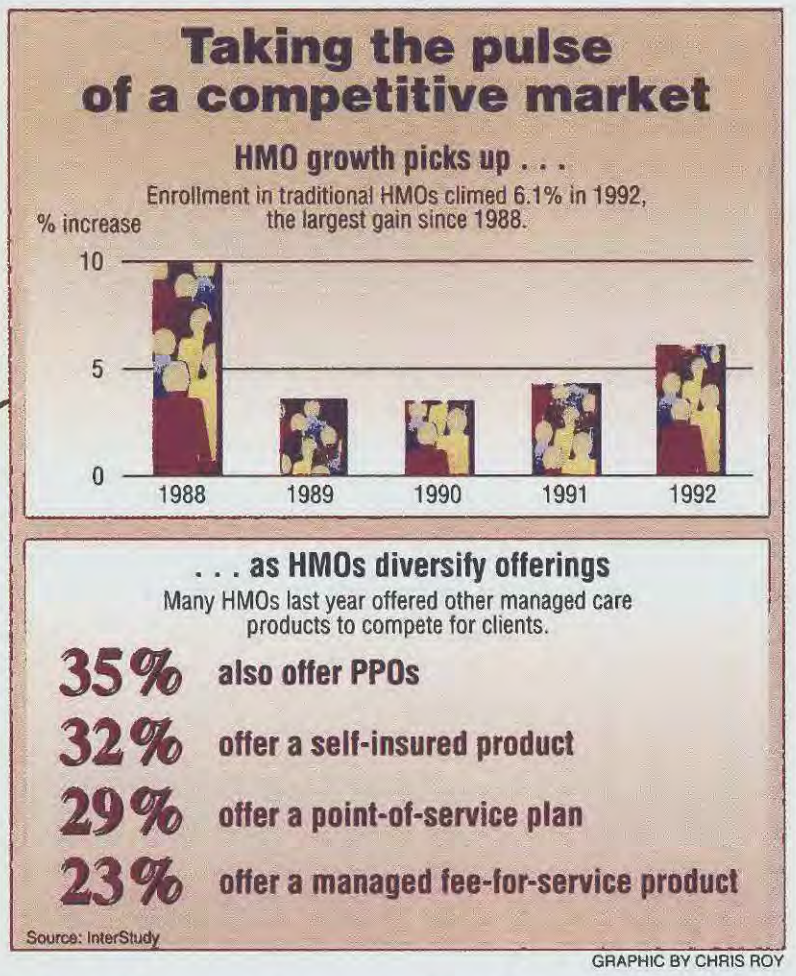
HMO competition escalates



GRAPHIC BY CHRIS ROY

New growth spurt reported among traditional plans

By CHRISTINE WOOLSEY

Enrollment in traditional health maintenance organizations increased in a recent 12-month period at the fastest annual pace since 1988, a new survey finds.

The survey also found intense competition among HMOs, which benefit experts speculate may prompt HMOs to offer a wider range of managed care products to meet employers' specific needs.

Enrollment in traditional HMOs jumped 6.1% between July 1991 and July 1992, reported InterStudy, a managed care research firm in Excelsior, Minn. As of July 1992, roughly 37.2 million people were enrolled in traditional HMOs, up from about 35.1 million in July 1991, according to the latest "InterStudy Competitive Edge" report, a biannual survey of HMOs.

That level of growth is the highest since 1988, when enrollment in traditional HMOs jumped nearly 10% (see chart.)

However, semiannual enrollment rates actually slowed in the second half of that period, suggesting that

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Defined contribution plans boom

Cost control features, administrative ease fueling growth

By JERRY GEISEL

WASHINGTON—The most important pension development of the next several years will be the explosive growth of defined contribution plans, says the former top U.S. pension regulator, David George Ball.

Mr. Ball served in the Bush administration as assistant secretary of labor in charge of the Office of Pension and Welfare Benefits Administration.

Speaking last week in Washington at the 1993 GIC Assn. National Forum, Mr. Ball, now a partner with law firm Williams, Mullen, Christian & Dobbins, outlined several factors that will propel future defined contribution plan growth:

- Lower administrative costs. Insurance premiums paid by employers with defined benefit

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Housecleaning begins—quietly—at Transamerica

By JOANNE WOJCIK

WOODLAND HILLS, Calif.—The ax has already begun to fall at Transamerica Insurance Co., even though the insurer has not yet received the green light to begin its initial public offering.

Officials at the Woodland Hills, Calif.-based property/casualty insurance subsidiary of Transamerica Corp. are mum pending Securities and Exchange Commission approval of its IPO.

But the insurer's new management has already begun major changes.

Although the exit of Gerald A. Isom as president and chief executive officer was made public when Transamerica announced it was seeking to spin off its property/casualty unit, other top executives have since left the company with little or no fanfare. Mr. Isom last week was named to head CIGNA Corp.'s domestic property/casualty operations.

The greatest casualties were suffered by Transamerica's specialty insurance division, which underwrites coverage for entertainment and sporting events and other leisure activities, and other commercial lines operations.

Transamerica announced last July that it would divest Transamerica Insurance Group, which includes Transamerica Reinsurance Co., to focus on less cyclical and more profitable financial services and life insurance activities (*BI*, July 27, 1992).

The company later announced it would sell the property/casualty unit to the public in spring 1993 to provide more benefits to shareholders than selling to a single buyer (*BI*, Nov. 23, 1992).

Transamerica Insurance Group has been temporarily renamed TIG Holdings Inc. as part of its separation agreement with Transamerica. The company's permanent new moniker has not yet been announced.

Under its current spinoff plan, TIG will offer 30 million common shares to the public for $21 a share. That would leave 47% of the company's ownership with its former parent, which would receive approximately $419 million from the sale. TIG would receive about $211 million.

Upon completion of the IPO, Jon Rotenstreich, former president of Torchmark

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Dingell reintroduces bill with few changes

Multistate insurers would have to meet federal standards

By MARK A. HOFMANN

WASHINGTON—All insurers operating in more than one state would have to meet federal uniform solvency standards under a bill introduced last week by U.S. House Energy & Commerce Committee Chairman John Dingell, D-Mich.

H.R. 1290, the Federal Insurance Solvency Act of 1993, is otherwise very similar to the proposal, H.R. 4900, that Rep. Dingell introduced last spring (*BI*, April 13, 1992).

Like last year's bill, the new bill would allow life/health and property/casualty insurers to choose whether to be subject to state or federal insurance solvency regulation. Insurers that received a federal solvency certificate would participate in a new Federal Insurance Protection Corp., rather than state guaranty funds, and be exempt from state solvency regulation, although most insurers would remain subject to state rate and form regulation.

A partial exception would be made for large commercial insurers—defined as those with a net worth of more than $50 million—that sell policies to large commercial buyers—defined as those with a net worth of at least $10 million.

Such policies would not be subject to rate and form regulation and would not be covered by the federal guaranty fund.

The new uniform solvency standards for interstate insurers would be determined by a Federal Insurance Solvency Commission, which would set standards for insurers opting for federal regulation.

State regulators would enforce the standards for multistate insurers that choose state regulation.

In a related development, House Consumer Credit and Insurance Subcommittee Chairman Joseph Kennedy, D-Mass., introduced H.R. 1257 to create a Federal Insurance Administration that would monitor reports of illegal "redlining" in urban areas and create a federal certification program for foreign-owned insurers. Rep. Kennedy recently began holding hearings on alleged redlining—or refusing to sell insurance in minority or inner city neighborhoods (*BI*, March 1).

The National Assn. of Insurance Commissioners condemned both the Dingell and Kennedy bills. They are "competing visions of how to establish a new layer of federal bureaucracy," charged NAIC President Steven T. Foster.

"One would think that the experience of the 1980s—when cumbersome federal bureaucracies creating conflict with state regulators proved themselves inadequate to the task of regulating banks and thrifts—would have cured policymakers from the temptation to superimpose a new federal bureaucracy upon an existing state-based regulatory system. Sadly, it would appear that some have not yet learned that painful and costly lesson," said Mr. Foster, who is Virginia's insurance commissioner.

David M. Farmer, vp-federal affairs for the Alliance of American Insurers, said the Dingell bill would burden consumers and insurers with new costs for duplicative regulation. He called the approach "unworkable."

Lowell R. Beck, president of the National Assn. of Independent Insurers, also opposes the Dingell bill, charging it would create "an onerous, conflicting and overlapping regulatory system."

However, David Pratt, senior vp-federal affairs for the American Insurance Assn., called the proposed uniform solvency standards "a very positive development." The AIA broke with other insurance company groups more than a year ago to support federal solvency regulation. BI

Changes in *BI* edit staff in Chicago

CHICAGO—*Business Insurance* has made two editorial staff changes in its Chicago office.

Copy Editor Nancy P. Johnson has been named an associate editor, while Regis J. Coccia joins the *BI* staff replacing Ms. Johnson.

Ms. Johnson, 38, is joining *BI's* reporting staff after three years as a copy editor. Since joining the magazine in 1990, she has been responsible for the Perspectives and Insurer Topics sections.

Ms. Johnson

Mr. Coccia

She previously was an associate editor at Charles D. Spencer & Associates in Chicago.

Ms. Johnson holds a bachelor's degree in English from North Dakota State University in Fargo.

In her new reporting position, she will cover employee benefits and health care issues, as well as life/health insurance companies. Ms. Johnson can be reached at 312-649-7784.

Mr. Coccia, 24, joined *BI* in February. Previously, he worked as the assistant city editor at The Herald in Jasper, Ind.

He interned as a reporter and copy editor at The South Bend, Ind., Tribune while earning a bachelor's degree in American studies at the University of Notre Dame in Notre Dame, Ind. He also held internships with Dow Jones Voice Information Services in Princeton, N.J., and The Courier-News in Bridgewater, N.J.

Mr. Coccia can be reached at 312-649-5274. BI

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For more information about Wausau's HPR/Property Special Risk Division contact Paul Enos, senior vice president, (715) 842-6248, or your local Wausau Insurance office.

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Dodgers put 401(k) plan into their lineup

Benefit Beat

While Darryl Strawberry and the rest of the Los Angeles Dodgers are currently training in Florida for another season, the team's home office staff and other non-Major League members of the Dodgers organization are beginning their first full season with a 401(k) savings plan and an incremental retirement program.

Last summer, as the Dodgers struggled through an unusual last-place season, not all was blue in Dodgertown.

The Los Angeles Dodgers Inc. unveiled its Hall of Fame Retirement Plan featuring a generous 401(k) plan, bonuses and a unique program that helps older Dodger employees ease into retirement.

About 325 Dodger employees, including coaches, scouts, minor league players and other front office staff are eligible to participate in the plan.

Major League players have their own savings and pension plans through Major League Baseball and the players' union.

At the center of the Dodgers' retirement package is a 401(k) savings plan that permits employees to annually allocate up to 6% of their salary to the plan with the Dodgers fully matching the first 2% and contributing 50% of the next 4%.

In addition, the Dodgers organization contributes a flat 5% of each employee's salary to the fund at the end of each year as a bonus, and an additional 2% of salary to help participants pay for future retiree medical coverage.

Employees have full investment control over their fund balance. Scudder, Stevens & Clark Inc. administers the fund, which allows employees to direct all or a portion of their funds to a cash/money market account, a bond fund or an equities fund.

The 401(k) plan replaced a discretionary profit-sharing plan that consistently contributed 15% of salary to Dodger employees. However, last year, facing the probability of having to greatly reduce the 15% contribution, the Dodgers decided to create a plan that required employee participation, but still provided rich contributions from the organization, said Irene Tanji, director of human resources and administration.

"The club for years had a discretionary profit-sharing plan that employees had counted on because the contributions were always there and always very good. But last year, there was going to be drastic change. The company wasn't going to make a contribution, but it still wanted to do something," she explained, adding that funds held in the profit-sharing plan were transferred over to the 401(k) plan.

In addition to the 401(k) program, the Dodgers implemented what they call their RBI (retirement by increment) plan.

The three-year plan requires that employees work only half-time during the first year. The second year of the plan calls for employees to reduce their work load by two-thirds. The employee then retires in the third year.

During the incremental retirement period, the Dodgers pay full benefits, and in cases where an employee's reduced salary leaves that person with insufficient money to live on, the Dodgers allow the employee to borrow money from the new 401(k) fund with no early withdrawal penalties.

"The new plan is designed to provide employees with safety and profitable savings options. They were never able to invest their money before," said Ms. Tanji.

The Hall of Fame plan satisfies Major League Baseball's requirement that every club participate in a league-wide defined benefit savings and profit-sharing plan for non-uniformed staff and minor leaguers, or offer a similar plan that vests participants in five years.

The Dodgers have had their own retirement plan—the profit-sharing plan, and now the 401(k) plan—since 1981, Ms. Tanji said.

—By Michael Schachner

'No frills' health plans

"No frills" health insurance policies have not caught on as well as expected, according to a new study.

Although 24 states have authorized the sale of such policies since 1990, the policies currently are being sold only in 11 states, according to a study by the Blue Cross & Blue Shield Assn.

Mandated benefits can be costly. So several states now allow private insurers to offer "no frills" benefit policies that waive coverage of all or some mandated benefits.

These basic policies provide basic primary and acute care, including inpatient and outpatient hospital benefits as well as physician and diagnostic services. The policies generally exclude costly mandated benefits such as treatment for mental illness, alcoholism or substance abuse.

These policies can be purchased by small groups in eight states and by individuals and their families in seven states. All but three of the states limit eligibility to firms or individuals who have been uninsured for a significant length of time.

"There are several legitimate reasons why these policies have not caught on as quickly as initially hoped," the report says:

- Even with lower premiums than traditional insurance products, some small employers and individuals still cannot afford them. Several states that have passed laws waiving mandated benefits also enacted tax credits to encourage small firms to offer health insurance.
- The requirement that groups or individuals have gone without insurance for 12 months or longer significantly reduces the potential market. For example, it is estimated that 40% of the uninsured in Maryland have been without coverage for less than 12 months, and, therefore, are automatically excluded.

Continued on next page

Continued from previous page

• Marketing insurance plans to small employers is more difficult and time-consuming than dealing with large employers because of high employee turnover, lack of sophistication in purchasing health care coverage, and frequent business-site relocation.

The study points out that it takes time for any new policy to be introduced to the market and for new subscribers to step forward. Many of the basic benefit policies have only been available for a year or less.

And, the report adds that some small employers do not believe that they need to offer health insurance benefits to their workforce to attract and retain qualified employees.

"To date, these basic benefit plans have had mixed results," said the report's author, Susan S. Laudicina, director of research at the Blue Cross & Blue Shield Assn. in Washington. But the plans have done well in the states where they are marketed well, she pointed out.

"These policies are useful for an important segment of the population. They help the individual and employers who don't have anywhere else to go.

"They aren't the solution to the problem of the uninsured, but until we get comprehensive health reform, this is one step that will help," Ms. Laudicina added.

—By Nancy P. Johnson

Retiree plan changes

Almost three-quarters of organizations that provide medical benefits to retirees have changed their retiree medical plans during the last three years, but the majority of these firms grandfather current retirees when changes are made, according to a new survey.

Seventy-four percent of the 330 employers responding to a survey conducted by New York-based Buck Consultants Inc. said they have already modified their retiree medical plans, and another 16% said they are considering doing so.

However, 59% of the firms said they either have or will exempt current retirees from the changes, according to the survey released last month.

Predominantly, the most popular changes require beneficiaries to share a greater portion of their retiree medical costs than they had previously, according to the survey.

For example, more than one-third of the employers that offer retiree medical plans either have increased or plan to increase deductibles, the survey found. More than one-third of the employers also have increased or plan to increase retiree contributions to health insurance premiums. And approximately one-third of firms also have increased or plan to increase out-of-pocket limits.

"Many employers are attempting to balance their desire to provide core medical benefits to retirees with their need to reduce costs and liabilities prior to the adoption of" Financial Accounting Standard 106, commented Marsha Venturi, a consulting actuary in Buck's Secaucus, N.J., office. "In most cases this requires increasing participants' costs."

To avoid legal challenges to an employer's attempts to modify retiree benefits, 87% of the firms specifically state in plan documents and corporate communications that retiree benefits are not guaranteed and can be changed or terminated. Eleven percent of the organizations do not make such statements, while 2% guarantee retiree medical benefits.

The 21-page study also covers the prevalence of retiree non-pension benefits, retiree medical benefit eligibility requirements, coordinating retiree medical benefits with Medicare, retiree medical benefit modifications and how firms communicate retiree medical benefits.

"Postretirement Non-pension Benefit Design: A Delicate Balance," is available for $75 from Carolee Martin, Manager of Marketing, Buck Consultants Inc., Secaucus, N.J. 07096-1533; 201-902-2555.

—By Deborah Shalowitz

Insurance program via satellite

NEW YORK—"The Premium Dollar Today," a half-hour cable television series on insurance industry issues, will be available to at least five million satellite dishes across the country starting April 5.

Access America will air the programs at 12:30 p.m. and 11:30 p.m. EST Monday through Friday on GE Americom Satellite F-2 Transponder 7.

This marks the first time a business show like "The Premium Dollar Today" has been available on a mass market satellite network, said Executive Producer Rudy Marinelli.

Rebroadcasts of "The Premium Dollar Today" will be available on satellite through the end of June in addition to the series' current schedule on the USA Network Tuesdays at 6 a.m. EST.

"The Premium Dollar Today" is co-sponsored by: A.M. Best Co.; KPMG Peat Marwick Financial Services; Reliance National Insurance Co., a unit of Reliance Group Holdings Inc.; and The Society of Chartered Property & Casualty Underwriters.

Herbert E. Goodfriend, director of insurance analysis with KPMG Peat Marwick, is the host.

Business Insurance provides special editorial assistance to the series.

In March, "The Premium Dollar Today" will address alternative markets, insurance crime and inner city insurance.

The schedule of programs through March is:

• March 16, "Alternative Markets," including panelists John Kessock Jr., chairman of Commonwealth Risk Services Inc.; Thomas V. Hallett, senior vp of Alexander & Alexander Services Inc.; Tony Rodolakis, vp-risk management & insurance at Holiday Inn Worldwide. The program is airing for the first time.

• March 23, "Insurance Crime," featuring panelists Arnold Schlossberg Jr., president and CEO of the National Insurance Crime Bureau; Bill Kizorek, president of InPhoto Surveillance; Evo Riguzzi Jr., director of corporate security and consumer affairs for The Home Insurance Co.; and Frank Doolittle, director of Florida's Division of Insurance Fraud. The program first aired in 1992.

• March 30, "Inner City Insurance" including panelists Selwyn Whitehead, president of the Economic Empowerment Fund; Robert M. Willis, superintendent of insurance for the District of Columbia; and Robert M. Wallach, president and CEO of the Robert Plan Corp. The program is airing for the first time.

Opinions

Retirees' plight no sob story

YOU'D HAVE TO HAVE a heart of stone not to be moved by the stories that retirees told a Senate panel this month about the impact of losing their employer-provided health coverage.

Take Herman Fasching, who retired from Unisys Corp. in 1988 after 33 years with the computer systems manufacturer. Both Mr. Fasching and his wife have serious medical problems. When Unisys stops contributing to its retiree health care plan in 1996, Mr. Fasching says he will have to pay $8,000 for coverage that Unisys had been providing. The cost of health care coverage alone will just about wipe out his pension benefits, Mr. Fasching and other retirees told the Senate Labor and Human Resources Committee (*BI*, March 15).

This story is not unique. Thousands of retirees whose former employers either have or intend to eliminate health care coverage live in fear and anxiety.

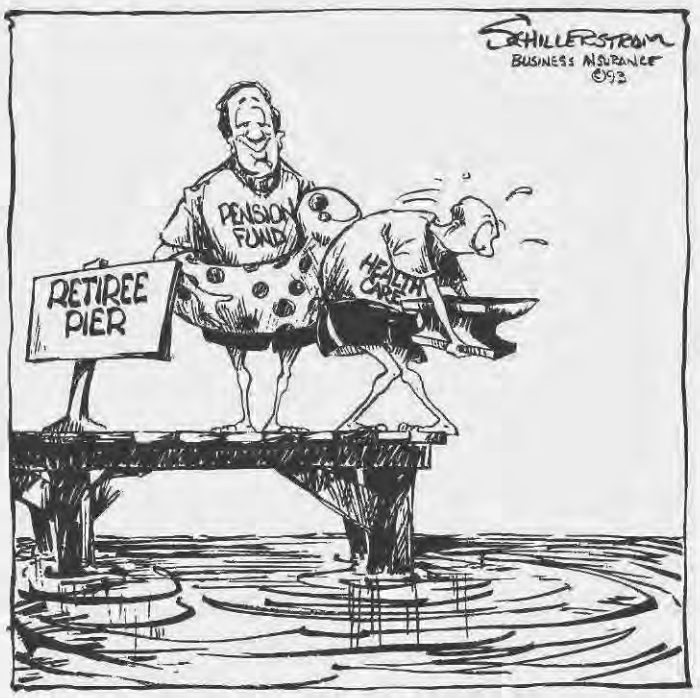
However, it would be easy to draw the wrong conclusions after listening to these stories.

It would be wrong to conclude that employers cutting or eliminating retiree care benefits are doing something illegal or improper. Federal courts have consistently upheld the right of employers to change or eliminate their retiree health care programs as long as they reserved the right—in plan documents—to make changes.

It also would be wrong to blame the Financial Accounting Standards Board for the wave of retiree health care plan cutbacks. Certainly, FAS 106 has resulted in many employers reporting enormous losses. But FAS 106 only has changed the way retiree health care obligations are reported. The liabilities would be just as large if there was no FAS 106.

On the other hand, employers and legislators can learn plenty from the victims of retiree health plan cutbacks.

Employers must re-examine plan documents to be sure employees understand the limits of retiree health care programs. How the programs work should be spelled out clearly and prominently. These benefits are too important to be tersely mentioned on page 143 of a benefits booklet.



For legislators, the lesson should be that employers need more financial incentives to offer and maintain retiree health care programs. Legislators recognize it is in the public interest for employers to offer pension plans and, correspondingly, allow companies to tax-effectively prefund pension benefits. Retiree health care programs are no less important and deserve the same tax treatment.

Of course, if tax laws are changed to encourage employers to prefund retiree health care benefits, the government will force employers to promise that health care coverage will be offered when workers retire. While employers are likely to resist such an obligation, it will be a boon for retirees like Mr. Fasching.

Letters

Self-insurance should be part of health care reform

To the editor: Two thumbs down for Dr. Paul Ellwood's unfortunate views concerning self-insurance (*BI*, Feb. 15). Dr. Ellwood's opinion that employers will abandon self-insured health plans if managed competition is adopted ignores the positive role of self-insurance in the current health care system.

More than 65% of the workforce currently covered by group health care plans participate in self-insured plans. The desire to provide high-quality health care at affordable cost has been the principal reason employers have adopted self-funded plans. Recent studies confirm that the administrative costs of self-funded plans are significantly less than the similar costs of commercial insurers, HMOs and Blue Cross/Blue Shield-type programs.

To write self-funded plans out of the health system infrastructure is to overlook the important factors that have contributed to the phenomenal growth of these plans during the 1980s—a trend that is continuing into the '90s as more and more employers with fewer than 100 workers utilize self-insurance.

Managed competition is not a proven panacea for solving the nation's health care problems. Although the concept has been embraced by the California public employee system, it remains an untested concept in the private sector. Important questions have been raised about the cost containment and quality aspects of managed competition. Indeed, a new Congressional Budget Office study concludes that managed competition would leave health expenditures at the same level they would reach without it (*BI*, Feb. 8), and President Clinton's transition team concluded that managed competition would only provide minor cost reductions.

With regard to data collection, the self-funding industry is light years ahead of both traditional insurers and government. The backbone of self-funding lies in administration, creative plan design and data management. Third-party administrators, in conjunction with the computer industry, are on the cutting edge of data collection and outcome management.

If managed competition is implemented, its goal should be to bring more, not less, competition into the health care system and give consumers more choice in selecting efficient, affordable health plans. The challenge should be to combine managed competition with the most efficient health plans, not to discourage or eliminate such plans. To work effectively, managed competition must encompass a framework of consumer choice among a variety of competing health plans, including both insured and self-insured plans that meet requisite federal standards.

To do otherwise would be to ignore the self-funding alternative in providing employers with a cost-efficient method of managing heath care costs.

James A. Kinder
Executive Vp
Self-Insurance Institute of America
Irvine, Calif

* * *

To the editor: Who's kidding whom?

In my opinion, Dr. Ellwood's high and mighty conclusions, as well as those of some consultants, exhibit astonishing evidence of ignorance and the appearance of self-service that the powerful market force of self-funding will dry up and fall back to the de facto insurer monopoly.

One of the reasons managed care entities have had difficulty cracking the self-insured marketplace is the lack of ability to provide employers with "outcomes and costs" that independent third-party administrators and case managers provide as a matter of course. Why would anyone believe that capitated fees are easier to budget than prospectively priced, fully insured indemnity plans or self-funded employers with stop-loss coverage?

We all appreciate the exhilarating beauty and splendor of Jackson Hole and the beauty of the Pacific, but Dr. Ellwood's group and similar-thinking benefit consultants should respectively come out of the thin air and fog to the "street" before making inaccurate statements and innuendoes about self-funding and its administrative capabilities.

Health reform should concentrate provider costs by leveling the public and private playing field and preventing employers from having to revert to de facto insurer monopoly and insured managed competition or being forced into new-breed risk transfer entities like HMOs. The self-funding infrastructure has matured and is poised to meet its responsibilities to the national health care reform effort. If not blown away by powerful forces that fear its competitive presence, self-funding will be the financing vehicle of choice.

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Policyholder information

Continued from page 3

sharing between insurers and policyholders.

Ms. O'Hare follows this rule of thumb: "If a document is sensitive, I don't want to give it to the insurance company."

Among the information frequently requested by an insurer, according to a paper distributed by Ms. O'Hare, are:

- All other policies that might provide coverage, including all policies above or below the insurer's own layer.
- Legal bills.
- Pleadings, notes, memoranda and depositions from legal files related to the underlying litigation.
- In environmental cases, site evaluations and expert reports.

Policyholders should be careful not to release internal memoranda, notes and other material protected by attorney-client privilege, Ms. O'Hare admonished. Otherwise, the attorney-client privilege may be waived by the disclosure, she explained.

"This is particularly true when the insurance company itself is not defending the suit," she said.

Policyholders also should make their insurers aware of the time and expense necessary to provide copies of requested documents.

For example, because continuous trigger cases "can certainly result in a voluminous copying job. . .ask the insurer if they will accept just the potentially applicable policies, such as policies in their year or the policies underneath them," Ms. O'Hare suggested.

Any potentially sensitive information released to insurers should be protected from disclosure to third parties by a confidentiality agreement, both lawyers agreed.

In some cases, when insurers are made aware that information a policyholder has on file could increase its liability if released, "they will say they don't want it in their files anyway," Ms. O'Hare said.

When the policyholder retains its own counsel and supervises the litigation, the policyholder should provide its insurer with periodic updates on cases that may result in large settlements or verdicts, or in cases in which legal fees are substantial, according to Ms. O'Hare.

Among the information that she advised policyholders to provide in these instances are: the amount spent on defense and in settlements or judgments; the product or products involved; relevant history, such as when a subsidiary was acquired or sold; and the status of the case.

"A policyholder does not need the insurance company's consent to settle if the insurance company does not unconditionally assume liability under the policy," she explained.

Reserves set for claims that fall within a company's self-insured retention also are protected from the discovery process, she noted.

One easy way for policyholders to provide information to insurers without taking up too much time and expense is to hold an informational meeting, Ms. O'Hare suggested.

"We did this with the heart valve case," she said, referring to the numerous lawsuits filed against Pfizer subsidiary Shiley Inc. of Irvine, Calif., for fractures in its Bjork-Shiley Convexo/Concave heart valves.

In the past year, Pfizer has negotiated a class-action settlement with about 50,000 heart valve recipients. However, about 850 plaintiffs have opted out of the settlement. About 330 of these claims were settled individually, leaving 520 cases open (*BI,* Nov. 30, 1992).

"We held an informational meeting with the insurers after the class-action settlement was reached," she recounted. "It was well-received by the carriers and a good way to get a lot of information out all at once." BI

Audits are useful tools to control legal costs

By JOANNE WOJCIK

PHOENIX—Policyholders and insurers both can benefit from keeping tabs on their lawyers' expenses, legal experts say.

But while an audit may sometimes be necessary when it seems legal fees are getting out of hand, selecting lawyers who understand their clients' business needs will often ensure the most cost-effective legal representation, they add.

"The insured can benefit a great deal from audits," asserted James P. Schratz, vp of major claims for Fireman's Fund Insurance Co. in Santa Rosa, Calif.

However, the purpose of the audit should be solely to verify legal bills that have been submitted, not to conduct a witch hunt, Mr. Schratz stressed.

"The goal of an audit is to find cost-effective billing," concurred John J. Marquess, chairman and chief executive officer of Legalgard, a Philadelphia-based legal-fee auditor.

And lawyers who learn how to think like their clients "as if it were their money and not someone else's" are less likely to provoke an audit, said Michael E. Bragg, an in-house attorney for State Farm Fire & Casualty Co. in Bloomington, Ill.

"Lawyers are more inclined to think in terms of winning cases than settling cases," he said. "But lawyers have to start thinking like businesspeople" and consider such things as "how much they are willing to pay to make a case go away."

Messrs. Schratz, Marquess and Bragg spoke at separate sessions held during last month's meeting of the Insurance Coverage Litigation Committee of the American Bar Assn.'s Tort & Insurance Practice Section.

Audits are more likely to produce savings when they are used to track expenses associated with high-profile cases in which legal fees exceed $500,000, according to Mr. Schratz.

"We don't have a blacklist of attorneys. It usually comes down to the amount," he said.

Mr. Schratz spearheaded a 1990 investigation into fraudulent billing practices by a group of insurance defense attorneys in Southern California.

Fireman's Fund and Allstate Insurance Co. filed a massive fraud suit three years ago charging the attorneys, known as "the Alliance," with conspiring to inflate insurers' legal bills in lawsuits during the 1980s, bilking them of more than $200 million in excessive legal fees (*BI,* April 2, 1990).

In addition, a federal grand jury indicted several of the attorneys named in the suit on charges of defrauding insurers of up to $50 million by manipulating and prolonging litigation (*BI,* April 30, 1990).

Other factors likely to point up the need for a legal expense audit are excessive billing on a certain file or overstaffing on certain cases.

For example, Fireman's Fund audited one firm after learning that a large number of attorneys attended a deposition of a famous rock star.

"They clearly just wanted to go and meet the rock star," he said.

Some of the typical problems likely to turn up in an audit, according to Legalgard's Mr. Marquess, include:

- Inefficiency.
- Fraud.
- Charges for "tools of the trade," such as law books or the use of legal data bases.
- Costs of doing business, such as rent, heating, training, etc.
- Deceptive billing practices, such as charging paralegal prices for secretarial work.
- Lack of lawyer accountability, such as irregular tracking of time spent on a particular case or expenses associated with it.

Audits are aimed at trimming the fat from legal expenses, not at lawyer's pocketbooks, Mr. Marquess assured the attorney audience.

"We do not advocate the cheapest representation," he said. "Just the most cost-effective."

And most audits can be avoided if lawyers simply "open their books to clients so they can justify their rates," he suggested.

What is required, by both lawyers and purchasers of outside legal services, is "a frank examination of the attorney-client relationship and a commitment to reaching an understanding of how litigation is to be handled and staffed, how services will be billed and paid and what outside counsel and claims professionals alike truly expect of each other," said Mitchell A. Orpett, an attorney with Tribler & Orpett in Chicago, in a paper he presented during the meeting.

While "ultimately the responsibility of litigation cost management lies with the client," he said, "it's necessary for lawyers to be better businesspeople and more sensitive to the business needs of their clients." BI

ABA group holds first conference

PHOENIX—A total of 90 lawyers attended the Feb. 25-27 meeting of the Insurance Coverage Litigation Committee of the American Bar Assn.'s Tort & Insurance Practice Section in Phoenix.

The meeting was the first to be held by the newly formed TIPS committee. Session topics included: information sharing by insurers and policyholders; insurance coverage for derivative liabilities of successor corporations; alternative dispute resolution; litigation expense management; and the structure of the London insurance market.

The committee targets plaintiff, defense, insurer and other corporate attorneys who devote a substantial portion of their practice to insurance coverage issues.

Details about next year's meeting, to be held in Orlando, Fla., are still being finalized. For further information contact committee Chairman Thomas J. Minton, at Quinn, Ward & Kershaw, 113 W. Monument St., Baltimore, Md. 21201; 410-685-6700.

Unlimited liability

Continued from page 3

facturers were excluded from the liability limit.

In 1955, most nations adopted the Hague Protocol, which raised the Warsaw limit to about $16,600 per passenger.

In 1966, after the United States threatened to withdraw from the Warsaw Convention over dissatisfaction with the limits, airlines signed the Montreal Agreement, which capped their liability to $75,000 per passenger on flights to, from and stopping in the United States.

In the early 1970s, another international agreement, the Montreal Protocols, proposed changing the Warsaw limit to 100,000 special drawing rights ($137,500). SDRs are a monetary unit based on the exchange rates for British, French, German, Japanese and U.S. currencies. The Montreal Protocols limit was adopted by Japan and most European countries, but the United States has so far failed to ratify this agreement.

In addition to the protocols, the U.S. Department of Transportation in 1989 proposed a supplemental compensation plan that would provide U.S. citizens and residents on international flights with unlimited recovery for economic damages, subject to a per-incident, per-aircraft limit of $500 million (*BI*, March 19, 1990; March 27, 1989).

But so far, "nothing has happened," said Mr. Tompkins.

And President Clinton's agenda is unlikely to include adopting the Montreal Protocols or the proposed supplemental plan, he said, which means it is unlikely that they will be acted on by Congress.

In the meantime, the European Commission last October published a paper proposing that all airlines in the European Community adopt a per passenger liability limit of 250,000 SDRs ($343,750) for cross-border flights within the community, Mr. Martin said at the DYP conference. The European Commission's suggestion also would make it possible for passengers to buy first-party insurance from the airline above 250,000 SDRs.

"I suppose it has the benefit of relative simplicity and a relatively small (insurance) hike increase. And given the anxiety of airlines about the increase of insurance costs and not going too far too quickly, 250,000 SDRs might have some appeal. . . .But I think 250,000 is nickel and diming it and is not enough. It would be unpopular and instigate more litigation."

As for first-party insurance, Mr. Martin said airlines don't have the mechanisms to provide this coverage to passengers and, at the moment, it would be too costly.

Yet while governments argue over airline passenger liability limitations, "the Japanese with the stroke of a pen solved their problem," observed Mr. Tompkins.

The Japanese airline industry's concern about the liability limit for international flights in their country followed the 1985 crash of a Japan Air Lines Boeing 747, which killed all but one of the 502 people on board. The disaster was one of the worst in aviation history, and awards averaging $800,000 per passenger were paid, mainly by aircraft manufacturer Boeing Corp.

The JAL disaster highlighted a disparity in Japanese airline regulations. Passengers ticketed for a domestic flight in Japan had unlimited liability while passengers with international tickets carried a liability limitation, even if they were sitting on the same plane.

After the JAL loss, the Japanese "felt that they could no longer wait for the U.S. and others to ratify (the Montreal Protocols) and for their own government to make a supplemental compensation plan," said Mr. Martin.

After two years of preparation, 10 Japanese airlines—with government approval—last November adopted two paragraphs into their conditions of carriage, which apply to passenger liability on all international flights. The paragraphs, printed on each passenger ticket, say that:

- Each airline shall not apply the applicable limit of liability in Article 22(1) of the Warsaw Convention in defense of any claim arising out of the death, wounding or other bodily injury of a passenger within the meaning of the convention.
- Each airline shall not use any defense for negligence as stated in Article 20(1) of the Warsaw Convention up to 100,000 SDRs ($137,500), but will use those defenses thereafter, excluding legal costs awarded by a court.

The waiver is only intended for Japanese airlines and does not apply to other airlines involved in an inter-airline ticket, said Mr. Tompkins. For example, if a passenger with a JAL ticket is injured during a non-JAL airline connection, unlimited liability would not apply.

At the end of last year, Japanese airline AlNippon Airways sought approval of this waiver from the U.S. Department of Transportation. The other Japanese airlines are expected to follow suit.

According to Mr. Tompkins, the Department of Transportation in agreeing to the exemption wrote: "While the Montreal Agreement binds the parties to a liability limit of $75,000. . .it was not intended to preclude the waiver of limitations of liability for higher amounts or to unlimited liability as proposed. . .in a manner which would benefit the traveling public in the form of additional protection. Therefore, we find the release sought by AlNippon Airways is consistent with the public interest of the United States."

The Department of Transportation "has embraced and endorsed what the Japanese have done," said Mr. Tompkins.

But, while the department approves of this liability waiver,

Continued on next page

Unlimited liability

Continued from previous page

American airlines are reluctant to follow the Japanese lead, he said. Rather, he said, American airlines are committed to pushing the Montreal Protocols and supplemental agreement through Congress.

"It doesn't make sense to me because I don't think any U.S. airline insures based on a liability limit applying," said Mr. Tompkins. U.S. airlines already have unlimited liability on all domestic flights, he pointed out.

However, airline insurers are concerned that unlimited liability on international flights will increase their underwriting losses. Some of the leading aviation underwriters therefore plan to charge additional premiums to airlines with unlimited liability.

"While no one can produce precise figures to indicate the effect on liability awards if the limitations are removed, it is unrealistic to suggest that in the majority of instances such an action would not translate into extra potential exposure to insurers," said Tony Medniuk, underwriter for Lloyd's of London's MLP Aviation Group. "Depending on the detail, carriers should contemplate paying additional premium for additional exposure."

Mr. Medniuk also wants airlines to make sure that limits of liability are not removed for baggage and cargo, which are separate from passenger bodily injury limits under the Warsaw Convention. Under the convention, the limits basically are about $9 per pound of checked baggage and $400 per passenger for unchecked baggage.

"My fear is that if there are no liability limits on baggage claims, then the prospect of every claimant seeking compensation for loss of Gucci shoes or designer suits will rise dramatically," he said.

But Ralf Oelssner, director of corporate insurance for Lufthansa German Airlines of Cologne, Germany, told aviation underwriters to look on the bright side of this new trend.

"There is a chance of a lifetime in the oncoming subject of doing away with present liability limits," said Mr. Oelssner. "Don't just think of the limits or possibly non-limits, think of the potential savings."

The waiver of Warsaw liability limits means that costly and lengthy litigation to prove willful misconduct in order to negate the Warsaw Convention limits "won't be necessary," according to Mr. Tompkins. "If you get rid of it, you'll save money as an insurer."

The costs of litigation will be reduced substantially, he argued.

Litigation by injured parties seeking to void the Warsaw liability limit has postponed compensation to passengers and their relatives, created anger against the airline, and increased the costs to insurers that pay for the litigation.

Take, for example, the ongoing litigation between plaintiffs and the aviation underwriters of defunct Pan American World Airways Inc. resulting from the 1988 explosion of Flight 103 over Lockerbie, Scotland.

Last July—four years after the disaster—a jury found Pan Am and subsidiary Alert Management Systems Inc. guilty of willful misconduct for failing to detect an unaccompanied bag carrying a terrorist bomb on board Flight 103 (*BI*, July 13, 1992). This decision meant the Warsaw liability limit of $75,000 per passenger did not apply.

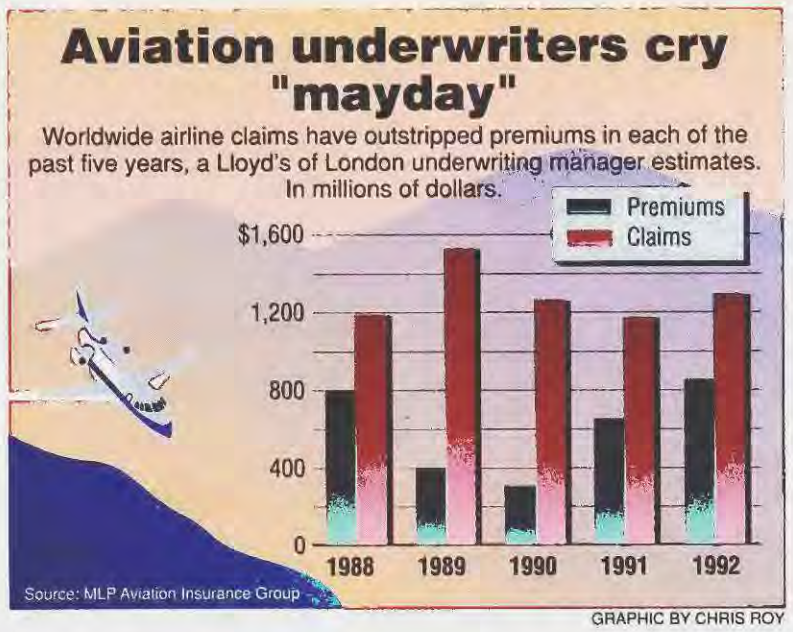
After the jury verdict, U.S. District Judge Thomas C. Platt heard four damage cases out of 135 before allowing Pan Am to appeal the jury verdict.

The awards to the families of the victims ranged from $225,000 to $9.2 million, said Mr. Tompkins.

In the appeal, to be heard April 26, Pan Am is challenging the judge on the way he conducted the trial.

But Mr. Martin says he is concerned about the Pan Am litigation, whichever way the appeal goes. If the appellate court favors Pan Am, then the Warsaw limit of $75,000 will apply and "many say that it is quite likely that the United States will pull out of Warsaw altogether" in the face of public criticism over low awards, he speculated.

"If the decision goes against Pan American, then there may be an enormous row over the length of time that it will have taken the families of the victims of the accident to make recoveries because of the complexity of the law," he said. BI



GRAPHIC BY CHRIS ROY

Aviation rate hike vital to industry

By STACY SHAPIRO

LONDON—Worldwide airline hull and liability insurance premiums must rise 76% this year for underwriters to make a profit, a Lloyd's of London aviation underwriter contends.

"If the insurance market is going to have any realistic prospect of making a profit in 1993," then it will need to charge a premium close to $1.5 billion, contends Tony Medniuk, Lloyd's aviation underwriter for syndicates managed by MLP Aviation Insurance Group.

The world's airlines last year generated an estimated $850 million in premium, but incurred an estimated $1.29 billion in claims, he said.

In fact, over the past five years, aviation claims have totaled an estimated $6.42 billion, while premiums were only an estimated $3 billion (see chart).

"Although still at an early stage, rate increases are now being applied which do suggest the premium target I referred to has a chance of becoming a reality. Will we carry it on throughout the year? There is no alternative. We have to," Mr. Medniuk said.

Aviation underwriters will not survive if they don't increase insurance prices, he said at the Eighth Annual International Airline Insurance Conference sponsored by the DYP Insurance & Reinsurance Research Group Ltd. in London earlier this month.

Underwriters charged an average of 0.06% of the insured value for hull coverage and seven cents per 1,000 revenue passenger kilometers for liability insurance in 1990, he said. RPKs are a unit of measure that reflects an airline's passenger volume and distances traveled.

In 1991, rates were increased to 0.12% on average for hulls and to 13.5 cents on average for liability.

Further efforts were made in 1992 to increase rates "but, it will be apparent to you, they were far from sufficient," he said. Hull rates increased to 0.14% on average in 1992, and liability rates increased to 17.5 cents on average.

However, to break even, underwriters need to charge closer to 0.25% on average for hulls and 28 cents on average for liabilities, said Mr. Medniuk.

"Pressure from management and shareholders to take appropriate action is becoming intense, and this is backed up by a much flintier reinsurance market which is not prepared to support indefinitely those markets which will not, or cannot, grasp the nettle to increase rates," he said.

Aviation underwriters are also examining the scope of coverage they provide.

For example, the London aviation market is reviewing coverage for leased aircraft.

The market introduced to brokers a new clause in airline coverage, known as AVN67, which would require airlines to pay an additional premium for leased aircraft to be covered by their hull insurance, Mr. Medniuk said. Many leased aircraft are also covered by warranties from leasing companies.

But following an outcry from airlines about the clause, it has not been enforced and is going to be reviewed by the market, he said. He did not elaborate on why the market sought an additional premium.

"I do not recall the publication of any other clause which has attracted so much heated comment," said Mr. Medniuk, who predicted that in the future, about 85% of new airline equipment will be leased.

"We're not happy," said one airline source. "Either lessors' interests are not going to be protected or it's going to cost us a lot more money."

Underwriters also are questioning whether they should cover low-level cargo and baggage losses of airlines. "Many underwriters feel that the level of liability coverage offered in respect of cargo and baggage comes down far too low," said Mr. Medniuk. "Others feel that, save for losses arising out of accidents to aircraft, we should not cover these aspects at all."

Perhaps this is an area where an airline's risk management skills could be deployed, he suggested. "I feel that many airlines, when they evaluate more carefully how they handle baggage losses, may decide there are better solutions than opting to go down the insurance route."

Meanwhile, the aviation market is consolidating, although capacity has not been diminished.

In the past four years, the number of underwriting organizations that write airline insurance has dropped to 134 companies from about 200 in 1988, according to Mr. Medniuk.

Despite the contraction in the London market, aviation underwriters can still provide enough capacity for $150 million per aircraft in hull insurance and liability limits of more than $1 billion, he said. BI

More to Avianca crash than no fuel

Airline argues air traffic controllers contributed to crash

By STACY SHAPIRO

LONDON—When Avianca Airlines Flight 052 crashed on its second approach into John F. Kennedy Airport in New York on Jan. 25, 1990, killing 73 of 149 on board, the reason looked simple.

"On the day it happened it looked obvious that the aircraft ran out of fuel," said Avianca attorney George N. Tompkins Jr., senior partner with Condon & Forsyth in New York.

The National Transportation Safety Board, which investigated the disaster, began and ended with that fact, he said.

But Avianca decided there was more to the crash than fuel exhaustion, Mr. Tompkins told underwriters and brokers in London at a special lecture sponsored by his law firm at The Royal Aeronautical Society earlier this month.

The Colombian airline decided to try and find out how and why the jet, which was en route from Bogota to New York, crashed when landing.

As soon as it was appointed, Condon & Forsyth made sure the "the passengers were taken care of from a humanitarian viewpoint. Insurers paid all the expenses for hospitals, doctors, funerals, everything, with no strings attached," he said.

The airline also offered to pay the Warsaw Convention liability of limitation for international flights of $75,000 per passenger "with no strings attached," he said.

A total of $8 million was paid for all of these expenses.

But Avianca still believed that more than fuel exhaustion led to the crash, said Mr. Tompkins. "No pilot would allow that to happen to him if he knew it was happening."

Condon & Forsyth went immediately to court and obtained information about the last hours of the Avianca flight—from the New York air traffic control center and other air traffic control centers the flight passed through. This included Miami, Jacksonville, Washington and all the centers in New York.

The defense attorneys concluded that a Federal Aviation Administration air traffic controller at Kennedy Airport delayed the landing of the Avianca flight despite the pilot's warning that he

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Alternative risk financing on horizon for airlines

By STACY SHAPIRO

LONDON—One day in the not-so-distant future, many airlines could fly solo—navigating their risk financing needs without traditional means of insurance.

As larger, stronger airlines emerge from an industry contraction, they are likely turn to self-insurance, captive insurers and mutual insurance companies for their coverage needs, observers predict.

At the same time, reinsurers will offer a range of protections —both aviation and non-aviation oriented—directly to airlines, circumventing insurers, they say.

Swiss Reinsurance Co., for example, recently opened a multinational department in Zurich to offer this type of package reinsurance directly to all types of companies.

The next step for the airline industry is globalization, said Jeffrey M. Jackson, vp and treasurer of American Airlines, in charge of insurance buying for the airline. He spoke at the Eighth International Airline Insurance conference sponsored by DYP Insurance & Reinsurance Research Group Ltd. earlier this month.

Non-U.S. airlines like British Airways P.L.C. already are trying to build global companies. They are interested in buying U.S. airlines because more than half of the world's flights are in the United States, said Mr. Jackson.

But U.S. airlines are disadvantaged when trying to buy airlines or acquire airport slots in some overseas destinations because of heavy regulation and restrictions on foreign ownership.

This puts a stranglehold on developing a global airline network. Instead, he said he favors free trade worldwide, and a "multilateral conference on civil aviation" to sort out these problems.

Nevertheless, the wind of change has blown already for the airlines, said Ralf Oelssner, director of corporation insurance for Lufthansa German Airlines of Cologne. The number of airlines already is decreasing following the $9.3 billion loss of revenues from scheduled international flight services between 1990 and 1992. At least another $600 million loss is expected for 1993.

Pressures from this "ocean of red ink. . .will obviously lead to fewer, considerably bigger airlines," said Mr. Oelssner. Some forecasters predict there will eventually be five major airlines in Europe and another five in the United States. This is not so far-fetched when you look at the three big U.S. airlines—American Airlines Inc., United Airlines and Delta Air Lines Inc.—which accounted for 56% of all U.S. air traffic last year, he said.

As individual airlines become bigger, "I am sure the airlines will become much more concerned with the thinking of the ultimate risk-taker, and there will be links with the reinsurers directly," predicted Mr. Oelssner. "The potential of self-retention will certainly be used much more fully to cut out money-swapping exercises and to cut down on premium volumes. Bigger boys can take bigger bumps."

Captives and mutuals will be used to retain layers of risk between a self-insured retention and true catastrophe cover, said Mr. Oelssner. Airline captives also might become more involved in other airlines' coverages. Already, British Airways captive Speedbird Insurance Co. Ltd. writes part of the hull and liability insurance of USAir Inc., said Mr. Oelssner. "The process within the airline industry will obviously reduce the premium base of today."

Peter Lerwill, general manager-risk management for British Airways, was in the audience and did not contradict Mr. Oelssner. But, Mr. Lerwill commented, "To expand and be global you have to be innovative. So watch this space."

"I'm beginning to know how the dinosaurs felt when their food supply ran out," said Brian Beagley, a leading Lloyd's of London aviation underwriter. "If we do get to the global scenario with only 15 airlines left, can such a situation support a specialist aviation insurance industry?"

"The simple answer is that the airlines will own the underwriters. If you get down to 15 mega-carriers and 15 underwriters, my guess is that they will own each other," said a delegate to the DYP Airline Insurance conference.

"The short-term future is not 15 airlines within the next year, nor is it 15 mega-insurers within the next year," said Tony Medniuk, Lloyd's aviation underwriter for syndicated managed by the MLP Aviation Insurance Group. "There will be fewer airlines and rather fewer insurers, and I do think the specialist (aviation insurance) markets are better equipped to understand and make the technical adjustments to coverages than a generalist insurer."

Another London-based aviation broker asked whether aviation underwriters were equipped to offer the whole gamut of coverages that airlines need.

"All the problems we have had in our business were when (underwriters) dabbled in risks they didn't understand," said Mr. Medniuk. "I have no problem with broadening the scope of coverages that we give in a simple policy. I'm not sure, with the structure of the market as it is at the moment, if we can handle it."

If an airline wanted to wrap up its property/casualty programs with its hull and liability and its workers compensation coverages, aviation underwriters might not know what exclusions are relevant. Such all-risk insurance can be priced, but aviation underwriters would do so at their peril without proper research, he said.

Swiss Re, which just created a department for multinational risks, may offer the whole scope of coverages and services to companies like airlines "because we think that is exactly what the client is looking for," said Carol Franklin Engler, head of Swiss Re's aviation department. BI

Avianca crash

Continued from previous page
was running out of fuel.

"We never tried to say that Avianca was completely free of fault," said Mr. Tompkins. But the FAA alleged the disaster was created solely by pilot error, "which was simply not credible," he said.

To get Avianca to pay more than the $75,000 per passenger liability limits set by the Warsaw Convention, plaintiffs' attorneys would have had to prove willful misconduct. However, Avianca offered to waive the liability limit if the trial would be held in front of a judge rather than a jury, said Mr. Tompkins.

After three days into the trial to assess damages, the U.S. government agreed with Avianca's reinsurers to pay part of the liabilities (*BI*, Nov. 23, 1992). *Business Insurance* learned last week that the U.S. government's portion will be between 40% and 45% of the claims.

At the time of the crash, Avianca had $600 million of liability insurance written by La Nacional de Seguros in Colombia, which was reinsured with markets worldwide and led by British Aviation Insurance Group (*BI*, Jan. 29, 1990).

Before the settlement was reached with the government, however, Avianca had a sophisticated computer program produced to show how the air traffic controller delayed the landing of Flight 052.

The product, known as the Aircraft Data Analysis and Presentation System, was never used in the trial. But Mr. Tompkins brought the system to show to the London aviation insurance market.

The graphics and the sound tapes between air traffic controllers, Avianca and several other airlines coming into Kennedy showed Avianca's case.

On the day of the crash, the weather was bad over Kennedy Airport. The FAA decided that morning there would be 33 flights per hour, excluding international flights and only one runway would be used, which was "the worst one to land on a bad day," said Mr. Tompkins. "The winds were tremendous."

Avianca left Bogota with 81,000 pounds of fuel on board, enough for more than a six-hour flight. The flight to New York was supposed to take four hours and 40 minutes.

The trouble began when Avianca was told to hold near Norfolk, Va. The flight from there to New York should have taken 36 minutes, but it took two hours and 40 minutes.

Several aircraft were told to fly into Kennedy before Avianca.

When Avianca made its approach, the pilot had to abort the landing because the wind shear was rocking the aircraft too much. The wind shear conditions were not reported to the Avianca pilot although the airport told other pilots about it, Mr. Tompkins said.

After the aborted attempt, the controller told the Avianca pilot to make a sweeping turn, during which the jet's fuel ran out and it crashed.

During the viewing of the computer graphics, London delegates heard an American Airlines pilot ahead of Avianca tell Kennedy controllers he had 14 minutes before he would have to call an emergency. He landed with six or seven minutes of fuel left.

Mr. Tompkins contends the Avianca pilot told the tower he also was running out of fuel, but "the controllers didn't seem to pay attention to Avianca."

Avianca asked for priority, but never received an answer from the controller, he said. BI

FHP adds workers comp underwriter, claims administrator

FOUNTAIN VALLEY, Calif.—FHP International Corp. has bolstered its drive into "24-hour coverage" by acquiring a workers compensation underwriter and claims administrator.

FHP, a managed care firm based in Southern California, late last month consummated the $23 million cash acquisition of Great States Financial Corp. and its two subsidiaries: Great States Insurance Co., a specialty workers compensation insurer licensed in California and Arizona; and Skandia Benefit Services Co., a workers comp third-party administrator.

Great States Insurance will retain its name, but Skandia Benefit Services will be renamed Intercare Benefit Administrators Inc., said FHP President and Chief Executive Officer Westcott W. Price III.

"An FHP affiliate will now be able to issue workers compensation policies directly to customers, as well as provide administrative services for employers that self-insure their workers compensation programs," he said.

FHP introduced a 24-hour managed care program in January 1991 as a way to coordinate the administration of workers compensation and health benefits. The acquisition will eliminate some of the costs associated with the initial program, according to Mr. Price.

Anaheim-based Great States Financial Corp. has 85 employees and generated approximately $35 million in annual revenue. It was a subsidiary of Skandia Direct Operations Corp., a U.S. holding company based in Miami and a member of the Stockholm-based Skandia Group.

John G. Pasqualetto will remain as president and CEO of the new FHP subsidiary and there are no plans to move Great States from its current location or to make staffing changes, according to Mr. Price.

FHP International Corp. is the parent of FHP Inc., a managed health care services company based in Fountain Valley, Calif.

FHP's HMOs provide coverage to more than 805,000 enrollees through some 4,000 employers in California, Arizona, Utah, New Mexico, Nevada and Guam. The company also manages UltraLink, a national HMO network, and owns FHP Life Insurance Co., an indemnity health and life insurer.

RHH consolidation

CHICAGO—Rollins Hudig Hall will consolidate its San Francisco operations this week at 1 Market Plaza.

The move consolidates the offices of the former Rollins Burdick Hunter/Curtis Day and Frank B. Hall & Co. Inc. operations.

Chicago-based Aon Corp., RHH's parent company, acquired Frank B. Hall, then the world's seventh-largest broker, and Curtis Day & Co., then the nation's 69th-largest broker, in 1992 (*BI*, July 27, 1992; Feb. 3, 1992).

RHH's Northern California operation includes employee benefit consultant Godwins Inc., which has combined operations with Palo Alto-based Miller Mason & Dickenson; Rollins Technology Brokers and a Rollins real estate and investment division.

Richard S. Schmidt serves as chairman of the consolidated operation. Phil Buchanan is vice chairman and Russell Sands is president.

A new floor has been leased in addition to the three floors previously occupied by Frank B. Hall of Northern California.

Nearly 250 RHH staff members work in San Francisco, with more than 100 in offices in Fresno, Sacramento, Salinas and San Jose.

RHH of Northern California will be based at 1 Market Plaza, Spear Street Tower, Suite 2100, San Francisco, Calif. 94105; 415-543-9360; fax 415-543-5628.

Grayston launches firm

HAMILTON, Bermuda—Stuart Grayston, the former head of Frank B. Hall & Co. Inc.'s Bermuda captive insurance and brokerage operations, has formed his own consulting business.

Markets

Mr. Grayston, who was president and chief executive officer of the Hall operation for four years, resigned in November, three months after Aon Corp. acquired Hall (*BI*, Aug. 3, 1992).

Grayston Consulting Services will focus on risk financing advisory services, supporting companies that handle Bermuda's alternative market. Targeted clients are companies offering management, accounting, investment and brokerage services, as well as companies providing capacity in the alternative risk transfer market.

Mr. Grayston's first client, Atlantic Security Ltd., the insurance management and brokerage company, says it currently is putting new products together and has retained Mr. Grayston to help develop its business.

The consulting company is not the first private venture for the 52-year-old Bermudian. He formed S.H. Grayston Management in July 1977, selling it eight years later to Hanna Insurance. However, he points out that unlike S.H. Grayston Management, his new business is purely a consultancy and is not offering insurance management or brokerage.

For more information, contact Mr. Grayston at 809-236-0774. BI

GIC meeting draws 170

WASHINGTON—More than 170 people attended The 1993 GIC Assn. National Forum held March 8-9 in Washington.

The forum was co-sponsored by *Business Insurance*; Pensions & Investments, another Crain Communications Inc. publication; John Hancock Financial Services; and Prudential Asset Management Co. in conjunction with IBF Conferences.

The GIC Assn. Inc. represents employers with defined contribution plans, providers of guaranteed investment contracts and bank investment contracts as well as consultants.

For more information about the group, contact Larry Mylnechuk, Executive Director, The GIC Assn. Inc., at P.O. Box 1594, 9 Monroe Parkway, Suite 260, Lake Oswego, Ore. 97035; 503-697-8616.

Pension outlook

Continued from page 3

plans to the financially struggling Pension Benefit Guaranty Corp.—a big component of defined benefit plan administrative expense—are soaring and are likely to climb higher in the future.

"You can absolutely count on higher (PBGC) premiums in the future," Mr. Ball said, referring to the agency's need for more revenue to fund a growing deficit.

Over the last decade, the PBGC premium—paid by all employers with defined benefit plans—has risen sharply as the agency's financial problems have worsened. For example, in 1983, the annual premium was $2.60 per plan participant. Today, after several interim increases, the premium is $19 per participant for fully funded plans and as much as $72 for severely underfunded plans.

By contrast, defined contribution plans are not insured by the PBGC and thus plan sponsors are exempt from paying PBGC premiums.

• Employer interest in controlling their costs and liabilities. In defined contribution plans, an employer's financial obligation is to make a specific contribution, such as an amount equal to a percentage of employees' salary.

The contribution can, for example, be adjusted each year as company profitability fluctuates.

In defined benefit plans, employer liability and costs are harder to control. For example, the cost of plans whose benefits are based on final average pay will soar during periods of high inflation when salaries increase.

• Employee appreciation. Defined contribution plan benefits are highly visible and easy to understand.

By contrast, the arcane benefit formulas in many types of defined benefit plans make them confusing and mysterious to employees, Mr. Ball said.

Employees also appreciate the tax advantages of the most popular type of defined contribution plan—401(k) plans—which allow employees to make pretax contributions. Defined contribution plans also allow employees relative ease in transferring account balances to individual retirement accounts or to a new employer's defined contribution plan when they terminate employment.

These advantages of defined contribution plans have not gone unnoticed by employers.

After years of steady growth, total enrollment, including retirees, in private defined contribution plans now exceeds the number of participants in defined benefit plans.

Last year, according to Labor Department projections, 40 million people, including retirees, were covered by defined contribution plans compared with the 39 million participants in defined benefit plans, Mr. Ball said.

Defined benefit and defined contribution plans each had about 39.5 million participants in 1990, he said.

Looking at only active employee participation, the difference in coverage between the two types of plans is even more striking. In 1992, there were 36 million active employee participants in defined contribution plans and 25.6 million in defined benefit plans.

Defined benefit plans' assets still slightly exceed defined contribution plans' assets. Last year private defined benefit plans held $1.3 trillion in assets, compared with $1 trillion in defined contribution plans assets.

But by 1996, Mr. Ball said, the $3 trillion in total private plan assets are expected to be divided equally between defined benefit and defined contribution plans.

Defined contribution plan growth also will be aided by new Labor Department rules that make it easier for employers to avoid fiduciary liability for employees' investment decisions if they meet plan rules, Mr. Ball said.

To comply with the Labor Department's so-called 404(c) rules, employers must give participants, among other things, at least three investment options, each with materially different risk and return characteristics (*BI*, Oct. 12, 1992).

With the growing importance of defined contribution plans in meeting employees' retirement income needs, employers need to do a better job of educating employees on how the plans work.

"I can't emphasize enough the importance of employee communications. Employees need to be informed and employees need to be educated," Mr. Ball said.

If employees don't understand their defined contribution plans and make poor investment decisions, employees will not perceive the programs as providing important benefits, he said.

"It is in employers' interest to educate employees," Mr. Ball concluded. BI

Investors not informed about GICs: Study

By MARK A. HOFMANN

WASHINGTON—The overwhelming majority of defined contribution plan participants in a recent national survey reported that they had heard or read nothing about guaranteed investment contracts during the past year.

GIC ASSOCIATION

An even larger majority of those who had come across some information about GICs said that what they'd learned had no impact on their investment strategy. Those who did change investment strategy because of information about GICs were split between those who increased and those who decreased their dependence on them.

The survey also found that plan participants were unlikely to transfer money from one investment fund to another in any given year, and those who did were far more likely to say they did so to increase return rather than to reduce risk. Nevertheless, a quarter of the sample said they wished their employers offered more investment options in their defined contribution plans.

The results were released by Elizabeth Akiba at the 1993 GIC Assn. National Forum last week.

Ms. Akiba, research director-investment and pension marketing for John Hancock Financial Services in Boston, said the Gallup Organization telephoned 802 defined contribution plan participants nationwide last September and asked them about their investment plans. The participants' ages ranged from 23 to 65 years. They represented a wide income range, although relatively few were hourly workers, she said.

Only 27% of the sample reported that they had read or heard information about GICs during the past year. Eighty-nine percent of those who had received information said it had no effect on their investment strategy. Ms. Akiba said that of the 11% who did change their strategy in response to the information, half increased their reliance on GICs and half decreased their GIC exposure.

The survey found that participants in defined contribution plans generally were not too anxious to transfer funds among investment options. Eighty-six percent of the respondents said they had not transferred any money from one fund to another during the previous year. Twelve percent said they'd transferred money once during the year, and only 2% said they'd switched money two or more times.

The pattern of keeping money in the same fund held true over the long term as well. Sixty-seven percent of the participants reported having not switched money among funds during the previous three years. Sixteen percent said they had done so once, 8% said they'd transferred twice and 9% reported having made three or more transfers.

Of the 14% of all participants who reported having transferred money during the past year, 41% said they'd put money into stock or equity funds, while 17% said they'd reduced such exposures.

In contrast, only 13% said they'd switched money into fixed-income funds, while 25% said they'd transferred money out of such funds. Eight percent added money to money market funds, while 13% withdrew money. Seven percent added to their company stock fund and 10% said they had withdrawn money from company stock.

Eighty-six percent of those who transferred investments said they'd done so to increase return, 62% said they wanted to diversify their investment and only 36% said they switched money to reduce risk.

"What it really shows (is that) because of the low interest rates, if people did any movement at all, it's because they wanted to take advantage of better returns in the stock market," said Ms. Akiba.

She also noted that the majority of the survey participants—73% —said they did not wish their employer offered more investment options, while 25% wanted more options and 2% didn't know. Half of those who said they wanted more options didn't know which ones, she said, indicating that "just throwing more options at people doesn't appear to be the issue."

The survey also found that 98% of the participants said they intended to use their retirement savings plan assets for retirement; 27% for education expenses; 27% for medical and other emergency expenses; 12% to buy a house; and 6% for other reasons.

Participants aren't rushing to take out loans from their plans, even though about two-thirds of the plans had loan provisions. Only 14% percent of those whose plans had loan provisions said they currently had loans and an identical percentage said they planned to take out a loan in the next two years.

GICs and fixed-income funds remain the most popular investment options, with 47% of the respondents having money invested in such funds; stock and equity funds ranked second with 42%; company stock funds third at 40%; and money market funds fourth at 37%.

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For information on obtaining a free copy of "Insights Into Participant Behavior," contact Lisa Cohen Sharff, John Hancock Financial Services, P.O. Box 111, Boston, Mass. 02117; 617-572-9134.

Tax repeal prospects look dim

But burden of pension distribution withholding tax may be eased

By JERRY GEISEL

WASHINGTON—Congress is unlikely to repeal an unpopular law that imposes a 20% withholding tax on certain pension distributions, a Senate staffer says.

But legislators this year could make technical changes to ease the administrative burdens the law imposes on employers, according to Rick Grafmeyer, minority tax counsel with the Senate Finance Committee.

GIC ASSOCIATION

Speaking last week in Washington at a forum sponsored by The GIC Assn. Inc., Mr. Grafmeyer virtually ruled out congressional or Clinton administration action to repeal the withholding tax.

Within the Treasury Department, the 20% withholding tax "is viewed as a success story," Mr. Grafmeyer said.

The tax, which applies to many types of pension distributions, such as a lump-sum payment from a profit-sharing plan, can be avoided if an employee has his or her employer directly transfer the distribution to an individual retirement account or to the defined contribution plan sponsored by the worker's new employer, assuming the new plan accepts benefit transfers.

While definitive statistics are not yet available, many more employees are having their employers directly transfer distributions to IRAs or defined contribution plans, Mr. Grafmeyer said.

That meets a key congressional objective in passing the 20% withholding tax: discouraging workers from taking pre-retirement distributions in cash which diminishes the funds available to them at retirement.

However, Mr. Grafmeyer laid out the possibility that legislators may consider modest proposals to fix technical glitches with the law.

"I think we could do some technicals" on the 20% withholding tax, he said.

While Mr. Grafmeyer did not detail what those technical changes might be, Congress last year passed tax legislation with provisions that would have exempted small distributions—those less than $500—and hardship withdrawals from the 20% withholding tax.

However, President Bush later vetoed the tax bill for reasons unrelated to the pension provisions.

An array of pension simplification provisions—approved by Congress last year but vetoed by President Bush—also are likely to be considered this year, Mr. Grafmeyer predicted.

Those provisions include giving employers easier ways to run the 401(k) non-discrimination tests.

There also is congressional interest in shoring up the financial base of the Pension Benefit Guaranty Corp. by giving the agency more protection from terminations of big, underfunded pension plans.

Over the last year, former PBGC Executive James B. Lockhart III "raised a lot of red flags (about the PBGC's problems). That gets a lot of press and generates a lot of member interest," he said.

One key member of the Ways and Means Committee, Rep. J.J. Pickle, D-Texas, already has held hearings on the PBGC's problems and has introduced legislation to try to correct those problems.

Rep. Pickle is very serious about shoring up the PBGC, Mr. Grafmeyer said.

Among other things, the Pickle bill would require employers with underfunded pension plans to make annual contributions to the plans that at least equal benefits that are paid out.

That would prevent a pension plan from being bled when, for example, many workers retire early and elect to take lump-sum distributions.

Mr. Grafmeyer suggested that Congress is not likely anytime soon to boost insurance premiums charged by the PBGC.

Congress last boosted the minimum PBGC premium in 1990, increasing it to $19 per plan participant from $16 effective in 1991.

That increase, which some employer groups said was part of a series of congressional gimmicks to mask the size of the federal budget deficit, left a "lot of blood spilled," making legislators reluctant to try to raise premiums in the near future, Mr. Grafmeyer said.

He suggested that unless employers speak up, a Clinton administration proposal to slash the amount of pension contributions employers could make on behalf of highly compensated employees could become even tougher.

Under that proposal—included in President Clinton's economic package—the amount of an employee's "covered compensation" that could be considered in setting benefit formulas in defined benefit plans and making contributions to defined contribution plans would be slashed to $150,000 from the current $235,840 (*BI*, Feb. 22).

For example, assume an employer allows employees to contribute up to 6% of their salary to their defined contribution plan. Under current law, an employee earning $200,000 a year, could—assuming the plan passed basic non-discrimination tests—contribute $12,000. That same employee under the Clinton proposal only could contribute $9,000.

Despite the impact that the slashing of covered compensation would have on highly compensated employees, a groundswell of opposition has not developed.

"We have not heard from anyone" opposing the reduction, Mr. Grafmeyer said.

That lack of public opposition increases the likelihood that legislators could consider even steeper reductions in covered compensation, he said. A $120,000 limit "might sound good to some people," Mr. Grafmeyer said. BI

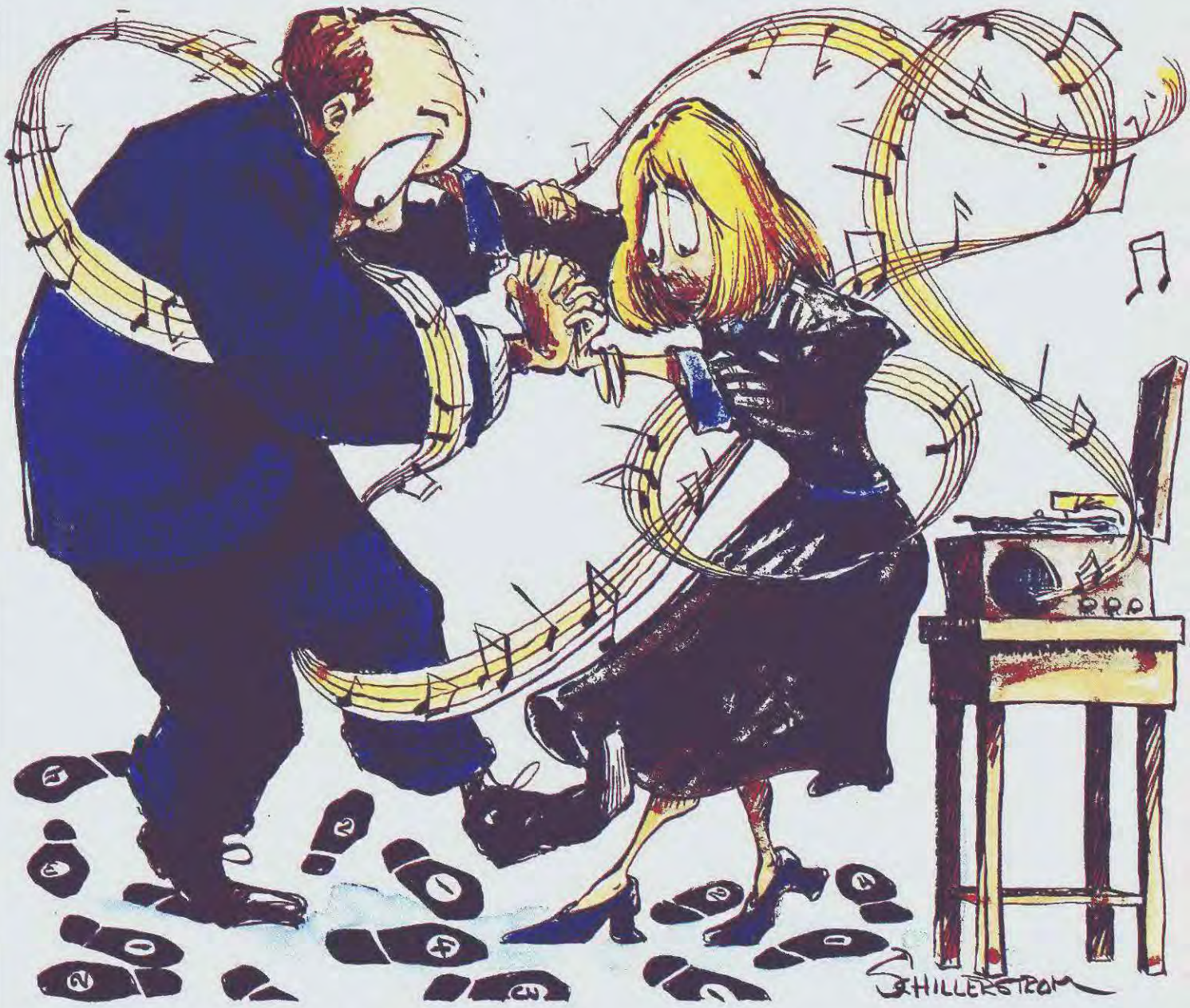
InsurerTopics

A special editorial section
sent exclusively
to insurers and reinsurers

Doing some fancy footwork

Insurers, agents try to keep in step with each other in tough market

By LOUISE KERTESZ



Insurers' strategies to survive the current tough market do not bode well for agents—at first glance.

In the long run, however, the agent/insurer relationships that survive are stronger, and agents are prompting creation of new products and services.

As insurers revise their marketing strategies and "refocus on the areas they want to concentrate on, there's a lot of disruption in the marketplace," explained Sean Mooney, senior vp and economist at the Insurance Information Institute in New York.

INSURER-AGENCY RELATIONS

Insurers are pulling out of less profitable markets to concentrate their capital in areas with more profit potential. And some insurers are reducing commissions in markets where they do not enjoy enough penetration.

"It's becoming very frustrating to those agents affected," said Patricia Borowski, senior vp-government and industry affairs at the National Assn. of Professional Insurance Agents in Alexandria, Va.

However, the good news for agents is that insurers are developing new products and improving services for the markets they are focusing on, Mr. Mooney said.

Meanwhile, independent agents are learning to make the best of a difficult situation and are becoming "more resilient," says Ms. Borowski.

Though problems remain for many agents, "an inordinate focus is placed on the negative aspects" of difficult market conditions, she asserted.

In the face of many insurers "changing their strategic marketing position an awful lot," successful agents are keeping their options open.

Even before an insurer pulls back from a market, agents are starting to line up other possibilities. "That's kind of exciting," she said, "because. . .there are some extraordinarily terrific (insurers) that have recognized the opportunities out there. They've got themselves involved in absolutely quality agencies and developed great relationships."

Travelers Corp. is one insurer that is nurturing its partnership with agents. "There's no question that these are tough times for agents," said Michael Policastro, vp of agency marketing at Travelers in Hartford, Conn.

The extended soft market and the weak economy—resulting in business failures, mergers and lower payrolls for agents' customers—are all "making it difficult for independent agents to see revenue growth," he said.

And, like other insurers, Travelers attempts to reduce its exposures where it doesn't see a long-term profit opportunity. That means Travelers has "backed away from certain lines or states" and is continually engaged in the "natural process. . .of weeding out" those producers without potential, he said.

But by the same token, Travelers will focus on those agents that will make a major commitment to them in terms of premium volume.

"We're selectively adding agents in commercial lines," Mr. Policastro said, and those chosen can avail themselves of "a wide range of services to help them grow, manage their operations better and be financially stronger and more professional."

Other insurers are focusing on cultivating fewer and stronger partnerships as well.

"We knew as a company that we couldn't be all things to everybody, and agents began to realize that too. So we made some good partnerships," said Glen Thompson, vp of marketing and agency operations at Amerisure Cos., a unit of Michigan Mutual Insurance Co. in Detroit.

"I firmly believe that a lot of regional companies, particularly, are hearing that we need to do things differently. I think we've responded in the last few years to what agents have been asking for. We've been listening to agents and working more closely with them," he said.

"The relationship has still got a way to go, but it's a different relationship (than in the past) especially for the regional companies," Mr. Thompson continued.

Among insurers who say that responding to agents' needs has resulted in excellent relations is SAFECO Insurance Cos. in Seattle. "We probably have about as good relations with our agents as we've ever had and maybe better," said Stephen Lease, assistant vp-property/casualty marketing.

Even in the difficult California marketplace, "we have 800 agents, and outside of California we've appointed over 1,000 new agents in the last three years," he said.

Travelers' agents can access 'a wide range of services to help them grow,' says Michael Policastro.

Consequently, SAFECO has been steadily increasing its share of business with its independent agents over the past three years, Mr. Lease added.

Consistency also leads to positive agent relations: "We've been able to maintain very strong relations with agents," said Edward R. Buhl, vp of marketing at Central Insurance Cos. in Van Wert, Ohio. "One of the reasons for our success in agency relations is we've been very consistent," making no major changes in commissions, underwriting programs or rate levels.

By contrast, a company that has undergone a major restructuring—United States Fidelity & Guaranty Co.—reports that it was able to maintain good relations with its producer plant by responding to agents' needs.

Responding to agents' needs requires good communications. Several insurers endorse active agency councils, like the one at Central Insurance. "A lot of insurers have some type of agents advisory council. What is uncommon is for those councils to have much impact on the companies," asserts Mr. Buhl.

USF&G's national, regional and branch office producer advisory councils were "set up to provide feedback and interaction as to how we're doing with our strategic initiatives, how our products are meeting their customers' needs and on the quality of our services," said Warren E. Coupland, executive vp-field operations.

For example, agents told USF&G that they would like to continue to provide products for the small business owner. "The obstacle is that this business can be very expensive to process," Mr. Coupland said.

So USF&G set up a specialized small

Continued on next page

Insurer Topics

Agent relations

Continued from previous page
business unit to develop products for small business "that can be processed in a highly automated and streamlined fashion," Mr. Coupland said. "We'll be able to provide a competitive product and an improved product, in response to customer needs as identified by our agents."

It was in response to agents' requests that SAFECO set up its first customer service center in California in 1985, Mr. Lease said. Through eight such centers now in operation, SAFECO offers agents policyholder services—such as changing an automobile on a policy—at less than what it costs the agent to do it.

"It's a way for agents to cope with the reduced commission income brought on by the soft market. They can take the savings and redirect it toward the sales effort," Mr. Lease added.

As a result of input from Travelers' producer council, the insurer "totally revamped every single product" in its life and annuities lines in the past 24 months, Mr. Policastro said.

"Our agents are thrilled with what we came up with. They told us what changes we needed to make—they were dramatic—and now our agents are selling these products like crazy," he said. BI

Meeting shows there's no place like The Home

By SALLY ROBERTS

NEW YORK—The element that sets The Home Insurance Co.'s annual meeting with producers apart from those of other insurers is the personal touch—the opportunity for agents and brokers to meet with company executives one-on-one.

INSURER AGENCY RELATIONS

In an effort to increase communication, Home's executives and producers discuss current issues, ideas and concerns.

While many insurance companies hold similar get-togethers, Home's National Hall Mark Council meeting is different, according to the council's chairman.

Home is a "little more dedicated," contends Gary Hambright, senior vp-marketing for the Lockton Insurance Agency in Prairie Village, Kan., referring to the close personal conversations Home executives conduct with their agents.

The key ingredient to the interpersonal relationships is the small-group atmosphere, he said.

At Home meetings, executives are available for individual discussions, "which is different from other companies," he said.

In addition, with a smaller number of people, there is less competition for an executive's time than there might be at other meetings, he said.

In February, Home held its annual National Hall Mark meeting, with the theme "Facing the Challenges."

The theme changes every year, said John McCue, executive vp-corporate communications and public affairs for Home. Last year's theme was education, and this year's theme reflected the huge losses incurred in 1992.

"Financial stability is important" to everyone, he said.

During this year's meeting at the LaCosta Resort and Spa in Carlsbad, Calif., 54 producers and about 20 Home executives broke up into five "roundtable" groups.

Home executives then made their rounds to each of the groups of agent representatives to present specific issues.

The five main subjects were industry image, workforce resources, social issues, information systems and tomorrow's marketplace.

Home executives "bare their souls," Mr. Hambright said. Executives from the special insurance department to national accounts discuss their marketing objectives. "It's good to hear the goals from the people who are directly responsible for them."

The Home's meetings with its Hall Mark Council bring agents and insurers together in a small-group atmosphere. Council officers include Nick Munson, Gary Hambright and Norm Peterson.

After the discussions, a representative from each roundtable group give feedback to the executives.

Bringing the group's responses to the executives "puts it back in broker-ese" instead of "company-ese," Mr. Hambright contends.

In addition to the annual Hall Mark meeting, each of Home's 27 branch offices holds one or two similar meetings every year, Mr. McCue said.

At these meetings, a group of about 10 agents discuss marketplace issues, product needs and other issues with Home branch managers.

The chairperson and vice chairperson of each group of agents make up the national advisory council and then attend the Hall Mark meeting.

The agents are a "good cross-section" of the industry, he said. There is a national geographic mix as well as an agent and broker mix. BI

Insurers hurt by Iniki storming out of Hawaii

By MICHAEL BRADFORD

HONOLULU—The rebuilding after Hurricane Iniki swept through last year will one day be complete, but the storm's damage to Hawaii's insurance landscape may not be so easily repaired.

Insurers leery of a repeat of the storm that caused $1.6 billion in insured damage mostly on Kauai last fall are abandoning the homeowners market, leaving policyholders, agents and brokers high and dry (*BI*, Sept. 28, 1992).

INSURER AGENCY RELATIONS

The market for homeowners insurance began drying up in January, with high-priced surplus lines insurers and a state facility remaining virtually the last resort for buyers.

State Farm Group, the state's largest homeowners insurer with 16.5% of the market, continues to write coverage but with restrictions identical to those it placed on agents in Florida after Hurricane Andrew hit (*BI*, Oct. 19, 1992).

Agents' pleas to mainland underwriters to enter the market have so far fallen mostly on deaf ears.

However, a plan to create a pool to fund the hurricane portion of homeowners risks is now before state lawmakers. If approved, this would take the exposure away from private insurers who may then reconsider entering the market.

"We have an availability problem," Hawaii Insurance Commissioner Linda Chu Takayama said. "Homeowners insurance is no longer easy to get, and what's out there is a lot more than what homeowners are accustomed to paying."

And if problems in the homeowners market aren't bad enough, the crisis may be spreading.

"I've heard from some agents that it may be filtering into the commercial lines market," said Terry Silva, executive vp of the Hawaii Independent Insurance Agents Assn. "Especially in smaller commercial lines risks."

Ms. Silva said there are reports that insurers are "becoming more strict and more selective" in the types of commercial risks they are writing.

"It is affecting the commercial property market," said Christopher G. Oda, vp with Alexander of Hawaii, a Honolulu subsidiary of Alexander & Alexander. "There are a lot of wind deductibles or wind exclusions on renewals and new business. There is some major re-underwriting going on."

Ms. Takayama said the insurance community is working hard to attract personal lines insurers to Hawaii.

The Insurance Department will quickly approve applications to enter the market if they meet state requirements, she noted, although those applications are not flooding in.

Iniki's fallout

Five of the nine largest homeowners insurers in Hawaii (in bold) have restricted their coverage or dropped it entirely since the hurricane. Market share is based on 1991 premiums.

Insurer	Market share
State Farm	16.5%
Island Insurance Group	13.6
Hawaiian Insurance Group	11.6
Continental	11.3
Allstate	9.8
ITT/Hartford	8.4
Transamerica	7.5
USAA	6.6
Fireman's Fund	5.0

Source: A.M. Best Co.

GRAPHIC BY JOHN J. BOHORQUEZ

"Our agents have been very aggressively pursuing the mainland markets," said Ms. Silva. "We've been visiting with them, encouraging them, telling them we will do what we can to make Hawaii a more attractive place to do business."

But so far, those efforts have not been fruitful.

"I've heard of one member who may be close to closing a deal with a market," said Ms. Silva, declining to name the insurer.

Agents and policyholders are finding themselves with an "any-port-in-the-storm mentality," said Jim Cavanah, vp of Cavanah & Associates Inc. in Honolulu and president of the HIIAA. "We're really searching for markets to come here."

"We've been getting some feelers from carriers, but only on a non-admitted basis," said Mr. Oda of Alexander of Hawaii. "That makes us very wary because they're not subject to the guaranty fund."

Mr. Cavanah said it's hard to blame insurers for leaving the market when taking a look at the decisions underwriters must make.

Many not only are absorbing losses from the hurricane but also face rising reinsurance costs if they decide to remain.

"I've been working with a couple of companies trying to get them in," he said. "I've seen their calculations. They are making business decisions and you can't blame them for protecting their companies."

Ms. Silva agreed that insurers are finding reinsurance "a major problem" with regard to Hawaii homeowners risks. "When they enter a new market, they want to make sure they can get enough reinsurance."

Insurers that left the market have all given policyholders adequate notice according to regulations, Ms. Takayama said.

Hawaii's problems reached a critical point on Feb. 19 when coverage for policyholders of Hawaiian Insurance Group's insolvent subsidiaries was canceled. The group was the third-largest underwriter of homeowners coverage in the state with 11.6% of the market, according to A.M. Best Co.

Hawaiian Insurance Group policyholders joined thousands of others whose coverage was not renewed by insurers leaving the state.

"In the meantime, there are no new carriers and nobody else wants to take on new values," Mr. Cavanah said. New entrants in the market don't want to pay high reinsurance prices, and "the companies that remain are in the same boat. They're not taking any new business."

For agents, "the end result is, if we don't have a company policy to sell, we can't sell a policy. So we can't make a buck," he added.

Before the cancellation of Hawaiian Insurance Group's policies, several insurers had already decided to leave the market, or at least institute restrictions.

For example, State Farm's new guidelines for its agents mirror the changes the insurer made in Florida following Hurricane Andrew.

The restrictions, which apply to new business, call for agents to write no more than $750,000 each per month in personal lines coverage for structures and contents and no more than $1 million per month in commercial property coverage for structures and their contents.

No new personal or commercial lines policies will be written on a guaranteed replacement cost basis by State Farm agents.

In January, Pacific Insurance Co. Ltd., a subsidiary of ITT Hartford Insurance Group, announced that it will stop writing new and renewal policies.

A letter to Ms. Takayama concluded that Pacific Insurance's "aggregate exposure was far in excess of (its) previously assessed hurricane potential."

The insurer, which wrote about 18,000 residential policies with premiums of about $5.2 million, was also finding it difficult to obtain adequate reinsurance, said Ron G. Hashimoto, Pacific's president and chief operating officer.

Mr. Hashimoto said the insurer "must act responsibly to protect our company's long-term financial strength against potentially very significant losses on the islands."

First Insurance Co. of Hawaii Ltd., a subsidiary of Continental Insurance Cos. and the fourth-largest homeowners insurer with 11.3% of the market, exited Hawaii on Feb. 1, leaving 16,000 policyholders to find replacement coverage.

In addition, Allstate Insurance Co., which held 9.8% of the market, has stopped writing at least until April.

Allstate's decision was reached after a flood of new policy applications began pouring in as insurers left the market.

"We need to evaluate what's happening in the marketplace and its impact on our customers," said Michael Clark, Allstate's regional vice president in Seattle.

The insurer began writing a "disproportionate amount of new homeowners policies" at the beginning of the year and

Continued on page 16D

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Insurer Topics

Hawaiian market

Continued from page 16B

began to worry about a strain on its ability to service existing accounts, according to Mr. Clark.

Liberty Mutual Insurance Co. found itself in a similar position and decided in February to stop writing new policies except for its existing customers.

Liberty Mutual, which held 2.9% of the homeowners market, made its decision solely because "we were unable to handle our existing customers and their needs," said a spokeswoman. It was not due to the hurricane losses: In the first four weeks of 1993, the insurer had a 400% increase in new applications over the same period in 1992.

Agents and brokers in Hawaii now find themselves turning to the state's Fair Access to Insurance Requirements plan, a facility established in 1991 to write property coverage in areas on the island of Hawaii threatened by lava.

Expansion of the facility means it now accepts homeowners policies statewide as an insurer of last resort. The cost of up to $250,000 worth of coverage through the facility is roughly three times the standard cost of homeowners insurance.

FAIR plans are pools maintained by private insurers and reinsured by the U.S. government.

Ms. Takayama and others also are working on a legislative solution to the crisis.

The commissioner is proposing the state create a pool that would insure hurricane exposures, freeing the private market to write other homeowner coverages.

The pool would be funded by premiums and a 2% assessment against insurers' annual premiums.

Additional funding for the facility would come from other sources, she said, including an increase in the state's conveyance tax on property transfer and an increase in the franchise tax paid by mortgage lenders.

Ms. Takayama pointed out, however, that even if the pool passes legislative muster, it will likely be the end of the year before it begins operating.

Meanwhile, said Mr. Oda, "It's a wait-and-see situation." BI

Insurer stands out where few stand

By LOUISE KERTESZ

LOS ANGELES—As a chorus of agents decries the abandonment of the inner city by major insurers, a tiny Woodland Hills, Calif.-based company aptly named Crusader Insurance Co. has been singled out for praise.

INSURER-AGENCY RELATIONS

"They deserve it—for having the guts to write in the inner city," said Morris Davis, president of Morris Davis Jr. Insurance Agency in Inglewood, a working-class suburb south of Los Angeles.

Following the Los Angeles riots last April, insurance agents decried the lack of markets available to inner-city businesses.

But Crusader "basically has proven that if you are really interested in writing in the inner city, you can turn a profit. It's not impossible, it's not what traditionally has been thought of as a losing proposition that has to be subsidized. They have proven the market wrong," said Javier Rodriguez, president of the Hispanic Agents & Brokers Assn. and of Rodriguez Insurance Agency in South Gate, near Los Angeles.

"We have used them in countless situations. Their service is good, the turnaround is great, it's almost like having a preferred market for the inner city. They've done a splendid job and the industry should take note."

Crusader, which grew from $1.8 million in capital and surplus in 1985 to $17.4 million in 1992, is the largest unit of Unico American Corp., a holding company in Woodland Hills.

But Crusader has had to pull back from the inner city as a result of riot-related losses.

The insurer sustained $21.5 million in losses, reduced to $10.5 million after reinsurance and tax write-offs, said Cary Cheldin, executive vp.

"For the time being," Crusader is cutting 75% of its property policies—which include coverage for damage caused by civil commotion—in the riot area through non-renewals, Mr. Cheldin said.

It will maintain 25% of its property coverage with riot exposure, and will write some additional property insurance coverage excluding riot damage.

Crusader will also write general liability insurance in the riot area on a monoline basis.

"We have 1,500 businesses insured there, but. . .if there's another riot, that would be more than we can handle. We're cutting it down to something more manageable. We're not completely quitting," said Mr. Cheldin.

Despite the company's cutbacks, Crusader's spirit and performance sustain a loyal following among independent insurance agents.

"The guys over at Crusader really do deserve applause. They're making an attempt where others are not," said Kerry Wright, owner of Wright-Way Financial Insurance Services in Westwood, an affluent area of Los Angeles.

Mr. Wright recently moved his agency from the inner city because he could not get appointments with major insurance companies from his previous location, he said.

"Just like their name—they're crusaders, they came in here and stuck their necks out where nobody else did, they gave agents a market with no volume requirements and no strenuous qualifi-

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Crusader

Continued from page 16D

cations and demands like most big companies make," Mr. Davis asserted.

"Hartford, Fireman's Fund, Mercury Casualty and CNA—all these people have so many requirements, you don't qualify no matter what you do. Three of us (inner-city agents) tried to pool our volume to get to CNA, but once we met that volume requirement, we didn't meet other requirements," he said.

Mr. Davis and other independent agents interviewed say the solution for inner-city businesses is "an open broker system where any broker would submit any piece of qualified business to any company."

"We always have offered our products and services to any (broker) in good legal standing that possesses a proper license to sell insurance in California. We don't qualify our producers other than that," said Mr. Cheldin.

"We also work hard to provide the products that agents ask us to. That includes businesses with no prior insurance or those in low-income communities," he added.

Mr. Kerry pointed out that Crusader's losses as a result of the Los Angeles riots were relatively large compared to losses by much bigger insurers. For example, Farmers Insurance Group in Los Angeles sustained $50 million in riot-related losses. Farmers wrote $7.24 billion in net premiums in 1991.

"After the riots, I sat in on a Los Angeles Board of Supervisors hearing on the lack of available insurance in the inner city," Mr. Kerry said. "Crusader and much larger companies had similar levels of loss. What this is telling me is that huge companies are not making an attempt to serve the inner city."

Besides, "the big companies will not insure the Mom-and-Pop business" in the inner city, Mr. Kerry said.

Crusader has offered "the most competitive pricing for a wide range of commercial lines in the inner city," said Mr. Rodriguez. "There is no other insurance company in this game right now with the same portfolio. If there was, we would roll it over" to them.

The big insurers don't have much presence in the inner city, the independent agents say.

"We're dealing with myths," countered a Farmers' spokesman, who said there were Farmers' agents in the riot-affected areas. "Our agents have an absolute incentive to write" coverage in the inner city.

"Industrywide there is no lack of coverage available in the inner city. I have yet to hear of an insurer refusing to write business in the inner city," agreed a spokesman for the Assn. of California Insurance Companies in Sacramento.

"There is no shortage of coverage" though it is priced according to risk factors, he noted.

But major insurers typically write inner-city coverage from suburban agencies, the agents say.

"It's a way to not be exposed to all the problems here but to suck out all the business," Mr. Davis said.

That discriminates against the less savvy inner-city business executives who "turn to what is familiar to try to solve their problems. They go to the agent who belongs to their lodge, or whose kids go to the same school," Mr. Kerry explained.

That neighborhood agent is denied appointments by large insurers, the agents say.

"We're in an age of niche marketing and it's hard for the neighborhood broker to satisfy the commercial marketplace," affirmed Jerry O'Kane, executive vp of the Independent Insurance Agents and Brokers of California in San Francisco.

It's very difficult for the small broker to satisfy most insurers' appetite for volume, Mr. O'Kane added.

"Crusader was the only market for independent brokers in the inner city," Mr. Davis asserted. With Crusader pulling back, a lot of the coverage will be placed with non-admitted insurers, he said.

Independent agents will place business through wholesalers with non-admitted insurers such as Scottsdale Insurance Co., but it will be more expensive, Mr. Davis noted.

As a recourse, some coverage might be placed with offshore insurers, though some have proven unstable. In that case, "you'll have to wait a week to get a quote and another month to get the policy," he added. "It's not really being fair to the people in the inner city. It's throwing them to the dogs. We're getting the crumbs off the table, and we have to sell tainted products. Then (regulators) squawk about putting people in a precarious position."

Inner-city executives need agents in their neighborhoods who can sell them good policies at reasonable prices, agents say.

If all insurers "were forced to do a certain percentage of business with the local agents, we wouldn't have a market or a price problem. Everybody would be doing their fair share," Mr. Davis said.

Because of its riot-incurred losses, Crusader has asked the California Department of Insurance for a 25% rate increase, "but our heart's not in it," Mr. Cheldin said.

"It's not an issue of a rate increase. We don't think the proper social response from the insurance industry to racial riots is raising rates. People who run businesses in the inner city should have the same opportunities to buy insurance as other businesses.

"We need to help inner-city commerce to establish a stronger foundation. . . .We should make changes in the law to spread the risk of riot so that companies who support inner-city commerce can continue to do so," he said.

Accordingly, Crusader is proposing the California Insurance Guarantee Assn. provide riot reinsurance to member companies.

In a letter last May to Insurance Commissioner John Garamendi, Mr. Cheldin wrote, "If another riot occurs, the proposed changes would require CIGA to reimburse its members for all losses in excess of $3 million or 5% (whichever is greater) of each member's capital and surplus, resulting from claims from more than five different businesses.

"Crusader's management believes that adoption of this proposal would eliminate its currently perceived need to raise insurance premiums and would create an incentive for other insurance companies to transact inner-city business at reasonably affordable prices."

Independent agents agree. "We have a lot of terrible legislation being passed," Mr. Rodriguez said. "I think this is one of the few good (proposals). In rebuilding the community, there's lots of talk, but legislation like this has not even been given a serious look.

"The main thing is we need to press the powers that be through legislation or the Department of Insurance to really take a good look at Crusader and what they've done—it's an American success story—and try to encourage a similar type of growth and do whatever is feasible to encourage this type of endeavor," Mr. Rodriguez said. BI

A word from our counsel

Ads by lawyers seen as encouraging lawsuits, comp claims

By MARK A. HOFMANN

OAK BROOK, Ill.—A growing proportion of consumers think attorney advertising is causing an increase in the number of lawsuits.

In addition, almost as many consumers believe that such advertising has helped raise their auto liability insurance costs.

The findings appear in "Public Attitude Monitor 1992," the most recent in an ongoing series of annual reports measuring public opinion on insurance-related issues.

The Roper Organization Inc. conducted the study on behalf of the Oak Brook, Ill.-based Insurance Research Council, a nonprofit research group supported by the property/casualty insurance industry. Roper interviewed 1,976 adults during a one-week period beginning June 6, 1992.

Seventy-eight percent of the respondents to the newest survey reported having seen or heard attorney advertisements, an increase from 72% in 1989, the last year the question was asked.

Of those who said they had been exposed to lawyer advertising, 78% said they thought advertising has increased the number of liability claims and lawsuits, compared with 73% in 1989. Two percent thought advertising had decreased the number of lawsuits, a doubling of 1989's 1% response. Only 13% thought such advertising had no effect on the number of lawsuits, down from 17% four years earlier.

Seven percent didn't know or had no opinion on the impact of lawyer advertising on the number of lawsuits, a slight drop from 9% in 1989.

Attorney advertising also has increased the cost of auto insurance, according to respondents. Seven out of 10 of those who had been exposed to such advertising said it helped increase auto insurance rates, compared with 64% in 1989. Two percent thought lawyer advertising had cut auto insurance rates, compared with 1% in 1989. Seventeen percent thought such advertising had no impact, a decline from 23% in 1989.

Ten percent of last year's respondents and 13% of the 1989 sample offered no opinion.

The survey also asked people whether they regarded certain types of insurance fraud as acceptable.

About 8% of respondents think it is morally acceptable for someone injured at home to claim the injury is work-related so he or she can collect workers compensation benefits. And nearly 20% said a worker who still feels some pain should stay at home and collect workers comp benefits, even if the doctor says the injured person can return to work.

The acceptance of fraud to obtain benefits diminishes to 4% when the perpetrator "knowingly" cooperates with lawyers, doctors or chiropractors who file false and exaggerated claims to tap into insurance money. A similar percentage found it acceptable for someone collecting workers comp benefits to work at another job while receiving the payments.

Ten percent of the respondents also said that claiming disability benefits "in order to take a month or so off work because you are feeling 'stressed out,' " is an acceptable practice.

Four percent said they thought it acceptable for someone to claim reimbursement under an employer-provided disability insurance policy for loss of wages that had already been reimbursed by the employer's workers comp insurer. Also, 3% found it acceptable for a worker who has been laid off or who is facing a layoff to fraudulently file a disability claim.

In addition to determining moral attitudes, the survey also attempted to uncover the public's awareness of the earthquake threat and attitudes toward earthquake insurance.

Not surprisingly, awareness of the earthquake peril was far more acute in the western United States than in other sections of the country, even though each region has some earthquake exposure.

Nearly nine out of 10 Westerners—89%—were aware they live in a region where a damaging earthquake could occur, but the awareness dropped dramatically among residents of other regions.

Only 27% of the Midwesterners were aware they live in an earthquake-prone zone, even though the New Madrid Fault—site of the Great Earthquake of 1811-12—runs along the Mississippi and Ohio rivers. Among residents of the East and South, awareness dropped to 16%.

Only 23% of the respondents who said they live in an earthquake-prone area said they had a special earthquake insurance endorsement to their homeowners policy. Nine percent of the total sample reported they had such coverage.

When asked why they did not carry it, 36% of all respondents said they didn't need it, 36% said they don't live in an earthquake zone, 11% said they never heard of such coverage and 8% said earthquake insurance costs too much.

Other reasons given for not buying earthquake insurance included: simply having not gotten around to doing so; believing earthquake damage was covered under existing homeowner's policies; and believing the large deductibles contained in earthquake policies make such coverage an "unattractive buy for the money."

•

Public Attitude Monitor 1992 costs $5. It can be ordered from the Insurance Research Council, 1200 Harger Road, Suite 300, Oak Brook, Ill. 60521; 708-572-1177.

Insurer Topics

Quick reaction can nip workers comp fraud

By Ty Hutchison

FAKING A BODILY INJURY and submitting a phony workers compensation claim is, unfortunately, big business.

Unscrupulous medical clinics are only too willing to "treat" fraudulent injuries and pocket income for services never rendered or, if treatment was provided, to greatly inflate the charges for these services. In the fraud capital of the world, Southern California, millions of dollars a year are paid out for phony workers compensation claims.

A majority of fraudulent claims stem from disgruntled employees who were terminated or denied a promotion or raise. Seizing the opportunity, corrupt attorneys and medical clinics approach these employees with capping, kickback or fee-splitting schemes that can make a tidy profit for all involved. As if that weren't enough, "injury hot lines," constantly advertising their services on television, radio and in newspapers, are reaching a growing number of individuals looking for a quick way to riches.

Employers can help thwart this growing tide of illegal activity. Whenever an injury is claimed, whether legitimate or suspicious, the employer should act immediately to document the incident by completing the necessary reports and interviewing the injured employee and witnesses to the alleged accident. The employee should be immediately examined at a company-approved medical facility. Employers should post their injury and site investigation policies in conspicuous locations in the work area so all employees are aware of the procedures.

Insurers are also beginning to take a proactive approach to fraudulent workers compensation claims. Until recently, insurance companies would regularly pay medical bills without investigating their legitimacy, believing this policy to be the most cost-effective means of disposing of these claims. Many still adhere to this practice. But more and more insurers are fighting back.

Many insurance companies are now aggressively investigating suspicious medical costs and are inspecting medical clinics and their records for evidence of fraudulent medical reports or inflated medical bills.

When red flags appear that make an injury suspicious, insurers often use private investigators not only to conduct an investigation regarding the facts surrounding a particular injury claim, but also to inspect the medical facilities where treatment supposedly took place.

Investigators normally follow an investigative process that can put the brakes on a medical clinic's illegal activities. Before a workers compensation claim is paid, insurance investigators must verify that the medical treatment was, in fact, completed, the equipment necessary to perform the treatment is present at the clinic, the amount billed by the medical facility was consistent with the type of treatment received by the claimant and those performing the treatment are appropriately licensed or supervised.

In a classic example of overkill in some unethical "multi-line" clinics, a battery of specialists such as internists, chiropractors, orthopedists and neurologists will routinely see patients whether necessary or not and dutifully bill for their time, which, of course, drives up the overall cost of treatment. This also brings up the question of how much time the doctor actually spent with the claimant (if the doctor saw the claimant at all).

Additional "bill padding" techniques include unwarranted or unnecessary medication and diagnostic tests.

Investigations of clinics should include:

- Obtaining the claimant's medical records.

The investigator's first order of business when investigating a medical clinic is to obtain a signed medical authorization from the claimant allowing the investigator to photocopy the claimant's entire medical file. This includes doctor's notes or comments scribbled on the file folder and patient sign-in sheets (both in the medical file and at the reception desk).

The investigator also checks to see if information on the claimant is stored in the clinic's computer system and, if so, the investigator obtains copies of these records as well. Any logs or charts pertaining to the injury that are not contained in the claimant's files are retrieved. Investigators should be on the watch for computer-generated "boiler plate" medical reports that are used in high volume clinics.

- Inspecting the clinic itself.

While at the medical facility, the investigator makes note of the way patient treatment is conducted.

The therapy and X-ray rooms, for example, should be inspected to confirm the equipment that would render the type of treatment charged by the clinic actually exists.

In addition, the investigator verifies that any lab results, including X-rays, are in the file and are appropriately labeled with the claimant's name, the date on which the tests were taken, and the reason for the lab work.

The investigator requests the medical license numbers of the doctors, chiropractors and physical therapists associated with the clinic. All licenses should be verified as current with state regulatory agencies or professional organizations.

Sometimes, important medical records can be forged or otherwise illegally filled out. If there is a question about a signature on a medical record, log or sign-in sheet, handwriting experts can usually determine if the patient's signature was forged.

- Obtaining a statement from

Continued on next page

Insurer Topics

Quick reaction

Continued from previous page
the claimant.

Ideally, the claimant's statement should be taken after the medical records have been obtained from the clinic. The medical documentation greatly improves the ability of the investigator to interview the claimant.

The medical records must support the injured party's account of his/her course of treatment. By comparing the claimant's testimony and the medical records, the investigator should know if the claimant is being truthful and, at this point, if the medical clinic overcharged or billed for services that were never rendered to the claimant.

- Researching clinic ownership.

Researching the layers of ownership of a medical facility might reveal the name of an attorney or another non-medical person as part owner and thereby establish a connection between a claimant's legal representation and the facility. Ownership information, such as fictitious business filings, business licenses and corporation records, is obtained by contacting the appropriate government agency within the state and/or county in which the clinic is doing business.

Real estate records can uncover a connection between the claimant's attorney and the clinic owner in property investments outside the clinic. A search of these records can also establish that the doctor or attorney own businesses providing support services for the clinic—such as interpreters, court reporters, diagnostic examiners, referral agencies and rehabilitation counselors. These searches can be done through various online data bases.

If these records reveal improper associations, the investigator can often develop enough evidence to close down a shady medical operation and bring professional misconduct or even criminal charges against the doctor or attorney.

Instead of eliminating one phony claim, the investigation can expose hundreds, if not thousands, of fraudulent cases.

Insurers are beginning to realize they are missing excellent opportunities to uncover fraudulent medical operations when they investigate only the facts pertaining directly to an injury or accident and not the following medical treatment.

With the tab for workers comp at $70 billion a year (nearly triple what was paid in 1980), and the average workers comp claim cost at more than $19,000, it pays for insurers and employers to thoroughly investigate all aspects of questionable claims. BI

Ty Hutchison is president/chief investigator of T.B. Hutchison & Associates, a Westlake Village, Calif., private investigation agency specializing in workers compensation cases, auto insurance fraud, internal corporate investigations and sexual harassment claims.

Insurer not afraid to attack comp fraud

By NANCY P. JOHNSON

GLENDALE, Calif.—One workers compensation insurer is attacking comp fraud with every tool it can get its hands on.

Fremont Compensation Insurance Co. is using newspaper ads, billboards, consumer video packages and an aggressive investigation program to fight fraud. And, its fraud investigation unit recently helped the ABC news program "PrimeTime Live" pull off a comp sting operation.

Fraud is a big problem for California's $8 billion workers compensation industry, in which 20% of all claims involve fraud, according to state estimates.

"Southern California is the workers compensation fraud capital of the world," says James E. Little, Fremont's president and chief executive. The Glendale, Calif.-based company writes workers comp policies in California and Arizona.

A turning point in the fight against comp fraud came in 1991, when one of the major Los Angeles TV news stations ran a series on doctors and other providers taking part in workers comp fraud, said Mr. Little. After that, state lawmakers passed a workers comp reform program—S.B. 1218—that, among other things, set up a mechanism to provide up to $4 million per year to local prosecutors to fight workers comp fraud.

"Fremont decided to take the message to the public, which is as important as putting people in jail," he said.

Fremont geared up for the fight by staffing its fraud investigation unit with former law enforcement professionals and expert fraud investigators, giving them authority to work with district attorneys and law enforcement officials throughout California. And, rather than just filing the two-page forms required by state law, Fremont investigators deliver fully prepared cases to the Bureau of Fraudulent Claims so prosecutors can act on them immediately.

The insurer launched its attack on fraud with a newspaper advertising campaign in late 1992. Fremont took out full-page ads in major California newspapers announcing the results of a major offensive on comp fraud. The ads noted that in one year, there were 17 arrests in California for felony comp fraud and 16 were a direct result of information gathered by Fremont's fraud investigation unit. And, Fremont personnel trained the investigators in the 17th case, which involved the California Public Employee Retirement System.

As of December 1992, Fremont had presented 78 fraud cases to local prosecutors, and many more are under investigation.

The ads also noted that Fremont's anti-fraud campaign has helped reduce total claims, resulting in an estimated $12 million savings for policyholders in just five months.

The ads make it clear how serious Fremont is on pursuing fraud, saying: "We will aggressively contest every penny of every claim we suspect is fraudulent—in court, if necessary."

After the newspaper ad campaign, Fremont's post-employment stress claims—a frequent source of comp fraud—fell to 10 to 12 per week from an earlier average of 25 to 30 per week.

The ads also offered a video for non-policyholders, containing advice on how businesses can crack down on comp fraud.

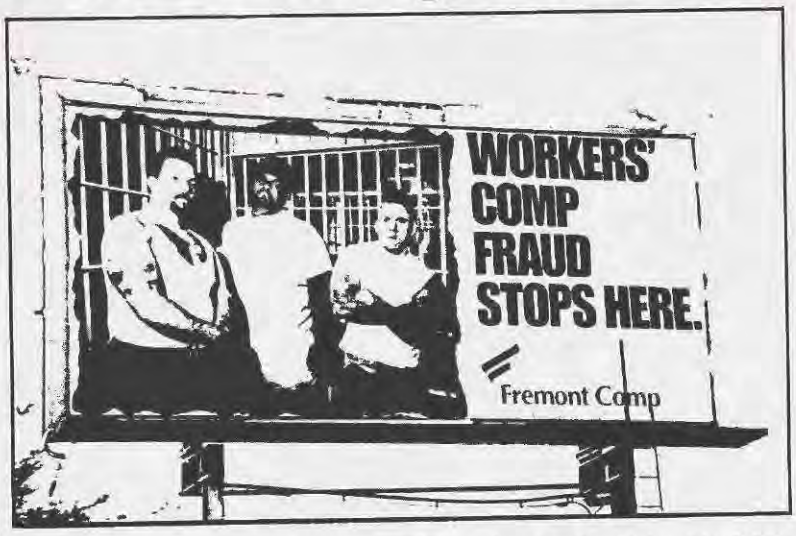
Next, the insurer took to the skies, with a statewide billboard campaign in early 1993. The signs read, "Workers' Comp Fraud Stops Here," and show a grim black-and-white photo of three inmates in a jail cell.

The two-month campaign used 613 billboards, which were estimated to have been seen more than 13 million times per day.

But California's comp fraud artists really took note last month when "PrimeTime Live" aired a sting operation put together with Fremont's help.

"PrimeTime" set up a phony medical clinic, with hidden cameras. The nameplate was barely on the door when doctors and middlemen arrived with offers to arrange bogus insurance claims by buying or selling patients for illegal kickbacks.

At the end of the segment, the program's narrator, Diane Sawyer, confronted the doctors one by one with videotapes of their proposals.



Fremont Compensation Insurance Co. estimates its statewide 1993 billboard campaign was seen more than 13 million times per day.

One doctor, viewing his illegal deal, coolly remarked, "I don't remember saying that," but the others immediately stormed out of the clinic.

"Forensic doctors are getting paid tremendous sums of money because of loopholes in the law," said Mr. Little. "The law permits unlimited medical evaluations, and these doctors are billing the system as much as $40,000, even when the claim is phony."

Fremont's involvement with "PrimeTime Live" came when the TV show contacted the insurer for assistance, he said. "We worked with them and with policyholders for about 10 months, to steer them in the right direction."

Feedback on the "PrimeTime Live" show was impressive, said Mr. Little. He has received calls and letters from legislators, policyholders and non-policyholders. Plus, he has received calls from several high-profile industrial medical practitioners—whom ABC did not film—"wondering if they were going to be shown."

Mr. Little found more proof of Fremont's reputation as being tough on fraud. "We found during the 'PrimeTime Live' investigation that the team had a hard time getting unscrupulous providers to take Fremont claimants," he said.

And, he noted, the number of Fremont's reported workers compensation claims continues to fall. Fremont's comp claims dropped 40% from January 1992 to January 1993, with the same amount of premium volume, he said.

Noting that workers comp fraud will flourish as long as criminals find it so easy and profitable, Mr. Little said comp fraud "is like narcotics. The penalties include life imprisonment, but people still do it because so much money is involved."

Just how profitable is such fraud?

If "PrimeTime Live's" phony clinic had accepted all the fraudulent deals it had been offered in three months, it would have netted $20 million in comp claims—about $666,666 per day. BI

IT Letters

Insurers shouldn't overlook recent college graduates

To the editor: I am writing in reference to your segment on employee recruiting in the Feb. 15 Insurer Topics.

I am a 22-year-old male who has recently entered the reinsurance/insurance field. What I find odd about this industry is the overall lack of recruiting of college graduates. In the story, "Insurers consider necessity of MBAs," the statistic that only 2.5% of New York University MBAs enter the insurance industry is truly astonishing, if not embarrassing. This statistic takes into consideration that these students are concentrated in one of the largest insurance areas of the world. The trend must change.

The Independent Reinsurance Underwriters Assn., based in Canton, Ga., offers an internship program each summer for college students; students work with a reinsurance intermediary, as well as a reinsurance company. I was fortunate to be accepted for one of these internships, and this program solidified my decision to enter the industry.

The insurance industry needs more of these programs. Today's students are literate in computer, business and communication skills, which are necessary if the industry is to prosper. Many of my college friends showed interest in the insurance field, but were unaware of how to get their foot in the door. They have moved on to jobs in accounting, brokerage and law.

Insurance and reinsurance executives should do more to recruit college students. The IRUA program is a step in the right direction, but more should be done.

Andrew Pyle
Assistant Vp
Cypress Creek Intermediaries Inc.
Heathrow, Fla.

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HMO enrollment

Continued from page 3

growth in traditional HMOs may be leveling off. Between January 1992 and July 1992, traditional HMO enrollment growth slowed to 2.9%, compared with 3.1% for the previous six months, the survey found.

In citing reasons for the current slowdown, the authors note that medium-sized HMOs—those with between 5,000 and 50,000 members—lost nearly 120,000 enrollees during the 12-month period from July 1991 to July 1992. Those HMOs "were less likely than others to report new contracts with groups previously covered by other local HMOs, PPOs, indemnity insurers or self-insured arrangements."

The slowdown also may be explained by a change in employers' behavior, said Richard L. Hamer, director of publications at InterStudy and a co-author of the report.

"Employers are trying to decrease the number of health plan options they offer employees and they are looking for broad networks with lots of flexibility," Mr. Hamer said. Employers "also are looking for increased accountability, which leads to the desire for one health plan that agrees to the employer's reporting requirements," among other things.

Midsize HMOs "are having trouble competing in that environment," Mr. Hamer observed.

Meanwhile, open-ended HMO enrollment has slowed significantly over the last few years, the study found. "The annual rate of enrollment growth for open-ended HMO products has been dropping from its peak of nearly 40% in 1990 to 14.8%" from July 1991 to July 1992, the survey says. "During this period, 212,108 new enrollees were added to open-ended plans, bringing the national total to about 1.6 million."

InterStudy defines an open-ended HMO as one that allows participants to obtain services outside the network at reduced benefit levels. Traditional HMOs restrict participants to network providers.

The study also found wide variability in growth rates among the 556 HMOs surveyed. For example, 20% of HMOs reported a 10% or greater decline in enrollment between July 1991 and July 1992, while 9% reported growth between 4% and 10% and 42% reported growth in excess of 10%.

"There is wide variability in HMO performance, but we can't really nail down the reason empirically," Mr. Hamer noted. "One factor, though, may be the relationship between the health plan's managers or administrators and the network providers in the HMO. To the extent that providers and administrators can agree on the financial objectives of the HMO—that is, how to control costs and such—HMOs are more likely to be effective" and continue to grow, he explained.

Eighty-six percent of the HMOs surveyed reported that their enrollment increase could be attributed to an increase in the number of group contracts held by their HMO. Of those, 68% said their new groups had originally contracted with another local HMO; 65% said the new groups were previously policyholders with indemnity insurers; and 42% said the new groups switched from a local preferred provider organization. In addition, 35% of HMOs reporting increased group contracts said the business came from formerly self-insured employers and 31% cited a gain from employers with groups enrolled in "other managed care products." The total exceeds 100% because HMOs could cite more than one source.

"To maintain a competitive advantage in a dynamic marketplace, many HMOs have worked toward diversifying their product lines to include a range of managed care programs," the survey authors note.

According to the survey, 35% of HMOs that offer additional managed care products offer or are affiliated with a PPO; 32% offer a self-insured product; 29% offer or are affiliated with a point-of-service product; and 23% offer a managed fee-for-service product.

Marketing other managed care products is a "lucrative business," Mr. Hamer said. But, it's too early to tell whether there will be an increase in such activity. And, the survey found, over the last three years some HMOs have actually decreased the number of additional managed care products they offer.

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The "InterStudy Competitive Edge Databook and HMO Directory" is available for $100 from InterStudy, P.O. Box 4366, St. Paul, Minn. 55104; 612-474-1176.

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Fighting in the trenches

Health care reform will be won through a grass-roots battle

By Peter Boland

WILL HILLARY RODHAM CLINTON be able to wrestle the $900 billion health care gorilla? If not, the beast will consume one out of every five dollars of our nation's total economic output by the end of the decade. The only certainty is that it will be a bloody match.

To win this battle, the administration must frame the debate around the guiding principles of health care reform by orchestrating grass-roots support on a region-by-region basis. A series of health care summits in each part of the country should be convened as a centerpiece of the national dialogue on reform options and choices facing Americans.

Health care is local, not national. The real battle is not in Washington—only the first fight. Health care reform will be won or lost in the trenches—doctor's offices, hospitals, long-term care facilities, health maintenance organizations and preferred provider organizations—where hundreds of thousands of choices are made every day about getting and giving medical care. It is on these front lines that the problem lies and these are the only places where substantial savings can be wrung out of the system.

Unless this reality is grasped early on, health care reform efforts will fail and thereby derail economic recovery.

For health care reform to generate enough savings to cover the uninsured, Americans should be told soon that everyone must sacrifice. The public must be educated about the trade-offs involved in reform.

More importantly, how will health care reform trade-offs affect people with different needs and priorities, such as:

- The chronically ill sales clerk who must choose between his trusted family physician of 14 years or signing up with a new managed care group that may provide more sophisticated care.
- A hospital administrator who must either lay off more employees due to further Medicare and Medicaid cutbacks or create turmoil throughout the organization by redesigning work functions and clinical services to improve efficiency.
- A 59-year-old electrical worker who is asked to accept a lower-cost HMO with reduced benefits, although the expected savings may increase the odds of protecting his retiree health care coverage.
- A newly trained cardiologist who must choose between using high-cost procedures she believes are essential for high-risk patients or following arbitrary health plan guidelines as a condition for more patient referrals.

These are not easy choices. No one likes to give up cherished beliefs, hard-won benefits, expected payment levels or ingrained ways of doing business. But that is precisely what is called for to make health care reform work. Otherwise, access to affordable care will remain beyond the reach of too many Americans.

To get the job done, three things must happen right away:

- Begin a serious dialogue about the practical consequences of health care reform trade-offs.
- Seek the advice and counsel of a broad range of people in the trenches outside the Beltway who understand the day-to-day implications of proposed policies and how to actually implement them.
- Mount a 50-state political campaign as the vehicle to sell the principles of health care reform and build grass-roots support as a counterweight to powerful special-interest groups.

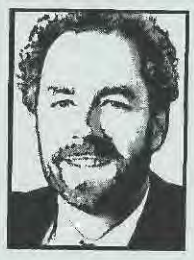
Ms. Clinton can put her personal stamp on the health care debate by orchestrating a full-fledged public relations effort in the best sense of the word. The American people are ready to hear a bold new agenda that links the objectives of economic recovery and growth with the specifics of health care reform.

Just as the Economic Summit in Little Rock set the stage for developing an overall economic strategy, serious roundtable discussions must set health care solutions, not positions, as the goal. This requires individuals and organizations to focus on pragmatic answers that cut across narrow ideological and economic interests.

If the process works well, no one will feel they have won a clear victory. But everyone should gain a clear understanding about what they had to give up to achieve broader societal goals such as fairness, expanded access and cost control.

The administration must develop a nuts-and-bolts health care political strategy that is just as relentless, comprehensive and demanding as the campaign that brought them to the White House.

Without marshaling broad-based public understanding and support, special-interest views and entrenched congressional positions will shackle the health care reform debate. And the president might rue the day he enlisted his most trusted aide to fight what could be a losing battle. BI



Peter Boland is president of Boland Healthcare Inc. in Berkeley, Calif., editor of "Managed Care Quarterly" and author of "Making Managed Care Work."

Unraveling family leave law

Time, regulation needed to clarify new law's impact on employers

By Seth H. Tievsky

ENACTMENT OF the controversial and long-debated family leave law has left employers wondering exactly what their obligations are unde the new law.

The Family and Medical Leave Act of 1993, signed last month by President Clinton, is supposed to be fairly straightforward in its requirement that employers must give their workers 12 weeks of unpaid leave to care for newborns or attend to family medical crises. But the details of the law, which is effective Aug. 5, are far from simple. And many issues await clarification in regulations.

For many employers, compliance will turn on the ability to mesh the new federal law with state family leave laws currently in place as well as individual corporate policies. State laws that are more generous than the federal law will continue to govern. But any feature of the federal law that is more liberal will apply. Given the breadth of the federal law, it is all but certain that changes in virtually all leave policies will be necessary.

To be eligible for the family leave benefit, an employee must have been employed for at least one year and must have worked at least 1,250 hours during the past 12 months. Also, an employee is only covered if his or her employer has at least 50 employees within a 75-mile radius of the employee's work site (*BI*, Feb. 8).

A key element of the law is that the worker must be allowed to return to the same job or an equivalent position with equivalent benefits and pay. Previously accrued benefits may not be forfeited. But, the worker need not accrue any additional benefits or seniority during the leave.

For example, the worker apparently may not forfeit unused vacation that might otherwise be lost, though additional vacation accruals are not required during the leave. The same holds true for pension benefits.

Other issues raised by the law include:

- **Health insurance.**

The employer must continue to provide health benefits during the leave at the same level as if the worker had continued in his or her regular position. The worker must continue to pay appropriate premiums, copayments and other out-of-pocket costs required under the health plan.

Though benefits are preserved, this would not prevent the employer from revising a health arrangement that applies to employees generally.

It is not clear how leave taken under the law will be interpreted as a COBRA qualifying event. The law mandates that regular health benefits continue, so returning employees would be unaffected. But an employee who does not return presumably is entitled to elect COBRA coverage.

For example, if a sick employee takes 12 weeks of family leave with employer-provided health benefits, then terminates employment and elects COBRA coverage, would the 18 months of coverage run from the beginning or the end of the family leave period? Let's hope government regulations will provide an answer.

The law allows an employer to recover health premiums (but apparently not regular medical expenses) paid on behalf of the worker during unpaid leave if that worker fails to return to the job, unless that failure is due to continuation of the medical condition or "other circumstances beyond the (employee's) control."

What those circumstances may be is unclear and could become a contentious issue. Would an employer be entitled to reimbursement if the employee quit for a higher-paying job and claimed it was necessary to pay for uninsured medical expenses? The answer is unclear.

- **Employer rights and employee responsibilities.**

An employer may require that the 12-week leave be taken all at once, in the case of birth or adoption. Intermittent or reduced leave may be taken by employees when medically necessary to care for themselves or children, spouses or parents. Intermittent leave refers to leave on an occasional basis. Reduced leave is taken on a regular, reduced work schedule.

The law provides that if an employee requests intermittent or reduced leave that is foreseeable based on planned medical treatment, the employer may require the worker to transfer temporarily to an equivalent alternative position that has the same pay and benefits but might better accommodate planned absences.

There was some controversy in Congress surrounding the reduced leave requirements. In the bill originally introduced in the House, reduced leave could only be taken by agreement between the worker and the employer. However, in the final version as enacted, no such agreement is required; it seems the worker can simply opt to take the leave without agreement.

An employer already providing paid family leave may offset such leave

Continued on next page

Family leave law

Continued from previous page
against the 12-week leave required by the law. The employer also may generally require the worker to use his or her paid vacation, sick or personal leave (if any) until exhausted, making up the balance of the 12-week period with unpaid leave.

But a close reading of the law reveals that paid sick leave need not be exhausted to care for a newborn or adopted child. It isn't clear why this distinction was made.

To support a claim for family leave, the employer may require the worker to obtain a physician's certification of the existence of the health condition of the employee, spouse, parent or child. This may include a description of the condition, its starting date and expected duration. If the employer is not satisfied with the certification, it may require, at its own expense, a second opinion. The employer may pay for a third opinion if the first two conflict. The third opinion is binding on both parties.

Employees generally must give their employers at least 30 days' notice (or less if this is not possible) of their intention to take leave when the precipitating event is foreseeable, such as a birth, adoption or planned medical treatment. The law is ambiguous about failure to give notice. Under one interpretation, leave rights are forfeited, but this is far from certain. A staffer on the Senate Subcommittee on Children believes there is no penalty.

• Whether highly paid employees are excludable.

Contrary to early reports in the general media, there is no automatic family leave exclusion for highly paid employees. Rather, an employer may deny re-employment to certain highly paid employees whose absence could cause substantial and grievous economic injury to operations, possibly a difficult standard for an employer to satisfy.

And affected employees must have prior notice of the risk of denied re-employment before their leave begins. Otherwise, the exception does not apply. Regardless of whether re-employment is available, employer-provided health benefits must continue during the leave.

The higher-paid employee exception only applies to the highest-paid 10% of salaried workers employed in a 75-mile radius of a work site. So an employer with operations in widely dispersed areas could have different high-paid groups in each location. For example, the 10% threshold would likely cover a much higher-paid group at an employer's headquarters than at a manufacturing plant 100 miles away.

• Flexible benefits issues.

Unanswered by the new law are a number of issues affecting flexible benefit plans. For example, access to medical flexible spending accounts should still be available to a worker on family leave, but could be a problem for an employer if the worker exhausts a flex account during leave and then quits before all employee contributions are made.

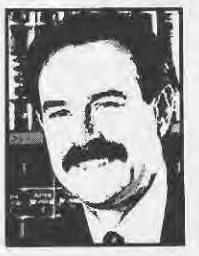
Also, if family leave overlaps the start of a new flex plan year, would the employee be entitled to a new FSA election (and coverage) though there is no assurance he or she will resume employment and make employee contributions? Separately, it appears that health insurance premiums and other cafeteria plan payments that are normally paid with pretax dollars will be required of the employee with aftertax dollars during the leave.

• Penalties.

An employer found by a court to violate the law will be liable to the employee for up to double the amount of lost wages and benefits. To ensure employees are able to enforce their rights, the law provides that the liable employer will also have to pay the employees' attorney fees and other court costs.

All employers that employ at least 50 workers each day, including part-time workers, over at least 20 calendar workweeks in the current or prior year, are affected by the law.

Regulations are expected this June from the Labor Department, but that may be too late to help in forming leave plans that workers can start to take in early August. Employers should plan now how they will implement the law's requirements. BI



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Underground storage tank coverage

State pollution funds may be straining from demand, claims

By Keith H. Cannon

IN THE EARLY 1970s, when the Arab oil embargo caused a quadrupling of gasoline prices and long lines at the pumps, many businesses decided to install underground storage tanks in order to maintain a stock of petroleum products. Unfortunately, that decision is now coming back to haunt those same businesses.

Pollution from underground storage tanks has become one of the largest liabilities companies face today. A single loss could potentially bankrupt most businesses.

With the last of the U.S. Environmental Protection Agency leak-detection and financial responsibility compliance deadlines approaching on Dec. 31, 1993, many service stations, convenience store chains, and other tank owners and operators will be turning to the various state funds that insure the risks in the event they have a leak from their underground tanks (*BI*, Nov. 23, 1992).

With the potential for UST losses to jeopardize one's business survival, companies should be aware of what these state funds are covering or not covering, how financially stable they are, and if they can be depended upon. Will they be there when they are needed?

Many EPA-approved state funds, once promoted as well-run and well-funded, are now in serious financial straits and unable to provide the coverage on which business owners have been depending.

Florida's Department of Environmental Regulations—after recent changes in the state's storage tank laws that increase gasoline taxes to 1.2 cents per gallon, generating more than $100 million a year for the trust fund—has decided to phase out coverage by 1994.

The Texas Petroleum Storage Reimbursement Program, which has paid in excess of $170 million, has stopped paying for some cleanups.

The Michigan UST Financial Assurance Act, which generates more than $55 million a year and is now $164 million in the hole, sent certified letters in November 1992 to all registered UST owners, stating that "funding will no longer be available for claims or other requests received after Feb. 8, 1993." Requests in the interim may be paid to the extent that money is available.

Trust funds have been approved by the EPA in 29 states, including Michigan and Texas; seven others, including Florida, have been submitted for approval and are considered approved pending final review. Additionally, seven other states operate funds that have not yet applied for EPA certification. The remaining states and the District of Columbia have state regulations requiring proof of financial responsibility for UST owners/operators, but have elected not to develop financial assurance programs primarily because of the availability of coverage from the private insurance industry.

Although many petroleum and insurance industry analysts predict that various trust funds will continue to deteriorate, some contend that some state programs are operating successfully and in fact have surplus funds. However, in a May 1992 meeting of the Society of Independent Gasoline Marketers Assn. of America, Dave Ziegel of the EPA's Office of Underground Storage Tanks commented that many of these programs are not able to generate enough capital. States in that position will not acknowledge they are running out of money—they simply slow down payments.

State fund solvency has always been a primary concern of owners/operators and has now become a major issue with the EPA. The agency is currently reviewing the situation and has planned to issue a statement advising of the telltale signs whether a state fund is running low on cash.

In the meantime, businesses will have to closely examine their own state programs, taking into consideration more than just the current surplus levels.

For example, the Virginia Petroleum Storage Tank Fund claimed a surplus of approximately $17 million near the end of 1992. With deductibles of $50,000 for cleanup and $150,000 for third-party liability, the program has paid 42 claims totaling approximately $2.2 million, averaging $52,380 per claim.

In July 1992, VPSTF deductibles were reduced, ranging from as low as $5,000 for cleanup and $15,000 for third-party liability to as high as the original deductibles, depending on the volume of products stored annually by the owner/operator.

In addition, Virginia regulations will soon allow access to the fund for an estimated 10,000 above-ground storage tank facilities containing oil, and approximately 3 million farm/residential motor fuel USTs and home-heating oil storage tanks previously excluded from coverage.

Now, the state program will be under greater demand because more tank leaks will be eligible for coverage under VPSTF and a larger portion of these claims will be reimbursed by the fund. Virginia currently has approximately 50 claims pending at an average of $66,000 per claim, for an estimated total of $3.3 million.

The program is funded by a 0.2 cents per gallon gasoline tax that generates about $10 million per year, with provisions to increase the tax to 0.3 cents per gallon, or $15 million per year, if the fund size drops below $3 million.

Virginia state program officials currently know of at least 5,000 locations with contamination, and expect this figure to at least double in the near future. Assuming only half of the known sites generate claims at the current average of $52,380 per claim, the demand would exceed $120 million. The number of environmentally impaired sites will certainly increase as the final EPA leak-detection and tank upgrade regulations approach, forcing businesses to examine their USTs. Thus, as the number of known sites and average loss amount increase, demand on VPSTF could very well exceed $200 million.

All state funds suffer other drawbacks besides insufficient surplus and lack of funding. Many programs do not offer third-party liability coverage. In addition, very few funds provide any coverage for legal defense costs. Some programs are now setting caps on the amount they will pay for specific cleanup work, often resulting in a net return of only 60 cents to 70 cents on the dollar.

The majority of funds are reimbursement programs requiring the business owner to pay for the initial cleanup and incur considerable delays awaiting payment from the state, causing substantial cash flow problems.

In summary, state funds alone will not provide the protection that will ensure a company's survival. These programs should not be considered a substitute for true insurance. BI

Keith H. Cannon is assistant vp in charge of environmental programs and risk management services for Henderson & Phillips Insurance in Norfolk, Va.

Law of large numbers holds down costs

By John C. Myre

LARGE NUMBERS are frequently used to measure the insurance industry—hundreds of thousands of people employed, billions of dollars in premiums, trillions of dollars in coverage limits. One of the major keys to success for this industry is its ability to spread its risks over many companies using the law of large numbers—the broader the base, the more predictable the losses.

On a personal basis, many of us who have had the joy of insuring four to five cars at one time have used a simplified version of this theory. We normally use higher deductibles when we insure four to five cars than we would if we were only insuring one to two cars because of the broader exposure base.

However, even with all these examples in front of us, most organizations do not take advantage of this theory in purchasing their own insurance.

The purpose of this article is to point out the value of considering each coverage as part of a total insurance program, not as an individual coverage. This approach means buying insurance as if there was only one policy to purchase, instead of the six to 10 that most of us buy. As an example, Southwestern Bell Corp. used this concept to reduce its insurance costs by more than $5 million annually. These savings include normal recurring losses.

A summary of Southwestern Bell's original program, excluding primary liability and workers compensation coverages, which are self-insured, is provided in the chart labeled "Original Coverage."

For years we viewed each line of coverage as a separate transaction. We analyzed the losses, premiums and savings associated with various deductibles. For example, under one of the smaller exposures we could only save $23,000 by raising the deductible $500,000.

Invariably we came away thinking that there was a possibility, albeit remote, that at least once in the next 10 to 25 years we could sustain a loss under a particular coverage that would wipe out the net cash flow premium savings associated with the higher deductible.

This left us with deductibles that were higher than most companies' and comparable to those of our peers. However, in relation to assets and earnings, the deductibles appeared to be small.

We felt that we needed to raise the deductibles, but we were not comfortable with the facts we could marshal to justify increased deductibles to our senior management on an individual coverage basis. We then decided to approach this issue on a comprehensive basis.

A summary of an alternative program that was considered is shown in the chart labeled "Alternative Coverage."

The total differences in the proposed deductibles are primarily due to regulatory concerns and internal considerations. For most companies, the regulatory concerns would not be an issue.

In deciding to recommend higher deductibles, there were other factors, in addition to the premium savings, that supported the decision. These factors would apply to any company:

✔ Loss-prevention efforts within the company.

The company has a long history of good loss-prevention efforts. Higher deductibles reinforce the need to continue these efforts, because the managers realize there is much more at stake if a major loss occurs.

✔ Loss history for the company and the industry.

The company and the industry both had good loss histories during the last 25 years. During this period, the company's largest liability loss was $2.4 million, and the largest property loss was $2.2 million.

In looking ahead, no issues are arising that should

By treating each coverage as part of a larger program, risk managers can realize significant overall savings

significantly change the exposures. The major exposures involve automobile fleets and equipment locations. These exposures have been the focus of loss-prevention efforts through the years and recently additional actions have been taken to enhance these efforts.

✔ Financial impact from large loss.

The major senior management concern regarding deductibles is the impact on earnings and stock price in the event of a large loss.

To allay that concern, we asked several investment analysts for their opinion of what we were considering.

The analysts said they would not be concerned by a one-time loss of two to four times the highest deductible under consideration, unless it was something that fundamentally changed the business (for instance, Union Carbide's 1984 toxic gas leak in Bhopal, India; or the cyanide poisoning of Tylenol capsules in 1982) or was part of a series of bad management decisions.

However, several simultaneous large losses in the same year is a real possibility under this program and must be given careful consideration when recommending higher deductibles. Aggregate coverages must be considered for coverages with high deductibles.

✔ Improved cash flow.

The savings do not include any cash flow calculations. However, because any large casualty loss will probably take several years to settle, significant net cash flow savings should occur by raising the deductibles.

✔ Preference to stay with same insurers.

Many factors, in addition to price, play a role in the choice of insurers. We prefer to stay with the current insurers because it takes a while for them to become familiar with our operations. But we recognize that by doing so we will eventually pay for the losses in these lower layers, plus the overhead of the insurers, over a period of time. This premise also drove us toward higher deductibles.

Using figures from the original and alternative programs, the analysis in the "Savings" chart shows the significant savings that were possible by looking at insurance on an overall basis as opposed to an individual coverage basis.

The total increase in deductibles was determined by the following steps:

- 1. The original premium for a particular coverage was divided by the total original premiums to determine its percent, or weighting, of the total premiums.
- 2. This weighting was then multiplied by the increase in the deductible to determine the weighted increase in deductibles for that coverage.
- 3. The results of the calculations in step 2 were added to obtain the total increase in deductibles.

The final program that was selected reduced premiums by more than $5 million annually and involved even higher deductibles.

On an individual coverage basis it would have taken from nine to 48 years for the premium savings to equal the deductible increase.

However, on a combined basis we could experience up to $13.5 million in losses every three years for these coverages and layers and still make money, based on the premium savings of $4.5 million annually. This compares favorably to the largest losses in the last 25 years, which as noted earlier, were less than $2.5 million.

If a more comprehensive analysis is required, cost of money calculations, tax rates, and estimates of the frequency and severity of large losses could be included.

This approach recognizes the possibility of several large losses in a short time frame that could exceed the premium savings. However, the purpose of this article is to encourage organizations to look at their coverages as part of an overall program. They should not focus on how high we might have raised deductibles, but rather on how this approach might help them reduce their insurance costs.

For example, other alternatives with smaller increases in deductibles reduced the payoff time to periods much less than three years.

Determining deductibles is probably the most difficult job of a risk manager. The traditional approach of analyzing each coverage as an island unto itself usually leads to relatively low deductibles. Ideally, a risk manager would like to buy one policy that would cover all of the company's exposures. Because this is not possible, we feel the next best thing is to analyze each coverage as a part of the whole insurance package and use the law of the large numbers to the company's advantage. BI

Original coverage

Coverage	Deductible	Premiums
A	$1 million	$691,000
B	3 million	2.7 million
C	7.5 million	3.1 million
D	10,000	849,000
E	250,000	1.5 million
F	250,000	155,000
G	250,000	185,000
H	0	478,000
Total		**$9.6 million**

GRAPHIC BY CHRIS ROY

Alternative coverage

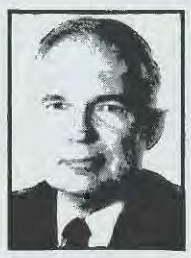
Coverage	Proposed deductible (millions)	Premiums
A	$10	$339,000
B	20	816,000
C	20	2.2 million
D	10	100,000
E	5	998,000
F	5	55,000
G	5	50,000
H	0	478,000
Total		**$5 million**

GRAPHIC BY CHRIS ROY

Savings

Coverage	Premium savings	Deductible increase (millions)	Years required for premium savings to equal deductible increase
A	$352,000	$9	25.6
B	1.9 million	17	9.0
C	850,000	12	14.7
D	749,000	10	13.4
E	460,000	4.8	10.4
F	100,000	4.8	48.0
G	135,000	4.8	35.6
H	0	0	0
Total	**$4.5 million**	**$11.2 million**	**2.5 years**

GRAPHIC BY CHRIS ROY



John C. Myre is the former director of risk management at Southwestern Bell Corp. He now owns Safety Line Consultants, a safety consulting firm in Chesterfield, Mo.

UNI Storebrand

Continued from previous page
government made an effort to reimburse the shareholders' losses by:

- Injecting money into UNI Storebrand to recapitalize it.
- Guaranteeing payment for UNI Storebrand creditors.
- Or abolishing restrictions on foreign investment in the Norwegian insurance sector, making it possible for a foreign investor to buy out UNI Storebrand.

Currently, foreigners can buy only 10% of a Norwegian financial institution. But the government is considering raising this cap to 33% (*BI*, Feb. 8).

Detailing the UNI Storebrand results, the holding company said it took a 1.28 billion Norwegian kronor charge ($184.6 million) in the write-down, and the new holding company took a 1.35 billion charge ($194.7 million).

Both the life and non-life operating subsidiaries improved their operating results in 1992, according to the company. The pretax profit for the life insurance company, UNI Storebrand Livsforsikring A/S, increased 75% to 1.91 billion kronor ($275.4 billion) from 1.09 billion kronor in 1991 ($182.7 million). Gross premium volume rose by 90 million kronor ($13 million) to 4.76 billion kronor ($686.4 million) But the share portfolio was written down by 537 million kronor ($77.4 million).

Of the life company's aftertax profit of 1.84 billion kronor ($265.3 million), approximately 1.64 billion kronor ($236.5 million) was transferred to policyholder surplus.

The non-life company reported a pretax profit of 345 billion kronor for 1992 ($49.7 billion), up 22.8% from 281 billion kronor in 1991 ($47.1 billion). The non-life company, UNI Storebrand Skadeforsikring A/S, reported that premium volume fell by 2.5% to 6.87 billion kronor ($990.7 million). Its losses included 124 million kronor ($17.9 million) due to the hurricane that struck western Norway, and 168 million kronor ($24.2 million) in realized losses and write-downs on the securities portfolio.

The non-life company's market share fell to 40.8% from 42.2%.

The UNI Storebrand International A/S reported a loss of 546 million kronor ($78.7 million), compared with a profit of 64 million kronor in 1991 ($10.7 million). Gross premium volume for this subsidiary increased by 6.5% to 4.70 billion kronor ($677.7 million). The poor result was partly due to a loss of 164 million kronor ($23.6 million) from Hurricane Andrew, UNI Storebrand said.

UNI Storebrand Chief Executive Per Terje Vold said that international operations will focus exclusively on reinsurance. The marine, oil, satellite and liability insurance lines will transfer to the non-life unit.

The company's major goal is high, stable earnings, Mr. Vold said, which will be achieved through an effective use of capital, greater concentration on insurance in Norway and a consolidation of international operations. The company "will strive to sell the Skandia shares as soon as possible at the best possible price," he said.

A UNI Storebrand spokesman denied that the intention to sell the Skandia stake was announced so prominently in the annual report because the company has had difficulty selling the stake. He would not comment on potential buyers.

According to Mike Wheelhouse, insurance analyst at London stockbrokers Hoare Govett, UNI Storebrand will only be able to sell its Skandia shares as a package to another insurer. But another insurance company may only agree to buy these shares if Skandia changes its current limitations on shareholder voting rights, he noted.

"We are examining ways of altering the present voting rights with the hope of creating a better balance between capital and voting power," said Skandia Vp Johan Bergenstjerna. At present, all Skandia shareholders have the same voting power, regardless of their share size.

In a separate development, Danish insurer Baltica Holdings A/S is expected to report a large 1992 loss after its 23% shareholder, France's Compagnie Financiere du Suez, announced it had lost 500 million French francs in 1992 ($90.5 million) from its Baltica investment.

Stock analysts have calculated that would imply a loss for Baltica Holding of 2.47 billion Danish kronor ($392.7 million). BI

Pleas for credit risk help

More reinsurance capacity a necessity: Trade Indemnity

By MARIA KIELMAS

LONDON—Trade Indemnity P.L.C. is calling for a partnership between the British government and the private insurance sector to increase political risk reinsurance capacity for U.K. exporters.

The U.K. credit insurer believes that tighter reinsurance capacity in the private sector will become "serious" and could place U.K. exporters seeking coverage at a severe disadvantage with competitors in other European Community nations.

As an interim measure, Trade Indemnity also is seeking government reinsurance support for its own operations.

The United Kingdom is the only major trading nation not to provide state-backed insurance and reinsurance for short-term credit risks.

This threat to capacity emerged after the 1991 privatization of the Insurance Services Group, which was the short-term credit division of the Export Credit Guarantee Department, the U.K. government's credit and political risk agency.

ISG was acquired by Holland's Nederlandsche Credietverzekering Mij. N.V. and renamed NCM Credit Insurance (U.K.) Ltd. (*BI*, Dec. 23, 1991). To aid the transition to the private sector, the U.K. government agreed to provide some reinsurance support for NCM (U.K.) for three years, which will end in late 1994.

In a position paper addressed to the government on the future of short-term export credit insurance in the United Kingdom, Trade Indemnity argued that it and NCM (U.K.) are the only insurers providing a full range of commercial and political risk protection to U.K. exporters.

Other markets—Lloyd's of London and American International Group Inc. for instance—provide coverage for segments of the U.K. market, but these account for less than 5% of total insured exports, Trade Indemnity says.

In terms of volume of U.K. exports covered, NCM (U.K.) claims to insure 14 billion pounds ($20.19 billion) of exports annually, while Trade Indemnity covers 4 billion pounds ($5.77 billion).

Furthermore, Trade Indemnity and NCM (U.K.) together purchase about 80% to 85% of the total private-sector reinsurance capacity worldwide for political risk in the export credit field, the paper claims.

In many other countries, governments reinsure state agencies providing export credit insurance.

Trade Indemnity has had extensive discussions with reinsurers on the need for additional capacity in the private sector. The two largest private reinsurance markets for political risk reinsurance—Swiss Reinsurance Co. and Munich Reinsurance Co.—are adamant that they will not increase capacity, and an additional nine major reinsurance companies have a similar view, according to Trade Indemnity.

The spokeswoman for Trade Indemnity said this is due to the the recession hitting reinsurers' balance sheets as much as their lack of appetite for political risk business.

Trade Indemnity's paper adds that under a proposed credit insurance directive from the European Commission, coverage for political risks outside of the European Community would essentially remain the responsibility of individual governments. Coverage for credit and political risks within the European Community would be largely reinsured in the private sector.

While governments could continue to provide cover for E.C. risks, they would have to be competitive with private markets. Member states would have to withdraw hidden subsidies, such as tax exemptions, loans at favorable rates and other exclusive arrangements, from private exporters.

The net effect of this proposed directive would be that E.C. member governments would be free to continue supporting their own exporters for political risks outside the European Community. This could put U.K. insurers without such support at a competitive disadvantage, particularly if the private reinsurance market cannot meet all capacity needs.

"Private reinsurers have, in any event, a problem with providing capacity, and their own weakened balance sheets make this area unattractive to them when placed alongside other categories which demand a greater amount of their time and effort and generate greater amounts of premium income. It is probable that reinsurers will eventually withdraw their support from the U.K.'s two main credit insurers and thus from a significant portion of the U.K. export effort," Trade Indemnity contends.

To solve the problem, Trade Indemnity proposes establishing a partnership between the U.K. government and private-sector credit insurers to provide reinsurance of political risk both inside and outside the European Community.

Estimation and pricing of the risks should be left with the private sector, ensuring that underwriting is on a commercial basis, the proposal suggests.

Trade Indemnity also recommends that in the interim, government reinsurance support should be made available to all private-sector insurers that underwrite export insurance, not just to NCM (U.K.).

British Industry Minister Richard Needham said last month before Parliament that the U.K. government will continue to provide reinsurance for short-term political risks until the end of 1994. Afterward, the government will provide reinsurance coverage for "cases in the national interest," he said.

A spokeswoman for Trade Indemnity said that the minister's statement does not alter its position, since the "national interest" case to which he referred is an exclusive arrangement between NCM (U.K.) and the government and does not include Trade Indemnity.

A spokesman for NCM (U.K.) in Cardiff, Wales, said that the insurer was not consulted about the Trade Indemnity position paper. However, he said NCM (U.K.) also hopes the British government will be able to provide some political risk reinsurance facility beyond 1994. BI

Bercanus

Continued from previous page
erty Special Services Co., Security Exchange Co., Taylored Investors Development Co., and Western Home & Overseas Exchange.

The Bercanus liquidation team alleged that all six companies were owned by Plano Real Property Investments Inc., a Texas company owned by the Portermains.

The team further contended that all reinsurance premiums received by the Avis Cos. from Bercanus Insurance were "promptly distributed as unsecured personal loans to (Bercanus director) Florence M. Portermain and other business acquaintances or entities of the Portermains and were never repaid."

Judge Kendall, who heard testimony from Mr. Whittle and an expert witness on reinsurance transactions, handed down his decision in a seven-page final judgment.

Judge Kendall declared the Portermains took money under false pretenses, carried out a fraud and breached fiduciary duties to Bercanus in causing the Bermuda company to enter into the South Rock producer agreement and the management agreement.

He ruled Bercanus suffered damages of almost $2.6 million under the producers agreement and nearly $1.7 million under the management contract.

"The reasonable value of the services that South Rock actually performed for Bercanus under the management agreement was not more than $30,000 per year," according to the judgment.

The ruling also said that Bercanus lost at least $3.1 million as a result of the Portermains' false pretenses, fraud and breach of fiduciary duties in connection with arrangements with the Avis Cos.

"The Portermains misappropriated assets of the Avis Cos. by means of a sham in order to perpetrate a fraud on Bercanus and/or to avoid the personal liability they had on notes due to the Avis Cos.," the judgment said.

Judge Kendall ruled the Portermains owed fiduciary duties to Bercanus, requiring "directors and officers to act, in all manners affecting the corporation, solely with an eye to the corporation's best interest, unhampered by any pecuniary interest of their own."

The court awarded Bercanus Insurance Co. about $7.34 million in damages and a prejudgment interest of about $10.29 million.

Mr. Whittle, who is a co-liquidator of Bercanus with Ernst & Young accountant Gil Tucker, said the award is a contingent asset of the insolvent company, whose only current asset is about $1.5 million in cash.

"The message that should go out from this matter is that Bermuda's liquidators pursue wrongdoers both here and overseas and that these people cannot come to the jurisdiction and operate with impunity," according to Mr. Whittle.

"But the hard part will be enforcing this judgment and collecting the award," he added.

Mr. Whittle's attorney, Jeff Ford of the Dallas law firm Winstead Sechrest & Minick, said he believed the Portermains also still have to pay a U.S. Tax Court award.

That award relates to the 1979 sale of Mr. Portermain's 90% stake in the managing agency, South Rock. The tax court ruling was handed down in January 1991 and was upheld by the 5th U.S. Circuit Court of Appeals in June 1991.

Mr. Ford said the couple's whereabouts are not known. He said there are "some indications that the Portermains are in another country" but declined to elaborate. BI

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preme Court, Appellate Division, First Department, No. 46624.

INTERNATIONAL

Allianz unit posts underwriting loss, sees job cuts

MUNICH, Germany—Non-life insurer Allianz Versicherungs A.G. suffered its worst year in decades in 1992 as claims soared and operating costs drained resources.

Rate hikes and drastic personnel cuts are necessary because of the poor claims situation, said Uwe Haasen, chairman of the non-life group of Allianz A.G. Holdings.

While an across-the-board rate hike is not planned, Allianz Versicherungs plans double-digit rate hikes in several sectors.

Allianz Versicherungs plans "considerable rate hikes" for companies that don't fulfill requirements for better risk management. "That is the case in fire, industrial fire and business interruption," a spokesman said. "Either that or we will not insure the risk."

Allianz Versicherungs posted 1992 underwriting losses of 137 million deutsche marks ($82.3 million) after an underwriting profit of 145.9 million deutsche marks ($87.6 million) in 1991.

Group premium volume at Allianz Versicherungs increased 6.1% to 12.1 billion deutsche marks ($7.99 billion) last year from 11.4 billion deutsche marks ($6.84 billion) in 1991.

Despite the underwriting losses, pretax profits in 1992 totaled 540 million deutsche marks ($356.5 million), down only 1.4% from 548 million deutsche marks ($329 million) in 1991.

In an effort to control costs, Allianz Versicherungs' east German subsidiary, Deutsche Versicherungs A.G., will reduce its staff by 1,000, in addition to the 8,500 positions that were cut in 1991. It also plans to cut its administration centers to 20 from 200.

Last year, premium volume for Deutsche Versicherungs A.G., which was the East German state-owned insurer before Allianz acquired it, was 2.3 billion deutsche marks ($1.52 billion), up 21% from 1991's 1.9 billion deutsche marks ($1.25 billion).

Catastrophes, auto insurance claims and criminal damage to property were the primary causes for Allianz Versicherungs' overall poor year in the property casualty market, Mr. Haasen said.

"That's the way it looks for the whole industry," he said. "This isn't a one-time phenomenon, but a long-term development."

Mr. Haasen expects much of the same for 1993. Allianz Versicherungs expects a 5% increase in premium volume due to rate hikes, despite pressure on premium growth from the recession.

"The amount of claims will likely increase before they decrease," he said. "Property damage will rise. We can expect losses. But we'll save where we can. It's going to be a year of lean operation."

Despite personnel cutbacks and underwriting losses at Allianz Versicherungs, Mr. Haasen said the insurance group is pushing to strengthen its foothold in European markets.

"European and domestic insurance markets are changing," Mr. Haasen said.

"By 1994, we'll see the end of insurance supervisory authorities and decontrol of prices and insurance conditions. It has increased the need for good working networks. Our new structure focuses on industry, business and private clients. Decentralization and more on-the-spot decision-making is better for the client."

To avoid environmental accidents, Allianz is campaigning for improvements of safety standards in shipping. A claim for a tanker spill near Sumatra, Indonesia, last year cost the company 40 million deutsche marks ($24 million).

"The situation demands that shipping companies and government establish a worldwide safety inspection authority," Mr. Haasen said. "Fifty-three percent of the world fleet is over 15 years old and we can count on a large increase in future claims."

Environment liability will be a future focus, says Mr. Haasen. As of April 1, Allianz will offer a German environmental liability insurance policy to cover liability for pollution damage to the environment.

Allianz last year played a central role in the development of a new model German environmental liability policy for HUK-Verband, the German Assn. of Liability & Casualty Insurers. (*BI*, Oct. 12, 1992). The model was approved late last year.

—By Don Lewis Kirk

GLOBAL BRIEFS

Colombian terrorism cover

BOGOTA, Colombia—The Colombian government has introduced a state-sponsored insurance program to cover bodily injury, death or public transportation vehicle damage from terrorist attacks.

The program comes after a wave of attacks and car bombings in Bogota and other major cities, which have been perpetrated by so-called "narco-terrorists" associated with the drug trade.

The attacks have escalated as Colombian law-enforcement officials claim to be moving in to capture Pablos Escobar, the country's No. 1 drug baron, who escaped from prison last July.

Compania de Seguros La Previsora, which is 95% state owned, will administer the program. According to La Previsora's president, Hernando Gomez, the program has two parts: Terrorism victims who are incapacitated, or the dependents of those killed by terrorists, will be compensated 8 million pesos ($12,400), and public transportation vehicles will be insured for the replacement value against terrorist attacks.

The government-backed insurance is a stop-loss program under which the government retains the first $2 million. A second layer of $3 million has been covered by a number of syndicates in the Lloyd's of London market.

The reinsurance premium for the second layer, which was placed by London brokers Holman Wade Reinsurance Brokers Ltd., was $600,000, according to Mr. Gomez.

The Colombian government considered covering some commercial risks through the program, but discarded the idea because of high costs.

Reliable loss statistics also proved prohibitive. "We have very good statistics for people (who have suffered from terrorist attacks), but no records for material damage," Mr. Gomez said. But he stressed that terrorism insurance coverage exists in the Colombian market as an endorsement to the standard fire insurance policies.

La Previsora is one of Colombia's largest insurers with gross annual premium volume of 46 billion pesos ($71.2 million). It is the largest in terms of paid-in capital, which is 6 billion pesos ($9.3 million).

The largest insurer in Colombia is Colseguros S.A., with annual premium volume of 80 billion pesos ($123.8 million). Colseguros is part of Grupo Santo Domingo, a family-owned conglomerate.

Colombian insurers should see improved results in 1993, because reinsurance rates have hardened and the increases have been passed on to the direct clients, Mr. Gomez said.

—By Maria Kielmas

Hudson Re runoff moving

HAMILTON, Bermuda—Skandia Group is moving the runoff of business written by treaty reinsurance subsidiary Hudson Reinsurance Co. Ltd. to Toronto from Bermuda.

The runoff will now be handled by Skandia Canada Reinsurance Co., which also is in runoff.

Hudson Re President Nichols Dove said the decision to move the runoff was made last month by senior management at the group's Swedish headquarters and will result in the loss of 17 jobs at the Bermuda company.

Hudson Re stopped writing third-party business in 1991 and has since put up $30 million of reserves for running off its worldwide property/casualty business.

The reinsurer continues to be used for rent-a-captive activities in Bermuda.

Meanwhile, Mr. Dove said that affiliate Skandia International Risk Management Ltd., a captive management company employing 23 staff members, will remain in Bermuda. However, Skandia International will become part of the Swedish parent's European insurance management subsidiary, Sinser Group, which has offices in Dublin, Luxembourg and Stockholm.

"The Bermuda company is going to have a more global approach in the future," he said. "Because of the relationship with Sinser, we'll have a more effective worldwide marketing effort than before and we'll be able to provide seamless services to those who need captive management facilities in more than one jurisdiction.

Skandia manages about 80 captives from Bermuda.

—By Roger Scotton

LONDON

Continued from page 23

rough times that lie ahead for Lloyd's agencies, said Ralph Sharp, chief executive of Castle.

Under the terms of the acquisition, Castle shareholders will receive 12.5 million Archer shares in exchange for their shares in Castle. The formula gives Castle a value of about 5 million pounds ($7.2 million).

Castle manages eight syndicates in the non-marine, motor, life and personal accident markets. The syndicates have a combined 1993 capacity of about 190 million pounds ($287.8 million).

Castle also acts as members' agent to more than 500 Lloyd's members. The members' agency will be merged with Archer's members' agent, which handles 140 members. The Castle managing agency will continue to operate as a separate entity.

Castle needed to become part of a bigger agency group to face up to the changes that will take place at Lloyd's in the next few years, Mr. Sharp said.

"We have to be realistic and realize the next two to three years are going to be tough for names and agents at Lloyd's," he pointed out.

If a market solution is found for the open-year problem at Lloyd's, agents are bound to be asked to contribute funds to enable it to be implemented. Also, the poor results due to be published this June for 1990 will lead to a further reduction in capacity at Lloyd's, Mr. Sharp said.

"Agents at Lloyd's need to be large economic units so as to position themselves to deal with the structural changes that will become necessary during 1993 and 1994," he said.

"The acquisition of Castle continues the strategy of developing a strong, broadly based agency group to take advantage of the recovery in underwriting performance in the Lloyd's market," said Bryan Kellett, chief executive of Archer.

Last year Archer acquired B.P.D. Kellett & Co. Ltd. It also attempted to acquire Cuthbert Heath Underwriting Ltd., but the acquisition fell through when the agencies failed to agree to terms.

Ralph Sharp will join Archer's board along with Alec Sharp, the chairman of Castle.

The acquisition is expected to take place in May, subject to Lloyd's and Archer shareholders' approval.

Zurich to buy MMI

Zurich Insurance Group has sealed its agreement to buy defunct British insurer Municipal Mutual Insurance Ltd.

Although Zurich will continue to offer renewal terms to MMI's policyholders, it will not take on the company's past liabilities.

MMI was Britain's largest local authority insurer and the business accounted for more than half of its premium income.

The mutual insurer ran into trouble last year after suffering large public liability claims. A previous attempt to save the company failed after its proposed European partners pulled out of the deal (*BI*, Oct. 5, 1992).

Zurich began offering renewal terms to MMI policyholders last October when negotiations with the company began.

Terms of the deal have not been revealed.

However, future payments to MMI will be linked to the profitability of the MMI business that Zurich takes on, an MMI spokesman said.

The new Zurich division, Zurich Municipal, will administer the runoff of MMI but it will not take on the liabilities from before Sept. 30, 1992, when MMI stopped underwriting.

At year-end 1991, MMI had assets of 1.4 billion pounds ($2.62 billion) and liabilities of 1.2 billion ($2.24 billion).

Merger authorities with the European Commission in Brussels are currently investigating the merger of the companies.

ILU, LIRMA to unite

Marine and non-marine insurance companies in the London market are merging their policy signing, central accounting and information technology operations.

The Institute of London Underwriters and the London Insurance & Reinsurance Market Assn. will phase in the merger over two years.

The decision follows the completion of a feasibility study on the merger by consultant KPMG Peat Marwick.

The combined ILU-LIRMA operations will be based at the ILU's existing office in Folkstone, Kent. BI

Hong Kong pensions

Continued from page 23

probably rose to about 13,000 at year end.

Still, pension plans in Hong Kong are much less common than in the United States or the United Kingdom.

"Some people work for years and then are left with no money," said Les Parry, a consultant at Hong Kong-based Swire Life Consultants, which caters to individual pension plans rather than corporate.

In the past, expatriates were the only workers in Hong Kong who benefited from any sort of retirement plan. These plans usually provided a lump-sum payment upon retirement.

Only in recent years has the indigenous population also begun to receive private retirement income benefits.

Hong Kong employers sponsor both defined benefit and defined contribution plans.

Upon retirement, benefits under both plans generally are provided in one or two payments.

The government currently is discussing legislation that would require employers in Hong Kong to offer retirement plans, but most likely would not change the type of retirement plans they offer.

ManuLife's Mr. Duggins expects that new legislation might mandate the percentage of income employers would have to contribute to plans.

At the end of last year, the Hong Kong government solicited comments about retirement plans from both industry and the public. It is expected that once the government has fully reviewed the comments it received, legislation will be developed and presented for further comment.

This means any change still is a while off, as it takes at least two or three years to finalize a new ordinance. Mr. Duggins predicts no new legislation will emerge until at least 1995.

Meanwhile, the retirement plan market continues the growth trend that began five years ago, says economist K.K. Chan of the Hong Kong Shanghai Bank Corp., which manages retirement funds under its HSBC Life division.

Mr. Duggins agrees. Between 1987 and 1992, the annual growth in retirement plans managed by ManuLife was 20%, both in terms of plans managed and assets under management. BI

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Captive proposal

Continued from page 1

needed to protect policyholders and ceding companies participating in fronted programs with unauthorized reinsurers that may not have sufficient financial incentives to stay solvent.

Specifically, the proposal seeks to ensure proper disclosure and regulation of reinsurance transactions in which an insurer delegates underwriting or claim settlement authority to an unauthorized reinsurer.

The act does so by establishing requirements for reporting, recordkeeping and reinsurance contracts, among other things. A handful of transactions, including those with "a captive insurer," would be exempt from the reporting and disclosure requirement.

But "captive" was narrowly defined. The original March 3 draft definition included "an insurance company domiciled in the United States which is owned by one or more affiliated persons and which writes directly or reinsures only: risks of the owners of such insurance company and affiliates of such owners; or risks related to or arising out of the business or operations of such owners and affiliates."

Commissioner Elizabeth Costle of Vermont, the largest U.S. captive domicile, told members of the task force: "If you don't allow pooling, you don't have a single-parent captive exemption."

The majority of task force members agreed to broaden the captive exemption to include risks shared by a pool of single-parent captives as long as the risks were homogeneous and each captive retained more than 50% of its business.

The task force also limited the exemption to captives based in a state or territory that has been accredited by the NAIC.

The final definition effectively excludes offshore and association captives from the exemption.

The exclusion of offshore captives sparked criticism from representatives of Bermuda, the world's largest captive domicile, and the Risk & Insurance Management Society Inc.

"Any captive exemption should be done on a unilateral basis and make no distinction between offshore and onshore," argued Malcolm Butterfield, Bermuda's registrar of companies. Such a distinction is "protectionist" and not necessary because Bermuda can provide regulators with certificates of compliance with U.S. regulations, he said.

NAIC President Stephen Foster, who chairs the task force, responded, "It may appear on its face to be protectionism, but I believe there really is a valid financial regulation basis for it."

He cited problems in obtaining financial information from many offshore jurisdictions. But, Mr. Foster said it may be possible to craft some language that would allow alternate treatment for Bermuda.

Paul Brown, RIMS' director of government and public affairs, also opposed the geographic distinction.

"Of the 3,000 captives out there, about 10% are located in the U.S.," he said. "U.S. industry is watching this very closely."

Meanwhile, Ms. Costle noted in an interview that association captives also would be subject to the provisions of the fronting law. However, she noted that association captives generally are less involved with fronting than single-parent captives.

Businesses with captives are likely to initiate a letter-writing and calling campaign to regulators, Mr. Brown said. Also, any controversy will be conveyed to state lawmakers, which could threaten the viability of the NAIC's accreditation program.

But Mr. Foster said "it was not a slam dunk" that adoption of the fronting bill will become part of the NAIC's accreditation standards.

And in a heated exchange, he took exception to what he described as "overstatements" by Mr. Brown: "Please don't sit here and tell us that we are telling Corporate America that they can't have offshore captives because of this regulation."

Mr. Brown said, "I didn't say they can't have them; I said it would make it more difficult for them."

Sandra M. Siegel, assistant deputy superintendent with the New York Insurance Department, closely questioned Mr. Brown on what new burdens the model law would create for businesses with captives.

"The (fronting) programs that the captives set up will become more expensive," and ceding companies will pass that cost on to the captives, Mr. Brown said. In addition, he said the model act calls for the reporting of some information captive owners now consider confidential, though he did not elaborate.

In addition to changing the definition of an exempt captive, regulators spelled out technical requirements for limited circumstances in which a reinsurance transaction could require prior approval.

The draft says the regulator granting such approval would be the domiciliary regulator of the ceding company or, at most, one other regulator that has a "stake" in keeping the company solvent would also be given authority for keeping the company solvent—for example residents of that state pay at least 15% of the insurer's annual gross written premium.

Comments on the fronting proposal should be sent to Edward Kelley at the NAIC's office in Kansas City, Mo. The deadline is three weeks before the NAIC's summer meeting in Chicago, June 20.

In other action at the spring meeting, regulators agreed to:

- Eliminate insurance industry-sponsored and funded events at NAIC meetings, following criticisms about the perception of impropriety.
- Stop using formal advisory committees, though regulators plan to hold public hearings and will still use technical assistance groups.
- Add seven new requirements to the NAIC's financial regulation standards.

In addition, regulators acting in subgroups:

- Received for comment an outline of a industry-written draft of risk-based capital standards for property/casualty insurers.
- Required guaranty funds to treat policyholders more uniformly by requiring each fund to cover all the policyholders in its state, regardless of where the insolvent insurer is located.

The NAIC is expected to vote in June on making that part of its accreditation standard.

- Released for public comment proposed regulations on 24-hour coverage pilot projects and on adding consumer representatives to all guaranty funds. BI

New York suspension

Continued from page 1

refuse to give insurance departments the tools—both financial and legal—they need to do an adequate job.

However, the suspension "shows we are serious" about beefing up state regulation through the accreditation process, said NAIC President Stephen T. Foster during the group's spring meeting last week in Nashville.

"New York has been—and continues to be—a leader in insurance regulation," said William H. McCartney, the chairman of the NAIC's Committee on Financial Regulation Standards and Accreditation.

The suspension was made because New York regulators lack a few "tools" required to do the job, said NAIC Vp David Walsh of Alaska.

Specifically, New York lawmakers did not enact a December 1990 requirement that accredited states have more control over managing general agents and reinsurance intermediaries. The Legislature also did not enact a portion of a model law on insurer financial examinations designed to make it easier for regulators and law enforcement agencies to exchange sensitive information.

The measures are contained in two bills now pending in the insurance committees of both the New York Senate—S. 8166 and S. 8176—and Assembly—A. 11006 and A. 10922.

"I don't know of any strong opposition to any of the bills," said a New York Insurance Department spokesman.

"Under the circumstances, we do not disagree with, nor object to the NAIC's action and we recognize that the action was necessary to maintain the effectiveness and the credibility of the NAIC's accreditation program," said Insurance Superintendent Salvatore R. Curiale. The program "has done a great deal to raise the quality and uniformity of state regulation of insurance throughout the country," he said.

Under NAIC rules, states undergo a full certification review every five years after they have been accredited and a desk audit every year. However, the Committee on Financial Regulation Standards and Accreditation has the authority to suspend a state's accreditation at any time, following notice and a hearing.

Sanctions against unaccredited departments become tougher beginning next year. For example, accredited state departments may refuse to accept an insurer examination performed by a non-accredited state, so insurers domiciled in non-accredited states could face examinations by several other states.

If and when the legislation is enacted, New York's suspension will be reviewed and its accreditation reinstated.

"We expect New York to rejoin the 18 other accredited states within the coming months," Mr. McCartney said.

Meanwhile, the Wisconsin Insurance Department narrowly avoided suspension last week by administratively changing its rules. Managing general agents and reinsurance intermediaries now are required to be licensed in Wisconsin, said Randy Blumer, assistant deputy commissioner. The state department had been waiting to develop a formal testing program before it began licensing MGAs and intermediaries.

"I don't think it will have major ramifications," because few people are affected by the change, Mr. Blumer said. BI

Ohio retiree plan

Continued from page 2

plan, the School Employees Retirement System, may join the block later.

The idea of having one provider compete against another for the same group of people is that if "network A" is not increasing enrollment, it will improve the quality of health care it provides to become more competitive, said John V. Caldarella, a Wyatt consultant who assisted in the project.

In addition, when listening to the national health care debate, retirees under age 65 are not mentioned often, he said. The plan is distinctive not only because of its competitive structure, but because it was developed for a group of these retirees, Mr. Caldarella said.

The plan, which becomes effective April 1, will provide coverage through Aetna and BC/BS preferred provider networks. For retirees in a given retirement plan, the benefits provided by Aetna and BC/BS PPOs will be the same. But, among the four retirement plans, the benefits will vary slightly, Mr. Caldarella said. Generally, though, all four plans will require retirees to pay higher deductibles and copayments if they choose to go outside the network for medical services, he said.

To avoid added administrative hassles, Wyatt earlier this year assigned the retirees to one of the two competing providers, Mr. Caldarella said. "We didn't want to say, 'Pick your own network' and have 85,000 responses come to us."

The benefit consultant studied claims data and assigned retirees to a network according to their physician relationships, hospital relationships or geographic regions, explained Deborah Young, medical benefits supervisor for the Columbus-based Police & Firemen's Disability & Pension Fund.

For example, if a retiree's current physician participates in one of the two networks, he or she was initially assigned to that PPO. The same initial assignment was made if a retiree received care from a hospital that was part of one of the networks. If neither the retiree's physician nor preferred hospital is in a network, he or she was then initially assigned according to geographical regions, Ms. Young said.

After the initial PPO assignments were made, retirees had the opportunity to change networks, Mr. Caldarella said. Less than 10% chose to do so, though, he said.

In addition to having the initial opportunity to switch networks, retirees will be offered a chance to change their network once each year, he said. Retirees will be annually provided with comparative data on cost and quality results of the two networks to help make their decisions.

Quality studies like outcomes research on morbidity and mortality rates, as well as length-of-stay rates, will be conducted to determine performance levels, Ms. Young said.

In addition, the four retirement plans will analyze quality data collected by Aetna and BC/BS and the changes they make in response to the data, Mr. Caldarella said. BI

RICO ruling

Continued from page 1

the bankruptcy trustee of the Farmers' Cooperative of Arkansas & Oklahoma Inc. The trustee filed the suit on behalf of farmers who held promissory notes issued by the co-op, which declared bankruptcy in 1984.

Among other things, the suit charged that an Ernst & Young auditor accepted an inflated valuation of a co-op-owned plant that was provided by a co-op accountant who had been convicted of tax fraud.

While the auditor valued the plant at $4.5 million, its fair market value was at most $1.5 million, and the co-op would have been insolvent based on the lower valuation, court papers say.

A federal court jury found that Ernst & Young had committed state and federal securities fraud. This verdict survived appeals, though a $6.1 million damage award was thrown out by the 8th U.S. Circuit Court of Appeals, which ordered a new trial on the damages issue.

Meanwhile, a federal judge had earlier granted partial summary judgment in Ernst & Young's favor, dismissing a RICO claim. A federal appeals panel later upheld the ruling, and the high court affirmed it.

The Supreme Court majority noted that RICO makes it unlawful "for any person employed by or associated with any enterprise. . .to conduct or participate, directly or indirectly, in the conduct of such enterprise's affairs through a pattern of racketeering activity."

Interpreting this section, the majority concluded that the double use of the word "conduct" requires that a person be involved in managing or directing a company's affairs for RICO liability to apply.

"Congress could easily have written 'participate, directly or indirectly, in (an) enterprise's affairs,' but it chose to repeat the word 'conduct.' We conclude, therefore, that. . .'conduct' requires an element of direction," Justice Harry Blackmun wrote for the majority. The majority further found that "participation" must be in the direction of a company's affairs.

RICO's legislative history also supports the conclusion that "one is not liable under (RICO) unless one has participated in the operation or management of the enterprise itself." The "operation or management" test can be applied despite Congress's directive that RICO be liberally interpreted by courts, the majority also found.

RICO's "liberal construction" clause "obviously seeks to ensure that Congress's intent is not frustrated by an overly narrow reading of the statute, but it is not an invitation to apply RICO to new purposes that Congress never intended," the opinion reads.

Reviewing Ernst & Young's role in preparing the co-op's financial statements, the majority found that its failure to reflect the plant's fair market value "is not sufficient to give rise to liability" under RICO.

In a dissenting opinion, Justice David Souter, joined by Justice Byron White, disputed the majority's reading of the statute.

"It is hard to imagine how the 'operation or management' test would leave the statute with the capacity to reach the indirect participation of someone merely associated with an enterprise," Justice Souter wrote. "I think, then, that this contextual examination shows 'conduct' to have a long arm, unlimited by any requirement to prove that the activity includes an element of direction."

Business interests and others praised the ruling. "This is a step in restoring some sort of balance and definition to RICO," said Jed S. Rakoff, a lawyer with Fried, Frank, Harris, Shriver & Jacobson in New York. He helped draft a friend-of-the-court brief filed by the AFL-CIO supporting Ernst & Young.

"People have abused the statute, have used it as a weapon for extravagant claims and extortionate settlement demands, and have perverted its intended purpose in literally hundreds of instances," Mr. Rakoff said. "That cannot have been Congress's intention and it's time the court called a halt to it."

The "operation and management" test does away with much easier tests applied by courts in several federal appellate circuits where most RICO claims are filed, including circuits covering New York, Chicago and California, said Gary Elden, a lawyer with Grippo & Elden in Chicago, representing the plaintiffs in the suit against Ernst & Young.

The ruling represents a loss for the NAIC and others.

"The key actors in successful frauds involving the illegal operation of insurance companies invariably include independent entities, such as insurance agencies, brokers and reinsurers, and consultants, such as accountants, actuaries and attorneys," the NAIC argued in a friend-of-the-court brief.

The "operation or management" test would effectively immunize these parties from RICO liability even though they contributed to insurer failures, regulators argued.

Nevertheless, the ruling does not preclude RICO suits against outsiders, noted North Carolina Insurance Commissioner James Long, who has testified before Congress against proposed limitations of RICO.

But the ruling will require regulators to show that outside professionals exercised control over failed companies, he said.

The U.S. Department of Justice also filed a friend-of-the-court brief supporting the plaintiffs. The department was concerned that limiting RICO claims against professionals could harm the government's civil and criminal RICO actions against those connected with S&L failures and others, experts say.

Still, the Supreme Court's ruling will not affect a variety of other charges that can be brought against professionals, including negligence and fraud claims.

"They are off the hook for treble damages" under RICO, noted Arthur F. Mathews, a partner with Wilmer, Cutler & Pickering in Washington. "They are still on the hook for punitive damages on state common law fraud claims." BI

IBM benefits

Continued from page 1

substantial freedom to pursue strategies that will make them competitive within their own industries, Mr. Tarre explained.

Formed in June 1992, WFS has already saved IBM more than $45 million in streamlined operations alone, said WFS President Bill Colucci.

For example, group health care benefit administration has been consolidated at a national service center in Raleigh, N.C. State-of-the-art technology at the center includes automated voice-response communications systems, Mr. Tarre said.

The human resources unit is not a separate business in the same sense as the manufacturing units. "But we operate as though we're a company," Mr. Colucci said. WFS handles all the specialized human resources services for the other business units, including research, consulting, and developing and designing benefit programs. IBM employs 158,000 workers nationwide.

For now, there is little risk to WFS. All IBM units are required to use WFS for their human resources services, including compensation and benefits design and administration, Mr. Colucci said.

By 1994, though, "all of the IBM businesses will be free to choose their human resources support from wherever they wish," he said. "Our intention, of course, is to be demonstrably the provider of choice."

In this new entrepreneurial role, Mr. Colucci says he is confident that WFS will retain the business. "The worst way you can have a customer is by fiat."

And, by the same token, WFS is also confident its services will become more marketable to outside customers, he said.

IBM is not alone in making this move.

"Internal staff services have previously just got a free ride," without having to compete for customers, agreed Lance Tane, a partner with benefit consultant Kwasha Lipton in Fort Lee, N.J.

Setting up quasi-independent companies "is part of a trend we see with a lot of our larger clients to make sure that they're getting cost-effective, high-quality services from their staff functions," Mr. Tane said.

Take American Telephone & Telegraph Co., for example. Since 1985, its Actuarial Sciences Associates Inc. unit has been providing benefit services both to its parent company and to outside customers (*BI*, April 1, 1991).

Based in Piscataway, N.J., the subsidiary grew out of AT&T's pre-divestiture actuarial organization. It provides employee benefit and compensation consulting services to its natural client base—the divested "Baby Bells"—and to a growing number of outside companies like W.R. Grace & Co. and Florida Power & Light Co., said Michael J. Gulotta, ASA's president and chief executive officer.

"Our competitors are the TPF&Cs, the Hewitts, the Wyatts and the Mercers of the world, and we compete very effectively," he asserted. "We've consistently achieved high revenue growth."

Obtaining employee benefit services from a subsidiary that is gaining "a breadth of experience" in many industries has worked to the advantage of AT&T and all of ASA's clients, Mr. Gulotta said.

At IBM, the human resources unit was formed as part of an overall move toward decentralization. "It became clear to us that the one-size-fits-all mentality was not going to be appropriate" in designing human resource programs for the various units, Mr. Colucci explained.

As it gained experience in customizing services for its sister organizations, WFS decided it could also provide these services to outside companies.

Among the services it currently provides to outside clients are recruiting, screening and assisting with a corporate downsizing program. Mr. Colucci would not identify those customers.

However, WFS eventually hopes to design, establish and administer employee benefit programs for outside companies, though it won't say which ones. "In terms of our target markets, at this point any company that can use outsourced human resource assistance is a potential customer," a spokesman said.

And as it evolves, WFS will gradually offer IBM business units a broader array of human resource services—including various health care plans aside from the current IBM program—and allow them to customize those services for the needs of their employees and their own business strategies, Mr. Colucci said.

"The real advantage" of this system is that the individual IBM units will decide "how much human resource services they want and how much they're willing to pay for them, instead of having a bunch of human resources people saying, 'You need this and that service,' " Mr. Tane said.

Along with IBM's corporate restructuring, two major steps in 1990 to 1992 have contributed to lower per-capita health costs, said Sherril Claus, manager of health and wellness programs at WFS.

"One, we are managing the expensive kinds of care—such as mental health and substance abuse, catastrophic medical and home health care," she explained. And secondly, some costs were shifted to workers through higher deductibles.

In the mental health and substance abuse area, "we have literally reduced costs through case management and use of networks," she said. Both services are provided by American PsychManagement Inc. of Arlington, Va. Employees use a point-of-service mental health and substance abuse network, while their claims are paid through IBM's indemnity plan.

"We've done similar things with catastrophic medical—primarily case management. Though we don't have a point-of-service network, we do have a preferred provider organization managed for us by Intracorp."

Also holding down costs is a home health care program—an alternative to costly hospitalization or nursing home care—also managed by Intracorp, a unit of CIGNA Corp. The home care, which includes skilled nursing care and respiratory therapy, must be prescribed by a physician to be eligible for coverage, Ms. Claus said.

IBM has also introduced a managed dental program as an alternative to its regular dental plan: "an HMO for teeth," Ms. Claus said. "Six major carriers manage the program, and in any given geographic area, employees can use one or two networks.

"The other major strategy is to revisit cost sharing," Ms. Claus continued. "The focus of this is we want our employees to become informed, involved health care consumers."

Effective Jan. 1, 1991, full reimbursement of all eligible services for accidental injury within 72 hours was discontinued, with those services now reimbursed at 80%, she said.

The medical plan deductible carryover provision was also eliminated in January 1991. Previously, the portion of the deductible that was satisfied during the fourth quarter of one year counted toward both the current and following year's deductible, Ms. Claus said.

Beginning last July, the hospitalization deductible under IBM's indemnity plan was increased to 100% of the first day's room and board charges, up from 40%.

Also beginning in July, a $40 per-person deductible was instituted for employees in IBM's regular dental plan.

Stricter coordination of benefits provisions also were adopted.

IBM employees have a choice of IBM's self-insured indemnity plan and more than 129 HMOs across the country. BI

Transamerica

Continued from page 3

Corp., a Birmingham, Ala.-based life and health insurer, will become chairman and chief executive officer.

Don Hutson, chairman, president and chief executive officer of American Eagle Group, a Dallas-based specialty insurer, will become president and chief operating officer.

Among those who are no longer with the company are:

- Richard W. Wratten, president of the commercial insurance division.

TIG has 'been very selective about what business they will accept,' says M&M's Alice Prine.

- Glenn S. Thomas, senior vp of commercial property/casualty underwriting.
- William Palgutt, president of the specialty insurance division.
- Michael E. Grady, senior vp of excess and special risks.
- Joseph K. Saad, senior vp of specialty claims.
- Robert Anders, resident vp at Transamerica Entertainment Insurance.

Calls to Mr. Wratten are being referred to Bill Ehlers, senior vp of commercial property/liability operations, or Kenneth M. Fujino, president and chief operating officer of the workers compensation division.

While spokesmen for the insurer will confirm these individuals are no longer with the company, they will not acknowledge whether their departures are part of a larger reorganization plan, citing SEC rules limiting their comments to the contents of their securities registration filing.

According to the SEC filing, Transamerica's new management is developing a business plan that will be made final after the closing.

"Preliminary plans include, but are not limited to, centralizing certain functions and consolidating operations to reduce expenses and reducing or eliminating business operations and products that do not offer, in new management's judgment, prospects for earning a satisfactory rate of return on invested capital," the securities statement says.

One of those operations apparently is Transamerica's entertainment division, which last year posted a combined ratio of 146.2%.

"As a result, specialty commercial has chosen not to meet competitive prices in certain elements of the entertainment business," according to the SEC filing.

In addition, Transamerica has taken the underwriting pen away from Albert G. Ruben & Co., the Los Angeles-based managing general agent.

Ruben had an exclusive contract with the insurer to produce business from the entertainment industry, including major motion pictures and television productions.

Although officials at Ruben declined to comment on whether its MGA contract had been suspended, citing the insurer's IPO, they insisted that they were still placing business with the insurer.

Ruben President Bob Chellan also declined to confirm reports that the broker had mothballed its venue department, which handles coverage for sports and concert arenas.

"We still place business with Transamerica on a daily basis," he said.

But the SEC filing suggests that Ruben's exclusive contract with Transamerica may be voided by the change in ownership.

The Ruben contract is "subject to certain rights of termination upon the occurrence of certain events," some of which "have occurred in connection with the offering and the related transactions," the statement says.

And even though "Ruben has not indicated to TIG whether it will exercise such termination rights," the filing adds, "management believes that the termination of the Ruben contract would not have a material adverse effect on TIG."

Meanwhile, other insurance brokers say they have been given the green light to begin placing entertainment coverage directly with the insurer or through its sports and leisure MGA, Fort Wayne, Ind.-based K&K Insurance Group.

And TIG's stricter, more profit-oriented underwriting policy has already begun to take shape.

"They have been very selective about what business they will accept," observed Alice Prine, vp-casualty manager of Marsh & McLennan Inc.'s sports and entertainment division.

TIG's premium quotes also have become comparable to its competitors, Ms. Prine noted.

"If they love the business, they'll go after it," but generally, "they're not buying the business anymore," she said. BI

Prudential Re

Continued from page 2

Prudential's move follows Aetna Life & Casualty Cos.' $1.3 billion sale of American Re-Insurance Co. to leveraged buyout specialist Kohlberg Kravis Roberts last year. American Re Corp., the reinsurer's new holding company, successfully raised $359.6 million in an initial public offering in January (*BI*, Feb. 1; Aug. 24, 1992).

Pru Re recorded gross written premiums of $740.9 million in 1992 and net written premiums of $704.2 million.

Hit hard by the hurricane losses, the reinsurer suffered a net underwriting loss of $320.4 million last year. Partially offset by investment gains of $238.7 million, Pru Re ended the year with a net loss of $54.6 million, compared with net income of $62.6 million in 1991.

The reinsurer's assets totaled $2.8 billion at year end.

While Pru Re is currently the largest broker market reinsurer in the United States, it may be surpassed if plans by Centre Reinsurance Co. Ltd. and Fund American Cos. to recapitalize Zurich Reinsurance Co. of New York prove successful (see story, page 2).

The Prudential spokesman denied that hurricane losses suffered by Pru Re and affiliate Prudential Property & Casualty Insurance Co. led to the decision to seek a buyer for its reinsurance unit. "We started to look into this situation months before the hurricane."

Rumors of Pru Re's sale were rife after the hurricane, though, and analysts suggest that the losses along with other factors may have accelerated Prudential's decision.

"Hurricane losses may have been a catalyst to their thinking, but not the cause," said Michael Smith, an analyst with Shearson Lehman Brothers Inc. in New York.

Prudential probably weighed the capital it would have to allocate to the reinsurance business and the related rates of return and decided it no longer wanted to be in that business, said John H. Snyder, senior vp with the property/casualty division of A.M. Best Co. in Oldwick, N.J.

"The strategic fit (with Prudential's other operations) has never been there," he observed of the reinsurance unit.

Hurricane losses and the favorable view investors currently have of the reinsurance business have given Prudential "a much better reason for jettisoning the property," Mr. Snyder said.

He also expressed doubts that Prudential will end up retaining Pru Re, saying that Prudential would probably consider a public offering or management buyout to shed the reinsurer if a private buyer can't be found.

"The die has been cast. They have (announced) that this no longer fits in the Prudential family," Mr. Snyder said.

Noting the reinsurance market's "hypersensitivity" to parent company financial commitment, he observed that Pru Re would suffer a slow drain of clients and personnel if it remains a Prudential subsidiary.

"This company has to be sold come hell or high water," he said. "It will be perceived as damaged goods if they do not sell this company." BI

Regulators to yank licenses of three surplus lines brokers

SAN FRANCISCO—California regulators are moving to revoke the licenses of three surplus lines brokers that helped place millions of dollars of business with several offshore insurers, some associated with Alan Teale, who has been jailed on multiple insurance fraud charges.

The California Insurance Department also issued a cease-and-desist order against a Washington state managing general agency that allegedly "rented" licenses from the three brokers to produce business illegally for the offshore companies.

The cease and desist order names International Insurance Underwriters of Washington State Inc., based in Lynnwood, Wash.; and John D. Nordstrom, Lawrence R. Hoehne and Robert Thul, IIU's chairman, vice chairman and president, respectively.

Also named in the order are: Toma Surplus Lines Insurance Brokers Inc., a Marina Del Rey, Calif., broker that is 90% owned by Mr. Nordstrom; and Thomas W. Whitaker Jr., 10% owner and president of Toma.

California regulators separately filed complaints to revoke the licenses of Toma; Response Insurance Brokers Inc. of Glendale, Calif., and President Chester Zalewski; and Great Republic Insurance Agency of San Diego.

Regulators accuse the three brokers of allowing IIU to rubber-stamp the brokers' names on policies it issued for offshore insurers to make it appear the coverage was legally placed by a licensed broker.

The complaint against Toma charges it continued to place business with two insurers—United States & Continental Reinsurance Co. of Belgium and Trelawney Insurances Ltd. of Ireland—after California barred brokers from doing business with the companies.

Mr. Whitaker also told Insurance Department investigators he knew of no claim problems with Trelawney at the same time Toma was sending form letters to claimants apologizing for claims payment delays. Toma also had letters from Trelawney's claims processor saying the insurer lacked funds to pay claims in full and offering nominal payments instead, regulators allege.

California regulators identified six offshore insurers for which IIU acted as MGA:

- US&C, which Mr. Teale allegedly controlled.

Mr. Teale and his wife, Charlotte C. Rentz, were arrested in January on multiple fraud charges arising from their operation of US&C and about 20 other allegedly fraudulent offshore insurers (*BI*, Jan. 25).

- Trelawney, also allegedly controlled by Mr. Teale and which Mr. Hoehne last year said he was acquiring (*BI*, May 4, 1992).
- Domestic Insurance Co. Inc. of the Philippines.
- Financial Services Insurance Ltd. of Bermuda.
- Universal Insurance & Reinsurance Co. of Panama.
- Provident Capital Indemnity Co. Ltd. of Dominica, which California regulators barred last year after alleging that its financial statements included $75 million in bogus assets (*BI*, Nov. 2, 1992).

Combined, the three brokerages reported $72.5 million in premium volume from various periods since 1990, the majority of it with IIU-managed companies.

Mr. Hoehne referred questions to his lawyer, who could not be reached.

Mr. Zalewski denied IIU was operating illegally as an MGA through Response, saying Response was using IIU as a "service center." He also said Response voluntarily discontinued its auto insurance programs in December 1991 and is now handling only aviation risks.

"We had no involvement with Teale," he added.

The other respondents could not be reached.

—By Douglas McLeod

Health reform developments

Continued from page 1

reform packages.

In a change of policy, the U.S. Chamber of Commerce proposed that employers must make at least some contribution toward their employees' health care benefits. However, the Chamber did not go as far as to say that employers should sponsor health care plans.

The Chamber also said it would not oppose taxing employees on a portion of employer-paid health care premiums.

In addition, the Chamber endorsed managed competition and the creation of regional purchasing groups to give small employers more buying clout.

Meanwhile, the ERISA Industry Committee also endorsed health care purchasing cooperatives and requiring that all individuals be covered either under government health plans, employer plans or purchasing cooperatives.

Neither proposal, though, goes as far as a package advanced last year by the Assn. of Private Pension & Welfare Plans. Among other things, the APPWP proposed that all employers must offer health care plans and pay for a substantial portion of their cost (*BI*, Dec. 21, 1992).

- A federal judge in Washington ruled that members of the health care reform task force and advisers can continue to meet privately with lobbyists, but that the task force must open formal, information-gathering hearings to the public.

U.S. District Court Judge Royce Lamberth's ruling is considered a victory for the administration.

The conflicting messages the administration sent out last week on benefit taxation continue a trend of confusion on the issue.

Last month, for example, the White House quickly scrambled to deny a newspaper report that the task force would not recommend workers be taxed on employer-paid health care premiums.

First, a White House spokeswoman denied the report, saying a decision on health care benefit taxation had not been made.

President Clinton later said no final decision had been reached, adding that he looked favorably on higher cigarette taxes as a revenue source to help fund coverage for the uninsured.

All the confusion on health care benefit taxation probably indicates the task force hasn't made a decision, noted James Klein, executive director of the APPWP.

Others caution in reading too much into Mrs. Clinton's statement.

Nothing she said would rule out taxes on "ultra-rich" health care benefits, said Henry Saveth, a principal with A. Foster Higgins & Co. Inc. in New York.

Others offer another interpretation of Mrs. Clinton's statement: Instead of taxing employees on employer-paid health care premiums, the task force might propose limiting employers' tax deduction for health care expenses.

"Employers should be real careful on how they read her (Mrs. Clinton's) statement. It does not mean that benefit taxation is off the table. It probably means the task force is focusing on taxing employers, such as limiting company tax deductions for health care costs, instead of taxing employees," said Frank McArdle, a consultant with Hewitt Associates in Washington.

Currently, employer-paid health care expenses are fully deductible.

On the open meetings issue, Judge Lamberth's ruling came in a suit filed by several health care groups that argued federal law barred the task force from meeting privately.

Judge Lamberth agreed that formal task force meetings must be public for the purpose of information-gathering. "The public has the right to know what information is being presented to the task force and by whom it is being given."

But decisions can be made in private to ensure that presidential advisers can speak freely and candidly, the judge ruled.

In addition, the ruling allows task force members and advisers to continue to meet informally in private with lobbyists and other health care experts to help shape the president's plan. BI

ZRC offering

Continued from page 2

Centre Re, whose main operating subsidiary is finite risk reinsurer Centre Reinsurance (Bermuda) Ltd., is 74% owned by the Zurich Insurance Co. of Switzerland.

Fund American, whose chairman is John J. Byrne, owned Fireman's Fund Corp. before it was sold to Allianz A.G. Holding in 1991.

Once the IPO is completed, Centre Re is expected to own about 55% of ZRC Holding's common stock.

Stephen M. Gluckstern, who now is president and CEO of Centre Re, will become chairman, president and CEO of ZRC and the holding company on March 23.

Richard E. Smith, formerly senior vp of Centre Re, has been named ZRC's executive vp and chief operating officer, while Peter Porrino, formerly a partner at Ernst & Young, will serve as senior vp, chief financial officer and treasurer.

Mr. Gluckstern will remain president and CEO of Centre Reinsurance Holdings, while Michael Palm, Centre Re executive vp, will replace him as president and CEO of the Bermuda reinsurer.

ZRC is expected to receive a warm welcome from brokers and ceding companies.

Centre Re is "creating the General Re of the brokered market," said John H. Snyder, senior vp with A.M. Best Co. General Reinsurance Corp., the largest U.S. property/casualty reinsurer, is a direct writer.

And given the growing sensitivity to security—both real and perceived—in the reinsurance market, "this company is going to be like a large magnet and it's going to attract a lot of business," he predicted.

"I think another leading reinsurer definitely has a place in the market," said Joanne Morrissey, principal with Firemark Consultants Inc. in Parsippany, N.J.

"This is a very good time to be coming into the market with that kind of capacity," agreed Kirk Roeser, president of Gill & Roeser Inc. in New York, a reinsurance broker. However, he noted that property catastrophe reinsurance is what is needed most, and ZRC will only be able to write a limited amount of that business.

Willis T. King Jr., president of Wilcox Inc. in New York, was more cautious. "They'll certainly have the financial capability. Will they have the underwriting staff to do it? I don't know."

The stock market also likely will receive the IPO warmly.

ZRC is registering 9.45 million shares at a proposed maximum price of $28 per share.

The market "will be highly receptive to a reinsurance company," said Charles Ronson, an analyst with Balestra Capital in New York.

"There's an appetite for high quality (reinsurance) companies that do a good job," said Herbert E. Goodfriend, a consultant with KPMG Peat Marwick in New York.

Michael Smith, an analyst with Lehman Bros. in New York, said: "They clearly recognized that size counts in this market, and if you're doing a public offering of a reinsurance entity, you'd better do it when investors have some interest."

In today's stock market, even insurance offerings of "variable quality" are selling, said Joyce Culbert of Chicago Corp. "It's amazing."

Observers said they are also pleased that Mr. Gluckstern will be running the company.

"He's maniacal, but he's very, very good," said Ms. Morrissey.

"Steven Gluckstern is one of the most original thinkers in the insurance business, and he has created a new way of looking at the insurance business that is very healthy," said Russell Miller, chairman of investment banker Russell Miller Inc. in San Francisco. BI

Update

Clinton launches PBGC panel

Continued from page 2

The task force will comprise high-ranking officials from the PBGC, the Commerce, Labor and Treasury departments, and the Office of Management and Budget.

Employer lobbying groups welcome the formation of the task force as a sign that the administration is aware of the agency's massive problems and may propose remedies.

GM seeks retrial in pickup case

ATLANTA—General Motors Corp. filed a motion for a new trial last week in the case that resulted in a $105.2 million award to the parents of a teen-ager killed when his GMC pickup truck crashed.

The parents of Shannon Moseley, 17, were awarded $101 million in punitive damages and $4.2 million in actual damages (*BI*, Feb. 8).

General Motors says it has uncovered two new witnesses who say the teen-ager died before the truck burst into flames and did not suffer in the fire.

Meanwhile, the state of Georgia has appealed a judge's ruling that a law giving the state 75% of punitive damage awards in certain product liability cases is unconstitutional.

The Feb. 26 ruling cost Georgia $75.8 million it was seeking as its portion of the $101 million punitive award to the Moseleys.

Judge Albert L. Thompson of the State Court for Fulton County said the Products Liability Punitive Damages Statute discriminated against product liability plaintiffs because plaintiffs in other tort cases are allowed to keep all damages.

Private bank deposit insurance

STAMFORD, Conn.—Bank depositors will be able to buy private deposit insurance to cover deposits exceeding the $100,000 limit insured by the federal government under a new program underwritten by General Star Indemnity Co.

Kevin P. Brooks, chairman of General Star Indemnity, a unit of General Re Corp., said the surplus lines insurer is now taking applications for the new policies, which will be effective April 1. Under the program, depositors can buy a minimum $200,000 policy to cover deposits of more than $100,000, the maximum insurable by the Federal Deposit Insurance Corp. Mr. Brooks said Gen Star will limit its exposure in any one bank and its branches to $5 million.

He said the program is aimed at firms like insurance agencies and travel agencies "where someone is acting as a fiduciary" and could at any given time have more than $100,000 on deposit in one bank.

The program was developed by Veribanc, a Wakefield, Mass., banking research firm, and Centrex Underwriters, a Memphis, Tenn., insurance agency specializing in liquor liability.

Briefly noted

Peter T. Pruitt, the former president of Frank B. Hall & Co. Inc., has retired as chairman of Rollins Hudig Hall of New York. . . .**Wind, hail and tornadoes** caused an estimated $75 million in insured property damage to portions of Georgia, Kentucky and Tennessee Feb. 22-23, reports the Property Claim Services division of the American Insurance Services Group. The severe weather was assigned Catastrophe No. 43. . . .Fremont Compensation Insurance Co. says it will **prosecute cases of alleged workers comp fraud** featured on ABC's "PrimeTime Live" last month. . . .In an attempt to **break the deadlock on workers comp reform**, California Gov. Pete Wilson will create an advisory work comp task force of business and labor representatives. The panel will be modeled after an Oregon panel that produced a successful law. . . .A former **Lloyd's of London broker killed himself** last month due to the uncertainty of his potential losses at Lloyd's, a coroner ruled last week. Richard Burgoyne, 53, sold his brokerage, Burgoyne Alford, in 1984. . . Ben Lytle, chairman and CEO of brokerage **Acordia Inc.**, recently assumed the additional position of president. . . .New Jersey officials last week reached a $42.7 million settlement with Hanover Insurance Co., Selective Insurance Co., Continental Casualty Co. and Newark Insurance Co.—four of 15 insurers it alleges mishandled claims under the **defunct Joint Underwriting Assn.** The agreement brings to seven the number of companies named in a 1990 lawsuit that have settled with the state.

Brokers hopeful market will firm up

By LEONARD M. WILSON

Special to Business Insurance

PUBLICLY OWNED insurance brokers reported fourth-quarter and full-year 1992 results several weeks ago without much fanfare (*BI*, March 1). Most of the fireworks from an investor's standpoint revolved around rising expectations of a change in premium rates. And it is clear that investors already have raised their sights on prospects for 1993. This optimism is yet to be fully validated, but no assessment as to upcoming developments would be complete without a passing review of results for the latest reporting period.

Not surprisingly, little evidence of firming rates could be discerned in the fourth-quarter numbers. Revenue growth was generally on the weak side and expense control continued as the front line against profit deterioration. Overall, earnings progress in both the quarter and the full year was lackluster, as expected.

Direct brokerage business in the United States generated modest year-over-year gains for the quarter, typically in the low single-digit range. Several brokers suggested that commissions had accelerated slightly, compared with the first nine months of 1992. But the source of this marginal additional strength was not ascribed to premium rates. Marsh & McLennan Cos. Inc., for example, posted an estimated 6% advance in direct domestic brokerage commissions in the fourth quarter.

Net new business ran at about 5% to 6% of the prior year's commissions, with total new business at 10% to 12% by our estimate. Lost business was in the area of 5%. These quarterly figures are thoroughly consistent with the performance for all of 1992. New business was a mainstay during the year and clearly ranked with expense control as a critical preserver of operating profits.

We ordinarily back into our estimates of premium rate changes for any quarter. The movement in rates prior to the effect of Hurricane Andrew was centered in marine, aviation, workers compensation and in some specialty lines. Mainstream exposures, though, were generally soft in the fourth quarter.

If we calculate domestic commission growth at 3% as an average for the public brokers, we can then derive the extent of rate reductions as a residual. To our estimate of net new business of 5%, we reckon underlying growth in the existing book of business at 3%, combining both increased units of exposure and any rise in insurable values. We think this is a reasonable number despite the lingering effects of the sluggish economy and the slowing rate of inflation.

These three drivers of commissions—new business, units and values—add up to 8% against estimated actual commission growth of 3%. Premium rate reductions across the book of business then must have been about 5%. This calculation seems consistent with what contacts have indicated during the fourth quarter about the general tenor of price-cutting: still competitive, but perhaps somewhat more selective.

Gains for reinsurance brokerage are difficult to encapsulate simply because there is considerable variation in business mix from one broker to another. Alexander & Alexander Services Inc. likely achieved double-digit increases in reinsurance brokerage, but advances of this magnitude were not uniform. Rising premium rates in the reinsurance area have in many instances been offset by shortages of capacity, thereby restricting top-line growth.

Contacts uniformly attested to better pricing outside the United States, citing the United Kingdom, continental Europe and even Australia. As a result, we think international brokerage probably outstripped domestic gains. The strength in the dollar against the pound diluted the year-over-year increase in dollar-denominated revenues and earnings.

Benefits consulting posted moderate gains throughout the year. Recession, uncertainty posed by the new administration and possibly a degree of temporary saturation in immediate client needs accounted for the less-robust showing in 1992.

Self-insurance demand, gauged by the performance of Arthur J. Gallagher & Co. Inc. through its Gallagher-Bassett division, has not abated. Gallagher recorded a 27% rise in fees, principally from varied aspects of self-insurance services during the fourth quarter. Soft markets usually do not favor self-insurance, but the sophistication of the insurance buyer has rendered this axiom obsolete.

Investment income for the brokers suffered from the low level of short-term interest rates and modest growth in the throughput of premiums.

As for total revenues, gains were in the area of 5%, except for Gallagher, whose comparisons were bolstered by self-insurance. Expenses mostly advanced a bit faster than revenues, with resultant continuing slippage of profit margins. The erosion of profit margins has been a repetitive theme of the soft market, an outcome that leaves the broker little recourse but to do the best possible job of cost control.

Did the fourth quarter offer any insights into the hoped-for development of a firmer market? Most contacts were queried well after the close of the year, and at a time when many renewals were still being shopped. Evidence on premium rates remained ambiguous outside of the property area, and even there rate changes appeared to be selective. We conclude from the fourth quarter that brokers are still prepared for tough market conditions even though they are hopeful. Cost reduction, cautious expansion of staff and tight controls on non-employment costs persist as ingrained initiatives.

Judging by the action of stock prices, the detached observer might conclude that the turn in the market is in the bag. Insurance brokerage managers, however, are still tuned to the as-yet-unforgiving operating environment. BI

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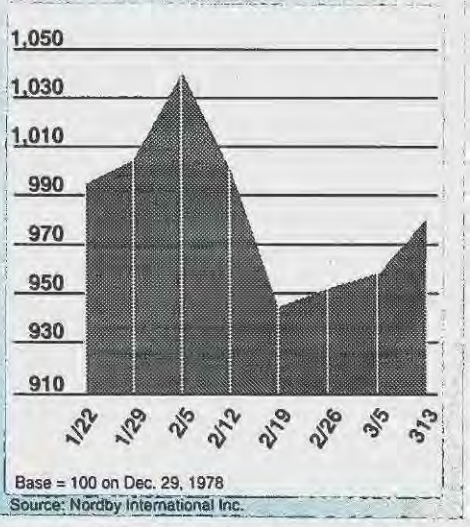
BI Insurance Index



Insurance industry stocks rose last week as the *Business Insurance* Index climbed 22.7 points to 979.8 March 12 from 957.1 on March 5. Advancing issues for the week were led by Statesman Group, up 15.9%; FHP International, up 15.1%; and U.S. Healthcare, up 12.1%. Declining issues for the week followed Seibels Bruce, down 24.2%; American Indemnity/Financial, down 5.6%; and Guaranty National Corp.,down 4.2%. The most active issue was U.S. Healthcare, 10.6 million shares traded. The *BI* Index was up 2.4%; the NYSE Composite was up 0.9%; the Standard & Poor's 500 was up 0.8%; and the Dow Jones 30 Industrials rose 0.7%.

British Issues

March 11 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	612	N/M	32.5	5.3	635—612	
Genl Accident	601	N/M	35.7	5.9	603—594	
Gdn Royal Exch	186	N/M	9.3	5.0	192—186	
Royal	300	N/M	6.7	2.2	304—300	
Sun Alliance	338	N/M	19.0	5.6	346—333	
Brokers						
Bradstock	140	16.5	6.8	4.9	140—140	
CE Heath	359	20.8	21.3*	5.9	363—359	
Hogg Group	185	17.7	10.9	5.9	185—185	
JIB Group	183	13.9	10.0	5.5	183—183	
Lloyd Thompson	295	23.7	7.5	2.5	295—295	
Lowndes Lmbrt	349	13.8	16.8	4.8	351—348	
PWS Holdings	64	9.5	5.3	8.3	64—60	
Sedgwick Grp	182	21.9	8.0	4.4	182—168	
Steel Brrl Jones	244	11.9	17.7	7.3	244—244	
Willis Corroon	208	19.4	8.8	4.2	208—190	

Source: Philip Olsen, London * Estimated

BI Industry Stock Report

MARCH 8, 1993 THROUGH MARCH 12, 1993

BROKERS		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
Acordia Inc.	NYS	24.50	8.89	13.95	24.75	15.13	118	0.36	1.47	16	7.01	3.50
Alexander & Alexander	NYS	25.50	-0.49	-3.77	28.88	18.00	1204	1.00	3.92	19	10.00	2.55
Gallagher Arthur J. & Co.	NYS	33.25	-3.27	17.70	35.00	21.00	151	0.72	2.17	21	6.35	5.24
Hilb, Rogal & Hamilton	NYS	15.75	-3.82	0.80	16.88	11.00	173	0.44	2.79	22	3.11	5.06
Marsh & McLennan	NYS	92.50	-0.13	1.23	97.63	71.25	391	2.68	2.90	22	14.40	6.42
Poe & Associates	OTC	16.50	-2.94	-1.49	19.00	11.25	13	0.40	2.42	21	2.64	6.25
BROKERS	AVERAGE		-0.3	4.7					2.2	17		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	46.25	-1.07	7.56	50.50	31.00	671	0.36	0.78	18	23.51	1.97
Berkshire Hathaway Inc.	NYS	12700.0	-0.86	8.09	12900.0	8675.00	1	0.00	0.00	51	6437.25	1.97
ITT (Hartford Group)	NYS	78.00	0.65	8.33	78.50	62.50	1906	1.96	2.51	-30	68.23	1.14
Sears (Allstate)	NYS	52.25	-1.42	14.84	54.75	37.75	3580	1.60	3.06	-9	40.18	1.30
CONGLOMERATES	AVERAGE		-0.7	9.7					1.6	7		
INSURERS/REINSURERS												
AEGON N.V.	NYS	46.88	0.27	12.61	47.63	33.00	47	0.68	1.45	8	34.06	1.38
Aetna Life & Casualty	NYS	47.63	-1.04	2.42	53.75	38.00	799	2.76	5.80	87	67.08	0.71
Allied Group Inc.	OTC	41.25	-2.37	29.92	42.50	18.75	110	0.72	1.75	10	11.29	3.65
Allmerica Prop. & Casualty	NYS	56.75	0.44	12.38	60.25	34.75	252	0.44	0.78	9	40.44	1.40
American General	NYS	31.63	6.30	-44.52	31.63	20.25	2204	1.08	3.42	13	39.89	0.79
American Heritage Life Ins.	NYS	33.25	4.31	9.92	33.88	24.88	11	0.84	2.53	16	16.51	2.01
American Indemnity/Fin'l	OTC	8.50	-5.56	41.67	9.75	4.75	1	0.08	0.94	5	14.43	0.59
American International	NYS	122.63	0.51	5.71	127.88	82.00	1460	0.56	0.46	16	54.21	2.26
American RE Corp.	NYS	39.25	3.29	6.08	41.75	34.25	269	0.00	0.00	39	N/A	N/A
Aon Corp.	NYS	54.25	2.36	0.46	55.50	39.75	319	1.68	3.10	18	27.17	2.00
Argonaut Group	OTC	32.75	5.65	7.38	33.25	25.50	133	0.84	2.56	10	21.70	1.51
AVEMCO Corp.	NYS	24.25	-0.51	3.74	28.00	21.00	37	0.40	1.65	30	7.33	3.31
Baldwin & Lyons Inc.	OTC	36.00	0.00	-1.37	36.50	26.50	0	0.48	1.33	9	30.85	1.17
Chandler Insurance	OTC	3.88	-3.13	-18.42	7.63	3.88	0	0.00	0.00	18	8.63	0.45
Chubb Corp.	NYS	91.75	0.69	3.23	95.50	62.38	530	1.72	1.87	13	40.67	2.26
CIGNA Corp.	NYS	60.25	1.05	2.77	68.00	47.13	882	3.04	5.05	11	81.73	0.74
CNA Financial Corp.	NYS	92.00	1.10	-6.12	102.88	79.75	91	0.00	0.00	-9	80.24	1.15
Continental Corp.	NYS	26.25	-0.47	-2.33	34.75	20.00	704	1.00	3.81	12	38.32	0.69
EXEL Ltd.	NYS	47.63	0.53	0.79	51.00	32.13	263	1.00	2.10	9	N/A	N/A
Fund American Corp.	NYS	77.38	4.38	7.47	77.50	62.50	98	0.00	0.00	56	81.85	0.95
Fremont General Corp.	OTC	39.75	-0.93	15.22	39.75	17.00	174	1.08	2.72	9	25.62	1.55
Frontier Insurance Group	NYS	47.00	3.30	8.05	47.00	27.03	66	0.60	1.28	16	13.97	3.36
Gainsco Inc.	ASE	18.25	-0.68	29.20	19.50	7.78	174	0.04	0.22	23	2.65	6.89
General RE Corp.	NYS	116.75	-0.43	0.86	130.50	77.50	592	1.88	1.61	17	46.07	2.53
Guaranty National Corp.	NYS	22.75	-4.21	15.19	24.00	13.50	40	0.48	2.11	14	9.12	2.49
Harleysville Group	OTC	28.75	7.48	1.77	32.75	17.75	263	0.64	2.23	13	16.77	1.71
Hartford Steam Boiler	NYS	58.50	0.00	1.30	59.88	46.75	77	2.12	3.62	22	19.74	2.96
Kemper Corp.	NYS	31.25	0.81	5.49	35.25	20.75	592	0.92	2.94	-9	37.66	0.83
Lawrence Insurance Group	ASE	7.63	0.00	-11.59	10.25	7.00	1	0.48	6.30	17	4.66	1.64
Liberty Corp.	NYS	31.50	2.44	11.50	32.88	22.25	98	0.56	1.78	13	18.43	1.71
Lincoln National	NYS	76.25	1.33	4.27	78.25	50.50	454	3.04	3.99	10	58.92	1.29
Markel Corp.	OTC	35.25	0.00	12.80	36.00	23.00	63	0.00	0.00	8	15.44	2.28
Mutual Risk Mgmt. Ltd.	NYS	39.00	-2.19	-3.70	46.00	25.75	111	0.28	0.72	22	7.51	5.19
NAC Re Corp.	OTC	41.75	2.77	3.09	44.75	21.75	233	0.16	0.38	73	13.60	3.07
National Re Corp.	NYS	35.88	3.99	21.10	39.00	17.00	132	0.12	0.33	20	N/A	N/A
Navigators Group	OTC	33.25	3.91	2.31	47.00	28.50	47	0.00	0.00	23	15.69	2.12
Nobel Insurance LTD.	OTC	7.50	5.26	27.66	8.25	4.25	280	0.00	0.00	5	3.91	1.92
NWNL Companies	NYS	63.38	7.42	24.57	63.38	29.88	274	1.48	2.34	15	46.21	1.37
Ohio Casualty Corp.	OTC	67.00	1.52	6.14	68.75	49.00	147	2.84	4.24	12	43.08	1.56
Old Republic Int'l	NYS	25.50	-0.49	2.51	27.38	18.75	289	0.40	1.57	8	18.63	1.37
Orion Capital Corp.	NYS	44.13	1.73	24.73	44.13	23.19	110	0.80	1.81	10	28.62	1.54
Phoenix RE Corp.	OTC	26.00	0.00	65.08	27.00	8.88	265	0.20	0.77	-40	13.32	1.95
Provident Life	NYS	28.00	-1.32	-1.75	31.50	20.00	162	1.04	3.71	11	30.38	0.92
Re Capital Corp.	ASE	14.88	0.85	-9.85	16.63	12.25	38	0.24	1.61	71	16.88	0.88
Reliance Group Holdings	NYS	6.88	10.00	12.24	7.13	4.13	1250	0.32	4.65	3	2.94	2.34
RLI Corp.	NYS	27.13	-1.36	9.60	28.63	17.75	24	0.52	1.92	12	17.92	1.51
St. Paul Companies	NYS	80.00	3.06	3.90	83.25	66.50	516	2.80	3.50	-14	59.79	1.34
SAFECO Corp.	OTC	62.25	-1.19	9.69	64.63	42.00	733	1.64	2.63	14	35.37	1.76
SCOR U.S. Corp.	NYS	20.50	0.00	17.14	20.63	13.13	3	0.28	1.37	85	14.39	1.42
Seibels Bruce Group	OTC	1.38	-24.16	-26.67	6.13	0.38	123	0.00	0.00	0	6.22	0.22
Selective Ins. Group	OTC	25.00	0.00	13.64	25.75	16.75	88	1.12	4.48	12	20.22	1.24
Statesman Group Inc.	OTC	16.38	15.93	36.46	16.38	5.00	1109	0.05	0.31	9	6.71	2.44
Tokio Marine & Fire	OTC	48.00	1.32	0.00	52.63	32.25	2	0.00	0.00	96	70.93	0.68
Torchmark Corp.	NYS	60.13	-1.43	5.95	64.75	36.00	386	1.04	1.73	17	14.87	4.04
Transamerica	NYS	49.13	1.81	2.34	51.00	40.00	691	2.00	4.07	12	35.86	1.37
Transatlantic Holdings	NYS	51.75	-0.48	-7.80	56.75	29.38	114	0.28	0.54	17	21.85	2.37
Travelers Corp.	NYS	27.38	2.34	0.46	30.75	17.13	1207	1.60	5.84	-3	43.85	0.62
Trenwick Group Inc.	OTC	48.75	1.30	19.63	48.75	25.00	114	0.80	1.64	19	23.87	2.04
United Fire & Casualty	OTC	37.75	2.03	-9.04	43.00	35.66	1	1.00	2.65	108	28.47	1.33
Unitrin	OTC	42.75	0.59	0.00	44.00	32.75	227	1.20	2.81	13	36.51	1.17
UNUM Corp.	NYS	56.63	0.22	6.84	58.00	32.00	819	0.64	1.13	15	21.83	2.59
US Facilities Corp.	OTC	8.38	6.35	-16.25	17.00	6.50	892	0.00	0.00	11	9.64	0.87
USF&G Corp.	NYS	13.63	1.87	10.10	15.00	8.00	968	0.20	1.47	-80	10.29	1.32
USLICO Corp.	NYS	16.50	4.76	-8.33	20.00	15.00	45	0.24	1.45	-5	29.80	0.55
USLIFE Corp.	NYS	38.88	0.00	7.24	42.63	28.41	338	1.20	3.09	13	64.90	0.60
Washington National	NYS	27.88	5.69	21.20	27.88	16.88	61	1.08	3.87	16	30.27	0.92
Zenith National Ins.	NYS	25.88	0.49	31.01	25.88	15.50	192	1.00	3.86	27	14.81	1.75
INSURERS/REINSURERS	AVERAGE		1.2	7.0					2.4	20.4		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	21.88	15.13	9.38	29.00	12.50	1663	0.00	0.00	20	9.61	2.28
Pacificare Health Sys.	OTC	35.75	7.52	-29.90	57.50	25.25	399	0.00	0.00	19	3.90	9.17
Safeguard Health Enter.	OTC	9.00	1.41	-7.69	14.75	7.00	13	0.00	0.00	11	4.03	2.23
Sierra Health Services	ASE	15.88	6.72	-26.59	21.69	8.06	302	0.00	0.00	14	2.01	7.90
United Healthcare Corp.	NYS	50.25	6.91	-11.65	68.00	34.25	2442	0.03	0.06	30	4.68	10.74
United Medical Corp.	ASE	9.13	0.00	43.14	9.75	6.13	2	0.20	2.19	22	10.30	0.89
U.S. Healthcare	OTC	47.63	12.06	6.72	59.75	29.00	10584	0.52	1.09	26	3.60	13.23
HMOs	AVERAGE		7.1	-2.4					0.4	18		
ALL COMPANIES	AVERAGE		1.8	4.8					2.1	19		

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