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Updates

Bill would require large employers to detail pension plan differences

WASHINGTON—Legislation introduced last week in the Senate and House would require large employers to provide employees a benefits comparison when converting defined benefit pension plans into cash balance plans.

The bill, The Pension Right to Know Act, sponsored by Sen. Daniel Patrick Moynihan, D-N.Y., calls for employers with more than 1,000 employees to issue individualized statements comparing retirement benefits under the current plan with benefits under the cash balance plan. The comparison would look at

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Patient rights bill advances

By JERRY GEISEL

WASHINGTON—In spite of sharp partisan differences, patient protection legislation is on its way to the Senate floor.

After defeating more than a dozen amendments that would have broadened the scope of the legislation, S. 326, the Senate Health, Education, Labor and Pensions Committee last week approved the bill with a party-line 10-8 vote.

The bill largely mirrors a proposal that was assembled last year by a Senate Republican health care task force but was never acted on. The current bill would set new federal standards to assure patients the right of independent, external reviews of coverage determination decisions, as well as give patients more information about benefits offered by their health care plans and about their providers.

Other provisions apply only to employer-sponsored, self-funded plans, including measures that would: prevent health care plans from imposing "gag" rules on providers; assure patients greater access to emergency medical care; mandate a new point-of-service option; and give patients direct access to obstetric/gynecological care and pediatric care.

During the last congressional session, partisan differences derailed enactment of patient protection legislation.

Those differences, judging from the debate surrounding the debate on the committee bill, remain intact. Sen. Edward Kennedy, D-Mass., the panel's ranking member, labeled the measure as a "Bill of Wrongs." Sen. Kennedy added, "If you have a right without a remedy, you don't have a right."

But Committee Chairman James Jeffords, R-Vt., said, "For the first time, millions of people will have protections they did not have before."

Panel Republicans and Democrats both agreed, though, that the bill will go forward to the Senate floor, where Sen. Kennedy and other Democrats are expected to continue their drive to broaden the bill and press again for amendments that were defeated last week by the Republican-majority committee.

Those amendments would apply all of the bill's provisions to all health care plans, not just to

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Amtrak crash suit filed

Suit names rail companies, trucker

By ROSEANNE WHITE

WASHINGTON—While it may take months to determine conclusively who was at fault in last week's crash of an Amtrak train and a truck, the first lawsuit was filed two days after the accident.

Both Amtrak and Illinois Central Railroad Co., which owns the track on which the accident occurred and operates the signals at the site, are covered for any property losses and liability from the incident.

Eleven people were killed and more than 100 were injured when Amtrak train No. 59, en route from Chicago to New Orleans, struck a flatbed tractor trailer loaded with steel at a highway/railroad grade crossing near Bourbonnais, Ill., about 50 miles south of Chicago. The train was carrying 196 passengers, 18 crew members, one off-duty Amtrak employee and one Illinois Central employee, an Amtrak spokesman said.

The Amtrak spokesman said last week that the railroad had no assessment of property damage from the incident, which occurred shortly before 10 p.m. March 15. The City of New Orleans train was made up of 14 cars and two locomotives, Amtrak said in a release.

Amtrak has several hundred million dollars in excess liability coverage over a $10 million-per-occurrence attachment. The first $50 million is written by Amtrak's Bermuda-domiciled captive, Passenger Rail Insurance Ltd. PRIL reinsures 100% of the risk with commercial reinsurers, Amtrak said. Above $50 million, Amtrak purchases excess limits from Starr Excess Liability Insurance Co. Ltd., ACE Ltd., XL Capital Ltd.

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PHOTOS: KRT

Cars from Amtrak's "City of New Orleans" lie strewn across the tracks in Bourbonnais, Ill., where it collided with a truck on March 15. Firefighters (below) probe the wreckage.

AIRMIC hopes other brokers follow

Aon adopts U.K. conduct code

By SARAH GODDARD

LONDON—U.K. risk managers praise a new code of conduct adopted by the U.K. unit of a megabroker, and buyers hope it will bring greater transparency in U.K. insurance transactions and serve as a model for other brokers.

Aon Risk Services U.K. Ltd. last week unveiled a new code of business conduct, developed with the Assn. of Insurance & Risk Managers, and will implement it starting next month.

The code calls for full disclosure in all its dealings with clients, including its remuneration. Aon Risk Services U.K. aims to eliminate incentive-based compensation from insurers, such as volume overriders and profit commissions. Instead, it will charge specific fees for any services it provides to insurers, fully detailing them to buyers. The code also sets out terms of trade, dispute resolution arrangements and an overriding principle of dealing with clients with "good faith at all times" and striving to attain the best solutions for the client.

The Aon code largely echoes an AIRMIC proposal submitted last year in an ongoing government review of proposals for broker regulation in the United Kingdom.

The move in London comes on the heels of a similar, though more-limited, arrangement between a rival broker and a U.S. risk manager organization.

Broker Marsh Inc. in January reached an agreement with the Risk & Insurance Management Society Inc. on a procedure for

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Exec challenges ouster from Sable Insurance

By DOUGLAS McLEOD

SAN FRANCISCO—The union between Reliance Group Holdings Inc. and an African-American businessman to form a minority-owned insurer was always a marriage of convenience. Now it is leading to a messy divorce.

Reliance struck a deal with African-American insurance executive Aaron Richardson to create Sable Insurance Co. in 1996, and as recently as last June it was trumpeting its niche writing property/casualty coverage for companies seeking to do business with a minority-owned company.

Mr. Richardson

Earlier this month, though, Reliance forced Mr. Richardson out, going so far, he says, as to post a guard to bar him from Sable's San Francisco offices.

Edward S. Rice Jr., an African-American executive recruited from The St. Paul Cos. Inc. last year to be Sable's chief operating officer, has taken over as president and chief executive officer.

As with most divorces, the answer to what went wrong depends on whom you ask.

A Reliance spokesman says the company became dissatisfied with Mr. Richardson's slow progress building Sable's premium volume.

Mr. Richardson says Reliance never expressed this dissatisfaction to him and that many of Sable's start-up problems were, in fact, caused by Reliance itself, which handled some of the insurer's operations under an administration agreement.

"I wish I knew what precipitated this," Mr. Richardson said.

The impact of the bitter breakup on Sable is uncertain.

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Updates

Bill seeks pension disclosure

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differences at the time of conversion and at three, five and 10 years into the future, as well as at the projected age of retirement.

Sen. Moynihan's goal, he indicated, is to inform employees of changes in their benefits, not to oppose conversions.

"I feel strongly that employers must fully and comprehensibly inform their workers regarding whatever pension benefits the company offers," he said in a written statement. "It is time to let the sun shine on pension plan conversions."

The statement also said that upwards of 500 large U.S. employers have converted to cash balance plans from defined benefit plans.

The bill also calls for employers to use standard assumptions for interest rates, mortality rates and wage inflation.

One problem with converting to cash balance plans from defined benefit plans is that older workers nearing retirement might actually lose money. Under current law, Sen. Moynihan's office noted, employers don't have to inform employees of any changes in their individual pensions.

This bill is an overreaction in addressing this problem, said Larry Sher, a principal with PwC Kwasha in Fort Lee, N.J.

"It goes too far," he said. "While there may very well be some good policy reasons" to expand disclosure in those cases, the bill imposes too high a burden on employers, especially in making the projections for years to come.

Mr. Sher also questioned how it would benefit employees to receive statements comparing the differing plans. "How does that help an employee?" he said.

Identical legislation was introduced in the House of Representatives by Rep. Jerry Weller, R-Ill.

Papers seized in London probe

LONDON—City of London police confirmed last week that they have seized papers from a number of U.K. insurance brokers as part of "Operation Chain."

Acting in conjunction with police forces in Kent, Suffolk and Norfolk, City of London police officers searched 10 premises at the end of February for documents relating to the reinsurance of Caribbean offshore insurers.

The investigation is being led by the U.S. Internal Revenue Service, which is looking into allegations of asset rental by insurance companies operating out of several Caribbean countries. IRS information has determined that some of the insurers under investigation may have tried to reinsure exposures in the U.K. market, particularly at Lloyd's of London.

A member of the Lloyd's regulatory staff has been helping the IRS sift through papers seized in the Caribbean to search for indications that reinsurance was placed into Lloyd's. David Gittings, director of regulation at Lloyd's, said he is confident that no reinsurance was placed with Lloyd's syndicates, and he praised the "timely action" by U.S. and U.K. authorities in preventing the scam from reaching Lloyd's.

NCQA to require outside review

WASHINGTON—The National Committee for Quality Assurance will require health plans to provide participants with an independent outside review of treatment decisions before receiving NCQA approval.

The change is part of the NCQA's draft "Accreditation 2000" standards. The new standard requires health plans to have an independent appeals process after a patient exhausts the plan's internal appeals system. Many employers and health care coalitions require the health plans they contract with to have NCQA accreditation.

In addition to outside appeals, the new standards include a requirement that internal appeals of decisions be conducted by a specialist in the same field of medicine as the treatment in question.

Also, the draft standards include a provision that patients undergoing treatment continue with the same physician for 90 days even after the provider is removed from the network. This is especially important for pregnant women, the NCQA noted.

The final Accreditation 2000 standards will be available July 30, and final standards will be released in August or September. Until April 30, the NCQA will accept comments on the new standards, which are available from its web site at www.ncqa.org.

South Dakota reforms comp

PIERRE, S.D.—Gov. Terry C. Anderson has signed legislation aimed at helping South Dakota employers reduce workers compensation expenses.

The legislation, S.B. 211, amends the state workers comp code and incorporates several changes recommended by a governor's task force.

Among the changes is that mental injury is compensable only if there is "clear and convincing" proof of a relationship to a compensable physical injury. This establishes a higher standard of proof than existed before.

The changes also establish a statute of limitations on workers comp claims. Under the statute, a lawsuit cannot be filed if no medical treatment has been sought within seven years of the first report of injury. The changes also allow an employer to be free of workers comp obligations for permanent total disability claims if it can show that a suitable job is available within 60 miles of an injured worker's home. The job no longer needs to be with the current employer.

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Errors & omissions

• Due to a production error, a March 15 story on Lloyd's syndicate results incorrectly stated that managing agency D.P. Mann Ltd. was involved in a line slip for U.S. extended-warranty business. D.P. Mann is not affiliated with the line slip.

Broker sues risk manager over terminated contract

By RODD ZOLKOS

CHICAGO—A broker hired to participate in a construction wrap-up insurance program for the Chicago Board of Education is suing the school system and its risk manager for terminating its contract.

Near North Insurance Brokerage Inc.'s suit charges that the school board improperly broke its contract at the urging of Cynthia Asghar, the school system's director of risk and benefits management, who also is named in the lawsuit.

Neither Ms. Asghar nor Michael Segal, president and chief executive officer of Chicago-based Near North, would comment on the lawsuit. The suit, which was filed late last month in Cook County Circuit Court, seeks several million dollars in compensatory and punitive damages.

In adopting a wrap-up program in 1998 for a $1 billion-plus capital improvements program, Chicago public school officials said they hoped to save more than $10 million in costs that they would otherwise incur if individual contractors each obtained their own coverages and passed their insurance costs back to the districts (*BI*, Feb. 16, 1998).

School officials also hoped the

See **Lawsuit** *on page 22*

Brokers' clients want more: Speaker

Demand driving M&A

By SALLY ROBERTS

PHOENIX—Fast-paced acquisition activity in the insurance brokerage market is the result of buyers demanding more resources and services, according to an executive from one of the megabrokers.

During a dinner reception at Standard & Poor's Corp.'s 15th annual insurance symposium last week, Harvey N. Medvin, executive vp and chief financial officer of Chicago-based Aon Corp., said that demand for global services is

STANDARD & POOR'S

creating a need for some brokers to align themselves with other global leaders in order to maintain their large international accounts.

While Aon and Marsh & McLennan Cos. Inc. together have spent nearly $7 billion in the past 2½ years acquiring various brokers, effectively shrinking the brokerage arena, competition in the distribution market remains as fierce as ever, Mr. Medvin maintained.

"Distribution in the industry is undergoing very, very dramatic change," he said. "There's been a lot of focus on the global players—ourselves, of course, and Marsh—and that's been for a number of reasons, not the least of which is, in the last 2½ years, Marsh has invested $4.2 billion in the business and we, in that same

See **S&P** *on page 22*

Rate increases, cost control focus help fuel optimism

By JUDY GREENWALD

HMO Results

Managed care companies are looking forward to improved financial results this year as rate increases begin to take hold.

"I think things are going to improve, I definitely do," said David Olson, vp-investor relations for Woodland Hills, Calif.-based Foundation Health Systems Inc.

'I think that a strong pricing environment and a more conscientious effort on the part of the industry to address the whole drug cost problem is going to bear fruit in 1999," said Mr. Olson. In addition, "the industry has also matured and is pricing its premiums consistently with health care cost trends."

"From our perspective, I think 1999 is going to be a better year overall than 1998 was," agreed David Erickson, director of investor relations for Santa Ana, Calif.-based PacifiCare Health Systems Inc.

In addition to a better pricing environment, "you have the HMOs that are focusing more intently on their core competencies, if you will, sticking to what they do best and exiting things that they aren't so good at, and I think there's just an increased focus

See **HMOs** *on page 6*

Directory deadline

Business Insurance will publish its annual Directory of 401(k) Plan Administrators in the May 10 issue. The directory is published as an editorial service, and there is no charge to be included.

To be listed, companies must provide 401(k) plan administration services, such as enrollment recordkeeping, daily maintenance of participants accounts and handling of account activity. Plan administration services must be offered on an unbundled basis.

If your company meets the requirements but has not received a questionnaire, please request one immediately by calling Directory Editor Kevin Edison at 312-649-5279.

Copies of the questionnaire also can be printed from the *BI* Web site at www.businessinsurance.com/magazine/directories.html.

Completed questionnaires must be submitted by the extended deadline of April 9.

Inside

• Last week's collision of an Amtrak train and a semi-trailer truck demonstrates that basic changes are still needed in the nation's railway safety system, this week's editorial says. **PAGE 8**

• A National Assn. of Insurance Commissioners working group has endorsed the use of fully funded securitization transactions conducted thrcugh "protected cells" independent of insurers' general operations. **PAGE 10**

Departments

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Consolidation continues in insurance sector

Insurance-related transactions, in billions of dollars

Sector	Number of deals 1997	Number of deals 1998	Total value 1997	Total value 1998
Property/casualty	111	117	$30.87	$55.83
Life	51	51	12.25	32.47
Health/managed care	75	76	7.26	5.28
Services	86	138	3.03	15.88
Distribution*	109	183	2.72	55.90
Total	432	565	$56.13	$165.36

* Includes agents, brokers and financial services companies
Source: Conning & Co.

M&A activity sets another record in '98

By MICHAEL BRADFORD

As any risk manager knows, insurance-related businesses are gobbling each other up through mergers and acquisitions.

But insurance buyers who are seeing new names appear on their policies might not realize how furious the feeding frenzy has become.

Last year, insurance industry mergers and acquisitions reached a record level, with 565 transactions at a total value of $165.4 billion, a recently released study says. According to the study, the 1998 dollar figure is a 194.6% increase over the $56.1 billion value of the 432 deals posted in 1997.

The Conning & Co. study, entitled "Mergers & Acquisitions and Public Equity Offerings, Whole Lotta Shakin' Goin' On," said a "general trend of building bulk and gaining economies of scale played into many of the acquirers' strategies. In today's highly competitive, overpopulated market, more deals involved insiders buying insurers to gain scale. This contrasts with more nontraditional buyers outside the insurance market seeking only financial opportunities during the early 1990s."

"Growth in most companies has been small or flat," said Nancy Carini, vp at Hartford, Conn.-based Conning & Co. and author of the study. "It's difficult to sustain any growth unless you buy it."

Most of the total transaction value last year, 77.4%, was concentrated in the 10 largest deals, according to the study; the top five deals accounted for 60.9% of the total.

Mergers and acquisitions among companies in the distribution sector led the way. The study expanded its definition of the distribution sector in 1998 to include not only those transactions among agents and brokers but also deals that "reflect the change that is occurring with alternative distribution channels," particularly in the financial services area.

Overall, there were 183 deals among those companies, with an aggregate transaction value of $55.9 billion. That compares with 109 deals with a total value of $2.7 billion the year before.

The Travelers/Citicorp merger, valued at $37.4 billion, was at the top in the distribution sector and was the highest-valued among all 1998 transactions.

There were 117 property/casualty insurance company deals, valued at an aggregate $55.8 billion in 1998. The

See **Deals** *on page 16*

Poor defense can spark insurer bad-faith suits

By DAVE LENCKUS

TUCSON, Ariz.—How insurers handle their duty to defend, regardless of their less-broad duty to indemnify, exposes them to potentially costly bad-faith claims by policyholders, according to two policyholder attorneys.

Indeed, even an insurer that a court eventually finds has no duty to indemnify a policyholder still can be held liable for bad-faith damages if the insurer bungles the policyholder's defense, an attorney said.

But, an insurer attorney said, bad-faith awards essentially provide policyholders with coverage they did not have. She asserted that the more judicious way of handling disputes is under contract law. That provides a remedy that more closely matches the policyholder's damages, she said.

Unlike in bad-faith cases, contract law does not allow policyholders to recover punitive damages. Contract law also does not allow the recovery of treble compensatory damages, which is permissible in some jurisdictions or when an insurer's conduct exposes the company to liability under federal racketeering law.

Courts in some states, most notably Texas, are beginning to agree that disputes between policyholders and insurers should be resolved under contract law, said some panelists during a session at an American Bar Assn. conference. The ABA held the conference, the 11th Annual Insurance Coverage Litigation Committee Midyear Meeting, in Tucson,

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RIMS members learn the art of influence

Lessons in lobbying

By MARK A. HOFMANN

WASHINGTON—Know both sides of an issue before you lobby your congressman. That was one bit of practical lobbying advice a member of Congress gave risk managers as she delivered the keynote address to the Risk & Insurance Management Society Inc.'s first Washington "fly-in" last week.

"Just make your side be the strong side," added Rep. Jo Ann Emerson, R-Mo., to appreciative chuckles from the 50 or so risk managers who attended the Capitol Hill event.

Rep. Emerson, a former senior vp for the Washington-based American Insurance Assn., stressed the importance of grass-roots lobbying.

"A lot of folks are intimidated by the thought of meeting with your member of Congress," she said. But she said there's no need for trepidation. "We're normal people."

Risk managers and others who wish to influence public policy need to see themselves as educators, not only for congressmen but for their staffs as well, she said. Staffers are the ones who work with the issues on a day-to-day basis and understand the "minutiae" of issues, she pointed out.

When approaching congressmen, risk managers should "keep your pitches short," otherwise lawmakers' eyes will glaze over, she warned. Those approaching congressmen should frame their concerns in such terms as how the resolution of an issue will affect their bottom lines and how many employees in the lawmaker's district will be affected by the issue, she said.

"Just remember that you represent a core of people in your con-

See **Lobby** *on next page*

Insurers hear insights on investing in brokers

By JUDY GREENWALD

SAN FRANCISCO—Insurers investing in regional brokers use different approaches, but regardless of the approach, the investment can help build business for both the insurer and broker and be mutually profitable as well, say officials of insurers active in this area.

Insurers representing three approaches to investing in brokers—debt capital, large syndicated transactions and equity capital—discussed each at a session at the National Insurance Symposium Leadership Conference earlier this month. The conference was sponsored by the Russell Miller Cos. and Swiss Re.

Harold N. Marsh III, senior vp and treasurer for Novato, Calif.-based Fireman's Fund Insurance Co., said the insurer provides debt capital, or a loan, to regional producers. He said Fireman's Fund does so selectively, "with what we call strategic partners."

There must be a long-term commitment that is mutually beneficial to both parties, said Mr. Marsh. There also must be a recognition that "profitable growth is important for both parties in meeting our customers' needs," said Mr. Marsh.

He said Fireman's Fund prefers to use debt—rather than equity—capital to invest in brokers because it believes the latter creates potential conflicts of interest in terms of the broker's independence.

Furthermore, "It's a cheaper source of financing, frankly, over the long haul," said Mr. Marsh.

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Societal trends raise workers comp issues: Panel

By MEG FLETCHER

CAMBRIDGE, Mass.—Certain societal trends are changing the nature of employer-worker relationships and raising new questions about the relevance and adaptability of state workers compensation systems, panelists say.

"Can a 90-year-old system, designed for an industrialized economy, adapt for the information age?" asked Glenn Shor, senior policy analyst for the California Division of Workers' Compensation.

It is not a easy question to answer, according to comments from the state administrator, the union representative and the employer who considered the topic during the annual issues and research conference of the Workers Compensation Research Institute. The conference was held in Cambridge, Mass., earlier this month.

Workers comp systems began when society was shifting from an agriculture-based economy to an industrialized one, Mr. Shor said. As work became concentrated into large product manufacturing and distribution centers, issues of negligence and responsibility changed.

The earlier workers comp systems "worked best with injuries that were caused by single events, clearly related to work hazards or exposures and that occurred with knowledge of employers and coworkers," Mr. Shor said.

More WCRI conference coverage on page 20

Determining cause and compensability was easier for these more-obvious claims, such as, for example, the loss of a worker's arm in a punch press. But claims have become more difficult now that the nature of work has changed, with more workers claiming, for example, musculoskeletal repetitive stress injuries that may not be entirely work-related.

In addition, the relationship between an employer and an employee has become less direct, as workers telecommute from home or hold more than one job.

Contingent workers pose a particular problem.

According to federal labor statistics, there are at least 6.5 million contingent workers in the United States, said Heather Grob, a labor economist and director of economic research for the Center to Protect Workers' Rights, the research arm for the Building and Construction Trades Department of the AFL-CIO.

"The AFL-CIO believes that all workers should be covered by workers comp," she said.

A special concern is that the increased use of contingent workers reduces employers' ability to control training, and that could increase the risk of those workers being hurt through accidents and

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Amtrak

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and Chubb Atlantic Indemnity Ltd.

Amtrak has limits of several hundred million per occurrence in its master property insurance. The property insurance deductible on rolling stock damaged in a derailment is $10 million. Amtrak has a layered program in which several commercial insurers participate. The top excess layer, which attaches at $100 million, is written by HSB Industrial Risk Insurers.

A spokesman for Chicago-based Illinois Central said the company does not release damage estimates. He would not release insurance information, but he said, "Our coverage is adequate for any liability that we foresee here."

The lawsuit was filed in the Circuit Court of Cook County, Ill., on behalf of passengers David and Laura Roe of New Orleans, who were treated for injuries sustained in the crash, said their attorney, Brian Murphy. The suit names as defendants Amtrak; Illinois Central; the truck driver, John Stokes, and the company for which he was hauling a load of steel, Melco Transfer Inc. of Peotone, Ill.

The suit will be amended and expanded as more is learned from the official investigation and from the attorney's discovery, said Mr. Murphy, a senior associate with Hofeld & Schaffner, a plaintiffs' personal injury firm in Chicago. "Through investigation, the responsibilities of the various parties are going to flesh themselves out," he said.

The suit alleges that Amtrak failed to properly operate the train, failed to keep a proper lookout and failed to maintain signaling devices, said Mr. Murphy. Although Illinois Central said it is responsible for the signaling devices at the site, Mr. Murphy said, it is unclear how or whether responsibility for maintaining the signaling, track and crossing is shared with Amtrak.

The complaint alleges that Illinois Central was negligent in maintaining the signaling, track and crossing, the attorney said.

The suit also accused Mr. Stokes of simple negligence for failing to stop, look and listen and pay attention to warning signals, Mr. Murphy said. Melco is being sued under vicarious liability or respondeat superior, the principle that when an employee is negligent in the course of employment, the employer can be held liable, he said. Whether Mr. Stokes was a Melco employee or not will be determined during discovery, Mr. Murphy said.

The suit seeks for each of the six counts damages in excess of $50,000, the minimum threshold for filing in the Law Division of the Cook County Circuit Court, Mr. Murphy said.

Melco had no comment on the suit. An Amtrak spokesman said the railroad does not comment on pending litigation. The Illinois Central spokesman said he was not sure if the company had seen the suit.

The risks at grade crossings have declined markedly over the past 35 to 40 years, says Ian Savage.

The case was filed quickly, the attorney said, to enable the lawyer to seek protective orders to preserve documents related to the investigation until attorneys are allowed access to them and to begin discovery while the investigation is fresh and ongoing.

The on-scene portion of the National Transportation Safety Board's investigation was expected to be completed last week, though certain investigators will return to the area to reinterview the Amtrak engineer, who was hospitalized with injuries last week, NTSB board member John Goglia said during a press briefing last week. However, it will take between nine and 12 months for the NTSB to determine a probable cause for the accident, he said.

The NTSB found no indication of signal malfunction last week, Mr. Goglia said.

The NTSB and the Federal Highway Administration last week still were analyzing tire tracks that could indicate whether the driver went around the crossing gate. The NTSB also conducted sight-distance tests of the accident, using the actual cab from the semi-trailer and a flatbed carrying a load of steel.

An NTSB spokesman said Friday that several people have come forward who claim to have witnessed the accident. The NTSB began interviewing them last week and is trying to determine the validity of the statements.

Benjamin Slater III, principal of the Slater Law Firm in New Orleans and vice chair of the Defense Research Institutes Railroad Law Committee, said the case is complex. But, he said, "As far as liability issues, it may not be terribly complex."

"If the accident reconstruction is pretty clear that the truck driver went around the crossing gates, it doesn't seem to me the railroad should be liable," he said.

The risks at grade crossings have declined markedly over the past 35 to 40 years, said Ian Savage, a professor of economics and transportation at Northwestern University in Evanston, Ill.

In 1960, 1,410 road users were killed at grade crossings. Last year, there were about 420 fatalities.

The decreased risk can be attributed to three factors, he said. Under a program that began in the 1970s, the federal government pays 80% of states' costs to install lights and gates at such crossings. And a joint government/railroad industry program called Operation Lifesaver puts out public service announcements and literature warning drivers of the dangers of going around railroad crossings. Finally, the federal government has been encouraging closure of some grade crossings so that traffic will be consolidated at fewer crossings and the most high-tech signaling devices can be installed, Mr. Savage said. BI

Lobby

Continued from page 3
gressman's constituency," she said. Lawmakers listen to voters, she assured her audience.

Effective lobbying means presenting the other side of the issue as well, said Rep. Emerson. Lawmakers don't want to hear just one side. The trick for risk managers is to make their argument stronger than that of the other side.

Drawing on her own experiences as a lobbyist, Rep. Emerson cautioned her listeners to avoid getting "overly aggressive and nasty." Instead, amateur lobbyists should try to "close the sale" with the congressman before leaving. Try to get the lawmaker to take a position, and if the lawmaker demurs by expressing a need for more information, make sure the congressman receives the information necessary to make the decision, she said.

"The hotter the issue is, the more impact you'll have," she said.

As she fielded questions after the address, Rep. Emerson predicted that some form of patients' bill of rights legislation will pass this year. Although she said she "hates" managed care, Rep. Emerson said she does not see a workable alternative right now in the face of rising health care costs.

She emphasized that she does not favor exposing employers to lawsuits stemming from managed care decisions. Instead, she favors creating appeals boards that would review managed care disputes, and she emphasized that she thinks the boards should be made up of physicians, not insurers.

Rep. Emerson urged her audience not to send postcards or e-mails to Capitol Hill, but rather to employ a more personal touch. Telephone calls, personal letters and face-to-face meetings in a lawmaker's home district in addition to Washington visits all are effective ways to get a message across, she said.

"Don't forget: You are the experts in your field—we are not." BI

Y2K needs bipartisan help

By MARK A. HOFMANN

WASHINGTON—Partisan bills that seek to limit liability arising from Year 2000 computer problems aren't likely to win approval in the U.S. Senate.

That's the read of James T. McIntyre, a former head of the Office of Management and Budget and who has served as Risk & Insurance Management Society Inc's RIMS Washington lobbyist for years. Mr. McIntyre assessed the outlook for Y2K legislation—one of RIMS' trio of major federal legislative issues—at RIMS Capitol Hill "fly-in" in Washington last week.

The other issues he reviewed for risk managers were medical records privacy and managed care regulation, both of which are relatively new concerns for the risk management professional group.

Mr. McIntyre also noted that a pair of RIMS longtime legislative concerns—reform of Superfund and of the Occupational Safety and Health Administration—appear unlikely to be dealt with this year.

And, Mr. McIntyre made clear, he doesn't expect there will be any movement on Y2K legislation in the Senate unless a bill enjoys bipartisan support. He said there are three major bills under consideration—two in the Senate and one in the House—that share certain approaches to limiting liability stemming from Y2K. Mr. McIntyre focused on the proposals in the Senate, where passage is likely to be more difficult.

One of those Senate bills—sponsored by Senate Commerce Committee Chairman and presidential hopeful John McCain, R-Ariz.—appears to have little Democratic support. Another, sponsored by Senate Judiciary Committee Chairman Orrin Hatch, R-Utah, and Sen. Dianne Feinstein, D-Calif., which has been introduced but has not come to a full committee vote, appears to be on hold while Sen. Christopher Dodd, D-Conn., puts the finishing touches on his Y2K bill (*BI*, March 15), said Mr. McIntyre.

While all of the bills share common characteristics, such as reliance on alternative dispute resolution to stave off a flood of Y2K-related litigation, the Dodd bill is expected to avoid the controversial subjects of punitive damages caps and limits on attorneys' fees, Mr. McIntyre said. Nevertheless, passing a bill will take a lot of effort because of opposition from the trial bar, he said.

Medical records privacy, particularly as affects workers compensation, is another area of concern to risk managers. Michael Ferguson, a lobbyist for the Self-Insurance Institute of America in Washington, noted that the Health Insurance Portability and Accountability Act mandates that Congress set federal guidelines on patient privacy this year, though Congress might be able to extend the deadline. But, warned Mr. Ferguson, a situation could arise where Congress fails to act or extend the deadline, allowing the Department of Health and Human Services to impose its own privacy regulations without pre-empting state efforts to do the same.

Jim Green, risk manager for Fort Worth, Texas-based Justin Industries Inc., addressed managed care legislation by noting that "we believe the best patient protection is insurance coverage." He said he believes that certain reforms, such as instituting some sort of external review for managed care disputes, will pass in this Congress. BI

For citizen lobbyists, patience is a virtue

By MARK A. HOFMANN

WASHINGTON—A trip to a congressman's office often is not exactly what a first-time citizen lobbyist expects.

That was a theme repeated last week by several speakers at the Risk & Insurance Management Society Inc.'s first Washington "fly-in." The fly-in brought about 50 risk managers from all over the country to Capitol Hill to learn the art of lobbying and then to practice it as they presented RIMS' concerns to their lawmakers.

Risk managers and others hoping to get involved in the political process need to keep their expectations reasonable, said Francis D. Bouchard, vp and director-federal affairs in the Zurich Group's Washington office. Citizen lobbyists shouldn't expect that meetings will begin right on time, because there is always a lot going on in a typical congressional office. Although lobbyists should be prepared to wait, they should not miss their next meeting, because lawmakers do not like to be kept waiting, he said.

The visitors also should not be surprised if their meetings with lawmakers get interrupted—that's simply the nature of life on Capitol Hill, he said. Citizen lobbyists also shouldn't expect to be ushered into "luxurious corporate digs" when they meet with congressional staffers, he advised.

In fact, Capitol Hill visits can be frustrating, said Joel Wood, senior vp-government affairs for the Council of Insurance Agents & Brokers in Washington. Such frustration often occurs when the citizen lobbyist is shuffled off to a congressional intern or other low-ranking staffer, said Mr. Wood, who was himself legislative director for former Republican Rep.—and current Tennessee Gov.—Don Sundquist.

Those visiting the Hill need to remember that "there are many instances where the staff is more powerful than the member," he said. "The staff is the policy-making backbone of the Congress," he noted a few minutes later.

"One of the best pieces of advice" Mr. Wood said he has ever received was to send a personal letter—indeed, a letter marked "personal"—to a congressman after a meeting with a staffer, informing the lawmaker "how delightful it was" to talk with the staff member. The letter also should say that the visitor looked forward to working with the congressman's office again, he said. Despite the torrent of mail that floods the typical congressional office, such personal letters do get read, Mr. Wood assured his listeners.

Mr. Wood also urged his listeners to speak with "one voice" on issues. "The harmony of their tongues hath to attention brought my ear," he said, quoting William Shakespeare's "The Tempest."

Daniel J. Conway, senior vp in Chubb Corp.'s Washington office, also stressed the importance of unity. "Uniting as a trade association is extremely effective," particularly regarding complex issues. A divided trade association loses its effectiveness, he pointed out. If a group isn't united, a congressman can "duck the question" and tell his visitors to return when they are united, said Mr. Conway.

Mr. Conway praised RIMS as representing a "cross-section of American industry" that could prove to be a "very potent" advocate on Capitol Hill if it presents a united voice.

RIMS' efforts also drew praise from Mr. Wood, who said "this legislative conference is the first in what I hope will be a long series."

The risk managers also heard from some of the people they'd be trying to influence: Hill staffers. Anne Allen, the outgoing RIMS director of government affairs, asked Hill staffers whether they think "insurance" or "employers" when they hear "RIMS." David Wescott replied that they think "Who the heck is RIMS?"

Mr. Wescott, legislative assistant to Sen. Edward M. Kennedy. D-Mass., suggested that RIMS members carry a one-page fact sheet with them when visiting the Hill, explaining that RIMS represents "such-and-such companies with so-and-so employees" in a given state or district.

Another staffer, Roger Morse, was asked how many issues RIMS members should stress as they visit the Hill. Mr. Morse, legislative director for Rep. Van Hilleary, R-Tenn., said citizen lobbyists should stress no more than three issues, as they risk losing the attention of their listeners. Mr. Wescott added that, if possible, the three issues should be woven together to enhance the effectiveness of the presentation. BI

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What can we do to help you?

HMOs

Continued from page 2

on performance that we haven't seen in several years."

It sounds like there is a good year ahead, agreed Rob Mains, an analyst with Advest Inc. in Albany, N.Y. "There still are questions about the ability to control medical costs, and government Medicare reimbursement programs are kind of a quagmire, but a 7% to 10% commercial price premium increase can smooth over a lot of those hills," said Mr. Mains.

"We're cautiously optimistic about improved operating performance for this sector as a whole in 1999," said Douglas L. Meyer, an analyst with Duff & Phelps Credit Rating Co. in Chicago.

"The pricing lag in the business caught several of the players in 1998, and I think everyone has (now) pretty much priced in appropriate rate increases to improve operating results," said Mr. Meyer.

"We're looking for incremental margin improvements and some stability in the sector," said Mark Jamilkowski, an analyst with Hartford, Conn.-based Conning & Co. "There's a chance for everybody to get their footing."

From a commercial pricing perspective, the outlook appears to be favorable, said Michael Barry, a director at rating agency Fitch IBCA in New York. He noted that two-thirds of the business renews in January, so the industry already has a pretty good idea of this year's rate hikes.

However, "What's not so certain," he added, is "will the industry be able to keep a lid on pharmaceutical cost trends?"

"We're in the midst right now of the first of the year optimism about the outlook," said Michael LeConey, an analyst with National Securities Corp. in New York. "It's a tough period, because the optimism sort of peaks right about now, and people get a little more worried as the year goes on."

However, he added, "I think it's probably reasonable that the worst is, if you will, over in terms of the shakeout of the industry. In other words, people who are still standing are survivors at this point."

Mr. LeConey said that while he would not necessarily predict 1999 will be a good year, "I think at least the odds seem to favor that it will be the last bad year. . . .We ought to see better trends."

Among the reported HMO results:

• Philadelphia-based CIGNA Corp.'s employee health care, life and disability benefits business segment, which includes its HMO and indemnity operations, posted $617 million in operating income, up 20.7% from 1997. Its fourth-quarter income increased 32.4% to $184 million.

• Hartford, Conn.-based Aetna U.S. Healthcare reported operating earnings of $381.8 million, which was a 0.6% decline from 1997. Its fourth-quarter operating earnings, though, increased 15.1% to $100.8 million.

• Thousand Oaks, Calif.-based WellPoint Health Networks Inc., parent company of Blue Cross of California, reported $231.3 million in net income, up 1.7% from 1997. However, its fourth-quarter net income increased 8.7% to $67.4 million, after excluding discontinued operations, a one-time gain and certain one-time charges.

• Louisville, Ky.-based Humana reported $213 million in net income, excluding charges, up from $173 million in 1997.

• PacifiCare posted $202 million in earnings, compared with a $22 million loss in 1997.

• St. Louis-based RightCHOICE ManagedCare Inc. reported $5.7 million in net income, compared with a $24 million net loss in 1997.

• Los Angeles-based Maxicare Health Plans Inc. reported a $27.5 million net loss for 1998, compared to a $25.1 million net loss in 1997.

• Minnetonka, Minn.-based UnitedHealth Group, which changed its name from United HealthCare Corp. in December, reported a $166 million loss, vs. a $460 million profit in 1997. The company's $900 million second quarter loss lead to the collapse of its planned merger with Humana last year (*BI*, Aug. 17, 1998).

• FHS reported a $165.2 million loss, vs. a $187.1 million loss in 1997.

• Oakland, Calif.-based Kaiser Foundation incurred a $288 million net loss last year, following 1997's $266 million loss.

• Norwalk, Conn.-based Oxford Health Plans Inc. reported a $624.5 million net loss, compared to a $291.3 million loss in 1997. For the fourth quarter, the company posted an $18.8 million loss, compared to a $284.7 million loss for the comparable period in 1997.

Whether HMOs will be able to 'keep a lid on pharmaceutical cost trends' is uncertain, says Michael Barry.

The fourth quarter "was the first quarter in a while that didn't have any surprises," said Conning's Mr. Jamilkowski. In addition,"the relative recovery by the large franchise players tended to outpace the rate of margin improvement seen by the smaller, less leveraged HMOs."

Arun N. Kumar, director at rating agency Standard & Poor's Corp. in New York, said results for commercial managed care operations were "pretty good," while some of the Blues plans had a good quarter as well.

Among the commercial operations, for instance, WellPoint, PacifiCare, Aetna and CIGNA had "decent" fourth quarters. And while FHS did take a substantial fourth-quarter write-off, it is expected to be the last one the company reports. Non-profits, however, including Kaiser, fared relatively poorly, said Mr. Kumar.

Improvement in fourth-quarter results is a reflection of rate improvement among the commercial HMOs as well as acquisition-related membership growth and a tighter focus on medical costs, said Patrick Finnegan, senior vp at rating agency Moody's Investors Service Inc. in New York.

"The Medicaid HMO business has been a thorny problem for many companies throughout the year, but in the fourth quarter, I think, a number of companies were able to arrest the problems they were having in the area by virtue of either withdrawing from markets, or slowing down their marketing of the Medicare risk products," said Mr. Finnegan.

Also evident, he added, are the initial effects of the renewal rate hikes, which will emerge more fully in 1999. "I guess the key word I would say here is not rapid

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or robust improvement, but stabilization to gradual improvement that we can expect over the near term."

Mr. Finnegan also said the business' cyclical nature appears to be re-emerging. The health care industry had a three-year cycle for many years, but "that seemed to be interrupted with the advancement and wide penetration of managed care products in the early to mid-90s," said Mr. Finnegan.

Now, however,"I think you're going to see a return to the cyclicality of this industry. Whether the cycle will be shorter or longer is not clear, but it's very clear that the cycles have not been broken entirely," said Mr. Finnegan.

Meanwhile, analysts expect merger and acquisition activity to continue, but say it will involve more smaller firms than in the past. "I don't think there's going to be any big activity in '99," said S&P's Mr. Kumar.

"There are not many big companies out there for sale any more, but there are several medium-sized companies that are on the block, and we expect that some of the large companies will continue to do small to medium-sized acquisitions," focusing on firms that operate in attractive markets where they want to build critical mass.

Mr. Finnegan also said that while merger and acquisition activity may abate somewhat toward the end of the year because of concern about the Y2K issue, "I don't see any lack of interest on the part of the large players in trying to consolidate regional and metropolitan plans."

He added, "Large scale mergers, I think, are not necessarily as likely, but I wouldn't necessarily rule them out either." BI

Analysts predict improved HMO stock performance

By JUDY GREENWALD

Anticipated improvement in managed care companies' 1999 financial results is expected to be reflected in their stock market performance, say analysts.

Last year, the stock prices of six health maintenance organizations tracked by *Business Insurance* declined 1.82% as a group through Dec. 30, 1998. To date this year, the group's stock price has declined 5.45% through March 12.

But analysts are generally optimistic the stocks will do better during the year.

"I think what investors want more than anything else out of HMOs is dependability, and if they deliver the types of earnings that they're all expecting this year, then

I think the prices could still go up," said Rob Mains, an analyst with Advest Inc. in Albany, N.Y.

That assumes, however, that there are no negative surprises, which have marked the past three years, he added.

"I would expect (HMO stocks) would improve," said Patrick Finnegan, senior vp at Moody's Investors Service Inc. in New York. While much of the stocks' performance will depend on technical factors that affect the stock market as a whole, improving margins or stabilized medical loss ratios "will go a long way to buoy the stock prices of a lot of these companies, so I see it as being a more attractive situation over the long term."

"As a whole, this sector should be better than it's been over the past three or four years" because of improved results, said Douglas L. Meyer, an analyst with Duff & Phelps Credit Rating Co. in New York.

"Most HMO stocks have actually done fairly well in the past few months," noted Arun N. Kumar, director at rating agency Standard & Poor's Corp. in New York.

The group "appears to slowly be coming back in favor," he said. There has been some recent improvement in the prices of some companies—including United HealthGroup, which changed its name from United HealthCare Corp. in December, Oxford Health Plans Inc. and WellPoint Health Networks Inc.—though he said Aetna U.S. Healthcare "hasn't moved too much."

"Meeting earnings expectations is more likely in '99 than it was in '98 and presumably for the year 2000 as well. The outlook is somewhat positive, and I think the stock market generally reacts well to prospective expectations," said Mr. Kumar.

"I think there are some real undervalued names in the group," said Mark Jamilkowski, an analyst with Hartford, Conn.-based Conning & Co. "I think the larger, more well-established franchise names are going to outperform," though he added: "I would be cautious of companies that have too high a concentration or exposure to Medicare, just because we don't know how that's going to evolve."

Michael LeConey, an analyst with National Securities Corp. in New York, said he expects a "see-saw year" for HMO stocks.

But, "when the year's over, I think the stocks will have generally done well against the market averages," he said.

Among those who recommend specific stocks, analyst favorites include Oxford, WellPoint and Aetna.

Oxford, which is Mr. Mains' sole recommendation, is "tough to get your arms around," the Advest analyst said. "I think that's created some misunderstanding in the investment community," which in turn creates an opportunity for investors.

Mr. LeConey recommends Wellpoint and Aetna. "Generally speaking, I think the enthusiasm for Wellpoint is well focused," he said. "California gets better faster, sooner. Trends start in California and proceed to the East Coast, and Wellpoint is the best-managed, best-positioned player on the coast," he said.

"We may be early, but I would be a buyer of Aetna here, just because they've got a big business that's well positioned. . .they've got plenty of financial muscle and a good name, and that counts for a lot," Mr. LeConey added. BI

Opinions

Stop danger in its tracks

INVESTIGATORS LAST WEEK were still trying to determine who is at fault for the Amtrak crash in Illinois in which 11 people were killed and more than 100 injured when Amtrak's famed "City of New Orleans" collided with a semi-trailer truck near Bourbonnais, Ill.

Regardless of who is to blame, the fact that a truck was in the intersection at all shows that more solid accident prevention measures are required.

To their credit, the railway industry and federal regulators have together made huge strides in reducing the number of accidents in recent years.

That trend continued last year: There were 3,446 highway/rail crossing incidents in 1998, down 10.8% from 1997, and 422 fatalities, down 8.5%, according to the Federal Railroad Administration's Office of Safety Analysis.

Public education and awareness campaigns, voluntary safety compliance programs and joint regulatory and management initiatives, among other efforts, have all helped reduce the number of accidents and fatalities involving vehicles and trains.

However, the Bourbonnais crash demonstrates that even more basic changes still are needed in the railway system.

The sad fact is that a railway safety system reliant upon the common sense of car and truck drivers is doomed to fail. Impatience and idiocy are a volatile combination in too many people and will lead some to ignore warning signs, signals or safety gates if there's an avenue to bypass them.

Of course, the safest solution to the problem is the increased construction of overpasses and underpasses, which altogether prevent trains and street traffic from sharing crossings. One step down from this expensive and labor-intensive response is the wider use of a newer type of barrier that physically prevents traffic from crossing rail lines. These more-effective barriers are in use in some parts of the country and should be adopted universally at public grade crossings.

The breach in the rail crossing barriers near Bourbonnais has been attributed to intentional design. The purpose of not having an impassable barrier allegedly is to allow emergency vehicles, such as police cars and ambulances, to cross the tracks through the gaps without waiting.

The logic of such a bypass system is flawed. If working properly, the only reason a gate would be down is because it is unsafe to cross a rail line because of an oncoming train. Regardless of whether it's an emergency or private vehicle bypassing the gates, the risk of a collision with a train is not diminished, nor are the consequences.

Why, therefore, don't government safety officials insist on rail barriers that truly bar vehicles from entering the rail crossings when trains are about to pass through?

Past arguments against such safety improvements have likely included the expense of upgrading the systems. Another, no doubt, is public resistance to any measure that would create longer traffic delays when freight and passenger trains cross public roads. And many also will argue that barrier malfunctions are an all-too-common occurrence requiring that motorists have an "out."

Those arguments, hopefully, will be lessened by last week's crash, which amply demonstrates the high cost of *not* doing more to assure that cars and trucks are kept out of the paths of trains.

Letters

OSHA should slow down on ergonomics

To the editor: Your Feb. 8 editorial, "Ergonomics Draft Chilling," is right on point. One wonders why the Occupational Safety and Health Administration is in such a hurry to issue a final rule before the end of 1999. It appears that OSHA hopes to push through its proposed rule on ergonomics before the National Academy of Sciences completes its ergonomics study.

Particularly troubling is OSHA's apparent lack of concern for the cost of compliance on business, particularly to the small employer. While OSHA likes to tout cooperative efforts between the agency and business, clearly the new standard would create an additional layer of costs on employers already struggling to remain in compliance with numerous federal laws. For example, general industry employers with manufacturing and/or manual handling operations would be required to establish an ergonomics program, even if no musculoskeletal disorders are reported or identified on the job. In many cases, trying to maintain compliance with such an open-ended and ambiguous set of obligations would devastate smaller employers.

Many associations representing employers of all sizes support the National Academy of Sciences' review process. This process would define concrete views and identify abstract areas concerning ergonomics. It defies logic that OSHA would try to release a final rule before the appropriate research is completed.

OSHA characterizes the proposal as a "work in progress." I suppose employers should be thankful the draft is not the agency's final product.

Margaret Fiester
Director, Human Resource Services
National Employers
Resource Alliance Inc.
Baltimore

Settling issues through court legitimate

To the editor: In a Feb. 22 story an attorney representing the gun industry, Mark Behrens, comments that "courts are trying to legislate certain products off the market. The courts shouldn't be making these decisions. If there's a broad public policy here, then it should be up to the legislatures."

Of course this is a Catch-22. The legislative branch of government, both state and federal, has long been a black hole to reasonable gun control and gun safety bills thanks to the National Rifle Assn. and its Republican allies. When such blockage happens on public policy issues, settling issues through the court system, a co-equal branch of government in this country, is perfectly legitimate albeit inefficient and slow.

For example, take civil rights. There was little movement on civil rights and desegregation until the 1954 U.S. Supreme Court decision in *Brown vs. Board of Education of Topeka*. Congress certainly never would have passed such a law and only passed meaningful legislation starting in 1964 after considerable litigation and agitation.

Those special interests that make legislative progress impossible on broad public policy issues in turn make litigation inevitable, e.g., civil rights, tobacco, firearms, product liability.

William E. Murray Jr.
Portola Valley, Calif.

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Securitization gains momentum with regulators

By MEG FLETCHER

WASHINGTON—A National Assn. of Insurance Commissioners working group recently endorsed the concept of fully funded securitization transactions conducted

NAIC

through "protected cells" independent of insurers' general operations.

However, in action taken earlier this month in Washington at the NAIC's quarterly meeting, members of the NAIC's Securitization Working Group first made some minor changes to a proposed model law in order to emphasize that such transactions must be fully funded and indemnity-triggered.

Under the current timetable, the working group will soon release an exposure draft of the proposed model law at an unspecified interim meeting and take comments during a hearing at the NAIC's next quarterly meeting, June 5-9 in Kansas City, Mo., according to Arnold Dutcher, chairman of the working group. Mr. Dutcher is chief deputy director of the Illinois Insurance Department. If that timetable stands, NAIC members could then vote on formal adoption of the model at the fall meeting, Oct. 2-6 in Atlanta.

Meanwhile, regulators and other interested parties continue to consider securitization-related tax and accounting issues, as well as other proposals to make it easier for U.S. insurers to use onshore capital market instruments for their catastrophic exposures. Currently, nearly all securitization transactions involve offshore special-purpose reinsurers (*BI*, Feb. 15).

"It seems like we have a lot of momentum on the concept of securitization," said Jeffery C. Alton, director-statutory accounting and financial regulation for Chicago-based CNA Financial Corp.

"This will provide additional opportunities for insurers to spread risk in this country, as opposed to having to go outside the country to accomplish it," said Phillip Schwartz, vp-financial reporting and associate general counsel of the Washington-based American Insurance Assn.

Onshore deals 'will provide additional opportunities for insurers to spread risks in this country,' says Phillip Schwartz.

In other action during the meeting, state insurance regulators:

• Approved allocating an additional $500,000 to the $300,000 already provided to state insurance departments for Y2K preparedness and monitoring activities.

In addition, states are directing domestic insurers to disclose specific Y2K information in the management discussion and analysis letters filed with their 1998 annual statements. The NAIC also has developed a process to share the insurers' Y2K information with other states, using a uniform confidentiality agreement.

• Adopted a model regulation for synthetic guaranteed investment contracts. Under synthetic GICs, unlike traditional GICs, the assets underlying the insurer-issued investment contracts are owned by the contract holders.

• Announced that Connecticut, Montana and Pennsylvania received second-round accreditation certificates, bringing to 32 the number of states that have achieved that status.

• Adopted at the working group level an "efficiency and effectiveness" project for the NAIC's Securities Valuation Office. The proposal would eliminate SVO filing requirements for some insurers' investment securities that are already rated by other organizations.

• Heard that a Florida lawsuit between two workers compensation rating organizations over intellectual property rights to workers comp data is nearing settlement.

Representatives of the National Council on Compensation Insurance Inc. and Insurance Data Resources Inc., both of Boca Raton, Fla., told the Workers Compensation Task Force that they are putting an oral agreement in writing.

• Heard Jamie Beletz, the new executive director of the International Assn. of Industrial Accident Boards & Commissions, say that he wants to increase the IAIABC's participation at NAIC meetings as a way of enhancing communication between the organizations. South Dakota Insurance Director Darla Lyon, chairwoman of the NAIC's Workers Compensation Task Force, is considering Mr. Beletz's request to resume periodic joint meetings between the groups. BI

Consumer information study findings disputed

WASHINGTON—The National Assn. of Insurance Commissioners and the Consumer Federation of America recently traded barbs

NAIC

over the CFA's study of all state insurance departments' consumer information brochures and written materials.

The study, by the Washington-based non-profit CFA, was based primarily on a written questionnaire and review of insurance departments' literature. It focused on the quantity and quality of consumer information for major lines of insurance bought by individual consumers, including auto, homeowners, life, health and disability. The study was conducted by former Texas Insurance Commissioner J. Robert Hunter, the CFA's director of insurance.

The CFA study gave seven states an "A": Colorado, Florida, Kansas, Missouri, Ohio, Texas and Wisconsin.

In addition, the CFA gave 13 states a "B"; 14 a "C"; seven a "D"; five an "F"; and five an "I," or incomplete.

NAIC President George Reider Jr. challenged the study's findings, saying in a recent statement that the survey was "incomplete and flawed" for not considering the broad range of consumer information and services state insurance departments provide.

For example, the CFA's analysis did not consider insurance departments' use of toll-free hot lines, consumer outreach meetings, public service announcements and regular newspaper columns, he said. In addition, Mr. Reider said that several states provided information that the CFA did not acknowledge.

Mr. Reider also faulted the CFA for including Internet information, primarily because, he said, not all consumers have Internet access. But Mr. Hunter said departmental World Wide Web site addresses were merely listed in the report; Internet information was not used in the evaluation of the individual insurance departments.

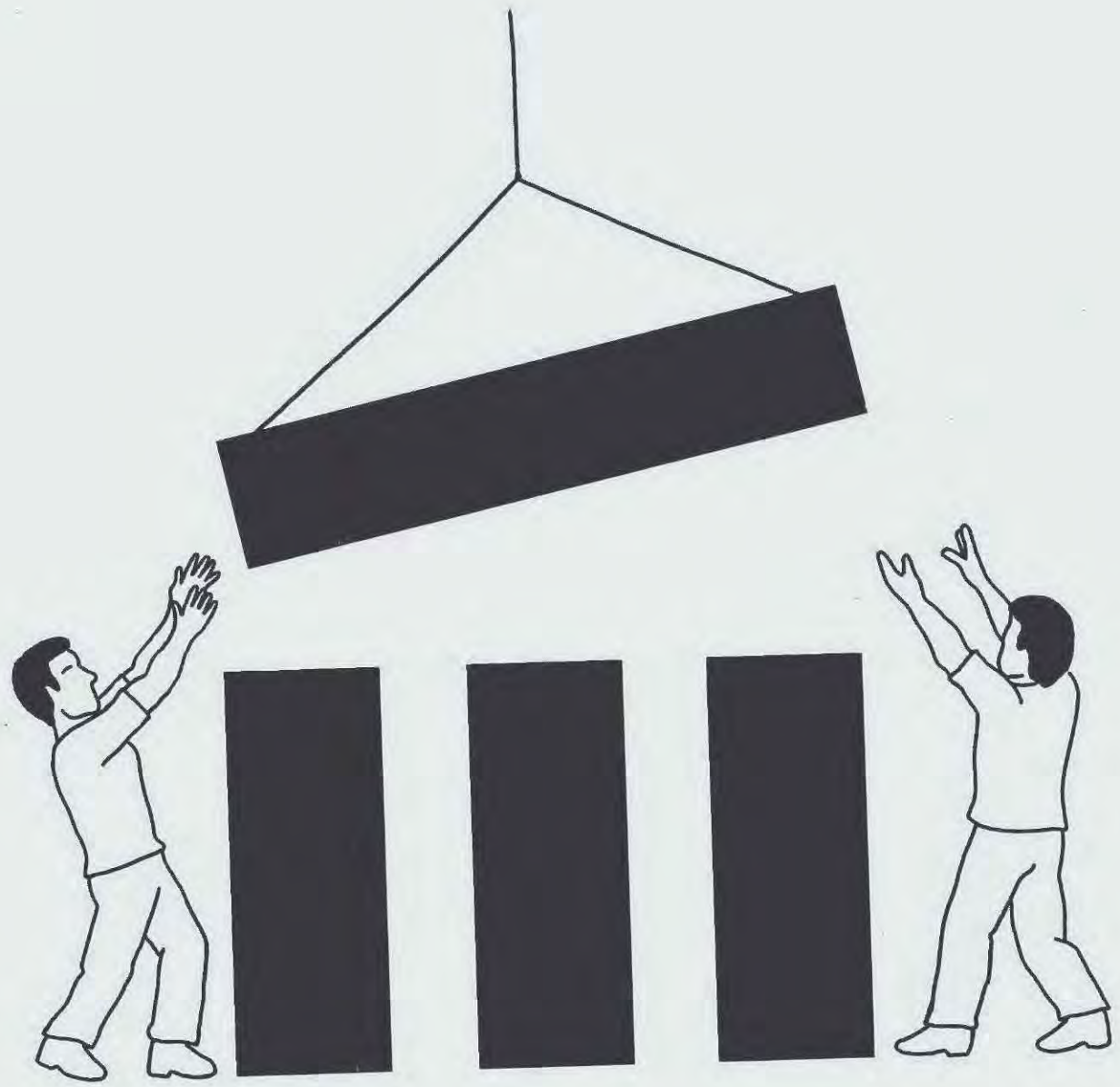
While the NAIC was critical of the CFA study, at least one commissioner publicly touted his state's "A" rating.

In a release, Florida Treasurer and Insurance Commissioner Bill Nelson said: "This is a nice honor." Also, "we've worked hard here to assist and protect consumers."

Mr. Hunter said in an interview that he disagrees with Mr. Reider's criticism that the report was "incomplete and flawed," calling this criticism "silly," in light of the fact that the CFA reviewed about 350 pieces of written material.

"The quality of brochures sent to consumers is something you can discretely study to measure the quality of response by states to their consumers' insurance information needs," Mr. Hunter said.

—By Meg Fletcher



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ASK A CASUALTY ACTUARY

Q **Why do actuaries use several methods to derive estimates, while accountants generally use only one method?**

A While I can't provide a definitive answer regarding the practice of accountants, I can specifically address the question regarding actuarial practices.

First, I will venture an educated guess. Almost by definition, estimates derived by actuaries involve the effects of future events. While accountants do provide such estimates in a variety of circumstances, in many other instances their work involves the quantification of the effects of past or current events.

It is widely acknowledged by actuaries that every estimation method is based on specific underlying assumptions that may or may not be satisfied. In some way, the future is expected to replicate the past, at least by analogy. If the underlying assumptions of a particular method are not satisfied, then the projections of that method may either be understated or overstated—sometimes by a substantial percentage.

It is because of this potential risk that actuaries generally apply more than one method and make selections based on a range of indications. In truth, most actuarial methods are highly sensitive to changes in case reserving practices and/or settlement practices. Often, the effect is leveraged.

In applying the incurred-loss development method, for example, it is assumed that development patterns exhibited in the recent past will be repeated in the near future. If there have been no changes in the level of adequacy of the case reserves in recent years, then this assumption probably is reasonable.

There are, however, several possible events that can noticeably change the adequacy level of case reserves. Here is a partial list:

- A claims audit finds that case reserves are generally weak, and the claims adjusters are exhorted to strengthen their provisions.
- Guidelines for reserving long-term workers compensation claims change from estimating reserves at ultimate values to their present values, such as with a reduction for anticipated investment income.
- The head of the claims division issues a directive that case reserves are no longer to be set at their expected settlement value but are to be minimum possible settlement values. This could be done in the belief that claims adjusters' performance often is measured by comparing final settlement amounts with the previous case reserves. By making this shift, it is hoped that adjusters will be pressured into generally settling cases for less.
- An account is shifted to an incurred-loss retro, and the insurer, out of concern that case reserves may be short at the time of the final retro calculation, attempts to set case reserves at a higher level.
- There has been a change of claims administrators or of some other personnel adjusting claims.
- The definition of a claim that can be fast-tracked—settled quickly with one check and without the establishment of a case reserve—increases to $5,000 from $1,000.
- Retention levels double or triple within a short period of time, causing a fundamental upward shift in development patterns.
- Recent legislation or court decisions significantly change the expected settlement value of many outstanding claims or cause the settlement process to become much more complicated.
- A claims operation becomes increasingly short-handed, and the number of claims per adjuster rises markedly. As a consequence, adjusters fall behind in reviewing claims and in making sure that case reserves reflect the current facts on major cases.

When one or more of these changes occur, they can cause major distortions in incurred-loss development patterns. Unless the actuary or analyst is fully aware of the existence and extent of such changes, he or she may make projections that implicitly assume that such one-time distortions will keep repeating themselves into the future. In this way, undetected or unmeasured shifts can have a multiplying effect on reserve or funding estimates.

To gain a greater appreciation for and understanding of this multiplication effect, let's look at a relatively simple example. It will illustrate how a 50% increase in the adequacy level of case reserves during the most recent calendar year can easily have the effect of causing projected total reserves to be nearly twice what they should be.

For the sake of simplicity and illustration, suppose that total claims for each accident year are the same at the end of each year of development. These assumptions are shown in Figure 1.

Profile of every accident year illustrated by taking accident year 1994 as an example

As of year end	Paid losses	Case reserves	Reported incurred losses
1994	2.0	2.0	4.0
1995	4.5	3.0	7.5
1996	6.5	2.0	8.5
1997	8.0	1.5	9.5
1998	9.0	1.0	10.0

All amounts are in millions of dollars.

FIGURE 1

Accident year 1994 is taken as an example. It comprises solely claims arising from incidents occurring during 1994. As of year end 1994, $2 million has been paid; as of year end 1995, a total of $4.5 million has been paid; and so forth. Similarly, total case reserves as of each year end are shown, as are total reported incurred losses.

We will assume that every accident year's claims—from 1994 through 1998—develop by exactly the same amounts. If this occurs, then we can exactly calculate, for example, what the total loss reserve should be as of year end 1998. This is done in Figure 2.

Calculation of correct total indicated reserve at 12/98

Accident year	(A) Ultimate losses	(B) Paid losses at 12/98	(C) Indicated reserve [(A)-(B)]
1994	10.0	9.0	1.0
1995	10.0	8.0	2.0
1996	10.0	6.5	3.5
1997	10.0	4.5	5.5
1998	10.0	2.0	8.0
Total indicated reserve:			20.0

All amounts are in millions of dollars.

FIGURE 2

For each year, the indicated-loss reserve is equal to projected ultimate losses minus paid losses through year end 1998. As documented in Figure 2, the total indicated-loss reserve is $20 million.

In calculating indicated-loss reserves, the standard approach is to organize the various historical values of reported incurred losses by accident year and year of development—as displayed in Figure 3. Months of development are counted from the beginning of each given accident year.

For example, for accident year 1994, 12 months of development is the same as year end 1994, and 36 months is the same as year end 1996.

Estimation of cumulative development percentages

Development of reported incurred losses ($ millions)

Accident year	Months of development 12	24	36	48	60
1994	4.0	7.5	8.5	9.5	10.0
1995	4.0	7.5	8.5	9.5	
1996	4.0	7.5	8.5		
1997	4.0	7.5			
1998	4.0				

Percentage changes in reported incurred losses

Accident year	Months of development 24/12	36/24	48/36	60/48	Ult./60
1994	87.5%	13.3%	11.8%	5.3%	
1995	87.5%	13.3%	11.8%		
1996	87.5%	13.3%			
1997	87.5%				
Average of latest 2 years	87.5%	13.3%	11.8%	5.3%	0.0%
Cumulative development	150.1%	33.4%	17.6%	5.3%	0.0%

FIGURE 3

In the bottom half of Figure 3, we have displayed the development percentages that correspond to the development triangle in the top half of that figure.

For example, the 87.5% development percentages shown in the 24/12 column were calculated as the increase in reported incurred losses between the 12th and 24th months of development ($3.5 million), divided by the earlier incurred amount of $4.0 million.

No development beyond 60 months was assumed, because a review of development experience for accident years 1985 through 1993 showed that incurred losses have not tended to increase to any degree once an accident year has reached 60 months of age.

Cumulative development is calculated by starting from the rightmost average percentage change and taking the cumulative product of the corresponding development factors.

See **Casualty Actuary** *on next page*

Estimation of cumulative development percentages

Development of reported incurred losses ($ millions)

Accident year	Months of development 12	24	36	48	60
1994	4.0	7.5	8.5	9.50	10.5
1995	4.0	7.5	8.5	10.25	
1996	4.0	7.5	9.5		
1997	4.0	9.0			
1998	5.0				

Percentage changes in reported incurred losses

Accident year	Months of development 24/12	36/24	48/36	60/48	Ult./60
1994	87.5%	13.3%	11.8%	10.5%	
1995	87.5%	13.3%	20.6%		
1996	87.5%	26.7%			
1997	125.0%				
Average of latest 2 years	106.3%	20.0%	16.2%	10.5%	9.0%
Cumulative development	246.4%	68.0%	40.0%	20.5%	9.0%

FIGURE 4

Casualty Actuary

Continued from previous page

For example, the cumulative development percentage of 33.4% from 24 months to ultimate was obtained by taking the product of 1.0, 1.053, 1.118 and 1.133 (1.334), and then subtracting 1.0.

What would happen to the projection of total indicated-loss reserves if the adequacy level of case reserves increased by 50% during calendar year 1998?

We can model this by simply taking the amount of case reserves shown in Figure 1, increasing it by 50%, and adding paid losses to obtain the revised amount of reported incurred losses for each accident year. This is shown in Figure 4. The increased values of incurred losses are shown in boxes along the lower right diagonal in the top of that figure.

In the lower half of Figure 4 is a display of the percentage increases in reported incurred losses, given a constant level of adequacy of case reserves for calendar years 1997 and prior and case reserves that are 50% higher than they otherwise would have been at the end of 1998.

By comparing Figures 3 and 4, we can readily see the effect that the change in the adequacy of case reserves will have on the reserve analysis.

A 9% tail factor was selected as an estimate of incurred development from 60 months to ultimate. This selection was based on the rate of decline of the average development percentages for prior development years as you move from left to right.

Figure 5 displays the standard approach used to calculate the indicated reserve by accident year. It is worth noting that the total indicated reserve of $39.5 million is almost twice the $20 million reserve that we know to be correct.

There are three reasons why a 50% increase in the adequacy of case reserves has led to a virtual doubling of the indicated-loss reserve.

First, the selected development percentages are applied to a higher-than-usual base of reported incurred losses.

Second, some of the selected factors are applied to the reported incurred losses of several successive accident years.

And finally, higher reserves for very old cases led to an upward revision in the selected tail factor. That factor is applied to all accident years.

How would projected funding for accident year 2000 be affected? If we simply fit an exponential curve down Column (C) of Figure 5, projected funding for the year 2000 would be $20.8 million, which is more than twice the correct funding of $10 million.

Actual calculation of total indicated reserve at 12/98

Accident year	(A) Reported incurred	(B) Cumulative development percentage	(C) Projected ultimate losses	(D) Paid losses	(E) Indicated reserve [(C)-(D)]
1994	10.50	9.0%	11.4	9.0	2.4
1995	10.25	20.5%	12.3	8.0	4.3
1996	9.50	40.0%	13.3	6.5	6.8
1997	9.00	68.0%	15.1	4.5	10.6
1998	5.00	246.4%	17.3	2.0	15.3
Total indicated reserve:					39.5

All amounts are in millions of dollars. (C) = (A) x [1.0 + (B)].

FIGURE 5

Although this example is a bit laborious, I have attempted to make it as simple as possible while still illustrating how changes in claims practices can become amplified in terms of reserve indications.

The incurred-development method is not the only one for which the projections are highly susceptible to distortions based on changes in claims practices. While the projections of the paid development method are not affected in any way by changes in reserving practices, they are quite sensitive to circumstances that might change the rate of settlement of claims. The method basically assumes there have been no changes in the rate of settlement.

But this rate of settlement can change due to any one of the last five phenomena cited above with regard to the incurred method. In particular, a noticeable change in the average case load can result in definite changes in the rate of settling claims.

The rate of settlement also can change because of a shift toward greater use of structured settlements, and it can be affected by changes in the relative emphasis given to defending claims vs. the more rapid resolution of claims.

Because of the sensitivity of each method to dynamic changes in the claims environment, the chances of significantly misstating loss reserves are reduced when several methods are applied and differences among the sets of projections are "reconciled."

Investigating the reasons behind such differences often involves the review of various statistics that can measure the extent of shifts in the adequacy level of reserves (e.g., average case reserve) and the rate of settling claims (e.g., claims disposed ratios).

It also can include the application of various techniques to adjust past loss experience to attempt to place it on a relatively constant basis—with respect to any of the kinds of changes we have mentioned. BI

Would you like advice from an experienced colleague on an actuarial, risk management or benefits management problem? Four quarterly features in the Perspective section of Business Insurance *can give you some answers.*

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This month's column on actuarial issues in the casualty field is written by Richard E. Sherman, president of Richard E. Sherman & Associates Inc. in Ashland, Ore. Dennis J. Nirtaut, managing director of compensation and benefits for Arthur Andersen Worldwide in Chicago, answers questions on employee benefit plans. William J. Miner, an actuary with Watson Wyatt Worldwide in Chicago, answers actuarial questions on benefit issues.

Mr. Sherman

And Christopher E. Mandel, director-global risk management at Tricon Global Restaurants Inc. in Louisville, Ky., answers questions on risk management.

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Neutrals can resolve recurring, multiparty suits

Instead of acting as advocates for one side or another, independent panels decide key issues and procedures

By Donald V. Jernberg

Recurring, multiparty litigation presents a significant challenge not only for the American judicial system but also for the economy overall. The transaction costs in such litigation can be staggering and can divert dollars from addressing the root causes of the litigation. Varying reforms are suggested from time to time, often with at least an undercurrent of the acclaimed Shakespearian solution. However, little seems to change. Therefore, when an innovation appears that might make a difference, it is worth noting and analyzing.

Thousands of women with silicone breast implants have brought personal injury lawsuits in various courts across the country. The Honorable Sam C. Pointer of the U.S. District Court for the Northern District of Alabama took a creative approach to expedite the resolution of this extensive breast implant litigation. Under the federal rules governing multidistrict litigation, Judge Pointer was appointed to oversee discovery on common issues of fact (*In re: silicone gel breast implants product liability litigation*). One recurring issue in the cases of many of the women is whether the use of silicone products causes or exacerbates connective tissue disease.

To address this issue, Judge Pointer, with the support and urging of the plaintiffs' steering committee, appointed a neutral scientific panel to render a report on whether systemic illnesses in women are caused by breast implants. The panel recently issued its report, which happened to support the position of the manufacturers. While the report and its authors will be subject to questioning by the lawyers for all parties and the breast implant litigation will continue, there can be no doubt that Judge Pointer's decision to appoint the panel will prove to be a material contribution to expediting the resolution of this mass litigation in a fair and objective manner. Judge Pointer is to be commended.

Judge Pointer's initiative also should be analyzed to see whether there are lessons that might be applied to other types of mass litigation. The obvious point is that, in circumstances where the determination of a defined scientific or factual issue is pivotal to settlement of multiple claims, it may pay dividends for the court to appoint qualified neutrals to provide reports on those subjects. This approach can reduce transaction costs by focusing the debate on a key issue.

However, not all instances of mass litigation involve a defined, single issue where the opinion of neutral experts can serve to expedite the process. The extensive savings and loan litigation of the mid-1980s and early 1990s is an example from the past; the recurring pollution and related insurance coverage litigation is a current example. And, by many accounts, the anticipated flood of Y2K litigation will be a future example of mass litigation that will not revolve around a fairly narrowly defined set of factual issues. Indeed, the challenge in these types of recurring litigation is that, while the factual scenarios are often quite similar, there are differences that are, at least, sufficient to prevent any single determination from having a material influence on the resolution of multiple claims.

Nonetheless, Judge Pointer's innovative step still may have an application in repetitive litigation such as that surrounding the question of insurance coverage for Superfund and other legacy environmental liabilities. To understand the application, it is necessary to view Judge Pointer's action as doing more than employing qualified neutrals to opine on the relative positions of the parties, which is more of a traditional mediation function. Rather, Judge Pointer integrated a qualified, neutral process that addressed a key impediment to the resolution of multiple claims.

Continued on next page

Continued from previous page

Further, the process operated independently of the parties' advocacy in arriving at its neutral observations and conclusions.

A major obstacle to the resolution of breast implant cases was a particular scientific issue. With the extensive litigation that continues over pollution liability and related insurance coverage matters, one material difficulty involves the structure of these cases. Nevertheless, the same principles as followed by Judge Pointer could be employed to facilitate a more-efficient resolution.

The structural hurdles to the efficient resolution of such matters come from the liability scheme established under Superfund and the equivalent state statutes. These laws create joint-and-several liabilities among many parties, spanning decades and encompassing thousands of sites. In turn, each of the potentially liable parties at the thousands of hazardous waste sites is likely to present a claim under the various insurance policies that were in place over the decades during which the party may have had involvement at the different sites. As a result, enormous numbers of old insurance policies become part of the claim resolution process. For example, it is not uncommon for 250 parties to share liability for a hazardous waste site. If each of these parties places three of its prior insurers on notice, the ultimate resolution of the liability at this single site involves 1,000 decisions. This notion is called "fragmentation of liability."

A single corporate policyholder's environmental liabilities may involve 20 sites and claims against 15 insurance companies. The relative share of liability of each insurer and the policyholder likely will vary from site to site. This, too, is a form of fragmentation of liability.

Compounding the problem of fragmentation is the notion of interdependence. Put simply, the ability to make any individual decision resolving liability with respect to a single site or a single policyholder is affected by the decisions made by many other parties. If we visualize Humpty Dumpty being assembled by all the king's lawyers and all the king's experts, we can see the structural impediment to efficiently resolving environmental and related insurance coverage claims. This vision also helps explain why transactional costs have been extraordinarily high with respect to pollution claims. A study done in the early 1990s for the RAND Corp. found that 88 cents out of every dollar spent by insurers on environmental claims went toward transactional costs. A more-recent report by Standard & Poor's Corp. concluded that about 40% of the total dollars spent by insurers was going to litigation costs.

In the breast implant situation, the panel introduced its neutral observations and conclusions into the litigation.

The importance of Judge Pointer's approach stems not only from the use of the neutral process but also from how the process operated. In traditional mediation, the neutral operates as an intermediary between opposing parties. The neutral listens to each party and, through various techniques, tries to narrow the differences in those positions. In the breast implant situation, the panel operated outside the advocacy process and introduced its neutral observations and conclusions into the litigation. The input from the panel is then intended to bring about the resolution of a number of separate, independent claims. This differs from mediation and most common forms of alternative dispute resolution, and it presents an interesting example of how innovative claims resolution processes can be employed in mass litigation.

In the context of pollution claims, Judge Pointer's model would suggest the use of a qualified neutral process to address the difficult issues of fragmentation and interdependence. The process also would operate outside of—as opposed to as an intermediary among—the positions of the opposing parties. The focus would be on advancing the resolution of multiple claims, not simply of one or a limited number. To address fragmentation and interdependency issues, the neutral process would need the ability to effect the simultaneous resolution of multiple subsets of claims revolving around either a single site or a single policyholder.

From breast implant to pollution claims, taming mass litigation will require innovative approaches. The ability to employ neutral processes that operate independently and address basic impediments to the efficient resolution of multiple claims will be an important step in the right direction. Again, Judge Pointer is to be applauded. BI

Donald V. Jernberg practiced as an attorney in the environmental and related insurance area for nearly 20 years. He is now president of EClass Inc. in Chicago, which focuses on providing insurance claims solutions.

Developing human capital is vital, says book

"Delivering on the Promise: How to Attract, Manage, and Retain Human Capital"
By Brian Friedman, James Hatch and David Walker
Published by The Free Press,
1230 Avenue of the Americas,
New York, N.Y. 10020; 800-223-2348
$26

By Kevin M. Quinley

"People are our most important resource. . ." intone the chief executive officer, the annual report and the corporate mission statement hanging in the lobby.

Oh, please! Sensations evoked by such stimuli have many business professionals reaching for the anti-nausea pills. Contrasted to the obligatory corporate mantra is the reality of massive downsizings, rising CEO salaries and declining training budgets. Against this backdrop, it is tempting to view such biz-speak as, at best, a cliche and, at worst, a corporate lie.

According to Arthur Andersen partners Brian Friedman, James Hatch and David Walker, many companies simply don't know how to value their people. Based on their own and their firm's experience helping hundreds of organizations realize the potential of their employees, the consultants' new book, "Delivering on the Promise: How to Attract, Manage and Retain Human Capital," explains how to clarify business strategy; assess existing human capital policies and programs; and how to design, implement and monitor new ones.

Risk managers increasingly are involved in human resource management. Benefits administration, employment practices liability and workers compensation claims all demand that today's risk manager be conversant with the personnel function. Even if the risk manager has little contact with these areas, he or she typically manages a staff, however far-flung or compact. In this capacity, the risk professional is just another manager, grappling with the challenges of achieving results through the efforts of others. For a background perspective on human resource issues, risk managers should consider reading "Delivering on the Promise."

"We recognize that people are an asset that should be valued and developed, not a resource that should be consumed," write Friedman, Hatch and Walker. Moreover, they argue, if companies do not learn how to enhance human capital, they will not achieve business success. That, they write, is especially the case in today's scarce labor market, a market that will only get tighter in the years ahead.

In "Delivering on the Promise," the Andersen troika claims that companies must transcend the notion of human resources as an available supply for companies to draw upon when needed, embracing the notion of human capital as something that gains or loses value depending on how companies invest in it. In other words, companies must treat their people as their most valuable asset in order to attract and retain the employees they need to prosper.

The authors argue that only through a systematic methodology—a step-by-step, conscious, committed approach—can companies successfully manage human capital. In "Delivering on the Promise," they tout Arthur Andersen's approach for human capital enhancement. Risk managers will find within these pages tips on how to:

- Align human capital programs to business strategy.
- Evaluate the current worth of human resources and the efficiency of current human resource programs.
- Assess the return on investment in human resources.
- Minimize the risks inherent in managing human resources.

The book is organized into individual chapters that address what the authors see as the five stages of human capital development: clarification, assessment, design, implementation and monitoring. At each stage, the authors show how companies can evaluate key management issues such as:

- Recruitment, retention and retirement.
- Performance management and rewards.
- Career development, succession planning and training.
- Organizational structure.
- Human capital "enablers"—systems for improving legal compliance, employee and industrial relations, and communications and information flow.

In addition to checklists, questionnaires and red flags that risk managers must watch out for, "Delivering on the Promise" offers success stories from a number of well-known companies that, in the authors' view, have programs that recognize the value of their people.

"Delivering on the Promise" is a top-level treatise that attempts to show risk managers and others how to develop and implement a human capital program by applying one major consulting company's approach. Some readers may object to such a narrow view. Others may view the book as a bit too ethereal, appealing to business school types rather than to front-line operational managers. Despite these quibbles, "Delivering on the Promise" provides risk managers a needed perspective on the human resources function. BI

Kevin M. Quinley is senior vp of risk services for MEDMARC Insurance Co. Inc. and subsidiary Hamilton Resources Corp., both of Fairfax, Va. He holds the Chartered Property & Casualty Underwriter and Associate in Risk Management designations.

Bad faith

Continued from page 3

Ariz., earlier this month.

Insurers' mishandling of their duty to defend policyholders against third-party claims typically generates bad-faith claims, which can arise regardless of the insurers' duty to indemnify policyholders, said policyholder attorney R. Hugh Lumpkin, a partner in Ver Ploeg & Lumpkin P.A. in Miami.

"In a third-party context, the duty to indemnify has little to do with bad faith," he said.

An insurer's duty to defend can exist for years before a court rules on whether the insurer has a duty to indemnify, he said. During that period, he said, insurers are obligated to act with the policyholder's best interests in mind.

"The insurer is not properly defending if it is not properly considering settlement opportunities as they arise at any point prior to a court determining there is no coverage," Mr. Lumpkin said.

Insurer bad faith occurs because of insurers' arrogance, failure to communicate and "downright stupidity," all of which can be traced back to the amount of money involved in the business, he said. Mr. Lumpkin noted that U.S. property/casualty insurers annually collect about $275 billion of premiums, nearly as much as the U.S. government collects in personal income tax every year.

"Money leads to power, and power leads to corrupting influences," he said.

However, insurers can easily avoid bad-faith claims, he said.

One way is for insurers to draw up bilateral agreements with their policyholders. In the agreement, an insurer would pledge to resolve claims—including settling them—and its policyholder would promise to reimburse its insurer if a court later rules that the insurer had no duty to indemnify.

The peril of a court awarding damages that far exceed the amount for which a case could have been settled "should not rest with policyholders but with insurance companies," he asserted.

"Not if there's no coverage," responded insurer attorney Linda B. Foster. She said policyholders also have a "duty of good faith" in handling claims that likely will not be covered.

"If you didn't buy coverage to cover a claim, why should you believe your insurer should pay?" asked Ms. Foster, a partner with Weissman, Nowack, Curry & Wilco P.C. in Atlanta.

She said sophisticated policyholders or wealthy individuals generally are reasonable about handling such settlements.

"The problem is when the policyholder has no money," she said.

She said the biggest problem with bad-faith claims is that "there are always creative lawyers like Hugh thinking of ways to get money out of insurance companies beyond what's provided for in insurance policies." That creates confusing case law, she said.

Fueling her concern is a 1996 South Carolina Supreme Court decision.

The case involved the damage that several cars in an employee parking lot sustained when Tadlock Painting Co. oversprayed the commercial building it was contracted to paint.

Tadlock's insurer, Maryland Casualty Co., reserved its rights to deny coverage. The insurer offered to settle the claims against Tadlock, but it insisted that Tadlock was subject to its deductible for each car it damaged. That meant the contractor would bear the full cost of the claims.

After a court supported the insurer's claims-handling decision, Tadlock decided to resolve the claims itself. But, upset over how long its employees' claims went unresolved, Tadlock's long-time commercial account dropped the contractor. The contractor sued Maryland Casualty for bad faith.

'If you didn't buy coverage to cover a claim, why should you believe your insurer should pay?' asks Linda B. Foster.

On appeal, the South Carolina Supreme Court upheld a $5,000 compensatory award and a $200,000 punitive damages award against Maryland Casualty.

The court stated that not all of the benefits that policyholders should expect from their insurers are expressly stated in their contracts, Ms. Foster said.

Noting that all parties in the case agreed that Maryland Casualty had not breached its contract with Tadlock, she said, "This is the type of case that scares me."

Contract law would provide sufficient policyholder compensation while also guarding against unfair compensation, according to Ms. Foster.

Attorney Michael Sean Quinn, who represents mainly insurers at Sheinfeld, Maley & Kay P.C. in Austin, Texas, agrees.

He said that courts until recently "were blind to the fact" that under contract law, policyholders could recover consequential damages, such as attorneys fees, in addition to compensatory damages.

More courts are recognizing that, which has led to a reduction in bad-faith cases, said Mr. Quinn, a former University of Texas insurance law professor.

Recovering damages for mental anguish under contract law "can be a problem," Mr. Quinn acknowledged. He said the best way to recover for such injuries "is if it slops over into a physical injury."

Even courts in Texas, famous for their colossal jury awards, now will award bad-faith damages only in "extreme" situations, Mr. Quinn said.

To recover a bad-faith award in Texas now, policyholders must show they faced a serious risk of harm and that insurers knew of that risk but ignored it, he said. "That's where (insurer) arrogance comes in."

The biggest indication of the Texas courts' change in attitude in bad-faith cases is that insurers typically will not cave in any longer and settle such claims before they reach trial, said policyholder attorney James C. Plummer, a partner with Plummer & Associates in Houston.

Unlike Ms. Foster, Mr. Quinn did allow that there is a place for punitive damages in resolving claim disputes.

"Punitive damages are, through and through, moral," Mr. Quinn said. "You get them where a party is acting immoral."

Mr. Plummer said the difference between a breach-of-contract and a bad-faith activity is that bad faith involves egregious conduct that causes mental anguish and "should have happened to nobody."

Claims-handling specialist Walter T. Zehnder said insurer claims handlers generally "try to do the right thing." But "they also have the carriers' interest that they have to look at," noted Mr. Zehnder, a partner with Tampa, Fla.-based Wilson Heausler & Zehnder Inc., which specializes in claim services and risk management training and development.

He advised insurers to keep policyholders informed about issues such as reserving rights to deny coverage and to explain their actions in detail.

Mr. Zehnder also cautioned insurers against becoming so overzealous in handling claims that they put their interests ahead of their policyholders'.

A statute, enacted in about 10 states, that tries to split the difference between bad-faith and contract law still is "frightening," because it creates coverage where none exists, Ms. Foster said.

This law precludes punitive damages in claim disputes. But if an insurer fails to defend a policyholder, even when a court subsequently determines the insurer had no duty to indemnify, the insurer loses all of its indemnification defenses.

Despite her objections to the law, Ms. Foster said it is better than the bad-faith law found in most other states, because it prohibits punitive damages. BI

Deals

Continued from page 3

largest was the acquisition of General Re Corp. by Berkshire Hathaway Inc.; it was valued at $21.4 billion. In 1997, 111 property/casualty deals were valued at a total of $30.9 billion.

The 51 mergers and acquisitions that took place among life insurers in 1988 had a total value of $32.5 billion. The number of deals was unchanged from the year before; those transactions were valued an aggregate $12.25 billion.

The number of deals among insurance services companies totaled 138 last year. The total value of those transactions reached $15.9 billion, up sharply from the 86 deals that totaled $3.0 billion in 1997.

Seventy-six mergers and acquisitions were finalized among health and managed care companies, with a total value of $5.3 billion in 1998. That figure represented only one more transaction than the year before; the 75 mergers and acquisitions in 1997 had a total value of $7.3 billion.

Regarding the dip in transaction values among health care companies, the Conning study said that the "lofty prices paid in the mid-1990s are being replaced with more-conservative valuations, a pattern we expect to continue over the next couple of years."

Ms. Carini said merger and acquisition activity should continue strong in 1999, "barring any turn in the economy or market." She did acknowledge, though, that concerns over the Year 2000 computer bug could affect the trend.

Companies that uncover concerns related to the bug may delay or call off transactions, or they may make deals at significantly lower prices than first negotiated to account for potential fixes and problems, Ms. Carini said.

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Copies of the Conning & Co. study are available for $575 by calling 860-520-1521, or they can be purchased through the company's World Wide Web site, www.conning.com.

Brokers

Continued from page 3

Brokers maintain an independent relationship, while debt capital also better serves Fireman's Fund's liquidity and accounting needs, he said.

Mr. Marsh said transactions "must be recommended and supported by its underwriters." Funds also should be used to support the additional production of business, rather than for purposes such as paying off debt, he said.

Fireman's Fund tries to keep the period of the debt transaction within seven years, he said. It is important as well that there be a good financial plan to structure these transactions, said Mr. Marsh.

Each transaction is different, he said. "We continue to be open-minded as long as it supports our goal of profitable growth."

Chicago-based CNA Financial Corp. is dedicated to the preservation and support of the independent broker-agency system, said William H. Sharkey Jr., CNA senior vp and chief marketing officer. He discussed how the insurer offers permanent sources of capital to independent agencies through syndicated transactions, which are those involving investment by more than one insurer.

CNA is open to proposals, said Mr. Sharkey. "The key is the potential success of the business plan and its link to the need for more permanent financing," he said.

Such deals are difficult, he said. "Certainly an independent distributor doesn't want to have a single majority shareholder that's an underwriter," because it can undermine the marketplace's perception of its objectivity.

But at the same time, having additional underwriter investors also adds significant complexity, "both from the underwriter's side and the distributor's side," said Mr. Sharkey.

In these deals, it is important that the brokerage's or agency's management retain a significant amount of personal wealth that is tied up for the long term in the business, he said. "That's because we have no idea how to run an agency. . .we need to make sure that the agency is run by people who know distribution."

Antitrust issues can complicate negotiations, said Mr. Sharkey. Negotiations also must be mediated by attorneys, he said. "It's a very complex set of negotiations," said Mr. Sharkey.

"The stars really have to be aligned," he said. The objectives of the distributor as well as the individual investors must come together, and this can rarely be accomplished in a way in which all the parties "can really get comfortable."

Richard W. Wratten, president-commercial insurance services for CIGNA Property & Casualty, discussed why the insurer prefers equity financing. Purchase is the "easiest and the cleanest" approach, said Mr. Wratten, who will continue in his present role after completion of the sale of the operation to ACE Ltd.

"We work together to make sure it works for both parties," said Mr. Wratten. Mr. Wratten said he arranges for exit agreements, so if there is a change in ownership, "You're not stuck with somebody you don't want to be a partner with."

These deals bring value to CIGNA shareholders "because we're building value with that money we've invested, and even though we might not capture it today, we have an appreciated value," said Mr. Wratten.

He added that the money's purpose is not to help undo agency mismanagement "or to bail them out of something else," but to help them buy another agency, get into in a joint venture, or to perhaps add staff or systems. BI

INTERNATIONAL

Global Briefs

The **General Insurance Standards Council**, the new self-regulating agency for property/casualty insurance in Britain, has appointed Chris Woodburn as chief executive, effective April 6. Mr. Woodburn is currently chief executive of another self-regulating agency, the Securities and Futures Authority Ltd. . . .One dozen, or less than 8%, of Britain's financial services companies facing a high impact on retail customers from the Y2K problem are in serious danger of **not achieving Year 2000 compliance**, according to a study by the Financial Services Authority. The study found about 58% of financial services companies are on track for compliance, while 35% are behind but likely to get on track. . . .**Liberty Syndicate Management Ltd.** reports that Lloyd's of London syndicates 190 and 282, which it manages, made a profit for the 1996 year of account. Syndicate 190, which writes property and professional indemnity coverage, achieved a 9.5% return on capacity of £40 million ($66.4 million), while syndicate 282, which underwrites marine excess-of-loss, liability and space risks, had a return of 19.5% on capacity of £25 million ($41.5 million). . . .**Stockton Reinsurance Ltd.** of Bermuda has completed its acquisition of Crowe Insurance Group Ltd. Crowe, which manages six Lloyd's syndicates and has two Lloyd's corporate vehicles, Crowe Dedicated Ltd. and Crowe Corporate Capital Ltd., will continue to operate under its own name and current manage-ment. . . .**Brockbank Syndicate Management Ltd.** in conjunction with **Aon Group Ltd.** has initiated the first reinsurance recovery using the computer-based World Insurance Network. Brockbank said the transaction took four minutes, rather than the usual seven days, and the managing agency plans to request future reinsurance recoveries be done electronically. . . .Hans Eichel will take over the post of **German finance minister** April 4 following the abrupt resignation this month of Oskar Lafontaine. Mr. Eichel is the outgoing premier of the state government of Hesse, Germany. . . .**Copenhagen Reinsurance Co. Ltd.** has taken on three underwriters in London who formerly were with Liberty Re in London. Paul Brown has joined as a property treaty underwriter, Andrea Newman as a motor and liability treaty underwriter, and Phil Sloan as a pro-rata treaty underwriter. . . .**Aon Consulting** in London has made two appointments. Karen Butroid, formerly with Sedgwick Noble Lowndes, joins as an actuary and consultant. Samantha Dixon, who has joined as a consultant, was formerly with Abbey National Benefit Consultants. . . .French insurer **AXA Group** reported a 16.5% rise in 1998 income before taxes and minority interests to 24.5 billion francs ($4.41 billion). Profit increases in life and reinsurance offset a 12.5% fall in property/casualty profits, which fell to 2.1 billion francs ($378.4 million). Revenues rose 2% to 371.91 billion francs ($67.02 billion). . . .**Winterthur Swiss Insurance Co.** reported that its aftertax net income rose 32% in 1998 to 892 million Swiss francs ($653.2 million). Winterthur's results were aided by the sales of its reinsurance business and its stake in Australian insurer HIH.Gross premiums grew 14% to 28.6 billion Swiss francs ($20.94 billion), mainly from life operations. . . .American International Group Inc. has set up a joint venture company in the Republic of Azerbaijan with Nurgun Group, an Azerbaijani trading and financial services conglomerate. The joint venture company, **AIG Caspian Insurance Co.**, will write personal and commercial property/casualty business and provide reinsurance to the local market.

No insurance regulatory change seen in wake of E.C. resignations

By EDWIN UNSWORTH

BRUSSELS, Belgium—The decision by all 20 European Commission executives to resign following a damning report into corruption and mismanagement within their ranks is unlikely to have any effect on insurance regulation within the 15-member European Union.

Among those who resigned is Mario Monti, who, as head of financial services within the EU, had responsibility for insurance regulation. However, like the other commissioners who quit, Mr. Monti will remain in office until his replacement is found.

Although not singled out individually for criticism in the "Report on Allegations Regarding Fraud, Mismanagement and Nepotism in the European Commission," Mr. Monti was part of the mass resignation of the 20-member executive committee late March 15. They had little choice but to step down after members of EU political parties, led by the dominant Socialists, had threatened to try to censure them if they did not resign. Although some committee members were not criticized individually, the EC was criticized collectively for its failings and faced mass censure.

A European Commission spokeswoman in London said that despite Mr. Monti's resignation and no appointment yet of a successor, "the day-to-day running of the (entire) Commission will carry on as normal." The only possible short-term effect for insurance regulation—as for all other areas of governance—is that no new decisions are likely to be made until new executives are appointed.

See **E.C.** *on page 19*

PHOTO: AFP

The entire executive committee of the European Commission, including Chairman Jacques Santer, resigned March 15 after the release of a critical report.

Major insured natural disasters 1998

Losses in millions of dollars

Dates	Event	Location	Insured losses	Economic losses
Sept. 20-30	Hurricane Georges	Caribbean	$3,300	$10,000
May 15-16	Hailstorm, severe storm	U.S.	1,345	1,800
Jan. 5-10	Ice storm	Canada, U.S.	1,150	2,500
May-Sept.	Flooding	China	1,000	30,000
June 9-11	Tropical cyclone	India	400	1,700
Oct. 30-Nov. 11	Hurricane Mitch	Central America	150	7,000

Source: Munich Reinsurance Co.

Cats growing in cost, number

By DON LEWIS KIRK

MUNICH, Germany—Extreme weather patterns continue to take a heavy toll worldwide, according to a study by Munich Reinsurance Co. released earlier this month.

Munich Re's analysis of natural catastrophes shows that catastrophic events of the 1990s not only are more frequent but the economic and insured losses are much greater than those of the 1960s.

The current decade has had nearly three times the number of catastrophes as occurred in the 1960s. Total insured losses for the 1990s are 15 times the total for the 1960s, according to Munich Re.

The dramatic rise in economic and insured losses is due largely to both global warming and higher concentrations of people and property in disaster-prone areas, said Gerhard Berz, Munich Re's chief meteorologist and head of its Geoscience Research Group. Mr. Berz was one of the authors of the study.

"We see an indication of an increase in extreme weather

See **Disasters** *on page 19*

New Cap Re seeks trading suspension

By SARAH GODDARD

HAMILTON, Bermuda—New Cap Reinsurance Holdings Ltd. last week requested its shares be suspended on the Australian Stock Exchange because its actuaries and auditors need more time to complete the reinsurer's annual accounts.

New Cap Re was due to file its final figures by March 16, but a severe deterioration in its loss exposures and late claims meant the company was unable to meet the deadline. The reinsurer expects to file at least one week after the due date.

The company requested the Australian Stock Exchange suspend trading in its shares at the beginning of last week. At the time, however, company management said it was confident trading would be resumed when the final figures for 1998 are released some time this week, even though those figures are expected to be "materially worse" than the $90 million previously estimated.

The delay in issuing the audited results for last year is due to late claims reporting, plus an "extensive claims review. . .to ensure reserves are adequate in the light of the company's recent adverse claims experience," the company said in a statement.

Only last month, New Cap Re warned it was facing losses in the region of $90 million following a run of catastrophes last year. It suspended underwriting toward the end of February, when its reserves fell below the statutory minimum of $100 million.

Now the reinsurer expects the losses to be "materially worse" than its recent calculation, which itself was more than double its earlier estimate of $41.5 million.

New Cap Re is a Bermuda holding company with operating subsidiaries in Australia and Bermuda. It was set up in late 1996 with $200 million in capital and was listed on the Australian Stock Exchange in December 1996.

Last year, New Cap Re reported aftertax losses of $3.1 million Australian ($2 million) for 1997.

At the time, Chairman Udayan Daniel Ghose said in a statement: "The loss was largely driven by some large claims that were reported late in the fourth quarter 1997 and early

See **New Cap** *on next page*

European Y2K risk not yet managed

AIRMIC issuing guidelines to help address exposure, backup plans

By CAROLYN ALDRED

LONDON—With just 10 months to go before the dawn of the next millennium, European risk managers still face uncertainty over their exposure to the problem and what insurance protection is available.

Lack of disclosure on Y2K compliance by suppliers makes it difficult for many companies to accurately assess their corporate risk, and there is still "a lot of confusion among risk managers as to what insurers are doing about Y2K coverage," said Derek Brighton, head of insurance and risk for the London-based publisher Reed Elsevier P.L.C.

As head of the Y2K working group of the U.K. Assn. of Insurance & Risk Managers, Mr. Brighton stresses the vital role of the risk manager in managing the exposure as the next millennium approaches.

"It is not an (information technology) risk; it is a business risk. The risk manager should certainly

be there as a facilitator and a catalyst in making sure there is a contingency plan and that it will work," said Mr. Brighton.

AIRMIC is preparing guidelines that risk managers can use to identify the risks and prepare contingency plans. The organization also has been active in alerting its members to the potential problem, he said.

However, "one of the problems everyone will face is that information of others' compliance is not readily available," said Mr. Brighton, noting that "many organizations are hesitant to be open about their preparations because of potential litigation."

Lack of disclosure by suppliers makes it difficult for companies to come up with a comprehensive view of their exposure to the millennium bug, he said. Governments across Europe have tried to remedy the situation by pushing companies to be more open about their Y2K problems (see related story).

Meanwhile, risk managers' Year 2000 headaches are compounded by a lack of uniformity in the insurance market over the issue, Mr.

See **Year 2000** *on page 19*

New Cap

Continued from page 17

this year. The company has taken significant steps to ensure such outsized losses will not occur in the future, including exiting certain classes of business, substantially boosting underwriting controls and purchasing additional retrocessional protections to reduce 'frequency' types of losses."

Despite Mr. Ghose's statement, the major deterioration in 1998 figures has taken place over recent weeks, culminating in last week's trading suspension.

But the factors leading up to this point have been building up since the end of the last year's third quarter. In October, the reinsurer announced that it was facing net exposures to Hurricane Georges and the Swissair Flight 111 loss of just under $10 million for each event; it stated those amounts were "within the net event limits targeted by the company."

Less than two weeks later, New Cap Re announced a capital-raising rights issue, "to enhance the capital base of the company to take advantage of business opportunities available to it during the forthcoming January 1999 reinsurance renewal season by being able to select from a broader and better-quality pool of business."

At the same time, funds raised would be used to lower the company's borrowings, said a company statement. The $80 million Australian ($50.3 million) 7-10 stock split, in which the company issued seven new shares for each 10 shares, and a placement of converting notes closed at the end of December. However, only 87% of the issue was subscribed in the market.

When the share offering was announced, New Cap Re also released estimates on its catastrophe exposures, as calculated by Australian actuary Trowbridge Consulting. The estimates showed likely net losses for Swissair and Hurricane Georges reaching about $14.8 million in total. At the time, New Cap Re said the estimated $6.5 million loss from Georges would be set against net earned property premiums of $25 million, while the net loss on aviation business due to the Swissair disaster would be $7 million. It also anticipated a net loss of $2 million for the losses of Galaxy X and 12 Globalstar Communications Ltd. communication satellites in 1998.

In addition, Trowbridge calculated reserves needed at the end of June 1998 to be $139.6 million. At that point, New Cap Re had reserves of $141.1 million.

Before the rights issue had closed, New Cap Re had published a statement on its claims position after what it described as "an unusually high incidence of major claim events" in the second half of the year. In less than two months, the net loss for Swissair and Hurricane Georges had topped $18 million, and it was notified of other claims relating to Hurricane Mitch and December's Thai Airlines crash.

By the end of last month, claims led the company to announce it expected an operating loss of $90 million for the year. New Cap Re blamed continuing claims deterioration on 1997 business as well as the onslaught of catastrophes in 1998. In addition, the company had increased its reserves and commuted liabilities for some of its "worst-performing contracts."

New Cap Re also changed its underwriting criteria for this year, taking a "considerably more cautious approach to the 1999 renewal season," it said in a statement.

Less than a week later, the company suspended underwriting in its Bermuda subsidiary, New Cap Reinsurance Corp. (Bermuda) Ltd., because its capital and surplus were set to fall below the statutory $100 million minimum.

Duff & Phelps Credit Rating Co. reacted by lowering its claims-paying ability rating of both subsidiaries to B from BBB+, with an "uncertain" ratings watch. Also, two directors of New Cap Re and the Bermuda subsidiary, Craig Deery and Jonathan Beach, have resigned from both the company and subsidiary in the past three weeks. BI

Bill may limit investment in India

BOMBAY, India—Legislators considering a bill that would deregulate India's insurance market have recommended reducing the level of foreign investment that would be permitted.

A parliamentary standing committee assessing the Insurance Regulatory Authority Bill, introduced in 1998, recommended in a report earlier this month that foreign investors hold only 26% of Indian insurance companies, as opposed to the 40% proposed in the bill.

India's Union Cabinet last week approved the 26% limit on foreign ownership. It rejected, however, the recommendation that initial capital investment be set at more than $47 million.

The Insurance Regulatory Authority Bill would allow for the deregulation of India's currently nationalized sector and would permit limited foreign participation and investment.

Under the bill, foreign companies' equity in Indian insurance companies would be limited to 26%, but an additional 14% stake could be held by non-resident Indians (individuals), foreign institutional investors (fund or asset management companies based outside India) and overseas corporate bodies (overseas companies at least 60% owned by non-resident Indians or persons of Indian origin.) In essence, the original bill would permit foreign interests to hold up to 40% of an Indian insurer. However, the committee studying the bill rejected allowing the additional 14% stake.

The Insurance Regulatory Authority Bill was expected to be reintroduced in Parliament last week, but that move was delayed until the next session, set for mid-April. A government official who spoke on condition of anonymity said passage is likely.

The investment cap is not "an issue for Indian investors. The innate fear (for the government is) of money going out of India," the official said.

Mark Mileusnic, vp and India country manager for Chubb Corp. in New Delhi, which has an Indian venture with large finance company Kotak Mahindra Finance Ltd., said it is too soon to determine how the legislation would alter foreign companies' investment strategies.

"Those with long-term interests in India view the equity position as an important factor, but just one. Until the bill is passed, and all points are clarified, there is little point in guessing what impact any one factor would have," he said.

A 26% equity stake "would allow an investor to block any changes to the articles of incorporation of the new entity—an important consideration for an investor, actually having some control over what he has invested in. So in the larger scheme of things, a 26% starting position is solid point of entry," Mr. Mileusnic said.

—By Kaumudi Marathe

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★ *Source Business/Occupational breakdown of qualified circulation, May 25, 1998 Issue, as submitted to BPA for June 1998 BPA Publisher's Statement*

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E.U. governments readying for Y2K

Companies facing pressure to comply

By CAROLYN ALDRED

As Jan. 1, 2000, approaches, European governments are increasing efforts to identify risks and stepping up the pressure on companies to demonstrate they are fully prepared to face the millennium.

Action 2000, the U.K. government agency set up to tackle the so-called millennium bug, recently announced that the United Kingdom's water, gas, electricity, oil, telecommunication and financial services industries have their preparations well under way.

A color code—from red to amber to blue—was introduced last month to measure companies' preparedness.

The six key industries, which are all part of the National Infrastructure Forum, a gathering of representatives of the essential services, now are all in the amber category.

'There is a shortage of information about what smaller firms are actually doing' about the Y2K problem, says David Eves.

"This means that, although risks remain, robust plans are in place to manage them," said Don Cruickshank, chairman of Action 2000, in a statement.

"By April, when the NIF next meets, I expect reports to show much more blue," indicating no risk of disruption, he added.

Reports on the readiness of lower-tier essential services, including health care, emergency and postal services, food production and distribution, and transportation of people and goods will follow, according to Action 2000.

A similar survey of vital services is being undertaken by the German government, confirmed Alexander Quack-Grobecker, who is on the panel of experts advising the German government's group that is studying the problem.

Mr. Quack-Grobecker, a casualty director for General & Cologne Reinsurance Co. in Cologne, Germany, noted that gas and water supplies and transportation, including the airlines and airports, are believed to be safe. With a general oversupply of electricity and a very flexible distribution network in Europe, there should be an adequate electricity supply even if some power stations default.

Meanwhile, the United Kingdom's Health and Safety Executive, the government agency responsible for workplace safety, is beginning a major campaign to make sure that all employers assess the safety risks of the millennium bug.

Starting this month, the HSE and local authority inspectors will visit companies to help them address their problems and, if necessary, to take legal action against employers that fail to make the grade.

"Where there is a potential risk to health and safety, employers had better be able to demonstrate readiness to identify and deal with the potential consequences of the Year 2000 problem, or inspectors will demonstrate their readiness to take legal action," said David Eves, the HSE's deputy director general in a statement.

"What inspectors will look for is evidence that employers' health and safety risk assessments have been extended to cover risks from any effect of the Year 2000 problem," he said, adding that, if inspectors "find inadequacies, either in the way firms have identified potential safety-related failures in programmable electronic equipment or in the steps they are taking to deal with them, they will act."

In particular, the HSE will be targeting small and medium-sized companies.

"We expect all organizations, large and small, will be working on this program. Reports from our own inspection activities and from elsewhere in the government network tell us quite a lot about programs of checking and remedial work being carried out by larger firms in the U.K., especially in the more hazardous industries. This gives us confidence that, for the most part, those firms are taking the right approach to the issue," said Mr. Eves.

"But while there has been much raising of awareness about the Year 2000 problem," Mr. Eves said, "there is a shortage of information about what smaller firms are actually doing. They figure large in the economy and are important as suppliers to the larger firms." BI

Year 2000

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Brighton said.

There is little consistency among insurers across Europe in their response to coverage of the Y2K problem, agreed Alexander Quack-Grobecker, a casualty director for General & Cologne Reinsurance Co. in Cologne, Germany. Mr. Quack-Grobecker is one of several experts advising a German government panel on the problem.

German insurers approached the issue "far too late to cope with the problem," he said.

The prevailing coverage of industrial property business in Germany is on a named-peril basis. Therefore, insurers are exposed only to severe secondary losses created by a Year 2000-related problem, such as fire and explosion, which the insurance industry obviously is prepared to cover, he said. German insurers have looked with more scrutiny at all-risk policies and policies for large or high-risk companies and have introduced exclusions in some cases, Mr. Quack-Grobecker explained.

For casualty insurance lines, Y2K exclusions have been included in directors and officers coverage and professional liability and errors and omissions policies, particularly for computer-related industries.

In Germany, most professional liability business still is written on an act-committed basis, so "policyholders are keeping their old policies in their cupboards, and I think insurers have a lot of exposures sleeping in their books," said Mr. Quack-Grobecker.

French insurers, meanwhile, generally are taking a different position.

Although they have drafted Y2K exclusions, French underwriters are using them only in professional indemnity coverage and, occasionally, in directors & officers insurance, he said. French insurers are rarely using Y2K exclusions in general and product liability or property coverage, according to Mr. Quack-Grobecker.

"There's a widespread belief among French underwriters that the argument of foreseeability and lack of fortunity will be a strong defense against all kinds of Y2K-related claims, even if they are not specifically excluded," he explained.

"It's a very risky position, because if the courts rule that a specific incident was not foreseeable," it could cost French insurers a lot of money, he said.

In the United Kingdom, the Assn. of British Insurers in 1997 developed a recommended millennium exclusion clause for material damage and business interruption risks. According to the ABI's recommendations, direct and indirect accidental damage caused by Y2K failure would be excluded, but fire and other defined secondary perils would be covered, provided that the policyholder had taken reasonable action to deal with the underlying Y2K problem.

The millennium bug problem has been 'a marvelous exercise for everyone,' says BIIBA's Peter Staddon.

"The test of reasonableness will vary from case to case but is likely to include the implementation, in sufficient time, of an adequate Year 2000 compliance plan which has the support of the insured's senior management," according to a bulletin prepared by the British Insurance & Investment Brokers' Assn.

However, many U.K. insurers have not adopted the exclusion, and others have adopted wordings different from that recommended by the ABI due to differing legal advice, said Peter Staddon, technical service manager for the BIIBA.

"There is no clear, consistent message being delivered by insurers. There is a need for consistent international messages, as Year 2000 is a global issue," Mr. Staddon stated in a recent bulletin sent to BIIBA members.

As a result, European brokers and policyholders are faced with a wide variety of approaches, ranging from blanket exclusions to partial exclusions to no exclusions at all.

According to the BIIBA, many insurers are including blanket exclusions for engineering risks, legal expenses coverage, product and public liability, and professional indemnity coverage. In addition, many are applying partial exclusions to business interruption risks, contractors risks, directors and officers liability, and motor and theft risks. No exclusion has been applied to employers liability, according to the BIIBA.

A spokesman from the ABI pointed out that it was up to each insurance company to decide on its own policy.

Meanwhile, the BIIBA's Mr. Staddon noted that the Year 2000 problem has been an excellent means of focusing minds on risk management.

"It's been a marvelous exercise for everyone. It's showed companies their vulnerabilities and made them devise disaster scenarios," he said.

"It's going to be an interesting period, and there will be some interesting cases, but I don't think many problems will be insurmountable, and most companies will make contingency arrangements," he said.

But Mr. Staddon's optimistic outlook is not shared by all in the industry.

In a memorandum prepared last year for the U.K. government's Year 2000 committee, the ABI warned that the problem "is very difficult to quantify but, under some scenarios, the cost could be so vast it could threaten the capital base of the U.K. insurance industry if widespread cover was provided." BI

E.C.

Continued from page 17

The spokeswoman said a clearer view on the appointment of successors should emerge from a meeting of heads of government set to take place in Berlin this week. Even before the resignations, part of the meeting's agenda was the routine replacement of commissioners in January 2000.

Last week's report on European Commission operations was prepared by five independent experts who were appointed over six weeks ago by the European Parliament after the Commission survived a censure vote in the parliament.

The report criticized several commissioners, including E.C. President Jacques Santer. While it found no proof of commissioners having been personally involved in or having gained from any fraudulent activities, it did find "instances where commissioners, or the Commission as a whole, bear responsibility for instances of fraud, irregularities or mismanagement in their services or areas of special responsibility."

Despite the fact that their renominations may not be endorsed, a number of commissioners not criticized individually are expected to be reappointed to office. If a European Union country contends that its appointed commissioners are qualified, that country is free to renominate them to office.

Britain already has said it will press for the reappointment of its two commissioners, trade commissioner Sir Leon Brittan and transport Commissioner Neil Kinnock, who were not singled out for criticism in the report. BI

Disasters

Continued from page 17

events with growing damage," he said. "A deterioration of natural environmental conditions is accelerating the process."

To better assess risks, Munich Re has developed a new model for tracking accumulation losses—multiple losses caused by a single event—from flooding in Germany.

"Flood risk is influenced more by local aspects such as soil conditions and topography, the exact elevation and the effectiveness of flood prevention measures," said Mr. Berz. Flood risk thus is a good candidate for modeling, because many of its causal factors are known.

Consequently, Munich Re began accumulation analysis and what-if calculations of insurers' liabilities similar to those developed for earthquake and windstorms. In cooperation with two Munich-based universities, the reinsurer developed a model that links geographical information with data about weather, topography and the capacity of rivers.

Munich Re said the frequency of flooding in Germany was one incentive for the model. "On account of the usually large masses of snow in the Alps, the probability of major floods on the Rhine and Danube is higher than usual," said Mr. Berz.

"Snow melt alone does not lead to extreme floods, however," he explained. Those are caused by additional heavy rainfall in already soaked flood plains, or catchment areas, he said. Munich Re estimates 30 billion cubic meters (39 billion cubic yards) of snow have fallen this winter in the Rhine catchment area, which equals about 3 billion cubic meters (3.9 billion cubic yards) of water.

According to the study, Germany has had 459 natural-hazard events since 1970. Windstorms predominated, making up 65% of the total, followed by floods and other extreme weather events, such as hail. Most economic losses came from windstorm damage, amounting to 27 billion deutsche marks ($15.10 billion), of which 9 billion deutsche marks ($5.03 billion) was insured.

Worldwide, particularly severe catastrophes occurred last year, according to Munich Re. Economic losses totaled $93 billion, of which $15 billion was insured. The only year with higher economic losses was 1995—the year of the earthquake in Kobe, Japan—which totaled $180 billion.

According to mean global temperatures, 1998 was the warmest on record. Mr. Berz said in the study, "The manmade greenhouse effect may, on the basis of present estimates, produce a rise in temperature of several degrees within the next hundred years," leading to an increase in the number of extreme weather events.

Last year, Munich Re recorded 707 events worldwide, whereas the "normal" range is between 530 and 600 events per year. In 1998, Canada and parts of the Northeastern United States were hit by ice storms. The storms caused Canada's most expensive insured catastrophe, costing insurers there $950 million. U.S. insured losses totaled $200 million.

Munich Re blamed El Nino, the periodic warming of the equatorial eastern Pacific, for economic catastrophe losses of nearly $14 billion and insured losses of about $2 billion last year. Related weather effects included heavy precipitation in regions of Africa, Asia, Australia, Central and South America, and New Zealand. El Nino also caused dry weather and cyclone activity in the eastern Pacific.

Other effects that came from El Nino were strong hurricanes in the Caribbean and the United States, including hurricanes Georges and Mitch. Munich Re expects another "particularly stormy hurricane season" if the effects related to El Nino and La Nina, a cooling effect following El Nino, persist.

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Munich Re published a new version last year of its "World Map of Natural Hazards," which is available in English, French, German, Italian and Spanish. A CD-ROM version is expected to be available at the end of 1999. For information, contact Munich Re by fax at 49-89-3891-5696.

FTR FOR THE RECORD

Panel upholds verdict for plaintiff

NEW YORK—Even if a manufacturer designs a product that is reasonably safe to begin with, it can still be considered negligent if it does not warn of the danger that could result from its modification, says a federal appellate court in a decision involving a meat grinder that had its safety guard removed.

Luis Liriano, a 17-year-old supermarket worker, was severely injured in 1993 when his hand was caught in the meat grinder, which bore no warning that it should not be operated without its safety guard attached.

After consulting with the New York Court of Appeals on the legal issue involved, a three-judge panel of the federal appellate court in New York upheld a jury verdict in *Liriano vs. Hobart Corp.* that found Troy, Ohio-based Hobart was partially liable for the accident despite the apparent obviousness of the danger involved. "One who grinds meat. . .can benefit not only from being told that his activity is dangerous but from being told of a safer way," says the decision.

The decision "has national significance in product liability law," said Mr. Liriano's attorney, Jeffrey Lichtman of Trolman, Glaser & Lichtman in New York.

However, Aaron D. Twerski, a professor at Brooklyn Law School who submitted an amicus brief in Hobart's support, said he does not expect the decision to be influential. "I do not think it will catch on," he said.

A decision has not been made as to whether to seek a rehearing before the full appellate court. If the appellate panel's decision stands, Hobart is liable for about $46,000.

Second-injury fund close to repeal

PIERRE, S.D.—South Dakota Gov. William J. Janklow is expected soon to sign a bill he helped propose that would repeal the state's second-injury fund.

Under S.B. 49, companies are required to file notice of any remaining claims against the fund by June 30 and complete claim filing by Oct. 1, said Darla Lyon, director of the South Dakota Insurance Department.

A second-injury fund originally was designed to pay a portion of the workers compensation benefits due when a worker with a pre-existing injury sustains a subsequent job-related injury.

"Second-injury funds no longer achieve their original purpose of promoting employment of individuals with disabilities or equitably spreading the costs of previous injuries," said Paul Blume Jr., vp-Midwest region for the American Insurance Assn.

Newer federal laws, including the Americans with Disabilities Act, and other state laws now prevent employers from discriminating against workers, as long as they can perform job-related duties, Ms. Lyon said. In addition, repealing the fund will stem the growing trend toward higher assessments on insurers and self-insurers in the state, she said.

About 12 states and the District of Columbia have eliminated such funds in recent years, and several states are currently considering similar legislation to do so, according to the AIA.

Three brokers leave J&H M&M

MILWAUKEE—Three brokers from the Milwaukee office of J&H Marsh & McLennan have left to start up a new office for The Hays Group.

Daniel Sapiro, a former vp and middle-market services manager for J&H Marsh & McLennan, is now president of The Hays Group of Wisconsin in Milwaukee. Daniel Kwiecinski, a former vp and bond department manager; and Wendy Miller, a former vp and property department manager, now are senior vps at the new office.

The Hays Group was founded in 1994 by Jim Hays, who previously was chairman of Rollins Hudig Hall of Minneapolis. The Hays Group is headquartered in Minneapolis and has offices in Chicago and New York.

"We weren't unhappy at Marsh, but we felt that we could better serve our clients working for an alternative broker," said Mr. Sapiro.

Gallagher buys two agencies

ITASCA, Ill.—Arthur J. Gallagher & Co. has acquired Goodman Insurance Agency Inc. of Laguna Niguel, Calif., and Dallas-based Dodson-Bateman & Co. Terms of the transactions were not disclosed.

Goodman is a retail property/casualty agency operating primarily in Southern California, specializing in all lines of coverage for artisan contractors and hospitals.

Steve Goodman, area president of Goodman Insurance and affiliated managing general agency ARM, and Goodman's employees will operate from their present location under the direction of James McFarlane, Gallagher's southwestern regional manager. Linda Abell, area vp of ARM, and ARM's employees will continue working in Canoga Park, Calif., as part of Gallagher's Risk Placement Services Inc. wholesale brokerage operation.

Regional retail insurance agency Dodson-Bateman specializes in property/casualty insurance and surety bonding for the commercial construction industry.

Derrell Dodson, area president, and his employees will operate from their present location under the direction of James Agnew, Gallagher's south central regional manager.

Anderson Kill to trim staff

Law firm Anderson Kill & Olick P.C. plans to cut its current staff by about 22 attorneys and 25 support personnel, a majority of whom handle policyholder insurance coverage litigation, according to a company statement. Increased competition and a drop in large cases made the cuts necessary, a company spokesman said. Anderson Kill, which was founded in 1969, still considers its main business to be representing policyholders in insurance coverage matters, the spokesman said, despite the fact that more than half of the firm's revenues come from business other than insurance coverage litigation.

Texas Blues buying HMO

AUSTIN, Texas—Blue Cross & Blue Shield of Texas is one step closer to expanding its operations through its parent's acquisition of Harris Methodist Health Plan.

The Texas Attorney General's office has said it was satisfied in its investigation that the sale of the Arlington, Texas-based health maintenance organization did not violate laws governing charitable trusts. Harris' parent, Texas Health Resources, is a nonprofit organization. The Texas Blues plan is owned by BC/BS of Illinois.

The deal, which still must be approved by both companies' boards and the Texas Department of Insurance, would add Harris' 300,000 HMO members to Blue Cross & Blue Shield of Texas' more than 2 million members.

Harris Methodist Health Plan recorded 1998 losses of $49.6 million.

Information in brief

Two top insurance regulator posts were filled through recent gubernatorial appointments. **Terry Vaughan** was reappointed in Iowa, and **Lee Covington**, a current deputy commissioner with the Arkansas Insurance Department, was appointed in Ohio. . . .The **Pension Benefit Guaranty Corp.** last week released an updated model notice that employers can use to inform participants about the funding level of their pension plans. A 1994 law requires employers whose plans are less than 90% funded to distribute such notices to participants. BI

Benchmarking program applauded

By MEG FLETCHER

CAMBRIDGE, Mass.—A new program for multistate benchmarking of workers compensation claims data is expected to generate excitement among researchers.

"This information has never been available before," said Ann Clayton, deputy director of the Workers Compensation Research Institute in Cambridge, Mass., during the institute's annual issues conference earlier this month.

The new program is centered on a database that the WCRI says will provide meaningful comparisons of workers comp information across states, across data sources and across time. The Detailed Benchmark/Evaluation database now contains data from eight states on about 4.5 million claims with injury dates from 1994 to 1997. The WCRI plans to expand the database to include 20 million claims from up to 25 of the largest states, which would represent 80% of all workers comp benefits paid nationally.

"The program is called CompScope because it provides stakeholders with the opportunity to put their system under a performance microscope and compare their outcomes to those of other participating states," the WCRI said in a statement.

To participate, a group of workers compensation stakeholders from a specific state joins the research program by agreeing to fund its participation in the project and help supply the necessary data. A state's participants typically include representatives of government, business, labor and service providers.

The WCRI collects the state-specific data and incorporates it into the database. Researchers then use that data to produce reports that allow states to look at how their workers comp system is functioning on a key number of indicators, including the timeliness of claim reports, cost of medical and indemnity claims, and expenses for defense fees and medical cost containment.

A state's estimated cost to participate ranges from roughly $150,000 for only a multistate report, to up to $250,000 for both a multistate and detailed individual state report.

Each state also must establish an advisory committee to help finalize the report and make it responsive to constituent groups and policymakers, according to the WCRI.

The CompScope program's overall public policy goals are "to build tools that will assist policymakers and state constituents in monitoring the major outcomes of systems," the WCRI said. That will allow them to focus their limited resources on those issues that will provide better outcomes for workers and mitigate the traditional cycles of "crisis-reform-crisis," it said.

CompScope already has received the support and endorsement of workers comp stakeholders in California, Massachusetts, Minnesota and Pennsylvania. WCRI intends to do both a multistate and detailed state reports on all of those states.

The first detailed state report, which will focus on Pennsylvania, is expected in June. The first multistate report will be available in the first quarter of next year, Ms. Clayton said.

Several other states are also considering participating, the WCRI says.

For more information, contact Ron Stone, director of resource development, at 617-661-9274, ext. 282. BI

Meeting attracts over 200

CAMBRIDGE, Mass.—About 220 people gathered at the Workers Compensation Research Institute's annual issues conference March 3 and 4 in Cambridge, Mass.

The assembled group heard researchers and panelists, including employer and labor representatives, discuss current issues in the workers comp marketplace.

The WCRI describes itself as a non-profit research group that analyzes issues but does not take positions on them. Its work is funded through contributions primarily from insurers, employers and individual workers comp administrative agencies in the United States and the United Kingdom.

Details about the WCRI's next annual issues conference are not yet available. For information about the organization, contact the WCRI at 955 Massachusetts Ave., Cambridge, Mass. 02139; 617-616-9274.

WCRI

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injuries, she said.

In addition, workers may feel more needy because of larger societal trends such as the lack of health care benefits and an aging workforce, Ms. Grob said.

Such factors may induce workers to file comp claims for conditions that are marginally work-related to obtain medical care they otherwise couldn't afford.

Employers, too, are facing new challenges, because trends such as consolidation require them to operate "better, faster, cheaper," said Andrea Trimble Hart, director of insurance and risk management for The Pillsbury Co., based in Minneapolis.

But continuity, commitment and cooperation can help them make their workplaces better and safer for workers, she said.

For example, many workers are attracted to the new employee benefits employers can offer, such as flexible work arrangements; family or unpaid leaves; long-term care insurance; employee assistance programs; and child or elder care resources, referrals and centers. BI

ADVERTISER INDEX

Issue of March 22

Commentary

Bermuda attains predicted stature

The presentation of two new awards at the Bermuda Insurance Institute's annual gala dinner March 20 vindicates my declaration of almost 20 years ago that Bermuda had become the third insurance center in the world, giving London and New York new competition.

I freely admit that 20 years ago I had jumped the gun on trumpeting Bermuda's stature in the worldwide market. I had based my report on just a week's visit to the island, where I interviewed some of the first underwriters and brokers to set up shop there, as well as captive managers and government officials. I was bowled over by their enthusiasm for the future of captive insurers and the ability of Bermuda-based insurers to compete in the commercial insurance market worldwide under Bermuda's tax and regulatory systems.

Even worse than having jumped the gun by about a decade, I also have to admit that not in my wildest imagination did I fathom just how large and powerful the tiny island of Bermuda would become in the world's insurance market. I didn't envision the large excess-liability insurers that would be formed out of necessity in the 1980s by Fortune 500 companies and then later sold to the public to grow into today's diversified insurance and reinsurance companies. I didn't know enough about catastrophe reinsurance to imagine that there would ever be a capacity crunch in that market, driving the development of these specialist reinsurers in Bermuda. The term financial reinsurance had not even been coined. And the idea that Bermuda-based companies would invest in Lloyd's of London and buy U.S. insurance companies was way beyond my imagination.


Kathryn J. McIntyre

I also was a cub reporter.

But while I am a little embarrassed that I was too quick to elevate Bermuda's stature in the commercial marketplace and that my vision was too limited as to what the Bermuda market would one day encompass, I do take heart that my instincts were right.

And now, the Bermuda Insurance Institute's creation of two awards to recognize leadership in the island's insurance industry reflects the self-confidence that exists in the Bermuda marketplace.

The BII says the creation of the awards is a signal that the Bermuda insurance market has matured to the extent that the BII can recognize not only an outstanding insurance executive during the past year, but also can trace developments historically to recognize the pioneers that helped advance insurance commerce on the island.

The first recipients: Brian Duperreault, chairman, president and chief executive officer of ACE Ltd., has been named the Bermuda Insurance Market Leader of the Year. And Fred Reiss, a pioneer in the development and management of captive insurance companies, has been named, posthumously, the first recipient of the BII Lifetime Achievement Award.

The pending acquisition by ACE Ltd. of CIGNA's property/casualty insurance operations is just one of the reasons the Bermuda insurance market has selected Mr. Duperreault as its first Bermuda Insurance Leader of the Year. ACE made several other acquisitions during 1998, each one propelling it and Bermuda into a stronger leadership position.

While those newer to the business may not recognize the name Fred Reiss, he coined the term "captive insurance" and convinced Bermuda's leaders that it could be an important business for the island. The formation of his captive management company, International Risk Management, required an act of Parliament. I am only sorry that Fred was so press-shy that I never was fortunate enough to meet him.

I am honored that I was asked not only to chair the committee that selected the honorees but also to make the award presentations at the gala dinner.

The BII award selection committee included representatives of Bermuda-based underwriters, brokers, captive management companies, the BII, the president of The College of Insurance in New York and the editor of The Royal Gazette, Bermuda's daily newspaper.

I write this on the eve of my departure for Bermuda for what I know will be a great evening. And I will smile broadly as I say, in so many words, "I told you so."

Publisher and Editorial Director Kathryn J. McIntyre's commentary appears fortnightly.

Senate

Continued from page 1

self-funded plans. They would also allow patients in group health plans to seek damages allowed under state law, such as punitive awards, from insurers and employers for adverse coverage decisions.

In response to criticism of the bill's focus on self-funded plans, Sen. Jeffords said it was not necessary to set new federal patient protection standards for HMOs and insurers because states can regulate HMOs under the McCarran-Ferguson Act. By contrast, the pre-emption provisions of the Employee Retirement Income Security prevent states from regulating self-funded plans, thereby justifying federal rules for those plans, he said.

Provisions in the bill that would apply only to self-funded plans include:

- Point of service. An employer with more than 50 employees offering only a closed-end network of providers would be required to offer participants a point-of-service option. An employer would be free to impose higher premiums and higher out-of-pocket cost-sharing requirements for employees opting for the POS.
- Patient access to medical care. Health care plans would have to give—without financial penalty—female patients direct access to obstetrician/gynecologists, something plans already increasingly are doing on their own.

In addition, a health care plan would have to give direct access to pediatric care and cover care provided in an emergency room in any situation that a "prudent layperson" would consider an emergency. A prudent layperson is one who possesses an average knowledge of health and medicine and who could identify a medical condition as one for which there are severe symptoms.

- Continuity of care. A self-funded plan would have to give timely notice to a participant undergoing a course of treatment when that provider's contract is terminated.

A patient who was terminally ill could keep his or her existing provider for up to 90 days, while a pregnant woman who had entered her second trimester could continue to see her current provider through the post-partum period.

While committee Republicans rejected Sen. Kennedy's effort to make health care plans liable under state law for coverage decisions, the legislation includes provisions—applicable to all group plans—that would set new federal standards for coverage determinations and patient appeals of those decisions.

Under the legislation, routine coverage determinations would have to be made within 30 days and notice would have to follow within two working days. If the medical problem is one that could seriously jeopardize the life or health of a patient, a plan would have to give a determination and notice within 72 hours.

If a participant is denied coverage, he or she would first appeal the decision to the plan. Routine appeals would have to be determined within 30 days; a decision would have to be made within 72 hours in situations that could seriously jeopardize the health of an individual. A reconsideration request would have to be reviewed by a physician with the appropriate expertise and who was not directly involved in the initial coverage determination.

If the decision to deny coverage is upheld by a plan's internal appeals process, a plan participant could seek an independent, external review in situations exceeding a "significant financial threshold," which is not defined in the legislation, or in a situation where there is a significant risk of placing the life or health of a patient in jeopardy.

External reviews also would be allowed for treatments considered by the plan to be experimental or investigational.

The health plan would select the external review organization and pay the costs of the review. The external review organization would select an independent expert medical reviewer. The independent medical reviewer decision's would be binding on the plan, though the participant could go to court to appeal the reviewer's decision. BI

Conduct

Continued from page 1

disclosing contingent commissions to clients (*BI*, Feb. 1). A spokeswoman for Marsh in London declined to comment on Aon Risk Services U.K.'s code, saying only that Marsh would continue the disclosure policy it negotiated with RIMS.

Some brokers simply refuse to accept such forms of compensation.

Lloyd's of London broker Berry, Palmer & Lyle Ltd. publicly stated last year that it does not accept any incentives from insurers when placing clients' business.

"Berry Palmer & Lyle has no hidden or special incentive remuneration arrangements with any insurers and believes in transparency as to its remuneration," said Director Anthony Palmer. He said the broker was unlikely to expand this policy to match the Aon code.

A year ago, London-based Jardine Lloyd Thompson Group P.L.C. stated in its 1997 annual report that less than 2% of revenue came from incentive commissions. JLT Chief Executive Ken Carter wrote in the report: "We will operate a policy of transparency with our clients by providing, where requested, appropriate disclosure of incentive commission whilst, at the same time, separately identifying the total remuneration which the group derives from these incentive commissions in future report and accounts."

While other brokers do not yet have formal arrangements with RIMS or AIRMIC, many now disclose contingent commissions at a client's request.

U.K. risk managers welcomed the new code of conduct.

"My key feeling is that there is a demonstrable commitment to transparency," Richard Reddaway, group insurance manager for pharmaceuticals company Glaxo-Wellcome P.L.C. in Greenford, England, said of the Aon code. "It is answering a lot of questions as to how clients' monies are handled through brokers."

David Gamble, executive director of AIRMIC, said in a statement: "The Aon code is a positive, tangible initiative which we hope other brokers will adopt or emulate, both here in the U.K. and in other world markets, because it goes further than any other disclosure agreement."

Implementing the code will improve relationships between commercial insurance buyers and their brokers, said Mr. Gamble.

The origin of Aon's work on the code, which has been in development for several months, came from industry initiatives to clarify the relationship between brokers and their clients, said Ron Forrest, chairman of Aon Risk Services U.K. in London.

"We felt it was sensible to put our position down with AIRMIC," he said. "We genuinely have a desire to be transparent in negotiations with the client."

Full compliance with the code is not mandatory until the beginning of 2001, but the transition period starts April 1 this year.

Key to the code is a set of basic principles by which an Aon broker will deal with an AIRMIC member.

Before business is accepted from a client, Aon will send a terms of business letter to the client, outlining several factors, including the nature of the service to be provided, compensation, complaints procedure, a statement of duty of disclosure and duty of utmost good faith, and information about Aon's client confidentiality arrangements.

The code also sets out mediation measures if disputes arise between the client and broker, aiming to avoid litigation in favor of negotiation or dispute resolution.

Where the code differs from previous broker attempts to establish accepted business procedures is in its treatment of broker compensation.

The code states: "ARS will disclose to the client the amount of brokerage and/or commission it receives in relation to each placement on behalf of the client (including any captive insurance subsidiary). This disclosure will include all prompt payment discounts and long-term agreements or renewal incentives."

The code also calls for Aon to charge underwriters by either an administration fee or a standing charge for services, such as credit control and claims support, that the broker provides to insurers.

In situations where incentive-based compensation exists—such as a volume overrider, growth incentive or profit commission from an insurer—the code calls for those arrangements to be disclosed to the applicable client.

"In the past, the whole question of overriders and contingent fees was looked at as a way of paying for brokers' work for insurers," Mr. Forrest explained. "Now that it is out in the open, we won't take volume payments as a rough-and-ready way of getting payment. We want to change the way we do business so that we are not paid by volume overriders, etc., in the U.K."

However, if an insurance company does not want to pay a specific fee, Aon Risk Services U.K. will continue to work on an incentive basis, but with full disclosure, Mr. Forrest said, adding that he hoped Aon would not need to use this provision.

Mr. Reddaway, a former AIRMIC chairman and a leading voice in the campaign for public disclosure of insurer compensation arrangements, described the payment information as "revolutionary."

"My hope is that this is the death-knell of incentives (from insurers)," he said.

Increased disclosure may have benefits beyond a full knowledge of the costs of business, said Mr. Reddaway. "What you're now doing is focusing on services provided by underwriters and brokers," and the code may well help identify unnecessary duplication of tasks or general inefficiencies in the commercial insurance market.

As a result, Mr. Reddaway foresees costs decreasing because obsolete or unnecessary practices will be identified and weeded out of the process.

"I expect (the code) will lead to the re-examination and ultimately an overall reduction in costs to the client," agreed Aon's Mr. Forrest. "It will continue the sharpening-up of who does what and remove elements of conflicts of interest."

Regulation of U.K. brokers currently is in a state of flux, as the Insurance Brokers' Registration Act is to be superseded by legislation handing regulation over to the brokers themselves. The Aon code already has been handed over to the General Insurance Standards Council, the body currently being formed to take over broker regulation from the Insurance Brokers' Registration Council at the beginning of next year. BI

Lawsuit

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owner-controlled insurance program would allow smaller contractors to compete on a more even footing with their larger counterparts for Chicago public school construction contracts.

The Chicago school board in late 1997 had awarded Near North a two-year, $550,000 per year contract to provide brokerage services and safety consulting for the four-year construction project.

The brokerage services provided by Near North were to focus on obtaining environmental and professional liability coverages as part of the wrap-up program.

Aon Risk Services Inc. was chosen separately to market the workers compensation, employment liability, commercial general liability, excess liability and all-risk builders risk coverages.

The lawsuit by Near North suggests that a proposed plan to use an affiliated wholesaler operation, MWS Inc., to place coverage for the wrap-up program—and including the wholesaler's commission in its insurance price quotes—was a point of dispute with the school system.

Near North's suit notes that "Insurance brokers such as NNIB often use 'wholesalers' to procure specialized coverages such as environmental and professional liability policies for their clients."

The broker's lawsuit also contends that at a pre-bid conference held during the development of the wrap-up plan, a potential bidder had asked whether a broker would be allowed to use a wholesaler to obtain price quotes for the wrap-up program, and whether price quotes provided to the board could include the wholesaler's commissions.

According to the suit, a school board executive responded that brokers could use wholesalers and include the wholesaler's commission in price quotes submitted to the board.

Near North's suit seeks damages from the risk manager, whom it claims encouraged breaking the contract.

Near North also contends that a "competitor's contract with the board indicated that a wholesaler's commission was included in the price quotes provided to the board by the competitor."

Based upon those facts, "NNIB initially intended to use an affiliated wholesaler in the same manner," the lawsuit says. Ultimately, however, the final price quotes that Near North submitted to the school board did not reflect the payment of commissions to any wholesaler.

Near North charges that Ms. Asghar and other Chicago public school staff members improperly and maliciously used the broker's original plan to include wholesale commissions "as an excuse to interfere with the board's contract with NNIB."

After the Chicago Public Schools terminated the Near North contract, the services it originally provided reportedly have been transferred to Aon. Aon did not return calls.

The suit claims that the damages the broker suffered due to the alleged breach of contract exceed $1 million. It also claims the broker provided considerable services to the school board prior to the contract's termination for which it was never paid, and requests compensation for the value of that work.

The suit further seeks compensation and punitive damages from Ms. Asghar, whom it claims acted maliciously in encouraging the school board to break the contract with Near North. The suit also contends that Ms. Asghar defamed Near North in discussions with the underwriter of the school system's environmental insurance coverage by blaming the broker for a lapse in that coverage.

According to Near North's suit, Ms. Asghar "deliberately ignored repeated requests by NNIB to act on a proposal for a renewal policy which was negotiated and obtained by NNIB."

Ultimately, when the underwriter did agree to extend the environmental policy retroactively, it did so on terms previously negotiated by Near North, the suit claims. BI

S&P

Continued from page 2

period, have invested $2.6 billion."

Mr. Medvin noted that in addition to Marsh and Aon acquisitions, Willis Corroon Group P.L.C. was acquired by a group led by Kohlberg Kravis Roberts & Co. L.P., and both USI Insurance Services Corp. and Arthur J. Gallagher & Co. are acquiring agents and brokers focusing on the middle-market.

Despite the frenzy of acquisition activity, Mr. Medvin said he was not surprised by it. "We did see it coming, and it's coming not because of any other reason than by demand by clients," he said.

"In our service business, clients are demanding that we give them the service coverage and global coverage seamlessly around the world," he said. "They expect us to be where they are, servicing them."

At the same time, Mr. Medvin said, clients also are demanding more resources, which do not come cheaply.

"We clearly have all kinds of new technology initiatives and service initiatives and other programs that require substantial financial investments," he said.

Putting the changing distribution system into perspective, Mr. Medvin noted that of the top 31 brokers ranked in 1988, 19 no longer exist. And of the top 10 brokers in 1988, only three remain today.

"Aon's and Marsh's combined revenues in 1998 are almost equal to the top 20 brokers' in '92," he added.

Mr. Medvin attributes the consolidation frenzy to the fact that many brokers were no longer able to service their major clients who were demanding global services.

"These clients demanded services that were probably beyond the level where (the brokers) wanted to make investments," Mr. Medvin said.

As a result of the UNISON network's demise—which collapsed after Marsh's 1997 acquisition of Johnson & Higgins, UNISON's largest and sole U.S. member—Aon was able to make four "very strategic and very important" acquisitions in Germany, France, Spain and Italy, Mr. Medvin noted.

"Each one of those organizations, because of the consolidation, needed to make some changes and needed to do something," he added.

At German broker Jauch & Huebener KGaA, for example, Mr. Medvin said that without the benefit of UNISON partners, its major clients had said: "How are you going to service us outside of Germany? Tell us your plan and tell us, importantly, how are you going to control it?"

The frenzy of broker consolidation is being fueled by clients' demand, says Aon's Harvey N. Medvin.

Mr. Medvin said by owning offices around the world, as opposed to forging relationships or affiliations with global partners, Aon is in better control of its worldwide operations.

"I can imagine what it would be if we had affiliations and had revenue sharing or some other type of arrangement," Mr. Medvin said. "I can assure you that even with the ownership of all of these offices and employees around the world at Aon, controlling all of the activities is still a challenge. In our view, (an affiliation) really wouldn't work with all the control that we would need to have."

Mr. Medvin said that despite the advent of the megabrokers, direct writers and other companies are aggressively going after insurance-buying clients.

"There is enormous competition and an enormous battle going on" as to who is going to be close to the insurance buyer and who the insurance buyer is going to look to for advice, he said.

Mr. Medvin said that in the competitive market, brokers need to set up alternative ways of accessing markets and accessing clients to compete.

While the Internet still is in its early stages, Aon is "looking at it and where and how it fits for our products and sales force," Mr. Medvin said.

For example, "We are investing significant amounts of money to try and service small commercial organizations through a variety of electronic commerce activities," he said.

Aon also is working with a large credit card organization that also is looking at how it can sell insurance products to small commercial clients that use credit cards and other services.

"We're trying to joint venture with them to see where and how that program could work," Mr. Medvin said.

In addition to the Internet, banks also offer a new way to distribute insurance products.

Mr. Medvin said that while selling insurance through banks is "nowhere near as successful in the U.S. as it is outside the U.S.," some bank initiatives in the annuity and credit-related area are being forged very rapidly.

"Now it's too early to tell, but there is a new player in Citigroup that changes the landscape drastically in terms of what they manufacture and what their distribution capabilities are," Mr. Medvin added.

In terms of how far Aon will delve into the investment banking community, Mr. Medvin said the broker is comfortable in having the ability to find capital market solutions when appropriate for the client.

"We're not so fearful that we need to do everything," he said. BI

Updates

Ward's to replace pension plan

CHICAGO—Montgomery Ward & Co., pressed for cash to pull itself out of Chapter 11 bankruptcy, is terminating its pension plan in order to gain access to surplus funds.

The company plans to replace its current, overfunded defined benefit pension plan with a new defined benefit plan that will use the same formula to determine benefits, according to a company spokesman. The company will take 25% of the surplus funds and add that amount to the new plan, the spokesman said. Under federal law, a 50% excise tax is normally imposed on plan reversions. However, that tax is cut to 20% if the employer transfers 25% of the surplus to the new plan.

The present pension plan covers 22,000 active Ward's employees and 30,000 retirees. Participants will have the choice of receiving an annuity from an insurance company, which Ward's has yet to select, or as a lump sum from the company.

The Pension Benefit Guaranty Corp. estimates the plan—on a termination basis—has $1.1 billion in assets and $882 million in liabilities. Ward's has filed with the PBGC a notice that it intends to terminate the plan.

The surplus funds will be used for general purposes of emerging from Chapter 11, planned for this summer, he said.

M&M to form Lloyd's syndicate

LONDON—Marsh & McLennan Capital Inc., the insurance investment arm of Marsh & McLennan Cos. Inc., plans to set up a Lloyd's of London managing agency and syndicate.

Newmarket Managing Agencies will be headed by Ralph Sharp, who currently is the managing director of Duncanson & Holt Syndicate Management. Other underwriters joining the agency are Lloyd's underwriters Jonathan Barnes and Robin Todd, and Peter Trend, who was formerly an underwriter in Assicurazioni Generali S.p.A.'s London office.

The syndicate, which will likely be formed later this year, will write a broad range of coverages, a Marsh & McLennan spokesman said. He would not say how much would be invested in the new venture. The investments will be made by funds Marsh & McLennan Capital manages; the brokerage will not be investing any of its own money in the venture.

The holding company for the agency, NM Holdings Ltd., has been formed in Bermuda.

No RightCHOICE approval yet

ST. LOUIS—A modified settlement agreement between Blue Cross & Blue Shield of Missouri and state officials over the creation of the health organization's for-profit subsidiary has been submitted to a court for approval, but its future is unclear.

Although the agreement is supported by almost 100 consumer groups, the Blues plan says Cole County Circuit Court Judge Thomas Brown III made statements on the record last week indicating he has continued concerns about a number of issues, including whether the agreement gives full and fair value to the foundation it would create.

A dispute involving Blue Cross & Blue Shield of Missouri, its for-profit subsidiary, called RightCHOICE Managed Care Inc., the Missouri Insurance Department and the state attorney general led to a Sept. 15 agreement that requires the court's approval.

However, a special master appointed by the court issued a report suggesting the court withhold a ruling on the agreement until certain concerns are addressed (*BI*, Feb. 22). The modified agreement then was worked out.

At last week's informal status hearing, where he made his comments, Judge Brown did not indicate when he will issue a formal ruling on the modified agreement.

Briefly noted

New York-based **Capital Re Corp.** and Bermuda-based **ACE Ltd.** have reached a modified agreement under which ACE still will invest $75 million in the financial guarantee reinsurer's common stock. A condition of the original agreement was that Moody's Investors Service Inc. would affirm Cap Re's AAA financial strength rating, but the rating agency instead lowered it two notches to Aa2 (*BI*, March 15). . . .Washington Insurance Commissioner Deborah Senn said last week that the insurance industry estimates that **insured damage from windstorms** on March 2-3 reached $30 million in Washington and $20 million in Oregon. The dollar amounts mostly reflect automobile and home damage and do not include self-insured damages suffered by utility companies or local governments. . . .A federal judge in Los Angeles has certified as a **class action** a suit by 4,000 former and current employees of Walt Disney Co. to restore health benefits the company reduced or eliminated. The two sides reached a tentative agreement in 1997, but that dissolved before becoming final. . . .The **China Reinsurance Co.**, successor to the reinsurance arm of the People's Insurance Co. of China, was officially opened in Beijing last week with 3 billion yuan ($362.4 million) capital. The PICC was disbanded last October, and all subsidiaries were privatized. . . .A jury in U.S. District Court for the Northern District of Ohio ruled last week that a group of more than 100 Ohio labor union health care funds cannot recover the costs of treating workers' **smoking-related illnesses**. . . .The California appellate court in Los Angeles last week affirmed a judgment against the State Compensation Insurance Fund for **unfair business practices**, based on charges related to its case reserve and claims handling policies and practices (*BI*, Sept. 28, 1998; Sept. 4, 1995). However, a three-judge panel lowered a punitive damages award in the case, *Joe Notrica vs. State Compensation Insurance Fund*, to $5 million from $20 million. A Fund spokesman said it is reviewing its legal options, which include an appeal to the California Supreme Court. . . .Salt Lake City businessman **Pete J. Buffo has pleaded guilty** to federal securities fraud charges stemming from his sale of bogus corporate promissory notes guaranteed by New England International Surety Inc. of Panama (*BI*, Sept. 14, 1998). Separately, New England International has settled a civil lawsuit filed by the defrauded noteholders seeking recovery under the guarantees.

Sable

Continued from page 1

Questions had been raised even before Mr. Richardson's departure about whether Sable is truly a minority business enterprise. This month, the City of Los Angeles denied the insurer MBE status, citing Reliance's extensive role.

After leaving Sable, Mr. Richardson asked an agency that certifies minority enterprises for California public utilities to review Sable's status. Separately, the Washington-based National Black Chamber of Commerce has said it will decertify Sable and challenge its certification by other entities.

"They need to know that what they are doing will not fly," NBCOC President Harry C. Alford said of Reliance. "You don't fire the owner and put some other black guy in there and say, 'OK, we're a (MBE).' It's fantasyland."

For his part, Mr. Rice, Sable's current CEO, says the insurer will survive whether or not it is recognized as a minority business enterprise.

While MBE certification may help, "I'm not interested in MBE status per se," Mr. Rice said.

"Aaron and Reliance need to settle their differences so we can get on with our business," he added.

This isn't how things were supposed to turn out when Mr. Richardson began looking for a partner for a long-held dream to build an African-American-owned insurer.

Beginning his career in 1967 as a Fireman's Fund Insurance Cos. underwriter, Mr. Richardson, now 55, moved on to Johnson & Higgins and Marsh & McLennan Inc. in San Francisco before starting his own brokerage firm in 1990.

Aware of the difficulty public entities and some corporations were having meeting commitments to deal with minority-owned enterprises, Mr. Richardson devised the idea for Sable and approached several potential backers.

Reliance proved the most receptive, and with a $6 million capital contribution from Reliance, Sable was incorporated in California in April 1996. Reliance contributed another $10 million to the insurer last year.

While technically independent, Sable was tied to Reliance in a number of ways. Mr. Richardson owned 51% of the common stock of Sable Insurance Holding Co., the insurer's parent, while Reliance held 49%; however, Reliance insurance units owned 100% of the holding company's preferred stock, issued in exchange for Reliance's capital contributions.

Sable's seven-member board included Mr. Richardson and two of his appointees, along with four Reliance employees, one of whom Mr. Richardson says he was allowed to name.

Mr. Richardson worked under one-year employment contracts that included the unusual provision that the board give him 60 days' notice of its intent to renew—rather than terminate—the contract. If Mr. Richardson ceased being president and CEO, he was required to return his 51% stake to the company at book value.

In addition to the administration agreement, Reliance also assumed 90% of Sable's business as a quota share reinsurer, and Sable carries Reliance's A- rating from A.M. Best Co. based on the reinsurance deal.

Reflecting on the extent of Reliance's control, Mr. Richardson conceded "I had some reservations (in the beginning), but I'm kind of a positive thinker. . .I knew was I was getting into."

Mr. Rice says Sable is a long-term investment for a 51% shareholder: It won't pay off until Sable's surplus grows to the point that the value of its common stock outweighs Reliance's preferred stock.

In the meantime, he suggested, Reliance is necessary. "Who's got $20 million on the table to start an insurance company from scratch?"

Sable's business got off to a slow start. While Mr. Richardson had hoped to begin underwriting in January 1997, Sable wasn't able to open its doors until September, and the insurer wrote no business that year.

Last year, Sable generated gross direct premiums of $13.5 million and ceded $12.1 million of this to Reliance. After a small amount of other ceded reinsurance, net premiums totaled $948,326, its1998 statutory statement reports.

Thanks mostly to investment gains, Sable reported 1998 net income of $433,344 and ended the year with surplus of $16.7 million.

Sable's launch was hampered by Reliance in a number of ways, according to Mr. Richardson.

For one thing, he said, Reliance was responsible for handling Sable's license applications and rate and form filings. By the time it finally opened for business in September 1997, though, rate and form filings made months earlier already were obsolete, and Sable was in a poor competitive position, Mr. Richardson said.

Reliance-dictated changes in Sable's business plan also threw the insurer off, shifting its focus away from minority-owned business to middle-market accounts and back again between December 1997 and June 1998, he says.

Mr. Richardson's relationship with Reliance was already beginning to sour when Mr. Rice was hired last June. Sable's board did not give Mr. Richardson notice of its intent to renew his contract at its August expiration. This came, he says, despite the fact that in May he had been granted a 50% raise in his annual salary to $300,000, retroactive to September 1997, a move he says may have been prompted by Mr. Rice's hiring at a $250,000 salary. Sable's board ratified the raise in September, he said.

On Feb. 1, two Reliance executives, including Sable board member and Reliance National Insurance Co. Executive Vp Albert J. Marino, flew to San Francisco and told Mr. Richardson that Mr. Rice was taking over.

The Reliance officials offered Mr. Richardson an advisory job at $100,000 per year and 5% of Sable's stock, he said. Mr. Richardson then hired a lawyer, who told Reliance he thought the move amounted to unlawful termination.

At the same time, while reviewing Sable's 1998 financial statements, Mr. Richardson says he discovered that Reliance had shortchanged Sable on reinsurance ceding commissions by about $1.3 million.

Reliance paid the money immediately, but Mr. Richardson, calling Reliance's action "an egregious breach of good faith," notified it that he was canceling their reinsurance agreement.

He also notified Reliance that he was removing Mr. Marino—the Reliance-employed director he had appointed—from Sable's board.

"Then I knew they were going to come after me," he says.

He was right.

Reliance called a Sable board meeting for March 3. At the meeting, which Mr. Richardson and his two other board appointees boycotted, the remaining board members fired him.

Reliance has since demanded that he return his 51% stake, which it values at zero. The valuation excludes Sable's surplus, which is tied solely to Reliance's preferred Sable stock.

Mr. Richardson has refused to turn over the shares—which would be given to Mr. Rice—and he and his lawyer contend the March 3 termination was improper.

A Reliance spokesman insists that Mr. Richardson was fired properly under the terms of his contract because Sable's $13.5 million premium volume "fell far short" of its goals. Mr. Rice noted that all but $2 million of that volume was booked after he joined the company.

Reliance National President Dennis Busti said in a statement, "From top management down, Reliance National supported and still supports the idea of a truly successful African-American insurance company. We put our time and our money behind our beliefs, and we will continue to work to make a success of Sable."

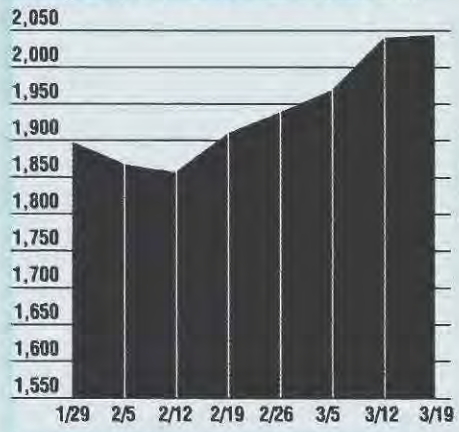
Both sides insist that litigation is the last thing they want, but they seem to have hit an impasse. Mr. Richardson says he hopes to form an investor group to buy out Reliance's stake in Sable.

"This has been my dream," he said. "I've been working on it for 10 years, and I'm not going to let them steal it from me."

Reliance does not appear eager to take him up on it, though.

"We owe it to our shareholders to look at any reasonable offer," the spokesman said. "But we believe that, right now, with Ed Rice and with our structure, this can be very profitable and successful as a continuing operation." BI

BI Insurance Index



Base=100 on Dec. 29, 1978
Source: *Nordby International Inc.* (nordby.com) Boulder, Colo.

PCS catastrophe options

As of March 19

Call spread	Price bid/ask
National Annual 1999	
40/60	12.0/16.0
60/80	6.0/12.0
80/100	4.0/8.0
150C	5.0/6.0
200/250	3.3/4.0
Southeastern September 1999	
40/60	2.8/—
60/80	2.1/3.0
80/100	2.0/2.4
Eastern September 1999	
40/60	3.0/—
California Annual 1999	
60/80	1.2/2.3
80/100	1.0/1.9
150C	0.5/2.5
Western Annual 1999	
80/100	0.5/2.2
Midwest June 1999	
10/20	1.2/1.4
Florida Sept./Dec. 1999	
100/150	2.6/—

Total volume: 0 Total open interest: 10,999

For information on PCS cat options, call the Chicago Board of Trade at 312-435-3674.

Source: Chicago Board of Trade

British Issues

	Price	P/E	Div.	Yield	52-week
Companies	pence		pence	%	high-low
Gdn Royal Exch	350	5.4	10.1	3.6	494-227
Legal & Gen	736	34.7	14.5	2.5	946-500
Royal & Sun	571	19.9	23.0	5.0	825-439
Brokers					
Lmbrt Fenchurch	70	5.7	5.7	10.2	121-58
JLT	216	9.5	12.0	7.1	237-150

Note: Prices are March 19 closings; other numbers from March 18.

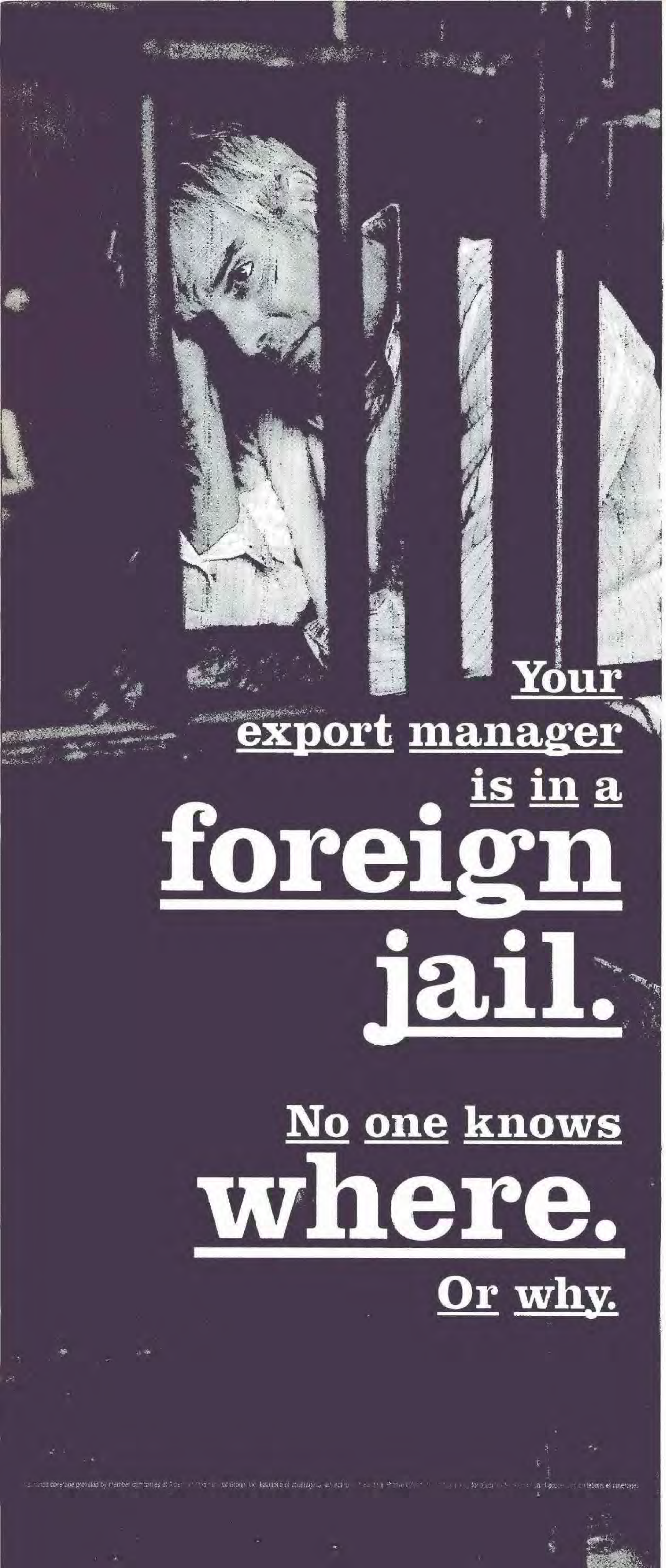
Source: *Nordby International Inc.*(nordby.com) Boulder, Colo.

BI Industry Stock Report MARCH 15, 1999, THROUGH MARCH 19, 1999

BROKERS		Price	Weekly % change	Year to date % change	Year to date High	Low	Vol.(000)
Aon Corp.	NYS	65.81	0.10	17.39	75.56	48.25	2505
E.W. Blanch Holdings Inc.	NYS	55.50	5.34	18.88	60.00	34.69	410
Gallagher Arthur J. & Co.	NYS	46.50	-1.59	6.29	50.63	34.88	237
Hilb, Rogal & Hamilton	NYS	15.56	-4.23	-16.44	19.88	15.38	932
Kaye Group Inc.	NDQ	7.25	-6.45	0.00	8.06	5.13	11
Marsh & McLennan	NYS	76.38	-1.05	29.18	79.38	43.38	2867
Poe & Brown	NYS	31.06	-5.15	-11.09	42.50	31.06	41
BROKERS	AVERAGE		-2.19	4.47			
INSURERS/REINSURERS							
ACE Ltd.	NYS	31.75	0.59	-2.87	43.00	24.38	2577
Accel International Corp.	NDQ	2.69	0.00	-10.42	3.50	2.13	16
Acceptance Insurance Cos.	NYS	15.31	6.99	-22.96	25.63	13.63	325
AEGON N.V.	NYS	98.56	-3.96	-19.17	130.13	59.75	342
Aetna Life & Casualty	NYS	81.19	1.64	1.72	91.44	60.19	1954
AFLAC Inc.	NYS	50.69	4.51	15.20	51.50	25.13	3170
Allmerica Financial Corp.	NYS	54.50	5.57	-3.75	75.25	38.38	598
Allstate Corp.	NYS	38.50	-0.16	0.00	52.38	34.75	9064
AMBAC Indemnity Corp.	NYS	54.38	-4.19	-9.28	65.94	40.88	1274
American Bankers Ins.	NDQ	51.94	0.12	8.77	65.94	30.13	1326
American Financial Group	NYS	36.63	-1.35	-11.08	45.75	30.50	255
American General	NYS	74.63	-1.32	-4.63	79.00	52.38	2407
American Heritage Life Ins.	NYS	25.25	4.39	4.94	26.69	18.63	304
American Indemnity/Fin'l	NDQ	12.69	-3.33	19.41	15.38	10.25	27
American International	NYS	118.75	-0.52	21.95	123.38	64.88	11390
American Safety Insurance	NYS	8.13	2.36	-14.47	15.06	6.75	30
Argonaut Group	NDQ	24.00	-1.54	0.00	37.00	21.25	319
AXA-UAP Group	NYS	69.06	3.56	-3.49	80.25	38.25	205
Baldwin & Lyons Inc.	NDQ	20.88	-0.60	-10.70	26.00	18.50	25
Berkley W.R. Corp.	NDQ	25.25	-2.42	-25.19	49.88	24.38	383
Berkshire Hathaway Inc.	NYS	77800.00	-3.11	13.91	84000.00	57000.00	3
Capital RE Corporation	NYS	16.63	4.31	-15.02	38.69	11.94	857
Capitol Transamerica Corp.	NAS	14.88	-4.80	-15.90	22.75	14.50	29
Centris Group Inc.	NYS	9.63	-2.53	2.67	14.81	7.94	85
Chartwell Re	NYS	20.00	-2.44	-13.98	34.56	20.00	86
Chubb Corp.	NYS	61.00	2.31	-6.06	88.81	54.00	4490
CIGNA Corp.	NYS	82.13	2.42	5.63	86.44	57.19	3523
Cincinnati Financial Corp.	NYS	38.00	0.41	6.48	45.31	30.50	1661
Citigroup	NYS	64.13	-2.75	26.82	73.50	28.50	38124
CNA Financial Corp.	NYS	37.50	-1.64	-4.61	53.25	33.00	593
CNA Surety	NYS	12.50	-3.85	-16.32	16.75	10.19	126
EMC Insurance Group Inc.	NDQ	11.31	0.56	-11.27	15.88	9.00	20
ESG Re Limited	NDQ	16.50	-1.49	-16.72	28.00	12.75	95
Enhance Financial Services	NYS	22.06	-3.02	-27.07	37.56	17.31	504
Everest Reinsurance	NYS	33.69	-2.71	-8.18	45.25	28.75	1256
Executive Risk Inc.	NYS	72.44	3.02	34.45	74.94	35.50	583
EXEL Ltd.	NYS	58.00	-4.23	-18.95	83.25	58.00	1179
Fremont General Corp.	NYS	19.38	-4.32	-19.69	31.06	18.00	873
Frontier Insurance Group	NYS	11.81	-4.06	-5.50	25.69	11.06	1300
Gainsco Inc.	NYS	4.94	0.00	-21.78	10.00	4.81	155
Harleysville Group	NDQ	21.13	5.63	-17.16	28.50	17.25	130
Hartford Steam Boiler	NYS	37.31	2.05	-7.15	59.56	34.75	342
HCC Insurance Holdings	NYS	18.44	-1.67	8.86	23.94	16.00	651
ING Groep N.V.	NYS	55.81	0.22	-8.50	76.75	36.06	389
IPC Holdings Ltd.	NDQ	20.25	-2.41	-10.99	33.25	19.00	417
Hartford Financial Services	NYS	58.19	5.68	4.26	60.00	37.63	3571
LaSalle Re Holdings Ltd.	NYS	17.31	-3.15	-16.06	42.94	16.75	219
Lincoln National	NYS	97.13	2.04	17.19	99.69	67.00	2070
MAIC Holdings nc.	NYS	27.81	-0.45	-13.09	33.13	23.25	89
Markel Corp.	NYS	181.00	0.42	0.42	187.00	132.00	15
MBIA Insurance Group	NYS	61.56	-1.40	-7.16	80.94	46.06	1630
Meadowbrook Insur. Group	NYS	16.88	0.00	3.45	35.00	14.94	47
MMI Cos. Inc.	NYS	15.19	0.83	-8.99	25.00	13.75	147
Mutual Risk Mgmt. Ltd.	NYS	39.88	-3.77	5.11	43.25	25.38	408
NAC Re Corp.	NYS	51.06	-4.33	9.37	55.88	43.69	459
Navigators Group	NDQ	13.88	-4.31	-9.02	20.75	13.25	30
NYMagic Inc.	NYS	14.75	-0.84	-29.34	34.25	13.88	39
Ohio Casualty Corp.	NDQ	40.31	0.31	-1.98	51.75	33.75	304
Old Republic Int'l	NYS	18.88	-3.82	-11.95	32.25	17.94	1077
Orion Capital Corp.	NYS	32.13	-1.91	-18.02	59.25	28.00	363
Partner Re Ltd.	NYS	42.00	-0.88	-7.05	52.50	33.63	725
Penn-America Grcup Inc.	NYS	11.19	-0.56	20.95	22.13	8.13	111
PMA Capital Corporation	NDQ	19.75	-1.25	0.96	23.75	16.63	21
Philadelphia Cons. Holding	NDQ	21.75	-0.57	2.35	24.50	18.63	116
PXRE Corp.	NYS	19.63	-2.48	-22.28	32.88	19.00	117
Reliance Group Holdings	NYS	7.88	-8.03	-39.13	19.81	7.75	3086
ReliaStar Financial Corp.	NYS	44.50	1.14	-0.56	52.44	29.00	1924
RenaissanceRe Holdings Ltd.	NYS	35.00	1.08	-3.11	50.75	31.50	111
Risk Capital Holdings	NDQ	13.63	-21.01	-35.50	25.50	13.63	184
RLI Corp.	NYS	30.00	-3.03	-10.11	45.63	28.00	47
St. Paul Companies	NYS	32.81	-1.13	-6.25	47.19	28.06	2245
SCOR	NYS	52.50	-9.58	-19.23	72.75	50.06	73
SAFECO Corp.	NDQ	42.50	1.64	0.00	56.00	36.69	2587
SCPIE Holdings Inc.	NYS	27.19	-7.84	-9.56	38.38	26.63	NA
Seibels Bruce Group	NDQ	3.25	0.00	-7.14	6.38	2.94	223
Selective Ins. Group	NDQ	18.88	-0.66	-6.79	29.25	16.69	301
Terra Nova Ins Co. Ltd.	NYS	22.81	-3.44	-6.41	35.00	21.25	263
TIG Holdings	NYS	16.25	0.39	4.84	27.75	11.63	2373
Tokio Marine & Fire	NDQ	62.00	12.47	5.31	62.25	39.00	153
Torchmark Corp.	NYS	33.81	-0.18	-2.70	49.81	30.69	1607
Transatlantic Holdings	NYS	74.94	-0.08	-0.91	94.50	73.50	80
Travelers Property Casualty	NYS	36.00	-1.03	17.55	45.94	24.13	926
Trenwick Group Inc.	NDQ	27.00	-4.42	-14.62	41.75	26.75	194
Unico American Corp.	NDQ	10.38	-3.49	-10.03	16.88	8.88	83
United Fire & Casualty	NDQ	28.75	-0.43	-13.62	44.00	27.75	21
Unitrin	NDQ	68.50	1.48	-3.35	75.47	55.56	133
UNUM Corp.	NYS	49.50	3.26	-17.41	62.50	41.75	2593
Vesta Insurance Co.	NYS	3.75	-17.81	-34.78	59.00	3.75	733
Zenith National Ins.	NYS	24.94	-1.97	7.84	30.50	20.31	29
INSURERS/REINSURERS	AVERAGE		-1.21	-5.66			
HEALTH MAINTENANCE ORGANIZATIONS							
Foundation Health Systems Inc.	NYS	9.50	-1.30	-13.64	32.63	5.88	1355
Humana Inc.	NYS	18.81	-0.33	-0.66	32.13	12.25	2142
Oxford Health Plans	NDQ	17.81	8.78	27.23	20.50	5.81	8022
Pacificare Health Sys.	NDQ	63.00	-11.27	-11.89	88.88	53.75	29
Safeguard Health Enter.	NDQ	2.81	-4.26	-21.05	9.44	2.69	108
Sierra Health Services	NYS	13.13	-5.41	-37.13	27.63	13.13	473
United HealthGroup	NYS	53.63	2.02	20.34	73.94	29.56	3698
Wellpoint Health Networks	NYS	79.63	7.69	-7.28	87.88	50.50	1252
HMOs	AVERAGE		-0.51	-5.51			
ALL COMPANIES	AVERAGE		-1.30	-2.23			

Top advancing issues: Tokio Marine & Fire, Oxford Health Plans, Wellpoint Health Networks. Leading decliners: Risk Capital Holdings, Vesta Insurance Co., Pacificare Health Sys. Most active issue: Citigroup. The *BI* Index gained 0.2%; the Dow Jones 30 Industrials increased 0.3%; the S&P 500 gained 0.4% and the NYSE Composite declined 0.2%. Average P/E: Brokers, 17.8; Insurers/reinsurers, 23.7; HMOs, 18.0.

Source: *Nordby International Inc.* (nordby.com), Boulder, CO



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