MARCH 24, 1997

# Business Insurance®

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## Updates

### Dow Jones & Co. contesting record $222.7 million libel verdict

HOUSTON—Dow Jones & Co. is asking a federal judge in Houston to set aside a $222.7 million libel award stemming from a 1993 story in The Wall Street Journal.

The March 20 Houston federal court jury verdict against Dow Jones, the Journal's parent company, is four times the previous record libel award. The award included $200 million in punitive damages on top of $22.7 million in actual damages.

The plaintiffs in the case, the now-defunct MMAR Group Inc., a Houston-based invest-

*See* **Updates** *on next page*

## M&A mania coin has two sides, buyers say

By MARK A. HOFMANN and GAVIN SOUTER

Risk managers view the continuing trend toward mega-mergers among brokers and underwriters with decidedly mixed emotions.

On the one hand, such consolidations as that announced earlier this month by Marsh & McLennan Cos. Inc. and Johnson & Higgins, and the acquisition of Alexander & Alexander Services Inc. and Bain Hogg Group P.L.C. late last year by Aon Group Inc., can mean risk managers will benefit from economies of scale and a wider variety of goods and services in one place, say some risk managers (*BI*, March 17). The trend may also mean more favorable reinsurance prices for risk managers who buy reinsurance for captives and greater business opportunities for captive managers that are not affiliated with the broker-age giants.

On the other hand, mega-mergers could have a more significant downside than simply reducing risk managers' choices when seeking a broker. Consolidation can mean more market power in the hands of fewer players.

Some risk managers are concerned that the industry's urge to merge also could mean a more homogenized approach to business that will give risk managers more headaches as they try to place unusual risks and the possibility that a less competitive brokerage market could also mean a less creative broker-age market.

"My reservation is that consolidation among the insurers and brokers reduces the options that the buyers have. On the other side, I can see the economic benefit of consolidation on their part because it can make them more efficient and offer more services to their buyers," said John Toay, director-risk management for Family Dollar Stores Inc. in Charlotte, N.C.

Mike Kaddatz, principal with Lake Forest, Calif.-based risk management consultant ARM Tech, said:

*See* **Mergers** *on page 25*

## Tobacco company breaks ranks

### Liggett's settlement with 22 states not expected to start trend

By MICHAEL PRINCE and MICHAEL BRADFORD

Liggett Group Inc.'s settlement of tobacco liability suits with 22 states is unlikely to be copied soon by other tobacco companies but has undermined their defenses against liability, legal experts said.

And even though one state suit added the tobacco company's insurers as defendants, tobacco liability is not expected to become a huge potential area of loss for insurers.

Liggett, the country's fifth-largest cigarette maker, reversed the tobacco industry's long-standing position that cigarettes are not harmful and agreed to assist in suits against the rest of the tobacco industry in exchange for ending all present and future litigation against the company.

In a settlement, reached with 22 state attorneys general suing to recoup the cost of state-funded medical care for smoking-related illnesses, Liggett admitted that cigarettes are both harmful and addictive and that it has marketed cigarettes to teenagers.

The company will put a warning label on its cigarettes saying "Smoking is addictive." In addition, the company will pay 25% of its pretax profits for the next 25 years into a fund for the states which can be used to reimburse their medical costs and pay for smoking awareness programs. Additionally, Liggett's employees will cooperate and testify on behalf of the attorneys general against the other tobacco companies. Because Liggett has not been profitable, attorneys general do not expect the company to make any monetary contributions.

"It should be viewed as a settlement that provides access to documents, witnesses and provides admissions," said Michael Ciresi, an attorney with Robins, Kaplan, Miller & Ciresi in

*See* **Liggett** *on page 23*

## K&R coverage can apply to more than just employees

By JOANNE WOJCIK

Companies seeking to shield their proprietary information and data from sabotage may find an unlikely source of protection: kidnap and ransom coverage.

"One would think that you would have to buy special coverage," observed David Gauntlett, a partner with Gauntlett & Associates, an insurance coverage law firm based in Irvine, Calif.

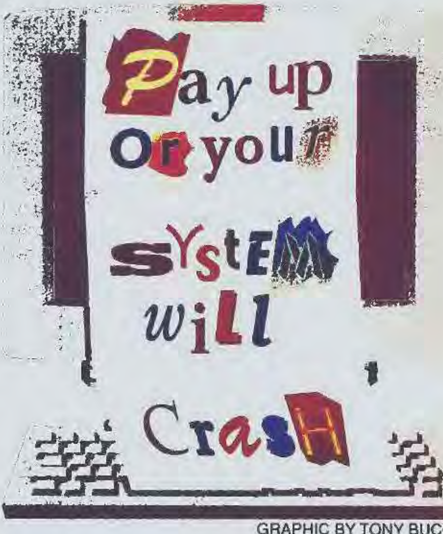
But a lot of electronic data and information risks are covered under existing insurance policies, he said.

For example, in cases where criminals threaten to release a virus unless the company pays a ransom, "kidnap and ransom policies would be and should be quite responsive," according to David Steuber, a partner with Troop, Meisinger, Steuber & Pasich in Los Angeles. This situation is commonly known as "EDP Extortion" or electronic data processing extortion.

"Most often these policies cover extortion demands," he explained. "It's not simply a policy to respond to the kidnap of a person, but also to demands that might be applicable to a business or its products."

When the best-laid risk management plans fail, companies may find they not only have insurance coverage to respond to the losses but also to help foot the bill for additional security that may be required to respond to threats of a computer theft or virus being implanted.

*See* **Ransom** *on page 16*




GRAPHIC BY TONY BUCCINI

## Battle for market share benefiting risk managers

By JUDY GREENWALD

Insurance buyers can expect better coverage at lower prices as insurers continue to battle it out for market share.

"Risk managers are no doubt looking forward to another easy year with regard to limits and pricing," said Barbara Stewart of Stewart Economics in Atlanta.

"It's the same old story," said Ms. Stewart. "The talk that I hear is that if anything, the business is becoming more competitive and that pricing is becoming less and less rational. So one would think that at least on the underwriting side, it's not going to be a good year."

Ms. Stewart said that "unless the securities markets are kind" as they were during last year's booming market, insurers will have "a very tough year."

David McDonald, senior vp and chief underwriting officer at Royal Insurance USA in Charlotte, N.C., said, "There's not enough emphasis being placed on the underwriting process, pricing the product commensurate with the exposures presented. But," he added, "so long as the stock market continues to perform as it does, I don't see any fundamental change in the price of the products being sold."

Insurers and analysts shared the perception of a keenly competitive buyers' market.

"We don't see any mitigation of this intense competition that's been taking place over the last year or two in most lines," said Louis G. Paglia, senior vp and treasurer at TIG Holdings Group in New York.

*See* **Insurers** *on page 24*

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NEWSPAPER

## Indemnity health plans likely to raise rates

By JUDY GREENWALD

Rate hikes may help group health insurers bounce back from a tough 1996.

Group indemnity insurers and health maintenance organizations are expected to introduce rate increases later this year, though group indemnity insurers' boosts are likely to be higher, says Richard Haw, a financial analyst with A.M. Best Co. in Oldwick, N.J.

Indemnity increases will be higher than HMOs because insurers do not have the same cost controls in place, "so basically they are paying whatever the doctor is billing," Mr. Haw said.

Meanwhile, the fourth quarter "was pretty much a repeat of the third quarter, with companies on the indemnity side continuing to struggle in light of the competition from other managed care operations," said Manfred Nowacki, vp with A.M. Best.

That struggle, "along with the downturn of the cycle in 1996, meant it was not a good year for indemnity companies."

As HMOs increase their market share, "you're seeing the shift from indemnity-based products to HMO-type products, which is causing a shift in the profitability in that bus-

*See* **Health** *on page 24*

## Updates

### Dow Jones contests libel ruling

*Continued from previous page*

ment firm, claimed the 1993 article contained falsehoods and contributed to the firm's going out of business.

New York-based Dow Jones said that for now, an article in Friday's Journal stood as the company's statement on the verdict. The article includes a statement from Journal Managing Editor Paul Steiger that in his view the newspaper was "chronicling the difficulties of this company; we did not cause them." Dow Jones indicated it will appeal if the verdict is not set aside. Mr. Steiger said, "We are optimistic, based on applicable law, that it will not stand." The company said it has $45 million in libel coverage.

While this verdict could be reduced, its impact on the media liability insurance market would come as part of a trend toward larger and more frequent libel verdicts, said Chad Milton, senior vp at Media/Professional Insurance in Kansas City, Mo. "It seems to me that this would have the effect of hardening the media liability market," he said. "A big verdict used to be a million or two or three. Now the big verdicts are bigger, they're coming more often, and the prospects on appeal are not as bright as they were in the past."

He said part of Dow Jones' coverage is with Media/Professional.

Other recent awards against the media include a January verdict of $5.5 million in punitive damages and $1,400 in compensatory damages levied in December against American Broadcasting Cos. Inc. related to a 1992 episode of "PrimeTime Live" about the Food Lion Inc. supermarket chain. The verdict was based not on libel but on fraud allegedly committed by ABC News employees in obtaining jobs at the Salisbury, N.C.-based chain. ABC is appealing those awards.

Also in December, a Miami jury awarded $8.75 million in damages to a bank executive in a libel lawsuit against the news organization.

### Ohio Blues plan ends merger

CLEVELAND—Blue Cross & Blue Shield of Ohio last week agreed with state regulators to discontinue its efforts to be acquired by Nashville, Tenn.-based Columbia/HCA Healthcare Corp., effectively ending the giant hospital chain's gambit to buy the Blues plan for $299.9 million.

The Ohio Department of Insurance previously had ruled against approving the proposed deal (*BI*, March 17), arguing that it would change the Blues plan's nature as a mutual insurance company. Although the plan had 30 days to appeal, the new settlement with the state includes giving up that right.

Under the agreement, Ohio BC/BS President Kent Clapp will continue in his job, but company Chairman John Burry Jr. will leave with benefits, deferred compensation and pension totaling $14.4 million. The insurer also has agreed to drop most of its outstanding litigation involving control over BC/BS of Ohio and other matters relating to the Columbia/HCA deal.

### AIA calls for equal laws

WASHINGTON—The American Insurance Assn. is calling for "functional regulation" of the financial services industry as the relationship of banks and other financial institutions to the property/casualty insurance industry changes.

In a list of principles it wishes to see applied to financial services modernization legislation, the AIA says it prefers state or federal legislation that "establishes a level playing field" to court decisions or "regulatory pronouncement under current laws" as the way to set rules governing the relationship between depository entities and insurance.

"The regulation of all insurance activities should be by the insurance regulator carrying out the insurance laws. Bank regulatory authority, whether directed at bank solvency or otherwise, should not be used in a way to circumvent the functional regulatory structure of the legislation, or to try to affect insurance activities, or to broaden the powers of financial institutions," according to the AIA principles, which were announced last week.

The AIA also calls for allowing depository institutions to underwrite insurance only through a "separate corporate entity which is financially insulated from the bank." All such entities should also be required to participate in guaranty funds and any "relevant state residual markets" that insurers must support, the AIA holds.

Among the other principles are allowing banks and insurers to engage in joint ventures and other activities, prohibiting the characterization of property/casualty products as "banking," and enforcing adequate consumer safeguards against banks coercing customers to buy insurance from them.

### Implant suits dismissed

DETROIT—Michigan has become the third state to dismiss all silicone breast implant lawsuits against Dow Chemical Co., the parent corporation of Dow Corning Corp.

The March 20 ruling by Wayne County Circuit Judge Robert J. Colombo Jr. will affect about 800 lawsuits filed against the company in Michigan.

*See* **Updates** *on page 26*

### Errors & omissions

• Due to an editing error, a statement in a story on page 14 was incorrect. A study on securities litigation indicated that rising stock prices in 1996 may have led to fewer lawsuits.

• Revenues for RMI Consulting Inc. were listed incorrectly in the March 17 directory of risk management consultants. Total gross revenues are $2,300,000 and revenues generated from pure risk management consulting are $2,000,000.

• Due to an editing error, Zenith Administrators Inc. was omitted from the Feb. 17 directory of claims administrators specializing in benefit claims. A complete listing appears on page 14.

# Lloyd's fights EMLICO deal

**By DOUGLAS McLEOD**

BOSTON—Lloyd's of London underwriters are seeking permission to intervene in court proceedings on a proposed settlement that would make the Massachusetts Insurance Division U.S. receiver for the hugely insolvent Electric Mutual Liability Insurance Co.

Meanwhile, court filings brought to light in the settlement reveal that a lawyer for EMLICO's former president and treasurer identified the two men as "possible subjects" of a federal grand jury probe of EMLICO's controversial 1995 move to Bermuda.

The two men, who are now top officers of former EMLICO affiliate Electric Insurance Co., refused to be examined under oath last December by Insurance Division officials investigating EMLICO's redomestication.

Lloyd's last week filed a motion to intervene in proceedings to confirm the proposed settlement, charging that it "represents yet another instance of (Insurance Commissioner Linda Ruthardt's) abandonment of her regulatory obligations."

Under the settlement announced earlier this month, EMLICO, a longtime General Electric Co. liability insurer, would continue its liquidation in Bermuda but would send GE environmental claims settlements to Massachusetts for review. The review would be conducted by a special master chosen by GE, EMLICO

*See* **EMLICO** *on page 4*

# Deregulation on fast track

## Brokers, risk managers support NAIC re-engineering plan

**By MEG FLETCHER**

ORLANDO, Fla.—Buyers and brokers are enthusiastic about state insurance regulators' acceptance of the concept of deregulating commercial lines and the fast track it is on for further development.

The two groups plan to help a National Assn. of Insurance Commissioners subgroup meet a June deadline to finalize a new, preliminary white paper on regulatory re-engineering.

The subgroup also will develop prototype options for states to implement, according to the draft released last week at the NAIC's spring meeting in Orlando.

The Risk & Insurance Management Society Inc. "commends the NAIC Special Committee on Regulatory Re-Engineering for its continued effort to explore deregulation and in preparing the draft of the white paper," said David A. Holcombe, risk manager for International Speedway Corp. in Daytona Beach, Fla. He chairs RIMS' Government Affairs Committee. "The NAIC should continue the focus of deregulation on the insurance buyer," Mr. Holcombe said.

*See* **NAIC** *on page 26*

### Association among first groups to offer plan option

# PIA sponsors MSA program

**By JERRY GEISEL**

ALEXANDRIA, Va.—The National Assn. of Professional Insurance Agents is giving its agency members a new health care plan option with the introduction this month of tax-favored medical savings accounts.

The PIA program takes advantage of a federal law that went into effect Jan. 1 allowing employers with 50 or fewer employees to provide MSAs linked to high-deductible medical plans.

The PIA, which currently offers its agent members a traditional indemnity plan and a preferred provider organization, is one of the first major trade associations to offer MSAs to its members since Congress enacted legislation last year giving MSAs their tax-favored status.

"MSAs are a boon to employers looking to save money on insurance premiums," said Bruce Scholnick, division vp with the Alexandria, Va.-based PIA, which represents about 15,000 insurance agencies.

Indeed, some PIA members signing up for the MSA program say it will cut their group health costs substantially. For example, James Probus, the self-employed owner of the Probus

*See* **MSA** *on page 6*

# Administration backing OPIC despite 'corporate welfare' charges

**By MARK A. HOFMANN**

WASHINGTON—The Clinton administration wants to reauthorize the Overseas Private Investment Corp. for three years, despite charges by critics that the federal political risk insurer is nothing more than corporate welfare run amok.

OPIC President and Chief Executive Officer Ruth Harkin presented the administration's proposal last week during an appearance before the House International Affairs Committee's Subcommittee on International Economic Policy and Trade. It was Ms. Harkin's final scheduled Congressional appearance before she steps down from OPIC at the end of this month. No successor has been nominated yet.

**Ms. Harkin**

OPIC offers limits of up to $200 million on 20-year political risk policies for U.S. companies seeking to do business in selected developing countries. During fiscal year 1996, it provided $16.5 billion in political risk insurance to U.S. companies, nearly double the premium it wrote the previous year. The 26-year-old federal agency came under serious

*See* **OPIC** *on page 14*

## Inside

• The measures that the Massachusetts insurance commissioner proposes to resolve the EMLICO case are inappropriate, one of this week's editorials says. **PAGE 8**

• Donated insurance is expected to cover damage a political activist caused to the America's Cup. **PAGE 19**

• A comprehensive set of managed care rules has taken effect in New Mexico. **PAGE 22**


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# Medicare shift to HMOs continuing

By JERRY GEISEL

WASHINGTON—The rapid movement of retirees from traditional Medicare programs to health maintenance organizations is likely to continue even if Congress passes legislation reducing the growth of federal payments to HMOs, consultants say.

More than 4.3 million retirees now receive health care coverage through so-called Medicare risk HMOs, with roughly 80,000 to 100,000 new retirees moving into HMOs each month.

Many of these retirees also receive additional benefits from the HMOs, such as prescription drug coverage, reducing costs for employers that had been providing the supplemental benefits from their post-employment health care plans.

Benefit managers, while not endorsing the Clinton administration package, say the formula the federal government uses to pay HMOs is fundamentally flawed and needs to be overhauled.

Under the current system, HMOs receive from Medicare 95% of what Medicare believes it would cost the federal government to provide traditional Medicare benefits to retirees in counties where the retirees live.

Benefit managers say that results in a huge skewing effect.

They say payment rates in counties where Medicare costs are high allow the HMOs to offer benefits Medicare does not provide, charge retirees little or no premium and still make a healthy profit.

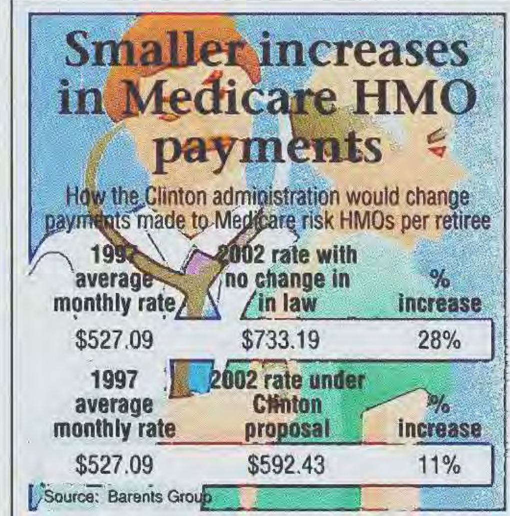
On the other hand, payment rates to HMOs in counties where Medicare costs are low often are insufficient for HMOs to offer coverage to retirees eligible for Medicare and operate profitably.

"It is a very peculiar public policy. In some markets, you can get everything under the sun" from HMOs providing coverage to retirees, said Helen Darling, manager of health care strategy and programs at Xerox Corp.

But in other markets where Medicare payment rates to HMOs are low, the benefits are poor, she said.

Indeed, in South Florida, Medicare payments to HMOs are so high that HMOs have been able to offer a rich array of supplemental benefits, including free transportation to health care providers, said Jack Romeo, director of health care systems for Bethlehem Steel Corp. in Bethlehem, Pa., which now has 10,000 retirees receiving coverage through Medicare risk HMOs.

See Medicare on page 6




GRAPHIC BY TONY BUCCINI

# Priorities outlined as U.K. vote nears

By STACY SHAPIRO

LONDON—Life as Britons and risk managers know it may soon change if a new party comes to power after the general election May 1.

The two major parties generally agree on issues of importance to business and insurers. In addition, several pieces of legislation important to business already have been passed by Parliament and so are not at risk of being held up by politics.

Mr. Major

Even so, there are still several issues on risk managers' and insurers' wish lists for whichever party wins the election.

U.K. Prime Minister John Major last week called a general election to be held May 1. Under U.K. law, the prime minister may call an election at any time but must do so by the fifth anniversary of the last election, which in this case was May 1992. At stake are 651 seats in the House of Commons. During the last election, Mr. Major's Conservative Party won the majority, allowing him to "form" a government.

Since then, however, the prime minister's majority has been lost due to a number of deaths and subsequent elections to replace those vacant Member of Parliament seats.

There are two other major parties in the House of Commons: the Labour Party, led by Tony Blair, and the Liberal Democratic Party, led by Paddy Ashdown.

Many Britons are disenchanted with Mr. Major and the Conservative Party, which has been in power for 18 years. The Labour Party currently leads the polls by more than 20 percentage points, leading to wide speculation that Tony Blair will be the next prime minister.

At first glance, the outcome of the election may not make much difference to risk managers. Most business executives support Mr. Blair's "new" Labour Party, which has moved from the left to the middle ground in recent years.

But observers wonder privately whether the Labour Party will revert to its former ways if it comes to power.

Mr. Blair

Traditionally, the Labour Party has been the political party to increase taxes and to strengthen trade unions' grip on industry.

Labour also supports the Social Chapter of the Maastricht Treaty, which governs employee rights such as a minimum

See Election on page 27

# Quality concerns up: Survey

By ROBERT KAZEL

Despite fears that managed care prices will rise, employers are buying health care increasingly based on quality concerns and less on cost, a new survey says.

It also showed that most smaller companies still focus on price, while the largest companies have grown more interested in sophisticated quality measurement yardsticks.

The survey, by Bethesda, Md.-based Watson Wyatt Worldwide and the Washington Business Group on Health, found 51% of employers surveyed mentioned cost as a definition of value in choosing a health plan, down from 59% in a similar survey last year.

In contrast, 51% of respondents said they look for quality in their definition of value, up from 45% in 1996.

But as employers recognize the importance of comparing the quality of health care choices, they also are facing their lack of knowledge on complex quality-measurement issues, said Maureen Cotter, a consultant in Watson Wyatt's Southfield, Mich., office who helped organize the study.

"Fewer companies think they are very effective at buying health care," she said.

Whereas 20% of employers in the 1996 survey said they felt they were "very effective" at buying health care, this year only 12% expressed that level of confidence.

In descending order of significance, companies ranked the following as most important in their definition of "value": access of facilities; cost; medical outcome data; employee satisfaction; utilization data; accreditation; and Health Plan Employer Data & Information Set data.

Large employers were much more likely to consider factors other than cost as important.

For example, large employers used performance standards 88% of the time, while small employers used such standards only 37% of the time.

The study conducted mail-in surveys of 252 companies and in-person interviews with 46 large employers.

•

*Copies of the survey, "Partnering For Value," will be available in early May for $100 each from Watson Wyatt Worldwide by calling 800-243-1349.*

## Cummins converts to cash balance pension plan

# Engine maker switches gears

By JERRY GEISEL

COLUMBUS, Ind.—Employees at Cummins Engine Co. Inc. now receive their pension benefits through a cash balance plan.

The new plan, which covers about 7,000 employees, replaces a traditional, final average pay plan that Cummins officials, after an extensive review, decided no longer met the needs of employees.

"The workforce was changing. We wanted a plan that better meets employees' needs throughout their entire careers. And we wanted a plan that would be easier to understand," explained Jan Nolander, executive director of performance management and rewards for Cummins, a Columbus, Ind.-based manufacturer of diesel engines and components.

The previous plan met none of those objectives. As a final average pay plan, the design was skewed in favor of long-service employees so that workers who left after a few years received very small benefits.

"We wanted to say to employees that we value your service at Cummins throughout your employment at the company," Ms. Nolander said.

In addition, because the previous plan had a complex benefit formula, it was difficult for employees to readily know the value of the benefits they had accrued.

Cummins' cash balance plan, which was put in place Jan. 1, addressed each of those problems.

As career average plans, cash balance plans provide a smoother accrual of benefits compared with traditional final average pay plans, where the bulk of benefits are earned during employees' later years of employment. That means employees leaving after a few years of service receive significantly higher benefits under a cash balance plan than they would have in the final average pay plan. It also means benefits don't suddenly jump—as they do

See Cummins on page 15

# Employers warned not to wait on Year 2000

## Mistakes could be costly: Speaker

By JOANNE WOJCIK

PALM SPRINGS, Calif.—Employers shouldn't wait until Dec. 31, 1999, to determine whether their benefit administration systems are "millenium compatible."

Costly business disruptions and lawsuits may occur if an employer fails to reprogram the computers it uses to recognize the year 2000, warns Alan R. Parham, administrator of the Laborers District Council Construction Industry Pension Fund in Philadelphia.

"Say a medical claim you received Dec. 20, 1999, isn't paid until after Jan. 1, 2000," he said. "If your claims administration system doesn't recognize the year 2000, it will think the claim is 99 years old."

This is because computers that don't recognize the year 2000 will think a year whose last two digits end in "00" is actually the year 1900, Mr. Parham explained.

Such a mistake could be costly for the employer, especially if the system calculates late-payment charges it owes to health care providers, he pointed out.

"If you send out a bill for late payment, it would include 99 years worth of interest and liquidated damages," Mr. Parham told a group of benefit specialists attending the Administration Automation Institute in Palm Springs, Calif., earlier this month.

The conference, sponsored by the Brookfield, Wis.-based International Foundation of Employee Benefit Plans, also provided information on legal and regulatory aspects of cyberspace, utilizing technology to enhance benefit plan participant services, the Internet and specific technologies regarding benefits processing, communication and document printing.

Employers also must ensure that their systems can properly

See Millennium on page 15

# EMLICO

*Continued from page 2*

and Commissioner Ruthardt (*BI,* March 17).

In return, the Insurance Division will drop its investigation into charges that EMLICO concealed its insolvency in a fraudulent scheme with GE to take advantage of Bermuda liquidation laws that would accelerate reinsurance payouts on GE claims.

Only months after getting the green light from Massachusetts regulators to move to Bermuda, EMLICO declared itself hugely underreserved for GE pollution and asbestos claims and insolvent by more than $500 million (*BI,* Dec. 11, 1995).

After refusing to reopen the EMLICO redomestication last year, Commissioner Ruthardt began her investigation of the fraud charges as part of a examination of EIC, which was spun off from EMLICO in the redomestication. EIC is managed by former EMLICO officers, including David F. St. Laurent, EIC's president, and Laurence J. Cohen, its treasurer.

Only hours before its settlement with GE, EMLICO and EIC was announced, the Insurance Division was still maintaining in court that it would "vigorously pursue" its investigation of the alleged fraud, Lloyd's complains in its filing with the state Supreme Judicial Court.

However, the settlement "utterly fails to. . .hold GE or EMLICO accountable for the damage to public confidence in the integrity of the Commonwealth's insurance regulatory process since, despite the evidence and preliminary findings of fraud, GE and EMLICO will continue to reap the benefits of their fraudulent redomestication to Bermuda," Lloyd's charges.

"Throughout the underlying proceedings up to and including the negotiations leading to this 'settlement,' the Commissioner has sought to shield her regulatory actions from judicial and public scrutiny," the filing adds.

The settlement, for example, includes several side agreements between the Insurance Division and GE, EMLICO and EIC that were not included in the settlement documents filed in court, Lloyd's lawyers note.

In one of these side letters, the division agrees that EMLICO's Bermuda liquidators "will be entitled to direct the disposition of all EMLICO documents whether in the form of writings or computer data."

In a separate filing in state Superior Court, Lloyd's argues that this agreement makes it "clear that GE and EMLICO have demanded, and the Commissioner has agreed, that the written proof of the GE/EMLICO fraudulent scheme will be forever concealed, if not actually destroyed." In this filing, Lloyd's is seeking a court order that EMLICO documents not be altered, destroyed or moved out of state.

Lloyd's argues in its Supreme Judicial Court filing that the Insurance Division won't protect reinsurers' interests and that Lloyd's should be allowed to intervene as a party in the settlement case.

Intervention would give the reinsurer broader standing to contest the agreement.

Lloyd's is also asking the court to postpone the scheduled April 8 hearing on the settlement deal.

The Insurance Division plans to ask Supreme Judicial Court Justice John M. Greaney to reject the Lloyd's motion, a spokeswoman confirmed.

Meanwhile, the settlement has highlighted earlier court filings in which a lawyer for EIC's Mr. St. Laurent and Mr. Cohen identified them as "possible subjects" of a federal grand jury investigation of EMLICO.

The Insurance Division filed suit against EIC last December to compel Mr. St. Laurent and Mr. Cohen to testify under oath about the redomestication.

Each man had earlier refused to answer questions at separate Dec. 10 and Dec. 12 hearings after their lawyer had read a prepared statement.

The lawyer, John J. Curtin Jr., with Bingham, Dana & Gould in Boston, cited several reasons for their refusal, including that Insurance Division officials conducting the examination were biased and that GE and EMLICO had instructed the men not to do anything that would "prejudice (the companies') privilege and confidentiality rights."

GE and EMLICO had advised Mr. St. Laurent and Mr. Cohen that "violation of those rights would amount to a breach of (their) fiduciary duties" as former employees of EMLICO, Mr. Curtin said.

In addition, Mr. St. Laurent and Mr. Cohen are "possible subjects" of the probe being conducted by the U.S. Attorney's office in Boston, he said.

"When the potential for criminal accusations has ended, (Mr. St. Laurent) will be happy to answer. . .questions and he hopes that the Division of Insurance will give him a fair opportunity to do so then. Now, however, it is not fair to make Mr. St. Laurent run the risk of losing his rights under the Fifth Amendment of the U.S. Constitution," Mr. Curtin said.

His statement for Mr. Cohen was virtually identical.

In an interview, Mr. Curtin denied that either man had actually claimed the constitutional privilege against self-incrimination.

"What I said was they should not be in a position to claim the Fifth Amendment," Mr. Curtin said.

Assistant U.S. Attorney Paul Levensen declined to comment on whether Mr. St. Laurent or Mr. Cohen are targets of the investigation.

An Insurance Division lawyer didn't get very far with either man after their lawyer's statement, transcripts of the hearings show.

In one exchange, Eric Smith, the division's lawyer, asked Mr. St. Laurent, "In June of 1995 (when EMLICO's redomestication was approved), did you believe that EMLICO was insolvent?"

"I have no further statement at this time," Mr. St. Laurent replied.

"At any time prior to July 1, 1995, did you believe that EMLICO was insolvent?"

"I have no further statement at this time."

". . .Did you believe that the 1994 EMLICO financial statements accurately represented EMLICO's financial condition when you signed them?"

"No further statement at this time."

"Are you invoking the Fifth Amendment in response to that question?"

"I object to that question," Mr. Curtin interjected.

"Will you answer the question, please?" Mr. Smith asked.

"I'm relying on the statement of counsel," Mr. St. Laurent said.

The refusal of the two men to answer questions under oath is grounds under Massachusetts law to trigger a receivership filing against EIC, according to the Insurance Division's complaint. Regulators decided instead to file suit for an order compelling testimony, the suit says.

The complaint is still pending but is one of several actions Commissioner Ruthardt has agreed to withdraw as part of the EMLICO settlement. BI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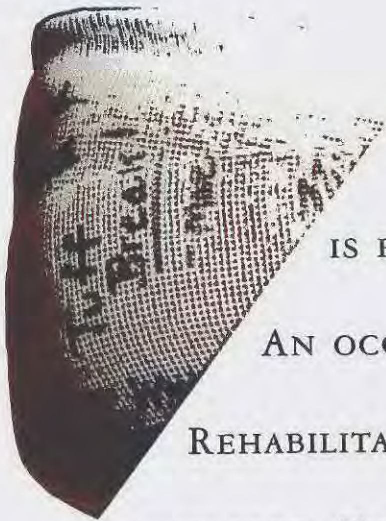

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# MSA

*Continued from page 2*

Insurance Agency in Louisville, Ky., says moving to the MSA from a Blue Cross & Blue Shield plan he now has will reduce his monthly premium for individual coverage to $167 from $224.

The MSA has a higher deductible than Mr. Probus' BC/BS plan but a lower limit on total out-of-pocket costs.

"This is a win-win program," Mr. Probus said.

The PIA program follows the parameters laid down by the federal law. Members can purchase a high-deductible medical plan written by John Hancock Mutual Life Insurance Co.

**Moving to the MSA from a BC/BS plan will reduce James Probus' individual premium to $167 a month from $224.**

The program offers $1,500 and $2,000 deductibles for individual coverage and deductibles of $3,000 and $4,000 for family coverage.

Members then establish medical savings accounts, which are accounts used to pay health care-related expenses that are not covered under the high-deductible medical plans.

Contributions to the MSAs, which can come from savings gained by moving to a high-deductible plan, are tax-deductible. Annual MSA contributions cannot exceed 65% of the deductible for individual coverage and 75% of the family plan deductible.

Contributions to the MSAs earn tax-deferred interest. The current interest rate paid on the PIA program's account balances is just under 5%.

Funds can be withdrawn tax-free to pay for uncovered health care expenses. Under federal law, though, income taxes and a 10% excise tax are levied on MSA withdrawals to pay for non-health care-related expenses.

In the PIA program, the MSAs are administered by Crestar Bank of Richmond, Va. PIA members have 24-hour access to their accounts to check balances and make withdrawals through a toll-free number. BI

# Medicare

*Continued from page 3*

"It seems to us that we need more equity," Mr. Romeo said.

These reactions come after a new study released last week by the American Assn. of Health Plans, a Washington-based managed care trade group, that analyzes the impact of proposed changes to payment methodology for HMOs that provide coverage to retirees.

Changes the Clinton administration is proposing include:

• Reducing the basic payment to HMOs to 90% from 95% of the cost the federal government believes it would cost provide Medicare benefits to retirees.

• Basing rates not just on Medicare costs in a county but also Medicare costs nationally. Specifically, rates for a county would be a blend of national and local costs. The weight of national costs gradually would increase. National costs are not considered now in the payment formula but they would be 10% of the formula in 1998 and rise to 30% in 2002.

This change would lower payment increases in counties with high Medicare costs and accelerate payment increases in counties where Medicare costs are below the national average.

• Establishing a minimum basic payment rate of $350 a month per retiree.

The AAHP study, prepared by the Barents Group, a research arm of KPMG Peat Marwick L.L.P., found that under the administration proposals, basic payment rates to Medicare risk HMOs would rise to an average of $592.43 per retiree by the year 2002 from the current basic rate of $526.09. By contrast, under current law, basic rates are expected to rise to an average of $733.19.

In some counties, though, the cut in payment increases would be especially high. For example, in Dade County, Fla., the basic payment rate, which is now $748.23—the highest of any county in the United States—only would nudge ahead 1.3% to $757.95 by the year 2002, the study found. That compares with a 56.9% projected rise to $1,173.76 if the current payment methodology is unchanged.

On the other hand, rates would rise faster in some areas of the country where payment rates are low. In San Luis Obispo County, Calif., the basic payment rate would rise 30.6% to $504.76 under the administration's plan, compared with the projected rate of $462.99, a 19.8% rise, according to the study.

AAHP President and Chief Executive Officer Karen Ignagni said that, overall, most retirees would be in parts of the country where projected payment increases would be lower than compared with current law. As a result, additional, supplemental benefits provided by HMOs to retirees could be jeopardized, she said.

But benefit consultants say that providing coverage to retirees is so profitable that HMOs likely would only have to trim benefits to maintain profit levels.

"HMOs still will be able to offer attractive benefits. All that we are likely to see is a trimming of supplemental benefits," said Will Applegate, a consultant with The Kwasha Lipton Group in Fort Lee, N.J.

The administration proposal, from an employer perspective, "is not bad news. HMOs will still be attractive enough for retirees to join," he added. BI

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# Opinions

## At what cost convenience?

LOOKING OUT FOR POLICYHOLDERS is a regulator's job, but Massachusetts Insurance Commissioner Linda Ruthardt is taking protection of one policyholder—General Electric Co.—to unreasonable extremes.

Commissioner Ruthardt has proposed a settlement under which she would become U.S. receiver for GE's hugely insolvent Electric Mutual Liability Insurance Co. In return, she will drop her investigation—and withdraw her support of other investigations—into charges that GE and EMLICO concealed the insurer's insolvency in a scheme to move it to Bermuda to take advantage of the island's favorable liquidation laws.

The deal is a bad one and should be rejected by a Massachusetts court.

GE and EMLICO representatives have repeatedly argued that this case is about greedy reinsurers launching fraud charges to avoid paying valid EMLICO claims. They are wrong. The case is about whether EMLICO lied to regulators to further GE's interests and, if so, whether they will be allowed to get away with it.

Documents filed in the case strongly suggest that EMLICO misled regulators and show a concerted effort by GE to stonewall subsequent inquiry.

This evidence includes a memo prepared for EMLICO by London law firm Clifford Chance & Co. six months before Commissioner Ruthardt approved EMLICO's redomestication, outlining advantages of a Bermuda runoff.

When the Insurance Division finally began to investigate, former EMLICO President David St. Laurent and another former EMLICO official refused to answer questions under oath, raising among other things the issue of their Fifth Amendment rights. This refusal alone is enough under Massachusetts law to place the insurer they now manage—former EMLICO subsidiary Electric Insurance Co.—into receivership.

Instead, Commissioner Ruthardt has agreed to a deal in which she will abandon her investigation; absolve GE, EMLICO, EIC and all of their employees and consultants of any liability connected to the redomestication; declare all documents obtained in the investigation confidential; turn over control of all EMLICO material to the insurer's Bermuda liquidators; and withdraw her support of efforts by the U.S. Attorney in Boston—who is still investigating—to obtain the Clifford Chance memorandum.

This goes beyond any reasonable settlement of disputed issues; Commissioner Ruthardt now appears willing to help GE and EMLICO bury potentially incriminating information.

And what does she get in return? An appointment as U.S. receiver that offers severely limited control at best and at worst is a sham. Under the deal, GE's huge environmental claims still will be settled in Bermuda and will only be reviewed in Massachusetts by a special master picked by GE, EMLICO's liquidators and Commissioner Ruthardt. The special master may not "substitute his or her judgment for that of the parties"—GE and EMLICO.

Commissioner Ruthardt says this settlement avoids the "uncertainty and expense" of trying to regain real control of EMLICO.

The cost of this approach, though, is the integrity of the Massachusetts Insurance Division. It isn't worth it.

Meanwhile, Bermuda's regulatory role in the EMLICO mess also is worth a note.

The Bermuda government has steadfastly maintained that this was Massachusetts' problem to solve. While Bermuda authorities could have undertaken their own investigation, they did nothing; they appear instead to agree with EMLICO that this is a mere business dispute and seem content to gain the jobs the EMLICO liquidation will generate.

Even if Bermuda regulators didn't believe they were deceived in the redomestication, though, they should not have remained inert when evidence suggested their U.S. counterparts were duped.

Bermuda's hands-off attitude in this case should be a concern to all companies—particularly reinsurers—that do business in the domicile.

## Looking out for No. 1

BIG MAY NOT ALWAYS BE BETTER, despite the consolidation trend in the insurance industry.

Amid all the merging and acquiring in the quest to be king of the hill, we hope the brokers and insurers remaining don't lose sight of their customers' needs.

Those that keep this focus have an opportunity to bring their new strengths to bear in terms of enhanced customer service, market leverage and lower pricing. Those that overlook the client as they strive to get bigger risk losing business to more focused or more nimble competitors.

In the wake of the mega-mergers between Marsh & McLennan Cos. Inc./Johnson & Higgins and Aon Group Inc./Alexander & Alexander Services Inc., there are certain to be layoffs, early retirements, and consolidation of offices and teams for various lines. As in past mergers, there may be new edicts to use new affiliates wherever possible, to the exclusion of prior business relationships.

But there also may be new services and products, more resources to solve problems, broader geographic reach, more clout with underwriters and lower prices.

As we report in this week's issue, many buyers are taking a wait-and-see attitude to the brokerage mega-mergers.

While some are hopeful the new behemoths will provide them with more and better services, others are skeptical they will benefit as much as the companies' shareholders, if at all.

But buyers—especially current customers of the combined firms—that expect to reap the rewards of these mega-mergers, rather than pay the price, have to make their wishes known. They should not expect any service enhancement to be automatic. If they wish to benefit from the innovation, resources and leverage that supposedly come from such combinations, then they will have to insist on it.

As the punch line of an old joke goes, "Yesterday you were a prospect, today you're a client."

If the giant brokers cannot deliver as promised, there are plenty of companies waiting in the wings for a chance to prove that big is not always better.

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JANUARY 6, 1997

# Business Insurance

Reporting Weekly on Corporate Risk, Employee Benefit and Managed Health Care News

## RIMS gears up to push liability reform in 1997

By MARK A. HOFMANN

NEW YORK—The Risk & Insurance Management Society Inc. plans to push for broad-ranging liability reforms at both the state and federal level after Congress and state legislatures convene later this month.

But in addition to pursuing such traditional goals, the risk management group also plans to give emphasis to certain issues not usually prominent on RIMS' agenda, such as health care and pension reform.

Issues that retain their long-standing spots at the top of RIMS' agenda this year include reform of Superfund's pollution cleanup liability system, creating uniform standards for product liability and reforming the operations of the Occupational Safety and Health Administration.

"I don't see any big changes in RIMS' wish list," said Louis J. Drapeau, RIMS president. "The same kinds of things we've been working on for the past several years we'll keep plugging away at," said Mr. Drapeau, who is also manager of insurance and risk management for The Budd Co., a Troy, Mich.-based automotive parts supplier.

"Obviously, we're hoping Superfund reform gets the attention of the leadership and the members," said [illegible] Brown, RIMS' director of government affairs. "And we're still hoping for [illegible] retroactive liability [illegible] ing that we'll have to [illegible] the political realities [illegible] issue arises."

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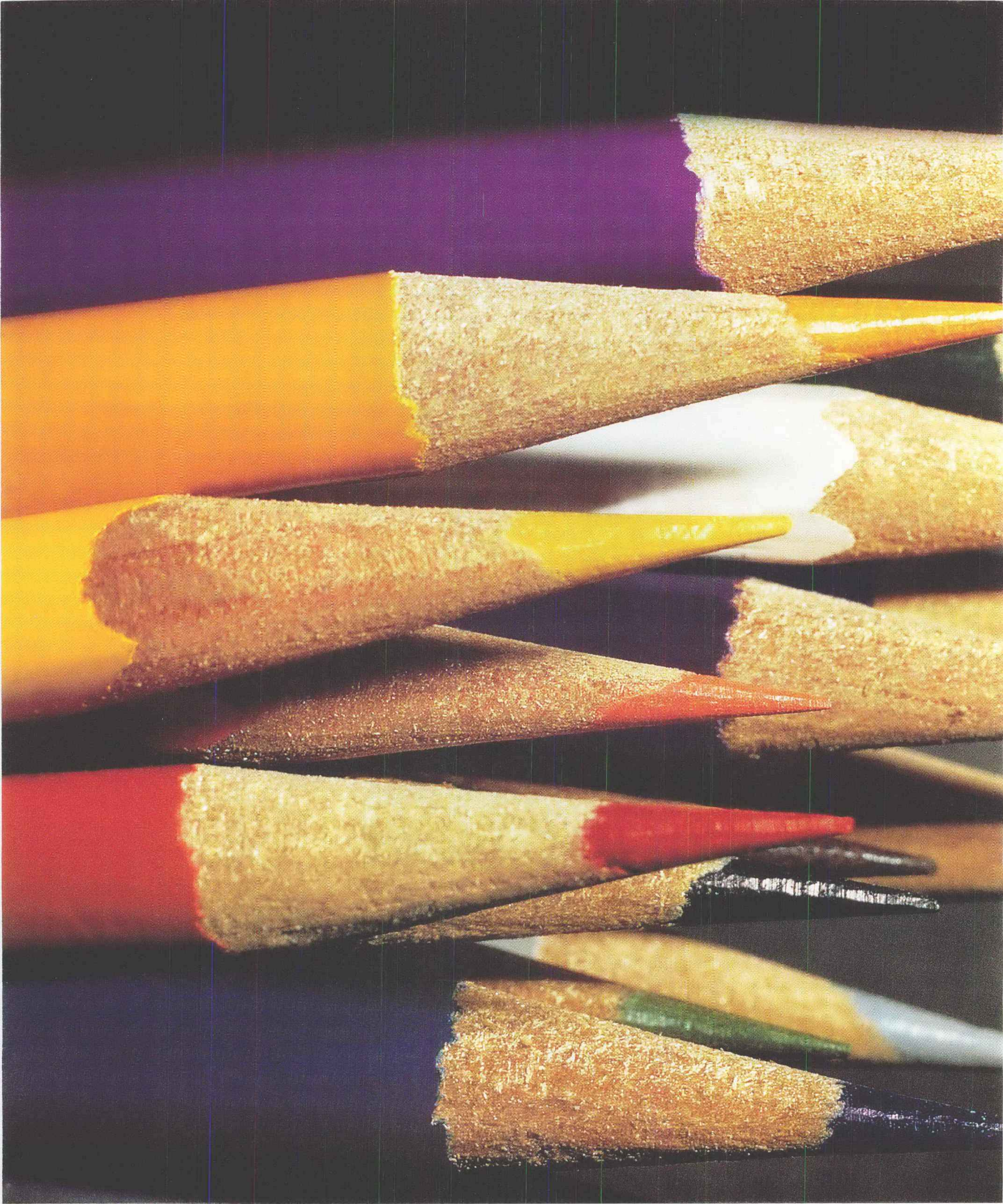

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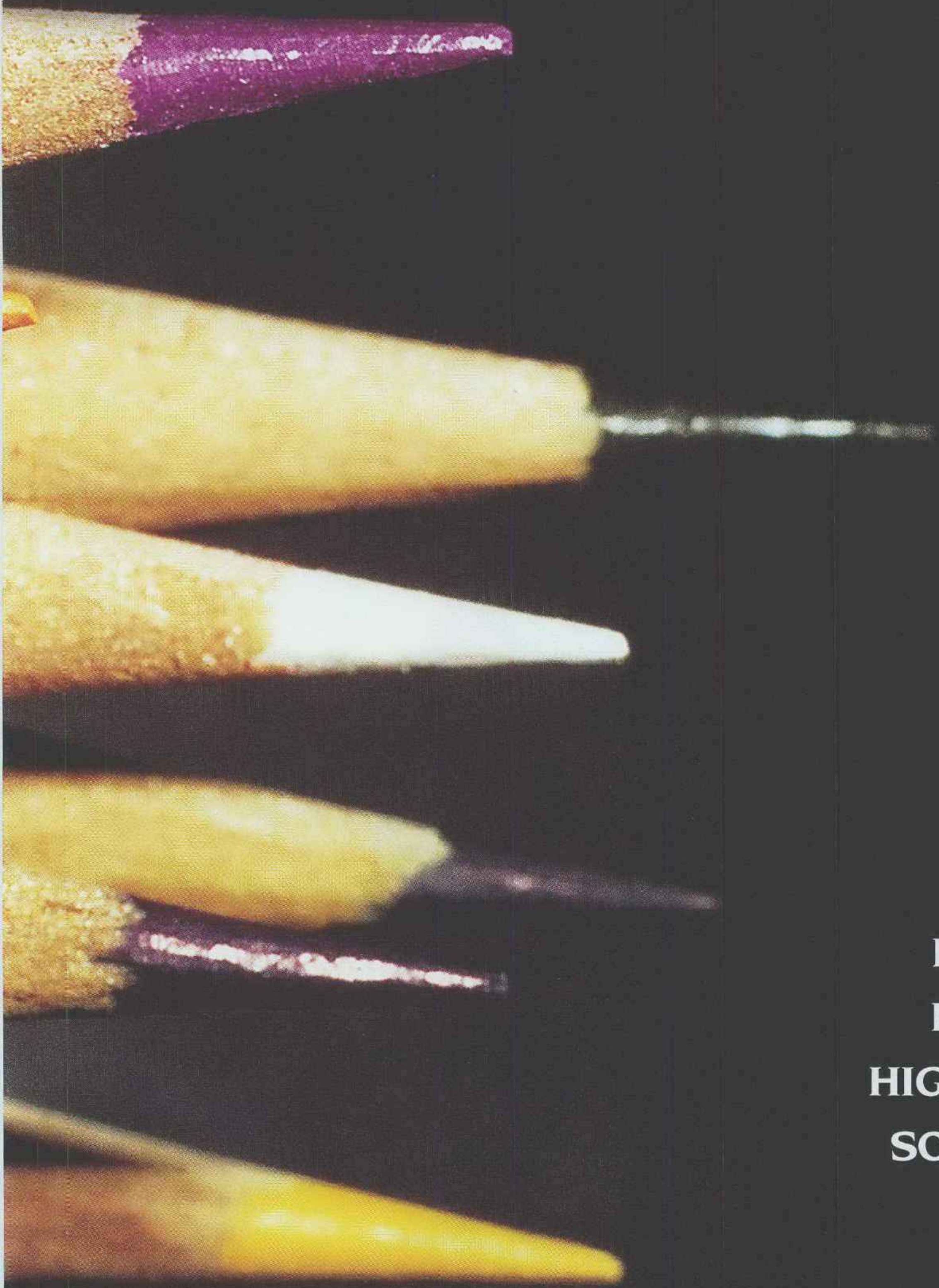


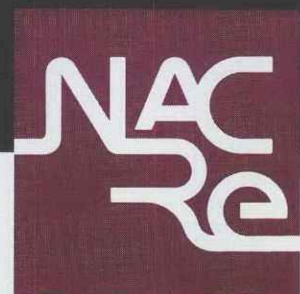


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# For the Record

## Florida comp insurer faces hearing

LONGWOOD, Fla.—PCA Property & Casualty Insurance Co., a Longwood, Fla.-based workers compensation insurer, is showing a deficit estimated at $128.3 million and faces a May 2 hearing in Leon County Circuit Court that will determine whether the company is placed in rehabilitation.

Already under administration by the Florida Department of Insurance, the subsidiary of Physician Corp. of America will continue to pay claims under supervision of the department. The company wrote mostly workers comp coverage, and its policyholders include 32,940 Florida employers.

Regulators say the company has about $350 million in cash and short-term investments that can be used to pay claims. The $128.3 million deficit was determined after independent actuaries found that $80 million would be needed to pay claims in addition to the $48.3 million shortfall PCA already has acknowledged.

A.M. Best Co. lowered its FPR-2 rating, or below average, on the company to an E rating, indicating the insurer is under supervision.

## Allianz shuffles U.S. business

BURBANK, Calif.—Allianz Insurance Co. will renew about $90 million of Novato, Calif.-based Fireman's Fund Insurance Co.'s high excess layered property and energy business effective April 1.

The move is part of an effort by both companies' parent, Allianz A.G. of Munich, Germany, to restructure its North American operations, said Trevor E. Care, an Allianz Insurance senior vp.

In addition, Allianz Insurance will integrate its workers compensation division into Fireman's Fund for underwriting and servicing.

Mr. Care said the large risks that Allianz is assuming from Fireman's Fund better fit Allianz's strategy of focusing on large account, Fortune 1,000 business.

"The Fireman's Fund strategy is really the middle market type business," he said. Allianz hopes eventually to write working-layer coverage for this property and energy business, said Mr. Care.

## Court limits coverage for Alcoa cleanup

SEATTLE—A Washington state court has rejected the Aluminum Co. of America's attempt in its long-running pollution coverage dispute to hold each insurer jointly and severally liable for all the cleanup costs.

Judge Kathleen Learned's allocation of damages, combined with the deductibles on the coverage, has reduced by 90% the amount Alcoa can collect from its insurers.

Two separate rulings resolved questions that were left unanswered from a jury's verdict rendered in October 1996 for three sites in the United States. The jury limited insurers' liability to $20 million but did not allocate that amount among various years (*BI*, Oct. 21, 1996). Judge Learned allocated the cleanup costs evenly over the years it occurred.

"The damage occurring in any particular year is covered by the insurance policies, if any, on the risk during that year, with the liabilities being divided amongst the insurance companies pursuant to their policy limits and/or 'other insurance' provisions," according to the decision. "Alcoa is responsible for damages occurring in years in which no coverage was purchased."

In addition, each policy contained a $250,000 per occurrence deductible that further lowered Alcoa's recovery. Alcoa's insurers are responsible for $2.01 million of the $20 million the jury awarded.

Attorneys for the primary insurer, Lexington Insurance Co., said they were pleased with the judge's rulings. "The decision supports our position that a first-party insurer is only responsible for the damages that occurred during their policy coverage," said Wayne Glaubinger, a partner with Mound, Cotton & Wollan in New York.

Mr. Glaubinger added that because an earlier ruling upheld notice of loss and suit limitation clauses in the policies, the damages will be further reduced to about $175,000. The Lexington attorneys said Judge Learned now has the option of allowing Alcoa to appeal or have a new jury resolve the remaining outstanding issues.

Suits over approximately 35 additional sites have yet to be tried.

## Five Norplant cases dismissed in Texas

BEAUMONT, Texas—A federal judge has thrown out five lawsuits by women claiming injuries from the contraceptive Norplant and will determine whether to consolidate remaining claims into a class action.

Wyeth-Ayerst Laboratories, the St. Davids, Pa.-based manufacturer of Norplant and a subsidiary of American Home Products Corp., is facing product liability and other claims filed on behalf of more than 20,000 users of the contraceptive, which is implanted under the skin.

All the cases have been consolidated for trial before Judge Richard A. Schell in U.S. District Court in Beaumont, Texas.

The judge ruled earlier this month that plaintiffs in the five cases failed to prove their allegations that physicians who prescribed Norplant were not adequately warned by the manufacturer about health effects the women claim to have suffered from using the contraceptive.

Judge Schell has said he will decide whether enough similarities exist in claims from 10 other representative plaintiffs in two other suits to consolidate all claims into a single class action.

*Continued on next page*

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*Continued from previous page*

## Virginia legislation sets RSI standards

RICHMOND, Va.—Gov. George Allen has signed into law a bill spelling out the requirements for carpal tunnel syndrome to be treated as an occupational disease covered by workers compensation.

The new law takes effect July 1. It requires that a "claimant must prove to an absolute degree of medical certainty that the disease arose out of and in the course of employment" (*BI*, Feb. 3).

Business and insurance interests support the law, which also lists the actions a physician must take to certify that a claimant's condition falls within the definition of an occupational disease under Virginia law.

Under the new law, claimants who receive benefits for carpal tunnel syndrome "may not receive workers compensation for any permanent partial and permanent total loss and disfigurement that occurs as a result of carpal tunnel syndrome."

## Oklahoma OKs cut in comp rates

OKLAHOMA CITY—The Oklahoma State Board for Property and Casualty Rates has approved a 10.1% cut in Oklahoma's workers compensation loss-cost rates over the insurance commissioner's objections.

The rate cut, scheduled to take effect April 1, is the largest in 13 years and follows a 4.5% cut in loss-cost rates last year. The rate cut is smaller than the 12.9% decrease the Oklahoma attorney general's office sought. But, the National Council of Compensation Insurers sought a far more modest 3.4% reduction, and an independent actuarial firm retained by the Oklahoma Insurance Department suggested a 4% cut.

Insurance Commissioner John P. Crawford, who is a member of the rating board and cast the lone dissenting vote against the 10.1% rate decrease, said he is concerned that the rate cut will backfire on the 30% of Oklahoma employers that buy workers comp coverage from private insurers. He said it could drive private insurers from the state.

The state has enacted several workers comp reforms in recent years, but he said additional reforms are needed for rates to continue falling. A package of proposed reforms is moving through the Legislature.

Of the remaining Oklahoma employers, about 54% are self-insured. The rest buy coverage from the competitive State Insurance Fund. The fund has approved, on average, maximum rate reductions of 18.5% for renewal business and 13.5% for new business.

## Hawaii auto reform would cost employers

HONOLULU—Legislation to reform Hawaii's no-fault automobile insurance system would shift medical costs onto employer-sponsored health plans.

"We don't like it at all," said Clyde Mark, risk manager for Outrigger Hotels Hawaii in Honolulu. "All (employers) are lobbying against it in force."

H.B. 100 was introduced as part of a package by several Democrats. It has already passed through the state's House of Representatives and Senate and now is in a conference committee. Trial attorneys back the bill, which is similar to one submitted by Gov. Benjamin Cayetano, who is expected to support the latest legislation.

The bill would move auto insurance closer to a tort-based system. One of its provisions would make an automobile accident victim's health care plan, rather than an automobile insurance plan, responsible for covering accident medical expenses above $3,000.

Health plan providers in the state estimate they would have to increase employer health premiums by 3% to 5%. But Mr. Mark said he believes the amount will be greater than that. It could also force many employers to reduce employee health-care coverage, he said.

A repeal of no-fault auto insurance in Hawaii likely would be used by trial attorneys in other states who would argue that its repeal reduces cost, said Dave Snyder, assistant general counsel for the American Insurance Assn. in Washington. "Our point is that the repeal of no-fault means that bills that had originally been paid under automobile insurance are shifted to employers," he said.

## Contractor may still get MTA safety bonus

LOS ANGELES—The Los Angeles subway contractor that lost a worker in a fatal accident last month still is eligible to receive up to $500,000 in safety bonus pay, according to the Metropolitan Transportation Authority.

But it is unlikely that Los Angeles-based contractor Tutor-Saliba/Perini will receive the full bonus, because one fatal accident is the equivalent of five lost-time accidents for workers compensation reporting purposes, an MTA spokesman said.

"They'd have to run a near-perfect job the rest of the way," he said.

Under terms of the MTA's project safety incentive program, Tutor-Saliba's lost-time accident rate must average 3.8 per 200,000 man-hours worked to be eligible to receive the full $500,000 safety bonus, the spokesman explained. The bonus is the equivalent of 1% of the value of the contract.

But Tutor-Saliba still can receive at least a partial, pro-rated, bonus if its lost-time rate remains below 5.8 until its work is completed, scheduled for May 2000.

Conversely, if Tutor-Saliba's lost-time injury rate averages greater than 5.8, it must pay a penalty to the MTA. The penalty would be pro-rated in the same way as the bonus, with Tutor-Saliba's maximum exposure set at $500,000, the spokesman explained.

"It's an industry practice that provides a useful incentive to have a safer workplace," he said.

The MTA has not yet calculated Tutor-Saliba's lost-time injury rate since the Feb. 15 fatality. Before the accident, the contractor's lost-time rate was 2.2. The national average for similar work was 4.9 per 200,000 man-hours in 1996 (*BI*, Feb. 24). BI


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# OPIC

*Continued from page 2*

political pressure last year when the House of Representatives not only refused to grant OPIC's request for a five-year reauthorization and a near-doubling of its insurance capacity but refused reauthorization completely (*BI*, Sept. 16, 1996).

Although the Senate did not follow suit, lawmakers agreed to reauthorize OPIC for only one year, which runs through Sept. 30.

OPIC came under renewed fire earlier this year from an unusual alliance of deficit hawks, consumer groups, environmentalists and economic libertarians called the Stop Corporate Welfare Coalition (*BI*, Feb. 3). The group, which includes such politically diverse figures as consumer advocate Ralph Nader and House Budget Committee Chairman John Kasich, R-Ohio, views OPIC as a prime example of unnecessary government spending.

But Ms. Harkin received a generally warm reception at last week's hearing when she presented the administration's case for a three-year extension and an additional $9 billion in OPIC's contingent liability cap. OPIC currently has a cap of $23 billion to divide as it chooses between political risk insurance and development financing. The additional funding would raise that capacity to $32 billion over the next three years.

Ms. Harkin went on to call those who criticize OPIC as corporate welfare "ill-informed." She added that "no corporation, big or small, receives any subsidy or grant or handout of any kind from OPIC."

"If anything, OPIC is a corporate welfare reform," she said. The agency generates money for the U.S. Treasury, subjects applications for loans and insurance to close analysis and does not help companies that could not otherwise compete in the marketplace, she said.

In the questioning that followed Ms. Harkin's testimony, Rep. Sam Gejedson, D-Conn., went so far as to liken the debate over OPIC's future to that which preceded the Louisiana Purchase in 1803. Some lawmakers fought spending money for that immense tract of land just as fiercely as OPIC's opponents are fighting against reauthorization, even though both have been proven to be in the nation's best interest, he said.

Rep. Donald Manzullo, R-Ill., asked Ms. Harkin about concerns that OPIC was performing functions that private insurers could do. Ms. Harkin replied that there is "a definite gap in countries in which we do business" in the sense that private insurers are unwilling to underwrite political risk insurance, at least initially. OPIC is "serving as a catalyst" until private insurers feel comfortable to underwrite business in a given country.

She added that she thinks the private political risk insurance market is expanding and noted that "there's no reason for us to exist" if the private sector could fill the gap.

Rep. Doug Bereuter, R-Neb., said that while he does not consider OPIC to be corporate welfare, he wanted Ms. Harkin to be "candid" in discussing any instance where any private business has approached OPIC and said it could do what OPIC is doing.

Ms. Harkin replied that there were no such instances, although OPIC has entered into cooperative agreements with some political risk insurers.

One of two congressmen to speak against OPIC acknowledged that he thinks the agency has done a "great job" and that his opposition is "philosophically driven." OPIC is the "wrong thing for the government to be doing," said Rep. Lindsey Graham, R-S.C.

During an impromptu news conference in the hallway outside the hearing room after testifying, Ms. Harkin commented on the impact of recent announcements by underwriters that they would offer political risk policies with terms of up to 10 years under some circumstances (*BI*, March 10).

American International Group Inc.'s AIG Global Trade & Political Risk Insurance Co. raised its policy term to 10 years from the seven-year term first adopted last year.

In addition, ACE Insurance Co., X.L. Insurance Co. and Risk Capital Reinsurance Co. are creating a Bermuda-based managing general agency called Sovereign Risk Insurance Ltd., scheduled to begin operations May 1. Although the new policies generally will carry a seven-year term, some will be written for up to 10 years.

Ms. Harkin replied that OPIC already works "very closely" with AIG and other political risk underwriters. But private insurers still do not always offer coverage for every country in which OPIC is willing to underwrite political risk insurance for U.S. projects, she said.

Nevertheless, "I think there are ways we can work together," she said. BI

# Securities litigation reform hasn't halted suits: Study

By MICHAEL PRINCE

Congressional reform of securities laws has not reduced the amount of securities class-action litigation but has shifted it to different courts, a study has found.

The recent study examined the number of class-action securities fraud defendants since the law, known as the Private Securities Litigation Reform Act of 1995, took effect Dec. 22, 1995 (*BI*, Jan. 8, 1996). Its results show the amount of litigation decreased in 1996 but not below levels seen in recent years. It is still too early to evaluate any long-term effects of the reform, the authors warn.

The law, which passed when Congress overrode President Clinton's veto of the measure, is designed to reduce frivolous securities litigation by narrowing the grounds for such suits and giving companies new protection for public statements while also reducing damages for successful suits.

According to the study, conducted by Joseph Grundfest and Michael Perino, professors at Stanford University Law School in Palo Alto, Calif., between 148 and 163 securities suits would have been filed in 1996 if the law had been well-publicized in the first quarter. The actual number of class actions filed in 1996 was 109, but the professors used the extrapolated range of 148 to 163 as the basis of study, because they perceived that the figure for the first quarter of 1996 was artificially depressed due to the initial lack of knowledge about the law.

Between 1991 and the enactment of the law, an average of 176 suits were filed each year, with 162 filed in 1995.

"The total volume of litigation activity in 1996 is thus down by about 7% to 16% but is not very different from the level of activity observed in 1991, 1993 and 1995," the study says. Falling stock prices in 1996 also may have limited suits. Thus, it is too soon to draw firm conclusions on whether reform "has had any material effect on the aggregate securities class-action litigation rate."

But, of the total filed in 1996, 39 were filed solely in state courts, whereas prior to 1996 that number had been near zero. That increase is in direct response to the new law, the study's authors say.

"This increase in state court litigation is likely the result of a 'substitution effect' whereby plaintiffs' counsel file state court complaints when the underlying facts appear not to be sufficient to satisfy new, more stringent federal pleading requirements, or otherwise seek to avoid the substantive or procedural provisions of the act," the study states.

Such state actions do not indicate increased litigation activity but are evidence of a new litigation strategy, the study adds.

Since the reform, smaller companies have been sued, the researchers found. The market capitalization of defendant companies dropped to $529 million on average after the reform from an average of $2 billion before.

What has caused this drop is the nature of the post-reform suits. In complying with the more stringent pleading requirements, more suits allege accounting violations and insider trading, which are more likely to occur in smaller companies, the study reports. "Larger, more established firms are less likely sources for material accounting irregularities or statistically significant trading by insiders," the study states. "Larger firms are therefore less likely to be named as defendants."

Two aspects of securities litigation have not changed because of the law: the industries of the defendants and location of the suits. Before and after the law's passage, high-tech firms were the most likely targets of suits. Since the new law, 34% of suits in federal court are against high-tech firms, essentially unchanged from before the reform.

In addition, two federal district courts dominate the filing of the suits. Both the U.S. District Court for the Northern District of California, which encompasses the Silicon Valley, and U.S. District Court for the Southern District of New York, which includes Manhattan, had 15 suits each between Dec. 22, 1995 and the end of 1996. Combined, more than 25% of securities class-action were filed in these two districts since the reform law became effective.

•

*For a free copy of the study, contact James Malernee at Cornerstone Research, 212-551-3671.*

## TPA directory omission

The following item was omitted from the Feb. 17 directory of claims administrators:

**Zenith Administrators Inc.**
7645 Metro Blvd., Edina, Minn. 55439-3060; 612-835-7035; fax: 612-835-2803

| 1996 revenues | |
|---|---|
| Total | $46,500,000 |
| Claims revenue | $21,000,000 |
| Claims administration | 52% |
| Claims adjusting | 44% |
| Claims auditing | 4% |
| **Claims business by type** | |
| Disability | 5% |
| Health insurance | 90% |
| Employees covered | 240,000 |
| Dependents covered | 650,000 |
| Life | 5% |
| **Claims business by volume** | |
| Administration claims paid | 500,000,000 |
| **Clients** | |
| Total | 155 |
| Corporations | 55 |
| Multiemployer plans | 90 |
| Public/government entities | 10 |
| **Staff** | |
| Total | 740 |
| Claims services | 300 |

**Claims services since:** 1967.
**Parent:** ULLICO Inc.
**Service area:** Nationwide.
**Charges:** Administration: $6 to $12 PEPM.
**Branch offices:** Administrative offices in 31 locations nationwide.
**PPO access.**
**Officers:** Robert A. Georgine, James W. Luce, Gary L. Eng, Jerome P. Pollock, E. Dean Kalahar, Joann K. Zurzolo.

# U.S. mediation program launched

By MICHAEL PRINCE

It might lack the drama of a John Grisham courtroom thriller, but another mediation program is coming to a city near you with the promise of reduced litigation costs.

After a multiyear trial period in two test cities, the National Pre-Suit Mediation Program has elected officers and plans to expand throughout the United States. The organization, founded in 1992 by the defense attorney group International Assn. of Defense Counsel with money from the insurance industry, will establish mediation programs through local bar associations to resolve disputes before litigation erupts.

"We're trying to make the lawsuit the last resort, not the first resort," said James Readey, NPSMP director.

Over the next year, the organization plans to add nine cities, including New York, Chicago and San Francisco, to its programs already existing in Columbus, Ohio, and San Antonio. Within five years, it hopes to run programs in 40 cities. The NPSMP will not supervise the local programs but rather will help establish local programs to be run independently.

Mr. Readey said he hopes that one day 10% to 15% of disputes will be settled through mediation rather than litigated. He acknowledges he faces an uphill battle. "It's hard to get people to change the way they always have done things," he said.

NPSMP works by enlisting insurance companies to sign an agreement calling for mediation of claims before a suit is filed. When a dispute arises over a claim, the claimant can request mediation, and the insurance company will pay 75% of the first $1,000 in mediator's fees. Insurers that enlist in the program do so voluntarily. Signing on to the program is not legally binding. In the two test cities, most of the claimants have learned of this program from the publicity it has received.

The mediator, frequently a former judge, then talks to both sides in hopes of reaching a settlement. If the sides cannot agree, the claimant is free to leave the mediation and pursue a suit. Besides insurance companies, other signatories to the mediation agreement include hospitals, for medical malpractice, as well as utilities and municipalities.

Mediation proponents present the process as able to cure what ails all sides when a case is litigated. Plaintiffs like it, Mr. Readey said, because their claims get resolved faster. Their attorneys also favor it because it allows them to earn a fee in a much shorter time and focus their time on more complicated—and lucrative—cases. Defendants and their insurers like it because it lowers legal fees in defending suits. And the judges like it because each case successfully mediated means one less suit clogging their dockets.

**'We're trying to make the lawsuit the last resort, not the first resort,' says James Readey, president of the National Pre-Suit Mediation Program.**

Practically any type of dispute might qualify for mediation, Mr. Readey said. To date, the organization has successfully resolved personal injury, automobile accident, employment, environmental, construction and contract disputes.

"Any kind of case that ultimately might settle before going to trial might qualify," Mr. Readey said. "Ninety-five percent of cases settle, and we're trying to settle them sooner."

Nothing shows the broad support within the legal community for mediation more than last month's meeting, during which the organization's first officers were elected. Edward Schrenk, senior vp/general counsel of USAA Property & Casualty Insurance Co. in San Antonio, was elected president. Also elected were representatives from the plaintiffs bar, the defense bar and the insurance industry.

Of the more than 600 cases mediated so far, about 85% have been successfully resolved. Mr. Readey estimates that each mediated case saves insurers 90% compared with defending a suit.

The hope of savings of this magnitude drove six insurance companies to provide initial financing for the program. The initial sponsors—State Farm Group, Allstate Insurance Co., Nationwide Group, GEICO Corp., USAA Group and Farmers Group Inc.—each provided $25,000 per year for five years.

Insurers expect that they will more than recoup this investment through reduced legal fees, Mr. Schrenk said.

What distinguishes NPSMP from other mediation programs, according to Mr. Schrenk, is going to mediation before the filing of a suit. This greatly increases the savings compared with mediating a case shortly before trial, when most of the legal costs already have been spent.

"This gets people face to face," Mr. Schrenk said. "It gets plaintiffs, the lawyers and a mediator in a room to talk the thing through." BI

# Millennium

Continued from page 3

handle calculation of retirement benefits for employees who retire after the year 2000, according to Mr. Parham. Otherwise, the employer could be setting itself up for problems that could lead to lawsuits, he said.

"At 12 a.m. on Jan. 1, 2000, what's going to be the date on your PC?" Mr. Parham queried. "It might not be 01/01/2000," he cautioned, especially for users of International Business Machine Corp.'s AS 400 systems.

Because the AS 400 platform contains 50 lines of coding that uses only six-digit dates, such as 01-01-00, the dating format does not permit a four-digit year to be input. As a result, such systems could interpret 01/01/00 to mean 01/01/1900.

Programs that automatically calculate dates, such as those that print deadlines for responding to COBRA benefit continuation letters, will likely produce the biggest headaches for employee benefit managers, according to Mr. Parham.

Benefit managers also need to talk with the banks that handle direct payroll deposits to make sure their systems are millenium compatible, Mr. Parham said.

"Make sure you talk to everyone you exchange data with," he said. "Ask them what they are expecting as far as a year 2000 fix is concerned."

The cost of upgrading computer systems to be millenium compatible will likely fall on employers—if not directly, at least indirectly, according to Mr. Parham.

"If you own the software, then you are on the hook to fix it," he said. "But if it's licensed software, your vendor may provide an upgrade."

"But don't expect a free fix. The cost of this fix will be passed on to you in some form," he predicted.

The cost and type of cures that will be available will largely depend on the nature of the problem, and how extensive the solution is, Mr. Parham explained.

"The bigger the change, the more it will cost," he said.

There also will likely be implementation costs in addition to the actual software upgrade costs, he added.

For example, staff will need to be retrained and old data will need to be converted.

"And testing is very important," Mr. Parham stressed. "There may not be a single cure, so you'll have to test your systems over and over to find any dates that were missed" in the conversion process, he said.

In some cases, old systems will need to be replaced entirely. And if that's the case, "then start now," he advised. "It usually takes two years to select and implement it. If you wait any longer, you may have problems."

In some cases, all that may be needed is to download a program upgrade from a disk or perhaps from the Internet.

"There's a huge body of work on the Internet. All you've got to do is type 'the year 2000' on any of the browsers," he said, and a wealth of resources will appear.

An easy way to find out whether a company's existing benefits administration system is "millenium compatible," according to Mr. Parham, is to "try to change the date while in DOS. If it accepts a four-digit year, you're OK. If not, call the vendor."

But don't wait too long to make that call, he warned.

"2000 isn't that far off," he said. "Remember, there's only two years left until this problem becomes a reality." BI

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# Cummins

Continued from page 3

in many traditional plans—when an employee completes a certain number of years, typically 30.

At the same time, because accrued benefits in cash balance plans are expressed as an account balance, employees instantly know, much as they do in a profit-sharing or 401(k) plan, the value of their benefits.

"We wanted to help employees better plan for retirement. Since benefits are expressed as an account balance, employees always know what they have earned under the plan," said Scott Japko, a principal with The Kwasha Lipton Group in Fort Lee, N.J. It administers the Cummins cash balance plan.

On Jan. 1, Cummins converted benefits earned under the old plan to lump-sum amounts. These lump-sum amounts were recorded as opening balances in the newly created individual employee accounts.

These account balances are credited with an annual "contribution" by Cummins. As a defined benefit plan, while amounts are credited to individuals' "accounts," Cummins' actual contributions are made to the plan itself. Benefits are funded on an aggregate basis with the employer contribution to the plan determined by a variety of factors.

"Contributions" or credits to individual account balances are based on employees' years of service. Employees with less than five years of service receive credits equal to 4% of pay, while employees with five or more years of service receive credits equal to 6% of pay.

Cummins also guarantees an annual return on the accounts based on the 30-year U.S. Treasury bond rate, plus one percentage point, as of September of the prior year.

In addition, certain transition benefits are provided to ensure that employees with longer service records will receive comparable benefits to what they would have accrued under the previous plan.

Employees can call a toll-free number—maintained by a Kwasha Lipton outsourcing center—to find out the exact amount of their account balance. This service will be expanded in April so that employees will be able to project the value of their future benefits using certain assumptions.

In addition, quarterly statements that provide the cash balance plan account balances as well as the value of employees' 401(k) plan accounts are mailed to employees' homes.

Ms. Nolander said cost was not a factor in changing to the new plan. While the cash balance plan costs somewhat less than the previous plan, Cummins enriched its 401(k) plan so that its overall retirement benefit plan costs remain about the same. BI


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# Ransom

*Continued from page 1*

For example, if a criminal were to threaten to introduce a malignant, malicious virus if a ransom were not paid, "this quite clearly would fall within the confines of kidnap and ransom policies," according to Mr. Steuber.

Mr. Steuber, an intellectual property and insurance coverage specialist, addressed this issue at a February conference in Laguna Niguel, Calif., on "Emerging Insurance Battles." Legal publisher Mealey Publications Inc. of Wayne, Pa., and Gauntlett & Associates cosponsored the conference.

American International Group Inc. recently said that to respond to computer virus and other threats, it has broadened the coverage available under its Corporate Kidnap and Ransom/Extortion Insurance Policy, which is marketed through American International Underwriters' Crisis Management Division.

Among the expenses covered by the expanded K&R/Extortion policy are ransom/extortion monies, in-transit/delivery costs, consulting costs, judgments, settlements, legal costs, death and dismemberment, and other expenses related to trade secret/EDP extortions.

As part of the expanded coverage, AIU has eliminated most limits on covered expenses during an insured event so that any reasonable and necessary expense will be reimbursed.

While AIU underwriters say they have not seen an increasing number of claims for EDP extortion, there is increasing interest in K&R coverage from corporate policyholders, especially financial and high-technology firms.

"There's not been an increase in claims, but there's been an increase in interest in the coverage," especially because standard electronic data processing protection policies do not provide extortion coverage, according to Jean McDermott-Lucey, vp of AIU Crisis Management in New York.

"Multinationals are usually interested in protecting personnel, while domestics are more interested in the extortion side," she said.

Theft of sensitive information has been a concern of the federal government for decades, and it is now increasingly becoming a concern of private businesses as they become more information-dependent and realize the value of their proprietary data, experts say.

**Most companies do not report computer crime, to avoid public embarrassment, says Dixie Baker.**

Computerized accounting systems, for example, make it possible to steal more money faster and more surreptitiously.

However, reliable data is hard to come by on which companies suffer from what types of "cybercrime."

Most companies do not report computer crime, to avoid public embarrassment and possible revenue loss, according to Dixie Baker, chief scientist in the El Segundo, Calif.-based Center for Information Security Technology. The Center is a unit of Science Applications International Corp., a San Diego-based computer systems integration contractor.

In fact, 37% of the 236 respondents to a recent U.S. Senate subcommittee survey of Fortune 1,000 companies said they would report computer crime only if they were required to do so by law.

Fifty-eight percent of the survey respondents reported break-ins to computer systems during the past year, with nearly 18% estimating losses exceeding $1 million.

More than 66% reported losses exceeded $50,000, according to the study, conducted by WarRoom Research L.L.C. in Baltimore for the Permanent Senate Subcommittee on Investigations. The report was released at "Security in Cyberspace" hearings late last year.

All of the empirical data collected over the past 20 years suggest that computer crime more frequently is committed by people within an organization than by outsiders, Ms. Baker said.

Often crimes thought to have been perpetrated by outsiders later were found to involve some insider collaboration, she said.

The Senate study found that the majority of the losses up to $500,000 were from insiders, while losses exceeding $500,000 were more likely to be attributable to outside attacks.

About 22% of the companies surveyed said they thought corporate competitors seeking trade secrets or documents of primary interest to the competitor were responsible for outside attacks.

Besides selling insurance, brokers and insurers usually contract with security consultants such as Encino, Calif.-based Pinkerton's Inc. and New York-based Kroll Associates to help their clients and policyholders develop risk management strategies to protect their information system assets.

There's really no substitute for good loss control where the protection of intellectual property in concerned, said Karen J. Miller, risk manager in the corporate legal department at LSI Logic Corp., a semiconductor manufacturer based in Milpitas, Calif.

"People have the wrong notion that insurance is a panacea," she said. "We haven't really looked to insurance to provide protection. We tend to focus on loss control and then use insurance as a backup."

Like most high-tech firms, LSI is very concerned about protecting its intellectual property and has gone so far as to take legal action against former employees for misappropriating trade secrets, Ms. Miller said.

Furthermore, she said, "When we enter into negotiations or discussions with third parties, we have a requirement that they sign non-disclosure agreements which protect our intellectual property."

"We've also set up a fairly extensive system of firewalls to protect access to our systems, which is where our IP resides," she said. "We have all sorts of password protection, and our codes are encrypted."

In addition, access to outside computers—such as to the Internet—is through servers rather than through individual modems, which provide two-way communication, Ms. Miller explained. While someone could upload a virus unintentionally with a modem, that is not possible with a server.

Although claims for sabotage to proprietary information and data would be covered by the K&R policy, this information is kept confidential by everyone who knows about it, experts note.

"Chances are if there's a payoff, you'll never hear about it, because that's the nature of the policy," points out Mr. Gauntlett.

"It's that kind of coverage. Once you know about it, it's an invitation to use it," agreed Mr. Steuber. BI

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# Make sure EPL policy really covers you

By Peter Foster

EMPLOYMENT PRACTICES LIABILITY insurance has quickly become an important concern of many risk managers, human resource directors, and corporate counsel due to the onslaught of allegations of workplace discrimination and the recent multimillion dollar settlements reported in the news media.

In the aftermath racial bias suits involving major U.S. corporations, risk managers and chief executive officers are reviewing their internal practices and looking at their general liability and directors and officers liability policies to determine the extent of their coverage. Most are finding that employment discrimination, wrongful termination and sexual harassment either are completely excluded from coverage or that only limited coverage is provided.

Insurers introduced stand-alone EPL coverage in 1992 with narrow coverages and high premiums for the low liability limits. Broadly defined, EPL policies cover workplace discrimination, sexual harassment, and wrongful termination claims brought by past, current, and prospective employees. In the past year, certain coverages have become standard; many EPL insurance markets now are endorsing other coverages that formerly were unobtainable.

In today's corporate environment, acquisitions, office closings and downsizing have increased employers' liability risks and placed enormous responsibility on the human resource and risk management departments to effectively manage an ever-changing workforce. Many of these executives view EPL coverage as insurance against perils such as sexual harassment, discrimination and wrongful terminations that they were hired to prevent, meaning the coverage should be unnecessary if they are doing their jobs well.

However, EPL coverage was designed to transfer risk unknown, unseen, or unmanageable, not to be a substitute for sound risk management practices.

Sexual harassment often goes undetected by human resource personnel and risk managers until the allegation or claim. Anti-sexual harassment postings and sensitivity training may mitigate potential damages, but liability that the harasser creates is likely to be imputed to the employer.

Insurance markets have developed coverages to correspond with the way companies do business while protecting the employer from the unknown. Broad EPL coverage is more readily available today. However, insurance buyers should review these coverage components carefully before binding coverage:

**• Full prior acts coverage.**

As a hypothetical example, sexual harassment, corporate layoffs and branch closings occurred last month at XYZ Corp., a high-technology company. No allegations or claims of sexual harassment, hostile workplace, discrimination or wrongful termination were brought until today. Risk management and human resources never saw it coming. All practices and procedures were in place. The layoffs, XYZ Corp. thought, were handled with strict adherence to federal guidelines with respect to the protected classes.

If XYZ Corp. had purchased EPL coverage prior to knowing of the allegation or claim, there would be coverage under many EPL policy forms. EPL coverage should not be procured without full prior acts coverage. All incidents—sexual harassment, wrongful termination, etc.—occurring prior to the inception of EPL coverage with the allegation or claim arising subsequent to the purchase of coverage are covered with full prior acts coverages.

**• Acquisitions (full prior acts).**

XYZ Corp. last month acquired ABC Corp., contingent upon the assumption of liabilities, including ABC Corp.'s employment practice liability risk. XYZ Corp. knew little about ABC Corp.'s human resource department or risk management practices; its intent was to obtain a greater market share in the high-tech industry. Today, John Doe,formerly employed with ABC Corp. and currently employed by XYZ Corp., filed a lawsuit alleging, for the first time, workplace discrimination. The suit claims the discrimination began more than two years ago, when Mr. Doe was an employee of ABC Corp. and continued to this date and his employment with XYZ Corp.

A risk manager/human resource director could defend XYZ Corp. based on the corporation's employment policies and procedures, but XYZ Corp.'s assumption of liabilities with the acquisition created an exposure of risk over which XYZ Corp. had no control.

A few EPL underwriters have extended full prior acts coverage to acquisitions. If a corporation is growing the top line and its employee base through acquisitions, full prior acts coverage for the acquisition is needed to provide a safeguard for management in the transitional process.

**• Potential-claim reporting.**

During the EPL policy period, XYZ Corp. terminated two African-American employees. Though it was rumored the employees would file civil suits alleging racial discrimination, neither employee actually made an allegation or brought a claim against XYZ Corp.

**Today, EPL coverage is broader, and more endorsements are available, than it was when it was introduced with low limits and high premiums.**

Some EPL markets let policyholders choose whether or not to report the incident as a potential claim in the current policy period. If the policyholder exercises that option and a claim arises after the expiration of the policy period, the claim will trigger coverage pursuant to the date of notice of the potential claim.

The decision to report the incident as a potential claim would be made near the expiration of the policy period, when an employer was in position to assess whether available coverage would satisfy the potential exposure arising out of the incident.

The potential claim reporting coverage is necessary to help employers manage their aggregate liability limits more effectively from one policy period to the next.

**• Restrictions on downsizing.**

Two-hundred fifty of the 921 total employees of XYZ Corp. were laid off last month due to a sudden downturn in sales of the company's high-tech products and services. Yesterday, three of the terminated employees filed lawsuits alleging breach of implied employment contract, wrongful termination and gender-based discrimination.

Until recently, the claims would not have been covered under most EPL policies, which excluded claims arising out of downsizing of more than 20% of the workforce. Many of the markets do not exclude such claims today, but a careful review of the policy's exclusions is recommended.

**• Consent to settle-"hammer clause."**

XYZ Corp. is defending against John Doe's discrimination claim. The EPL insurer's claims examiner advises XYZ Corp. that it wishes to settle the matter for $2 million. XYZ Corp. vehemently opposes settlement and wishes to continue the case to trial. There is an impasse.

Traditionally, the insurer has had the right to settle under a duty-to-defend policy. The claims examiner would settle, essentially cutting the losses within the policy limit. The business relationship/partnership would be damaged.

The "hammer clause" will allow XYZ Corp. to continue to trial but forfeit coverage for damages assessed through adjudication over and above $2 million plus defense costs incurred post-impasse.

One EPL market has agreed to pay—and another market is considering paying—70% of the adjudicated damages and defense costs over and above the $2 million. The concession maintains the partnership, but XYZ Corp. will assume a portion of the risk. The coinsurance approach is considered only with employers willing to take high deductibles or retentions.

**• Coverage for outsourced employees.**

XYZ Corp. outsources 355 of its employees to work with XYZ clients at the clients' premises. An outsourced employee could be with the client company for a few months or a few years and is instructed to follow XYZ Corp.'s employment policies and procedures while working with the client company's employees. With the outsourced employee not working or interacting with XYZ Corp. employees, the employer-employee EPL risk is reduced, but a third-party risk is created.

High-tech companies are moving more of their workforces into outsourcing roles to provide greater service to their client companies. Some EPL insurers have responded to the changing employee role by providing coverage for claims brought by the outsourced employee against the client company and its employees, and claims made by the client company and its employees against the outsourced employee and XYZ Corp.

**• Intentional harm exclusions.**

A federal jury determined her supervisor sexually harassed Jane Doe, a programmer at XYZ Corp. The jury also found XYZ Corp.—though having posted its anti-sexual harassment corporate policy—was vicariously liable for the supervisor's actions. All damages assessed against the supervisor were imputed to XYZ Corp.

EPL coverage could have protected XYZ Corp. from this risk. The breadth of coverage ranges from: no intentional harm exclusion; to exclusion for individuals found to have intended harm but not for vicariously liable policyholders; to an absolute exclusion for all intentional acts.

A court could find discrimination, wrongful termination or sexual harassment to be "intentional" conduct. In these instances, an absolute exclusion would remove all EPL coverage. Many EPL insurers exclude coverage for individuals in situations where harm is intentional but do not exclude coverage for the insured entity. Defense coverage of alleged intentional conduct always should apply until the act is determined judicially to be committed with malicious intent.

**• Punitive damages.**

The jury of Jane Doe vs. XYZ Corp. assessed compensatory damages of $200,000 and punitive damages of $2.3 million.

XYZ Corp. will appeal the decision, but is there coverage under the EPL policy? In this example, XYZ Corp. had the option to purchase punitive damage coverage. There are different forms of this protection with varying degrees of coverage. Most EPL insurers provide punitive damage coverage only where it is insurable—certain states deem insurability of punitive damages to be against public policy. Only a few insurers provide punitive damages coverage without restrictions of state laws. When reviewing the options, employers should consider the laws of the states where the majority of their employees work.

Eight key coverages have been reviewed here. The EPL insurers have incorporated some of the language in their standard forms; the other coverages, either all or some, will be endorsed by many insurers. Another sign of the EPL markets working with the employer is the insurer's consideration of the policyholder's employment counsel as defense counsel.

With the media creating awareness, many employees are turning from internal resolution to the administrative bodies, including the U.S. Equal Employment Opportunity Commission and the courts.

Corporate counsel, risk management, or human resource directors have a limited ability to control these situations. However, EPL policies give them the ability to reduce or mitigate the damage the situation causes. BI

*Peter Foster is an account manager with Johnson & Higgins in Boston.*

# Reasonable rules key in portability bill

By Terry Humo

## Clarification, guidance necessary to reduce burden of some provisions

THE ENACTMENT of legislation to promote the portability of health benefits clearly was one of the most significant achievements of the 104th Congress. As we now turn to the implementation stage for that legislation, employers and health plans need a flexible regulatory approach, clear guidance and ample time to collect the required information if the Health Insurance Portability and Accountability Act, or HIPAA, is to achieve its promise to improve the lives of millions of working Americans as they move from job to job.

One of the most important lessons learned from the national health reform debate and the enactment of health portability legislation last year was that successful government-sponsored health care reforms ought to work with, not against, voluntary, employer-based health care systems. While there continue to be problems and gaps in our nation's health care system, there is a fundamental and continuing public interest in maintaining private, voluntary sponsorship of health care benefits as the foundation of health coverage for most Americans.

Benefit mandates, anti-managed care legislation and increased regulatory burdens erode that foundation by raising the cost of health benefits, leading some employers—especially smaller and midsize companies—to scale back or discontinue coverage, and causing more employees to opt out of health coverage when asked to contribute to higher premiums.

Rather than enacting benefit mandates that only drive up health care costs and gradually take more employers and employees out of health coverage, private and public health purchasers should be encouraged to work together to develop the information needed to make better, more informed health care decisions.

Work already has begun in the three federal agencies charged with developing a single set of guidance and regulation on HIPAA by April 1. A number of provisions of HIPAA present practical difficulties in need of regulatory clarification or guidance in order to reduce the burden of implementation. These include the certification provisions, the definition of state vs. federal responsibilities, the state opt-out provision, and the fraud and abuse provisions.

### Certification issues

A basic HIPAA requirement is that an individual's prior health coverage—and that of his or her spouse and other dependents—must be certified by either the employer who sponsored the health benefits or by the health plan. Much now depends on how this basic requirement is implemented and whether employers and health plans will be able to meet the expectations and timetables set out in the act.

The act sets Jan. 1, 1998, as the date upon which certification of prior coverage must in most cases begin. While this date may provide sufficient lead time for many employers to issue coverage certificates to employees, certifying the coverage of spouses and dependents may be much more problematic.

Many health plans and employers simply do not have accurate records that track the exact time periods of enrollment for every individual who is eligible under a family coverage plan.

Children, for example, may drop out of a health plan at different times if they move to their other parent's plan or go off to school. A spouse may drop off the employee's health plan due to changes in family circumstances or because he or she elects coverage through another employer's plan. In some cases, employers will have knowledge about these changes, but frequently they do not. These sorts of circumstances will make it nearly impossible for either the employer or the health plan to comply with the requirement that all individuals be certified for the period of their prior coverage.

To address the practical difficulties that employers and health plans soon will face as they attempt to provide individual health coverage certificates, the regulations implementing the act should make a distinction between the certificates of prior coverage that must be provided to employees and those provided to spouses and dependents and allow a transition period for this latter group. The effective date for employer-based data on spouses and dependents should be established in consultation with employers and health plans based on a realistic assessment of the amount of time that will be needed to routinely obtain records on the coverage periods of every individual covered under a plan.

During the transition period, an alternative procedure could be made available to establish the prior coverage period of a spouse or dependent in those cases where the period could not be established by enrollment records maintained by an employer or health plan.

In these instances, a certificate could be issued based on an individual's attestation of the period during which a spouse or dependent was covered under the plan. Because these certificates would be issued based on personal statements and not plan records, the individual attestation could be accompanied by a warning concerning the penalties or sanctions associated with giving false information.

Employers and health plans could be allowed to obtain reasonable documentation to support a certificate based on such personal assertions of prior coverage (such as premium payment documents, claims statements, or copies of an insurance policy) before the individual's new health care coverage would become effective, usually at the point that the individual begins a new job.

Finally, the problems associated with complying with the certification requirements of HIPAA are becoming a subject of growing concern for employers and health plans as the effective dates of the act approach. Therefore, it is very important that the HIPAA regulations be issued no later than the April 1, 1997, date required by the act if employers and health plans are to have adequate time to prepare for the act's effective dates.

Furthermore, the regulations should take a flexible approach to compliance that recognizes the practical problems employers and health plans will face in their ability to produce reliable information on every individual who may have been enrolled in a plan in the past. If the regulations are delayed, or if flexible mechanisms are not established to minimize the expected compliance burdens, further action may be required to postpone the effective dates of the act.

### Pre-emption of conflicting state laws

In drafting HIPAA, much effort went into defining the federal and state responsibilities. In general, HIPAA builds on the legislative framework of the federal Employee Retirement Income Security Act of 1974, which for more than 20 years has established federal standards for employer-sponsored group health plans while leaving states their traditional authority to regulate insured health plans for those matters that relate to the business of insurance.

The provisions of HIPAA apply to group health plans whether they are insured or self-funded. HIPAA also includes an important provision that reinforces the primacy of the federal standards and limits future state action, except in several narrowly prescribed areas.

We strongly support the continuation of the pre-emption framework established by ERISA and continued under HIPAA. Few issues are more important to employers than possible changes in the ERISA pre-emption structure, especially for employers who operate on a national or multistate basis. Regulatory guidance in this area of the act should reinforce and clarify the uniformity and primacy of the new federal requirements and the limited scope available for further state actions.

As a logical extension of the pre-emption provisions of the new portability law, employers and health plans should be allowed to rely on:

- A uniform written notice to employees to inform them of their rights and responsibilities under HIPAA.
- A uniform certification form for prior health coverage that would not vary from state to state or among different employers.

Variation in the information obtained on previous health coverage for different state purposes or by different employers would significantly complicate the job already facing employer sponsors of health plans.

### State opt-out of HIPAA

State and local government plans are permitted to opt out of the requirements of HIPAA, which could result in several practical problems.

Has anyone considered the certification problems posed by individuals who leave state jobs for private-sector employment? If government plans are allowed to bypass HIPAA's requirements, state employees and their dependents may not have the same documentation to certify their prior health coverage as individuals who have had health coverage through private employer-sponsored plans.

It is also unclear whether the opt-out applies if the state or local government contracts with an insurance company, as many do, to provide coverage to its employees, as the opt-out privilege is not directly extended to insurers.

In any event, the state opt-out requirements need to be clarified, and employers who hire former state or local workers or their dependents should be allowed to verify claims of prior continuous coverage. It also may be helpful to allow individuals who had previous coverage under a state plan to request certification of continuous coverage, even if states are not routinely required to provide them.

### Fraud and abuse provisions

While efforts to combat fraud and abuse in all areas of the health care system are to be applauded, the criminal liability language in the act is very broad and leaves many doubts about whether particular practices might lead to unwarranted litigation.

For example, it is not clear how far the chain of liability might extend if a benefits manager, an outside consultant, or a health plan or third-party administrator is aware that an ineligible individual is receiving benefits under a plan.

Other ambiguities include the act's reference to the ability of law enforcement officials to provide "limited immunity" to individuals during a fraud investigation. In this case, it is simply not clear how the concept of limited immunity would work in practice and to which situations it might apply. Similarly, we have questions whether there will be standards or guidance for fraud-monitoring efforts that will limit an employer sponsor's vulnerability to fraud as well as its liability under the new criminal sanction provisions.

Many of these issues are fact-sensitive, and law enforcement officials will need to be prudent in their pursuit of health care fraud under this new act. Nevertheless, further guidance and examples of safe harbors need to be developed to inform plan sponsors and others on how these untested provisions of the law may be applied in the future.

Much hard work remains if HIPAA is to truly improve the lives of the more than 145 million working Americans and their families who have health care benefits that are voluntarily sponsored by employers.

The ultimate test of the legislation lies ahead in the ability of employers, health plans and plan participants to understand the provisions of the act and easily apply them on a daily basis. BI

*Terry Humo is senior technical consultant and an attorney with Sedgwick Noble Lowndes' Technical Resource Center in Roseland, N.J. Mr. Humo appeared along with John E. Doerr, national practice leader-group benefits for Sedgwick Noble Lowndes, before the Senate Labor and Human Resources Committee on Feb. 11, 1997, to present the position of the Assn. of Private Pension & Welfare Plans on the portability act.*

INTERNATIONAL

# Divorce may strain Irish pensions

## Recent legalization of divorce exposes gray areas in pension administration

**By SARAH GODDARD**

DUBLIN, Ireland—Trustees of Irish employer-sponsored pension funds fear the historic introduction of divorce into Irish law last month will mean new headaches for them.

Despite a plethora of regulations issued to pension trustees alongside the Family Law (Divorce) Act 1996, a number of gray areas surround the splitting and administration of pensions after a divorce.

Although judicial separation was passed into law in the Family Law Act 1995 and became available late last year, it has not proved particularly popular as it does not allow for remarriage, which the 1996 act allows. As a result, issues facing pensions trustees—issues that are the same in both acts—remain to be tested. The first divorce cases involving pensions are expected to hit the courts later this year.

"I think it's going to be a minefield,"

**Despite many regulations, guidance notes and booklets, 'a lot of issues have not been covered yet,' says Mary Wade.**

said Mary Wade, a legal consultant at Dublin benefit consultant Mercer Ltd. "There is a huge amount of regulations, guidance notes and booklets, but a lot of issues have not been covered yet."

Pension fund administrators and trustees still are waiting for the guidelines to be issued by the Pensions Board, said Brian Aylward, chairman of the Irish Assn. of Pension Funds, an association of pension fund professionals. Until the Attorney General has approved them, administrators and trustees remain in the dark about their bottom-line duties. Nevertheless, "generally speaking, it would be clearly better if a (non-member) spouse left the pension in the scheme," said Mr. Aylward, who also is personnel director of Irish Cement Ltd. in Dublin.

Under both Family Law acts, courts are able to make a pension adjustment order covering retirement benefits and contingency benefits, such as death-in-service provisions. This enables the benefits to be split between the plan-member spouse and the non-member spouse. The non-member spouse is allowed either to transfer the funds out of the employer-sponsored plan or to leave the benefits in the plan, gaining further benefit from the member spouse's salary increases. The proportion due to the non-member spouse will be decided by the court and is only for benefits up to the date of the judicial separation or divorce; the proportion would not change, but that amount would grow as the member spouse earns more.

Alternatively, "people can reach agreement and the courts will have respect for that," predicted Mr. Aylward.

Most important from the trustees' point of view is maintaining contact with a spouse who has become a

*See* **Divorce** *on next page*

# Mexican costs not foiling private health plan rise

**By ROBERTO CENICEROS**

MEXICO CITY—Consultants and other vendors expect the number of private health plans among employers in Mexico to rise, despite new research showing that private health care costs are increasing, while public health costs are declining.

Proposed reforms of the nation's social security system, which provides medical and retirement benefits, will help push more employers to offer private health care benefits, especially if they also have managed care cost containment features, said Beatriz Bojorquez, health consultant for Watson Wyatt Worldwide in Mexico City.

Most Mexican employers are required by law to participate in the social security system, but many large and sophisticated employers already opt to also offer private medical benefits because of perceived inefficiencies with the government health care program (*BI*, Sept. 16, 1996).

The private health care system is not without its problems, too, including soaring costs. Those problems—along with social security premium reductions scheduled to begin in July—could keep employers from further embracing private health care plans, some observers say.

"Vendors are looking to make money, but I think they have higher expectations than what is really in the market...and I think buyers are being very cautious, and they are right to be cautious," said Beatriz Zurita, health policy assessment coordinator for the Center for Health in the Economy, a unit of the Mexican Health Foundation. The foundation is a Mexico City think tank and policy research organization created by 135 Mexican businesses.

Center for Health researchers found that private sector health care costs in Mexico have increased a total of 70%, after factoring out inflation, over the past 16 years, said Ms. Zurita earlier this month, during a two-day conference on Health Service Strategies for the 21st Century sponsored by Watson Wyatt Worldwide in Mexico City.

The research is contained in a report on Mexico's medical cost trends from 1980-1993 that is scheduled for

*See* **Mexico** *on next page*

# Active insurers can cut climate losses: Exec

**By EDWIN UNSWORTH**

BRUSSELS, Belgium—When it comes to dealing most effectively with a likely future increase in climate-related property losses, insurers need to adopt a more active role, particularly in dealing with a wide variety of groups and policymakers, an insurance executive says.

Andrew Dlugolecki, group assistant general manager-underwriting for Perth, Scotland-based General Accident P.L.C. and a specialist in environmental issues, predicted that "in the future, we'll see more cooperation between the private and public sectors" in the area of climate-related disaster limitation.

Gerhard Berz, head of geoscience research at Munich Re Group, issued a similar message. He told delegates at conference last week, called "The Impact of Climate Change on Business and Industry," that the insurance industry can protect itself adequately against the effects of climate change if it has "its clients and the authorities as useful partners on its side."

Insurers' power lies in their ability to alter deductibles, to exclude certain perils or risk areas from coverage, or to severely restrict the scope of coverage, thus pressuring authorities to take measures to reduce risks, to tackle the cause of losses or even to transfer risk to the government, Mr. Berz said.

Mr. Dlugolecki said insurers need to improve cooperation with two key groups.

One is governments and their various departments, where insurers can use their influence to resist new development in high-risk areas, to protect existing developments in such areas and use loss control experience to help property owners prevent losses.

The other group is the construction industry, where insurers should be influential regarding methods, standards and regulation

*See* **Climate** *on page 21*

# America's Cup under donated coverage

## Sun Alliance policy to cover trophy battered by Maori political activist

**By MATTHEW MacDERMOTT**

AUCKLAND, New Zealand—A donated insurance policy will cover damage a Maori political activist caused to yachting's America's Cup.

Sun Alliance Insurance Ltd., the New Zealand operation of Royal & Sun Alliance Insurance Group P.L.C., has insured the America's Cup at no charge for the past two years.

The Royal New Zealand Yacht Squadron in 1995 won the America's Cup, one of the world's oldest and most prestigious sporting trophies.

The squadron is responsible for the safekeeping of the cup until New Zealand hosts an America's Cup defense in 1999. It is only the second time in the cup's 150-year history that it has been held outside the United States. Australia held the cup from 1983 to 1987.

The cup, which is on display at the Royal New Zealand Yacht Squadron in Auckland, was badly damaged by a Maori protester March 14.

Benjamin Peri Nathan used a short-handled sledgehammer to smash the glass cabinet housing the cup and badly dent the midsection and neck of the cup. Maoris are the original Polynesian settlers of New Zealand and have been campaigning for land rights and ownership of the country.

Bill Crowley, managing director in Auckland for Sun Alliance, said it was too early to estimate damage costs, but he predicted the final claim would be "about half" the $500,000 New Zealand ($347,000) insured value. He said the insured value of the America's Cup was agreed between Sun Alliance and the Royal New Zealand Yacht Squadron when the cup was won in 1995.

"We believe it is a fair value, although this (the damage claim) will be a good test."

Mr. Crowley said he was unaware of previous insured values for the America's Cup.

He said Sun Alliance was one of the largest insurers of yachting vessels in New Zealand and donated the premium cost for insuring the America's Cup as a contribution to New Zealand yachting.

The policy still is legally binding even though no premium was paid by the insured, Mr. Crowley said. "We treat it as a normal claim." He said Sun Alliance insured the America's Cup under a comprehensive

*See* **Trophy** *on page 21*

AP/WIDE WORLD PHOTOS

**The America's Cup after being damaged by political activist.**

## Global Briefs

U.K. insurer **Norwich Union Life Insurance Society** announced plans to convert to a new stock company, Norwich Union P.L.C., and issue shares to the public that will begin trading in May on the London Stock Exchange. At that point, Norwich's general insurance and international business will be transferred from the society to shareholders. Norwich Union's current members will receive free and discounted shares, and the public offering is expected to raise £1.75 billion ($2.80 billion)....Switzerland's **Zurich Insurance Group** has expanded its overseas operations by entering a joint venture with Thai insurer Thai Metropole Insurance Co. Ltd. Zurich has a minority shareholding in the joint venture, as required by Thai law, and will gradually transfer its international and corporate business in Thailand to Thai Metropole. Thai Metropole posted premium volume of $70 million last year....Lloyd's of London will achieve a profit of £400 million ($639.2 million) for the 1997 underwriting year, forecasts analyst **Syndicate Underwriting Research Ltd.**, a return of 4% on capacity. SURL also predicts a £1.3 billion ($2.08 billion) profit for the 1994 year, which closed at year-end 1996, not taking into account the special levy charged as part of the market's reconstruction and renewal plan. Syndicate managers will begin filing their results for 1994 this week....Last week saw the first official message transmitted across the **World Insurance Network**, marking the start of WINconnect testing. WINconnect, a venture of several leading insurance brokers, will provide a secure global network to exchange insurance information electronically and is due to be launched this summer....**The Benfield & Rea Investment Trust P.L.C.** has agreed to buy shares in a number of Lloyd's of London corporate investors, including Abtrust Lloyd's Insurance Trust P.L.C., Angerstein Underwriting Trust P.L.C., CLM Insurance Fund P.L.C., Euclidian P.L.C., Hiscox Select Insurance Fund P.L.C., Masthead Insurance Underwriting P.L.C., Matheson Lloyd's Investment Trust P.L.C. and Syndicate Capital Trust P.L.C....French broker **Groupe Le Blanc de Nicolay** and London broker **Crawley Warren Group P.L.C.** have broken off talks to merge the two organizations because they were "unable to reach agreement on various matters," according to a GLN statement....Italian insurer **Assicurazioni Generali S.p.A.** has made a $308 million tender offer for shares that would give Generali a 57% stake in Israeli insurer Leumi Insurance Holdings. Generali has recently come under fire for allegedly withholding payments from life insurance policies held by Holocaust victims issued by one of its former subsidiaries. Generali has denied the allegations.

# Divorce

*Continued from previous page*

member of a pension plan as part of a divorce agreement. "It is terribly important to note records and insist the non-member spouse keeps in touch," said Ms. Wade, pointing out that they may be living on the other side of the world when it's time to pay out the pension benefits.

"I envisage that unless they are very, very young and want a clean split, the non-member spouse will leave the benefit in the scheme until just before retirement," she added.

Another hurdle facing trustees is the amount of information provided to the non-member spouse. Certain information is required to be divulged under disclosure regulations, but after that point it can only be provided with the agreement of the member spouse.

Nevertheless, the non-member spouse can obtain a court order for that information to be disclosed. "If the trustee gives out too much information to the non-member spouse, they could be sued for breach of trust," warned Ms. Wade. "We are advising people that they don't give out anything except under the disclosure regulations, unless they have the agreement of the member spouse."

What's more, trustees could be opening themselves up to litigation if they reveal more than the plan member consents to, warned Paul Kenny, director of technical services at Irish Pensions Trust Ltd., a pension fund administrator in Dublin.

"If trustees divulge information without the specific and proper consent of the scheme member, they could be sued for damages (to the individual) and for breach of the Data Protection Act," Mr. Kenny said.

As the legal system starts rolling for divorcing couples, pension fund administrators may well find themselves deluged with requests for information. Only one divorce has been finalized since the implementation of the 1996 Act, and that came after a judicial separation.

"First of all, there will be lots of applications for information, probably a lot of court orders for discovery," said Mr. Kenny. "And they may not necessarily end up with pension-adjustment orders being made. There could be a lot of work involved with maybe not much to show at the end."

Expenses are proving a major headache. Although there are provisions for the divorcing couple to meet certain administrative costs, the act doesn't provide clear provisions for all the administration costs, said Mr. Kenny.

He called the act vague and said it does not specifically provide for items such as the increased administration costs of having a new category of plan member—the non-member spouse who has joined the plan—and the expense of keeping records on two people instead of one, issuing two checks instead of one, and so on. "It has the potential for hidden expense that isn't readily realized," he said.

**Ireland's divorce law 'has the potential for hidden (administrative) expense that isn't readily realized,' according to Irish Pensions Trust Ltd.'s Paul Kenny.**

These costs will have to be shouldered somehow. Although defined benefit plans could find the expenses being vacuumed up by the system, for defined contribution plans, "the choice is fairly stark," said Mr. Kenny. Either the employer or the plan itself picks up the tab.

"There will be a certain administrative burden for pension funds," agreed Mr. Aylward, but at the moment its impact is hard to assess. Official estimates are that 80,000 people in Ireland are separated, but he put the total number as "substantially more."

Spouses may choose the option of leaving the pensions alone, instead buying products such as annuities for the benefit of non-member spouses, Ms. Wade explained. But the popularity of that option will only be known over time, and it could become an avoidance measure, she warned, in which case the regulations would have to be tightened.

There is a lot of learning to be done by trustees and legal professionals alike. Neither judges nor lawyers in Ireland have faced these types of issues before.

"I don't know what the attitudes of judges are going to be," said Ms. Wade, though she said she suspects they will stick very closely to the letter of the law. "Under the legislation, it is very much the duty of judges to take account of the whole situation and ensure the spouses are provided for."

In practice, this could also mean that arrangements made on separation decades ago may now be changed under the new provisions.

With all the uncertainty surrounding the issue, the best way forward for trustees will be to get agreement between the spouses as to how the pensions are dealt with, advised Ms. Wade.

Meanwhile, the Irish Pensions Board is undertaking a major review of the country's pension system. The National Pensions Initiative is examining pension provisions "from the ground up," explained Mr. Kenny.

"There is a substantial gap in private sector (pensions) coverage," explained Mr. Aylward, with official figures stating that about 60% of employees do not have a private pension. The IAPF is undertaking its own survey of the level of private sector pensions coverage and will be using it as the basis of its submission to the NPI.

All submissions must be received by the end of May. They will then be collated and submitted in a report to the Minister for Social Welfare in September.

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*Copies of the questionnaire that forms the basis of the submissions are available free from the Pensions Board, Holbrook House, Holles Street, Dublin 2.*

The State of New Jersey is soliciting indications of interest with regard to the sale of its temporary disability insurance operations. The State is currently the largest provider of temporary disability insurance in New Jersey. Credit Suisse First Boston is serving as financial advisor to the State on this transaction.

Interested parties should respond in writing to the address below. Responses must be received by Friday, April 4.

Sarah Lee Martin
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Insurance Investment Banking
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# Mexico

*Continued from previous page*

release April 1. Portions of the report were presented at the conference.

Ms. Zurita is among those who believe that higher private medical costs will discourage employers from seeking options outside the public system.

While private sector health care costs have grown, public sector costs have been declining about 3% per year because of salary decreases for doctors, nurses and other workers in the social security system, the center found.

Although the public vs. private cost trends were expected, researchers were startled by the magnitude of their findings, said Ms. Zurita, in part because data for such a study has been hard to obtain in Mexico.

"Looking at the behavior of the private sector is a surprise," she said in an interview after the conference. "It makes sense, but it has never been studied before. I wouldn't have expected that 70% growth. That was a real, real surprise."

In fact, a general lack of health data is one of the biggest obstacles to system reforms and employer restructuring of health care plans, said several speakers at the Watson Wyatt conference.

**A lack of health data is one of the biggest obstacles to employer restructuring of health care plans in Mexico.**

In Mexico, there is no government or private organization overseeing quality of medical care or collecting cost data. In addition, data from the private sector is poor because the majority of private hospitals are small facilities with fewer than 15 beds.

"So you have to be a very good buyer with information in order to get the good things that the private market has to offer," Ms. Zurita said. "And as it is now, there is a lot of imperfect information for the purchaser."

Another disincentive to switching to private health care, she said, is that as of July 1, employers and employees will pay, on average, 30% less in social security health premiums.

However, after the initial reduction, social security premiums are likely to begin to gradually increase, rising by more than 20% over the next 10 years, predicted Watson Wyatt's Ms. Bojorquez. She also expects there will be additional reforms providing employers with rebates for purchasing private health care benefits for workers. That change could come within a year, she said.

Such a reform, along with employer dissatisfaction over social security care and more preventive care, will push many employers to the private sector, especially if managed care cost containment practices are introduced, she and other consultants predict.

Already, insurers, medical groups and new managed care companies in Mexico are positioning themselves to help employers make the transition. One is Maximed, a new managed care unit of insurer Seguros Monterrey Aetna S.A.

Jorge Carrera Prieto, director of operations for Maximed, said that he is counting on a growing employer need to monitor medical providers, introduce quality treatment protocols and arrange contracts that allow medical organizations to share in coverage risks. But there still remains plenty of work to pull the medical organizations together.

"Service suppliers (including medical providers) must have a change in attitude, because they are not used to working as a team in the private sector," he said. BI


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# Climate

*Continued from page 19*

of construction.

The insurance sector also can help the authorities improve the response to property damage from extreme weather events by providing information on the costliest types of weather hazards, advice on vulnerable construction design and disaster recovery services, Mr. Dlugolecki added.

Other steps the insurance industry should take include assisting research into weather patterns and monitoring new findings constantly, identifying the key hazards likely to cost the most damage and then working with those concerned to minimize those hazards as much as possible.

Mr. Dlugolecki and other speakers at the conference highlighted the importance of looking for options that would have positive net benefits even if they may be more costly to implement, such as using solar power instead of coal-generated electricity. In particular, this could include greater use of alternative power sources, including wind or waves, as a possible long-term option.

While acknowledging the controversy over whether insurers ought to lobby for government control of other industries whose products are believed to cause climate change, Mr. Dlugolecki said, "I believe it is very valuable to place before the policymakers the current vulnerability of society to extreme events, so that they are aware of the economic implications and can begin to appreciate the potential for even greater losses if the dice roll badly."

Mr. Dlugolecki said an international agency should be created to address the insurers' concerns. Currently, the only such organization is the United Nations Environment Program initiative for the insurance industry on sustainable development and the environment, of which he was a founding member in 1995. By giving the insurance industry its own international voice on climate change and other environmental issues, the UNEP initiative enables them to "help policymakers to discover appropriate solutions to cope with the financial challenges" these problem areas present, he said.

Mr. Berz warned that insurers' present climate-related problems will be "dramatically aggravated" if scientific predictions on the greenhouse effect come true.

"The increasing intensity of the convective processes in the atmosphere will possibly force up the frequency and severity of cyclones, tornadoes, hailstorms, floods and storm surges in many parts of the world with serious consequences for all types of property insurance," he stated.

Under such circumstances, insurance rates would have to be raised, and in certain coastal areas or flood plains, insurance coverage would be available only after considerable restrictions had been imposed, such as significant deductibles or low liability or loss limits, he warned.

Furthermore, in areas of high insurance density, the loss potential of individual catastrophes could reach a level at which the insurance industry would run into serious capacity problems, Mr. Berz added.

He warned that based on loss data showing a dramatic rise in catastrophe losses in the past few years, it is possible that by the end of the decade, average annual losses from "great" natural disasters could rise to $30 billion to $50 billion, in today's values. The remaining natural loss events, not categorized as great, would at least double the overall loss volume, added Mr. Berz.

Climate change will lead to natural disasters "of unprecedented severity and frequency," causing capacity problems that would be much more serious than those of the past few years, Mr. Berz warned.

"The whole future of this class of business in certain regions could be at stake if the development of this problem is misjudged," he added.

Like other conference speakers, Mr. Berz highlighted the considerable uncertainties surrounding scientific evidence related to climate change.

However, the real issue is "whether the climate data and computer climate models can provide enough information to allow sufficient time to assess future changes and develop the appropriate adjustment and preventive strategies," he said.

Mr. Berz claimed that while the uncertainties mean any strategies adopted should be flexible enough to be adjusted for any changes in circumstances, the "no regret" strategies, such as reducing car fuel consumption or a reduction of energy consumption generally, are successful from the outset. Even if the relevance of climate is lower than expected, such policies at least demonstrate to the Third World the industrialized countries' sense of responsibility, he said. BI

# Trophy

*Continued from page 19*

all-risks policy.

"Although we didn't anticipate this type of event, we acknowledge there is a claim under the policy."

Mr. Crowley said there were initial fears that the America's Cup was damaged beyond repair.

However, photos of the damaged trophy cup have been sent to the London company that made the cup, crown jeweler Garrards, and the jeweler is confident it can be repaired, he said.

The cup soon will be sent to London for repairs, which are expected to take six to eight weeks.

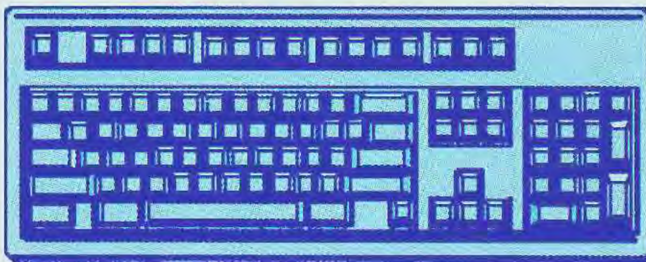
Sun Alliance still is waiting for repair cost estimates from Garrards, according to Mr. Crowley.

The all-risks policy will cover the cost of transporting the America's Cup to London and back, plus all repair costs, he said.

Mr. Nathan was charged with criminal damage and trespass, and his case will be heard at the beginning of next month. The Royal New Zealand Yacht Club has said it will review its security procedures as a result of the attack.

•

*Sarah Goddard contributed to this story.*

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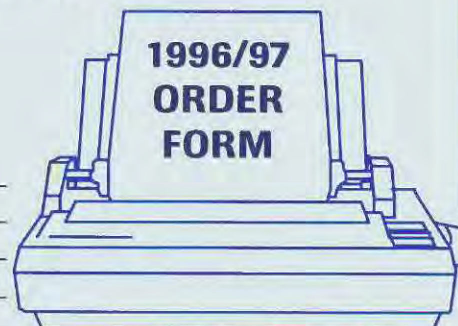


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# New Mexico implements revised managed care rules

**By JUDY GREENWALD**

SANTA FE, N.M.—A comprehensive managed care regulation for New Mexico that apparently satisfies major segments of the state's health care market took effect last Saturday.

While New Mexico has regulated health maintenance organizations since 1985, this more broadly covers all managed care organizations (*BI*, Nov. 4, 1996).

New regulations deal with patients' rights and responsibilities; basic health care services to be provided; access to health care services; prescription drugs; licensing of health care professionals and facilities; and information to be provided to enrollees.

The regulation also calls for the establishment of a grievance system, outlines complaint procedures and details circumstances under which coverage can be terminated.

Among other provisions, it also calls for managed health care plans to establish utilization management programs and continuous quality improvement programs.

Certain provisions of the original proposal, which was developed last year, had been criticized. Some of the rules that drew objections were removed, some were revised and some remained after the work of a special task force.

"I don't think there were drastic changes," however, said Gloria Tristani, chairman of the three-person State Corporation Commission. The commission oversees the New Mexico Insurance Department, which developed the regulation. "It's not that different from the original rule but somewhat refined," said Ms. Tristani.

**'I don't think there were drastic changes. It's not that different from the original rule but somewhat refined,' says State Corporation Commission Chairman Gloria Tristani.**

J.D. Bullington, vp-government affairs for the Assn. of Commerce & Industry of New Mexico in Albuquerque, which operates as the state Chamber of Commerce, said his impression is the final provisions "appear to represent all interests fairly."

Lynn Pitcher, director of government and media relations for Blue Cross & Blue Shield of New Mexico, based in Albuquerque, said her organization "is pleased with the final version, and we feel they will protect consumers. We appreciate the Department of Insurance and State Corporation Commission's diligence in working on the regulations with the industry."

Among the original provisions that came under fire was one that called for having at least two primary care physicians available no more than 45 miles or 45 minutes' average drive time from where a majority of the population lives. This was considered infeasible in a rural state such as New Mexico.

The provision was changed to say in population areas of 50,000 or more residents, two primary care physicians must be available no more than 20 miles or 20 minutes' average driving time for 90% of the enrolled population, while in less densely populated areas, the criteria is 60 miles or 60 minutes away. BI

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# Liggett

*Continued from page 1*

Minneapolis, which represents the state of Minnesota.

Perhaps most importantly, the company will release documents produced both internally and in conjunction with other tobacco companies going back decades. Attorneys general plan to use these documents in pursuing their claims against other cigarette manufacturers.

Separately, Liggett won approval to settle a class-action suit pending in an Alabama state court.

Liggett officials could not be reached for comment.

Andy Berly, a partner with the Charleston, S.C., firm of Ness, Motley, Loadholt, Richardson & Poole, who represents a number of the attorneys general, said he can't predict how the other tobacco companies will respond to the settlement "because of their unreasonable behavior in the past."

But, he said with the defection of Liggett, the other companies' position is weakened. "If they had any sense, now is the time to get reasonable and work out a general resolution," he said. "Now they have a fellow defendant who has broken ranks and admitted all they have denied. It will devastate them."

One expert on class-action suits said the other tobacco companies can't make a similar settlement as Liggett. John Coffee, a law professor at Columbia University Law School in New York, said the Liggett settlement established a limited fund of money and also prevents people from opting out of the settlement to pursue their own suits.

Liggett can attempt such a settlement because of its relatively small size and lack of resources, Mr. Coffee said. The other tobacco companies are too large to do this, because they cannot make the claim, as Liggett did, that they can only afford a limited fund, he said. "Liggett is a minnow compared to the other whales."

He added, however, that settlement funds without opt-outs have not been approved by the U.S. Supreme Court.

Bernard London, partner in the New York product liability defense firm of London Fischer, said the settlement is "troublesome" to the other tobacco companies. He said admissions made by Liggett that cigarettes are addictive and harmful and were marketed to minors might be imputed to other tobacco companies because of "a unity of interest" that exists because the tobacco companies signed a joint defense agreement.

Philip Morris, R.J. Reynolds Tobacco Co., Brown & Williamson Tobacco Corp. and Lorillard Tobacco Co. have challenged Liggett's intention to turn over documents that detail discussions with others in the industry. Those companies have obtained from a state court in Winston-Salem, N.C., a temporary restraining order barring such disclosures.

Diane Cooley, a Washington-based plaintiffs attorney with the firm Coale & Van Susteren, said settlements by other tobacco companies could depend on what's in the documents that Liggett has agreed to release. "The other defendants are standing firm and are going to court to block release of the documents. It depends in part on whether we get them and what they show. I think we're going to get them."

But waves of litigation might not begin "until you get a couple of wins with good amounts of money that are sustained," said Stanley Levy, partner with Levy, Phillips & Konigsberg in New York, a mass tort plaintiffs firm.

It's unclear how the settlement, which allows Liggett to continue to make a product it admits is dangerous, will impact similar product liability cases, said Edward L. Sweda, senior attorney at the Tobacco Products Liability Project based at Northeastern University Law School in Boston.

Cigarettes are unusual in that they kill when used as the manufacturer intended, Mr. Sweda explained. In addition, the industry apparently has conspired for more than 40 years to lie about the addictive nature of their product, he said.

An agreement that bars suits against Liggett may not stop plaintiffs from trying, Mr. Sweda noted. "I would imagine that people who come down with (smoking-related illnesses) will try and find some way around it."

Whether the agreement can actually prevent future lawsuits by attorneys who may try to find a way around it "is a tough question," Ms. Cooley said. "If it's properly drafted, I suppose there won't be a way around it."

Philip Morris Cos. said in a statement that the Liggett settlement "has nothing to do with the rest of the industry, and it changes nothing."

Besides the settlements, Louisiana Attorney General Richard P. Ieyoub earlier this month added more than 100 insurance companies as defendants to that state's suit to recover health care costs from tobacco makers.

The complaint names insurers that wrote 750 general liability policies from 1950 to 1997.

The complaint "provides a vehicle in which the state may obtain documents provided by the tobacco industry to its insurers," Mr. Ieyoub said in a statement. "Having these documents will significantly strengthen our case."

The attorney general's filing is serious "because of the amount of potential dollars involved and the open-ended nature that a positive verdict for the state of Louisiana would cause," said a spokesman for the Insurance Information Institute in New York.

Tobacco companies have not had coverage for product liability claims since the surgeon general mandated health warnings on cigarette packages in the 1960s, the spokesman added. "No tobacco company has requested that insurance pick up the bill for this."

Despite Mr. Ieyoub's suit, the London-based insurance community is confident that the Liggett settlement won't affect them significantly, mainly because they believe their exposure to U.S. tobacco-related claims is minimal.

They cite two main reasons. First, many insurers began excluding tobacco-related liability coverage in their policies in the early 1960s after the U.S. Surgeon General first acknowledged that smoking could damage health. Secondly, the apparent admission by Liggett that smoking is addictive could justify insurers' refusing to pay a claim on the grounds that the insured had prior knowledge that damage could be caused.

In addition, some of the insurers that would have had the greatest exposures are in runoff. Equitas Ltd., the company set up last year to reinsure claims against Lloyd's of London syndicates for 1992 and prior years, believes it has minimal exposure, a spokesman said. BI

# Ditch second injury funds: Expert

By SALLY ROBERTS

CHICAGO—States should abolish their second injury funds and begin to deal with the problem of unfunded liability, according to a workers compensation expert.

Second injury funds were developed in the early 1900s to encourage employers to hire disabled workers by providing them economic relief if the disabled worker had a second injury rendering him or her totally disabled.

Since then, states have broadened the qualifications to tap second injury funds, allowing more injured workers to receive benefits. And because second injury funds operate on a pay-as-you-go basis, all the system is doing is collecting enough money to cover the next year's payments, said Roger J. Thompson, a director with Travelers/Aetna Property Casualty Corp. in Hartford, Conn.

Many states now are burdened with excessive unfunded liabilities as a result.

Connecticut, for example, paid out $103.7 million in annual expenditures in 1994 but has total unfunded liability of about $2 billion, he said.

At the same time, federal legislation such as the Americans with Disabilities Act has been passed to promote the hiring of disabled employees, he noted.

**UBA, Inc.**
**CURRENT ISSUES IN WORKERS' COMPENSATION**

Second injury funds no longer serve their purpose, Mr. Thompson said during a session at UBA Inc.'s Current Issues in Workers Compensation conference held in Chicago last week.

"We've found most employers are not even aware of their state's second injury fund. They are much more aware of the ADA," Mr. Thompson noted.

In addition, most self-insured employers never have filed a claim with their second injury fund, he said. "Their focus is to get the employee immediately back to work."

In addition to Connecticut, which repealed its second injury fund in July 1995, eight other states have followed suit.

Maine was the first state to do so—in April 1992—and Kentucky became the latest when it repealed its second injury fund in December 1996. The six other states are Alabama, Colorado, Kansas, Minnesota, New Mexico and Utah.

The Florida Legislature may repeal its second injury fund, Mr. Thompson said. New York is starting discussions on the topic.

According to the most recent statistics, which do not include the state's total unfunded liabilities, Florida had an average of $125.3 million in second injury fund annual expenditures in 1995 and 1996, and New York paid $109.7 million in 1993, according to Mr. Thompson.

"When you're trying to get out of a hole, you've got to stop digging," he said. "I won't deny there is a cost (to employers) associated with this." But states "are going to have to deal with the reality of unfunded liability."

Repealing second injury funds "is ultimately the best thing for the (workers comp) system because we need to work with employees on returning to work," Mr. Thompson said.

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**Circulation Breakdown**
*Commercial Consumers*

**Administrative:**
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Vice Presidents, General Managers and Other Administrative Personnel .......... 5,129

**Financial:**
Chief Financial Officers and Vice Presidents of Finance .......... 3,166
Secretaries, Treasurers, controllers and other Financial Personnel .......... 2,973

**Risk/Employee Benefits:**
Vice Presidents, Directors, Managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations .......... 17,043

**Sub-total** .......... **30,511**
Associations .......... 290
Government, Unions and Educational Institutions .......... 946

**Commercial Consumers Sub-total** .......... **31,747**
Insurance Agents and Brokers .......... 8,588
Insurance Companies .......... 7,327
Accountants, Actuaries, Attorneys & Consultants .......... 2,831
Adjusters, Appraisers, TPA's, Captive Managers & Health Care Providers .......... 1,624
Others Allied to the Field .......... 966

**Total Qualified** .......... **53,083**
Non-qualified .......... 9
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**TOTAL CIRCULATION** .......... **53,108**

★ *Source Business/Occupational breakdown of qualified circulation, November 25, 1996 Issue, as submitted to BPA for December 1996 BPA Publisher's Statement*

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# Insurers

*Continued from page 1*

While there are individual pockets of business where there are exceptions, competitive pressures will remain strong as "people turn over many more stones to find adequate business," Mr. Paglia said.

"Certainly nothing we've seen in the first two months of '97 indicates any change from the trends that were in place last year," said Patrick A. Thiele, president and CEO of the worldwide insurance operation of St. Paul Fire & Marine Insurance Co.

"Pricing remains very competitive. Renewals are being competed for very hard and, frankly, prices are coming down," said Mr. Thiele.

Among the ranks of those seeing no change in the market is Ronald Frank, an analyst with Smith Barney in New York. "I think the dynamics of the industry are going to be similar in that you're going to have continued pricing pressure across most lines of business. So in a sense you start out every year behind—to the extent that kind of activity continues," Mr. Frank said. "From there, it'll really be a function of loss costs and how they develop, which to some extent is beyond your control and beyond the ability of anyone to forecast."

Robert M. Steinberg, chairman and chief executive officer of Reliance Insurance Group in New York, said the insurer has made the same prediction each year since 1987. There has been "virtually no change in the market," said Mr. Steinberg.

Observers point to the excess capital in the industry as a reason for the market remaining competitive. "There is still ample capital among commercial carriers, and without any shocks to the industry, we don't see anything that would change the supply-demand equilibrium," said Jay Cohen, an analyst with Merrill Lynch in New York. "So on a fundamental basis, we're not looking for much change in 1997."

"The industry still has an awful lot of capital," agreed George Yonker, vp-finance at Seattle-based SAFECO Corp. "There is a lot of capital chasing a limited amount of business, and unfortunately that doesn't look real positive from a pricing standpoint," Mr. Yonker said.

The intense competition is reflected in insurers' underwriting losses. According to a *Business Insurance* survey of 24 major insurers, underwriting losses in 1996 deepened by 57.4%, to $6.51 billion from $4.14 billion. While this is an improvement over the 102.3% decline reported for the nine-month period by a comparable group of insurers (*BI*, Nov. 25, 1996), it compares unfavorably with the 20.1% decline reported at year end 1995 (*BI*, March 25, 1996).

**'Pricing remains very competitive. Renewals are being competed for very hard and, frankly, prices are coming down,' says Patrick A. Thiele.**

Among other survey results:

- Net premiums written increased 9.9%, to $91.3 billion. But excluding the results of the Berkshire Hathaway Group Inc., which has started to include the results of GEICO Corp. in its report, the remaining 23 insurers reported a 6.3% increase.
- Bolstered by last year's booming stock market, insurers' investment income increased by 11.7%, to $14.62 billion. This compares with 1995's 5.2% increase.
- Insurers' combined ratio deteriorated to 106.1% from 104.6%. This is an improvement over the 107% combined ratio reported by a comparable group of insurers for the nine-month period. Insurers had reported a 107.3% combined ratio in 1995.
- Net income for the 21 insurers reporting this information increased 7.6%, to $9.46 billion. This compares with a 6.4% increase by a comparable group of insurers for the nine-month period and the 16.8% increase reported for 1995.
- Policyholder surplus for the 24 insurers reporting this data increased 21.7%, to $81.56 billion. This is comparable to the 22.7% increase reported for the nine-month period.

The fourth quarter results held few surprises.

It "wasn't really a shock one way or another," said Gloria Vogel, senior vp at Advest Inc. in New York.

Said Smith Barney's Mr. Frank, "I don't think the quarter really showed you a sea change in one direction or another."

The fourth quarter "was pretty much in line with the previous quarters," including slow premium growth, and an increased paid-to-incurred loss ratio, said Michael Smith, an analyst with Salomon Bros. in New York.

"I think generally the quarter tended to be a little more negative than the year did, just because the fourth quarter is frequently the time to get your one-time unfavorable adjustments on the books," said John L. Ward, chief executive officer of the Cincinnati-based Ward Financial Group.

Analysts note that while last year insurers were able to take advantage of reserve redundancies to bolster their bottom line, they may not have that option this year.

"Clearly it will become difficult with each passing year for all but the strongest and best-reserved companies to continue to find redundancies in their reserves," said Mr. Frank.

"I think by definition with every passing year you're going to have less and less of that available, because pricing isn't getting any better," he added.

Mr. Cohen of Merrill Lynch agreed. "In certain lines of business, specifically workers comp, which is a very big line of business, there have been reserve releases," he said. "And it is likely that companies will not be able to benefit from these releases in the future—to the same extent, anyway—that they did in 1996 and 1995."

Another concern is that the flat to modest increases in premium growth are taking place "in the context of rising exposures," said Mr. Ward. "For the same flat dollar premium," insurers are taking on more risk, more exposures and broader coverages. "That's becoming relatively prevalent," he said, and "it adds to the concern" about this tough cycle.

"The reserve adjustments and take downs will probably go down as a theme for 1996, but the rising exposures and the flat rates may well be the theme for '97," said Mr. Ward. This year, "I would anticipate continued flat premiums and probably mediocre to slightly positive bottom line performance, and I would think it'll probably end up. . .slightly below the '96 level of performance" in both respects, he said.

The soft market will have even more of an effect on individual insurers this year than it did in 1996, said St. Paul's Mr. Thiele.

"Market forces will begin to overwhelm the individual company's issues and opportunities," he said. "I think in 1996, there was more of an opportunity for individual underwriting strategy and individual company actions to offset the market deterioration, and therefore there was a wider spread in terms of results in the industry. I think that's going to change in 1997, and the market will have more impact on companies' results" due to the intensity of the competition.

"I think earnings discipline is going to be the order of the day," said Mr. Smith. The lack of a reserve cushion and a paid-to-incurred ratio that runs in the mid-90s "means that there is absolutely no room for surprises."

But, he added, because this is a business of recurring extraordinary losses, "you've got to anticipate there will be surprises, there will be large losses."

The industry would need a "perfect year in order to have a decent year, and nothing in life is perfect," he said. BI

# Health

*Continued from page 1*

iness," said Mr. Haw.

Group indemnity plans are "kind of dying out" because even large plans, such as those of CIGNA Corp., are trying to shift some of their people to managed care from traditional indemnity, said Gloria Vogel, senior vp with Advest Inc. in New York. While some employees will always stay with an indemnity plan, many employers " don't give employees a choice in the matter."

Retrenchment by indemnity companies can also be expected this year, according to Mr. Nowacki.

"We think that many indemnity companies are going to continue to retrench and pull out of marginal markets. Indemnity companies that thought they could operate throughout the country are taking a serious look at where they operate" and are planning to remain just within their core marketplaces, in areas that can contribute to their profitability, he said.

The increased scrutiny of managed care organizations from Congressional committees and regulators may work to the advantage of indemnity plans, said John L. Ward, chief executive officer of the Cincinnati-based Ward Financial Group.

The scrutiny is "going to make it a little bit tougher" for managed care operations, "which is going to benefit the indemnity companies," said Mr. Ward, who said he is "mildly optimistic" about this segment of the business.

Furthermore, he said, the HMOs now are facing intense competition among themselves. "That's a plus" for the indemnity insurers, he said. "It takes the pressure off" and gives them more time to "retrench and refocus" and concentrate on their performance, Mr. Ward said.

Mr. Ward estimated that managed care now has more than 75% of the group health care market and that the share is increasing.

## Major property/casualty insurers' year-end 1996 results

Ranked by change in net income. All amounts in thousands of dollars.

| Rank 1996 | | Corporate: Net income 1996 | Percent increase (decline) 1995-1996 | Consolidated revenues 1996 | Property/casualty operations: Combined[1] ratio 1996 | Combined[1] ratio 1995 | Net premiums written 1996 | Percent increase (decrease) 1995-1996 | Pretax underwriting income (loss) 1996 | Percent increase (decline) 1995-1996 | Pretax investment income 1996 | Percent increase (decrease) 1995-1996 | Policyholders surplus 1996 | Percent increase (decrease) 1995-1996 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | CIGNA Corp. | 1,056,000 | 400.5 | 18,950,000 | 101.6 | 104.1 | 3,424,000 | (2.8) | (53,000) | 64.0 | 385,000 | (0.8) | 2,030,000 | 4.6 |
| 2 | Berkshire Hathaway Group | 689,600 | 38.9 | 4,829,900 | 94.4 | 98.0 | 4,105,200 | 300.8 | 230,700 | 1,077.0 | 712,100 | 23.7 | 26,100,000 | 34.5 |
| 3 | CNA Financial Corp. | 964,800 | 27.5 | 16,987,800 | 108.6 | 109.9 | 10,572,400[2] | 4.1 | (1,036,200)[2] | 5.4 | 1,788,100 | (5.4) | 6,348,800 | 11.3 |
| 4 | Fremont General Corp. | 80,493 | 26.5 | 589,055 | 94.8 | 100.5 | 474,184 | (18.8) | 25,339 | 998.5 | 111,637 | 10.2 | 399,893 | 33.6 |
| 5 | USF&G Corp. | 261,000 | 24.6 | 3,497,400 | 105.9[2] | 106.1[2] | 2,638,900[2] | 3.0 | (166,600)[2] | (6.9) | 441,100 | 0.6 | 1,374,700 | 2.5 |
| 6 | American International Group | 2,897,257 | 15.4 | 28,305,272 | 96.9 | 97.0 | 12,691,679 | 6.7 | 398,944 | 10.3 | 1,689,371 | 9.3 | N/A | N/A |
| 7 | SAFECO Corp. | 438,951 | 10.0 | 4,072,004 | 98.3 | 99.7 | 2,313,073 | 4.8 | 38,456 | 505.8 | 281,580 | (3.4) | 2,142,575 | 14.9 |
| 8 | General Re/Cologne Re Group | 893,500 | 8.3 | 8,192,100 | 100.5 | 101.0 | 5,585,800 | 3.6 | (25,700) | 49.0 | 1,121,800 | 17.0 | 5,326,600 | 15.6 |
| 8 | Old Republic Int'l | 230,365 | 8.3 | 1,803,936 | 100.1 | 102.1 | 865,197[2] | (1.3) | (18,460)[2] | 45.5 | 194,338[2] | 1.7 | 1,415,445 | 2.4 |
| 9 | Ohio Casualty Corp. | 102,457 | 2.7 | 1,459,632 | 109.5[2] | 104.0[2] | 1,209,202 | (3.3) | (112,180) | (63.0) | 179,407 | (2.8) | 984,859 | 12.3 |
| 10 | Chubb Corp. | 694,700 | (0.3) | 6,328,300 | 98.3 | 96.8 | 4,773,800 | 10.9 | 30,300 | (67.8) | 646,100 | 7.2 | 2,625,100 | 15.8 |
| 11 | American States Financial Corp. | 169,700 | (4.8) | 1,984,000 | 105.8[2] | 103.6[2] | 1,600,900 | (4.2) | (81,600) | (61.5) | 243,900 | (3.8) | 966,000 | (4.5) |
| 12 | Sentry Insurance Cos.[2] | 100,646 | (5.0) | 1,588,777 | 106.5 | 104.9 | 1,232,602 | 6.7 | (86,105) | (42.4) | 201,937 | 3.7 | 1,303,733 | 13.8 |
| 13 | Travelers P/C Corp. | 390,500 | (6.8) | 8,197,400 | 116.8[2] | 104.6[2] | 6,332,300 | 75.6 | (1,138,300) | (341.4) | 1,653,500 | 133.4 | 5,423,400 | 122.5 |
| 14 | The St. Paul Cos. Inc. | 450,099 | (13.6) | 5,734,156 | 105.7[2] | 102.0[2] | 4,396,122 | 3.6 | (216,160) | (109.8) | 794,901 | 8.7 | 2,951,077 | 20.1 |
| 15 | Hartford Steam Boiler | 53,400 | (14.7) | 548,800 | 94.7 | 90.7 | 454,400 | 11.3 | 21,800 | (36.3) | 32,300 | 14.5 | 292,400 | 4.2 |
| 16 | TIG Holdings | 79,000 | (33.1) | 1,825,000 | 105.0[2] | 105.3[2] | 1,529,000 | (5.0) | (65,000) | (10.2) | 290,000 | 8.2 | 975,000 | 2.4 |
| 17 | Reliance Ins. Co. and subs. | 48,207 | (45.3) | 3,090,587 | 109.0 | 101.8 | 1,846,199 | 3.8 | (172,387) | (277.7) | 257,133 | 4.0 | 1,187,056 | 5.2 |
| 18 | Royal Insurance USA[2] | 85,700 | (54.8) | 1,928,700 | 124.7 | 110.2 | 1,536,600 | (8.1) | (376,400) | (112.1) | 289,000 | 1.1 | 2,105,600 | 8.8 |
| 19 | ITT Hartford Group Inc. | (99,000) | (117.7) | 12,473,000 | 105.1 | 104.1 | 6,899,000 | — | (1,036,000) | (213.0) | 824,000 | 3.6 | 4,009,000 | 10.2 |
| 20 | Argonaut Insurance Co. | (123,238) | (277.1) | 213,066 | 303.1 | 126.8 | 136,816 | (5.1) | (247,145) | (3,034.8) | 82,494 | (10.4) | 487,055 | (22.9) |
| — | Nationwide Mutual Ins. Co.[2] | N/A | N/A | N/A | 112.2 | 114.0 | 8,141,626 | 6.6 | (1,024,055) | 5.5 | 946,168 | 4.4 | 5,577,481 | 9.1 |
| — | Liberty Mutual Ins. Co.[2] | N/A | N/A | N/A | 112.3 | 111.2 | 5,142,266 | (1.8) | (638,161) | (4.4) | 1,040,825 | 2.2 | 5,620,198 | 20.6 |
| — | Kemper National Ins. Cos. | N/A | N/A | 3,975,797 | 122.4 | 109.6 | 3,386,722 | 4.7 | (766,447) | (145.4) | 417,141 | 4.5 | 1,918,166 | (0.8) |
| | Cumulative | 9,464,137 | 7.6 | 136,474,682 | 106.1 | 104.6 | 91,287,988 | 9.9 | (6,514,361) | (57.4) | 14,623,832 | 11.7 | 81,564,138 | 21.7 |

[1]After dividends [2]Statutory [3]Before dividends N/A-Company did not provide data

# Mergers

*Continued from page 1*

"The question clients most frequently ask is: How will that impact me? Will I get any more clout in the marketplace?"

"I truly don't believe there will be much change for the client from this merger" because M&M and J&H already have a great deal of clout, he said.

"I believe there will be a period of reduced competition, but that will quickly be filled by opportunist and regional firms that will fill any service void," because they would be more nimble and able to respond more quickly than their giant competitors, he said.

A key factor in whether consolidation ultimately proves to be good or bad is how well the mega-brokerages will be able to mesh their drive toward achieving operational efficiency with the need to maintain and cultivate the personal relationships critical to many risk managers when they deal with brokers.

"I personally don't have any particular concerns. We see a lot of consolidation, not just in brokerages but in the economy in general," said Charlotte Humphrey, director-risk management for Golden Corral Corp., a Raleigh, N.C.-based restaurant chain.

"I think that whether you're a client or a prospect, anytime there are changes in the industry, such as mergers or acquisitions, you may take a second look just to make sure that you don't have any worries in the transition. That would be up to the individual customer," Ms. Humphrey said.

"If there's ever been a business that's a people business, this is it," said Jim Spivey, executive director of C.J. Spivey Associates Inc., a Charlotte-based risk management consultant.

"Expertise is possessed by people, and I find that nobody has a lock on that. You will find where they have both an M&M and J&H office, one will be stronger in one area and one will be stronger in the other. I would hope that the merger will allow them to retain the stronger people in each area," Mr. Spivey said.

"It doesn't surprise me and it doesn't necessarily mean that getting big is going to mean less service or a less competitive market, but the whole drift depends on how much latitude they give the employees and good people who are working," he said.

"I really don't envision any change in the relationship with the brokers I deal with," said Christopher Mandel, director-risk management for PepsiCo Restaurant Services in Louisville, Ky. Mr. Mandel, a J&H client, said he doesn't think there will be a lot of change among the people who service the accounts of Fortune 1,000 clients.

Consolidation will continue, he predicted.

Predicted Steve Coombs, president of Risk Resources, a Westchester, Ill.-based risk management consultant: "I think the largest impact will be on the larger organizations or those with multinational operations or those that have multibroker relationships. In the short term, with risk managers, it's going to be a question of sorting things out regardless of which merger you're talking about. There will be some growing pains."

Other large brokers will have to struggle with finding more efficiencies in order to compete. It puts pressure on other brokers for additional strategic mergers, said Mr. Coombs.

Mr. Mandel noted broker compensation has been moving from commission to fee-based compensation for years, and that has lowered the revenues for brokerages. He added that he expects brokers to become less important to risk managers over time as risk managers negotiate directly with insurers.

"Direct communications with underwriters is the wave of the future," he said.

"It's kind of a two-edged sword. It's natural to worry about the consolidation because it gives you fewer choices, but actually it's only fewer choices among the big brokers," said David R. Haight, director-risk management for CF Industries in Long Grove, Ill. M&M is CF's broker.

That concentration "would tend to homogenize the markets" so that a risk manager with a unique risk might have a harder time finding a market for it than would be the case in a more competitive market, he said.

Mr. Haight noted, however, that large brokers' various offices always have competed with each other within the brokerage. A broker in one city might favor one insurer for a certain type of risk; another broker with the same company in another city might have a different insurer, he said. If that continued, some of the impact of homogenization might be mitigated, he said.

Diane Threlkeld, manager-corporate risk management for Intergraph Corp. in Huntsville, Ala., shared the concerns about lessened competition.

"My primary concern, and it's a concern that a lot of risk managers have, is the lack of competition. I think competition forces a person to be creative, and I think if there's only a few at the top, there will be less creativity. I think the competition makes a person stretch, forcing them to bring new things to the table," said Ms. Threlkeld.

Mr. Spivey took a more positive view, saying that no matter what the impact of the most recent round of mergers, "risk managers will always have the services and providers that they need, because if the commercial market doesn't provide them, then they (risk managers) will generate a response as they have been doing in the past. More and more risk managers have been looking to their own devices."

And if those devices require reinsurance backing, mega-mergers may ultimately make risk managers' lives easier, said reinsurance professionals.

Reinsurance rates will likely be pushed down even further as the large brokerages wield their clout, said John Berger, president of F&G Re Inc. in Morristown, N.J.

The large brokers will be placing a huge amount of business with insurers, and in return they will want to place the insurers' reinsurance. Then, the reinsurance arms of the brokers will have so much business to place with reinsurers they will demand lower rates in return for the huge volume of business, he said.

"It's a great time to be a buyer of reinsurance," Mr. Berger said.

And the buyers of reinsurance should not see a deterioration in service as a result of the mergers, as all four of the merging brokerages—Aon, A&A, M&M and J&H—are "first-class organizations," said John Smithson, chairman, president and chief executive officer of PMA Reinsurance Corp. in Philadelphia.

But reinsurers could see a deterioration in rates as the number of brokers dwindles and the survivors become more powerful, he said.

"From a selfish standpoint we would wish that instead of eight or 10 reinsurance brokers there were 20 . . .but there is still a viable competitive market," Mr. Smithson said.

Rates already may be so low that they cannot be driven any lower, said Bard E. Bunaes, chairman and CEO of Constitution Reinsurance Corp. in New York.

"The market is so soft now that the mergers will probably not have much impact on pricing levels in the market," he said.

In fact, the mergers will likely lead to the loss of some business by new gigantic brokerages, Mr. Bunaes said.

"In any merger there is a significant fallout, and business seems to follow people," he said.

For example, senior brokers at the large firms may leave and join or form smaller brokerages, largely with the book of business they serviced at the established brokerages, Mr. Bunaes said.

Large foreign brokerages could also take advantage of any dissatisfaction among senior U.S. brokers and hire away teams to strengthen or launch their own U.S. operations, said Mr. Berger of F&G Re.

The mergers also should lead to opportunities for rival captive managers, said Denville C. Reed, president of Sedgwick Management Services (Bermuda) Ltd. "It's a terrific opportunity for us," he said.

The captive management arms of the merging brokers will have to go through a disruptive period when they will have to focus much of their attention on uniting the different cultures, Mr. Reed said.

"You take your eye off the ball for a week or two and you find you have a few uncomfortable clients," he said.

The captive management arms of the merged brokers may be so large that they will find it difficult to provide the level of service that many clients require, said Colin C. James, president and CEO of Atlantic Security Ltd. in Bermuda.

For example, the combined Bermuda captive management operations of J&H and M&M will have nearly 300 captive clients, he said.

"The problem with controlling a management company that size is staffing it," Mr. James said.

Independent managers with long-term staff may benefit as clients seek a more personal service, he said. BI

# Future uncertain for UNISON network

By DON LEWIS KIRK

The merger plans of Marsh & McLennan Cos. Inc. and Johnson & Higgins have dealt a devastating blow to the UNISON network and its members.

Not only will the international brokerage network lose its largest partner, but risk managers also may withdraw business from network members due to the loss of J&H's support.

At a meeting of several UNISON member firms in New York last week, broker executives sought to pick up the pieces of a potentially doomed network.

For the remainder of 1997, at least, UNISON will continue to operate as usual, said Christian Dahms, a managing partner of Hamburg, Germany-based Jauch & Huebener KGaA. What members will do after that is "fully open," he said.

Some clients, however, say the nine-month reprieve is not reassuring.

"Without Johnson & Higgins, Jauch & Huebener loses 40% to 50% of its power," says Klaus-Wolfgang Schulze-Weslarn, risk manager and head of insurance at German consumer products manufacturer Henkel KGaA in Dusseldorf.

Mr. Schulze-Weslarn fears UNISON's demise could make it harder for buyers like Henkel to obtain coverage.

The competitive outlook for domestic brokers without the resources of an international network are not good, Mr. Schulze-Weslarn said.

"Jauch & Huebener must look for alternatives, and that will be difficult, expensive and take a long time. We'll have to see how they react and what we will do then," he said.

However, Mr. Dahms insists Jauch & Huebener has alternatives, and a final decision about UNISON'S future will be made by May, though the network will continue business through at least the end of the year.

Among the options are continued cooperation among remaining members or finding a new partner to join UNISON.

However, Mr. Dahms made it clear that any cooperation with Johnson & Higgins or anyone else would have to apply in all countries, including Germany.

Part of Jauch & Huebener's dilemma is that a portion of its business is derived from providing services to Johnson & Higgins' international clients in Germany. Marsh & McLennan, however, owns Jauch & Huebener's major German rival, Gradmann & Holler GmbH.

Gradmann & Holler has 800 employees and gross revenues of about 210 million DM ($146.2 million) compared with Jauch & Huebener's 1995 gross revenues of 310 million DM ($215.8 million).

Also, a number of international projects that Jauch & Huebener and Johnson & Higgins co-finance and maintain are in jeopardy. The two brokers participate in an international information network; a 50/50 venture in Amsterdam, Netherlands, set up to invest in other UNISON partners; ownership of Jauch & Huebener Reinsurance Brokers Ltd. in London; an office in Moscow; and UNISON S.A. of Brussels, Belgium.

Mr. Dahms insists all of those operations can be quickly changed to reflect a new UNISON structure. BI

# Insurers hail merger, expect more deals

Marsh & McLennan Cos. Inc.'s acquisition of rival broker Johnson & Higgins surprised some observers, but insurance executives say more such deals are on the horizon.

Louis G. Paglia, senior vp and treasurer at TIG Holdings Group in New York, said the consolidation is "another manifestation" of the pressures large brokers face on productivity and profitability.

"We don't expect to have a big impact from that transaction, but I can certainly see the economics of why they did it," he said.

David McDonald, senior vp and chief underwriting officer at Royal Insurance USA in Charlotte, N.C., said that based on brokerage and insurer consolidations over the past two or three years, "My sense is there's going to be more. I don't think it's stopped by any means."

"Certainly with respect to the Marsh & McLennan and J&H merger, I think it took everyone by surprise," he added. "They have been strong competitors for many, many years. My sense is, long term, the ultimate client is going to benefit by virtue of bringing those two organizations together," he said.

"For the Royal, we enjoy a very fine relationship with both organizations," added Mr. McDonald. "My sense is at the end of the day, we will continue to benefit."

He noted the brokers have been in touch with Royal. The next step, he said, is expected to be a face-to-face meeting, though no date has been set yet.

Robert M. Steinberg, chairman and chief executive officer of Reliance Insurance Group in New York, commented: "The brokers have been merging for a very long time, and we view consolidation, whether it's on the carriers' side or the broker side, as being positive long term for the business.

"Hopefully, as the brokers consolidate they will become more efficient providers of services and therefore hopefully as carriers become more efficient, the whole process becomes more efficient, and therefore in the end the customer benefits," said Mr. Steinberg, who added that he thinks these consolidations are inevitable and will continue.

No formal meetings have yet taken place between Reliance and J&H and M&M. "Until they work through some internal reorganization, they won't be contacting the market," said Mr. Steinberg, who said he believes this stage is still about a month away. "We've had very, very strong relationships with both Marsh & Mac and J&H, and we see that continuing," he added.

Mr. Steinberg said previous consolidations among major brokers "had very little impact on us. Our business with the alphabet brokers has continued to grow over the years and so for some reason or another, it seems to be working for us, so we would view this Marsh & Mac & J&H merger the same way."

John Kearney, chief underwriting officer at the Simsbury, Conn.-based Executive Risk Group, said, "These are two very fine organizations that, I believe, have a nice complement of business and cultures.

"I see it as a good development for Executive Risk, and I'm not sure that there's any real impact in the marketplace. It's still a very substantial market even with the consolidation that's occurred, and I'm sure there's still more than enough competition, so the dynamics of the buyer/seller distribution, I don't think, are really impacted. I'm sure it's not the end of consolidation, though, in the business," Mr. Kearney said.

As to the J&H and M&M merger, he said: "I have not actually been given much information from the companies. I've asked a couple of questions, but I don't think they have many answers at this point, quite frankly."

Past acquisitions have had little impact on Executive Risk, he said. "There's been very little change from our perspective," he said, noting he deals with many people who handle accounts for the brokers.

Most headcount reductions, however, occur "behind the scenes" in back-room operations, he said. "Our back room may see more of an impact than we do on the underwriting side," he said. But "the number of actual reductions in headcount that we've seen. . .is fairly minimal."

*—By Judy Greenwald*

# NAIC

*Continued from page 2*

Anne Flanagan, state affairs director for the National Assn. of Insurance Brokers in Washington, supports the pace of NAIC's efforts: "We think it's slow, but steady, progress to improve the market."

The new draft includes a new three-page, single-spaced summary of the NAIC's involvement, the paper's purpose and an overview of the issue.

Most of the draft consists of state surveys on regulatory re-engineering initiatives, copies of laws and preliminary recommendations made last year by the Commercial Lines-Property and Casualty Committee (*BI*, Dec. 23/30, 1996).

The draft is "very much of a first, working draft," emphasized Brian Atchinson, Maine's insurance superintendent and the new chair of the re-engineering committee. "We caution you not to make more of it than what it is."

Some were disappointed it was not more comprehensive.

"I expected more from this draft," said Larry Kibbee, vp and director of public affairs for the Alliance of American Insurers in Schaumburg, Ill.

However, brokers, as well as buyers, were encouraged by statements in the draft.

The planned white paper has a two-fold purpose. It will describe and evaluate the issues and the proposals that have been presented to the NAIC committee since its inception. It also will recommend "the development and prioritization of specific regulatory re-engineering initiatives regarding commercial lines insurance and prototype options to promote efficiency and coordination among regulators and industry."

"The rationale for the focus on commercial lines is that large, sophisticated commercial insureds no longer require the protections provided by old laws and regulations drafted before large insureds were represented by risk managers, brokers and other professionals," the draft states.

Buyers and brokers also were encouraged by the draft's explanation of the goals of streamlining commercial lines regulation:

- Simplifying multistate transactions currently hindered by regulatory inefficiencies.
- Increasing the viability of commercial lines products.
- Reducing the potential strain on guaranty funds.
- Allowing regulators to concentrate on personal and small commercial risks."

While regulators appear to support the concept in general, they are aware that some details may be controversial. More than a dozen industry trade groups and companies have recommended various deregulation proposals.

They include asking regulators to: improve the surplus lines tax mechanism; allow state licensing of non-resident brokers; eliminate counter signature laws for admitted and surplus lines transactions; simplify agent licensing laws; reexamine data reporting requirements; make residual markets more self-supporting; amend bond requirements in surplus lines laws; and reduce regulation of statutorily mandated coverages such as workers comp insurance.

Those recommendations and their sources are summarized in a chart included as one of seven appendices to the draft.

The draft also briefly discusses the NAIB proposal that policyholders with a risk manager and annual property/casualty premiums of at least $100,000 be exempt from rate and form regulation, guaranty fund coverage and assessments and residual market charges (*BI*, June 10, 1996).

However, the re-engineering committee identified 10 separate concerns about the broker organization's proposal, including the risk of shifting guaranty fund and residual market burdens onto small and midsized insurers.

The re-engineering committee faces a challenge in completing its final draft by the time the NAIC holds its summer national meeting June 7-11 in Chicago. To achieve it, Mr. Atchinson established an April 7 deadline for comments on the current draft. Comments should be sent to Ellen Wilcox at the NAIC's Kansas City, Mo., headquarters.

He also plans to discuss the draft during a conference call in mid-April with the the re-engineering committee and interested parties; produce a new draft in late April;

**'We think it's slow, but steady, progress to improve the market,' Anne Flanagan of the NAIB says of NAIC efforts.**

hold another conference call in May; and issue a revised draft by late May that will be available for public comment.

"Based on the committee's openness and receptiveness, we are hopeful our comments will be received and included," said Patricia C. Vaughan, associate general counsel for RIMS.

The committee also is expected to receive comments from a technical study of deregulation issues, said Robert W. Klein, a former NAIC staff member who is now director of Georgia State University's Center for Risk Management and Insurance Research. About seven to 10 insurance industry groups are contributing to fund the $60,000 study, which should be completed this summer, he said.

NAIC deliberations about regulatory re-engineering may be making slow progress within the organization, but they already are having an impact in the states, said the Alliance's Mr. Kibbee.

"If nothing else, this NAIC process has given state regulators the impetus to go forward in their own states without waiting for the committee to act," he said.

"Approximately half the states have recently initiated some types of regulatory re-engineering study to identify ways to streamline state laws and regulations," according to a 1996 NAIC survey quoted in the study.

Most states conducted broad studies, according to the NAIC survey. However, efforts in Massachusetts, New York and Pennsylvania specifically included streamlining commercial lines regulations.

In addition, an earlier survey by the commercial lines committee found that 10 states changed the way they regulate commercial property/casualty coverages during the past five years. Those states are Maine, Michigan, Minnesota, Nebraska, Nevada, North Carolina, South Carolina, Texas, Virginia and Wisconsin.

In related action, the NAIC's commercial lines committee decided to wait until it saw the re-engineering committee's June draft to appoint a working group to consider excluding commercial lines coverages from the scope of two, pre-existing NAIC model rating laws.

In other action at the NAIC meeting:

- A nearly unanimous vote by the NAIC's 17-member Executive Committee reaffirmed regulators' support for a strong but flexible accreditation program in a reform proposal to make the standards more results-oriented.

Members voted to toughen a results-oriented reform proposal to reinstate four of six standards that were designed to prevent insolvencies and related problems. The reinstated standards control the actions of managing general agents, reinsurance intermediaries, business transacted with producer-controlled insurers and guaranty funds.

However, states in the future would need only to provide evidence of basic regulatory tools to meet any such problems, rather than strictly adhere to NAIC model laws. Any state that can prove such issues don't apply to operations in its state need not comply.

The committee did agree to eliminate two of the six model standards dealing with regulation of risk retention groups and disclosure of material transactions.

The reform proposal stemmed from a controversial compromise that drafters approved by a 9-4 vote in December, said Insurance Director Hal Duryee of Ohio.

Texas was the chief proponent of that compromise, which Commissioner Elton Bomer described in a March 14 letter to commissioners as "a modest beginning point for the rest of the reform issues." Caroline Scott, the department's general counsel who represented the absent Mr. Bomer at the meeting, also argued that the accreditation program had been made strong enough by tightening regulatory practices and procedures.

Acting Superintendent Greg Serio of New York, which previously lost its accreditation for failing to adopt new models, supported Texas' position and said his Legislature would not approve all the reinstated standards.

However, Executive Committee Chairman Glenn Pomeroy of North Dakota argued that the four standards relate to solvency "in some important way."

Regulators should "not dismantle the basic and fundamental safeguards which protect consumers and promote uniformity," he said in a six and one-half page letter to executive committee members that recounted the history of several insolvencies that led to the original adoption of those standards.

The NAIC's full membership is expected to support the changes when it votes at the June meeting, said Mr. Pomeroy, who is also NAIC vp.

- The full membership of the NAIC approved sending a firm message to Congress urging federal lawmakers to recognize the states' authority to regulate the business of insurance, especially the insurance activities of financial institutions. State insurance laws safeguard the solvency of insurers while protecting consumers, the resolution emphasized.
- The NAIC split—rather than linked—its final voting session and Executive Committee meeting so they meet on Monday and Tuesday, respectively. By conducting the voting session before the Executive Committee meeting, which sets the voting agenda, no final votes could take place until the next quarterly meeting. That will add three additional months to the process by which the NAIC adopts measures. **BI**

## Updates

### Implant suits dismissed

*Continued from page 2*

Courts in New York and California in 1996 also dismissed Dow Chemical from all suits in those states (*BI*, Sept. 30, 1996).

Among the questions addressed and rejected in the Michigan proceeding was the plaintiffs' claim that Dow Corning relied on Dow Chemical to establish the safety of silicones for medical use.

But in granting Dow Chemical's motion for summary judgment, Judge Colombo found that Dow Chemical never tested silicones for human implantation.

Judge Colombo also found that Dow Chemical had made no misrepresentations or failed to disclose any facts in connection with the use of silicones for medical implantation.

Silicone breast implants were products of Dow Corning, a joint venture of Dow Chemical and Corning Inc.

Plaintiffs had amended their lawsuits against Dow Corning to include Dow Chemical when the Midland, Mich.-based Dow Corning filed for bankruptcy protection in May 1995 (*BI*, May 22, 1995).

### NCCI puts off for-profit vote

ORLANDO, Fla.—The National Council on Compensation Insurance has indefinitely postponed a board vote on a proposal to convert the data-gathering organization to for-profit from non-profit.

Member insurers' questions about whether such a conversion is the best alternative prompted the board's action, Senior Vp Everett Brookhart told members of the National Assn. of Insurance Commissioners' Workers Compensation Task Force during the NAIC's meeting last week in Orlando, Fla.

The NCCI began considering the change last April. It hoped the move would enable it to access capital and strengthen its ability to form external alliances so it could better compete with other data-gathering organizations (*BI*, April 8, 1996).

However, the conversion proposal led state insurance regulators to look at several issues, including preserving public access to state-mandated workers comp data as well as the price of NCCI products.

After board approval, at least two-thirds of the NCCI's members would have to ratify the proposal for it to be adopted.

### Chicago OKs partner benefits

CHICAGO—Domestic partners of gay and lesbian city employees will be entitled to city-sponsored benefits under legislation the Chicago City Council passed last week.

Chicago aldermen voted 32-18, with Mayor Richard M. Daley spearheading the change in policy. Various religious groups fought to defeat the proposal.

Under the ordinance, which takes effect next month, any city employee wishing a domestic partner to receive health or other benefits from the city must, with the partner, sign an affidavit. They must attest to conditions including: they both are at least 18, reside at the same residence and are of the same sex. The partners also must meet at least two other conditions from a variety in a list outlined in the ordinance.

City officials estimate 300 to 400 partners of city workers will be eligible to take advantage of the new ordinance, though anywhere from 20% to 80% of those partners actually can be expected to apply for benefits, said Alderman Bernard Hansen, a leading proponent of the new policy. The city has about 39,000 workers.

Paying the new benefits will cost the city a maximum of $800,000 a year out of an annual benefits expenditure of $290 million, he said.

The new benefits will not be available to live-in heterosexual partners of city workers, which would have cost the city an additional $3 million to $5 million a year, Mr. Hansen said.

The real question, however, was not of cost but one of "equity," he said. "Gays and lesbians are prohibited from marrying by state law," he said. "Heterosexuals aren't."

### Briefly noted

**David J. Saul** resigned as premier of Bermuda last week after less than two years in the job and 18 months before the next election has to be called. Polls conducted by the ruling United Bermuda Party have shown that with Mr. Saul as leader, the party would only win a narrow majority. . . .Hans-Juergen Schinzler, former chief executive of German reinsurer Munich Re A.G., has been named chairman of **American Re Corp.** following the resignation of Paul Inderbitzin. Munich Re acquired American Re in 1996. . . .The Pension Benefit Guaranty Corp. will use a 5.8% **interest rate assumption** in valuing 1996 liabilities for its annual list of the 50 worst-funded corporate pension plans, which will be published later this year. For the 1995 list, the PBGC used a 5.3% interest rate assumption to value plan liabilities. . . .Buck Consultants Inc. and Mellon Bank Corp. have signed a definitive agreement in which **Mellon will acquire Buck**, the eighth-largest benefit consulting firm. Buck shareholders will have the option to receive Mellon common stock or cash. Other terms of the transaction have not been disclosed (*BI*, Jan. 6). . . . **American International Group Inc. has hired Charles Ruoff**, a former executive vp at Sedgwick James, to head its newly created Commercial Accounts division of its Domestic Brokerage Group. The division will service clients with revenues of $100 million to $700 million. . . .The U.S. Supreme Court agreed last week to review a case involving the level of scientific evidence required before **expert testimony** is admissible in certain lawsuits. In seeking high court review of the case, *General Electric Co. vs. Joiner*, Robert K. Joiner holds that federal circuit courts have divided three ways over what standards must be met before expert testimony qualifies as admissible evidence. . . .Richard M. Plato, a Houston lawyer, has pleaded guilty to federal fraud charges related to his dealings with the now-defunct **National Heritage Life Insurance Corp.** Prosecutors charged that Mr. Plato stole more than $16 million from National Heritage and concealed more than $39 million in losses on the sale of securities the insurer owned (BI, March 11, 1996).

# Election

*Continued from page 3*

wage in the European Union. Mr. Major's Conservative party opted out of the Social Chapter and left the United Kingdom the only E.U. nation not to implement it.

Both the Labour and Conservative parties have stated that they will review Lloyd's of London's self-regulation under Lloyd's Act 1982.

In anticipation of such a review, Lloyd's own regulatory review will be completed by the middle of this year, said a spokesman last week. It is likely that Lloyd's eventually will be regulated externally, he said.

"Lloyd's has managed to survive with all governments of just about any color (for the past 311 years) in power, so we will work together with whoever forms a government," said the spokesman.

In addition, several pieces of legislation important to risk managers recently have passed Parliament, which means they will be unaffected by the elections.

For example, the Policyholders Protection bill became law last week after it received Royal Assent. The bill, which is now known as the Policyholders Protection Act 1997, enacts amendments that are designed to prevent North American professionals from recovering 90% of their claims from a U.K. guaranty fund if their U.K.-based insurers become insolvent (*BI*, March 10).

The act was signed by Queen Elizabeth II last Wednesday, according to a spokesman for the Assn. of British Insurers.

Regardless of who wins the election, risk managers and insurers will continue to press their legislative concerns.

The Assn. of Insurance & Risk Managers has several issues on its agenda, according to Executive Director Ina Barker.

In particular, she said AIRMIC is concerned about:

• Deregulation. The government for the past 18 months has had a deregulation task force chaired by Deputy Prime Minister Michael Heseltine charged with reducing various compliance burdens imposed by regulations that have been issued by Parliament and the European Union. These include health and safety regulations.

AIRMIC hopes that under the next government the task force would continue to make sure that industry is "not overencumbered by regulation," said Ms. Barker.

The association would like to see "regulation that is less complicated and less costly for compliance," she said. "If there is a new government (under Mr. Blair), we support the view that there shouldn't be overregulation, although regulation should achieve results."

• The Insurance Premium Tax. The IPT for non-life insurance products was first introduced in 1994 and is scheduled to be increased in April to 4% of premiums from the current level of 2.5%.

AIRMIC lobbied against the increase, said Ms. Barker. The association would be "very much against" another increase as a way for a new government to increase revenue through indirect taxes.

The Assn. of British Insurers would like to take that a step further: it would like to see the insurance premium tax abolished altogether.

"IPT is a poor vehicle to raise tax revenue as it is a regressive tax on the prudent" who buy insurance, stated a recent ABI Parliamentary newsletter. "Penalizing those who insure by increasing the rate . . . is likely to discourage individuals and businesses from taking out adequate insurance."

**Both the Labour and Conservative parties have said they will review Lloyd's of London's self-regulation under Lloyd's Act 1982.**

The Conservative party, which introduced the tax, continues to support it. It is an example of the party shifting taxes from income-based levies to spending taxes, said a Conservative party spokesman last week.

A spokeswoman for Labour party Member of Parliament Dawn Primarolo's office, who is dealing with IPT for the party, said last week, "we cannot say at this stage whether we would abolish it."

The Labour party will not outline its tax policy during the election campaign, she said.

• Employee health and compensation. The Law Commission, which recommends legal reforms, published a consultation paper last year that suggested the government try to recoup state-funded medical costs from negligent parties. The commission estimated that up to £100 million ($159.3 million) in National Health Service costs could be recovered from those responsible for injuries (*BI*, Dec. 23/30).

AIRMIC is not in favor of this proposal because, among other things, it would increase employers liability insurance costs, said Ms. Barker.

Regardless of which party gets into office, "there should be a whole review of employee compensation so that genuinely injured parties receive compensation but the cost is not burdensome to employers," she said.

Meanwhile, in addition to the IPT, the ABI also has several issues it would like the next government to address, said an ABI spokesman.

He said these issues include:

• Simplification of government rules relating to pension funds.

• Adoption of laws allowing employees belonging to an employer-provided pension fund to have a personal pension account as well.

• Exploration by the government, with the insurance industry's participation, of "the continuing changes in the boundaries between state welfare provision and insurance products."

Following the call for a general election, none of the parties divulged much information on specific positions or platforms. However, general positions are known.

For example, there are certain changes that Labour MP Mike O'Brien, as spokesman for the party on financial services issues, has suggested. In particular, the Labour party would introduce legislation that would enable financial services contracts, including insurance policies, to deal with the European Union's proposed single currency, "the euro."

The Conservatives have yet to agree on whether the United Kingdom should be a party to the single currency.

The Labour party also proposes merging the financial services watchdog, the Securities Investment Board, with the three "self-regulatory organizations" that govern the pensions, investments, and financial advice industries. If Lloyd's were to be regulated externally, it could report to the SIB.

Meanwhile, some legislation has been passed recently which will not be affected by the election.

In particular:

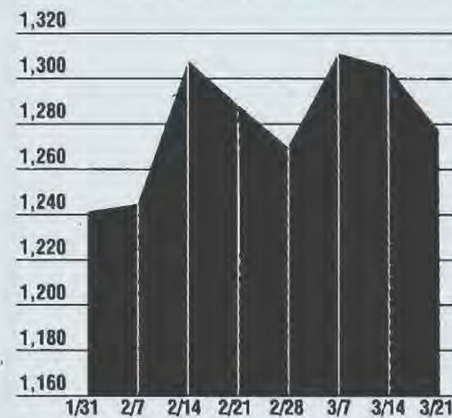
• Last week Parliament passed the Social Security (Recovery of Benefits) law. It enables the Compensation Recovery Unit of the Department of Social Security to recover the total amount of government benefits, excluding actual medical costs, given to an injured worker if that injured worker has received compensation from an insurer.ok as rewritten?

The ABI is concerned that the this law will increase the cost of insurance as more cases are litigated. The government has called on insurers to monitor the reformed plan to see whether problems arise.

• The Civil Procedure law was enacted several weeks ago. This is enabling legislation which would allow a radically rehauled civil justice system for England and Wales as proposed by Lord Justice Woolf's committee (BI, March 3).

"In principle, we agree with the Woolf report because there would be quicker access to justice," said AIRMIC's Ms. Barker BI

## *BI* Insurance Index




Base=100 on Dec. 29, 1978
Source: Nordby International Inc.

## PCS catastrophe options

**As of March 21**

| Call spread | Price bid/ask |
|---|---|
| **Eastern September 1997** | |
| 40/60 | 3.1/3.9 |
| 60/80 | 2.4/3.5 |
| 80/100 | —/2.3 |
| **National Annual 1997** | |
| 80/100 | 5/6.5 |
| 120/140 | 3.5/4.2 |
| **June Midwestern 1997** | |
| 10/20 | 1.4/1.5 |

| Call spread | Price bid/ask |
|---|---|
| **California Annual 1997** | |
| 40/60 | —/3.4 |
| 80/100 | —/2 |
| **Western Annual 1997** | |
| 40/60 | 1.5/3.4 |
| 80/100 | .8/2 |

**Total volume: 650 Total open interest: 12,393**

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

## British Issues

| March 21 | Price | P/E | Div. | Yield | 52 week |
|---|---|---|---|---|---|
| **Companies** | pence | | pence | % | high—low |
| Comml Union | 636 | 12.4 | 30.3 | 5.5 | 759—550 |
| Genl Accident | 773 | 7.8 | 34.3 | 5.3 | 876—613 |
| Gdn Royal Exch | 280 | 6.0 | 10.0 | 4.3 | 301—218 |
| Independent | 678 | 8.7 | 13.3 | 2.4 | 710—373 |
| Royal & Sun | 444 | 13.9 | 19.0 | 4.9 | 515—349 |
| **Brokers** | | | | | |
| Bradstock | 74 | 10.6 | 5.7 | 11.0 | 81—54 |
| CE Heath | 102 | 12.7 | 4.5 | 5.4 | 115—74 |
| JIB Group | 158 | 11.4 | 9.8 | 6.4 | 161—101 |
| Lmbrt Fenchurch | 117 | 13.6 | 8.4 | 9.0 | 150—101 |
| Lloyd Thmpson | 197 | NA | 10.0 | 6.4 | 206—167 |
| Nelson Hurst | 126 | NA | 8.6 | 8.8 | 206—123 |
| Sedgwick Grp | 120 | 10.9 | 8.0 | 6.3 | 152—115 |
| Steel Brl Jones | 24 | 6.5 | 3.8 | 17.0 | 48—24 |
| Willis Corroon | 165 | 13.2 | 6.6 | 5.3 | 169—117 |

Source: Nordby International Inc.

# *BI* Industry Stock Report MARCH 17, 1997, THROUGH MARCH 21, 1997

## BROKERS

| | | Price | Weekly % change | Year to date % change | Year to date High | Year to date Low | Vol.(000) |
|---|---|---|---|---|---|---|---|
| Acordia Inc. | NYS | 32.88 | 0.77 | 13.36 | 33.75 | 27.25 | 83 |
| E.W. Blanch Holdings Inc. | NYS | 22.50 | 0.00 | 11.80 | 25.25 | 17.75 | 54 |
| Gallagher Arthur J. & Co. | NYS | 31.88 | -3.04 | 2.82 | 37.88 | 29.13 | 167 |
| Hilb, Rogal & Hamilton | NYS | 13.50 | 2.86 | 1.89 | 14.00 | 11.38 | 95 |
| Kaye Group Inc. | NDQ | 4.88 | -2.50 | -7.14 | 7.50 | 4.63 | 0 |
| Marsh & McLennan | NYS | 122.63 | -4.20 | 17.91 | 129.63 | 88.00 | 1062 |
| Poe & Brown | NDQ | 25.81 | 0.73 | -2.59 | 27.50 | 22.75 | 30 |
| BROKERS | AVERAGE | | -0.77 | 5.43 | | | |

## INSURERS/REINSURERS

| | | Price | Weekly % change | Year to date % change | Year to date High | Year to date Low | Vol.(000) |
|---|---|---|---|---|---|---|---|
| ACE Ltd. | NYS | 63.63 | -1.55 | 5.82 | 66.38 | 40.50 | 544 |
| Acceptance Insurance Cos. | NYS | 19.00 | -3.80 | -3.80 | 23.13 | 14.63 | 306 |
| AEGON N.V. | NYS | 70.38 | -4.09 | 11.26 | 73.63 | 42.25 | 157 |
| Aetna Life & Casualty | NYS | 88.25 | -2.89 | 10.31 | 93.38 | 55.38 | 2859 |
| AFLAC Inc. | NYS | 41.00 | 0.31 | -4.09 | 44.00 | 28.25 | 1005 |
| Allied Group Inc. | NYS | 34.63 | -4.48 | 6.13 | 38.63 | 22.38 | 143 |
| Allmerica Prop. & Casualty | NYS | 31.25 | -0.79 | 2.88 | 32.25 | 25.00 | 316 |
| Allstate Corp. | NYS | 64.13 | -0.97 | 10.80 | 68.25 | 37.38 | 4574 |
| AMBAC Indemnity Corp. | NYS | 66.00 | -3.47 | -0.56 | 74.00 | 47.00 | 295 |
| American Bankers Ins. | NDQ | 54.38 | -4.81 | 6.36 | 59.50 | 32.50 | 490 |
| American Financial Group | NYS | 37.50 | 0.67 | -0.66 | 38.88 | 28.50 | 238 |
| American General | NYS | 42.00 | -0.88 | 2.75 | 44.63 | 32.88 | 2045 |
| American Heritage Life Ins. | NYS | 24.75 | -1.00 | -5.71 | 27.75 | 19.00 | 64 |
| American Indemnity/Fin'l | NDQ | 13.00 | 0.00 | 26.83 | 14.00 | 9.38 | 0 |
| American International | NYS | 127.00 | 1.70 | 17.32 | 129.63 | 88.13 | 5080 |
| Aon Corp. | NYS | 64.88 | -1.33 | 4.43 | 67.25 | 47.50 | 928 |
| Argonaut Group | NDQ | 29.13 | -0.85 | -5.28 | 34.25 | 27.25 | 102 |
| AVEMCO Corp. | NYS | 23.88 | 0.00 | 52.80 | 27.38 | 11.75 | 93 |
| Baldwin & Lyons Inc. | NDQ | 17.50 | 0.72 | -4.76 | 20.75 | 14.25 | 21 |
| Berkley W.R. Corp. | NDQ | 50.75 | -0.73 | 0.00 | 55.00 | 40.25 | 1090 |
| Berkshire Hathaway Inc. | NYS | 37400.00 | 1.36 | 9.68 | 37700.00 | 30000.00 | 1 |
| Capital RE Corporation | NYS | 46.00 | -2.13 | -1.34 | 48.00 | 32.50 | 87 |
| CapMac Holdings Ltd. | NYS | 26.50 | -20.30 | -20.00 | 36.88 | 23.50 | 643 |
| Capsure Holdings Corp. | NYS | 12.38 | 3.13 | 7.61 | 18.88 | 8.00 | 132 |
| Chartwell Re | NYS | 27.13 | -2.25 | 1.40 | 28.50 | 19.88 | 96 |
| Chubb Corp. | NYS | 57.75 | -2.74 | 7.44 | 62.75 | 40.88 | 3933 |
| CIGNA Corp. | NYS | 152.50 | -2.40 | 11.62 | 161.63 | 100.75 | 1010 |
| CNA Financial Corp. | NYS | 109.50 | -4.58 | 2.34 | 114.75 | 95.75 | 165 |
| EMC Insurance Group Inc. | NDQ | 11.75 | -1.05 | -2.08 | 14.50 | 10.13 | 18 |
| Enhance Financial Services | NYS | 38.88 | 1.63 | 6.51 | 39.38 | 25.38 | 59 |
| Everest Reinsurance | NYS | 30.25 | -3.97 | 5.22 | 32.75 | 21.38 | 1026 |
| Executive Risk Inc. | NYS | 46.75 | -2.60 | 26.35 | 49.00 | 29.25 | 162 |
| EXEL Ltd. | NYS | 42.13 | 0.30 | 11.22 | 45.13 | 31.75 | 845 |
| Fremont General Corp. | NYS | 30.38 | -2.80 | -2.02 | 32.63 | 21.50 | 241 |
| Frontier Insurance Group | NYS | 41.75 | -4.57 | 9.15 | 44.63 | 30.13 | 333 |
| Gainsco Inc. | NYS | 9.13 | -2.67 | -5.19 | 11.75 | 8.75 | 172 |
| GCR Holding Ltd. | NDQ | 23.00 | -1.60 | 3.37 | 27.25 | 21.50 | 585 |
| General RE Corp. | NYS | 167.63 | -1.11 | 6.26 | 177.75 | 138.75 | 779 |
| Gryphon Holdings | NDQ | 14.63 | 0.00 | 3.54 | 19.75 | 12.00 | 65 |
| Guaranty National Corp. | NYS | 18.00 | 0.70 | 7.46 | 18.25 | 13.50 | 17 |
| Harleysville Group | NDQ | 31.38 | 1.62 | 2.87 | 31.50 | 24.50 | 45 |
| Hartford Steam Boiler | NYS | 45.75 | -1.08 | -1.35 | 51.00 | 42.75 | 435 |
| HCC Insurance Holdings | NYS | 24.88 | -1.00 | 3.65 | 32.75 | 19.13 | 195 |
| IPC Holdings Ltd. | NDQ | 24.75 | -1.49 | 10.61 | 26.38 | 19.00 | 55 |
| ITT Hartford Group | NYS | 75.13 | -0.99 | 11.30 | 81.00 | 44.50 | 1347 |
| LaSalle Re Ltd. | NDQ | 28.25 | 1.35 | -3.42 | 29.50 | 19.75 | 358 |
| Lincoln National | NYS | 57.38 | -6.71 | 9.29 | 61.63 | 40.75 | 1161 |
| MAIC Holdings Inc. | NYS | 33.88 | -5.57 | 0.00 | 36.00 | 28.25 | 36 |
| Markel Corp. | NDQ | 106.50 | -3.18 | 18.33 | 113.50 | 78.00 | 16 |
| MBIA Insurance Group | NYS | 99.00 | 1.02 | -2.22 | 104.63 | 70.13 | 962 |
| Meadowbrook Insur. Group | NYS | 23.75 | -1.04 | 13.10 | 34.13 | 15.25 | 34 |
| Mid Ocean Ltd. | NYS | 48.38 | 3.48 | -7.86 | 55.38 | 35.50 | 362 |
| MMI Cos. Inc. | NYS | 23.25 | -0.53 | -27.91 | 33.38 | 22.50 | 150 |
| Mutual Risk Mgmt. Ltd. | NYS | 36.88 | -5.45 | -0.34 | 40.00 | 26.88 | 124 |
| NAC Re Corp. | NYS | 38.50 | -0.96 | 13.65 | 40.63 | 28.50 | 474 |
| Navigators Group | NDQ | 17.75 | -0.70 | -2.74 | 20.25 | 15.75 | 38 |
| Nobel Insurance Ltd. | NDQ | 12.94 | 0.00 | 2.99 | 13.88 | 10.88 | 84 |
| NYMagic Inc. | NYS | 19.88 | -3.64 | 10.42 | 21.13 | 17.00 | 13 |
| Ohio Casualty Corp. | NDQ | 40.25 | -3.59 | 13.38 | 42.00 | 30.00 | 348 |
| Old Republic Int'l | NYS | 25.25 | -5.61 | -5.61 | 27.75 | 20.13 | 815 |
| Orion Capital Corp. | NYS | 62.50 | -2.15 | 2.25 | 67.75 | 42.63 | 96 |
| Partner Re Ltd. | NYS | 35.13 | -2.43 | 3.31 | 36.50 | 25.63 | 356 |
| Penn-America Group Inc. | NDQ | 13.25 | -1.85 | -17.83 | 14.50 | 8.13 | 12 |
| Philadelphia Cons. Holding | NDQ | 29.38 | 0.43 | 26.34 | 30.25 | 16.75 | 107 |
| PXRE Corp. | NYS | 25.75 | 1.48 | 4.04 | 27.00 | 22.25 | 81 |
| Reliance Group Holdings | NYS | 11.63 | 1.09 | 27.40 | 12.25 | 6.50 | 1432 |
| Reliastar Financial Corp. | NYS | 61.50 | -0.61 | 6.49 | 65.38 | 40.00 | 602 |
| RenaissanceRe Holdings Ltd. | NYS | 38.25 | -4.38 | 15.91 | 41.25 | 26.75 | 82 |
| Risk Capital Holdings | NDQ | 17.25 | -2.13 | -10.97 | 20.75 | 15.88 | 77 |
| RLI Corp. | NYS | 33.25 | -4.66 | -0.37 | 36.63 | 22.38 | 55 |
| St. Paul Companies | NYS | 69.38 | -0.18 | 18.34 | 72.63 | 50.13 | 842 |
| SAFECO Corp. | NDQ | 39.13 | -2.34 | -0.79 | 44.00 | 30.88 | 1418 |
| Seibels Bruce Group | NDQ | 1.91 | -1.61 | -7.58 | 3.13 | 1.81 | 97 |
| Selective Ins. Group | NDQ | 41.25 | -1.20 | 8.55 | 43.50 | 31.00 | 96 |
| Sphere Drake Holdings | NYS | 9.75 | -1.27 | 9.86 | 11.75 | 8.13 | 7 |
| TIG Holdings | NYS | 34.00 | -2.86 | 0.37 | 38.00 | 27.00 | 327 |
| Titan Holdings, Inc. | NYS | 16.88 | -2.17 | 2.27 | 17.88 | 13.13 | 35 |
| Tokio Marine & Fire | NDQ | 51.88 | 8.92 | 11.26 | 69.00 | 42.00 | 128 |
| Torchmark Corp. | NYS | 58.50 | -0.85 | 15.84 | 61.88 | 40.25 | 777 |
| Transatlantic Holdings | NYS | 85.88 | -0.29 | 6.68 | 88.25 | 62.38 | 103 |
| Travelers Aetna Property | NYS | 34.38 | -3.51 | -2.83 | 39.63 | 23.13 | 1240 |
| Travelers Corp. | NYS | 50.75 | -4.47 | 11.85 | 58.38 | 28.38 | 8451 |
| Trenwick Group Inc. | NDQ | 49.75 | -1.49 | 7.57 | 54.25 | 46.00 | 35 |
| Unico American Corp. | NDQ | 10.25 | -1.20 | -5.75 | 11.00 | 6.63 | 21 |
| Unionamerica Holdings | NYS | 16.25 | -5.80 | -8.45 | 20.75 | 14.75 | 58 |
| United Fire & Casualty | NDQ | 31.75 | -5.22 | -9.93 | 40.00 | 29.25 | 20 |
| Unitrin | NDQ | 51.25 | -3.76 | -8.07 | 56.38 | 44.25 | 267 |
| UNUM Corp. | NYS | 75.38 | -1.31 | 4.33 | 79.63 | 55.50 | 1019 |
| US Facilities Corp. | NYS | 20.25 | 1.89 | 3.16 | 20.38 | 14.88 | 29 |
| USF&G Corp. | NYS | 22.63 | 0.56 | 8.38 | 23.13 | 15.00 | 1759 |
| USLIFE Corp. | NYS | 47.50 | -0.78 | 42.86 | 48.63 | 26.88 | 836 |
| Vesta Insurance Co. | NYS | 36.38 | -6.13 | 15.94 | 41.50 | 24.50 | 175 |
| Washington National | NYS | 28.38 | -0.87 | 3.18 | 30.75 | 25.13 | 114 |
| Zenith National Ins. | NYS | 27.00 | -0.92 | -1.37 | 28.88 | 23.50 | 81 |
| Zurich Reinsurance Centr. | NYS | 38.00 | -0.33 | 21.60 | 38.75 | 28.38 | 372 |
| INSURERS/REINSURERS | AVERAGE | | -1.69 | 4.84 | | | |

## HEALTH MAINTENANCE ORGANIZATIONS

| | | Price | Weekly % change | Year to date % change | Year to date High | Year to date Low | Vol.(000) |
|---|---|---|---|---|---|---|---|
| Healthsource Inc. | NYS | 20.50 | -1.20 | 56.19 | 40.38 | 9.75 | 2334 |
| Humana Inc. | NYS | 22.00 | -3.83 | 15.79 | 27.00 | 15.00 | 2698 |
| Oxford Health Plans | NDQ | 61.50 | -3.34 | 5.02 | 67.13 | 27.69 | 7474 |
| Pacificare Health Sys. | NDQ | 81.50 | -2.10 | 0.31 | 87.75 | 59.63 | 132 |
| Safeguard Health Enter. | NDQ | 11.13 | -11.44 | -36.43 | 22.50 | 11.00 | 21 |
| Sierra Health Services | NYS | 26.38 | -0.47 | 7.11 | 35.88 | 22.38 | 296 |
| United Healthcare Corp. | NYS | 51.13 | -5.32 | 13.61 | 64.25 | 30.00 | 3892 |
| Wellpoint Health Networks | NYS | 42.25 | -7.14 | 22.91 | 45.88 | 23.38 | 598 |
| HMOs | AVERAGE | | -4.36 | 10.56 | | | |
| ALL COMPANIES | AVERAGE | | -2.27 | 6.95 | | | |

**Top advancing issues: Tokio Marine & Fire, Mid Ocean Ltd., Capsure Holdings Corp. Leading decliners: CapMac Holdings Ltd., Safeguard Health Enter., Wellpoint Health Networks. Most active issue: Travelers Corp. The BI Index fell 2.2%; the Dow Jones 30 Industrials decreased 1.9%; the S&P 500 decreased 1.1% and the NYSE Composite decreased 1.2%. Average P/E: Brokers, 17.3; Insurers/reinsurers, 17.5; HMOs, 29.3.**

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