

Business Insurance

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RIMS outlines areas of support for reforming nation's tort laws

NEW YORK—The Risk & Insurance Management Society Inc. hopes that its new civil justice recommendations will help bring order to what it considers an "often unreasonable, unpredictable and inefficient" system.

The recommendations, issued last week, do not endorse any particular tort reform or product liability reform legislation, such as the bills already passed by the House of Representatives. Instead, the group advocates reforming six broad areas of tort law by: establishing limits on, and higher

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A new round in billing battle

By JERRY GEISEL

WASHINGTON—A federal appeals court victory for employers that could prevent Medicare from recovering hundreds of millions of dollars in claims that group health plans should have paid may be short-lived.

Officials at the Health Care Financing Administration—the federal agency that administers Medicare—say they are weighing whether to ask Congress for legislation that would overturn a court decision that the U.S. Supreme Court let stand earlier this month.

Otherwise, that ruling could ef-

HCFA mulls options to recoup Medicare funds

fectively cripple a massive government project to get reimbursement from employers, insurers and third-party administrators for medical bills Medicare improperly paid for older workers and other beneficiaries.

Under that project—known as the Medicare Data Match—government officials have been combing through medical claims records going back to the early 1980s, when Congress passed a series of laws shifting to employer plans from Medicare the primary

responsibility to pay physician and hospital claims of certain beneficiaries.

The Medicare Data Match project has turned up thousands of cases where providers billed Medicare for claims that employer plans should have paid, such as claims by workers who stayed on the job after turning 65. This incorrect billing occurred because some providers were unaware of the changes that made employer plans the primary payer. In other cases, providers sent bills to both

Medicare and employer plans.

So far, HCFA has sent out demand letters for \$1.6 billion to employers, insurers and TPAs to recover mistaken Medicare payments. To date, it has collected about \$400 million.

But the 1994 U.S. Court of Appeals for the District of Columbia ruling, which the Supreme Court last month declined to review, threatens the size of future recoveries and raises the possibility that the government could have

See HCFA on page 11

Regulators seek to bar union plan

By DOUGLAS McLEOD

NORFOLK, Va.—Regulators in several states are trying to bar a Virginia-based organization from marketing a self-funded health insurance plan to small employers that sign up their workers as members of a local police union.

The focus of the controversy is Centurion Health Trust of Virginia Beach, Va., which has offered health benefits to small groups and self-employed individuals who join the Virginia Beach Police Benevolent Assn. Local No. 34.

The PBA local was formed in 1982 and represents police officers employed part-time as security guards at a Virginia Beach amusement park.

Five state insurance departments have formally or informally ordered Centurion and its representatives to stop soliciting business in their states.

For example, the Colorado Insurance Department issued a cease and desist order earlier this month, charging Centurion and several affiliated groups and individuals with unauthorized insurance sales in its state.

Centurion, however, argues that it is exempt from state oversight

See Centurion on page 21

Reinsurers see no signs of change

By JUDY GREENWALD

Like a weary traveler trudging through a desolate landscape, U.S. reinsurers continue to search the horizon in vain for signs of change.

The U.S. reinsurance industry's full-year 1994 results followed the same pattern established for the first nine months of the year, as net income continued to decline while premium volume increased, according to the Reinsurance Assn. of America's annual survey.

"Most industry observers and people we talk to don't see any early change in what I consider a dismal market," said Bard E. Bu-naes, chairman and CEO of Con-



Employers Re makes a bid to boost its global reach with offer for Frankona Group. Page 17.

stitution Reinsurance Corp. in New York. "It becomes monotonous."

Others are also pessimistic about the prospects for change in the reinsurance market.

"I'm worried about where things go," said Paul Ingrey, president of Morristown, N.J.-based

F&G Re, a unit of USF&G Corp. "You hear more and more people saying the cycle's broken, there is no cycle, people can underwrite to the market and make a reasonable return. A lot of analysts think the market can continue like this indefinitely."

"A cycle or market turn doesn't really happen until everybody thinks it's a terrible business to be in" and then gets out or cuts back on business, said Mr. Ingrey.

"There are no signs of people taking that kind of action, but enough competitive signs to make me think it's erroneous to think that we can continue this way and that there will be a soft landing with reasonable returns going out

from here. Competition is just too significant."

"We see a continued (soft) market trend at least through the 1/1 renewals with no end in sight emerging," said Paul Malvasio, senior vp and chief financial officer of NAC Reinsurance Corp. in Greenwich, Conn. "There's no evidence that I see of any change in that trend."

However, he added, "You do get the beneficial impact of yields having increased over most of '94 up until early '95, which might soften somewhat any impact of pricing deterioration."

Jerry Karter, president and CEO of SCOR Reinsurance Co. in

See Reinsurers on page 12

OSHA scales back repetitive-stress rules

(estimate of how many affected)

1994 draft

Rules would apply to all employers (6.1 million companies).

Employers would have to give all employees information about musculoskeletal disorders and their causes (96 million workers).

Employers would have to evaluate the effectiveness of their ergonomic programs annually and revise them as needed.

Employers would have to provide eye exams and needed corrective lenses to employees who work with video display units and have developed neck/shoulder disorders.

1995 draft

Would apply only to organizations where employees are exposed to certain risk factors or where work-related musculoskeletal disorder is recorded after rule takes effect (2.6 million employers).

Employers need to inform only workers exposed to certain risks or in jobs where work-related disorder has been reported (21 million workers).

No evaluation required.

No eye exams or corrective lenses need be provided to any workers.



Source: Office of Safety & Health Administration

GRAPHIC BY MIKE GARVEY

New ergonomics draft fails to appease critics

By MEG FLETCHER

WASHINGTON—The Occupational Safety and Health Administration has significantly eased proposed regulations for work-related repetitive motion injuries, but the rules are still likely to run up against anti-regulatory sentiment and employer opposition.

OSHA last week circulated among a limited group of business and labor leaders a revised draft of its "Ergonomic Protection Standard," which has been substantially revised from a draft released a year ago.

Even watered-down proposals, though, are unlikely to lessen criticism from employers and a Republican-dominated Congress.

The current anti-regulatory political climate is expected to further dilute the final regulations, which are still months away.

In recent weeks, for example, the House of Representatives passed a moratorium on new federal regulations and put pressure on

OSHA by cutting its current budget. The Senate has not yet voted on either measure.

"We are absolutely not trying to defy the Congress," OSHA Administrator Joseph Dear said of the release of the draft.

The draft is being circulated by OSHA in hopes of building a consensus to counterbalance Congressional opposition. The goal also is to "make sure employers can live with the regulations," Mr. Dear said.

Several provisions of the new draft are considerably lighter than the regulatory approach outlined in June 1994 (see chart).

For example, the new draft regulations would apply to only 2.6 million employers—down from 6.1 million employers initially—whose employees are exposed to "signal risk factors" for musculoskeletal disorders caused by repetitive stress.

The factors, which OSHA said were chosen after a review of scientific literature, would include: prolonged exposure to frequent

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Updates

RIMS offers civil justice reform

Continued from preceding page

standards for, punitive damage awards; eliminating joint liability for non-economic damages; establishing more severe sanctions for frivolous lawsuits; adopting the "loser pays" concept for frivolous lawsuits and investigating stricter contingency fee rules; restricting the use of certain expert testimony evidence at trial; and imposing stricter statutes of limitations and repose.

"RIMS' goal for civil justice reform is simple: to eliminate inefficiencies, while restoring balance and fairness to the American legal system. RIMS believes that federal reform legislation, crafted around (these) recommendations and applying to all civil actions, will help achieve that goal," the three-page document says.

Some of the RIMS recommendations are already in legislation. For example, a "clear and convincing" standard of proof for the award of punitive damages is already included in H.R. 956, the House tort reform bill, and in S. 565, the Senate product liability reform bill (BI, March 20; March 13). Both bills also would abolish joint liability for non-economic damages in many cases. The bills differ, however, on statutes of repose, which limit the time during which a cause of action can arise. H.R. 956 calls for a general 15-year statute of repose on most manufactured goods, while S. 565 would set a 20-year statute of repose on capital goods and durable workplace goods. RIMS endorses no particular time limit, calling only for "reasonable" limits.

Lawyer pleads guilty to fraud

BATON ROUGE, La.—An attorney hired by the Louisiana Insurance Department pocketed \$527,105 of an insolvent insurer's money with the help of a former state senator whose son-in-law was the insurer's president, federal authorities allege.

Johnny C. Moore, a Baton Rouge, La., lawyer hired to represent policyholders of defunct Physicians National Risk Retention Group Inc., has pleaded guilty to a mail fraud charge and is cooperating with an investigation, said L.J. Hymel, U.S. attorney in Baton Rouge.

At an arraignment hearing, FBI Special Agent Susan Phillips said Mr. Moore stole the money in 1992 with the knowledge of Michael H. O'Keefe Sr., whose son-in-law headed Physicians National. Mr. O'Keefe later asked Mr. Moore to help him "stonewall" an inquiry into a purported Physicians National reinsurance agreement with Builders & Contractors Insurance Co. Ltd. of the Bahamas, the agent charged. Mr. O'Keefe also suggested Mr. Moore could conceal his theft by writing a phony check to make it appear the \$527,105 had been transferred to BCI, the agent alleged.

Louisiana regulators have charged in separate civil litigation that Mr. O'Keefe, his son-in-law and others used the BCI agreement to divert millions of dollars from Physicians National, which was ordered into liquidation in 1991 (BI, March 21, 1994).

Charles A. Donaldson, a Bahamas-based BCI officer, was indicted in January on charges related to the allegedly fraudulent reinsurance agreement (BI, March 13).

Mr. O'Keefe, a former state senator who spent 18 months in prison on unrelated federal fraud charges in the 1980s, has not been charged in the Physicians National criminal case.

"I don't think anybody should give it any credence, it's just so absurd," Mr. O'Keefe said of the charges.

Mr. Hymel said additional indictments are expected.

Home posts big 1994 loss

NEW YORK—With a hearing on the Zurich Insurance Group's proposal to buy Home Holdings Inc. set for a week from today, Home closed out what could be its last active underwriting year with what is certainly its largest net loss ever: \$385 million.

That loss, which compares with a \$165 million net loss in 1993, includes a writeoff of about \$200 million of goodwill.

Rating agency downgrades late last year put a damper on Home Holdings' revenues, which fell 18.5% to \$2.2 billion in 1994 from \$2.7 billion in 1993.

After those downgrades, Home sought new capital and in December, an investor group led by John J. Byrne proposed to take over Home and maintain it as an active insurance company.

However, the bid was trumped by Zurich, which proposes to take over selected business of Home and place the remnants of the company in runoff (BI, Feb. 13). The Zurich offer is opposed by a large group of Home Holdings bondholders who fear that Home will have insufficient assets to repay the notes (BI, March 20).

Insurance regulators in New Hampshire, where The Home Insurance Co. is domiciled, have scheduled a public hearing on the Zurich proposal for April 3 in Concord, N.H.

Meanwhile, state insurance commissioners have approved the interim facility set up by Zurich that allows Home to issue Zurich policies with the same terms and conditions of Home policies.

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Errors & Omissions

- Due to an editing error, ANISTICS' listing in the March 20 directory of risk management consultants incorrectly identified CNA Financial Corp. as its parent company, not Alexander & Alexander Service Inc. A&A sold a different subsidiary, Alexsis Inc., to CNA earlier this year.

- Dan Malloy and N. Steve Ober left Private Healthcare Systems Inc. to join Response Technologies Inc. of East Greenwich, R.I. The company's name was incorrectly reported in a March 20 article on the HEDIS report card project.

- George N. Tompkins Jr., a partner at Tompkins, Harakas, Elsasser & Tompkins, does not represent Pan American World Airways, as was incorrectly stated in a March 20 article.

ADA guidelines fall short of employer expectations

By SALLY ROBERTS

WASHINGTON—Employers say no surprises are found in new federal guidelines for defining a protected disability under the Americans with Disabilities Act, though some wish the guidelines had gone further.

The Equal Employment Opportunity Commission issued its 56-page guidance memorandum to its investigators earlier this month. The guidelines contain few substantive changes, though a clarification to the law serves to expand

the protection of mental and emotional disabilities.

"Our intention was to give further help to investigators to make it easier to determine when a case doesn't involve a (protected) disability," said Peggy R. Mas-troanni, director of the ADA policy division for the EEOC.

The new disability guidelines, "explain the act further, but do not change anything," she explained.

Under the law, a protected disability is defined as an individual with a physical or mental impair-

ment that substantially limits a major life activity; has a record of such an impairment; or is regarded as having such an impairment.

ADA experts point out that despite no substantive changes to that definition, individuals with severe stress or depression claims are now more likely to be protected under the act.

Under ADA regulations, "major life activities" are defined as seeing, hearing, speaking, walking, breathing, performing manual

See Guidelines on page 7

Planning for catastrophes

Congress and White House advance federal disaster policies

By MARK HOFMANN

WASHINGTON—Commercial insurance will be part of a new Natural Disaster Protection Act to be introduced in Congress within the next two months.

Companion bills will be sponsored by Reps. William Emerson, R-Mo., and Norman Mineta, D-Calif., in the House and by Sens. Ted Stevens, R-Alaska, and Daniel Inouye, D-Hawaii, in the Senate. Rep. Mineta, who sponsored such legislation last year, has said he wants to broaden the bill's scope to include commercial losses.

Meanwhile, the effort to set a new federal disaster policy got a boost when Reps. Emerson and Mineta and other representatives sponsored a congressional resolution advocating, among other things, that insurers create a privately funded pooling mechanism for spreading the risk of disaster

to keep private insurance available and affordable nationwide.

The Clinton administration recently made public its recommendations for natural disaster policy. Unlike Congress, though, the administration would focus mostly on homeowners insurance. In an effort to "expand the supply of catastrophe reinsurance," the White House advocates auctioning federal excess-of-loss contracts that would respond in the event of a natural disaster that caused between \$25 billion and \$50 billion in insured personal and commercial losses.

Critics said the plan marks considerable progress in the administration's thinking but still falls short of what they wanted.

The \$25 billion trigger is too high, complained said Jack Weber, executive director of the insurer-funded Natural Disaster Coalition in Washington. And, the White

House envisions perhaps as few as 250 of the yearlong contracts being auctioned, which could allow a handful of insurers to buy them up, he said.

The disaster coalition has endorsed a privately funded catastrophe pool like the one called for in the congressional resolution. Mr. Weber also noted that the group is working with private risk analysts to determine the nation's aggregate catastrophe exposure.

In a related development, a group of insurers and reinsurers is examining the possible effects of climate changes on disasters.

The project began after Frank Nutter, president of the Reinsurance Assn. of America, and several other insurance association leaders were invited by Vice President Albert Gore to discuss the matter at a recent breakfast. No date has been set for formally reporting to the vice president. **BI**

Disney, Mattel risk managers cut down policy paperwork

Insurance certificate covers new products

By ROBERTO CENICEROS

Donning mouse ears and strumming a "Mousegetar" were nifty in the mid-1950s, when The Walt Disney Co. originally struck a deal allowing Mattel Inc. to manufacture and market the stringed instrument coveted by Mouseketeer fans.

Relations between the two companies since have remained amicable and, through the decades, the stream of products with Disney's trademark rolling off Mattel's assembly lines—everything

from "Mousegetars" to stuffed Lion King toys and a wide assortment of Goofy, Pluto and Mickey Mouse toys—has grown.

The requirements of the typical licensing agreement, however, provide that an insurance certificate be drawn up for every product manufactured, requiring the involvement of risk managers, various attorneys and a licensing department. About 30 certificates a year were required for products subject to Disney's and Mattel's agreement.

"It just got to be a real pain in the neck," said John G. Pinner, assistant treasurer for Mattel in El Segundo, Calif.

"You had to reinvent the wheel with each (individual certificate) because attorneys would come back and say, 'You've got to change the wording,' or 'We don't like this one'," he said.

Now, thanks to a recent arrangement that shows how risk managers from different companies can lighten their workload through creativity and cooperation, the companies have streamlined the process. Risk managers for the two companies created a certificate that is good for one year, or the length of time the supporting insurance policy is in effect, and which covers all prod-

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- Employers shouldn't relax yet over a ruling on amending benefit plans, this week's editorial says. **PAGE 8**

- There may be a silver lining for insurers in California's Proposition 103 ruling, says attorney Lawrence Monin in Perspectives. **PAGE 15**

- The gas attack in Tokyo's subway is not leading officials in other cities to take special precautions. **PAGE 17**

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Captives seen playing key financing role

By JOANNE WOJCIK

TUCSON, Ariz.—Despite the longstanding soft market, businesses increasingly are assuming larger retentions in their captives and self-insurance programs.

The move toward higher retentions is a natural offspring of the increasing "financialization" of risk management, in which risk managers are taking a more holistic approach to measuring and managing their organizations' exposures, according to Jenny P. Emery, a principal in the Weatogue, Conn., office of Towers Perrin Risk Management.

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This integrated approach—which Ms. Emery dubbed "strategic risk financing"—permits corporations to achieve more control at less cost.

The approach also is increasing the profile of risk managers who are better able to demonstrate how loss control and risk financing affect the corporate balance sheet, acknowledged other captive management experts speaking at the Captive Insurance Cos. Assn.'s 22nd annual conference held

March 19-22 in Tucson, Ariz.

"Proper analysis is going to lead a lot of people to want to retain more risk—not because they're being driven out of the market, but because they want to take control of their own business," Ms. Emery said.

For example, "there are a lot of corporations in the \$100 million to \$500 million (annual) revenue range that could retain a lot more risk than they do now," Ms. Emery said.

It is ironic that the same companies that are willing to assume huge risks in other financial transactions, such as mergers and

acquisitions, still purchase large amounts of primary insurance, she said.

But these companies—many of which already own captive insurers—can use their captives to assume these larger retentions, Ms. Emery explained.

"As more risks are looked at in the same pot—which they should be because it increases financial leverage—there's an opportunity for more of those risks to be funneled through a captive," she added.

Using a strategic risk financing approach makes it easier for the captive to access the reinsur-

ance market, according to Ms. Emery.

Treaty reinsurers, which traditionally have written coverage for entire books of insurers' business, are more comfortable combining coverage for a corporation's heterogeneous risks, Ms. Emery explained.

Indeed, the growth of the financial reinsurance market is a direct result of corporations' increasing use of strategic risk financing to assume larger self-insured retentions, according to David May, managing director and head of risk management services for

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Risk groups retaining hope

NRRA optimistic after annual meeting

By RODD ZOLKOS

CHICAGO—Members of the National Risk Retention Assn. received encouraging dispatches from regulatory battlefields at the group's annual meeting last week, though any optimism was tempered by suggestions that more must be done to ensure risk retention groups' future.

Discussions during the March 19-21 meeting in Chicago included examination of an ongoing legal challenge of New York law, the future of the federal Risk Retention Act and the National Assn. of Insurance Commission-

ers' approach toward risk retention group regulation, which is a key factor in the NAIC's denial of accreditation to Vermont.

"I think things are starting to break our way," said Jon Harkavy, chairman of the NRRA's government affairs committee, in his committee's report to NRRA membership.

"The focus on Vermont has switched from 'Will Vermont get accredited or not get accredited?' to a factual question of due process at the NAIC. I think the NAIC is clearly on the defensive," he said.

See NRRA on page 20

Court decertifies class in HIV suit

Ruling will be cited by cigarette makers

By MICHAEL SCHACHNER

CHICAGO—Four companies that sold HIV-contaminated blood-clotting products to hemophiliacs cannot be forced into a single jury trial to determine whether they were negligent, a federal appeals court has ruled.

By ordering a federal judge to decertify the class of as many as 10,000 potential plaintiffs he authorized last August, a three-judge panel of the 7th U.S. Circuit Court of Appeals in Chicago is requiring plaintiffs to individually bring their negligence and strict product liability claims against the four companies.

The panel's majority found that forcing the companies to defend themselves in a consolidated class action would be akin to blackmail, pressuring them to consider settling rather than face the risk of being hit with a jury verdict that could pave the way to large-scale damages.

The decertification of the class is being closely examined by the tobacco industry, which is facing a consolidated class action suit in federal court in New Orleans.

Under U.S. District Court Judge John Grady's original ruling in the blood products case, one single trial would have been held to determine whether the four companies negligently marketed products they knew were unsafe and then delayed screening donors once they became aware of

See Decertify on page 10

Fatal construction accident investigated at Olympic site

By MICHAEL BRADFORD

ATLANTA—Federal safety investigators, insurers and engineers at the site of the XVIII Olympic Games are trying to determine why a light tower buckled and collapsed in a fatal accident last week.

The 150-foot steel tower at the construction site of the Olympic Stadium collapsed and fell 50 feet while steelworkers were welding, killing one man and injuring two others.

The cause of the accident had not been determined late last week and no estimates of the property damage were available.

"We're still trying to find out why it collapsed," said Harold Gill, assistant area director in the Atlanta office of the Occupational Safety and Health Administration. "It will be several weeks before we have any conclusions or decide on any actions we may take."

And in a move that the Atlanta Committee for the Olympic Games says is unrelated to the accident, the organization has let go its entire risk management department and is contracting with Johnson & Higgins of Georgia Inc. for those services.

Insurers and contractors are sorting through insurance policies to determine whose coverage will pay for the property damage and benefits to the injured workers and family of the man who was killed.

The \$168.8 million, 85,000-seat stadium is being built by Atlanta Stadium Constructors, a joint venture headed by lead general contractor Beers Construction Co. of Atlanta. Construction began last fall and is slated for completion in April 1996.

The worker who was

killed and another who was seriously injured were employed by subcontractor Helmark Steel Inc. of Wilmington, Del. A third worker, who was not seriously hurt, was employed by another subcontractor. The subcontractors could not be reached to provide comment on the accident.

Beers Construction Co. has coverage for the stadium project written by Argonaut Insurance Co. of Menlo Park, Calif. However, a spokesman for the contractor could not provide details of its coverage. The coverage was placed by J&H of Georgia.

A spokeswoman for ACOG said that the com-

See Olympics on page 21

The recent collapse of a bank of lights during construction of the Olympic Stadium in Atlanta killed one worker and injured two others. It was the first major accident at an Olympic facility in Atlanta, which will host the Summer Games in 1996.



AP/WIDE WORLD

Oregon bill would rewrite pollution liability

By ROBERTO CENICEROS

SALEM, Ore.—Legislation currently before a panel of the Oregon House is designed to encourage the cleanup of contaminated industrial sites and expedite the resolution of environmental coverage claims.

The Oregon bill, H.B. 3352, introduced by Rep. Ray Baum, R-La Grande, was drafted with the backing of Associated Oregon Industries, a 2,400-member business group.

"It's basically our bill from start to finish," said Jim Whitty, legislative council for the Salem-based association. "It's a basic rewrite of our state's 'Superfund' law."

Certain provisions of this legislation are similar to environmental insurance regulations nearing completion in neighboring Washington state (BI, Oct. 24, 1994).

Among other things, the Oregon bill would limit the liability of prospective buyers of polluted property. It would do so by releasing the buyer from potential lia-

bility stemming from existing contamination in exchange for a commitment to clean up the site and to redevelop the property.

It also would set standards for "cost-effective remedies," including balancing such factors as cost against the thoroughness of a remediation method.

The bill would also set guidelines for cases where environmental claims are made on old liability policies lost by the policyholder.

Insurers would be required to

commence investigations within 15 days of notice of a lost policy or of a claim; set minimum standards for reconstructing lost policy forms; and retain copies of policies for 40 years.

It also calls for mandatory insurer participation in non-binding mediation when requested by a policyholder in disputes over coverage or lost policy forms.

The proposed bill would also label several insurer actions as "unfair trade practices," such as requiring policyholders to hold an

insurer harmless in return for settlement of environmental claims.

H.B. 3352 is currently before the House Environment and Energy subcommittee. Public hearing dates have yet to be set.

Washington Insurance Commissioner Deborah Senn last fall proposed a set of regulations—identical to the insurance provisions of the Oregon bill—that were the first of their kind introduced by a state commissioner.

Following public hearings,

See Oregon on page 11

More the merrier for some captive owners

By JOANNE WOJCIK

TUCSON, Ariz.—Owning more than one captive insurance company can enable parent companies to take advantage of new business opportunities worldwide, captive experts say.

For example, a company with a Vermont captive insurer that has operating units in Europe may want to also open a captive insurer in Dublin, Ireland, suggested Robert Davis, managing director of AIG Insurance Management Services in New York, a unit of American International Group Inc.

"A large number of U.S. companies are forming Dublin captives to take advantage of the European Union regulations allowing a single policy to be issued for all European risks," Mr. Davis told those attending a session on mul-

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tidomiciled captive insurers during the 22nd annual Captive Insurance Cos. Assn. conference held March 19-22 in Tucson, Ariz.

Approximately 140 captive insurance company owners already have more than one facility, representing about 10% of the world's captive insurer population, according to John R. Weale, vp in charge of offshore management services for American International Co. Ltd. in Hamilton, Bermuda.

"Sixteen of the 50 largest U.S. industrial companies have multidomiciled captives," he said, pointing out that Dearborn, Mich.-based Ford Motor Co. has 20 captive insurers worldwide. "Many large European and Cana-

dian companies also have multidomiciled captives."

Several business reasons lead captive insurer owners to open more than one facility, the most prominent of which is changes in either the legislative or regulatory climate, Mr. Davis said.

For example, new Bermuda regulations requiring minimum capital and surplus of \$1 million for captive insurers that write more than 20% third-party business may cause some captive owners to open facilities elsewhere, he suggested.

Another reason for owning a second captive insurance company is to separate domestic and foreign risks, he added.

Often, a parent company that merges with or acquires another company may find itself owning more than one captive insurer after the transaction has been com-

pleted, he said.

Or perhaps a parent company forms a captive facility solely to run off certain liabilities, such as environmental or asbestos liabilities, he suggested.

Captive insurer owners may open more than one facility because of regulatory changes, says Robert Davis.

Other reasons to have more than one facility include taking advantage of certain double-taxation treaties, fronting another captive insurance program or reinsuring risks that are insured by another captive insurer on a primary ba-

sis, according to Mr. Davis.

"By having multidomiciled captives, you get a greater degree of flexibility," said Mr. Weale. "You can write more types of business from more geographic sources on both a direct and indirect basis."

"There are also some possible tax benefits," he added. "And if you set up a direct-writing company, you can eliminate fronting fees."

However, multidomiciled captive insurance companies can create additional management costs, whether the facilities are self-managed or managed by an outside source, Mr. Weale warned.

Therefore, before adding captive insurers, companies should consider the economic or business reasons for doing so, he advised.

Multidomiciled captive insurers "shouldn't be formed just because it's fashionable to do so." **BI**

Captives want to know how they rate

By JOANNE WOJCIK

TUCSON, Ariz.—A captive insurer that has been rated by one of the independent insurance rating agencies may have an easier time obtaining reinsurance and letters of credit, some financial analysts believe.

Obtaining a rating also "provides captive owners with information and advice as well as insight into how their company compares with other captives and traditional insurers of the same size," said William J. Payton, a financial analyst for A.M. Best Co. in Oldwick, N.J.

While many captive insurance companies that use A-rated fronting insurers don't see a need for obtaining a rating of their own, "if fronting fees get too high or if the relationship ends, a rating can help the captive front its own program," Mr. Payton explained.

Mr. Payton was speaking at a workshop on "Rating your Captive" during the 22nd annual Captive Insurance Cos. Assn. confer-

A rating can ease reinsurance, fronting concerns: Best

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ence held March 19-22 in Tucson, Ariz.

Best, which has already rated about two dozen captive insurers, assesses the insurers' financial condition through a combination of qualitative and quantitative evaluations, according to Mr. Payton.

For example, in addition to looking at the captive insurers' financial performance over the last five years, Best reviewers also consider the parent's commitment to the insurer, its operating strategy and how its surplus is invested, explained Marvin L. Shulman, assistant vp at Best, who also spoke during the rating workshop.

Other sources of information that Best considers in its reviews include:

- Annual and quarterly reports

provided to regulators in the captive insurance company's domicile.

If the captive insurance company is based in a domicile with less stringent disclosure requirements, its owners will be required to assemble some kind of comparable financial statement, Mr. Payton said.

- Securities and Exchange Commission filings.
- Reinsurance audits.
- Loss reserve reports.
- Capital structure analyses.
- Stockholder and/or policyholder reports.
- Pertinent newspaper and trade journal articles.
- Types of coverages written, forms used (claims-made vs. occurrence).
- Pooling or reinsurance arrangements.
- Contingent liabilities.
- Composition of investment portfolio.
- Possible environmental expo-

sures.

In addition, a team of Best reviewers will meet with the captive insurer's management in person at least once a year.

The rating process can take anywhere from a few weeks to a month or more, depending on the time of the year the captive insurance company files its application.

Best also charges a rating fee that ranges from \$250 to \$12,000, depending on the size of the insurer.

For example, a captive insurance company with \$2 million in surplus would likely pay only \$250 for the service, according to Mr. Payton.

Captive insurance company owners interested in obtaining a rating from Best or who simply want more information should contact either Mr. Payton or Mr. Shulman at A.M. Best Co., Ambest Road, Oldwick, N.J. 08858; 908-439-2200. **BI**

250 attend annual captive conference

TUCSON, Ariz.—More than 250 captive owners and service providers attended the Captive Insurance Cos. Assn.'s 22nd annual conference March 19-22 at the Loews Ventana Canyon Resort in Tucson, Ariz.

In addition to sessions on retentions and reinsurance, multidomiciled captives and rating services, the CICA conference featured workshops on investment alternatives for captives, loss control programs and tax developments affecting captives.

Next year's meeting will be held March 17-20 at the Arizona Biltmore hotel in Phoenix.

For more information, contact CICA at 655 Third Ave., New York, N.Y. 10017; 212-687-4501.

Finance

Continued from previous page
Marsh & McLennan Inc. in New York.

Mr. May also is "seeing a lot more of what we call a strategic long-term approach" to risk financing, with more focus on the effect of losses on company profitability, he said.

This approach has long been taken by financial institutions, he said.

"The market for financial (reinsurance) products is expanding rapidly" as more industrial corporations take the broader view of risk that financial institutions have taken for years, Mr. May explained.

"A lot of financial institutions have taken a very comprehensive view of risks and basically have a risk management function that covers their operation exposures as well as what we call 'passive risks,'" he said.

Today, "there are a number of large, industrial corporations that are beginning to think along the same lines," he added.

For example, "we're seeing a lot more interest in corporations looking to integrate risks that previously have been uninsurable," such as catastrophe and en-

vironmental exposures, Mr. May explained.

The growth of the financial reinsurance market is facilitating this shift toward a more financial institution-like approach to corporate risk financing, other experts believe.

In fact, one reinsurance company—Swiss Reinsurance Co. of Zu-

rich, Switzerland—is marketing a risk-financing product that blends financial reinsurance with other financial services, such as lines of credit and investing in various derivative instruments available through Credit Suisse Financial Products, which is 20% owned by Swiss Re (BI, Dec. 19, 1994).

In many cases, financial reinsurance premiums can be tax-deductible, unlike premiums paid to single-parent captives, says Ray Oberg of Marsh & McLennan.

rich, Switzerland—is marketing a risk-financing product that blends financial reinsurance with other financial services, such as lines of credit and investing in various derivative instruments available through Credit Suisse Financial Products, which is 20% owned by Swiss Re (BI, Dec. 19, 1994).

Carolyn Helbling, international business account manager for Swiss Re, and George Fallegger, head of underwriting for financial reinsurance, outlined the program during a session on the future of

reinsurance in the risk financing of major corporations.

Because of the increasing complexity of corporate risk management, especially with the emergence of new exposures like repetitive strain injuries and electromagnetic fields, "there is the need to spread financial impact of (loss payments) over an extended pe-

riod of time to avoid, for example, an impact on earnings per share in a given accounting period," said Ms. Helbling.

The Swiss Re/Credit Suisse program does this by combining liability management with aggressive asset management, said Mr. Fallegger.

Vt.

"Financial reinsurance also encourages organizations to be more loss-sensitive, thus emphasizing loss control," he said.

"Because pricing is based on an insured's own losses and because of the long-term contract provisions, financial reinsurance can also provide protection from insurance market cycles," Mr. Oberg added.

In many cases, financial reinsurance premiums also can be tax-deductible, unlike premiums paid to single-parent captives, Mr. Oberg pointed out.

In the most significant captive premium deductibility case, *Humana Inc. & Subsidiaries vs. Internal Revenue Service*, the 6th U.S. Circuit Court of Appeals ruled that a captive must write a "substantial amount" of unrelated business for the premium to be tax-deductible to the parent company (BI, Aug. 7, 1989).

Other benefits of financial reinsurance include that it:

- Allows payment of losses to be distributed over a longer period of time in order to protect corporate earnings.

"You or your CFO may appreciate a smoothing of loss recognition for budget presentation purposes," Mr. Oberg said. "Instead of variable and long-tail losses

hitting your bottom line, a flat, consistent premium via a financial reinsurance policy may be more desirable."

- Permits loss portfolio transfers.

"Let's say your accountant wants to add a \$100 million liability to your balance sheet because of a pollution problem or products recall or litigation issue, and he won't allow you to discount the reserves for that liability," he suggested.

"A financial reinsurance policy requiring a premium that's lower than that \$100 million liability paid over time is a way to possibly reduce the liability to a lower number," he said.

- Provides specific and/or aggregate stop-loss protection between a large self-insured retention and a high-layer excess policy.

- Long-term rates reflect actual loss experience.

- Ensures reinsurers' long-term commitment to coverage and capacity.

Ms. Emery spoke during a session on why retentions stay low, while Mr. May and Mr. Oberg spoke during a session on keeping up with financial insurance and reinsurance products and the Bermuda catastrophe and reinsurance markets. **BI**

Working part time pays off at Starbucks Coffee

SEATTLE—The only difference between a part-time worker and a full-time worker in the eyes of Starbucks Coffee Co. is the amount of hours they work.

Since 1987, the Seattle-based coffee company's philosophy has been to treat its part-time workers like its full-time workers, which means offering the same benefits to employees who work as little as 20 hours per week as the benefits offered to those who work 40 hours per week.

All Starbucks' part-time employees, therefore, are offered medical, dental, vision and short-term disability insurance, as well as paid vacation, paid holidays, mental health/chemical dependency benefits, an employee assistance program, a 401(k) savings plan and a stock option plan.

According to its employee benefits manager, Starbucks believes what comes around goes around.

"Our part-timers are on the front line with our customers," said Bradley Honeycutt, director of compensation and benefits. "If we treat them right, we feel they will treat (the customers) well."

This treatment includes offering part-time employees—who represent roughly two-thirds of its 10,000 employees—the same health care coverage as full-time workers. Starbucks also pays 25% of the coverage costs for dependents and domestic partners of all employees.

Part-timers and full-time employees are covered by an Aetna Health Plans point-of-service plan and an indemnity plan is available for workers who live more than 20 miles or 20 minutes from at least two primary care physicians in the network, Ms. Honeycutt said. Only 2% to 3% of its employee population is in the indemnity plan, she noted.

Benefit Beat

Employees pay 25% of the premium for the POS plan, which averages about \$33 per month for part-timers, and pay a \$10 copayment for office visits. Starbucks pays 70% of the cost of out-of-network medical care.

In addition, Starbucks pays for one eye exam per year plus \$70 per year toward a new pair of corrective lenses, Ms. Honeycutt said.

Starbucks also covers 100% of the cost of diagnostic and preventive dental care for full and part-time employees, who pay no deductible. Starbucks contributes 80% toward basic dental procedures and 50% toward major procedures, up to \$2,000 per year.

Starbucks also offers all employees crisis counseling, assessment and referral for treatment of such problems as family and marital, work-related and emotional issues. Starbucks will pay for three visits for each situation that warrants counseling.

The company also offers part- and full-time workers the option to set aside pretax dollars in a dependent care reimbursement account.

Starbucks also pays 100% of the premium for employees' short-term disability coverage, which provides 66⅔% of their base salary for a maximum of 26 weeks.

Non-retail hourly employees also receive additional life insurance coverage and long-term disability insurance, for which Starbucks pays 100% of the cost.

Ms. Honeycutt said there is no particular reason that retail hourly employees do not receive life insurance or LTD, but noted that the company is looking at introducing a flexible benefit ar-

range that would allow retail part-time employees the option to choose those coverages.

Part-time employees become eligible for paid vacation time after six months of service, which is pro-rated based on hours they worked.

After part-time employees complete 1,000 hours of service, they are eligible to take part in the company's 401(k) savings plan. Once eligible, Starbucks will match 25% of the employee's contribution, up to a maximum of 4% of the employee's compensation.

After completing 500 hours of service, part-time employees are also eligible to take part in Starbucks' stock option program, which is awarded each year based on wages, stock price and company profits.

According to benefit consultant Hewitt Associates L.L.C., Starbucks is not alone in offering its part-time workers benefits.

A recent Hewitt survey of more than 500 employers showed that an increasing number of employers are extending benefits to part-time workers.

Employers today "are competing for the best and the brightest," said Marie Lipari, a work/life consultant for the Lincolnshire, Ill.-based Hewitt. "If an employer is willing to put the time and effort into training its employees, it makes sense to provide the benefits to retain them."

According to the survey, the most common benefit offered to part-time employees is paid time off. Eighty-three percent of the employers surveyed offer paid holidays to employees working at least 30 hours per week, and 86% offer paid vacations. For employees working 20 to 29 hours per week, 78% of the surveyed employers offer paid holidays and

80% offer paid vacation. More than half of the employers—51%—offer paid holidays to employees working fewer than 20 hours per week and 47% offer paid vacations.

Medical coverage is another benefit frequently offered to part-time employees, the survey found.

More than three-quarters of the surveyed employers—76%—offer some form of medical coverage to employees who work 30 or more hours per week. Sixty-two percent offer medical benefits to employees working between 20 and 29 hours per week, while only 25% of employers offer medical coverage to employees working less than 20 hours per week.

Of the employers that offer medical coverage to part-time employees, 10% pay the full cost of coverage for employees working at least 30 hours per week; 8% pay full coverage for employees working between 20 and 29 hours per week; and 3% pay full coverage for employees working less than 20 hours.

In addition to medical benefits, a majority of employers with part-time employees offer dental benefits. According to the survey, 69% of employers offer dental benefits to employees working at least 30 hours per week; 56% extend benefits to those working between 20 and 29 hours; while 23% extend dental benefits to those working less than 20 hours per week.

Other benefits typically offered to part-time employees include life insurance, long-term disability, paid sick leave and flexible benefits, the survey found.

Copies of the "Survey of Benefits for Part-Time Employees" are available for \$100 by contacting Diane Schuett at Hewitt Associ-

ates L.L.C., 100 Half Day Road, Lincolnshire, Ill. 60069; 708-295-5000.

—By Sally Roberts

Shipbuilder's POS plan

NEWPORT NEWS, Va.—Beginning this July, Newport News Shipbuilding will replace a self-insured indemnity plan covering 12,800 hourly employees with a fully insured point-of-service health care plan.

The new POS plan, underwritten by Trigon Blue Cross & Blue Shield of Richmond, Va., is part of a four-year collective bargaining agreement ratified in February by members of United Steelworkers Local 8888.

The POS plan requires employees to select a primary care physician and features improved benefits for employees and dependents who seek treatment from network providers, explained Bob Walker, benefits manager for the Newport News, Va.-based ship manufacturer.

For example, employees who visit network physicians will pay \$10 per visit, while those visiting non-network physicians must pay 30% of the cost of the office visit. Similarly, employees that seek treatment from network hospitals will receive 90% reimbursement vs. 70% for non-network hospitals.

The network includes 600 primary care physicians and 18 hospitals in the area.

The POS plan also includes a prescription drug benefit that mandates use of generic medicines. Employees will pay \$5 per prescription filled for generics and for branded prescriptions when generics are not available, Mr. Walker said.

The new health plan pays for some preventive services not covered under the former indemnity plan, like an annual physical for women, and covers screenings to detect breast and cervical cancers, as well as coronary artery disease and high blood pressure.

The BC/BS plan also offers a medical and lifestyle management program for health plan members with chronic illnesses, such as diabetes, high blood pressure, cancer and asthma. Employees and dependents have access to a toll-free telephone number that will connect them with a personal nurse consultant.

The lifetime maximum under the new POS plan is \$2 million. Single employees pay \$1.50 per week for coverage and \$1 per week for each dependent up to a maximum of \$6 per week. Under the former indemnity plan, single employees paid nothing and employees with dependents paid \$1 per dependent, Mr. Walker noted.

Newport News Shipbuilding chose to offer a fully insured health plan in order to achieve some predictability in health plan costs, he pointed out.

"This gives us a guaranteed rate over four years, so we know what our costs are going to be," Mr. Walker explained. He declined to discuss the plan's costs further.

The four-year agreement with Local 8888 also called for improvements in employees' pension plan benefits, Mr. Walker added. Among other things, the company improved its early retirement reduction factors so that employees can retire with full pension benefits at age 62 rather than age 65, he said.

—By Christine Woolsey

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Guidelines

Continued from page 2

tasks, learning, caring for oneself, and working.

The new EEOC guidelines expand that definition of major life activities to include mental and emotional processes, such as thinking, concentrating and interacting with others.

"This is significant because this would allow individuals with severe depression or stress to attempt to claim they have an impairment which substantially impacts upon one or more major life activities," said Gerald L. Maatman Jr., an employment law attorney with Baker & McKenzie in Chicago.

"To date, courts interpreting the ADA have been somewhat unresponsive to claims that stress and depression are protected disabilities under the statute," he said.

Mental and emotional disabilities were generally regarded as part of working, which is considered a "major life activity," said Dennis Lindsey, president of Cognitive Ergonomic Systems Inc., a behavioral consulting firm in Anaheim, Calif. Now, "it will make it easier for individuals to claim they are qualified under the act" with such impairments as depression, phobias and stress, he said.

However, experts do not expect a flood of new claims to be filed to the EEOC as a result of the clarification.

The EEOC's Ms. Mastroianni said that while mental and emotional processes are new "major life activities," nothing has really changed in the law.

In order to make a case under the ADA, there still has to be a finding of impairment, which means a medical diagnosis of stress or depression, and the impairment still must substantially limit a major life activity, she explained.

"This doesn't open the door to undocumented claims of stress," Ms. Mastroianni said.

The ADA became law for all employers with 25 or more workers July 26, 1992, and last July the law was extended to employers with 15 or more workers.

The law prohibits discrimination on the basis of disability in virtually all aspects of employment. Employers that hire disabled workers are required to extend certain job accommodations to qualified individuals.

Nearly 40,000 claims alleging violations of the ADA's discrimination provisions were filed to the EEOC from July 26, 1992, through Dec. 31, 1994. Emotional and psychiatric impairments was the third most common claim—representing 11.4% of the cases—behind back impairments and neurological impairment.

Employers have been waiting for the EEOC to issue clearer guidelines defining "disability" since the ADA took effect.

In the interim, the EEOC issued guidelines to help employers comply with the ADA when making disability-related inquiries and requiring medical exams of job applicants (BI, May 30, 1994). Those rules were needed because the disabilities act bars employers from asking certain questions and doing certain types of exams before making an offer of employment.

The EEOC also issued interim guidelines on how the ADA applies to disability-based distinctions in employer health plans (BI, June 14, 1993).

Employers that have been waiting for the guidelines to be issued said the EEOC didn't provide

them with much new guidance in interpreting the law and would have preferred further guidance in another area.

"I was hoping (the guidelines) were more definitive," said Wendell Phillips, director of equal opportunity programs for the City of Colorado Springs, Colo. "Whenever a new law comes out, you hope you're not a court test case" especially when one doesn't know what the enforcement people are thinking, he said. "I would have liked the EEOC to have defined a 'reasonable accommodation' better," he said.

The new guidelines "don't add

much new," agreed James E. Crockett, manager-risk and benefits for Denver Water, the city's

what is reasonable accommodation and the ability to look at other positions easily," he said.

'Courts interpreting the ADA have been somewhat unresponsive to claims that stress and depression are protected disabilities under the statute,' says Gerald Maatman Jr.

water authority.

"I would like (the EEOC) to assist me with further guidance on

Margaret Hart Edwards, an employment law attorney with Landels, Ripley & Diamond in San

Francisco, added that while the new guidelines do not change any existing definitions of a disability, they do clear up some questions many employers have asked concerning disabilities and the use of illegal drugs.

Under the guidelines, the ADA protects individuals who have a record of being addicted to illegal drugs, but no longer use them, or who are erroneously regarded as engaging in such use.

Individuals are excluded from protection if they are currently engaging in the illegal use of drugs or if their prior use was not considered an addiction. **BI**

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Opinions

Don't relax yet

EMLOYERS DODGED A judicial bullet earlier this month in the closely watched benefit plan amendment case when the U.S. Supreme Court overturned two lower court decisions against Curtiss-Wright Corp.

We are glad that reason finally prevailed in the 11-year-old legal dispute, but employers that sponsor health plans remain at risk to a dangerous legal ricochet if they relax too soon.

The Supreme Court on March 6 allayed the fears of thousands of plan sponsors nationwide that have reserved their rights to amend their plans but have not spelled out their amendment procedures in detail. If the Supreme Court had upheld the lower courts' rulings, it surely would have unleashed a horde of plaintiffs attorneys seeking to recover the value of benefits that retirees have lost in recent years. The cost to employers could have been enormous.

But, unlike the lower courts, the Supreme Court refused to get tangled up in some awkward wording in a section of the Employee Retirement Income Security Act.

The Supreme Court justices unanimously concurred that the primary purpose of that section is "to ensure that every plan has a workable amendment procedure."

A simple reservation of rights sufficiently meets that requirement because it tells plan participants that they have to look to the company and its officials for plan amendment procedures, the court decided.

As for protecting plan beneficiaries, other portions of ERISA are designed to do that, the court said.

In ruling so, the justices rejected the arguments of more than 520 Curtiss-Wright retirees who lost their company-sponsored health coverage in 1983 shortly after Curtiss-Wright amended its plan. Under the amendment, retirees lose their coverage if the plant from which they retire closes.

But while the Supreme Court's ruling gives plan sponsors a wide berth in how they may describe their plan amendment procedures, employers still will be



required to play by the rules they set forth.

That is the issue a lower court now has to resolve in the Curtiss-Wright case, because there is no clear record of whether the company officials who were authorized to amend the plan did so.

Also left unclear is what ramifications Curtiss-Wright faces if it loses this next round in court. The Supreme Court did not rule on whether an amendment can be voided if a plan sponsor violates its plan amendment procedures. Such a ruling would cost Curtiss-Wright about \$2.7 million, the value of the benefits the 520 retirees have lost.

The high court's ruling sends a clear signal that plan sponsors must play by their own rules. That should be easy enough.

Plan sponsors should now be scrambling to determine whether they are adhering to their own plan amendment rules and documenting their actions.

They can be certain that plaintiffs attorneys will be looking into that.

Letters

Client satisfied with Home's response to needs

To the editor: In the Feb. 20 issue of *Business Insurance*, I was quoted in the article, "Improved Offer for The Home Placates Most But Not All," about changes at The Home Insurance Co. While the quotes in the article accurately reflect my thoughts and comments during the interview, I would like to provide an update.

The article referenced an upcoming meeting scheduled with representatives of The Home. That meeting and yet another have since taken place. As a result, I am reasonably certain that my concerns with recent claims handling result not from the proposed merger but from other strategic changes within The Home. Based on our candid communications, I have every confidence that The Home has and will accommodate our needs and continue to be the responsive provider we have always known.

Concerning the rewrite of our Home

policies on Zurich-American Insurance Co. paper, we now understand that to be imminent with policy dates to be adjusted appropriately.

In our industry, many people talk of desiring long-term relationships, yet few people work at them. The current tumult in the insurance marketplace demands that we both protect our employer's assets and act reasonably and responsibly in the insurance market. Just as we do not want our insurers to "knee jerk"

when confronted with our own volatility, neither should we impulsively react to what may be a short-term provider blip.

We are looking forward to an ongoing relationship with our current service team combined with the financial stability of Zurich-American.

David G. Adler
Risk Manager
The Portman Cos.
Atlanta

Benchmarking risks helpful

To the editor: In the Feb. 27 letter to the editor, "Cost of Risk Can't Be Used for Benchmarking," Richard F. Denning makes some good points but misses others.

Cost of risk is a valuable set of statistical benchmarks that can be used to gauge performance progress. These benchmarks, in turn, allow the risk manager to identify potential problems in the cost structure.

For example, here are some other points to consider: Are the costs out of line in property, liability or workers compensation? Premiums or retained losses? Is the problem claims frequency or severity? Is medical, indemnity or expense driving claim severity? Are there geographic factors? Is claim processing

efficient?

This is a sequential methodology that moves from cost indicators to process solutions.

It's true that progress can only come when the processes underlying each cost component are improved. But with limited resources, risk managers must identify and attack the "hot spots" quickly and efficiently.

Benchmarking all the processes involved in risk management is fine, but the greatest success will come to those people who know where to start and get fast results.

Richard H. Moscicki
Principal
Towers Perrin
Dallas

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**Business
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Decertify

Continued from page 3

the risk of transmitting blood-borne disease. If the jury found the companies had been negligent, victims would then have been able to bring potentially thousands of individual suits for damages.

The four companies are: the Armour Pharmaceutical Co. division of Rhone-Poulenc Rorer Inc.; Baxter International Inc.; Miles Inc.; and Alpha Therapeutic Corp., a unit of Green Cross Corp. of Osaka, Japan. The National Hemophilia Foundation was also a defendant charged with negligence and breach of fiduciary duty (*BI*, Aug. 15, 1994).

The defendants, which have won 12 of 13 suits that have already gone to trial over the allegations of negligence, sought to have the class overturned. They argued that class members were too dissimilar. And they said a two-tiered system, with one jury ruling first on negligence and others on liability and damages, violated their 7th Amendment right to a single jury trial.

Spokeswomen for Collegeville, Pa.-based Armour and Deerfield, Ill.-based Baxter said they were pleased by the ruling, which will let them defend each case individually.

"Ultimately, we still believe a (mass) settlement is the best way to resolve this issue both for hemophiliacs and (blood product companies). But, for now, we're pleased with

this decision. We never felt there was a legal basis for class certification," Baxter's spokeswoman said.

Originally, Baxter and Armour had offered to settle their liabilities with most hemophiliacs who contracted AIDS from tainted clotting products known as Factors VIII and IX for a total of about \$150 million, which would have paid each person in the class about \$25,000. That offer was rejected as being too small.

Lawyers for the hemophiliacs say as many as 2,000 hemophiliacs have died from AIDS and as many as 10,000 of the estimated 20,000 hemophiliacs that used the blood-clotting medications are HIV-positive. But only about 300 liability lawsuits are pending in state and federal courts against the blood product companies, partly because those afflicted with AIDS do not want to reveal their illness publicly.

As soon as the hemophiliac suits were certified as a class-action, the ante was raised. Had the federal jury found the companies negligent, they could have faced billions of dollars in damages and would have had to up their settlement offer.

The specter of one jury forcing the companies to settle, perhaps bankrupting themselves by doing so, led 7th Circuit Chief Judge Richard Posner and Judge William Bauer to overturn the class.

"With all due respect for the district judge's commendable desire to experiment with an innovative procedure for streamlining the adjudi-

cation of this mass tort, we believe his plan so far exceeds the permissible bounds of discretion in the management of federal litigation as to compel us to intervene and order decertification," Judge Posner wrote.

Although Judge Grady's ruling was never certified for appeal, Judge Posner said the 7th Circuit acted on the defendants' request for review because such an appeal would come too late to afford the defendants relief.

If they were found negligent at trial, "they might easily be facing \$25 billion in potential liability and, with it, bankruptcy. They might not wish to roll these dice and will be under considerable pressure to settle," the judge wrote.

Judge Ilana Diamond Rovner dissented, saying class certification almost always increases the likelihood of settlement, not just under the circumstances of this case.

And, she questioned whether the defendants met both requirements to have the class decertified—proving that irreparable harm would be done by delaying an appeal, and that the trial judge grossly overstepped judicial discretion.

The plaintiffs are already petitioning the full 7th Circuit to reconsider the panel's ruling, said David Shrager, of Shrager, McDaid, Loftus, Flum & Spivey in Philadelphia, which represents plaintiffs whose cases were consolidated in Chicago.

"Assuming the decision stands,

we're looking at a lot of individual cases. We'll see at the end of the day whether the industry has done itself a favor or not. But what strikes me is the judge's ruling that class actions serve to blackmail corporations into settling or bankruptcy. I haven't seen too many companies of this size that you can blackmail into anything," Mr. Shrager said.

Meanwhile, the 7th Circuit ruling is being watched closely by both sides in the consolidated class action suit against the tobacco industry.

In the tobacco case, U.S. District Judge Okla B. Jones II in New Orleans said as many as 50 million smokers could pursue suits based on negligence against the tobacco industry as a class (*BI*, Feb. 27).

Tobacco companies consider the 7th Circuit ruling very important because, they say, the issues in the two cases are nearly identical.

"The legal and negligence issues are exactly the same. Because this is a recent opinion from a reputable court and judge, it does us good on several levels and we intend to cite it," said Dan Donohue, senior vp-litigation with R.J. Reynolds Tobacco Co. in Winston-Salem, N.C.

"We'll either ask Judge Jones to reconsider his ruling based on this decision or we'll ask him to certify his ruling so it can be appealed, and once it does get to the 5th U.S. Circuit Court of Appeals, we believe this will be persuasive," he said.

When asked why companies that have had success defending negli-

gence cases individually are opposed to class actions, Mr. Donohue said there are no assurances that a favorable jury verdict on one class action based on one issue will put an end to litigation. "It's likely that it will come back at us in a different form. These aren't once-and-for-all cases."

Mr. Donohue also said the 72 suits pending against the tobacco industry and the 300 suits against blood products companies do not justify a class action. "Those numbers are small enough that the cases can be tried one at a time."

As an attorney for plaintiffs bringing cases against both the blood product companies and the tobacco industry, Diane Nast of Kohn, Nast & Graf in Philadelphia, was able to cast a unique perspective on how Judge Posner's ruling in Chicago might impact class certification in the smokers case.

"I don't think it will have a negative impact. If you follow Judge Posner's reasoning, which I believe was wrong, he's saying that one of the main reasons the class was decertified is that the potential for damages in each case is in the millions of dollars. Therefore, he feels recovery won't be dwarfed by the cost of pursuing a case."

"But in the tobacco case, the size of many claims isn't that great, so the cost of the suits will exceed potential recovery. So, if you take his analysis to the 5th Circuit, it supports class certification," Ms. Nast said. **[B]**

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Oregon

Continued from page 3

though, Washington has since narrowed the scope of its requirements. For example, insurers will be required to maintain policies for 20 years, instead of the 40 years first proposed.

Ms. Senn has indicated that her regulations are nearly complete, with "one last hearing" scheduled for April 4 in Tacoma, and April 10 set as the intended date of adoption.

Mr. Whitty said Associated Oregon Industries is interested in Washington's experience with regulations addressing lost insurance policies because some of its members have encountered stonewalling by insurers when filing environmental claims against policies that no longer may be in their possession.

But Diane Dailey, a partner with

the Portland office of Bullivant Houser Bailey Pendergrass & Hoffman who represents insurers, said the Oregon legislation is unnecessary because there are relatively few Oregon environmental cleanup sites.

Ms. Dailey also said that state regulations already cover claims handling procedures.

In addition, she said that the legislation would introduce a major change in insurers' liability. Under the bill, policyholders could sue insurers for alleged violations of insurance regulation or unfair trade claims, Ms. Dailey explained. Currently, Oregon policyholders can sue for breach of contract, but not for violation of insurance regulations.

Jack Munro, Oregon counsel for the American Insurance Assn., said that vague language and challenges to the bill will increase litigation rather than reduce it as proponents claim. **[B]**

California tort reform bill introduced

SACRAMENTO, Calif.—Surpassing his own campaign promises, California Gov. Pete Wilson recently introduced a 10-bill tort reform package that some businesses support, but trial attorneys and consumer groups are likely to oppose.

Among other things, the package would:

- Limit punitive damages to three times economic damages and require the trial judge to determine the amount instead of a jury. Currently there is no limit to the amount juries can award.
- Limit the amount of damages for future lost pay that a fired worker could receive in a wrongful termination case to one year's wages after a court judgment. Currently there is no limit.
- Require plaintiffs in product liability suits to prove that the risk posed by a product's design outweighed its benefits and that the risk of injury or damage was or should have been foreseen.
- Limit frivolous lawsuits by requiring judges to impose sanctions against attorneys and parties who abuse the process.
- Create a no-fault auto insurance plan, limiting a victim's ability to

sue after an auto accident, but retaining the right to sue for serious injury.

- Increase a judge's authority to require parties to submit to non-binding arbitration to solve disputes; particularly in cases where the amount in dispute does not exceed \$150,000, instead of \$50,000 as under current law.
- Allow defendants being sued for breach of contract, personal injury or property damage to request that cases go to mediation within 120 days after they are sued. The bill would require both sides to participate, but allow either party to terminate participation after the first day of a hearing.
- Limit a felon's ability to collect damages for injuries suffered while committing a crime.
- Encourage early settlement by requiring a plaintiff to pay attorneys fees for a defendant if a defendant's offer to settle is rejected and the plaintiff subsequently achieves a less favorable judgment.

So far, the California Manufacturers Assn. and the California Chamber of Commerce have expressed support for the tort reform package.

—By Roberto Cenicerio

HCFA

Continued from page 1

to refund much of the money it has already recovered.

The ruling struck down two HCFA regulations that were challenged by the Health Insurance Assn. of America and Blue Cross & Blue Shield Assn. Among other things, the appeals court ruled:

- HCFA could not demand payments in situations in which a beneficiary, such as an older worker, or a provider had not filed a claim within the plan's or insurer's deadline. Typically, plans and insurers require a claim for a medical or hospital service to be filed within a year of the time the service was performed. HCFA earlier said it could seek recoveries for mistaken Medicare payments regardless of whether or not beneficiaries or providers submitted a claim within the plan's filing deadline.

Striking down that regulation is a huge blow to HCFA's recovery efforts, because employers and TPAs say the most frequent HCFA demand for mistaken Medicare payments involves claims that employees and providers never submitted to them.

- HCFA cannot demand payments from TPAs that only administer an employer's health plan and do not also insure the benefits.

Under the HCFA regulations, the agency said it had the right to seek overpayments from TPAs, as well as from insurers and employers.

That part of the court ruling complicates, though does not cripple, HCFA's recovery efforts in its Medicare Data Match program. It is simply far easier for HCFA to recover funds from a single TPA than

from the thousands of employers whose plans the TPA administers.

But it may be too soon for employers, insurers and TPAs to celebrate the appeals court victory.

HCFA officials say the agency can go to Congress to thwart the appellate decision.

"In our view, the decision frustrates the intent of Congress" for the agency to recover mistaken Medicare overpayments, a HCFA official said.

"Legislation always is an option," he said, adding, though, that a decision on seeking legislation has not yet been made.

But some observers say it is only a matter of time before HCFA seeks a legislative fix and that Congress will respond favorably to that request.

"I don't think HCFA will roll over. I think it will try for retroactive legislation," said Linda Meyer, vp-compliance and quality assurance at Harden & Co. Insurance Services Inc., a Concord, Calif.-based TPA.

"It wouldn't be so hard for Congress to make a retroactive change as part of a technical corrections bill," said Frank Nessel, vp-third party administration services with Sedgwick Noble Lowndes in Warminster, Pa.

Others, though, say the chances that Congress would enact legislation to supersede the appeals court decision depend on how HCFA presents its proposal.

"The more the legislation is presented as a technical correction than a change in policy, the better its chances of passage," said Frank McArdle, a consultant with Hewitt Associates L.L.C. in Washington.

Legal experts suggest that rather than trying to read the political tea

leaves in Washington, employers and others should try to determine whether HCFA owes them a refund—assuming the appeals court decision is not overturned by Congress.

"You should at least start looking at demand payments you made" to see how they mesh with the appeals court decision, said Robert Roth, counsel to the law firm of Dechert Price & Rhoads in Washington.

HCFA officials say they are not aware of any employers, insurers or TPAs that have formally sought

program.

They note that the cost of compiling records again to prove, for example, that employees or providers did not submit claims within their plan's filing period, as well as retaining legal counsel, might exceed a potential recovery.

"We'd have to analyze whether or not it is worth the cost," said Barbara Decker, manager of health planning at Southern California Edison Co. in Rosemead, Calif., which hasn't decided yet what it will do.

"The cost of data recovery al-

Legal experts suggest that rather than try to read the political tea leaves in Washington, employers and others should try to determine whether HCFA owes them a refund.

refunds in the wake of the appeals court decision. But last week a source said a major Hartford-based insurer is considering whether it will sue to recover payments.

Refund actions would be filed with the U.S. Court of Federal Claims in Washington, says Mr. Roth, a former attorney with the Department of Health and Human Services' Office of General Counsel.

"If you don't file a claim, HCFA is not going to issue a refund on its own," said Ed Winterbauer, a principal with The Apex Management Group in Princeton, N.J.

But filing a refund claim may not always make sense, say employers that have made payments to HCFA under the Medicare Data Match

most certainly would outweigh the potential for a refund," said Dan Spiller, manager of welfare planning and administration at The Mead Corp. in Dayton, Ohio.

A real practical problem that could stand in the way of a refund is that employers simply may have pitched old claims records, said Judy Bauserman, a consultant with William M. Mercer Inc. in Washington.

Some benefit experts suggest that employers and others return to HCFA new demand letters for overpayments that fit the appeals court decision and cite that decision and the Supreme Court's refusal to review the decision as their reason not to pay.

But such a response would be

unacceptable, the HCFA official said. If the employer's plan paid the claim, the agency would want evidence of that payment. If no claim had been filed with the employer's plan, the agency would want to know, for example, if the plan had a filing deadline and whether or not it was consistently enforced.

Meanwhile, echoing earlier complaints, TPAs say many of the HCFA demand letters for mistaken Medicare payments are incorrect.

For example, Ms. Meyer said that out of \$189,000 that HCFA demanded from Harden & Co., the TPA deemed \$27,300 was bona fide and paid that amount to the agency. Some demand payments, though, were sent for claims incurred by employees who had retired and for whom Medicare was indeed the primary payer, she said.

Mr. Nessel of Sedgwick Noble Lowndes said about half of the demand letter claims requests involved claims in which it was not the plan administrator. In cases where it was the TPA, about two-thirds of the demand letters were for claims that it paid at the time they were filed, he said. That meant the provider originally probably billed both the employer's health plan and Medicare, he said.

Others say that they continue to be bombarded by HCFA demand letters even after they have supplied evidence that they properly paid the claim when it was filed or even after they made demand payments.

"It can take a while to get them off your case," said Richard Raup, president and chief executive officer of Business Administrators and Consultants Inc., a TPA in Reynoldsburg, Ohio. **B**

I N S U R E D R E S U L T S



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Largest U.S. reinsurers' 1994 results

Ranked by net reinsurance premiums written. All amounts in thousands of dollars.

Reinsurers	Net reinsurance premiums written 1994	Net reinsurance premiums written 1993	Policyholder surplus (reinsurers only)	Net income 1994	Losses & loss adjustment expenses	Loss ratio	Underwriting expenses	Expense ratio	Combined ratio 1994	Combined ratio 1993
1. General Re	2,581,029	2,275,346	3,770,077	511,114	1,708,753	70.7	788,595	30.6	101.2	101.5
2. Employers Re	2,155,364	2,232,745	2,481,585	414,176	1,687,858	80.4	521,239	24.2	104.6	104.5
3. American Re	1,536,247	1,358,704	1,096,344	129,573	1,026,349	71.1	500,991	32.6	103.8	99.5
4. Transatlantic/Putnam	868,370	631,693	590,930	86,336	681,904	80.1	221,837	25.5	105.7	107.2
5. North American/Swiss Re	851,210	776,409	574,857	(27,140)	634,476	76.5	312,969	36.8	113.2	111.2
6. Prudential Re	733,383	760,526	600,679	2,987	619,807	85.8	238,855	32.6	118.4	110.1
7. Berkshire Hathaway	689,834	528,698	N/A	N/A	476,879	69.3	130,844	19.0	88.3	96.1
8. Munich Re	665,973	669,135	711,279	21,129	560,145	84.0	217,898	32.7	116.7	114.7
9. The St. Paul Cos.	513,321	431,242	N/A	N/A	372,802	77.1	143,231	27.9	105.0	109.9
10. Constitution Re	481,774	453,889	301,003	34,227	321,489	69.0	154,408	32.0	101.0	102.2
11. Hartford Re Mgt. Co.	481,330	375,411	N/A	N/A	345,365	75.9	124,668	25.9	101.8	98.3
12. TIG Re Co.	440,288	346,109	371,968	42,205	299,295	75.9	125,392	28.5	104.4	109.7
13. NAC Re	412,412	336,941	407,024	27,313	250,383	66.6	161,081	39.1	105.7	110.9
14. F&G Re	409,083	398,033	N/A	N/A	271,821	68.5	93,148	22.8	91.3	92.1
15. Kemper Re	319,994	266,006	416,024	10,458	263,078	82.9	82,907	25.9	108.8	133.4
16. National Re	309,612	332,560	353,237	40,293	234,355	70.4	86,886	28.1	98.4	99.8
17. Zurich Re Centre	302,188	98,873	607,470	(41,933)	182,845	82.4	97,159	32.2	114.6	126.1
18. SCOR U.S. Group	232,720	236,866	243,416	(1,109)	192,470	83.7	81,527	35.0	118.7	103.7
19. CIGNA Re	219,454	214,283	199,666	(12,916)	225,007	106.6	43,123	19.7	126.2	125.0
20. Winterthur Re	207,215	218,948	204,916	16,251	157,904	76.0	68,582	33.1	109.1	106.0
Totals for Top 20	14,410,801	12,942,417	12,930,475	1,252,964	10,512,985	76.1	4,195,340	29.1	105.2	105.3
Total for all companies	17,116,949	15,243,906	17,857,296	1,582,153	12,564,438	76.6	5,057,796	29.5	106.2	106.9

Source: Reinsurance Assn. of America and *Business Insurance*

Reinsurers

Continued from page 1

New York, also pointed to the higher interest rates. The outlook for reinsurers is better than it was for 1994, "but that's partly because one can expect some growth in investment income, assuming that cash flows remain relatively strong," he said.

"We're now in a stronger interest rate environment. From that point of view, I think we should be able to see the earnings margin increase. But the pricing at the front end isn't doing any better, it's only getting worse. So from the point of view of premium growth that's where I guess I have the big question mark," Mr. Karter said.

The outlook is "certainly not encouraging as far as the rate levels are concerned for both casualty and property," agreed John Lombardo, president and CEO of Munich American Reinsurance Co. in New York. "There doesn't seem to be any hardening anywhere, and a year or two years ago we could say with the exception of catastrophe-prone areas, and I can't say that any more. That seems to be eroding rapidly."

"Our perspective on the reinsurance business is that we're not expecting to see great financial performance by reinsurers, or a significant improvement in financial performance because the underlying business is not improving," said Alan Levin, managing director at Standard & Poor's Corp. in New York.

"The increase in supply in property reinsurance has resulted in a plateauing of rates in the property market, whereas the casualty market is still very competitive," he said.

"Unfortunately, there's nothing that's causing reinsurers to restructure their pricing," though higher retentions by primary insurers do insulate reinsurers to a degree, said Mr. Levin.

Net premiums written for the 58 reinsurers participating in the annual survey increased 12.3%, to \$17.12 billion last year from \$15.24 billion in 1993, according to the RAA. The Washington-based trade association has revised some of the figures since it reported the industry's results earlier this month (*BI*, March 13).

This compares with a 14.2% increase in net premiums, to \$12.95

billion, reported for the first nine months of the year, and a 15.1% rise reported by reinsurers at midyear (*BI*, Nov. 22, 1994; Sept. 5, 1994).

The Top 20 reinsurers based on net written premiums reported an 11.3% increase in premium volume to \$14.41 billion last year from \$12.94 billion in 1993. This compares with a 14.5% increase to \$10.88 billion for the first nine months, and a 15.1% increase in the first half for comparable groups of reinsurers.

Net income for all reinsurers in the RAA survey declined to \$1.58 billion, down 16.1% from \$1.89 billion for a comparable group of reinsurers in 1993. This is an improvement, however, when compared with a 35.7% decline in net income to \$861.2 million reported for the nine-month period.

The 16 companies among the Top 20 that reported net income posted \$1.25 billion in profits last year, 16.6% lower than the \$1.5 billion reported by a comparable group of 16 reinsurers at year-end 1993.

U.S. reinsurers reported a 106.2% combined ratio, which compares with a 106.9% ratio for all of 1993, according to the RAA survey. It is an improvement from the 107.1% combined ratio reported for the nine-month period.

The Top 20 reinsurers reported a 105.2% combined ratio for 1994, a slight improvement from 105.3% for 1993. This compares with a 106.7% combined ratio for a comparable group of reinsurers for the nine-month period.

"I think everybody was sort of surprised that the Northridge quake didn't have more of an impact," said Mr. Bunea of Constitution Re, who said that a 106.2% combined ratio is "not all that bad."

The reinsurance industry's 106.2% combined ratio compares with a 108.1% combined ratio reported for 1994 by major property/casualty insurers surveyed by *Business Insurance* (*BI*, March 20).

"Clearly, the reinsurance industry has done better than the primary," said SCOR's Mr. Karter. "I think that's somewhat inevitable considering that over the last few years, a number of things have occurred."

One such occurrence is that reinsurers have "become more of an excess writer rather than proportional, so the pure results on the primary level are not necessarily being passed on," he said. "And with

changes in retention levels at the primary level that has also in the same way probably affected reinsurers somewhat positively."

Except for one or two anomalies, "the growth (in premiums) has been pretty consistent," commented NAC Re's Mr. Malvasio. "The fourth quarter is generally a reflection of a lot of the business that's already written, so you see the same consistent trend in writing...with the composite improving somewhat" due to the absence of any significant cat losses since the Northridge quake, he said.

Pointing to the higher premium volume, Michael R. Pinter, chairman and CEO of Kemper Reinsurance Co. in Long Grove, Ill., said, "Remember that the premium volumes that you recognize in 1994 are based upon perceptions and conditions in the marketplace that primarily related back to the beginning of '94, and at the beginning of '94 there was still a fair amount of good pricing available for catastrophe business."

"I think companies are also taking a look at their retentions in light of current conditions and making adjustments...there's a whole host of conditions that influence it," Mr.

Pinter added.

Peter Cheney, executive vp and chief financial officer of National Reinsurance Corp. in Stamford, Conn., noted that investment income for the reinsurance industry totaled \$2.93 billion, up 8.7% from \$2.69 billion in 1993.

However, he added, realized capital gains totaled \$155.7 million in 1994, compared with the \$906.2 million reported in 1993, "so the trend in capital gains is clearly significantly diminished."

This is a "reflection of the very poor, difficult bond market throughout 1994. But the regular investment income is showing the benefits of the increasing interest rates," said Mr. Cheney. "It's finally beginning to roll through" and should accelerate this year, he said.

Michael Smith, an analyst with Lehman Bros. in New York, also pointed to the growth in reinsurers' policyholder surplus as a significant factor for the industry.

According to a report he has prepared, at year-end 1990, 65 professional reinsurers surveyed by RAA had \$12.1 billion in statutory net worth. Of the 65, only 30, or fewer than half, had surplus of more than \$100 million in 1990, he said.

PMA Re offers new ways to rank reinsurers

Financial guarantee reinsurer Capital Reinsurance Co. may have ranked only No. 50 among U.S. reinsurers in net premiums written, but it was No. 7 in terms of 1994 net income with \$36.7 million, an analysis by PMA Reinsurance Co. shows.

Philadelphia-based PMA Re uses data from the Reinsurance Assn. of America's annual survey of U.S. reinsurers, as well as some of its own data, to develop a report ranking 59 U.S. reinsurers in a variety of ways based on their 1994 results.

Some new names emerge when reinsurers are ranked in ways other than on the typical premium volume or policyholder surplus.

In addition to New York-based Capital Re, another reinsurer that frequently appears high in PMA Re's rankings is Baltimore-based Inner Harbor Re, a USF&G Corp. unit. The reinsurer, which began business in 1992, mainly writes quota-share U.S., worldwide and marine catastrophe business on behalf of F&G Re, another USF&G unit.

With its \$6.3 million in 1994 net premium volume, Inner Harbor

ranked No. 58 out of the 59 reinsurers. But it has the lowest combined ratio among the reinsurers included in PMA Re's survey, at 46.7%.

It is followed by New York-based PXRE Reinsurance Co. and by Greenwich, Conn.-based Transnational Reinsurance Co., which are under the same management, and which each have a 64.3% combined ratio. Next is Capital Re, with a 72.6% combined ratio, and Enhance Reinsurance Co., another New York-based financial guarantee reinsurer, with a 73.5% ratio.

Inner Harbor also had the biggest boost in surplus, rising 240.3% as a result of USF&G increasing its surplus to \$22.1 million as of year-end 1994 from \$6.5 million at year-end 1993, the PMA Re report said.

It is followed by New York-based Great Lakes Reinsurance Co., a unit of Munich Reinsurance Co., which increased its surplus by 93.3% to \$100.8 million from \$52.2 million, and by Employers Reinsurance Corp., which increased its surplus 53.4% to \$2.48 billion from \$1.62 billion.

As of year-end 1994, 52 companies, or 20% fewer reinsurers, had close to \$18 billion in capital, said Mr. Smith. Of these, 44, or about 85% of the companies, had more than \$100 million in statutory capital, and 24 have at least \$200 million, he said.

"Very clearly, the ticket entry has gone significantly higher in just four years," said Mr. Smith, noting that a number of reinsurers increased their capital substantially just in the fourth quarter of 1994 alone.

Meanwhile, observers expect the consolidation within the reinsurance industry to continue.

Consolidation "is still very much alive and well and present within the reinsurance community," said Jack Snyder, senior vp at A.M. Best Co. in Oldwick, N.J.

"There's no wholesale market turn that people should base their business plans on but, rather, you rely on selective opportunities within lines and sublines of business," said Mark W. Hinkley, executive vp of TIG Reinsurance Co. in Stamford, Conn. "I guess the consolidation of the business offers a chance for redistribution of certain business to players that are adept at underwriting those lines of business." **BI**

Inner Harbor also ranks No. 3 for its percentage of net income to average surplus, which was 18.5%, behind Employers Re, at 20.2% and Park Ridge, Ill.-based American Agricultural Insurance Co., at 19.6%.

Enhance Re ranked No. 1 for its operating ratio, which PMA Re derives by subtracting the ratio of investment income to earned premium from the combined ratio. Enhance Re, which has a negative 13.4% operating ratio, is followed by Capital Re with a negative 9% ratio and by Inner Harbor, with a 31.3% ratio.

Ranked No. 1 for change in premiums written is Transnational Re, which boosted its premiums written 6,047.3% to \$68.3 million in 1994 from \$1.1 million in 1993.

It is followed by New York-based Zurich Reinsurance Centre Inc., which had a 205.6% increase in premiums to \$302.2 million from \$98.9 million, and by financial guarantee reinsurer Asset Guaranty Insurance Co., based in New York, which posted a 141.3% increase to \$22 million from \$9.1 million.

—By Judy Greenwald

For the Record

Manville unit fights cigarette fiber use

DENVER—Manville Corp. unit Schuller International Inc. sued R.J. Reynolds Tobacco Co. in U.S. District Court in Denver earlier this month to prevent the company's fiberglass from being used in cigarettes.

Manville filed for bankruptcy in 1982 as it faced at least \$2 billion in asbestos liability.

Suppliers to tobacco manufacturers may be a target in the growing tide of tobacco-related litigation. Last fall, the West Virginia attorney general named Kimberly-Clark Corp. in its lawsuit to recoup the state's Medicaid costs for smoking-related illnesses from cigarette makers (*BI*, Oct. 3, 1994). Kimberly-Clark, which supplied paper used to make cigarettes, is seeking to be dismissed from the suit.

Schuller provided glass fiber to RJR for cigarette development but not for commercial production, the company claims. When Schuller notified RJR it would no longer supply the fiber, RJR indicated it had a contractual obligation to do so, the lawsuit says.

An RJR spokeswoman called the lawsuit a "misunderstanding" and said the company hoped it could be resolved without going to court.

Blues plan to pay policyholder refund

COLUMBIA, S.C.—Blue Cross & Blue Shield of South Carolina will refund about \$2.5 million to 40,000 customers who overpaid medical bills between 1987 and 1993.

The billing adjustments are a result of a coinsurance policy that did not pass along discounts the Blues plan negotiates with hospitals. M. Edward Sellers, president and chief executive officer of the Columbia, S.C.-based plan, said its competitors often do not base copayments on negotiated discounts, but "we feel it is our obligation to set a new industry standard."

Separately, Blue Cross & Blue Shield of Colorado simultaneously settled two identical class-action lawsuits in which plaintiffs alleged the Blues plan did not fully disclose the calculation method of coinsurance payments. In a March 9 announcement, the plan denied the allegations but agreed to change language in its membership booklets and pay \$3 million into a plaintiffs' fund.

Blue Cross & Blue Shield of Ohio has come under attack from state regulators for refusing to apply discounts to policyholder deductibles and copayments. Late last year, Ohio's insurance commissioner required BC/BS of Ohio to disclose the practice to its policyholders.

Infertility procedure denial upheld

SAN FRANCISCO—The 9th U.S. Circuit Court of Appeals has overturned a district court ruling ordering Costco Wholesale Corp., a Kirkland, Wash.-based wholesaler, to pay for an employee's infertility procedure.

The appellate court concluded that Concept Administrators Inc., the third-party administrator of Costco's self-insured indemnity plan, did not abuse its discretion in denying the woman's claim, which sought payment for a procedure Costco's health plan clearly

excluded from coverage.

Costco employee Donna Cole Winters sued her employer for expenses related to a gamete intrafallopian transfer—or GIFT—procedure performed in December 1990.

Costco's indemnity plan excludes charges that are not related to accident or injury and specifically excludes coverage of "charges in connection with in-vitro fertilization," court papers show.

Ms. Winters' attorneys claimed the contract's exclusions made no specific mention of "gamete intrafallopian transfer procedures," which differs slightly from "in-vitro fertilization." The attorneys argued that the contract language was ambiguous and therefore must

be construed against the employer and its health plan administrator.

A district court granted plaintiffs summary judgment and awarded Ms. Winters \$10,000 in medical and legal fees.

However, in its March 6 ruling, the appellate court said the plan administrator properly denied payment for the procedure based on the medical information it reviewed to make its decision.

Winters vs. Costco Wholesale Corp., 9th U.S. Circuit Court of Appeals; No. 93-35851, March 6, 1995.

ADA pre-empts comp, California court rules

SAN FRANCISCO—The Americans with Disabilities Act pre-empts a state's workers compensation exclusive remedy provision, a U.S. District Court ruled.

Lois M. Wood, an employee of

Alameda County, Calif., was injured in 1992 and filed a workers comp disability claim. A physician cleared her to return to work, but the county declined to let her assume her former job or a comparable one. She sued, claiming she was denied reasonable accommodation in violation of the ADA.

In *Lois M. Wood vs. County of Alameda*, the defendant argued that a California statute establishes the state's workers comp remedy as exclusive, while the ADA states Congress' intent not to "invalidate or limit" state laws when they provide greater or equal protection.

The county also argued that allowing plaintiffs to avail themselves of ADA remedies when they also seek workers comp benefits could invalidate or limit workers comp statutes.

But, the U.S. District Court for the Northern District of California

ruled that whether the California law provides greater or equal protection than the ADA is immaterial because Congress did not intend for the statute to defer to any state laws. The court ruled that in the language in question, Congress intended to ensure that compliance with federal law does not excuse compliance with state law that establishes higher standards.

Lois M. Wood vs. County of Alameda, U.S. District Court for the Northern District of California; No. C 94-1557 TEH, Jan. 30, 1995.

Talegen, Monsanto settle bad faith suit

SEATTLE—Talegen Holdings Inc. will pay \$34 million to settle bad faith claims by Monsanto Corp. involving an underlying case where Talegen, formerly Crum &

See FTRs on next page

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For the Record

Continued from previous page
Forster Inc., insured both Monsanto and the plaintiffs suing the company.

The March 2 agreement settles a long-running dispute in which Monsanto claimed Talegen encouraged and financed suits against the St. Louis-based chemical company.

"They essentially sued their insured," a Monsanto spokeswoman said. "That was the crux of the whole issue."

The dispute began in 1985 when Monsanto was sued by homeowners and a savings and loan in Texas. The homes were near a former refinery that later was designated a Superfund site. Monsanto and other companies had sold chemicals to the refinery.

The homeowners sued the savings and loan for failing to disclose the Superfund site's proximity. Monsanto charged that the homeowners and S&L settled their differences so they could sue Monsanto. Crum & Forster insured both the S&L and Monsanto.

In 1989, Monsanto sued the insurer and three units, including United States Fire Insurance Co., The North River Insurance Co. and Commonwealth Lloyd's Insurance Co. Monsanto alleged the insurers manipulated the litigation and inappropriately denied Monsanto reimbursement of defense costs, eventually winning a \$91 million award that was later upheld by an appeals court (*BI*, May 4, 1992). Talegen's appeal to the state Supreme Court was pending when the settlement was reached.

Talegen will take a \$20 million one-time aftertax charge to earnings in the first quarter of 1995.

Work-related injury rate falls in California

SACRAMENTO, Calif.—Work-related injuries and illnesses in California hit an all-time low in 1993, the Department of Industrial Relations reports.

Work-related injuries and illnesses per 100 full-time workers declined to 9.0 in 1993 from 9.8 in 1992, the Non-Fatal Occupational Illness and Injuries Census said. This is the lowest rate since the census began in 1972.

The census is conducted annually by the DIR's Division of Labor Statistics and Research in cooperation with the U.S. Bureau of Labor Statistics.

Illinois tort reform draws fire

CHICAGO—A new Illinois tort reform law that caps pain-and-suffering awards for accident victims is coming under fire.

Moments after Republican Gov. Jim Edgar signed H.B. 20 into law earlier this month, five Chicago residents filed a lawsuit in Cook County Circuit Court alleging the new law violates the state Constitution by infringing on the rights of citizens seeking restitution for injuries suffered due to the negligence of others.

Under the new law, non-economic damages are limited to \$500,000. It also limits punitive damages to three times economic damages and employers liability to no more than the amount owed under the Workers Compensation Act. Other provisions shield manufacturers that make adequate written warnings from product liability suits.

Manufacturers also now can create a presumption of safety for their products—thus increasing the

plaintiff's burden—if they show the product met federal or state safety standards or that no practical or feasible alternative design existed at the time of manufacture.

The American Medical Assn. supports the new law, which covers medical malpractice suits. The AMA said a cap on non-economic damages would help mitigate health care costs, increase access to care in rural and inner-city areas and strengthen the patient/physician relationship.

In the two weeks before Gov. Edgar signed the bill, there were 3,501 personal injury lawsuits filed in Cook County Circuit Court—more than four times the average. The office's normal intake is about 400 suits per week, he said.

Blues plan reduces its PPO rates

WOODLAND HILLS, Calif.—Citing intense competition in the California health care market, Blue Cross of California is slashing by 6.8% the maximum fees paid to specialist physicians in its popular Prudent Buyer preferred provider organization.

In contrast, Blue Cross is increasing payments to primary care physicians in the 2 million-member network by an average of 2%.

Maximum fees for maternity care will not change.

Although this is the third year that Blue Cross has cut specialist fees, it is the largest percentage reduction yet. Other California managed care companies also have been trimming specialist payments to encourage the use of lower-cost primary care physicians such as general practitioners and internists.

"The fee adjustments reflect what consumers, from individuals to large corporations, are willing to pay for health care," said Dr. David Chernof, Blue Cross medical director. "The marketplace is demanding that costs not only be controlled but reduced."

Information in brief

Blue Cross & Blue Shield of Minnesota will cut health insurance rates for small businesses by 5% to 6%, effective July 1, due in part to claims stability in Minnesota's largest small-group purchasing pool. The reductions will be granted to new and existing customers with 29 or fewer employees. . . **A.M. Best Co.** has raised its rating of **Liberty Mutual Group intercompany pool** to A from A-, citing dramatically higher operating earnings in 1993 and 1994, improved capitalization and other factors. . . The European Commission has not yet decided whether to extend the **International Group of P&I Clubs' exemption** from E.U. competition rules. The exemption, which expired, allows the P&I clubs to jointly set rates. . . **B.A.T Industries P.L.C.** set aside £123 million (\$192.8 million) to cover payments it may have to make to buyers of pension investments from its Eagle Star Holdings P.L.C. and Allied Dunbar Assurance P.L.C. units. The U.K. government has recommended that insurers make pensioners whole for any shortfall between actual benefits and benefits promised via potentially misleading sales tactics (*BI*, Oct. 31, 1994). . . **Blue Cross & Blue Shield of Connecticut** is seeking legislative approval to demutualize its Connecticut American Life Insurance Co. unit. The move would enable the North Haven, Conn.-based plan to sell stock to raise capital, something various BC/BS plans around the country are attempting to do to compete with for-profit insurers and health plans. **[B]**

Looking for the silver lining

By Lawrence O. Monin

THE U.S. SUPREME COURT has spoken. Six and one-half years after its approval by the California voters, there is no longer any question that Proposition 103 is the law in California and that insurers must refund premiums for 1988.

Late last month, the U.S. Supreme Court declined to review the California Supreme Court decision in *20th Century vs. Garamendi*. That unanimous and sweeping decision has been widely regarded as a stunning defeat for the California insurance industry (*BI*, Aug. 29, 1994). In it, the court granted the Insurance Department extremely broad authority to implement Proposition 103 and in the process upheld former Insurance Commissioner John Garamendi's Proposition 103 rebate regulations against every objection raised by the insurance industry.

The immediate impact is on the 160 or so insurers that did not pay rebates and instead awaited the outcome of the litigation. These insurers will now have to come to terms with newly elected Insurance Commissioner Chuck Quackenbush, who holds the upper hand. Some legal skirmishes, of course, will probably continue. State Farm Group has already said it plans to submit arguments to an administrative judge, and Farmers Insurance Group asserted it is ready to go to court if discussions fail. But, for the most part, the insurers' legal war on Proposition 103 rollbacks is over.

The bigger question, however, is what this holds in the future for the industry—and insurance consumers—in California.

Although most observers continue to see Proposition 103 as spelling doom and gloom for the California insurance industry, I see two very hopeful signs. The first comes from the *20th Century vs. Garamendi* decision itself. Although it is certainly bad news for insurers on the rollback question, I believe it contains an important "silver lining" for insurers as they move forward into the new Proposition 103 prior-approval system.

The second hopeful sign for the California insurance industry is that the combative and politically ambitious Mr. Garamendi is out of office. He has been succeeded by Mr. Quackenbush, who seems intent on resolving California insurance issues in a balanced and open manner.

For example, rather than posturing for headlines, Mr. Quackenbush has offered a "window of opportunity" for negotiating Proposition 103 rebates so that both the department and the industry can get on with the future.

Ending the political battles

Like it or not, prior approval is now the law in California. But that does not necessarily spell the end of insurance in the state. Insurance markets have long operated—and at times quite well—in prior-approval-type markets. Like many things in life, the workability of regulatory systems often depends more on the attitude of the process managers than on the actual regulatory framework.

In fact, I believe former Commissioner Garamendi's political combativeness was largely at the root of Proposition 103's implementation problems. In the *20th Century* case, the California Supreme Court was obviously miffed by the multiple, overlapping litigations filed by various insurers challenging the commissioner's actions. Unfortunately, the court did not look beyond those dysfunctional symptoms to see that the industry was not the only one at fault.

Thus, the court began its opinion by chastising the insurance industry. In doing so, it failed to call an offsetting provocation "foul" on the commissioner. Instead, the court immediately moved its attention to the objective details of the department's rebate formula. With such a focus, it is not surprising that the court ruled so overwhelmingly in favor of the commissioner's regulations. Undoubtedly, the court wanted to end the bickering.

Proposition 103's aftermath leaves hope for consumers

Courts are not well equipped to deal with the details of rate regulations. That's why administrative agencies exist, and courts have long given them tremendous deference. Indeed, it is extremely rare that litigation is ever successful in resolving an industry dispute with a rate regulator. These differences are generally dealt with in one-on-one negotiations. If acceptable agreements are not reached, regulated companies are left with either finding business or legal loopholes, or exiting the business, as many California homeowner insurers have done over the past year.

Shortly after the voters approved Proposition 103, the California Supreme Court in *CalFarm vs. Deukmejian* correctly found that a mandatory flat 20% rebate could often be unconstitutionally confiscatory. Having directed the Insurance Department to resolve this problem, it was not unreasonable for the court to now conclude in *20th Century* that the department had broad implied authority to develop an alternative rebate system.

Moreover, I think the court was generally correct in sustaining the department's efforts to reduce the process to manageable proportions by establishing generic guidelines as to leverage, accounting protocols, the treatment of investment income and expenses and the like. Finally, the court was obviously impressed that the industry, during the past decade, earned only about 10% on equity. Given that, it is hard to see where the California Supreme Court can be faulted for upholding the commissioner's 10% profit standard, especially when that standard was defined as a return that is only marginally above confiscatory.

In short, I was not surprised by the *20th Century* decision and believe it is substantially correct. But, I think the decision can be faulted in three respects:

- First, in its haste to end the Proposition 103 rebate debate, the court may have too quickly concluded that a general rate review system—as opposed to specific applications of that system—is exempt from review by the Office of Administrative Law. This holding, which was reached in a very cursory manner, may have a far reaching impact on other regulated industries.

- Second is its muddled explanation of "confiscatory." The court begins with the standard announced by the U.S. Supreme Court in *Power vs. Hope*. Under the *Hope* standard, a company would experience deep financial hardship if it did not earn a "return to the equity owner" that is "commensurate with returns on investment in other enterprises having corresponding risks" and "sufficient to assure confidence in the financial integrity of the enterprise, so as to maintain its credit and to attract capital." The *Hope* standard makes sense. Anyone knowledgeable about the inherent risks of the insurance business would readily conclude this standard requires insurers to earn at least a 10% return, and, on a prospective basis, requires that they have the opportunity to earn significantly more.

The latter point—the riskiness of the insurance business—is fairly obvious but is generally unappreciated by the public. Perhaps the simplest demonstration of the industry's risk is to take a quick look at where the industry giants of 20 years ago are today. For example, The Home Insurance Co., Continental Corp., CIGNA Corp., Aetna Casualty & Surety Co., The Travelers Inc., Crum & Forster Insurance Co. and the venerable Lloyd's of London have all recently experienced difficulties.

However, in applying *Hope*, the California court believed this standard needed to be balanced against the "interest" of consumers to pay low prices. Rates are confiscatory, the California court said, only if they do

not allow a regulated firm to "operate successfully." I don't have the foggiest idea what "operate successfully" means, and I doubt anyone else does.

From the tone of Judge Mosk's opinion, one could interpret "operate successfully" as meaning merely being able to open the doors in the morning. By that standard, a firm would be "operating successfully" until the day it shut down for good. Despite this muddy discussion, the department's 10% profit standard was probably close enough to the ballpark to be sustainable even if "confiscatory" were more fairly defined.

- The third area where I fault the court's opinion is in its resolution of some of the "details." For example, as part of its expense efficiency standards, the department disallows recognition of "institutional advertising." It is one thing to disallow items not connected with the business, yet it is entirely another matter to disallow items, such as "institutional advertising," which constitute a standard—and very legitimate—business expense.

If the department is permitted to overreach on the details, it can transform an objectively reasonable methodology into a tool of oppression. The insurance industry has legitimate fears that this will happen, and the disallowance of "institutional advertising" is an excellent case in point. One wonders if separate, more focused litigation of such narrow but important issues might produce more enlightened results.

The U.S. Supreme Court's decision not to review *20th Century vs. Garamendi* does not mean it has blessed the California Supreme Court decision. This action may only mean that the U.S. Supreme Court didn't think this particular case was the right vehicle for addressing the types of economic regulatory issues embedded in California's insurance regulatory system. Indeed, the Court was virtually forced to decline review of *20th Century* when early this year the principal party to the litigation—20th Century Insurance Co.—dropped its appeal and settled with the department.

The silver lining

Thus, with *20th Century* now the law, where is there a silver lining?

In assessing the legality of the "rebate" rules, the California court, I think, made several observations that could prove beneficial to the insurance industry when the focus shifts to the prospective rate approval system.

In *20th Century*, the court made it very clear that it was dealing only with the legality of the "rebate" system. It recognized that this was a one-year, one-shot proposition. It was endeavoring to implement in a constitutional manner the spirit of a voter approved, one-time, across-the-board rebate. As such, the court sanctioned the rebate of all profits up to the point of apparent actual confiscation. The important point, I think, is that the court clearly saw the 10% profit standard as resting just above the point of confiscation.

In its analysis, the court saw the prior-approval system as being very different than the "rebate" system. It noted, with seeming approval, that the department's proposed prior-approval regulation would establish a range of permissible rates—between the boundaries of "excessive" and "inadequate"—with insurers being free to choose within that range where they wish to set their own rates. The 10% rebate standard was recognized as being at "the lower boundary of the range of reasonable rates of return."

Specifically, the court stated:
"At the outset, we must make the following observation. Through the ratemaking formula, the insurance commissioner does not himself 'set' rates for insurers. Rather, he simply determines the rate or rates that the individual insurer may itself set within the constraints of Proposition 103 as construed in *CalFarm*. For the 'prior approval' system, the ratemaking formula is used to fix for the individual insurer the range of rates within the bounds of the

See Proposition on next page

Proposition 103

Continued from previous page

'excessive' and the 'inadequate.' For the rate rollback, with which we are here concerned, it is used to fix for the individual insurer its maximum rate under Proposition 103 as construed in *CalFarm*; i.e., the rate that is 80% of the 1987 rate or such rate greater than 80% of the 1987 rate as is minimally non-confiscatory."

This recognition by the court of the substantial difference between the rebate and prior-approval systems is very encouraging to me. Moreover, the court recognized that "determining rates of return is not an exact science" and that "the economic judgments required in rate proceedings are often helplessly complex and do not admit of a single correct answer."

I think the court will now likely view 10% as a floor. Also, the court may not look kindly upon attempts to unreasonably narrow the range of "reasonableness," or to deny insurers the right to set their own rates within the range of reasonableness.

Finally, I am encouraged by the broad authority the court gave the insurance commissioner to "consolidate cases" and generally "take whatever steps are necessary to reduce the job to a manageable size."

Of course, such broad authority could be used punitively against the insurance industry. But this flexibility can also be the key to the sensible implementation of Proposition 103.

When all is added up, *20th Century* may be giving California insurers a fairer shake than the industry has in many other prior-approval states.

The California rating statutes—which prohibit rates that are "excessive, inadequate" or "unfairly discriminatory"—is the same standard used in virtually all states. However, various states apply this identical standard differently.

Most states don't have published standards. Instead, individual company rates are often in effect set following private department and company *ad hoc* negotiations. In sharp contrast, the California court seems to anticipate and endorse a prior-approval system that would truly permit insurers to "set" their own rates within relatively broad and realistic ranges. If this interpretation is correct, it would be a tremendous plus for California insurers.

A choice for the commissioner

What does the future hold for California? Will California see the return of a stable and innovative insurance market, or will the market distortions of the

Garamendi era continue?

In some ways, it's up to Mr. Quackenbush. He can take advantage of the flexibility granted to him by the court to permit insurers to set rates within a range of reasonableness. Or, he can try to artificially drive down permissible rate ranges to the lowest possible levels.

If he takes the latter course, and in the process guesses wrong and overreaches, California consumers will be the eventual losers. The availability problems that began under Mr. Garamendi will expand, and the development of new products would be stifled. Moreover, although misguided, strident regulation might draw some initial cheers from the crowd, resulting market problems will create political problems for the new commissioner as well.

On the other hand, if insurers are given the flexibility to price their products within truly reasonable ranges, California consumers will be the winners. California would get the availability and innovative benefits of a customer-focused competitive market. Moreover, by focusing regulatory attention on the few pricing transactions that do suggest abuse, regulatory energies would be freed to deal with other matters of more pressing consumer concern.

Let's hope Mr. Quackenbush appreciates this choice and recognizes that the court has given him the flexibility to make Proposition 103 work for the benefit of all.

The early evidence is that he does appreciate it. One of his first steps was announcing a six-month "window of opportunity" for companies to resolve their Proposition 103 rate rollback obligations. A deputy has been appointed to oversee this process, and the department has formed three-person negotiating teams to deal with each company. To facilitate constructive dialogue, these negotiating teams have apparently been empowered to use the rebate regulation as a guideline rather than a rigid set of rules. Thus, these negotiators can exercise common sense to tailor rebate agreements based on each company's specific experience, rather than being bound by rigid rules that do not make sense in all cases.

The department's next challenge will be to establish a prospective prior-approval regulatory system that upholds the spirit of Proposition 103. Putting such a system together may be difficult. Ideally, this system would focus on true abuse, while at the same time encouraging competition and innovation. The California Supreme Court in *20th Century vs. Garamendi* has given the commissioner all the tools he needs.

In tackling this job, Mr. Quackenbush's biggest hurdle may be in gaining media understanding.

Currently, much of the media in a knee-jerk sort of way have characterized Mr. Quackenbush as being anti-consumer just because he has shown a willingness to listen to business concerns.

This attitude has been inflamed by Mr. Garamendi and Harvey Rosenfield, the author of Proposition 103. One hopes the media will give Mr. Quackenbush a fair hearing. If the media ignore the rhetoric and instead look at the record, they must see that California insurance consumers are far worse off today than when Mr. Garamendi began four years ago. Hopefully, the media will realize this and give Mr. Quackenbush a chance to try a new approach.

Many think former Commissioner Garamendi won the rebate case the day he chose *20th Century* as the test case. It's difficult—in the context of a one-shot rollback—to feel sympathetic for a company that prior to the Northridge earthquake was one of the nation's most profitable. For the rollback year, *20th Century* earned in excess of a 30% return on equity.

But just as *20th Century* may have been the ideal case for Garamendi on the rollback issue, it may be the industry's ideal test case on the prospective prior-approval issue.

Just after the *20th Century* decision, Neil H. Ashley, who was then chief executive officer, stated: "The real losers... are the people of California in need of affordable, available insurance... We believe the company should be rewarded for low premiums and lean operations rather than penalized for profitability."

I believe Mr. Ashley's lament may be a bit premature. What is important is what will happen under prospective prior-approval regulation. The court has given Mr. Quackenbush wide latitude to implement a system that would reward—rather than punish—innovative insurance companies like *20th Century*.

One hopes that Mr. Quackenbush will give the Californians the benefit of a competitive marketplace by rewarding the insurance companies that find efficient ways to deliver quality insurance products at low cost.

If one believes common sense will prevail, perhaps it is time—again—to be bullish on California. **BI**



Lawrence O. Monin specializes in reinsurance and insurance corporate and regulatory law as a partner with the San Francisco law firm of Ropers, Majeski, Kohn, Bentley, Wagner & Kane. He is a member of the American Management Assn.'s Insurance & Risk Management Council.

ERISA liabilities bind in collective bargaining agreements

Legal Briefs

A corporate officer who assumes responsibility for his company's Employee Retirement Income Security Act obligations as part of a collective bargaining agreement qualifies as an employer who is obligated to make contributions to a multiemployer plan, according to the 2nd U.S. Circuit Court of Appeals.

This suit was brought by a union, its pension funds and the funds' administrator against several individuals who operated and were employed by a family construction business known as Lollo Brothers Inc.

Jeffrey Lollo became president in 1987. The plaintiffs sought to hold the individuals personally liable for unpaid contributions owed to the funds under the collective bargaining agreements. The agreements provided that Mr. Lollo, as an employer under ERISA, would contribute to the funds based on employee work hours. The trial court held Jeffrey Lollo personally liable for the company obligations to the union and the funds under a 1987 collective

bargaining agreement he had signed.

The appellate court said that by signing the 1987 collective bargaining agreement, Jeffrey Lollo became contractually obligated, wholly independent of ERISA, to make pension contributions. "As such, he qualifies as an employer who is obligated to make contributions to a multiemployer plan under the terms of the plan or under the terms of a collectively bargained agreement," the court said, pursuant to ERISA. Thus, the court found Jeffrey Lollo personally liable for the unpaid pension contributions.

Cement & Concrete Workers Dist. Council vs. Lollo, 2nd U.S. Circuit Court of Appeals, June 16, 1994, *Amended Opinion Filed After Petition for Rehearing*, Sept. 9, 1994 (BI/05/A.-\$10).

Conflicting policies apply

In a dispute over coordination of

benefits between two group health insurance policies, the 11th U.S. Circuit Court of Appeals upheld language in the first of the two policies purchased that made the second policy the primary payer and the other policy secondarily liable.

Sally King was insured under two group health policies. The first, which was issued by United Benefit Life Insurance Co., became effective June 1, 1991. The second policy, issued by U.S. Life Insurance Co., became effective Dec. 1, 1991.

Both policies, standing alone, provided primary coverage for Ms. King's medical expenses. However, the policies also contained coordination of benefits provisions.

In December 1991, Ms. King sustained a gunshot wound to her back and incurred substantial medical expenses. The two health insurers could not agree on the net effect of their respective coordination of benefits provisions.

United Benefit filed this suit seeking a declaration that U.S. Life was

primarily liable for Ms. King's medical expenses. The trial court found for United Benefit.

The appellate court found that the coordination of benefits provision in the U.S. Life policy dictated that United Benefit pay its benefits first. Thus, the court held that there was no conflict between the policies' respective coordination of benefits provisions, and United Benefit was the sole primary insurer of Ms. King's medical expenses. U.S. Life was held responsible only for such expenses that exceeded the limit of United Benefit's coverage.

United Benefit Life Insurance Co. vs. U.S. Life Insurance Co., 11th U.S. Circuit Court of Appeals, Oct. 27, 1994 (BI/04/M.-\$10). **BI**

These abstracts were prepared by Mayo H. Stiegler. Copies of these decisions are available by sending a \$10 check payable to Mayo H. Stiegler, to Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590. List the number for each opinion.

INTERNATIONAL

Employers Re in talks to buy Frankona Group

By JUDY GREENWALD and CAROLYN ALDRED

COLOGNE, Germany—Employers Reinsurance Corp. could rival General Re Corp. for the No. 3 spot among the world's largest reinsurers if a proposed deal to acquire the Frankona Group is consummated.

The deal also would significantly strengthen Employers Re's growing overseas operations, while giving Frankona a strong reinsurer parent, say observers.

Frankona's majority owner, Gerling-Konzern Versicherungs-Beteiligungs A.G., confirmed last week it is holding talks with Overland Park, Kan.-based Employers Re to sell its 61.2% stake of Frankona Rueckversicherungs A.G., which, along with affiliated reinsurers, was ranked the world's eighth-largest reinsurer based on 1993 net premiums written (BI, Aug. 29, 1994).

While talks are expected to con-

tinue for several weeks, the sale has been accepted, subject to terms and conditions, by both Gerling's and Frankona's boards of management, according to Herwig Gueckelhorn, a member of the Gerling board. Officials of Employers Re, a unit of General Electric Co., could not be reached for comment last week.

However, Peter Kellogg, senior insurance analyst with A.M. Best Co. in Oldwick, N.J., said that based on his discussions with the company he believes "from Employers Re's standpoint it's extremely preliminary at this point."

Based on Frankona's \$2 billion in 1994 net premium volume, the two companies combined would have premium volume of about \$6.15 billion. This reflects Employers Re's volume, which was \$3.4 billion on a statutory basis in 1994, as well as at least \$750 million in net premiums written by German reinsurer Aachen Re,

which Employers Re agreed to acquire last month (BI, Feb. 13).

General Re itself has grown through international acquisitions. The Stamford, Conn.-based reinsurer last year acquired control of Cologne Re through a new holding company jointly owned by General Re and Cologne Re's parent, Colonia Konzern A.G. (BI, July 4, 1994). Their estimated combined 1994 premiums are expected to total approximately \$6.20 billion.

"Part of the reason Gen Re was interested in the acquisition (of Cologne Re) was to enhance its ability to write globally. If Employers Re does this with Frankona, it can only enhance their visibility internationally and open doors for them that they might otherwise not have had," said Joanne Morrissey, a principal with Firemark Consultants Inc. in Morristown, N.J.

"It will give them a whole new
See Frankona on page 19



AP/WIDE WORLD

Passengers injured in last Monday's deadly gas attack on the Tokyo subway receive medical attention outside the Tsukiji Station.

Subway gas attack in Tokyo serves as warning for others

Transportation officials in major cities around the world are more alert in the wake of the recent deadly gas attack in Tokyo's subway system, but so far are not taking any special risk management measures.

The gas attack in Japan last week killed at least 10 subway riders and injured more than 5,000 people. Japanese police believe the gas leaked from packages left on board a train by a religious cult.

New York City transit police have told officers and Transit Authority employees to be more vigilant as a result of the recent gas attack in Tokyo, a police spokesman said. "We've increased our alertness and notified the 4,500 cops and 40,000 transit employees to be on the lookout for anything that's out of the ordinary," he said.

But, given the size and usage of the New York subway system, it will always be susceptible to a gas attack similar to the one in Tokyo, he said. "It's an open system with 3.5 million people using it every day... There is not a subway system anywhere that could not be subjected to an attack."

The Chicago Transit Authority has not upgraded its security as a result of the attack in Japan.

"Our security is not reactive; it's in place all the time," a CTA spokesman said. Chicago's system is patrolled by police and private contractors, including a canine unit, he said.

"We really don't see any need or reason for extra measures, especially now that it looks like this is a domestic Japanese situation with a religious cult there," the spokesman said.

Officials at London Transport Ltd., which manages London's underground rail network, would not comment on the Tokyo incident but said security arrangements in the London system are well established.

A rumor last week that a U.S. insurer in Seoul, South Korea, may have been the target of a gas attack the day after the Tokyo subway incident proved to be false.

American International Group Inc. said that six employees in its Seoul office were overcome by an accidental leak of natural gas.

—By Gavin Souter and Maria Kielmas

UNISON unveils group results

Broker network's revenues rank it just behind M&M

By ADRIAN LADBURY

LONDON—Members of international brokerage network UNISON S.A. have moved a step closer to being identified as a single group, by publishing for the first time their combined revenue figures.

Taken together, UNISON's members would rank second only to Marsh & McLennan Cos. Inc. in terms of gross revenues. However, *Business Insurance* does not rank UNISON because its member brokerages are independent companies.

In 1993, the leading UNISON partners culminated almost 20 years of cooperation with a resolution to act as a single company with a "unified global strategy." Directors of the boards of each of the five biggest member brokerages also took positions on each other's boards.

Earlier this year, the members also signed a resolution that commits the partners to "rapid automation" and adoption of common standards for electronic data interchange and further sharing of resources and expertise.

Johnson & Higgins, which ranked as the sixth-largest brokerage in the world based on 1993 revenues, founded the UNISON network in 1962. The network is made up of 24 privately owned brokerages that refer business to each other. J&H is by far the biggest single brokerage in the network and accounts for about two-thirds of UNISON's revenues.

John Gussenhoven, a director of J&H and current president of UNISON, announced in London last week that, on the basis of exchange rates at the end of each year, the group generated gross revenues of \$1.59 billion in 1994, a 7.1% increase over 1993 revenues of \$1.48 billion. That, in turn, was a 3.5% increase over 1992 revenues of \$1.43 billion. No earlier figures were given.

Revenues for the individual companies are not yet available for 1994, but Mr. Gussenhoven said that they will "not be materially different" from the previous year.

J&H in 1993 contributed 65% of UNISON's gross revenues with \$962 million.

Next biggest, contributing 12.3% of the total, was UNISON's German partner Jauch & Huebener KGaA of Hamburg, which was the world's 13th-largest broker in 1993 based on gross revenues of \$183.3 million.

Third largest in the network and the 14th-largest broker in the world in 1993 was Paris-based Gras Savoye S.A., with \$145 million in gross revenues, or 9.7% of the network's total.

These three brokers are joined by Gil y Carvajal, affiliated to the network since 1964 and Spain's largest brokerage, and Mees & Zoonen, the second-largest broker in the Netherlands. All of the network's brokers elect directors to each other's boards.

See UNISON on page 19

Scandinavian insurers report mixed results

By MARIA KIELMAS

Investment income losses negate improved insurance results

Falling bond and currency markets took their toll on four of Scandinavia's largest insurers in 1994, though their underlying insurance business showed signs of improvement.

Sweden's Skandia Group, Finland's Pohjola Group and Norway's UNI Storebrand A/S were hit particularly hard by falling interest rates and fluctuating currency markets. Trygg-Hansa Insurance Co.'s results were hurt by a \$545 million charge to cover its stake in Home Holdings Co.

Stockholm-based Skandia posted a net operating loss of 1.72 billion Swedish kronor (\$231.3 million) last year, compared with a profit of 4.07 billion Swedish kronor (\$488.4 million) in 1993. The company cited fluctuations in the world financial and currency markets as the main reason for the loss.

However, Skandia's operating results were better than expected. "Despite all of the warnings about the Scandinavian non-life market falling off, it didn't happen in 1994," said Mike Wheelhouse, an insurance analyst at London-based Nomura Securities.

Skandia's gross written premiums increased 20.1% to 52.25 billion Swedish kronor (\$7.03 billion), from 43.5 billion Swedish kronor (\$5.22 billion) in 1993. The increase was due mainly to the continued growth of its annuity business and last year's acquisition of Spanish pension insurer Intercaser.

Non-life and reinsurance underwriting profits increased 87.6% to 1 billion Swedish kronor (\$134.5 million) from 533 million Swedish kronor (\$63.9 million) in 1993, because of lower claims costs and operating

expenses.

Skandia's combined ratio has improved by eight percentage points during the past two years, to 108%.

Total gross premiums written by Skandia International, the group's non-life reinsurance operations outside North America, was 3.38 billion Swedish kronor (\$454.6 million). Underwriting profits increased to 130 million Swedish kronor (\$17.5 million), compared with profits of 27 million Swedish kronor (\$3.2 million) in 1993.

Results were not as bright for Skandia America Corp. Its gross premiums written decreased to 2.98 billion Swedish kronor (\$400.8 million) from 3.79 billion Swedish kronor (\$454.8 million) in 1993. Skandia America had underwriting losses of 93 million Swedish kronor (\$12.5 million), an improvement

over 1993 losses of 111 million Swedish kronor (\$13.3 million).

Overall, Skandia's net operating profits for life and unit-linked insurance amounted to 716 million Swedish kronor (\$96.3 million). Of this, 669 million Swedish kronor (\$89.9 million) was due to unit-linked insurance, which benefited from strong premium growth. Life insurance companies registered a 47 million Swedish kronor (\$6.3 million) underwriting profit. The Spanish pension insurance company, Intercaser, reported an underwriting profit of 71 million Swedish kronor (\$9.5 million).

Stockholm-based Trygg-Hansa's net loss of 3.66 billion Swedish kronor (\$492.2 million) in 1994 compared with a 1993 profit of 1.18 billion Swedish kronor (\$141.6 million). The 1994 result is due mostly

to a charge of 4.06 billion Swedish kronor (\$545.9 million) related to its 64.5% stake in Home Holdings. Trygg-Hansa wrote down its investments in the U.S. insurer and took losses on loans as part of a deal to sell Home Holdings to Zurich Insurance Group (BI, Feb. 6).

Trygg-Hansa reported an underwriting loss of 1.29 billion Swedish kronor (\$174.3 million), compared with a loss of 470 million Swedish kronor (\$56.4 million) in 1993. The losses were due to a reserve strengthening of approximately 400 million Swedish kronor (\$53.8 million) and higher operating expenses.

The insurer reported an underwriting loss of 322 million Swedish kronor (\$43.3 million) on non-life business.

Gross premiums written fell to 7.17 billion Swedish kronor (\$964.6 million) from 7.83 billion Swedish kronor (\$939.4 million), due mainly

See Results on page 19

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LEGAL NOTICE

UNITED STATES BANKRUPTCY COURT SOUTHERN DISTRICT OF NEW YORK

IN THE PETITION OF PAUL ANTHONY BRERETON EVANS AND
RICHARD CLAUDE BOYS-STONES,
AS JOINT PROVISIONAL LIQUIDATORS OF
THE ORION INSURANCE COMPANY PLC AND
THE LONDON AND OVERSEAS INSURANCE COMPANY PLC
(THE "COMPANIES")

Case Nos. 94-B-44968 (SMB) and 94-B-44969 (SMB)
Jointly Administered

NOTICE IS HEREBY GIVEN that on March 14, 1995 an order was entered by the United States Bankruptcy Court for the Southern District of New York (the "Bankruptcy Court") in connection with the cases filed with respect to the Companies pursuant section 304 of the Bankruptcy Code (the "Order"):

1. Enjoining and restraining all persons and entities from (a) transferring, relinquishing or disposing of any property of the Companies in the United States, or the proceeds of such property, to third parties; (b) commencing or continuing any action or other legal proceeding (including, without limitation, arbitration, or any judicial, quasi-judicial, administrative or regulatory action, proceeding or process whatsoever) against the Companies or any of their property in the United States, or any proceeds thereof; (c) enforcing any judicial, quasi-judicial, administrative or regulatory judgment, assessment or order or any arbitration award, and commencing or continuing any act or any action or other legal proceeding (including, without limitation, arbitration, or any judicial, quasi-judicial, administrative or regulatory action, proceeding or process whatsoever) to create, perfect or enforce any lien, set-off or other claim against the Companies or any of their property in the United States or any proceeds thereof, including, without limitation, rights under reinsurance contracts; and (d) drawing down any letter of credit established by either of the Companies, or withdrawing from, setting off against, or otherwise applying property that is the subject of any escrow agreement or similar arrangement in which either of the Companies has an interest, in excess of what is expressly authorized by the terms of the contract and any related trust or other agreement pursuant to which such letter of credit, escrow, or similar arrangement has been established;

2. Requiring all persons and entities that are beneficiaries of letters of credit established by either of the Companies, or parties to any escrow or similar arrangement in which either of the Companies has an interest, to (a) provide notice to Petitioners' United States counsel of any drawdown on any letter of credit established by either of the Companies, or any withdrawal from, setoff against, or other application of property that is the subject of any escrow agreement or similar arrangement in which either of the Companies has an interest, together with information sufficient to permit the Petitioners to assess the propriety of such drawdown, withdrawal, setoff, or other application, including, without limitation, the date and amount of such drawdown, withdrawal, setoff or other application and a copy of the agreement pursuant to which any such drawdown, withdrawal, setoff or other application was made and provide such notice and other information contemporaneously therewith; (b) turn over and account to the Petitioners for all funds resulting from such drawdown, withdrawal, setoff, or other application, in excess of what is expressly authorized by the terms of the contract, any related trust or other agreement pursuant to which such letter of credit, escrow, or similar arrangement has been established;

3. Requiring every person and entity that has a claim arising under a contract of insurance, reinsurance or retrocession written or entered into by either of the Companies and who is a party to any action or other legal proceeding (including, without limitation, arbitration, or any judicial, quasi-judicial, administrative or regulatory action, proceeding or process whatsoever) in which either of the Companies is named as a defendant, to place the Petitioners' United States counsel on the master service list of any such action or other legal proceeding and to take such other steps as may be necessary to ensure that such counsel receives (a) copies of any and all documents served by the parties to such action or other legal proceeding or issued by the court, and (b) any and all correspondence, or other documents circulated to parties named in the master service list.

The Order shall remain in effect pending the hearing scheduled to be held in Room 621 of the Alexander Hamilton U.S. Custom House, One Bowling Green, New York, New York on July 13, 1995 at 10:00 o'clock a.m. before the Honorable Stuart M. Bernstein. Any party in interest who has not received a copy of the Order should contact counsel for the Joint Provisional Liquidators in writing at the address listed below.

Chadbourne & Parke
30 Rockefeller Plaza
New York, New York 10112
Attention: Kenneth P. Coleman, Esq.

The Orion Insurance Company PLC, a U.K. company, is not affiliated in any way with Orion Capital Corporation or any of the Orion Capital Companies.

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INTERNATIONAL

Lambert names may sue Lloyd's agents over U.S. losses

By ADRIAN LADBURY

LONDON—Lloyd's of London members agents and managing agents may face yet another lawsuit by members with losses, after a review of U.S. long-tail liability losses suffered in 1984 by names on syndicate 604, managed by Lambert Brothers (Insurance) Ltd. It is too early to launch litigation against agents and auditors because the Lambert Brothers Syndicate 604 1984 Action Group has not yet "fully digested" the loss review's implications, Sir Mark Goodson, chairman of the action group, said last week. He added the group has not yet hired legal counsel.

Sir Mark called the offer Lloyd's made to his group as part of last January's failed settlement offer "derisive," and he suspects the amount was low mainly because the group had not filed any legal action at that stage (*BI*, Jan. 17, 1994).

A Lloyd's spokesman said that no firm decision had been made on how claims by groups would be weighted within a possible new settlement offer but confirmed that those with claims "further down the line" had received better offers last January.

James A. Smart, a partner with London accounting firm BDO Binder Hamlyn, which Lloyd's hired in October 1994 to carry out the syndicate 604 review, said that when the 1984 year was left open in December 1986, members faced pre-expense losses of only £1.3 million (\$1.9 million). By December 1991, the loss had risen to £80.5 million (\$150.5 mil-

lion).

The net loss faced by the 225 Lambert 1984 Action Group members as of December 1991 was £56 million (\$104.7 million) after accounting for recoveries under two time-and-distance reinsurance policies arranged by Cuthbert Heath Underwriting Ltd. when it acquired the syndicate in April 1991.

These policies provided a \$30 million indemnity for 1984 and prior years.

The agent was forced to buy these policies because of the inadequacy of a time-and-distance policy that Lambert had purchased in April 1985 to replace a failed \$14.4 million indemnity policy.

Time-and-distance policies are a type of financial reinsurance that guarantees ceding companies specific payments at specific times in the future based on the initial premium paid and the investment returns expected by the reinsurer.

The managing agent bought the time-and-distance policy in 1985 because it was unable to find any London company or Lloyd's underwriter willing to provide runoff reinsurance for its ever-growing, mainly asbestos-related losses.

When it arranged the policy, the agent believed that the policy would sufficiently cover deterioration in the syndicate's losses and so closed the 1982 and 1983 years of account.

Lambert members believe that the managing agent acted negligently in its decision to close the prior years into 1984 and leave them "holding the baby."

Members say they should have

been warned of the potential liabilities.

The pure year 1984 underwriting loss as of December 1991 was only £3.7 million (\$6.9 million). The remainder consists of £11.5 million (\$21.5 million) for the 1978 to 1983 years and £65.3 million (\$122.1 million) for the 1977 and prior years.

Mr. Smart wrote that he was instructed not to lay blame, but his summary was fairly damning. "From the evidence I have received, the 1979 box exercise (an effort to assess losses) comprised records of considerable importance for assessing the syndicate's potential exposure to asbestos-related claims, but the managing agent attached little importance to these records. No steps were taken

to modify or update them to see if they could be of any use in determining provisions for IBNR claims at subsequent year ends. The relevant papers remained in the box until 1991," Mr. Smart wrote.

"Our main concern is the fact that in September 1986, we were told that the 1984 year would prove to be better than the 1983 year. But, by February 1987, the 1984 year had turned out to be a disaster. Somebody clearly got their sums wrong for our members to face losses on line of up to 450% in the space of a few months. We require compensation and our losses to be refunded in full, and we intend to get it," said Sir Mark.

As with most other action group leaders, Sir Mark says no offer to settle will be acceptable unless it

contains provisions to cap members' future losses.

But also in common with a growing body of opinion, he is not confident that Lloyd's Chief Executive Peter Middleton can deliver an acceptable deal.

"I personally do not see how on earth it can be done. I wish him (Mr. Middleton) well and hope he can do it, but there is no way we will accept an offer without a cap on future liabilities because if Lloyd's ceases to trade, my members are in a much better position," said Sir Mark.

Sir Mark explained that under English law the U.S. policyholders claiming on policies issued by syndicate 604 would be forced to seek payment from each individual member in the U.K. courts. **[BI]**

UNISON

Continued from page 17

By region, most business of UNISON's business is produced in North America, which reflects J&H's dominance of the network. In 1994, 52%, or \$825 million, of the network's revenues were generated in North America; 38%, or \$614 million, from Europe; and 10%, or \$146 million, from the rest of the world.

In 1993, a slightly higher proportion of revenues was generated from North America, according to UNISON. North American clients accounted for 55%, or \$810 million, of the total; 37%, or \$544 million, was from European clients; and 8%, or \$126 million, came from other areas.

None of the UNISON partners would reveal net income because

they are privately held companies.

But, top executives of the five largest brokers in the network—David A. Olsen, chairman and chief executive officer of J&H; Christian Dahms, partner with Jauch & Huebener; Patrick Lucas, chairman and CEO of Gras Savoye; Ad Strijbos, chairman and managing director of Mees & Zoonen; and Santiago Gil de Biedma Vega de Seoane, chairman of Gil y Carvajal—all assured *BI* they are not losing money.

Excluding 3,351 staff who work for smaller, correspondent partners, UNISON's full-time members collectively employed 12,037 in 1994.

Revenues per employee last year totaled \$131,677, which compares favorably with figures from the world's 20 largest brokers. For example, in 1993 J&H reported \$111,317 in revenues per employee,

Jauch & Huebener posted \$130,939 and Gras Savoye reported \$105,342.

But, it is difficult to make comparisons of productivity with other brokerages because of wildly different social costs in different countries, said Volker Preuss, managing partner of Jauch & Huebener.

Mr. Gussenhoven, the network's president, said the combined revenues would now be published regularly and is further proof of greater cooperation within the network.

Expansion for UNISON's members has lately focused on Eastern Europe. Jauch & Huebener opened an office in Budapest, Hungary, in 1990 and Prague, Czech Republic, in 1993. Also last year, Gras Savoye bought Polbrokers in Warsaw, Poland, while J&H and Jauch & Huebener opened a joint venture office in Moscow. **[BI]**

Results

Continued from page 17

to the reinsurance runoff. Finland's Pohjola reported improved underwriting profits for its subsidiaries. As with Skandia, though, Pohjola's investment income dropped because of falling interest rates and the fluctuating currency and capital markets.

Pohjola reported a 177 million Finnish markkaa (\$37.4 million) operating profit, compared with a 118 million markkaa (\$20.4 million) profit in 1993.

Consolidated gross premiums written amounted to 3.01 billion markkaa (\$519.7 million), the same as in 1993. Overall underwriting profits were 522 million markkaa (\$90.1 million), a substantial improvement compared with underwriting losses of 33 million markkaa (\$5.7 million) in 1993.

Pohjola's domestic underwriting profit was 476 million markkaa (\$100.5 million), compared with 312 million markkaa (\$53.9 million) in 1993. Foreign underwriting profits were 48 million markkaa (\$10.1 million), compared with a profit of 338 million markkaa (\$58.4 million) in 1993.

Oslo-based UNI Storebrand reported slumping operating profits of 1.99 billion Norwegian kroner (\$294.3 million), compared with profits of 5.97 billion Norwegian kroner (\$794 million) in 1993. The decrease in profits was due entirely to a lower investment income, the company said, citing volatile capital markets and interest rates.

UNI Storebrand Skadeforsikring, its non-life insurance

subsidiary, reported operating profits of 712 million Norwegian kroner (\$105.3 million), compared with profits of 1.163 billion Norwegian kroner (\$154.7 million) in 1993. Premium volume for this subsidiary rose by 10% to 6.91 billion Norwegian kroner (\$1.02 billion).

The increase in 1994 premium volume was due mostly to profitability measures and lower personal injury claims, the company said.

Gross premiums written for the life insurance subsidiary rose by 26% to 5.69 billion Norwegian kroner (\$841.6 million). The subsidiary increased its market share to 29.9% from 28.8%.

UNI Storebrand International reported an operating loss of 344 million Norwegian kroner (\$50.9 million) in 1994, compared with a loss of 357 million Norwegian kroner in 1993. The company's U.S. subsidiary, Christiana Re Corp., accounted for 209 million Norwegian kroner (\$30.9 million) of the 1994 loss (*BI*, Sept. 5, 1994).

UNI Storebrand said that international reinsurance will no longer be a strategic core area for the group and that the business will be wound down (*BI*, March 14, 1994). Premium volume for that sector has been reduced during the year by 34% to 1.9 billion Norwegian kroner (\$281 million).

The group hopes to spin off the remaining reinsurance business through a secondary offering of 90% of the shares of its Oslo Reinsurance Co. subsidiary.

The offer, in which UNI Storebrand shareholders have preferential rights, will take place once approval is received from the government. **[BI]**

Frankona

Continued from page 17

group of business to write and the strength of the two companies is going to put them in a tier that will allow them to write business that perhaps in the past they might not have been considered for. But the merger of the two, I think is very wise, very sound," she said.

"I think it's definitely a plus for ERC if they can do the transaction," said A.M. Best's Mr. Kellogg.

"It certainly increases their size and global presence," he observed.

If Frankona remains a separate entity, it also should benefit from having a committed, larger reinsurance parent, he said.

"Basically this transaction as well as the Aachen Re transaction are all part of Employers Re's strategy to be a very broadly diversified major reinsurance company," said Alan Levin, managing director of Standard & Poor's Corp. in New York.

"They're buying approximately 60% ownership of Frankona and Frankona is one of the more significant reinsurers in the reinsurance marketplace, so it's a good geographic expansion for ERC," Mr. Levin said.

The deal would have implications for other U.S. reinsurers as well, said Firemark's Ms. Morrissey.

"If they look at the example set for them by Gen Re and by Employers Re, they are going to have to make some structural changes themselves," Ms. Morrissey said. See Frankona on page 20

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OSHA

Continued from page 1

forceful hand exertions; use of a vibrating tool; fixed or awkward posture; and unassisted frequent or heavy lifting.

In addition, the draft would require employers to inform 21 million employees whose jobs include the risk factors, rather than 96 million employees under the previous version.

The draft says an employer could identify risky jobs by using an optional OSHA checklist or its equivalent. The previous version would have required employers to identify risky jobs through use of the OSHA checklist as well as a review of the employer's workers compensation and injury logs for the prior two years.

The new draft would exempt employers with what OSHA considers "existing, effective programs" to prevent repetitive stress injuries from certain requirements and would no longer require an annual review of any programs.

In terms of medical management of repetitive-stress injuries, the new draft focuses on responding to problems and getting employees back to work. The latest proposal eliminates an earlier requirement that employers provide eye examinations for video display terminal users who experience neck or shoulder muscle problems. In addition, the current draft also eliminates requirements that employers provide "medical removal protection" for workers, which includes salary protection and continued employment for the duration of the medical problem.

The new draft also gives a break to small employers—those with fewer than 10 employees—by giving them additional time to com-

ply with most provisions and complete exemptions from other provisions.

Other key draft provisions call for controlling a worker's exposure to risk factors through ergonomics engineering and administrative controls. That could include installing a waist-high assembly table to reduce bending.

The proposal also calls for the wider use of personal protective equipment like thermal-lined gloves, but excludes back belts and wrist splints, which are considered to be of questionable usefulness in preventing injuries.

"The most efficient approach is to design out problems up front," OSHA said in a statement.

The draft regulations are part of an effort to curb the growing number of repetitive stress injuries like carpal tunnel syndrome, tendinitis and neck and back injuries among workers, including those on assembly lines and using computer keyboards.

The Bureau of Labor Statistics reported 302,400 cases of repeat trauma disorders in 1993, a tenfold increase from 1984. About 90,000 cases accounted for about 4% of the total 2.3 million days lost in 1992.

Despite the more relaxed stance of the new proposals, some employers remain critical of OSHA's draft proposals.

A full version of the current draft, which consists of several hundred pages, "seems completely at odds with the notion of 'reinventing government' and the trend toward relieving the costly burden of regulations on businesses," said June Stadheim, the National Assn. of Manufacturers' associate director of employee relations.

"These sweeping ergonomic standards could affect millions of workers and cost billions of dol-

lars," she said. "We should not lose sight of the real objective: improving safety and health in the workplace."

NAM is among the businesses and organizations that OSHA asked to comment on the latest draft. NAM and several employers also questioned whether the extensive list of rules was based on sound science.

"It is premature for OSHA to attempt to draft a standard for anything but vibration exposure," said Gregory Worrell, a certified professional ergonomist and corporate ergonomics director for ConAgra Red Meat Cos. and Monfort Inc. in Greeley, Colo. The American National Standards Institute, which is also studying the issue, has said that data is incomplete to establish threshold values for repetitive stress disorders, Mr. Worrell said.

"There are so many pieces of the pie; No one has been able to determine what really works," said Lucille Gallagher, vp-risk management at ConAgra and Monfort and also president of the Risk & Insurance Management Society Inc. "We have seen no controlled studies about which approach is best."

Employers also disagreed with some of the specifics.

Ms. Gallagher, for example, said she disagrees with the proposal to eliminate records review as an identification technique because such records provide "a good starting point," if incidence rates are not evaluated.

"When it comes to back belts, I think OSHA throws out the baby with the bath water," said Jim Harper, director of the Citywide Central Insurance Program in New York, which oversees an insurance program for 60,000 employees of non-profit agencies. He supports use of the belts by 300

properly trained home health care aides, who are currently part of a study on the belts' usefulness.

In addition, even the extended phase-in period for small employers does not give them enough time, said Peter Eide, manager of human resources laws and policy for the U.S. Chamber of Commerce. Complying with OSHA regulations is "extremely burdensome" for small employers, those with between two and 250 employees, he said.

Labor-oriented organizations are more supportive of the regulations.

"What OSHA basically has done is tighten and focus the draft standard to those jobs where we are at risk because of exposure to ergonomic hazards and where there has been a work-related musculoskeletal disorder reported," said Peg Seminario, the AFL-CIO's director of safety and health in Washington.

"We are glad to see that the draft still applies across all industry sectors," she said.

However, the AFL-CIO sees a "major" problem in the elimination of the requirement that employers review prior claims and injury logs to identify risky jobs. It also is concerned about eliminating medical removal protection for workers, which encourages them to come forward when they have a problem. "In these cases, you want to catch things early. If you do, it is better for the workers and cheaper for the employers," she said.

"The regulations have been watered down substantially, but could still be effective if adopted," said Neal Taslitz, president of The BackCare Corp. in Chicago and executive director of the National RSI Foundation. "Anything is better than nothing." **B**

Frankona

Continued from page 19

added. "Remember, it is not too long ago that reinsurers could do business with only \$50 million in capital. Then it went to the \$100 million plateau. Well, that's changing now too. To be taken seriously, reinsurers have to have a real international bent to them. They have to be able to service clients all over the world," Ms. Morrissey said.

"I think we're going to see continued interest in U.S. reinsurers making joint ventures or purchasing or acquiring—whatever you want to call it—foreign reinsurers and, on the other hand, as they prove to be successful we're going to see perhaps the Munich Res and the Swiss Res looking for additional acquisitions. I think we'll see action on both sides of the Atlantic," Ms. Morrissey said.

U.S. reinsurers may look at acquiring companies in Japan, as well, she added.

Meanwhile, the proposed acquisition by Employers Re will offer existing Frankona clients considerable opportunities, said Dieter W. Luer, a member of Frankona's management board. "Our clients will increasingly see us as a global player linked to a strong and strongly-capitalized reinsurer," he said.

The company's remaining equity not held by Gerling is widely spread among institutional and small investors, said the spokesman.

The spokesman would not specify the company's capitalization or comment on the likely cost of the sale.

The deal would not affect Gerling's clients because Gerling Global is a separate company, said Mr. Gueckelhorn.

Both German executives agreed that the sale will be regarded as evidence of further penetration of the German market by outside insurers, but noted that the German market already is very international.

"There's a myth that the German market is a closed shop. There's a lot of international activity in the market and a lot of international companies already operate in Germany," said Mr. Luer.

However, the continuing emergence of a Europe-wide market will only lead to further internationalization, Mr. Luer predicted.

"I think the German market will become more international," agreed Mr. Gueckelhorn, noting, however, that there is still a lot of "emotional" concern about foreign purchases. **B**

NRRA

Continued from page 3

Mr. Harkavy, vp and general counsel of USA Risk Group, Arlington, Va., noted that the Commerce Committee in the U.S. House of Representatives plans to take up both the question of the NAIC accreditation process and review the existing Risk Retention Act in the spring of 1996.

"I think we can use this year to get input from our members, input from our board and come up with a laundry list of possible changes to the Risk Retention Act that will allow us to better serve our members," he said.

During a conference session on regulation of risk retention groups and purchasing groups, Jill B. Berkeley, a partner with Schiff, Hardin & Waite in Chicago, discussed five areas for "pitching battle with regulators."

The potential battlefields included state administrative proceedings, litigation occurring in both state and federal courts, and legislative action at both the state and federal level.

To facilitate pressing the group's cause in state administrative proceedings, Ms. Berkeley suggested the NRRA create a clearinghouse for information on state regulators' efforts to restrict RRG and purchasing group activities.

Such a clearinghouse could work with the Coalition of Alternative Risk Financing Mechanisms, a group representing risk managers involved in non-traditional risk financing vehicles, and an informal coalition being created by captive insurance-regu-

lating states—including Vermont, Colorado, Hawaii and Illinois—to develop model captive regulations, she suggested.

The federal courts could be a forum for taking on the NAIC, Ms. Berkeley said, though she added, "That is not going to be a suit that is lightly brought."

"We will have to have a coordinated action. Although there are indications Vermont has a small litigation budget, Vermont will not be able to do it alone," she said.

Another litigation effort discussed was *Preferred Physicians*

'One state regulator against one RRG is an unequal match,' says attorney Jill B. Berkeley.

Mutual Risk Retention Group and U.S. Physicians Mutual Risk Retention Group vs. Mario M. Cuomo, Salvatore Curiale et al. Phyllis H. Weisberg, a partner at Kurzman, Karsen & Frank, New York, who is representing Preferred Physicians, said "Preferred is fighting an industry battle."

"I think we are winning the war," Ms. Weisberg said. "It's lonely and it's expensive out there, however."

The two risk retention groups claim that a New York law governing excess liability insurance for physicians violates the federal risk retention act and the U.S. Constitution by directly regulating their activities.

In October, U.S. District Judge Peter Leisure of Manhattan agreed, ruling that RRGs and their members should be exempt from New York's Excess Insurance Law (BI, Nov. 7, 1994).

The New York law provides excess liability insurance to doctors and dentists who have primary medical malpractice insurance coverage with a New York-licensed insurer.

"If their primary coverage is with a risk retention group, however, they do not get the free coverage," said Ms. Weisberg, adding that the act has given licensed insurers a competitive advantage and has scared some RRGs away from doing business in New York.

New York has appealed Judge Leisure's ruling, submitting final briefs earlier this month.

On the federal legislative front, reconsideration of the risk retention act could strengthen risk retention groups' hand in dealing with regulators and the courts, Ms. Berkeley said, though she noted that opening up the act for tinkering brings with it the threat of unintended outcomes.

Wherever the risk retention groups find themselves facing their regulatory battles, Ms. Berkeley believes they must take a cooperative approach if they are to succeed. And such cooperation is somewhat antithetical to the RRGs nature, she conceded.

"It may not be the most natural response for you to open up your confidential privileged information and share it with others," she said.

But, while NRRA members might fear giving up competitive advantages, it's necessary that they share and coordinate experi-

ences, she believes.

"We have no choice because one state regulator against one RRG is an unequal match," Ms. Berkeley said.

"An association of regulators like the NAIC is an imposing match for NRRA. I don't think this can be done by one or even a few," she said.

Still, she agreed that methods for sharing information must be developed with an eye toward protecting that information from traditional insurers, which might use it to compete with the alternative market vehicles.

Another panelist, Robert H. Myers Jr. of Neely & Player in Washington, suggested interstate compacts could provide "a state-based solution to several problems."

"Compacts provide the opportunity for state regulation to evolve to a higher level and a better level," Mr. Myers said.

One particularly attractive feature of compacts—given criticism of the NAIC accreditation process for trying to force a "one size fits all" approach to insurance regulation—is that under compacts, "states can differ in areas where uniformity may not be essential," he said.

Not everyone was sold on the idea, however.

"I personally have a problem with a large interstate compact, because it will be like dealing with the European Union in Brussels to get them to do anything," said Philip C. Olsson, NRRA general counsel and a partner with Olsson, Frank & Weeda in Washington.

"There'd be a number of strings to pull," he said. **B**

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Centurion

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under provisions of the Employee Retirement Income Security Act governing collectively bargained union plans.

Two Centurion trustees and PBA Local 34 filed suit in federal court this month against four insurance departments, seeking a ruling that the states have no authority to regulate the plan.

Centurion is also awaiting a federal judge's ruling on whether the U.S. Department of Labor is required to issue an advisory opinion on the validity of the plan's underlying collective bargaining agreement.

The Labor Department refused to issue such an opinion in 1993 and reiterated its stance in a 1994 letter to Sen. Charles S. Robb, D-Va., who had inquired on behalf of Centurion representatives.

While purported union health plans have increasingly become a concern for regulators, Centurion representatives say their plan complies with the law and is financially sound.

"These people in the police department, they aren't going to get involved with a scam," said Edward S. Garcia, a Virginia Beach businessman whose amusement park company helped start Centurion. "What a black eye that would be."

Mr. Garcia was approached three years ago by Edward M. Zinner, a Virginia Beach health plan operator who was seeking financial backing for National Insurance Consultants Inc., a third-party administrator he controlled, according to Mr. Garcia and his accountant, Andrea Kilmer.

Mr. Zinner—who pleaded guilty this month to operating fraudulent health plans through NIC and other firms (see related story)—wanted financing for NIC in exchange for stock in the company, Ms. Kilmer said.

A September 1991 NIC newsletter reported that Mr. Garcia had in fact become a NIC shareholder, bringing "a substantial amount of credibility to our efforts to expand the marketing operation into other states."

But, the newsletter's assertion was false, according to Ms. Kilmer, who said she conducted a due diligence exam of NIC between October 1991 and February 1992 and found irregularities that she reported to the Federal Bureau of Investigation.

Mr. Garcia never invested in NIC and had no involvement with Mr. Zinner after this, Mr. Garcia and Ms. Kilmer said.

Centurion Health Trust grew out of a 1992 labor agreement between Ocean Breeze Festival Park Inc., an amusement park operator headed by Mr. Garcia, and PBA Local 34, which represents the park's security guards, court papers say.

The PBA wanted a health plan that would be a less expensive alternative to a program available to police officers from the city of Virginia Beach, court papers filed by the PBA show.

The health plan is managed by United Benefit Administrators Inc., a Virginia Beach TPA formed in 1992 and headed by Sandra Garcia, Mr. Garcia's wife, and Ms. Kilmer, who is also an Ocean Breeze officer.

While regulators are concerned about purported union health plans, Centurion representatives say their plan complies with the law and is financially sound.

Trustees of the plan are: Michael F. Gelardi, an Ocean Breeze official; Eli S. Chovitz, a local attorney; Robert W. Mathieson, president of PBA Local 34; and Michael T. Leibig, a Fairfax, Va., attorney who represents the union.

Since its formation, the Centurion plan has expanded beyond local police officers. It has been offered in several states to small employers whose workers become associate members of PBA Local 34.

Associate membership is "open to anyone who supports law enforcement and feels the furtherance of law enforcement is a worthy goal," explained John P. Wren, a Norristown, Pa., agent who has marketed the plan but says he has stopped doing so until the dispute is resolved.

"If they are interested enough in law enforcement to join the union and pay dues," non-law enforcement employees can get access to the Centurion plan, agreed Wyatt B. Durette Jr., a Richmond, Va., lawyer for Mr. Gelardi, a plan trustee.

Centurion now has about 10,000 participants, the majority of whom are associate members, said Valerie Wilkinson, comptroller of United Benefit.

The union's expansion plans include targeting companies that employ off-duty police officers as security guards, she said.

The plan is self-funded, with excess-of-loss reinsurance attach-

ing when losses hit \$100,000 per participant in a given plan year, she said. Ms. Wilkinson would not name the reinsurer but said it is a "highly rated" U.S.-licensed company.

Centurion's reserves currently exceed levels recommended by the plan's outside actuary, Ms. Wilkinson added.

Several state insurance departments have taken a dim view of the organization's marketing efforts, though.

In April 1993, the Virginia Corporation Commission charged that Centurion was operating as a multiple employer welfare arrangement and announced it would permanently enjoin the plan.

After Centurion countered that it was a union welfare plan exempt from state regulation under ERISA, Virginia officials gave it time to obtain a Labor Department opinion on the validity of its underlying collective bargaining agreement.

While ERISA provides that MEWAs can be regulated by the states, it includes an exemption for collectively bargained union plans.

The Labor Department refused to rule on the issue, though, and Centurion agreed in July 1993 to stop soliciting new Virginia participants.

This in turn led PBA Local 34 and two Centurion trustees to sue the Labor Department in U.S. District Court in Norfolk, seeking to force the department to issue an advisory opinion.

The two sides are now awaiting a judge's ruling.

Messrs. Garcia and Mathieson also sought help from Sen. Robb, who wrote to Labor Secretary Robert Reich asking that the department reconsider its decision.

Olena Berg, assistant secretary for pension and welfare benefits, replied to Sen. Robb last August, reiterating the department's decision against issuing an opinion. The department has generally declined to issue such opinions, she explained, partly because the review process could be used by health plan operators to "frustrate and delay state enforcement efforts."

Meanwhile, regulators in other states have sought to bar Centurion, according to court papers filed by health plan representatives and other documents. These include:

- The New Jersey Insurance Department, which demanded in a February letter that Centurion stop marketing health care coverage to state residents, court papers filed by the PBA and Messrs. Gelardi and Mathieson show.

New Jersey regulators also subpoenaed documents and testimony from Mr. Wren, the Norristown, Pa., agent who was soliciting memberships in the PBA.

A department spokeswoman said the February letter is not an official cease and desist order and that the department is still deciding what official steps to take.

- The Pennsylvania Insurance Department, which notified Centurion last December and again on March 3 that it must cease and desist soliciting business in the state.

The department had earlier warned a Pennsylvania agent against marketing the plan and recently informed a preferred provider network that Centurion is an unauthorized insurer, causing the network to cancel its contract with the Centurion, court papers filed by plan representatives show.

A Pennsylvania spokeswoman said the department has not issued an official cease and desist order and that any information it has is part of a confidential investigation.

- The New York Insurance Department and state attorney general's office, which labeled Centurion "an uninsured MEWA" and threatened last November to enjoin the plan unless it came into compliance with state law, according to papers filed by plan representatives.

A New York department spokesman confirmed that the department warned "a handful" of agents who inquired about Centurion that the plan was unlicensed and that the agents should not produce business for it.

New York regulators suspect that 25 or 30 agents may still be soliciting business for Centurion in the state, he added.

- The Colorado Insurance Department, which issued its cease and desist order March 10 against PBA Local 34, Centurion, the plan's four trustees, United Benefit and a Colorado agent who sold the plan.

Mr. Durette, the lawyer representing plan trustees, faxed a letter to the Colorado department the same day saying Centurion is

Guilty pleas entered in MEWA scam

PHILADELPHIA—A Virginia health plan operator and three associates have pleaded guilty to federal charges arising from the collapse of two multiple employer welfare arrangements.

Edward M. Zinner of Virginia Beach, Va., pleaded guilty earlier this month to a racketeering charge related to his operation of the allegedly fraudulent Atlantic Healthcare Benefits Trust and a successor MEWA, American Fidelity Trust (BI, Feb. 13).

Jeffrey C. Neal, a plan administrator and trustee, also pleaded guilty to a racketeering charge, while plan trustee Mark Waldron pleaded guilty to wire fraud. And William E. Moulton Jr., a plan sponsor, pleaded guilty to making a false statement in a document required by federal law, said Pamela Foa, assistant U.S. attorney.

Messrs. Moulton and Neal are scheduled for sentencing in May, while Messrs. Zinner and Waldron are due for sentencing in June.

Messrs. Zinner and Neal face a statutory maximum of 20 years in prison on the racketeering charges, while Messrs. Waldron and Moulton each face a maximum of five years. Under federal sentencing guidelines, actual terms are likely to be less.

—By Douglas McLeod

governed by ERISA and is exempt from state regulation.

The same day that Colorado issued its order, PBA Local 34 and Messrs. Gelardi and Mathieson filed suit in federal court in Norfolk against the New Jersey, Colorado, Pennsylvania and New York departments.

The suit charges that the departments have violated ERISA by trying to regulate Centurion and have interfered with the plan's operations in an "irrational, arbitrary (and) capricious" way.

The suit seeks a declaratory judgment that Centurion is exempt from state regulation, along with an order enjoining the states from "attempting to regulate...threatening, intimidating or harassing" Centurion and its representatives. **BI**

Olympics

Continued from page 3

mittee is not involved in construction of the Olympic facilities and therefore has no liability in construction accidents. The committee's property/casualty coverage is written by Fireman's Fund Insurance Co. of Novato, Calif., and Allianz Insurance Co. of Los Angeles, both units of Germany's Allianz A.G. Holding.

An owner-controlled wrap-up policy, which would have covered all contractors and subcontractors for general liability, workers compensation, property and other coverages, was considered for the stadium project but was rejected, according to an insurance administrator that had placed a bid on the job.

As a result, each contractor and subcontractor is responsible for

its own insurance coverages at the stadium site.

A single wrap-up policy would have simplified loss control for the stadium site, since a single safety manager would have overseen the project instead of relying on each individual subcontractor to provide a project manager, according to Jeanne Ward, insurance administrator for D.H. Lloyd & Associates of Georgia Inc.

The firm would have handled administration of the wrap-up program if the ACOG had decided on that type of insurance coverage for the project.

Under the wrap-up proposal, risk management staff from D.H. Lloyd & J&H of Georgia also would have met with all contractors to explain safety procedures that could reduce the odds of injuries, Ms. Ward noted.

But a spokesman for Beers Construction said the site had a stellar

safety record.

Before last week's accident, "there were only 14 lost-time ac-

cident site, and "it was investigated and found there was no basis for it."

Cost savings led the ACOG to outsource its risk management department to J&H, says Richard Stogner, the committee's chief financial officer.

cidents," none of which was serious, he noted.

The Beers spokesman added that OSHA's accident incident ratio for the site was less than half the national average. "The site had a great safety record," he said.

Mr. Gill of OSHA said the agency has received only one complaint regarding safety at the sta-

He said a fine of \$91,000 was levied against Citadel Corp., a contractor at another Olympic construction site in Atlanta that was found to have violated safety standards during an excavation.

That case has been contested and is in litigation, according to Mr. Gill.

Meanwhile, Risk Manager Deborah Collins and 10 other mem-

bers of ACOG's risk management department were laid off last week.

"We're outsourcing our risk management department," said Richard Stogner, ACOG's chief financial officer. Mr. Stogner said that because the committee has "almost a consulting relationship with J&H, it became apparent that there would be cost savings" in having the broker handle risk management services for the games.

Five of ACOG's 11 risk management employees will be re-hired by J&H and will remain at their current offices, he said.

Like the risk management team, which Mr. Stogner said did an "outstanding job," other departments will be outsourced as the games draw nearer.

"Eighteen months from now, we will all be phased out," Mr. Stogner said. **BI**

Golub to head Hobbs Group

Thomas A. Golub was named chief executive officer of Hobbs Group Inc., a Waltham, Mass.-based brokerage subsidiary of Arkwright Mutual Insurance Co. Mr. Golub, who was named president in June 1994, succeeds W. Glenn Yancey, who retired but will remain chairman of the board.

In other agent/broker changes:

Stephen H. Meyers named a vp at Alexander & Alexander Services Inc. in New York. Previously, he was senior vp-finance at JWP Inc., an electrical and mechanical contractor in Rye Brook, N.Y.

Steven K. Brandon named vp of Willis Corroon Corp. of Michigan in Livonia.

Mark Ferraro named chairman of Johnson & Higgins' national unit in New York serving governmental entities.

Ashley Martineau named senior vp of Rollins Hudig Hall of Rhode Island Inc. in Providence with responsibilities for marketing and technical services.

Also at RHH, **Malachy T. Hogan** named executive vp and production manager of the Boca Raton office of RHH of Florida Inc.

Jim W. Henderson named executive vp of Poe & Brown Inc. in Tampa, Fla.

Robert Norwood named vp-sales and marketing for USI Insurance Services Corp. in San Francisco. Previously, he was agency services vp for the Independent Insurance Agents & Brokers of California.

Other suppliers

James B. O'Dell named vp and director of Integrated Management Services, a unit of Willis Corroon Corp. in Nashville that provides claims and loss control consulting services.

Linda Berghold joined Lewin-VHI, the health care policy unit of Value Health Inc., as a vp. Ms. Berghold will work from both the San Francisco and Washington offices.

William E. Grier joined the Insurance Services Office Inc. as senior vp-information systems in New York. Previously, he was chief information officer of Continental Insurance Corp.'s agency/brokerage group in Cranbury, N.J.

Donald P. Koziol, former chairman and CEO of the U.S. operations of R.K. Carvill & Co. Ltd. of

Comings & Goings: Industry

London, joined Aon Corp. unit Aon Risk Services Inc. as executive vp and chief operating officer in Chicago.

Matthew M. Murphy, former senior vp and director of Aon's Aon Risk Consultants unit, joined Bates, Meckler, Bulger & Tilson, a Chicago law firm specializing in insurance.

Ken DiBella named president and chief executive officer of Harrington Benefit Services Group, a unit of Harrington Services Corp., a health care service provider based in Columbus, Ohio. Mr. DiBella is assuming the responsibilities of **Tom McDonough**, who will remain executive vp of Harrington Services Corp.

Insurers

Anthony Clark joined Farmers Group Inc. as chief financial officer in Los Angeles. Previously, he was finance director of Eagle Star Insurance Co. Ltd., an insurance subsidiary of B.A.T. Industries P.L.C., which also owns Farmers. Mr. Clark succeeds **Fran Shanahan**, who resigned from the company.

Robert K. Herbert Jr. named senior vp-operations for Ranger Insurance Co. in Houston. Previously, he was senior vp at Highlands Insurance Co.

Theresa M. Stone named executive vp and **John J. Degnan**, **Edward Dunlop** and **George T. Van Gilder** named senior vps at Chubb Corp. in Warren, N.J.

Also at Chubb, **Richard V. Werner** named executive vp and **Ronald R. Angarella** named senior vp-strategic development of Chubb LifeAmerica in Concord, N.H. Also at Chubb Life, **Patrick A. Lang** named vp-marketing services; **Edward C. Mackenzie** named vp of Chubb Life's Chattanooga, Tenn., office; and **Donna L. Metcalf** named vp-staff management.

Carolyn King named senior vp-investment products for Protective Life Corp. of Nashville, Tenn. She previously was senior vp and chief investment officer of Provident Life & Accident Insurance Co. and president of Provident National Assurance Co. in Chattanooga, Tenn.

Glenn H. Gettier Jr. named chairman and CEO of Southwest-

ern Life Corp. in Dallas, replacing **Robert Beisenherz**, who resigned last October. Also, President **James R. Kerber**, who succeeded Mr. Beisenherz as interim chairman and CEO, was named to the additional posts of vice chairman and chief operating officer.

Diana A. Seitz named vp-administration for Ranger Insurance Co. in Houston.

Richard Lutenski named chief financial officer of Crum & Forster Insurance Co. in Parsippany, N.J. Previously, he was chief financial and investment officer at Amerisure Cos. in Southfield, Mich. He replaces **Scott Moore**, who left the company.

Michael Stocker, president and CEO of Empire Blue Cross & Blue Shield, named interim head of managed care operations, succeeding **Patricia Minicucci**, who resigned Jan. 31. Also at Empire: **Michael Gomes**, formerly senior vp-group accounts, will now be responsible for sales and underwriting functions for all Empire customers; **Gloria McCarthy**, senior vp-Medicare operations, will now handle all operating aspects of Empire's traditional indemnity products; and **Rock Tonkel**, formerly president and CEO at St. Vincent's Hospital & Medical Center in New York, will be in charge of information systems.

Reinsurance

Gail M. Ross named a vp of AM-RE Consultants Inc., a Princeton, N.J., subsidiary of American Re Corp. Previously, she was a principal and consulting actuary with Tillinghast.

Kenneth F. Kiernan named vp-claims for Chartwell Re Corp. in Stamford, Conn.

Zurich Reinsurance Centre Inc. announced four new vp appointments in its New York office: **David S. Cash**, vp-specialty casualty; **Suzanne Martin**, vp-actuarial; **Mary Anne Noonan**, vp-ZRC Special; and **Bryan C. Ware**, vp-actuarial.

Robert L. Mendes joined PMA Reinsurance Corp. as vp and general counsel. Previously, he worked with Intere Intermediaries Inc.

William A. McKenna named vp-finance at Reliance Reinsurance in Philadelphia. [B]

Certificate

Continued from page 2
ucts licensed during that time, Mr. Pinner said.

He estimates the agreement between Mattel and Disney on the certificate of insurance will save his risk management department at least 100 hours annually.

Stephen Wilder, Disney's vp of risk management, said he doesn't consider the new certificate to be a huge time-saver for him but it is helpful.

The risk managers for the two companies have a close relationship that goes back several years. Risk managers at other companies, Mr. Wilder suggested, can also contact each other through organizations like the Risk & Insurance Management Society Inc. to facilitate relations and smooth out contracts, rather than leave the process up to attorneys' haggling.

"I don't think that happens enough," he said.

Mr. Wilder recalled a contract that Disney hammered out three years ago with a construction company for an amusement park attraction. The two companies had a sticking point over the construction company's insurance coverage.

The risk managers for the two companies spent the day together and worked out a solution.

In the case of Disney and Mattel, Disney-licensed products account for more than 10% of Mattel's \$3.2 billion in annual worldwide sales, Mr. Pinner said.

Disney requires licensed manufacturers, such as Mattel, to name Disney as an additional insured under their insurance policies.

The insurance certificates serve as proof that Mattel has sufficient amounts of personal property, product liability and general liability coverage.

Mattel self-insures the first \$1

million of its overall liability exposure through its Bermuda-based captive, Far West Insurance Co. Ltd., with INA Corp. serving as a fronting insurer. Above the first million, Mattel is covered by a \$25 million American International Group Inc. umbrella policy for product liability and general liability.

Streamlining the certificate process did not require a change of insurance policies or coverage, Mr. Pinner said. It was strictly an agreement between the two companies, carried out by risk managers.

Other risk managers can similarly evaluate their responsibilities and find areas where standardization might replace repetition, he said.

"It wasn't just the quantity (of certificates that were previously issued annually)" Mr. Pinner said. "It was just the fact that there wasn't any standardization," he said. [B]

Updates

Wyatt, U.K. firm team up

WASHINGTON—The Wyatt Co. and R Watson & Sons, a major British employee benefit and actuarial consulting firm, are expected to announce this week a final agreement to operate jointly under the name Watson Wyatt Worldwide.

While each firm is making a modest financial investment in the other, Wyatt will remain an independent corporation and Watson will continue as a partnership.

The link to Watson of Reigate, England, gives Washington-based Wyatt a greatly expanded presence in the United Kingdom, where Wyatt has more than 700 employees compared with Wyatt's 200 U.K. workers. By linking with Wyatt, Watson—which is especially known for its actuarial services—gains new capabilities in areas such as human resource and health care consulting.

Aside from operations in the United Kingdom, Watson, which was founded in 1878, has offices in Ireland, continental Europe, the Caribbean and Africa. Most of its about \$80 million in revenues are derived from employee benefit consulting. In 1994, Wyatt posted benefit consulting revenues of \$368 million, making it the world's third-largest benefit consultant.

Comp ruling favors employers

WASHINGTON—A federal workers compensation agency lacks authority to file an appeal on behalf of an injured dock worker, the U.S. Supreme Court ruled last week in a victory for maritime employers.

The high court justices unanimously decided that the director of the Labor Department's Office of Workers Compensation Programs may not appeal to federal courts for review of a decision denying full compensation by a federal Benefits Review Board interpreting the Longshore and Harbor Workers Compensation Act.

The worker, who injured his back in 1984, declined to appeal the board's award of partial rather than full disability compensation from his employer, the Newport News Shipbuilding & Dry Dock Co., a Tenneco unit based in Newport News, Va. The workers comp agency's director, though, appealed on his behalf, arguing that she should be considered "an adversely affected or aggrieved" party under federal law.

That "would put the federal courts into the regulator business of deciding intrabrand and intra-agency policy disputes—a role that is most inappropriate," wrote Justice Antonin Scalia for the court.

Justice Ruth Bader Ginsburg concurred with the court but wrote in a separate opinion that Congress probably hadn't intended to deny the workers comp director the authority to file such appeals, since the director has that authority under the Black Lung Benefits Act. But, it is up to Congress to remedy the "disharmony."

The decision upholds a 4th U.S. Circuit Court of Appeals ruling.

Briefly noted

Shares in **Health Systems International** on Friday rose 7.7%—to close at \$31.50 in New York Stock Exchange trading—amid reports of a purchase being worked out by Wellpoint Health Networks Inc. of Woodland Hills, Calif. Wellpoint would not comment; HSI officials could not be reached. . . . A federal appeals court judge last week overturned a \$45.7 million settlement by Los Angeles County and 150 municipalities to compensate for damage done by DDT and other chemicals discharged into the ocean off California. The suit, brought by the U.S. Justice Department, is one of three lawsuits that led to the landmark continuous trigger of coverage ruling in *Montrose vs. Admiral* (BI, March 9, 1992). . . . Investors, including the state workers' pension fund, will suffer no loss in principal after the Wisconsin State Investment Fund suffered a \$95 million investment loss that officials blame on unauthorized derivatives trading. Other investors in the \$6.7 billion fund include the state and about 1,000 local government entities. . . . **Ford Motor Co.** will pursue motions to dismiss a class-action suit after a federal judge rejected a proposed settlement between the company and Bronco II owners last week. Ford would have provided 700,000 Bronco II owners with warning stickers and videotapes on defensive driving but no money. . . . The storm system responsible for California's early March flooding and landslides caused an estimated \$380 million in insured property damage throughout the Western and Plains states, said the American Insurance Services Group. . . . The Senate last week passed legislation to allow the self-employed to take a tax deduction for 25% of their health insurance premium cost in 1994 and 30% in 1995. . . . U.S. District Court Judge Charles A. Legge could give his final approval to settlement of the massive antitrust litigation at a hearing scheduled for Wednesday (BI, Dec. 12, 1994; Oct. 10, 1994). . . . Zurich, Switzerland-based **Swiss Reinsurance Co.** confirmed that it is planning an internal restructuring, but no layoffs or acquisitions are foreseen. . . . **Senate Judiciary Chairman Orrin Hatch**, R-Utah, may introduce a tort reform bill this week. Sen. Hatch's bill will serve as a companion to the product liability reform bill introduced earlier this month by Sens. Slade Gorton, R-Wash., and John D. Rockefeller IV, D-W.Va. (BI, March 20). . . . **Standard & Poor's Corp.** has downgraded the claims-paying ability of **Hartford Fire Insurance Co.** to AA+ from AAA reflecting, along with downgrades of other ITT Corp. units, in part the company's exposure to environmental liabilities. . . . **First Line**, the program managed by Bermuda financial reinsurer Stockton Reinsurance Ltd. to issue guarantees for certificates of financial responsibility for carrying oil to the United States, has issued over 700 guarantees for vessels totaling almost 25 million gross tons. . . . **White Mountain Insurance Co.**, a new Fund American Enterprises Holdings Inc. unit, has been licensed in New Hampshire. The company is capitalized at \$25 million and will write commercial property and casualty insurance. . . . The Senate Governmental Affairs Committee unanimously approved S. 291, the **Comprehensive Regulatory Reform Act of 1995**, last Thursday. The measure would require federal regulatory agencies to subject proposed rules that would have an impact of more than \$100 million per year to new risk assessment and cost/benefit analysis.

Malmgren takes new risk management post

Bob Malmgren has been named director-risk management for Northwest Airlines Inc.

In the newly created position, he directs all of the Minneapolis-based airline's risk finance and claims management programs, including insurance negotiation and placement.

Mr. Malmgren, 40, reports to Rolf Andresen, who is vp and controller.

Before joining Northwest, Mr. Malmgren was risk manager at Supervalu Inc. in Minneapolis and a risk analyst with Dayton Hudson Corp.

Mr. Malmgren holds a bachelor's degree in business administration from the University of Minnesota in Minneapolis and a master of business administration degree in marketing from the University of St. Thomas in St. Paul, Minn.

He has earned the Chartered Property Casualty Underwriter designation and is a deputy member of the Risk & Insurance Management Society Inc.

Clifford R. Feldman has been named to the position of director-health and welfare benefits for GTE Corp. of Stamford, Conn.

In this newly created position, he plans and directs the development, implementation, management and reporting of corporate benefits funding and expense policies for all GTE health and welfare plans worldwide.

Mr. Feldman, 38, reports to William F. Tichy, assistant treasurer-insurance and pensions.

Since 1990, Mr. Feldman served as director-finance for GTE Spacenet in McLean, Va. GTE sold the unit to GE Americom, a subsidiary of General Electric Corp., in October 1994.

Prior to joining GTE Spacenet, Mr. Feldman worked for Old Stone Leasing Corp., Emery Worldwide and Potomac Electric.

Mr. Feldman holds a bachelor of science degree in accounting from American University in Washington and a master's degree in finance and investments from George Washington University, also in Washington.

Michael J. Cawley has been elected vp-risk management by the board of trustees of Eastern Enterprises.

Mr. Cawley was previously assistant vp-insurance for the Weston, Mass.-based holding

Comings & Goings: Buyers

company. Eastern operates Boston Gas Co. and Midland Enterprises Inc., a barge operator on inland waterways.

Mr. Cawley has held various positions in Eastern's treasury and financial departments since he joined the company in 1979.

Mr. Cawley holds a bachelor's degree in economics from the College of Holy Cross in Worcester, Mass., and an M.B.A. from Babson College in Babson Park, Mass. He has earned the Associate in Risk Management designation and is pursuing a CPCU designation.

Mr. Cawley is president of the Massachusetts Self-Insurers Assn. and past president and director of the Massachusetts chapter of RIMS.

George A. Wheat has been named vp of insurance and risk management at Greyhound Lines Inc.

He will oversee all of the Dallas-based company's insurance and claims functions and will report to Craig Lentzsch, Greyhound president and chief executive officer, in the newly-created position.

Mr. Wheat, 51, was director of insurance and claims for Motorcoach Industries International Inc. in Phoenix since 1991 and served as director of claims for Phoenix-based Dial Corp. from 1988 to 1991.

From 1972 to 1987, Mr. Wheat served as senior litigation attorney for the Greyhound Corp. He joined Greyhound Lines Inc. in 1987 as associate general counsel when the company was sold by the Greyhound Corp.

He holds a bachelor's degree from Wichita State University in Wichita, Kan., and a law degree from Washburn University in Topeka, Kan. He is licensed to practice law in Arizona, Kansas and Texas and served on the governor's task force for tort reform in Arizona in 1992.

Frederick M. Haubert has been promoted to manager, risk/insurance at Leaseway Transportation Co.

Mr. Haubert is responsible for identifying, developing and implementing cost-effective in-

surance programs in the newly created position. He reports to Jim Brogan, vp-safety.

Cleveland-based Leaseway provides customized transportation and logistics support to retailers, wholesalers and distributors.

Mr. Haubert joined Leaseway in 1990 as manager of risk analysis. He holds a bachelor of science degree in accounting from Tiffin University in Tiffin, Ohio. He is a deputy member of RIMS.

Also at Leaseway, **Kathy L. Schroeder** has been promoted to manager, workers compensation and liability. Ms. Schroeder will manage a 10-person claims team responsible for handling all workers compensation and liability. She also reports to Mr. Brogan.

Ms. Schroeder joined Leaseway in 1992 as manager of workers compensation. She holds a bachelor's degree in criminal justice from Central Michigan University in Mount Pleasant, Mich. She is a deputy member of RIMS and a member of the Self-Insured Group of Ohio and the Cleveland Claims Assn.

Joan Spiegel has been promoted to vp-risk management at Safeway Inc.

Ms. Spiegel, 41, joined the Oakland, Calif.-based grocery store chain in 1991 as director of risk management.

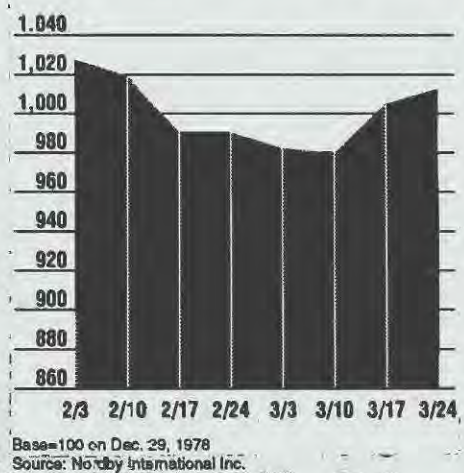
She reports to Michael Ross, Safeway's senior vp-law and general counsel.

Prior to joining Safeway, Ms. Spiegel was manager of risk management at Lucky Stores and worked in the risk management department of Pacific Telesis Group in San Francisco.

Ms. Spiegel holds a bachelor's degree in political science from the University of Southern California in Los Angeles.

We'd like to report on staff changes in your company's risk management, safety and employee benefit departments. Contact Sara Marley, Associate Editor, Business Insurance, 740 Rush St., Chicago, Ill., 60611-2590, or call 312-649-5313. Please send a photograph, too.

BI Insurance Index



Catastrophe insurance option call spreads

As of March 24					
Call spread	Price bid/ask	Rate on line %	Call spread	Price bid/ask	Rate on line %
Eastern September 1995			Western Annual 1995		
45/65	5.8/6.5	29/32.5	20/30	0.5/3	5/30
50/70	5.3/6	26.5/30	30/40	0.3/1.8	3/18
60/80	4/5.5	20/27.5	30/50	0.5/2.5	2.5/12.5
100c	3.5/12	8.5/12	50/70	0.6/1.8	3/9
150c	3.5/5	7/10	60/80	0.3/2.5	1.5/17.5
Total volume: 140		Total open interest: 5,116			
For quotes, call the CBOT trading floor at 312-341-3342. For general information, call 312-435-3674.					
Source: Chicago Board of Trade					

British Issues

Mar. 23	Price	P/E	Div.	Yield	1 week
Companies	pence		pence	%	high-low
Comml Union	543	10.9	33.0	6.1	546-540
Genl Accident	581	8.5	36.3	6.2	581-568
Gdn Royal Exch	190	N/M	10.3	5.4	192-184
Independent	272	7.5	11.9	4.4	274-272
Royal	292	5.6	15.0	5.1	299-290
Sun Alliance	328	11.1	19.7	6.0	328-324
Brokers					
Bradstock	86	9.7	7.1	8.2	86-86
Fenchurch	143	10.0	10.0	7.0	145-143
CE Heath	229	11.4	20.0	8.7	229-229
JIB Group	121	10.5	9.4	7.8	121-121
Lloyd Thompson	151	10.5	9.8	6.5	151-151
Lowndes Lomb	145	8.5	10.4	7.2	145-145
Nelson Hurst	168	13.2	3.3	4.9	169-168
PWS Holdings	20	N/M	0.8	4.0	20-16
Sedgwick Grp	153	13.9	8.1	5.3	153-153
Steel Brit Jones	113	13.3	11.3	10.0	113-109
Willis Corroon	144	N/M	8.3	5.8	145-144
Source: Philip Osen, London					
* Estimated 1994 data					

BI Industry Stock Report MARCH 20, 1995, THROUGH MARCH 24, 1995

BROKERS												INSURERS/REINSURERS													
		Price	Weekly % change	Year to date % change	Annual High	Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt./Bk. value			Price	Weekly % change	Year to date % change	Annual High	Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt./Bk. value
Accordia Inc.	NYS	32.25	-1.15	-3.73	34.50	24.63	14	0.72	2.23	16	13.24	2.44	NAC Re Corp.	NDO	29.75	-4.80	-11.19	34.00	24.00	61*	0.16	0.54	15	13.75	1.51
Alexander & Alexander	NYS	22.38	4.07	20.95	22.50	14.00	113	0.10	0.45	-8	6.08	3.68	National Re Corp.	NYS	30.00	-1.64	14.29	31.75	22.25	2*	0.16	0.53	19	17.31	1.73
E.W. Blanch Holdings Inc.	NYS	19.13	-2.55	-7.27	23.00	16.75	47	0.40	2.09	16	4.55	4.20	Navigators Group	NDO	15.00	-10.45	3.45	20.50	13.75	13	0.00	0.00	-4	13.21	1.47
Gallagher Arthur J. & Co.	NYS	35.75	2.88	11.72	36.00	28.13	46	1.00	2.80	16	6.48	5.52	Nobel Insurance Ltd.	NDO	9.25	2.78	12.12	9.63	7.63	8*	0.20	2.16	4	3.84	1.35
Hibb, Rogal & Hamilton	NYS	11.13	-2.20	-8.25	13.38	10.75	107	0.56	5.03	14	4.72	2.36	Ohio Casualty Corp.	NDO	33.19	-0.19	17.48	34.00	26.50	431	1.52	4.58	14	23.68	1.34
Marsh & McLennan	NYS	82.38	-0.30	3.94	88.75	71.25	393	2.90	3.52	16	19.40	4.25	Old Republic Int'l	NYS	24.38	-1.02	14.71	25.50	18.88	221	0.48	1.97	10	24.60	0.99
Poe & Brown	NDO	21.50	-2.27	-1.15	22.75	18.00	112	0.48	2.23	14	4.49	4.79	Orion Capital Corp.	NYS	34.88	-0.36	-1.06	37.88	28.13	75	0.80	2.29	9	25.86	1.35
BROKERS	AVERAGE		-0.2	2.3					2.6	12			Partner Re Holdings Ltd.	NDO	20.25	-2.99	-2.41	22.25	18.50	1811	0.40	1.98	8	N.A.	N.A.
INSURERS/REINSURERS													Penn-America Group Inc.	NDO	7.31	4.46	-0.85	8.00	6.50	13	0.00	0.00	9	3.21	1.18
ACE Ltd.	NYS	24.25	0.52	3.74	28.88	20.75	380	0.44	1.81	-8	22.45	1.08	Phoenix RE Corp.	NDO	23.00	-0.54	-18.58	29.25	18.50	62	0.60	2.61	5	22.86	1.01
Acceptance Insurance Cos.	NYS	14.75	-0.84	-1.67	18.00	11.38	363	0.00	0.00	9	9.83	1.50	Provident Life	NYS	22.75	-0.55	4.60	29.88	21.50	135	0.72	3.16	8	27.09	0.84
AEGON N.V.	NYS	68.63	-1.79	8.07	70.88	49.38	7	2.92	4.26	12	43.84	1.57	Re Capital Corp.	NDO	18.19	-0.34	48.47	18.25	12.00	63	0.32	1.76	16	17.63	1.03
Aetna Life & Casualty	NYS	56.00	-0.44	18.83	58.25	42.25	2237	2.76	4.93	14	57.21	0.98	Reliance Group Holdings	NYS	5.50	7.32	6.02	6.75	4.88	1033	0.32	5.82	14	3.48	1.58
Allied Group Inc.	NDO	26.63	0.47	7.58	31.00	22.00	87	0.68	2.55	6	23.43	1.14	Reliastar Financial Corp.	NYS	34.38	1.10	18.53	35.50	27.00	469	0.90	2.62	10	24.81	1.39
Allmerica Prop. & Casualty	NYS	19.25	3.36	14.07	20.13	14.25	161	0.16	0.83	12	19.45	0.99	RLI Corp.	NYS	23.38	-1.58	14.02	24.50	19.88	23	0.60	2.57	-28	20.51	1.14
Allstate Corp.	NYS	28.50	4.11	20.00	28.50	22.63	1846	0.78	2.74	26	19.60	1.45	St. Paul Companies	NYS	50.63	-0.25	13.13	51.00	37.69	641	1.60	3.16	10	31.88	1.59
American General	NYS	32.25	0.39	14.16	32.38	24.88	2278	1.24	3.84	23	20.39	1.58	SAFECO Corp.	NDO	55.50	-0.22	6.73	59.75	46.75	801	1.96	3.53	12	45.94	1.18
American Heritage Life Ins.	NYS	18.50	2.78	-2.63	19.75	16.50	19	0.64	3.46	11	12.42	1.49	SCOR U.S. Corp.	NYS	8.13	3.17	-2.99	12.25	7.50	43	0.20	2.46	-18	13.60	0.80
American Indemnity/Fin'l	NDO	12.00	-2.04	18.52	14.25	10.00	8	2.24	2.00	3	15.92	0.75	Seibels Bruce Group	NDO	1.38	-15.38	-45.00	3.50	1.38	33	0.00	0.00	6	1.05	1.31
American International	NYS	105.88	0.95	8.04	106.88	82.38	2229	0.46	0.43	15	49.75	2.13	Selective Ins. Group	NDO	28.00	0.00	10.89	28.50	23.00	41	1.12	4.00	10	23.36	1.20
American Re Corp.	NYS	33.25	-0.37	3.10	35.75	25.25	131	0.32	0.96	17	16.85	1.97	Sphere Drake Holdings	NYS	13.88	1.83	0.00	17.00	10.75	43	0.18	1.15	7	13.15	1.06
Aon Corp.	NYS	36.63	2.09	14.45	36.63	29.25	408	1.36	3.71	12	21.96	1.67	TIG Holdings	NYS	20.75	0.00	10.67	21.75	17.00	1074	0.20	0.96	26	17.25	1.20
Argonaut Group	NDO	29.50	-2.88	4.42	31.25	26.25	68	1.16	3.93	10	29.80	0.99	Titan Holdings, Inc.	NYS	10.00	2.56	2.56	11.00	7.75	5*	0.28	2.80	8	3.31	1.07
AVEMCO Corp.	NYS	16.75	10.74	8.94	17.38	13.38	41	0.44	2.63	14	6.30	2.66	Tokio Marine & Fire	NDO	54.00	-3.14	-11.11	66.00	49.88	14	0.44	0.81	47	57.72	0.94
Baldwin & Lyons Inc.	NDO	15.75	0.00	6.78	17.63	14.00	6	0.24	1.52	11	13.56	1.16	Torchmark Corp.	NYS	41.75	3.41	21.01	44.50	32.38	383	1.12	2.68	11	17.49	2.39
Berkley W.R. Corp.	NDO	37.00	3.68	-1.33	42.00	32.50	160	0.48	1.30	26	36.47	1.01	Transatlantic Holdings	NYS	60.75	0.83	8.72	60.75	45.63	20*	0.40	0.66	14	32.43	1.87
Berkshire Hathaway Inc.	NYS	22650.00	2.03	11.03	25200.00	15400.00	1	0.00	0.00	29	9157.79	2.47	Transnational Re Corp.	NDO	19.75	0.00	-15.96	25.50	17.25	84	0.00	0.00	7	N.A.	N.A.
Capital RE Corporation	NYS	23.75	2.15	-13.24	27.38	18.63	8	0.20	0.84	9	21.48	1.11	Travelers Corp.	NYS	39.00	0.65	20.46	39.88	30.38	3132	0.80	2.05	10	24.26	1.61
Capsure Holdings Corp.	NYS	12.63	-3.81	-13.68	16.13	12.13	110	0.00	0.00	13	13.72	0.92	Trenwick Group Inc.	NDO	42.75	-1.16	0.88	44.25	33.75	52	1.12	2.62	14	23.20	1.46
Chubb Corp.	NYS	78.88	-0.16	1.94	82.63	68.63	856	1.96	2.48	13	48.40	1.63	United Fire & Casualty	NDO	28.00	2.75	1.20	29.81	24.66	1	0.80	2.86	9	23.96	0.97
CIGNA Corp.	NYS	75.13	-0.99	18.07	76.38	57.00	977	3.04	4.05	10	80.98	0.93	Unitrin	NDO	49.00	-1.26	13.95	51.50	38.50	136	2.00	4.08	16	33.64	1.27
CNA Financial Corp.	NYS	76.00	2.88	17.15	76.00	60.00	47	0.00	0.00	149	73.83	1.03	UNUM Corp.	NYS	45.88	2.23	21.52	56.75	35.13	1466	0.96	2.09	22	27.78	1.65
Continental Corp.	NYS	19.50	0.00	2.63	23.63	12.00	586	0.00	0.00	-2	29.69	0.66	US Facilities Corp.	NDO	13.63	1.87	36.25	14.63	8.25	323	0.20	1.47	13	11.07	1.23
EMC Insurance Group Inc.	NDO	10.38	-3.49	9.21	10.88	8.50	10	0.52	5.01	8	10.77	N.A.	USF&G Corp.	NYS	14.00	0.00	3.70	15.50	11.69	1433	0.20	1.43	7	12.04	1.38
Emphysis Financial Gr. Inc.	NYS	37.25	-0.67	17.32	38.88	21.25	685	0.60	1.61	10	N.A.	N.A.	USLIFE Corp.	NYS	37.63	3.08	7.89	40.25	30.88	20*	1.32	3.51	9	40.82	0.92
EXEL Ltd.	NYS	44.25	-3.54	12.03	46.00	36.00	744	1.32	2.98	17	31.62	1.40	Washington National	NYS	18.63	1.36	-1.97	24.75	17.75	109	1.08	5.80	7	23.61	0.79
Fremont General Corp.	NYS	20.13	2.55	-13.90	26.00	19.38	183	0.76	3.78	6	22.90	0.88	Zenith National Ins.	NYS	20.00	-1.23	-12.09	27.38	19.50	34	1.00	5.00	10	17.54	1.14
Frontier Insurance Group	NYS	21.88	2.34	0.00	37.50	16.75	81	0.48	2.19	17	14.94	1.46	Zurich Reinsurance Centr.	NYS	30.38	0.83	5.19	30.38	24.50	15	0.00	0.00	-26	22.26	1.36
Gaisco Inc.	ASE	10.88	8.75	31.82	10.88	7.63	171	0.04	0.37	14	3.79	2.87	INSURERS/REINSURERS	AVERAGE		0.4	6.3					2.3	13.5		
General RE Corp.	NYS	131.13	1.25	6.17	133.00	102.75	1866	1.96	1.49	16	57.17	2.29	HEALTH MAINTENANCE ORGANIZATIONS												
Guaranty National Corp.	NYS	16.38	-1.50	-10.88	18.50	14.25	4	0.48	2.93	9	11.84	1.38	FHP International	NDO	29.00	0.87	12.62	31.00	20.25	715	0.00	0.00	16	12.22	2.37
Harleysville Group	NDO	24.50	1.55	1.03	26.50	19.75	9	0.68	2.78	18	20.18	1.21	Humana Inc.	NYS	24.13	-1.03	6.63	25.75	15.88	1943	0.00	0.00	22	5.04	3.99
Hartford Steam Boiler	NYS	43.25	2.06	8.46	50.75	35.88	135	2.20	5.09	17	14.62	2.96	Pacificare Health Sys.	NDO	69.75	2.57	7.10	79.50	44.25	325	0.00	0.00	22	14.21	4.91
HCC Insurance Holdings	NDO	24.50	3.16	16.67	25.75	15.00	148	0.00	0.00	16	10.75	2.28	Safeguard Health Enter.	NDO	8.81	-9.62	-4.73	15.00	8.25	3	0.00	0.00	33	3.16	1.43
Home Holdings Inc.	NYS	8.13	-1.52	-13.33	15.13	3.00	92	0.00	0.00	-1	22.36	0.36	Sierra Health Services	NYS	30.50	-1.61	-3.56	33.50	21.25	73	0.00	0.00	18	3.04	5.05
ITT (Hartford Group)	NYS	102.63	0.74	15.80	102.63	77.00	1374	1.98	1.93	13	49.95	2.05	United Healthcare Corp.	NYS	46.63	0.00	3.32	55.38	37.25	3660	0.03	0.06	28	3.57	7.10
Kemper Corp.	NYS	42.25	-0.88	11.55	65.00	35.75	2587	0.92	2.18	23	28.68	1.47	U.S. Healthcare	NDO	45.00	3.15	9.09	49.00	33.75	6322	1.00	2.22	19	5.04	8.93
Lincoln National	NYS	40.63	0.93	16.07	43.88	34.63	398	1.72	4.23	12	31.99	1.27	Wellpoint Health Networks	NYS	31.13	2.05	6.87	35.38	24.25	581	0.00	0.00	15	12.73	2.45
Markel Corp.	NDO	47.00	2.17	13.25	47.00	37.50	50	0.00	0.00	14	25.15	1.87	HMCos	AVERAGE		-0.5	4.7					0.3	19		
Mid Ocean Ltd.	NDO	29.00	4.50	6.42	30.50	22.25	415	1.00	3.45	9	20.24	1.43	ALL COMPANIES	AVERAGE		-0.1	4.4					2.5	16		
Mutual Risk Mgmt. Ltd.	NYS	22.00	3.30	0.86	22.00	14.25	73	0.00	3.40	15	2.25	0.25													

The snowshoe rabbit changes color with the season, adopting a white coat in winter and a brown coat in summer. This change, which is governed by the shortening length of day, enables the rabbit to blend into its background for protection.



The Ability To Adapt To The Environment Is Necessary For Survival In Nature. And In Benefits Management.

In nature, the ability to change and adapt is required for survival. In managing employee benefits programs, it's also becoming a necessity.

The Mutual of Omaha Companies recognize this need. Our experience in developing and offering PPO, EPO, HMO and point-of-service plans gives us the ability to work with companies to design benefit programs that can meet their changing needs. Our years of experience have taught us the best ways to prepare for change — and therefore, we're ready to help benefits managers meet it.

Nature is experienced at managing change. And so are we.

Find out what the Mutual of Omaha Companies Group Operation can offer your company. Call Patrick Moeschler, 1-800-877-1052.



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