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UPDATES

HHS reopens comment period on privacy regulations

WASHINGTON—Employers and others concerned about implementation of a controversial medical records privacy bill now have until March 30 to submit written comments to the Department of Health and Human Services.

HHS had originally issued its rules on Dec. 28, 2000, but a paperwork error pushed the effective date of the rule to April 14 from the original date of Feb. 26. HHS Secretary Tommy G.Thompson an-

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Bush budget plan would improve FSAs

By JERRY GEISEL

WASHINGTON—The Bush administration is readying a proposal to make flexible spending accounts more attractive to employees.

As part of a federal budget "blueprint," the administration disclosed last week that it is preparing legislation to improve FSAs. In that same document, the administration also said it wants to make permanent a pilot program that allows small employers to offer tax-favored medical savings accounts to employees, provide new tax breaks for long-term care and adoption expenses and add a prescription drug benefit to Medicare for low-income retirees.

The administration did not provide any more details about the FSA proposal. Those details are expected to be disclosed when the administration presents its formal budget package next month.

But the FSA proposal likely would resemble one President Bush made during the election campaign. In October, he proposed allowing employees to carry over from one year to the next up to $500 in unused FSA balances.

That proposal would effectively overturn an Internal Revenue Service regulation known informally as "use it or lose it." That rule, issued in the mid-1980s, requires employees to forfeit unused account balances at the end of the year.

While awaiting more detail, employer groups say they would welcome any liberalization of the "use it or lose it" rule as good health care policy.

Use it or lose it "encourages waste as employees rush at the end of the year to spend those unused dollars. That should be a signal that there is something wrong with the current system," said Kenneth Feltman, director of the Employers Council on Flexible Compensation in Washington.

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PHOTO: AP/ WIDE WORLD

President Bush's budget plan includes several benefit-related provisions, including expanding FSAs.

Hewitt mulls benefits of IPO

By JERRY GEISEL

LINCOLNSHIRE, Ill.—Hewitt Associates L.L.C. is considering whether going public is the best way to fulfill its vision as a benefit consultant.

In a brief statement released last week, privately held Hewitt said its executive committee and management are evaluating the merits of an initial public offering.

"Hewitt Associates has an aggressive vision of our future as an HR consulting and delivery firm. We see major opportunities to serve the current and emerging needs of our clients and their people and believe we're very well positioned to pursue those opportunities. We believe that becoming a public organization could help us in our pursuit of that vision," the company said.

Hewitt

As a result, it now is evaluating "whether an IPO is the right way for us to deliver on our vision and to take steps that would better position us to proceed if the answer is 'yes,'" Hewitt said.

While Hewitt declined to comment beyond its statement, outside observers say one factor behind Hewitt's consideration of an IPO could be the need to raise funds for investments in technology.

"They may want to infuse the organization with additional funding to invest more broadly in total outsourcing. What they want to do requires massive amounts of money," said Donn Bleau, national director of the employee benefits practice at Solomon-Page Group Ltd. in San Diego, an executive recruiter.

Furthermore, Mr. Bleau said, an IPO could generate funds

See **IPO** *on page 20*

Insured losses may reach $1 billion in Seattle quake

PHOTO: AFP

Seattle's Pioneer Square was one of many areas in the city hit hard by the Feb. 28 earthquake.

By ROBERTO CENICEROS

SEATTLE—Insured losses from the earthquake that shook the Pacific Northwest last week could reach $1 billion or more, which would make it one of the most costly U.S. quakes for insurers.

Property damage from the Feb. 28 quake, a 6.8-magnitude temblor that was centered 35 miles southwest of Seattle, is widespread. But property damage is expected to be largely superficial, and major structural losses are not likely, according to preliminary reports.

Risk managers in the region credit advance planning and preparedness for helping keep casualties and insured losses from being far greater.

Initial estimates of insured losses from the quake ranged from hundreds of millions of dollars to as much as $1 billion as of late last week, though estimates are expected to grow as more loss data becomes available. The quake also caused injuries to about 320 people and resulted in one death from a heart attack, according to media reports.

State and federal officials late last week estimated total eco-

See **Quake** *on page 22*

Were carpal tunnel injury reports withheld?

Feds eye Burlington data

By ROBERTO CENICEROS

FORT WORTH, Texas—The Federal Railroad Administration is investigating whether Burlington Northern Santa Fe Railroad Co. improperly withheld information from the agency about employees making claims for work-related carpal tunnel syndrome during the past year.

The FRA's investigation comes several weeks after the Equal Employment Opportunity Commission threatened to sue the railroad for discrimination over its practice of conducting genetic tests on employees who filed carpal tunnel claims. BNSF agreed to halt the practice (*BI*, Feb 19).

In light of the testing controversy, the FRA suspects BNSR may have failed to report certain carpal tunnel incidents to it as required under federal law, a spokesman for the FRA said last week.

"We have heard that there have been several cases over at Burlington Northern Santa Fe that are under dispute that should have been reported," he said.

A spokesman for Fort Worth, Texas-based BNSF said that it is required to report only work-related ailments, which it determined was not the case with any of the carpal tunnel claims it investigated. Consequently, the spokesman said, no carpal tunnel claims have been reported to the FRA within the past year.

Unlike other employers that must report workplace

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NEWSPAPER

UPDATES

HHS seeking comment

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nounced a few days ago that he would reopen the comment period, "to ensure a thorough review" of the issues involved. The notice of the extended comment period, which began last Wednesday, appeared in the Feb. 28 Federal Register.

Under the rules, health plans and health care providers would be required to disclose how a patient's information is used and to whom it's released, and physicians would generally have to obtain written permission from patients to release any information (*BI*, Jan. 1).

The rules drew fire from employers, insurers and others. Opponents complained that the HHS regulations would apply to all medical records, rather than only to electronic records, as Congress had specified when it originally called for a privacy rule. Opponents also charge that the rules would make obtaining patient authorization to release personal medical information very difficult. In addition, insurers and employers fear the regulation would cause health care providers to withhold necessary information about treatment from insurers and other payers for fear of fines and jail time for unauthorized release.

Patient advocacy groups and privacy advocates, on the other hand, have hailed the rules as necessary to protect confidential records.

HHS issued the regulations in the final weeks of the Clinton administration, after Congress failed to meet its own deadline for doing so, as set by the Health Insurance Portability and Accountability Act of 1996.

U.S. insurer failures up: S&P

NEW YORK—The number of U.S. insurers that failed in 2000 increased 40% from 1999, and the increased rate of failures could continue through 2001, according to Standard & Poor's Corp.

In 2000, 56 insurers failed, up from 40 in 1999, according to a new study published by the New York-based rating agency. Of the 56 companies, 31 were property/casualty insurers; 17 were health insurers; five were life insurers; and three were title insurers, the study found.

With one exception, all the insurers rated by S&P that failed in 2000 had ratings that fell below the secure financial strength level.

S&P said that, even though the U.S. insurance industry has been long recognized for its strength, resilience and ability to provide policyholder protection even in troubled times, the number of failures could continue through 2001.

The full text of the study is available at *www.standardandpoors.com/ratings*.

COLI taxes force charges

Two companies have announced they will take charges to earnings in connection with interest deductions claimed on their corporate-owned life insurance policies following a Feb. 20 federal court decision in Columbus, Ohio.

More companies are expected to make similar announcements.

Columbia, Md.-based W.R. Grace & Co. said it will take a $75 million charge against its 2000 financial results in connection with potential additional taxes and interest related to loans secured by the cash value of its COLI policies. W.R. Grace said it would report an $89.7 million net loss for 2000.

Similarly, Cleveland-based National City Corp., a financial services company, said last week that it will take a $40 million charge to first-quarter 2001 earnings related to tax exposure on interest deductions for its COLI policies.

Depending upon the outcome of negotiations with the Internal Revenue Service, National City may have to record an additional $40 million charge either later this year or in a subsequent year, said Thomas A. Richlovsky, National City senior vp and treasurer.

What prompted both company announcements was a U.S. District Court judge's ruling in *American Electric Power Inc. vs. United States*. Judge James L. Graham ruled that the interest deductions claimed by Columbus, Ohio-based AEP on its federal income tax returns in connection with its COLI program were not allowable under applicable tax laws. The Internal Revenue Service had challenged the deductions. The company said it would appeal the decision.

An AEP spokesman said the Feb. 20 decision will have no cash impact on the company because the taxes had already been paid to the IRS in anticipation of the decision.

The AEP spokesman said he expects additional companies will make announcements similar to Grace's and National City's as a result of the decision. "It wouldn't surprise me to see other announcements," Mr. Richlovsky said.

Some black lung rules on hold

WASHINGTON—Recent court action has temporarily suspended some of the new federal black lung regulations, which greatly expand the ability of miners to obtain benefits for the disease.

U.S. District Court Judge Emmet G. Sullivan of the District of Columbia issued a preliminary injunction earlier last month suspending some of the new regulations until he decides the merits of a lawsuit filed by the National Mining Assn. and some workers compensation insurers (*BI*, Jan. 29).

The new regulations went into effect Jan. 19, one day before President George W. Bush was sworn in.

The judge's injunction against some of the regulations grants, in

See **Updates** *on page 22*

OSHA rule may be at risk

Senate invoking CRA to overturn ergonomics standard

BY MARK A. HOFMANN

WASHINGTON—The Senate is scheduled to vote this week to overturn the controversial federal ergonomics standard by invoking the Congressional Review Act.

A spokesman for Assistant Senate Majority Leader Don Nickles, R-Okla., confirmed Friday that a vote would take place.

Sen. Nickles had promised last Thursday that "We'll have that vote in the not-too-distant future," speaking before a group of employer representatives during a brief address at the U.S. Chamber of Commerce. Although Sen. Nickles had initially been slated to focus on health care reform—which he addressed—he also told his audience that the ergonomics standard, promulgated by the Occupational Safety and Health Administration during the last days of the Clinton administration, would drive up health care costs if allowed to go into effect as written.

OSHA "put some things into this that people just couldn't imagine that they did," said Sen. Nickles. He cited in particular a provision that would create a special federal benefit for er-

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All eyes on Pennsylvania for pollution clause case

By DAVE LENCKUS

PITTSBURGH—In a case that is drawing wide interest from policyholders and insurers, the Pennsylvania Supreme Court today is scheduled to hear oral arguments on the meaning of the sudden and accidental pollution exclusion and whether insurers misrepresented the exclusion to regulators 30 years ago.

The policyholders in the case, who have lost in two lower state courts, want the court's seven justices to rule in favor of at least one policyholder argument:

- The exclusion does not bar coverage for unexpected and unintended gradual pollution losses, which would reverse more than 16 years of case law established by lower Pennsylvania state courts.
- The court should look beyond the wording of the exclusion, find that insurers promised regulators 30 years ago that the exclusion would not bar coverage for unexpected gradual losses, and hold insurers to that promise.

The Pennsylvania case has drawn eight amicus briefs from numerous policyholders, the Pennsylvania Department of Environmental Protection—which supports policyholders' arguments—and U.S. and London market insurers.

The plaintiff, household products manufacturer Sunbeam Corp. of Fort Lauderdale, Fla., would not allow its attorney to comment on the case.

Policyholder attorney John Ellison, who filed an amicus brief for several companies, said he rarely has seen such a flurry of such briefs. One exception, he said, was a 1993 New Jersey Supreme Court case that ended with the court lambasting the insurance industry for misrepresenting the exclusion to state insurance regulators.

Mr. Ellison, a partner with Anderson Kill & Olick P.C. in Philadelphia, said the Pennsylvania case poses a threat to insurers because the state has a significant industrial base with "heavy environmental issues."

He also said that the insurance industry might be concerned about the "unfavorable trend" for insurers in recent pollution rulings. For example, Rhode Island's Supreme Court last summer ruled that the sudden and accidental pollution exclusion does not bar coverage for unexpected gradual losses and that insurers made that clear to regulators in 1970 when seeking approval for the exclusion (*BI*, June 26, 2000).

The attorney for Boston-based Liberty Mutual Insurance Co., the lead defendant in the Pennsylvania case, could not be reached for com-

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Trend toward growth

Encouraging use of programs

By LEE FLETCHER

ORLANDO, Fla.—How do work and family programs move from being mere ideas to becoming common company practice?

Panel members addressed that question at the keynote presentation of the annual conference of the Alliance of Work/Life Professionals, held Feb. 7-9 in Orlando, Fla.

Malcolm Gladwell, the author of "The Tipping Point: How Little Things Can Make a Big Difference," explained that what is known about how disease epidemics spread can also be applied to societal trends, including the growing activity in the area of work/life programs.

The Alliance of Work/Life Professionals

W. Fred Jenkins Jr., executive director of work/life strategies with Verizon Communications Inc. in New York, emphasized that it is unrealistic to expect rapid work/life changes within a company.

"We can't grab the whole brush and change the world in one fell swoop. It's those small, incremental steps that we can engage in within our respective markets that will collectively make a dif-

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INSIDE

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- The meltdown in Internet stocks is driving up prices for D&O coverage, according to experts at a Professional Liability Underwriting Society's symposium. **PAGE 10**
- In Perspectives, Steven D. Baderian and Joanne Seltzer write that federal guidance is needed in the debate over genetic data. **PAGE 13**
- Britain's rail industry suffered another disaster in a two-train accident that killed at least 13 people. **PAGE 15**

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High court rejects cost/benefit argument

By MARK A. HOFMANN

WASHINGTON—The Supreme Court's unanimous ruling that the federal government does not have to consider compliance costs when setting certain environmental standards underscores the need for Congress to subject proposed rules to cost/benefit analysis before they take effect, employer groups say.

The case, *Whitman vs. American Trucking Assns.*, revolved around the question of whether the Environmental Protection Agency had overstepped its bounds when it set new standards for soot and ozone under the Clean Air Act in 1997. Business groups held that Congress, rather than the EPA, had the power to set such new standards and that the agency should consider compliance costs when setting environmental standards.

The U.S. Circuit Court of Appeals for the District of Columbia rejected the notion that costs had to be taken into account but agreed that the EPA had strayed too far into congressional territory in the way it set the rules.

The Supreme Court ruled Tuesday that the EPA had done nothing wrong in its general approach to the issue, though the agency needed to revisit its ozone standard.

In fact, the text of the relevant section of the Clean Air Act, "interpreted in its statutory and historical context and with appreciation for its importance to the CAA as a whole, unambiguously bars cost considerations" from the national ambient air quality standards-setting process and, thus, "ends the matter for us as well as the EPA," wrote Associate Justice Antonin Scalia for the court.

The EPA also did not usurp congressional authority by setting its 1997 standards, he wrote. The scope of the EPA's discretion spelled out in the relevant section of the Clean Air Act is "well within the outer limits of the court's nondelegation powers," he wrote. Justice Scalia added that the high court has overturned regulations for granting too much traditionally legislative power to federal agencies only twice—both in decisions issued in 1935.

While the Supreme Court said that the EPA had the power to regulate ozone under the Clean Air Act, it ruled that the agency had implemented its standard in the wrong way and would have to come up with a new way to do so.

Despite that provision, the EPA hailed the ruling as a vindication of its policies. "The Supreme Court issued a solid endorsement of EPA's efforts to protect the health of millions of Americans from the dangers of air pollution and affirmed our constitutional authority to set these kinds of health-

See **EPA** *on page 21*

2000 broker results

Year-end results for the world's largest publicly held brokers. Dollar amounts in millions.

	Brokerage & Consulting		Corporate			
	Revenues	Percent change from 1999	Gross revenues	Percent change from 1999	Net income	Percent change from 1999
Marsh & McLennan	$6,915.0	6.8%	$10,180.0	10.9%	$1,181.0	62.7%
Aon	5,137.0	7.0	7,304.0	6.0	474.0	35.0
Arthur J. Gallagher*	699.2	11.6	740.6	12.8	87.8	24.9
Jardine Lloyd Thompson†	435.4	7.3	467.6	7.3	79.2	6.6

*1999 figures have been restated.
† British pound= $1.5156 (2000), $1.6172 (1999)

Broker results get a boost

By SALLY ROBERTS

After years of being plagued by soft pricing in the property/casualty insurance market, the world's largest insurance brokers finally saw some relief in 2000.

All of the world's largest publicly held brokers reported better top- and bottom-line growth for the year ending Dec. 31, 2000. Much of that growth was characterized by new business, a better pricing environment and acquisitions, according to the brokers and the analysts that cover them.

London-based Jardine Lloyd Thompson Group P.L.C. reported the largest increase in brokerage and consulting revenue in 2000, with a 14% rise, to £287.3 million over 1999 revenues. Converted to U.S. dollars using average annual exchange rates, though, JLT's revenues increased only 7.3%, to $435.4 million for the year.

Itasca, Ill.-based Arthur J. Gallagher & Co. reported an 11.6% rise in brokerage revenues, to $699.2 million. Chicago-based Aon Corp. reported a 7.0% increase in brokerage and consulting revenues to $5.14 billion, and New York-based Marsh & McLennan Cos. Inc. saw its brokerage and consulting revenues grow 6.8% to $6.92 billion.

"In general, 2000 was really a positive inflection year for brokers," said Adam Klauber, managing director of Cochran Caronia Securities L.L.C. in Chicago. "Across the board, brokers had substantially better revenue growth, better earnings and better cash flow," he said.

Much of that growth is attributable to property/casualty rate firming, which analysts said gradually grew more

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RIMS adds work time to FRM requirements

Workshops needed for fellow designation

By MICHAEL BRADFORD

NEW YORK—Risk managers will have to spend a little more time in the trenches to qualify for the industry designation awarded by the Risk & Insurance Management Society Inc.

RIMS is changing the requirements for receiving its Fellow in Risk Management designation so that those who earn it must have at least three years of experience in the profession. Previously, there existed no industry experience requirement. That and other changes apply not only to risk managers but also to brokers, underwriters and others who pursue the FRM designation.


Mr. Hampton

Other changes include a new requirement that six two-day workshops be completed. The workshops, which begin Sept. 1, will be interactive programs in which participants will be asked to work out risk management problems under the guidance of instructors. The titles of the three fall programs are Perspectives in Risk Management, Disaster Planning and Recovery, and Litigation: Minimizing the Total Cost of Risk. Three other programs will be offered in the spring of next year.

The workshops replace one of the requirements, which had called for three elective college-level courses, although other such college-level requirements remain in place. Also gone in favor of the workshops is the required completion of a "capstone" project—which tested understanding of accounting, finance, information systems and business law as those disciplines relate to risk management.

RIMS is making the changes partly because it wants to offer a designation that has a broader application, providing value to professionals managing risk in a variety of organizations. The revisions also are designed to indicate the competency of those who earn the FRM designation.

"In order to be a RIMS fellow, a person has to demonstrate an understanding of what it takes to manage risk across the organization," said Jack Hampton, executive director of the New York-based society.

Those who earned the FRM before Jan. 1, 2001, must comply with continued-standing requirements of the revised designation. Those requirements are 15 continuing education credits every two years, which can be earned by attending the workshops or RIMS-approved educational programs. Twenty hours of professional activities related to risk management—such as participation in the society's annual conferences, regional meetings or other activities—also must be completed. Adherence to ethical standards, which are being developed, and membership in the Global Risk Management Institute are requirements as well.

The institute, which administers the FRM program, may also see its structure revised. The revisions continue to require that those who pursue the designation be members of the institute.

"Obviously, there will be a governing board or an institute; how that will be revised is what we are looking at now," said Mike Phillipus, vp of RIMS' education committee and manager, risk management, at Pennzoil-Quaker State Co. in Houston.

Mr. Phillipus pointed out that it is possible to take courses offered as part of the FRM curriculum without pursuing the

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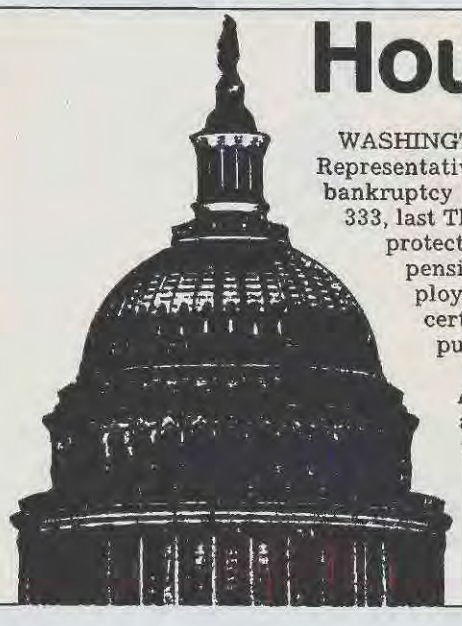
House passes bankruptcy reform bill



WASHINGTON—The House of Representatives approved a bankruptcy reform bill, H.R. 333, last Thursday that would protect from creditors the pension benefits of employees who work for certain nonprofit and public employers.

The Bankruptcy Abuse Prevention and Consumer Protection Act also contains a provision that could help some U.S. investors in Lloyd's of London to avoid paying outstanding liabilities related to asbestos losses. The bankruptcy legislation would bar the enforcement of foreign judgments that involve allegations of fraud occurring in the United States between 1975 and 1993 (*BI*, Feb. 19).

Lloyd's sustained large asbestos-related losses in the late 1980s and early 1990s and was subsequently sued by investors, known as names. The Lloyd's names alleged, among other things, that the market fraudulently recruited investors during the 1970s and 1980s. Names alleged that executives at Lloyd's had attempted to conceal the magnitude of impending asbestos-related losses and duped them into becoming investors.

In October, the U.K. High Court dismissed those charges last year in a high-profile case (*BI*, Nov. 6, 2000). Courts in both the United States and the United Kingdom have so far upheld Lloyd's attempts to collect unpaid debts from names.

The pension provision contained in the bankruptcy bill would extend the same protection from creditors enjoyed by plans subject to the Employee Retirement Income Security Act to non-ERISA plans.

These include 457 plans that cover employees who work for state and local governments. The provision also covers certain types of 403(b) plans—chiefly those funded solely by employee salary deferrals—that are typically offered by hospitals and colleges.

The Senate has yet to act on the bankruptcy measure, which has drawn the opposition of consumer groups that fear its other provisions are tilted too heavily in favor of creditors, notably credit card companies. The Senate could vote on its version of the legislation as early as next week.

—By Mark A. Hofmann

Budget highlights

What the Bush administration's budget plan would do:

- **Improve flexible spending accounts**
- **Add Medicare prescription drug benefit for low-income seniors**
- **Permanently extend tax-favored medical savings accounts**
- **Offer new tax breaks for long-term care expenses**
- **Expand tax breaks for adoption expenses**
- **Impose liability protection for certain corporate donations**

Budget

Continued from page 1

In fact, Mr. Bush said last year that permitting FSA rollovers would encourage "more efficient use of medical benefits and enable employees to meet their health needs more efficiently."

Benefit experts concur, saying that if rollovers were permitted from year to year, employees likely would contribute more to the accounts, resulting in bigger accounts to meet uncovered health care-related expenses.

"'Use it or lose it' probably results in employees putting in less money than they otherwise would," said Frank McArdle, a consultant with Hewitt Associates L.L.C. in Washington.

With the ability to roll over unused account balances from one year to the next, employees also would be less likely to indulge in end-of-the-year spending splurges for items that they don't really need, such as an extra pair of glasses, and instead would have more funds available for future uncovered health care costs.

"This would be a very tax-effective way to meet future expenses," said Mary Case, a principal in the New York office of Unifi Network, a PricewaterhouseCoopers unit.

Since flexible spending accounts were authorized under a 1978 tax law, they have become a mainstream benefit offering. While exact figures are not available, a sizable majority of major corporations offer FSAs.

Under an FSA, employees make pretax contributions to an account that is used to pay for uncovered health care expenses, such as a medical bill deductible or eyeglasses. In addition, many employers offer FSAs to cover dependent care expenses. Dependent care FSAs do not appear to be covered by the Bush proposal.

The attraction of FSAs for employees is that they are able to use pretax dollars to pay for benefit expenses, cutting their true cost significantly. Because employees' effective costs are less, employers can place higher cost-sharing requirements on employees.

Under the "use it or lose it" rule, forfeitures revert to the employer. Employers use forfeitures, which tend to be small, in a variety of ways.

Some companies use the funds to offset their own costs of administering FSAs, while others redistribute the funds to plan participants. Such distributions are legal as long as they are done on a uniform basis and not linked to any individual employee's forfeiture. In addition, some employers donate the amounts to charities.

While benefit experts say modifying the FSA "use it or lose it" rule would be good health care policy, they acknowledge that it would entail additional, largely one-time, administrative costs to employers.

"Employers would have to communicate the change" and they would have to adjust their administrative systems to keep track of rollovers, said Randy Abbott, client strategy leader with Watson Wyatt Worldwide in Philadelphia.

Aside from the FSA proposal, which Congress would have to approve, the administration also wants to make permanent a provision in a 1996 law that lets employers with up to 50 employees offer tax-favored medical savings accounts. That provision will expire at the end of 2002, though current policyholders could keep their MSAs.

During his presidential campaign, Mr. Bush said he favored making MSAs a permanent benefit option and allowing all employers to offer them. He also said he favored removing the current 750,000 cap on the number of MSAs that are allowed.

Other benefit-related provisions in the budget plan include expanding tax breaks for adoption expenses and creating new tax breaks for long-term care expenses. BI

BI hires ad sales director

NEW YORK—*Business Insurance* has added to its sales staff in New York.

Ken Luker has joined the magazine as advertising sales director. He succeeds Martin J. Ross III, who was promoted to publisher at the beginning of this year.

In his new role, Mr. Luker will be responsible for directing the magazine's 11-person sales staff, coordinating print, online and RIMS-TV sales and special projects.

Mr. Luker

Before joining *BI*, Mr. Luker was advertising sales director for The Aviation Week Group, a multimedia division of the McGraw-Hill Cos. whose operations include a magazine, a Web site and television programming.

Prior to joining The Aviation Week Group, Mr. Luker held various sales positions at AutoWeek and Advertising Age, both sister publications of *Business Insurance*.

He has a bachelor of science degree in marketing from the University of South Carolina.

Mr. Luker can be reached at 212-210-0133.

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What can we do to help you?

Brokers

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pronounced toward the end of 2000.

Fourth-quarter numbers were "generally characterized by accelerated organic revenue growth," said Jay Cohen, first vp with Merrill Lynch & Co. Inc. in New York. "It's pretty apparent that the improving pricing environment is gradually working its way into the revenue numbers."

"The momentum continues in the insurance marketplace toward higher premium rates across all lines of coverage, contributing to increased commissions and growth in risk management opportunities," Michael J. Cloherty, executive vp of Arthur J. Gallagher, said in the broker's year-end results statement.

Marsh, Aon and JLT also expressed optimism within their own organizations regarding rising premium rates. In fact, a recent market forecast issued by Marsh predicted double-digit rate hikes for most lines of coverage at least through the first six months of the year (*BI,* Feb. 26).

"The outlook for all brokers is encouraging, given that the pricing is rising not only in the U.S. but it also is starting to rise in other parts of the world," noted Gary Ransom, senior vp for Conning & Co. in Hartford, Conn.

Buoyed by better pricing and new business development, corporatewide revenues at Marsh, which include investment income and revenue from Putnam Investments Inc., its Boston-based investment management company, increased 10.9%, to $10.18 billion. Net income improved 62.7%, to $1.18 billion, for the year. Excluding a $233 million special charge taken in the fourth quarter of 1999—relating to the integration of Sedgwick Group P.L.C., which Marsh acquired in 1998—profits rose 23% in 2000.

In a statement, Marsh noted that the integration of Sedgwick has "proceeded smoothly and ahead of schedule." Marsh said its earnings were helped by net consolidation savings, which totaled $30 million in 1999 and $90 million in 2000. The broker anticipates an additional $40 million in savings for 2001.

"Significant improvement" in Aon's operating segments contributed to the Chicago-based broker's revenue and profit growth in 2000, the company said. Corporatewide revenues, which include investment income and revenues from Aon's underwriting operations, increased 6.0% to $7.30 billion.

As expected, Aon took an $82 million special charge against its fourth-quarter earnings as part of a comprehensive business transformation plan it announced last year (*BI,* Dec. 18, 2000; Nov. 6, 2000). Including the special charge, net income increased 35% for the year, to $474 million.

Unlike other publicly traded brokers whose stocks fared well in 2000—Gallagher's stock, for example, was up more than 100% at the end of December—Aon's share price tumbled last year.

Gallagher shares closed Friday at $27.51, while Marsh finished at $104.26 and Aon ended at $36.27.

Aon's shares fell following the company's announcement that it would spend up to $325 million over the next three quarters to improve the way it conducts its business, services clients and creates shareholder value. Aon also said it would eliminate 3,000 jobs.

In Aon's year-end results statement, Patrick G. Ryan, chairman and chief executive officer, said, "Implementation of our business transformation plan is proceeding well, and we are on track toward achieving the objectives we announced last November. The more challenging phases of the transformation lie ahead, but we are encouraged by our initial performance."

Analysts are optimistic about Aon's future.

"Aon will work its way back," said Conning's Mr. Ransom.

"I think Aon will ultimately turn itself around," agreed Cathy Seifert, an equity analyst with Standard & Poor's Corp. in New York. This is due in part to the dominant market position Aon holds, she said. Both Aon and Marsh should be better able than smaller brokerages to capitalize on the rising pricing trend, she added.

In addition to improved pricing, acquisitions continue to play a major part for many brokers.

Aon, which made a name for itself in the acquisition world during the 1990s, continued to make smaller strategic deals in 2000. For example, Aon acquired the captive management and risk financing consulting operations of Bermuda-based International Risk Management Group Ltd. in December. In September, it acquired Horizon Consulting Group Inc., a New York firm specializing in commercial policyholder claim consulting services. And in August, Aon acquired Actuarial Sciences Associates Inc., a Somerset, N.J.-based employee benefits and compensation consulting firm.

Most recently, Aon said it entered into a definitive agreement to acquire ASI Solutions Inc., a New York-based human resources and compensation consulting firm. The stock deal, expected to be completed within the next 90 days, shouldn't have a material impact on Aon's earnings, the broker said in a statement.

Arthur J. Gallagher also maintained an active growth-by-acquisition strategy throughout 2000. The world's fourth-largest broker acquired roughly 13 insurance intermediaries in 2000. The deals included the acquisition of reinsurance intermediary John P. Woods Co. Inc., which made Gallagher one of the world's largest reinsurance brokers. Last year, Jersey City, N.J.-based John P. Woods was the world's ninth-largest reinsurance broker, based on $25 million in 1999 revenues (*BI,* Oct. 23, 2000). Earlier in the year, Gallagher purchased a majority shareholding in MBR Pty. Ltd., a Sydney, Australia-based reinsurance broker.

Overall, Gallagher's corporatewide revenues, which include commission, fee and investment income, rose 12.8%, to $740.6 million. Net income grew 24.9% to $87.8 million.

Gallagher "continues to be helped out by a successful acquisition strategy," Merrill Lynch's Mr. Cohen noted. "It's not as big as Marsh or Aon, so acquisitions still make a difference in their revenues. For Marsh or Aon to make a difference in revenues, they would need a very large acquisition, and there's not much left to buy."

Revenues at Jardine Lloyd Thompson also continue to benefit from acquisitions. Last November, the world's fifth-largest insurance broker paid £22.5 million ($34.1 million) in cash to acquire Abbey National Benefit Consultants Ltd., the pension administration and consulting division of Abbey National Group P.L.C. In August, its subsidiary, JLT Risk Solutions Ltd., agreed to acquire a portfolio of marine and energy reinsurance business from Bradstock Ltd., a London market reinsurance broker and subsidiary of The Bradstock Group P.L.C. In May, JLT Corporate Risks & Services acquired Burke Ford Group, a U.K. retail and employee benefits broker.

"We have made substantial investments and acquisitions in all three core businesses in 2000, with the aim of further developing our existing services to benefit our clients, particularly as harder market conditions now apply," Ken Carter, chief executive officer of JLT, said in a statement.

Overall, JLT's 2000 corporatewide revenues, which include investment income, rose 14.5%, to £308.5 million ($467.6 million), and profits grew 13.5% to £52.25 ($79.2 million). BI

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OPINIONS

Speak out on privacy rule

SECOND CHANCES may be rare, but they are not unheard of, as critics of a recently issued medical records privacy regulation are learning.

Now that they've got that second chance, it's up to those critics to make the most of it.

Like a similarly troublesome federal ergonomics standard, the medical privacy regulation appeared in the final weeks of the Clinton administration. But while the arrival of the Occupational Health and Safety Administration's final ergonomics regulation was something of a surprise, the Department of Health and Human Services' privacy regulation had been expected before President Bush took office.

The surprise, though, came in how sweeping the regulation would be.

Whereas earlier drafts of the regulation would have covered only the dissemination of electronic personal medical records, the final rules would cover all types of medical records and communications.

The rule would put new restrictions on self-insured employers and would require, under most circumstances, written permission for the release of even the most routine information. Ironically, the final regulation includes a loophole that would still permit the release of information for certain marketing purposes—one of the chief activities the regulations were supposed to curb.

Employers, insurers and others immediately cried foul, claiming they had not been given a chance to comment on any expansion of the scope of the privacy regulations before the complicated final rule was promulgated.

In fairness to HHS, the department didn't get much help from Congress in drafting the regulation. In fact, the Health Insurance Portability and Accountability Act of 1996 put the onus of drafting privacy rules on Congress, which failed to meet its own deadline for doing so. As a result, the responsibility passed to HHS, which delivered its rule on Dec. 28.

But, because of a paperwork error, what appeared to be the final rule is turning out to be not so final after all. HHS failed to deliver the regulation to the General Accounting Office on time, which led the new HHS secretary, Tommy Thompson, to postpone the effective date of the rule to April 14. At the same time, Mr. Thompson ordered that a comment period be reopened until March 30.

Employers, insurers, health care providers and others worried about the expansion of the rule should seize this opportunity to make their concerns known.

While there is broad agreement that that personal

medical information deserves stringent protections, HHS also should realize that the guarantee of privacy cannot be absolute. A variety of interests—including those of employers that need to make sure their health plan participants are receiving appropriate treatment—must be balanced against the right to privacy. Effective cost-containment measures also require the gathering of information, and if that information is overly expensive or impossible to obtain, everyone ends up paying, in the form of higher premiums and co-payments. And that could lead some employers to drop employee health care coverage altogether.

During a luncheon address at the U.S. Chamber of Commerce last week, Mr. Thompson said that the issue of medical records privacy must be approached with a good dose of common sense. We couldn't agree more, and that's why the extended comment period is so important.

There's no guarantee that the regulation will be modified to address every concern raised by employers. But there's a good chance that if employers don't bother raising their legitimate concerns, fewer changes will be made than would otherwise have been the case.

Mr. Thompson has used a paperwork error as a way to give employers and others an unexpected chance to correct another sort of mistake. It's up to them to make the most of that opportunity—by making sure their voices are heard.

LETTERS

Violence story raises questions

To the editor: Your Feb. 19 article "Showing No Mercy to Violence at Work" was a bit too self-serving from the insurance perspective.

Unless there are unreported facts in the case of William Baker, I can not imagine what steps Navistar Corp. could have taken in this case.

The employee was terminated six years prior to the outbreak of violence! Can one expect the employer to monitor Mr. Baker's court appearances in the expectation that a jail date might/would trigger some unforeseen act? Likewise, what is the "trigger" for insurance coverage to begin? At what level of threat, perceived or actual, will a policy "meet the costs associated with increased security to prevent an event" of violence?

Mention was also made in the article of a 49% rate of employers performing "thorough background investigations of prospective employees." From my many years of experience, I would believe a figure of only 4% to 9% to be more realistic. I base this assumption on the number of times that others have contacted me for a reference of my ex-employees. And yes, I do obtain references on all new hires. I am constantly amazed by the lack of reciprocal requests from other employers.

The article did address a serious workplace problem. Unfortunately, answers, easy or otherwise, are not readily available.

Michael Herman
Vp
Hargro Fabrics Inc.
New York

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Taking stock of securities litigation reform

1995 law has slowed number of suits, but plaintiffs now seek bigger settlements, speakers say

By MICHAEL PRINCE

NEW YORK—One aim of the Private Securities Litigation Reform Act of 1995 was to reduce the number of frivolous securities fraud lawsuits filed. Three law professors who took part in a recent panel discussion about the changes in the nature of directors and officers suits disagreed about the effectiveness of the law.

While the number of suits filed annually has changed little in the past five years, the figures are somewhat deceiving, said John Coffee, a professor at Columbia Law School in New York. That's because the number of publicly traded companies has increased significantly, he said. Consequently, Mr. Coffee concludes that the law has had a limiting effect on the filing of suits.

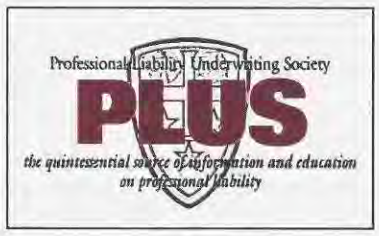
But it's not clear yet that the law has reduced worthless suits while allowing valid actions to proceed, said Michael Perino, assistant professor of law at St. John's University School of Law in New York.

"That, to me, is still an open question," Mr. Perino said.

The panel discussion took place at the Professional Liability Underwriting Society's D&O Liability & Insurance Issues Symposium, held last month in New York.

Mr. Coffee said that the types of cases being filed have changed in recent years. Rather than finding fault with projections by a company's executives of future good times that never develop, lawsuits today tend to be filed after companies announce they have discovered financial irregularities in their financial statements.

For these cases, a plaintiff has to show only that a company's executives sought to commit fraud when the false financial statement was made, said Elliott Weiss, professor of law at the University of Arizona College of Law in Tucson, Ariz.



In a case in which the restatement of results is significant, it's often difficult for a trial judge to accept that fraud was not intended, he said.

When the restatement is very large, "I don't think the motion to dismiss is going to work," Mr. Coffee said.

In a major shift since the law was enacted, institutional investors are now usually the lead plaintiffs in the suits, the panelists said. Before the law, the lead plaintiff was, typically, the first shareholder to file the suit, regardless of how many shares that individual owned. But the 1995 law changed the way the lead plaintiff is chosen; it was designed to bring in more large investors as lead plaintiffs.

Mr. Coffee said, though, that these investors—frequently state pension funds—often are not versed in the value of these cases, and they assume that the cases are worth more than plaintiffs customarily receive.

Additionally, Mr. Weiss said, these investors tend to seek the maximum settlements allowed by law and object to the lower settlements that have customarily resolved such cases.

The law's drafters held that if institutional investors were invited to become lead plaintiffs, they would be less likely to pursue the cases aggressively. But such a belief has not held up, Mr. Perino said.

Having investigated virtually every shareholder suit in the last five years, Mr. Perino said, he found that not one institutional investor had dropped a case. In fact, he said, state pension funds are very aggressive in recovering as much money as possible for their beneficiaries.

The value of settlements has also gone up following a $2.83 billion settlement reached in late 1999 to resolve a shareholder class-action lawsuit against Cendant Corp. As a result, defendants are laboring under "Cendant shock," Mr. Coffee said. The Cendant lawsuit charged that the defendants had artificially inflated the company's stock price through accounting fraud.

Mr. Perino said that if more cases are dismissed, plaintiffs attorneys will seek larger settlements from the surviving lawsuits.

He said that more lawsuits today focus on insider trading by key corporate executives. Such a suit will often allege that an executive sought to sell stock before some bad news about the company became public. To avoid such suits, a company should create a trading plan that determines in advance when its executives can sell shares, as well as the amounts they can sell.

Because a plaintiff must show that a stock sale was out of the ordinary in order to succeed, it makes the plaintiff's case more difficult if the sale was executed according to the trading plan, Mr. Weiss said.

Boris Feldman, a partner with Wilson, Sonsini, Goodrich & Rosati in Palo Alto, Calif., moderated the session. BI

As stocks fall, D&O rates head upward

By MICHAEL PRINCE

NEW YORK—The meltdown in Internet stocks last year has pushed up rates for directors and officers liability coverage, according to a panel of experts.

And the price increases are expected to worsen as more companies whose stocks plunged last year renew their D&O coverage, they say.

In addition, large losses from D&O settlements and verdicts are more frequently penetrating excess D&O layers and making excess insurers increasingly wary, they say.

As insurers take on these growing exposures, they should scrutinize the risks they cover more thoroughly, experts say.

"It's going to be a rapidly changing environment over the next three to six months," said Christopher Sparro, president of the middle-market division at the National Union Fire Insurance Co. of Pittsburgh, Pa., a unit of the American International Group Inc. in New York.

Mr. Sparro spoke at the Professional Liability Underwriting Society's D&O Liability & Insurance Issues Symposium in New York recently.

While rates have gone up in the past year, "unfortunately, there is a long way to go," said Chris Warrior, an underwriter with Lloyd's of London syndicate 435, which is managed by D.P. Mann Ltd.

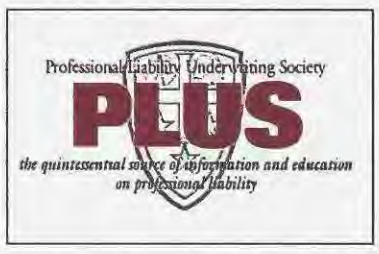
In particular, premiums will increase in the excess layer, because some insurers will withdraw from the market, he said.

In the past several years, stock prices have become more volatile, said Kevin LaCroix, president of Genesis, an underwriting manager in Beachwood, Ohio.

These wild swings in stock prices make shareholder suits more likely, he said.

Furthermore, executives at companies that have seen their stocks plunge "may do desperate things," such as creating false financial statements, Mr. LaCroix said. And if they are caught, lawsuits will likely follow, he said; criminal prosecutions could follow as well.

But a steep stock drop does not mean the company's directors and officers will necessarily be sued, said Christopher Duca, executive vp at Axcelera Specialty Risk Inc. in New York. The plaintiffs have to show that the directors and officers intended to defraud investors.



"There must be a misconduct by the company and the directors and officers," he said.

If there is misconduct, though, a large drop in a company's stock price means greater losses for shareholders and greater potential damages in a suit, Mr. Duca said.

The losses from such suits are also extending to different insurers, Mr. LaCroix said.

In the past few years, there has been an increase in exceptionally large losses. These large verdicts and settlements have penetrated into excess layers that in the past have not seen claims, he said. Nor were these excess layers priced with the expectation of such large and frequent losses, Mr. LaCroix said.

Because of these greater risks, insurers are raising rates and even refusing to offer coverage for some riskier companies, he said.

"There will be dogs that can't find homes," Mr. LaCroix said.

Policyholders seeking coverage should come up with creative strategies to control costs, such as mixing layers of excess coverage with self-insured layers, he said.

Because of increased exposures, insurers must probe deeper with companies that seek D&O insurance, especially those that are preparing for initial public offerings, said National Union's Mr. Sparro.

While it's important to read a company's stock offering documents carefully, any prudent D&O insurer should also engage in detailed discussions with management.

"The issues you don't know about are the ones that cause you problems," D.P. Mann's Mr. Warrior said.

For example, Mr. LaCroix recommended that an insurer ask why a company is going public. A satisfactory answer would be that the company seeks to raise capital to expand operations. An answer that should raise a red flag is that the company needs money to launch its operations.

Also, it's important to look at whether the company has received venture capital. If it has not, that is a sign that venture capitalists may have looked at the company and decided it was too risky to fund. If it's too risky for venture capitalists, insurers should stay away as well, he said.

The management team is critical. A team that lacks experience in the field or that lacks experience in running a publicly traded company should also serve as a warning to insurers, Mr. LaCroix said.

After a company has filed its IPO documents with the Securities and Exchange Commission, insurers should attend its "road show." This is when the company's executives travel to meet with various securities underwriters to gather their support for the stock offering. Sometimes, at these presentations, the management will make statements that are inconsistent with the company's public filings, Mr. LaCroix said.

"If the facts are altered, you need to alter your terms and conditions," he said.

When evaluating a company's financial statements, D&O insurers must be skeptics, said Martin Perry, president of Chicago Underwriting Group Inc. in Chicago.

"Underwriters need to be more like bond analysts, looking at the company's downside," he said.

A few key areas should be examined with extra care, because they are places where companies typically try to hide their weaknesses, Mr. Perry said.

For example, how a company decides what is revenue should be clearly spelled out, he said. Some companies count bartered goods or services as revenue although no cash has been received, he noted.

Also, companies often receive revenue from customers that are unprofitable. This raises questions about whether the prospective policyholder's revenue can continue, Mr. Perry said.

The cash flow statement should also be carefully examined, he said.

In earnings press releases, a company may report its earnings on a pro forma basis. But by checking the SEC filings, insurers can learn the actual numbers, Mr. Perry said. Pro forma numbers "usually show a bigger gain or smaller loss than in SEC filings," he said.

It's also important to be skeptical of public statements made by company executives, said Jane Kornesczuk, senior vp of the executive liability division at Great American Insurance Cos. in Schaumburg, Ill.

"Any statements that sound like more hype than substance should be looked at with caution," she said.

She also noted that the management team should have experience in the company's particular field.

"A CEO in one industry can fail miserably in a different industry," Ms. Kornesczuk said.

John Semeraro of ARC Excess & Surplus L.L.C. in Mineola, N.Y., moderated the session. BI

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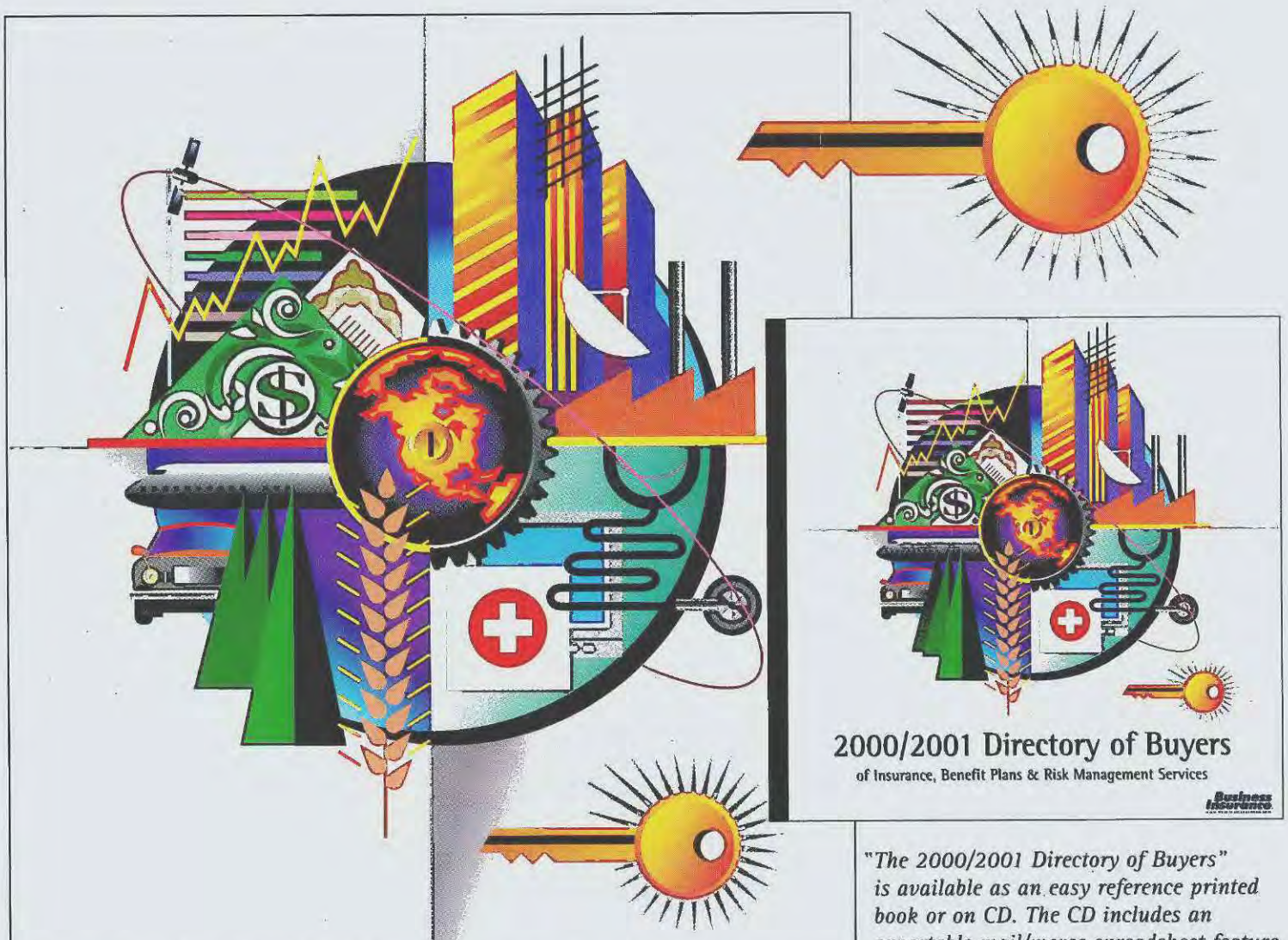

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Proposed changes to M&A accounting awaited

By JUDY GREENWALD

A recommendation to eliminate the pooling method of accounting for U.S. mergers and acquisitions and instead require purchase accounting is not likely to have a significant impact on the insurance industry if approved.

Until now, insurers and brokers have been able to use either method, though the tendency has been to use the pooling approach in large transactions.

But the Financial Accounting Standards Board, which issued the recommendation, also is suggesting that the treatment of goodwill under purchase accounting be modified to bring it closer to the approach that is used in pooling. This change is likely to satisfy insurers and brokers that prefer the pooling method's treatment of goodwill when accounting for mergers. FASB's recommendation on the treatment of goodwill was issued on Feb. 14 with a 30-day comment period.

Some observers contend, however, that the introduction of goodwill provisions for purchase accounting could create new complications, because the FASB recommendation would allow more discretion on a company's part than is permitted under existing rules pertaining to goodwill.

Pooling-of-interest deals are tax-free, all-stock transactions in which the balance sheets of the two merging companies are simply added together.

Under purchase accounting, the acquired company is considered an investment. As a result, any premium paid over the market value of its assets is treated on the balance sheet as goodwill, which typically is amortized, or written off on the company's income statement over a period of 40 years.

One advantage of pooling over purchase accounting has been that because goodwill is not written off over time, it does not create a potential hit to the buyer's balance sheet.

In a move that makes purchase accounting more like pooling, however, the Norwalk, Conn.-based FASB is proposing that goodwill be written only off if the asset's value has been "impaired."

"They've really done a compromise here that ends up being something that's fairly easy to live with," said Tom Bradley, senior vp of finance for The St. Paul Cos. Inc. in St. Paul, Minn.

In some ways, by revising the goodwill provisions for purchase accounting, the FASB recommendation "is better than pooling, because pooling was very restrictive in terms of the types of capital transactions you could do in order tc keep the pooling accounting, and those things aren't present with the purchase accounting rules," said Mr. Bradley.

'I think FASB has come up with an approach that seems of have addressed a lot of the concerns,' raised by the elimination of pooling, says Richard Gilli of Swiss Re New Markets.

"Fundamentally, it looks like they're providing a reasonable replacement for pooling of assets," said John Pottridge, of Alexandria, Va.-based Pottridge & Associates, which advises agents, brokers and banks on mergers and acquisitions.

"I see this as something very favorable to the industry. It's a great compromise," said Richard Grilli, associate director at Swiss Re New Markets in New York.

Goodwill amortization was the main issue in considering pooling vs. purchase accounting, "so I think FASB has come up with an approach that seems to have addressed a lot of the concerns," said Mr. Grilli.

FASB Chairman Edmund L. Jenkins said in a statement that the purchase method "reflects the underlying economics of business combinations by requiring that the current values of the assets and liabilities exchanged be reported to investors.

"Without the information that the purchase method provides, investors are left in the dark as to the real cost of one company buying another and, as a result, are unable to track future returns on the investment," he said.

When the proposed change in accounting was announced in 1999, it was expected to slow the pace of M&A activity in the industry. But, in general, expectations have changed.

"Deals get done because they make economic sense—they support a strategic objective and complement the growth strategy of the company," not because of a particular accounting method, said John Wicher, managing director of San Francisco-based Russell Miller Advisors Asia L.L.C., an insurance investment banking firm.

"Over the long term, it's going to have little effect on the overall desires of different business sectors to consolidate," said Kevin Donaghue, senior vp at Hartford, Conn.-based BMG Capitol Advisors Group. a consultant to brokers, agents and banks.

"I don't think there's going to be any impact at the end of the day. The companies that need to be acquired will find acquirers," said Michael Smith, an analyst with Bear, Stearns & Co. in New York.

Sean Mooney, chief economist for reinsurance intermediary Guy Carpenter & Co. in New York, said that on paper the change would reduce the attractiveness of merger or acquisition activity. However, he added, "Our sense is that the effect

See **Pooling** *on next page*

Pooling

Continued from previous page

is not strong enough to make a major difference in the motivations of companies to merge or not to merge."

But Michael A. Cohen, vp at Oldwick, N.J.-based A.M. Best Co., said he believes that the change would mean "acquisition targets will be a lot less desirable in a financial sense."

If the rule change is slated for approval in June, "you could see some extra M&A activity" in the months prior, he said.

Brokers' reactions to the recommendation vary.

Bernard H. Mizel, chairman and chief executive officer of San Francisco-based USI Insurance Services Corp., which uses purchase accounting in its acquisitions, said he welcomes the proposal.

"It makes companies like ours much more attractive," because such companies will no longer necessarily have to write off the goodwill on their books, he said.

Edward J. Bowler Jr., USI's vp-finance, said the proposal "puts companies that were pooling historically and companies that were historically purchasing on par with one another for the first time."

But J. Patrick Gallagher Jr., president and CEO of Itasca, Ill.-based Arthur J. Gallagher & Co., which has used the pooling method, is unhappy with the recommendation.

"I think we're a classic example of how pooling accounting, when used properly, is extremely effective, and I think you can look at our track record and see shareholders have not been misled, or deals overpriced."

Mr. Gallagher noted, though, that certain provisions of purchase accounting will give the brokerage more flexibility in arranging deals than it enjoyed under pooling.

Some observers are concerned with how companies may interpret the proposed goodwill provisions.

The FASB recommendation would give companies some discretion in deciding whether an asset is impaired and, therefore, whether its goodwill should be written off.

Previously, companies simply had to amortize their goodwill over a 40-year period, said Swiss Re's Mr. Grilli. "It was simple, it was clear, it was arbitrary. The impairment tests now probably will not be as crystal clear," he said. "Each company will adopt the way they test for impairment slightly differently."

BMG's Mr. Donaghue said it could be very difficult for a company to effectively judge whether goodwill will be impaired, "so there still exists a cloud of uncertainty as to how that could be properly managed."

John Modin, controller of Enterprise Reinsurance Holdings Corp. in New York, said: "Companies are going to have to be more careful when analyzing a potential acquisition. If a company overpays, an impairment charge will most likely result."

The recommendation "may discourage an acquisition that otherwise would be based on the underlying economics" because of concern about the impaired goodwill, Mr. Modin said.

"I think it would be in FASB's best interest to set out strict guidelines regarding the testing of impairment," said Beth Harper Briglia, knowledge manager for the financial services M&A practice at Arthur Andersen L.L.C. in New York. BI

M&A not affected by pricing

By SALLY ROBERTS

Firmer insurance pricing is unlikely to affect the degree of merger and acquisition activity among insurers and intermediaries in the near future, industry experts predict.

While the soft pricing environment limited the profitability of many in the insurance industry and contributed to a flurry of acquisitions throughout the 1990s, several other factors are likely to have a bigger impact on continued industry consolidation.

"I believe that consolidation (in the insurance industry) is an inexorable force that has been going on for 20 years," said Michael Allen, director of Strategic Decisions Group Inc., a Menlo Park, Calif.-based consulting firm. Within that 20-year span, "we've been through a number of insurance cycles," he said. "Is there going to be any more impact with this cycle than in previous cycles? I doubt it."

Paige Proctor of Paige Proctor Consulting Inc., an agency consulting firm based in Carlock, Ill., agreed. "So far, the change in the marketplace has not had any impact on the rate of consolidation that has been going on, and I'm beginning to think that it probably won't have much impact as the market continues to firm up," he said.

Mr. Proctor pointed out that, because insurers continue to want sizable premium volume from agencies they have under contract, consolidation among agencies will continue regardless of the changing pricing environment.

"So much is driven by premium volume that there doesn't seem to be any other factor" significantly affecting consolidation activity, Mr. Proctor said.

Insurer consolidation "will continue regardless of premium rates," concurred Barbara D. Stewart, president of Stewart Economics Inc., an insur-

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Continued from page 12B

ance consulting firm in Atlanta. Consolidation is driven by many factors; not the least is the shrinking of the insurance-buying market, she said.

"It doesn't matter if premiums are going up; there is less and less business out there," Ms. Stewart said. The only ways companies can grow are through mergers and acquisitions and exploring new markets and products, she said.

Others say the firming will have little impact on consolidation because it will be short-lived.

"I think it would be pretty unlikely that companies make a decision on the perception of a short-term change in the marketplace," said Rodger Lawson, president of the Alliance of American Insurers in Downers Grove, Ill.

Timothy J. Cunningham, a principal with INSIGHT Management Consultants in Chicago, said that those agencies that are less driven to sell their firms due to an "inflated sense of worth" have a "false sense of hope."

The market is firming, not hardening, and the trend will not last long, Mr. Cunningham said.

But at least one insurance expert says firming could trigger more mergers and acquisitions in the industry.

"The return on investment in the property/casualty insurance sector has not been significant enough to make property/casualty insurance firms enticing targets...to those outside the insurance sector," said Terry Tyrpin, senior vp for the National Assn. of Independent Insurers in Des Plaines, Ill.

The firming pricing environment may help change that, though, Mr. Tyrpin said. And passage last year of the Gramm-Leach-Bliley Financial Services Modernization Act could provide a foundation for more merger and acquisition activity, as financial conglomerates look to property/casualty insurers as an opportunity, he said. BI

A prediction you can take to the bank

More agency purchases by banks seen

By PETER VAN AARTRIJK JR.

A/BT PERSPECTIVE

Driven by fear, anxiety, greed and "me too" competitive pressures, banks and property/ casualty independent agencies are marrying up at a feverish pace that isn't expected to let up in 2001.

And the hardening market could bring even more deals, as the potential value of agency revenue increases.

"The amount of activity coming this year will dwarf that of prior years," said John Wepler, senior vp-mergers and acquisitions for consultant Marsh, Berry & Co. in Concord, Ohio.

The implications of the buying spree for the independent agency system are profound:

- Banks and agencies will be merging faster than agencies will be combining with other agencies.
- Agents will be part of larger conglomerates but will retain their autonomy instead of rolling up their business into brokerages.
- Larger agents will have deeper pockets to help them grow, which could put more pressure on small and midsized agencies.
- Insurance companies eventually could be affected by the increased leverage that bank-owned agencies will bring to bear.

For banks, agencies seem to be a smart fit. Banks lack the service platform and sales and product expertise for commercial property/casualty, surety, bonding, and group life and health. And because three-fourths of their customers prove unprofitable or marginally profitable, banks surely are driven by the need to diversify their income streams beyond interest income. Changes in accounting for intangibles in acquisitions also will drive more bank interest in insurance agencies.

As pressure mounts on banks to build "wallet share" of higher net-worth business owners, the banks are obsessed with snapping up the consultative selling style of peak-performing insurance agencies and the problem-solving relationships the agencies have with the entrepreneurial owners of middle-market commercial businesses.

But because most of the potential of bank-agency mergers has yet to be realized, banks are choosing their targets more carefully these days. The most-attractive market will be the midsized-to-large commercial property/casualty agents that also round out their nonlife accounts with group life/health products.

"When you get into personal lines and small commercial and individual life/health, that's where you broaden the scope of distribution options. And in some areas, banks will find other ways," said Bobby Reagan, president and chief executive officer of Atlanta-based Reagan Consulting, which tracks merger activity. While there have

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Banks

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been nearly 200 transactions in the last four years—and 75 predicted for this year alone—only 1% of U.S. banks has been involved in mergers, he said.

Larger agencies are more attractive, as banks are looking to establish a "high-quality foundation agency," said Mr. Wepler of Marsh, Berry. More than 40 of the top 100 independent agencies will be owned by banks by 2002, he predicted.

"Most banks have failed in insurance," Mr. Wepler said. "Those that have succeeded have taken a very specific strategy to look at market territories they want to enter and find the highest-quality commercial broker in the area that has the people, the infrastructure, the technology, the growth, wants to stay independent and has no compelling interest to sell."

Large regional banks, in particular, have been very active in buying agencies. The largest 5% of banks have completed 75% of deals, Mr. Reagan noted.

And larger community bankers—those with $500 million to $10 billion in assets—have been getting out the checkbook lately, looking for local beachheads for insurance operations, Mr. Reagan said. "A larger community bank will be doing business in a tight geographic area—such as a city, county or larger part of a state—which, from an insurance standpoint, is more appealing. Because an acquisition can match up much better with that footprint, as opposed to a large financial institution that has a lot more marketing territory to cover."

For independent agents and brokers in certain parts of the country that haven't seen any action yet, stay tuned.

"You see a lot (of mergers) in the Southeast and Northeast," said Tim Cunningham, a principal with Kansas City, Mo.-based consultant IMCG. "Frankly, I think a lot of it is a 'me too' mentality."

Texas is shaping up as a hotbed of activity, Mr. Wepler said. That's because, in part, banks want to position themselves for an insurance border strategy to drive south in the wake of the North American Free Trade Agreement. Meanwhile, there also could be more consolidation in Chicago and Denver and on the West Coast.

"California has advanced from a simmer to a boil," said Mr. Wepler, noting some major deals will hit the streets by mid- to late 2001.

Bank acquisitions of agencies have worked better than strategic alliances, some argue.

"Joint ventures are, typically, the chosen route when neither party is truly committed," Mr. Wepler said. "They are more focused on their entity independent of the joint venture. The only way the cross-referral process will work is if it is the core strategy of both operations. And a bank will never drive cross-selling as a core strategy."

But some banks do view strategic alliances as viable, according to Anita Gentle Newcomb, president and managing director of Washington-based A.G. Newcomb & Co. and author of a recent study, "Winning Strategies in Retail Sales Delivery: Cross-Selling Investment and Insurance Products with Traditional Bank Offerings."

Because banks lack a strong sales culture, Ms. Newcomb said, they're "often better off entering into the insurance business through a joint venture with a local agency. Under a joint-venture arrangement, the bank can learn about insurance, cross-selling and working with insurance agents while building equity and value. There is minimal financial outlay in terms of cash, employees and brick and mortar, and less risk."

One thing that hasn't changed in regard to bank-agency mergers is the problem of culture shock. After a merger, agents often lose autonomy and must work in a bureaucratic environment that in many cases lacks a sales mentality.

"A bank can just kill an agency if they try to implement a bank culture," Mr. Reagan said. "At the same time, the agency must realize they can't just conduct business as usual; banks are one of the most regulated industries around. They have to work effectively with the bank. Banks bring a financial discipline, in terms of business planning, organizational planning, (human resources) planning."

Banks are still learning how to be realistic about growth after an acquisition, Mr. Reagan said. "We have seen some naiveté about levels of (cross-selling) penetration, how quickly things can take place, and it's very important for bank and agency management to be strategic about what they try to do together," he said.

A lot of deals don't deliver intended results, IMCG's Mr. Cunningham said. "If it's an exit for the seller, they begin to check out mentally before they check out physically. And it's very acute for the bank, because they don't have the expertise. In many cases, they're not buying the very, very best agencies in their area. The reality is, the really good firms don't need to sell out."

Turning down a bank's offer could be tough, though. Banks, by and large, continue to pay full price—or to overpay—for acquisitions.

"Some agents have made out like bandits, especially if they have nobody else to perpetuate the firm," Mr. Cunningham said.

"If I'm an agent," he said, "I'll take the money and run." BI

Peter van Aartrijk is managing director of The van Aartrijk Group L.L.C., a Springfield, Va.-based branding firm specializing in insurance and financial services.

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PERSPECTIVES

Federal guidance needed in genetics debate

Court rulings, patchwork of state laws serve to muddle testing issues

By Steven D. Baderian and Joanne Seltzer

Employers, benefit managers and insurers writing employment practices liability coverage should anticipate a new area of potential employment claims: genetic discrimination.

Increasingly, the courts, as well as some state legislatures, are acknowledging that employees and their dependents may have rights to privacy and other legal claims arising from the use of genetic data to evaluate fitness for employment and insurability.

On June 27, 2000, newspapers across the country heralded a long-awaited milestone—the deciphering of the human genome, the elusive double helix of DNA molecules that predetermines a large part of an individual's physical and mental destiny. Unlocking the elusive genetic code almost five years in advance of its original goal of 2005 has caught employers and insurers unprepared for the potential legal and ethical problems that will arise once access to an employee's genetic information becomes a possibility. Although a number of states have enacted conflicting statutes preventing access by employers and insurance companies to a person's genetic information, the federal government has not yet enacted legislation that would guide employers and insurers in the ethical and legal use of genetic information.

Although genetic tests are still not used by the insurance industry in the United States, it would be naive to assume this trend will continue once genetic testing becomes both cost-effective and widely available. Considering the fact that insurers already base policymaking decisions on more basic genetic information, such as family history and diagnostic tests performed previously on the applicant as part of medical care, the use of actual genetic data to make insurance decisions is only to be expected.

Although genetic tests are still not used by the insurance industry in the United States, it would be naive to assume this trend will continue once genetic testing becomes cost-effective.

The Human Genome Project, the contribution of the United States to the international venture to sequence and map the entire human genome, has been estimated to cost $3 billion over the 15 years from its inception in 1990 to its prospective completion in 2005. The overriding goal of the project is the identification of the estimated 80,000 genes in human DNA and the determination of the sequences of the 3 billion chemical bases that comprise DNA. Although much of the human genome remains to be sequenced, a number of genetic tests are becoming available not only for single-gene diseases such as cystic fibrosis and Huntington's disease, but also for multifactorial diseases such as cancer and heart disease. To date, commercial tests are available for the detection of mutations in approximately 15 genes, resulting in about 450 disorders, including breast and colon cancer, Alzheimer's disease, Parkinson's disease, glaucoma and Fragile X Syndrome.

The Health Management Act of 1973 forever changed the landscape of insurance by marking the beginning of the era of managed care. The goal of the new for-profit, market-driven managed care organizations is to control costs through improved efficiency and coordination. Significantly, managed care has effectively shifted the locus of control of medical practice from physicians to financial managers, with a resulting emphasis on cost rather than care.

It is well documented that some managed care organizations use discriminatory practices, such as "cream skimming" and "cherry picking," whereby they insure only the healthiest individuals, to control costs and maintain their market position. Clearly, to make a healthy yearly profit from the sale of policies, an insurance company must target the majority of its plans to individuals who have a lower probability of getting sick. Based on the profitability mandate of the managed care organizations, access to genetic information would provide a scientifically justifiable way with which to identify and exclude individuals who seemingly have a higher probability of contracting costly illness. In the absence of laws requiring community rating and prohibiting discrimination on the basis of genetic information, it would be ludicrous to expect an institution dependent on risk prediction for its survival not to act in its best interests in the collection and use of an individual's genetic information.

In addition to the transformation of the medical insurance industry, the rapid progress in the sharing of patient information among physicians, hospitals, payers, employers and other related health care agencies, will significantly contribute to the stigmatization of individuals who possess detrimental genetic traits. The use of networked computers and relational databases has become a common and permanent feature of the medical care landscape. Information about our individual future health care costs is available to both medical personnel and managers/policymakers in the health care system that have cost-saving as their primary imperative. This sharing of information would be particularly damaging to individuals with a genetic predisposition to disease.

To further add to the potential for widespread dissemination of personal genetic information, the physician—once the stalwart protector of an individual's medical information—has often been forced into a position of "double agency." Torn between the ethical mandates of a patient's right to confidentiality and the cost-saving mandates of a managed care organization—which is often the physician's employer—the physician's role as protector of a patient's medical information could be quickly eroded.

Confronted with the potential legal and ethical dilemmas of the use of genetic information, employers and insurers have, justifiably, looked to legislatures for guidance in using the newfound knowledge of genetic discoveries.

To keep pace with the rapid advancements of biotechnology, and in the absence of federal response, state legislatures saw an explosion of bills addressing genetic privacy in the insurance and employment contexts. According to the National Conference of State Legislatures, more than half of the states passed legislation prohibiting the discriminatory use of genetic information by insurance companies. The common goals of the state initiatives are to limit the ability of insurers to use genetic information to deny coverage, raise rates or reduce benefits; and to protect the privacy of the genetic information of both individuals and family members. Although the goals are laudable, state legislatures have exhibited varying levels of success in achieving them, and they offer varying and often conflicting guidance to insurers. This poses a particular dilemma for larger insurers that operate in more than one state and that will be forced to juggle diverse and often conflicting mandates from different state legislatures.

An examination of the legislation of even progressive states such as New Jersey, Wisconsin and Oregon highlights the problems that must be resolved in order to offer comprehensive guidance to insurers and protections to individuals. Simply put, most state laws are too narrow to offer the broad protection necessary to prevent discrimination.

For example, many state laws exclude a number of classifications from protection. Private, self-funded insurance plans are usually exempt from state insurance laws pursuant to the Employee Retirement Income Security Act, leaving nearly half of all Americans, including the majority of people who are not on Medicare or Medicaid, uncovered. Moreover, a number of state laws offer no protections for family members of the individual tested, and still others limit their protections to specific types of insurance, such as life or accident insurance.

A lack of uniformity in states that have enacted legislation on genetic testing, and the total absence of legislation in approximately half the states, points to a need for federal action.

This lack of uniformity in states that have enacted legislation, and the total absence of legislation in approximately half the states, points to a need for federal action to provide guidance to insurers. The federal government, however, has been less than responsive to the challenges posed by access to genetic data.

Currently, the main protection against the misuse of genetic information in the health insurance industry is the Health Insurance Portability and Accountability Act of 1996, better known as HIPAA. Significantly, HIPAA allows group health insurance companies to impose a pre-existing condition exclusion only when the exclusion relates to a condition for which advance treatment, diagnosis or care was rendered, and the exclusion must last less than one year. HIPAA also expressly provides that the presence of an adverse genetic marker is not to be considered a pre-existing condition without the actual manifestation of the condition that the genetic test identifies.

HIPAA's protections, however, do not extend to uninsured individuals who apply for individual coverage or who fail to continue coverage through COBRA provisions. Moreover, the act also does not prevent insurance companies from charging higher premiums to an entire group on the basis of the genetic information of individual members, thereby encouraging employers to discriminate against individuals to gain lower insurance rates. These limitations in HIPAA's protections have spurred Congress to introduce a large number of bills addressing genetic discrimination in employment and insurance, none of which has yet been enacted into law.

The latest entry into the federal race to legislate protection of genetic information is the Genetic Nondiscrimination in Health Insurance and Employment Act. This Senate bill and its House counterpart purport to amend ERISA and the Public Health Service Act to prohibit health insurance discrimination on the basis of predictive genetic information.

Initially, the bill would restrict its purview to group health plans or health insurance issuers that offer group health plan coverage, thereby excluding from its protections persons seeking individual coverage. Secondly, although the bill would limit the ability of a health plan or health insurance issuer to request an individual or a family member of an individual to undergo a genetic test as a condition of eligibility, it would not impose similar limitations on health care

See **Genetics** *on next page*

Testing

Continued from previous page
Science and Technology Committee have been listening to testimony from insurers, reviewing the findings of the Genetics and Insurance Committee and reading public comments. The House of Commons panel expects to publish its findings by the end of this month.

During the committee hearings, Mike Urmston, chief actuary for Norwich Union Life Insurance Society, the York, England-based life insurance division of CGNU P.L.C., told members of Parliament that NU's underwriters have been asking to see the results of genetic tests voluntarily taken by insurance applicants for all of the seven diseases originally identified by the ABI.

A spokesman for London-based CGNU—one of the United Kingdom's largest life and property/casualty insurance companies—stressed that it has not asked applicants to undergo any of the tests as a condition of obtaining coverage.

"The Norwich Union, along with other member companies of the ABI, has been following the ABI code on genetic testing. If someone applies to us for life insurance and has a family history of any of the seven diseases, we ask them to show us the results of any genetic tests they have had for the diseases. We do not ask for a test to be carried out," the spokesman said.

Following the decision by the ABI to withdraw its requests for approval for some of the tests, NU now will ask only for the results of tests for Huntington's disease, breast and ovarian cancers and Alzheimer's, the spokesman said. The insurer also will "re-underwrite any policies that have been adversely affected" by underwriters' access to test results for the four diseases for which test approval was withdrawn, the spokesman said. Only 30 policies fell into this category, and only three were subject to higher rates due to the test results, the spokesman said.

While the potential use of genetic testing by insurers is generating controversy, insurers already commonly ask applicants to disclose knowledge of hereditary illnesses, such as heart disease or cancer, or asking whether an applicant has tested positive for the presence of certain life-threatening diseases, such as the human immunodeficiency virus that causes AIDS.

Meanwhile, a new survey commissioned by the Human Genetics Commission indicates considerable public concern about the use of genetic information by insurers and employers.

Of 1,038 individuals surveyed between Oct. 6 and Dec. 17, 2000, four out of five believe that information from genetic testing should not be used to set insurance rates. While 70% of the respondents said they think it is inappropriate for an employer to see the results of a test for a employee or potential employee, a majority said it might be appropriate if the test indicates that the individual may be sensitive to certain substances he or she may come into contact with on the job.

The poll is part of the government's attempt to seek comments on genetic testing following the publication last November of a discussion document, "Whose Hands on Our Genes?" The comment period, which had been scheduled to end Feb. 28, was extended to March 23.

The Consumers' Assn., a London-based consumer advocacy group, also supports public participation in resolving the controversy. "A full, public debate needs to happen before genetic insurance becomes widespread," says a recent statement issued by the group.

"Our main concerns are that a 'genetic underclass' could be created if the potential for disease is identified in the genes of part of the population and they find it too difficult or expensive to get insurance. Insurers carrying out genetic testing could also mean people are less likely to take tests which could benefit their health," the statement said. BI

Outbreak

Continued from previous page
stem from the virus' highly contagious nature. Although it affects only cloven-hoofed animals, such as cattle, sheep and pigs, the disease can be carried by other animals and humans, and even by the wind. As a result, certain sporting events likely to draw spectators from other countries have been canceled or postponed to stop the spread of the virus. Cattle-hauling companies also are losing business due to a ban on the movement of cattle, and in some farming communities, schools have even been closed.

Grocers and butchers also are concerned about the increasing scarcity of meat supplies, particularly because the suspected spread of the disease to Northern Ireland has dashed their hopes of importing from that area.

The fatality rate of the disease, which causes blisters on the mouth and feet and can lead to lameness and reduced milk output, varies considerably among different animals. Although people can aid in transmission, foot-and-mouth disease is thought to be largely harmless to humans.

Most farmers whose herds have been affected by the disease are unlikely to have insurance coverage for losses, insurers say.

Stratford-upon-Avon-based National Farmers Union Mutual Insurance Society Ltd., the country's main livestock insurer, which insures 80,000 livestock farms, says that only about 10% to 20% of these farms have coverage specifically for foot-and-mouth disease. Standard farm business interruption policies, which generally are linked to property exposures, do not cover losses related to livestock, an NFU spokesman noted.

He said that, based on the 18 foot-and-mouth cases confirmed as of Wednesday, payouts by NFU Mutual likely would not be significant. If the outbreak were prolonged, however, claims could reach "several million pounds," he said. As of last Thursday, there were 28 confirmed cases in England and Wales, two suspected cases in Scotland and one suspected case in Northern Ireland. Fears of the disease spreading to Continental Europe grew last week after U.K. animals exported to Germany were found to have antibodies to the disease.

A spokeswoman for Lloyd's of London, where a few syndicates write foot-and-mouth insurance, confirmed only about 10% to 20% of U.K. livestock farmers have the coverage.

Chris Smith, head of agribusiness for loss adjuster Crawford & Co. in London, who has been watching the crisis, said, "we believe that few farmers will be insured for this outbreak, as many are facing near bankruptcy in the aftermath of BSE (bovine spongiform encephalopathy), swine fever and tuberculosis," referring to other diseases that have plagued livestock in recent years.

The NFU Mutual spokesman said that interest in the coverage has steadily declined over the past 20 years, since the last serious outbreak of the disease in Britain. He attributes the reduced interest to the declining incidence of the disease and the fact that the government compensates farmers for the full market value of animals destroyed because of foot-and-mouth. He also said that the financial woes of farmers in the wake of the ongoing cattle crisis involving BSE—commonly known as mad-cow disease—and swine fever had shifted farmers' attention away from foot-and-mouth disease and hindered them from buying additional insurance.

'Few farmers will be insured for this outbreak' in the aftermath of BSE, says Crawford's Chris Smith.

Standard & Poor's Corp. said that even if the current outbreak of the disease were to reach the scale of the last major epidemic, which occurred in 1967, "it is unlikely to have a big impact on the financial strength of most insurers."

Rowena Potter, managing director of S&P's financial services group, said, "the extent of insurers' liability will, for the most part, be limited to business interruption claims."

Ms. Potter also points out that with the decline in demand for cattle insurance—for the same reasons noted by the NFU Mutual spokesman—many insurers that covered livestock in the past have found it necessary to diversify. Such companies, notably Equine & Livestock Co. Ltd., which now writes livestock business only on specialist breeds, are unlikely to be significantly affected by even a prolonged outbreak, she said.

A Lloyd's spokeswoman said the main impact for insurers will likely be business interruption and contingency claims from parties other than livestock farmers. She added, however, that few of the affected businesses are likely to have business interruption coverage, which many such businesses view as unnecessary.

Most contingency claims, she said, will likely come from organizers of horse racing and sporting events. For example, the U.K. government has imposed a seven-day suspension on horse racing in the country starting last Wednesday.

However, because many of the events will be postponed rather than canceled, insurers will be liable for only rearrangement costs, the Lloyd's spokeswoman noted.

The Road Haulage Assn. said that few cattle hauling companies, which are losing about £4 million ($5.8 million) per week from the ban on cattle movement, are covered for foot-and-mouth incidents. That ban, initially imposed for one week, has now been extended for two more weeks and will expire March 16.

Meanwhile, the U.K. government will consider recommendations from a working party on the effects of cattle diseases, including a proposal that it require farmers to insure against animal disease. The Working Party to Review the Commercial Impact of Animal Disease, which was set up after last year's outbreak of swine fever, is due to publish its report this month.

As the crisis worsens, farmers are turning to the government for aid.

The main compensation to farmers will come from U.K. government and European Union funds. The government has agreed to pay 100% compensation for animals slaughtered in the attempt to eradicate food-and-mouth disease. In addition, it will compensate farmers who incur other costs stemming from the ban on livestock movement, which it initially refused to do.

Prime Minister Tony Blair last week unveiled a £168 million aid program for farmers after calling the outbreak and the destruction so far of over 12,000 animals "the worst nightmare for the livestock farmers." The "agri-monetary" compensation, 80% from the U.K. government and 20% from the European Union, is the maximum permitted under the E.U. agri-monetary program.

The aid package will help compensate livestock farmers for losses as a result of not being able to send animals to market and for the loss of overseas sales after most other countries banned U.K. cattle and meat imports. According to Meat and Livestock Commission figures, the total value of U.K. meat and livestock trade is around £8 million ($11.6 million) per week.

Already the problem has affected Continental Europe. France and Germany have begun destroying livestock imported from Britain, while Belgium has closed its cattle markets and banned the movement of livestock, and the Netherlands is banning a long list of British food products.

The key issue now in the foot-and-mouth crisis is whether measures taken to curb the spread of the outbreak will bring a swift end to the crisis, or whether it will reach proportions of the 1967 epidemic, in which more than 2,000 farms were affected. In that outbreak, however, foot-and-mouth cases were restricted to Northern and west-central England. In the current crisis, however, because of the much-greater movement today of animals between farms and to distant markets, cases have been reported over a much wider area. BI

Train

Continued from previous page
coal. The freight train is owned by Freightliner Ltd.

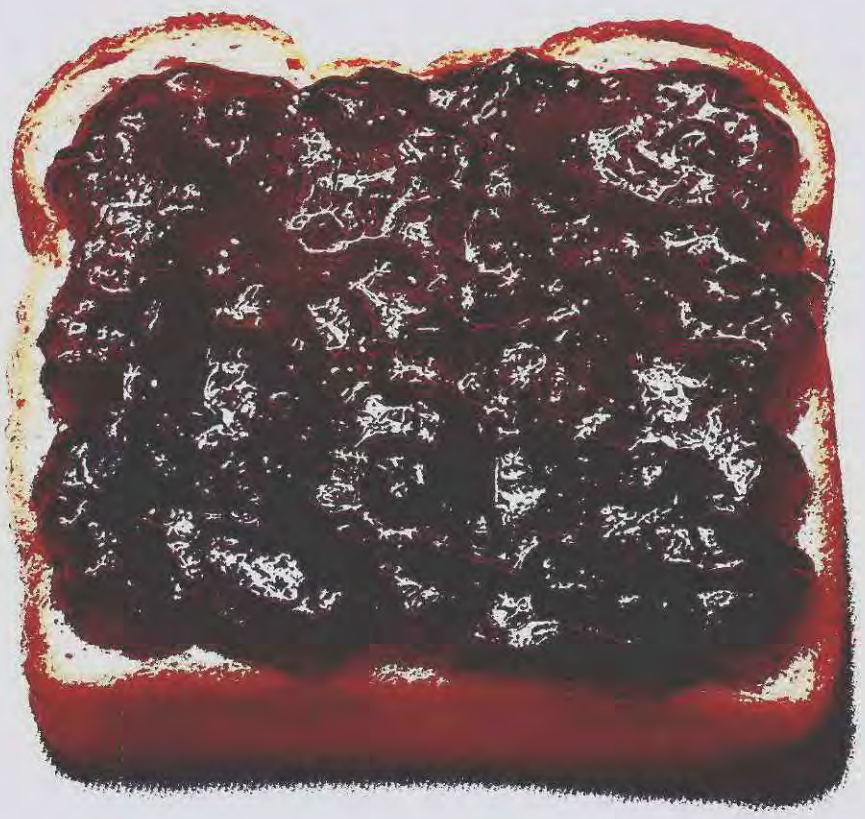
The derailment occurred near the Yorkshire village of Great Heck, about 150 miles north of London.

In its statement, Railtrack said is unable to confirm exactly the sequence of events, but that the incident "triggered a catastrophic combination of events, which the railway industry was powerless to prevent."

Private passenger rail operating companies are required to have liability coverage of at least £155 million ($223.9 million).

The last four months since the Oct. 14, 2000, rail crash at Hatfield, just north of London, have been devastating for Britain's privatized rail industry. The Hatfield crash, which investigators concluded was caused by a broken rail, prompted Railtrack to conduct a major overhaul of its track network and to set aside about £150 million ($218.0 million) to compensate the 27 train operators for disruptions to service (*BI*, Nov. 20, 2000).

The British Transport Police and the Health and Safety Executive are considering corporate manslaughter charges against senior Railtrack executives (*BI*, Jan. 29). BI



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IPO

Continued from page 1

needed for alliances or joint ventures Hewitt might pursue with other firms.

Hewitt's consideration of an IPO—an evaluation that began about a year ago—comes amid growth unmatched by its major competitors. Over the last decade, the benefit consulting revenues for Lincolnshire, Ill.-based Hewitt have increased more than fourfold, rising from slightly more than $250 million in 1990 to just over $1.1 billion last year.

Hewitt is now the world's second-largest benefit consultant, according to *Business Insurance*'s annual ranking—compared with its No. 4 ranking in 1990. For the past several years, Hewitt has been the largest consultant based on U.S. revenues. Its workforce, which numbered about 3,000 a decade ago, now exceeds 12,000.

Unlike most of its competitors, whose growth has been fueled at least in part through acquisitions, Hewitt's growth has largely been organic. One exception was its acquisition—announced last year—of Bacon & Woodrow, a U.K.-based benefit and actuarial consultant with a little over $100 million in revenues.

Observers say part of Hewitt's success has been its ability to attract and retain top talent and to spot trends, such as the growth of flexible benefit plans, as well as its development of resources to meet employer needs.

Hewitt has been well positioned to meet the most recent trend—employer interest in outsourcing administration to third parties. For years, Hewitt has made significant investments in the technology needed to support its outsourcing operations, such as its call centers.

"They have invested in technology at the right time," Mr. Bleau said.

And, most recently, Hewitt has taken its outsourcing services to another level. Last year, it launched Sageo, an e-commerce service that provides the complete administration of health plans. Among other things, Sageo allows the employees and retirees of clients to use the Internet to compare and enroll in health plans.

While profitable, the technology needed to develop and improve outsourcing is, as Mr. Bleau puts it, "hugely expensive." As a privately held firm—ownership is held by an undisclosed number of employees—Hewitt doesn't have the option of raising funds through the public sales of stock.

If Hewitt does launch an IPO, it would be the second major benefit consultant to do so. Last year, Watson Wyatt & Co. and its employees raised just over $80 million through the sale of 6.4 million shares of stock; roughly half the shares were sold by the company and half by its employees.

Watson Wyatt President and Chief Executive Officer John C. Haley said one reason for his company's IPO was to make funds available if an attractive acquisition should present itself.

One beneficial side-effect of the IPO, Mr. Haley said, has been a significant boost in the profile of the Washington-based benefit consultant.

Purchasing Watson Wyatt shares also has been a good investment. The corporation's shares, listed on the New York Stock Exchange, now are just under $20, down from a high of $24.50 but up significantly from the opening-day price of $14.

Still, going public isn't for every organization, Mr. Haley said. He noted that public ownership necessitates the disclosure of detailed financial information. With the exception of Watson Wyatt, major benefit consultants either are privately held or are part of larger firms and, consequently, don't have to disclose such information as profits.

But public disclosure was not an issue for Watson Wyatt, which had been filing financial reports with the Securities and Exchange Commission prior to its IPO. Watson Wyatt officials believed the firm had an obligation to do so because ownership was so widely held by employees. BI

Standard

Continued from page 2

gonomics-related injuries that would be more generous than that generally available under state workers compensation systems. The benefit, which would compensate workers with ergonomics-related injuries at 90% of pay for up to six months, would encourage all injuries to become ergonomics-related, he said.

"We're going to try and make an effort to stop this regulation," he said. The Senate will attempt to pass legislation under the Congressional Review Act of 1996, which allows federal regulations with an annual impact of more than $100 million to be reviewed and rescinded by simple majorities in both houses of Congress, provided that the president doesn't exercise the veto, he said.

The CRA has never been used to overturn a regulation before.

Sen. Nickles called the ergonomics rule "an unbelievable power grab by the Clinton administration."

He said that during negotiations with the White House before the rule was published in the Nov. 14, 2000, Federal Register, opponents of the regulation were told "if you don't like it, use the CRA." The CRA is "now our only congressional recourse," he said, predicting that both the Senate and House would vote to rescind the rule.

"We're going to kill the regulation. If not, you're going to be in court for a long, long time and spend lots of money, and hopefully you'll win," he told the employer representatives.

Employer and insurer groups, including the Risk & Insurance Management Society Inc., are seeking federal court review of the standard. Employers have long opposed the idea of what they consider a "one-size fits all" standard.

By invoking the CRAm 'We're going to try and make an effort to stop this regulation,' says Sen. Don Nickles, R-Okla.

They claim the OSHA standard lacks adequate scientific justification, will be overly expensive to implement and will illegally encroach on state workers compensation systems.

Organized labor has long supported the idea of a federal ergonomics standard, saying it is needed to prevent hundreds of thousands of injuries per year. BI

Pollution

Continued from page 2

ment.

But insurance industry attorney Laura Foggan said interest in the case has been generated by policyholder attorneys, who have mined for clients to help in their attempt "to dislodge settled case law" on the exclusion in Pennsylvania. Ms. Foggan, a partner with Wiley Rein & Fielding in Washington, filed an amicus brief for the Insurance Environmental Litigation Assn. in the case.

Mr. Ellison said a pro-policyholder ruling could help win over supreme courts in states where those courts have not settled the issue and lower courts have sided with insurers.

But Ms. Foggan said the Pennsylvania Supreme Court's eventual ruling probably would have little impact outside the state, because many states have resolved the issue already.

Policyholder attorneys say insurance buyers hold a 20-18 edge in state supreme court rulings on the sudden and accidental pollution exclusion. But insurer attorneys, saying that fewer courts have ruled pointedly on the exclusion's meaning, claim at least a 16-13 advantage.

In the Pennsylvania case, Sunbeam is suing several insurers for tens of millions of dollars to cover its cost of cleaning 11 polluted sites nationwide.

The insurers have refused to defend and indemnify Sunbeam, arguing that Sunbeam's predecessor companies generated the pollution during routine business operations. The sudden and accidental pollution exclusion in 1970 and later general liability policies bar coverage for such gradual pollution losses, the insurers argue.

A trial court, an appellate court panel and the state's full appellate court ruled for the insurers between May 1997 and November 1999.

In briefs filed with the Pennsylvania Supreme Court, Sunbeam and other policyholders cite various dictionaries that list "unexpected" as the primary definition of "sudden." That means the exclusion does not bar coverage for gradual pollution losses as long as they were unexpected and unintended, the briefs maintain.

Sunbeam and the other policyholders note that those reference materials list "abrupt" as a secondary definition and that courts nationwide disagree over the primary meaning of "sudden." Because the word is subject to more than one reasonable interpretation, it is ambiguous, they argue. State law requires courts to construe ambiguous terms in favor of policyholders, they note.

The IELA argues, however, that most words have multiple meanings, but "that fact alone does not make them ambiguous."

The IELA also suggests that courts would lose their power and obligation to independently interpret contracts if conflicting rulings automatically rendered a term ambiguous.

Sunbeam argues that even if the high court determines that "sudden" means abrupt, the lower courts in this case erred by not reviewing evidence that the insurance industry has modified the word's meaning through usage.

In standard boiler and machinery liability policies written before 1970, the insurance industry used the term "sudden and accidental" in coverage descriptions, the Sunbeam brief notes. Many courts and authoritative treatises agreed that those policies covered damage that occurred gradually as well as abruptly, the brief points out.

Sunbeam is suing several insurers for tens of millions of dollars to cover its cost of cleaning 11 polluted sites nationwide.

But Liberty Mutual and the IELA argue that the Supreme Court should not look beyond the pollution exclusion's language, because it clearly means coverage is intended only for abrupt occurrences. Even if the court considers such extrinsic evidence, there is no proof that the insurance industry interpreted and used the term "sudden and accidental" in a universal manner, Liberty Mutual argues.

Citing a 1993 Florida Supreme Court decision, Liberty Mutual argues that the boiler and machinery policy covered damage that occurred gradually. The pollution exclusion, however, refers to an event that causes pollution—not the damage itself, the insurer maintains.

A brief explanation of the exclusion that insurers submitted to insurance regulators in Pennsylvania and other states in 1970 notes that the exclusion was designed to clarify that general liability insurance policies do not cover damages that were expected or intended.

The explanation further states that pollution coverage is available when the damage results from an accident. The explanation does not define "accident," and policyholders and insurers disagree over whether that word includes a temporal element.

The exclusion's explanation is a vital piece of Sunbeam's regulatory estoppel argument, which contends that the court should hold insurers to the alleged coverage promises they made to regulators in 1970, regardless of how the court might define "sudden."

Indeed, much of the focus of policyholders' and insurers' briefs is on how the Pennsylvania Supreme Court should treat that argument.

Policyholders have had some limited success with that argument in other jurisdictions. Besides the New Jersey and Rhode Island high courts, the West Virginia Supreme Court in 1992 found that insurers won regulatory approval of the exclusion by promising it would not bar coverage for unexpected gradual losses.

In policyholders' favor in Pennsylvania, the state Supreme Court throughout the 20th century and as late as last year has barred litigants in various types of cases from taking positions that were inconsistent with those they argued in administrative and other non-judicial proceedings, according to Sunbeam's brief.

Liberty Mutual contends that Sunbeam's regulatory estoppel argument is another effort "to avoid the plain meaning of the exclusion" and has been "universally" rejected outside of New Jersey. Unlike the West Virginia and Rhode Island supreme courts, the New Jersey court found that "sudden" meant abrupt and then ruled insurers had to cover gradual pollution losses because they told regulators the exclusion would not bar coverage for such losses.

In 1999, the Pennsylvania Supreme Court refused to consider the drafting and regulatory history of the absolute pollution exclusion, the insurers' briefs note. The court ruled that considering such evidence would violate state law, because the exclusion clearly barred coverage for any type of pollution loss (*BI*, July 30, 1999).

Adopting the argument also would usurp the authority of the Pennsylvania Insurance Department, which could have voided the exclusion any time over the past 30 years if regulators had determined that insurers had misrepresented the exclusion's impact on coverage, Liberty Mutual and the IELA argue.

•

Sunbeam Corp. et al. vs. Liberty Mutual Insurance Co. et al., No. 0032 W.D. Appeal Docket 2000; Pennsylvania Supreme Court.

FRM

Continued from page 3

designation and therefore, without belonging to the institute. "The pricing structure will be different," Mr. Phillipus said, but he noted that individuals "not moving toward the FRM" will have the opportunity to participate in the classes as a way to broaden their risk management expertise.

In addition to the requirements for industry experience and completion of the workshops, others call for establishing a "risk management foundation" and a "business foundation."

Three college-level risk management courses are needed to establish a risk management foundation—one course each in risk management, risk control and risk financing. The Associate in Risk Management and Canadian Risk Management designations fulfill that requirement but are no longer prerequisites for the awarding of the designation as they were under the old FRM requirements. Credit earned in undergraduate and graduate courses also fulfills the requirement.

A business foundation is based on four college-level courses that help candidates understand risks in a variety of areas. Courses in accounting and finance are required; two other courses can be chosen from among business, economics, managing information security, law, marketing and management classes.

The business foundation requirement can be met if the candidate has earned an undergraduate or graduate business or management degree. The Chartered Property Casualty Underwriter and other professional designations also fulfill the requirement. The previous structure required four specific business courses.

The workshops will be offered in class periods of varying lengths. RIMS anticipates offering the workshops at its annual conference, regional and Canadian conferences and as part of chapter events.

Tuition for the workshops varies. For two-day programs, the cost will be $500 for members of the Global Risk Management Institute. For a participant who is not an institute member but is a RIMS member or associate, the cost is $600. Other participants will pay $700.

The cost may be reduced, though, if, for example, a local chapter were to hold a workshop in a free or low-cost venue, Mr. Hampton pointed out. Chapters or conferences that offer reduced fees have to have those reductions approved by the national organization.

RIMS plans to schedule the first workshops in New York, Chicago, Atlanta and Los Angeles.

"We've heard some very positive things," Mr. Phillipus said about the revisions. "A number of people said they like the changes," he said, noting that, previously, he had heard complaints from some who had opted not to pursue the FRM because of requirements such as completing a capstone project or taking semester-long courses.

It was also important to make the designation geographically and financially accessible, Mr. Phillipus said.

"We have to look at the environment in which we are working. Many employers are cutting back on time out of the office and on education and tuition reimbursements. Everybody is working harder, longer hours," he said. BI

COMMENTARY

A fair shake for insurers

Early estimates of the insured damage caused by last week's earthquake in Seattle range from hundreds of millions to as much as $1 billion.

I'm betting that the insured losses will be a lot more when we look back several years from now, partly because estimating insured losses is still a bit of an art as well as a science, and partly due to what one could call "creative claim compilation" by some policyholders.

Just recall what happened in the January 1994 Northridge earthquake in California.

The early estimates of insured damages caused by the Northridge earthquake were $1.5 billion to $3 billion. By August of 1994, insured losses were estimated at $7.2 billion. Just a few months later, in October, the insured damage estimate was increased 25%, to $9 billion. Now, the insured damages caused by Northridge are estimated to total $12.5 billion to more than $13 billion.

What happened? For starters, there was simply more damage caused than was initially thought. As Karen Clark, president of Applied Insurance Research Inc., patiently explained to me, the Northridge earthquake showed the "basin effect" in Los Angles—in which ground motion is amplified in basin areas—and caused more damage than expected, and certain construction performed worse than had been expected. For example, as *Business Insurance* reported back in 1994, there was an unexpected degree of damage to steel-frame buildings.


Kathryn J. McIntyre

In addition, many homeowners found out by the fall of 1994 that their repair costs exceeded their policy deductibles.

As Ms. Clark also told me, insured damages in earthquakes are trickier to model than other catastrophes because of varying deductibles and policy limits that are applied to earthquake losses.

But what is not discussed publicly is how many people—and, heaven forbid, even commercial enterprises—padded their claims by claiming damages from the earthquake that existed before the earthquake struck. And they got paid, because either they were good at making their case or insurers just decided it was easier to pay a small but questionable claim than to fight it.

This fraudulent milking of insurance companies is euphemistically referred to as "working the system" by those who believe that because they have paid insurance premiums, they should collect under their policies, regardless of the policy provisions.

Indeed, 35% of Americans believe it is acceptable to increase the amount of an insurance claim by a small amount to make up for a deductible, according to a recent Insurance Research Council survey. And nearly one in four respondents said that it is OK to increase the amount of a claim to make up for insurance premiums paid when no previous claims were made. As individuals file claims on behalf of commercial enterprises, could the attitudes be that different among less-sophisticated commercial insurance buyers?

Less than one-third of homeowners in western Washington currently has supplemental earthquake coverage, according to the Insurance Information Institute. But considering that the deductible applied to earthquake losses ranges from 10% to 25% of the insured value of the home, you can anticipate that there will be some very creative claim compilation by 35% of those with earthquake coverage to help reduce the amount of the loss they pay.

And, earthquake damage to an automobile is protected under the comprehensive portion of an auto insurance policy, so imagine 25% of those owning cars deciding to file claims for earthquake damage that was really caused in a minor brush up with a post or pillar weeks or months earlier.

Before I'm written off as too cynical, let me say that I do sympathize with those suffering injuries and loss of property in the Seattle earthquake, and I don't consider the residents of Seattle to be dishonest. In addition, I do understand that some people's knowledge of the mechanics of insurance would lead them to conclude that padding claims is not the act of theft that those of us who deal with insurance matters know it is. So this is a reminder to insurers that constant consumer education efforts are indispensable to making policyholders understand what they deserve—and don't deserve—under their insurance policies.

Having said that, I'm still betting that the losses from the Seattle earthquake will be higher than expected. There will be more to learn from this earthquake for the next generation of computer models, and computer models don't model people's honesty.

Publishing Director Kathryn J. McIntyre's commentary appears fortnightly and on www.businessinsurance.com. *She can be reached at* kmcintyre@crain.com.

Claims

Continued from page 1

illnesses and injuries to the Occupational Safety and Health Administration and to state officials, railroads must report certain work-related injuries to the FRA.

The controversy that followed the EEOC action over the railroad's use of genetic tests is bringing new attention to a bill in Congress that would prohibit the use of genetic testing by employers and insurers (see related story).

In the United Kingdom, insurers, lawmakers and the public are also debating the use of certain genetic tests in underwriting (see story, page 15).

As part of an "extensive investigation," the FRA will review BNSF files and interview railroad employees and medical providers who treated injured workers, the FRA spokesman said.

He said the agency "heard through multiple sources" that the railroad company might have withheld the reporting of claims. He declined to name those sources.

BNSF said in a Feb. 12 statement that "about 125 BNSF employees have filed claims since March 2000 for carpal tunnel syndrome." The statement came in response to the EEOC's Feb. 9 announcement that it was taking legal action against the company.

The railroad is not under legal obligation to report worker injuries if it deems they are not work-related, a BNSF spokesman said. And in the railroad's opinion, the cases of carpal tunnel syndrome reported by its employees were not work-related, he said.

The federal regulatory agency can "do whatever they would like to do," the BNSF spokesman said of the FRA investigation.

The FRA spokesman agreed that if the railroad found injury cases were not work-related, it would not be obligated to report them.

But an attorney for the Brotherhood of Maintenance of the Way, a union representing railroad employees, said the union knows of specific cases in which BNSF workers filed carpal tunnel claims and were told by doctors that their injuries were work-related.

It is inconceivable that the railroad has workers who for years operated jackhammers or worked as clerks typing on keyboards, yet did not receive any work-related carpal tunnel claims, said Harry Zanville, the attorney representing the union.

Mr. Zanville said the union suspects other railroad companies also have failed to forward work injury reports to the FRA as required.

The FRA spokesman said that if its probe of BNSF's claims determines that valid claims were not reported as required, then the agency could expand its investigation to include other railroads. BI

Bill would limit use of info

WASHINGTON—The controversy over an employer's use of genetic testing for carpal tunnel syndrome is sparking new interest in federal legislation that would restrict how such information is used.

The measure, the Genetic Nondiscrimination in Health Insurance and Employment Act, would prevent health insurers from using predictive genetic information to deny, cancel or change the rates and conditions of coverage, according to a statement issued by the legislation's sponsors. It would also prohibit employers from using predictive genetic information in hiring, firing and performing other employment-related actions.

Supporters say that they introduced the legislation because of advances in genetic studies, including the mapping of the human genome, and concern over how that information could be used. Disclosure that some organizations are moving ahead with genetic testing could help their case, they said.

"If any more cases like the Burlington Northern one surface, the interest will be raised even higher," said a congressional staff member, who asked not to be identified.

"We certainly think it is getting more attention because of that situation. It would directly relate to that. In other words, it bars companies from testing folks without their permission and sharing that information," the staff member said.

Although the legislation does not specifically address workers compensation, it is intended to cover many employer-provided benefits, the staff member noted.

The legislation was first introduced two years ago but failed to pass beyond certain congressional committees, the staff member said. Opponents have argued that cases of genetic discrimination did not exist.

Currently, the bill has 150 sponsors, including about 20 Republicans, the staff member said. But it is impossible to predict whether it will pass. The main sponsors of the legislation are: Sens. Tom Daschle, D-S.D.; Tom Harkin, D-Iowa; Christopher Dodd, D-Conn.; and Edward Kennedy, D-Mass.; as well as Reps. Louise Slaughter, D-N.Y.; and Constance Morella, R-Md.

The bill's supporters argue that few Americans are participating in genetic testing that could lead to health improvements because they fear the results could result in discrimination against them.

—By Roberto Ceniceros

EPA

Continued from page 3

protection standards in the future. Congress delegated to EPA the standard-setting function, and EPA carried it out appropriately," EPA Administrator Christine Todd Whitman wrote in a statement issued after the ruling.

The American Lung Assn. also praised the ruling. "The court affirmed the health-based premise of the Clean Air Act by supporting the principle that air pollution standards must be set to protect public health with an adequate margin of safety and not based on costs," wrote John R. Garrison, the group's chief executive officer, in a Feb. 28 statement.

Business groups that have long complained that many federal regulations are imposed without being subjected to cost/benefit analyses had hoped that the high court would view the EPA's powers narrowly, while a number of states filed briefs in support of the EPA's broader interpretation of its powers under the Clean Air Act.

Nevertheless, the business groups found positive aspects to the ruling.

"The big impact is that the Supreme Court found EPA's ozone implementation policy to be unlawful," said Robin Conrad, senior vp of the National Chamber Litigation Center Inc. in Washington. Ms. Conrad noted that the high court sent the matter back to the circuit court "to decide whether EPA acted arbitrarily in setting those standards in the first place. The bottom line is, implementation of the revised ozone standard is blocked for the foreseeable future."

"There probably are not too many other environmental laws that are written the way this is written," said Glenn Lammi, chief counsel-legal studies division of the Washington Legal Foundation, a think tank that supports free-market measures.

"I definitely see it having an impact on the way the Clean Air Act is implemented. If Congress truly wants to have them take cost into consideration, it will have to go back and change the law. It's a boost for the EPA, because everybody was beating up on them for not taking cost into consideration, and their response was, 'Congress told us we couldn't.' And they ended up being right in the eyes of the Supreme Court," Mr. Lammi said.

Quentin Riegel, deputy general counsel for the National Assn. of Manufacturers, said the decision will make it more difficult to use the nondelegation of powers doctrine when trying to block regulations.

"The language they used in respect to the nondelegation doctrine was pretty sweeping. Even though the EPA's authorizing statute is broadly worded, the court found it not to be an unconstitutional delegation of legislative power from Congress," said Mr. Riegel. "In the future, it will be difficult to challenge an agency's power under the nondelegation doctrine."

But Mr. Riegel noted that the cost/benefit analysis portion of the decision might have a narrower impact. The provision addressed by the decision "is specific to this law, and we will continue to argue in any congressional debate on agency power that cost/benefit factors be considered together when issuing a rule," he said.

Mr. Lammi noted that Associate Justice Stephen Breyer's concurrence did not slam the door on cost/benefit analysis in regard to other regulations, noting that Associate Justice Breyer said that, in some cases, a rule could cause more harm to health than it prevents.

"In order better to achieve regulatory goals—for example, to allocate resources so that they save more lives or produce a cleaner environment—regulators must often take account of all of a proposed regulation's adverse effects, at least where those adverse effects clearly threaten serious and disproportionate public harm. Hence, I believe that, other things being equal, we should read silences or ambiguities in the language of regulatory statutes as permitting, not forbidding, this type of rational analysis," Associate Justice Breyer wrote.

The Chamber's Ms. Conrad noted that the Clinton administration had issued an order directing agencies to "to consider costs and benefits when they issue regulations," but, she said, that order had been often "honored in the breach."

The ruling should "absolutely serve" to emphasize the need for cost/benefit analysis when regulations are considered in the first place by Congress, she said.

"Rational agency decision-making should include consideration of societal costs," Ms. Conrad said.

●

Christine Todd Whitman, Administrator of Environmental Protection Agency, et al. vs. American Trucking Assns., et al. and American Trucking Assns., et al. vs. Christine Todd Whitman, Administrator of Environmental Protection Agency, et al., U.S. Supreme Court; Nos. 99-1257 and 99-1426. Decided Feb. 27, 2001.

Quake

Continued from page 1

nomic losses from the earthquake at $3.6 billion, including damage to roads, bridges and government buildings.

One day after the quake, Swiss Reinsurance Co. estimated that insured property losses would reach at least several hundred million dollars, based on an estimated $1 billion in total economic damage, said Luzi Hitz, head of Swiss Re's earthquake group in Zurich.

But that preliminary assessment—which does not include damage to insured public property or business interruption losses—could change, he said, as more data and insurance company reports become available and provide a better picture of the event.

Catastrophe modeling company Applied Insurance Research Inc. estimated that insured losses could reach up to $1 billion, including claims for damaged contents and business interruption, said Uday Virkud, senior vp for the Boston-based company.

Other companies with catastrophe modeling software estimated insured damages would fall in a similar range, between $500 million and $1 billion.

Even within that range, the quake would rank as one of the five largest U.S. quake losses. Still, it would fall far behind California's 1994 Northridge quake—the most costly quake, with an estimated $12.5 billion in losses—and the 1989 Loma Prieta quake, which caused an estimated $7 billion in insured losses, according to the Insurance Information Institute.

One reason for the lower loss estimate is that only about 30% of insured structures in the Seattle-area have earthquake coverage, said Mr. Virkud and other insurance industry sources. Statewide, Insurance Commissioner Mike Kreidler estimated that only about 12% of policyholders have earthquake coverage.

Mr. Virkud said that he expects that many of the claims from last week's quake will involve residences, rather than commercial buildings.

According to preliminary reports on commercial properties, older, masonry buildings bore the brunt of structural damage, while modern office buildings and other newer commercial buildings likely suffered limited structural damage, according to Mr. Virkud.

Much of the damage to newer buildings likely was limited to cracked facades, broken glass and fallen ceiling tiles, Mr. Virkud said.

There are probably thousands of small property losses, far outnumbering severe losses from the quake, said Swiss Re's Mr. Hitz. As of Thursday, he had received no reports of claims for severe damage to commercial buildings.

As of Friday, Factory Mutual Insurance Co. had received loss reports from about 25 policyholders, of which 10 to 15 were claims for sprinkler leaks, said Jeff Tenn, operations vp-engineering for FM Global Earthquake Services in Woodland Hills, Calif.

One of the highly protected risk insurer's immediate priorities in response to the earthquake was contacting its policyholders in the area to make sure their sprinklers were operational and prepared for the secondary risk of fire, Mr. Tenn said. None of the insurer's commercial policyholders reported fires, he noted.

Water damage from broken sprinklers accounted for damage to some retail operations and a few office buildings, said Ed Rhone, branch manager in Seattle for GAB Robins North America Inc.

"We are not seeing a whole lot of it, because most of the systems have been changed to dry systems, but there are some continuing exposures from wet systems that are out there," he said.

Additionally, water gushing in from broken water mains caused damage to three or four retail businesses, Mr. Rhone said.

Retail stores also may experience business interruption losses because damage to streets is keeping shoppers and workers away, he added.

Initial inspections by loss adjusters with McLarens Toplis North America Inc. revealed a high volume of claims is likely from the quake, but claims will be limited mostly to cracked walls, floors and building facades, said Robert J. Barnett, property operations leader for McLarens Toplis in Los Angeles.

One reason that properties appear to have avoided more significant losses is the depth of the quake's epicenter.

Last week's quake had roughly the same magnitude as the Northridge earthquake, which killed 57 people and caused an estimated $12.5 billion in insured damage against $40 billion in total economic damage. But the Washington temblor was centered more than 30 miles below the earth's surface, while the Northridge quake was only about 10 miles below ground.

While the earth's crust absorbed a large portion of the quake's energy, to risk managers, it still felt plenty strong.

'We have some damage here, but nothing catastrophic,' says John W. Lambdin, of Weyerhaeuser Co.

"It felt like I was on the deck of a boat. It was really rolling," said John W. Lambdin, insurance manager for Weyerhaeuser Co., a Tacoma-based forest products company. But damage was relatively light and, based on initial estimates, is expected to fall within Weyerhaeuser's self-insured retention, he said.

"We have some damage here and there, but nothing catastrophic," Mr. Lambdin said. Weyerhaeuser's business interruption losses also are limited. One company pulp and paper mill in Longview, Wash., south of the epicenter, shut down for a damage appraisal. But operations were expected to resume quickly, he said.

"As a whole, the region did very well," Mr. Lambdin said.

Other risk managers agreed.

"It was as realistic and friendly a drill as the Pacific Northwest could hope for," said Lewis Leigh, executive director of the Renton-based Washington Cities Insurance Authority, which provides property/casualty coverage for about 100 pool members. "It was a good test of our emergency communication plan."

Still, the WCIA had to evacuate its headquarters for a few hours during a precautionary inspection. Total damage incurred by its members will easily exceed a $100,000 self-insured retention the WCIA holds for earthquake risks, Mr. Leigh said.

In some cases, damages at a single member will probably exceed that deductible, he said. But, he added, it is still too early to determine the precise extent of damage. Members likely suffered losses to older buildings, infrastructure and other property such as golf courses. In addition to insurance coverage, cities also are likely to receive disaster assistance funds from the Federal Emergency Management Agency.

Prior to the quake, federal funds had already helped WCIA members to reinforce buildings, bridges and other public infrastructure, which helped limit damage, Mr. Leigh said. City emergency plans also helped minimize damage.

"Everybody knew their jobs, and they worked through the night to do their jobs," Mr. Leigh said.

At GES Exposition Services Inc.'s two Seattle-area locations, the quake broke some fire sprinkler connections, causing widespread water damage, and upset racks of stored goods and crates, according to Lance Ewing, the company's senior director of insurance and loss prevention.

"We were fortunate we had no injuries" among the 140 people working at the two offices, which are located just south of Seattle, he said.

Earthquake preparedness drills helped workers cope, as did the company's crisis management plan, which Mr. Ewing directed from the company's Las Vegas headquarters.

In the wake of such an event, a company must remember that there is "a human side" that must be addressed, Mr. Ewing said. GES employees were told to take care of their home needs first, he said.

One big difference between this and earlier catastrophes, Mr. Ewing noted, was the rapid communication capabilities provided by e-mail and digital photography. "Within two hours, we already had digitized photos of the damage," he said. As a result, he was able to contact his insurer and promptly arrange for sprinkler system repairs.

A few school districts and some individual schools shut down because of the earthquake, said David Hayasaka, executive director of Puget Sound Schools Risk Management Pool in Burien, Wash. Some closed only temporarily for precautionary inspections.

"But I fear some of it is to assess real damage," Mr. Hayasaka said. He credited school drills with helping avoid student injuries.

The quake caused a significant crack in the state's Capitol dome in Olympia, which is not insured for the damage, said Betty Reed, risk management administrator for the state of Washington. As of Friday, about 10,000 state workers in Olympia began returning to work, as the capitol complex began reopening.

Additional damage could result to policyholders' pocketbooks when they attempt to renew earthquake coverage.

"I suspect it will tighten up capacity and terms and conditions," said Don Chapman, chief operating officer for SAFECO Insurance Co.'s commercial enterprise unit in Seattle.

It is probably too early to determine the impact on pricing and availability, because the losses are not yet all known, said Anne Anderson, a senior vp for Marsh Inc. in San Francisco. Many losses will not be determined for weeks to come, she said.

"We really do not have a sense of what the commercial insurable loss will be," she said. "As that develops, we will see carriers decide where they will be."

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Meg Fletcher contributed to this report.

UPDATES

Some black lung rules on hold

Continued from page 2

effect, a delay sought by Elaine Chao, the new secretary of the U.S. Department of Labor. Ms. Chao, Mr. Bush's appointee, had sought 60 days to study all of the controversial black lung regulations before taking a position on them, according to the Labor Department.

In a related development, the United Mine Workers of America, which supports the new regulations, was granted intervenor status by the court. After the union unsuccessfully argued against the delay, the judge agreed to shorten the hearing schedule.

Oral arguments are scheduled for May 21.

Brown free during appeal

BATON ROUGE, La.—Louisiana Insurance Commissioner Jim Brown remains free on bond while he appeals his conviction of lying to the FBI.

The 5th U.S. Circuit Court of Appeals in New Orleans ruled earlier this week that the commissioner can remain free during the appeals process. The ruling meant Mr. Brown did not have to begin serving a six-month prison term that was supposed to start on March 1.

Mr. Brown is appealing his conviction in the case involving the defunct Cascade Insurance Co. of Shreveport, La. He was prosecuted on charges that he gave false information to federal investigators who were looking into what they have called a "sham settlement" that helped the insurer avoid a lawsuit by the state.

Mr. Brown's attorney said the appeal could be lengthy. "We're looking at a process that could take some months," said William H. Jeffress Jr. of the Washington law firm of Miller, Cassidy, Larroca & Lewin L.L.P. "We're optimistic about the outcome."

PacifiCare fined on late payment

SANTA ANA, Calif.—PacifiCare Health Systems Inc. will pay a $250,000 fine as part of an agreement reached with the California Department of Managed Health Care, which found the health maintenance organization was taking more than the mandated maximum of 45 days from receipt to pay doctor and hospital claims.

As part of the understanding, the department agreed to lift a censure, known as a "cease and desist" order, that it had placed on PacifiCare of California last month, said a PacifiCare spokesman.

PacifiCare said that the combination of the $250,000 fine and the associated interest is not expected have a material effect on its profitability this year.

Brad A. Bowlus, president and chief executive officer of the company's health plans division, said in a statement, "We are pleased we were able to address this issue and bring it to resolution promptly."

The company said it has taken steps to improve the staffing and systems in its claims administration area.

Mr. Bowlus said PacifiCare "will continue with our business strategy that calls for system upgrades to facilitate our business expansion and turnaround efforts."

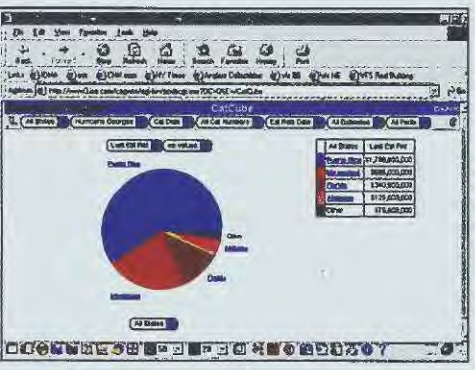
Briefly noted

Accused swindler **Martin R. Frankel** was scheduled to be extradited from Germany last Friday to face federal charges that he siphoned about $200 million from a group of life insurers he controlled. Mr. Frankel fled the United States in 1999 and was later arrested in Hamburg, Germany, where he was convicted of smuggling diamonds and holding several false passports. German authorities announced the extradition shortly after Mr. Frankel unsuccessfully tried to escape by cutting through the bars of his cell....Royal & SunAlliance P.L.C. is buying much of the **Canadian operations of Kemper Insurance Cos.** for an undisclosed amount. Kemper's Canadian operations had $73.5 million Canadian ($47.8 million) in personal lines premiums and $12 million Canadian ($7.8 million) in commercial lines premiums in 2000. Kemper will retain the commercial lines business related to the subsidiaries of U.S.–based policyholders, as well as its Canadian environmental liability business....A federal judge has sentenced former insurance executive **Albert W. Lawrence** to 37 months in prison, following his conviction last year on charges of defrauding his companies and their policyholders of $37 million. The 72-year-old Mr. Lawrence, former chairman of the Schenectady, N.Y.-based Lawrence Group Inc., was found guilty last June on 20 counts of mail and wire fraud, embezzlement of insurance company assets and tax evasion....Six lawsuits charging drug makers with knowingly selling potentially dangerous cold and allergy drugs and appetite suppressants were filed in federal court in Seattle last week. The suits, filed individually against six different drug makers, seek class-action status. They charge that the companies were aware of studies that had linked over-the-counter drugs containing **phenylpropanolamine**—known as PPA—to increased risk of stroke, seizure and heart attack in users. The lawsuits were filed against American Home Products; Bayer Corp., Bristol-Myers Squibb, Novartis Corp., Schering-Plough Corp., and GlaxoSmithKline P.L.C. Last November, the six companies pulled products containing PPA after the U.S. Food and Drug Administration urged them to remove the drugs from the market....**Programming Resources Co. Corp.**, a Hartford, Conn.-based provider of software and services for the property and casualty marketplace, agreed to purchase Cumming, Ga.-based Insurity Solutions Inc., an Internet rating, underwriting and policy services vendor.

FOR THE RECORD

Excerpts from *BI*'s Daily Online Updates, Feb. 26 - March 2, 2001

QUAKE RISK SECURITIZED As a result of a reinsurance and capital markets transaction worked out with Swiss Reinsurance Corp., Swiss Re Capital Markets and Goldman Sachs & Co., another $100 million will be available to California Earthquake Authority policyholders if there are one or more earthquakes over the next 23 months. As part of the transaction, CEA signed a $100 million reinsurance contract with Swiss Re. Then, New York-based Swiss Re Capital Markets and Goldman co-led a private offering and jointly placed $97 million of floating-rate notes and $3 million of preference shares that, in effect, will replenish Swiss Re's capital if an earthquake occurs.



NEW ONLINE ISO DATABASE Insurers, risk managers and other industry professionals can now access a catastrophe loss history database online via ISOnet, the New York-based Insurance Services Office Inc.'s Internet information service. The new online database, called ISO CatCube, uses data from the Property Claims Service division of ISO. CatCube users armed with only a Web browser and a password for ISOnet will be able to explore any combination of database elements and examine how different types of information interact. For example, an insurer may look at information on catastrophes such as windstorms, fires or hurricanes; by catastrophe serial number; date of occurrence; state or states affected; any of 10 categories of catastrophe types; the amount of loss; and the type of insured loss estimate, such as preliminary or final. Users also can view multiple levels in each category of information and display the results in preformatted reports or graphs. For further information on access fees for ISOnet members and nonmembers, contact Gary Kerney at Property Claims Service, at 732-388-2525.

AON TO BUY ASI Aon Corp. has agreed to acquire ASI Solutions Inc., a human resources and compensation consulting firm in New York. The deal, a stock swap, is valued at between $99.7 million and $123.2 million, depending on the price of Aon's stock when the sale closes. The acquisition is expected to close within 90 days. ASI, which reported revenues of $22.7 million for the quarter ending Dec. 31, 2000, will likely become part of Aon's benefit consulting arm, Aon Consulting, according to an Aon statement. No change in the senior management of ASI is expected.

FMLA SERVICES OFFERED To help organizations better comply with the Family and Medical Leave Act, ComPsych Corp. is now offering FMLA administration and consultative services. Chicago-based ComPsych will track employees' FMLA requests and eligibility while ensuring and documenting company compliance with federal and state FMLA requirements. The service, called FMLASource, aims to reduce employers' corporate liability and the probability of legal scrutiny under the tightened guidelines of the Health Insurance Portability and Accountability Act, according to a company release. Additionally, FMLASource provides consultative services for an employer and employee regarding FMLA before, during and after the employee takes family leave.

DEFINED CONTRIBUTION HEALTH GROUP An association is being formed to promote defined contribution health plans. The group, which will be composed of the leading players in this emerging market, will be called The Consumer-Driven Healthcare Assn., according to an association spokesman. The group's primary objective will be to promote the consumer-driven health care model through conferences, public relations, and other educational efforts. The association does not plan to lobby Congress for legislative changes, however, because, so far, all of the plans its members offer meet current regulatory requirements, the Minneapolis-based spokesman said. Although the companies participating in the organization offer different business models, "they are all focused on creating access to health services in a way that meets consumer needs for more choices and control over health care spending," the spokesman said.

DEMUTUALIZATION PROPOSAL A policyholder group is pressing Massachusetts Mutual Life Insurance Co. to convert to stock ownership. The Mass Mutual Owners Assn. is calling for the distribution of $4 billion in stock, cash and policy credits to policy owners in exchange for the voting rights and claims on earnings they would give up in the demutualization. The owners association says its proposal is in the best interests of policyholders and is collecting proxy ballots for demutualization to be cast at the annual meeting of Springfield, Mass.-based MassMutual in April. The company has said that while it will examine its structure as the business environment changes, for now the mutual form allows it to meet its corporate objectives and best serve its policyholders and clients.

KAISER SEES TURNAROUND Kaiser Foundation Health Plan Inc. reported net income of $584 million on revenues of $17.7 billion for the year ended Dec. 31, 2000. The results demonstrate a turnaround from 1999, when the health maintenance organization posted a net loss of $6 million on revenues of $16.8 billion. Kaiser was able to improve its financial results by reducing administrative costs, selling some non-essential assets and raising premiums, according to a company statement. In addition, Kaiser's membership increased 1.6% to 8.1 million members nationwide in 2000.But while the Oakland, Calif.-based health plan has made significant progress in recent years, it still has a way to go to meet its financial objectives, Kaiser President Dale Crandall said in a statement.

MUTUAL PAYS PREMIUM DIVIDENDS The American Bankers Professional & Fidelity Insurance Co., a mutual reinsurance company for the American Bankers Assn.-sponsored insurance program, will distribute more than $4 million in underwriting profits to 939 financial institution customers. Qualifying ABA member banks—those involved in the insurance program as of Jan. 15—will receive a distribution of up to $46,000. Each bank's share is based on premiums it paid over the past five years on policies that are still in place. Since 1991, eligible member banks have received approximately $34 million in distributions from the Bermuda-domiciled mutual. The ABA program, which is underwritten by Progressive Casualty Insurance Co. and reinsured by ABPFIC, provides coverage for directors and officers liability, financial institution bond, trust errors and omissions, employment practices liability, entity errors and omissions, and other related insurance coverages.

BRIEFLY NOTED A.M. Best & Co. has downgraded **Meadowbrook Insurance Group Inc.** to B++ from A-. The downgrade reflects the Southfield, Mich.-based insurance group's poor results and diminished capital after it increased loss reserves last year, the rating agency said....The **Pension Benefit Guaranty Corp.** is taking over a severely underfunded pension plan sponsored by Outboard Marine Corp., a Waukegan, Ill.-based recreational boat and engine manufacturer, which is now in bankruptcy liquidation. The plan, which has about 10,000 participants, is underfunded by about $73 million, according to the PBGC....**Jim Ansaldi** has been named executive vp at Aon (Bermuda) Ltd., where he will be responsible for property/casualty programs. Mr. Ansaldi was previously a senior vp at XL Capital Ltd. BI

To get breaking news as it occurs, visit Business Insurance's free online Updates at www.businessinsurance.com. All of the material in the For The Record column, as well as other content in this week's issue, is generated from daily news postings that appeared on the Web site in the previous week.

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BI Industry Stock Report FEB. 26, 2001, THROUGH MARCH 2, 2001

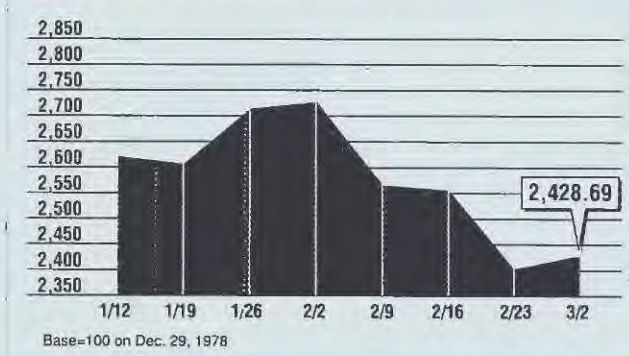
BROKERS		Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)
Aon Corp.	NYS	36.27	9.44	5.90	42.31	20.94	4509
Brown & Brown	NYS	38.95	1.04	11.29	39.92	15.63	114
Clark Bardes Holdings	NDQ	10.50	-10.64	3.70	17.88	8.50	68
E.W. Blanch Holdings Inc.	NYS	8.40	-11.58	-51.83	56.94	7.70	1047
Gallagher Arthur J. & Co.	NYS	27.51	3.58	-13.52	34.25	11.53	1410
Hilb, Rogal & Hamilton	NYS	37.90	1.34	-4.95	42.13	26.56	105
Kaye Group Inc.	NDQ	12.81	0.49	65.32	12.88	5.00	14
Marsh & McLennan	NYS	104.26	-1.03	-10.89	135.69	70.50	6166
BROKERS	AVERAGE		-1.44	-3.17			

INSURERS/REINSURERS							
ACE Ltd.	NYS	37.60	2.73	-11.40	43.94	14.06	4850
Accel International Corp.	NDQ	0.19	-5.00	-36.01	1.13	0.10	1
Acceptance Insurance Cos.	NYS	4.55	1.56	-13.33	6.94	3.75	125
AEGON N.V.	NYS	34.80	8.24	-16.02	43.00	31.27	720
AFLAC Inc.	NYS	61.92	7.30	-14.22	74.94	33.56	4991
Allmerica Financial Corp.	NYS	53.91	2.65	-25.64	74.25	35.06	1121
Allstate Corp.	NYS	41.44	4.25	-4.87	44.75	17.19	12410
Ambac Financial Group	NYS	57.25	0.44	-1.82	61.25	25.91	4198
American Financial Group	NYS	24.00	0.00	-9.65	29.00	18.38	1191
American General	NYS	39.80	5.33	-2.33	83.44	39.80	4987
American Intl Group	NYS	82.25	1.73	-16.55	103.75	52.38	24596
American Safety Insurance	NYS	7.84	5.95	28.00	7.95	3.25	12
Argonaut Group	NDQ	16.75	2.68	-20.24	21.25	14.44	144
AXA-UAP Group	NYS	62.74	6.25	-12.63	81.50	58.00	1156
Baldwin & Lyons Inc.	NDQ	22.44	-6.51	-3.49	28.75	15.25	10
Berkley W.R. Corp.	NDQ	46.13	8.37	-2.25	47.63	14.00	4769
Berkshire Hathaway Inc.	NYS	69500.00	1.61	-2.11	74600.00	668.00	2
Capitol Transamerica Corp.	NAS	13.00	4.00	4.52	13.25	10.00	10
Chubb Corp.	NYS	72.00	3.31	-16.76	90.25	43.25	3605
CIGNA Corp.	NYS	112.42	10.00	-15.03	136.75	60.75	4674
Cincinnati Financial Corp.	NYS	37.13	4.12	-6.16	43.31	26.19	1450
Citigroup	NYS	48.00	-0.41	-6.00	59.13	35.81	72522
CNA Financial Corp.	NYS	37.83	4.07	-2.37	41.94	24.56	685
CNA Surety	NYS	13.25	-0.38	-7.02	14.94	10.38	121
EMC Insurance Group Inc.	NDQ	10.69	1.79	-9.04	13.13	6.81	5
ESG Re Limited	NDQ	2.19	-5.41	18.64	5.50	1.72	64
Enhance Financial Services	NYS	13.45	-1.10	-12.87	17.00	8.63	2242
Everest Reinsurance	NYS	66.50	11.24	-7.16	74.75	23.63	2714
Fremont General Corp.	NYS	3.51	23.59	24.80	7.56	1.50	1074
Gainsco Inc.	NYS	2.00	-42.86	-23.81	6.38	1.40	2317
Harleysville Group	NDQ	26.06	-5.33	-10.90	30.63	12.00	670
HSB Group Inc.	NYS	38.75	0.00	0.00	40.63	21.50	0
HCC Insurance Holdings	NYS	26.00	16.07	-3.48	27.19	10.94	5080
ING Groep N.V.	NYS	69.99	2.16	-12.65	83.94	46.81	1357
IPC Holdings Ltd.	NDQ	23.06	-1.34	9.82	24.50	11.25	301
Hartford Financial Services	NYS	65.40	2.59	-7.40	80.00	29.38	7073
John Hancock Financial Services	NYS	35.42	1.78	-5.86	38.25	13.44	2854
LaSalle Re Holdings Ltd.	NYS	18.88	0.00	0.00	19.38	10.88	0
Lincoln National	NYS	43.80	2.46	-7.42	56.38	22.63	4194
MAIC Holdings Inc.	NYS	16.77	14.47	0.49	21.13	10.00	111
Markel Corp.	NYS	182.00	8.29	0.55	183.25	111.50	342
MBIA Insurance Group	NYS	77.68	3.78	4.80	77.95	36.50	2514
Meadowbrook Insur. Group	NYS	4.45	-7.29	-45.23	8.38	3.94	19
MetLife	NYS	31.83	4.91	-9.06	36.63	14.25	6959
Mutual Risk Mgmt. Ltd.	NYS	10.30	-11.59	-32.18	23.75	10.30	1738
Navigators Group	NDQ	14.00	2.75	5.16	14.38	8.63	29
NYMagic Inc.	NYS	18.40	0.27	-2.52	19.25	12.25	1
Ohio Casualty Corp.	NDQ	8.81	-0.70	-11.88	17.88	6.13	735
Old Republic Int'l	NYS	28.12	6.76	-12.13	32.06	10.63	2342
Partner Re Ltd.	NYS	52.55	5.06	-13.85	62.50	30.00	654
Penn-America Group Inc.	NYS	9.30	1.09	21.97	9.75	6.88	9
PMA Capital Corp.	NDQ	17.75	0.00	2.90	19.13	15.19	55
Philadelphia Cons. Holding	NDQ	29.88	3.02	-3.24	31.25	14.13	234
PXRE Corp.	NYS	18.10	1.12	7.26	20.10	12.50	213
ReliaStar Financial Corp.	NYS	53.94	0.00	0.00	53.94	23.75	0
RenaissanceRe Holdings Ltd.	NYS	74.60	-2.04	-4.74	84.19	35.88	882
RLI Corp.	NYS	42.00	-0.57	-6.01	46.16	26.25	39
St. Paul Cos.	NYS	47.05	3.32	-13.37	57.00	21.31	3736
SCOR	NYS	49.35	1.33	-1.79	53.75	38.38	32
SAFECO Corp.	NDQ	22.81	-0.82	-30.61	35.88	18.00	7228
SCPIE Holdings Inc.	NYS	25.00	-6.68	5.86	34.63	18.31	NA
Seibels Bruce Group	NDQ	1.00	1.01	77.78	2.25	0.53	52
Selective Ins. Group	NDQ	21.56	-1.15	-11.08	26.94	14.88	1559
Tokio Marine & Fire	NDQ	51.13	-4.33	-10.31	61.00	46.00	77
Torchmark Corp.	NYS	36.28	7.82	-5.61	41.19	18.75	3217
Transatlantic Holdings	NYS	102.00	5.37	-3.66	107.06	68.75	45
Trenwick Group Inc.	NYS	21.14	-1.72	-14.80	27.13	12.00	658
Unico American Corp.	NDQ	6.00	0.00	2.13	7.75	4.50	5
United Fire & Casualty	NDQ	20.94	2.13	6.01	25.00	15.50	12
Unitrin	NDQ	39.19	5.91	-3.54	41.94	27.19	403
UNUM Corp.	NYS	27.35	9.27	1.77	30.44	11.94	6601
Vesta Insurance Co.	NYS	6.90	9.87	36.30	8.39	4.13	496
XL Capital Ltd.	NYS	80.50	5.92	-7.87	89.25	39.00	2723
Zenith National Ins.	NYS	27.85	-2.07	-5.16	30.70	18.75	68

		Price	Weekly % change	Year to date %change	Year to date High	Year to date Low	Vol.(000)
INSURERS/REINSURERS	AVERAGE		2.02	-4.72			

HEALTH MAINTENANCE ORGANIZATIONS							
Aetna Inc.	NYS	37.45	5.14	-8.80	42.69	32.94	2590
Health Net Inc.	NYS	22.18	8.73	-15.30	26.94	7.63	2870
Humana Inc.	NYS	13.63	9.04	-10.62	15.81	4.75	4237
Oxford Health Plans	NDQ	32.25	1.18	-18.35	42.75	13.50	10809
Pacificare Health Sys.	NDQ	32.38	-12.20	115.83	72.31	9.81	12675
Sierra Health Services	NYS	5.00	0.00	31.58	6.70	2.44	394
United HealthGroup	NYS	60.79	11.89	-0.95	64.36	23.19	9671
Wellpoint Health Networks	NYS	103.19	12.42	-10.46	121.50	56.94	3784
HMOs	AVERAGE		4.44	13.10			
ALL COMPANIES			1.67	1.74			

BI Insurance Index



Base=100 on Dec. 29, 1978

Top advancing issues: Fremont General Corp., HCC Insurance Holdings, MAIC Holdings Inc. Leading decliners: Gainsco Inc., PacifiCare Health Systems Inc., Mutual Risk Management Ltd. Most active issue: Citigroup. The *BI* index rose 1.1%; the Dow Jones 30 Industrials increased 0.3%; the S&P 500 decreased 0.9%, and the NYSE Composite went up 0.6%. Average P/E: Brokers, 21.6; Insurers/reinsurers, 34.3; and HMOs, 18.4.

Source: *CNET Investor* (investor.cnet.com) Boulder, Colo.

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