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Updates

Sweetened settlement offer benefits most Lloyd's members

LONDON—Most members should be better off under a revised settlement offer issued by Lloyd's of London late last week.

Brokers and auditors have entered Lloyd's reconstruction and renewal plan, with each group contributing about £100 million (\$152.3 million) to the ambitious plan. With their contributions, Lloyd's increased its settlement offer to £3.1 billion (\$4.72 billion). Other additions come from stronger than expected central resources, such as the Central Fund.

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Mental health fight is on

Business takes hard line on planned parity with other health benefits

By JERRY GEISEL

WASHINGTON—Vowing no compromise, business groups are pulling out all the stops to pressure congressional conferees to drop part of a Senate health bill that would require group plans to cover mental health problems to the same extent as physical ailments.

Business is using every lobbying tactic in its arsenal—visits to Capitol Hill, group and individual letters to legislators and press conferences—in an effort to kill the provision, part of a Senate bill designed to curb pre-existing condition exclusions. Over the next few weeks, conferees will try to iron out differences between that bill and a House-passed bill that contains no comparable language.

As part of the battle for the hearts and minds of legislators, benefit managers are putting a price tag on mental health parity.

At a press conference last week, Xerox Corp. Director of Benefits Pat



"Forty-five minutes of debate with a half a dozen senators... is not the way to treat a serious issue,"

Mark Ugoretz

rox Corp. Director of Benefits Pat Nazemetz explained that the Stamford, Conn.-based company's mental health costs grew dramatically after benefits were liberalized in 1988.

"We experienced significant and excessive utilization," she said. Claims shot up for "adjustment disorders" such as teen problems and dealing with death and divorces.

In 1992, Xerox imposed several dollar caps on mental health benefits, including a \$5,000 annual limit on outpatient care and a \$100,000 combined outpatient/inpatient lifetime limit on mental health care.

Those caps and other changes cut mental health care costs to 9% to 10% of Xerox's overall health care costs from 20% in 1992, according to Ms. Nazemetz.

Small employers also are joining the battle. Donald Rainville, president of Universal Dynamics Corp., a Wood-

See Mental on page 12

Price suit settlement may alter drug market

13 companies to scale back managed care discounting

By ROBERT KAZEL

CHICAGO—Employers, faced with the bitter pill of high prescription drug costs, may find within a few months a new option as close as the corner drugstore.

In a potentially far-reaching agreement unveiled in a federal courtroom in Chicago last week, lawyers for more than 30,000 independent pharmacies and 13 large drug manufacturers announced they had reached a settlement that would help end a legal battle over pricing and, druggists believe, permit them to compete with their rivals in managed care.

Three years after the filing of the antitrust suit, the settlement still must be approved by pharmacists nationwide who are part of the class action. The agreement also must get the final approval of U.S. District Court Judge Charles P. Kocoras, who will preside at a final hearing June 11. Approval by both the pharmacists and judge is expected.

Though it is too early to know precisely how the price and distribution of drugs will change after the settlement, those who fought for the agreement are hailing it as a big free-market victory that will promote lower prices. Although the settlement is probably more significant for pharmacists' livelihoods than for corporate purchasers, pharmacists argue it also could pay off for companies seeking cost-effective alternatives other than pharmaceutical benefit managers or mail-order services.

The pharmacies that brought the suit will receive about \$311 million in cash under the settlement. Though that will amount to several thousand dollars apiece for most of the plaintiffs, the real treasure of the settlement to the pharmacists is an amendment hammered out after Judge Kocoras rejected a previous proposal April 4. Judge Kocoras said the previous proposal failed to give pharmacists much relief in their future business with drug companies.

Under the amendment, pharmacies would be guaranteed access to the same kinds of discounts given by drug manufacturers to for-profit managed care drug vendors, as long as the pharmacies or pharmacy buying groups can show they can affect market share in a similar way. The agreement codifies the judge's opinion, issued last month, that pricing policies based

See Agreement on page 22

California comp stable—for now

By ROBERTO CENICEROS

LOS ANGELES—In the second year of open workers compensation rating in California, prices are not shooting up. At least not yet.

And insurers are not going bellyup, though solvency remains a concern of regulators and insurance executives.

Insurers today may not be as quick to price policies below expected losses as they were immediately after the state stopped setting minimum rates.

"Just recently I was looking at a number of renewals and we find that the deep discounts that we had seen earlier, immediately after the rating changes, are not there to the extent they were," said Robert E. Kuntz, senior vp of Sedgwick James of Califor-

nia Inc.'s risk finance services in Irvine. "But I still think the margin between expected losses and premium is fairly tight."

And there are signs of rate hikes on the horizon.

Insurers are not offering two-year guaranteed-rate policies as readily as they were a year ago, said Stephen Paulin, senior vp of commercial lines for broker Sullivan & Curtis in Irvine.

"That is probably not as prevalent simply because the carriers realize that in the near horizon there is going

to be a need to adjust rates," Mr. Paulin said. "So they certainly don't want to get themselves into a commitment for two years at a lower rate."

Yet insurers are still jostling for market share, so rates are not rising, Mr. Paulin said.

"Carriers are continuing to reposition themselves," he said. "We have seen some carriers pull back and then come back in and new players come in, providing a competitive price."

"Rates are holding," reported Anita Percuccio, risk manager for C.J. Segerstrom & Sons, a property management and ownership company in Costa Mesa. In 1995 she obtained a 33% rate cut for 325 employees. At January renewals the rates did not change.

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Greatest show of risk on Earth

By SALLY ROBERTS

VIENNA, Va.—It's called the "Globe of Death." Three motorcycle riders race 60 m.p.h. in a steel sphere 17 feet in diameter, weaving one intricate pattern after another as a woman stands nonchalantly in the middle.

Then there is the high-wire act, where performers play leapfrog, jump rope and ride bicycles 30 feet above an arena floor without a balance pole, net or safety belt.

And don't forget the elephants, about 16 per show, performing one stunt after another in arenas holding thousands of children and adults.

While these perilous acts may leave audiences gasping for breath and their palms sweating, it's just another day at the office

Judy Godfrey's handling of colorful risks at circus is a high-wire act in itself

for Judy Godfrey, vp-risk management for Irvin Feld & Kenneth Feld Productions Inc., which produces the two traveling Ringling Bros. and Barnum & Bailey Circus shows, as well as several units of Walt Disney's World On Ice and Las Vegas attraction Siegfried & Roy.

"It is an inherently dangerous business," Ms. Godfrey said at Irvin Feld's colorful corporate headquarters in Vienna, Va.

After seeing all the performances, though, "you realize just how infrequently these people get hurt and how good they are at

their jobs," she said.

They're not the only ones. As risk manager for Ringling Bros., Ms. Godfrey runs her own three-ring circus every day. She juggles all the property/casualty insurance at Irvin Feld and all the health benefits for its roughly 2,500 employees; she procures insurance for 120 animals; and she handles health and workers compensation benefits for about 300 circus performers from around the world who travel 35,000 miles by train to perform in about 90 cities every two years.

Managing the risks of a circus "definitely requires somebody who can go with the flow," said Jack Wallace, senior vp of Willis Corroon Corp. of Tennessee, Ringling Bros.' long-time broker in Nashville.

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From elephants to trains, Judy Godfrey manages a three-ring circus of risks.

Updates

Lloyd's ups settlement offer

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In addition, massive reductions in Equitas' needed funding have enabled Lloyd's to put more money on the table to attract members and to reduce many names' Equitas premiums to £50,000 (\$76,150) on top of the assets already dedicated to past underwriting.

Lloyd's Chairman David Rowland said he is confident the changes will make the settlement offer "substantially more attractive" to members. By the middle of next month, members will be updated on how much their estimated Equitas premiums will be. Final figures are to be issued in July.

The new settlement money will be targeted at specific areas of the membership, said Mr. Rowland, who added that this is the final amount and form of the offer. Members who have paid all losses to date and those facing extreme hardship will get a big break. And those still underwriting in 1996 will not be asked for any extra money on top of their funds at Lloyd's.

An extra £200 million (\$304.6 million) is being added to the settlement pot in an effort to pacify action groups. Yet the groups may not be happy about the auditors' participation, which may effectively buy them immunity from member lawsuits (*BI*, Feb. 19).

The amount of additional reserves needed to launch Equitas has almost halved from the original estimate of £1.9 billion (\$2.89 billion) because the "balance of account" liabilities—core business such as marine, aviation and transport—are better reserved for at syndicate level than originally thought. And, syndicates' reinsurance programs are looking stronger than when the R&R plan was put together a year ago, though Lloyd's declined to provide details.

Overall, Lloyd's estimates that about 10,000 names either will not be asked for more cash on top of their Lloyd's funds, or will receive a rebate. However, some names on long-tail syndicates may lose ground on their next interim statements.

Caterpillar plant inspected

YORK, Pa.—Caterpillar Inc. last week allowed federal health and safety officials into its York, Pa., plant—but only after a federal judge the company in contempt of court for refusing to allow them in earlier.

U.S. District Judge James F. McClure Jr. in Williamsport, Pa., on May 3 found Caterpillar in civil contempt of court for refusing to allow the inspection by two National Institute for Occupational Safety and Health investigators.

If the company had continued to deny the investigators access to the facility, it could have been fined \$10,000 per day.

Caterpillar last month refused to allow NIOSH investigators to enter the plant even though they had a federal warrant authorizing them to inspect the facility (*BI*, April 29). NIOSH officials have been investigating allegations by the United Auto Workers that some workers at the plant have suffered health problems from exposure to cadmium.

In a statement, Caterpillar Vp Duane Livingston said cadmium levels at the plant have been within acceptable lifetime exposure limits set by the Occupational Safety & Health Administration. Nonetheless, the company in January 1993 instituted a program to remove cadmium completely from the York facility, "well before NIOSH became interested in this subject," Mr. Livingston said.

Caterpillar declined to discuss the situation further.

Flood settlement insured

CHICAGO—Great Lakes Dredge & Dock Co., the bridge contractor blamed by the city of Chicago for its 1992 underground flood, will pay an undisclosed but fully insured settlement to a group of businesses that suffered losses in the mishap, the firm's attorney said.

Among the businesses that settled were Dayton Hudson Corp. and Filene's Basement Inc., said Great Lakes attorney Jeffrey Stone, a partner with McDermott, Emery & Will in Chicago.

Oak Brook, Ill.-based Great Lakes has not resolved its liability coverage dispute with its insurers, but that case involves the scope of Great Lakes' coverage, Mr. Stone said. There is no question that the firm is covered for the business' claims, he said.

Great Lakes seeks more than \$100 million of coverage.

The insurers' attorney could not be reached.

Chicago last year reached a \$36 million settlement with a group of businesses and insurers that suffered losses in the flood. They originally sought \$400 million of damages (*BI*, Aug. 14, 1995).

Great Lakes still faces litigation from about 400 business that claim they suffered losses in the flood, which caused \$300 million of insured damage, according to Mr. Stone.

However, the U.S. Supreme Court last year ruled that admiralty law governs the litigation against Great Lakes (*BI*, Feb. 27, 1995). As a result, the company can argue in remaining litigation that it and its surety bond underwriter's liability should not exceed \$634,000—the value of the two barges used in a Chicago River bridge project.

Fires off to destructive start

BOISE, Idaho—There have been three times as many forest fires so far in 1996 as there were at this point last year, said the National Interagency Fire Center.

Some 50,930 fires have engulfed 1.3 million acres, destroying 76 structures, primarily homes. That includes 42 in Texas and 32 in New Mexico. The 32 New Mexico structures were all destroyed in last week's Carson National Forest fire, which fire fighters were containing as of late last week.

No loss information from that fire was available late last week from the Western Insurance Information Service in Englewood, Colo.

Dry weather is expected to make Arizona and New Mexico vulnerable to fires throughout the summer.

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Model law on fast track

By MEG FLETCHER

KANSAS CITY, Mo.—After more than two years of deliberation, the National Assn. of Insurance Commissioners' first model investment law for insurers is on a surprisingly fast track and may be formally adopted as early as next month.

The only potential road block could come from insurers, which will have one last shot at the proposal at a special meeting of the NAIC's Financial Condition Subcommittee in New York on June 1.

Insurers are expected to repeat their arguments that the model is too restrictive and may have a broader reach than was intended two years ago. That's because the

Insururer opposition is unlikely to derail investment proposal

model's definitions are being incorporated into accounting rules that other regulators are drafting.

Insurers will also report on whether the proposed model would conflict with any individual state's investment laws or individual insurer's investment practices, said Utah Insurance Commissioner Robert Wilcox, who chairs the subcommittee.

"If there are no particular problems raised, there is no real reason to hold up action on the model," Mr. Wilcox said last week. The

subcommittee could approve the model at the special meeting, he said, and all members could vote on it as early as two days later.

However, if significant problems are identified, the subcommittee will have to determine whether to address them immediately or refer the proposal back for more work, he said.

Many regulators and consumer groups think the time has come for the "Investments of Insurers Model Act," a complex, 68-page proposal that identifies the types of investments a state will accept as admitted assets. Packaged with it is a separate, five-page model regulation on derivatives.

Were states to adopt the model, *See Model on page 23*

SEC stand may help Lloyd's member suits

By GAVIN SOUTER

SAN FRANCISCO—In its first foray into Lloyd's of London litigation, the Securities and Exchange Commission is weighing in on the side of members who want to have their grievances heard in U.S. courts.

If Lloyd's membership is deemed to be a security, members have a right to sue Lloyd's in U.S. courts despite agreeing only to sue in England when they first joined Lloyd's, the SEC said in an amicus brief filed with the 9th U.S. Circuit Court of Appeals.

Under federal securities laws, investors cannot waive the protection of the U.S. legal system no matter what agreement they sign, the SEC said.

A lawyer for Lloyd's characterized the brief as concerning only a minor issue, and said it went against the only two previous U.S. court rulings on where member suits against Lloyd's were to be heard.

Other lawyers, though, say the intervention is a departure from the SEC's previous lack of interest in Lloyd's cases and should be viewed seriously.

The SEC filed the brief last Monday in a case brought by 650 *See Lloyd's on page 22*

Captives in New York? Governor's domicile call enters legislature

By DOUGLAS McLEOD

ALBANY, N.Y.—New York may finally be joining the parade of onshore captive domiciles.

Gov. George E. Pataki last week sent the state legislature a bill that would allow formation of captive insurers. The long-awaited bill, aimed mainly at large corporations looking to set up property/casualty captives, is patterned after captive laws in Vermont and Colorado and is part of the governor's package of economic development initiatives.

The measure had not yet picked up legislative sponsors late last week, though the Pataki administration is hoping for sponsorship

by the chairmen of the state senate and assembly insurance committees, according to a spokesman for the New York Insurance Department, which drafted the proposal.

The measure would have to pass the insurance committees before reaching floor votes.

The new law would allow the formation of single-parent captives and stock or mutual group captives by parent companies with net worth or gross revenues exceeding \$100 million.

Minimum capital and surplus would be \$250,000 for single-parent captives and \$500,000 for group captives, though the insur-

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Insurers fighting for rate hikes

Malpractice hearing scheduled in Texas

By MICHAEL BRADFORD

AUSTIN—Three insurers that together write one-third of all medical malpractice insurance in Texas are fighting for double-digit rate increases.

In hearings scheduled for early June, the three—Medical Protective Co. and two CNA Insurance Cos. units—will make their case to the State Office of Administrative Hearings.

Last month, Insurance Commissioner Elton Bomer rejected requests for rate hikes of 22.9% for Medical Protective and 45% for both CNA units.

Allowing the increases "would result in overcharging Texas doctors for this essential coverage," he said.

This is the first time since the state adopted a file-and-use system in 1993 that regulators have rejected a medical malpractice rate increase.

Medical Protective is the state's largest medical malpractice underwriter.

The Fort Wayne, Ind.-based company's \$61.7 million in 1994 premiums represented 25.3% of the state's medical malpractice market.

Together, the two CNA units—Chicago-based Continental Casualty Co. and American Casualty Co. of Reading, Pa.—were the state's fifth-largest underwriter. They wrote \$20.5 million in 1994 medical malpractice premiums, or 8.39% of the market.

All told, 42 insurers wrote \$243.7 million in malpractice pre- *See Malpractice on page 12*

Inside

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• Floating casinos offer huge risks in exchange for their booming business. **PAGE 16**

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• Sara Lee found its network physicians very open to a disease management program. **PAGE 20**

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HMOs are tops in efficiency

By MICHAEL SCHACHNER

Health maintenance organizations nationwide are approximately 18% more cost-efficient than indemnity plans and 16% more cost-efficient than point-of-services plans, according to a study of health plan performance.

Hewitt Associates L.L.C.'s Health Value Initiative—a study that measures cost-efficiency and quality of an array of health care plan types—shows that there is a strong correlation between the level of HMO penetration in a given region and how cost-effective those HMOs are compared with traditional indemnity plans.

For example, in the West, where HMOs have long been the leading form of health plan, the spread between HMO and indemnity plan cost-efficiency is 41%.

Study finds efficiency linked to penetration

In the East, a region where HMO penetration has skyrocketed recently, the spread between traditional indemnity insurance and HMOs is 24%. Meanwhile, cost-efficiency spreads in the Midwest, Southeast and Southwest ranged from only 10% in the Midwest to 21% in the Southwest, another region where HMO penetration is growing.

Interestingly, the HVI, which began last fall when Hewitt gathered health plan data on 2,200 health plans used by 240 different employers (BI, Dec. 18, 1995), found that the cost-efficiency spread between POS plans and HMOs is only 2% closer than indemnity plans.

"If you look across the nation, there's very little difference between point-of-service and indemnity, which tells the employer that point-of-service is not extremely cost-effective," said Tom Beauregard, a principal at Hewitt Associates in Rowayton, Conn., who is overseeing the HVI project.

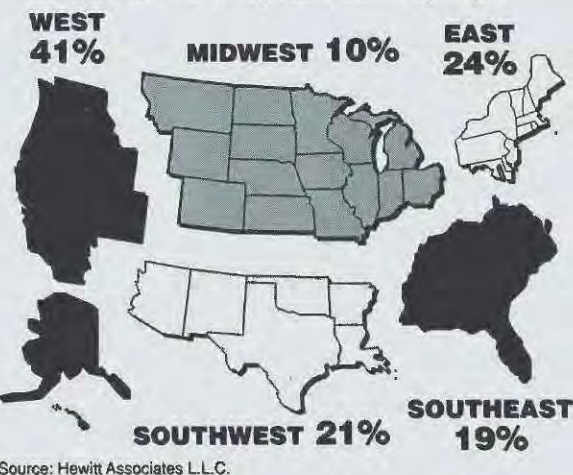
"This result tells employers enamored with point-of-service that they must make sure that administration costs don't outstrip the discounts and utilization control of managed care," he said.

Mr. Beauregard also said the fact that HMOs recorded their highest cost-efficiency scores in regions with heavy managed care penetration dispels the common argument that HMOs have only been cost-effective because they cover the best risks.

See HMO on next page

The HMO advantage

The degree to which they are more efficient than traditional indemnity plans varies by region.



GRAPHIC BY JOHN HALL

Target retiree efforts

Medicare risk HMOs are not for everyone

By ROSEANNE WHITE

WASHINGTON—Medicare risk HMOs won't suit every retiree, so employers should target their managed care marketing resources at persuading those retirees most likely to be convinced.

"A little research probably pays dividends," said Joseph J. Martingale, a principal with Towers Perrin in New York.

After honing in on the group of retirees that would be most receptive to another type of health plan, employers

The basic community rate is then adjusted for age and sex of individual retirees. If HMOs can provide Medicare benefits for much less than what they receive from the government, they can afford to offer additional benefits, like 100% hospitalization coverage and unlimited prescription drugs, and still make a profit.

When retired workers move into Medicare risk HMOs, employers can reduce retiree health care costs because the HMOs often will be providing a significant portion of benefits that the employers have been paying for in their Medicare supplemental programs.

In order to convince retirees that the concept has merit, employers should carefully select a group of Medicare risk HMOs to offer to retirees. Towers Perrin last year launched the National Medicare HMO Initiative in cooperation with about 70 employers (BI, June 19, 1995). Under the initiative, the consultant has evaluated more than 200 Medicare HMOs in 64 health care markets, and negotiated plan designs and rates favorable to employers in many of those markets.

Bethlehem Steel Corp., which did not participate in the Towers Perrin program, also began navigating the Medicare Risk HMO market last year, working with UltraLink Inc., a Costa Mesa, Calif.-based HMO network association representing HMOs in every region of the country. UltraLink is Bethlehem Steel's network manager.

Jack Romeo, director of health care systems for the Bethlehem, Pa.-steel manufacturer, used the following pieces of information to evaluate HMOs: accreditation by the National Committee for Quality Accreditation, Health Plan Employer Data Informa-

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In the computer industry, anti-theft systems crash

Billions in parts are stolen the old-fashioned way

By DOUGLAS McLEOD

PONTE VEDRA BEACH, Fla.—Low-tech thieves are making off with billions of dollars of high-tech computer components and manufacturers often do too little to prevent it, a security expert says.

"The high-tech industry is literally under attack," said Michael Boggess, a sergeant with the San Jose, Calif., police department and a consultant with McMahon & Associates, a high-tech risk management firm based in Morgan Hill, Calif.

"Chip theft is replacing narcotics as the crime of the '90s and beyond," Mr. Boggess said last month at the annual Inland Marine Underwriters Assn. meeting.

While the average bank robbery nets about \$2,000, thefts of computer chips typically range from \$200,000 to \$2 million, adding up to a total loss to the industry of about \$8 billion in 1994, he said.

'Chip theft is replacing narcotics as the crime of the '90s and beyond,' says Michael Boggess.

Chips are eminently stealable, since they are unmarked and since \$100,000 worth can easily fit in the back of a car, according to Mr. Boggess.

Many recent thefts have been carried out by Asian crime organizations, many of them Vietnamese, Mr. Boggess said.

In a typical theft, an organizer will pre-sell the stolen merchandise and pick a lieutenant, who will recruit "soldiers" from Vietnamese coffee houses in the vicinity of the Silicon Val-

ley, he said.

"This is what makes the crimes so difficult to solve. Nobody knows anyone else," Mr. Boggess said.

The organizer will also recruit an insider at the targeted chip manufacturer—a temporary worker, guard, clerk or disgruntled employee—to provide information like shipping times or high-value locations within the "campus," he explained.

Information may also come from former spies who since have turned to industrial espionage.

"Remember all those spies that used to work for the Soviet block? They need jobs too," Mr. Boggess observed.

After having studied the location, the gangs then usually carry out the theft with "military efficiency," Mr. Boggess said.

Thefts range from quick burglaries to takeover robberies, in which armed men take over a location for an average of 12 minutes, often assaulting employees in the process, according to Mr. Boggess.

Computer companies may also become victims of internal thefts, with insiders bleeding the company of merchandise over a long period.

Once stolen, chips disappear quickly, often passing through three sets of hands within 24 hours and many more within three days, Mr. Boggess said.

A thriving black market exists for stolen computer chips, which can also be sold into a "gray market" of companies that probably suspect they are stolen, according to Mr. Boggess.

Often, chips are eventually sold back to their original owners—the victims of the thefts—who are under pressure to make promised deliveries.

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Managed
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Congress
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should be careful "not to endorse a specific HMO" but to "endorse the concept as an end worthy of consideration," Mr. Martingale said during a session of the National Managed Health Care Congress, held April 28-May 1.

Medicare risk health maintenance organizations, which number about 200 nationwide, are those that contract with the federal government to provide benefits to Medicare-eligible retirees at a fixed rate. The Health Care Financing Administration pays these HMOs 95% of what HCFA believes it would cost the government to provide Medicare benefits to retirees living in a given county.

From mail room to executive office

By MICHAEL SCHACHNER

NEW YORK—In 1963, Cecilia E. Norat was simply a "kid out of school" who had come to New York City from Argentina to spend a year with relatives.

Deciding that she liked the Big Apple and wanted to stay a while, she quickly found work in the mail room of Commercial Union Insurance Co.

That humble start unexpectedly turned out to be the beginning of a permanent life in the United States and a successful insurance career.

More than 30 years after starting out as a "gopher" at CU, Ms. Norat, a lawyer since 1986, is currently wrapping up her tenure as

APIW honors Norat as Woman of the Year

executive director of the New York State Insurance Fund, the state's insurer of last resort for workers compensation and disability coverage, which reported \$1.5 billion in gross premiums last year.

Next month, Ms. Norat will assume the newly created position of president of the AIG Vendor Services unit of AIG Insurance Services Inc.

Over the past 25 years, Ms. Norat has held numerous positions in the insurance industry, many centered around underwriting international casualty insurance. She has also

been very active in promoting women and minorities in the industry.

In recognition of her achievements and leadership, Ms. Norat was recently named Insurance Woman of the Year for 1996 by the Assn. of Professional Insurance Women, a group she co-founded with five other women about 20 years ago.

"It's a particular honor to be recognized by a talented group of insurance professionals who give so much of their time and energy to better the industry and to mentor other female professionals building their careers," Ms. Norat said.

Helping other women has always been important to Ms. Norat. She co-founded

See Norat on page 19



Ms. Norat's career has taken her a long way.

ATG head convicted of health fraud

'I didn't do anything wrong,' protests Lawrence Kenemore

By MICHAEL BRADFORD

DALLAS—A Texas man convicted of defrauding employers of \$1.2 million through phony union health insurance plans says he expects a new hearing.

"I didn't do anything wrong," said Lawrence Derwood Kenemore Jr., whose Arlington, Texas-based Assn. of Trust & Guarantee sold benefit plans to employers in at least 17 states through three allegedly bogus unions.

Mr. Kenemore is scheduled for sentencing this summer on 25 fraud, conspiracy, theft and money laundering counts, and

faces up to 270 years in prison and fines of up to \$8.5 million.

He expects the court to re-hear his case before that happens, though.

"I'll probably get a new trial," Mr. Kenemore said last week.

"I can't tell you why, but there

'There was a major error that caused the jury to rule the way they did,' says Lawrence Kenemore Jr.

was a major error that caused the jury to rule the way they did," he said.

A request for a new trial had not been filed as of last week.

Jurors in U.S. District Court in Dallas earlier this month handed down the verdict after a six-week trial.

Prior to the conviction, Mr. Kenemore's wife, son and five others connected with the unions and ATG entered guilty pleas to charges related to the missing funds.

Federal prosecutors charged that while ATG's operators set aside \$488,000 to pay claims, another

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HMO

Continued from previous page

"I think we're finally able to quantify the fact that over major markets, there's a direct correlation between managed care efficiencies and penetration. It's quite simple that HMOs become more effective as they gain enrollment, and with that comes clout over providers to negotiate discounts," said Mr. Beauregard.

By obtaining data for the study from virtually all major health plans and numerous large employers, including Minneapolis-based Dayton Hudson Corp., Armonk, N.Y.-based International Business Machines Corp. and Bethesda, Md.-based Marriott International Inc., the benefit consulting firm was able to compute cost-efficiency scores for HMOs, indemnity plans, preferred provider organizations and POS plans in about 140 major health care markets. It did

the same for quality, but only for managed care plans, where data necessary to measure quality was obtainable.

Among the 20 largest U.S. markets, Miami, New York and Los Angeles scored highest in terms of HMO cost-efficiency with scores 14.4% to 12.6% above the national average.

Quality and cost-efficiency scores were based on how HMOs stacked up against other types of competing health care plans in individual markets.

Mr. Beauregard said the fact that New York, a very expensive health care market, scored so well in HMO cost-efficiency is not as surprising as it may sound. "There are some very efficient plans in New York that dominate the market and as they gain enrollment, their leverage with providers continues to grow."

Other metropolitan areas that scored above the national average for comparative HMO cost-efficiency were, in order of performance: Dallas; Cleveland; St. Louis; Houston; San Francisco; Tampa, Fla.; Chicago; and Washington.

Large cities whose HMOs came in below the national cost-efficiency average included: Philadelphia, Boston, Seattle, Phoenix and Minneapolis. "Minneapolis is more or less where managed care began. I think their low score reflects the fact that there really isn't any indemnity business left there, so there's very little risk and cost differential between whatever indemnity business still exists and managed care," Mr. Beauregard explained.

For HMO quality, Seattle scored highest at 31.6% above the national quality average followed by Boston at 23.8%. Other cities with strong quality scores were: San Francisco, Minneapolis, San Diego, Pittsburgh and Los Angeles.

Miami HMOs offset their leading cost score by posting the lowest quality score—30.7% below the national average.

"Once again, if you look at the more mature managed care markets, that's where the higher" cost and quality scores are, said Mr. Beauregard. "These places have plans with high enrollment and mature provider relationships. These HMOs can drive down utilization rates by influencing physicians."

In terms of overall quality, HMOs performed better than PPOs and POS plans, because HMOs can better influence clinical management and utilization rates. Key findings on quality include:

- The number of pregnant women enrolled in HMOs, PPOs or POS plans that obtained prenatal care ranged from 40% to 100% by plan. The average was 86%.

- The percentage of covered children under the age of two who were properly immunized ranged from 35% to 97%, with an average of 73% satisfying criteria.

- The average waiting time for a routine physician appointment was one to 21 days. The average was five to six days.

- Mammogram screening rates ranged from 28% to 92%, with a national average of 67%.

Hewitt will complete the final phase of the HVI in August, measuring employee satisfaction levels with the plans already studied. The national employee satisfaction study will gauge one employer group's satisfaction ratings against others.

Hewitt did not disclose how specific health plans scored by vicinity and is not divulging to the public the scores of the plans of the companies that participated.

For more information about the study, contact Mike Jurs, Hewitt Associates L.L.C., 100 Half Day Road, Lincolnshire, Ill. 60069, 847-295-5000.

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First steps for wellness

By ROBERT KAZEL

SAN JOSE, Calif.—Many employers have made impressive strides in corporate wellness programs, but companies have to walk before they can run. A business coalition in Northern California is turning some companies into personal trainers that are in turn passing along health promotion knowledge to less experienced firms.

The San Jose, Calif.-based Joint Venture Silicon Valley Network has been matching up companies seeking to act as wellness mentors with those that need to learn. Seven pairs of companies have participated so far, said Laurel Hayler, executive director of the joint venture's "Healthy Community-Healthy Economy" pilot program.

Wellness activities have been var-

Benefit Beat

ied, but most were successful enough to prompt the network to establish the mentor project permanently, said Ms. Hayler. Projects included a health fair, put on by the city of San Jose, which was attended by 1,900 city workers; cardiac risk assessments of more than 1,400 employees of two companies and the city of San Jose; increased use of fitness rooms by workers in a major office building; and weight-loss programs.

The mentor program, which is supported by grants from hospitals, health maintenance organizations, insurers and other sources, allows companies to develop wellness programs at an accelerated pace and avoid common mistakes.

"Instead of having to flounder around, we get someone to walk them through it and get them off the ground fast," said Ms. Hayler.

The mentor program has included Fairfield, Conn.-based General Electric Co., the city of San Jose and a local school district as "student" companies. Among the mentors have been Cupertino, Calif.-based Apple Computers, San Francisco-based Charles Schwab Corp., Palo Alto-based Stanford University and a local plant of Cleveland-based TRW Inc. A total of 10,000 employees have been included in programs.

Hospitals, benefits merge

COVINA, Calif.—The merger of two nearby hospitals in Southern California is giving owners the opportunity to test a merger of benefits systems as well: 24-hour coverage that combines administration of medical coverage and workers compensation.

The hospitals, which administrators say is the first in the region to attempt 24-hour coverage, wanted to streamline operations after the merger in May 1994. The merger included Inter-Community Medical Center of Covina, Calif., Queen of the Valley Hospital in West Covina, together with affiliates Hospice of East San Gabriel Valley in West Covina and Homecare Advantage, a home health agency, also in West Covina.

The new corporation, which is self-insured for both health insurance and workers comp, was able to reduce the total number of third-party vendors from six to two and cut overhead, said Mary Tenney, vp of human resources of the merged hospital system.

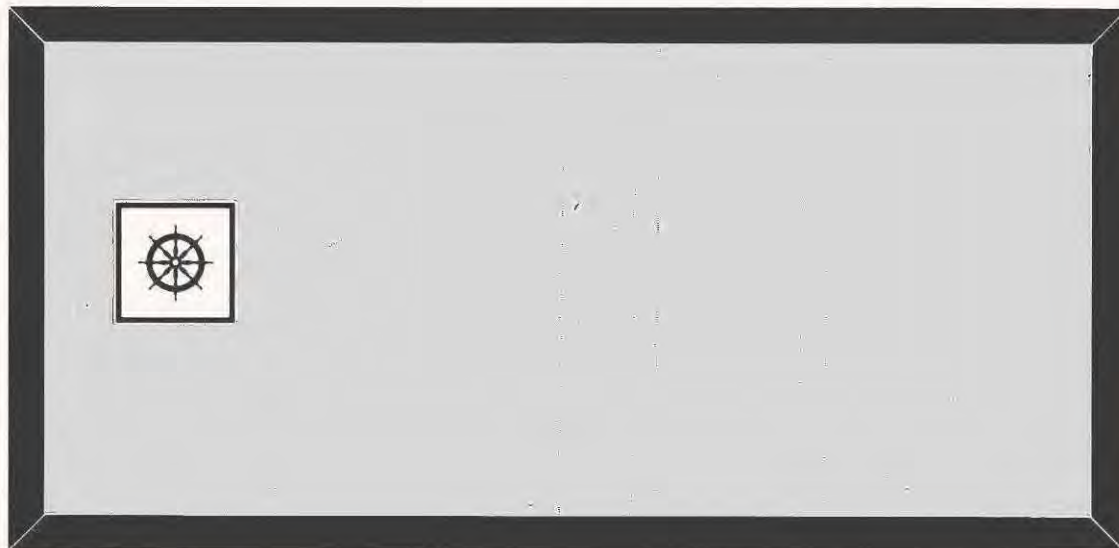
In addition, the hospitals have been able to ferret out potential benefit abuse by comparing workers comp and medical insurance databases against each other to spot duplicate treatment or promote efficiencies, she said.

"We still can take care of the employee, but we do it out of the right pocketbook," she said.

Through 24-hour coverage, the hospitals have been able to boost expense control by obtaining more information on the medical insurance side than previously, including diagnoses and severity reports that were before available only for workers comp cases, Ms. Tenney said. More information on expenditures, providers, and treatment patterns of doctors also is becoming available, she said.

"On one page, I have a report that tells me, by providers, how much we've paid to them on the medical side and the workers comp side," she said. "It will be helpful in contract negotiations, and it's made my life a lot easier."

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Opinions

Principles, what principles?

HERE WE GO AGAIN.

Once again, a promising federal product liability reform bill is dead. And once again we are left wondering what principles guide President Clinton and whether those principles involve much more than campaign contributions.

Cynical as that might sound, remember this is a president who supported tort reform in general and product liability reform in particular as governor of Arkansas. And he'd said he could support "limited but meaningful" product liability reform as president.

So what happened when a limited but meaningful bill, promoted in large part by two of his staunch supporters—Sens. John D. Rockefeller IV, D-W.Va., and Joseph Lieberman, D-Conn.—arrived at the Oval Office?

For a couple of days, nothing.

Earlier this year, the president had hung out the tantalizing prospect that, with a tweak here and a touch there, the bill might pass muster. But there's little evidence that he or his staff used the 48 or so hours between the time the bill left Capitol Hill and the time his veto pen hit paper to find room for negotiation. Instead, it looks like the time was used to assemble the cast required for a bit of political theater. This included survivors of people killed by defective products and gun control advocate Sarah Brady.

One thing appears certain: The president didn't spend the time reading the bill. Among the reasons he gave for his veto was the bill would somehow absolve the sellers of guns to felons and alcohol to drunks of liability for their actions. Trouble is, it would have done no such thing. All it would have done is give product sellers a defense when they'd unknowingly sold defective products they had not altered.

The president's stirring defense of federalism and states rights also rang hollow. It's true, as the president alluded, that there is a whiff of hypocrisy when devolution-minded Republicans call for a single federal product liability standard. But that hypocrisy pales next to the proponent of a failed national health insurance plan trying to wrap himself in the mantle of states rights.

Perhaps most troubling was a choice bit of presidential disingenuousness. Republicans have characterized his veto as a "payback" to trial lawyers who have contributed to his campaigns. Asked for his response, the president said, "Well, I've known they've



said that" and then began talking about the unemployment rate and the rights of the injured. Though the president insists that he would sign legislation that the trial lawyers disagree with, the fact remains that he vetoed such legislation.

Sound familiar? It ought to. Earlier the president has said he would support a securities litigation bill. But then, after a trial lawyer friend spent the weekend lobbying him, he vetoed it. For that about-face, the president suffered his first veto override.

He deserves another one, though he almost certainly won't get it.

Discouraging as it is to say yet again, it's time for reform advocates to dust themselves off and start working for reform in the next Congress. President Clinton has left little doubt that he will veto any new attempt at reform. Perhaps he'll change his mind the next time around once he no longer has to worry about collecting money from the trial bar.

Of course, perhaps he won't. But that's all the more reason to keep pushing for reform. Consistent pressure from the business community and others helped turn the congressional tide this session to reform. Enough pressure could also turn the tide at the other end of Pennsylvania Avenue—whether or not it's President Clinton behind the desk that the next reform bill lands on.

Bottom line on family leave

A GOVERNMENT STUDY'S welcome finding that the Family and Medical Leave Act has had a minimal impact on businesses costs comes as a little surprise.

We have always believed that many businesses overstated the potential impact of the 1993 law. Now the Family and Medical Leave Commission appears to confirm that (*BI*, May 6).

Based on surveys of both employers and employees, the panel found the law has had next to no impact on most business' benefits costs or administrative costs. An overwhelming majority said the law has had no

impact on employee productivity. What's more, among those that did notice an impact more said it improved productivity than said it hurt

productivity.

This modest impact is hardly surprising, because the law itself is a modest one. It allows up to 12 weeks unpaid leave after the birth or adoption of a child; to care for an ill child, spouse or parent; or when an employee suffers from a serious health problem. The law also holds that the employer must continue the employee's health coverage on the same basis as prior to the leave.

Though some employees have abused the law through unexplained absences, the survey found that relatively few covered employees have taken leave under the law. That's to be expected, too: Very few people would willingly give up their paycheck for anything less than a very compelling reason.

The report indicates that the law has been working as it should—to provide people with real emergencies a chance to deal with them. No one should have to choose between a caring for a sick child or losing his or her job. The report indicates that the price employers have paid for that humane assurance has been a modest one indeed.

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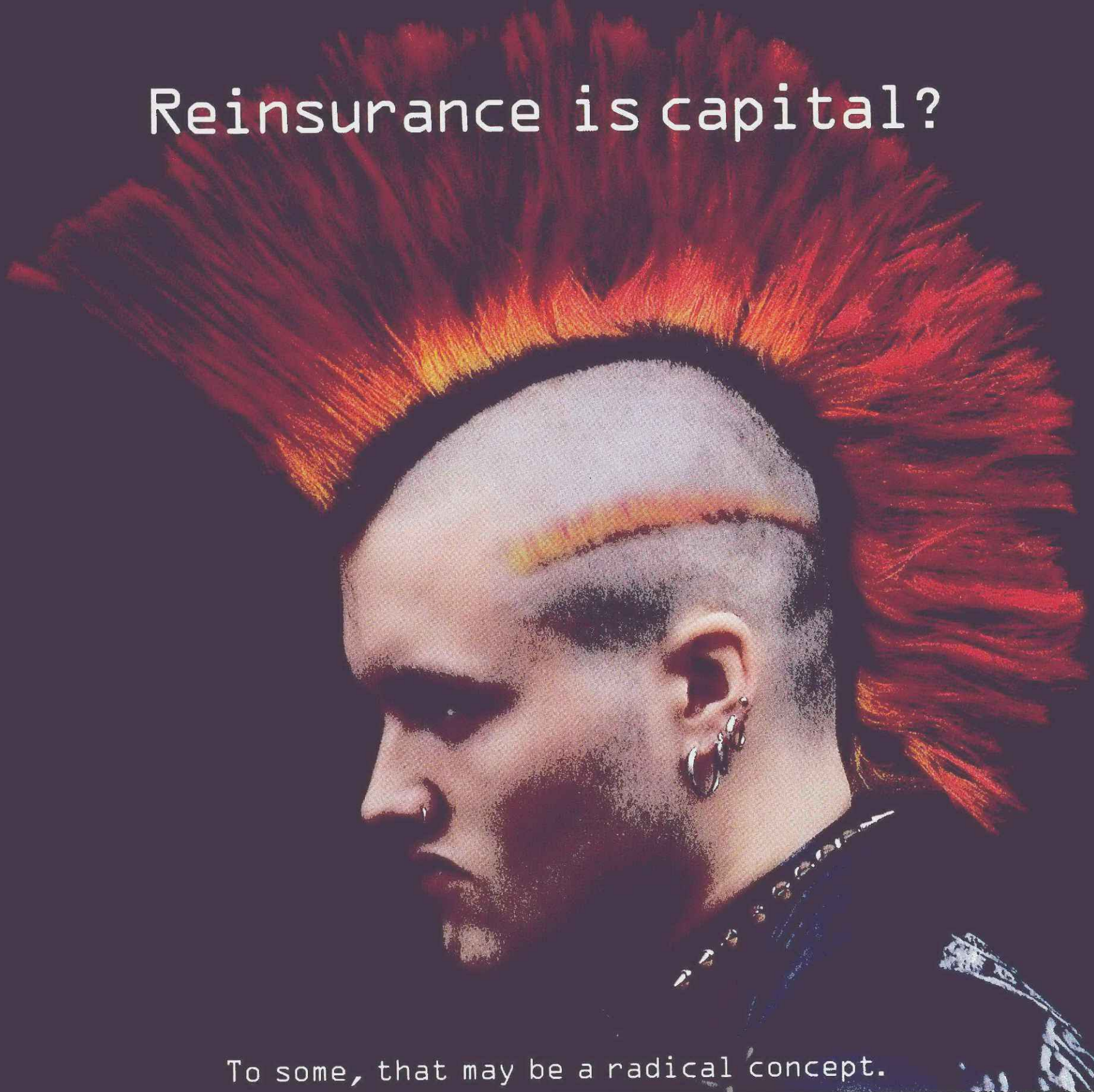
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Rating

Continued from page 1

But she agreed that talk of eventual rate increases is "in the wind with everyone."

For example, research firm Firemark Group Inc. sees higher rates and trouble ahead for California workers comp insurers, especially specialty underwriters, though not the State Compensation Insurance Fund. Among the warning signs the Morristown, N.J., firm cited in a January report were trends in premium volume, loss ratios, combined ratios and operating cash flow.

"When prices inevitably rise, whether in 1996, 1997 or even later, we expect a tumultuous change in the market as a plethora of packaging, deductible, cash flow, retrospective rating and other plans, as well as self insurance and alternative market programs, are offered to employers facing sharply higher premiums," Firemark said.

Market turmoil and the potential for hardening, availability and solvency issues are among the topics to be discussed during an investigatory hearing on open rating that Insurance Commissioner Chuck Quacken-

bush will hold May 23 in Los Angeles.

Industry observers credit the commissioner with keeping a watchful eye on potential problems associated with rate low-balling and the grab for market share that insurers made in anticipation of open rating and immediately after.

"Some insurers may be carefully preparing to survive fierce competition for the long term; others may be sacrificing tomorrow's stability for today's performance," according to a notice of the hearing.

Bolstering his case, a deputy commissioner pointed out that in 1995 more workers were covered for far less in total premiums than in the year before open rating. Total premiums fell 20.7% from 1994 to 1995, even as an improving economy added 300,000 people to the job rolls in the state.

It is that sort of data that makes Frank Floyd, education center manager for the State Compensation Insurance Fund in San Francisco, believe rates could shoot up dramatically. He noted that in 1995 several workers compensation insurers stopped paying policyholder dividends for 1993 and 1994, both profitable years. Instead of paying divi-

dends they exhausted those funds to subsidize 1995 rates, he said. They no longer have a cushion to subsidize 1996 rates.

Mr. Floyd also noted that the commissioner last fall approved an 11.3% increase in loss costs for 1996. It was only an advisory guideline, but was below the 18.7% initially recommended by Workers Compensation Insurance Rating Bureau of California. Yet on average, insurers have only sought an 8% increase. Those numbers are bound to catch up with the industry, he argues.

"You look and you say, 'Well an 8% average price increase for the industry for 1996... is not too bad because everybody acknowledges the rates were low-balled below where they should have been in 1995,'" Mr. Floyd said. "You can hulk yourself into a sense that there is no problem, but there really is and it's indicative of what is on the horizon."

He says it is only a matter of time before insurance company stockholders start demanding some return.

In what might be a sign of how tough the California market has become, some California insurers are turning their attention elsewhere.

In the midst of a tough market, there are signs some insurers are

tightening up their underwriting. As Mr. Paulin pointed out, two-year guaranteed-rate contracts are less common. And Mr. Floyd notes that insurers are taking advantage of their new ability, under open rating, to create worker sub-classification codes for rate setting.

Before the repeal of the minimum rate law, insurers were bound to stick to a limited number of classification codes. Now they are developing new sub-classification codes, allowing them to set higher rates for higher risk workers in industries where they would have previously been lumped together with lower risk workers.

"From that sense underwriting has tightened considerably," Mr. Floyd said. "They can actually charge so much they deliberately price themselves out of (some sectors of) the market."

Because of that, State Fund is picking up some new accounts that other insurers priced higher, by using sub-classifications.

Insurers are also attempting to trim costs, Mr. Paulin said. Some employee perks are gone and so are some employees, which could have an impact on the services policyholders receive.

In laying off adjusters they are leaving greater case loads for those who remain, meaning the quality of claims handling may slip, Mr. Paulin said. Insurers are also making some cuts in other areas such as loss control assistance.

But insurers can only make so many staff cuts, Mr. Floyd said. In California they face penalties and fines for not meeting strict guidelines for benefit delivery, claims handling, loss control and fraud fighting.

For example, insurers must decide

on their liability within 15 days from the filing of a claim and loss control plans must be certified by the State Department of Industrial Relations.

Slashes in fraud fighting and the mandated funding of special investigation units are among the concerns to be addressed at the upcoming investigatory hearing. The commissioner wants to learn whether there have been cuts and, if so, whether they have resulted in a resurgence of fraud.

Claims frequency has flattened in the state after four years of declines,

and there are no other structural changes under way that will impact cost, said Edward C. Woodward, president of the California Worker's Compensation Institute in San Francisco.

"That doesn't mean the market isn't changing, or pricing is not changing," he said.

Because the data is not yet available for the first year of open rating, insurers have not yet seen its full impact in their financial and statutory reporting, Mr. Woodward said. That will come following the second half of this year.

However, most insurers know what the results will be and they won't be good, he added.

"The main thing employers need to understand," he advised, "is whatever the market does, whether it hardens, whether it firms slowly, whether it does it radically, or even if it goes lower, those (insurers) who have positioned themselves, who have controlled their losses, who have the lowest loss ratios, the best experience, and demonstrated the best management attitudes are going to be the best off no matter what happens in a pricing situation. Don't let the price war distract you." ■



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ATG

Continued from page 4

\$1.2 million was diverted to run ATG and pay legal fees associated with civil lawsuits filed against Mr. Kenemore by insurance regulators in 12 states. Those states were suing him on a number of allegations, including practicing law without a license and marketing illegal insurance plans.

Civil suits in several states seek to recover another \$500,000 in unpaid medical claims related to the plans sold by ATG.

Mr. Kenemore's troubles in Texas began several years ago (BI, Dec. 27, 1993).

In 1994, then-Texas Insurance Commissioner J. Robert Hunter issued a cease-and-desist order against ATG. Mr. Hunter charged that the "bogus health insurance scheme" was operating under the claim that it was structured to sell union-sponsored health plans exempt from state regulation under the Employee Retirement Income Security Act of 1974.

The insurance department said a letter issued by the U.S. Department of Labor just prior to the cease-and-desist order indicated that the ATG product did not qualify as an ERISA plan exempt from state regulation.

Evidence presented at the trial indicated that Kenemore created the union and promised employers that their payments would be deposited into "union trust funds" that would provide employee medical payments.

Mr. Kenemore, who defended himself without an attorney, insisted in a telephone interview last week that the benefit plans offered by ATG were qualified ERISA plans.

However, Assistant U.S. Attorney Jennifer Bolen, one of the prosecutors, said this was irrelevant because the case was about the diverted funds, not how the scheme was structured.

"He argued continuously that his plans were not insurance," said Ms. Bolen. "We don't care," she added, because money promised to pay employers' claims was missing whether it was insurance or not.

Trial testimony by Mr. Kenemore's son and others included details of money laundering through Swiss American Bank in Antigua. Funds were funneled to Swiss American from U.S. accounts and then wired to co-conspirators' accounts in various other banks, the prosecutors charged.

'He argued... that the plans were not insurance,' says Jennifer Bohen. 'We don't care.'

Testimony from an official of the union set up by Mr. Kenemore and an ATG office manager indicated that Mr. Kenemore directed a coverup that involved fictitious loan documents and other paperwork to disguise the diversion of funds.

Mr. Kenemore maintained that the \$1.2 million was loaned legally to ATG by the union.

The conviction brought praise from Texas Insurance Commissioner Elton Bomer.

"This is a just and fair verdict that sends a strong signal that insurance fraud doesn't pay," Mr. Bomer said in a statement following the conviction. "I'm particularly proud of the contributions made by TDI's Insurance Fraud Unit in shutting down Mr. Kenemore's phony health insurance schemes and in helping bring him to justice."

"That statement by Bomer was crazy," said Mr. Kenemore. "The department had nothing to do with the case." ■

Mental

Continued from page 1

bridge, Va.-manufacturer of large industrial dryers and auxiliary equipment, warned that requiring parity in mental health benefits would increase the cost of goods and services.

That, in turn, will make companies less able to compete in world markets, a problem already faced by Western European countries, such as Germany, where high taxes used to pay for an extensive social welfare system increase costs for employers in those countries, he said.

"Putting the burden on business (for providing benefits) is not the way to do it," Mr. Rainville said.

Other business groups criticize the Senate amendment—sponsored by Sens. Pete Domenici, R-N.M., and Paul Wellstone, D-Minn.—for failing to define which mental health care claims would be covered.

"What do we mean by mental illness? Does it mean teen-age adjustment problems? There is no definition," complained Mark Ugoretz, president of the ERISA Industry Committee in Washington.

Business groups, citing Congressional Budget Office statistics, say the mental health requirement would increase health costs by \$65 billion over the next five years, which they contend would force some companies to cut or even eliminate benefits.

'The problem with a compromise is that it takes you down the road of the federal government dictating the content of benefit plans,' says Mark Isakowitz.

Business lobbyists also fault the Senate for not debating the measure extensively. "Forty-five minutes of debate with a half a dozen senators present at the time is not the way to treat a serious issue," Mr. Ugoretz said.

There are signs that the stepped-up pressure may not be working. "We wish we were getting more of a response" from legislators, a small employer lobbyist said.

Still, business groups say they won't ease up the pressure.

"We are and will continue to do everything we can" to kill the amendment, said Leslie Aubin Pryor, senior director of government relations with the National Assn. of Wholesaler-Distributors in Washington.

While rumors circulated last week of a possible compromise on the mental health issue—one in which parity of coverage would have to be offered for "serious" mental disorders—employer groups say they would stick to their hard-line opposition to any mental health benefits requirement.

"The problem with a compromise is that it takes you down the road of the federal government dictating the content of benefit plans. The precedent would be terrible," said Mark Isakowitz, chief House lobbyist for the National Federation of Independent Business in Washington.

"For the small business community, nothing beyond a commission or a study is acceptable," Mr. Isakowitz added.

Parity for mental health benefits is only one of the controversial issues that conferees must resolve if they are to produce a health care reform bill that they can send back to the House and Senate, including:

- Medical savings accounts. The House bill would allow employers to establish MSAs in which employer contributions of up to \$2,000 for individual coverage and \$4,000 for family coverage could be made without employees being taxed on those contributions. The MSAs would be coupled with high-deductible health insurance policies. Employees could withdraw the money tax-free to pay for uncovered health

care-related expenses. The Senate bill lacks a comparable provision.

The MSA provision has been sharply criticized by Clinton administration officials who argue that young, healthy workers would opt for MSAs, leaving older, less healthy individuals in other plans and drive up the costs of those plans. Administration officials have suggested, but not said explicitly, that President Clinton would veto a bill if MSAs were included.

One possible compromise that conferees are likely to examine would be removal of both the MSA and mental health care provisions, lobbyists say.

- Multiple employer welfare arrangements. The House—but not the Senate measure—would give to the Labor Department and take away from the states regulation of special self-funded MEWAs.

The late 1970s and early 1980s saw the collapse of dozens of self-funded MEWAs, then known as multiple employer trusts. MEWAs, which were often organized by those with an insurance sales background, were typically offered to small employers. Many organizers paid themselves high fees and set premiums low, leading to the eventual collapse of the entities and tens of millions of dollars in unpaid

claims.

In 1983, Congress cracked down and gave states greater regulatory control over MEWAs. A new surge of MEWA scandals would result if a resource-poor Labor Department becomes the lead MEWA regulator, critics of the provision say.

Small business MEWA proponents, though, say controls in the House bill, such as allowing only bona fide trade groups to establish MEWAs, would reduce the risk of MEWA failure.

Contentious add-ons aside, the core of the House and Senate bills is identical: curbing pre-existing medical condition exclusions. Under both measures, group health care plans could deny coverage for up to 12 months for new employees' pre-existing medical conditions.

But that 12-month period would be offset by new employees' coverage under their previous health care plans.

Benefit managers say that if all health care plans had to abide by the same rules, a curb of pre-existing medical condition exclusions would have little or no cost impact on their benefits programs.

About 70% of traditional indemnity and preferred provider organizations have the exclusions; HMOs generally do not. **BI**

Malpractice

Continued from page 2

miums in Texas in 1994, the most recent year for which figures are available.

Each of the three companies overestimated future claims, Mr. Bomer said in rejecting the rate hike requests.

The three insurance companies declined options to refile their requests for rate increases or keep rates the same, and will pursue the hearings.

American Physicians Insurance Exchange of Austin dropped its

effort to increase malpractice rates after the commissioner rejected its request for a 32% increase.

The insurer decided to leave its current rates in place for at least two more years.

APIE is the third-largest medical malpractice underwriter with 1994 premiums in Texas of \$27.5 million and a market share of 11.3%.

Preferred Physicians Insurance Co., of Omaha, Neb., was recently granted a 30% rate increase. The company had 1994 medical malpractice premiums of about \$1 million. **BI**

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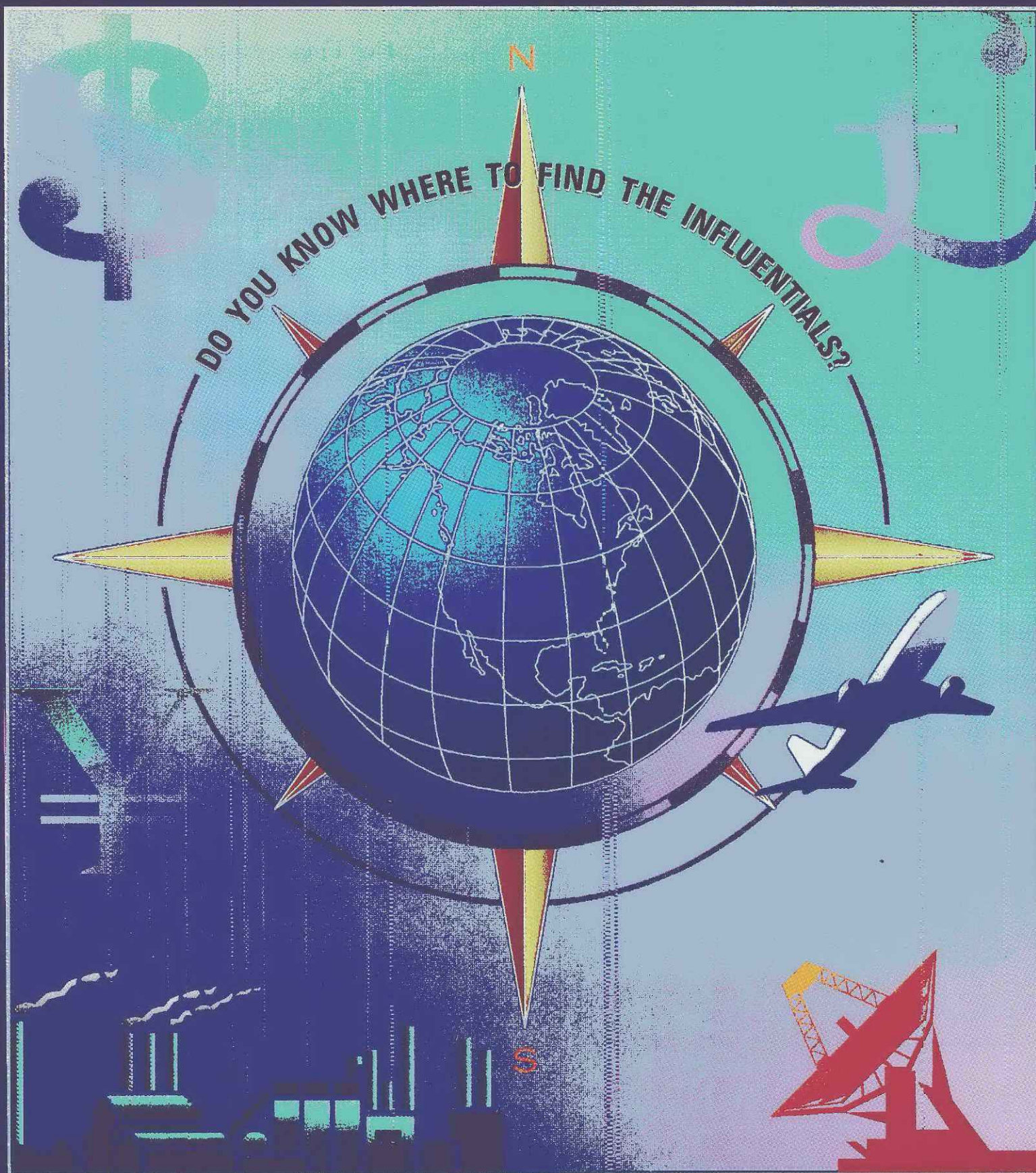
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Circus

Continued from page 1

"There are so many things going on," he said. There are benefit questions from non-English speaking employees to field, insurance problems with municipalities to resolve, and contractual issues to resolve with the railroads on which the company's private rail cars travel.

"I don't remember the last time I had a boring day," said Ms. Godfrey, a 24-year veteran of the organization. Contrary to what most people might believe, though, Ringling Bros.' has an excellent loss record and no trouble finding coverage.

As the 126-year-old circus became more and more comfortable with its safety programs and with controlling costs, its insurance evolved to higher deductibles and higher retentions.

"We have long-standing relationships with a number of carriers," said Ms. Godfrey.

Lloyd's of London syndicates underwrite a portion of Ringling Bros.' excess general liability and all of its contingency and property coverage. The broker is Byas, Mosley International Ltd. National Union Fire Insurance Co. of Pittsburgh, Pa., underwrites its workers comp coverage, and another American International Group Inc. unit, AIG Claims Services, administers its claims. Warren,

Risks faced by Ringling Bros.' performers are hardly run-of-the-mill. Routines include a tight-rope walker playing leap-frog—without a net (above). At right, three motorcyclists zoom around the "Globe of Death."



RINGLING BROS. BARNUM & BAILEY



RINGLING BROS. BARNUM & BAILEY

N.J.-based Chubb Corp. handles executive risk and directors and officers liability coverages.

Parsippany, N.J.-based GAB Robbins North America Inc. administers its liability claims. MedTrac Inc., a Willis Corroon subsidiary, manages large cases and, through a national agreement with HealthCare COMPARE Corp./The AFFORDABLE Medical Networks, provides a workers compensation preferred provider organization.

"We have the same coverages as everyone else, it's just our claims are unique," Ms. Godfrey said.

"The very first case we were ever involved with dealt with a performer that had been gorged by a rhinoceros," recalled Terry Warren, president and chief executive officer of MedTrac in Nashville.

Though workers comp produces the largest volume of claims for Ringling Bros., its experience modification factor is a low .84.

Performers are a major reason why. They play an important role by making sure their equipment is in good condition and is rigged properly. And as professionals, they do not take chances recklessly. "This is their life and livelihood," Ms. Godfrey said. "They are not going to put it in jeopardy."

When accidents occur, performers are cared for by specialists and, if need be, are flown back for treatment after the train has moved on.

Getting performers back to work quickly is not a problem. Many work as a family, so the family act may not go on until an injured performer is fully recovered.

Indeed, the real issue "is not getting them to return to work early,

it's keeping them from going back to work too early," MedTrac's Mr. Warren said. "They love to perform."

Also helping keep workers comp claims in check is in-house claims monitoring. Since the beginning of the year, Ms. Godfrey's department has been analyzing claims to see, for instance, whether accidents happen more frequently during multiple show runs, or during circus setups or takedowns.

"We're hoping that with a year of loss data, we'll see a pattern emerge," she said.

At Ringling Bros., safety control efforts are not limited to performers.

Formal safety training covers everything from running its railroad trains to setting up the hundreds of lights, nets, ropes and pulleys used in



RINGLING BROS. BARNUM & BAILEY

Keeping the circus safe

Risk management extends to animal performers, too

By SALLY ROBERTS

With a menagerie of more than 100 elephants, horses, tigers, lions, camels, llamas and zebras, Ringling Bros. and Barnum & Bailey Circus does not focus its risk management efforts solely on the people under the big top.

"The animals are a top priority," said a spokesman for Irvin Feld & Kenneth Feld Productions Inc., which produces the two traveling Ringling Bros. shows.

And despite occasional attacks on trainers or spectators by panic-stricken animals, especially elephants, "it's just as safe to go to the circus as any other event in an arena," contends Judy Godfrey, vp-risk management for Irvin Feld.

"Liability claims by patrons are really very low," she said.

Indeed, potential harm to the animals themselves may exceed any potential harm to patrons.

The animals are covered on a named peril basis on a property policy from Lloyd's of London syndicates, Ms. Godfrey said. The circus does not carry animal mortality coverage, though.

Public risks from the animals are limited. The only time the animals are not on the trains, in stables or performing—in other words, the only time public safety is an issue—is during the animal walks, the spokesman said.

As soon as the specially designed trains arrive in a new city for a performance, the animals are taken off and with the help of roughly 25 animal attendants—and a police escort to stop traffic—they travel from the train to the stables set up behind the arena.

Spectators line the streets to watch the elephants, horses, camels and llamas walk the street. The lions and tigers also are in the procession, but they are in cages.

"There is no risk at all to the public," the spokesman said. "They do need to stay on the sidewalk, but we have escorts walking with the animals who make sure a child doesn't bolt out between the animals."

Because the animals are all used to loud noises and colorful sights, the company's biggest fear during the walks is a run-away car.

In addition to reducing the risk of public harm, Ringling Bros. also works to reduce the risks faced by its animal trainers and handlers.

Ringling Bros. "has an incredible safety record," the spokesman said. "But accidents do happen."

In May 1993, elephant trainer Alex Gautier was crushed to death by an elephant while visiting Ringling's elephant breeding farm in Florida.

In Mr. Gautier's case, the spokesman said, he walked

into the yard with three elephants he was unfamiliar with.

It is believed that one of them was frightened and stepped on the trainer. There were no witnesses.

"Animals are going to react like animals and sometimes there are accidents," said the spokesman, adding that he knew of no other trainers killed by animals.

Scratches, though, are common, primarily from trainers trying to break up fights between the animals rather than from attacks on the trainers.

Good relationships reduce the chances for any harm



Trainers stick to carefully planned routines, which helps to keep all of the animals calm.

from the animals. The trainers know each animal individually. They know their personalities and their habits. In addition, the animals, after years of captive training, know and understand their own routines. They are lined up in the same order during every show and always sleep next to the same animals, making their behavior more predictable. "It is their routine, week-in and week-out," the spokesman said.

It is when their routine becomes interrupted that problems can occur. For instance, when male Asian elephants are in musth, or heat, they are more difficult to train because "they have sex on their minds" rather than following directions, the spokesman said. For this reason, Ringling Bros. predominantly uses female Asian elephants for circus performances, "which are a lot easier to be around during reproduction."

Most of the male Asian elephants are kept for breeding at Ringling Bros.' new \$5 million, 200-acre Center for Elephant Conservation in Polk County, Fla. **BI**

PPO suits performers

Despite logistical problems, managed care has come to the circus

By SALLY ROBERTS

VIENNA, Va.—When Judy Godfrey, vp-risk management for Irvin Feld & Kenneth Feld Productions Inc., looked into a managed care plan for the roughly 300 Ringling Bros. and Barnum & Bailey Circus performers, most companies lacked physicians in at least some of the 100 or so cities the circus gets to on each two-year tour.

Equally as frustrating, the performers were ideal candidates for a managed care plan. "Our people don't stay long enough in one place

to develop relationships with a specific doctor," Ms. Godfrey said.

So when Hartford, Conn.-based Aetna Health Plans matched network physicians with the circus' itinerary, Ms. Godfrey scrapped Ringling Bros.' old indemnity plan, underwritten by Boston-based John Hancock Life Insurance Co. of America, and in January began offering employees a preferred provider organization.

"We recognized that managed care was going to be the wave of the future," Ms. Godfrey said. "We had looked at other PPOs in the past, but

no one matched for us because we're in a different city every week."

For Aetna, the biggest challenge was not finding physicians in each Ringling Bros. venue. Instead, it was distributing information to the performers, said Deb Standeven, account manager for Aetna Health Plans in Washington. They don't work in offices and don't carry physician directories with them from city to city.

So Aetna lists all its providers on a World Wide Web site, allowing Ms. Godfrey to plug in the zip code where the show will stop, identify all the physicians and hospitals in the area and fax a list to the insurance coordinator. She gets the list out five shows in advance.

Providing a new managed care plan created another challenge for Ms. Godfrey: explaining it to performers who speak Romanian or Chinese or Bulgarian, but not English.

Rather than translating brochures into several languages and mailing them out, Ms. Godfrey's staff and Aetna representatives went to circus performances and explained the new PPO. With the help of several translators, they explained the program in employee meetings done by national-ity. **BI**



Ringling Bros.' performers have been all smiles since the company implemented a PPO in January.

RINGLING BROS. BARNUM & BAILEY

Theft

Continued from page 3

The crimes pay handsomely, he added. In executing a search warrant on one suspect's house, police found what amounted to a profit and loss statement for a \$1.2 million chip robbery, according to Mr. Boggess. The statement showed that the chips were sold for \$783,000 and the organizer netted \$761,000 after deducting about \$22,000 in carefully itemized expenses that included beer and a cheap hotel room for the robbery crew.

Despite facing this hugely expensive problem, many high-tech companies ignore it, believing that they are not vulnerable or that their insurance will cover losses in any case, Mr. Boggess observed.

Underwriters should not trust high-tech companies' assertions about their security programs, he said, recommending that the programs be reviewed by an outside security specialist.

One Colorado chip maker, he recounted, kept \$23 million in chips in a high-value vault that it insisted was secure. On a visit, though, Mr.

Boggess found that the vault had a back door and that the alarm system had been disabled to allow the guard to go outside to smoke.

Chip makers need to develop credible plans to make their operations less attractive to thieves, Mr. Boggess said. These plans must have the support of senior management and employees, who should be convinced that they are at risk in robberies.

Steps companies should take include:

- Formation of threat assessment teams to analyze a company's weaknesses.
- Establishing a written and updated security plan.
- Promoting a policy of "zero tolerance" for theft that includes immediate reporting of thefts of any size to law enforcement officials.
- Toughening pre-employment screening, particularly for temp workers.

A temp at one company, Mr. Boggess recalled, was stealing so much that a gang warned him to slow down or he would attract too much attention. The worker ignored them, so the gang turned him in and the company fired him.

The same worker was later hired

at another branch of the same company on the basis of his "experience" with the company, Mr. Boggess said.

While high-tech theft is a big problem, high technology car also be used as a deterrent.

Joseph Vieira, a manager with Holmes Protection of New Jersey Inc. in Edison, N.J., demonstrated a satellite-based cargo tracking system. The system, which also uses computer mapping software, allows Holmes to track the precise speed and location of a hijacked truck and even shut off its engine by remote control.

Underwriters, though, should look warily at such systems, said Thomas P. Prevas, president of General Security Consultants of West Hartford, Conn.

There are no current standards to gauge equipment reliability, installation and maintenance, and it's uncertain how some systems will stand up to wear and tear and even neglect by the cargo carriers using them, Mr. Prevas said.

In fact, some carriers may opt for the cheapest, most stripped down systems to satisfy underwriters and may end up having little protection as a result, he suggested. **■**

Cargo theft shifts gears as insurers stall

PONTE VEDRA BEACH, Fla.—Shippers and cargo carriers aren't doing all they can to stop a theft epidemic, and insurers are paradoxically rewarding them for the lack of effort, a panel of experts says.

"No one can claim ignorance of the problem" of hijackings and other cargo thefts, said Richard D. DeSimone, senior vp with Atlantic Mutual Insurance Co. in Madison, N.J.

Despite the "staggering" cost of thefts, "the insurance industry has responded with lower rates and broader coverage," he said last month at the annual Inland Marine Underwriters Assn. meeting. "The market has responded basically the opposite of what you would expect."

Underwriters should examine several aspects of a company's operations before offering coverage, he said, including the company's:

- Attitude toward repelling theft.
- Hiring standards and driver training practices, looking specifically at whether drivers are coached in security measures.
- Vehicle maintenance record. "If a truck breaks down, it's going to be stolen," Mr. DeSimone said.
- Financial condition. If a cargo carrier is in poor financial health, it becomes a much larger insurance risk, he observed.

One key problem is the failure of shippers, cargo carriers and others to report thefts, said Keith R. Paul, a

supervisory special agent with the Federal Bureau of Investigation in Washington.

Port officials, for example, may not report thefts because competition among ports is fierce and port officials may not want to concede they have a theft problem, Mr. Paul said.

There is also little communication among shippers, cargo carriers, insurers and law enforcement officials about their losses, possibly because victims have concluded that the chances of arrests and prosecution are slim.

"Our intelligence base on cargo theft has really deteriorated a lot," Mr. Paul said.

—By Douglas McLeod

Gaming not only risk aboard casino boats

Lack of preparation, storms may deal overzealous insurers losing hand

By DOUGLAS McLEOD

PONTE VEDRA BEACH, Fla.—As the gambling business booms, insurers are getting more interested in floating casinos as a source of new business, a panel of experts says.

But the risks—ranging from hurricanes to financially unstable casino operators—are big, panelists say.

More Americans visit gambling spots than go to baseball games, and gambling now generates more revenue than movies and several other forms of entertainment combined, they said last month at the annual Inland Marine Underwriters Assn. meeting.

With this expansion, the number of gambling boats has grown to about 90, most of them located in flood plains or catastrophe-prone coastal areas.

These vessels fall into three basic categories, according to Len Resto, senior vp with Rollins Hudig Hall of New York Inc.: navigating vessels capable of short and longer range travel; dockside vessels intended to be permanently moored; and "boats in moats," typically barges floating in a few feet of water in a trench.

Casino operators, concerned about their capital investment and ensuring a steady stream of revenue for debt service, focus on insuring property damage and business interruption exposures, Mr. Resto said. These include:

- Flood, earthquake and windstorm risk.
- Ingress/egress risk, which could be covered by a form of business interruption protection that would be triggered if gamblers were unable to reach an undamaged casino because of an event like a flood.
- Interruption of utility services.

Gambling boats initially caused confusion among underwriters, who didn't know whether to treat the risks as ocean marine, inland marine or property business, panelists said.

Lately, though, more insurers have focused on the business, setting up gaming departments, designing package policies covering several lines and offering stand-alone services like engineering, loss control and claims manage-

ment, Mr. Resto said.

Underwriters had better take a hard look at the odds before betting on these risks, warned Ronald G. Thornton, executive vp with Marine Office of America Corp., a unit of Chicago-based CNA Financial Corp.

"Don't be uninformed if you decide to play," Mr. Thornton cautioned.

Hurricane risk to coastal casino boats is a big concern, but there are big holes in some casino operators' plans to be towed to safer waters in advance of an approaching storm, he noted.

In Biloxi, Miss., for example, 14 local casino boats would have to be towed under a drawbridge at about the same time authorities would probably need the bridge to evacuate people from low-lying areas, he said.

The plans also rely on promises of local tugboat operators to show up as a hurricane approaches, promises the panelists viewed skeptically.

"The tug operators are promising 20 other people the same thing. It's not going to happen," Mr. Resto said.

The best solution is to develop standards for "super moorings" that will stand up to a Category 5 storm and allow the boats to stay at their berths, he said.

Underwriters face a variety of other risks, Mr. Thornton said, including:

- Vessel stability. In checking one boat, U.S. Coast Guard inspectors found that if all the coins used in the casino operation were stacked in one location, the vessel tipped seven degrees toward the water, he said.
- Vessel construction. Some casino boats are built on converted barges—hulls of which are not compartmentalized. A leak can thus flood the entire hull, and even if the boat doesn't sink, listing can cause severe damage to the superstructure.
- Financial instability of the casino operator. If the operator files for bankruptcy, insurers may be stuck on the risk throughout the reorganization proceedings as maintenance and loss control measures likely deteriorate. **■**



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Growth anchored by costs

PONTE VEDRA BEACH, Fla.—The inland marine market is poised to grow with the U.S. economy, but it is still saddled with unacceptably high expenses, a panel of underwriters says.

The expense ratio for the inland marine line totaled 43% in 1993, with commissions paid accounting for an "unbelievable" 19.3% of expenses, said Alan K. Crater, vp with USF&G Corp. in Baltimore. Insurer overhead accounted for much of the remaining costs, and must be brought down, said Frank Oleskiewicz, property facultative manager with General Reinsurance Corp.

Panelists also stressed the need to contain commercial inland marine losses and the importance of specialized training of inland marine underwriters in the face of insurance company mergers and cutbacks.

The 66th annual meeting of the Inland Marine Underwriters Assn. drew 185 people to the Ponte Vedra Inn & Club April 28-May 1. Along with the state of the market, topics covered included cargo and high tech equipment theft, insurance of casino vessels and provisions of the North American Free Trade Agreement.

Next year's conference will be held June 1-4 in Williamsburg, Va.

For more information, contact IMUA at 111 Broadway, New York, N.Y., 10006; 212-233-7958.

—By Douglas McLeod

INTERNATIONAL

Members of Lloyd's in U.S. urged to back recovery plan

Pursuing litigation could topple ailing market, leader contends

By SARAH GODDARD

LONDON—U.S. members of Lloyd's of London should actively support the Lloyd's of London Reconstruction & Renewal plan to avoid a worse fate in the future, warns a representative of U.S. members.

The interests of Lloyd's of London's U.S. policyholders ultimately will be put ahead of those of U.S. members if the current crop of state securities actions proceed to courts.

But just proceeding with these actions could be enough to bring down Lloyd's plan, says a U.S. member of Lloyd's.

Writing to all U.S. names, Roderick Macdonald, the Assn. of Lloyd's Members regional organizer in New England, warns that if pending litigation prevents Lloyd's from drawing down on substantial numbers of members' letters of credit in the near future, the U.K. Department of Trade and Industry could revoke its authorization of proposed runoff reinsurer Equitas Ltd. And that move would automatically lead to the failure of the so-called R&R plan.

"If the R&R plan fails, we are all going to be in a much worse situation and are going to have to continue living with the specter of the Lloyd's disaster for many years to come," Mr. Macdonald said.

If Lloyd's ultimately failed, "the DTI would take over and its power to tie up assets and compel payments are vast," he said. And there would be little chance of escape, he predicted, pointing out that British court judgments are routinely enforced in the United States.

The plan will become more acceptable once the widely anticipated additions to the settlement pot are made, Mr. Macdonald wrote.

If the plan fails, we will live 'with the specter of Lloyd's disaster for many years to come.'

The final plan will "mete out rough justice on as equitable a basis as is possible, given the limited resources available," he said.

Mr. Macdonald urged U.S. names to contact their state securities office to voice support for the plan. "Your support of the R&R plan is not an endorsement of Lloyd's; it is your way out of the problem," he concluded.

Meanwhile, Lloyd's has won a landmark case in the U.K. courts which will pave the way for collecting more outstanding debts from names. Justice Cresswell handed down his verdict last week in the long-running *Lloyd's of London vs. Clementson* case, a test case backed by the Writs Response Group, an association representing 2,000 members in contesting suits against members for unpaid losses (*BI*, Nov. 14, 1994).

John Stewart Clementson, on behalf of the WRG, alleged in his suit that some of Lloyd's operations—including the provision of the Central Fund—were anti-competitive and in breach of the Treaty of European Unity, formerly called the Treaty of Rome, because Lloyd's unique structure gives it a competitive advantage over other European insurers.

While hearing an appeal on the full case in November 1994, the Court of Appeal had dismissed other facets of the litigation but decided that the Eu-

ropean Union competition point needed to be thoroughly examined before it could rule on the matter.

Judge Cresswell dismissed the WRG allegations, which now means that all arguments in the case have been found in Lloyd's favor, but the WRG has been given leave to appeal the decision.

The spiraling amount of litigation at Lloyd's has helped generate an after-tax deficit of £13.8 million (\$21.03 million) in the Corporation of Lloyd's accounts, published May 7. In 1995, the service arm of the insurance market spent £4.7 million (\$7.3 million) on legal fees to defend cases including the *Clementson* case; suits over premium trust deed amendments; and U.S. securities actions.

In addition, professional fees associated with putting together the R&R plan totaled £7.3 million (\$11.3 million) for the year.

Overall, the accounts show that the cost of the R&R plan adds up to almost £28 million (\$42.7 million), including more than £1 million (\$1.5 million) in extra staff costs.

What's more, the setup costs of Equitas is estimated at approximately £110 million (\$167.7 million), though this amount will be recouped from members' Equitas premiums rather than being carried by the market centrally.

"When set against the benefits provided to members by Equitas, I am confident that this expenditure will be seen to have been entirely justified," Lloyd's Chief Executive Officer Ron Sandler wrote in his introduction to the accounts.

Chairman David Rowland—who on the same day said he will stay in his post for another year—said that Lloyd's was continuing to seek ways of

See Lloyd's on page 19

France putting AGF up for sale

Privatization moves forward

By MARIA KIELMAS

PARIS—The much-heralded resumption of France's privatization process will kick off with the sale of most of the French government's 56.9% share in Assurance Generales de France, one of the country's largest insurers.

The Finance Ministry gave the go-ahead to the sale just as AGF top executives were embarking on a road show for stock market analysts and potential investors around the world. AGF President Antoine Jean-court-Galiagnani said that the return of the company to the private sector after five decades of state ownership marks a fresh start. "It is an ideal opportunity for us to capitalize on the restructuring of recent years to create an increasingly profitable group," he said.

AGF plans to concentrate on core insurance businesses and has already scaled back its banking interests.

Stock market analysts are not so sure that the privatization is a ticket to increased profitability. Many questions remain unanswered.

"Is this a real privatization?" asked Michael Huttner, insurance analyst at Barclay de Zote Wedd in London.

AGF management, noted Mr. Huttner and other analysts, has not clarified several issues: the French government's traditional role in appointing a chief executive in companies in which it holds a stake; the role of larger French shareholders, known as "hard core" shareholders, who have indicated that they will take 26% of the privatization issue; and what the real differences are between the upcoming AGF sell-off and a similar exercise held two years ago for Union des Assurance de Paris, which received a concerted thumbs down from the international capital markets. Since its 1994 initial offering (*BI*, April 4, 1994), UAP's stock has fallen 20.8% from 138.4 francs (\$26.85) to close at 109.5 francs (\$21.24) last Tuesday.

The AGF privatization involves a 45.6% share offering, which cuts the French state's stake in the company to 11.3%, and is expected to bring in some 8 to 10 billion francs (\$1.56 billion to \$1.59 billion). No date has been set for the sale, but it is expected by French market sources to take place between May 21

See AGF on next page

Fire devastates Paris bank

By MARIA KIELMAS

Insured damages to Credit Lyonnais may top \$300 million

PARIS—A fire which destroyed the headquarters of France's largest bank, Credit Lyonnais, will generate insured losses of at least 1.6 billion francs (\$310 million), insurance industry sources estimate.

The May 6 fire is thought to have been caused by a short circuit in the electrical system in the computer room. However, the cause of the fire is being investigated by the bank, its insurers and the Economic and Financial Affairs Section of the Paris police department.

The building, a 19th-century historical monument near the Paris Opera, was valued at 1.6 billion francs (\$310 million), according to the bank's president, Jean Peyrelevade. Credit Lyonnais' insurance program consists of a property policy, business interruption coverage, and contents-of-safes coverage. The first layer of property coverage has a limit of 1.6 billion francs (\$310.6 million), market sources said.

Assurance Generales de France holds a 30% share of this coverage. Other participating companies include: Union des Assurance de Paris; Abeille Assurances, a division of the Commercial Union

P.L.C.; American International Group Inc.; Groupe des Assurances Nationales; Allianz Assurance Co. Ltd.; AXA Assurances; Union Mutuel des Mais; Preservatrice Fonciere Assurances; and Zurich Insurance Co.

An AGF spokeswoman in Paris confirmed her company's participation in the Credit Lyonnais program, adding that AGF's maximum retention on facultative and treaty coverage for the risk is 50 million francs (\$9.7 million). AGF's headquarters is just blocks away from the burned Credit Lyonnais building.

"You can see the damage from our roof, it is very, very bad," the spokeswoman added. No decision has yet been made on whether the damaged building will be demolished or partly rebuilt.

France's leading insurer, AXA, says it expects to pay out 90 million francs (\$17.5 million)—50 million francs (\$17.5 million) on the direct insurance and an additional 40 million (\$7.76 million) on the reinsurance. Although AXA, with just a 5.5% share on

the primary layers is losing the same as AGF with a 30% stake, industry sources said they believe the higher AXA losses may occur because AXA ceded a much smaller portion of the risk to reinsurers.

The business interruption policy is led by Abeille Assurances with a stake of 32%, market sources said. AGF has a smaller stake in business-interruption coverage.

The safe-contents policy was led by Preservatrice Fonciere Assurance, or PFA, a division of Athena Assurance, itself a part of the Worms and Company financial group. PFA had 30% of the coverage.

Industry sources do not expect the safe-contents coverage to be triggered by the fire. Initial reports after the fire said that the safes appeared to be untouched, but access to them was forbidden since the floors on which they were located had collapsed.

Credit Lyonnais resumed its banking activities virtually the day after the fire. The 2,500 staff at the Boulevard des Italiens headquarters have been relocated in the bank's numerous offices within central Paris. Most of the foreign exchange dealing activities have been transferred to London, a bank spokeswoman said. **BI**



A devastating May 6 fire at its 19th-century headquarters is causing some very modern problems for the largest bank in France. Some trading operations were immediately moved to London.

INTERNATIONAL

AGF

Continued from previous page and May 29. The Finance Ministry will announce a share price on May 20.

According to an AGF statement, banking concern Societe Generale, and Banque Paribas S.A. will increase their stakes from 3.5% and 1.5% to 5% and 2.5% respectively.

Swiss Reinsurance Co. will acquire a 3% stake; Credit Suisse will acquire 2%; Athena Assurance of France and Italy's Istituto Nazionale delle Assicurazioni, or INA, will take 1%. The German insurer AMB Aachener und Munchener Beteiligungs AG, in which AGF holds a 33.5% stake, will maintain its holding at 5%.

In addition, about 10.5% to 12.5% of the shares will be reserved for company employees. The state's remaining 11.3% share will be gradually reduced to below 10%.

In contrast to previous French privatizations, there will be no binding legal agreement between the existing shareholders stipulating that none may sell its holding without the permission of the others.

AGF said in a statement that its strategy is to achieve a 10% return on equity by the year 2000. As an intermediate objective, the group plans to double earnings per share in the period between 1994 and 1997.

In order to achieve that aim, AGF intends to focus on its strengths:

- A strong presence in Europe, notably Belgium, Spain, Ireland and the United Kingdom.

- The partnership with AMB.
- A selective presence in high-growth emerging markets such as Chile, Brazil, Malaysia and Korea. The insurance company plans to withdraw from markets where it does not have a strong presence, as evidenced by last year's sales of its subsidiaries in Portugal, Germany and a fund manager in Chile.

- Niche specialties such as credit insurance via its holding in French credit insurance company Cie Francaise d'Assurances pour le Commerce Extérieur, or Coface, as well as its acquisition of U.K. credit insurer Trade Indemnity P.L.C.

This strategy has raised further questions among stock market analysts.

"AGF has a problem with returns. People do not doubt that

they can improve, the question is by how much and how quickly?" said Michael Lindsay, insurance analyst at Lehman Bros. in London.

AGF management today is much more open and more realistic, focusing on giving value to shareholders and on core business

competition is increasing in the non-life market and could cause results to deteriorate after 1997, Mr. Lindsay said.

And, although he said he is bullish about the French life sector, companies in France offer short-term (seven to 10 years) products dependent on capital gains and a

market fundamentals and not on privatization issues," Mr. Lindsay said.

AGF reported that its consolidated gross written premiums for the first quarter fell by 8.9%, compared with the same period last year, because of changes in company structure.

Gross written premiums fell to 17.3 billion French francs (\$3.42 billion), compared with 19 billion French francs (\$3.92 billion) one year ago, primarily because of the sale of several units this year and last, together with the deconsolidation of SCOR, effective July 1995.

Excluding the sold units, AGF reported that first quarter premium volume rose 5.6% from 1995 to 1996.

Life insurance gross written premiums grew 12.2% from 4.8 billion francs to 5.39 billion francs (\$931.7 million to \$1.05 billion). Non-life business grew 1.3% from 5.1 billion francs to 5.2 billion francs (\$989.9 million to \$1 billion).

This figure does not include revenues from Coface and AMB, as these are not consolidated, or of newly acquired companies such as Trade Indemnity and Paris-based insurer Cie. d'Assurances Maritimes, Aeriennes & Terrestres, or CAMAT. **BI**

AGF plans to withdraw from markets where it does not have a strong presence, as evidenced by last year's sales of subsidiaries in Portugal, Germany and Chile.

issues, "but everything is really going to depend on the yield on assets and that means selling property, which is difficult and is slow," Mr. Lindsay said.

Mr. Lindsay conceded that AGF has already embarked on a property sale, selling apartments to existing tenants. "But commercial property is where the real problems lie, and people are not optimistic."

He also questioned growth potential in life and non-life insurance sectors.

Results have improved, but

tax break.

"If the yields start dropping and interest rates creep up, sales of life products will slow as people will switch their investment to the money markets," Mr. Lindsay said.

Mr. Lindsay concludes that the markets are adopting a wait-and-see attitude to the sale. Analysts believe that the stock is likely to take off because it will be priced low.

"We'll just sit tight and wait. We will make our decisions when there is more information—and on

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INTERNATIONAL

Lloyd's

Continued from page 17

improving the R&R offer. "Complete fairness is not achievable. However, we remain determined to make this settlement as fair as it can be."

The accounts show that the sale of Lloyd's of London Press Ltd. resulted in a profit of £66.4 million (\$101.2 million).

The sale and leaseback of Lloyd's 1986 building earlier this year for £180 million (\$274.4 million) to German property company Despa Deutsche Sparkassen-Immobilien-Anlage GmbH led to a profit of £55.8 million (\$85.1 million).

The corporation's annual accounts show that the Lloyd's Central Fund, which the market says operates "primarily as a fund available for the protection of policyholders," dropped 26.6% during the year to £541 million (\$838.6 million).

As well as protecting policyholders, the fund is contractually required to meet liabilities concerned with Lioncover Insurance Co. Ltd., the reinsurer of the collapsed PCW syndicates; Centrewrite Ltd, the reinsurance company for certain syndicates in runoff; and hardship members. The Central Fund accounts include a provision of £73 million (\$111.3 million) to cover a shortfall in Lioncover assets.

Overall, the accounts show that

Lloyd's provided assets to cover member solvency shortfalls of £1 billion (\$1.55 billion), down 5.4% from 1994. Assets used included the Central Fund, 1986 building and a credit for the "double counting" of error and omissions losses within the market which have been reserved.

David Rowland's salary of £450,000 (\$685,935)—plus benefits amounting to £18,000 (\$27,437)—has not been changed for this year.

Mr. Sandler, who was appointed CEO in December at a salary of £250,000 (\$381,000) with £62,500 (\$95,269) pension contribution,

'We remain determined to make this settlement as fair as it can be,' says Chairman David Rowland.

also received a performance bonus of £30,000 (\$45,729).

In 1995, 139 corporation employees earned more than £50,000 (\$77,500), compared with 90 employees in 1994.

Although former Chief Executive Officer Peter Middleton had planned to reduce staff numbers within the corporation to 1,600 by year-end 1995, the year saw an 8.2% increase to 2,042 staff members. **BI**

Sun, Royal ratings reviewed

Weaker Royal might benefit most from planned merger

By EDWIN UNSWORTH

LONDON—Rating agencies see the merger of Royal Insurance Holdings P.L.C. and Sun Alliance Group P.L.C. as a wise move for both, but especially for Royal, the financially weaker of the two.

Standard & Poor's Corp. placed the claims-paying ratings of both companies on CreditWatch in view of the merger plans.

For Royal, the review is to consider a possible upgrade from the A ratings that Royal Insurance P.L.C. and the Royal Indemnity Co. Intercompany Pool now have. But for Sun Alliance, it could mean a downgrade of the AA- rating now held by Sun Alliance & London Insurance P.L.C. and other units.

"The positive CreditWatch implications for Royal stem from the benefit of merging with a financially stronger company. The negative CreditWatch implications on Sun Alliance reflect the possibility that the historically excellent capital strength of Sun Alliance may be somewhat diluted," S&P said.

Moody's Investors Service also is reviewing the A2 insurance financial strength rating of Royal Insurance P.L.C. and its U.S. subsidiaries for possible upgrade.

Sun Alliance & London P.L.C.'s Aa3 rating will not be changed.

Moody's explained that a merger would create a much broader base of earnings and cash flow, making operating results less susceptible to severe catastrophe losses.

However, it also noted that the potential could be limited for the achieving the sizable economies of scale the companies are aiming for and that the merger could aggregate risks in certain territories.

Aggregation would be a particular concern in the United Kingdom. Royal Sun Alliance P.L.C. would have such market share that a major problem in a given line could create serious exposure, said Moody's Senior Analyst Rafael Villarreal.

As an example, he cited property portfolios which could be at risk if there were a serious flood.

Moody's said its review will focus on the corporate structure, financial and operating leverage and cost savings opportunities.

A.M. Best has also placed its A rating of Royal Insurance P.L.C. and its A- rating of Sun Alliance Group P.L.C. under review after the merger announcement.

It notes "several long-term positive implications" of the proposed marriage, in particular the enlarged company's greater global presence, its enhanced capital base to support business expansion, greater distribu-

tion capabilities, increased operational efficiency, a wider range of products and services and its potential for cost savings.

Additionally, A.M. Best has placed its A- rating of Royal's U.S. operation, Royal Group Inc. of Charlotte, N.C. under review with positive implications. This is because its merger with Sun Alliance's U.S. operations should lead to modest expansion in Royal's domestic commercial market position and improve its capital position.

However, A.M. Best has placed under review with negative implications its A++ rating of the Sun Alliance Pool in New York. It said the rating is likely to be downgraded one or two rating levels. This is because of a decision earlier this year by Sun Alliance and the Chubb Corp. units to phase out a long-standing reinsurance agreement under which they ceded a portion of their business to one another and also to reduce their reciprocal ownership in one another.

A.M. Best said that this will result in the majority of Sun Alliance's current business volume being eliminated over the next three years.

Meanwhile, Sun Alliance and Royal said that they plan to seek shareholder approval in June for the merger, and hope to complete it by early August. **BI**

Norat

Continued from page 3

APIW in 1976 when professional women in insurance were few and far between. In 1994, she was honored for her leadership and commitment to the Latino community and was presented with the Governor's Office of Hispanic Affairs' Outstanding Hispanic Women Achievers Award. She has also received several other leadership and achievement awards over the past decade.

She seems pleased to be recognized, but unfazed by the number of awards she has been given over the years.

"When I got going at APIW I really wanted to get women established as professionals and I wanted to make insurance a career for women. Over time, APIW has become a great place for people to meet and develop," she said.

Since arriving in New York from Buenos Aires in 1963, Ms. Norat's career has done nothing but develop.

Her own development took her from the Commercial Union mailroom to junior underwriter in the casualty department within two years.

She then took the skills she honed at CU to the American Foreign Insurance Assn., where she was an underwriter of international casualty insurance.

From AFIA, Ms. Norat moved on to Chubb & Sons Inc. just as Chubb was gearing up its international operations and needed experienced people. "At that time, you either trained people from scratch or hired them from AFIA," Ms. Norat said.

She spent five years at Chubb and then joined C.I.U. Inc., a managing general agent that specialized in international insurance.

Ms. Norat spent 10 years at C.I.U., where she served as the director-vp in charge of casualty underwriting, claims, accounting and

administration.

While at C.I.U. she met Mary Lowery Fitzmaurice. Together, along with help from Josephine Hoey, Barbara Brown, Ruth Curry and Gloria Nimetz, the group formed the APIW in 1976.

Ms. Fitzmaurice, who was the APIW's first Insurance Woman of the Year in 1977, recalled her time working with Ms. Norat, and said her being named Insurance Woman of the Year is long overdue.

"Frankly, I think she should have been the second award winner after me," said Ms. Fitzmaurice, who retired from the industry in 1980. "As a professional, she was bright, quick, industrious and she speaks five languages. And as a friend, we shared a lot of laughs together. She was always lighthearted and smiley. She always had time for a laugh no matter how hard she was working."

One of the hardest periods of Ms. Norat's career began in 1978 while she was at C.I.U. "I realized at that time that to really make it in this business I needed a college degree. And, from the age of eight, I always wanted to be a lawyer. So, I decided to give myself eight years to get my degree, go to law school and pass the bar."

Sure enough, Ms. Norat graduated from Fordham University Law School in 1986. While at Fordham, she was co-chair of the Fordham Law Women group. And, during all eight years of school, she attended classes only at night and held a full-time job at C.I.U.

Upon graduating, Ms. Norat decided her career should move toward government. So, she turned to former New York Gov. Mario Cuomo, on whose campaigns she had regularly volunteered. The fact that Ms. Norat's mother was the governor's press officer for Hispanic affairs also made the governor more than just an acquaintance.

The call paid off. Gov. Cuomo contacted the State Fund's Board of Commissioners, and Ms. Norat was

hired as deputy executive director.

In 1987, Salvatore Curiale, former New York Insurance Superintendent and now senior executive vp with Mutual of America Life Insurance Co., took over as executive director of the fund.

When Gov. Cuomo appointed Mr. Curiale to the post of chief regulator of insurance in 1990, Ms. Norat was promoted to take his place.

"When I became director of the fund, I was probably one of the very few woman CEOs of a company of that size. Today, I'm sitting on about \$8 billion in assets and I oversee a unionized workforce of about 3,100 people," she said. "We do about 40% of the comp market here, so it's quite a job."

Mr. Curiale, reflecting on his time together with Ms. Norat at the fund, said she is an excellent choice for APIW Insurance Woman of the Year.

"When I got to the fund, Cecilia was already there. She was just a great individual, someone you could rely on. As a lawyer, she had great knowledge of state government and finance. And, she was always great with people," he said. "In terms of her personal and professional growth, she's one of those real interesting people who succeeded the old-fashioned way."

Pat Saporito, current APIW president, said that while she had heard much about Ms. Norat over the years, she only got to meet her extensively while interviewing her for the award.

"All I had heard was wonderful things about her, but I only met her in person for the first time last year at an APIW meeting. Of course, that was a pleasure and I only became more impressed with her professionally while interviewing her for this award," Ms. Saporito said.

Ms. Norat will be presented with her APIW award on June 4 in New York at a 5:30 p.m. cocktail reception at the City Mid-Day Club at 140 Broadway, on the 50th floor. For more information, contact Pat Saporito at 212-361-5880. **BI**

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Medicare

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tion Set, satisfaction surveys, financial data, the HMOs Medicare experience, administrative costs and client experience to select the Medicare risk HMOs. Fourteen plans were selected to offer coverage to 40,000 lives in 23 cities in nine states as of Jan. 1, 1996.

Bethlehem Steel covers a total of 99,000 retirees and dependents, 66,000 of whom are Medicare eligible, Mr. Romeo said. Annual health costs for retirees and their dependents totaled \$157 million before the Medicare risk program, with more than 80% of that group in an indemnity plan with unlimited prescription drug benefits.

In negotiating with Medicare risk HMOs, eliminating prescription drug coverage caps is often a top priority.

While almost all of the Medicare risk HMOs affiliated with the Towers Perrin initiative offer unlimited coverage for prescription drugs, typical caps in the Medicare risk marketplace would be \$500 or \$1,000.

Removing caps, said Mr. Romeo, will help ensure that "not only the healthy (retirees) enter into the HMOs."

Dental, vision and hearing benefits are nice incentives to enroll, but not as important as generous prescription drug coverage, Mr. Romeo said.

Employers should "be on the look-

out for HMOs that have pared down their networks significantly to manage Medicare risk," Mr. Martingale said. The HMO should offer the same network of providers through its Medicare risk plan as it does in its general plan. Additionally, the HMO should have parallel plans so a post-65 retiree and a pre-65 spouse can join as a couple, he said.

The evaluation checklist also should include the following items, Mr. Martingale said.

- Whether the plan has a "demonstrated focus on special needs of the elderly."

- Whether the plan shows an understanding of the expectations of retirees who have been accustomed to receiving health care coverage from their former employers.

- Whether the plan offers broad access to health care in terms of service area and providers.

Once an employer has selected Medicare risk HMOs, several measures will ensure success of the program.

Bethlehem Steel's approach is to communicate effectively and thoroughly, but to make no guarantees or promises that it can't fully stand by indefinitely.

One qualified promise that should encourage retirees to join is to eliminate premium contributions. "Try to stress that this is not a lifetime guarantee," Mr. Romeo said.

Bethlehem Steel retirees who enroll in Medicare HMOs pay no other

costs except a \$10 copayment for office visits. Retirees receive wellness and preventive coverage not available under the indemnity plan. In some cases, retirees in the Medicare HMOs also have vision, dental and hearing aid coverage. Retirees who are under indemnity coverage pay the Medicare deductible and 20% of the costs remaining. Monthly indemnity plan premiums range from: \$6 to \$35 for individual coverage.

Bethlehem Steel spends an average \$24 monthly per retiree in a Medicare HMO, compared with \$190 for those with indemnity coverage.

It's also in the company's best interest to allow retirees to opt out of the Medicare risk HMO and re-enter their former plan.

Bethlehem Steel introduced the program with a letter to retirees from Chairman Curtis H. Bernette, which included four pages of questions and answers about the plans.

That letter was followed by a letter from the manager of benefit services, Thomas J. Broderick, with HMO names, a benefit summary and more questions and answers.

Then the HMOs mailed enrollment packets in Bethlehem Steel envelopes with a cover letter from Mr. Broderick and a meeting schedule.

Once retirees have the information, be prepared. The steel company's potential enrollees obviously studied the materials and were well prepared at a series of two-hour meetings around the country

Make sure that a company official is present at all meetings in which HMO representatives are selling the plan to retirees on the employer's behalf. Employers must "counter the HMO sales pitch and the wild promises they may make on your behalf," Mr. Romeo said.

The employers and HMOs must work closely in preparing the meeting presentation. Employers must help educate HMO customer service representatives about Medicare regulations so they can answer employee questions. Have a rehearsal prior to the meetings to make sure the HMOs are saying what you want them to say, Mr. Romeo advised.

The presentation should get across that the HMO—not the employer—is running the plan. That's "so retirees don't come back to (the employer) and say, 'You promised me that benefit and you have to replace it,'" Mr. Romeo said.

Employers can take other steps to successfully offer Medicare risk HMOs to retirees.

- Make sure that the HMO not only is a quality operation, but is perceived as such in the community.

- Be ready to respond to news stories that cast a negative light on HMOs.

- Employers must make sure that their plans accommodate "snowbirds," retirees who move to a warm climate in the winter but then return to another area.

- Avoid calling them Medicare

Risk HMOs. "Retirees are uncomfortable when they talk about risk and (employers) ask them to take risk," Mr. Romeo said.

- Charge retirees something. Believe it or not, everyone is skeptical of something that costs nothing, Mr. Romeo said. While Bethlehem Steel did not charge enrollees in the 1996 program any premium contribution, Mr. Romeo said he learned that "charging retirees \$1.99 is better than giving it to them for nothing."

Bethlehem Steel has reduced its FAS 106 liability—which was \$2 billion in 1995—by \$17,000 per person covered. Launching the program has cost the company about \$60,000 to conduct the meetings, related travel expenses and meals, and the costs of UltraLink. The only item not included in that \$60,000 is UltraLink's per-enrollee service charge.

"It's well worth the investment," said Mr. Romeo.

He is embarking on the next steps in the company's Medicare HMO program. Mr. Romeo will be holding meetings with HMOs to discuss the company's needs, review the plan's actual prescription drug experience with the aim of lowering premiums, and standardize copayments and benefits.

He also is looking for Medicare HMOs in additional geographic areas in order to expand the program into Harrisburg and Johnstown, Pa., the West Coast of Florida, among other areas. **BI**

Doctors may welcome disease management

By ROBERT KAZEL

WASHINGTON—A company that wants to set up a disease manage-

ment program may find network physicians are more apt to be supportive than to bellyache about their loss of control, says a benefits man-

ager who helped create a program for ulcer sufferers.

Sara Lee Corp. managers were pleasantly surprised at how well both workers and the 400 physicians in a preferred provider organization reacted to a pilot program to manage ulcer costs it recently installed at its largest plant, said Diana L. Murray, senior manager of group insurance plans for Chicago-based Sara Lee.

The 2,000 employees at the Winston-Salem, N.C., plant, which produces brassieres, underwear and other personal apparel, were spending \$2 million a year on ulcer medicine, Ms. Murray recalled last month at the annual National Managed Health Care Congress. Ulcer drugs accounted for 14% of all prescriptions used by employees at the site, and had become the No. 1-ranked class of all drugs taken.

Sara Lee management viewed the plant as a potential model for disease management for its 30,000 U.S. employees and additional 70,000 workers abroad. Managers set in motion programs to educate doctors,

pharmacists and employees on issues relating to ulcer treatment.

The employee awareness segment of the program, called "Rx for Better Health," was combined with educational programs for doctors on issues such as patient support and compliance, utilization review and consultation with druggists to ensure that ulcer drugs were effective and appropriate.

Initially, Sara Lee managers were uncertain how doctors would react. But they were surprisingly amicable.

Companies should not underestimate the importance of doctors' help or feedback in introducing such a program, she said. "They can be instrumental in supporting a program, encouraging a program, and working with us," she said. "Not one doctor responded negatively or said 'Stay out of my business, I'm doing it my way.'"

The doctors not only told Sara Lee managers that they were happy about the company's proactive stance on ulcer treatment, they said they would be willing to support future initiatives in disease management, Ms. Murray said.

The company during this period also tried to control costs on drugs by instituting a retail and mail order drug carve-out with Edina, Minn.-based Diversified Pharmaceutical Services Inc. Pharmacists in the stores, it was found, began to do more health counseling of patients.

The program, according to Sara Lee estimates, will save the company \$150 per patient in medical and drug costs annually, or \$50 on each prescription.

While the company does not see these as big savings, Ms. Murray said, the goal was to turn Winston-Salem into a working laboratory.

Similar success may or may not happen in other corporate settings, Ms. Murray cautions. In addition to obliging doctors and pharmacists, the pilot program was fortunate to serve workers who did not seem afraid that disease management was being imposed from on high. In part, this was Sara Lee's doing: The company rallied worker support through an intensive communications cam-

paign that included posters, newsletters and talks with workers.

"We spent a great deal of time at the work site, talking about employee awareness," Ms. Murray said.

"They trusted us and they knew we really were there to help them."

But, she said, "In spite of the clinical data, I would not take this program to an area I thought was going to be hostile."

Disease management programs will be especially popular among companies in the areas of cardiovascular health and mental health, she said, because the potential savings are high. But benefit managers need to be able to sell these programs to their superiors based on business reasoning, using the "language of marketing" to show how disease management will reduce costs and enhance productivity.

Compelling evidence to back those claims may come from human resources data such as health care claims, employee turnover rates, productivity measures, absenteeism and disability claims. **BI**

10,000 at managed care meeting

WASHINGTON—More than 10,000 managed care executives, benefit managers, physicians, pharmacists, information systems specialists and others gathered at the 8th Annual National Managed Health Care Congress April 28-May 1 for speeches and workshops plus legions of exhibitors hawking products from cholesterol tests to non-skid shoes.

They heard a diverse mix of opinions on how managed care is changing, and how health plan sponsors can help to promote quality through contract negotiations, buyer coalitions, managed care standards and direct contracting with providers.

More than 100 sessions in 12 subject areas were scheduled, with additional discussion taking place in smaller round table groups. Smaller group topics included managed workers' compensation, wellness programs, specialty carve-outs and working with uninsured populations.

The meeting also included summit meetings for employers, medical directors and pharmacy directors.

The conference, which took place at the Washington Convention Center, featured five keynote speeches, a networking banquet and exhibits by more than 500 companies and associations.

Next year's congress will be held April 14-17 in Washington. For more information, call 617-270-6000.

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Dam needed to control data flood

By ROBERT KAZEL

WASHINGTON—Buyers of health insurance will in the next several years be flooded with medical outcomes data they may or not be prepared to use effectively, and such information will have to be audited carefully for accuracy.

That was one of many visors discussed last month in a keynote address by two speakers—a “futurist” accustomed to predicting tomorrow’s trends and an economist who analyzes the health statistics of today. The setting was the annual National Managed Health Care Congress.

Ian Morrison, president of the Menlo Park, Calif.-based Institute for the Future, spoke with Uwe Reinhardt, professor of political economy at Princeton University in Princeton, N.J.

“What we’re seeing is a group of people who are as smart as their doctors,” said Mr. Morrison, a frequent lecturer and consultant in health care forecasting. “It really aggravates the physicians. But we are seeing a transformation of the patient relationship. They’re asking more, they’re demanding more of their health plans and of their physicians.”

These more enlightened patients, Mr. Morrison said, will de-

mand more data on every aspect of their providers.

“Information at the plan level is insufficient,” he said. “This is a group that wants to know at the place level, they want to know at the procedure level, at the provider level, and we’re going to be buried in report cards. Everybody’s going to have a World Wide Web page with data, some of which will be accurately and scientifically determined

and most of which will be made up.”

Since most data will be coming from providers themselves, the information will have to be audited before it reaches the public, he said.

Mr. Reinhardt was not optimistic that outcomes data would have much value for the majority of patients.

“We’ll drown in information that gives us no knowledge,” he said. The average consumer, he said, cannot be loaded down with clinical information on which to base medical decisions, just as mortality data tables can’t be foisted on 85-year-olds who don’t want to receive them.

Other prognostications for the years 1996 to 2000 included:

- Employer frustration. Plan sponsors will make do with a piecemeal approach to health care. “Many of them have been forced, because

of the differences across the country in terms of regional markets, to abandon the strategy of national accounts and go instead to what we call national ‘stitches,’ where they stitch together the best point of service plans in each market,” Mr. Morrison said.

Such employers, he said, want quality in a health plan “but they’re more than happy to buy cheap if they can’t buy smart.”

- Potentially climbing costs. Overall pricing for health insurance could rise, partly due to unbridled use of high-tech medical gadgetry, Mr. Morrison said. “If it does go up, I think we’re going to have some very cranky employers or some health plans that are going to have to eat it in terms of profits and disappoint their shareholders or they’re going to have to really stick it to the delivery system.”

- Day counting. The practice of many managed care organizations to strictly watch the number of inpatient days will continue, Mr. Reinhardt said—and he stressed that such strategies are inappropriate and economically unsound. Health maintenance organizations that are “obsessed with the average length of stay” cheat the overall health system by putting not-quite-well patients out of the hospital too fast—patients who then need further care.

- Medicare managed care. The entry of Medicare patients into managed care will remain largely a Western U.S. phenomenon because residents there already are familiar with capitated care, Mr. Morrison said. “I think we’re overestimating the speed with which Medicare risk is going to transform every market across the country,” he said.

BI



‘We’ll drown in information that gives us no knowledge.’

Uwe Reinhardt

New York

Continued from page 2

ance superintendent could require higher amounts based on the type and volume of business a captive is writing.

Companies would have to post the minimum amounts in the form of cash, U.S. government securities, New York State direct obligations, such as bonds, or irrevocable letters of credit approved by the superintendent.

New York captives wouldn’t be much use for writing employee benefit programs, since the law bars them from insuring life, accident and health and annuity risks, as well as title insurance, mortgage guaranty and financial guaranty coverages.

Captives also would not be permitted to write mandatory coverages,

like workers compensation and auto liability, on a direct basis.

However, the captive could reinsure this business if it’s written by a licensed fronting insurer.

The law also includes an unusual provision that specifically allows captives to reinsure unrelated business written by a licensed insurer as long as unrelated premiums don’t exceed 50% of the captives’ gross written premium volume.

This provision was included so that captive owners could seek federal tax deductions for captive premiums on the basis of captives’ unrelated underwriting, the New York department spokesman said.

A 1991 Tax Court ruling suggested that premiums are deductible if unrelated business accounts for 30% of a captive’s net written premium volume. The Clinton administration is seeking to raise the unrelated busi-

ness threshold to more than 50% of net premiums (BI, March 25).

Even if the bill becomes law, it remains to be seen whether New York will draw business away from long-established domiciles such as Vermont.

The state would have to offer advantages over other U.S. domiciles to attract significant business, and it is unclear whether New York’s unrelated business provision amounts to that kind of advantage, captive observers say.

One attractive feature would have been to allow direct workers comp underwriting, noted Glenn Weber, a vp with Johnson & Higgins in New York.

The New York department opted against this, though, and generally sought to follow laws developed in other states in framing its own legislation, the spokesman said.

BI

Retrial sought in dental nightmare

LIVINGSTON, Ala.—A hospital and two other defendants are seeking a retrial after a jury awarded \$3 million to the family of an Alabama woman who died of a blood disease after having a tooth pulled.

The Sumter County Circuit Court jury decided in late March that the family of 69-year-old Eva Davis was entitled to the award assessed against Bryan Whitfield Hospital in Demopolis, Ala., her dentist and a physician that treated her.

“We’re disappointed,” said John Owens, defense attorney with the Tuscaloosa, Ala., firm Owens & Carver. Mr. Owens represented Charles Quarries, Ms. Davis’ physician. “We don’t think Dr. Quarries did anything wrong at all.”

The lawsuit charged that Ms.

Davis, who suffered from liver disease that inhibited blood clotting, died in 1989 after receiving inadequate care from dentist Thomas Looney, Dr. Quarries and the hospital for bleeding that could not be stopped after the tooth was pulled.

Ms. Davis sought care from her dentist, the hospital’s emergency room and Dr. Quarries over three days before her condition worsened to the point that she needed blood transfusions, said plaintiffs’ attorney Danny Evans of Homewood, Ala.

Ms. Davis’ condition worsened and by the time transfusions were begun she had experienced “massive organ failure” from the loss of blood, according to Mr. Evans. “When you lose that much blood, you’re susceptible to infection.”

Ms. Davis developed sepsis, a blood disease listed as the cause of death, he said.

The defendants have malpractice insurance that will help cover an award if one is upheld, the attorneys confirmed.

The hospital has coverage written by the Alabama Hospital Assn. Trust Fund. Because it is a municipal hospital, liability is capped at \$100,000 under state law.

Dr. Quarries has \$1 million in malpractice coverage written by St. Paul, Minn.-based St. Paul Fire & Marine Insurance Co. and Dr. Looney’s \$1 million in coverage is written by Mutual Assurance Inc. in Birmingham, Ala., according to Mr. Owens.

—By Michael Bradford

Integrating benefits saves time, money

Take holistic view on disability

By ROSEANNE WHITE

WASHINGTON—Employers that have been trying to control work time lost due to disability are on the right track, but often don’t have a complete grasp of the reasons, according to experts.

“When disability absence occurs, the issue at hand can be profitability and productivity,” said Linda Culliton, a principal at William M. Mercer Inc. in Stamford, Conn.

Replacing an absent worker’s on-the-job hours in order to maintain productivity is often done through overtime, at a rate of 1.5 times to 2 times the absent worker’s wages, Ms. Culliton said. The bottom line can take a hit from these increased labor costs and other costs associated with paid time off benefits.

For that reason, it’s wise for companies to take an integrated approach to all paid time off benefits and the reason employees are seeking these benefits, she explained during a session on integrating workers compensation and disability at the National Managed Health Care Congress held April 28-May 1.

“The reason for a comprehensive approach to all time off is to avoid cost and issues from shifting,” she said.

Workplace issues that can lead employees to look for an escape valve, such as the disability program, have been increasing due to the pressure of corporate downsizing and restructuring, Ms. Culliton said.

Add to that the child care and elder care pressures common to the so-called “sandwich generation,” and some employees, including salaried professionals, are prompted to claim disability when it may be unnecessary. Therefore, medical costs, absences and return-to-work opportunities should be looked at in the aggregate, rather than by their source of origin, according to Ms. Culliton.

In other words, if a company looks in isolation at controlling workers comp costs, it may notice results in this arena but miss the fact that costs are rising in an unmanaged area, such as under short- and long-term disability plans, she said.

Disability costs must be managed through loss prevention and loss control, and that requires a major commitment and often a different way of thinking, she said. Getting the most effective control over disability costs requires taking several steps, according to Ms. Culliton:

- Develop a baseline of data on the company’s current program to use as a measure of future progress.
- Allocate costs to various departments to promote accountability.
- Give employees incentive to report injury, illness or absence promptly.
- Provide specific descriptions of all jobs to make it easier to spot return-to-work and light-duty opportunities.
- Communicate programs and everyone’s roles in them to everyone in the workplace.

Ms. Culliton said that a company’s human resources department may have to put in place other programs to meet employees’ needs so they are not tempted to try to attain disability benefits. Childcare and eldercare, employee assistance programs, wellness initiatives and other efforts to promote the total well-being of employees and the community can all be a wise corporate investment, she said.

“This is big,” Ms. Culliton acknowledged. “For most companies, it’s a three- to five-year run” to get these programs in place.

The philosophy and commitment required to take an integrated approach to managing workers comp, disability and group health is familiar to Ted Rooney, manager of employee health management at L.L. Bean Inc. in Freeport, Maine.

“We must get the whole system helping people to make positive changes in their own lives,” said Mr. Rooney, who also holds a master’s degree in public health and is a registered nurse.

The apparel and sporting goods marketer, which generates annual sales of \$1 billion has a workforce of 4,000, but also must have workers comp coverage for an additional 5,000 employees that are added on a seasonal basis. L.L. Bean operates on a philosophy that employees, employers and providers share responsibility for employee health.

The company encourages employees to: comply with benefit plan requirements, be good consumers of health care services, use preventive benefits, adopt healthy lifestyles and return to work when able.

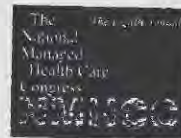
L.L. Bean sees its responsibility as reinforcing those employee efforts through all of its communications, internal policies, management practices and health plan offerings. Steps toward fulfilling those responsibilities can range from evaluating whether the food served in the company cafeteria is healthy to covering screening tests under the health plan to using ergonomic principles in the design of a job rather than just in the prevention of injuries, Mr. Rooney said.

The company seeks value from its health care providers, and has adopted a definition of value as improving employees’ health status, making sure they are satisfied with the care and outcome, and doing so at reasonable cost.

Employers must consider what the employee’s health status was prior to the disability and determine not just whether the employee can again attain the pre-disability health status, but even better health than before, Mr. Rooney said.

And “it’s not enough to improve the employee’s health status,” he said, but it is necessary to consider how well the employee can function not just during work hours but in life in general.

Taking that broader view means, for example, not just treating a back injury when it occurs but looking at factors associated with increased risk for lower-back injuries and getting those employees into a wellness program, Mr. Rooney said.



Agreement

Continued from page 1

merely on the pharmacies' status as pharmacies, and not on their ability to sell products on behalf of manufacturers, are illegal.

Drug makers that signed the agreement are: American Cyanamid Co., American Home Products Corp., Bristol-Myers Squibb Co., Burroughs Wellcome Co., Eli Lilly & Co., Glaxo Inc., Knoll Pharmaceutical Co., Merck & Co. Inc., Pfizer Inc., Schering-Plough Corp., Warner-Lambert Co. and Zeneca Inc.

Two drug makers which did not go along with the new accord—Ciba-Geigy Ltd. and Abbott Laboratories—as well as other makers that have refused to settle from the start, face a trial that has not been scheduled.

The pricing changes outlined in the settlement would start 90 days after final approval by the judge. A Milwaukee attorney for the Alexandria, Va.-based National Assn. of Retail Druggists, David Melnick, predicted a fight between pharmacists and pharmacy benefit managers for the business of plan sponsors once new pricing levels take hold.

"I think we are about to enter truly a new age," Mr. Melnick said. "They have awakened a sleeping giant, and that's pharmacy."

PBMs will have the choice of developing cooperative programs with pharmacies for the good of both, or engaging in "a battle for control of lives in the marketplace," he said.

"The battle is going to be for payers' loyalty and their business," he said. "The market absolutely will change. How much will depend on how aggressive pharmacists become."

A Chicago pharmacist, who was one of a few druggists who filed the original suit against the drug manufacturers, said he is optimistic that

the agreement would allow retail pharmacists to rise to the challenge of winning over corporate customers.

"It opens the doors and begins the process," said the pharmacist, who requested anonymity. "Give us access to the prices, and we'll move market share."

The agreement will encourage independent pharmacies to join or form large buying groups that will purchase certain drugs and promote them to physicians and, with the newly won discounts, gain new prominence in the market, said Mark Pilkington, executive director of the Illinois Pharmacists Assn. in Chicago. "The employers will get the benefit of that additional competition," he said. "Pharmacies will be pressed to give discounts to the marketplace and to employers' groups, because if they don't their competition will get the business."

Mail order drug services, in particular, will almost certainly decline in popularity, he predicted, because few companies will want workers to be greeted by a box instead of a personal druggist as long as prices are similar.

But not all pharmacists are glowing about the agreement. The Alexandria, Va.-based National Assn. of Chain Drug Stores considers it "a small step" in the direction of fair treatment for retail druggists, a spokesman said. But even with reservations, any increase in competition would aid corporate buyers, he said.

"Our industry is highly competitive," he said. "People shop for prices of medicine, whether it's individuals or companies. Companies will continue to be price sensitive."

Many expect that PBMs will adapt to the new pricing environment by stressing products and services not related only to price. As PBMs have grown and become sophisticated, PBM executives argue, they have taken on roles that are valued by corporate America beyond that of

discounter—roles that save the buyer money in other ways.

"Our value delivered to employers is less in price than in clinical management," said Jeff Sanders, vp of marketing at Scottsdale, Ariz.-based PCS Health Systems Inc., the nation's largest PBM with 56 million enrollees.

"Our focus for employers right now is not to negotiate a nickel off a very high-priced drug," he said, but to intensively promote the use of generic drugs wherever appropriate.

Although employers do look at prices of medications when choosing a drug supplier, Mr. Sanders said, the discounting of name-brand drugs has become much less a part of PCS's business than studiously taking advantage of every opportunity to avoid name brands altogether. "Our industry got too caught up in the discounts well before this settlement," he said.

Calling pharmacies "good healthy competition," Mr. Sanders said PCS would continue to firm up ties with employers through programs such as disease-state management, and would build close relations with pharmacists through new incentive programs that reward or penalize participating druggists based on cost trimming.

"The PBMs are now coming up with innovative ways of involving the pharmacies in patient care," said Michael J. Barberi, a principal in William M. Mercer Inc. in New York and a specialist in PBMs.

A Mercer study last month found that 50% of surveyed employers are interested in a managed prescription drug plan to be integrated with their health insurance plan.

Those that continue to develop new services involving pharmacists and buyers can succeed, Mr. Barberi said, while "unsophisticated PBMs will fall way behind the eight ball and some of them may go out of business."

BI

Lloyd's

Continued from page 2

Lloyd's members in California who accuse Lloyd's of fraud. The case was originally turned down by a district court in San Diego which ruled that the case should be heard in England (*BI*, Sept. 18, 1995).

The SEC filed the amicus brief after several meetings with representatives of Lloyd's and Lloyd's members.

In the brief, the SEC says that under the anti-waiver provisions of federal securities laws, investors in securities cannot give up their rights to have any disputes involving their investments heard in U.S. courts.

"Congress has made a legislative determination of the obligations and rights that are necessary to protect investors in the U.S., and has expressly directed that those protections cannot be waived," the brief says.

Allowing the district court ruling to stand could open a floodgate of foreign vendors who wanted to sell securities in the United States but avoid liability under U.S. law, according to the brief.

"Such a holding would seriously impair the ability of defrauded investors to obtain compensation for their losses and would hamper the deterrent function of the federal securities laws by discouraging private actions. The commission strongly urges this court to reverse the district court's erroneous dismissal of the action," the brief says.

The San Diego case was the first opportunity in several years that

the SEC has had to file an amicus brief at a significant level, said John W. Avery, an attorney at the SEC.

Other courts have previously ruled that Lloyd's cases should be heard in England.

"We felt that it was appropriate for the agency to make its views known to the court and Monday was the day plaintiffs' briefs had to be filed," Mr. Avery said.

Importantly, the brief assumes that membership of Lloyd's is a security and is governed by securities laws, but the SEC takes no position on that issue, Mr. Avery said.

"That is not an issue that is be-

ing in Washington who represents the Assn. of Lloyd's State Chairmen.

But Lloyd's attorneys hold that the intervention addresses only the technical issues of the anti-waiver provision and not the more important issue of whether membership of Lloyd's is a security.

"We believe that the 9th Circuit will follow other court rulings that have upheld the forum-selection agreements," said Dean Hansell, a partner at LeBoeuf, Lamb, Greene & MacRae in Los Angeles.

However, the SEC filing is significant as it marks the first time that the SEC has shown any inter-

Importantly, the brief assumes that membership of Lloyd's is a security and is governed by securities laws, but the SEC takes no position on that issue, says John W. Avery.

est in the Lloyd's cases, said Richard Blatt, a partner at Blatt, Hammesfahr, & Eaton in Chicago.

"And when a major agency like the SEC gets involved you have to sit up and take notice," Mr. Blatt said.

Meanwhile, a California district court judge has dismissed a case brought by the California Department of Corporations seeking to freeze the \$10 billion in Lloyd's American trust funds. Judge Terry Hatter ruled that the department had violated procedural rules in its filings.

The department intends to re-

file.

BI

Updates

N.Y. managed care proposals

ALBANY, N.Y.—Standardized grievance processes for HMO members and the elimination of controversial "gag clauses" in doctor contracts are among sweeping managed care changes proposed last week by New York Gov. George E. Pataki.

Gov. Pataki said his proposal would help balance the needs of patients, providers, insurers and employers, all of which were involved in months of negotiations that produced the bill.

Under the new grievance system, HMOs would have to provide members with a written explanation of grievance procedures and a toll-free hotline for filing grievances.

The bill also would: protect doctors by requiring HMOs to supply a reason for termination and allowing them to challenge HMO employment decisions; prevent HMOs from transferring legal liability to providers for any of its activities; and standardize the process HMOs use to determine whether treatments are medically necessary.

Other proposals would give the State Health Department more access to HMO and individual patient data, create guidelines for adequate managed care networks, and require HMOs to report to a central authority any disciplinary action they have taken against a provider.

COBRA coverage may expand

WASHINGTON—Employees age 55 and older who lose their jobs could retain COBRA health care continuation coverage for up to 10 years under legislation introduced by Rep. Pete Stark, D-Calif.

Under the Stark bill, H.R. 3342, older employees who lose their jobs could keep COBRA coverage until they became eligible for Medicare at age 65. This change, if enacted, would vastly expand COBRA eligibility. Under current law, employees who terminate employment—regardless of age—can retain health care coverage provided by their former employers for a maximum of 18 months by paying a premium equal to 102% of the group policy rate.

To obtain the expanded COBRA coverage, older former employees would have to pay a premium equal to 110% of the group policy rate.

Rep. Stark, who a decade ago sponsored the original COBRA legislation, says his new bill would provide a health insurance bridge for older employees who lose their jobs but aren't yet eligible for Medicare.

But business groups say expanded eligibility for COBRA would increase their health care costs because those most likely to opt for the new COBRA coverage would be those who anticipate using health care services.

A similar bill was advanced several years ago by Rep. Barbara Kennedy, D-Conn., but she later withdrew the proposal after opposition surfaced from business lobbying organizations.

Bankers Trust, P&G settle suit

CINCINNATI—Procter & Gamble Co. will pay Bankers Trust New York Corp. \$35 million in a settlement of a lawsuit with Bankers Trust over two disputed derivatives contracts.

Under the settlement, the consumer products manufacturer also will assign to New York-based Bankers Trust the benefits of an interest rate swap the investment bank values at \$14 million (*BI*, May 2, 1994).

Cincinnati-based Procter & Gamble's suit against Bankers Trust sought nearly \$200 million in damages. Bankers Trust, meanwhile, had claimed Procter & Gamble owed it nearly \$200 million in the two derivative transactions.

Procter & Gamble said it would charge the settlement to a reserve established in March 1994. Bankers Trust said the settlement will have no effect on its earnings.

Briefly noted

A three-judge panel for the 3rd U.S. Circuit Court of Appeals on Friday derailed the landmark \$1 billion proposed asbestos personal injury settlement between the 20 former asbestos makers that now comprise the Center for Claims Resolution and millions of present and future claimants (*BI*, Jan. 25, 1993). In decertifying the class, the 3rd Circuit ruled that the plaintiffs were not similar enough to warrant the massive class action. . . . FHP International Corp. has set aside \$45 million in reserves after a U.S. Justice Department audit found that its Fountain Valley, Calif.-based HMO may have violated the federal False Claims Act by overcharging federal employees for four years starting in 1987. That transfer helped cut FHP's earnings for the nine months ended March 31 94% to \$2.9 million from \$51.7 million in 1995. . . . Related reinsurers PXRE Corp. and Transnational Re Corp. in Edison N.J. are merging to create a company with \$350 million in capital that will meet the increasingly stringent capital requirements of rating agencies. PXRE had spun off Transnational to write retrocessional reinsurance in 1993. . . . Robert F. Powell Jr., who had been chairman and chief executive officer of A. Foster Higgins & Co. Inc. in New York since 1992, died of cancer May 5. Mr. Powell, whose employee benefits career with Johnson & Higgins spanned 29 years, also was a director and executive vp of the parent company. . . . Three Florida bills awaiting the signature of Gov. Lawton Chiles would: require banks selling insurance to use state-licensed agents and insurers; allow suits against HMOs for unfair claims settlement practices or failure to provide services; and give sole authority to physicians in determining the length of maternity stays. . . . As expected, the House of Representatives failed to override President Clinton's veto of H.R. 956, the Common Sense Product Liability Legal Reform Act, late last week (*BI*, May 6). . . . A federal judge has rejected a motion to dismiss the indictment of United States Aviation Underwriters Inc. and former USAU Chairman John V. Brennan on mail fraud charges related to their handling of claims from the 1987 crash of a Pacific Southwest Airlines commuter jet (*BI*, May 15, 1995). Jury selection in the case began Friday and opening arguments are expected today.

Model

Continued from page 2

it would provide greater uniformity in the regulation of investments of nearly all life/health and property/casualty insurance companies.

Currently, individual state laws generally govern investments of insurers domiciled there.

Regulators periodically check to make sure insurers are complying.

Some states such as New York also require that an insurer domiciled elsewhere in the U.S. substantially comply with New York's investment law if it wants to be licensed there.

The proposed model tries to strike "a reasonable balance" among several objectives: preserving insurer principal, assuring diversification—of investment type, issuer and credit quality—and allowing insurers an adequate rate of return.

Its drafters say they are trying to protect policyholders by promoting insurer strength and solvency.

That goal sits well with consumers.

"We want insurer investment guidelines to be appropriate in order to ensure solvency," said Patricia C. Vaughan, associate general counsel of the Risk & Insurance Management Society Inc.

"We certainly don't want the poor investments of the 1980s to repeat themselves," she said.

States need to develop "a clear, national minimum standard," said J. Robert Hunter, director of insurance for the Consumer Federation of America in Washington.

"In my view, you have to have a state-based, national standard approach or you open the door to a federal national approach," said Mr. Hunter, who is a former Texas insurance commissioner.

Some regulators think that after two years of work they are close to that point.

Their proposal would set limits on certain types of investments. For example, limits on some investments guaranteed by a single entity are 3% for life/health insurance companies and 5% for property/casualty insurance companies.

Higher limits would apply to other investments, such as those insured by a financial

guaranty insurer that meets certain qualifications.

But the proposal would also give individual regulators more discretion than they have now over insurer investments, explained Carol Ostapchuk, who chaired the drafting group.

Ms. Ostapchuk is director of the Florida Insurance Department's Insurer Services Division.

The proposal, though, does not fully resolve the tension between the two schools of thought on regulating insurance company investments: the strict "pigeonhole" approach, which sets limits on specific types of investments, and the more flexible "prudent person" approach, in which regulators determine which assets will be admitted based on the standards a prudent person would apply.

The proposal reflects a compromise between the two, what Ms. Ostapchuk has termed a "prudent pigeon" approach.

The proposal reflects a compromise, what Carol Ostapchuk calls a 'prudent pigeon' approach.

Meanwhile, another NAIC subgroup under the direction of Michigan is exploring a prudent person approach and will make recommendations to NAIC members.

That effort could eventually lead to the NAIC adopting a "prudent person" investment law as an alternative to the firmer one that is currently under discussion, though it would not happen soon, according to Mr. Wilcox.

Some supporters of a prudent person approach think NAIC adoption of firm investment guidelines for insurers is an invasion of states' rights, the CFA's Mr. Hunter noted.

NAIC leaders respond that they do not plan to make adoption of the model law an accreditation requirement.

Insurance companies, for their part, consider the NAIC proposal too restrictive.

"There continues to be problems with restrictions on well-managed companies that want to be able to continue with many of their existing investment practices," said Phillip Schwartz, vp-financial reporting for the American Insurance Assn. in Washington.

For example, some definitions of admitted assets are more detailed or include more requirements for admitted assets than do state laws. In addition, the model regulates certain instruments—such as "rated credit instruments," which are contractual rights to receive cash or other investments that are evaluated by the NAIC's Securities Valuation Office.

Insurers also complain that the proposal would restrict their investment practices by:

- Deducting borrowings from the amount of admitted assets in calculating the amount of allowable investments in different categories.

- Excluding non-insurance affiliates and non-affiliated insurers from participating in an investment pool.

- Limiting general partnership investments and limiting hedging.

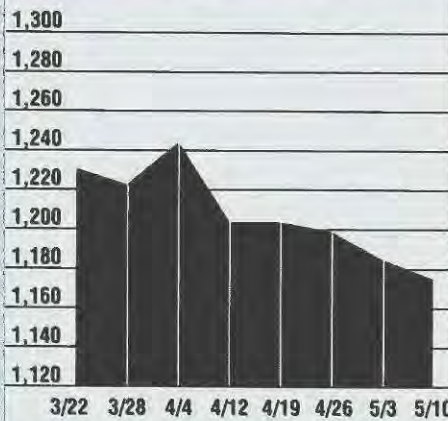
- Prohibiting some uses of derivatives and ownership of junior or secondary mortgages, if the insurer does not own the first mortgage.

Insurers also say the model act could have a broader impact than originally intended because some of its definitions are being incorporated into accounting rules that would apply to insurers even in states that do not adopt the model act.

"If there is an issue there, it has to some degree been blown out of proportion," responds Mr. Wilcox. A state that did not adopt the NAIC's model investment law language could always allow an auditor to add a note to a domestic insurer's financial statement explaining that the state's investment law was followed and not the NAIC's model, he said.

In addition, "a very important concern of the industry is once we have a model law, how do we keep it current?" said Mary J. McGinn, vp and assistant general counsel of Allstate Insurance Co. in Northbrook, Ill. She is also spokeswoman for a group of primarily insurers active in lobbying on the investment act.

BI Insurance Index



Base=100 on Dec. 29, 1978
Source: Nordby International Inc.

PCS catastrophe options

As of May 10			
Call spread	Price bid/ask	Call spread	Price bid/ask
Eastern September 1996		Midwest June 1996	
40/60	5.3/5.8	5/10	1.6/2.5
50/70	4/6	5/15	1.8/3.5
80/100	2.5/4	5/20	1.6/4
Southeast Sept. 1996		California Annual	
40/60	4/4.2	40/60	1.5/2.5
Total volume: 70 Total open interest: 2,844			
For information on PCS cat options, call 312-435-3674.			
Source: Chicago Board of Trade			

British Issues

May 9	Price	P/E	Div.	Yield	1 week
Companies	pence		pence	%	high—low
Comml Union	608	11.7	35.3	5.8	615—603
Genl Accident	651	9.8	38.8	6.0	651—630
Gdn Royal Exch	268	9.9	11.3	4.2	271—266
Independent	497	9.3	14.1	2.8	507—493
Royal	429	8.1	20.0	4.7	437—422
Sun Alliance	408	9.3	21.6	5.3	414—401
Brokers					
Bradstock	72	12.0	7.1	9.9	72—72
Fenchurch	125	8.4	10.6	8.5	125—119
CE Heath	97	21.6	6.3	6.5	97—97
JIB Group	116	11.5	9.4	8.1	116—116
Lloyd Thompson	174	10.7	11.3	6.5	174—169
Lowndes Lmbt	144	7.8	11.0	7.6	144—144
Nelson Hurst	197	12.1	9.8	5.0	197—197
Sedgwick Grp	149	11.6	8.1	5.4	149—147
Steel Brl Jones	47	6.1	5.6	11.9	47—45
Willis Corroon	147	13.2	8.3	5.6	154—147
Source: Philip Olsen, London * Estimated. Others actual					

BI Industry Stock Report MAY 6, 1996, THROUGH MAY 10, 1996

BROKERS												INSURERS/REINSURERS												HEALTH MAINTENANCE ORGANIZATIONS											
		Price	Weekly % change	Year to date % change	Annual High	Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value		Price	Weekly % change	Year to date % change	Annual High	Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value		Price	Weekly % change	Year to date % change	Annual High	Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value		
Acordia Inc.	NYS	32.25	0.00	8.40	32.50	23.50	97	0.8	2.48	20	14.00	2.30	NAC Re Corp.	NYS	32.25	1.57	-10.42	39.00	28.50	508	0.2	0.62	8	18.23	1.77										
Alexander & Alexander	NYS	19.75	3.95	3.95	26.44	17.88	168	0.1	0.51	25	19.17	1.03	National Re Corp.	NYS	34.375	-2.48	-9.54	38.13	30.00	116	0.2	0.58	11	17.05	2.02										
E.W. Blanch Holdings Inc.	NYS	22.375	7.19	-4.28	25.50	16.50	61	0.4	1.79	17	4.93	4.54	Navigators Group	NDQ	18.5	0.00	4.96	20.25	12.75	14	0	0.00	12	10.21	1.81										
Gallagher Arthur J. & Co.	NYS	33	-0.75	-11.41	39.50	32.13	290	1.16	3.52	13	6.48	5.09	Nobel Insurance Ltd.	NDQ	11,3125	0.56	-0.55	12.75	9.38	103	0.2	1.77	11	6.84	1.65										
Hibb, Rogal & Hamilton	NYS	13.625	0.93	1.87	14.38	11.50	50	0.6	4.40	16	1.21	11.26	Ohio Casualty Corp.	NDQ	34	-0.73	-12.26	40.00	29.25	636	1.6	4.71	14	23.64	1.44										
Kaye Group Inc.	NDQ	6.8125	-6.03	-14.84	10.50	6.75	11	0.1	1.47	9	NA	NA	Old Republic Int'l	NYS	21.625	-1.70	-8.63	24.38	16.63	1087	0.35	1.62	9	25.79	0.84										
Marsh & McLennan	NYS	93	-0.40	4.79	101.63	76.13	762	3.2	3.44	16	19.95	4.66	Orion Capital Corp.	NYS	44.75	1.70	3.17	47.75	36.75	102	1	2.23	9	26.00	1.72										
Poe & Brown	NDQ	24.375	-0.51	-2.01	25.50	22.75	90	0.48	1.97	14	5.15	4.73	Partner Re Ltd.	NDQ	30.75	5.58	11.82	31.75	22.25	1171	0	0.00	-	20.37	1.50										
BROKERS	AVERAGE		0.5	-1.7					2.8	19			Penn-America Group Inc.	NDQ	13.25	0.95	-7.02	15.50	8.13	24	0.16	1.21	10	6.40	2.07										
													Philadelphia Cons. Holding	NDQ	20.5	-4.09	26.15	22.50	13.25	108	0	0.00	14	11.58	1.77										
													PXRE Corp.	NDQ	24.75	-1.98	-6.60	29.75	21.00	489	0.72	2.91	5	21.27	1.16										
ACE Ltd.	NYS	44.25	1.14	11.32	50.38	24.38	257	0	0.00	-	22.45	1.97	Reliance Group Holdings	NYS	8.375	6.35	-2.90	9.25	6.00	1176	0.32	3.82	11	3.42	2.45										
Acceptance Insurance Cos.	NYS	15.875	0.79	6.72	17.50	13.13	54	0	0.00	42	10.76	1.48	Reliastar Financial Corp.	NYS	44.25	5.36	-0.28	51.63	34.75	963	1.12	2.53	10	24.53	1.80										
AEGON N.V.	NYS	49.75	2.84	13.07	50.38	30.13	25	1.23	2.47	16	17.28	2.88	RenaissanceRe Holdings Ltd.	NDQ	27.75	1.83	-8.64	33.13	20.72	322	0	0.00	-	NA	NA										
Aetna Life & Casualty	NYS	69.75	2.95	0.72	78.75	58.38	3385	2.76	3.96	18	48.85	1.43	Risk Capital Holdings	NDQ	19.75	0.00	-15.51	23.38	19.63	40	0	0.00	-	NA	NA										
AFLAC Inc.	NYS	30.875	4.66	6.47	33.13	24.38	612	0.4	1.30	13	17.58	1.76	RLI Corp.	NYS	23.375	-0.53	-6.50	25.88	19.88	103	0.56	2.40	24	20.51	1.14										
Allied Group Inc.	NDQ	37.75	2.03	4.86	44.25	27.25	72	0.88	2.33	8	21.81	1.73	St. Paul Companies	NYS	52.25	1.46	-6.07	60.50	46.13	1152	1.76	3.37	8	32.46	1.61										
Allmerica Prop. & Casualty	NYS	25.375	0.00	-6.02	27.25	19.63	72	0.16	0.63	10	19.87	1.28	SAFECO Corp.	NDQ	33.875	9.72	-1.81	39.75	28.13	2136	1.16	3.42	10	44.95	0.75										
Allstate Corp.	NYS	39.375	1.94	-4.26	46.00	28.88	5088	0.85	2.16	10	18.75	2.10	Seibels Bruce Group	NDQ	3	0.00	100.00	4.25	0.44	169	0	0.00	43	0.04	75.00										
American Financial Group	NYS	29.25	-3.31	-4.49	34.50	24.50	665	1	3.42	7	24.94	1.17	Selective Ins. Group	NDQ	32.25	2.38	-9.15	38.75	28.50	122	1.12	3.47	9	23.23	1.39										
American General	NYS	34.375	1.48	-1.43	39.13	31.00	1491	1.3	3.78	13	17.03	2.02	Sphere Drake Holdings	NYS	10.25	-2.38	-26.79	19.13	9.75	54	0	0.00	-	13.86	0.74										
American Heritage Life Ins.	NYS	21.75	-5.95	-4.92	24.25	17.75	10	0.76	3.49	11	12.51	1.74	TIG Holdings	NYS	29	0.87	1.75	34.25	22.25	780	0.2	0.69	27	16.62	1.74										
American Indemnity/Fin'l	NDQ	12.5	0.00	25.00	13.38	9.00	4	0.3	2.40	-5	15.92	0.79	Titan Holdings, Inc.	NYS	15.5	3.33	7.83	15.75	10.25	81	0.28	1.81	11	9.04	1.71										
American International	NYS	92.125	4.54	-0.41	103.38	71.00	4313	0.34	0.37	17	34.66	2.66	Tokio Marine & Fire	NDQ	63.5	-4.51	-3.79	69.25	50.88	10	0.32	0.50	22	57.72	1.10										
American Re Corp.	NYS	42.75	3.32	4.59	45.00	34.00	309	0.32	0.75	-27	16.77	2.55	Torchmark Corp.	NYS	43.125	3.29	-4.70	49.88	36.75	413	1.16	2.69	21	17.37	2.48										
Aon Corp.	NYS	52.875	0.24	6.02	56.00	35.63	865	1.44	2.72	15	18.30	2.89	Transatlantic Holdings	NYS	63.625	-0.20	-13.29	75.25	62.38	129	0.48	0.75	11	33.30	1.91										
Argonaut Group	NDQ	31	0.00	-4.62	35.00	28.88	27	1.48	4.77	11	29.91	1.04	Transnational Re Corp.	NDQ	23.625	13.17	-3.57	27.25	19.63	219	0.2	0.85	6	18.84	1.25										
AVEMCO Corp.	NYS	15.5	-1.59	-3.13	18.00	14.63	4	0.48	3.10	17	6.28	2.47	Travelers Aetna Property	NYS	27	0.47	NA	28.13	26.00	3027	0.3	1.11	300	24.77	1.09										
Baldwin & Lyons Inc.	NDQ	15.5	1.64	-4.62	18.00	14.25	349	0.32	2.06	8	13.90	1.12	Travelers Group Inc.	NYS	59.25	2.38	-5.39	70.50	40.88	6755	0.9	1.52	10	24.77	2.39										
Berkley W.R. Corp.	NDQ	44.25	2.91	-17.67	55.50	35.00	290	0.52	1.18	15	34.46	1.28	United Fire & Casualty	NDQ	31	3.33	10.71	37.25	18.25	11	0	0.00	12	28.96	1.07										
Berkshire Hathaway Inc.	NYS	335.00	0.00	4.52	380.00	221.25	1	0	0.00	55	10089.11	3.33	Unilin	NDQ	47,0625	-3.09	-1.95	51.75	44.50	658	2.2	4.67	13	37.51	1.25										
Capital RE Corporation	NYS	36.625	0.00	19.11	38.00	23.75	145	0.24	0.66	12	27.82	1.32	UNUM Corp.	NYS	58.25	1.30	5.91	63.00	39.88	1004	1.1	1.89	15	26.45	2.20										
Capsure Holdings Corp.	NYS	17.75	2.16	0.71	18.38	12.88	102	0	0.00	13	14.61	1.21	US Facilities Corp.	NDQ	17.25	-0.72	-19.30	23.38	14.13	661	0.24	1.39	7	14.20	1.21										
Chartwell Re	NDQ	21	-4.55	NA	24.75	10.00	148	0	0.00	11	11.13	1.89	USF&G Corp.	NYS	16	3.23	-5.19	19.50	14.25	1542	0.2	1.25	10	10.86	1.47										
Chubb Corp.	NYS	46.375	-0.54	-4.13	52.25	28.50	2257	1.08	2.33	12	48.92	0.95	USLIFE Corp.	NYS	29	4.50	-2.93	33.25	24.88	285	0.93	3.21	9	38.45	0.75										
CIGNA Corp.	NYS	111.625	6.31	8.11	125.50	72.63	1885	3.2	2.87	57	80.46	1.39	Washington National	NYS	26.625	-2.74	-3.62	30.50	19.38	86	1.08	4.06	10	25.13	1.06										
CNA Financial Corp.	NYS	98.375	1.03	-13.33	123.25	81.25	144	0	0.00	7	71.13	1.38	Zenith National Ins.	NYS	25.125	-2.90	17.54	26.13	20.00	287	1	3.98	36	16.35	1.54										
EMC Insurance Group Inc.	NDQ	13.5	-4.42	-1.82	15.25	10.50	4	0.56	4.15	9	11.13	1.21	Zurich Reinsurance Centr.	NYS	30.625	2.30	0.82	32.63	27.88	259	0	0.00	18	21.64	1.42										
Everest Reinsurance	NYS	23.125	5.11	-1.07	25.13	18.50	1565	0.12	0.52	122	NA	NA	INSURERS/REINSURERS	AVERAGE		1.1	0.3				2.0	18.9													
EXEL Ltd.	NYS	69.125	-2.98	13.55	73.13	45.75	1649	0.4	0.58	-	31.47	2.20																							
Fremont General Corp.	NYS	23.625	-2.58	-3.57	26.25	15.75	323	0.6	2.54	8	19.04	1.24																							
Frontier Insurance Group	NYS	33.5	7.20	4.69	33.75	23.50	165	0.48	1.43	13	14.65	2.29																							
Gainco Inc.	ASE	10.625	6.25	-6.59	12.38	8.31	164	0.05	0.47	13	3.98	2.67	FHP International	NDQ	29	3.11	1.75	34.25	19.75	1298	0	0.00	-32	28.15	1.03										
General Re Corp.	NYS	141.875	0.44	-8.47	158.25	129.50	1183	2.04	1.44	13	59.35	2.39	Humana Inc.	NYS	24	0.52	-12.33	28.88	17.00	3408	0	0.00	21	6.56	3.66										
Guaranty National Corp.	NYS	17.125	5.38	11.38	19.00	13.38	168	0.5	2.92	30	11.60	1.48	Oxford Health Plans	NDQ	47.625	-4.27	28.93	55.25	21.63	13778	0	0.00	58	6.56	7.26										
Harleysville Group	NDQ	26.75	-2.73	-17.37	33.00	23.75	41	0.76	2.84	11	20.72	1.29	Pacificare Health Sys.	NDQ	74.75	-8.84	-14.08	98.75	44.50	286	0	0.00	19	15.02	4.98										
Hartford Steam Boiler	NYS	48.5	1.31	-3.00	52.50	42.63	164	2.28	4.70	15	14.68	3.30	Safeguard Health Enter.	NDQ	18.125	-0.68	55.91	19.00	10.25	93	0	0.00													

Steel Mill

Magdeburg
Germany

4 March
0910 hrs



**SOME SEE A SMOKESTACK INDUSTRY.
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