

Business Insurance

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Stephen Merrett relinquishing underwriting duties at Lloyd's

LONDON—Lloyd's of London Deputy Chairman Stephen Merrett will resign as underwriter for one of the market's largest marine syndicates in January but will continue his other market duties.

He will remain chairman of underwriting agency group Merrett Holdings P.L.C. and also deputy chairman of Lloyd's.

To quash rumors about his future role at Lloyd's, Mr. Merrett's agency, Merrett Holdings, confirmed his resignation last week prior to the upcoming publication

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Insurer results give no sign of change

By JUDY GREENWALD

Insurance industry executives and analysts looking for signs of a broad turn in the commercial property/casualty insurance market are finding little in first-quarter results to cheer them.

Results continue to reflect the same trends that marked 1992, and it likely could be late this year at the earliest before there are any indications of an overall turn in the market.

"Overall, I didn't see anything

PROPERTY/ CASUALTY INSURERS 1st QTR. RESULTS

in first-quarter results that represented to me any kind of evidence of fundamental shifts in the industry, but then I would not have expected to," said Ronald W. Frank, an analyst with Smith Barney Harris

Upham & Co. in New York.

"We think that the first quarter of 1993 showed a continua-

tion of the key trends of 1992," said Bruce Ballantine, an analyst with Moody's Investors Service.

These trends include: a shakeout of excess capacity as insurers pull back from unprofitable lines and locations; earnings pressure from declining interest rates; continued uncertainty about environmental liabilities; and new approaches to managing catastrophe exposures.

Nevertheless, Mr. Ballantine said, "We do not yet see evidence of a broad upturn in property/casualty pricing" despite im-

provement in selected areas, particularly in property lines where there is catastrophe exposure.

"It's a blah market, nothing exciting is happening," said Dennis Busti, president of Reliance National Insurance Co. in New York.

The market remains competitive, said George Yonker, assistant controller at SAFECO Corp. in Seattle. "We're just trying to hunker down and weather it at this point. We really don't see anything that would lead us to believe things are going to im-

prove very quickly. In fact, there just doesn't seem to be anything in the wind."

Net income for the 23 out of 27 insurers surveyed by *Business Insurance* that report this information increased just 1% to \$2.09 billion from \$2.07 billion in the first quarter of 1992.

Insurer results were affected by the most disastrous first quarter on record, primarily due to the East Coast blizzard and the World Trade Center bombing (BI, April 5).

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Piper seeks trust to pay future claims

By DAVE LENCKUS

MIAMI—Piper Aircraft Corp., currently in Chapter 11 reorganization, hopes to create a novel trust fund to pay future product liability claims against the company.

Piper's bankruptcy judge may consider allowing the company to establish a fixed-asset fund that would pay claims only on behalf of victims of accidents involving Piper aircraft currently in use, according to Piper's attorney.

Unlike the trust funds established by asbestos producer Manville Corp. and A.H. Robins Co., which made the Dalkon Shield intrauterine device, the Piper trust would cover claimants injured only after Piper emerges from reorganization. The trust could conceivably cover claimants who have not yet been born.

The Piper trust would cover claimants injured or killed in accidents involving 53,000 Piper aircraft that remain in use worldwide and have a life span of decades.

In contrast, the Dalkon Shield Trust Fund covers claimants already injured when the device was pulled from the market following a flood of product liability claims.

Formation of the trust, which would likely preclude future claimants from pursuing claims in court, would allow Piper to emerge from bankruptcy and provide some measure of indemnification to future claimants, said Paul Singerman, bankruptcy attorney for the Vero Beach, Fla., general aviation

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Miro admits he bribed regulators

Convicted insurance executive says he paid off Louisiana, Georgia officials

By DOUGLAS MCLEOD

WASHINGTON—It took four years for a House subcommittee to hear testimony from now-convicted insurance con man Carlos I. Miro, but his story—if true—is probably worth the wait.

In more than three hours of testimony, Mr. Miro, among other things, said he funneled bribe money for Louisiana and Georgia regulators through an associate of Louisiana Gov. Edwin Edwards.

In addition, Mr. Miro, who is cooperating with federal authorities while awaiting sentencing on a fraud conviction, traced his activities as a managing general agent for the defunct Transit Casualty Co. and as the driving force behind the fraudulent Anglo-American Insurance Co. of Louisiana.

In occasionally glib and sometimes sarcastic testimony, the di-



Photo by Tom Reed

Carlos I. Miro detailed cases of insurance fraud last week during testimony to the House Oversight and Investigations Subcommittee.

minutive Mr. Miro—who was extradited from Spain last year—spread the blame for the

Transit and Anglo-American debacles among several former business associates, employees,

lawyers and regulators.

During his testimony before the House Oversight and Investigations Subcommittee, Mr. Miro also explained how he, Gov. Edwards—who served as outside counsel to Anglo-American between terms as governor—and Gus Mijalis, an associate of the governor, discussed an ultimately unsuccessful plan to generate millions of dollars for themselves by monopolizing the Louisiana workers comp system.

"I didn't have to fool anyone (in operating Anglo-American) because everyone in Louisiana wanted to be on my payroll and Gov. Edwards wanted to be my partner," Mr. Miro told the subcommittee.

Gov. Edwards denied the charges in a statement last week. Mr. Mijalis could not be reached for comment.

Asked at another point in the

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Few favor federal review of drug prices

By NANCY P. JOHNSON

WASHINGTON—A federal drug price review board is one health care reform trial balloon that many hope will float away.

President Clinton's policy advisers are suggesting that the government create a review board to set guidelines for drug prices. The board would collect information on drug prices and manufacturing costs and could pressure—through "adverse publicity"—pharmaceutical companies to reduce prices.

The board would set price guidelines for drugs that have no therapeutic alternative, and would have the authority to publicly condemn companies that price drugs above the guidelines.



The proposal signals that the Clinton administration may be cooling its rhetoric on prescription drug prices following intense lobbying from the drug industry. In February, Mr. Clinton had blasted drug makers for their "shocking" prices, and Hillary Rodham Clinton castigated drug makers for the cost of

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Employees may suffer from health reform: NFIB

By MARK A. HOFMANN

WASHINGTON—Health care reform proposals that depend heavily on employer mandates could put millions of jobs "at risk," warns a study commissioned by a small-business lobby.

Three of five reform proposals examined in the study could result in: lower wages or fewer hours for employees of small businesses; longer, more frequent layoffs; and "diminished prospects for job growth," according to the study.

"The Employment Impact of Proposed Health Care Reform on Small Business," conducted by Pittsburgh-based consultant Consad Research Corp., was commissioned by the NFIB Foundation, an affiliate of the Washington-based National Federation of Independent Business.

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Update

Merrett to quit syndicate

Continued from previous page of the company's business plan.

The resignation of Mr. Merrett, 53, as underwriter for syndicate 418 has "been under consideration for some time," the company stated. He is stepping down to devote more time to corporate activities in his agency and to his role as Lloyd's deputy chairman, it said.

However, the announcement was made following syndicate 418's decision to keep its 1990 underwriting year open and make a cash call of about 10% of each member's premium income capacity. Syndicate 418's 1985 year also remains open (BI, May 10).

Syndicate 418's deputy underwriter, Barnabas Hurst-Bannister, 40, will take over as underwriter of the syndicate.

Action Staffing loses comp suit

TALLAHASSEE, Fla.—A Florida judge has ordered Action Staffing Inc., a Tampa employee leasing firm, to pay \$8.8 million in damages after finding the firm misclassified employees and failed to pay workers compensation premiums it owed.

Hillsborough County Circuit Judge Robert H. Bonnano entered the award in favor of Aetna Casualty & Surety Co., the National Council on Compensation Insurance and the National Workers Compensation Reinsurance Pool. Aetna insured Action Staffing employees through the Florida assigned risk pool from September 1988 to 1989.

Meanwhile, the Florida regulators are working on a plan to settle \$4.3 million in unpaid health insurance claims for Action Staffing workers. Over different periods, Action Staffing maintained health benefit programs insured by Aetna Life & Casualty Co. and Metropolitan Life Insurance Co., and later formed a self-funded plan administered by Employee Benefit Plans Inc. (BI, April 13, 1992).

David Miller, former chief executive of Action Staffing, was sentenced to a 20-month prison term last year for making fraudulent statements in personal and business tax returns unrelated to Action Staffing in the late 1970s and early 1980s.

The Home sets new strategy

NEW YORK—The Home Insurance Co.'s board of directors has approved a new strategic plan for the insurer that involves moving away from a product-based approach and targeting businesses and accounts instead.

President and Chief Executive Officer Lars-Goran Nilsson said in a letter to employees that The Home's plan involves creation of customer-focused business groups. Four profit centers will operate under a new commercial accounts group to be headed by Executive Vp Fred Mina: middle market, major property, major casualty and international accounts. A new ventures unit to develop new markets will also operate within the group.

Other elements of the plan involve making The Home's specialty lines group a stand-alone unit and decentralization of the insurer's profit centers.

Also, a company spokesman confirmed that William L. Munson, executive vp-underwriting, left the company in April, while David Ladd, executive vp-corporate planning, and John McCue, executive vp-corporate communications, both left in March.

James Meenaghan remains Home's chairman.

A&A, M&M executives named

NEW YORK—Michael K. White has been elected president and chief operating officer of Alexander & Alexander Services Inc.

Mr. White, who joined A&A in 1970, most recently has directed the broker's global insurance and risk management services as executive vp and deputy chairman.

He assumes the title of president from Tinsley H. Irvin, who continues as chairman and chief executive officer of A&A, the world's second-largest insurance broker.

Meanwhile, Hady Wakefield has been named president of reinsurance intermediary Guy Carpenter & Co. Inc. in New York.

Mr. Wakefield was previously chairman of Carpenter Bowring Ltd. in London and deputy chairman of Guy Carpenter, a subsidiary of Marsh & McLennan Cos. Inc. and the largest U.S.-based reinsurance intermediary (BI, Oct. 26, 1992). Carpenter's chairman and CEO, Richard H. Blum, previously held the title of president.

Mr. Wakefield will be succeeded in London by Charles J.S. Cullum, who was previously deputy chairman of Carpenter Bowring Ltd.

M&M consolidated Bowring's reinsurance operations under Carpenter's management in 1990 (BI, Aug. 20, 1990).

Florida moratorium on pullouts

TALLAHASSEE, Fla.—In the wake of Allstate Insurance Co.'s announcement that it intends to drop coverage for 300,000 Florida homeowners, Insurance Commissioner Tom Gallagher on Wednesday ordered a 90-day moratorium on all cancellations and non-renewals of homeowners policies.

Under the moratorium, insurers cannot cancel or refuse to renew an expired policy until the middle of August. If an insurer still wants to cancel coverage at that time, the company must provide a 45-day notice of cancellation to policyholders.

"Hopefully by that time we'll have a catastrophe-only fund in place that will function as a reinsurer and lessen companies' exposure," a spokeswoman for the department said.

Allstate, which is preparing a public offering of more than \$2 billion of stock, said it would not immediately fight the order's legality. "This affords Mr. Gallagher time to conduct a careful and thorough review of the situation," a company statement said.

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Malpractice award caps in California challenged

By JOANNE WOJCIK

SAN FRANCISCO—An 18-year-old California law limiting non-economic damage awards in medical malpractice cases has not reduced medical costs and should be repealed, trial lawyers assert.

Even if doctors were granted total immunity from malpractice liability, which would eliminate the need for malpractice insurance and "defensive medicine," health care costs would drop by a scant 0.6%, contends Mary E.

Alexander, vp of the California Trial Lawyers Assn.

"If that savings were passed on to the consumer, the cost of a \$40 office visit would be reduced by a mere 24 cents," estimated Ms. Alexander, a partner with Cartwright, Slobodin, Bokelman in San Francisco.

However, proponents of the 1975 Medical Injury Compensation Reform Act, or MICRA, maintain that without the law doctors would have been forced to leave the state or sharply increase their fees to pay astro-

nomical medical malpractice insurance premiums.

Malpractice premiums today for high-risk specialists practicing in California are one-half to one-third lower than those charged in other states because of the law, said Barry Keene, a former state legislator and author of MICRA. He now serves as president of the Assn. for California Tort Reform.

MICRA also has relieved pressure on physicians to practice defensive medicine, he said

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Planning for survival

Risk managers seek new ways to communicate their worth

By SARA MARLEY

CHICAGO—Are risk managers breaking new frontiers, or are they lost in the wilderness?

"I don't take the survival of risk management for granted," said Suzanne H. Crager, assistant vp-risk management and insurance for PNC Bank Corp. in Pittsburgh and immediate past president of the Risk & Insurance Management Society Inc.

"I'm not sure risk managers have sold themselves—or the value of risk management—to

their employers," Ms. Crager said. "When we fail to communicate effectively the value of the function, the function is in danger of becoming obsolete. We are our own worst enemy. We are too content with the status quo."

Ms. Crager was one of four panelists from different areas of the insurance industry who addressed the future of risk management and other issues during the eighth annual Harold H. Hines Jr. Memorial Symposium earlier this month.

Mr. Hines was president and

chief executive officer of Rollins Burdick Hunter Co. at the time of his death in 1984. The symposium, sponsored by the Chicago and Northeastern Illinois Chapters of the RIMS, the Insurance School of Chicago and Business Insurance, addressed "Risk and Uncertainty in the '90s."

"There is a frontier between risk and uncertainty," said Barbara D. Stewart, president of Stewart Economics in Atlanta, an insurance industry consulting firm. And that frontier is con-

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Court OKs hospital surcharge on self-insured health plans

ERISA pre-emptions reviewed

By MICHAEL SCHACHNER

PHILADELPHIA—The U.S. Supreme Court may be asked to again rule on the pre-emptive powers of the Employee Retirement Income Security Act of 1974 after a federal appeals court panel approved a state law requiring self-insurers to help fund care for the uninsured.

The 3rd U.S. Circuit Court of Appeals ruled May 14 that a 19.1% surcharge levied on virtually all inpatient hospital bills in New Jersey was permissible

under ERISA. The surcharge, which was part of a now-defunct hospital rate-setting system in the state, was applied to offset the costs of uncompensated care.

In the 2-1 decision, the panel of judges ruled the surcharge was permissible because it was broad-based and didn't restrict self-insured plans from conducting their own affairs.

In addition, the majority ruled that the relationship between the New Jersey law authorizing the surcharges and the self-insured plans that challenged the law

was too remote and tenuous to trigger pre-emption.

The ruling will be appealed to the full 3rd Circuit and, if not overturned, may wind up before the Supreme Court.

The decision reverses a decision issued last May by U.S. District Judge Alfred Wolin of Newark, N.J. (BI, June 1, 1992). Judge Wolin ruled in favor of 14 unions with self-funded health plans that had argued ERISA pre-empted any state law requiring self-insured health plans to

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BI to list alternative risk financing facilities

Business Insurance will publish its seventh annual guide to alternative risk financing facilities in the July 19 issue.

That issue also will feature the Midyear Property/Casualty Market Report.

There is no charge for an alternative risk financing facility to be listed. However, each facil-

ity must submit a completed Business Insurance questionnaire by the extended deadline of June 14.

If you have not yet received the risk financing facility questionnaire in the mail, please request one by calling Editorial Assistant Kerry Dziubek at 312-649-5398.

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- ✓ The major British multiline insurers report higher first-quarter profits. **PAGE 23**
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Firms embrace large-deductible comp plans

By MEG FLETCHER

Workers compensation policies that carry large deductibles have become so popular among large employers and insurers they are causing workers comp insurers' premium volume to drop.

But many workers comp insurers would rather give up some premiums through these policies than lose all of an employer's business to self-insurance.

Large-deductible workers comp policies combine many of the advantages of self-insurance with the advantages of an insurance product.

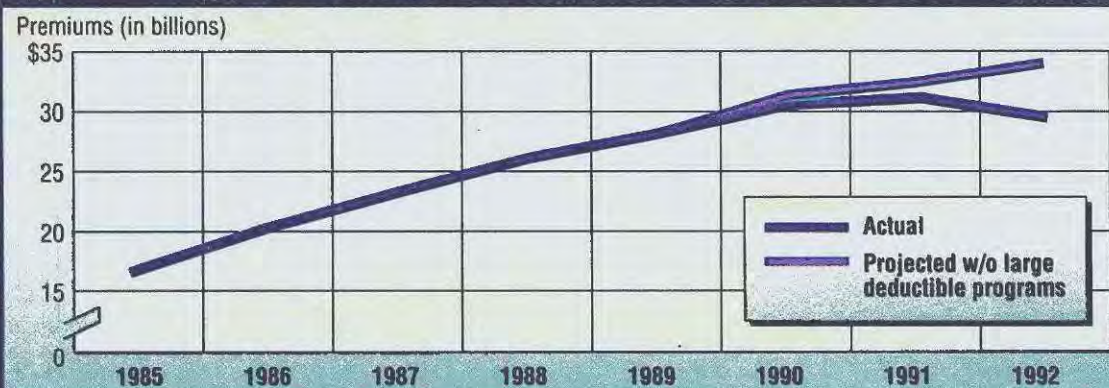
California is the latest stop for the bandwagon of large employers and insurers singing the praises of these policies.

At a hearing in San Francisco last week, regulators heard testimony on a proposal to approve

individual insurer requests to offer large-deductible workers comp policies. If allowed, Cali-

A big entrance

The growth of large-deductible workers comp policies—which were introduced in 1989—is credited with reducing insurers' net written premiums by billions of dollars.



Source: National Council on Compensation Insurance

GRAPHIC BY CHRIS ROY

fornia would be the 40th state to approve individual insurers' requests to sell such policies.

In addition, a bill—S.B. 1076—that expressly would allow insurers to sell large-de-

ductible policies last week was still pending in the California Senate's Industrial Relations Committee.

Large-deductible plans are a relatively new approach to insuring workers comp exposures, though the concept has been widely used in other liability lines.

Connecticut was the first state to approve a large-deductible policy in 1989. Since then, 38 other states have approved individual insurer requests to use them, according to Travelers Corp., which is credited with originating the large-deductible workers comp policy (BI, Sept. 16, 1991).

In fact, the policies were a primary factor behind the decline in workers comp insurers' net written premium volume last year, said Ronald C. Retterath, senior

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Insuring footlights puts N.Y. brokers in the spotlight

By NANCY P. JOHNSON

NEW YORK—There may be a broken heart for every light on Broadway, but not for Bob and Margery Boyar.

For them, the Great White Way has provided a rewarding 45-year career of insurance brokerage for the theater industry.

In fact, Robert Boyar is so much a part of the theater business that his caricature hangs alongside those of Broadway stars at Sardi's, a favorite see-and-be-seen restaurant for New York's theatrical crowd.

Mr. and Ms. Boyar's expertise in theater insurance caught the attention of Marsh & McLennan Cos. Inc., which purchased their brokerage, Robert A. Boyar Inc., in 1987. Now, Mr. Boyar is senior vp and Ms. Boyar is assistant vp for M&M's Arts & Entertainment division. With desks side by side, the two share an office in midtown Manhattan.

A list of Broadway productions insured through the Boyars' efforts reads like the New York Times' theater directory. They include "Crazy For You," "Guys and Dolls," "Les Miserables," "The Phantom of the Opera," "Tommy"

Bob and Margery Boyar

and "The Goodbye Girl."

One of the Boyars' areas of expertise is "star non-appearance" coverages, which protect a production from financial ruin if the unthinkable happens: the star—and the show—can't go on. Over the years, the Boyars have placed non-appearance policies for productions starring big-name performers like Elizabeth Taylor, Richard Burton, Leslie Caron, Henry Fonda and

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Aviation cover crunch felt across marketplace

By STACY SHAPIRO

LONDON—Aviation insurance and reinsurance capacity is in a tailspin, causing premiums to soar this year in most sectors of this specialized market.

Airlines, aircraft manufacturers and general aviation operators this year can find most of the limits they seek. However, a few specialized aviation risks, like owners of hot air balloons, cannot buy excess liability coverage for any price (see story, page 28).

Nevertheless, airline hull and liability prices are rising by about 50% this year; major aircraft manufacturers are paying as much as 40% more for their aviation product liability coverage; and even general aviation operators are seeing some nominal increases.

The reason: Capacity has dropped through the floor for aviation risks following the demise or withdrawal of several key players, mainly in the London insurance market and at Lloyd's of London, but also in the United States.

The only saving grace is the move by some underwriting agencies and insurers to reorganize to offer new capital to the market.

"Today the talk in the international market has

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AP/Wide World Photo

Lessons learned from the 1989 crash of a United Airlines DC-10 in Sioux City, Iowa (see story, page 27), were one of the topics discussed at the 17th annual Aviation Insurance Assn. conference in Scottsdale, Ariz., this month.

Prepared for anything

Public entities must be ready for any disaster

By DEBORAH SHALOWITZ

CINCINNATI—The keys to an effective disaster management plan for public entities are expecting the unexpected and hav-

ing a single person coordinate all response efforts.

And after a disaster strikes, public risk managers must learn from it so disaster plans are im-

proved for the future, experts say.

Disaster management planning must be comprehensive, anticipating all possible ramifications of a disaster, yet flexible enough to respond to different kinds of disasters, advises Francis W. Moriarty, deputy coordinator of the City of Chicago Fire Department, Emergency Preparedness and Disaster Services section.

"The circumstances always change," so a disaster manage-

ment plan "has to be flexible—it's very generic in nature," Mr. Moriarty said at the Public Risk Management Assn. conference May 16-19 in Cincinnati.

The disaster plan should not be too lengthy: "If you get too voluminous and too detailed... it's too much for the people" handling the disaster, he said.

However, public entities should have a comprehensive list of resources they can draw on in the event of a disaster, Mr. Moriarty noted.

For example, the City of Chicago has a thick book of resources, such as vehicles of different kinds and people with special skills, that can be called upon if a disaster occurs, he said.

In addition to human and physical resources, public entities must make sure to "have contingency funds set aside to handle these special needs," he advised. For example, Chicago has contingency funds to pay

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Coverage of PRIMA's 1993 conference will continue in the May 31 issue of BI



Plan administration changes needed

By MICHAEL SCHACHNER

NEW YORK—Companies making significant changes in their employee benefit programs should consider accompanying those moves with appropriate changes in benefit administration, according to an employee benefit consultant.

With so many U.S. corporations including benefit changes

in their efforts to restructure, downsize and cut costs, implementing updated and cost-effective methods of benefit administration deserves ample attention, he said.

"Many companies are changing their employee benefit plans today, and this trend will only speed up in the future as tax structures and savings incentives change," said Lance D. Tane, a

partner with Kwasha Lipton in Fort Lee, N.J. "This all leads to a greater need to re-engineer benefit administration."

Speaking May 11 at a Kwasha Lipton-sponsored seminar in New York, Mr. Tane said companies can increase the cost-effectiveness of their benefit administration by increasing employee involvement in the

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Reform study

Continued from page 1

The survey did not quantify how many jobs could be lost with the adoption of any specific proposal, though its authors said "small-business job losses will be substantial unless there is great flexibility and choice in the employer-employee relationship."

The NFIB is not alone in its concerns.

"We have been concerned for some time about the impact of employer mandates on job creation, particularly in the small business sector. That's why our preference is income-related subsidies for individuals," said Pam Bailey, president of the Washington-based Healthcare Leadership Council, a diverse group of managed care firms, hospitals, physicians and pharmaceutical manufacturers.

However, Walter B. Maher, direc-

tor of federal relations for Chrysler Corp. in Washington, criticized the study. "This segment of the small business community is doing a disservice to the larger small business community. No one is factoring into the equation what the current system is costing in job loss" for businesses that offer insurance and bear the costs of those that don't.

According to the NFIB study, the so-called managed competition proposal by the Jackson Hole Group would have the most negative effect on small business employment.

Using a computer model that assumed that employers must pay 75% of the average employee health care premium for each full-time employee as well as an 8% payroll tax on the first \$22,500 in wages paid to each part-time employee, the survey held that the managed competition proposal would put more than 13.2 million jobs "at risk" nationally.

The HealthAmerica plan, which

was introduced by Senate Majority Leader George Mitchell, D-Maine last year as S. 1227 and has not been reintroduced, was ranked second-most harmful by the study.

The study holds that HealthAmerica, which is based on the "play or pay" concept that calls for employers to either provide health coverage for their employees or pay a payroll tax, would put about 12.2 million jobs at risk.

California Insurance Commissioner John Garamendi's "California Health Care System for the 21st Century" plan also relies on payroll taxes and employer mandates to achieve a 24-hour universal health care plan (*BI*, Feb. 24, 1992). The NFIB survey claims that national adoption of this plan would put about 7.4 million jobs at risk.

Two other health care reform plans were judged by the study not to present any significant risk to jobs. These were:

- H.R. 5936, the Managed Competition Act of 1992, introduced last year by Rep. Jim Cooper, D-Tenn. Under this plan, which has not been reintroduced in the 103rd Congress, a health care plan that did not meet national standards would essentially be unable to compete. Employers could not take tax deductions for buying coverage from a plan that did not meet those standards.

- The Heritage Consumer Choice Health Plan devised by the Heritage Foundation, a conservative Washington think tank. This plan calls for replacing tax breaks for employer health plans with tax credits for individuals to buy health insurance.

However, the report added a caveat to its assessment of these two reform proposals, stating: "The observed result has only been obtained by expressly granting employers the option of not paying for their employees' insurance. Only by sacrificing the objective of compelling

the purchase of health care insurance can the adverse consequence of placing large numbers of jobs at risk be avoided."

The survey did not, however, consider how possible relief efforts for small employers, like subsidies or tax breaks, could ease the burden of providing mandated coverages.

Chrysler's Mr. Maher contends that the NFIB study set up a "straw man" by not taking into the account the possibility that small business will receive some sort of subsidy to meet the demands of a reformed system. No system in the world expects small businesses to pay as much as large businesses for health care coverage, he said.

Two congressmen who attended the survey's release stressed that the course health care reform will take is not yet clear.

"One thing we do know is there are going to be business mandates," said Rep. J. Dennis Hastert, R-Ill.

Rep. William H. Orton, D-Utah, said that before businesses are burdened with new taxes, Congress should enact a variety of cost-containment measures.

"I'm not opposing the president's proposal because we haven't even seen it yet," he stressed.

Rep. Orton suggested several reforms that could be implemented quickly, including: cutting administrative costs; malpractice liability reform; an increased emphasis on primary rather than specialized care; and amending antitrust laws to allow hospitals and clinics to share medical technology.

Copies of "The Employment Impact of Proposed Health Care Reform on Small Business" cost \$15 and can be purchased from the NFIB Foundation, 600 Maryland Ave. S.W., Suite 700; Washington, D.C. 20024.

A Global Perspective...



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Kathryn McIntyre promoted to vp of BI's parent

CHICAGO—Kathryn J. McIntyre, publisher and editorial director of *Business Insurance*, has been elected a vp of Crain Communications Inc., which publishes *BI*.

"We are delighted at the promotion of Kathryn McIntyre to vice president," said Keith E. Crain, vice chairman of Crain Communications. "She has done a terrific job for us, first as editor and now as publisher of *Business Insurance*."

Ms. McIntyre, 41, joined *Business Insurance* in 1977 as associate editor. She was promoted to news editor in 1978 and to managing editor in 1979. She was named editor in 1980 and added the title of associate publisher in 1987.

She was promoted to her current positions, as publisher and editorial director of the magazine, in 1992.

Ms. McIntyre, a magna cum laude graduate of Syracuse University in Syracuse, N.Y., is a member of Phi Beta Kappa and has earned the Associate in Risk Management designation. In 1989, she received the Dorothy and Harry Goodell Award from the Risk & Insurance Management Society Inc., recognizing outstanding achievement in furthering the goals of risk management. She was named 1989 Insurance Woman of the Year by the Assn. of Professional Insurance Women.



Ms. McIntyre



IF YOU THINK HIGH TECHNOLOGY REQUIRES INNOVATION, IMAGINE INSURING IT. *Advanced scientific disciplines like solar cell technology and genetic engineering are exploding with possibilities. And fraught with hidden risks. The professionals at AIG Companies who underwrite these and other specialty risks possess a much-sought-after talent: the ability to evaluate the unknown and assess businesses on the cutting edge of technology. Over the years we've developed the necessary rational skills and intuitive talents to a degree most others have not. It's part of why AIG is a global organization known for its innovative insurance solutions. Particularly when dealing with endeavors as complex as capturing the energy of the sun.*



WORLD LEADERS IN INSURANCE AND FINANCIAL SERVICES.

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NFL players score with new benefit plan

A seven-year collective bargaining pact between the National Football League and the NFL Players Assn. will guarantee players more than \$1 billion in pension, health and post-career benefits—the largest benefit plan in professional sports.

The contract is the NFL's first collective bargaining agreement since the 1982 pact expired in 1987.

The NFL Management Council Executive Committee approved the new agreement unanimously on behalf of the 28 clubs earlier this month. A vote on the agreement by all players is expected by mid-June, a players' association spokesman said.

The new deal sets up a generous three-pronged retirement plan for the players, including \$10,000 in severance for every season of credited service that will be paid beginning the year after a player leaves the league.

A "credited season" requires players to earn at least three game paychecks.

The pact also improves a 401(k) plan designed to serve as a player's second-career savings plan. Starting this year, each club must pay \$3,350 per player per year into a 401(k) plan for eligible players. Those players have the option each year to contribute up to \$9,000 of their salary into the tax-deferred plan. Players can choose from among three options to invest the funds, which can be taken out as cash or transferred to an annuity at age 45.

The pension plan agreed to under former NFL Commissioner Bert Bell in 1982 has been merged with the plan formed during former Commissioner Pete Rozelle's tenure.

Players will receive a 40% increase in benefit payments for all years under the Bert Bell plan prior to 1993. Players with a credited season in 1993 now are vested in three years rather than four and are eligible to collect pension payments starting at age 55.

Players' medical benefits have been improved, and the agreement stipulates that any player vested in the league's pension plan who leaves before retirement age is eligible for an extra year of medical benefits beyond the current three years of coverage that is currently extended to players at no charge.

Medical benefits are paid by a Taft-Hartley trust. Players pay a \$200 deductible for single coverage and \$400 for family coverage. The NFL pays 80% of the first \$3,000 in expenses and 100% thereafter.

Players are entitled to a maximum of \$1 million in medical benefits.

Payments for disability benefits also have been increased. A player who sustains a career-ending injury will receive half of his designated salary for the following season up to a maximum of \$150,000 in 1993. Those payments will more than triple by 1999.

Life insurance benefits have been increased to \$100,000 per year for rookie players, increasing \$20,000 each year for a maximum benefit of \$200,000. Under the prior agreement, rookies received \$50,000 per year in life insurance benefits, increasing \$10,000 per year for a maximum benefit of \$100,000.

—By Christine Woolsey

Benefit Beat

'Family' redefined

Family size might not be growing, but the definition of family is expanding in many companies with work/family programs, according to a new survey.

Twenty-eight percent of 117 companies with work/family programs have revised their definition of family within the past two years for all or some human resource policies, according to a survey by The Conference Board. And, another 16% are considering changing the definition.

Fifty-five percent of those surveyed use a narrower definition

for medical, welfare and regulated benefits but use a broader definition for work/family benefit programs, the survey found.

One-third of those surveyed have changed or plan to change benefits available to domestic partners of employees.

Three types of non-traditional families are most likely to receive special information: adoptive, single-parent and stepfamilies. Gay or lesbian parents are less likely to receive targeted information, the survey found.

The survey, "Work-Family Roundtable: Diverse Families," is available from: The Conference Board, 845 Third Ave., New York, N.Y. 10022; (212) 339-0356. The survey is free to Conference Board associates and is

\$20 for non-members.

—By Deborah Shalowitz

Health reform poll

A majority of Americans polled in a national telephone survey favored one uniform system of health care reform over letting states design their own plans.

In the random survey of 1,252 individuals conducted by Louis Harris & Associates for the Kaiser Family Foundation, 61 favored a uniform health system nationwide, while 36% favored allowing flexibility in health reform to individual states. Three percent were unsure.

"Our interpretation is that people have been convinced that this is a national problem re-

quiring a national solution, and that they want to be assured that they will have adequate health insurance regardless of the state in which they live," said Kaiser Family Foundation President Drew E. Altman.

When asked if they support the idea of giving non-elderly Americans the option of enrolling in Medicare when they select their health insurance, 75% of the respondents said yes.

The Menlo Park, Calif.-based Kaiser Family Foundation is an independent health care group and is not associated with Kaiser Permanente or Kaiser Industries.

The survey was conducted in late April and early this month. The survey is available free from

Continued on next page

UFO aliens
secretly meet with
President.

Boy raised by
wolves in
New Jersey.

HMO and
indemnity combined
in affordable plan.

Continued from previous page
the Kaiser Family Foundation.
415-854-9400.

—By Louise Kertesz

Baby Bell labor pact

In an ongoing effort to cut health care costs, Cincinnati Bell is asking some of its employees to pay more for their medical benefits.

Negotiators for the Communications Workers of America and the telephone company reached a tentative agreement May 9 on a new three-year contract that, among other things, would increase medical benefit costs for about 2,600 technical and clerical workers in two CWA locals.

Self-insured Cincinnati Bell is dropping one of two health maintenance organizations it offers and will continue to offer a preferred provider network.

Under the new agreement, employees who do not seek care from network providers will pay higher deductibles and out-of-pocket maximums.

Increasing employee costs has been a contentious issue for Cincinnati Bell and unionized workers. In 1990, the two CWA locals—Local 4400 and 4401—went on strike for 10 days, derailing a Cincinnati Bell demand for health care cost sharing (BI, May 21, 1990).

The new contract, which is scheduled to become effective Jan. 1, 1994, must be ratified by June 17, said Mike Timmerman, president of Local 4400. Union members have been notified of the proposal by mail, but he would not say whether they would accept the plan.

Under the proposed agreement, Cincinnati Bell will pay 100% of medical expenses for

employees who receive care from Choice Care, a Cincinnati-based HMO, and from Community Preferred Health Plan, a PPO jointly owned by Community Mutual Insurance Co. and Blue Cross & Blue Shield.

Employees and dependents who seek care outside the networks must continue to pay 20% of all medical expenses in 1994, but this percentage will rise to 25% in 1995, a spokesman for Cincinnati Bell said. Information on employees' contributions for 1996 was not available.

Copayments for doctor visits will rise to \$12 this year from \$8 for all employees and dependents under the new agreement.

In addition, employees with single coverage who receive care from non-network providers must pay a \$300 deductible, up from \$200, while employees with family coverage must pay \$900

for non-network care, up from \$600, he said.

Out-of-pocket maximums for employees who do not use network providers also increase under the new pact.

Workers with individual coverage will pay \$1,200 per year, up from \$900, and workers with family coverage will pay \$3,600 per year, up from \$2,700, the spokesman said.

The proposal also increases workers' defined benefit pension benefits by 14% over the three-year term. Monthly contributions to employees' pension plans will increase 5% in October 1993 and in October 1994 and 4% in October 1995.

The agreement also increases wages by 11%, enhances job security and revises a program that provides performance-based bonuses to employees.

—By Christine Woolsey

High benefit costs forcing cutbacks, employers affirm

Faced with rising benefit costs, employers are reducing their contributions to the most costly—but also the most popular—benefit programs, according to a recent study.

In a survey of brokers and employee benefit managers conducted recently by UNUM Corp. of Portland, Maine, respondents overwhelmingly predicted that the high cost of benefits will force employers to continue trimming their contributions to benefit packages.

Ninety percent of the 205 responding brokers said financial constraints are causing employers to scale back their contributions to benefits, while 88% of 356 corporate benefit managers cited diminishing corporate economics as a key reason for cutting back contributions to benefits.

According to respondents, the most likely targets of increased cost shifting are benefits that are widely offered, cost the most and are desired the most by employees.

The target that best fits that description is group medical benefits, which are offered by 98% of the responding companies.

Conversely, less prominent benefits that are not as costly—disability insurance and sick pay, for example—are less susceptible to cost shifting and elimination.

"Medical benefits are the hot issue because the expenses are high and the potential for cost savings through cost shifting is greatest," said Patty Berg, director of strategy and development with UNUM. "People are questioning the value of medical benefits for the price."

As a result, more cost shifting to employees for health care benefits is inevitable, the survey found. Ninety-one percent of brokers and 87% of benefit managers say employees will pay a bigger share of medical benefit costs in the future.

However, while workers will shoulder more of these costs, it is unlikely that employers will ever shift 100% of medical costs to employees or cancel health care benefits all together, said Ms. Berg.

"If a company made this benefit employee pay-all, more than half of the people wouldn't pay for it. They'd simply go without. So we'll never see the complete transfer of costs to the employee," she said.

Meanwhile, lower-cost benefits that are offered less frequently than health care coverage are also less likely to be eliminated or experience greater cost shifting, Ms. Berg said.

"Disability, sick pay and some other luxury benefits are considered a good value for the money. They're not high-cost items, so employers are not going to get much by cost shifting or cutting them out. What they do is go after the benefits with the highest perceived need... the benefits that employees have experience with and value," she said.

The survey was conducted as a strategic positioning study for UNUM, which specializes in disability coverage. It is unavailable to the public.

—By Michael Schachner

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Opinions

It's a fine line, or is it?

WHERE DO YOU DRAW the line? That's a question that must be raised after the latest employee benefits mischief-making by the House Education and Labor Committee.

Earlier this month, the committee approved a proposal to give special waivers to benefit laws and rules in Hawaii, Maryland, Minnesota and New York from the pre-emption provisions of the Employee Retirement Income Security Act.

Hawaii wants an ERISA waiver to make certain changes in its 1974 universal health care statute. A waiver Congress granted a number of years ago to Hawaii's 1974 law does not apply to future changes the state may want to make.

New York wants a waiver so the state once again can slap self-insured employers with a 13% surcharge on hospital bills. A federal court ruled earlier this year that the New York law violates ERISA, which pre-empts state laws and rules that relate to employer benefit plans.

Maryland wants a waiver to protect the state's hospital rate-setting system from possibly being overturned in the future as violating ERISA.

Minnesota is seeking a waiver to protect a 1992 law that allows it to assess special taxes on health care providers to help fund a state program that provides subsidized coverage to the uninsured. Some employer groups fear that once Minnesota receives an ERISA waiver, it will broaden its law to impose new taxes on employers that self-fund their health care benefit programs.

We have no doubt that if these waivers are approved, it will be the beginning—not the end—of a long line of states that will pass benefit laws and then ask Congress to protect those laws from ERISA pre-emption. Indeed, Rep. Harris Fawell, R-Ill., was right on the mark when he said if the four waivers are allowed to stand, 46 more states will follow.

Many members of this generation of Congress have to be reminded that lawmakers back in 1974 did not add ERISA's pre-emption provision as an afterthought. Pre-emption is a cornerstone of ERISA. It was included to protect employers from a hodgepodge of state benefit rules that would make it difficult, if not impossible, for national employers to offer a uniform benefit package and significantly boost employers' administrative costs.

This isn't to say that we believe that ERISA's pre-



emption of state benefit laws should be iron-clad. Arguably, there may be cases when ERISA waivers are warranted. The Hawaii law, for example, has ensured nearly universal health care coverage among residents, while employer costs are lower than in many other states. Certainly, Hawaii's law should be protected.

On the other hand, New York's request should be rejected. It seems patently unfair to levy more costs on employers that already provide health care coverage to their workers.

We'd like to see more information on the Maryland law before taking a position, while the Minnesota law—as long as state legislators do not attempt to broaden it to directly tax employers with health plans—appears acceptable.

Indeed, each state situation will be different. That is why Congress needs to look at each request for an ERISA waiver carefully. Bundling those requests, as the Education and Labor Committee has done, as part of a massive, unrelated budget bill virtually guarantees that the requests will not receive the scrutiny they deserve.

We hope legislators strip out the waiver requests from the budget bill and consider—after hearings—their individual merits.

Letters

Health reform must include all medical care systems

To the editor: In spite of the Alliance of American Insurers' heavy propaganda effort to the contrary, every employer should recognize that a basic premise of any cost-effective national health care plan must be that the costs of treating an injury or disease has nothing whatever to do with whether the cause of the injury or disease was work-related or whether it was caused by someone's negligence. It has everything to do with how to accomplish cost-effective treatment while maintaining adequate incentives for preventing such injuries and diseases.

If we leave workers compensation medical or any other medical care system (Medicare, Medicaid, Veterans Administration, etc.) outside the national health

care plan, we leave the field wide open to the costly game of cost shifting that helped to get us into the increasing cost spiral that we are in now.

The medical component of workers compensation and all personal injury—including auto, general, aircraft and marine liability—should be taken out of the hands of law firms and insurance companies manned by expensive people who don't treat anyone.

Lawyers and insurers are too often an unnecessary and expensive surcharge on

legitimate medical treatment charges.

If we create a truly comprehensive national plan, direct workers comp and personal injury claims will be a lot less than they are now. Yet loss prevention incentives will largely remain because of the continuing need to alleviate the costs of disability income awards, pain and suffering, etc.

W.T. Howard
Director of Risk Management
Arch Mineral Corp.
St. Louis

Comparing PBGC's deficit to others not the point

To the editor: I am writing in reference to your May 3 editorial and Marty Slate's comments (BI, April 26), both of which stated that the Pension Benefit Guaranty Corp. deficit is not as serious as the savings and loan debacle. It is my opinion that comparisons of this type are not the important point, but such implications may divert Congress from solving the problems that exist.

The important point is the PBGC does have a deficit of over \$2 billion, which I certainly call serious. The problem has not been solved since the agency was created

in 1974. Congress must take action to either eliminate defined benefit pension plans altogether or create a mechanism whereby these plans are fully funded, which I don't believe can or will be done.

It is wrong for the taxpayers of this country to have the risk of an increased deficit due to the fact that corporations have not properly funded their defined benefit pension plans, especially when there are other types of pension plans that do not pose this risk to the taxpayer.

Murray P. Hayutin
Littleton, Colo.

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Large deductibles

Continued from page 3
vp of the National Council on Compensation Insurance in Boca Raton, Fla.

Insurers' 1992 net written workers comp premium volume declined 4.7% to \$29.8 billion in 1992 from \$31.2 billion in 1991, the NCCI reports.

Richard W. Palczynski, senior vp with Travelers in Hartford, Conn., estimated that large deductible policies may have been responsible for about \$2 billion of lost premium.

Under a typical plan, a workers comp insurer calculates the employer's standard premium and applies a credit for a higher per-claim deductible, which typically ranges from \$100,000 to \$1 million. Some insurers also offer a policy that caps aggregate losses within a deductible.

The insurer pays all losses—even those falling within the deductible—and then seeks reimbursement from the policyholder, on a monthly or quarterly basis, for loss amounts within the deductible. Most insurers require a policyholder to provide a letter of credit or other security to secure expected losses within the deductible.

"Large-deductible plans combine the advantages of self-insurance with the advantages of insurance," said Lynn Gaughan, director of risk management for Reebok International Ltd. in Stoughton, Mass.

"Large-deductible plans can produce savings," she said. By reducing the actual premium paid, residual market loadings have been reduced 50% to 75% in some cases, she said. In addition, premium taxes, assessments and surcharges also are reduced.

Also, "the directness of the deductible makes people very safety-conscious," said Fred Hunt, vp and manager of underwriting operations for Liberty Mutual Insurance Cos. in Boston.

Such plans also can enhance an employer's cash flow because the employer does not pay claims as they are incurred, as it would under self-insurance.

Large-deductible plans provide many of the benefits of self-insurance without requiring an employer to qualify financially as a self-insurer or bear the administrative burden of meeting each state's reporting requirements.

"For the first time, the insurance industry has a product that

is competing with self-insurance," Travelers' Mr. Palczynski said.

That competitive approach also is filtering down to smaller employers.

For example, Mr. Hunt said Liberty Mutual has obtained approval in about half of the 35 states where it writes large-deductible workers comp policies so it can offer policies containing a minimum \$25,000 deductible to clients with at least \$100,000 in annual pre-deductible premiums.

While insurers are marketing large-deductible plans to a broader range of employers, they are not for everyone.

Employers with unpredictable loss experience or those in an unsound financial position may find them unsuitable, said Reebok's Ms. Gaughan.

In addition, from a state perspective, large-deductible programs diminish the assessment base for premium taxes and residual market loadings.

"It's somewhat controversial, but I don't sense a strong controversy," said Travelers' Mr. Palczynski.

The NCCI calculated that the premium after a large deductible is taken is about one-fifth of the

gross premium before the deductible, said Mr. Retterath.

Large-deductible programs may have already cost states about \$100 million in premium taxes and other assessments in 1992.

For example, the growth of large-deductible programs may have been a significant reason behind a \$24 million drop in Texas' 1992 premium tax revenues, according to a Texas Insurance Department spokesman.

However, loss of premium tax revenue "is not necessarily something insurance departments would get upset about," he said. Texas regulators would be more inclined to say offering large-deductible programs shows that the state's workers comp market is working and the business climate is better, the spokesman said.

A diminished assessment base is more of a concern for small insurers—which are not as likely as large companies to offer the programs—because they may be stuck with a greater share of residual market losses. Theoretically, a large-deductible program can reduce an insurer's voluntary market premium in a state, which is the basis for assessing an insurer's share of residual market losses.

The National Assn. of Independent Insurers has "fairly strong feelings" about that issue, but thus far has not met with much success in getting its views across to state regulators, said Nancy Schroeder, director of workers comp for the Des Plaines, Ill.-based trade group. NAII members primarily are small and medium-size insurers.

NAII members would prefer "to fix the underlying programs of residual markets rather than shift the problem around," she said.

Massachusetts took a unique approach to these assessment-related concerns by limiting the volume of large deductible policies an insurer can write annually. "Gross" large deductible premiums, which are calculated as if first-dollar coverage was provided, cannot exceed 33% of an insurer's voluntary market premiums, as calculated by a formula, said Stephen D'Amato, director of the State Rating Bureau of the Massachusetts Division of Insurance.

"We try to maximize assessable premium by allowing some business which could go to self-insurance to go to large-deductible plans, while preventing wholesale conversion to the plan," he said.

Large-deductible plans preserve at least some of an employer's premium for assessments, which would otherwise go to self-insurance, said Eric Oxfield, assistant general counsel for the American Insurance Assn. in Washington.

Another issue affecting large-deductible policies is the way losses are reported.

Essentially, the NCCI asks workers comp insurers to report "net" premium and losses, which is the amount a large-deductible client is actually charged and the losses associated with that premium. It typically uses those figures for ratemaking and other purposes.

However, the NCCI also asks insurers to report "gross" exposures (payroll) and losses on individual policyholders' records so an individual's experience rating would be complete. This would allow the policyholder to easily convert to a policy without a large deductible, Mr. Retterath said. That data may also be used in developing class ratings, he said.

The vast majority of states receive net premium figures, he said. However, some require loss statistics on a gross and net basis.

In addition, Florida required the NCCI to use gross loss statistics in its rate filing earlier this year because "it made the experience more complete," said Jim Watford, an actuary with the Florida department.

Excluding the generally good loss experience of large-deductible policyholders would have resulted in NCCI data showing a greater rate need, Mr. Watford said.

The NCCI's position is that insurers have to artificially create the gross loss data, since they have no other use for it, Mr. Retterath said.

The loss ratio resulting from that data "is artificially lower due to carriers' inability to accurately report grossed up premium from high-deductible policies," he said. **BI**

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For the Record

Empire BC/BS plan operations audited

NEW YORK—Empire Blue Cross & Blue Shield's financial troubles are largely the result of the plan's commitment to insuring all risks and the spiraling cost of health care, a recent mandatory audit finds.

An Arthur Andersen & Co. audit attributes Empire's woes to health care costs that have risen faster than the New York-based insurer has been willing or able to raise premiums.

Empire's senior management "has been slow to appreciate the accelerating pace of change in the insurance marketplace and even slower to respond to ensuing challenges," the audit report says, but the insurer's massive underwriting losses are primarily due to "economic forces and market pressures."

Auditors recommended that Empire become more competitive in a market now governed by New York's 1992 open enrollment and community rating law, which went into effect April 1 for individuals and small groups (**BI**, June 15,

1992). The audit also urged Empire to improve its managed care operations to avoid losing significant parts of its existing business.

Contrary to some press reports, Empire's management was not overcompensated and the company did not have unreasonable travel and entertainment policies, the audit said.

The audit was mandated by the 1992 law.

Early retirement plans for N.J. public entities

TRENTON, N.J.—New Jersey Gov. James Florio signed legislation earlier this month that permits counties, municipalities and state and local agencies to offer employees early retirement.

About 12,000 employees covered by the Public Employees' Retirement System, the Teachers' Pension and Annuity Fund or the Alternate Benefit Program may be offered one of three early retirement programs that improve either pension or post-retirement health care benefits.

Under one of the plans, employees *Continued on next page*

Continued from previous page
age 50 or older with at least 25 years of pension plan membership would have five years added to their pension benefit calculation formula and receive another year of base salary.

The extra pension membership credit provides approximately a 16% increase in retirement benefits. Approximately 3,400 public employees are eligible for this benefit.

Under a second plan, employees age 60 or older with between 20 and 25 years of pension credit would receive employer-paid health benefits for the remainder of their lives. Retiree health benefits otherwise are paid only to retirees with 25 years of pension membership credit. About 2,100 employees are eligible for this option.

A third program is open to employees age 60 or older with 10 to 20 years of pension membership credit. They would receive \$500 per month for up to two years in addition to normal retirement allowances. About 6,300 employees are eligible for this plan.

County employees have until Dec. 1 to apply. Municipal and public agency employees have until March 1, 1994, to apply.

California state fund may guaranty GICs

SACRAMENTO—Legislation has been proposed to expand guaranty fund coverage in California to include guaranteed investment contracts offered in 401(k) plans.

Sen. Newton R. Russell, R-Glendale, introduced S.B. 435 in response to last year's insolvency of Inter-American Insurance Co. of Illinois.

The Chicago-based company, which wrote nearly \$91 million in 1990 premiums nationwide for products including annuities and GICs, was liquidated by the Illinois Insurance Department after it discovered a \$30 million shortfall in the required capital and surplus (*BI*, Jan. 20, 1992).

Because California's life insurance guaranty fund does not cover "unallocated" annuity contracts, such as those that are sold to an employer to provide employees with deferred compensation or pension benefits, policyholders here were left "out in the cold," according to Kay Lentz, chief of staff for Sen. Russell in Sacramento.

Fewer than half of the states provide guaranty fund coverage to such instruments, according to the National Organization of Life & Health Guaranty Assns.

S.B. 435 is scheduled to be heard by the Senate Insurance Claims and Corporations Committee on Wednesday.

Massachusetts comp reform impact viewed

BOSTON—Massachusetts' 1991 workers compensation reform law saved the state system by sharply cutting back benefits, but it has not prevented rates from soaring or deficits from rising in the state pool for companies with high accident rates, says a state Senate committee report.

The overhaul "simply shifts costs from insurers and employers to employees," said state Sen. Thomas C. Norton, chairman of the Senate Post Audit and Oversight Committee.

Disputing that conclusion, the state Department of Industrial Accidents says the "Workers Compensation Reform Act has had an immediate and dramatic positive impact on the system." Insurance rates were flat in 1992 and rose only 6.2% in 1993, after years of double-digit increases, the agency said.

Even that 6.2% increase will cost employers \$100 million, the com-

mittee report said.

The committee recommended creating an unpaid special commission on workers comp health costs to study 24-hour coverage.

N.Y. hospital group seeks surcharge fine

ALBANY, N.Y.—The Hospital Assn. of New York State is asking state insurance regulators to fine Connecticut General Life Insurance Co. for failing to pay the 13% surcharge regularly added to all hospital bills paid by commercial insurers.

In a letter sent earlier this month to State Insurance Superintendent Salvatore Curiale, HANYS asked regulators to fine the CIGNA Corp. subsidiary for not paying the surcharges since October and to force it to pay its member hospitals "millions of dollars" in delinquent surcharges.

CIGNA, meanwhile, contends that a New York federal district court's February ruling that the surcharges are pre-empted by the Employee Retirement Income Security Act reinforces its position (*BI*, Feb. 8). That ruling, however, has been stayed pending an appeal by the state.

Therefore, CIGNA and other commercial insurers must pay the surcharges until the case is ultimately resolved, HANYS contends.

HANYS's May 3 letter to the New York Insurance Department states its position that CIGNA should be ordered to pay the required and contractual hospital charges, or be fined up to \$500 for every patient whose bills are not paid in full.

Court told to address ERISA's effect on law

AUSTIN, Texas—Even in instances where coverage is clearly not afforded under a group health policy, the issue of ERISA's impact on state law as applied to that policy must be considered, the Supreme Court of Texas ruled earlier this month.

Edwaine Forbau, as Next Friend of Amy Miller, Petitioner, vs. Aetna Life Insurance Co., Respondent, was brought by the mother of Amy Miller, who in 1983 suffered permanent injuries in an auto accident, leaving her a paraplegic.

She was covered as a dependent under her father's group medical policy with Aetna. Aetna paid her medical expenses until April 30, 1985, when her father's employer terminated the group contract.

Aetna continued to pay benefits until May 1, 1986, under the policy's one-year extension of benefits clause. Ms. Forbau then filed a suit against Aetna, alleging breach of contract.

At trial, Aetna claimed that the Employee Retirement Income Security Act of 1974 pre-empted the petitioner's claims under state law.

The trial court rejected Aetna's argument and awarded Amy \$238,000 in past damages, \$2.5 million in future damages and an additional \$500,000 in attorneys' fees.

A state appellate court reversed the trial court's judgment. The appellate court held that under the unambiguous policy terms, the petitioner's right to recover was limited to those medical expenses Amy incurred while Aetna's policy was in effect.

Because it concluded that judgment should have been rendered for Aetna under state law, the appeals court did not address the issue of ERISA pre-emption.

While the Supreme Court of Texas affirmed that the policy wording was unambiguous, and does not afford coverage claimed by the petitioner, the appeals court

should "address the effect ERISA necessarily has on the application of state law," Judge John Cornyn wrote.

The plaintiff's attorney expects to file a petition for rehearing.

Wichita insurer found liable for injury claim

DENVER—Scottsdale Insurance Co. is liable under an additional insured endorsement for a judgment against the city of Wichita, Kan., in a case brought by a man injured while attending a city fair.

Reversing a lower court order, the 10th U.S. Circuit Court of Appeals ruled last month that a policy issued to the non-profit Wichita Festivals Inc. naming the city as an additional insured covers liabilities arising from the city's negligence as well as Wichita Festivals'.

The coverage case resulted from injuries suffered by Scott McIntosh when he fell 20 feet after jumping over a retaining wall trying to find a public toilet at the 1988 Wichita River Festival.

The city agreed that it was at fault and a \$74,571 judgment was entered against it. However, Scottsdale, which was Wichita Festivals' insurer, denied coverage.

A U.S. District Court judge agreed that Scottsdale was not liable, concluding that the policy—despite the additional insured endorsement—covers only Wichita Festivals' negligence.

The appeals court overruled the decision, though, finding that the city's liability arose from Wichita Festivals' operations and that the additional insured endorsement is ambiguous about which entity's negligence is covered.

Information in brief

James H. Dill was named **Alabama insurance commissioner**, replacing Mike Weaver.

F. David Rolwing, president of Montgomery Mutual Insurance Co., was named chairman of the Alliance of American Insurers. . . . **Bankrupt Eastern Airlines Inc.** is putting \$15 million into its retiree health care trust and hopes to put in another \$10 million over the next two years. Eastern deposits money into the trust and retirees then set up their own medical plan (*BI*, March 1). . . . **Chubb Corp.** has begun offering an "optional **guaranteed defense costs** allocation" endorsement to its D&O policies. The allocation allows policyholders the option of agreeing before a claim occurs to receive a pre-arranged percentage of defense costs. . . . **Wind, hail and tornadoes** caused an estimated \$45 million of insured property damage to portions of Texas in an earlier storm that hit areas of the state April 28 and 29. . . . **Coopers & Lybrand** will pay \$4.5 million to the Resolution Trust Corp. to settle a dispute involving audits of failed Centrust Federal Savings Bank in Miami and three California thrifts. . . . **Houghton Freeman** will retire as CEO of **American International Group Inc.**'s companies in Japan, Korea, and China on June 30. He will be succeeded in Japan and Korea by Evan Greenberg, son of Chairman H.R. Greenberg and currently chief operating officer of AIG companies there. AIG business in China will be headed by Edmund Tse, senior vp and president of American International Assurance Co. Ltd. in Hong Kong. . . . **Litigation costs in California's workers comp system** reached a record \$2.2 billion last year, reports the California Workers' Compensation Institute. That represents 21% of the estimated \$10.6 billion in employers' work comp costs.

B

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Hines Symposium

Continued from page 2

stantly shifting, she noted.

Companies are assuming more of their predictable losses and transferring only unmeasurable uncertainties to the insurance marketplace, Ms. Stewart noted. "Conventional insurance is considered the technique of choice only for uncertainty."

One result of the shift is that the practice of risk management appears to have lost some of its value, according to Ms. Stewart.

"There are few savings left," she said. The longer that risks have been financed internally, a risk manager finds it more difficult to demonstrate the savings compared with conventional risk financing, she said.

And, the same cost-cutting pressures companies previously placed on commercial insurers now are being applied to their risk management departments, she added.

However, the shrinking of risk management departments and budgets, "doesn't imply the dead end of the risk management movement," Ms. Stewart said.

While some risk managers are focusing on assuming more predictable risks, others are venturing to the cutting edge of alternative risk financing to cover uncertain exposures, she said.

Facilities like ACE Ltd. and X.L. Insurance Co. in Bermuda "are the far end of uncertainty. Their pricing is without basis. The question is whether they will be able to stabilize pricing without acting like the conventional market they are trying to replace," she said.

The two other panelists—Jeffery Greenberg, executive vp of American International Group Inc. in New York and Tinsley H. Irvin, chairman and CEO of Alexander & Alexander Services Inc. in New York—were more confident about risk management's future.

"I don't see the demise of risk management," Mr. Irvin said. "The risk management profession is so much more professional. It's technically more sophisticated."

The presence of more long-tail and catastrophic risk in the market means that scrutinizing the security of insurance companies is more important than ever, Mr. Greenberg said.

"The gap between the most secure (insurers) and the rest will widen over time," he warned.

One way to protect policyholders and make U.S. insurers more competitive is federal regulation, Mr. Irvin contends. "Risks are moving offshore with no protection," he said. "The solvency issue is moving offshore. We need federal oversight."

Risk managers can travel overseas to negotiate policies that U.S. insurers are not permitted to sell on an admitted basis, Mr. Greenberg pointed out.

In effect, insurers and their business customers are moving in opposite directions, added Mr. Irvin.

Companies are becoming more globally oriented and pacts like the North American Free Trade Agreement and the General Agreement on Tariffs and Trade would open up many new business opportunities, particularly for middle-market companies, Mr. Irvin said.

At the same time, however, U.S. insurers are selling off international and even Canadian subsidiaries, he said.

Despite the disintegration of

the Soviet Union, the world might not be as stable politically as was expected at the end of the Cold War.

"I see unstable regions," Mr. Irvin said. "The risks might be greater than they ever were. Localized uprisings may be smaller, but they can be terrible—and they are less containable and more spontaneous."

Other topics addressed by the panel include:

- Expanding liability and rising loss costs.

New risks—like employment practices, environmental claims and health care liability—are often not fully appreciated and therefore not taken into account by the risk manager, Mr. Greenberg said.

Rising costs "have focused the marketplace on premium," he said. "To me, that's not attacking the problem from a risk management standpoint." Instead, risk manag-



Photo by Michael A. Marcotte

Panel members at the Hines Memorial Symposium were, from left, Suzanne Crager, Jeffrey Greenberg, Kathryn McIntyre, Tinsley Irvin and Barbara Stewart.

ers should focus more effort on controlling the losses that are behind the escalating costs.

- The property/casualty insurance cycle.

"The longer it goes on, the less I believe there is a cycle happening," said Ms. Stewart.

"There are cycles, but each is different," Mr. Greenberg said.

"With changes in the state of the market, I don't think you can predict the shape of the curve by looking to the past," he added.

- Merging the medical component of workers compensation coverage with health care benefits.

"It's an attempt to make a simple solution to a complex problem," Mr. Irvin said. "I'm afraid we'd be swapping a headache for an upset stomach with no risk management control."

It's unclear how national health care would address the role of workers comp as an exclusive remedy to employers' liability for

workplace injuries and whether community rating would wipe out certain companies' and industries' premium credit for good loss experience, he said.

"Would it turn us into one giant assigned risk pool?" Mr. Irvin asked. "Would we have to sink to the lowest common denominator?"

- Industry surplus and reserves.

While the commercial property/casualty insurance industry's surplus grew in 1992, the "major source" was capital infusions by parent companies to their property/casualty subsidiaries, Mr. Greenberg said.

Estimates still place the industry's reserves at 10% to 12% below what is adequate, Mr. Greenberg said. "Much lies behind the published numbers."

Kathryn J. McIntyre, vp, publisher and editorial director of *Business Insurance*, moderated the symposium. **BI**



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Disaster planning

Continued from page 3

for additional salt, snowplows and personnel to handle an out-of-the-ordinary snowstorm.

However, a disaster management plan should not just address typical local concerns, such as snowstorms, tornadoes or floods, he explained.

Anything can happen, he noted, adding that after people heard about the Chicago flood they said, "A flood in the Loop? That's crazy."

Mr. Moriarty was referring to the April 1992 incident when the Chicago River leaked into an underground tunnel system throughout Chicago's business district, flooding basements, causing power shutdowns and damaging inventory (BI, April 27, 1992; April 20, 1992).

In some cases, a disaster could

destroy public facilities, so alternate facilities should be addressed by a plan, he advised.

Fearing the potential loss of vital city tax records during a disaster, Mr. Moriarty noted that copies of Chicago tax records are stored in two cities in other parts of the country.

Alternate communication mechanisms should also be planned, he advised.

Public entities should also address how these alternate arrangements can be used to collect and disseminate information in a disaster, he said. For example, an emergency operating center should be planned that can be used to communicate with field personnel. And, one person should be in charge of letting the public know what is going on, he said.

William F. Jenaway, assistant vp of loss control services at

CIGNA Property & Casualty Cos. in Philadelphia, also recommended having one public information officer in charge of updating the public and media about the disaster.

"If you don't have (a public information officer), shame on you," he said. "Get one quick."

A good, comprehensive plan is only part of the job, the experts agree. The other crucial part is having one person—and preferably only one—in charge of disaster management.

There are "a lot of turf problems" when several different public agencies must interact during a disaster, so select one strong person to lead the effort, suggested Mr. Moriarty.

Also, "the authority's got to be invested in this person" so he or she is able immediately to get the equipment or personnel that is needed, he added.

Mr. Jenaway said contracts should be pre-signed by this lead person in case he or she is not available during or immediately after a disaster. Similarly, pre-arranged agreements with contractors can be very helpful immediately after a disaster, he said.

Although one person should lead the disaster management process, the leader is only as strong as his or her support, the experts said.

"Besides a plan and a process, there must be supervisor training and employee education," Mr. Moriarty advised.

Ultimately, it takes a disaster to test the effectiveness of a disaster management plan.

After several disasters, including the 1991 Oakland, Calif., inferno that caused as much as \$1.7 billion in insured damages, "what we learned was we needed

a better disaster plan," said Jon M. Ingenthron, risk manager for the city of Oakland.

The 1991 fire roared through the Oakland hills, ravaging 1,900 acres and destroying 2,449 houses (BI, Oct. 28, 1991).

The city's disaster plan did not address many ramifications of the fire, Mr. Ingenthron noted. For example, the city had to cap sewer lines, remove huge chimneys no longer supported by houses and remove burned trees, he said.

And, even the simplest of assumptions is tested after a disaster, Mr. Ingenthron noted.

For example, clearing the streets of cars following the fire turned out to be quite complicated, he explained.

Originally, the municipality decided to simply let private citizens and insurers claim and remove the 7,000 abandoned cars, Mr. Ingenthron related. However, many people could not find their cars because they were abandoned at addresses that no longer existed or were just plain burned beyond recognition, he noted. "Our nifty little plan... fell flat."

Ultimately the police examined each car and spray-painted license plate numbers and vehicle identification numbers on the cars—or shells of cars, he explained. And, the police made a master list of all the damaged cars for insurers, he added.

After private citizens and insurers had removed their cars from the streets, the police impounded the remaining cars, he said.

"This very simple task of clearing the streets" grew into a much larger one, Mr. Ingenthron stated.

Another seemingly simple task—communicating with the public—can take on gargantuan proportions after a disaster, the experts noted.

For example, "How do you talk to 7,500 people who were displaced" by the fire? Mr. Ingenthron asked. The answer turned out to be through neighborhood networks.

As a result of these and other unforeseen problems in the wake of the fire, Oakland formed five committees to handle vital issues. The committees were communications, cleanup, erosion control, public safety and rebuilding.

The public safety committee handled problems such as sidewalks with no support and the lack of traffic signals, traffic signs, guardrails and streetlights. The rebuilding committee worked on shortening the building permit process from 18 months to the current three to four months.

During the fire, Oakland officials discovered several other problems with their disaster management plan, Mr. Ingenthron noted.

For example, the municipality's fire hydrant attachment threads were incompatible with many assisting fire department trucks. Also, the reservoirs that were tapped for water did not have backup generators, so when they were empty they could not be refilled. And, some roads in Oakland are so narrow—only 12 feet wide—that people could not escape quickly enough and firefighting equipment could not get through, Mr. Ingenthron said.

Sharon Rodebaugh, risk manager for the city of Grand Prairie, Texas, moderated the pre-disaster planning session. BI

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Theater coverage

Continued from page 3

Peter Allen.

Even Mr. Boyar's history reads like a script from a '40s musical.

Fascinated with the theater, he was determined to enter a showbiz career over the objections of his father, Ben A. Boyar, a theater manager and producer. His father thought his children "would be well-served if they went into 'legitimate business,' not the theater," said Mr. Boyar.

But Mr. Boyar found a way to combine "legitimate business" with the footlights and greasepaint of Broadway. After working for a time with his uncle, an insurance broker, Mr. Boyar in 1948 decided to try the theater insurance brokerage business.

Taking advantage of his family's theatre connections, Mr. Boyar used notices of casting calls as his cue to visit producers and pitch insurance policies.

At the time, there was a lot of room for innovation in the theatrical insurance business, Mr. Boyar found. Though insurance for props and business interruption for theater productions had been available since the 1930s, these policies were designed for productions that stayed in one place, even though most productions make at least a few out-of-town tryout engagements, and many make tours lasting from four weeks to two years.

However, in pitching business interruption policies to producers of touring shows, he found a skeptical audience.

"The producers believed they would always be able to manage with a catastrophe," Mr. Boyar recalled. "One of them asked me, 'Bob, when was the last time a show burned up?'"

But producers began listening to Mr. Boyar after two theatrical catastrophes in the early

1970s: The Shubert Theater in Washington burned down with no business interruption coverage, causing financial ruin for the producers of the show playing at the theater. Shortly afterwards, a show—ironically called "Good News"—was disrupted by a fire at another theater, but collected a \$250,000 payment because it purchased business interruption insurance through Mr. Boyar's office. "That opened people's eyes completely" about theatrical business interruption coverage, he said.

Mr. Boyar also opened producers' eyes in another area of coverage: star non-appearance.

If a production's major draw is a certain big-name star, ticket sales will slow if the star can't appear, he explained. "If the star is laid up for six to eight months, or permanently, the financial investment for the whole production could go down the drain."

For example, a revival of the Rogers & Hart musical "On Your Toes" in the early 1980s starred Leslie Caron, the actress and ballerina known for her movie roles in "An American in Paris" and "Gigi."

"On Your Toes" required the lead actress to perform demanding ballet sequences, which created a tough problem for the producers when Ms. Caron tore a hip muscle while the show was on tour in Houston. The producers found ballerinas who could meet the dance requirements, but they couldn't find one with as much name recognition as Ms. Caron. Ticket sales plummeted, and when the production was eventually abandoned, underwriters at Lloyd's of London paid a claim for \$1.4 million.

Producers of a 1981 Broadway revival of "The Little Foxes," starring Elizabeth Taylor, contacted Mr. Boyar to draw up a star non-appearance policy. Ms. Taylor, who is as well-known for

her frequent illnesses and hospitalizations as for her flamboyant personality and glamorous film career, was disabled three times with upper respiratory infections during the production. Lloyd's underwriters eventually paid a \$216,000 claim on a non-appearance policy (BI, June 1, 1981).

And, when the show went to London, Ms. Taylor's high-heeled shoe broke onstage, which caused torn ligaments in her ankle. "But Liz Taylor is a trouper," said Mr. Boyar. She played her role in a wheelchair, and because the script calls for the male lead—her invalid husband—to play in a wheelchair,

**'If the star is laid up'
the play's financial
backing could go
down the drain,
says Bob Boyar.**

they put him on crutches.

A few years later, Richard Burton joined his famous ex-wife in a revival of "Private Lives." Producers believed having two mega-stars meant an indirect insurance policy—after all, if Liz fell ill, people would surely come to see Dick, they reasoned. But, according to Mr. Boyar, who helped draw up the star non-appearance policy, things didn't work out that way. When illness forced Ms. Taylor to cancel her appearances, "there were enormous refunds given out each night," though an understudy played opposite Mr. Burton. The producers decided to cancel performances until she came back, Mr. Boyar said. Lloyd's and various European underwriters eventually paid more than \$500,000 in non-appearance claims (BI, Sept. 18, 1983).

Sometimes important props, not people, call for the Boyars' insurance skills.

When props and lighting systems became increasingly computer-driven, Mr. Boyar pioneered a policy to cover computer-operated lighting and set changes. For example, "Les Miserables" depends on many set changes made possible by a computer-operated turntable.

However, sometimes even the best-known props can be insured routinely. In "The Phantom of the Opera," a huge chandelier swings out over the audience and drops just above the theatergoers' heads, a thrilling effect for the audience but not scary for in-

surers: The prop is covered under a standard theatrical property policy, and no special liability insurance was needed to cover the risk to the audience.

It is expertise in handling one-of-a-kind risks like these that made M&M take notice of the Boyars.

Six years after the deal, both sides feel they came out ahead.

"As I got older it seemed logical to merge with a larger firm. It has improved our market position and relieved us of some burdens. It has been a pretty happy arrangement," said Mr. Boyar.

Mr. and Ms. Boyar's co-workers at M&M have nothing but applause for the couple.

"The man is truly a genius. He has seen almost everything and can solve problems like no one else in the business can," said Alice Prine, vp-casualty manager with M&M's Arts & Entertainment division.

And according to Ms. Prine, Ms. Boyar complements the department: "She is one of our best salespersons. She can get her foot in the door of any account she wants. She really has a flair for creativity."

Ms. Prine, who has worked with the Boyars for six years, appreciates Mr. Boyar's experience and willingness to teach the ins and outs of the business. For example, Mr. Boyar once warned Ms. Prine to not give too much detailed paperwork in a proposal to a client, because the client may just take the paperwork and give it to his or her current broker. Unfortunately, Ms. Prine's client did just as Mr. Boyar predicted, she recalled.

M&M has another reason to be pleased with having the Boyars' operation on board. They brought with them some notable clients, including Joel and Ethan Coen, producers of movies like "Raising Arizona," "Miller's Crossing," "Barton Fink" and "Bloodhounds of Broadway."

The Boyars also get rave reviews from Chubb & Son Inc.,

which underwrites many policies brokered by M&M Arts & Entertainment.

The Boyars are "extraordinary professional specialists in the theater business," said Edward O. Darwin, senior vp at Chubb in Warren, N.J.

Mr. Darwin, who is manager of the Chubb Custom Market department, which among other things writes theatrical coverage policies, has worked with the Boyars for 10 years. In fact, Mr. Boyar helped Chubb draw up its first theater package policy in the early 1980s, a successful policy that takes into account the rapidly changing technology in theater. "You don't have people pulling ropes backstage any more—those people are now operating computers," said Mr. Darwin.

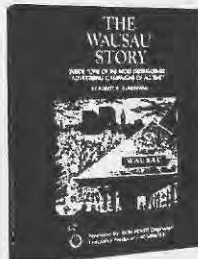
Although the Boyars have seen a lot in their years of insuring Broadway productions, their most unusual assignment was to get a quote on a star non-appearance. In this case, the star was a mouse.

The 1980 musical "Charly," based on the book "Flowers for Algernon," featured a mouse that was trained to follow a spotlight. The general manager for the production called Mr. Boyar to get a quote on the star mouse. The manager believed the understudy mouse would need about a week's worth of training to get up to speed. If the show had to close down for a week while the understudy rehearsed, the loss would be \$100,000.

When Mr. Boyar called his underwriters at Lloyd's about this risk, "everyone was laughing," he said. Finally, the Lloyd's underwriters composed themselves and offered a six-month policy for a premium of \$5,000.

Mr. Boyar took the offer to the general manager, who mulled it over for a few days. When Mr. Boyar called him back, the manager replied, "We decided that for \$5,000, we could get the understudy up in the part." **BI**

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C

New endowment fund for CPCU

MALVERN, Pa.—The CPCU-Harry J. Loman Foundation has created a new endowment fund.

According to Joseph P. Decaminada, chairman of the foundation and executive vp of Atlantic Mutual Insurance Co. in New York, all contributions to the foundation will be added to the endowment. That system would ensure that gifts can be invested on a long-term basis and earn greater income, since only interest income will be spent, Mr. Decaminada said.

The 32-year-old non-profit foundation works with the Society of Chartered Property & Casualty Underwriters to encourage insurance research and education.

For more information on the foundation or contributing to it, contact: Mary Lee Moran, CPCU-Harry J. Loman Foundation, Kahler Hall, 720 Providence Road, CB No. 9, Malvern, Pa. 19355; 215-251-2754.

—By Mark A. Hofmann

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N.J. court ruling

Continued from page 2

pay for the care of anyone who is not a plan member.

At the time, Judge Wolin's ruling that the surcharge-driven system violated ERISA grabbed headlines because it effectively killed New Jersey's entire hospital reimbursement system and raised questions about the legality of any system that contained surcharges.

Although enforcement of that ruling was stayed pending appeals, New Jersey lawmakers chose not to wait for judicial responses and changed their law to omit the surcharges (BI, Nov. 2, 1992).

Still, the recent appellate ruling is far from moot for at least two reasons:

- The unions that sued the state in 1991 and other self-funded health plans affected by Judge Wolin's ruling had been putting the surcharge equivalents into an escrow account pending conclusion of the litigation.

The size of the account, to which the unions have set aside about \$130 million to \$150 million, will have to be forwarded to the hospitals if the appellate ruling isn't overturned.

To determine how much the hospitals could be owed, the New Jersey Hospital Assn. now is requesting an audit of the unions' and other self-insurers' escrow account.

- The ruling further muddies the waters as to whether states can require self-insurers to pay surcharges for indigent care under ERISA.

Both New York and Connecticut have uncompensated care systems that are funded by hospital surcharges.

In fact, several unions with self-insured plans filed a lawsuit last year challenging New York's 5.5% surcharge on the grounds that it requires them to pay for the care of those other than plan members (BI, Feb. 8). However, that lawsuit, which is awaiting trial in U.S. District Court in Brooklyn, may lose some of its steam in the wake of this ruling.

Connecticut imposes an 8.4% hospital bill surcharge and puts the money into a state-run uncompensated care pool. Although no lawsuits have been filed challenging that requirement, many self-insured Connecticut payers have not paid the surcharges with the hopes that the law will eventually be struck down.

The 3rd Circuit's appellate ruling is likely to influence ongoing debate over ERISA's pre-emptive powers and state efforts to handle health care-related problems on their own.

"New Jersey has a new way of financing indigent care, so the money in escrow is all that counts here," said Mark Arian, a legal consultant with Hewitt Associates in Bedminster, N.J.

"But if the ruling holds up on appeal it could have serious ramifications on New York and Connecticut, even though those states are in the 2nd Circuit's jurisdiction," he said.

Another health care expert also downplayed the immediate impact of the ruling in light of New Jersey's new law, but said it raises more questions about ERISA's pre-emptive power.

"I don't know how much other courts follow each other. It's questionable whether other appellate courts will follow this ruling," said Donna Lynne, executive director with the New York Business Group on Health.

"But ERISA pre-emption is now in a different light after this rul-

ing" and after a congressional panel earlier this month included ERISA pre-emption for four states, including New York, in a budget bill, she said (BI, May 17).

In the appellate decision, Judges Walter Stapleton and Anthony Scirica voted to overturn the original decision, but Judge Richard Nygaard's 10-page dissenting opinion said New Jersey's old hospital reimbursement law, which sanctioned the surcharges, clearly should have been pre-empted under ERISA.

New Jersey "conceded that the scheme was not viable without the money from the plans," Judge Ny-

gaard wrote. "The state said these plans represented a major segment of the bill-paying public to the point that it would have been impossible to devise a hospital rate-setting scheme if that segment was excluded or exempted."

"This concession dispels any doubt that the effect of the act is to reach into the deep pockets of ERISA plan funds," the judge wrote.

In conclusion, Judge Nygaard's dissent said the majority's decision gives states "free rein to spend and experiment with ERISA funds, held in trust for those workers who have labored for their secu-

rity. . . . The connection between ERISA plans and the act is not too tenuous, remote or peripheral at all, not when the plan is predicated on the existence of ERISA plans."

Mr. Arian of Hewitt Associates agreed with Judge Nygaard's dissent and predicted that the case will eventually be overturned.

"I think the state will have a hard time in front of the Supreme Court. Something tells me that this decision was prompted more by public policy demands and the Clinton administration's push for state freedom than an accurate reading of whether the law related to the plan in only a remote and

tenuous way," he said.

A union leader also expressed confidence that the recent ruling will be overturned.

"It wasn't a unanimous decision and we feel the dissenting opinion was worded more strongly than the majority's. Case law is on our side, as is the original decision and a similar case in New York," said Charles Marciante, president of the New Jersey AFL-CIO.

He was referring to a February ruling by a federal judge in New York that struck down a state system of levying surcharges on commercially insured and self-insured plans (BI, Feb. 8). **BI**

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Carlos Miro

Continued from page 1

hearing how he was able to pursue his schemes, Mr. Miro replied, "I was basically your A-student type and I stumbled into the insurance business and found a lot of B- and C-students."

"Regulators are GED (graduate equivalency diploma) types," Mr. Miro added.

Last week's hearing was the latest in a series that began in 1988 and included subcommittee inquiries into Mr. Miro's role in the estimated \$4 billion collapse of Transit in 1985 and the roughly \$20 million insolvency of Anglo-American in 1988.

Those hearings led subcommittee Chairman John D. Dingell, D-Mich., to ask the Justice Department to investigate possible criminal prosecution of Mr. Miro and several associates. Mr. Miro was indicted by a federal grand jury in New Orleans in 1991 (BI, June 24, 1991).

In his testimony last week, Mr. Miro said he had been living in Spain and had run out of money while being sought by federal agents.

Ironically, he complained that he had become the victim of betrayal by a former associate: Melvyn Stein, Mr. Miro's London lawyer, barred access to Swiss bank accounts that Mr. Stein had set up for Mr. Miro's benefit in the names of dummy Panamanian and Liechtenstein corporations, Mr. Miro testified.

"This sort of system protected my anonymity so perfectly I couldn't even prove it was my own money when Stein double-crossed me and froze my assets," he testified.

Mr. Stein—who was indicted in New Orleans last month on fraud charges related to Anglo-American—was hospitalized and unavailable for comment last week, according to David Swede, a partner of Mr.

Stein's with the London firm of Finers.

"We will stand behind Mel Stein. He is going to deny the criminal charges and deny the allegations made by Mr. Miro," Mr. Swede said.

Virtually broke, Mr. Miro said he tried to cash in a life insurance policy written by Equitable Life Assurance Society of the United States and found—"in the 'when it rains, it pours' tradition"—that his Equitable agent had stolen the cash value of his and several other clients' policies, he testified.

After discussions with other Equitable officials and several months of delay, Mr. Miro said he was told to pick up an Equitable check at a courier service called "Expresso Express" in Madrid, where he was arrested.

In an exchange that drew laughter from the packed hearing room audience, Rep. Marjorie Margolies-Mezvinsky, D-Pa., asked Mr. Miro if he was relieved to be caught.

"Not particularly," he said.

Extradited to New Orleans, Mr. Miro last year pleaded guilty to 16 wire fraud charges relating to Anglo-American and has cooperated with prosecutors in investigations of several Anglo-American officials and former Louisiana Insurance Commissioner Sherman Bernard.

Mr. Bernard last month pleaded guilty to shaking down officials of five Louisiana insurers, including Anglo-American (BI, May 3). In addition to Mr. Stein, a number of former Anglo-American officials have also been indicted, and several have entered guilty pleas.

Mr. Miro began his career with Hartford Insurance Group in Dallas, but moved to the Dallas office of Alexander & Alexander Inc. in 1977. He remained with A&A until 1980, when he left for a brief stint with Insurance & Reinsurance Brokers Ltd. in Bermuda before forming the first of several of his own companies.

Searching for a fronting insurer for a Cayman Islands company he helped create, Mr. Miro found Transit through Donald F. Muldoon & Co., a New York-based Transit MGA.

He later formed Miro & Associates Inc. to act as a sub-agent of Muldoon and produced nearly \$100 million in premiums for Transit between 1981 and 1984. About 60% of this business came from A&A offices through his contacts at the brokerage, Mr. Miro said.

As Transit's financial problems worsened, the insurer terminated Miro & Associates' contract in December 1984. Transit later filed suit

European reinsurers oppose tight regs

LONDON—European reinsurers are stepping up their campaign to dissuade U.S. regulators, led by Rep. John Dingell, D-Mich., from imposing stringent new reporting requirements on alien reinsurers in the United States.

British, French and German reinsurers and insurers accept U.S. insurers' concerns about the recent spate of offshore reinsurer failures. But they argue that the U.S. regulators must recognize that most major alien reinsurers hail from countries with solvency and reporting regulations that are often more onerous than their own.

The Europeans also argue that if the proposed rules force alien reinsurers out of the United States, U.S. insurers will face a capacity crisis, especially for catastrophe reinsurance. They point out that the only beneficiaries from an alien exodus would be domestic U.S. reinsurers, which could impose huge rate hikes.

The Europeans have not officially pooled their collective muscle in a lobbying effort yet. Recently, however, leading London reinsurer Victor Blake, chairman of CNA International Reinsurance Co. Ltd., testified as an unofficial spokesman before a U.S. House subcommittee chaired by Rep. Dingell and voiced the Europeans' worries.

Last week, Mr. Blake flew to the United States, where he hopes to meet with interested congressional advisers in Washington and with Rep. Dingell to reit-

erate his arguments, but he did not say when he plans to do so.

Mr. Blake hopes to convince Rep. Dingell and others that insurance centers like London and Munich should not be tarred by the same brush as "obscure offshore centers like the Turks & Caicos."

Mr. Blake gave his original testimony April 22 to the House Commerce, Consumer Protection and Competitiveness Subcommittee.

The Europeans hope U.S. insurers will lend their support, but it seems the Europeans may be left out in the cold.

"I think (Mr. Blake) is right, but it is very difficult to stand up and argue on behalf of U.K. reinsurers and say (to U.S. reinsurers), 'Don't worry about it, we don't need your accounts,'" said Richard Hefferan, vp and general counsel of the Schaumburg, Ill.-based Alliance of American Insurers.

U.S. reinsurers will undoubtedly support the regulatory proposals and make life as hard as possible for alien reinsurers, Mr. Hefferan said.

However, James W. Schacht, Illinois' chief deputy director of insurance and a former member of the National Assn. of Insurance Commissioners' Reinsurance Task Force, believes that alien reinsurers from more sophisticated nations may gain some form of exemption.

—By Adrian Ladbury

against Mr. Miro, his agency and others, charging that they failed to report millions of dollars of premiums written for Transit and that three offshore reinsurers set up by Mr. Miro had failed to pay claims (BI, July 11, 1988; June 10, 1985).

Transit's receivers later raised similar allegations during House subcommittee testimony, though Mr. Miro last week largely tried to deflect blame for Transit's problems.

He denied allegations of deliberately underpricing business, saying that Lloyd's of London syndicates—which reinsured portions of the Transit risks—agreed to the pricing and that Muldoon "sanctioned and even encouraged it."

"With the benefit of hindsight I realize this was all part of Transit management's and shareholders' scheme to maximize cash flow in order to liquidate their business, either intentionally or conveniently setting me up as the fall guy in the end," Mr. Miro maintained.

Nevertheless, Mr. Miro noted that he moved to London in 1985 on the advice of Mr. Stein and U.S. lawyers Al Kroemer and David Vaughn to avoid service of the Transit lawsuit. He also said he took Mr. Stein's advice that he protect his "nest egg" by moving it to Swiss bank accounts.

Mr. Kroemer—whom Mr. Miro said was one of his "co-conspirators"

in the Transit and Anglo-American affairs—could not be reached. Mr. Vaughn, a former Anglo-American president, pleaded guilty last month to charges involving the insurer.

By late 1985, Mr. Miro had taken steps to form Anglo-American, which regulators and prosecutors would later charge was capitalized with bogus assets in a scheme to siphon millions of dollars in premiums to a network of offshore companies Mr. Miro controlled.

Asked last week why he formed the insurer, Mr. Miro replied, "The type of overachiever who makes \$6.5 million by the time he's 30 is not the type that would be happy tending the rose garden in London. Basically I was pretty much just bored."

Mr. Miro testified that he and an associate, Sheldon Irion, were told by Mr. Mijalis that he could arrange a Louisiana license for Anglo-American for "\$50,000 C.O.D." Mr. Miro said he later turned over a cashier's check to Mr. Mijalis, who would not say whether he'd actually paid a bribe to Mr. Bernard.

"He gave the coy response that he banked his money, payed his taxes and what he did with the cash he withdrew from his bank account was his business," Mr. Miro said.

Mr. Mijalis later demanded a \$100,000 "retainer" from Anglo-American, "intimating that getting the license was easy, keeping it was the hard part," Mr. Miro alleged.

Mr. Mijalis also asked for another \$100,000 when Anglo-American sought a Georgia insurance license in 1987, saying he now had to "grease two commissioners," meaning Mr. Bernard and the Georgia commissioner, Mr. Miro testified.

Responding to a question from Rep. Sherrod Brown, D-Ohio, Mr. Miro identified Warren Evans as the Georgia commissioner at the time.

Mr. Evans could not be reached for comment.

Mr. Bernard—who also received \$45,000 in campaign contributions from Anglo-American—helped the insurer more than once with regulatory problems and was "was clearly a co-conspirator," Mr. Miro charged.

For example, when Mr. Miro objected to the Insurance Department's requirement of \$1.5 million in initial capital, Mr. Bernard told him he only needed to "flash the cash" long enough for the license to be issued and could then do what he pleased with the money.

When a Louisiana department auditor later threatened to disqualify a \$3.5 million real estate asset, Mr. Bernard—conferring with Mr. Miro at a National Assn. of Insurance Commissioners meeting—suggested replacing it with the proceeds of a loan on the insurer's accounts receivable. Mr. Mijalis then introduced Mr. Miro to a Natchitoches, La., banker who arranged the transaction, Mr. Miro testified.

In 1988, as Gov. Edwards was preparing to leave office, Mr. Miro and Mr. Mijalis came up with a plan to generate money for themselves by making Louisiana a "monopolistic fund state" for workers comp, Mr. Miro alleged.

Under the scheme, the state would become the sole workers comp insurer, with Anglo-American appointed as a "servicing carrier," and Messrs. Miro, Mijalis and Edwards splitting reinsurance commissions through a jointly owned offshore intermediary, Mr. Miro explained.

Mr. Miro formed the intermediary and Gov. Edwards introduced a bill to create the state fund, Mr. Miro testified. However, the bill never passed and the idea died when Gov. Edwards left office, he said.

Gov. Edwards—who was elected again in 1992—denied the allegations in a statement.

"I have nothing to do with (Mr. Miro's) business, never had anything to do with his business, never talked to him about being a partner, never owned nor discussed owning any interest in his business, and never had anything to do with regulating the insurance business in this state or any other state," Gov. Edwards said.

Elsewhere in his testimony, Mr. Miro acknowledged his attempts to take over two other insurers after Anglo-American collapsed. Neither effort succeeded, and the two insurers—Mid-American Insurance Co. of Bossier City, La., and Oxford Indemnity Insurance Co. of Wyoming—have since collapsed.

Responding to questions from Rep. Dingell, Mr. Miro predicted that he could probably get back into the insurance business with few regulatory problems if he found people to "front" for him and was able to "run the company by remote control."

"The states don't look at things the way they probably should," Mr. Miro said. "They either are looking the other way or—like Mr. Sherman Bernard—they want a piece of the action."

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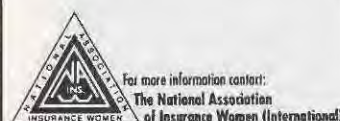
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Re-engineering

Continued from page 3
process and by exploring outside administration services.

"Voice-response enrollment and information systems as well as personal computer systems are out there, and they're very good. A good number of companies are already evaluating them on a continual basis," Mr. Tane observed.

"We believe most companies realize that health care enrollment has become burdensome, especially if you offer two HMOs, an indemnity plan and other plans. Voice response can make it much easier to get people into the appropriate plans," Mr. Tane added.

In addition, the availability of outside service providers capable of administering one or more employee benefit programs is growing every day, he noted.

"Outsourcing allows a company to reduce its headcount and get out of the sometimes cumbersome administration business," Mr. Tane asserted.

"At the same time, a PC-based system also can handle the complexities of administering a program such as a pension plan," he said.

When pondering whether to re-engineer or stick with an administration system that's currently in place, employers must decide if they are going to target just one benefit program or re-engineer the administration process of several coexisting benefit programs.

"The strengths of solving one problem on an isolated basis is that it can be accomplished in the shortest amount of time, it maximizes impact and it costs the least," said Mr. Tane.

But conversely, employers may lose out on potentially greater savings by not reworking all administration systems at once, he warned.

"If you're outsourcing, you lose negotiating leverage if you only want to target one type of benefit. There are economies involved in redesigning the entire administrative workflow. Remember, you're not mechanizing just for the sake of doing so. Re-engineering is all about doing what makes the most sense," he insisted.

Some examples of benefit re-engineering outlined by Mr. Tane include implementing a single voice-response system for all employee transactions.

"This can really save a lot of money for your company. Consolidation on one data base can substantially reduce maintenance costs and employees seem to like accessing their plans through a single 800 number," he said.

Another example of cost-effective administration re-engineering would be providing employees access to personal computers so they can directly update and select their own human resource and benefit information.

"The more manual updating you can eliminate, the greater the potential for savings," Mr. Tane said.

Companies can also transfer administrative recordkeeping responsibilities from internal personnel to an outside vendor, eliminating what Mr. Tane called "redundant staff."

If a company decides to outsource, one key to cost savings is negotiating with one vendor for multiple services whenever possible.

"This will maximize your return on investment in the long run. It's amazing how much more negotiating leverage you have when talking with one vendor as opposed to three different vendors," said Mr. Tane.

Like most philosophical or policy changes that occur within a corporation, the decision to re-engineer benefit administration requires a strong commitment from senior management.

"Re-engineering crosses traditional boundaries. Without management's support, you'll be mired in internal negotiations that will certainly prevent ultimate savings," he said.

"Thus, you must develop a consensus about what the project is designed to achieve before you begin. This will help you keep focus when the inevitable stumbling blocks are uncovered," Mr. Tane said.

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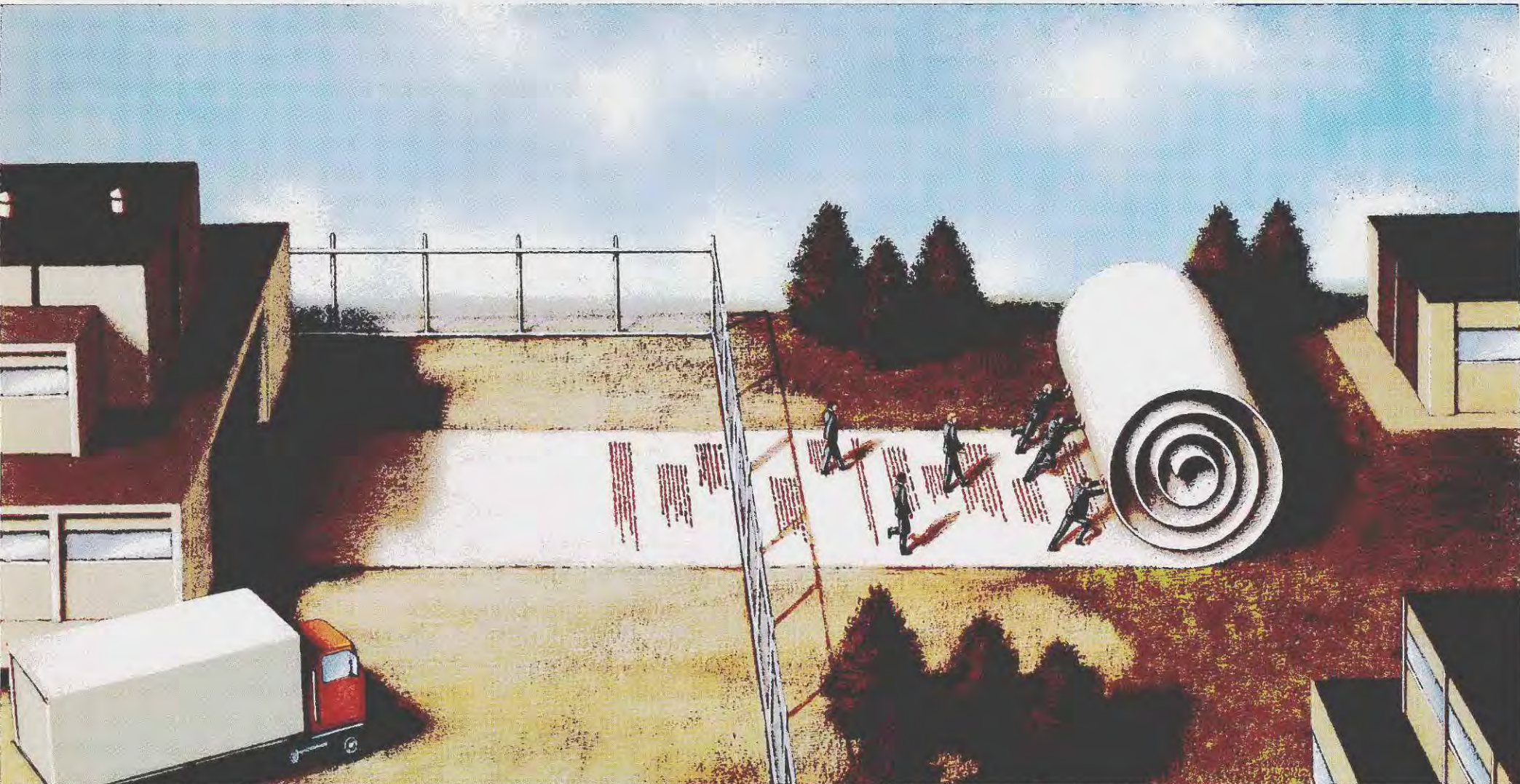


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Making health reform work

Managed competition can succeed—even in rural areas

By Douglas G. Cave

DEBATE CONTINUES with regard to the viability of various health care reform proposals. A recent article concluded that managed competition as a health care reform plan is feasible in medium-size or large metropolitan areas, but "smaller metropolitan areas and rural areas would require alternative forms of organization and regulation of health care providers to improve quality" and lower costs (*BI*, Feb. 1).

Medium-size areas were defined by the authors of the study, as those with populations of at least 360,000 people. Large areas were defined as those with populations greater than 1.2 million and small areas as those with populations of at least 180,000.

The authors found that up to 37% of the population—those not in medium-sized or large areas—may not benefit from managed competition.

In estimating the minimal population required to support managed competition, the authors used four assumptions:

- The extent to which competing health care organizations need to be independent.
- The minimal number of health care organizations needed to support healthy competition.
- The ratios of physicians to enrollees and of hospital beds to enrollees in efficiently managed health plans.
- The geographic boundaries of health services markets.

Of these assumptions, the authors' definition of the location and size of the health care market is important to consider. They assumed that "metropolitan areas, as defined by the Office of Management and Budget, are the relevant market areas for health services in non-rural parts of the United States. Metropolitan areas are defined as a place with a population of at least 50,000 or an urbanized area, as defined by the U.S. Bureau of the Census, with a population of at least 50,000 and a metropolitan area with a total population of at least 100,000. This definition of metropolitan area results in high-density geographic units with economic and travel ties that are consistent with a regional economic market."

We agree that a central tenet of the managed competition theory is that providers are divided into competing economic units as defined by some geographic boundary.

However, we suggest that geographic boundaries need not be defined by the Office of Management and Budget or the Bureau of the Census. Instead, the location and size of the health care market might be defined more broadly to include many surrounding small areas and rural counties.

Using this broader definition, demographic factors will not limit the full implementation of managed competition as the vehicle for reforming the U.S. health care economy.

Instead, the limiting factor now is whether competing health plans will extend their current network coverage areas from existing medium-size and large metropolitan areas to small areas and rural counties. The answer is yes, if the proper financial incentives are employed under the managed-competition theory.

The federal government could offer financial assistance to encourage new and existing health plans to extend their network coverage areas to the new geographic boundaries established under managed competition. Authorized grants up to \$100,000 could be offered to conduct feasibility studies, grants of up to \$200,000 for more detailed planning and grants of up to \$2 million for initial network development costs.

These grants are similar to those Congress

authorized for prepaid health plan development under The Health Maintenance Organization Act of 1973.

Another approach could be to implement a surcharge on all health plans that fail to expand their networks to all areas within the geographic boundary of their respective health care markets. A reasonable surcharge might be 10% on all hospital bills or 5% of all medical care bills. And health plans can reduce the surcharge by 25%, 50%, and 75% as they expand their coverage areas and enroll an equivalent percentage of the targeted small areas and rural counties.

This type of financial arrangement is presently being used by the state of New York to give HMOs incentive to enroll Medicaid patients.

Alternatively, the federal government could provide financial incentives that more directly address the distribution of health care providers. For instance, a health plan could exclude from taxable income, say, \$20,000 for physicians devoting 50% or more of their medical practice to patients in small areas and rural counties. The provincial government of Ontario, Canada, uses this type of incentive, though the government directly compensates physicians annually for practicing in rural areas.

Another way to target health care providers is to require all new physicians to devote 100% of their medical practice to small areas and rural counties for four years—or 50% for eight years. If these physicians insist on practicing in medium-size and large metropolitan areas, they would be reimbursed for only 70% of their bills or 70% of the health plan's average salary or capitation level.

The provincial governments of Ontario and Quebec in Canada have proposed reforms along these lines.

A qualified health plan must provide primary care services, specialist services, acute-care hospital services and tertiary hospital services.

There are ways for health plans to expand their networks to small areas.

To provide full coverage under an established geographic boundary, health plans must target a minimum number of enrollees in each small area within that geographic boundary.

Mr. Kronick's study showed that 2,000 people are required to support one full-time-equivalent primary care physician. This is not a large number. Consequently, health plans should be able to establish extensive independent primary care networks.

Primary care physicians presently living in small areas will need to fully commit their practice to one health plan's network. If some small-area physicians will not participate, a health plan could hire one or more new primary care physicians to service the area.

Competition for patients could become fierce, and physicians not fully committed to one organization may be forced out of the market.

For most populations, 10% of the individuals spend about 70% of health care dollars. Vice versa, 90% of the individuals in a geographic area spend only about 30% of the health care dollars. These findings generally imply that 90% of the individuals in small areas can be cared for through a health plan's primary care network.

The remaining 10% will require more resource-intensive specialist and hospital care. However, a health plan enrolling only 2,000 persons in a small area could not commit any one type of specialist physician full-time to that area. Instead, the health plan will need to develop specialist travel programs to service these areas.

For example, Ontario and Quebec's governments arrange for urban-based specialists to travel to

rural areas once a week and provide services. When small-area enrollment reaches 10,000 persons, a health plan can commit one full-time-equivalent obstetrician/gynecologist. Once small-area enrollment reaches 20,000, a health plan can support one general surgeon, one orthopedist, one emergency medicine physician, one anesthesiologist, one radiologist and one psychiatrist.

A specialist travel program would still need to be developed for cardiology, urology and many other specialty services. Specialist travel programs actually will enhance access to specialty care for many patients in small areas. In those small areas that cannot support full-time specialists, patients presently have to travel long distances, sometimes hundreds of miles, to receive specialist care. Under the specialist travel program, the provider comes to the patient.

Research has shown that 35% to 40% of all hospital admissions are planned and are single, non-repeat events.

For small areas, these hospital services can be delivered in one of several ways. Ideally, a health plan would enroll 60,000 members per small area and then build and support a 125-bed hospital. Under certain circumstances, this enrollment level can be achieved.

However, this is more the exception than the rule. A more realistic goal would be small-area enrollment of 20,000 persons. For this population size, a health plan could deliver acute-care hospital services by building mini-hospitals with about 45 beds.

Essentially, the mini-hospitals would be expanded surgicenters and would provide mainly maternity, some general surgery, emergency medicine and some radiology services. Other specialist services could also be provided, but each health plan would need to determine the cost efficiency of delivering these services at mini-hospitals.

For small areas with enrollment between 2,000 and 20,000 persons, health plans could arrange for patient travel programs to their acute-care hospitals in medium-size or large metropolitan areas. Generally, well-organized patient travel programs should be viewed favorably by many small-area residents. Once enrollment reaches the 20,000-person threshold, a mini-hospital could be supported.

Of course, there will be clinical situations in which a patient travel program will not be sufficient. For example, if a woman goes into premature labor, a planned hospital admission instantly becomes an emergency admission. For this reason, a contingency plan must be developed that replaces the patient travel program. The federal government may need to legislate that health plans owning a hospital in small areas open their doors to all other health plans for emergency admissions.

In addition, two distinct types of patients will require tertiary hospital care. The first type of patient is characterized by either a single cost-intensive or single prolonged hospitalization.

About 10% to 15% of all hospital admissions fall under this category. Conditions include spinal cord injuries, head trauma, strokes, neurological diseases, organ transplants and birth of premature infants.

Many existing small-area hospitals are not equipped to deal with these tertiary-care patients. Consequently, once vital signs are stabilized, the patients are airlifted to an urban tertiary-care hospital for treatment.

Health plans servicing small areas could treat these patients in a similar fashion. Mini-hospitals or acute-care hospitals providing emergency services would be responsible for patient stabilization. Then,

Continued on next page

Managed competition

Continued from previous page

the health plan would employ a state-of-the-art air transport program to fly the patient to the health plan's tertiary-care hospital. Resource-intensive care would be provided at this facility.

The other type of patient requiring tertiary hospital services is characterized by repeated hospitalizations for the same disease. These patients account for about 50% of all admissions. Conditions include acquired immune deficiency syndrome, cancer, congestive heart failure, diabetes mellitus and renal failure/nephritis.

One way to properly manage this group of patients is for health plans to develop coordinated care gatekeeper programs in small areas. Primary care network physicians would serve as the foundation of this

program. Each patient would be assigned to one primary care physician. Working with the health plan, this physician would closely monitor the patient's natural disease process.

As greater complications and systemic involvement occur, the primary care physician would be required to develop a treatment plan and to coordinate all care delivered. Patient travel, specialist travel and air transport programs would all play a role in treating these types of patients. The primary care physician would continually re-evaluate the patient's medical condition and have the power to recommend any treatment plan modifications.

We have illustrated how health plans could extend their current networks and provide services to small area enrollees. But, "could" and "will" are often two different things. Thus, we defined financial incentives

that the federal government could use to encourage qualified health plans to extend their present service areas. In this manner, at least five or six health plans could feasibly compete to enroll small area populations. Geographically isolated areas where providers have a natural monopoly would effectively be eliminated. And, managed competition would work. **BI**



Douglas G. Cave is a consultant with Hewitt Associates in Newport Beach, Calif.

Early intervention is paying off

By Evelyn Davis

INCREASINGLY, INSURERS and self-insurers are looking at managed care techniques to contain skyrocketing workers compensation costs. Among the most talked about techniques is expanded use of case management. For years, case management has been a standard means to managing care and costs associated with catastrophic injuries and illnesses. More recently, however, buyers and vendors have been considering the merits of early intervention in cases that do not involve serious injuries.

Proponents assert that early intervention by case managers can prevent a case from getting out of control and can shorten the duration of injury. Others question the utility of early intervention and express their concerns about potentially high costs associated with expanding the use of case managers.

Indeed, the more vocal critics of early intervention argue that cost savings analyses performed by case management firms simply are too hypothetical and too complicated.

We believe the debate over the merits of early intervention should be reduced to two basic questions. First, is early intervention a good investment? Second, can case managers be held accountable?

A 1992 study of a statistically significant sample of our cases assigned for case management examined the effectiveness of early intervention. The elapsed time between the date of injury and the date of assignment was calculated, as were the elapsed time between date of assignment and the date the case was closed.

To determine if early intervention affected the duration of a case, it was necessary to limit the sample to comparable cases and screen out extraneous factors. The only cases included in the study met the following criteria: the primary diagnosis was back pain; the case did not involve surgery; the case was closed by return to work at either the same or another employer; the case received full case management; we had a basic understanding of the work culture of the employer from whom the case was referred. In the end, 819 cases were included.

Our field staff then reviewed the cases, providing a case history and noting exceptional factors, like employer or insurer decisions, that prolonged or truncated the duration of a case while under management.

Dividends increase with timely referrals

By comparing the profile of every case, we found that early intervention was indisputably associated with faster successful case closure. For example, if a case manager received the case two weeks after injury, that case was typically resolved in about four weeks. If the case manager was assigned a case four weeks old, that case typically took an additional 10 weeks to be resolved. In other words, the longer the delay in assignment to case management, the longer (and more expensive) case management was needed to close the case successfully.

The attached exhibit describes in a graph the relationship between early intervention and case closure. This demonstrates that as intervention is made earlier, the duration of the case

is calculated as follows: indemnity benefit (67% of \$450 weekly wage) is \$300; medical benefit is \$150. The total weekly benefit is about \$450, or a daily benefit of \$64.

In addition to indemnity and medical benefits, the cost of a lost-time case includes expenses like claims staff time, independent medical examinations, legal defense and, in many instances, settlement costs. Generally speaking, the longer the duration of a case, the more these additional costs grow. It is reasonable to estimate that, for every additional day of duration, these additional costs are equivalent to 25% of direct benefits, or approximately \$16 per day. Total daily equivalent costs come to \$80.

Using this equivalent cost per day, one

duration of disability declines by 2½ days. If case management were brought into the case one day earlier, the duration of the case would decline by 2½ days. In other words, \$20 of case management results in a savings of \$200, for a 10-to-1 financial payback.

Our analysis has uncovered a valuable tool for case managers to hold themselves accountable.

The intervention curve describes the average duration of a case under case management based on decreasing delays in assignment. Any significant variance from the intervention curve in a particular case history should be carefully analyzed (see chart).

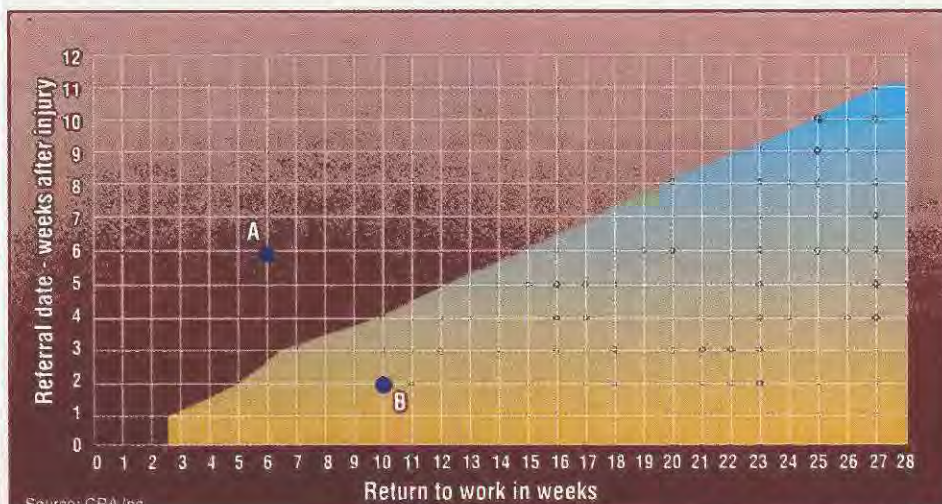
For example, Case A was assigned on the sixth week and was closed successfully just six weeks after case management intervention. However, the intervention curve "predicted" a duration under case management of about 15 weeks. Its dramatic distance from the curve forces one to examine the causes. Perhaps the case manager performed heroic measures to facilitate early return to work, or perhaps the case was just about to resolve itself, in which event credit should not be given to the case manager for early resolution.

On the other hand, Case B appears to have stayed in case management far too long, as the intervention curve "predicted" a duration of five weeks instead of 10. The curve prompts the case manager to explain why the case went five weeks longer than predicted.

In short, the curve becomes an invaluable tool to reinforce accountability and establish whether cost savings were earned or fortuitous.

Case management value can be maximized as part of the cost care process if it is integrated with other cost containment products.

The study shows early intervention makes financial sense. The intervention curve provides a reliable tool to hold case managers accountable. We believe that is what managed care is all about: quality care, delivered cost-effectively, with accountability. **BI**



GRAPHIC BY CHRIS ROY

under case management declines sharply. In fact, as intervention is made earlier by one day, the duration of disability under case management declines by 2½ days.

Critics might argue that the early intervention cases we selected were medically less severe than late intervention cases, and this explains the faster closures. That opinion is refuted by the case records themselves, which show severe injuries were not noticeably concentrated among our late intervention samples.

The intervention curve suggests early intervention is very cost-effective. This finding is based on a simple but reliable estimate of the cost of case management compared with the savings from reducing the duration of a case.

Over the lifetime of a lost-time case, the cost of a typical case is equivalent to about \$80 a day. A weekly estimate

can estimate that for a typical lost-time cost of 60 days, the total costs will be about \$4,800.

The cost of case management was based on actual charges billed to individual cases. When allocated on the basis of each calendar day of disability, case management costs averaged about \$20 per day.

Both of these daily figures—the \$80 daily cost of disability and the \$20 daily cost of case management—are averages over the lifetime of cases and vary significantly by case—but over a large number of cases under management, they are representative and reliable.

From these estimates it follows that, on average, for every avoided day of disability through the use of case management, an employer or insurer saves \$80. Note the intervention curve indicates that for every day's shortening of referral to case management, the

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Helping all to win in workers comp

"Workers' Comp Case Management: A 'User-Friendly' Approach for Employers"

By Charles A. Warnes

Published by LRP Publications, Department 450, P.O. Box 980, 747 Dresher Road, Suite 500, Horsham, Pa. 19044-0960, 800-341-7874, ext. 347 \$18.50, including shipping & handling

By Kevin M. Quinley

USER FRIENDLY IS one of those '90s buzz phrases that has gained currency, yet often lacks credibility. Far too often, a user-friendly computer system or software product is user friendly... if you happen to be a computer programmer!

The user-friendly claim has all the credibility of "Your check is in the mail" or "Yes, of course I'll respect you in the morning."

Once in a while the moniker fits, however, and that genuinely is the case in "Workers' Comp Case Management" by Charles A. Warnes. The subtitle is "A 'User-Friendly' Approach for Employers," and no truth-in-advertising standards are violated here. Are workers compensation claims draining your company's valuable resources? Chances are, the answer is yes.

Risk managers are frequently asked to list their top on-the-job challenges. Invariably, workers compensation percolates to the top of the headache list. What is the solution? Is there any one solution?

Mr. Warnes argues that risk managers can learn

Books & Ideas

how to trim their losses by working more effectively within the workers compensation system—to the benefit of all parties involved. It really is possible to craft win-win solutions, he contends.

The principles suggested in "Workers' Comp Case Management" are not the product of some academic "think tank." Instead, they are fundamentals successfully used every day by professional risk managers.

Most risk managers have neither the time nor the interest to become experts in workers compensation. On the other hand, they need to combat rising workers comp costs and prevent the morale problems and legal complications that too often surface after injury and illness claims.

This book can help.

Mr. Warnes' advice will equip risk managers with relevant and useful insights into case management techniques, such as:

- Recovery management, which requires risk managers to be vigilant about subrogation opportunities.
- Light duty and modified work, which gets injured employees back into the stream of work, much better than watching the commercials for the local whiplash law firm between Donahue and Oprah.
- Employer-employee interaction. At one construction firm, each injured worker gets a phone

call and handwritten note from the company president. Motivational? You bet!

• Vocational rehabilitation, in which skilled professionals can help injured workers gain employment in other settings, saving employers a bundle in comp benefits.

Mr. Warnes has more than 24 years of insurance industry loss-control experience and works for Hartford Insurance Co. in Fresno, Calif. He also has served as president of the American Society of Safety Engineers.

Mr. Warnes presents time-tested management principles in seven realistic sample cases with just enough dry wit to entertain as well as to inform readers.

This slim book—54 pages—will be a quick read, a plus for harried risk managers without the time to digest lengthy tomes.

There will likely never be a "one-minute risk manager," but Warnes offers a succinct blueprint for taming the workers compensation beast. Read and profit!

BI



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Date of comp injury determines dependents

An Arizona appellate court ruled in a workers compensation case that the dependency of a widow, child or stepchildren is determined as of the date of the injury, not the date of death.

James Dunn sustained an industrial injury in 1975 for which he received workers compensation benefits. At the time of the injury, he was married to Marilyn Dunn. They were divorced in 1978. Mr. Dunn later married Rose Marie and they had one child. Rose Marie also had two children from a previous marriage who were partially dependent upon Mr. Dunn for their support.

Mr. Dunn died in 1989, allegedly as a complication of the 1975 injury. Rose Marie and her children filed a death benefit claim in 1990 that was denied by the state workers comp commission because she was not married to Mr. Dunn at the time of his injury.

The appellate court ruled that a wife who was not married to a husband at the time of his compensable injury was not entitled to recover death benefits, even though she and the husband were married at the time of his death, whether or not there was a question of actual dependency.

Furthermore, the appeals court said that children born after the date of a worker's compensable injury were ineligible for death benefits, even if the child was otherwise within the class of those conclusively presumed dependent.

The denial of the death benefits was affirmed.

Dunn vs. Industrial Commission of Arizona, Court of Appeals of Arizona, Dec. 4, 1991, Nov. 29, 1991; As Corrected Dec. 4, 1991; Review Granted June 16, 1992 (BI/04/A.-\$10).

Legal Briefs

Excess insurer doesn't drop down

The Missouri Court of Appeals held that an excess umbrella liability insurer was not required to "drop down" and fill the gap in a company's coverage created by the insolvency of the insurer that provided the first layer of excess coverage.

Integrity Insurance Co. had insured Fred Weber Inc. under a commercial catastrophic liability policy. For a \$35,000 annual premium, Integrity provided first-tier excess coverage of \$5 million in excess of an underlying primary insurance company identified in Integrity's policy schedule.

During the same period, Granite State Insurance Co. provided a second layer of excess umbrella liability coverage. The Granite policy contained a \$5 million liability limit in excess of Integrity's underlying policy limits. The Granite policy premium was \$15,611 annually.

Weber settled a lawsuit filed against it, but the settlement exceeded the policy limits of its primary insurer. Weber sought recovery for the excess settlement amount it owed; however, Integrity had been declared insolvent. Weber then brought this action seeking a declaration that Granite be obligated to fill in the gap created by Integrity's insolvency. The trial court ruled against Weber.

The appellate court said that there was absolutely no ambiguity in Granite's policy where its limit of liability provision clearly stated that "liability shall attach only after the Underlying Umbrella Insurer have paid or have been liable to pay the full

amount of their respective ultimate net loss liability. . . ."

According to the court, nowhere was it alleged or proved that Integrity paid or was held liable to pay in order to trigger Granite's obligation to pay. Nor could the court find any language in the Granite policy that could reasonably be said to have insured against the insolvency of the underlying insurer.

The trial court decision was affirmed that Granite had no obligation to pay any loss that was written within the policy limits of the insolvent primary insurer.

Fred Weber vs. Granite State Insurance, Missouri Court of Appeals, March 24, 1992, motion for rehearing/transfer to to Supreme Court denied, April 20, 1992; application to transfer denied, June 2, 1992 (BI/02/D.-\$10).

Right to reduce retiree benefits

The 3rd U.S. Circuit Court of Appeals ruled that a clause in a summary plan description reserving a company's right to reduce retired employees' welfare benefits was ambiguous, remanding the case to a trial court for further determination.

Judd Alexander and Richard Edwards were retired salaried employees of American Can Co. As retirees, they received health and life insurance from the employer group insurance plan.

In this class action, they contested a ten-fold increase in their premiums instituted by Primerica Holdings Inc., a successor to American Can.

The employees claimed that the increase violated the terms of the plan. A plan summary provided that the company "... necessarily reserves the

right to amend, modify or discontinue the plan in the future in conformity with applicable legislation."

In 1989, shortly after it acquired American Can, Primerica raised monthly premiums to \$50 from \$5 per person. The employees filed this suit alleging that the reduction in vested benefits violated ERISA. The trial court ruled against the employees.

On appeal, Primerica argued, in part, that the summary plan descriptions notified the employees of the plan's absolute right to reduce or terminate benefits and, therefore, the plan did not promise vested benefits. The appellate court said that the summary plan descriptions must warn employees of adversity.

The court was of the opinion that the amendment clause here was ambiguous. The court said that the word "amend" could include either an enhancement or reduction of benefits. "It is unclear," the court said, "why a company would reserve the 'right' to enhance benefits."

"Neither ERISA nor common sense requires notice of future benefit enhancement," the court said, concluding the phrase was ambiguous and returning the case to the trial court for further determination.

Alexander vs. Primerica Holdings Inc., 3rd U.S. Circuit Court of Appeals, June 25, 1992 (BI/03/Ju.-\$10).

BI

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

Summary of major property/casualty insurers' first-quarter results

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

Corporate

Property/casualty operations

Rank 1992	Consolidated revenues 1993	Net income 1993	Percent increase (decline) 1992-1993	Combined ¹ ratio 1993	Combined ¹ ratio 1992	Net premiums written 1993	Percent increase (decrease) 1992-1993	Pretax underwriting income (loss) 1993	Percent increase (decline) 1992-1993	Pretax investment income 1993	Percent increase (decrease) 1992-1993	Policyholders surplus 1993	Percent increase (decrease) 1992-1993	
1	USF&G Corp.	875,000	61,000	1,425.0	110.6 ²	113.8 ²	687,000 ²	(3.8)	(68,000)	68.0	110,000	(10.6)	1,518,000	4.9
2	Hartford Steam Boiler	163,100	17,800	559.3	92.1	94.0	90,800	6.4	7,100	39.2	8,500	(11.5)	382,900	-
3	Hartford Insurance Group	2,508,000	103,000	137.7	107.3	111.6	1,598,000	0.6	(126,000)	29.8	215,000	(31.1)	3,053,000	1.1
4	Reliance Ins. Co. & subs.	677,340	28,267	50.0	112.2	108.2	460,542	2.4	(43,497)	(52.6)	56,884	22.7	874,938	10.0
5	Aetna Life & Casualty Co.	4,294,100	166,300	40.1	118.3	116.1	1,151,800	(8.9)	(201,700)	4.7	218,200	(0.9)	2,276,700	2.4
6	Sentry Insurance Cos. ²	395,395	14,835	28.2	104.4	105.8	334,225	(5.5)	(21,510)	12.3	44,467	2.7	859,353	10.5
7	Old Republic Int'l	403,166	40,169	16.8	108.5 ²	111.6 ²	200,788 ²	29.8	(17,446) ²	9.2	42,543 ²	(4.3)	1,117,769	20.0
8	Berkshire Hathaway Group	215,178	54,240	16.4	124.9	153.4	224,592	2.9	(31,927)	31.8	87,030	(3.8)	N/A	N/A
9	American International Group	4,643,240	495,921	12.8	99.6 ²	100.1 ²	2,443,810	7.9	21,134	3,132.1	330,656	7.0	N/A	N/A
10	Argonaut Insurance Co.	102,206	20,544	(8.0)	100.0 ²	99.7 ²	68,623 ²	(12.9)	1,908 ²	401.9	25,126 ²	(13.2)	520,378	4.9
11	SAFECO Corp.	843,107	75,381	(11.3)	108.2	100.1	462,825	6.7	(37,728)	(6,938.8)	69,374	(0.9)	1,427,432	17.0
12	Chubb Corp.	1,237,500	125,800	(12.1)	99.8 ²	98.1 ²	817,400	8.7	(3,100)	(127.9)	128,900	9.1	1,840,000	8.9
13	Travelers Corp.	2,849,300	194,500	(13.2)	109.1	111.3	1,003,000	(8.3)	(105,000)	21.8	168,000	(8.2)	1,814,300	17.6
14	Ohio Casualty Corp.	434,560	19,844	(16.9)	111.0 ²	108.9 ²	332,963 ²	(14.1)	(37,286)	(13.0)	49,976	1.0	699,413	10.9
15	General Re Corp.	925,400	160,600	(22.7)	106.6 ²	105.4 ²	658,600	9.9	(38,900)	(1.0)	183,000	(2.4)	3,555,300	6.3
16	Home Insurance Co.	628,000	21,000	(27.6)	110.3 ²	106.5 ²	504,000	14.5	(52,000)	(36.8)	65,000	(8.5)	945,000	2.2
17	CNA Financial Corp.	2,920,000	313,600	(29.0)	121.1 ²	117.6 ²	1,500,000 ²	(10.2)	(318,900) ²	(7.0)	276,400 ²	(12.0)	3,370,000	7.3
18	Continental Corp.	1,258,300	22,600	(30.0)	109.4 ²	110.0 ²	1,059,800 ²	13.5	(112,300) ²	(12.9)	128,000	(14.0)	1,989,000	5.1
19	CIGNA Corp.	4,374,000	46,000	(43.2)	132.4	117.8	1,068,000	(15.8)	(342,000)	(48.1)	170,000	(13.3)	1,570,000	(20.2)
20	The St. Paul Cos. Inc.	1,114,028	88,031	(51.7)	108.9 ²	106.3 ²	761,152	0.9	(60,216)	(46.1)	161,830	1.2	1,802,564	4.3
21	Fremont General Corp.	151,506	9,227	(82.2)	102.6	105.4	120,001	15.4	(2,754)	45.6	17,178	(4.2)	170,943	7.1
22	Lincoln National Corp.	2,003,100	14,900	(85.2)	113.8 ²	110.1 ²	463,800	(11.0)	(61,300)	(21.1)	64,700	(8.7)	1,467,600	3.4
23	Royal Group (U.S. subs.) ²	N/A	(7,100)	(118.7)	123.4 ³	119.1 ³	427,000	12.0	(104,500)	(41.6)	74,700	(12.1)	808,100	(5.7)
—	Nationwide Mutual Ins. Co. ²	N/A	N/A	N/A	106.2	105.2	1,738,475	5.8	(154,160)	(69.6)	216,561	4.2	3,714,993	(2.4)
—	Commercial Union Ins. (U.S.) ²	N/A	N/A	N/A	108.4 ³	107.1 ³	415,300	4.6	(37,400)	(18.7)	48,400	5.7	894,100	24.8
—	Kemper National Ins. Cos. ²	N/A	N/A	N/A	111.1	107.0	936,754	(1.1)	(121,964)	(36.7)	86,550	(7.4)	1,831,054	0.4
—	Liberty Mutual Ins. Co. ²	N/A	N/A	N/A	116.9	115.5	1,515,057	(2.9)	(248,716)	(16.7)	253,293	(12.7)	2,916,506	2.7
Cumulative		33,015,526	2,086,459	1.0	110.9	109.9	21,044,307	(0.1)	(2,318,162)	(12.4)	3,300,268	(6.7)	41,419,343	4.1

¹ After dividends

² Statutory

³ Before dividends

N/A—Company did not provide data

P/C results

Continued from page 1

"Between the bombing and the blizzard, the first quarter was pretty horrendous," said Gloria Vogel, first vp with Lehman Bros. in New York.

However, profits did rise—albeit slightly—in the first quarter, which is a big improvement over full-year 1992 results, when net income shrunk by 44.2%, which reflected Hurricane Andrew's impact (BI, March 22).

Other first-quarter results of the 27 insurers surveyed by BI indicate:

- Net written premiums decreased by 0.1% to \$21.04 billion from \$21.06 billion for 1992's first quarter. For all of 1992, net written premiums were down 2.9% to \$81.33 billion from 1991 levels.

- Underwriting losses deepened by 12.6% to \$2.32 billion from \$2.06 billion. Underwriting losses in 1992 increased 66.7% to \$14.7 billion.

- The combined ratio deteriorated in 1993's first quarter to 110.9%, compared with 109.9% for the comparable quarter a year ago. Insurers reported a 118% combined ratio for all of 1992.

- With interest rates still low, and many insurers having realized capital gains last year, first-quarter investment income fell 6.7% to \$3.3 billion from \$3.54 billion in the same period last year.

- Policyholder surplus increased 4.1%, to \$41.42 billion from \$39.78 billion.

"I haven't seen any change. I see things continuing" as they have been, said Charles Ronson, an analyst with Balesra Capital in New York. "As near as I can tell, what we had, we still have."

"In general, it was a tough quarter, with no signs of any immediate improvement," agreed Michael A. Lewis, first vp with Dean Witter Reynolds in New York. Except for workers compensation in California, where results did improve slightly, "generally it was a weak quarter for the industry," he said.

"It was a non-event kind of quarter, and a lot of people took their lumps in the fourth quarter," said Joanne Morrissey, a principal with Firemark Consultants Inc. in Morristown, N.J.

Any significant improvement is unlikely this year, observers say.

"We expect that results will worsen," with the combined ratio remaining about the same or a little bit worse, said Ms. Morrissey.

The outlook is "generally continued lackluster results," said Mr. Lewis.

With most of the year's business already booked, "I think '93 is in the bag, so to speak," said John H. Snyder, senior vp at A.M. Best Co. in Oldwick, N.J. Barring a major catastrophe, he said, "there'll probably be some improvement" compared with 1993. "Obviously, it's still going to be a mediocre year."

"It looks to me like we're seeing a turn in the marketplace for property lines" and improvement in workers compensation as well, said James S. Kemper III, executive vp-commercial lines group for Kemper National Insurance Cos. in Long Grove Ill.

But there is not much change in other casualty lines, he said. "If there's no turn in the market, I think combined ratios will continue to get worse and it would set up a bad year for next year as well," he said.

Insurers are being hurt by low investment yields, observers say. The declining investment income growth is particularly significant in light of the poor underwriting results and low premium growth, because it means insurers are losing an important source of earnings growth, said Mr. Lewis.

He also noted that many insurers took capital gains last year and reinvested the funds at lower rates. The resulting decline in investment income adds more pressure on insurers, though the industry has been "very reluctant to do much on the rate side," he said.

"There's a growing difference in

most results between companies that took capital gains in '92 and those that did not sell higher-yielding securities," said analyst Jay Cohen with Salomon Bros. in New York.

He pointed specifically to American International Group Inc. and Chubb Corp.—whose investment income rose 7% and 9.1% respectively in the first quarter—as opposed to Continental Corp., which posted a 14% decline in investment income.

"Companies are going to have to learn how to underwrite again," said Firemark's Ms. Morrissey. Over the past five to 10 years, a whole generation of underwriters has not been taught how to underwrite for profit because insurers were earning those profits through investment income. Now, however, "property/casualty companies aren't going to be saved by their investment income."

Observers disagree as to when a marketwide turn is likely.

"There's some indication the market has begun to firm," said Michael Crall, president and chief executive officer of Argonaut Insurance Co. in Menlo Park, Calif., noting he is now seeing competitors introduce underwriting restrictions.

"By the end of the year, we'd expect to see some signs of a cyclical turn," said Mr. Cohen.

"I think toward the end of this year we're going to see some relief," agreed Ms. Morrissey.

Change will begin later in the year, concurred Lehman Bros.' Ms. Vogel, but "I think it's going to be slow and modest and hard to see. I think each quarter that passes we'll see a little bit more."

But others are less optimistic.

Mr. Frank predicts "a continuation of the current environment for the rest of the year."

"I continue to think it's likely to take some other jolt to the system" to turn the market, whether it is a great reserve deficiency or another major catastrophe on the scale of Hurricane Andrew, he said. "The industry's threshold of pain, whatever

it is, still seems to be in front of us."

It is not apparent what would cause a "sudden and mass withdrawal" from the market, which would lead to a dramatic change, said Barbara D. Stewart, president of Stewart Economics in Atlanta.

"I would not be surprised to see another two years before there's a meaningful turn," said John L. Ward, CEO of the Ward Financial Group in Cincinnati, an investment

banking and management consulting firm specializing in the insurance industry.

The market will turn "when it hurts," said Alan Levin, senior vp at Standard & Poor's Corp. in New York, who added he does not know when that will be. "It's a real psychological situation at this point. The industry has gone well beyond any logical point of (saying), 'Well, this should do it.'"

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INTERNATIONAL

Lloyd's names prepare suit as a safety net

By ADRIAN LADBURY

LONDON—Disgruntled members of Rose Thomson Young (Underwriting) Ltd. syndicate 255 are threatening to sue their members agents if Lloyd's of London cannot engineer a marketwide settlement among members, members agencies, and errors and omissions underwriters.

Members of syndicate 255 last week announced their intention to sue their members agencies for losses on the syndicate's still open 1988 and 1989 accounts.

A big factor behind the members' decision was a report by Stephen

Edwards, the syndicate's current underwriter, that contained up-to-date estimates of the syndicate's losses. In the worst-case scenario for the 1989 account, losses are projected to be 700% of 1989 capacity of 34.1 million pounds (\$61.7 million at appropriate exchange rates), or 239 million pounds (\$432.5 million), much worse than original estimates.

Representatives of the Rose Thomson Young Syndicate 255 Names Action Group say they still hope that a settlement can be reached before Lloyd's June 22 annual general meeting, at which the market's 1990 results will be released. However, they do not believe

the talks will succeed and are preparing to file litigation over the 1988 and 1989 losses.

A Lloyd's members agent earlier this month said that a significant portion of the market's 1990 losses could be wiped out if Lloyd's names and members agents' E&O underwriters settle current litigation before 1990 accounts are finalized (BI, May 17).

The Rose Thomson Young Action Group told *Business Insurance* of its intentions last Tuesday, the day after it and three other members action groups—Devonshire Names Action Group, Feltrim Names Assn. and Gooda Walker Action Group—

met with Lloyd's Chief Executive Peter Middleton to discuss marketwide settlement options.

After the meeting, Christopher Stockwell, chairman of the Lloyd's Names Action Working Party, an umbrella organization for the action groups, said there is still "room for negotiation."

However, Ken Grant-Coker, secretary of the Rose Thomson Young Action Group, said, "Our duty is to protect the interests of the RTY names, and we have got to litigate on behalf of our names. If no settlement can be reached by the time of the AGM—and I don't believe they will—we will whack the writs in."

Days before the group's announcement, Lloyd's published its Loss Review Report on syndicate 255's 1989 year of account.

The action group believes the report shows that the syndicate's former underwriter—Norman Bullen—and its managing agent—Rose Thomson Young (Underwriting) Ltd.—were guilty of negligence.

Mr. Grant-Coker said the members in the group were persuaded by their members agents' E&O underwriters to postpone legal action over the syndicate's 1988 and 1989 losses until the outcome of any possible wider settlement. The group on

Continued on next page

Thailand factory tragedy

While insured losses still are unknown, fire shows safety enforcement problems

By TEYMOOR NABILI

BANGKOK, Thailand—Two weeks after the worst factory fire in Thai history, the full financial implication of the Kader Industrial disaster remains unclear.

The incident highlights safety problems that have followed the rapid pace of industrialization in this developing nation.

While no one is criticizing Thailand's ongoing initiatives to introduce satisfactory safety standards, the government is regarded as unable to cope with widespread abuse and corruption in its regulatory system.

Despite worldwide interest and hasty public relations efforts by the tremendously embarrassed Thai government, progress in investigating the cause of the tragedy has been slow.

The Kader factory fire is the worst since 1911, when a fire at the Triangle Shirtwaist Co. in New York killed 146 people.

Confusion still surrounds almost every aspect of the disaster, from the number who died to exactly which part of the complex organization that owned the factory was responsible for its day-to-day manage-

ment.

One thing does appear certain: Losses will not be borne by any Western insurer. Thai law prohibits foreign firms to underwrite coverage, except for foreign joint ventures with local firms.

Insurance analysts say there are a number of fairly large Western reinsurers active in the Thai market, though.

Property and business interruption insurance for the Kader Industrial factory was underwritten by Bangkok-based non-life insurer Safety Insurance Co. Ltd.

A Safety Insurance Co. spokesman said the insurer wrote limits of about 1.217 billion Thai bahts (\$48.2 million) for property, business interruption and related coverage for Kader Industrial (Thailand) Co., and sister companies Tai Chiu Fu Co. and KCP Packaging.

Of that total, 842 million bahts (\$33.4 million) was written for Kader Industrial (Thailand) Co., with 300 million bahts (\$11.9 million) of coverage applying to business interruption risks.

Reports in the English-language newspaper "Nation," speculate the coverage is quite comprehensive, perhaps unusually so for a devel-

oping market.

Kader is likely to face steep costs for rebuilding, though victim compensation is small by Western standards.

The victim compensation offer currently on the table from the company is an ex-gratia payment of six months' salary or about 510 pounds (\$782.90) to the relatives of the deceased, and two months' salary to the injured.

The Interior Ministry has steadily and inexplicably reduced the number of dead to 184, from an early official count of 240. The number of injured stands at 469. At least 80 others have been reported missing. Thai police say the remains of 31 people are not identifiable, and there is a possibility that nothing remains of some victims.

It is uncertain where the compensation promised to the victims' families will come from or whether it will be insured, given the complex structure of the group that operates the factory.

Kader Holdings owns 50% of KCP Toys through wholly owned subsidiary Kader Industrial (Hong Kong). The other 50% is held by Honbo In-

Continued on next page

Property claims from a fire in a Thailand doll factory are expected to be paid by a local insurer.



AP/Wide World Photo

Hong Kong proposal would spark huge rise in workers comp rates

By KATE McILWAINE

HONG KONG—Rising court awards and proposed benefit increases could drive up workers compensation premiums as much as 40% for Hong Kong employers.

Chris Sharrock, a partner in the Hong Kong law firm Barlow Lyde & Gilbert, explained that Hong Kong's Employees' Compensation Ordinance provides for a system of no-fault liability for worker injuries and illnesses.

If a worker is hurt on the job, even if he or she contributed to the injury, the employer's insurance pays. Employees can claim damages for permanent or temporary incapacity and medical expenses under the ordinance.

In addition to the worker's right to compensation under the ordinance, the injured party can sue the employer for negligence. The nature of no-fault liability under the ordinance also means employers are generally found liable for employees' tort claims, Mr. Sharrock said. However, an employee's award from a lawsuit is reduced by the amount of compensation received under the ordinance.

Employers must buy insurance to cover payouts under the ordinance and to cover their potential common law claims. The law requires employers to have unlimited coverage, thus the court awards are a concern for insurers.

Continued on next page

Large U.K. insurers see upturn

By ADRIAN LADBURY

LONDON—The first-quarter results of the big U.K. multiline insurers confirm that rate recovery is well under way in almost all classes of business, supporting the insurers' predictions for a return to profitability in 1993.

Among the top six U.K. insurers, the four that release quarterly figures posted profits in the first three months of 1993, compared with losses during the same period of 1992. The two that do not release figures were equally bullish on the quarter.

Perth, Scotland-based General Accident P.L.C. registered the biggest turnaround. The company reported a first-quarter pretax profit of 41.9 million pounds (\$64.9 million), compared with a loss of 29 million pounds (\$50.3 million) for the same period in 1992.

GA attributes much of the recovery to its U.K. business. The company made an underwriting profit of 4.1 million pounds (\$6.3 million) on U.K. business for the

LONDON

first three months of this year, compared with a loss of 65.2 million pounds last year (\$113.2 million).

One of the best performing lines was personal auto insurance, which posted a 3.4 million pound (\$5.2 million) underwriting profit in the first quarter, against a 20 million pound underwriting loss (\$34.7 million) in the year-earlier quarter.

GA attributed the improvement to rate increases and tighter underwriting and claims control.

Royal Insurance Holdings P.L.C. also managed an impressive change in fortunes on the back of rate increases and more selective underwriting. Royal posted a profit of 2 million pounds (\$3.1 million) for the first quarter of 1993, compared with a 48 million pound loss (\$83.3 million) a year earlier.

Royal hopes all of 1993 will be profitable, after losing a total of 679 million pounds (\$1.04 billion at current exchange rate) from 1990-1992.

Other factors that it believes have helped its recovery are better weather, lower subsidence claims and a slowdown in the level of domestic mortgage indemnity claims.

Royal also announced plans to raise 404 million pounds (\$620.1 million) through a rights issue of ordinary shares. The offer, under which existing shareholders will be able to buy one ordinary new share at 255 pence (\$3.91) per share for every three they hold, is described by Royal as proof of its confidence in the improving market.

The three years of losses have almost halved Royal's assets. Group net assets dropped to 1.48 billion pounds as of Dec. 31, 1992 (\$2.24 billion), from 2.663 billion pounds (\$4.30 billion) at year-end 1991.

Commercial Union P.L.C. also posted a big improvement in the quarter. It made a 16.2 million pound (\$24.8 million) pretax profit, compared with a 19.2 million pound (\$33.3 million) loss in the first quarter of 1992.

Its underwriting loss fell to 99.8

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Syndicate 255

Continued from previous page
Jan. 1 served the E&O underwriters with points of claim, which outline the basis of their complaint but do not initiate proceedings, for the 1988 losses and had planned to do the same for 1989.

"These points of claim have been ignored," Mr. Grant-Coker said. "We therefore decided to issue a full writ for 1988, and once we get all the levies and applications in from the 1989 names, we will go ahead with a writ for that year, too."

Syndicate 255 has 1,038 names on the 1988 account and another 300 for 1989.

The current managers of syndicate 255 were hired to carry out the syndicate's runoff at the beginning of last year after the syndicate ceased underwriting new business.

Mr. Edwards, the syndicate's current underwriter, reported that as of Dec. 31, 1992, he expects losses on the 1988 year of account to be between 79.6 million and 111.4 million pounds (\$120.6 million and \$168.8 million at Dec. 31, 1992 exchange rate); 1989 losses to be between 113.7 million and 239 million

pounds (\$172.3 million and \$362 million); and 1990 losses to be between 20.5 million and 21.5 million pounds (\$31.1 million and \$32.6 million).

Mr. Edwards' predictions represent a deterioration in the estimated losses on the syndicate of 59% to 173% for 1988, 131% to 498% for 1989, and 157% to 165% for 1990.

He blamed the dramatic downturn in the expected results on four key factors:

- The need for larger reserves for catastrophe exposures that had exceeded the syndicate's reinsurance capacity.

- The need to create additional reserves for other, smaller losses.

- An extra amount set aside for a "special priority treaty" or facultative obligatory treaty, that caused bad debts on the 1989 account.

- More reserves for losses on personal stop-loss business.

Mr. Edwards emphasized the "pessimistic" loss prediction would only occur if a large number of factors went against the syndicate.

Mr. Grant-Coker said, however, that it would take the upper limit as its basis of claim against E&O underwriters. **BI**

Continued from previous page
million pounds (\$152.8 million) from 113.6 million pounds (\$197.2 million) a year earlier. Investment income for the first three months of 1993 rose to 84.1 million pounds (\$128.8 million) from 64.3 million pounds (\$111.6 million), and life insurance underwriting income more than doubled, reaching 57 million pounds (\$87.3 million), up from last year's 27 million pounds (\$46.9 million).

CU Chief Executive Tony Brend told shareholders at its annual general meeting last Wednesday that "premium writing increases, expense ratio reductions and improvements to our insurance portfolios are being implemented in all territories to reinforce the recovery in profitability which we are now seeing."

Eagle Star Insurance Co. Ltd., the multiline insurer owned by B.A.T Industries P.L.C., reported a 10 million pound profit (\$15.3 million) during this year's first quarter, compared with a 36 million pound loss (\$62.5 million) a year earlier.

Eagle Star's recovery was also generated primarily by U.K. business. The company's U.K. underwriting loss for the period fell to 57 million pounds (\$87.3 million) from 96 million pounds (\$166.7 million).

Life insurance underwriting income of 14 million pounds (\$21.4 million) and a 15% increase in investment returns to 51 million pounds (\$78.1 million) also helped push its overall results into the black.

Estimates for Sun Alliance Group P.L.C. and Guardian Royal Exchange P.L.C., which do not report quarterly figures, fell in line with their competitors. Both companies predicted 1993 results would be a significant improvement over last year's.

Conditional legal fees

The British Parliament is considering proposals that, if accepted, will introduce a U.S.-style "no win, no fee" system of compensating lawyers in certain types of litigation.

The Lord Chancellor's Department, which governs civil procedure in the United Kingdom, has issued a draft order and draft regulations to the House of Commons. If ratified, it will pass to the House of Lords before it becomes law.

The proposed "conditional-fee" system would differ from the U.S. contingency fee system, though, be-

cause it would limit the amount a solicitor or barrister could earn from a court victory and the type of cases that could be handled on a conditional-fee basis.

The Lord Chancellor has decided to limit the new arrangements to three areas of litigation: personal injury claims; actions against insolvency practitioners; and proceedings heard before the European Commission of Human Rights and the European Court of Human Rights.

The proposed limit on attorneys' recovery would be 20% more than the normal fee. The Chancellor's Department hopes this cap will prevent excessive claims and awards as it believes has happened under the U.S. contingency fee system.

The draft legislation also suggests that plaintiffs eligible for Legal Aid not be allowed to enter into a conditional-fee contract.

Copies of the Order and Regulations have been circulated for comment by June 11. The Chancellor's Department hopes the proposals will become law by year-end.

Chubb in Lloyd's box

Chubb Insurance Co. of Europe is the eighth London market insurer to take space in the Lloyd's of London building since the corporation reopened its doors to companies last autumn.

The twofold appeal of a box at Lloyd's is access to business that brokers take to Lloyd's before the company market and the relatively low cost of the accommodations.

Chubb has not hired any new underwriters to staff the Lloyd's operation. Paul Kluger, U.K. regional manager, said underwriters from Chubb's main London underwriting office around the corner on Fenchurch Street will staff the box "on a rotational basis."

The Lloyd's box will concentrate on the same business as Chubb's London office, the U.K. regional office in Manchester and a new Birmingham office. Its four main areas are marine, liability, financial institutions and executive protection.

Mr. Kluger said Chubb had decided to move into Lloyd's to tap business that Lloyd's brokers may bring to Lloyd's underwriters by not the company market.

Eagle Star dispute

A protracted legal dispute over six commercial mortgage indemnity guarantee contracts written by

Eagle Star Insurance Co. Ltd. is one step nearer to conclusion.

Eagle Star, which to date has paid 87.5 million pounds (\$134.3 million) under the policies, says it has "reached a settlement" with Maurice Markovits, the intermediary who placed the six contracts.

Mr. Markovits has agreed to pay Eagle Star 4.08 million pounds (\$6.26 million) for counter-indemnities—a form of reinsurance—he offered to the insurer when he arranged the coverage in the first place.

The original dispute was between Eagle Star and policyholder Banque Bruxelles Lambert of Belgium.

In 1989, the insurer issued commercial mortgage indemnity policies to BBL for six commercial properties.

When the properties were sold, a huge difference—estimated to be more than 100 million pounds (\$153.5 million)—emerged between the sale price and their original purchase price.

Neither party could agree on the amount each party was liable for, so BBL took Eagle Star to the English Commercial Court. During trial, the two parties agreed to a settlement in which Eagle Star paid BBL 70 million pounds (\$107.5 million).

BBL and Eagle Star then joined forces to seek recoveries from two real estate agents involved in the property deals.

One agent, Lewis & Tucker, agreed to a settlement of 25 million pounds (\$38.4 million) with Eagle Star and BBL.

Because Eagle Star had already advanced BBL 17.5 million pounds (\$26.9 million) in anticipation of a settlement with Lewis & Tucker, its net gain on the deal was 7.5 million pounds (\$11.5 million).

Eagle Star and BBL now hope to negotiate a settlement with the other estate agent, John D. Wood Commercial Ltd., which Eagle Star Director Michael Heath said will not lead to such a large settlement.

BBL was not a party to Eagle Star's action against Mr. Markovits.

A spokesman for Eagle Star would not comment on the case against the second real estate agent, but said he is pleased the case had been settled with Mr. Markovits.

The spokesman added that the settlements with Lewis & Tucker and Mr. Markovits will help offset the 87.5 million pounds (\$134.3 million) Eagle Star has paid out to BBL. **BI**

Hong Kong benefits

Continued from previous page
Nick Helms, agency manager for New Zealand Insurance Ltd. in Hong Kong and past president of the Accident Insurers' Assn. of Hong Kong, says a plan to increase maximum benefits payable under the law is being considered by the Hong Kong Legislative Council.

The Hong Kong Department of Labor, which normally reviews benefit payments every two years and recommends increases in line with inflation, recommended steep increases after it conducted a special review requested by the council.

If the proposed payment rates become law, as insurers expect, the maximum death benefit would rise to \$1.26 million Hong Kong (\$163,044) from the current maximum of \$465,000 Hong Kong (\$60,171), and the benefit for permanent disability would rise to \$1.44 million Hong Kong (\$186,336) from \$540,000 Hong Kong (\$69,876).

Hong Kong damage awards are based on a formula that includes the employee's age and average earnings over the previous year.

Insurers have lobbied to delay implementation of the new rates, which are not expected to become effective until April 1, 1994, Mr. Helms said. Insurers would need to raise premiums by 40% just to allow for the increased payouts, he said, and would get "a backlash" from employers if workers comp rates were hiked that much.

He expects the Legislative Council, under pressure from employers, to ask insurers to explain any steep premium increases. The council cannot tell insurers what premiums to charge, he said, but could put pressure on them because too costly premiums could be used as an argument in favor of a government-run workers comp program.

The Department of Labor and labor unions in the colony favor a statutory, government-run scheme, he said.

Malcolm Clarke, an assistant vp with Continental Insurance Co. in Hong Kong, said the increased compensation payments would "close the gap" between common law

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Thailand factory fire

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vestments, a Thai firm.

Factory owner Kader Industrial (Thailand) is one of four subsidiaries of KCP Toys, along with KCP Marketing, KCP packaging and Thai Chiu Fu.

Kader could face litigation from the families of deceased workers and injured employers alleging negligence on the basis of the factory's safety standards.

According to news reports, a number of survivors insist the factory owners misled them over the seriousness of the incident—even as the fire was gaining in intensity—and tried to persuade factory staff to continue working.

When panicking workers finally made their way to exits, they claimed access to escape routes was blocked, and half of the fire escape doors were locked, a situation they described as "usual."

And the workers' accusations were not confined to poor safety practices but included poor design.

One Australian fire inspector who works in Thailand and surveyed the wreckage said it was clear the Kader factory was designed with "nowhere near" an acceptable fire protection standard. He described the factory as a "basic four-story structure, with a steel truss roof that was not protected against fire."

The remains of the steel structure after the fire showed the steel had heated up very quickly and then "melted like Plasticine," he said.

In most developed countries, a factory more than one story high will have steel elements protected against fire. But even though the factory may not have reached acceptable Western standards, there is nothing to suggest it had not been awarded the necessary government approval for occupancy.

One of the key reasons for Thailand's rapid industrial expansion has been the country's lax regulatory enforcement.

Although efforts are being made to improve safety enforcement, inspectors earn low wages and reportedly welcome the chance to supplement their income.

Prime Minister Chuan Leekpai has promised to launch a nationwide investigation of every factory, but that promise has also been greeted with some skepticism. An estimated 30,000 production facilities operate in Thailand. And the best estimates put the number of government inspectors at 90.

But more comforting to the victims' families is Thailand's history of compensating workplace victims. The government has pledged to pay \$10,000 to \$15,000 to the families of each dead worker. **BI**

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INTERNATIONAL

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awards and statutory payouts, and that may have been a factor in the Legislative Council's proposal.

Mr. Clarke said workers compensation insurance has been underpriced for many years because of market competition and some insurers' failure to recognize "the full impact of the long tail of the common law claims, which can take up to nine years to settle."

Hong Kong insurers' underwriting loss on workers compensation over the past five years has totaled about \$600 million Hong Kong (\$77.6 million).

Annie Tong, a broker with Hong Kong-based Jardine Insurance Brokers Pacific Ltd., said employers have no alternative but to pay whatever increases insurers impose, because coverage is compulsory. "We are trying to get competitive terms, but it's very difficult," she said.

Common law damage awards have "caused insurers to dig ever deeper into their pockets," Mr. Sharrock said. "Recent court awards have had a significant impact on insurers' ability to derive a profit from this class of busi-

ness. . . Most insurers would admit to fairly severe losses," he said.

Mr. Sharrock said recent court awards bore no resemblance to the perceived risk at the time insurance coverage was purchased. He cited a March 1992 court decision in which an injured worker was awarded \$5.9 million Hong Kong (\$762,000). At the time, it was probably the highest award for work-related injuries, Mr. Sharrock said.

"Subsequent awards and settlements are now being calculated in the light of this benchmark decision, making it increasingly expensive for insurers to dispose of their long-tail liabilities," Mr. Sharrock said.

Mr. Helms said insurers' payouts for common law workers comp claims rose to 23% of earned premium in 1991 from 4% in 1983. He said the trend will continue. The judicial process in Hong Kong is slow, and it can take eight to nine years to finalize common law claims, he said.

"It's evident that the courts do have a bias toward injured workers," said Peter Dunn, chairman of the Accident Insurers' Assn. and general manager of Eagle Star In-

surance Co. in Hong Kong. Courts think insurers have "deep pockets," and workers have become more claims conscious because of the court awards, he said.

Mr. Dunn said that to allow for court awards, some insurers may increase rates more than the 40% suggested by the association, which was meant only to allow for increased payments under the ordinance. The association is urging insurers to lobby for a phased-in implementation of what are considered inevitable increases in benefit payouts under the ordinance.

Six months ago, insurers and Hong Kong's Legal Aid Department established a system to speed up claims by having parties get together to discuss claims before going to court. Mr. Helms said that has helped insurers avoid big interest payments on damage awards.

Insurers also put pressure on the Department of Labor to improve safety standards in Hong Kong, which are poor, and fines for employers with unsafe workplaces are "minimal," Mr. Helms said. "We're not a Westernized country when it comes to that." **BI**

Losses from coal mine explosion covered

JOHANNESBURG, South Africa—Property losses from a May 13 explosion at coal mines operated by Sasol Ltd. likely will be within the company's insurance deductibles.

Liability for the accident, which killed all 53 employees underground during the explosion, will be covered by company pension and accident funds, and a government-run workers compensation program.

Sasol, which produces chemicals and synthetic fuel from coal, is still assessing the extent of the property damage.

"It will take time. It's extremely dangerous to get to various places," said Robin Hugo, assistant general manager at Sasol's headquarters in suburban Johannesburg.

The methane gas explosion and resulting fire affected two of the 10 production sections of Sasol's Middlebult colliery located about 100 miles east of Johannesburg.

The collieries comprise five mines—one strip mine and four underground—which produce 33 million tons of coal annually. Although all sections of the 300-foot-deep Middlebult mine are served by the same ventilation system, Mr. Hugo said, the unaffected sections are producing coal as normal.

The South African government owns 20% of the company, and small shareholders own 10%. The remaining 70% of Sasol is split among South African insurers and industrial concerns. The country's two largest insurers, South African National Life Assurance Co.—a subsidiary of Gencor Ltd., a Johannesburg mining and finance concern—and the South African Mutual Life Assurance Society, are the two largest individual shareholders.

Mr. Hugo said Sasol has property and business interruption coverage totaling 40 billion rand (\$12.58 billion), excess of 50 million rand retention per incident (\$15.73 million). Mr. Hugo said he believes losses from the Middlebult explosion will not trigger an insurance claim in excess of 50 million rand.

Sasol also has 650 million rand (\$204.4 million) worth of general liability coverage.

Sasol's insurance program is placed by its own captive broker, Chemoil, a company established by the country's two largest insurance brokers, Lumleys and Price Forbes Volkas. The company also uses Lumleys JFS and Sedgwick Group

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Families and dependents of victims who were in the company's pension fund will be compensated from that fund. Covered employees pay 7% of their gross salaries to the pension fund, and the company contributes 11% of salary. A separate personal accident fund is entirely funded by the company. Victims' families will also be compensated from: government funds; the Local Workers Death and Disability Fund, to which the employer contributes; and the company's personal accident fund, said Mr. Hugo.

The compensation paid per victim will amount to four times the deceased employee's salary. Employees not covered by the company's pension plan will be partly compensated by the government-run Workers Compensation Act, to which all employers make a compulsory contribution.

The compensation paid for victims through this scheme will be augmented by Sasol until the total compensation figure is four times the salary, Mr. Hugo said.

—By Maria Kielmas

Spanish P/C market

MADRID, Spain—Some small signs indicate that the Spanish property/casualty insurance market might be hardening, insurance executives say.

The possible upturn would follow five soft years, caused by domestic and foreign insurers competing to acquire shares of the Spanish insurance market.

According to a government audit of the Spanish insurance industry, for the first six months of 1992, non-life insurers incurred losses and loss adjustment expenses of 16.12 billion pesetas (\$167.5 million) against net earned premiums of 233 billion pesetas (\$2.42 billion).

"The market is still soft except for certain specialist lines such as energy, hull and construction," said Rafael Merry del Val, regional manager for Southern Europe at Marsh & McLennan Europe in Madrid. "The overall underwriting picture is not exceptional, but some companies are still making money."

Other executives are more bullish.

"Although the market is tougher and the soft market is definitely finished, there has been only a modest increase in rates," says Felipe Gangoi, chief executive of Alexander & Alexander Spain in Madrid. Liability rates increased by 20.6% in 1992, but the loss ratio was still 101.1%, he said. Property insurance premiums only rose 1.6% in 1992.

"We expect to see rates rising by the end of this year and certainly in 1994" for both lines, he said.

Mr. Gangoi said the 1992 renewals brought a clear increase in deductibles, which have been very low compared with the rest of Europe.

Spain traditionally has had a very large number of insurers and agents operating in a small market. Capacity has decreased, but mainly because international reinsurance has become more difficult to obtain.

"We still have too many insurance companies," said Marsh & McLennan's Mr. Merry del Val. He believes foreign acquisitions of Spanish insurers have leveled off and said only a few companies have 100% Spanish ownership, such as Corporacion Mapfre, the largest Spanish insurer, and the much smaller Catalana Occidente S.A. de Seguros y Reaseguros.

According to a study by London-based consultant Datamonitor, French companies had the greatest share of the Spanish non-life market in 1991. French-owned companies had a 9.2% share of non-life premiums written in Spain in 1991.

Swiss companies were second with a 7.6% market share, and U.K. companies third, with an overall market share of 5.9%.

A joint venture set up by Spain's Banco Central Hispano America and Italy's Assicurazioni Generali accounts for 5.2% of Spanish non-life premiums, while purely Spanish-owned companies accounted for the remaining 65.6% of non-life business.

According to the Spanish insurer organization UNEPSA—Union Espanola de Entidades Aseguradoras Reaseguradoras y de Capitalización—foreign companies account for 40% of the non-life premiums in Spain, up from 30.2% in 1991.

The top foreign operator was Winterthur Swiss Insurance Co. with non-life premium income of 38.74 billion pesetas (\$337.3 million) and an annual growth of 8.9%.

—By Maria Kielmas

Aviation market

Continued from page 3

to be about those companies and syndicates that are floundering," summed up Tim Dumenil, underwriting manager-aviation treaty and personal accident for Zurich Re (U.K.) Ltd. "Coffee shops and bars are full of talk about underwriters of syndicates and companies, in both insurance and reinsurance, who are striving to keep apace—ever mindful of the presence of accountants who wake up in a cold sweat worrying about every catastrophe."

The aviation insurance market is "undoubtedly shrinking," he added. In particular, airline reinsurance capacity has shrunk to about \$2.5 billion from \$4 billion a year ago, he said. "If it continues to shrink, there will not be enough capacity in the future to cover airline placements by the end of the millennium."

Indeed, talks during an aviation session at the Risk & Insurance Management Society Inc. conference in Orlando last month and throughout the 17th annual Aviation Insurance Assn. conference, held May 2-4 in San Antonio, Texas, focused on the contraction of the market and its consequences.

In less than a year, many major aviation insurers and reinsurers have ceased underwriting.

In the past month, for example, two well-known aviation underwriters at Lloyd's have been laid off: David Peachey and John

Nevitt.

Mr. Peachey, former chairman of the Lloyd's Aviation Assn., is out of a job because his syndicate 79, managed by Janson Green Ltd., decided to pull out of aviation business after four years of disappointing results, according to its main underwriter, Richard Youell.

"It was a strategic decision," Mr. Youell said in London. No more than about 25 million pounds (\$37.9 million) of the syndicate's 150 million pounds (\$227.2 million) in premium capacity this year was devoted to aviation, he said.

Aviation is a small market "and we don't think it will show a net return that we can see in other sections of our syndicate's account," like energy, directors and officers liability, and errors and omissions coverages, he added.

Mr. Nevitt retired as part of Sturge Holdings P.L.C.'s recent closing of eight syndicates, including his aviation syndicate 980.

Altogether, Lloyd's current market premium income capacity for aviation syndicates in 1993 has dropped 23.1% to 698 million pounds (\$1.06 billion) from 908 million pounds (\$1.7 billion) in 1992, according to Philip Freeman, deputy underwriter for aviation syndicate 97 managed by Wellington Underwriting Agencies Ltd.

There are now 24 aviation syndicates at Lloyd's grouped into

Continued on next page

UNITED STATES BANKRUPTCY COURT SOUTHERN DISTRICT OF NEW YORK

In re: : In Petition Under
: Section 304
Petition of David Llewellyn Morgan : Case No.
and Nicholas Roger Lyle, as : 93-B-41539 (PBA)
Joint Provisional Liquidators of :
CHANCELLOR INSURANCE COMPANY LIMITED :

Debtor in Foreign Proceedings :

NOTICE OF INJUNCTION

YOU ARE HEREBY NOTIFIED THAT ON OR ABOUT MARCH 26, 1993, A PETITION WAS FILED PURSUANT TO SECTION 304 OF THE UNITED STATES BANKRUPTCY CODE BY THE JOINT PROVISIONAL LIQUIDATORS OF CHANCELLOR INSURANCE COMPANY LIMITED (93-B-41539 (PBA)) ("CHANCELLOR") IN THE UNITED STATES BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK ("BANKRUPTCY COURT").

YOU ARE HEREBY FURTHER NOTIFIED THAT, PURSUANT TO AN ORDER OF THE BANKRUPTCY COURT, ALL SUBSEQUENTLY IDENTIFIED PARTIES WITH INTERESTS ADVERSE TO CHANCELLOR ARE PRELIMINARILY ENJOINED AND RESTRAINED FROM: (1) RELINQUISHING OR DISPOSING OF ANY PROPERTY OF CHANCELLOR IN THE UNITED STATES, OR THE PROCEEDS OF SUCH PROPERTY, TO THIRD PARTIES; (2) COMMENCING OR CONTINUING ANY JUDICIAL, ADMINISTRATIVE OR REGULATORY ACTION OR PROCEEDING OR ANY ARBITRATION PROCEEDING INVOLVING CHANCELLOR OR ANY OF ITS PROPERTY IN THE UNITED STATES; AND (3) ENFORCING ANY JUDICIAL, ADMINISTRATIVE, OR REGULATORY JUDGMENT, ASSESSMENT OR ORDER OR ANY ARBITRATION AWARD OR DECISION AND COMMENCING OR CONTINUING ANY ACT OR ANY JUDICIAL, ADMINISTRATIVE, ARBITRATION OR REGULATORY PROCEEDING TO CREATE, PERFECT OR ENFORCE ANY LIEN, SET-OFF OR OTHER CLAIM AGAINST CHANCELLOR OR ANY OF ITS PROPERTY IN THE UNITED STATES.

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Aviation market

Continued from previous page
22 units, compared with 38 syndicates grouped into 35 units in 1989, Mr. Freeman told AIA conference members.

"The effects of these consolidations is to focus key underwriting decisions down to no more than eight or nine syndicates. On a large risk, the decisions made by these syndicates are crucial as to whether a risk is completed in the London market or placed overseas or not completed at all," Mr. Freeman said.

Other London market aviation writers also gone from the market are:

- English & American Insurance Group P.L.C. and its subsidiary, English & American Insurance Co. Ltd., which stopped underwriting last November. The group's gross premiums in 1991, the last year available, totaled 93.2 million pounds (\$174.3 million) on paid-in capital of 11 million pounds (\$20.6 million). About a quarter of its business was aviation.

E&A wrote about 4% of every airline hull and liability insurance program placed in the London market, AIA members were told.

The demise of English & American was especially poignant to AIA members because for the past few years Martin Belcher, underwriter for E&A-managed Polygon Insurance Co. Ltd. in Guernsey, has delivered a London market update at the AIA conference.

This year the update was delivered by Mr. Dumenil, though Mr. Belcher is still underwriter for Polygon, which is now managed by its airline industry owners.

- The Orion Insurance Co. P.L.C., which wrote gross premiums in 1990, the last year available, totaling 169 million pounds (\$326.2 million) with capital of

55 million pounds (\$106.2 million).

- Andrew Weir Insurance Co. Ltd., which stopped underwriting in November 1991 and appointed provisional liquidators last November (BI, Nov. 23, 1992).

- NRG Victory Reinsurance Ltd., which has stopped accepting new business.

Earlier this year, the Aviation Insurance Offices Assn. in London said the number of member companies fell to 17 during 1992 from 19 at year-end 1991.

U.S. aviation lawyers at the AIA conference expressed concern about shortfalls in claims payments caused by some companies no longer paying claims and wondered whether Lloyd's will pick up any of these defaulted claims.

"Nobody's going to make up the shortfall," said Chris Gasson, aviation claims manager at Lloyd's agency Murray Lawrence & Partners in London.

In the meantime, a number of other aviation players are seeing changes that could affect capacity.

In particular, three insurers participating in London's largest aviation underwriting pool, known as British Aviation Insurance Group Ltd., announced earlier this year that they would not be writing aviation coverage in January 1994. BAIG has said that their departure will not affect the capacity the group offers.

In addition, ITT/Hartford Group Inc. confirmed that it no longer underwrites aviation coverage through U.S. Aviation Insurance Group in New York.

"It was a business decision. We're not doing aviation, generally," said a Hartford spokeswoman.

The sharp reduction in capacity has meant that rates are rising for aviation risks all across the board.

"We're seeing some substantial increases," said Mr. Freeman. Airline hull and liability rates increased 50% to 100% during first-quarter renewals, depending on the loss experience of the airline, he said. Aviation product liability insurance prices for major manufacturers are increasing 10% to 40%, Mr. Freeman added.

"Major manufacturers are likely to see sizable increases" in rates this year for aviation product liability insurance, William Floyd Garner, senior vp for AIG Aviation Inc. in Atlanta, said at the RIMS conference in Orlando. Rates for aircraft component

'Overall, premiums are going up in all ends of the business,' says Peter E. O'Grady.

manufacturers will remain level this year, but they may rise steadily in the future.

And "there may be some capacity difficulties," Mr. Garner warned.

Currently, there are several players in the aviation product liability insurance market that can each provide \$300 million in capacity for major manufacturers, he said.

But for the past few years, many light-aircraft manufacturers either have bought no coverage or high deductibles as a result of rate hikes spurred by major awards to plaintiffs in light-aircraft accidents, he noted.

Underwriters also need to raise general aviation liability prices this year because rates still are too low at the moment, said Mr. Freeman.

In the past few weeks, his syn-

dicate has pulled out of U.S. general aviation reinsurance programs because the prices are still too low.

General aviation prices are going up this year, "but they are not as dramatic" as other increases in the aviation field, added Peter E. O'Grady, president of Navigators Insurance Co. in New York.

"Overall, premiums are going up in all ends of the business," said Mr. O'Grady. Prices in the market "are getting better. It's sad to see so many friends leaving the market, but (this contraction) is what the market needs to correct itself." During a question-and-answer session at the RIMS conference aviation seminar, some risk managers openly objected to price increases and other changes going on in the aviation insurance market.

For example, Floy Oliver Daugherty, supervisor-risk management for Delta Air Lines Inc. in Atlanta, asked why underwriters won't include contractors' liability risks in airline insurance programs.

Mr. Garner said he will "for a price," but the airlines don't want to pay that price.

Another risk manager noted that last year the aviation market earned \$800 million in premium but accumulated claims of \$950 million. "That doesn't make any sense" economically, he observed.

"That's the predicted outcome for 1993," said David Dann, deputy chairman of Lloyd's underwriting agency R.J. Kiln & Co. Ltd. in London. "Obviously the market will be trading at a loss; therefore we've got to examine our underwriting as well as our premium, because you can't go on selling at a loss or there won't be any insurance."

Underwriters don't want to make a fortune, but they must make some kind of return on

their capital, he said.

RIMS attendees also wondered whether underwriters would be charging higher rates to Japanese airlines that have waived the \$75,000 liability limit for international flights under the Warsaw Convention.

"We have said in the past that it won't have an effect on insurance rating," said Mr. Dann.

Asked whether U.S. airlines would follow the Japanese trend, Ms. Oliver Daugherty would not comment.

In the meantime, there are a few new initiatives in this contracting aviation market.

The Aircraft Owners & Pilots Assn. and Rollins Hudig Hall Co. are setting up an agency called AOPA Insurance Agency to offer hull and liability coverage to its members, confirmed Mr. O'Grady. The coverage will be underwritten by Navigators, but Mr. O'Grady would not comment further because details are still being discussed about the program.

Also, new executives at American Eagle Group Inc. in Dallas are preparing the company for a public offering in the third quarter in 1994 to raise new capital, confirmed George F. Cass, president and chief operating officer, who joined earlier this year from Maryland Insurance Group, where he was executive vp.

The company, formerly known as Aviation Office of America Inc., has closed six branch agencies and is underwriting in Dallas.

It is focusing on general aviation underwriting after pulling out of airline hull and liability insurance in 1991, said Joseph L. Benero, executive vp of American Eagle.

Through a private offering, American Eagle also hopes to raise an additional \$20 million in the near future on top of its \$41 million policyholder surplus at year-end 1992, said Mr. Cass. **B**

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Crash response saved lives

By STACY SHAPIRO

SAN ANTONIO, Texas—Five factors contributed to the survival of 184 people on board the ill-fated United Airlines flight that crash-landed in Sioux City, Iowa, in 1989, says the pilot of that flight.

Two of those factors are polar extremes—luck and preparedness.

Capt. Al Haynes, the man who has been hailed for saving so many lives in that crash, offered his perspective on the tragedy to attendees at the Aviation Insurance Assn. banquet in San Antonio, Texas, earlier this month: "You all have your personal beliefs and convictions, and I would never intrude upon those, so let's just label the first category luck. You may call it whatever you wish."

Murphy's Law caught up to the McDonnell Douglas DC-10 when it was flying at 35,000 feet on the afternoon of July 19, 1989, from Denver en route to Chicago. Capt. Haynes acknowledged. The No. 2 engine failed and sent 70 pieces of the engine through the tail of the aircraft, causing the crew to lose control of the rudders, wing flaps and brakes, and partially lose control of steering (BI, July 24, 1989). The chance of such an incident happening is one in a billion, he said.

For 45 minutes, the pilot, co-pilot, navigator and DC-10 instructor Capt. Denny Fitch, who happened to be a passenger, struggled with the aircraft to get it to the Sioux City airport, where the crippled plane skidded 75 feet short of the runway, killing 112 people. The plane broke into three pieces and there were survivors from all parts of the aircraft.

But as luck would have it, Flight 232 was over Midwestern flatlands rather than an ocean or the Rockies, the weather was good and it was daylight. It was also the only day in the month that 250 National Guardsmen were on duty at the airport. The morning and afternoon shift at the two major hospitals were switching, so most of the staff were on call; and 42 other doctors were visiting the city for a conference.

Communication also was good that day, "which you must have in a time of crisis," said Capt. Haynes. Once the five men in the tower of the Sioux Gateway Airport heard of



the DC-10's problems, the ground emergency services were contacted. The highway patrol was contacted to clear a freeway near the airport in case the plane didn't reach the runway. And the frequency was cleared to allow the tower and Capt. Haynes to communicate.

On a video overdubbed with the communication on the plane's flight recorder, AIA members heard the voice of Kevin Botman, the air-traffic controller, "and you hear no sign whatsoever of alarm," said Capt. Haynes. "I feel very strongly that his voice, his control, is what made everyone else (crew, flight attendants and passengers) stay calm."

Capt. Haynes learned later that Mr. Botman didn't think the aircraft was going to make it to the airport. And Mr. Botman had just transferred to Sioux City because he found his previous position "too stressful," the captain said.

A second factor in the fate of Flight 232 was "the training we get at United Airlines," said Capt. Haynes. "To this day" there is no written procedure to land without hydraulics as did Flight 232. But when the emergency struck, the crew worked as a team because of their training, he said.

None of the flight's nine attendants had been in an emergency situation before, but they followed their training "and kept the passengers calm," he said.

The third factor Capt. Haynes called "preparation." About a year earlier, the Sioux Gateway Airport and emergency services carried out their triennial "worst-case" scenario drill in which they imagined a wide-bodied aircraft landing on the runway with 150 survivors, said Capt. Haynes.

They never expected such an accident at the airport because wide-bodied don't land there, but the airport's director of emergency services decided to do the drill anyway because it is the "worst-case scenario" that companies and municipalities often don't take into account, said Capt. Haynes.

The United Airlines crash oc-

curred just months after the Sioux City airport's drill, said Capt. Haynes. "So no one could have been better prepared than the ground personnel at Sioux City because they took their drill seriously, they took the worst-case scenario and they learned a lot from their drill."

Also prepared were the passengers, a key element in the saving of lives that is often overlooked. Capt. Haynes urged everyone who travels by aircraft to listen to the attendants and read the material—even seasoned air travelers. "You as a passenger in an airplane have a responsibility to know how to get out of the aircraft," he said. "Think about that next time you fly."

The last two factors Capt. Haynes called "execution" and "cooperation" when explaining how the crew landed the aircraft, when the emergency services and hospitals went into action, how 400 area residents lined up to give blood, and the aftermath of the disaster.

Capt. Haynes said his therapy since retiring from flying last August is to talk to people nationwide about the elements that went into saving lives that day.

A photograph that shows Lt. Denny Nielson carrying a child from the crash has turned the officer into a hero. But Lt. Nielson has said, "God saved the boy. I just carried him." To Capt. Haynes, this statement epitomizes what happened on July 19, 1989, in Sioux City. "Thousands of people did what they had to do," he said.

Federal court actions involving victim compensation have been settled, though some state court litigation continues. An arbitration among United, McDonnell Douglas Corp. and General Electric Co., which built the engine, is still outstanding.

According to a London underwriter, as of March 1993 insurers have reported paid and outstanding hull and liability claims of \$355.1 million. Of this, \$52.2 million is to pay for the hull. Of the liabilities: United's insurers have calculated paid and outstanding claims of \$18.7 million; McDonnell Douglas insurers calculated \$106.9 million under aviation products liability coverage; and GE insurers calculated approximately \$90 million, also on products coverage. **BI**

Pilot flying high with perfect record

By STACY SHAPIRO

LONDON—Longtime flying veteran Clay Lacy, whose film credits include dogfights in the movie "Top Gun," is an underwriter's dream.

In 41 years of flying, he hasn't had one claim and he stresses safety in all aspects of his work.

"I have to report that I have flown over 41,000 hours and you haven't had to pay a claim on me," retired United Airlines Capt. Lacy told underwriters at the Aviation Insurance Assn. conference in San Antonio earlier this month. "I'll try to keep up that record."

Although he retired from United last August, he still flies all types of aircraft as the owner and president of Clay Lacy Aviation in Van Nuys, Calif., which mainly films flight sequences for commercials, promotions and movies.

But Mr. Lacy's company has had a few claims despite his perfect personal record. The largest was the confiscation—while it was characterized—one of the company's Lear jets by the Bolivian government for drugs alleged to be on board.

"It's the claim I hated the worst."



Mr. Lacy told *Business Insurance*, adding drugs weren't on the plane.

The loss was paid for by Lacy Aviation's hull and liability insurer, AIG Aviation Inc., through the Forbes Westar Aviation Inc. agency.

Mr. Lacy showed AIA members a video of some of the "fun times" he's had during his career, some of which he said were insured by people in the audience. "Through the years, every time I had a project that was a little hard to insure I would call (my agent) and say 'Hey, Bruce, two weeks from today I want to fly with a man standing on top of a DC-8. Is there any problem with the insurance? And he'd say, 'Well, I don't think so, but maybe I better call your insurer and explain it to him so he won't be surprised.'"

The video showed Mr. Lacy flying in various settings: at an airshow in a DC-8 with "The Human Fly" on top of the plane; during flight testing; filming commercials from his

aircraft for such products as the Datsun Turbo ZX; and while footage was being shot of aerial scenes in Hollywood for such films as "Top Gun," "Flight of the Intruder" and "The Great Santini."

In January 1988, Mr. Lacy also flew a United Boeing 747-400 around the world in a new speed record of 36 hours, 34 minutes and 15 seconds to raise more than \$500,000 for children's charities. The record has since been broken by the Concorde.

But Mr. Lacy told *Business Insurance* he is planning to break the record for the fastest time around the world over the North and South Poles to raise \$1 million. He hopes to organize this event in 1995.

Meanwhile, Mr. Lacy added that safety is the "name of the game" when it comes to aviation, especially when filming in the air. Before a sequence such as in "Top Gun" is shot, he choreographs the positions of all the aircraft with the pilots on the ground. He will stop filming in the air if these positions are not adhered to in order to avoid accidents. "We try to make it look wild, but we keep it safe," he said. **BI**

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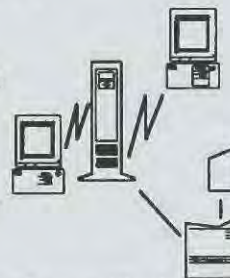
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Balloon liability market deflates

Excess cover grounded by loss of insurer

By STACY SHAPIRO

SAN ANTONIO, Texas—The capacity crunch in the aviation insurance market has cooled the availability of liability coverage for hot air balloons.

Hot air balloonists typically purchase liability insurance and hull coverage, which covers the nylon balloon, wicker gondola and gas burners that are used to

gain altitude.

A hot air balloon can still obtain primary liability insurance with \$1 million aggregate/\$10,000 per passenger in limits, said Richard E. Roth, president of Roth Insurance Agency Inc. in Maumee, Ohio.

However, excess liability coverage above \$1 million is no longer available, said Mr. Roth. "We're getting constant requests



for it, but it isn't there," he said.

The capacity crunch started last November when English & American Insurance Co. Ltd.—a major aviation underwriter that covered hot air balloons—stopped underwriting (BI, Nov. 30, 1992), Mr. Roth said at a

workshop during the Aviation Insurance Assn.'s 17th annual conference earlier this month.

In addition to primary coverage, E&A also offered excess liability coverage for up to \$10 million for hot air balloons "but now we don't have any excess coverage to offer," said Mr. Roth. "I don't think it's available anywhere in the marketplace."

One silver lining to E&A's withdrawal is that Mr. Roth's agency picked up additional hot

air balloon business. Intermountain Insurance Agency of Vail, Colo., had placed 235 hot air balloon insurance policies with an underwriter at Lloyd's of London who had relied on reinsurance from E&A to write the coverage.

Mr. Roth now places his hot air balloon insurance program with Generali-U.S. Branch, though the New York-based subsidiary of Italy's Assicurazioni Generali S.p.A. does not write excess liability coverage.

More than 20,000 hot air balloon pilots are licensed by the Federal Aviation Administration. About 500 rallies—competitions between hot air balloonists—are held in the United States annually. One of the biggest of these rallies will take place in July in Middletown, Ohio.

The most spectacular ballooning accidents that hit the headlines are often associated with the rare occurrence of fatalities, according to Mr. Roth. These typically occur because a hot air balloon has hit a power line, he said. In 1992, two people died in Texas and one in New York from these types of accidents, he said.

"But from a far more realistic viewpoint, claims occur far more frequently from hard landings and high-wind landings," he said. Passengers can be injured as the wicker basket hits the ground in a rough landing, he explained.

In a paper that Mr. Roth distributed to AIA members, he spelled out some ways of reducing passenger liability claims:

- Explain how the balloon works to passengers before they fly and prepare them for the possibility of a rough landing.
- If the wind picks up after takeoff, explain to passengers what to do if the basket tips.
- Have passengers sign an "assumption of risk" form which explains the dangers of flying in a hot air balloon and may relieve the balloon owner from liability.
- Notify insurers as soon as possible of an incident that could give rise to a claim.

Mr. Roth also suggested that balloonists not add promoters as additional policyholders to their liability coverage during hot air balloon events. Promoters often ask for this, but it means that if there is an incident, the amount of coverage will be split in half between the promoter of the event and the balloon company, he said.

Another speaker at the session pointed out that federal aviation regulations do not require hot air balloonists to purchase liability insurance.

The Federal Aviation Administration is frequently asked by the public and aircraft operators whether light aircraft, balloonists, parachutists and other general aviation risks must carry liability insurance, said Hugh Lyon, assistant manager-airports division of the Southwest region of the FAA in Dallas.

Some of the operators have claimed liability premiums are too high and coverage is unattainable so they are unprotected by insurance, he said.

There are airports whose liability insurers will not allow balloonists to use the facilities unless they do buy their own liability insurance, he observed.

However, while the FAA does not object to this restriction, there is no federal regulation that requires any airport or any operator using the airport to buy insurance, Mr. Lyon added. **B**

The IRI Difference:

OVERVIEW Reduces Property Damage During the "Storm of the Century"

IRI Hurricane and Flood Checklists Prepared Insureds

HARTFORD, CT—Hours before Storm Josh arrived with high winds and heavy snow, IRI representatives telephoned insureds and reviewed with them the hurricane and flood checklists in OVERVIEW, IRI's total management program for loss prevention and control.

"We emphasized OVERVIEW to all the customers we called," said Don Chaplin, Manager-District Loss Prevention, Richmond, Virginia Office. "We advised them to follow OVERVIEW closely to protect their properties."

"Losses were minimized, thanks to OVERVIEW."
—Wayne Sabins, IRI

From Louisiana to Maine, The Blizzard of '93 dumped two inches to four feet of snow on roofs and roadways, creating drifts up to 10 feet or more.

Once the storm passed, IRI staff made follow-up calls to customers. "We wanted to make sure that insureds cleared off roofs as quickly as possible," said Bill Brennan, District Manager, Pittsburgh Office. Because of the intensity of the storm and high wind gusts, people could not shovel roofs during the blizzard.

OVERVIEW Manuals are available in English, French and Spanish to help reduce property loss worldwide.

IRI staff also called insureds with facilities in low-lying areas, where flooding could occur, urging them to review OVERVIEW's flood checklist. "A lot of insureds we called

were grateful for our concern," said Wayne Sabins, District Manager, New Jersey Office. "... and I'd like to think that their losses were minimized, thanks to OVERVIEW."

For more information about the OVERVIEW Manual and Forms Packet, which includes the hurricane and flood checklists, contact your agent or broker, the IRI office nearest you or IRI Marketing (800) 243-8308 (in Connecticut, call Trish Sasso, 520-7412.)

IRI
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Drug costs

Continued from page 1

childhood vaccines, which she said had risen 1,000% in 10 years.

Critics say creation of such guidelines would only be one step away from imposing strict price controls.

Drug manufacturers naturally oppose the idea, contending that price controls will have a chilling effect on medical research and are incompatible with managed competition.

But others—including employer representatives and benefit managers—also are cool to the proposal, with some fearing that the review board is a forerunner to price controls that have been unsuccessful in the past and others predicting the board could turn into yet another federal bureaucracy.

The administration's proposal does not take into account the drug industry's financial burden for research and development, according to the Pharmaceutical Manufacturers Assn. in Washington. The drug industry will spend \$12.6 billion in 1993 on R&D, and each year plows 17% of its sales back into research.

In addition, such a board would duplicate the pharmaceutical industry's voluntary price restraint plan, according to the PMA. In the last two years, 16 drug companies representing two-thirds of the U.S. drug market have pledged to keep price increases at or below the rate of inflation, said a spokesman, who added that in April the pharmaceutical component of the Consumer Price Index matched the overall CPI at 3.2%.

While drug price increases may be leveling now, employers have seen daunting hikes in prescription drug costs in recent years.

Employers spent an average of \$345 per employee on prescription drugs in 1992, up 37.5% from \$251 in 1990, according to a survey of 2,351 employers by A. Foster Higgins & Co. Inc. During the same period, overall group health care costs rose 23.3% (BI, April 12).

High drug costs can be traced to a number of factors, including the aging workforce, doctors who prescribe high-priced drugs when less expensive ones are available, and the pressure placed on drug makers to squeeze out profits before drug patents expire.

Patents on new drugs last for 17 years, during which time the drug maker spends an average of 12 years and \$359 million in re-

search and testing before obtaining FDA approval, according to industry figures.

If the drug passes the research stage, the company has only about five years to recoup the investment before generic drug makers can jump in with less expensive versions.

Some employer groups are cautiously optimistic that a drug price review board would help keep drugs affordable for employers.

"Guidelines are preferable to cost controls. They may be worth a shot in dealing with health care costs," said Sharon Canner, assistant vp-industrial relations for the National Assn. of Manufacturers in Washington.

But some benefit consultants and think-tank researchers give the idea a mixed review.

"I'm not sure a voluntary program will be that effective in controlling prices, but it may be worth trying," said John O'Donnell, director-health care policy and legislation for William M. Mercer Inc. in Secaucus, N.J.

"Drug manufacturers feel it is a first step toward price controls, and I can't disagree," he added.

If any significant health reform legislation passed, it will probably include some controls on prescription drug prices, Mr. O'Donnell predicted. The Clinton administration has to show some quantifiable savings out of reform legislation, and it seems to believe that the only way to do this is to impose price controls across the board, he said.

"I think a drug price review board would have some effect on prices," but the experience of price controls in the 1970s shows

High drug costs can be traced to a number of factors, including the aging workforce, doctors who prescribe high-priced drugs. . . and the pressure placed on drug makers to squeeze out profits before drug patents expire.

that a rigid system of price controls doesn't work, said Barry Bosworth, an economist at the Brookings Institution in Washington. Drug companies and other players will hire consultants to find ways to get around the rules, he said.

"Historically, price controls have never been effective," said Steven I. Geringer, president and chief operating officer of PCS Health Systems Inc. of Scottsdale, Ariz., which offers prescription drug plans to employ-

Lloyd's hopes to raise capacity by 1.5 billion pounds (\$2.34 billion) from current levels to around 10 billion pounds (\$15.58 billion) by 1994.

Current Lloyd's members, for the most part, support the proposals in the business plan, he said. Lloyd's is holding a meeting in London this week for more than 3,000 members at the Royal Albert Hall to explain the plan.

"Names have been very happy that we will now be managing this place like a true professional company. They're also happy that we will be more open in the way we operate and that we'll be accepting corporate investors," Mr. Middleton said.

However, he acknowledged that names have expressed disappointment that the business plan does not outline how to settle disputes

Malpractice immunity proposed

WASHINGTON—A Clinton health reform task force proposal that would give physicians immunity from medical malpractice suits is being considered by the White House and a decision is expected soon, according to a task force adviser.

The task force last week also floated a proposal that may require states to pick up a greater share of health care financing for the poor.

Under the malpractice proposal, advanced several weeks ago and dubbed "enterprise liability," injured patients no longer would be allowed to sue physicians. Instead, lawsuits would be directed against the health plan, like a health maintenance organization, that employed or contracted for the physicians' services.

If health plans were exclusively liable, they would have a greater stake in monitoring the performance of physicians they use and setting practice guidelines, said Dr. Robert Berenson, a Washington internist who chaired a task force working group on malpractice reform.

When health plans assume more responsibility for patient care, "They will have a direct interest in trying to avoid malpractice in the first place," Dr. Berenson said last week at a meeting in Washington sponsored by the National Health Policy Council, a group of providers that supports health care reform.

Task force members have said that limiting liability to a single party would cut down on litigation overhead expenses.

However, consumer organizations are opposed to the concept, arguing that those who deliver

negligent care should be liable.

If such a proposal became law, it could lead to big changes in the medical malpractice insurance market.

Among other things, there no longer would be a need for the several dozen captives that physician groups have established to provide malpractice coverage.

The administration also is reviewing proposals that would encourage alternative forms of dispute resolutions as well as caps on damages, but no decisions have been made, Dr. Berenson said.

Meanwhile, administration officials released another idea last week: making states pick up a greater share of health care costs for the poor if costs in a state exceed a certain federally set target or budget on health care expenses.

Under this concept, which still is in discussion, a state might have to pay a higher percentage of subsidies for the poor who are enrolled in big health care purchasing cooperatives if health care costs in the state exceed a set budget.

Administration officials also said last week that President Clinton is now deciding what should be in the basic benefits package that all Americans will be entitled to as well as how universal coverage will be financed—the centerpiece of his health care reform package.

The administration is in the middle "of an intensive decision-making process," said Judy Feder, principal deputy assistant secretary for planning and evaluation at the Department of Health and Human Services. Ms. Feder also spoke at the National Health Policy Council meeting.

—By Jerry Geisel

ers. "I think the current measures in the marketplace combined with managed care initiatives will be much more effective and have a more long-lasting impact on drug costs."

The costs of research compared

and national practice leader for retiree health care at Foster Higgins in Philadelphia.

"A typical health plan's drug costs go up about 21% per year, but of that increase only about 7.5% is attributable to drug price increases, if we use the drug CPI as a benchmark for price," she said.

The other cost drivers are the aging workforce—because older workers take more medication than younger workers—and the fact that drug makers have to recoup expenses to find new drugs to treat new illnesses, like AIDS. Over-medication of patients is a big problem, especially with older workers and retirees, she added.

"I'd rather see the government co-opt the drug companies to be part of the solution—helping doctors provide better patient care—rather than beating them over their heads," Ms. Wilson said.

"In principle, the proposal has some appeal, but the practicalities of managing prices by committee are not consistent with our free enterprise system and are difficult at best," said Richard B. Spitznass, vp-compensation and benefits at Georgia-Pacific Corp. in Atlanta.

Benefit managers are skeptical of a drug price review board's effectiveness for controlling employers' health care costs.

Discussion of a drug price review board "will add pressure for drug companies to bring down prices, but I'm not sure it will keep increases down in the long term," said Dennis Nirtaut, employee benefit manager at Continental Bank in Chicago. And, drug makers' current complex pricing policies offer a great opportunity to get around price controls, he added.

Drug makers probably will control price hikes voluntarily, but "cuts will have to come from somewhere," said Jim Martin, president of RESTAT, a prescription claims processing firm in West Bend, Wis. A possible solution would be to extend patents so that companies can re-

coup their research costs over a longer period, he suggested.

Meanwhile, the Clinton administration continues to float new trial balloons as it makes final decisions on the health care reform package it intends to send to Congress next month.

One idea is to scale back the basic, guaranteed level of benefits to uninsured individuals.

Under this concept, individuals who are now uninsured would receive the same range of benefits from health care purchasing alliances as others. However, these individuals might be subject to higher deductibles or out-of-pocket costs.

Through such a two-tier benefit system, which would last for only a few years, the cost to employers and government of providing universal coverage would be somewhat lower than if everyone were initially entitled to the same coverage.

In another health care reform development, a study released last week estimates that eliminating employment-based health care coverage and instead funding health care with a new 7.75% payroll tax could lower projected increases in health care costs over the next decade by between \$2.7 trillion and \$3.1 trillion.

The study, commissioned by the Kaiser Foundation and performed by the Economic & Social Research Institute in Reston, Va., analyzed a proposal made last year by California Insurance Commissioner John Garamendi.

Under that proposal, employers no longer would offer health care plans. Instead, basic coverage would be provided through giant purchasing cooperatives that would contract with providers. The co-op's funding would come from a 6.75% payroll tax on employers and a 1% payroll tax on employees (BI, Feb. 24, 1992).

Health care costs would be curbed, because, among other things, the big purchasing pools would have only a fixed amount of funds to purchase health care.

Senior Editor Jerry Geisel contributed to this report.

Lloyd's business plan is just beginning

NEW YORK—In unveiling its first-ever business plan, Lloyd's of London is taking its first step toward recovery, says Chief Executive Peter Middleton.

Now, Lloyd's must strive to settle a morass of litigation stemming from past losses, improve accounting and information-gathering, establish a new method of debt collection and achieve full electronic processing capabilities over the next few years, he said at a press briefing in New York last week. Stronger central management should permit Lloyd's to accomplish all of its goals in a timely fashion and attract corporate and individual investors worldwide, Mr. Middleton said.

U.S. investors could account for 15% to 20% of the capital at Lloyd's within three years, up from the current 3% to 4%, he said.

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Current Lloyd's members, for the most part, support the proposals in the business plan, he said. Lloyd's is holding a meeting in London this week for more than 3,000 members at the Royal Albert Hall to explain the plan.

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However, he acknowledged that names have expressed disappointment that the business plan does not outline how to settle disputes

over Lloyd's massive losses in recent years.

The Assn. of Lloyd's Members last week estimated the market next month will report 1990 losses of about 2.7 billion pounds (\$4.1 billion).

The ALM predicts that 67% of syndicates will report a loss for 1990, and many syndicates will keep their 1990 account open.

Meanwhile, Lloyd's commissioned a study by Chris Hitchings, stock analyst for UBS Ltd., on the market's profitability.

The study, published last week, suggests that while the solvency position of Lloyd's has "weakened significantly" since 1989, Lloyd's solvency ratios "remain higher than those of either U.S. or U.K. (insurance) companies."

—By Michael Schachner and Stacy Shapiro

Piper trust fund

Continued from page 1
manufacturer.

"I think we're definitely going to make some law in this case," said Mr. Singerman, a partner with Strook & Strook & Lavan in Miami.

The trust will not cover claims from accidents involving aircraft that Piper produces after it exits Chapter 11.

But, plaintiffs' attorneys say the bankruptcy court will face difficulties in determining how extensive the class should be and the appropriate size of a trust to cover an unknown and unknowable class of claimants.

In addition, if the court establishes such a trust, plaintiffs' attorneys fear some manufacturers that would not have sought reorganization before would do so now to limit their liabilities stemming from defective products.

Piper was forced into Chapter 11 reorganization in July 1991 in large part by dozens of product liability claims. For several years before it sought reorganization, Piper self-insured its product liability exposure because of the high cost of insurance for general aviation manufacturers.

U.S. Bankruptcy Judge Robert Mark on May 7 appointed attorney David Epstein of King & Spalding in Atlanta to represent a class of future product liability claimants that will be limited only by attorneys' imaginations and compromises.

"It's a fascinating situation," Mr. Epstein said.

He said that while a trust fund is a "certainly possible" way to provide compensation for future claimants, "it's too early to tell" whether he will recommend that approach. "There are many ideas out there."

Piper still has to file a reorganization plan that proposes how it would indemnify future product liability claimants, he said.

However, other attorneys in the case expect that Piper, which hopes to sell its assets to one of about a dozen bidders as part of its reorganization, will seek such a trust fund. They explain that many of the company's suitors want to limit their liability through a single-funded, or fixed-asset, trust.

Without such a mechanism, the bidders would be unwilling to purchase the company and shoulder future product liability claims arising from the operation of Piper aircraft currently in use, explained attorney Howard J. Berlin, a partner with Kluger, Peretz, Kaplan & Berlin in Miami, who represents unsecured creditors.

The unsecured creditors, who have filed \$50 million to \$60 million in various business-related and some product liability claims against Piper, want the company sold so they can be paid

quickly.

But, the unsecured creditors are concerned that the amount of money they eventually will receive through Piper's sale and reorganization would be diluted by a trust for people who have not filed a claim yet, Mr. Berlin said.

"I am right now walking a high tightrope," he said.

Piper is being pursued because of its recent turnaround. It reported its first profits in 10 years in 1992. The privately held company would not reveal its net income for the year, but it says it posted \$7 million in operating profits. And, it anticipates much stronger sales of aircraft and spare parts this year.

The leading bidder for Piper's assets is Pilatus Aircraft Ltd. of Switzerland. In its letter of intent to purchase Piper for \$36 million, Pilatus proposed that a single-funded trust be created from a portion of Piper's sale proceeds.

Attorneys involved in the case say they are not considering requiring Piper or any new owner to purchase insurance to cover future product liability claims arising from the fleet of Piper aircraft currently in use. The cost would be prohibitive, they say.

Brokers estimate that \$100 million to \$200 million of first-dollar coverage would cost \$40 million to \$50 million. Additional limits would be much cheaper. Piper could possibly chop its premiums to about \$2.8 million for as much as \$500 million of limits if it assumed a \$50 million self-insured retention.

If Piper succeeds in establishing a single-funded trust to indemnify future product liability claimants, other financially troubled manufacturers that expect huge future product liability claims and cannot find coverage now may follow Piper's lead, said Mr. Singerman, Piper's attorney.

"If there's a manufacturer of a product with claims that's uninsured and is uninsurable, then what happens with Piper will have a beneficial effect on them," he said.

Plaintiffs' attorney Francis Patrick Murphy of Corboy & Demetrio in Chicago agrees. "If it flies, it could be very attractive in the industry sphere," he said. "In a way, it's circumventing the jury system."

But, other attorneys see many hurdles for the court before it can establish such a trust.

Mr. Berlin, the attorney for the unsecured creditors committee, noted the court first must determine the extent of the class. "The question is how far out are we going to look into the future to protect these interests," he said.

For example, the court will have to decide whether the trust should cover the family of the pilot who five to 20 years from now purchases a Piper aircraft

currently in use.

"How about the baby girl born in 2003 who is in a house that a Piper crashes into?" he asked. "Are we going to plan for that child born 10 to 15 years from now?"

Mr. Berlin does not think so. "When you start going down that line of argument, it's no longer logical to protect those interests today in 1993."

The problems in developing a Piper trust are greater than those in developing trusts covering claimants injured by asbestos and the Dalkon Shield, he said.

"The problem the courts had in those cases were that the victims were in existence but they were unknown," Mr. Berlin said. "In this case, we have no way of knowing. It's not that there are too many—but some haven't been born yet."

In addition, the Piper case involves "a very different tort situation," he said. The Manville and Robins trusts were established to cover claimants that were exposed prior to those companies' bankruptcies, he said. That raises the question of whether future Piper product liability claimants should be limited to recovering from a trust.

Mr. Murphy, another plaintiffs' attorney, also questioned how the trust could be set up to value claims filed by claimants of widely varying economic means. "I cannot see how the trust fund would handle a situation like that," he said.

"From a business point of view, it's very clever," said plaintiffs' attorney Marc S. Moller, a senior partner with aviation law specialist Kreindler & Kreindler in New York. "From the point of view of a guy stuck with a bad product, it's a disaster."

Mr. Moller said this use of bankruptcy laws would be "a perversion of what they are intended to do" because it would allow Piper to avoid debt rather than shed debt.

That places additional responsibility on Judge Mark to establish criteria that will limit the use of this case as a precedent for others, said product liability expert Victor Schwartz, a senior partner with Crowell & Moring in Washington.

In addition, "it is up to future judges to prevent shams" by other companies that misuse bankruptcy laws to avoid future liability, he said.

However, Judge Mark "has to consider the equities of this case" regarding future claimants against Piper.

If a trust is created for future product liability claimants against Piper, the company still may face problems, observers note.

For example, parts manufacturers may oppose the trust because they would be fighting future claims arising from the use of Piper aircraft alone in court, said Judy Beckner Sloan, a law professor at the Southwestern University School of Law in Los Angeles. And, the 11th U.S. Circuit Court of Appeals, which probably would ultimately rule in such a case, has not ruled on the legality of such trusts.

In addition, while Piper would use actuaries to help determine the size of a trust, an unexpectedly high number of claims could cause serious claims payment problems. Several observers pointed to the funding problems the open-ended Manville Personal Injury Settlement Trust faces (BI, May 17).

—By Adrian Ladbury

Update

FASB examines funded covers

STAMFORD, Conn.—Ceding insurers that would be entitled to payments from reinsurers if no future losses occur under funded catastrophe reinsurance programs should recognize this amount as an asset on their books, according to a tentative consensus reached by a Financial Accounting Standards Board task force last week.

The task force is expected to reach a final decision on this and other issues related to the contracts at its next meeting July 22.

FASB said in March that ceding companies' obligations under funded covers must be reported as liabilities on their financial statements, which raised concerns that it could cost the industry billions of dollars (BI, April 5). Some observers said at the time, however, that its impact could not be fully determined before additional guidance is received from the Emerging Issues Task Force.

ELIC annuity suit dismissed

SAN FRANCISCO—A civil lawsuit filed by retirees of Pacific Lumber Co. over the company's replacement of their pension plan with Executive Life Insurance Co. annuities has been dismissed.

As a result, the only litigation remaining against the company over its decision to purchase annuities from the now-defunct Los Angeles-based life insurer is a complaint filed by the Labor Department in 1991. A June 28 hearing date for that complaint has been set in federal court in San Francisco.

The Labor Department charges that Pacific Lumber and plan trustees failed to act in the best interests of plan participants when they selected ELIC as the annuity provider after terminating the pension plan in 1986 to recapture surplus assets (BI, June 17, 1991).

The retirees' suit, which had made similar charges (BI, July 15, 1991), was dismissed for lack of legal standing.

Meanwhile, Altus Finance, which is buying ELIC, has increased payments to holders of structured settlement annuities by some \$20 million, which will give these policyholders approximately 70% of the value of their contracts exceeding \$100,000.

A revised rehabilitation plan submitted in late April by the California Insurance Department had reduced these payments to 54% of contract values exceeding \$100,000 (BI, April 26). The enhancement agreement negotiated by the Insurance Department with state guaranty funds provides 100% of the first \$100,000 of these contracts.

The Group Annuity Participant Protection Assn., a coalition of more than 50 employers that invested their pension assets in Executive Life Insurance Co. guaranteed investment contracts, last week endorsed the revised rehabilitation plan.

\$1.5 million art theft insured

CORAL GABLES, Fla.—A Florida art gallery is covered for the theft last week of 11 paintings worth \$1.5 million.

Nader Fine Arts in Coral Gables has \$1.7 million in limits under a fine arts dealer policy, according to the broker, Richard T. Hall, president of Miami-based ACC Hall International. The policy is written by syndicates at Lloyd's of London and has a \$1,000 deductible.

On May 16, burglars entered the art gallery through a double-bolted steel door, taking 11 paintings, nine of which were by Cuban painter Wilfredo Lam.

Briefly noted

The Chicago Board Options Exchange plans to begin trading options contracts that track insurance stocks May 24. Investors will be able to invest in index options that are based on the stock movement of 16 major insurance companies. The index, which was put together by Standard & Poor's Corp., will have the ticker symbol IUX. . . . **Albert Cardone**, the embattled chairman and CEO of **Empire Blue Cross & Blue Shield** in New York, resigned last week. He was immediately replaced by Harold Vogt, president of the Westchester County Chamber of Commerce. . . . In the first action against an employer under a new **California anti-fraud** law, the owners of a construction company in Sun City were arrested on charges of defrauding the State Compensation Insurance Fund of nearly \$300,000 by underreporting more than \$1 million in wages. . . . California Insurance Commissioner John Garamendi seized and placed under conservation **Stoddard Insurance Administration** and other businesses operated by its two principals who allegedly accepted millions of dollars in payment for health insurance without placing the coverage. California regulators also seized **Underwriters Reserve Ltd.**, an insolvent offshore insurer that has written \$11.2 million in premiums since July 1992. . . . Wind, hail, tornadoes and flooding caused an estimated **\$165 million in insured property damage** to portions of Arkansas, Kansas, Louisiana, Nebraska, Oklahoma, South Dakota and Texas May 5 to 10. . . . The U.S. Supreme Court declined to review a ruling by the 7th U.S. Circuit Court of Appeals in *American Family Mutual Insurance Co. vs. NAACP et al.* that held that the federal Fair Housing Act applies to a **redlining** suit involving homeowners insurance. . . . The National Council on Compensation Insurance cut its **workers comp rate increase request in Kansas** to 9.5% from 21.3%, saying rates are still inadequate despite projected savings from a new reform law (BI, May 10). . . . Washington Gov. Mike Lowry signed compromise **universal health coverage** legislation last week that excludes seasonal workers. But he has ordered the new state Health Services Commission to make recommendations for the inclusion of these workers (BI, May 3). . . . Steven I. Geringer was named president and chief operating officer of **PCS Health Systems Inc.** of Scottsdale, Ariz. He had been chairman and CEO of Clinical Pharmacy Advantage of Nashville, Tenn., which was acquired by PCS in April. . . . Centre Reinsurance Co. of New York will assume the finite risk reinsurance portfolio of **Skandia America Reinsurance Co.**, which amounts to about \$25 million in reinsurance volume.

Fatal South America air crash covered

LONDON—A jet that crashed May 19 on a flight from Panama City, Panama, to Bogota, Colombia, killing all on board, is insured in the Colombian market and reinsured in London.

The aircraft crashed just south of Medellin, Colombia, during a storm, and all 125 passengers and seven crew are believed to be dead. The exact cause of the crash was still unknown late last week.

La Nacional de Seguros wrote both hull and liability insurance for the Boeing 727, which was operated by Colombian airline Sociedad Aer-

onautica de Medellin Consolidada S.A.

The reinsurance coverage was placed in the London market by C.T. Bowring & Co. (Insurance) Ltd. The lead underwriter is the British Aviation Insurance Group.

The aircraft is valued at \$2 million, according to reinsurers, which would not reveal hull and liability coverage limits.

The potential liability from the air crash was unknown until nationality and ticket types of the dead passengers were determined.

—By Adrian Ladbury

Malpractice law

Continued from page 2
during a discussion sponsored by the Northern California chapter of the Professional Liability Underwriting Society, a non-profit organization in Minneapolis that provides educational assistance to insurance executives, attorneys and others involved in professional liability issues.

Last week's discussion was one of the first in what is expected to be a long, statewide debate over MICRA's future following the expiration this year of a five-year "truce" between trial lawyers and tort reformers.

That agreement, hammered out in 1987 between lobbyists for some of the most powerful economic interests in California, was known as "the napkin deal" because it was scribbled out on a napkin in Frank Fat's restaurant in Sacramento.

Now that the truce has ended, both the CTLA and a coalition of medical malpractice insurers and medical providers called Californians Allied for Patient Protection have been mobilizing for the resumption of hostilities.

The opening salvo was fired in February when Ralph Nader demanded that MICRA be repealed because medical negligence victims have been hurt by caps on jury awards.

Most agree, however, that MICRA is unlikely to be repealed as long as Pete Wilson, a Republican, remains governor.

Likewise, the governor's recently introduced tort reform package, which would make the civil justice system even more restrictive, is likely to face stiff opposition from the trial lawyer group.

Since passage of MICRA in 1975, health care costs have continued to soar in California, making it the second most expensive health care market in the nation, said Ms. Alexander, citing a recent U.S. General Accounting Office report.

At the same time, losses incurred by malpractice insurers—including reserves for future claims—declined to \$2.7 billion in 1991, from \$3.2 billion in 1985, she said, using figures from the National Assn. of Insurance Commissioners.

Not surprisingly, some of the highest profits earned by medical malpractice insurers were in states with restrictive tort reforms, like Indiana and California, Ms. Alexander said.

That means that insurers have reaped the benefits of MICRA at the expense of injured patients whose compensation has been limited, she asserted.

But Mr. Keene insisted that "MICRA was the product of a genuine crisis. The media carried a malpractice story virtually every day for six months" reporting that physicians, fearing lawsuits that would wipe them out, were leaving the state in droves, he said.

At the same time, "hospitals were closing their emergency rooms and turning away high-risk patients. Babies were not being safely delivered in inner cities, in rural areas—some died," he recounted.

And, "defensive medical practices such as Ceasarians subjected patients to medically unwarranted but legally defensible risks," he said.

Between 1968 and 1974, the number of malpractice suits filed in California more than doubled and the number of large jury awards—those in excess of \$300,000—increased by 1,100%. As a result, malpractice insurance premiums surged 400% between 1974 and 1975 and the number of insurers willing to underwrite professional liability coverage for California doctors dwindled to three from 30, according to Mr. Keene.

MICRA capped non-economic damages at \$250,000, established a sliding scale for lawyers' contingency fees, allowed evidence of plaintiffs' compensation from "collateral sources" like health insurance and permitted insurers to make periodic payments when future damages are more than \$50,000.

The MICRA cap was never indexed to inflation—which critics have assailed—because the trial lawyers thought it would be easier to legally challenge the law if it weren't, Mr. Keene said.

But "they guessed wrong," he said, pointing out that attempts to overturn the cap have so far been unsuccessful. Legislation passed in 1987 also restricted juries from awarding punitive damages against doctors except in cases of intentional and malicious torts arising out of malpractice.

"It is far from perfect, but in the balance (MICRA) has alleviated more pain and suffering than it has caused," he said.

Furthermore, "MICRA allows high-risk medical procedures—some at the frontier of medicine—to continue to be performed," he added.

While Ms. Alexander acknowledged that premiums for medical malpractice insurance in California were astronomical when MICRA was passed, she said it was not due to excessive litigation.

Malpractice insurers "were attempting by doubling and tripling medical malpractice premiums to make up for years of ignoring dire warnings of responsible underwriters, who had sounded the alarms through the years of the soft market and high investment returns," she said. "They made bad investments and now they wanted California doctors to pick up the pieces."

As a result, California doctors "did what every self-respecting business person would do: They looked over the insurance business themselves" and formed alternative insurance mechanisms like captives and self-insurance pools.

Ms. Alexander also disputed claims that fear of malpractice suits prompts physicians to overmedicate and perform excessive tests.

"Tests and procedures that are uncalled for obviously will not provide any defense against claims of malpractice. In fact, they would help establish liability," she said.

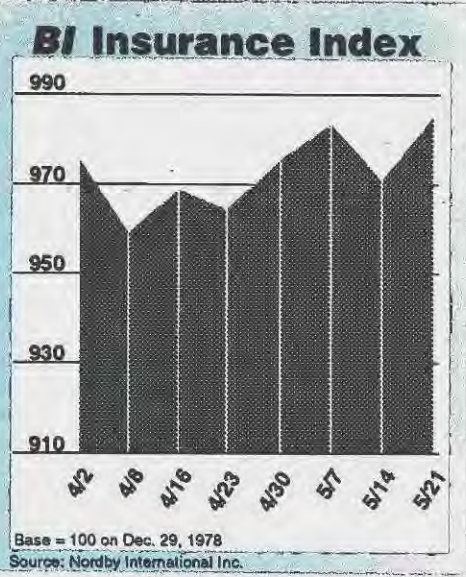
In reality, "real defensive medicine—i.e., medicine practiced in both a prudent and cautious manner—saves lives and money since it prevents both the occurrence and cost of malpractice, and it prevents the significant added cost of attempting to treat a medical problem once it has already escalated to a more serious stage," she argued.

"MICRA is not a law worth defending," said Ms. Alexander. Tort reforms that place statutory caps on malpractice awards "are simply a Band-Aid cure."

A better solution would be to have stricter requirements for physician recertification and peer review, make better use of practice guidelines, hospital bylaws and overall quality assurance programs, and improve doctor discipline, she urged.

Doctors, consumers, insurers and lawyers also should participate in a joint closed claim study of MICRA's economic effect on premiums and health care costs as well as an audit of its effect on victims of malpractice, she said.

The discussion was moderated by Arthur W. Curley, a partner with the San Francisco-based defense firm of Bradley & Curley.



Insurance industry stocks continued to rise last week, as the Business Insurance Index climbed 14.0 points to 984.7 May 21 from 970.7 on May 14. Advancing issues for the week were led by U.S. Healthcare, up 11.8%; United Healthcare Corp., up 6.5%; and Berkshire Hathaway Inc., up 5.2%. Declining issues for the week followed Seibels Bruce Group, down 11.8%; US Facilities Corp., down 9.5%; and Statesman Group Inc., down 7.5%. The most active issue was U.S. Healthcare, 8.0 million shares traded. The BI Index was up 1.4%; the NYSE Composite was up 1.2%; the Standard & Poor's 500 was up 1.4%; and the Dow Jones 30 Industrials rose 1.5%.

British Issues						
						1 Week
May 20 Companies	Price pence	P/E	Div. pence	Yield %	High—Low pence pence	
Comml Union	566	N/M	32.5	5.7	580—566	
Genl Accident	566	N/M	35.7	6.3	577—566	
Gdn Royal Exch	174	N/M	9.3	5.3	174—171	
Royal	300	N/M	6.7	2.2	305—299	
Sun Alliance	331	N/M	19.0	5.7	335—331	
Brokers						
Bradstock	120	14.0	6.8	5.7	124—120	
CE Heath	324	18.6	21.3	6.6	325—319	
Hogg Group	189	16.6	10.9	5.8	190—189	
JIB Group	192	19.0	10.0	5.2	193—192	
Lloyd Thompson	273	22.0	7.5	2.7	273—273	
Lowndes Lmbt	347	13.9	16.8	4.8	347—347	
PWS Holdings	61	9.0	5.3	8.7	63—61	
Sedgwick Grp	164	19.8	8.0	4.9	170—162	
Steel Brl Jones	207	12.1	17.7	8.5	207—207	
Willis Coroon	197	18.4	8.8	4.5	197—193	
Source: Philip Olsen, London						

BI Industry Stock Report

MAY 17, 1993 THROUGH MAY 21, 1993

BROKERS																													
		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value			Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value				
Acordia Inc.	NYS	19.88	0.00	-7.56	24.75	15.13	89	0.36	1.81	12	7.01	2.84	Market Corp.	OTC	35.25	0.36	12.80	36.50	23.00	56	0.00	0.00	11	20.24	1.74				
Alexander & Alexander	NYS	26.00	1.46	-1.89	28.88	19.75	297	1.00	3.85	22	10.00	2.60	Mutual Risk Mgmt. Ltd.	NYS	38.00	-1.30	-6.17	46.00	25.75	44	0.28	0.74	21	7.51	5.06				
E.W. Blanch Holdings Inc.	NYS	17.75	-2.74	N.A.	19.25	17.75	453	0.00	0.00	-	10.00	1.78	NAC Re Corp.	OTC	37.50	0.00	-7.41	44.75	21.75	78	0.16	0.43	53	13.60	2.76				
Gallagher Arthur J. & Co.	NYS	34.63	0.36	22.57	35.63	21.00	64	0.72	2.08	22	6.35	5.45	National Re Corp.	NYS	36.38	-3.00	22.78	39.63	17.63	45	0.12	0.33	14	N/A	N/A				
Hibb, Rogal & Hamilton	NYS	14.88	2.59	-4.80	16.88	11.00	112	0.44	2.96	20	3.11	4.78	Navigators Group	OTC	33.00	0.76	1.54	36.00	28.50	59	0.00	0.00	24	15.69	2.10				
Marsh & McLennan	NYS	89.38	0.28	-2.19	97.63	73.50	833	2.68	3.00	21	14.40	6.21	Nobel Insurance LTD.	OTC	6.50	-5.45	10.64	8.25	4.25	173	0.00	0.00	2	3.91	1.66				
Poe & Brown	OTC	19.75	-1.25	17.91	21.25	11.25	36	0.40	2.03	76	2.64	7.48	NNWL Companies	NYS	55.50	1.83	9.09	64.88	34.50	282	1.60	2.88	14	46.21	1.20				
BROKERS AVERAGE			0.1	4.0					2.2	25			Ohio Casualty Corp.	OTC	62.00	-2.36	-1.78	68.75	50.25	275	2.84	4.58	12	43.08	1.44				
CONGLOMERATES & HOLDING COMPANIES																													
Berkley W.R. Corp.	OTC	41.00	-1.20	-4.65	50.50	32.00	191	0.40	0.98	16	23.51	1.74	Old Republic Int'l	NYS	21.63	-1.70	-13.07	27.38	19.50	790	0.40	1.85	7	18.63	1.16				
Berkshire Hathaway Inc.	NYS	14200.0	5.19	20.85	14200.0	8875.00	1	0.00	0.00	38	6437.25	2.21	Orion Capital Corp.	NYS	38.38	-1.60	8.48	46.38	24.59	121	0.80	2.08	8	28.62	1.34				
ITT (Hartford Group)	NYS	81.13	-0.76	12.67	84.25	62.50	920	1.96	2.42	-35	68.23	1.19	Phoenix RE Corp.	OTC	29.25	-7.14	85.71	34.00	9.00	621	0.20	0.68	-64	13.32	2.20				
Sears (Allstate)	NYS	53.88	1.41	18.41	55.75	37.75	4187	1.60	2.97	-10	40.18	1.34	Provident Life	NYS	28.63	-0.87	0.44	31.50	20.75	67	1.04	3.63	11	30.38	0.94				
CONGLOMERATES AVERAGE			1.2	11.8					1.6	2			Re Capital Corp.	ASE	14.75	-1.67	-10.61	16.63	12.25	18	0.28	1.90	30	16.88	0.87				
INSURERS/REINSURERS																													
ACE Ltd.	NYS	30.13	0.00	-	32.00	27.50	266	0.40	1.33	26	34.06	0.88	Reliance Group Holdings	NYS	6.88	-3.51	12.24	8.50	4.25	203	0.32	4.65	3	2.94	2.34				
AEON N.V.	NYS	45.25	-1.09	8.71	49.38	33.50	24	2.94	6.50	8	34.06	1.33	RLI Corp.	NYS	25.50	-0.97	3.03	28.63	18.75	131	0.52	2.04	12	17.92	1.42				
Aetna Life & Casualty	NYS	53.13	-0.47	14.25	54.13	38.00	1182	2.78	5.20	115	67.08	0.79	St. Paul Companies	NYS	79.88	-2.29	3.73	83.25	67.88	520	2.80	3.51	-13	59.79	1.34				
Allied Group Inc.	OTC	36.38	-0.34	14.57	45.50	19.50	282	0.72	1.98	8	11.29	3.22	SAFECO Corp.	OTC	56.00	-0.88	-1.32	66.75	47.75	2696	1.80	3.21	13	35.37	1.58				
Allmerica Prop. & Casualty	NYS	54.63	0.00	8.17	60.38	34.75	111	0.44	0.81	5	40.44	1.35	SCOR U.S. Corp.	NYS	17.88	-2.05	2.14	20.75	13.13	13	0.32	1.79	223	14.39	1.24				
American General	NYS	30.50	3.39	7.02	33.25	22.63	1680	1.08	3.54	12	39.89	0.76	Seibels Bruce Group	OTC	0.94	-11.76	-49.97	6.13	0.38	51	0.00	0.00	0	6.22	0.15				
American Heritage Life Ins.	NYS	23.63	-5.50	17.15	25.33	18.75	10	0.68	2.88	11	16.51	1.43	Selective Ins. Group	OTC	23.00	0.00	4.55	25.75	18.75	79	1.12	4.87	13	20.22	1.14				
American Indemnity(Fin'l)	OTC	12.00	2.13	100.00	12.25	4.75	16	0.08	0.67	6	14.43	0.83	Statesman Group Inc.	OTC	10.75	-7.53	-10.42	16.50	5.00	1334	0.20	1.86	5	6.71	1.60				
American International	NYS	125.50	-0.69	8.19	132.75	84.25	2039	0.56	0.45	15	54.21	2.32	Tokio Marine & Fire	OTC	59.50	1.93	23.96	63.50	36.75	2	0.00	0.00	-	70.93	0.84				
American RE Corp.	NYS	35.00	-2.10	-5.41	41.75	33.13	752	0.00	0.00	32	N/A	N/A	Torchmark Corp.	NYS	51.63	-1.90	-9.03	64.75	37.75	897	1.04	2.01	14	14.87	3.47				
Aon Corp.	NYS	51.00	-0.97	-5.56	56.75	41.25	372	1.80	3.53	17	27.17	1.88	Transamerica	NYS	49.00	0.26	2.08	56.13	40.00	617	2.00	4.08	11	35.86	1.37				
Argonaut Group	OTC	33.00	-1.49	8.20	35.25	25.50	121	1.00	3.03	10	21.70	1.52	Transatlantic Holdings	NYS	52.38	0.00	-6.68	56.75	29.38	47	0.28	0.53	17	21.85	2.40				
AVEMCO Corp.	NYS	19.50	4.00	-16.58	28.00	18.50	41	0.40	2.05	23	7.33	2.66	Travelers Corp.	NYS	27.25	-1.80	0.00	30.75	17.13	694	1.60	5.87	-4	43.85	0.62				
Baldwin & Lyons Inc.	OTC	36.50	-3.63	0.00	39.00	27.50	1	0.48	1.32	9	30.85	1.18	Trenwick Group Inc.	OTC	43.25	-2.81	6.13	49.75	25.75	205	0.80	1.85	16	23.87	1.81				
Chandler Insurance	OTC	3.75	-6.25	-21.05	7.63	3.50	3	0.00	0.00	13	8.63	0.43	United Fire & Casualty	OTC	37.00	-1.33	-10.84	43.00	35.00	5	1.00	2.70	86	28.47	1.30				
Chubb Corp.	NYS	86.75	0.58	-2.39	96.38	65.88	1251	1.72	1.98	13	40.67	2.13	Unilin	OTC	43.25	-5.21	1.17	46.75	32.75	439	1.20	2.77	14	36.51	1.18				
CIGNA Corp.	NYS	58.75	-3.49	0.21	68.00	47.13	894	3.04	5.17	11	81.73	0.72	UNUM Corp.	NYS	52.25	-0.95	-1.42	58.38	37.50	1128	0.80	1.53	14	21.83	2.39				
CNA Financial Corp.	NYS	90.25	-2.04	-7.91	102.88	82.00	132	0.00	0.00	-12	80.24	1.12	US Facilities Corp.	OTC	9.50	-9.52	-5.00	11.50	6.50	197	0.00	0.00	12	9.64	0.99				
Continental Corp.	NYS	29.25	1.30	8.84	34.75	20.00	1117	1.00	3.42	22	38.32	0.76	USF&G Corp.	NYS	16.50	-2.22	33.33	19.63	9.88	1329	0.20	1.21	330	10.29	1.60				
EXEL Ltd.	NYS	46.13	-7.05	-2.38	52.25	32.38	506	1.00	2.17	9	N/A	N/A	USLICO Corp.	NYS	18.25	0.69	1.39	20.00	15.00	44	0.24	1.32	-6	29.80	0.61				
Fund American Corp.	NYS	85.25	0.15	18.40	85.25	67.50	41	0.00	0.00	15	81.85	1.04	USLIFE Corp.	NYS	38.13	2.69	5.17	42.63	29.34	299	1.20	3.15	12	64.90	0.59				
Fremont General Corp.	NYS	33.75	-1.82	-2.17	41.75	19.88	36	1.08	3.20	8	25.62	1.32	Washington National	NYS	25.13	-0.50	9.24	28.00	18.50	92	1.08	4.30	13	30.27	0.83				
Frontier Insurance Group	NYS	41.25	1.85	-5.17	49.00	30.25	102	0.60	1.45	13	13.97	2.95	Zenith National Ins.	NYS	24.75	0.51	29.25	26.38	119	1.00	4.04	23	14.81	1.67					
Gaisco Inc.	ASE	15.50	0.00	9.73	18.56	8.53	158	0.04	0.26	19	2.65	5.85	Zurich Reinsurance Centr.	NYS	33.13	-5.36	N.A.	35.13	32.75	1860	0.00	0.00	-	14.81	2.24				
General RE Corp.	NYS	111.63	0.22	-3.56	130.50	79.25	1069	1.88	1.68	16	46.07	2.42	INSURERS/REINSURERS AVERAGE										-1.6		2.5	22.3			
Guaranty National Corp.	NYS	20.50	-4.65	3.80	24.00	14.38	106	0.00	0.00	12	9.12	2.25	HEALTH MAINTENANCE ORGANIZATIONS																
Hartleysville Group	OTC	28.50	-1.72	0.88	32.75	18.00	111	0.64	2.25	16	16.77	1.70	FHP International	OTC	24.50	2.62	22.50	29.00	14.50	1849	0.00	0.00	23	9.61	2.55				
Hartford Steam Boiler	NYS	56.38	0.89	-2.38	59.88	51.38	70	2.12	3.76	21	19.74	2.86	Pacificare Health Sys.	OTC	42.75	4.91	-16.18	57.50	25.50	194	0.00	0.00	21	3.90	10.96				
HCC Insurance Holdings	OTC	21.00	-4.55	3.70	23.50	12.25	154	0.00	0.00	21	10.12	2.08	Salguedo Health Enter.	OTC	8.75	0.00	-10.26	12.50	7.00	0	0.00	0.00	11	4.03	2.17				
Kemper Corp.	NYS	35.00	-2.10	18.14	43.00	20.75	489	0.92	2.63	-9	37.66	0.93	Siena Health Services	ASE	17.50	2.19	-19.08	21.69	8.06	464	0.00	0.00	15	2.01	8.71				
Lawrence Insurance Group	ASE	6.38	4.08	-26.09	10.25	5.50	5	0.12	1.88	-159	4.66	1.37	TakeCare Inc.	OTC	37.00	-2.63	-16.85	50.25	25.75	600	0.00	0.00	14	2.01	18.41				
Liberty Corp.	NYS	30.00	-3.23	6.19	33.88	25.00	88	0.56	1.87	12	18.43	1.63	United Healthcare Corp.	NYS	59.63	6.47	4.84	68.00	37.75	1830	0.03	0.05	33	4.68	12.74				
Lincoln National	NYS	79.25	-0.63	8.38	83.63	56.50	606	3.04	3.84	10	58.92	1.35	United Medical Corp.	ASE	9.38	0.00	47.06	9.75	6.13	0	0.20	2.13	17	10.30	0.91				
													U.S. Healthcare	OTC	52.00	11.83	16.53	59.75	29.34	8031	0.52	1.00	26	3.60	14.44				
													HMOs	AVERAGE		3.2						0.4	20						
													ALL COMPANIES	AVERAGE		0.7						2.2	21						



Prehistory is full of species that were unable to adapt to changes in the world around them. While hundreds of thousands of these animals may have once roamed the land, they now leave nothing more than a fossil record.

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