

Business Insurance

Reporting Weekly on Corporate Risk, Employee Benefit and Managed Health Care News / \$4

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Portability law to set rules for privacy of benefit records

By ROBERT KAZEL

An employer, seeking to monitor abuses of habit-forming drugs by workers, uses computers to assemble lists of employees and the prescriptions they have received.

An HMO employee who is opposed to abortion jots down the names of workers who have received insurance payments for the procedure and submits them to the right-to-life movement for inclusion on mailing lists.

A corporate human resources department assistant, technically authorized to read benefits files, spends idle time leafing through medical files without a business purpose.

All of these hypothetical situations eventually could be barred by new federal guidelines regulating the use of medical records in the workplace and by health networks. Secretary of Health and Human Services Donna E. Shalala is expected to submit to Congress in August recommendations on medical confidentiality issues that long have been the province exclusively of states.

For benefit managers, new regulations from Washington eventually could require a sweeping evaluation of security standards for both paper and electronic files.

Until now, health care confidentiality law has been dominated by state statutes, a hodgepodge of varying and

sometimes conflicting rules ranging from provider credentialing and utilization review measures to substance review and mental health rights law.

That changed last August, when Congress passed the Health Insurance Portability and Accountability Act, commonly known as the Kassebaum-Kennedy Act.

Although the law is best known for curbing the use of pre-existing condition exclusions in health care plans, HIPAA also contains little-noticed amendments that create a timetable for implementing final rules for privacy and electronic standards for medical record-keeping and penalties for infractions.

See *Hipaa* on page 25

Liberty Mutual, AIG still vying for control of Golden Eagle

SAN FRANCISCO—A renewed attempt by Boston-based Liberty Mutual Insurance Co. to acquire Golden Eagle Insurance Co. calls for California Insurance Commissioner Chuck Quackenbush to drop charges against Golden Eagle's deposed owner and chairman, John Mabee.

New York-based American International Group Inc., whose bid for Golden Eagle was approved in April by regulators, has since amended its bid to include the settlement provision (*BI*, April 14). AIG's original bid
See *Updates* on next page

Medical records: Timetable for privacy

The Health Insurance Portability and Accountability Act of 1996 sets a schedule for implementing new health privacy standards:

- **August 1997.** Department of Health and Human Services will submit to Congress recommendations on medical information privacy rules.
- **February 1998.** HHS must release standards on electronic transmission of health care data.
- **August 1999.** Deadline for Congress to enact privacy legislation.
- **February 2000.** Large employers must be in compliance with rules for electronic data transmission security.
- **August 2000.** HHS must release rules on privacy, if Congress has not yet acted.

GRAPHIC BY ADAM DOI

NAIC panel calls for deregulation, but eligibility not determined

By MEG FLETCHER

KANSAS CITY, Mo.—State insurance regulators crafting a white paper on commercial insurance regulation are extending their June deadline, primarily to determine which buyers would be sophisticated

NAIB panel debates deregulation.
Coverage on page 4

enough to be exempt from state law protections.

A drafting group of the National Assn. of Insurance Commissioners had planned to finalize its work on a new, preliminary white paper on regulatory re-engineering during the NAIC's June 7-11 meeting in Chicago, but will probably need an extra three months to complete the task.

"We have made tremendous progress, but we still have a lot

to do," commented Brian Atchinson, Maine's insurance superintendent. Mr. Atchinson chairs the group that is drafting the paper, as well as the NAIC's Special Committee on Regulatory Re-Engineering, its parent committee.

The drafters' latest recommendations, which will be discussed at the June meeting, call for broad deregulation of rates, forms and market access for "industrial insureds."

That term is not precisely defined yet, though drafters use it to refer to large, sophisticated buyers of insurance.

"I'm really pleased with the recommendations that have been put forth," said Patricia C. Vaughan, associate general counsel for the Risk & Insurance Management Society Inc. in New York. "Most are consistent with recommendations that RIMS made last year," she said (*BI*, June 10, 1996).

See *Deregulate* on page 14

Regulators bar offshore insurers from Colorado

American International Surety defends quality of assets

By DOUGLAS McLEOD

DENVER—When one thinks of the kind of safe, liquid investments that most insurance companies favor, defaulted pre-World War II German government bonds don't normally come to mind.

Most insurance companies, though, aren't like American International Sureties Ltd. of Antigua.

AIS, a marine, aviation and surety underwriter, has reported assets of more than \$80 million, nearly all of it Weimar-era German bonds denominated in U.S. dollars and supposedly backed by gold.

While the Securities and Ex-

change Commission and others have challenged the value of these bonds in other cases, AIS officials insist they will collect the full value or sue the German government and stockbrokers involved in the 70-



Mr. Rosenblum

year-old transactions.

That this could take awhile apparently does not bother AIS

Chairman Marvin A. Rosenblum.

"We have not represented that they will be used to pay claims," he said of the bonds. "We do not represent that they are liquid."

"If that raises concerns—and it should to some people, justifiably—they should not purchase products from us," Mr. Rosenblum said.

The Colorado Insurance Department hit AIS and several other offshore insurers with a cease and desist order earlier this year, charging the companies had written aviation business in the state illegally.

Also named in the order are Trans International Insurance
See *AIS* on page 24

Acordia execs mum about company's future

By SALLY ROBERTS

INDIANAPOLIS—Executives at Acordia Inc. last week would not comment on rumors that management is in the process of buying out the broker's property/casualty operations from its parent, Anthem Insurance Cos. Inc.

Acordia's future was a hot topic among brokers attending the National Assn. of Insurance Brokers' annual meeting in Phoenix last week, especially after Frank C. Witthun, Acordia's president and chief executive officer, left the three-day conference a day early.

That same day, Anthem, which

owns 67% of Acordia's outstanding common stock, announced it could purchase the publicly owned shares of Acordia that it does not currently own. Anthem also said it was in discussions with a third party regarding the possible sale of Acordia's brokerage business, and also was in discussions regarding the possible reorganization of Acordia's health care business.

Approximately half of the world's fifth-largest broker's \$661 million in 1996 revenues was derived from property/casualty insurance brokerage. The remainder of the firm's revenues came from the sale and servicing of Anthem's

health insurance products.

Anthem, an Indianapolis-based mutual life and health insurer, retained Credit Suisse First Boston in February to explore the possible sale of Acordia's brokerage business and a possible reorganization of its health care business (*BI*, Feb. 10).

Anthem recently has focused exclusively on health and managed care business and has generally sold its non-health care

The day after Acordia's announcement last week, its stock price jumped \$35.875. The stock was at the same level on Friday.

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Updates

Insurers vie for Golden Eagle

Continued from previous page

for the troubled workers compensation insurer was still pending court approval, clearing the way for Liberty Mutual to submit a bid to the court. Liberty Mutual has served as a reinsurer of Golden Eagle while in rehabilitation.

Liberty Mutual's proposal was presented last week in San Francisco Superior Court, which is overseeing Golden Eagle's rehabilitation, and to the commissioner.

Under the proposed settlement agreement, Mr. Mabey would forgo his right to hearings contesting the commissioner's Jan. 31 takeover of his company, in exchange for the department dropping any charges against him, according to court observers.

The department seized Golden Eagle Jan. 31, charging that questionable business practices put policyholders, employees and clients at risk. The department also charged that Mr. Mabey, among other things, obtained \$69 million in unsecured loans from Mesa Re, Golden Eagle's Turks & Caicos-based reinsurance affiliate.

AIG's rehabilitation bid called for it to put \$200 million into a company the insurer is forming that would write new and renewal business, said Roxani Gillespie, former California insurance commissioner and a partner at Buchalter, Nemer, Fields & Younger, a San Francisco firm representing AIG. Golden Eagle would transfer \$1.1 billion of its assets into a runoff operation supported by American Home, an AIG unit. AIG would supply additional capital depending on the amount and quality of assets Golden Eagle turns over.

Liberty Mutual's new rehabilitation plan is similar to the one submitted by AIG, according to Karl Rubinstein, deputy conservator and chief executive officer for Golden Eagle. But it added the settlement agreement.

The new proposal prompted Superior Court Judge William Cahill to order AIG to talk with Mr. Mabey about producing a settlement agreement similar to the one proposed by Liberty Mutual.

AIG has done that and added an identical settlement proposal, Ms. Gillespie said.

Such a settlement is intended to speed the rehabilitation process so Golden Eagle will not linger in receivership, Ms. Gillespie explained.

Any settlement would require the commissioner's agreement. The department referred calls to Mr. Rubinstein, who said a decision has not been made.

PBGC chief being considered

WASHINGTON—David M. Strauss, currently deputy chief of staff to Vice President Albert Gore Jr., is under consideration to be the next executive director of the Pension Benefit Guaranty Corp.

Mr. Strauss, who advises the vice president on a wide range of domestic issues, including retirement security and health care, previously was chief of staff to Sen. John Breaux, D-La., and staff director of the Senate Committee on Environment & Public Works.

The appointment could be announced as early as this week. If named, Mr. Strauss would succeed Martin Slate, who died earlier this year of a heart attack.

The appointment does not require Senate confirmation.

AIG promotes Evan Greenberg

NEW YORK—Evan G. Greenberg was named president and chief operating officer of American International Group Inc. last week in a move that strengthens his position as the likely successor to his father, Maurice R. Greenberg, as chairman and chief executive officer.

The younger Mr. Greenberg succeeds Thomas R. Tizzio, who was named senior vice chairman.

The change in position will allow Mr. Tizzio to remain a mentor to Evan Greenberg but step away from day-to-day management responsibilities, said David Seifer, vp at Donaldson, Lufkin & Jenrette Securities Corp. in New York.

Edmund S.W. Tse, executive vp-life insurance, also was made a vice chairman of AIG.

The promotion of Evan Greenberg, 42, clearly marks him as the likely successor to Maurice Greenberg, who is 72, when the elder Mr. Greenberg eventually retires, observers say.

"It is fairly obvious that Evan is the leading candidate to take over the company," said Peter Wade, vp at Lehman Bros. in New York.

Evan Greenberg joined AIG in 1975 and most recently was executive vp-foreign general insurance and president of American International Underwriters. He was elected to the board in 1996.

Prior to 1995, Maurice Greenberg's elder son, Jeffrey W. Greenberg, was thought to be the heir apparent at AIG, but after his unexpected resignation in 1995 the focus shifted to his brother (BI, June 12, 1995).

Other appointments last week include: Martin J. Sullivan, senior vp-foreign general insurance, who was named to the additional post of president of AIU; and Hamilton C. DaSilva, vp-foreign general insurance, who was named to the additional post of executive vp at AIU. AIG also made several vp appointments in its Asian operations.

Death sparks copter safety probe

INDIANAPOLIS—The helicopter accident that killed a Conseco Inc. executive last week could lead to new safety guidelines for companies

See Updates on page 26

Errors & omissions

• Due to incorrect information initially supplied to *Business Insurance*, the policyholder surplus of Argonaut Insurance Co. in the chart on page 19 is incorrect. Argonaut's first-quarter surplus is \$532,361,000.

• A photo caption on page 3 of the May 12 issue was incorrect. Hartford Steam Boiler Inspection & Insurance Co. plans to inspect for electrical problems in about 12,000 of the hundreds of thousands of buildings it insures.

Fremont expands nationally with Industrial Indemnity

By GAVIN SOUTER

SANTA MONICA, Calif.—Fremont General Corp. is moving closer to its goal of writing workers compensation insurance nationwide with its \$365 million purchase of Industrial Indemnity Holdings Inc.

The deal also moves Xerox Corp., the current owner of Indus-

trial Indemnity, closer to its goal of exiting the insurance and financial services business.

The transaction comes several months after a proposed \$2.7 billion deal for Xerox to sell all of its insurance interests to Kohlberg Kravis Roberts & Co. fell through.

Instead, Xerox is now selling the individual units of its insurance holding company Talegen

Holdings Inc. The sale of Industrial Indemnity is expected to be followed by the sale of two remaining Talegen units by year-end.

In addition to the cash payment of \$365 million, which will be paid by subsidiary Fremont Indemnity Co., Fremont will pay off about \$79 million of Industrial Indemnity's debt.

See Xerox on page 13

Resignation raises questions for Aetna's health care strategy

By JUDY GREENWALD

HARTFORD, Conn.—The surprise resignation last week of Joseph T. Sebastianelli as president of Aetna Inc. could be a blow to implementation of the insurer's health care strategy, some analysts say.

But others believe the resignation of Mr. Sebastianelli, who was the expected successor to Aetna Chairman and Chief Executive

Officer Ronald E. Compton, will not necessarily hamper the company's operations.

Mr. Sebastianelli, former co-president of U.S. Healthcare Inc., which Aetna acquired last year, said in his letter of resignation, "The demands of my job and my personal responsibilities, including my family, are incompatible."

The resignation is effective June 1.

Mr. Compton, who is scheduled

to retire next March, said he accepted the resignation with regret. "Our efforts to complete the transformation of Aetna into a growth company that meets the needs of its customers for high quality health and related benefits and financial services will continue unabated," he said. Mr. Compton will re-assume the title of president, which he had just relinquished to Mr. Sebastianelli in

See Aetna on page 25

Labor Department to seek businesses' views

Liaison plan viewed as cooperative

By MARK A. HOFMANN

WASHINGTON—A proposal by Labor Secretary Alexis Herman to appoint a special liaison to employers is drawing cautious praise from the business community.

Employers welcome the proposal as a demonstration that Ms. Herman favors a cooperative rather than confrontational approach in dealings between the department and employers. In particular, some business group hope the liaison will give them an opportunity to voice their concerns about a proposal by the department's Occupational Safety and Health Administration to require employers to adopt a controversial ergonomics standard.

Businesses considered OSHA's original ergonomics

draft unrealistic and inflexible. Employers also hold that more research must be undertaken before the imposition of an ergonomics standards can be justified, if it can be justified at all. The House Committee on Education and the Workforce's Workforce Protection Subcommittee began holding hearings on ergonomics last week.

Ms. Herman announced her plan for the liaison during her first appearance before a congressional panel as labor secretary earlier this month. As she fielded questions from members of the House Appropriations Subcommittee on Labor, Health and Human Services and Education, Ms. Herman said she intends "to have someone available to relate to the business community" on specific issues, most notably

See Liaison on page 15

Soft market may spur M&A activity: Analysts

By JUDY GREENWALD

While risk managers enjoy soft pricing, the continuing soft market means commercial property/casualty insurers are struggling to make a profit and will likely accelerate industry consolidation.

"The consolidation trend is alive and well and 'If you can't grow it, you might as well buy it,'



Inc. in New York.

While first-quarter 1997 results

seems to be the motto of the day," said Michael Lewis, senior insurance analyst with Dillon Read & Co.

were helped by low catastrophe losses and are an improvement over the first three months of 1996, insurers cannot count on that continuing, and the year ahead could be tough.

"Stuff happens," said Ron Frank, an analyst with Smith Barney Shearson in New York. "Catastrophes occur. . . It's a long

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Inside

• A proposed Labor Department liaison with the business community is a good opportunity for employers, this week's editorial says. **PAGE 8**

• CIGNA Chairman Gerald Isom says other insurers could benefit from similar restructuring efforts. **PAGE 15**

• Israeli insurance executives involved in a price-fixing cartel are rejecting government calls to resign. **PAGE 21**

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HCC executive turning heads in aviation market

By STACY SHAPIRO

TAMPA, Fla.—Ask just about anyone involved in the U.S. aviation insurance market what's new and they will say Stephen L. Way.

Mr. Way, chairman and chief



Mr. Way

executive officer of HCC Insurance Holdings Inc. in Houston, has been behind the purchase of several major players in the U.S. aviation insurance market in the past few months. He's even rumored to be considering the purchase of another major aviation insurer.

In response to that rumor, Mr. Way said he doubts his company will make any more major acquisitions in the aviation field, "but I wouldn't discount it 100%."

He said he believes that HCC in a short time has already achieved its goal: to become one of the four largest aviation insurance underwriters in the United States.

"We can say we are one of the big four because we is (sic) one," said Mr. Way during an interview with *Business Insurance* at the 21st Aviation Insurance Assn. conference in Tampa earlier this month. The other three are Associated Aviation Underwriters, in Short Hills, N.J.; and two New York-based companies, U.S. Aircraft

Insurance Group and AIG Aviation Inc.

HCC, through its two Houston-based surplus lines subsidiaries Houston Casualty Co. and Trafalgar Insurance Co., specializes in general aviation, which includes non-airline commercial aviation and personal aircraft coverage; large property; and blue-water marine risks. These companies wrote about \$225 million in 1996 gross premiums. Mr. Way's company does not write airline, major aircraft manufacturer or space business.

By becoming one of the major players in the general aviation market, "we want to bring some order back to the market. We want to make an underwriting profit," he said. "We won't increase rates (across the board), but there are parts of the business that need rate increases and parts of the business that you shouldn't write, you should decline."

Mr. Way, 48, says his company has made 10 acquisitions

Coverage of annual Aviation Insurance Assn. meeting on page 12

since the formation of HCC in 1973.

His largest to date and the first of a publicly held company is the acquisition of Frederick, Md.-based AVEMCO Corp., an underwriter of general aviation risks.

HCC and AVEMCO are merging in a stock-for-stock transaction of 8.5 million shares valued at about \$220 million, according to Mr. Way (*BI*, April 7). AVEMCO Corp., which will continue to operate as a subsidiary, is the parent of AVEMCO Insurance Co. and U.S. Specialty Insurance Co. Those companies, both admitted insurers, wrote about \$105 million in 1996 gross premiums. See HCC on page 25

Cleanup coverage disputes denied jury trial in New Jersey

By DAVE LENCKUS

TRENTON, N.J.—Policyholders that sue general liability insurers in New Jersey for a defense and for coverage of future pollution cleanup costs no longer can obtain jury trials.

As a result of a state Supreme Court's May 12 decision, policyholders facing environmental liabilities no longer will be able to play the morality issue with jurors by portraying themselves as the victims of unresponsive insurers, said policyholder attorney William Greany of Covington & Burling in Washington.

And, insurers now may litigate rather than settle more coverage

disputes, he said. That is because bench trials are less expensive than jury trials and can be

New Jersey is 'in a kind of unique position as far as these cases are concerned,' says William Greany.

brought to trial more quickly.

But, the attorney for one of two policyholders involved in the case was unsure which side the decision would help. Many insurers

also prefer jury trials, said the attorney, Vincent R. FitzPatrick of Dewey Ballantine in New York, who represented Ciba-Geigy Corp.

He noted that among the dozens of insurers for the policyholders, most sat on the sidelines, and a handful sided with the policyholders. Only a few insurers, led by CIGNA Corp. subsidiary Insurance Co. of North America, opposed jury trials, he said.

Either way, the 5-2 ruling "puts New Jersey in a kind of unique position as far as these cases are concerned," compared with other states, he and Mr. Greany agreed.

The ruling upholds decisions by See New Jersey on page 10

Legislation would close gaps in '95 securities reform law

By MARK A. HOFMANN

WASHINGTON—A bipartisan group of legislators wants to close what it considers a gaping loophole in securities litigation law.

"This initiative is needed to complete the work we began in the last Congress," said Rep. Anna Eshoo, D-Calif., as she and Rep. Rich White, R-Wash., unveiled the Securities Litigation Uniform Standards Act of 1997. The bill, which already has 20 co-sponsors, would require that class action lawsuits brought against nationally traded securities be heard in federal, rather than state courts.

The bill's sponsors said that the new law was necessary to stop securities plaintiffs' attorneys from "circumventing" the Private Securities Litigation Reform Act of 1995—designed to prevent the filing of frivolous lawsuits—by filing in state courts.

Among other things, the 1995 act: set tougher pleading stan-

dards; set requirements for courts to select a lead plaintiff in a suit, which usually should ensure that the plaintiff with the most at stake leads the suit rather than the one who filed first; and introduced a concept of a "safe har-

A loophole in the 1995 law merely channeled frivolous lawsuits to state courts, says Rep. Anna Eshoo.

bor" to shield companies from liability for forward-looking statements not known to be false when they were made (*BI*, Nov. 25, 1996).

"Two years ago, we created a legal environment that would encourage companies to provide consumers with forward-looking

statements that could be used to make informed stock purchases. But instead of curbing frivolous lawsuits based on such statements, a loophole in the law merely channeled them to state courts," said Rep. Eshoo.

President Clinton vetoed the 1995 act and was repaid with the only veto override of his administration to date. California voters later decisively rejected Proposition 211, an initiative that would have made it easier to pursue securities litigation in state courts (*BI*, Nov. 11, 1996). Nevertheless, Rep. White estimated that nationwide about 100 securities-related class-action suits that should have been filed in federal courts have ended up in state courts.

The White-Eshoo act defines covered class actions as those that seek damages on behalf of more than 25 people, in which named parties seek to recover damages on behalf of unnamed parties or in

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High court clarifies marine injury claims

By DAVE LENCKUS

WASHINGTON—A U.S. Supreme Court ruling narrows the field of maritime workers who may seek tort as well as workers compensation damages if the workers are injured aboard navigable vessels.

The Supreme Court on May 12 found that injured workers must have been performing seaman's duties when injured to recover the additional damages. The court also ruled that a worker must have had a "substantial connection" with the owner of the vessel on which he or she was injured.

"The significance of the Supreme Court's decision is it takes away the broad expansive review of employees' employment history and makes courts focus on their current job status," said attorney Eric Danoff, a partner with Graham & James L.L.P. of San Francisco, who represented the

injured worker's employer in the case.

Attorneys agree the ruling could help owners of floating casinos avoid costly negligence lawsuits by dealers, waitresses and other workers who are injured while working aboard docked vessels.

The decision also may prompt some owners of riverboat casinos that cruise during gaming sessions to lease their workers, fostering an already growing trend to lease maritime workers, said attorney Josh Kantrow, head of the maritime practice at Blatt, Hammesfahr & Eaton in Chicago. "This is a very good decision for employers," said Mr. Kantrow, who was not involved in the case.

The high court's 6-3 decision, written by Justice Anthony M. Kennedy, overturned a federal appellate court ruling and clarified the Supreme Court's own 1995 decision on this issue.

See Maritime on page 10

Benefit provisions likely in 1997 budget bill

By JERRY GEISEL

WASHINGTON—Employee benefit plans are not likely to escape unscathed when the 1997 budget reconciliation bill is unveiled next month.

Possible benefit-related provisions in the bill could range from mandating coverage of certain treatments to reinstating a version of the controversial Medicare data bank. The scope of the Medicare-related provisions in a budget reconciliation bill are expected to be huge as legislators try to achieve the roughly \$115 billion in Medicare savings over the five-year period the budget resolution projects.

The House last week passed a resolution to balance the federal budget by 2002, and the Senate was nearing passage of its measure. The resolution lacks the weight of law, but its passage means legislators now will move into the next stage of the budget

process, crafting a reconciliation bill that will contain specific proposals to meet the objectives set in the budget resolution.

For more than a decade, budget reconciliation bills have become a magnet for proposals that have had a significant impact on benefit plans, including COBRA's health care continuation provisions back in 1986 as well as a 1993 law that cut back on the amount of employee compensation employers could consider when calculating employees' pension benefits.

Benefit related provisions that could be in the measure—or tucked in later as the measure works its way through congressional committees include:

- Federal benefit mandates that would require employer-provided health care plans to offer certain types of benefits. High on the list of potential mandates are proposals requiring group health care plans to

offer hospital coverage after a woman undergoes a mastectomy and perhaps other types of treatment for cancer.

"The list of potential mandates grows as a markup nears," said Paul Dennett, vp for health care policy at the Assn. of Private Pension & Welfare Plans in Washington.

- So-called anti-managed care proposals including one that would require health care plans to cover the cost of treatments in emergency rooms.

- Shifting part of the cost of the Medicare program from government to employers. Lobbyists, for example, expect proposals that would give the federal government a virtually unlimited time to file suit against employers and others to recover the cost of medical claims group health care plans—not Medicare—should have paid.

Such a proposal, which the Clinton administration earlier See Budget on page 13

Regulation stifling insurers: Buyer

By SALLY ROBERTS

PHOENIX—Unless the insurance regulatory system keeps pace with evolving insurance and financial markets, traditional insurance will lose relevance for many commercial buyers, a risk manager warns.

"Those buyers will either find new markets or develop their own," said Richard C. Heydinger, director of risk management services for Hallmark Cards Inc. in Kansas City, Mo.

Mr. Heydinger recalled a recent meeting with Hallmark's treasurer regarding a task force set up to explore integrating management of the company's financial risks with its property/casualty risks. He said the company's financial suppliers and its property/casualty insurers each were looking at ways to integrate the two

forms of risk within their products.

Mr. Heydinger said that later the same week, "I was visiting a potential new leading-edge supplier that just happens to be offshore who showed me models of integrated currency exchange risks, interest rate risks and commodity price movement risks in the same financial and risk transfer scheme with the P/C risks.

"Unless the traditional insurance suppliers move quickly with these emerging market trends and adapt their products, operations and technology to meet the buyers' needs in a streamlined, cost-effective way, the traditional market will be itself replaced by others. And unless the regulation changes to permit this transition in a timely fashion, the replacement firm is likely to be offshore."

Mr. Heydinger sparked a panel debate over commercial deregulation during a session at the 63rd annual National Assn. of Insurance Brokers meeting in Phoenix last week.

Glenn Pomeroy, North Dakota's commissioner of insurance, agreed that regulation must evolve to keep pace with insurance industry changes.

Mr. Pomeroy, who is slated to be the next president of the National Assn. of Insurance Commissioners, described the NAIC's new white paper on commercial insurance deregulation as "a good analysis of the need to provide more flexibility to the commercial insurance marketplace" (see story, page 1).

While Mr. Pomeroy predicted there will be some deregulation of commercial insurance, Gary Richardson,

Republican majority whip in the Arizona Senate and vp of the National Conference of Insurance Legislators, said he is still undecided on the commercial insurance deregulation issue.

"There are very strong reasons and arguments for commercial deregulation," Sen. Richardson said. "However, there also are very strong and compelling arguments that at least one feature in most of the existing proposals needs to be either dropped or modified substantially."

That feature, contained in many of the deregulation proposals, would take commercial insurers out of guaranty funds, he said. "That very attempt undermines the principle behind the insurance process."

While commercial insurance contracts are transacted between sophisticated buyers and insurers, the idea of ending guaranty fund protection "fails to embrace third-party liability cases where the victim of a negligent act is neither the insurer nor insured, but a seriously injured party," Sen. Richardson said.

There have been cases where "so-called sophisticated insurers and so-called sophisticated insureds have gone sophisticatedly bankrupt, leaving uncompensated victims of highway accidents, industrial pollution and product liability," he said.

Sen. Richardson went on to say that he believes not many state legislators will support proposals that exempt commercial insurance from guaranty funds. He did say, however, that there are sound reasons that do support the need for deregulation.

For example, "we've learned that the existing hodgepodge of state laws, state regulation and state rules and procedures have driven 40% of the commercial insurance business out of the country to the so-called alternative market," he said. And it can take longer than seven years for an insurer to become licensed in every state, he said.

Dennis H. Chookaszian, chairman and chief executive officer of CNA Insurance Cos. in Chicago, shared his own views on why commercial insurance deregulation is needed.

naib NATIONAL ASSOCIATION OF INSURANCE BROKERS



Richard C. Heydinger speaks at the NAIB conference.

"We at CNA spend \$375 million a year on regulation," he said. "Of that, about \$180 million is spent on the payment of premium-based taxes of some form or another. We file 48,000 premium-based tax returns and have 350 full-time-equivalent people doing regulatory activity. That's the effect of regulation."

Ms. Pomeroy countered that he thinks the effect of regulation, at the state level, is in consumer protection.

"I concede there are costs," he said. "I'm willing to concede that we as insurance regulators need to work very hard to identify what the unnecessary costs are and I think there are some, clearly."

Sen. Richardson summed up by recommending that all parties involved in commercial deregulation go slow.

"Go slow, do it right and make sure we have no unintended consequences," he said.

"With my career in the legislature, 10% to 15% of the bills passed every year are solving problems that we created with the well-intended legislation passed the year before. If we're going to err, err on the side of going slow, making sure we've dotted every 'i' and crossed every 't' before we move on any further."

Mr. Heydinger, however, cautioned the NCOIL vp that he does not have unlimited time in which to drive his company's cost of risk down.

"Things are moving much quicker in the industry than regulation has in the past," he said. **B**

7th World Captive and Alternative Risk Financing Forum



Completing the Concept

This year's program includes general sessions, roundtable discussions and concurrent workshops on the following:

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- The Tax and Regulatory Issues
- Latin American Captive Developments
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- Rent-a-captives: A Time to Lease; A Time to Buy
- Group Health Care Captives
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Expanding reinsurers walking a fine line

By SALLY ROBERTS

PHOENIX—As the reinsurance industry expands into the alternative risk transfer arena, one issue on many reinsurers' minds is whether they are now competing with their ceding company customers.

"This is a challenging issue for all of us," said Kenneth J. LeStrange, president of Am-Re Managers Inc., an alternative risk transfer unit of American Re-Insurance Co. in Princeton, N.J.



"We've tried to walk a fine line not to compete too directly with our customers, yet keep our own viability and success in play," he said.

"The fact is, it's a question that is front and center for all of us," said Heidi E. Hutter, chairman, president and chief executive officer of Swiss Reinsurance America Corp. in New York.

"There is room for us to be operating together," she said. However, "it is not an easy situation."

In today's market, Swiss Re must look for new ways to work in the market, which includes developing and marketing alternative risk transfer products. However, "we have to balance that with the interest of our ceding companies who themselves are in these markets and sometimes see us as a competitor."

Ms. Hutter and Mr. LeStrange participated in a panel discussion on reinsurers and their interest in the alternative market during a session at the National Assn. of Insurance Brokers' annual convention held in Phoenix last week.

Mr. LeStrange said American Re has addressed the situation by creating a separate subsidiary that deals exclusively with the alternative risk transfer distribution system and clients and does not engage in reinsurance with insurers.

"We have a confidential Chinese wall that keeps information coming into us and it never transcends the wall. We've also tried to work with our insurance clients to develop alternative market techniques, particularly in the cases of regional and mutual companies," Mr. LeStrange explained.

But, "most of our customers have reconciled the fact that one day, See NAIB on page 6



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ZURICH

NAIB

Continued from page 4

Am-Re may be a competitor, but more often a collaborator" in helping to service their clients, he said.

At Swiss Re, Ms. Hutter said the reinsurer is willing to provide a lot of capacity and has no exclusive distribution channel for its products, including its alternative risk products.

"Anything we've done, we'll at least make it available and share it with all of our ceding companies, which they in turn can use for their clients," she said.

Harry L. Richter Jr., chairman and CEO of Genesis Underwriting Management Co., a unit of General Re Corp., said the alternative risk unit targets program business and is not a

player in the Fortune 1000 marketplace because Genesis does not want to be in conflict with its parent's clients.

"There is no way that at some point in time you're not going to be in competition with your client or a client of your parent company," said Mr. Richter, directing his comments to reinsurers providing alternative risk transfer products to the large account market.

"We try to avoid head-to-head competition," Mr. Richter. "Our business profile is business that requires a great deal of underwriting apparatus."

The panelists agreed that alternative risk transfer growth lies in the middle market. They also agree, however, that with the current soft commercial pricing environment, growth is slow.

Daniel G. Marren, chairman, president and CEO of CORE Insurance Holdings Inc. in New York, said that despite the soft market, his company is growing. CORE targets the middle market, he said.

"Those that just look at price will stay where they are" in the standard market, Mr. Marren said.

The way to migrate an existing client into the alternative market is through the structure of the alternative program.

"We try to compete on product, not on price," Mr. Marren said. Alternative risk mechanisms also give a policyholder greater control over its long-term cost of risk financing, which is a selling point.

In answering a question on whether investment banks will be competitors or supporters of the rein-

surers in the alternative market arena, David E. Wasserman, chairman, president and CEO of Centre Reinsurance Co. of New York, said reinsurers should look to investment banks as an intermediary.

While he acknowledges investment banks eventually may compete with reinsurers, he said, "They are a source of business."

"They are the ones talking to the CFOs every day. They have a focus on

shareholder value, capital and share price. But until now, they haven't been thinking about how insurance companies can help their customers create shareholder value," Mr. Wasserman said.

"They are going to provide, ultimately, another source for capital," he predicted.

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

Netscape gives employees online access to benefit info

MOUNTAIN VIEW, Calif.—The employees of a computer software developer will use the company's own Internet technology in a pilot project to handle benefit information requests online.

Netscape Communications Corp. has joined with Sun Microsystems Inc., and Prudential HealthCare, the managed care division of Roseland, N.J.-based Prudential Insurance Co. of America, to create a new product designed to provide access to benefit data at work or from home. Netscape's 2,000 employees are testing the system. Both Netscape and Sun are based in Mountain View, Calif.

The system uses the World Wide Web to permit employee access to benefit records and informational material using an identification card and computer password. Information obtainable via the so-called "extranet" Web site includes lists of providers and their backgrounds; the status of pending claims and history of claims; online claim forms; request forms for insurance ID cards; and benefit summaries. Members also are able to change primary care physicians using their computer, transmit questions directly to Prudential and use mapping technology designed by Lucent Technologies Inc. to obtain detailed directions to a doctor's office from their home or another starting point.

The system will save Netscape's workers time and relieve the benefits staff of the need to answer so many telephone inquiries, said Steve Fridakis, Netscape product manager.

"From the employee's perspective, you don't have to call (the benefits office), you don't have to stay on the line and you can store the information," he said.

Benefit managers can also use the system to send personal messages to employees for receipt as they access the system.

Netscape workers who use the Web site can enter personal information for such programs as 401(k) retirement plans and vision plans without having to re-enter the data, said Myles Trachtenberg, vp and chief information officer of Prudential HealthCare.

"What's important from the employee's perspective is they don't face having to enroll five or six times for each provider," he said. "It's really looking at this from the eyes of the customer."

The pilot is using Netscape software and Sun is providing hardware and expertise in designing system architecture.

The pilot at Netscape rolled out May 7, and Prudential is exploring how it can market the technology to other Prudential plan sponsors, Mr. Trachtenberg said. No pricing has yet been developed, he said.

—By Robert Kazel

Long-term care rise

After a brief slowdown, employer sponsorship of long-term care insurance programs is rising again.

In 1995, 232 employer-sponsored

LTC programs were introduced, bringing the total number of group LTC programs in force to 1,260, according to a new survey of LTC insurers by the Health Insurance Assn. of America, an industry group.

That is a significant increase from 1994, when just 60 new group LTC plans were launched. The 1995 increase trails the big jumps in group

Benefit Beat

LTC plans that were racked up in the early 1990s, though.

For example, in 1992, 298 group LTC plans were set up, while in 1993 a record 402 group plans were introduced.

The death of the Clinton administration's sweeping health care reform legislation in 1994 may explain why more employers are again establishing LTC plans, said Susan Coronel, the HIAA's long-term care director and a co-author of the survey.

Back in 1993 and 1994, employers were fearful that Congress, as part of health care reform legislation, would eliminate the role of private insurers and employers in the group LTC market. With the death of the Clinton plan in 1994, that fear and uncertainty was lifted, Ms. Coronel said.

Steady growth in the group long-term care market is likely to continue, Ms. Coronel pointed out, with the passage last year of legislation that gives tax-favored status to LTC policies. Under that law, employers can pay employees, up to certain limits, LTC premiums without employees being taxed on the premiums (*BI*, Aug. 5, 1996).

While the number of employer-sponsored LTC plans is growing, the individual LTC market dwarfs the group market. For example, of the 4.3 million LTC policies that had been sold through 1995, more than 80% of the policies had been issued through the individual market.

According to an HIAA survey of top LTC sellers:

- The average annual premium for a 50-year-old buying a base plan providing a daily benefit of \$80-a-day for nursing home care and \$40-a-day for home health care was \$310. A 65-year-old, though, would pay an annual premium of \$817 for the same policy.

- For the same policy—except that the benefit limits automatically increase 5% a year, the annual premium for a 50-year-old would be \$651 and \$1,481 for a 65-year-old.

- For policies with a base \$100-a-day nursing home benefit and a \$50-a-day home health care benefit, the annual premium for a 50-year-old would be \$378, while the premium for a 65-year-old would be \$1,010.

Adding a feature that increases the \$100 nursing home and \$50 home health care benefit by 5% a year would boost the annual premium to \$798 for the 50-year-old and \$1,381 for the 65-year-old, according to the survey of top sellers.

Free single copies of "Long-Term Care Insurance in 1995," are available by contacting the Fulfillment Office, HIAA, 555 13th St. N.W., Suite 600 East, Washington, D.C. 20004-1109.

—By Jerry Geisel

NAIB meeting draws 200 to Phoenix

PHOENIX—Nearly 200 insurance professionals attended the National Assn. of Insurance Brokers' annual conference held in Phoenix May 18-21.

While the 100-degree weather halted the annual tennis tournament, it did not stop attendees from playing golf on The Phoenixian's championship golf courses.

Between rounds, conference-goers attended sessions on commercial insurance deregulation, the



impact of change on the way people lead and communicate, reinsurers' interest in the alternative market and ethics in an intensely competitive time.

W. Rob White-Cooper, chief executive officer of Sedgwick Group

P.L.C., gave the broker keynote address. Graham S. Anderson, a director of Acordia/Pettit-Morrey Co. and outgoing NAIB chairman, passed the leadership torch to Jane Hill Fleming, senior vp of Sedgwick Inc. Ms. Hill Fleming is the first woman to chair the NAIB.

Next year's conference will be May 31-June 2, 1998, in Colorado Springs, Colo. For information, call the NAIB at 202-628-6700.



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Opinions

Don't duck an opportunity

BUSINESSES HAVE A RARE opportunity to gain an ear in the Labor Department.

We see the proposal for a Labor Department liaison with the business community as a chance for employers to educate the government about business issues and needs, including the controversial federal ergonomics standard that so many employers oppose. Labor Secretary Alexis Herman has extended an olive branch to employers, but now they need to respond in the same spirit of cooperation if progress is to be made.

As we report this week, Ms. Herman last week announced her plan for a special liaison to employers, "to have someone available to relate to the business community" on various issues, including the proposed ergonomics standard. While details of the position have yet to be defined, we are encouraged by this overture to the business community.

This proposal comes after the Occupational Safety and Health Administration in January held a summit in Chicago to engage employers, labor unions, researchers and consultants in a dialogue about ergonomics issues. We were impressed then with OSHA's effort to solicit the input of employers and others on this important issue. Clearly, it learned from its initial mistake in promulgating a proposed standard in a vacuum.

Ms. Herman's proposed liaison seems to be evidence that the department is still willing to listen to employers.

This is a chance for employers not only to provide input on ergonomics and other safety issues, but also to seek more reasonable regulation of other areas within the Labor Department's purview, including regulation of pension and welfare benefits.

Indeed, one of the problems that not just the Labor Department but many federal agencies have in developing rules is the lack of everyday practical experience with business issues.



Back in the late 1980s, for example, the Labor Department embarrassed itself when it proposed requiring employers with 401(k) plans with loan programs to extend those programs to former employees. The proposal ignored the very practical issue of how employers would get former employees—who no longer drew a paycheck from the company—to pay back the loans. Amid much employer protest, the Labor Department withdrew the proposal and admitted it goofed.

A liaison to the business community, who would be charged with discussing issues and gaining input before formal rules are proposed, could greatly improve the regulatory process and reduce the likelihood of rules drafted out of ignorance.

We hope employer groups reach out to the hand the Labor Department is offering them. They have nothing to lose and much to gain.

Letters

Exclusive remedy protects individuals, too

To the editor: A number of years ago, the state of New Hampshire allowed employees to sue their fellow workers if they felt that the fellow employee—usually the company owner or immediate supervisor—either intentionally did something to cause their injury or neglected to do something, causing an injury.

During the first year of this travesty of justice, there were more than 100 suits, many of these wrecking perfectly innocent people's lives by forcing them to hire their own counsel and defend themselves in, all too often, frivolous lawsuits. Added to the financial outlay was the angst of supervisors who thought they had "done the right thing" but found out they were getting sued for it.

The rest of the country has much to learn from this experience.

Fortunately, when the state realized what was happening, this was reversed and the exclusive remedy doctrine restored.

There is ample recourse for employees who feel that their employer intentionally put them in harm's way. In Massachusetts, an employee can bring a Section 28 matter, an action that implies the employer intentionally placed the employee at risk. The insurer may elect not to defend the employer. However, these actions, and the threat of these actions, have sent ripples throughout the employer community, leading to self-policing of workplace safety.

To undermine the exclusive remedy

doctrine not only undermines the reforms passed over the past several years but also will cause every person thinking about accepting that management position to think twice and ask themselves: "Do I want to put myself in the position of getting sued?"

If the exclusive remedy doctrine is seriously eroded, there will be an explosion of litigation affecting ordinary people, not big business.

There has to be another way for an injured employee to express his or her anger at a co-worker, supervisor or company owner.

Robert K. Tuman
President
Compensation Claims Review Corp.
Andover, Mass.

NCQA to certify, not accredit, physician groups

To the editor: The May 12 article, "NCQA Expands Accreditation," about the National Committee for Quality Assurance's new Physician Organization Certification pro-

gram, incorrectly indicates that we will begin to accredit physician organizations directly.

There is a subtle but important distinction between accreditation and the certification program for physician organizations we just announced.

Accreditation surveys involve an overall assessment of an organization's quality, including how well its various systems work together.

By contrast, certification surveys are less comprehensive and involve an analysis of selected systems only, such as utilization management, credentialing, quality improvement, members' rights and responsibilities,

preventive health care and medical records.

NCQA's Physician Organization Certification program is designed to streamline our managed care organization accreditation process by reducing redundant oversight of physician groups. Indeed, certification is not meant as an overall assessment of the quality of a physician organization, and we want to make certain it is not interpreted in that way by employers, consumers or managed care plans.

David F. Arnold
Director of Product Development
National Committee
for Quality Assurance
Washington

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Maritime

Continued from page 3

In the case, John Papai suffered a permanently disabling knee injury during a one-day maintenance project in March 1989 aboard a tugboat docked in Alameda, Calif. The project, painting the tug's housing structure, would not have required Mr. Papai to sail with the tug.

The tug was owned by Harbor Tug & Barge Co., a subsidiary of Crowley Marine Services Inc. of

Oakland, Calif. Harbor Tug hired Mr. Papai through the Inland Boatman's Union's hiring hall.

Through the hall, Mr. Papai over the previous couple of years had obtained mostly deckhand jobs on various vessels operated by unrelated owners. He had performed a dozen jobs for Harbor Tug over the previous few months just before he injured his knee.

After his injury, Mr. Papai collected the workers compensation benefits—two-thirds of wages—provided under the Longshore Harbor Workers' Compensation

Act. That federal act covers land-based maritime employees.

But, he also sued to obtain seaman's status under the Jones Act. That act allows seamen to sue their employers for damages due to ordinary negligence and the unseaworthiness of vessels. Successful litigants can recover 100% of their lost wages as well as damages for pain and suffering.

In its 1995 decision in *Chandris Inc. vs. Latsis*, the Supreme Court outlined a two-pronged standard that injured employees must meet to earn seaman's status. At the time of their injuries, the court said, employees must have:

- Been performing duties that contribute to the function of the vessel or to the accomplishment of the vessel's mission.

- A substantial connection to a vessel in navigation or to an identifiable group of vessels under common ownership or control.

Harbor Tug argued that Mr. Papai did not have a substantial connection to its vessel, because he performed work for other vessel owners.

Harbor Tug prevailed in federal district court, but the 9th U.S. Circuit Court of Appeals reversed that decision in December 1995.

The appellate court ruled 2-1 that the "substantial connection" requirement the Supreme Court established does not mean a permanent connection.

The 9th Circuit said Mr. Papai's employment history with Harbor Tug "may in itself" establish the connection to a vessel or group of vessels that Mr. Papai needs to earn seaman's status.

The appellate court did not refer to the common ownership pro-

vision the Supreme Court spelled out in *Chandris*, the high court noted in its latest decision overturning the 9th Circuit's ruling.

"The only connection a reasonable jury could identify among the vessels Papai worked aboard is that each hired some of its employees from the same union hall where it hired him. That is not sufficient to establish seaman status under the group of vessels concept," Justice Kennedy wrote.

The appellate court also had ruled that "if the type of work a maritime worker customarily performs would entitle him to seaman status if performed for a sin-

same employer.

If the employee's duties when injured did not include the "regular exposure to the perils of the sea" that seamen face, the injured worker is not entitled to seaman's status, the Supreme Court ruled.

Under the 9th Circuit's decision, an injured worker who had not been out to sea for years could have collected LHWCA benefits and then argued he was entitled to seaman's status under the Jones Act, said Mr. Danoff, Harbor Tug's attorney. "This decision will make it harder to do."

Some workers still may fall into a "gray area" that would allow

them to take that course. An example would be land-based workers who perform a couple of hours of work on a vessel that has left the dock, Mr. Danoff said.

Employees of floating casinos still could be con-

sidered seamen because they contribute to the vessel's mission, attorneys said.

But, many of those casinos do not leave the dock, so their employees would not be exposed to perils of the sea. Under the Supreme Court's latest decision, employers could argue those workers do not enjoy seaman's status, Mr. Danoff said.

Courts still likely will consider casino employees as seamen if the riverboats on which they work sail during gaming sessions, Mr. Danoff noted.

But, if casino owners employ their workers through independent contractors and the employees work on various vessels that are not owned or operated by the same organization, the employees would not meet the Supreme Court's standard for seaman's status under the Jones Act, Mr. Kantrow said.

Harbor Tug & Barge Co. vs. Papai et ux., U.S. Supreme Court; No. 95-1621.

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If the employee's duties when injured did not include the 'regular exposure to the perils of the sea' that seamen face, the injured worker is not entitled to seaman's status, the court ruled.

gle employer, the worker should not be deprived of that status simply because the industry operates under a daily assignment rather than a permanent employment system."

The appellate court reached its conclusion by misinterpreting a phrase in *Chandris*, the high court said. In that case, the high court said, "We see no reason to limit the seaman status inquiry... exclusively to an examination of the overall course of a worker's service with a particular employer."

The appellate court interpreted that phrase to mean that courts could examine an employee's work history with different employers "during a relevant time period" to determine whether an employee mostly performed a seaman's duties.

But the Supreme Court said in its latest ruling that the phrase means courts should limit their examination to the employee's current duties with his or her employer and not consider the employee's past duties with that



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New Jersey

Continued from page 3

two lower courts in separate disputes that Ciba-Geigy and another policyholder, GEI International Inc., filed against their respective insurers. The New Jersey Supreme Court considered both cases together.

Although the Seventh Amendment to the U.S. Constitution guarantees jury trials in civil cases, state courts are not bound by that guarantee, the New Jersey Supreme Court said. Under a New Jersey statute, the right to a jury trial depends on whether a policyholder's claim for relief is legal or equitable in nature, the court ruled.

There is no right to a jury trial in equitable relief actions, the court noted.

The court determined that a policyholder claim for a defense and pollution coverage for future liabilities is an equitable action for a specific performance.

Legal actions include claims for specified damages, the court ruled.

But, jury trials are not permissible even in those cases if policyholders also seek a defense and coverage for future liabilities, the court ruled.

Likewise, the Supreme Court ruled that a jury sometimes should not hear factual issues that juries typically consider. Jury tri-

als are barred in those cases when such issues, including whether a policyholder intentionally polluted, are "ancillary and incidental to and subsumed within the main cause of action for equitable relief in the coverage trial," according to the court, quoting from an appellate court's decision in the litigation.

The Supreme Court majority said its ruling would help policyholders avoid multiple lawsuits with their insurers.

If policyholders had prevailed, they "would be required to file multiple future breach-of-contract actions each time an insurer refuses to defend or indemnify them," it reasoned.

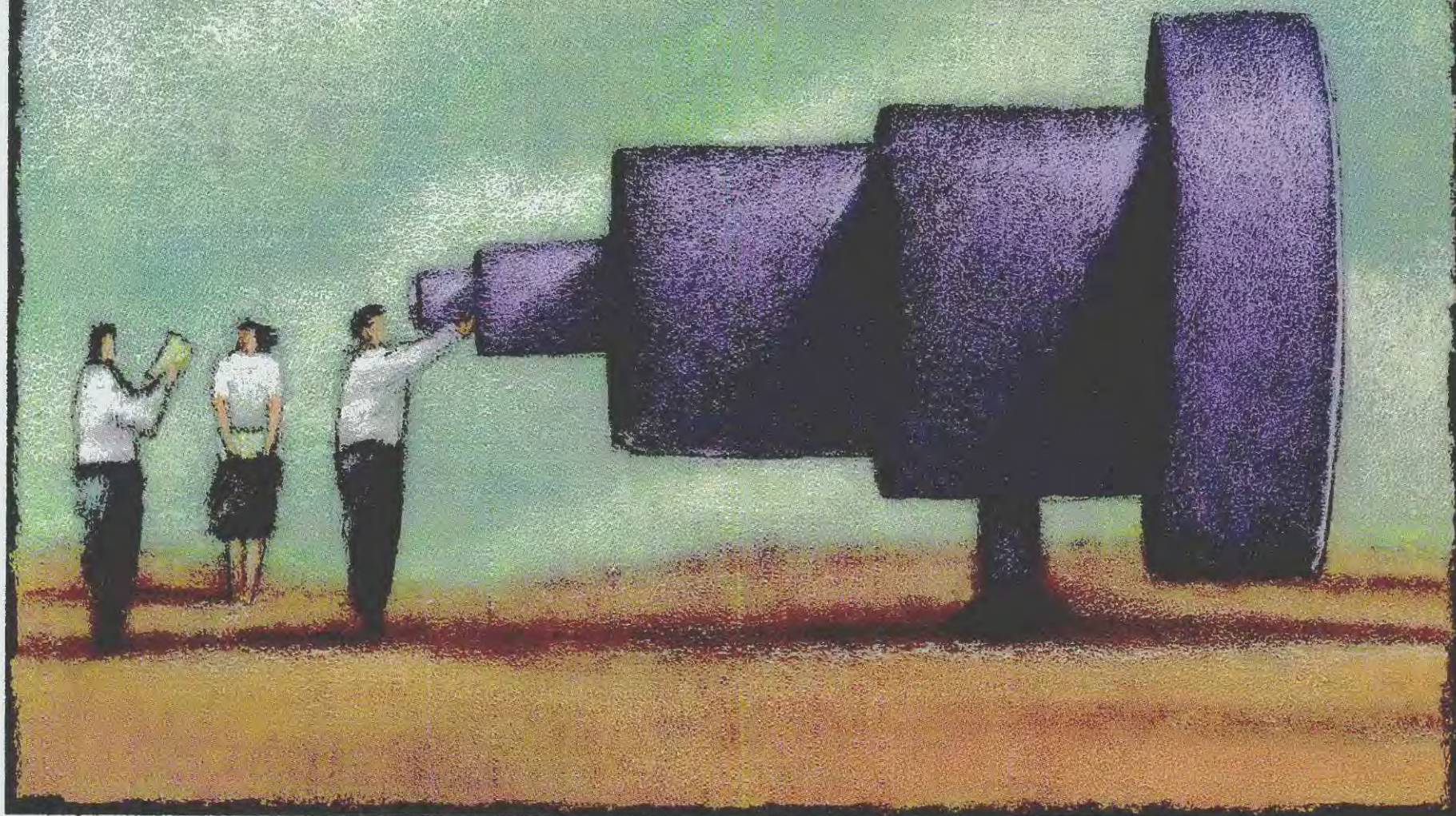
Mr. FitzPatrick said that because insurance companies likely will continue to deny such claims, he "can't understand" the court's reasoning.

Ciba-Geigy is seeking approximately \$525 million of compensatory damages to cover current and future environmental liabilities.

GEI International is seeking at least \$2 million in cleanup costs from several of its insurers and the former owners of a site it purchased in 1983.

Ciba-Geigy Corp. vs. Liberty Mutual Insurance Co. et al., and *GEI International Inc. vs. St. Paul Fire & Marine Insurance Co. et al.*, New Jersey Supreme Court; No. A-28/29/30/31.

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Jun 23	Benefits: Balancing Work & Family ^{RS, SS} <i>Directory: EAPs & Dependent Care Resources & Referral Services</i> <i>Distribution: AAHP, SHRM</i>		Jun 11
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^{RS}: Reader Service, ^{SS}: Starch Study

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Airline risk managers air concerns about disaster response guidelines

By STACY SHAPIRO

TAMPA, Fla.—Risk managers for U.S. airlines anticipate added costs and administrative burdens resulting from changes to domestic and international law governing passenger injuries and fatalities.

A section of the Federal Aviation Reauthorization Act of 1996, passed last September and implemented this year, calls for new procedures by federal aviation authorities and private airlines in dealing with the families of passengers killed in airline accidents.

Airline risk managers are heavily involved in the implementation of the new regulations, which among other things call for disaster response plans to be filed with the National Transportation Safety Board.

In addition, risk managers are affected by an agreement among airlines to remove the Warsaw Convention's passenger liability limitations. Some are concerned as to whether the pact will fulfill its intended purpose to reduce losses and make claims payment easier.

These issues were raised by Rita M. Evans, manager of claims and loss prevention administration for US Airways Inc. in Arlington, Va., during an airline risk manager panel at the 21st Aviation Insurance Assn. conference in Tampa, Fla., earlier this month.

Following a string of disasters in the United States, the National Transportation Safety Board in 1995 met with family groups and airlines to discuss how to treat

families of injured or deceased passengers in a more sensitive way.

The families were aggrieved because they "felt that the airline had just killed their loved ones," yet they had to work with that company after a disaster, Ms. Evans acknowledged.

To ameliorate that situation, the Aviation Disaster Family Assistance Act of 1996 was added as a section to the Federal Aviation Reauthorization Act of 1996.

The Family Assistance Act calls for the NTSB to appoint an employee to be the "point of contact within the federal government" for the families of passengers involved in the accident. The NTSB also is supposed to appoint an independent non-profit organization with experience in disasters and post-trauma communication to coordinate the "emotional care and support of the families of the passengers involved in the accident."

Each U.S. and non-U.S. air carrier licensed by the NTSB also must submit a plan to the federal agency that addresses how the airline will respond to the post-disaster needs of passengers' families. Although the act details the contents of such a plan, the NTSB in March issued additional guidelines on what should be included.

The guidelines address every aspect of the aftermath of the crash, "including how they wanted the room set up" for families to meet with the airlines' personnel, said Ms. Evans.

Much of what is in the act is not surprising, said Ms. Evans. When USAirways has had losses, she said, "I know how we responded. I know we had trained people there.

We had people who tried to work with the families and did whatever we could in terms of their economic concerns. The act asks us to do what has already been done" but takes it one step further by getting the NTSB involved, she said.

The act also mandates that plaintiffs attorneys not approach passengers' families for at least 30 days after the crash.

Currently, plaintiffs attorneys and the television media "show up about the same time I do" shortly after a disaster, said Christa Meyer Hinckley, managing director of insurance and risk management for American Airlines in Dallas.

Victims' families have two years in which to file an action, and it is not their priority or the priority of the airlines to settle compensation claims just after a disaster, according to the panelists.

"There's no way you can settle a claim within 30 days of someone dying," said Ms. Evans.

There are some loose ends to the Family Assistance Act, however, according to Ms. Evans. For example, she questioned who will be responsible for paying the additional costs for what the government has asked airlines to do.

Another issue that is unrelated to the act but which the legislation has raised is who is going to pay for the cleanup costs following a disaster, Ms. Evans said. At the moment, the cleanup is paid for by the government.

Ms. Hinckley also noted that there will be additional administrative duties for airlines flying overseas, because the response plan to be submitted to the NTSB only applies to accidents within the United States. Airlines will

then have to develop two plans, one for U.S. and one for non-U.S. disasters.

The plan submitted to the NTSB "doesn't necessarily work internationally, so the airline is put in the position of developing two plans for an international disaster as well as an American disaster," said Ms. Hinckley.

Airline risk managers also still want clarification about the application of the International Air Transport Assn.'s Inter-carrier Agreement, which waives Warsaw's liability limitation, which for U.S. flights is \$75,000 per passenger.

"If the purpose of these changes to the Warsaw liability limits was to eliminate losses and have a more seamless operation, I don't think we're there yet," said Ms. Evans.

AIA forum maturing with education focus

TAMPA, Fla.—The Aviation Insurance Assn. is coming into its own.

Once considered more of social club, the AIA now attracts all the major aviation underwriters in the world, a few airline risk managers and many brokers and lawyers in the aviation insurance field.

For the first time this year, the AIA's membership also includes two of the largest aviation underwriters in the United States, namely Associated Aviation Underwriters of Short Hills, N.J., and U.S. Aviation Underwriters Inc. of New York, part of the U.S. Aircraft Insurance Group.

The AIA's increased professionalism is in part due to its emphasis on education for its members. Each year at its annual conference one day is devoted to Continuing Insurance Education where agents and brokers can earn up to eight hours credit toward their continuing education requirements in many states.

In addition, the association has established the AIA Educational Institute and this year introduced its own comprehensive program to achieve a new professional designation known as the Certified Aviation Insurance Professional.

The course textbook has been written and the final details of the program will be ready by the autumn, said Bruce D. Chadbourne, professor of aviation business administration at Embry-Riddle Aeronautical University in Daytona Beach, Fla. Mr. Chadbourne and Alexander T. Wells, senior professor of the Aviation Technology Department of Broward Community College in Fort Lauderdale, are the co-authors of "Introduction to Aviation Insurance and Risk Management" and coordinators of the new CAIP course. Total estimated cost to take the course is expected to be between \$550 and \$825.

The new designation may not mean much in the first five to seven years of its life, acknowledged C.H. "Corky" Nason, president of aviation broker Nason Associates in Overland, Kan., who has worked hard to get this project off the ground. "But we're going to give it a try" and its prestige will

For example, the agreement calls for airlines to have strict liability up to 100,000 Special Drawing Rights (\$139,930) and for negligence to be proved above that. Previously, the liability limitation was broken only if willful misconduct could be proved.

However, victims' families now want to know if airlines will pay this 100,000 SDRs immediately before the families sue for additional damages, said Ms. Evans. "It's a good question," she said.

Airlines also wonder whether their liability insurance premiums will go up as a result of the change.

"Domestically, I think we've already paid for adequate liability coverage" because there has long been unlimited liability for internal U.S. flights. But for non-U.S. air carriers the new agreement "could be a real adjustment," said Ms. Evans.

Aviation underwriters are scrutinizing the IATA agreement and whether it will increase the cost of liability claims they cover (BI, May 12).

grow over time, he said.

This year's 21st AIA conference attracted about 500 people from around the world to Tampa. The delegates came mainly to talk about general aviation but also to find capacity for airlines and aviation reinsurance programs.

Among them was Alexander V. Goussarov, general director of CINCo Group in Moscow, who visited the conference seeking hull insurance capacity for some of the 200 airlines that have cropped up in Russia.

In the United States, there are now 176,000 active general aviation aircraft from business jets to

commuters to helicopters to personally owned aircraft, said

Robert E. Breiling, a business aviation consultant in Boca Raton, Fla.

Over the years, corporate aviation has become safer and the number of fatalities have reduced, but hull insurance costs have increased, Mr. Breiling said. For example, in 1988, there were 13 business jet accidents in which 14 people died, while in 1996 there were 11 accidents in which 11 people died. But the insured hull losses for business jets last year totaled \$66 million, more than double the \$27.3 million in losses in 1988.

One of the largest hull insurance losses last year involved the crash of a corporate jet that killed Arthur F. Quern, chairman and chief executive of Aon Risk Services Co. and three crew on board (BI, Nov. 4, 1996). The Gulfstream IV was insured for \$28 million, according to Mr. Breiling. New Gulfstreams are now being built that will be worth between \$36 million and \$40 million, he said.

Next year's AIA conference will be held May 2-5 in Vancouver, British Columbia. For further details and information on the new professional aviation insurance designation, contact the Aviation Insurance Assn., P.O. Box 2966, Redmond, Wash. 98073; phone: 800-354-7918 or 206-869-9522; fax: 206-861-6499.

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Budget

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said it would back, would overturn a 1994 federal appeals court decision that placed tight time limits on when the government could file to recover Medicare overpayments in situations in which a beneficiary, such as an older worker or a provider, had not filed a claim within a health care plan's or an insurer's deadline.

• A resurrection in some form of a federal data bank that would require insurance companies, and possibly employers, to supply certain health care coverage enrollment information to the federal government.

The Medicare data bank proposal has been shrouded in mystery ever since the Clinton administration earlier said it would prepare legislation that would require health insurers and administrators to provide basic information, such as birthdates, on employees and dependents enrolled in their plans.

The purpose of this proposal would be to give the Health Care Financing Administration more health care plan information up front to reduce the likelihood of the agency, which administers Medicare, paying claims for which employer plans are responsible.

The APPWP's Mr. Dennett says, though, that if such a proposal is presented there would be heavy congressional opposition, adding that a somewhat similar health care data bank measure—enacted in 1993—was repealed last year amid strong employer objections.

In addition, while the Senate last week defeated an effort by Sens. Edward Kennedy, D-Mass., and Orrin Hatch, R-Utah, to attach their so-called "KidCare" legislation to the budget resolution measure, benefit experts say congressional interest in the legislation is so high that the proposal could find its way as part of budget reconciliation legislation or another measure with wide support.

In its current form, the KidCare legislation would have only minimal impact on group health care plans. Among other things, the legislation would subsidize lower-income employees' health insurance premium contributions for family coverage.

But some benefit experts worry that if the KidCare bill begins to move through Congress, changes could be made—such as locking in the current level of employer contributions to their health care plans—that would crimp employers' flexibility to alter their programs.

"Prudence dictates watching this bill," said Frank McArdle, a consultant with Hewitt Associates L.L.C. in Washington.

The KidCare legislation suffered a blow—though perhaps only a temporary one—when the Senate defeated an effort to attach it to the budget resolution measure. Sen. Kennedy, a cosponsor, earlier said he will continue to work to get the bill passed, which would substantially increase the federal excise tax on tobacco to raise revenue needed to provide health insurance coverage to 5 million children who are members of lower-income families.

Under one provision in the legislation, states would pay the share of the health insurance premium employers charge for dependent coverage for lower-income employees.

But observers worry that the

measure later could be changed so that employers could be locked in to the level of contributions they pay to prevent them from shifting employee premium costs ultimately to the government.

"The legislation could be refined to prevent any manipulation by employers," said Henry Saveth, a principal with A. Foster Higgins & Co. Inc. in New York.

If legislators add new benefit mandates to the budget reconciliation bill, it would come on the heels of last year's congressional benefit mandate action. At the tail end of the last session, legislators tacked on amendments to an appropriations bill that, effective next year, will require group health care plans to offer limited mental health care benefits parity as well as at least 48 hours of inpatient coverage after a normal delivery and 96 hours of coverage after a Caesarean section. **BI**

Xerox

Continued from page 2

The main benefit of the purchase is that it adds greater geographical diversification to Fremont, said James E. Little, president and chief executive officer of Fremont Compensation Insurance Group, the holding company for Fremont General's workers comp insurers.

"It furthers our strategy of national expansion," he said.

Fremont traditionally focused on writing workers comp insurance in California. But it began to diversify in February 1995, with the purchase of Chicago-based Casualty Insurance Co., which writes business throughout the Midwest.

The purchase of Industrial Indemnity will bring to Fremont new workers comp business from most Western states, including Alaska, as well as additional business in

California, Mr. Little said.

The California offices of Fremont and Industrial Indemnity will likely be merged, he said.

The geographic diversification drive will continue through new Fremont offices recently opened in

The purchase will bring Fremont new workers comp business from most Western states, says James E. Little.

New York, Massachusetts and New Jersey. New offices are expected to be opened in the Southeast later this year, Mr. Little said.

In addition to widening Fremont's geographic scope, Industrial Indemnity has substantial re-

serves, he said.

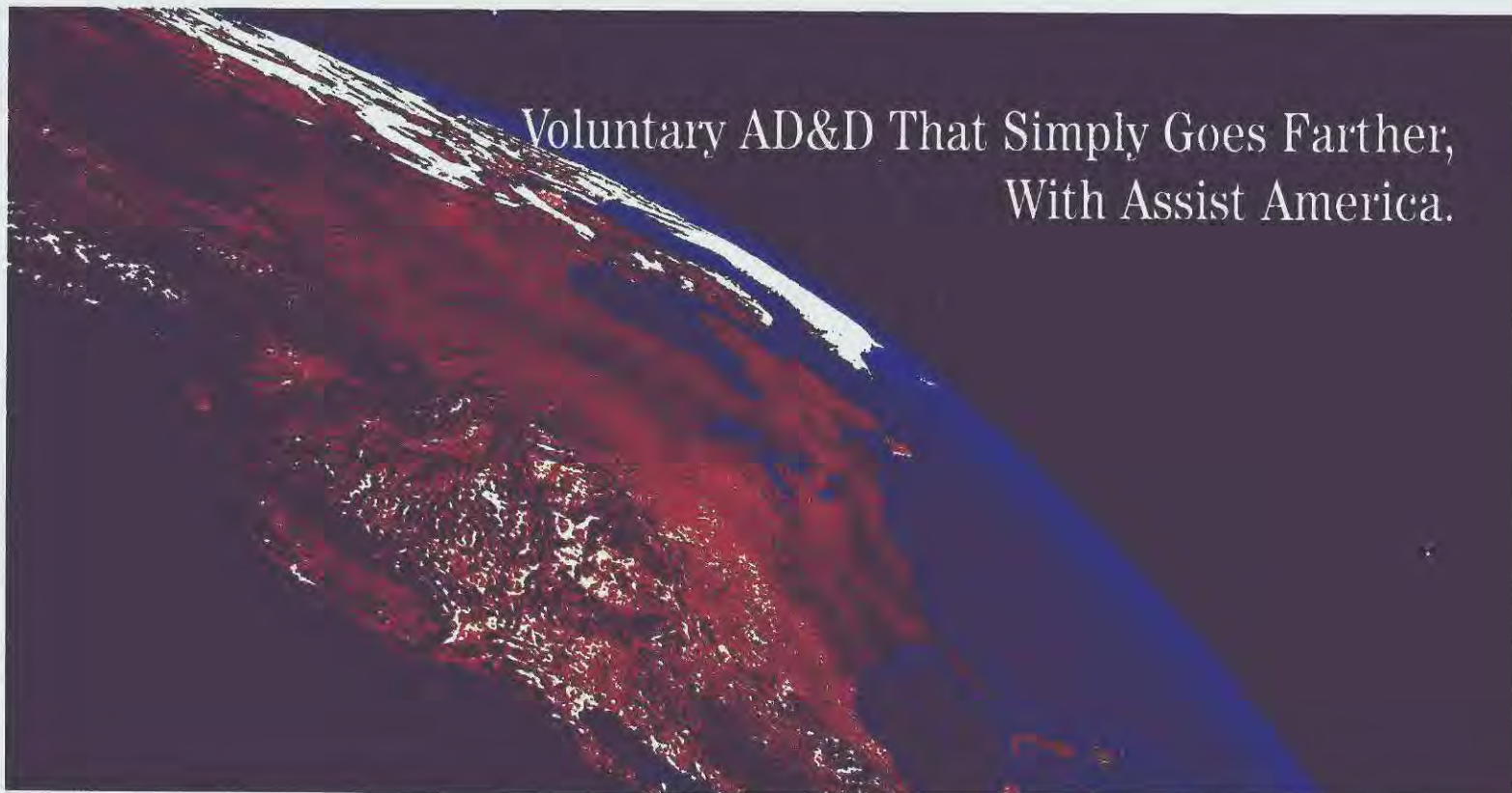
"Unlike many comp companies, it has \$1.2 billion in cash that comes in the form of loss reserves, and as comp is driven by investment earnings that is very attractive," Mr. Little said.

The purchase will also boost Fremont's revenues. In 1996, Industrial Indemnity had gross revenues of about \$325 million while Fremont's were \$795 million.

Fremont's earned premiums last year totaled \$487 million, more than 90% of which were attributable to workers comp.

Rating agencies and analysts welcomed the purchase.

"The key factor for us is that Fremont has improved its spread of risk and (Industrial Indemnity) fits into its game plan," which is to be a national workers compensation insurer, according to Matthew Coyle, associate director at *See Xerox on next page*



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Managing comp care a challenge

By Dr. Jennifer Christian

Nearly half of our nation's population is in a managed care plan, and within five years, treatment for most workers compensation injuries will be provided under managed care as well.

As competition in managed care workers compensation expands beyond price to quality, accreditation standards will become a necessity. Yet those who hope for a single "Good Housekeeping Seal of Approval" like the National Committee for Quality Assurance offers to HMOs are likely to be disappointed.

Establishing consistent quality standards will help safeguard employers and employees, but devising consistent measures for an evolving and consolidating system will be a challenge.

Managing the human situation is the fundamental work of the workers comp system. And those who are committed to quality and helping people deal with their injuries are responsible to make sure they are protected.

With regard to safety, employees must be protected from bad or dangerous doctors; overtreatment and undertreatment; careless disregard of risk of reinjury; avoidable discomfort or pain; unnecessary disability and career dislocation; and unnecessary financial loss.

Employee dignity issues also must be addressed. They include inconvenience or other difficulties with access to medical care; biased, arbitrary or capricious decision-making; unreasonable interference by payers and employers; rudeness; and poor service.

The American legal system reflects our cultural belief that individuals without free choice transfer the responsibility for making good choices onto those who constrain them. In the eyes of the law, employers, insurers and managed care companies have some responsibility for the quality of care arrangements they make—especially when they make explicit or implied promises.

Unfortunately, employers and insurance companies have not been the most sophisticated health care purchasers. They typically have focused on inadequate discount products. This short-term economic interest often increases overall claims costs and litigation rates.

Stories of group health plans—HMOs particularly—skimping on patient care, unscrupulous claim denial practices and substandard physician networks have made employers more sophisticated about what to look for in an HMO. State regulators also are moving to protect the public by scrutinizing HMO practices.

As a result, HMOs have begun to compete fiercely on quality, boasting their NCQA accreditation and Health Plan Employer Data & Information Set outcomes results. Employers are likely to use their newly developed quality sophistication in their managed care workers compensation decision-making.

Managed workers comp care

Less than 10 years ago, workers compensation was the last bastion of unmanaged health care, and property/casualty insurers responded by implementing primitive cost control programs focused on provider discounts and high-cost claims management programs.

Customers continue to press insurers, third-party administrators, cost containment and case management companies and industrial medicine clinics to provide managed care.

Most of the current managed care products are simply more aggressive versions of earlier offerings: attempts to channel patients into preselected discounted provider networks, earlier and more frequent case management and intrusive cost control techniques. Customers have grown somewhat cynical about claimed savings from some of these techniques, particularly with discounts on medical charges.

So today managed care workers compensation has become a catch-all term for many different kinds of services and means. Achieving somewhat different ends, a brief discussion of these follows:

• Insurer micromanagement.

Micromanagement techniques are the hallmark of the traditional insurer's managed care approach, focusing on cases one at a time. Micromanagement means someone other than the treating doctor tracks, constrains or redirects care to speed prompt recovery and return to work. This kind of micromanaged care has evolved to a high art in workers comp because most physicians neither are trained nor interested in managing disability.

Many insurers' managed care programs should be more realistically named "managed cost." Careful inspection reveals that they mostly change the way care is paid for, rather than what care is actually delivered.

For example, a recent study compared data on medical care given to thousands of patients in the Midwest with identical injuries, some from a group health data bank and others in two workers comp data banks.

Those covered by workers comp received three times as many health care services over a longer period as those covered by group health insurance. A sprained wrist is a sprained wrist, whether caused by falling off a skateboard or a scaffold.

As it turns out, one of the workers comp groups did have "managed care." Bill reprocessors and utilization reviewers refused to pay the bills.

A company cannot manage care if it only manages cost by retroactively refusing to pay for services. Instead, it must improve quality, outcomes and value. Changing

A company cannot manage care if it only manages cost by retroactively refusing to pay for services.

what happens to injured employees is what heals them faster and gets them back to productive work sooner. It also reduces cost the most.

• The HMO model.

The traditional workers comp industry is threatened by the rapid development of workers compensation HMO programs. Because HMOs have produced 15% savings in group health, some employers believe they can do the same for workers comp. A recent Milliman & Robertson survey confirmed this; nearly all HMOs have workers comp offerings in development or in operation.

In contrast with the micromanagement practices of traditional insurers, HMO success in cutting group health costs stems from macromanagement techniques. Mainly, these are financial arrangements such as physician capitation, performance-based incentive payments and bulk-purchase arrangements.

Macromanagement focuses on the front end by setting up incentives to improve initial physician decision-making and decrease the monitoring and rework required on a case-by-case basis. But, quality and customer satisfaction need to be monitored for the possibility of skimping.

• The HMO disadvantage.

While HMOs do some micromanagement, half of their dollars are spent on hospitalizations and very sick patients. Their case management expertise is in cancer treatment, sick newborns, heart surgery and other high-dollar cases.

Because group health medical costs dwarf workers comp medical costs—only 2% to 3% of national health care expenditures are for workers comp—HMOs tend to view workers comp as a sideline and feeder for their group health business.

HMOs may avoid the investment of time and money required to develop competence in workers comp, preferring to invest in their core business. Lacking familiarity with disability management and return-to-work programs, HMOs could increase case costs. Half of workers comp dollars still are spent on wage replacement.

• Provider-centered models.

Networks once offered little more than provider address lists. Now more sophisticated national, regional and local networks have entered the managed care arena.

Physician/hospital organizations and similar local networks of providers that originally banded together to bid for contracts are getting into the business. Many of these organizations were born out of the health care industry's determination to outwit managed care companies, but legislation that sets up managed care organizations for workers compensation also has created opportunities.

This group of organizations is relatively new and thinly capitalized. The inexperience and internal dynamics of some provider-based organizations may make it difficult for them to deliver good cost reduction results in the bottom-line business of managed care.

• The CMO model.

A new breed of company called a care management organization is emerging. A CMO is as different from a traditional casualty insurer as an HMO is different from a group health insurance company.

CMOs view themselves as part of the prevention and health care industry. They put the human event over financial transactions and claims processing. To CMOs, managed care is their core, even though they provide workers comp insurance and financial vehicles to customers who need them.

The difference between a CMO and a traditional insurer is internal identity and emphasis. Care management organizations also are very different from HMOs, because their specialty is workers comp. They recognize that there are three main ways to reduce workers comp costs: prevent injuries from happening, streamline injury care and speed return to work.

Like HMOs, care management organizations use macromanagement techniques to influence physician decision-making. They seek to align incentives with their networks and with individual physicians, emphasizing non-medical case outcomes, such as time off work, litigation and rehabilitation.

An example of this kind of innovation is paying providers to do more of the micro care tasks: tracking, monitoring, speeding and tailoring patient care to assure a prompt recovery and return to work. Although non-medical, these tasks speed the patient's transition from sick to well, and thus are legitimately part of the healing process.

Letting doctors practice

The most revolutionary tool in macromanaged care is letting doctors make more money when they use resources wisely.

The old-fashioned payment system, which pays a fee for every service, is basically piecework, known in manufacturing as a powerful incentive to increase output. In fact, doctors make lots of discretionary decisions between reasonable alternatives, though with different costs and consequences.

Progressive care organizations like CMOs see that physicians are sprung loose from a procedure-focused piecework-payment system. Encouraged to reach beyond technical medical treatment, these physicians become powerful allies.

The fundamental purpose of medical care is healing, so it's sensible to pay more those physicians whose overall results show they are faster and more efficient at getting their patients well.

Rudimentary incentive payment plans in place now focus almost entirely on average case costs, largely because of lack of adequate data about other quality measures. Managed care organizations are seeking to improve the data to include better outcomes and quality measurements.

Accreditation, certification

As data measurement improves, several aspects of

See *Managed Care* on next page

Managed care

Continued from previous page

workers comp care could be certified or accredited. Those include:

- **Loss prevention.** Work-related injuries and illnesses are preventable. That fact makes workers comp health care different. Machine guards, lock-out/tag-out and protective equipment stop injuries. Injuries are signals that prevention failed.

Consequently, quality standards for prevention are critical and should not be overlooked. Too many prevention programs in workers compensation are weak, window-dressing, optional or are available only for a fee.

The greatest failure of the workers comp system may be its inattention to preventing injuries. In fact, for many insurers, effective prevention programs would jeopardize their income stream by improving experience and thus reducing premium.

- **Provider credential checking.** This basic patient protection measure is not in widespread use in workers comp. Many employers still send their employees to providers with whom they have merely made informal business arrangements. Some workers comp networks' only selection criterion is whether the providers will accept heavily discounted rates. They may not check to make sure the doctors have medical licenses, aren't notorious drug or sex abusers and haven't had multiple malpractice judgments.

- **Network access to health care.** Access is both a patient safety and an employee dignity issue. Good access to health care means getting the necessary care from an appropriate provider, in a reasonably convenient location, at the time needed and in a manner that meets one's service expectations.

Employers that are interested in access, and regulatory agencies that oversee this issue, typically specify ratios of primary care providers to patients, require plots of providers on maps, specify ratios of specialists to primary care providers, set maximum acceptable travel distances to providers and hospitals, require arrangements for off-hour and emergency care, etc.

Obviously, access standards from group health care need modification before being applied to workers comp.

- **Case management.** This is a largely unregulated process. Nurses manage cases, but so do social workers and even insurance adjusters.

Case managers in different organizations work on different kinds of issues, depending on what piece of the health care pie interests them. Generic case management quality standards and accreditation will have to reflect the variability of practice location and dimensions being managed.

Most cases being managed in workers comp are musculoskeletal injuries, mostly sprains and strains. Forty percent of workers comp dollars are spent on back injuries, and case managers work hard to achieve good outcomes in these difficult cases.

Besides expediting the medical care process, workers comp case managers work on the return-to-work process, finding temporary transitional work so employees can finish their recovery on the job, and suffer the least life and vocational disruption.

An accredited case management program in workers comp needs to demonstrate its efficacy at preventing unnecessary disability by keeping employees productive, while protecting the patients from reinjury through premature return to work.

Case managers tend to work in the middle, in the gray zone, hired by payers to reduce cost but acting as patient advocates. Generally, making sure the patient is well cared for in as non-invasive and efficient a manner as possible reduces cost and improves quality of service and patient satisfaction. Ensuring professionalism of case managers by requiring training and documentation and tracking of results, including patient satisfaction, is important.

- **Utilization review.** Utilization reviewers are often, but not always, nurses. They usually compare the doctor's plan with medical care protocols or standards.

Although the decision not to pay for a service is technically not the same as the decision not to allow it to be performed, UR frequently seems to function that way. Sometimes nurses, or even non-health care professionals, countermand the decision of the treating physician without listening to reasons or consulting another doctor.

The blind application by laypersons of simplistic protocols enrages the medical community and has attracted the attention of some legislatures. Patients can be hurt by both over- and undertreatment.

Unfortunately, there is no generally accepted accreditation available for managed care workers comp organizations.

Accreditation for group health care could miss gross failings in workers comp. NCQA cannot do it, since its charter limits it to prepaid health plans. Other possible accrediting outfits are the Utilization Review Accreditation Commission, American Assn. of Ambulatory Health Centers, and the Joint Commission on Accreditation of Healthcare Organizations. However, none of them reviews with the breadth, thoroughness and objectivity of the NCQA—and none has the reputation in the marketplace.

A quality guide for today

Until such accreditation systems emerge, there are several aspects of workers comp medical care employers can scrutinize to ensure quality. Those are:

- **Providers.** Employers are advised to ensure that the providers they have selected have acceptable credentials. The easiest current solution is to use a network or managed care organization that abides by the credential-verification standards adopted by the NCQA or the new network standards promulgated by URAC.

In addition, quality and service complaints about providers should be carefully logged and evaluated to demonstrate a reasonable effort to avoid patient abuse.

- **Networks.** Aside from marketing and deal making, group health HMOs and networks eager to offer workers compensation services may not know what they are doing. It is wise to check on the training, occupational experience and track record of all the people who will be involved in providing care.

Workers comp managed care organizations must have physicians who provide initial care for injuries. These doctors need to be located close to the worksite and available on demand during work hours. Beyond immediate care, these doctors also should serve as the entry point and guide into the health care system for cases that require care from specialists, hospitals or other medical providers.

Remember, doctors who are whizzes at acute injury care—urgent care and emergency providers—usually know very little about managing disability and preventing unnecessary time off work. Check how much rework is being required because the initial providers have not got the right philosophy, approach and expertise.

The best initial care providers know both occupational medicine and the workplace. They specialize in prevention and care of industrial injuries and disability management. Specialists and other providers in the network should be selected for their medical capability as well as their experience in and willingness to pay attention to the practical issues in treating work-related injury.

- **Case management.** Pretty much every workers comp program includes case management, so the question is not if but when and how often and with what results. Programs that let claims adjusters decide when to call in case managers and organizations with only a few case managers and thousands of cases are way behind. The most innovative programs are moving case management to providers.

Does the managed care approach harness the discretionary capability of the providers? Is the main incentive for providers a negative one, i.e. fear of lost business? Is the incentive too big so it disturbs the physician's commitment to deliver good care to the patient? Are financial incentives aligned? Risk-sharing is not the only positive incentive and may be un-

kind because it is too risky for low-volume providers. Bonuses, preferential channeling, information and feedback are other potential positive incentives.

Is there a shared set of expectations on how the care process should go? Proprietary protocols and standards are becoming obsolete. Reducing variability in the kind of care given will increase efficiency.

Reducing wasted time reduces cost. Time can be wasted during active medical care—waiting for appointment, questions not answered because of poor communication—as well as wasted by delays in returning to work. Putting cases on schedules tightens up the system. Cases should be aged just like accounts receivable.

- **Report cards.** Providers need and want feedback and information on their performance. Crude report cards may reinforce the wrong behaviors, i.e. evaluation solely on cost may encourage skimping on care and reinjuries. Multidimensional report cards that compare provider performance on customer satisfaction, medical quality and utilization, disability management and other outcomes, give doctors a solid footing to compare themselves with their peers.

Customers are getting wary of assertions about managed care effectiveness. Programs increasingly will be required to document their claims with objective evidence.

The managed care program's performance across all its customers is one piece of evidence: overall loss ratio, average cost per claim, lost-time claims as a percentage of all claims, average days lost per lost-time injury are items that sophisticated customers are likely to request.

Also be wary of component vendors. Having all the components "available" is not the same as having them in use and working together.

A call to action

Employers, insurers, labor and managed care companies must work together to set quality standards for workers comp managed care. If we act slowly or fail, regulators will act state by state using the local political process. This will only guarantee a highly variable outcome.

Take California's certification of workers comp health care organizations, or HCOs. In more than three years, only seven organizations have managed to get certified—an example of overzealous standard-setting. On the other hand, accreditation that nearly anyone can get has a low value as a distinguishing feature in the marketplace. The balance is difficult to find but important.

Quality standards for the highly fluid workers comp industry must be generic enough that applicants can be from different kinds of organizations. Additionally, the practical economics of the accreditation industry say there need to be enough applicants to generate enough income in application fees to make the business viable.

However, the need for income must be balanced by scrupulous, thorough and even-handed program administration. Even a whiff of insider dealing will devalue the accreditation and discourage applicants.

The accrediting body must thoroughly and objectively evaluate an applicant's compliance with their own programs and policies, not just accept their word on it.

To gain acceptance, accrediting bodies need industry sponsorship. They also need advisory boards for credibility. These boards and sponsors need to be very careful not to spoil what they are trying to build by maneuvering to take care of vested interests. **BI**



Dr. Jennifer Christian is vp and chief medical officer for ManagedComp Inc., a national workers compensation care management organization in Waltham, Mass.

Major property/casualty insurers' first-quarter 1997 results

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

Rank 1997	Corporate					Property/casualty operations								
	Net income 1997	Percent increase (decline) 1996-1997	Consolidated revenues 1997	Combined ¹ ratio 1997	Combined ¹ ratio 1996	Net premiums written 1997	Percent increase (decrease) 1996-1997	Pretax underwriting income (loss) 1997	Percent increase (decline) 1996-1997	Pretax investment income 1997	Percent increase (decrease) 1996-1997	Policyholders surplus 1997	Percent increase (decrease) 1996-1997	
1	Ohio Casualty Corp.	32,715	822.1	359,536	105.6 ²	117.1 ²	307,762 ²	0.3	(14,445)	72.6	42,409	(4.3)	971,712	6.2
2	TIG Holdings	36,400	218.2	428,600	102.7	111.3	388,500	(3.8)	(8,900)	78.7	77,600	2.7	987,000	4.9
3	Travelers P/C Corp.	273,100	178.7	2,431,300	101.7 ²	109.9 ²	2,113,300 ²	120.3	(117,000) ²	0.9	499,700 ²	156.1	5,552,000	116.8
4	ITT Hartford Group Inc.	204,000	112.5	3,118,000	101.3	107.6	1,947,000	7.2	(39,000)	72.7	210,000	8.2	4,785,000	35.0
5	Berkshire Hathaway Group	211,200	64.2	1,199,900	92.8	97.7	1,376,700	13.5	70,600	216.6	216,900	41.8	N/A	N/A
6	Royal & SunAlliance USA ²	79,000	46.3	N/A	102.1	120.2	334,000	(17.1)	N/A	N/A	N/A	N/A	2,300,000	N/A
7	Old Republic Int'l	65,241	30.4	461,862	98.7	100.2	209,922 ²	1.8	(1,495) ²	76.0	49,017 ²	2.3	1,427,044	4.9
8	Chubb Corp.	192,100	26.9	1,576,900	96.3	101.3	1,421,800	26.1	40,900	328.5	171,600	9.0	2,530,000	8.4
9	Reliance Ins. Co. and subs.	28,386	26.1	781,945	101.1	101.9	507,328	6.7	(7,059)	30.1	66,326	4.7	1,141,415	(2.9)
10	Fremont General Corp.	21,093	21.2	140,724	91.2	99.5	121,733	(6.1)	10,122	1,642.2	26,027	(7.2)	426,161	30.7
11	CIGNA Corp.	260,000	18.7	4,645,000	100.4	104.9	803,000	(3.8)	(3,000)	92.5	94,000	(5.1)	2,000,000	0.5
12	American International Group	780,935	16.3	7,188,998	96.3	96.8	3,313,944	6.0	118,784	33.5	451,071	10.1	N/A	N/A
13	American States Fin'l Corp.	54,027	15.2	501,904	100.8	108.3	422,840	4.2	(2,521)	91.8	57,102	(4.4)	1,599,334	(0.5)
14	General Re/Cologne Re Group	243,800	3.0	2,061,200	101.0	100.3	1,262,900	4.4	(14,200)	(373.3)	292,400	9.6	5,597,500	16.3
15	SAFECO Corp.	111,525	0.7	1,030,191	98.7	99.6	583,115	5.6	7,290	248.0	70,400	(1.0)	2,232,300	15.7
16	The St. Paul Cos. Inc.	124,549	(3.3)	1,557,203	107.8 ²	106.3 ²	1,029,220	10.1	(51,053)	(21.4)	218,269	15.5	2,986,003	13.6
17	Hartford Steam Boiler	15,900	(6.5)	145,500	90.0	91.0	117,100	9.5	12,000	30.4	8,000	—	291,400	3.2
18	Sentry Insurance Cos. ²	17,254	(9.1)	387,341	109.6	109.0	292,204	(0.7)	(28,896)	(14.1)	50,161	0.6	1,310,549	11.3
19	USF&G Corp.	45,000	(20.8)	844,900	104.5 ²	106.3 ²	643,600 ²	(1.1)	(30,800)	23.2	112,200	3.3	1,421,400	2.5
20	Argonaut Insurance Co.	21,646	(31.2)	55,231	106.4	106.1	30,658	(29.2)	(440)	79.2	18,529	(18.4)	527,790	(15.7)
21	CNA Financial Corp.	178,000	(45.9)	4,130,000	111.6	107.9	2,670,000	—	(352,000)	(38.0)	428,000	(8.6)	N/A	N/A
—	Nationwide Mutual Ins. Co. ²	N/A	N/A	N/A	103.1	111.8	2,037,907	1.5	(68,631)	71.8	233,972	4.9	N/A	N/A
—	Kemper Insurance Cos.	N/A	N/A	979,348	106.5	109.3	944,050	(1.7)	(90,680)	20.9	110,993	(2.5)	1,924,828	(0.7)
—	Liberty Mutual Ins. Co. ²	N/A	N/A	N/A	109.7	117.2	1,464,113	7.2	(156,465)	33.7	259,669	1.3	5,752,796	20.7
	Cumulative	2,995,871	21.9	34,025,583	102.2	105.7	24,342,696	9.6	(726,889)	44.0	3,764,345	13.9	45,764,232	19.7

¹After dividends ²Statutory N/A—Company did not provide data

Results

Continued from page 2

year and, in particular, the wind season is still ahead of us."

Meanwhile, commercial buyers will continue to have a soft market.

"We see a continuation of the same competitive market conditions that persisted for at least the last year," said Louis G. Paglia, senior vp and treasurer at TIG Holdings Group in New York.

"You can't bank on weather to bail you out, and with the competitive environment only intensifying and no sign of any let-up in sight, I just think that it's going to be tougher and tougher to generate reasonable returns, especially for the commodity-type players," said Mr. Lewis.

"Rates aren't adequate and they're becoming less and less adequate, it seems, with every passing month," he said.

In general, "I think the trend is for fairly sluggish earnings trends for commercial insurance companies," said Weston M. Hicks, an analyst with Sanford Bernstein & Co. in New York.

Smith Barney's Mr. Frank said he expects "some upward pressure" on loss ratios.

Mr. Frank also sees the continuation of what he describes as the "pattern of haves and have-nots in terms of the stronger companies being able to hold up a little better

under the pressure and some others starting to show some cracks."

"In many ways, the results are going to be just an ongoing war of attrition," he said.

"Just about everybody we've talked to is budgeting a higher loss ratio as the year goes on," said David Seifer, vp with Donaldson Lufkin & Jenrette Securities Corp. in New York.

"Every one of our industry sources believes that industry conditions today are at the lowest level that they've been either since 1982-1983 or, in some instances, their entire careers," said Mr. Seifer.

Cash claims are growing faster than premiums, said Michael Smith, an analyst with Salomon Bros. in New York. "It's very difficult to envision any significant underwriting improvement from the current levels, given where pricing is," he said.

"The fundamentals are unchanged, and top-line growth is hard to find," said Barbara Stewart of Stewart Economics in Atlanta. "I think it's going to be very hard for companies to squeeze out any kind of improvement in earnings," she said.

If the deterioration continues as expected, not only is it assured results will be poor in 1997, but 1998's will be "equally weak, if not worse," said Eric Simpson, senior vp at A.M. Best Co. in Oldwick, N.J.

With the relative good fortune on the catastrophe front in the first quarter, Hamilton, Ohio-based Ohio Casualty Corp.'s results offer an example of how insurers benefited. Ohio Casualty reported \$5.3 million in catastrophe losses for the first quarter, compared with \$17.4 million for the comparable period a year ago.

The lower catastrophe losses, along with higher capital gains, helped boost its first-quarter net more than 820% to \$32.7 million.

Overall, the 21 insurers surveyed by *Business Insurance* that report this data posted a 21.9% gain in net income to \$3 billion.

Among other first-quarter results reported:

- Net premiums written for the 24 insurers surveyed increased 9.6% to \$24.34 billion. This compares with a 9.9% increase for year-end 1996 (*BI*, March 24).

- Travelers Property Casualty Corp.'s net premiums written rose by more than 120% to \$2.11 billion, reflecting Travelers' acquisition of Aetna Life & Casualty Co.'s P/C business.

- Investment income increased 13.9% to \$3.76 billion. This compares with an 11.7% increase in all of 1996.

- With fewer catastrophe losses this year vs. the comparable period a year ago, underwriting losses narrowed by 44% to \$726.9 million. In 1996, underwriting losses widened by 57.4%.

- Insurers' combined ratio improved to 102.2% vs. 105.7% for the comparable period a year ago. This compares with a 106.1% combined ratio for all of 1996.

- Excluding Royal & SunAlliance USA Inc., which did not report its first-quarter 1996 policyholder surplus, surplus for the 19 insurers reporting this data for both years improved 19.7% to \$43.46 billion.

"I think you saw, really, more of what you would expect to see in this environment, which is among the property/casualty insurers and reinsurers, increasing pressures on top-line growth in a more competitive environment," Smith Barney's Mr. Frank said.

Catastrophes were even lower than expected, he noted. "I think we all expected them to be light, but in some cases they ended up being virtually non-existent. It did boost the quarter results in some cases. Otherwise, I'd say the most remarkable thing about the quarter was probably how unremarkable it was," said Mr. Frank.

Gloria Vogel, senior vp at New York-based Advest Inc., agreed there were "no real shockers." There were no exceptional additions to reserves, and investment income was up because interest rates were higher, she said.

Except for the bright spot of a mild winter, "it was probably a mediocre to slightly below-average quarter," according to John L. Ward, of the Cincinnati-based

Ward Financial Group.

Consolidation may be the force that shakes up the market.

"I see some acceleration of merger and acquisition activity among marginal commercial insurance companies in '97," with larger insurers there to "pick up the pieces," said Peter Wade, an analyst with Lehman Bros. in New York.

The soft market "has been with us for such a long period of time it's now at the point where it's really driving consolidation, because a number of companies have started to really feel the pinch of this long soft cycle," agreed Mr. Ward.

"Probably it's going to occur more with the larger companies that we've already seen, like an Aetna or a Travelers, because the larger companies have the mind-set and the resources to do it," Ms. Stewart said of consolidation.

"Some of the smaller companies are not in the same kind of competitive bind as the larger ones are," she said. "They have established pretty strong positions regionally or in specialties and may not need to join forces with anyone else and, in fact, many of the smaller organizations have been living off the troubles of the large ones for quite a while."

"Most people, when they talk about consolidation, tend to say the big ones are going to acquire the little ones, and I don't think that's necessarily the case," she said. **BI**

White House too rigid on Superfund reform: Oxley

WASHINGTON—The Clinton administration's Superfund reauthorization principles are too rigid, according to one of the chief Republican advocates of reforming the controversial environmental cleanup program.

"To the extent they tell us where the administration is at this time, they are an addition to the process," said Rep. Michael Oxley, R-Ohio. He made his remarks during an address earlier this month to the National Assn. of

Manufacturers in Washington.

But Rep. Oxley noted that the principles, released earlier this month, emphasized the White House's opposition to more than 30 possible reforms (*BI*, May 12). For example, the administration remains adamantly opposed to changing the program's imposition of retroactive and joint and several liability for cleaning up sites that were used before Superfund's 1980 enactment.

"It's fine to be for and against things, but this is not the time to draw lines in the sand," said Rep. Oxley. He said he hopes negotiations on Superfund reform legislation begin in earnest after Congress returns from its Memorial Day recess.

The congressman said earlier this month that he would like the House to vote on the as-yet-undrafted reform bill sometime this fall.

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Managed care plans continue battle against federal program in Colorado

By ROBERT KAZEL

DENVER—Managed care plans and their allies, after persuading a federal court to temporarily halt a Medicare managed care demonstration project in Colorado this month, are preparing to spar again with federal health officials to keep the program dormant.

The Health Care Financing Administration's project would have required managed health plans in the Denver area to submit bids to insure Medicare recipients, and the bidding deadline was May 16. That day, however, U.S. District Judge Walker Miller granted a temporary restraining order after several local health maintenance organizations and the Washington-based American Assn. of Health Plans criticized the project for its potential adverse effects on HMOs, plan sponsors and Medicare beneficiaries.

The lawsuit was jointly filed by the AAHP; five local HMOs; the Colorado HMO Assn.; the Colorado Assn. of Commerce & Industry; the Colorado Medical Society; the Colorado Hospital Assn.; and a local Medicare beneficiary.

The judge will rule June 12 on the plaintiffs' motion for an injunction.

The managed care plans argue they are being forced to take part in a poorly designed experiment, one that they say is unfair to them and will drive some retirees out of managed Medicare and into fee-

for-service plans for fear of losing benefits.

For plan sponsors, the plaintiffs argue, this exodus could erode any savings to be achieved through enrollment of retirees in managed care plans.

The HCFA initiative, designed to be a prototype for paring Medicare expenses nationwide, presents HMOs with a package of standard health benefits that they must, at minimum, provide to all enrollees.

HMOs were to be allowed to en-

cap of \$1,500 to seniors in Medicare, whereas HCFA's standard benefit package has a cap of \$1,000.

Many local HMOs also offer free transportation to doctor appointments while the HCFA package does not, she said.

"We felt the people who would be most affected by this would be the people who are least able to afford it," she said.

HCFA designed the package with little input from the health care industry, she said. In addition, the HMOs argue that because the government will not also be mandating any changes in Denver's fee-for-service Medicare pricing, the attention being paid to managed care is unfair.

HCFA still believes its proposal is "very solid" and would benefit Denver residents, despite fears of some senior citizens that they would lose benefits if it became reality, an agency spokeswoman said.

"They're all going to make bids to make themselves as attractive as they can in the marketplace," she said. That, HCFA claims, will translate into lower costs for Denver-area plan sponsors.

That day may never come, however, because the HCFA plan has opponents in many corners. In addition to the pending lawsuit, U.S. Sen. Ben Nighthorse Campbell, R-Ohio, is trying to defeat the plan, and Colorado Gov. Roy Romer is seeking to postpone its implementation. **BI**

HCFA still believes its proposal is 'very solid' and would benefit Denver residents, despite fears of some senior citizens, says an HCFA spokeswoman.

ter the program by submitting bids. Taking all bids into account and finding a middle ground, government actuaries would then set a single rate for all retirees in Medicare HMOs in the Denver area.

HMOs declining to accept the rate would be excluded from serving local seniors.

Although there would be no premium charged to Medicare HMO enrollees under the HCFA plan, managed care plans say reduced payments from HCFA will force a reduction in some of the benefits that seniors in Denver-area HMOs already enjoy.

Susan Cox-Wagoner, executive director of the Denver-based Colorado HMO Assn., gave the example of several managed care plans that now offer a prescription drug

Meeting in Chicago, sponsored by IAIFA; \$200 for members, \$250 for non-members. IAIFA-Chicago Registration, P.O. Box 10018, Kansas City, Mo. 64171-0018; 816-756-5285.

JUNE 5-6. Crittenden's Third Annual Use the Alternative Markets to Increase Your Business seminar in San Francisco, sponsored by Crittenden; \$695. Also **June 12-13** in Washington. Crittenden Conference, P.O. Box 1150, Novato, Calif. 94948; 800-421-3483.

JUNE 5-6. Financial Analysis: Property/Casualty Insurance in Philadelphia, sponsored by Fells Road Group Inc./Michael Conn Associates Inc.; \$1,050. Also **Sept. 25-26** and **Oct. 30-31**. Fells Road Group Inc./Michael Conn Associates Inc., 271 Route 46 West, Suite D-207, Fairfield, N.J. 07004; 201-227-5955.

JUNE 8-11. The Western Pension & Benefits Conference in Phoenix, sponsored by WPBC; \$595. WPBC, 602-953-8007.

JUNE 9. Excel Basic for Risk Management workshop in Atlanta, sponsored by Shelter Island Risk Services; \$395. Also **June 11** in Chicago, **June 12** in New York, **Sept. 22** in Roswell, Ga. and **Dec. 4** in New York. Shelter Island Risk Services, P.O. Box 568, 14 Tarkette Road, Shelter Island, N.Y. 11964; 800-749-1535.

JUNE 9-10. Changing Market Condition and Emerging Exposures in Professional Liability conference in New York, sponsored by American Conference Institute; \$1,299. AMI, 175 Fifth Ave. Suite 2182 New York, N.Y.

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JUNE 2. The Pension Seminars Series: ERISA Update in Charlotte, N.C., sponsored by Accountant's Education Services; \$200. Also **June 5** in Atlanta, **June 12** in San Francisco, **June 16** and **Dec. 8** in Denver, **June 26** in St. Louis, **Aug. 7** in Honolulu, **Sept. 25** in Chicago, **Oct. 20** in Tampa, Fla., **Nov. 6** in Washington, **Nov. 20** in Minneapolis. AES, 1900 Olive St. #F-102, Denver, Colo. 80220; 800-426-8802.

JUNE 3. The Pension Seminars Series: 401(k) Seminar in Charlotte, N.C., sponsored by Accountant's Education Services; \$200. Also **June 6** in Atlanta, **June 13** in San Francisco, **June 17** and **Dec. 9** in Denver, **June 27** in St. Louis, **Aug. 8** in Honolulu, **Sept. 26** in Chicago, **Oct. 21** in Tampa, Fla., **Nov. 7** in Washington, **Nov. 21** in Minneapolis. AES, 1900 Olive St. #F-102, Denver, Colo. 80220; 800-426-8802.

JUNE 3. Reviewing Boiler and Machinery Coverages workshop in Dallas, sponsored by The CPCU Society; \$75 for members, \$85 for non-members. CPCU, 720 Providence Road, P.O. Box 3009, Malvern, Pa. 19355-0709; 610-251-CPCU.

JUNE 4. APIW's 1997 Insurance Woman of the Year Award Ceremony in New York, sponsored by APIW; \$75. Paula J. Gould or Lorraine C. Sullivan, APIW, 285 Hunting Ridge Road, Stamford, Conn. 06903; 203-968-1548.

JUNE 4-6. International Assn. of Insurance Fraud Agencies Inc. Annual

10010; 416-926-8200.

JUNE 9-11. The Construction Industry Benefits Conference in Monterey, Calif., sponsored by the International Foundation of Employee Benefit Plans; \$625 for members, \$715 for non-members. Registrations Department, International Foundation of Employee Benefit Plans, P.O. Box 69, Brookfield, Ws. 53008-0069; 414-786-6710, ext. 8257.

JUNE 9-12. Cost-Effectiveness Analysis for Medical Technologies and Pharmaceuticals seminar in Boston, sponsored by the Harvard School of Public Health Center for Continuing Professional Education; \$1,995. Harvard School of Public Health, Center for Continuing Professional Education, 677 Huntington Ave., LL-23, Dept. B, Boston, Mass. 02115; 617-432-1171.

JUNE 10. Excel Advanced for Risk Management workshop in Atlanta, sponsored by Shelter Island Risk Services; \$445. Also **June 13** in New York, **Dec. 3** in Chicago and **Dec. 5** in New York. Shelter Island Risk Services, P.O. Box 568, 14 Tarkette Road, Shelter Island, N.Y. 11964; 800-749-1535.

The Datebook is compiled from notices sent to Business Insurance. Notices should be sent at least eight weeks in advance to Datebook, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590. Please include the cost, if any, to attend the meeting and information on registration for interested readers. Business Insurance reserves the right to select meetings of most interest to its readers and cannot guarantee that notices will be printed.

Global Briefs

German insurance group Allianz A.G. Holding has become the fourth new member this year of RINET, the international reinsurance and insurance network. With the addition of the Allianz companies, RINET now has 540 members in more than 60 countries. Allianz also is working with RINET to set up an electronic data interchange system between its subsidiary companies and home office in Munich. The system is expected to launch at the beginning of next year. . . . Canadian insurers have a "more favorable" business outlook than in recent years, according to Standard & Poor's Corp., because of their successful efforts at corporate restructuring. Nevertheless, S&P anticipates ratings will continue to fall for the Canadian insurance sector because of "continued distribution challenges and competitive pressures from other financial services sectors."

. . . Brian G. Walford, chief financial officer of Bermuda-based EXEL Ltd., will retire at the end of 1997 at the age of 44. Mr. Walford decided to retire to "have fun" and said he has no plans to return to work. No successor has been named. . . . Specialist reinsurance broker Greig Fester Group Ltd. is sponsoring a new natural hazard and loss prevention research facility at University College London. The Greig Fester Centre for Hazard Research will aim to develop more accurate hurricane forecasting as part of its global weather trends analysis, as well as investigate earthquake threats around the world. . . . Reducing or abolishing the advance corporation tax would threaten the solvency of U.K. occupational pension funds, the Assn. of Consulting Actuaries has warned Chancellor Gordon Brown in a pre-budget submission. If the chancellor does reduce ACT, tax relief to pension funds will drop, and the ACA estimates the solvency of employer-sponsored plans may fall 10%, undermining plan security. . . . The U.K. P&I Club has closed the 1994 policy year with no further cash calls on its members. Because of a better-than-expected investment performance and a reduction in estimated claims, the club now expects a small surplus, which it will use to strengthen reserves. . . . Creditors of the Reinsurance Co. of Mauritius have agreed to a scheme of arrangement for the Mauritian company, which failed in 1983. In an unusual move, RCM also was put into liquidation in London in 1988 because of collection problems from debtors in the London insurance market, though this liquidation is ancillary to that in Mauritius. Runoff administrators De Chazal du Mee in Mauritius and Coopers & Lybrand in London anticipate the first release of funds to creditors will take place early next year.

INTERNATIONAL

Israeli insurance execs refuse to resign over price fixing

By MARIA KIELMAS

JERUSALEM—Executives from eight Israeli insurance companies that were convicted of running a price cartel are resisting government pressure to resign.

The companies were found guilty of creating a cartel between 1991 and 1992 to fix prices for contractors-all-risk, civil engineering insurance and personal lines coverages.

Israeli Insurance Commissioner Doron Shorer, who is leading the push to have the executives stand down, asserted that "people who are

convicted of such a thing against their clients cannot continue to serve as senior executives in insurance companies."

The 15 company executives charge that a plea bargain made last year with the attorney general allows them to remain in their jobs.

"The state is acting unfairly," said Uri Taiber, general manager of Tel Aviv-based Zion Insurance Co. Ltd., one of the companies convicted of price fixing.

The plea bargain, which took more than a year to negotiate, was economical and convenient for both

the state and insurance companies to settle the dispute, he said. "Then one day afterward the government comes in with the second part. No one would have signed the plea bargain knowing there would be dismissals," he said.

The dispute originates from losses totaling about \$300 million suffered by insurers during heavy and sustained flooding in late 1991 and early 1992.

"We had the worst year ever, all of the reinsurers were leaving the country," said Sammi Bassat, deputy general manager of Clal In-

surance Co. Ltd., another of the companies. "The market understood that if something was not done then many of the smaller insurers would collapse."

Mr. Bassat said that Israeli insurers got together to talk over how to improve matters.

He recalls that at the time the feeling within the insurance industry was that the losses were a problem the market had to sort out for itself.

But matters took a different turn in 1993, when the Israeli government's then-antitrust commis-

See Israel on page 23

Benefits of external regulation spelled out in report

Lloyd's self-regulation on way out?

By SARAH GODDARD

LONDON—Sweeping reforms proposed for Lloyd's of London's regulatory system would shift the ultimate responsibility for overseeing the market to external agencies.

Lloyd's last year asked a panel of market executives and regulators from other parts of the U.K. financial services sector to review its current form of self-regulation and make recommendations for a new system of market governance.

After six months of deliberations, the panel issued its report earlier this month. The main recommendations in the 50-page report were accepted by the Council of Lloyd's, the organization's ruling body. However, "some detail, clearly, the Council needs to look at," said Sir David Rowland, chairman of Lloyd's, at the report's release.

In widespread but not unexpected changes to the current system, the panel recommended that the powers of the U.K. Department of Trade and Industry be extended "to give it

a wider oversight role" of Lloyd's.

"We recommend . . . that while the Council of Lloyd's should retain the primary day-to-day responsibility for regulating the Lloyd's market, additional, formal, external accountability should be introduced in respect of the exercise of its regulatory responsibilities. This will demonstrate that policyholders' and members' interests are sufficiently and impartially safeguarded and that the Council's responsibility to ensure a properly regulated and solvent market is being discharged," the report said.

External regulation would have several benefits, the report contended, including:

- Diminishing possible conflicts of interest between regulators and those they govern. Several of the people in senior regulatory positions are also market executives and the report cited a "perception that the current structure . . . can lack objectivity in dealing with conflict."

- More consistency with regulation of other financial markets. In

general, other markets in the financial services sector are subject to greater external regulation than Lloyd's.

- Greater confidence from buyers in Lloyd's regulation, particularly following the market's near financial collapse in recent years. "There is a general willingness to make fundamental changes to restore that confidence," the report said.

- Greater confidence from traditional unlimited liability members that their interests are being safeguarded.

Currently, the DTI is responsible for certifying that both Lloyd's and its individual members are solvent.

Following the successful completion of the market's reconstruction and renewal plan last year, the DTI reviewed its solvency testing procedures, and will implement another test at the end of this year designed to ensure that each member is not only solvent, but also has an acceptable solvency margin.

This should go even further, the panel report said, to make Lloyd's

solvency standard comparable to that of U.K. insurance companies. It singled out two particular areas for reform, though implementing these would require changes to the Insurance Companies Act.

First, under the present regime, the Secretary of State for Trade and Industry becomes directly involved in regulating Lloyd's members should they fail the DTI's solvency tests.

Although this has never happened in practice—Lloyd's always has put up its own central assets to shore up members who did not reach the solvency levels required by the DTI—it gives the Secretary of State the power to demand that a potentially insolvent member of Lloyd's put sufficient assets into trust to meet all underwriting obligations, including future liabilities.

"We recommend that the Secretary of State should be empowered to act at an even earlier stage, should policyholders' interests be considered to be at risk, as is the case in respect of an insurance company," said

See Regulation on page 23

Broker consolidations even making waves South of the Border

By ROBERTO CENICEROS

MEXICO CITY—The effects of global broker consolidation are being felt in Mexico, where multinational brokers have strengthened their presence in recent years by buying interests in local companies.

In some ways, Aon Corp.'s purchase of Alexander & Alexander Services Inc. and Marsh & McLennan Cos. Inc.'s takeover of Johnson & Higgins are fostering a market response in Mexico similar to one that has emerged in the United States, said Alexis Marquard, international director in Mexico City for Bourchier, Marquard, Zepeda Agente de Seguros S.A. de C.V., one of Mexico's larger retail commercial brokerages. BMZ is Willis Corroon Group P.L.C.'s Mexico representative.

"You're going to have two big brokers with probably 70% of the multinational business, if not more, in Mexico," he said. "What's going to happen to us, the other brokers

left, is we are going to have to become niche players looking for mid-size accounts. We must be more service-oriented and take advantage of not being the biggest, but trying to be the most efficient."

In other ways, broker consolidation is expected to imprint uniquely on Mexican employers because of the peculiarities of their emerging insurance market.

"The brokers are very important because they have contacts all over the world," said Nora Del Carmen Leal, risk manager for CIGATAM in Mexico City and the president of Mexico's risk management association, the Instituto Mexicano de Administradores de Riesgos. "But I know some of the big companies in Mexico are trying to reduce their insurance costs by placing everything directly with the insurance companies."

Only during the last decade have Mexican companies been allowed by law to place their coverage direct

See Mexico on page 23



AP/WIDE WORLD PHOTOS

Sea Empress disaster will lead to prosecution

LONDON—The U.K. Environment Agency plans to pursue criminal charges stemming from pollution caused by last year's *Sea Empress* oil disaster off the coast of south Wales.

The agency would not provide details, but possible targets for prosecution include the Department of Transport's Coastguard Authority, Millford Haven Port Authority, the tanker's operators and the ship's master. The *Sea Empress* hit rocks last February when attempting to enter Milford Haven Waterway to deliver a cargo of North Sea crude oil to the Texaco Pembroke oil refinery (BI, Feb. 26, 1996). More than 503,850 barrels of crude oil leaked from the ship over the next six days, washing up on 125 miles of coastline.

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INVITATION FOR BIDS

INVITATION FOR MULTI-STEP SEALED BIDS for Disability & Survivor Benefit Insurance (GGRF 97-004)

The Government of Guam Retirement Fund is soliciting bids from qualified companies for disability and survivor death benefit coverage commencing September 1, 1997 to participants of the DC Plan of the government of Guam. Bid packets are available from John Rios, Acting Director, GovGuam Retirement Fund, #424-Route 8, Maite, Guam 96927. A \$50 non-refundable fee is required of vendors whose packets will be mailed.

Multi-step bidding is a 2-step process whereby all technical, licensure, and other requirements must initially be met. Only cost bids of qualified offerors will be opened. The lowest qualified bidder will be awarded an initial 13 month contract.

Completed bids and technical responses (4 copies) must be received by the Fund by 4:00 pm, Tuesday, July 1, 1997, Guam time. A pre-bid conference will be held on Tuesday, June 10, 1997, at 8:30 am in the Fund's Conference Room. Telephonic participation can be arranged by contacting the Fund at (671) 475-8900 or 8901 on or before 4:00 pm, June 6, 1997.

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LEGAL NOTICE

UNITED STATES BANKRUPTCY COURT
FOR THE NORTHERN DISTRICT OF NEW YORK
In re

LAWRENCE UNITED CORPORATION
Debtor.

NOTICE OF MOTION OF LAWRENCE UNITED CORPORATION
PURSUANT TO 11 U.S.C. §363 FOR AUTHORIZATION TO SELL CERTAIN ASSETS OF
ITS WHOLLY OWNED SUBSIDIARY, THE LAWRENCE GROUP OF
NORTH CAROLINA, INC., OUTSIDE THE ORDINARY COURSE OF BUSINESS

PLEASE TAKE NOTICE, that debtor Lawrence United Corporation, by and through its attorneys, Cooper, Erving, Savage, Nolan & Heller, LLP, has moved this court at the James T. Foley Courthouse, 445 Broadway, Suite 327, Albany, New York for an Order pursuant to 11 U.S.C. §363 (a) authorizing the sale of certain assets of its wholly owned subsidiary, The Lawrence Group of North Carolina, Inc. (hereinafter "Lawrence-NC") to Guilford Insurance Brokers, Inc. (hereinafter "Guilford") pursuant to the terms and conditions of a purchase offer dated May 13, 1997, together with such other and further relief as to this Court may seem just and proper.

PLEASE TAKE FURTHER NOTICE, that the assets to be sold SUBJECT TO HIGHER AND BETTER OFFERS, are as follows:

1. All insurance policy accounts of Lawrence-NC, including commercial, personal, and equine accounts;
2. All furniture, equipment and related personally located in the Lawrence-NC office.

FOR MORE INFORMATION CONTACT MR. JAMES FAUGHNAN ON OR BEFORE JUNE 4, 1997

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Vice Presidents, General Managers and
Other Administrative Personnel 5,129

Financial:

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

Risk/Employee Benefits:

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

Sub-total 30,511

Associations 290
Government, Unions and
Educational Institutions 946

Commercial Consumers

Sub-total 31,747

Insurance Agents and Brokers 8,588
Insurance Companies 7,327
Accountants, Actuaries,
Attorneys & Consultants 2,831
Adjusters, Appraisers, TPA's, Captive Managers
& Health Care Providers 1,624
Others Allied to the Field 966

Total Qualified 53,083

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LEGAL NOTICE

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK
IN THE PETITION OF ANTHONY JAMES McMAHON AND PHILIP WEDGWOOD WALLACE,
AS JOINT PROVISIONAL LIQUIDATORS OF ANGLO AMERICAN INSURANCE COMPANY LIMITED
Case No. 97-B-41556 (PCB)

NOTICE IS HEREBY GIVEN that on May 13, 1997 an order was entered by the United States Bankruptcy Court for the Southern District of New York (the "Bankruptcy Court") in connection with the case filed with respect to Anglo American Insurance Company Limited (the "Company") pursuant to section 304 of the Bankruptcy Code (the "Order"):

1. Enjoining all persons and entities from (a) transferring, relinquishing or disposing of any property of the Company in the United States, or the proceeds of such property, to third parties; (b) commencing or continuing any action or other legal proceeding (including, without limitation, arbitration or any judicial, quasi-judicial, administrative or regulatory action, proceeding or process whatsoever and any discovery in connection therewith) against the Company, or any of its representatives or agents, including run-off agents, or any of their property in the United States, or any proceeds thereof; (c) enforcing any judicial, quasi-judicial, administrative or regulatory judgment, assessment or order or arbitration award, and commencing or continuing any act or action or other legal proceeding (including, without limitation, arbitration, or any judicial, quasi-judicial, administrative or regulatory action, proceeding or process whatsoever) to create, perfect or enforce any lien, setoff or other claim against the Company, or any of its representatives or agents, including run-off agents, or any of their property in the United States, or any proceeds thereof, including, without limitation, rights under reinsurance or retrocession contracts; and (d) drawing down any letter of credit established by, on behalf or at the request of, the Company, or withdrawing from, setting off against, or otherwise applying property that is the subject of any escrow agreement or similar arrangement in which the Company has an interest, in excess of amounts expressly authorized by the terms of the contract and any related trust or other agreement pursuant to which such letter of credit, escrow, or similar arrangement has been established; except, however, no drawing against any letter of credit shall be made in connection with any commutation unless the amount has been agreed in writing with the Petitioners or permitted by further Order of the Court;

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

3. Requiring that every person and entity that has a claim against the Company arising under a contract of insurance, reinsurance, retrocession or otherwise, written or entered into by the Company and that is a party to any action or other legal proceeding (including, without limitation, arbitration, or any judicial, quasi-judicial, administrative or regulatory action, proceeding or process whatsoever) in which the Company is or was named as a party, or as a result of which a liability of the Company may be established, is required to place the Petitioners' United States counsel on the master service list of any such action or other legal proceeding and to take such other steps as may be necessary to ensure (a) that such counsel receives copies of any and all documents served by the parties to such action or other legal proceeding or issued by the court, arbitrator, administrator, regulator or similar official having jurisdiction over such action or legal proceeding, and any and all correspondence, or other documents circulated to parties named in the master service list and (b) that copies of the foregoing are provided to Chodbourne & Parke LLP, 601 South Figueroa Street, Los Angeles, California 90017-5704 (Attention: Jonathan Bank, Esq.); and

4. Providing that, with respect to any action, arbitration or other proceeding that may be commenced or become known to the Petitioners in the future, or the entitlement or alleged entitlement of any beneficiary of any letter of credit established by, on behalf or at the request of, the Company, or of a party to any escrow agreement or similar arrangement in which the Company has an interest that is identified by the Petitioners in the future (each a "Subsequent Claim"):

- (a) when informed of a Subsequent Claim, counsel for the Petitioners shall serve upon the holder of such claim a copy of the Summons and Petition, and the most recent injunction order entered by the Court;
- (b) the holder of a Subsequent Claim will have twenty (20) days from service of the Summons in which to submit a motion or answer to the Petition; and
- (c) on such notice to counsel for the Petitioners as the Court may require, the holder of a Subsequent Claim may file a motion seeking an order of the Court vacating or modifying the injunction entered in this proceeding with respect to such Subsequent Claim. Such request shall be the subject matter of a hearing as scheduled by the Court. Otherwise, the holder of a Subsequent Claim may file objections and be heard by the Court in accordance with the terms of any order of the Court providing for a hearing in the future on the relief sought by the Petitioners in this proceeding.

The Order shall remain in effect pending a hearing scheduled to be held on July 17, 1997 at 2:30 p.m. before the Honorable Prudence Carter Beatty, United States Bankruptcy Judge, in Room 617 of the Alexander Hamilton Custom House, One Bowling Green, New York, New York. All papers submitted for the purpose of opposing continuation of the Order after July 17, 1997, shall be filed with the Court, with a copy to the Chambers of the Honorable Prudence Carter Beatty, and served on Cadwalader, Wickersham & Taft, so as to be received on or before July 3, 1997, at 5:00 p.m. New York time. Any party-in-interest that has not received a copy of the Petition and Supporting Papers and/or the Order should contact counsel for the Joint Provisional Liquidators in writing at the address below:

CADWALADER, WICKERSHAM & TAFT
100 Maiden Lane, New York, New York 10038
Tel: (212) 504-6000 • Fax: (212) 504-6666
Attention: Kenneth P. Coleman, Esq.
Lisa C. Dor, Esq.

* As used herein, United States is defined to include the United States and its territories and possessions.

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DIRECTOR, COMMONWEALTH INSURANCE PROGRAMS

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For consideration, submit a state application to: DGS-HR, 805 East Broad Street, Room 117, Richmond, VA 23219, by 5:00 PM, June 16, 1997. For app. call (804) 786-5305 or e-mail <dbrown@dgs.state.va.us>

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INTERNATIONAL

Israel

Continued from page 21
 sioner, Viktor Bovic, began to investigate allegations of price fixing.

According to Commissioner Shorer, the insurance companies were found to have consulted with each other and set rates on various lines, and coordinated their actions in consultation with their reinsurers. Mr. Shorer declined to name the reinsurers involved but said they are large European companies.

"There is a possibility that this coordination has happened both before and after the 1991-92 period," he added.

The antitrust commissioner started examining the case in 1993, presented his findings to the attorney-general in 1995, and the eight companies were convicted of operating a cartel by a Jerusalem District Court in 1996.

The companies are: Ayalon Insurance Co.; Clal Insurance Co. Ltd.; Hamagen Insurance Co.; Israel Phoenix Insurance Co.; Menora Insurance Co.; Migdal Insurance Co., a subsidiary of Italy's Assicurazioni Generali S.p.A. and Israel's largest insurer; Safar Israel Insurance Co.; and Zion Insurance Co.

In addition, a total of 15 senior executives, mostly managing directors and general managers, from the companies were convicted of a conspiracy to create a price cartel. At Clal these included the chairman, Raion Benshaul, who has since resigned, and non-life manager Jacob Kil, according to Mr. Bassat.

Representatives from Migdal, Safar Israel, Hamagen, Menora, Israel Phoenix and Ayalon either declined to comment or could not be reached.

The companies were fined between \$500,000 and \$2 million, while the individual executives were fined between \$100,000 and \$300,000 to be paid from their personal assets, and given suspended prison sentences of between six months and two years,

according to Commissioner Shorer.

The plea bargain agreed to in late 1996 required the executives to admit to some of the charges in exchange for receiving suspended prison sentences. The personal fines were waived.

"It was decided not to prove in court that damage was incurred to (the companies') clients. In this case it would be difficult for the public to present a class action," said Mr. Shorer.

Six of the companies agreed to the plea bargain while two—Israel Phoenix and Ayalon—are continuing to appeal the convictions in court.

The insurance commissioner has sent a letter to the relevant executives demanding that they step down from their positions. Mr. Shorer said that he has consulted with the attorney-general on the matter. If the executives continue with their refusal to step down, he could limit the companies' licenses to operate, he added.

Zion's Mr. Taiber, who together with his company's chairman, Abraham Taiber, is among the executives whose resignations are requested, said that his company has applied to the District Court of Tel Aviv for an injunction stating that there is no reason to dismiss him and his colleague.

Mr. Shorer said that the issue will be discussed at a June 15 meeting of the insurance commissioner's advisory committee. This committee will decide how to proceed on the matter of the executives' refusal to resign. If it goes against the executives, they can appeal to the Supreme Court, the country's highest court, Mr. Shorer said.

Separately, Mr. Shorer said that his office is preparing an overhaul of Israel's insurance regulations. The hope is to bring these in line with existing European Union insurance legislation. In addition, a long process is under way to introduce more transparency in insurance company accounting through the adoption of U.S. generally accepted accounting principles. **BI**

Mexico

Continued from page 21
 with most insurers, said Graciela Soto, risk manager for MBS Comunicaciones in Mexico City. Previously, all coverage, except that placed with formerly state-owned insurer Aseguradora Mexicana, had to be placed via licensed brokers.

With a strained economy, some companies have attempted to trim expenses either by cutting out their brokers or by cutting risk managers, she added. Companies need both, Ms. Soto said, unless they have a very large and very sophisticated risk management department.

But even large sophisticated companies will likely benefit from the expertise and leverage of the giant brokers created by the mergers, risk managers say. Even very large employers that do not rely on brokers for placement of retail coverage still use them to access reinsurance markets, they say.

Mexican employers are also beginning to look to brokers more for consulting services, though that is not yet a full blown trend, said Richard Atherton, international director in Mexico City for Alexander & Alexander Mexico Agente de Seguros y Fianzas S.A. de C.V., now part of Aon Group Inc.

"We are still very much oriented to the retail business and obviously reinsurance is an important aspect of our business," Mr. Atherton said. "But consulting is coming. There is no question about it, but it's slow. The Mexican client still feels if he pays a premium he is entitled to all kinds of services and advice. The unbundling is still to come."

Meanwhile, Aon and A&A units have kept their distinct names in Mexico, though they are looking for office space in Mexico City big enough to house both operations, Mr. Atherton said. Although the brokers' offices in other Mexican cities have

been combined, each firm owned its own building in Mexico City and neither is large enough to house the combination of both operations. There are also more tax and red tape hassles slowing the office merger process in Mexico City than in other Mexican cities, Mr. Atherton said.

"A lot is happening, and not a lot is happening because of legal constraints," he said.

Foreign ownership of Mexican brokerages previously faced many restrictions, Mr. Atherton said. But a government decree 1993 loosened those restrictions and then "things really started to happen."

Alexander purchased 80% of Mexican broker Asesoros Kennedy Agente de Seguros S.A. in July 1993, after having a correspondent relationship with the broker since 1976.

Aon also has its own presence in Mexico, built in part on the former Rollins Hudig Hall's 1994 purchase of Mexican broker Ramos Rosado (BI, July 18, 1994).

Marsh & McLennan also has its own office in Mexico City. Now there is talk in Mexico that J&H Marsh & McLennan Inc. may buy out Mexico's largest commercial broker, Brockman & Schuh Agente de Seguros y de Fianzas S.A. de C.V. Johnson & Higgins already owned 25% of Brockman & Schuh and held an interest in Brockman & Schuh's reinsurance operation, Reinmex.

A spokesman for J&H Marsh & McLennan in New York declined to comment on a potential purchase of Brockman & Schuh and called it mere speculation. A designated spokesman for Brockman & Schuh could not be reached after repeated attempts.

But two sources inside the Mexican brokerage said that while there have been no formal negotiations with J&H Marsh & McLennan, the matter is pending and discussions are expected to begin soon. In addition, they said that J&H only provided Brockman & Schuh with a minor-

ity of its business, so the Mexican brokerage could readily survive on its own if its owners do not want to sell.

"I think all these mergers are a good opportunity for us," said BMZ's Mr. Marquard. Yet he is waiting to first see if the new, larger brokerages will cut commissions to win market share. That would be bad for him and other brokers, though it could benefit corporate policyholders, he said.

Yet Mr. Marquard also said he thinks good talent is bound to leave some of the merging brokerages, in which case BMZ could hire some of them for its nine offices throughout Mexico.

There may be other benefits as well for mid-size brokers in Mexico.

"I can think of six or seven of my clients who had J&H and Marsh & McLennan handle different parts of their business and now they have the same broker," he said. "That does not fit the employers' philosophy. They like to have two different brokers. So that is going to be an opportunity for the Sedgwicks and Willis. For us in Mexico it's definitely going to be an opportunity."

At the same time, the larger brokers also see a great opportunity to help international clients and Mexican enterprises, especially with signals of an improving Mexican economy.

"We look at it as a big growth area for us," said Bob Solomon, managing director for international specialty operations in New York for J&H Marsh & McLennan.

"A lot of our major multinational clients from Europe and the U.S. have invested a great deal down there," he said. "The large Mexican conglomerates are interested in new risk management techniques that we have offered. We have been able to pick up one or two of the large conglomerates in Monterrey as clients. We're very excited about Mexico." **BI**

Regulation

Continued from page 21
 the report.

Secondly, the report recommended giving the Secretary of State greater powers to seize the assets of Lloyd's members and agents "at the request of, or with the consent of, the Council of Lloyd's."

Currently, if a member defaults in paying losses, Lloyd's can only seize their "funds at Lloyd's," or assets backing their underwriting.

Members also may find themselves subject to external regulation, in the interest of better safeguarding their investment. The panel's report suggested the U.K. Securities and Investments Board would be best suited to oversee protection of members' investments in Lloyd's, though this would require a change in the Financial Services Act.

The SIB is responsible for protecting the interests of investors from malpractice in the securities industry. Although membership in Lloyd's does not constitute an investment under U.K. law, the panel still regarded the SIB as the most appropriate regulator.

Legally, members of Lloyd's are "sole traders" undertaking to write insurance. "But there are some similarities between members' interests and other investors," said Sir Alan Hardcastle, chairman of Lloyd's Regulatory Board and chairman of the panel that authored the report. Nevertheless, he said, "the detail remains to be discussed with the government and the SIB."

If the new Labour government implements the panel's recommended changes, both the DTI and SIB would

have very different roles with regard to Lloyd's.

It would then be their responsibility to establish fundamental regulatory principles governing the institution, as well as approving the more detailed "rule book" that the panel suggested could remain the responsibility of the Council of Lloyd's. Also, both bodies most likely would be required periodically to review the Council's regulatory performance, including investigating any complaints about its regulatory procedures.

A spokesman for the DTI said, "This is very much a Lloyd's report. However, we welcome its intention."

The SIB will be "carefully considering the panel's ideas," a spokesman said. The spokesman added that the need for legislative changes to implement the main recommendations would be a government, rather than an SIB, decision.

The Assn. of Lloyd's Members, a body representing the market's traditional members, praised the report. ALM Chairman Sir David Berriman said he personally welcomed the recommendations, saying they would "move Lloyd's regulation closer to the position of other high risk markets, and I hope any necessary legislation can be passed quickly. The burden of responsibility now is for the market to minimize the scope for conflicts of interest and to ensure the equal treatment of all its capital providers."

More immediately, the panel called for a senior member of the SIB to sit on both Lloyd's Council and its Regulatory Board, said David Gittings, director of regulation at Lloyd's and a member of the panel. He said that there may be an appropriate appointment later this year, adding that input

to the panel from former SIB chief executive John Young had been "quite invaluable."

The report recommended maintaining Lloyd's Regulatory Board but reducing its members to 12 from 18, with equal numbers drawn from the market, the external Council members and independent representatives. It also suggested setting up a series of subcommittees reporting to the Regulatory Board and focusing on specific areas of regulation.

Any moves to regulating Lloyd's externally most likely won't be swift.

This is mainly due to the time it would take for reform to be introduced and approved—a period the panel estimates at up to three years.

It does seem, however, that the government is willing to go full steam ahead with any changes it sees as strengthening the regulatory regime. Last week, Chancellor Gordon Brown announced major changes to the regulation of various sectors of the financial services industry. In a surprise parliamentary statement, Mr. Brown said he intended to extend the powers of the SIB, making the Bank of England accountable to it. Other self-regulating organizations governed by the Financial Services Act would also come under its watchful umbrella, said Mr. Brown. Lloyd's, however, is exempted from such regulation by the Financial Services Act.

Mr. Brown's proposals are expected to become law early next year.

The chancellor's statement contained no information on changes to the supervision of non-life insurers, which currently are accountable to the DTI. A DTI spokesman refused to comment but a spokeswoman for the Assn. of British Insurers said the pro-

posals may indicate the eventual move of all financial services regulation to the SIB.

In his statement, Mr. Brown commented on the "plethora of different supervisors" currently responsible for regulation, which he said "increases the cost and reduces the effectiveness of supervision." Welcoming Mr. Brown's proposals, the ABI spokeswoman said that streamlining regulation and reducing bureaucracy would lower costs for U.K. insurers.

Whether Mr. Brown's proposals on the SIB will delay Lloyd's external regulation proposals remains to be seen.

"Clearly we have a major task ahead of us," said an SIB spokesman, referring to a regulatory review Mr. Brown has asked to be ready by the end of July. Both Lloyd's and the ABI say they hope to be included in the review's consultation process.

Until primary legislation can be changed to accommodate changes to the Lloyd's regulatory regime, the panel report suggested that Lloyd's not only appoint an SIB representative, but also discuss with the SIB how it can "shadow the arrangements that would be formalized when the legislation was amended."

The panel also reaffirmed Lloyd's commitment to continuing the Central Fund, a guaranty fund that steps in if members cannot cover underwriting losses. The panel stressed, though, that using the Central Fund to pay losses is at the discretion of the Council of Lloyd's.

Other recommendations called for:

- An assessment of Lloyd's total exposure to aggregated risks.

"We recommend that Lloyd's should follow the example of other

regulators and establish a specialist financial risk assessment unit staffed by suitably qualified individuals," the report said.

- A review of the education and training requirements of senior agency staff.

- A review of the staffing levels, training and salary structure of the Corporation of Lloyd's regulatory division.

- A review of the Lloyd's Compensation Scheme, currently available to compensate members for losses resulting from fraud, dishonesty or accounting failures.

- A return to compulsory errors and omissions cover for Lloyd's agents and advisers, insured outside the Lloyd's market.

- Implementing a "user pays" system into the charging of regulatory services.

Broker regulation is expected to be addressed in a soon-to-be-released consultative document on distribution channels for Lloyd's products, so the panel did not tackle the issue.

Meanwhile, during the panel's investigation, a gray area emerged about the role of members' agents. It may be determined that they are providing investment advice to unlimited liability members, which would fall under the Financial Services Act rather than being subject to Lloyd's general exemption under the act, the panel said. "Uncertainty as to the scope of the exemption needs to be resolved as a matter of urgency," the report said. "We recommend that the (Lloyd's Regulatory Board) should take the appropriate legal advice and subsequent steps to ensure that the interest of members are properly safeguarded." **BI**

AIS

Continued from page 1

Co. Ltd. of St. Vincent and the Grenadines, Paramount Reinsurance Ltd. of Barbados and Underwriters Reserve Insurance Co. (see related story).

American International Sureties is not related to American International Group Inc.

AIS is the only one of the four insurers to respond to the order so far, and is expected to file a formal reply by June 1.

Mr. Rosenblum said he hopes to have the order "expunged."

"We have never walked into the state of Colorado to sell one dime of insurance to anybody," he said. "We are doing everything we can to create an honorable industry in the Caribbean."

Officials of the offshore companies, including AIS, have worked for other companies that are no strangers to regulatory inquiries.

Mr. Rosenblum, for example, formerly headed Capital General Corp., a self-described holding company that in 1989 launched ill-fated bids to acquire two U.S. insurers. The insurers were to act as front companies for offshore reinsurers lined up by Consortium of 89 Ltd., a now-defunct London intermediary (BI, Dec. 11, 1989).

Capital General itself was capitalized with \$2.1 million in assets, including intellectual property rights to Shirley Temple movies and a collection of nostalgic sheet music and movie posters, according to SEC filings.

Both proposed acquisitions fell apart in the face of regulatory opposition.

AIS officers and directors also include:

- Eamon Baird, senior vp. Until last year, Mr. Baird was an officer of Tangent Insurance Co. Ltd. of Antigua; in 1994, he was sued by the U.S. Department of Labor for his role in placing reinsurance for a fraudulent union health benefit trust with offshore insurers that later failed to pay claims (BI, Feb. 24; May 18, 1992).

- William A. Stehl, a "non-executive director." Mr. Stehl operates Financial Surety Services Inc., a unit of another company Mr. Rosenblum heads, Allstate Acceptance Corp.

In the early 1990s, Mr. Stehl and FSSI supplied millions of dollars of "Kwajalein guarantees" to New York broker Underwriters Financial Group Inc. to finance an acquisition push. The guarantees were purportedly backed by future payments the U.S. government owes to landowners on a Marshall Islands atoll, though Marshall Islands officials questioned their validity. UFG filed for bankruptcy in 1995 (BI, Aug. 14,

1995).

The British Department of Trade and Industry has also investigated AIS and Allstate Acceptance over a "cashback" promotion in which merchants would offer their customers an Allstate Acceptance-guaranteed refund of the purchase price of consumer goods after five years, documents show.

A DTI official would not confirm or deny an investigation.

Allstate Acceptance recently changed its name to Mineral Acceptance Corp. after Northbrook, Ill.-based Allstate Insurance Co. sued it for trademark infringement over its use of the name.

AIS itself was incorporated in Antigua in 1984 but was inactive until mid-1995, when it started writing reinsurance for European ceding companies, company documents say. Last year, it started writing direct insurance, including marine, aviation and surety coverages.

The company is not licensed or authorized to write business anywhere in the United States, though it has relied on regulatory exemptions for certain lines of coverage, including marine insurance.

AIS, Mr. Rosenblum says, is "a company that believes in total disclosure."

Perhaps for this reason, its year-end 1995 financial statement—its most recent—takes the unusual step of reporting in separate columns the "historic cost" of its assets and their "supplemental current value."

The difference is startling: The largest asset by far, for instance, is the block of pre-World War II German bonds, which AIS reports at a cost of \$37,500 but a current value of \$82.1 million.

The cost figure, Mr. Rosenblum says, is the "arbitrary" amount AIS paid him for the bonds, and doesn't reflect their actual value.

The original bonds were convertible to gold, and the current value is based on the increased value of gold since the 1920s, according to Daniel A. Zimmerman, a Westbury, N.Y., lawyer and AIS director.

Mr. Rosenblum wouldn't say where he got the bonds, but said he acquired them eight or 10 years ago as "historical documents." He became convinced of their value, he said, after a "very extensive review."

"I would not give them up for my life. I feel that strongly about the value of these bonds," he said.

His faith may be misplaced, government authorities suggest: A German federal agency has issued a warning about the validity of many such bonds, and the SEC challenged their worth in an unrelated case earlier this year.

According to Germany's Federal Debt Administration, the German government and other German is-

suers sold the dollar-denominated bonds between 1924 and 1930 to investors in the United States and other countries.

Germany's Nazi government later repudiated the debt, and when Berlin fell in 1945 many of the bonds that had been held in the city's banks were looted and illegally put back into circulation.

In 1953, the German government agreed to a procedure for exchanging some of the bonds for new securities. Since this settlement, the Weimar bonds have generally been considered void unless a holder clears several legal hurdles, according to the debt administration.

A bondholder has to prove, for example, that the bond was held outside



Mr. Zimmerman

Germany in 1945, that there is an unbroken chain of ownership to the current holder and that the bondholder is not at fault for missing the 1950s settlement deadline.

"Attempts are frequently made to deposit as securities bonds which are generally worthless since they cannot be accepted even belatedly due to lack of sufficient proof," the debt administration warned.

In February, the SEC sued a Miami stock broker who was selling the Weimar bonds to the public.

Among other things, the SEC charged that "the vast majority of the German bonds currently in circulation may be invalid and unredeemable."

One former law enforcement official compared the bonds to Confederate money, valuable only as collectors' items.

Mr. Rosenblum and Mr. Zimmerman dismissed the German government's position, with Mr. Zimmerman calling it "a version of the Big Lie." Both men pointed to a 31-page legal opinion AIS obtained from a Texas attorney saying the bonds are enforceable.

AIS's valuation of its bonds was also accepted by its auditor, Edmond A. Morrison, an accountant with J.H. Cohn & Co. of Roseland, N.J. Mr. Morrison also acts as financial consultant and chairman of AIS's advisory board.

"There is a big question about those bonds, and I'm not going to disagree with it," Mr. Morrison said. But AIS consultants "appear to be of the opinion that they are collectible. The only question is when, not if."

The "when," however, raises the question of whether the bonds make

sense as investments for an insurance company. Insurers' financial strength is usually judged in part on the spread and liquidity of their investments.

"For an American insurance company, no, they would not satisfy the National Assn. of Insurance Commissioners," Mr. Morrison conceded. "For an Antiguan insurance company, yeah, it meets their criteria."

"We explicitly say they are not convertible to cash," Mr. Rosenblum said of the bonds.

"I doubt very much that any insurance company doing business in the U.S. today started with very much more than we started with," he added. "It's the American way."

AIS hasn't demanded payment on its bonds from the German government "because we know what the result would be of a demand," Mr. Zimmerman said.

Instead, AIS will wait to see if Germany decides on its own to pay. If not, AIS may sue the German government and several of Wall Street's largest stock brokerages, which acted as trustees on the original bond sales, Mr. Rosenblum says.

The Weimar bonds aren't AIS's only asset: The insurer also reported owning reserves of "precious metals bearing cinder ore" located at a mine site in the Mojave desert near Baker, Calif.

The "supplemental current value" of this ore is \$983,599, though the cost to AIS was only \$1, according to the 1995 financial statement.

Overall, AIS reported assets with current values totaling \$83.9 million and shareholders equity—the equivalent of policyholders surplus—of \$82.8 million at the end of 1995.

On a historical cost basis, though, the assets totaled \$824,779 and AIS reported a shareholders equity deficit of \$316,502.

AIS booked \$7.7 million in earned premiums and paid claims of \$5.3 million in 1995, according to the financial statement.

Until earlier this year, AIS assumed business through London managing general agent CRM Insurance Services Ltd., which also represented the fraudulent Dai Ichi Kyoto Reinsurance Co. S.A. of Belgium.

Dai Ichi is the subject of criminal investigations in the United States, United Kingdom and Belgium. In April, Belgian police arrested CRM Chairman Michael A. Reeve in Antwerp and held him for questioning. Mr. Reeve has denied wrongdoing.

AIS has since parted company with CRM—largely because of the Dai Ichi scandal, Mr. Morrison said—and now underwrites largely through its Antigua office, headed by General Manager David Boorman.

Mr. Boorman has separately operated Allied General Investments Ltd., a Jersey, Channel Islands, company

that is owned by two Liberian trusts and that has acted as a managing agent for AIS.

The Colorado aviation business that triggered the cease and desist order passed through several intermediaries, all of them named in the order.

Snoaspen Insurance Group Inc., an Arvada, Colo., surplus lines broker, produced the business for AIS and the three other offshore insurers.

Documents show that money related to some of these risks was wired from an Irvine, Calif., claims adjuster to EJT (1996) U.K. Ltd., a British company operated from the Netherlands by Elwyn J.T. Llewellyn; and Eastwood Intermediaries Ltd., another British company headed by Christopher J. Boatwright, a former manager of Dai Ichi Kyoto.

EJT and Eastwood share the same registered address in Surrey, England.

Mr. Boatwright did not respond to written questions he requested by fax.

Mr. Llewellyn confirmed that EJT acted as an intermediary placing aviation risks with AIS through another agency, Van De Velde NV of Antwerp, Belgium.

Jan Van De Velde confirmed handling the business for AIS and said he has binding authority for the company. Mr. Rosenblum and Mr. Zimmerman acknowledged Mr. Van De Velde as a producing broker but denied that he has binding authority.

Meanwhile, a document has surfaced in the cease and desist action claiming that AIS reinsures its aviation business with: EJT; Merriam Reinsurance Co. Ltd. of Dublin, Ireland; and "TIG Reinsurance Co. Ltd." of London.

The origin of this document, apparently a promotional brochure, is unclear. Officials of AIS, EJT and Merriam Re all deny the purported reinsurance arrangement, and Mr. Llewellyn called the document "nonsense."

Officials of TIG Reinsurance Co. in Stamford, Conn., said TIG has never reinsured AIS and has no London unit called "TIG Reinsurance Co. Ltd." TIG Re has written to Mr. Rosenblum complaining about the use of its name.

Snoaspen, the surplus lines broker, has cooperated with the Colorado department's investigation, but Carolyn Burkett, a Snoaspen official, declined to comment.

All in all, the Colorado controversy is probably not what AIS intended by its corporate motto: "*Famam extendere factis*." Borrowed from Vergil's "Aeneid," the line translates to mean that to spread his reputation by deeds is the test of a man's virtue. **BI**

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Four offshore insurers named by Colorado

DENVER—A Colorado Insurance Department cease and desist order names three offshore insurers in addition to American International Sureties Ltd. They are:

- Trans International Insurance Co. Ltd. of St. Vincent and the Grenadines. In a Dec. 6, 1995, financial statement, Trans International reported assets of \$7.3 million, consisting entirely of over-the-counter stock in two companies, Nighthawk Capital Inc. and Venture Tech Inc.

The insurer's directors included Bernard J. Cutts and Geoff Waterhouse, who also heads The Finsure House Inc., a Stone Mountain, Ga., broker. Mr. Cutts formerly worked for Montgomery & Collins International in Bermuda, but was fired in 1990 for placing reinsurance with companies run by convicted

swindler Alan Teale (BI, July 29, 1991).

Mr. Waterhouse said that he resigned as a director last October and that Trans International has since been sold. Mr. Cutts could not be reached.

Stephen B. Allison confirmed that Trans International was acquired last year by an Antigua holding company he manages through Kansasians Consultants of Wichita, Kan.

The insurer has canceled its Colorado business, according to Mr. Allison, who said the Colorado controversy "came as a complete surprise to us."

A former Kansas insurance agent, Mr. Allison confirmed that his license was revoked in 1993 for failure to comply with continuing education requirements.

- Paramount Reinsurance Ltd. of Barbados. Paramount was formerly known as First Reinsurance Ltd. and was managed in the Bahamas by H. Wayne Hayes, who was later jailed in Hawaii for securities law violations.

The company was taken over by its Bahamas-based auditor, Michael Hepburn, and moved to Barbados in 1993, changing its name to Paramount: Re.

Mr. Hepburn—who could not be reached—was also the auditor for Alpine Assurance Ltd., a Turks & Caicos Islands insurer barred in California after regulators disallowed most of its assets; and Savoy Reinsurance Co. Ltd., also of the Turks & Caicos, which reported \$50 million in worthless assets in a 1988 financial statement (BI, Aug. 16, 1993;

June 19, 1989).

- Underwriters Reserve Insurance Co., which the Colorado order says is based in St. Kitts, British West Indies.

In 1993, the California Insurance Department moved to shut down a St. Kitts insurer called Underwriters Reserve Ltd. after finding it had sold millions of dollars of worthless auto insurance.

The insurer has apparently continued to operate, though: In a year-end 1995 financial statement, Underwriters Reserve Ltd. reports \$114.2 million in assets, including a \$100 million "equitable interest in corporate bonds" backed by an "interest in precious metal."

Representatives of the insurer could not be reached.

—By Douglas McLeod

Continued from page 3

million in gross premiums last year. HCC projects the new merged company will write more than \$250 million in gross premiums in general aviation business this year. Mr. Way said he expects the deal to close in June.

The AVEMCO merger brings HCC back into the U.S. general aviation market, according to Mr. Way.

HCC pulled out of writing U.S.-based aviation risks in 1991, "because the rates were stupid and the losses were growing," said Mr. Way. However, the company continued to write international general aviation, totaling \$75 million in premiums last year.

Mr. Way said HCC decided to buy "the best company in general aviation in the U.S.," namely AVEMCO, because there are signs that aviation reinsurers have had enough of a soft market and may stop supporting competitive underwriting.

Mr. Way said he thought of buying AVEMCO's largest competitor, Dallas-based American Eagle Group Inc., at the same time as he bought AVEMCO. However, "after we looked, we left," said Mr. Way. The business and assets of American Eagle have been sold to American Financial Corp. following a \$44 million loss at year end and a

downgrade by A.M. Best Co.

Mr. Way decided instead to buy AVEMCO's next largest competitor, which was managing general agent Signal Aviation Underwriters Inc. in Dallas. The purchase, for about \$20 million, was completed earlier this month.

While at the AIA conference, Mr. Way also was closing the purchase—for an undisclosed sum—of an MGA writing aviation business: Southern Aviation Insurance Underwriters in Alton, Ala.

Aside from the three major U.S. aviation underwriters and AVEMCO, the main competition in the domestic aviation market "are MGAs," said Mr. Way. Whether HCC will buy other MGAs besides Signal and Southern Aviation "remains to be seen," he said.

There will always be "responsible" competition from the major aviation insurers, but as the MGAs disappear, "we believe the profitability should return to the general aviation market," he added.

Born in England, Mr. Way still speaks with a bit of a British accent though he has lived in the United States longer than he lived in the United Kingdom. He is now an American citizen.

Mr. Way started in the insurance business in London in 1964 at the age of 15 working for broker Willis Faber, now Willis Corroon Group P.L.C. He worked for Stewart Smith for a short time, which eventually merged with Willis, and

then left to become managing director of the aviation division of what is now known as Bradstock Group P.L.C.

In 1969, after traveling in the United States, he suggested that Bradstock open a North American office, but the company's board rejected the idea twice, according to Mr. Way. Exercising his entrepreneurial spirit, he moved to New York that year to set up West-

'Starting an insurance company from scratch back then was difficult; today it's impossible,' says Stephen Way.

minster Insurance Managers. He later sold Westminster to Aviation Office of America, which eventually became American Eagle.

By 1973 he had moved to Houston to set up his own MGA/surplus lines brokerage, Stephen L. Way International, specializing in aviation. But the company hit hard times in 1980 because MGAs received a bad reputation, and "if you were one, you had to be bad," he said.

Because SWI was losing business, the company of 10 employees was converted into an insurance company in 1981. It initially was

called International Indemnity Co., with a capitalization of \$850,000 but soon after became known as Houston Casualty Co. "Starting an insurance company from scratch back then was difficult; today it's impossible," said Mr. Way.

The first five years were tough until HCC received its first A.M. Best rating, said Mr. Way. By 1987, HCC had a B+ rating, \$10 million in capital and about 25 employees, he said.

"I've had a lot of luck, but the first piece was in 1987" when banker J.P. Morgan & Co. Inc. agreed to invest \$10 million into the company that would be repaid when HCC went public. "The name (of J.P. Morgan) on the balance sheet was probably more important than the money" because it meant that HCC must be a sound company, said Mr. Way.

The company went public in 1992, raising its capitalization to \$100 million in two offerings. HCC had another stock offer in 1995 and two stock splits. After the AVEMCO purchase, HCC will have a market capitalization of about \$1.3 billion.

HCC has never exceeded a 100% combined ratio in its history, due to several parameters set in the group, according to Mr. Way. The company does not write non-marine casualty business and therefore states that it has no exposure to environmental liability claims.

"We believe in an underwriting profit" and investment income as a bonus, said Mr. Way. As a result, HCC invests conservatively in such instruments as municipal bonds. "It's boring. It's reliable. It's safe," he said.

Aside from AVEMCO, Mr. Way said his company has made two other strategic acquisitions in its history:

- IMG Insurance Co. of Amman, Jordan, in 1988 for an undisclosed sum, which gave HCC a "presence internationally" and sealed a long-time relationship with IMG General Manager Wasef Jabsheh. The company writes non-U.S. marine and energy business.

- LDG Management Co., a managing general agency in Wakefield, Mass., in 1995 for 4 million shares valued then at about \$70 million. LDG, with an office in London, specializes in accident and health business. Stephen Lockwood, founder and chairman of LDG, is now on the HCC board.

But there's one place where Mr. Way will not buy a company or invest in a syndicate and that's his native London. Lloyd's of London and the Institute of London Underwriters have not made a profit in seven years and many ILU companies and Lloyd's syndicates have gone out of business. Looking at the numbers, "tell me why I should buy?...What's this rush to buy London companies? I don't understand," he said. **[B]**

Privacy

Continued from page 1

Although it is likely that many of the new rules will not be put out in final form for another two years, employers should anticipate that their impact could be "huge and exponential," and that the rules will be "something which can be violated very easily," said Linn M. Visscher, an employee benefits attorney with Gardner, Carton & Douglas in Chicago.

The timetable for the implementation of the rules is complex and potentially lengthy. The recommendations on confidentiality, to be studied by congressional committees beginning this summer, will include such matters as the administrative, technical and physical security of health plan data and safeguards against unauthorized use. Congress will have until August 1999 to enact legislation to codify the rules and, if it fails to act, the Secretary of Health and Human Services has an additional year to write and enact them.

In addition, by February 1998, HHS is to adopt security standards for the electronic transmission of health insurance claims data. This includes information such as enrollment, eligibility, premium payments and referrals. For large health plans, these standards must be online and in com-

pliance by February 2000. "Small" plans, still to be defined by HHS, will have an extra year.

For the first time, health plans or employers with lax security will be liable for federal civil penalties: \$100 per violation up to a maximum of \$25,000 for multiple violations of the same standard. Employers that break the law repeatedly, if fined, could incur great expense.

"You can rack up 50 violations a day and it can last a month," said Devin Cuyler, who specializes in health information technology at Gardner, Carton & Douglas. "That's where it gets onerous. You could get killed."

The privacy rules that eventually emerge could constrain what employers and health plans can do with their cost-efficiency studies, quality evaluations, wellness programs, coordination of benefits and use of confidential information in decisions relating to the Americans with Disabilities Act, said Kathy Bakich, an attorney with William M. Mercer Inc. in Washington.

Although the schedule may not seem to demand much of benefit managers immediately, legal experts say it isn't too soon to begin a general review of data security and privacy procedures.

"Now is the time to look at what you've got and ask yourself, 'Does what we've got protect confidentiality?'" said Ms. Visscher. Companies should study who has con-

trol over benefit records and what kind of control they have, and be sure that online information systems, if in use, have audit trails that management can use to trace which benefits records were accessed and by whom.

But another attorney said it might be premature for plan sponsors to be concerned with complying with the HIPAA's data processing requirements and that any funds spent now could be wasted.

"It seems to me generally it

'It would be premature to spend money now to anticipate what these standards will consist of,' says Michael Langan.

would be premature to spend money now to anticipate what these standards will consist of," said Michael Langan, a principal with Towers Perrin in Valhalla, N.Y. "Employers certainly shouldn't start in the interim. I don't think people should be acting indiscriminately now only to have to go back and redo it when the specs take shape."

HIPAA provides that knowingly using, obtaining or disclosing someone's personal health identity number is a federal crime pun-

ishable by fines of up to \$250,000 and a jail term of up to 10 years, but it merely sets up a timetable for defining what kinds of "health identifier" the industry is going to use.

"It would seem to me to be hard to violate the rules before they come to life," Mr. Langan said. "Obviously, responsible employers don't release this kind of information willy-nilly, anyway."

The adoption of common standards, in addition to enhancing security, will bring cost efficiencies, once the early costs are met, according to Terry Humo, senior technical consultant at Sedgwick Noble Lowndes in Memphis, Tenn.

"In the long-term, it should save employers money, and I'm talking about administrative simplification, generally—standardized claim forms, standardized codes, so everyone is working off the same sheet of music," he said. "But to get the people trained and get the electronic systems in place, for smaller employers these are going to be initial upfront costs—and it's going to be costly."

Even though HIPAA contains the new, evolving privacy safeguards, some say that the act will undermine medical confidentiality regardless of the specific rules that emerge. Privacy and patients' rights groups worked to defeat HIPAA near the final hours of its passage, as confidentiality sections were added. They perceive

them as adding to the erosion of privacy, the inevitable result of instant availability of online records and the use of universal identifiers.

"In our view, this doesn't really do a thing to protect privacy," said Don Haines, the national American Civil Liberties Union's legislative counsel on privacy and cyberspace in Washington. "We are waging a multifront war against the invasion of privacy caused by administrative simplification."

The ACLU is working, through a fax campaign, to persuade HHS officials to write strict privacy rule recommendations to Congress, Mr. Haines said.

In addition, it is contacting state legislators to persuade them to exempt health plans in their state from the planned electronic claim processing standards. Under HIPAA, states are permitted to grant exemptions from such standards when health identifiers are involved.

As employees become more familiar with privacy issues, "privacy may even become a competitive edge" that affects where they seek employment, Mr. Haines said.

"There is a growing sense of resentment about information the public thinks is, or ought to be, confidential," he said.

But employers are generally supportive of the privacy safeguards of HIPAA, at least as they are anticipated, according to Nora Super Jones, manager of public policy at Washington Business Group on Health, a coalition of 150 large employers.

"We support national standards for protection of confidentiality but we do distinguish between privacy and confidentiality," she said.

Most employers would agree that medical information should be kept confidential from other employees, but the health system should be as interconnected as possible, she said. Workers should not have the power to demand absolute privacy and decide which providers should have access to their files, she said.

No delay in notification deadline

WASHINGTON—Federal regulators say there is no truth to a rumor circulating among employers and benefit consultants that the government will extend a June 1 deadline for employers to notify certain former employees about their prior health care coverage.

That deadline, set by the Health Insurance Portability and Accountability Act of 1996, phases in, starting June 1, a requirement that employers furnish employees with statements certifying coverage.

Starting June 1, employers are to provide certification statements to employees who lost coverage from June 1, 1996, through Sept. 30, 1996, and who request statements.

For employees who lost coverage from Oct. 1, 1996, through May

31, 1997, employers have a choice of providing certification statements to employees or informing them when they can obtain the statements.

Employees who lose coverage after June 1, 1997, generally must be given the statements.

According to the rumor, the federal agencies in charge of enforcing HIPAA are going to push back the June 1 compliance date about two weeks. Officials with the agencies—the Internal Revenue Service, the Department of Health and Human Services and the Department of Labor—say the June 1 compliance date remains in effect and will not be delayed.

—By Jerry Geisel

Aetna

Continued from page 2
March.

A possible internal candidate for the job is Vice Chairman Richard L. Huber, though Aetna may decide to seek someone outside the company.

"It's not good news," said Michael LeConey, an analyst with National Securities Inc. in New York. Mr. Sebastianelli is the linchpin of Aetna's managed care strategy, he said.

"I think it's unfortunate for Aetna in that one of the things that Aetna acquired when they acquired U.S. Healthcare was a culture of managed care, and that was in part embodied in Mr. Sebastianelli," said Doug Sherlock, a health care analyst and editor of Pulse, a Gwynedd, Pa.-based

health care newsletter.

However, Mark Jamilkowski, an analyst with Hartford, Conn.-based Conning & Co., said that while he is sure Mr. Sebastianelli "would have made a more than capable candidate, it may be in

'The organization has a tough decision to make' as to who will succeed Mr. Sebastianelli, says Larry Mayewski.

Aetna's best interest to perhaps get somebody with a stronger familiarity with other lines of business, such as the annuity line and international operations."

He added that Dick Huber fits

that bill very nicely.

"The organization has a tough decision to make" as to who will succeed Mr. Sebastianelli, said Larry Mayewski, senior vp at A.M. Best Co., adding that it is premature to judge the impact of his resignation.

While there is still a significant amount of talent within the organization, Mr. Mayewski said.

"I think that it will all come down to whether the board is looking for a high-profile leader or somebody internally who is less high profile, but has demonstrated a significant amount of competence," he said.

Meanwhile, in spite of Mr. Sebastianelli's statement, industry speculation remains as to whether there are undisclosed reasons for his unexpected resignation that may be connected with the company's operations. **BI**

For the record

Aon names Christie as vice chairman

CHICAGO—Peter S. Christie, chairman and chief executive officer of Minet Group, has been named vice chairman of Aon Group Inc.

In his new position, Mr. Christie will work with all Aon Group entities to develop long-term business strategies, with a special focus on increasing Aon's professional liability and service business.

Mr. Christie is well known in the industry for his experience with the Big Six accounting firms' professional liability insurance programs.

Aon recently completed its acquisition of Minet from The St. Paul Cos. Inc. (BI, April 14).

Legislation seeks contraceptive cover

WASHINGTON—Legislation introduced in the Senate earlier this month would require group health care plans that provide prescription drug benefits to cover contraceptive drugs and devices on the same basis as other prescriptions.

Sens. Olympia Snowe, R-Maine, and Harry Reid, D-Nev., who sponsored the legislation, S. 743, said expanding access to contraceptives would reduce the number of unintended pregnancies.

Typically, group health care plans only provide coverage for contraceptives such as birth control pills for medical reasons, such as reduction of pain or discomfort from menstruation, rather than to reduce the likelihood of pregnancy, said Mike Sass, a principal with A. Foster Higgins & Co. Inc. in New York.

Illinois to consider balance billing ban

SPRINGFIELD, Ill.—Legislation to amend Illinois' workers compensation law by outlawing so-called "balance billing" is awaiting action by the state Senate after passage by the House earlier this month.

S.B. 73 would outlaw the controversial practice of medical care providers billing injured workers for payments in excess of the amount paid by an insurer or self-insuring employer. Nearly every other state bans this practice (BI, Feb. 3).

Until now, Illinois employers, labor unions and insurers have been unsuccessful in urging legislators to pass such a ban.

Doctors and hospitals favor balance billing as a way to obtain adequate compensation for the extra

time and reports involved in treating workers comp claimants, maintain their incomes and prevent workers comp payers from dictating fees.

Massachusetts Blues to be monitored

BOSTON—The Massachusetts Insurance Division will increase its oversight of Blue Cross & Blue Shield of Massachusetts, after an analysis by a department consultant found that mismanagement caused substantial losses last year.

Arthur Andersen L.L.P. reported that BC/BS of Massachusetts last year had a \$145 million net underwriting loss and a \$90 million net loss, according to the company's 1996 annual statement. A draft report by the consultant concludes that as a result "of the severity of the 1996 results and the significant uncertainty regarding 1997 results, the current and future financial condition of the company is of serious concern." Insurance Commissioner Linda Ruthardt wrote in a letter to BC/BS management.

The Insurance Division plans to follow the consultant's recommendation that it more closely scrutinize BC/BS operations by having a representative attend all meetings and monitor onsite the day-to-day transactions at the company, including approving all large expenditures. In addition, the division or its designee will perform periodic premium and claims testing.

BC/BS managers indicated that they wanted to work with the division to help assure that they remain viable and improve performance, Ms. Ruthardt said.

Republicans criticize Superfund stance

WASHINGTON—The Clinton administration's Superfund reauthorization principles are too rigid, according to one of the chief Republican advocates of reforming the controversial environmental cleanup program.

"To the extent they tell us where the administration is at this time, they are an addition to the process," said Rep. Michael Oxley, R-Ohio, during an address earlier this month to the National Assn. of Manufacturers in Washington.

But Rep. Oxley noted that the principles, released earlier this month, emphasized the White House's opposition to more than 30 possible reforms (BI, May 12). For example, the administration remains adamantly opposed to changing the program's imposition of retroactive and joint and several liability for cleaning up sites that were used be-

fore Superfund's 1980 enactment.

"It's fine to be for and against things, but this is not the time to draw lines in the sand," said Rep. Oxley. He said he hopes negotiations on Superfund reform legislation begin in earnest after Congress returns from its Memorial Day recess. The congressman said earlier this month that he would like the House to vote on the as-of-yet-undrafted reform bill sometime this fall.

Breast implant suit allowed to proceed

DETROIT—Attorneys for Dow Chemical Co. are asking a federal judge to reconsider her decision to allow a class-action breast implant suit to go forward against the company in state court in Louisiana.

U.S. District Judge Denise Page Hood of Detroit allowed the trial in New Orleans to resume even though a federal appellate court ruled earlier this month that breast implant cases against Dow Chemical be consolidated in U.S. Bankruptcy Court with those against its subsidiary, Dow Corning Corp.

Meanwhile, in a separate case, Dow Chemical was found not liable for injuries claimed by temporomandibular joint implant recipients.

The May 16 ruling by the 8th U.S. Circuit Court of Appeals in St. Paul, Minn., upheld a lower court ruling dismissing the company from all federal lawsuits involving TMJ implants.

Employer burden for ESRD may grow

WASHINGTON—Budget reconciliation legislation to be unveiled next month is likely to include a provision that would lengthen the time that employers must pay the medical bills of employees with end stage renal disease, says the chairman of the House Ways and Means Health subcommittee.

Under current law, employer plans are the primary payers of medical bills for employees with ESRD for the first 18 months. After that, the liability shifts to Medicare.

But Rep. Bill Thomas, R-Calif., said last week he would like to double employer liability to 36 months as part of budget reconciliation legislation his subcommittee will consider next month. Rep. Thomas acknowledged, though, that it is unlikely that Congress would increase employer liability to more than 30 months.

Such a change in law would significantly increase employer costs for employees with ESRD. Typically, annual health care bills for those with ESRD—or kidney disease—amount to about \$50,000. **BI**

Updates

Death sparks copter safety probe

Continued from page 2

that provide their executives with helicopter shuttle services, says the federal safety official investigating the incident.

Executive Vp Lawrence Inlow, 46, who was Conseco's general counsel and secretary, was killed at Indianapolis International Airport Wednesday when he walked into the slowly rotating main rotor of a helicopter Conseco leases and operates.

The accident occurred after the pilot had applied the main rotor brake and a steward had assisted Mr. Inlow and another Conseco official from the helicopter, said David Bowling, the National Transportation Safety Board air safety investigator leading the investigation. Both officials began walking away from the helicopter toward a corporate plane. Without explanation, Mr. Inlow then turned parallel to the helicopter. After he began walking toward the front of the craft, he was struck by a blade, Mr. Bowling said.

The NTSB has not found any problems with the helicopter. But, it is investigating how much the main rotor blades flex at slow speeds. Mr. Bowling said he understood they could flex to as low as 8 feet above ground level. Mr. Inlow was 6 feet 2 inches tall.

The NTSB is investigating whether wind gusts of up to 24 mph could have caused additional blade flex. Mr. Bowling doubts that the NTSB will seek helicopter design changes. Instead, the NTSB will analyze Conseco's safety procedures in determining whether the agency should issue safety guidelines to companies operating helicopter shuttles. For example, the agency will look at whether passengers should remain inside helicopters until rotor blades have stopped spinning. Another option could be establishing no-walk zones for passengers.

Connecticut managed care law

HARTFORD, Conn.—The Connecticut Legislature has approved legislation that would establish sweeping managed care regulations, including provisions for enrollees to appeal coverage decisions.

The bill would establish an external appeal process allowing the insurance commissioner to rule on a managed care organization's rejection of an enrollee's request for coverage of care. The commissioner could refer the appeal to an independent board of physicians or other health care experts for their review. External appeals, which would cost \$25, could be made only after all internal appeals within the managed care plan have been exhausted.

Among other provisions, the bill would:

- Require all managed care companies to establish internal grievance procedures to resolve enrollee complaints over non-coverage of treatment.
- Bar gag clauses under which providers are prohibited from disclosing non-covered treatment options to patients.
- Require the insurance commissioner to develop an annual "consumer report card" for all managed care organizations beginning in 1999.

Gov. John Rowland is expected to sign the measure.

Congress Re exec indicted

CHATTANOOGA, Tenn.—A federal grand jury has indicted Mohamed K.M. Zayed II on multiple charges stemming from his operation of the allegedly fraudulent Congress Re-Insurance Corp.

The indictment, unsealed last week, charges that Mr. Zayed swindled buyers of Congress Re surety bonds by producing phony financial statements that reported millions of dollars of bogus Congress Re assets. These assets included a phony \$80 million Japanese yen bond and purported interests in an Idaho gold mine, a stockpile of uncut rubies and unrefined gold bars, prosecutors say (BI, May 19).

Mr. Zayed also used corporate names intended to mislead potential victims, including Genesis Insurance & Financial Services Inc., Congress Re's publicly traded parent. GIFS is unrelated to a General Re Corp. unit with a similar name, and General Re won an injunction against Mr. Zayed's company for trademark infringement.

The indictment charges Mr. Zayed with 17 counts of wire fraud, money laundering and interstate transportation of fraudulently acquired property. He faces a maximum of 170 years in prison if convicted.

Mr. Zayed's whereabouts last week were unknown, and he was considered a fugitive. A federal investigation of his companies is continuing, prosecutors said.

Briefly noted

Louisiana officials will not appeal a unanimous decision by a panel of the 5th U.S. Circuit Court of Appeals that affirmed a ruling striking down a Louisiana law and application procedures that set numerous standards for risk retention groups licensed in other states that want to do business in Louisiana (BI, May 12). . . Mitsubishi Motor Manufacturing of America Inc. is in mediation with 29 women plaintiffs accusing the company of sexual harassment at its Normal, Ill., plant. . . Enrollees in health maintenance organizations that operate in Texas will—effective Sept. 1—be able to sue HMOs for malpractice under a bill the state Legislature approved and which become law without the signature of Gov. George W. Bush, who declined to sign or veto the measure (BI, May 19). . . A Baltimore City Circuit Court judge last week tossed out nine of 13 counts of Maryland's suit against tobacco companies, ruling that the state cannot recover payments on behalf of individual smokers but can continue with consumer protection and antitrust claims. Meanwhile, state attorneys general and tobacco representatives continued settlement talks last week, focusing on the issue of the industry's ultimate liability. . . The American Law Institute has given final approval to the "Restatement of Torts (Third): Product Liability." The treatise seeks to set clear rules for applying product liability law. . . Neil D. Levin, has been confirmed by the New York Senate as the state's superintendent of insurance. Mr. Levin, who was formerly the Banking Superintendent, succeeds Edward J. Muhl, who resigned at the end of 1996 (BI, Dec. 16, 1996).

Securities

Continued from page 3

which one or more of the parties seeking to recover damages did not personally authorize the suit.

According to the sponsors, the legislation would apply only to those nationally traded securities on the New York Stock Exchange, NASDAQ or the American Stock Exchange.

"The plaintiffs' bar has found a clever detour around the federal statute, which is to do something that has never been done before, which is to create a new species of securities fraud lawsuits which are filed in state court," said Mark Gitenstein, partner

with Mayer Brown & Platt in Washington and counsel to Uniform Standards Coalition, a Washington-based group of high-tech companies, securities firms and others that support the White-Eshoo measure.

None of the protections against "fishing expeditions," or "bogus bounty payments or steering fees to plaintiffs" apply in state courts, said Mr. Gitenstein.

"You just get one judge to take your case and you've got it," he said.

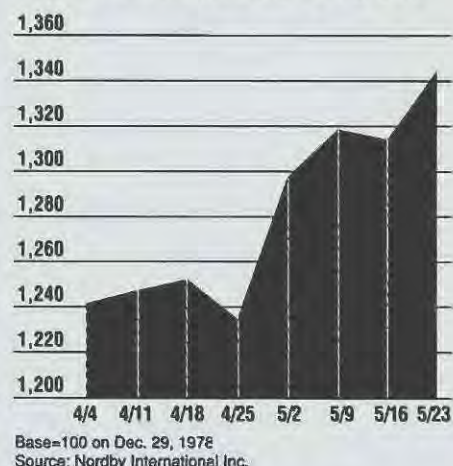
From an investor's point of view, the most important protection was the so-called safe harbor, which does not protect companies in state legal actions, he said. That provision encouraged companies to be more forthcoming with information, according to reform proponents.

But the perception that more legislation is justified is not universal.

Even before Reps. Eshoo and White unveiled their bill, H.R. 1689, the Washington-based Consumer Federation of America, the Government Finance Officers Assn. and other groups urged President Clinton to oppose it.

"At a minimum, we believe that you and Congress should insist on seeing real, conclusive evidence of how the litigation reform act has affected the ability of defrauded investors to recover their losses. Until such evidence has been generated, we urge you not to support legislative initiatives that would extend this untested experiment to lawsuits brought under state laws," wrote the CFA. **BI**

BI Insurance Index



Financial reform plan raises questions

By MARK A. HOFMANN

WASHINGTON—The Clinton administration's outline for financial services reform leaves numerous questions unanswered for the insurance industry.

The plan, unveiled by Treasury Secretary Robert Rubin last week, calls for allowing affiliations among banks, insurance companies, insurance agencies and securities firms. Insured depository institutions, however, would not be permitted to underwrite insurance other than credit-related insurance. Insurance activities of banks would be subject to "normal state insurance regu-

lations," provided the regulations did not "discriminate" against banks.

The administration proposal would also permit the creation of a new type of financial institution called a "wholesale financial institution" or "woofie," as Secretary Rubin called it. These new entities would not be federally insured, could not accept retail deposits and would be allowed to "engage in any lawful business."

The lack of legislative language spelling out exactly how the plan would work puts insurance observers at a loss.

"This is a framework we can work with, but we have questions like everyone else.

The key questions for us relate to holding company regulation, the precise way in which insurance regulators will interact with bank regulators, and how commercial affiliations will be treated as they relate to the insurance industry, which is a heavily regulated financial industry," said David Pratt, senior vp with the American Insurance Assn. in Washington.

Mr. Pratt said that while banks generally would be able to underwrite insurance either through an affiliate or an operating subsidiary, appropriate fire walls and safeguards would be installed so that banks would not enjoy an unfair competitive advantage in such an operation.

"The way the proposal stands, banks could get into the reinsurance business through an affiliate and reinsurers could get into the banking business. It appears to be leveling the playing field, though the details will determine just how level the playing field is," said Francis Bouchard, director-federal affairs for the Reinsurance Assn. of America in Washington.

Joel Wood, vp-government affairs for the Council of Insurance Agents & Brokers in Washington, said the biggest question for agents and brokers is who will be the ultimate authority for determining what constitutes discrimination. Mr. Wood noted that Federal Reserve Chairman Alan Greenspan did not answer that question during testimony before a House panel after the Treasury announcement.

"Clearly, I'm not that downbeat on this," Mr. Wood said. "I think the administration did about as well as they could under the circumstances." **BI**

ZRC shareholder says buyout offer too low

NEW YORK—The \$39.50 price that Switzerland's Zurich Insurance Group is offering for each outstanding share of U.S. subsidiary Zurich Reinsurance Centre Holdings Inc. is inadequate and should be re-evaluated, says a minority shareholder.

Baltimore-based investment advisory firm T. Rowe Price, which controls about 5% of New York-based ZRC's shares, says in a letter to the ZRC special committee dealing with the stock purchase that "Zurich's bid price does not adequately compensate ZRC minority shareholders for the growth in ZRC's business since its May 1993 IPO."

The May 5 letter, which was reported in a filing with the Securities and Exchange Commission, says the "continued uncertainty" created by the inadequate offer could hurt employee morale and "negatively affect ZRC's ability to attract new business."

A ZRC spokesman responded that the reinsurer's board has "unanimously determined that the offer is fair as well as in the best interest of ZRC's public shareholders."

Zurich made the offer in January and, at the time, held 66% of ZRC's shares (BI, Jan. 20).

—By Judy Greenwald

BI Industry Stock Report MAY 19, 1997, THROUGH MAY 23, 1997

BROKERS																													
	Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)		Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)		Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)									
Accordia Inc.	NYS	35.88	9.54	23.71	37.13	27.25	224	Enhance Financial Services	NYS	42.88	-0.58	17.47	45.00	26.13	138	RLI Corp.	NYS	31.75	-3.05	-4.87	36.63	22.00	349						
E.W. Blanch Holdings Inc.	NYS	23.88	3.24	18.63	23.88	17.75	85	Everest Reinsurance	NYS	32.75	0.38	13.91	33.88	22.50	1345	St. Paul Companies	NYS	70.50	-3.59	20.26	74.50	50.63	1065						
Gallagher Arthur J. & Co.	NYS	31.88	0.39	2.82	35.00	29.13	128	Executive Risk Inc.	NYS	50.13	0.75	35.47	50.63	30.75	222	SCOR	NYS	43.50	1.46	26.55	43.50	34.00	64						
Hill, Rogal & Hamilton	NYS	14.38	2.68	8.49	14.38	11.38	506	EXEL Ltd.	NYS	42.75	-2.56	12.87	45.13	31.75	366	SAFECO Corp.	NDO	43.06	2.84	9.19	44.00	32.00	1338						
Kaye Group Inc.	NDO	5.00	2.56	-4.76	7.00	4.38	6	Fremont General Corp.	NYS	33.38	16.59	7.66	33.38	21.50	1072	Selbels Bruce Group	NDO	8.00	4.92	-3.03	11.75	5.88	3						
Marsh & McLennan	NYS	130.75	2.35	25.72	131.50	88.00	1302	Frontier Insurance Group	NYS	54.00	1.17	41.18	54.88	32.63	277	Selective Ins. Group	NDO	44.31	1.29	16.61	45.00	31.00	14						
Poe & Brown	NDO	29.69	0.21	12.03	30.00	23.50	23	Gainsco Inc.	NYS	8.50	1.49	-11.69	11.13	8.13	102	Sphere Drake Holdings	NYS	8.75	-1.41	-1.41	10.50	8.13	57						
BROKERS AVERAGE																													
INSURERS/REINSURERS																													
ACE Ltd.	NYS	62.38	2.04	3.74	66.38	40.88	478	Guaranty National Corp.	NYS	20.50	1.23	22.39	21.63	13.50	55	Torchmark Corp.	NYS	54.50	0.00	27.72	66.25	40.25	810						
Acceptance Insurance Cos.	NYS	20.50	7.89	3.80	23.13	16.25	131	Harleysville Group	NDO	35.00	4.48	14.75	35.00	24.50	63	Transatlantic Holdings	NYS	38.50	2.16	9.94	38.50	64.00	105						
AEGON N.V.	NYS	75.13	0.67	18.77	75.38	42.25	126	Hartford Steam Boiler	NYS	50.00	2.04	7.82	50.38	42.75	169	Travelers Aetna Property	NYS	38.38	1.66	8.48	39.63	23.13	287						
Aetna Life & Casualty	NYS	95.25	0.53	19.06	100.38	55.38	2397	HCC Insurance Holdings	NYS	25.63	3.54	6.77	32.75	19.13	254	Travelers Corp.	NYS	56.50	2.26	24.52	56.38	29.13	7094						
AFLAC Inc.	NYS	50.00	3.90	16.96	50.00	28.25	1351	IPC Holdings Ltd.	NDO	25.63	3.54	14.53	26.38	19.13	330	Trenwick Group Inc.	NDO	32.88	1.94	6.62	36.25	30.75	230						
Allied Group Inc.	NYS	36.88	2.43	13.03	38.75	22.38	54	ITT Hartford Group	NYS	77.50	2.99	14.81	81.00	50.25	2010	Unico American Corp.	NDO	10.00	-1.23	-8.05	11.00	6.75	39						
Allmerica Prop. & Casualty	NYS	31.50	0.00	3.70	32.25	25.25	152	LaSalle Re Ltd.	NDO	28.88	0.43	-1.28	29.50	20.75	281	Unionamerica Holdings	NYS	16.50	3.13	-7.04	20.75	14.75	22						
Allstate Corp.	NYS	70.75	2.91	22.25	70.88	40.38	2757	Lincoln National	NYS	59.00	-3.48	12.38	61.53	40.75	2171	United Fire & Casualty	NDO	37.00	0.68	4.96	40.00	29.75	1						
AMBAC Indemnity Corp.	NYS	73.38	3.16	10.55	74.63	47.00	455	MAIC Holdings Inc.	NYS	38.38	3.37	13.28	38.38	28.25	28	Unitrin	NDO	52.50	-0.94	-5.83	56.38	44.25	147						
American Bankers Ins.	NDO	56.88	4.84	11.25	59.50	38.00	467	Market Corp.	NDO	121.50	0.83	35.00	121.50	80.50	17	UNUM Corp.	NYS	79.00	0.64	9.34	80.25	56.75	608						
American Financial Group	NYS	37.75	1.34	0.00	38.88	28.63	248	MBIA Insurance Group	NYS	103.88	1.22	2.59	104.63	72.38	333	US Facilities Corp.	NYS	19.00	0.00	-3.18	20.50	14.88	0						
American General	NYS	44.38	0.00	8.56	44.88	34.00	1780	Meadowbrook Insur. Group	NYS	23.38	8.09	11.31	34.13	15.25	26	USF&G Corp.	NYS	21.13	1.81	1.20	23.13	15.00	1813						
American Heritage Life Ins.	NYS	27.00	0.47	2.86	27.75	19.00	44	Mid Ocean Ltd.	NYS	44.50	-0.26	-15.24	55.38	38.00	293	USLIFE Corp.	NYS	48.63	0.52	43.24	48.75	28.88	536						
American Indemnity/Fin'l	NDO	13.13	7.14	28.05	14.00	9.50	1	MMI Cos. Inc.	NYS	23.13	2.21	-28.29	33.38	20.75	59	Vesta Insurance Co.	NYS	45.50	7.37	43.02	46.00	24.50	185						
American International	NYS	133.75	2.59	23.56	136.88	90.13	3585	Mutual Risk Mgmt. Ltd.	NYS	39.88	5.28	7.77	40.00	26.88	281	Washington National	NYS	27.88	-0.45	1.36	30.75	25.13	125						
Aon Corp.	NYS	47.63	1.06	14.99	48.38	31.75	749	NAC Re Corp.	NYS	40.88	0.93	20.66	42.75	30.25	204	Zenith National Ins.	NYS	25.63	-1.91	-3.39	28.88	24.88	51						
Argonaut Group	NDO	26.88	-5.70	-12.60	34.25	26.88	67	Navigators Group	NDO	17.88	4.38	-2.05	20.25	15.75	33	Zurich Reinsurance Centr.	NYS	38.63	0.65	23.60	38.88	28.38	278						
AVEMCO Corp.	NYS	25.38	4.10	62.40	27.38	11.75	47	Nobel Insurance Ltd.	NDO	12.63	-3.81	0.50	14.00	10.88	11	INSURERS/REINSURERS AVERAGE						1.35	9.93						
Baldwin & Lyons Inc.	NDO	17.81	0.00	-3.06	20.75	16.50	0	NYMagic Inc.	NYS	19.00	-0.65	5.56	21.13	17.00	960	HEALTH MAINTENANCE ORGANIZATIONS													
Berkley W.R. Corp.	NDO	53.63	0.94	5.67	55.00	40.25	236	Ohio Casualty Corp.	NDO	41.50	-1.19	16.90	42.63	30.00	123	Healthsource Inc.	NYS	21.25	0.00	51.90	24.00	9.75	272						
Berkshire Hathaway Inc.	NYS	42700.00	6.75	25.22	42700.00	30000.00	1	Old Republic Int'l	NYS	29.30	0.43	8.41	29.13	20.63	295	Humana Inc.	NYS	21.75	2.35	14.47	24.13	15.00	1443						
Capital RE Corporation	NYS	44.13	0.00	-5.36	48.00	32.50	57	Orion Capital Corp.	NYS	67.13	4.27	9.82	67.75	46.25	56	Oxford Health Plans	NDO	65.13	2.66	11.21	68.88	27.69	5925						
Capital Transamerica Corp.	NAS	21.38	-3.93	-30.49	27.37	12.12	16	Partner Re Ltd.	NYS	31.50	-1.56	-7.35	36.50	25.63	724	Pacificare Health Sys.	NDO	72.38	4.51	-10.92	86.25	59.63	1206						
CapMac Holdings Ltd.	NYS	29.88	0.42	-8.81	36.88	22.50	94	Penn-America Group Inc.	NDO	14.25	0.88	32.56	14.50	9.25	11	Safeguard Health Enter.	NDO	1.38	1.11	-35.00	22.50	9.63	115						
Capsure Holdings Corp.	NYS	12.25	1.03	6.52	18.88	8.00	39	Philadelphia Cons. Holding	NDO	32.50	-2.26	39.78	33.25	16.75	21	Sierra Health Services	NYS	30.88	4.66	25.38	34.88	22.38	396						
Chartwell Re	NYS	28.25	4.63	5.61	28.50	20.75	60	PXRE Corp.	NYS	27.30	1.41	9.09	27.00	22.25	152	United Healthcare Corp.	NYS	51.75	1.72	15.00	55.63	30.30	2838						
Chubb Corp.	NYS	60.25	3.43	12.09	62.75	40.88	1537	Reliance Group Holdings	NYS	11.25	-1.10	23.29	12.25	6.50	668	Wellpoint Health Networks	NYS	48.00	1.32	39.64	48.50	23.38	554						
CIGNA Corp.	NYS	173.75	2.06	27.17	173.75	105.50	886	Reliastar Financial Corp.	NYS	62.25	-0.20	7.79	65.38	40.00	563	HMOs AVERAGE						2.29	-5.21						
CNA Financial Corp.	NYS	102.13	1.11	-4.56	114.75	95.88	89	RenaissanceRe Holdings Ltd.	NYS	38.13	-3.79	15.53	41.25	26.75	22	ALL COMPANIES AVERAGE						2.21	2.50						
EMC Insurance Group Inc.	NDO	12.00	0.00	0.00	14.50	10.13	20	Risk Capital Holdings	NDO	19.13	-1.29	-1.29	20.75	15.88	130														

Top advancing issues: Fremont General Corp., Titan Holdings, Inc., Accordia Inc. Leading decliners: Argonaut Group, TIG Holdings, Capital Transamerica Corp. Most active issue: Travelers Corp. The BI Index increased 2.0%; the Dow Jones 30 Industrials gained 2.1%; the S&P 500 increased 2.1% and the NYSE Composite gained 1.8%. Average P/E: Brokers, 17.7; Insurers/reinsurers, 38.9; HMOs, 30.8. System design: Nordby International Inc.

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