NEWSPAPER

MAY 9, 1994

Business Insurance®

Reporting Weekly For Corporate Risk, Employee Benefit and Financial Executives / $4.00 a copy

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Updates

HCFA to ask Congress for delay in Medicare Data Bank reporting

WASHINGTON—The Health Care Financing Administration this week will ask Congress to delay for at least 18 months a requirement that employers compile and report health insurance data on employees and dependents.

In a notice to be published in the Federal Register, the agency will ask Congress to delay the requirement so that the "data bank is consistent with health care reform," said Bruce Vladeck, HCFA administrator.

Under the 1993 budget law, employers are

Continued on next page

Regulators scrutinize offshore insurer

By DOUGLAS McLEOD

NEW YORK—An offshore insurer that figured in a 1991 criminal fraud case is now soliciting marine business across the country under the direction of a new Irish management firm.

American Fire & Marine Insurance Co. Ltd., which claims to be domiciled in Liberia and Panama, is writing marine risks in several states under the management of International Marine Group Ltd. of Dublin.

IMG was incorporated in February by an Isle of Man firm whose representatives include Paul Yorke-Wade, former president of the defunct Victoria Insurance Co. and a former associate of late insurance con man Alan Teale.

American Fire's producers also include a New Jersey businessman, Douglas McDonough, who is on probation from an unrelated 1990 insurance fraud conviction.

Mr. McDonough's firm, Marine Marketing Services Inc. of Hillsdale, N.J., separately pleaded guilty to insurance fraud in Alaska in 1991 related to sales of American Fire commercial marine policies.

Despite widespread regulatory attention, regulators in other states have taken no action against American Fire or its producers, in some cases because state law exempts ocean marine insurance from state oversight, regulators confirm.

For their part, American Fire officials and producers say the insurer is a solid market operating legally in the United States.

"As far as I'm aware, we are on the up and up with the states," said Edward E. Grzelakowski, general manager of American Fire at IMG's offices in Dublin. "We are not transacting business illegally in any state we know of."

Representatives say American Fire was originally incorporated in 1990 in Monrovia, Liberia.

Its articles of incorporation list three officers—Thomas T. Gayflorson, Foley Kiatamba and Saye Guah—all at the same Monrovia address.

Lawyers consulted by Alaska officials in 1991, however, questioned the authenticity of stamps on American Fire's Liberia documents and found that the Mon-

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Superfund resurrected

Compromise bill would reduce litigation through insurer tax

By MARK A. HOFMANN

WASHINGTON—Like a cat granted a 10th life, Superfund reform is back on this year's legislative agenda.

Markup is scheduled to begin this week on yet another White House-backed compromise bill, this one including a proposal to reduce pollution coverage litigation through an $8 billion pool funded by an insurer tax.

Only weeks after declaring reauthorization dead for this year, Rep. Al Swift, D-Wash., said chances for legislation look even better now than before.

Rep. Swift, chairman of the key Energy and Commerce Subcommittee on Transportation and Hazardous Materials, was on hand Tuesday when weeks of White House meetings culminated in the compromise. The May 3 meeting "was to see where the thumbs are, and the thumbs were overwhelmingly up," he said.

Carol M Browner, Environmental Protection Agency administrator, said the new proposal was the result of "unprecedented consensus-building" among business, environmental and insurance groups.

While some insurance and business groups say the compromise has merit, others—including the Risk & Insurance Management Society Inc.—oppose the proposal.

One critical element of the com-

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AP/Wide World photo

EPA Administrator Carol Browner and Sen. Frank Lautenberg, D-N.J., were among those hammering out a compromise at last week's Superfund meeting.

A step closer to compromise

Developments signal support for alternatives to Clinton plan

By MARK A. HOFMANN

WASHINGTON—The decision of two Democratic senators to break with President Clinton and support a Republican health care reform bill could pave the way for passage of a less-sweeping compromise measure.

The potential for compromise was furthered by a Congressional Budget Office analysis of the bill regarded as the chief alternative to the president's proposal.

The CBO found that the Managed Competition Act of 1993, whose primary sponsor is Rep. Jim Cooper, D-Tenn., would extend coverage to about 40% of those currently uninsured without imposing an employer mandate. The bill also would bring the total percentage of the population with health care coverage to about 91% within 18 months' of enactment, the CBO concluded.

The decision last week of Sens. David Boren, D-Okla., and Robert Kerrey, D-Neb., to embrace the GOP health care reform bill sponsored by Sen. John Chafee, R-R.I., caught the attention of benefit pundits.

The Chafee bill would require individuals to purchase health coverage and would provide subsidies for low-income people. Employer-provided health coverage would no longer be fully tax deductible for employees.

The senators' decision is "very significant" because it means there are now two comprehensive bipartisan bills—the Chafee bill and the managed competition bill, said Frank McArdle, a consultant in Hewitt Associates' Washington

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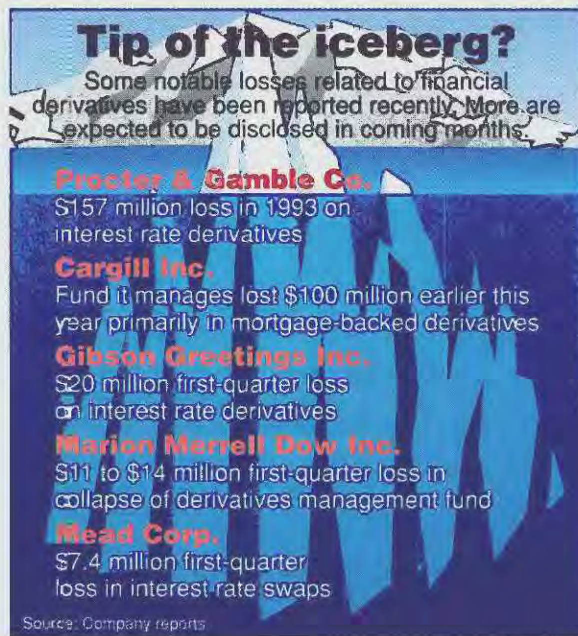
Derivatives may yield D&O losses



GRAPHIC BY JOHN HALL

By RODD ZOLKOS

Stunning losses in financial derivatives, which are starting to show up in company financial disclosures and front-page news, may soon turn up in directors and officers liability claims.

As both the Securities and Exchange Commission and the General Accounting Office begin scrutinizing derivatives more closely, the losses disclosed so far may be just the tip of the iceberg.

It's been suggested that top management at many of the companies that have suffered losses didn't fully understand the nature of these complex investments or the risks that went with them. And that, experts say, could open the door to securities and shareholder derivative suits and D&O claims.

D&O liability insurers say the scale of claims will not be clear for another quarter or two—until losses caused by recent interest rate swings show up on bottom lines.

The risk of derivatives losses is already causing D&O insurers to more closely scrutinize policyholders' derivatives portfolios before writing coverage.

Major public companies have recently begun reporting big losses from derivatives, which are largely unregulated investments that "derive" their value from underlying assets, such as securities or currencies, or movement in such indicators as interest rates or stock indexes.

The GAO is preparing a report to be released May 18 that is expected to recommend giving the SEC broad power to regulate derivatives dealers and the companies that use them. The GAO would not discuss the report.

According to press reports, the report will call for direct SEC regulation of the subsidiary operations of securities firms and insurance companies that deal in derivatives, and will suggest that the SEC and accountants develop standards for internal controls and disclosure by companies that use derivatives.

Currently, the SEC is examining the pub-

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Data reporting delay sought

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required to compile coverage data on a broader range of people—including retirees and their dependents—than they previously tracked, (*BI*, Sept. 13, 1993; Aug. 9, 1993). The data will feed a new data bank of secondary Medicare/Medicaid payers to help the government recoup an estimated $1 billion in claims that should have been paid by employers, not Medicare.

Employers complain that the cost of compiling the data would far outweigh any benefits. Bills have been introduced in both houses of Congress that would repeal the data bank law (*BI*, April 11).

The law was supposed to take effect Jan. 1, 1994, but was delayed until HCFA could provide employers with guidance about meeting the requirement. According to Mr. Vladeck, the proposed delay "will enable us to proceed in a manner consistent with health care reform—achieving the savings intended by the law with sound procedures developed with care and managed efficiently."

AMA endorses fee schedule

CHICAGO—The American Medical Assn. is fighting to preserve fee-for-service medicine and escape price controls under federal health care reform by urging physicians to bill patients based on a national fee schedule.

Physicians should base their rates on a standard fee schedule like the Resource Based Relative Value Scale, Dr. James Todd, AMA executive vp, said during the AMA's national conference. The RBRVS, which takes into account physicians' work, operating expenses and the cost of liability insurance, is used to set Medicare prices.

Doctors have complained that the RBRVS rates are too low. But, Dr. Todd explained that a fee schedule based on the rates, but with higher multipliers based on individual circumstances, would avoid more stringent price controls under a health care reform law.

Under the Clinton plan, "physicians would be forced to accept state or regional fee schedules for fee-for-service and out-of-network care, with balance billing prohibited," he said.

Dr. Todd said the fee schedule should not be used as a cost-containment device and physicians should be allowed to charge more based on their talent and experience. He also said physicians should disclose all rates in advance to help patients make informed decisions.

Partnership to buy Statesman

CARMEL, Ind.—Conseco Capital Partners II L.P., an insurance investment partnership, plans to acquire The Statesman Group Inc. in a transaction valued at $350 million.

The acquisition of Statesman, a Des Moines, Iowa-based financial services company specializing in life insurance and annuity products, is the first for Conseco Capital Partners.

The partnership was formed earlier this year with $623.8 million contributed by Conseco Inc., the California Public Employee Retirement System, the State of Michigan Retirement System, Armco Master Pension Trust and 32 other investors (*BI*, Feb. 7).

Statesman has total assets of about $4.6 billion and had $1 billion in annuity premiums and $37.2 million in net income in 1993.

The deal is still subject to shareholder and regulatory approval.

Lloyd's cover for racer's death

LONDON—The death last week of three-time Formula One world racing champion Ayrton Senna likely will trigger more than one insurance policy to cover income lost by his vast business empire, underwriters say.

A Lloyd's spokesman confirmed that the British-based Williams racing team bought a personal accident policy totaling $20 million to cover Mr. Senna throughout this year and next. The amount of the coverage declines after each successful race, he said, and since Mr. Senna completed three or four races this year, the coverage probably is worth $16 million to $17 million.

Broker T.L. Clowes & Co. Ltd. placed 30% of the coverage in Lloyd's, led by underwriter Ian Slater, and the rest is placed in the London company market. Mr. Slater said there was probably more than one policy covering Brazilian-born Mr. Senna's businesses. However, he would not comment on any of them, including the one he leads. T.L. Clowes did not return calls.

Mr. Senna's death follows that of rival Formula One driver Roland Ratzenberger at the San Marino Grand Prix on April 30.

US Facilities buyout proposal

COSTA MESA, Calif.—Title insurer Fidelity National Financial Inc. continues to pursue US Facilities Corp., a specialty insurer and reinsurer for which it made an unsolicited bid of $79 million last month.

Moves and countermoves continued last week as US Facilities neither accepted nor rejected the offer. Fidelity National sent proxy materials to US Facilities shareholders seeking support for a referendum that would require the board to seek a sale or merger of the company and the election of two independent directors, said Frank P. Willey, Fidelity National's executive vp and general counsel.

US Facilities directors, who have hired Morgan Stanley & Co. Inc. as an adviser, plan to meet in about a week to receive reports and recommendations on the proposal. They have refused Fidelity's request to delay the meeting for a month.

US Facilities specializes in marketing, underwriting and reinsuring medical stop-loss insurance and in property/casualty reinsurance. It also provides managed care and medical bill review products. Net premiums in 1993 totaled $85.6 million.

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Broker rankings jumbled by first-quarter results

By SALLY ROBERTS

Only a few months into 1994, the lineup of the largest U.S.-based brokers may be going through its biggest shakeup in years.

Rollins Hudig Hall Group Inc., the nation's third-largest broker based on 1992 revenues, is vying for the No. 2 spot, which Alexander & Alexander Cos. Inc. has held since 1977, when it surpassed Johnson & Higgins.

Based on year-end 1993 revenues, A&A will remain the second-largest U.S.-based brokerage,

but RHH may assume the No. 2 position after this year, if first-quarter revenues are any indication.

RHH posted a 14.9% increase in revenues in the first quarter of 1994 to $352.3 million, compared with A&A's 0.6% drop in revenues to $323 million.

While there are still three more quarters to go in 1994, Patrick G. Ryan, chairman and chief executive officer of RHH, said of its position in the first quarter: "If we are No. 2, we won't give it up very easily."

Indianapolis-based Acordia Inc. also outperformed rivals in the first quarter, with a 61.7% increase in gross revenues to $89.3 million. Fueled largely by acquisitions, that revenue growth was enough to carry Acordia, which was the sixth-largest U.S. broker based on 1992 revenues, past No. 5 Arthur J. Gallagher & Co., whose revenues increased 9.6% to

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Single-payer initiative

Campaign under way to defeat proposal on California ballot

By LOUISE KERTESZ

SACRAMENTO, Calif.—An informal coalition of health insurers, businesses and health care providers is mounting a campaign to defeat a ballot initiative that would establish a single-payer health care plan in California, even though they say the chances it will be enacted are poor.

Passage of Initiative 626, the Single-Payer Health Care Initiative, would guarantee comprehensive medical coverage to all state residents. Covered services would include preventive, mental health and long-term care, as well as prescription drugs and some dental care.

The initiative, likely to appear on the November ballot, would abolish private health insurance as well as public health care programs like Medicare in the state and replace them with a state-run plan financed by payroll, income and tobacco taxes. It is not clear whether the program would replace medical coverage now provided under automobile or workers compensation policies. Nominal copayments would be phased out after the first year of the program.

The program would be administered by an elected health commissioner and appointed regional administrators, who would set budgets and negotiate fees with providers. The system would preserve the right of residents to choose their own health care providers.

The initiative calls for benefits to commence in the second year following its passage. But, even if the ballot initiative is passed by

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More than tobacco firms may be exposed under bill

Florida firms are worried

By SARA MARLEY

TALLAHASSEE, Fla.—An amendment in a bill passed recently by the Florida Legislature would allow the state to sue companies whose products are found to cause illnesses for which Medicaid pays.

The drafters of the amendment say tobacco companies are the intended targets.

But opponents of the legislation point out that cigarette makers are not specified. Therefore, the opponents say, the law could create an avalanche of litigation against everyone from the makers of high-fat foods to the supermarkets that sell them.

Gov. Lawton Chiles is expected to receive the bill within the next several days and will have 15 days to act on it. Although he has supported the proposal, he now is coming under intense pressure from business groups to veto it.

The amendment was tacked onto a Medicaid fraud bill in the final hours of the legislative session without debate in committee or on the floor.

The bill would strengthen a 1979 law by allowing the state to file class-action lawsuits on behalf of all Medicaid recipients with a particular ailment and by eliminating "affirmative defenses" like arguments that the consumer knowingly assumed the risk.

Other provisions of S.B. 2110 would:

• Approve the use of statistical evidence that a product causes the injury.

• Base recovery on market

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Agent/broker directory deadline May 23

Business Insurance will publish its 23rd annual directory of insurance agents and brokers in the July 18 issue.

That issue will include a Spotlight Report on the commercial retail insurance brokerage business and profiles on the world's 20 largest brokers.

The directory is published as an editorial service; there is no charge to be listed.

However, brokers must complete and return a *BI* questionnaire by the May 23 deadline.

If your company generated at least $500,000 of its 1993 gross revenues from commercial retail brokerage and you have not yet received a questionnaire, please request one. For a questionnaire or additional information, contact Directory Editor Kathy Welyki at 312-649-5279.

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Vol.28, No.19—*Business Insurance* (ISSN 0007-6864) is published weekly by Crain Communications Inc., 740 N. Rush St., Chicago, Ill. 60611. Second-class postage is paid at Chicago, Ill., and at additional mailing offices. Canadian Post International Publications Mail Product (Canadian Distribution) Sales Agreement No. 0293512, GST No. 136760444. Printed in U.S.A. Postmaster: Send address changes to *Business Insurance*, Circulation Department, 965 E. Jefferson Ave., Detroit, Mich. 48207; 800-678-9595. Copyright 1994 by Crain Communications Inc.

NICO agenda varies little under new boss

By MARK A. HOFMANN

WASHINGTON—Could some insurers inadvertently end up among the roadkill of the information superhighway, with consumers left to pay their funeral expenses?

That's one of the questions being asked by the new president of the National Insurance Consumer Organization, which has never numbered among insurers' favorite groups.

Kathleen O'Reilly, who succeeded J. Robert Hunter as the organization's top official last fall, is concerned that insurers will be hit with huge claims for new exposures created by new communications systems.

But, otherwise, NICO's agenda under her leadership will be familiar. NICO will, she says:

- Continue its efforts to repeal the McCarran-Ferguson Act, which grants insurers limited immunity from federal antitrust laws. NICO supports the passage of H.R. 9, a McCarran reform measure sponsored by House Judiciary Chairman Jack Brooks, D-Texas.
- Push for tougher sanctions against alleged insurer redlining, including passage of an antiredlining bill like H.R. 1257, sponsored by Rep. Joseph P. Kennedy II, D-Mass.
- Seek legislation that would give banks greater insurance powers.

Photo by Tom Reed

'I think I'm the first one in the country who has been addressing some of the very significant insurance issues that are inherent in the information highway public debate.'

Kathleen O'Reilly

- Become increasingly involved in the debate on a natural disaster insurance program.
- Promote the "pay-at-the pump" auto insurance plan in California, in which the price of gasoline would include a flat liability insurance premium so that motorists who drive more would pay more for coverage.
- Expand its role in health care reform efforts by aiding groups like Citizen Action and Consumers Union, both of which support a single-payer system.

Ms. O'Reilly, a veteran public interest lawyer, was asked by NICO's board of directors to take over Mr. Hunter's job after he accepted the post of Texas insurance

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Tort system adds $450 to hospital bills: Study

By SALLY ROBERTS

INDIANAPOLIS—Any attempt to reform the nation's health care system must include tort reform measures to help reduce the enormous expenses related to defensive medicine, a Midwest think tank and other observers say.

According to a recent case study of a large, urban hospital in Indiana, legal liability expenses in 1993 added $450 on average to the facility's cost of treating every admitted patient.

Of that amount, $327 is attributable to defensive medical practices—doctors ordering extra tests and procedures to try to avoid lawsuits—and the remainder to medical malpractice insurance costs and legal fees.

Put another way, legal liability expenses constituted 5.3% of the hospital's total operating expenditures, while defensive medical practices alone accounted for 3.9% of the total, according to the study, which was conducted by The Competitiveness Center of Hudson Institute, an Indianapolis-based conservative think tank.

The study stresses that the numbers from the Indiana hospital understate the average national cost of liability, since Indiana reformed its tort laws nearly two decades ago.

Indiana's Medical Malpractice Act of 1975: capped total damages, both punitive and compensatory, at $500,000; capped legal contingency fees at 15% for awards over $100,000; and established mandatory medical review panels, among other reforms.

Despite these efforts, 92.7% of the hospital's 250 physicians on staff said the threat of malpractice liability influences the tests and procedures they order.

Medical malpractice experts say the Hudson study exemplifies the problems of excessive medical malpractice litigation and could encourage Congress to include tort reform provisions within health care reform legislation.

So far in the health care reform debate, tort reform has "not been talked about much at all," said David C. Murray, a research analyst at The Competitiveness Center and co-author of the study. "We hope this gives (Congress) some hands-on data that demonstrates that malpractice liability is a real problem that needs to be addressed in any health care legislation."

Most health care reform measures in Congress include a modicum of malpractice reform, ranging from proposals to cap damage

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Expanding the menu

Broadened effort helps McDonald's explain benefits

By DEBORAH SHALOWITZ COWANS

OAK BROOK, Ill.—Just as the menu has grown far beyond just burgers and fries, so has McDonald's Corp.'s work force grown increasingly diverse.

To make sure that benefit communications reach all segments of that workforce, the world's largest restaurant chain has taken steps to diversify its approach. In recent years it has conducted surveys and focus groups of employees, included a wide range of people in planning teams, trained a diverse group of workers to communicate benefits to their colleagues and made available Spanish-language materials and speakers.

Photo by Michael A. Marcotte

Employee benefits personnel Robert Wittcoff and Yolanda Velazquez confer with Ronald McDonald about communicating the company's benefits.

"We spend an awful lot of money on employee benefits," said Robert Wittcoff, director of employee benefits at the company's suburban Chicago headquarters. Good communications about the benefits plan "lets employees know more, value it more, appreciate it more."

Furthermore, "the efficiencies of the plan operation will go better" if it has been properly communicated, he said. "People will know what to do and what not to do."

McDonald's, which self-insures its benefit programs, provides health insurance to about 15,000 full-time employees in the United States. Among them are employees of some 1,400 company-owned restaurants, most in big cities; 40 regional offices; and the corporate headquarters.

McDonald's workforce is exceptionally young. Among insured workers, the average age is in the low 30s; few, if any, employees are over 65, said Mr. Wittcoff. McDonald's employs many minorities and there are more women than men in store management, noted Yolanda Velazquez, benefits and compensation project manager.

Benefit communications planning teams are designed to reflect those demographics and also to include people from various corporate departments.

"Good ideas are certainly not limited to a few select people," Mr. Wittcoff stated. To ensure diverse representation on a communication planning team, "we not only will look at age, sex and race but also position, education and geography."

Benefit planning teams are credited with simplifying and streamlining materials to improve communications with the diverse workforce.

Four or five years ago, many employees were dissatisfied with their paper health insurance

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Life insurers protest bill that would boost ratings of some GICs

By JUDY GREENWALD

ALBANY, N.Y.—Proposed state legislation that would allow financial guarantee insurers to confer their AAA ratings on lower-rated guaranteed investment contracts is likely to be welcomed by a market faced with a shortage of AAA-rated insurers.

But the bill is also attracting strong opposition: New York Life Insurance Co., Metropolitan Life Insurance Co., the Reinsurance Assn. of America and the American Council of Life Insurance criticize it as giving financial guarantee insurers an unfair edge.

The legislation has been approved by the New York Senate's Insurance Committee and is now awaiting a full vote in the Senate. In the Assembly, a companion bill is before the Insurance Committee. New York lawmakers' action on this proposal will be felt nationwide: All but two of the country's financial guarantee insurers are based in New York.

Recent failures of GIC issuers Mutual Benefit Life Insurance Co. and Executive Life Insurance Co. have led employers with 401(k) plans to diversify and seek better quality investments in their GIC portfolios.

But relatively few top-rated in-

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Adjuster cleared in bad faith case

Liability rests with comp insurer: Court

By DAVE LENCKUS

AUSTIN, Texas—Injured workers cannot recover damages from workers compensation claims adjusters for bad faith and unfair dealing, because workers comp insurers are liable for their contractors' actions, the Texas Supreme Court has narrowly ruled.

In reversing an appellate court ruling 5-4 on April 28, the state high court also ruled that claims adjusters are not liable for negligent and intentional emotional distress damages even if they are rude to workers comp claimants or give them the "runaround."

The attorney representing a Revco D.S. Inc. employee who sued workers comp claims adjuster Alexsis Inc., a subsidiary of Alexander & Alexander Inc. of New York, said she will ask the state high court for a rehearing.

But workers comp attorneys not involved in the case say the court's decision on the bad faith allegation formally brings Texas in line with case law or statutes in most other states.

The worker, Rosa Natividad, was injured in separate incidents in 1987 and 1988 when she was struck by a box that was being unloaded from a truck and when lifting another box. Ms. Natividad

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Court limits employer liability for drunk worker

By SALLY ROBERTS

BOSTON—An employer that provides a refrigerator for its employees and is aware of the storage and imbibing of alcoholic beverages at work does not have a duty to prevent the employees from driving while intoxicated, the Massachusetts Supreme Court has ruled.

Under the doctrine of host liability in Massachusetts, an employer only has a duty to protect members of the general public if it supplies the alcohol to its employees, the high court said in its April 25 ruling in *Kelly vs. Avon Tape Inc.*

Juan Rodriguez, an employee of the Brockton, Mass.-based manufacturer of adhesive tapes, injured two people in a car accident while driving home from work intoxicated.

The plaintiffs, Carole Kelly and Roger Calvin, alleged that Avon Tape not only provided a refrigerator for its employees but also was aware that Mr. Rodriguez was drinking beer at work on the day of the accident and made no attempt to stop him or to keep him from driving home.

The plaintiffs sued Avon Tape in October 1989 in Norfolk County Superior Court, which ruled in favor of Avon Tape and granted summary judgment. The case bypassed the appeals court and the state Supreme Court, in a 5-2 decision, upheld the lower court's ruling.

'We have never imposed social host liability on a private defendant who has not engaged in conduct that fairly might be described as negligent by furnishing alcohol to an obviously intoxicated person (or to a minor),' the majority opinion says.

"We have never imposed social host liability on a private defendant who has not engaged in conduct that fairly might be described as negligent by furnishing alcohol to an obviously intoxicated person (or to a minor)...because only when a host controls the liquor supply is it reasonable to assume that a host has the ability to monitor the guests' alcohol consumption," the Supreme Court judge wrote.

The case originally came before the state trial court on a motion for summary judgment.

Solely for purposes of that motion, Avon Tape did not contest Mr. Rodriguez's allegations that it knew he stored beer in the refrigerator and drank it at work the day of the accident, said Carol A. Griffin, a lawyer with Morrison Mahoney & Miller in Boston who represented the company. Had the case actually gone to trial, she added, Avon Tape would have contested those allegations.

Employers should be aware that if they do provide alcohol to employees and one of them drinks and drives, the employer can be held liable for the consequences, she warned (*BI*, Dec. 13, 1993).

The dissenting judges said that whether the employer provided the alcohol is "irrelevant."

Employers owe a duty to travelers on the highway if the employer allowed the consumption of alcoholic beverages during the working hours, knew or reasonably should have known that the employee was leaving work intoxicated and could have but did not take reasonable steps to prevent the employee from operating a motor vehicle, the dissent said.

•

Carole Kelly et al. vs. Avon Tape Inc., Supreme Judicial Court of Massachusetts; N-6405.

L.A. self-insured for settlement of police liability

LOS ANGELES—The city of Los Angeles is self-insured for a $4.5 million settlement with the family of a teen-age girl who was molested by a uniformed police officer.

Separately, hearings continued last week over whether several Los Angeles police officers are liable for punitive damages in the 1991 beating of Rodney King.

The recent settlement follows a 1992 Los Angeles Superior Court jury order that the city pay the girl $6.1 million in compensatory damages and that the officer, Stanley Tanabe—who has since resigned—pay $3.1 million in punitive damages. The family of the girl settled to avoid protracted appeals.

Thomas C. Hokinson, senior assistant city attorney, said the settlement is one of the largest on record for the police department. The city is not liable for the punitive damage award against Mr. Tanabe, which is still outstanding, Mr. Hokinson said.

The settlement stems from a 1989 incident in which Mr. Tanabe entered a home, telling the 13-year old girl's parents that he was investigating reports of screaming. He went into the girl's bedroom and told her he was searching for guns, then fondled her, said Mr. Hokinson. The incident was reported, but Mr. Tanabe was not identified as the perpetrator until he returned to the girl's home 30 days later, Mr. Hokinson said.

At that time, the girl fled and called police, and Mr. Tanabe was arrested as he left the house. He was convicted in 1990 on criminal charges of sexual battery and served two years in prison.

To reduce litigation against the city, council members called for immediate internal investigations when lawsuits are filed involving the police department.

Meanwhile, testimony continued last week in a hearing to determine whether 14 current and former police officers are liable for punitive damages in the beating of Mr. King.

Jurors already ordered the city to pay Mr. King $3.8 million in compensatory damages.

It was the 1992 acquittal of four of the officers that sparked rioting that took more than 50 lives and caused more than $775 million in insured damage (*BI*, May 4, 1992).

The Los Angeles City Council would have to decide whether to pay any punitive damages from city funds or leave the police officers responsible.

—By Louise Kertesz and Judy Greenwald

WHEN THE HEAT'S ON, YOU CAN TRUST US TO PERFORM.

Wherever there's business to be done, employee benefit plans meet your most demanding insurance needs with solutions to be prepared, people to be insured, you'll find a member of the Swiss Life Network. Every one a leading local life insurer. And we're represented throughout the EU and in Eastern Europe.

We provide multinationals with first class employee benefit plans as well as the information you need to control benefit levels and achieve significant financial savings. And we're there at once when you need us.

You'll find your Swiss Life Network Partner understands the pressures you face. He'll backed by our immense international expertise and the local, personal and flexible response you expect. Plus, highly competitive investment returns.

That's when the Swiss Life Feeling, the quiet certainty that you've chosen the right insurance partner, begins to grow on you. Tangible, cool and refreshing - right next door and no mirage.

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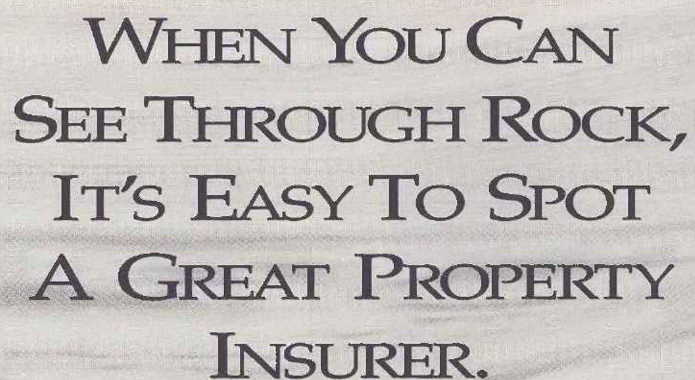

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Stanford offers early retirement bonus

Benefit Beat

PALO ALTO, Calif.—Stanford University is offering bonuses to professors who opt for early retirement under a new incentive program introduced last month.

Professors who are 60 or older with at least 15 years of Stanford service are eligible for bonuses equal to double their annual salary under the offer, which is good through December, said Kathy Gillam, the university's associate provost for faculty affairs.

Upon retirement, professors would be eligible for full retirement benefits.

Beginning next year, the bonus will continue to be offered but on a sliding scale basis tied to the age of the employee at retirement. Professors between 60 and 65 would still get a bonus equal to two times base salary, while the size of the bonus would decrease for older professors. For example, the bonus would equal only 0.6 times salary for 69-year-olds and there would be no bonus for retiring professors aged 70 or older, said Ms. Gillam.

About 200 of Stanford University's 1,400 faculty members are eligible for the early retirement bonus, said Ms. Gillam. The average salary for a full-time Stanford professor is $95,200, except for professors in the medical school, whose salaries are higher on average.

A federal law that took effect Jan. 1 eliminated mandatory retirement for college professors at age 70.

The fact that there is no longer mandatory retirement at age 70 "strengthens our desire for faculty turnover for financial, but also for nonfinancial reasons, from the point of view of new blood and new faculty initiatives," Ms. Gillam said.

"We wanted something mutually beneficial to our individual faculty members as well as the institution," she added.

Ms. Gillam said Stanford has had an early retirement program since the early 1970s, except for the past two years, when an unclear legal environment, among other factors, led to its temporary suspension.

Ms. Gillam could not estimate the costs of the bonus incentive program because it is unclear how many faculty members will retire. However, the university expects to recover the costs of the program in four to five years by hiring younger faculty members at lower salaries than the retiring faculty.

A recently-introduced retirement program at the University of California has caused potential problems at its four law schools, with administrators worried too many professors will decide to retire and they will be unable to replace them due to budgetary constraints (*BI*, March 28).

However, Stanford, which is a private university, is not under the same budgetary restraints and, in general, will replace the retiring professors with junior faculty members, said Ms. Gillam. "This will not be a cataclysmic event," she said.

—By Judy Greenwald

Extending benefits

OAKLAND, Calif.—Unmarried partners of physicians and other non-union employees of Kaiser Permanente's medical group in Northern California will be eligible to collect health care benefits starting next year.

The move to extend health care coverage to domestic partners will affect about 8,000 of Kaiser's 34,000 employees in Northern California, a spokeswoman for the Oakland-based health maintenance organization said. Kaiser is expected to extend benefits to its non-union Kaiser Foundation Health Plan and hospital employees in addition to its medical group. It eventually could be extended to union employees under their collective bargaining agreements as well, she said.

Kaiser is studying whether to extend additional benefits to domestic partners, the spokeswoman said.

"The fundamental point right now is that philosophically the concept of domestic partners has been endorsed and that is really the most significant step in terms of future implementation," she said.

"It's getting over, I think, that philosophical first step that's important. Details, practicalities and implications is something that can all be worked out."

—By Judy Greenwald

Early retirement offer

HOUSTON—In an effort to improve efficiency in a slumping oil and gas industry, Halliburton Co.'s energy services division is offering early retirement and a special termination package to salaried employees in order to trim its payroll by 500 to 700 people.

In order to avoid forced termination, employees age 50 and above can retire early with full retirement benefits as well as a severance package that includes 1.5 weeks of salary for every year of service as well as full medical benefits for a period determined by length of service.

The benefits are the same for the termination program, which will be forced upon certain salaried employees if the voluntary program does not produce enough retirees.

A spokesman for the Houston-based division of Halliburton, one of the world's largest energy services, engineering and construction companies, said the reduction in the energy division's 23,000-person workforce is necessary due to "low oil prices and reduced spending among the companies we service."

—By Michael Schachner

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NCCI aiming to distance itself from insurers

By MEG FLETCHER

ORLANDO, Fla.—The National Council on Compensation Insurance is trying to reduce its reliance on insurance company sponsors.

In the face of growing criticism, the workers comp industry's largest statistical and ratemaking organization is demonstrating a lesson learned from the dinosaurs: It is better to adapt than to become extinct.

"We have no inherent right to exist and, ultimately, if we are to survive we must offer products that the marketplace wants, all consistent with regulatory demands," NCCI President William D. Hager said at the organization's 75th annual issues symposium last month in Orlando, Fla.

The NCCI's board has directed the organization to eventually eliminate assessments on insurers, which is its primary method of financing its operations, and instead rely solely on revenues produced through the sale of its products and services, he said.

"This obviously creates an environment in which many current members will choose to be customers only and many others will choose to become first-time customers," he said.

In keeping with this new philosophy, NCCI insurer members, for the first time, were charged a fee of $150 to attend the 1½-day conference, though it still was less than the $275 fee for non-members.

"As all of NCCI's operations are shifted to a fee-for-service basis, we are entering a brave new world in which the services offered will depend upon the market for them," said outgoing NCCI Board Chairman J. John Wortman.

"As a market-driven, independent enterprise, NCCI will be expanding its customer base, not only seeking out new customers for its products and services but more accessible than ever to those who seek out NCCI's expertise to assist them in solving their problems," said Mr. Wortman, who is president and chief executive officer of Michigan Mutual Insurance Co. of Detroit and the Amerisure Cos.

The NCCI is "well on the way" to expanding its customer base for its valuable data, he said. The fastest-growing demand is coming from non-members, especially self-insurers, joint underwriting associations and producers.

Customers can purchase more than 200 products from the NCCI, including an annual statistical bulletin and numerous NCCI manuals on safety, job classifications and compilations of state-specific workers comp laws.

The NCCI's effort to distance itself from insurer sponsorship is in response to criticism from some state insurance regulators and consumer groups that argue states should no longer rely on insurance industry-supported groups for claims and loss data because the public may perceive the data as inaccurate and self-serving.

Supporters of the NCCI and other ratemaking groups counter that their public image problems are not based on fact and can be solved by greater regulatory scrutiny—rather than elimination—of existing organizations (*BI*, Dec. 13, 1993).

It remains to be seen whether critics will regard the NCCI's growing independence from insurer sponsorship a sufficient solution.

Other previously mentioned options include requiring insurers to sell their stakes in such organizations or having individual states contract with an outside firm or perhaps the National Assn. of Insurance Commissioners, assuming it agreed to provide such services.

In other business at the meeting:

- Joseph A. Dear, assistant U.S. secretary of labor and director of the Occupational Safety and Health Administration, urged employers to realize that workers comp costs are variable—not fixed—and can be managed cost-effectively.

To that end, he asked insurers to continue emphasizing the importance of accident prevention through safety information, loss control services and by nominating clients with good safety records for OSHA's special recognition programs, which exempt recipients from some inspections.

- A final report summarizing 18 months of work by the NCCI's National Fraud Advisory Commission was released, making several recommendations to fight fraud.

Among other things, the report urges state insurance departments and workers compensation insurers to establish and adequately fund fraud-fighting units.

It also urges the creation of comprehensive data bases to assist the fraud units. One data base, for example, should provide information on specific employers' workers comp coverage and premium history.

Another data base could contain detailed information about pending lawsuits involving allegations of workers comp fraud.

The commission also supports development of a "multifaceted educational program" about the workers comp system directed at regulators, administrative law judges, attorneys, health care professionals, employers and employees.

Commission member Allyn C. Tatum, a member of the Arkansas Workers Compensation Commission, said in an interview that he plans to ask state insurance commissioners to help the International Assn. of Industrial Accident Boards & Commissions draft a specific anti-fraud statute that could be adopted by states.

•

The National Fraud Advisory Commission report is available for $150 to NCCI members and $275 to non-members. Government and labor representatives are eligible for a $50 discount. Contact NCCI Order Processing Department, 750 Park of Commerce Drive, Boca Raton, Fla. 33487; 800-622-4123.

McDonald's

Continued from page 3

cards. Among the information that they wanted on the cards was identification of an employee as a member of the group insurance plan, claim filing instructions, utilization review information, preferred provider organization information and prescription drug claim information.

Workers on the planning teams complained that paper cards would get torn in a wallet, so McDonald's made the cards plastic, like credit cards. And at the request of the firm that provides its prescription drug benefits, McDonald's also included a magnetic strip on the card to automatically bill for prescriptions.

Another effort to improve communications with the diverse workforce involved training a varied group of employees to explain programs to other workers.

"We really stretch the definition of who is a front-line communicator," said Suzanne Peck, a consultant with Towers Perrin in Chicago, which works with McDonald's on its benefit program. For example, secretaries who answer a lot of questions could be included in this group.

When forming such groups, "avoid BOWGSAT—a bunch of white guys sitting around a table," she recommended.

Relying on people who are much different from the audience to relay benefit information can create problems, said Mr. Wittcoff.

"We find that the fewer hurdles you have to go through, the easier communication is going to be," he said.

Good communication ideas can come from anywhere—even a corner office.

Mike Quinlan, McDonald's chairman and chief executive officer, is credited with simplifying health plan enrollment. For the past two years, each enrollment package has included a simple chart devised by Mr. Quinlan that outlines which of three medical plans would be most cost-effective for an individual or a family based on anticipated future medical costs.

"Simplicity is a big thing here," said Mr. Wittcoff.

McDonald's offers three comprehensive medical plans, which differ only in deductible and coinsurance requirements and out-of-pocket limits:

- Plan 1 requires a $200 deductible, 90% coinsurance and a $2,000 out-of-pocket cap.
- Plan 2 requires a $250 deductible, 80% coinsurance and a $2,000 out-of-pocket cap.
- And Plan 3 requires a $750 deductible and 100% coinsurance.

McDonald's pays 80% of the premium.

Although an attorney might be concerned that the chart could create some fiduciary responsibility on the part of the company, there have been "no employee complaints that they've chosen the wrong plan," Mr. Wittcoff said. "I just can't tell you the raves we've gotten" about the chart. "One hundred percent of the comments have been positive."

McDonald's also has simplified its other written benefit materials.

Spanish-language materials are available and Spanish-speaking representatives available to answer questions during health plan enrollment periods.

The company also offers interactive telephone enrollment, slide shows and a video to help explain benefits.

Efforts to involve the workforce in benefit planning have paid off in other ways, too.

For example, focus groups and surveys two years ago revealed that employees thought their claims were not being paid properly and that the claim form was burdensome, Mr. Wittcoff.

McDonald's met with its claims administrator, Travelers Corp. After reviewing the insurer's claims administration activities, McDonald's determined that most of the necessary data is included on a hospital or physician bill.

So, in February 1993, McDonald's eliminated the claims form entirely and had pre-addressed yellow envelopes printed that outline for employees what information must be included on the bill and what to write in by hand if the bill is incomplete. McDonald's notified employees of the new claims filing method by sending a letter to each worker's home, along with a few of the yellow envelopes.

Improving claims-handling efficiency cut turnaround time for the payment of a claim to six days in June 1993 from 23 days a year earlier.

A survey in May 1993 of employees who had filed health insurance claims under the new method revealed that overall satisfaction with claims administration jumped to 74% from 58% the previous year, according to Mr. Wittcoff. BI

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Opinions

Opening Pandora's box?

AS THE WHEELS of health care reform continue to move at a snail's pace in Washington, about 1 million Californians are proposing a way to radically speed up the process: Implement a statewide single-payer health care plan via a ballot initiative (see story, page 2).

However, to do so would spell disaster—for several reasons.

First of all, as we have said many times before, a single-payer health care plan—be it on a national or statewide basis—is not the cure for the health care crisis.

While the problems with health care in the United States are more serious than many may want to think, junking a system that has evolved over 200 years—and putting total control over health care in the hands of government—would be a big mistake.

In fact, the most flawed component of the Clinton administration's health care proposal is the huge level of bureaucratic control over the proposed health care alliances. Forming one giant California health care alliance would just exaggerate the problems that would be created by the Clinton plan.

We believe that the current employer-based health care system, while far from perfect, allows the opportunity for universal access to health care services—the prime attraction of a single-payer plan—with private-sector control over the provision of medical services and their accompanying costs.

Secondly, creating a single-payer plan in the nation's most populous state would make for a very unwieldy health care system. Private health insurers would operate in the other 49 states but not California. Such a fractured system would cause headaches for multistate employers.

But, perhaps most importantly, allowing voters to pass laws via the ballot box is simply a lousy way to legislate, as California's Proposition 103 has proved. Efforts to clarify gaps in the initiative—such as whether it replaces workers comp medical coverage—are likely to result in a quagmire of litigation.

The checks and balances of a legislative process—in which such flaws in proposals are spotted and amended—is not possible in an election campaign. And, voters' minds can be swayed by personal biases and flashy advertising campaigns, not by true understanding of the issues.

While many will write off the chances that the single-payer initiative will be approved by California voters in November, this is not a time for lethargy among employers, insurers and others that want to maintain the current health care system. It cannot be assumed that voters won't be swayed by the promises of "free" health care that surely will be bandied about. And, it's clear that at least 1 million Californians already perceive some merit in the single-payer proposal.

It now appears that implementing sound, rational health care reform on a national level may take several years. California voters should not be encouraged to attempt to accomplish the same thing in only one day—Election Day.

Letters

NAIC program may be overstepping its bounds

To the editor: James W. Schacht, acting director of the Illinois Insurance Department, is to be commended on his outstanding Perspective article, "NAIC Should Return to Basics" (*BI*, April 11).

Unlike your earlier editorial (*BI*, March 21), Mr. Schacht recognizes that one may criticize the implementation of the National Assn. of Insurance Commissioners' accreditation program without supporting federal regulation of insurance.

Prior to Rep. John Dingell's interest in federal oversight of insurance, the standard defense of state insurance regulation was that it allowed greater accountability and sensitivity to local consumer needs than would a monolithic federal regulator. We now are substituting the federal monolith with self-appointed regulation by an association of largely non-elected officials under a program designed to usurp state legislators' powers with one-size-fits-all criteria.

Perhaps the cure is worse than the disease.

Jon Harkavy
Vp/General Counsel
USA Risk Group
Arlington, Va.

Careful review of PBGC reform plans sought

To the editor: In his April 11 letter, Martin Slate, executive director of the Pension Benefit Guaranty Corp., says surprisingly little about the detailed financial analysis of the agency's financial condition that I presented in an earlier letter (*BI*, Jan. 17).

I asserted that the size and the trend of the PBGC's deficit do not support Labor Secretary Robert Reich's comments that the deficit poses a threat to the PBGC.

I noted, too, the declared $45 billion of underfunding in ongoing plans is not a shadowy menace and that the PBGC does not have the ability to project deficits meaningfully. Given Mr. Slate's access to a panel of experts whose "unanimous opinion" he says I differ with, it should be a simple matter to have them point out where our differences lie.

With regard to the validity of the PBGC's practice of adding "probable net claims" to its deficit, I could not find in the General Accounting Office's report of its audit of the PBGC any confirmation of this practice that Mr. Slate claims.

I understand the addition of such claims is not the practice of life/health insurers and is questionable in the property/casualty field, particularly where there is substantial investment income derived from assets, as is the case with the PBGC.

Mr. Slate agrees there is no need for haste in reforming the PBGC, so valuable opportunity exists to screen proposals thoroughly to ensure that those adopted will—in accordance with the PBGC's mandate—encourage the adoption of new pension plans, not discourage employers from continuing or improving their existing plans, while keeping PBGC premiums at the lowest feasible level.

David Langer
Consulting Actuary
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New York

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Published weekly at 740 Rush St., Chicago, Ill. 60611-2590, Telex 6871241, Fax 312/280-3174, Cable CRAINCOM. Offices: 220 E. 42nd St., New York, N.Y. 10017-5806, Fax 212/210-0704, CRAIN COM NYK; 1 Northpark, East Suite 114, 8950 N. Central Expressway, Dallas, Texas, 75231-6415, Fax 214/696-1936; Suite 814, National Press Building, Washington, D.C. 20045-1801, Fax 202/638-3155; 6500 Wilshire Blvd., Suite 2300 Los Angeles, Calif. 90048-4947, Fax 213/655-8157; 540 Latimer Circle, Campbell, Calif. 95008, Fax 408/379-3257; Cowcross Court, 2nd Floor, 75-77 Cowcross St., London EC1M 6BP, England, Fax 71/608/1173. $4 a copy. $80 a year in U.S. $126 in Canada (includes GST). First-class mail subscriptions in U.S. $175, in Canada $198 (includes GST). All other countries $200/yr (includes expedited air delivery). DAVE KELLEY, circulation manager. Four weeks' notice required for change of address. Send subscription correspondence to Circulation Department, Business Insurance, 965 E. Jefferson Ave., Detroit, Mich., 48207-3185, or phone 800-678-9595 or 313-446-0450, Fax 313/446-6777. Microfilm copies are available from University Microfilms, 300 Zeeb Road, Ann Arbor, Mich. 48013. Microfiche copies available: Bell & Howell, Micro Photo Division, Old Mansfield Road, Wooster, Ohio 44691. Portions of the editorial content of this issue are available for reprint or reproduction in other media. For information and rates to reproduce in general circulation media, contact: JOSEPH P. HANLEY, Crain News Service, 220 E. 42nd St., New York, N.Y. 10017-5806, 212-254-0890. For reprints or reprint permission contact: KAREN BROWN, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590, 312-649-5319, Fax 312/280-3174.

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For the Record

Arbitration witnesses can't be sued: Court

SAN FRANCISCO—Witnesses can't be sued for statements they make in private arbitration proceedings, a state high court has ruled.

In a 5-1 ruling, the California Supreme Court on April 28 gave arbitration witnesses the same protection as those in court proceedings.

The decision, *Moore vs. Conliffe*, stemmed from a physician's testimony in an unsuccessful medical malpractice suit. The ruling overturns a 1993 appellate court ruling that found statutory immunity did not apply because arbitration proceedings are not judicial or official.

State to appeal ruling on labor agreements

BOSTON—Massachusetts will appeal directly to the state Supreme Court a ruling that bars it from hiking unionized state employees' group health insurance premiums even after labor's collective bargaining agreements with the state expire.

The ruling would apply to all state workers as well as the labor group that brought the suit, the state says.

The 15,000 members of the National Assn. of Government Employees filed suit last year after Massachusetts increased their monthly share of group health insurance premiums to 15% from 10%.

The state increased the employee contribution after its multiyear collective bargaining agreements with the labor group expired on June 30, 1993. The state imposed the same hike on nearly all state employees at about the same time.

Massachusetts figures the higher contributions would save it more than $14 million in 1994.

But, Suffolk Superior Court Justice Peter M. Lauriat on April 12 rejected state arguments, including:

• The agreements do not remain in force after they expire, as the contracts stipulate, if the Legislature does not appropriate funds to meet the terms of the agreement.

He ruled the Legislature agreed to finance the pacts in full when it appropriated funds for their first year.

• Impairment of contract terms is justifiable if it is reasonable and serves the public's interest.

He ruled that finding funds to meet the state's contractual obligations is solely the state's "problem."

Woman wins damages for pregnancy bias

KANSAS CITY, Mo.—In one of the first pregnancy discrimination suits filed under the Civil Rights Act of 1991, a federal court jury last month awarded a woman $403,320.

Edna L. Pace claimed Captain D's restaurant in Harrisonville, Mo., demoted her in 1992 to food preparer from manager because she was pregnant. Captain D's said she would be unable to work the necessary hours as manager. She refused the demotion and quit, said one of her attorneys, Jane McQueeny, of The Popham Law Firm in Kansas City.

The jury awarded Ms. Pace: $350,000 in punitive damages; $43,000 in compensatory damages for inconvenience, mental anguish and loss of enjoyment of life; and $10,320 in lost wages. The plaintiff's attorneys also intend to petition the court for payment of attorneys fees, which could total $20,000 to $40,000.

Immediately after the suit was filed, Ms. Pace offered to settle for $25,000, Ms. McQueeny said, but Shoney's Inc., Captain D's parent, did not respond. Shoney's attorneys are considering an appeal. They declined to comment.

Ethics rules developed for work comp judges

SAN FRANCISCO—Outside ethicists are developing standards for workers comp judges after five state judges were recently implicated in violations of state ethics rules.

A year-long investigation by the California Division of Workers Compensation found no evidence of crimes but found two judges appear to have improperly accepted fees for speeches and three may have violated the Code of Judicial Conduct.

The division has hired the Josephson Institute of Ethics to help develop standards, said Administrative Director Casey L. Young. He would not identify the judges or discuss the alleged violations, which reportedly included having travel expenses to a Hawaii seminar paid by a doctor with claims before the judges.

Asbestos claimants to appeal ruling

TAMPA, Fla.—About 150,000 plaintiffs with asbestos personal injury and property damage claims against a former Walter Industries Inc. subsidiary will appeal a U.S. Bankruptcy Court ruling that the parent company is not liable for their damages.

But, Walter Industries' creditors still want to settle the claims.

The asbestos claimants want to pierce the corporate veil between Walter Industries, which is seeking Chapter 11 reorganization, and former unit The Celotex Corp. Celotex has exhausted its liability insurance and is also seeking reorganization.

The asbestos claimants say they can pierce the corporate veil because Walter Industries controlled Celotex's operations. Florida law also requires the plaintiffs to prove, among other things, that Celotex's 1987 spinoff was unjustified and resulted in its insolvency. Celotex was spun off when its parent was taken private in a leveraged buyout.

But, Judge Alexander L. Paskay ruled April 18 that Walter Industries did not control Celotex's business and had no obligation to ensure it was adequately insured. He also noted most of the asbestos claims involve products made by a company before Celotex acquired it in 1972.

Meanwhile, Walter Industries' creditors back a reorganization plan that would settle the asbestos claims for $525 million, said plaintiffs attorney Frederick M. Baron of Baron & Budd in Dallas.

Walter Industries, though, continues to push its own plan, which would fully compensate the company's non-asbestos creditors.

The bankruptcy court has scheduled a May 19 hearing.

Information in brief

A group of excess insurers have sued Baxter Healthcare Corp. and its primary and other excess insurers seeking a declaration that they have no duty to defend or indemnify Baxter for **silicone breast implant claims.** The suit was filed March 8 in Lake County Circuit Court in Waukegan, Ill., by: Allstate Insurance Co., successor to Northbrook Excess & Surplus Insurance Co.; First State Insurance Co.; First State Underwriters Agency of New England Reinsurance Corp.; and Hartford Accident & Casualty Co.... **ITT Hartford Group Inc.** will pay $13 million to settle a suit that 30,000 Texas employers filed against about 270 workers comp insurers in 1991. The employers say the insurers illegally hiked premiums to recapture residual market losses.... House Ways and Means Chairman Dan Rostenkowski, D-Ill., last month introduced a bill, H.R. 4245, that would shore up **Social Security** funds for future generations. Among other things, it would raise the normal retirement age to 67, gradually increase the Social Security payroll tax to 8.15% by 2058 and cut the 1995 cost-of-living increase to 2.5% from 3%.... U.S. businesses spent more than **$55.2 billion to insure or self-insure work injury risks** in 1991, 3.9% more than in 1990, the U.S. Chamber of Commerce says.... By a 4-3 vote, the **Florida Supreme Court** on March 31 denied rehearing of its pro-insurer ruling in *Dimmitt Chevrolet Inc. vs. Southeastern Fidelity Insurance Corp.* Last July, it ruled that Southeastern Fidelity was not liable for Dimmitt's future cleanup costs at an oil recycling plant because the pollution occurred gradually, not suddenly (*BI*, July 5, 1993). BI

Bad faith

Continued from page 3

filed claims for both injuries and settled them for nearly $44,600.

But, in February 1989, she sued Twinsburg, Ohio-based Revco, its workers comp insurer, Alexsis and William Steen, an Alexsis claims adjuster.

Ms. Natividad alleged, among other things, bad faith, unfair dealing, and negligent and intentional infliction of emotional distress because of how her claims were handled.

According to court papers, she charged, among other things, that:

• Her benefit checks were delayed.

• The defendants "gave her the 'runaround' when she and her lawyer attempted to inquire about the payments, putting her on 'hold' and fabricating excuses of lost files and computer malfunctions."

• The defendants treated her rudely.

Revco, National Union Fire Insurance Co. of Pittsburgh, Pa., and affiliate AIG Risk Management, which contracted with Alexsis to provide loss adjusting services, settled with Ms. Natividad for a total of $77,500. National Union and AIG Risk Management both are units of New York-based American International Group Inc.

A trial court ruled for Alexsis and Mr. Steen in a summary judgment.

But, an appeals court reversed the decision in part. It ruled that an adjusting firm owes the same duty of good faith and fair dealing that an insurer owes. It did not hold Mr. Steen liable because "he did not issue an insurance policy and did not contract with the carrier."

The appeals court also ruled that Ms. Natividad could pursue her emotional distress claims.

But, the state high court, in a majority opinion written by Justice Raul A. Gonzalez, disagreed and reversed the appellate decision.

On the bad faith and unfair dealing charges, the court ruled: "When the insurance carrier has contracted with agents or contractors for the performance of claims-handling services, the carrier remains liable for actions by those agents or contractors that breach the duty of good faith and fair dealing owed to the insured by the carrier."

Alexsis and Mr. Steen did not owe Ms. Natividad a duty of good faith and fair dealing because they had no contract with her, the court ruled.

The high court also refused to allow Ms. Natividad to pursue her emotional distress claims against Alexsis, because its alleged actions were not sufficiently outrageous.

Alexsis attorney Frederick Wulff said the decision does not rewrite Texas law but does clarify claims adjusters' liability, which he expects will reduce litigation.

It only makes sense to hold the insurer liable in such cases and force the insurer to then subrogate against its adjuster if the adjuster mishandled claims, said Mr. Wulff, a partner with Cohan, Simpson, Cowlishaw, Aranza & Wulff LLP in Dallas.

Otherwise, plaintiffs could begin suing various individuals involved in the claims-handling process, from those who answer the phones to adjusters. "You'd end up with an incredible mess over who's responsible for each little piece," Mr. Wulff said.

He also emphasized that Alexsis never denied Ms. Natividad's claims.

•

Rosa Natividad vs. Alexsis Inc. and William Steen, Supreme Court of Texas; No. D-2786.

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Upping the ante

Reinsurers may need $2 billion to compete, Gluckstern says

By MICHAEL SCHACHNER

PHILADELPHIA—For reinsurers to succeed in the future they will have to build capital, master new technology, expand globally and reassess investment strategies, a leading reinsurer executive says.

As the reinsurance marketplace consolidates, only reinsurers with capital above $2 billion will thrive because only they will be able to safely assume ever-increasing risk, said Stephen M. Gluckstern, president of Zurich Centre Investments Ltd., a subsidiary of Zurich Insurance Co. that serves as a holding company for the Centre Reinsurance group of companies.

In the 21st century, "insurers won't be able to have enough capital because risk already dwarfs capital," he said, adding that continually larger companies will control the market.

Major reinsurers today have more than $1 billion in working capital, compared with less than $400 million that leading companies had 10 years ago, he said in a recent speech at Temple University. "By the year 2000, $2.5 billion will be the average and that will be necessary to assume risk."

Technology will be another factor in defining the reinsurance market of the future, Mr. Gluckstern said. "People won't be carrying pieces of paper to each other via airplanes in 10 years. It will be replaced by something as simple as improved electronic mail."

And, in the increasingly international marketplace of the future, positioning throughout the world will determine where and what reinsurers can underwrite.

"The global strategies of companies like American International Group Inc. and Zurich already show this. For example, if the Chinese per capita expenditure on life insurance grows to even $100, that's 1.2 billion people. That's an immense market," he pointed out.

Reinsurers will be changing their investment strategies in the future, said Mr. Gluckstern. Already the commercial mortgages that dominated many of their portfolios in the 1980s have been replaced with more conservative investments.

"The risk-and-return relationship is real. It is being proven that you cannot have a risk-free investment that guarantees a 15% return. That doesn't exist," Mr. Gluckstern said, noting that "investment income and capital gains are declining."

He also defined several factors that will influence the underwriting marketplace of the future.

First, market conditions will be more stable. Wild swings in the underwriting cycle are history, he insisted. "Never again will there be a swing like 1986 because the buyers won't accept it. They simply won't buy the products if they're overpriced."

Capital flow will also be more dramatic. "Look at the catastrophe facilities that popped up last year: $4.5 billion in capital was committed in only 160 days," he noted (*BI*, Nov. 1, 1993).

Of great importance to reinsurers is the probability that catastrophic losses will continue to soar in size and frequency. "Did you ever think that fire protection sprinkler systems would be set off by the recent earthquake and cause an estimated $1 billion in damages?" he asked.

"And then there's the environmental issue, which is still unsolved and largely unfunded. The question of who's going to pay needs to be answered," Mr. Gluckstern said.

The bottom line for the future, he insisted, "is that if you're bigger, you're better, because the flight to security is real. . . .Smaller companies can't influence trade, so to be larger is critical."

The future of reinsurance will also be defined by more use of analytical information, improved data and hopefully the incorporation of more real-time data. "Now, reinsurance is bought in December when the Florida storm season doesn't come until the fall, which is bad," he said.

Education and training are subjects that reinsurers need to concern themselves with now and in the future. "An issue for all of us to consider is what type of skills will be demanded later on. I predict analytical ability to be one. The capability of understanding technology can't be underestimated. Even if it's as simple as operating a personal computer. Today, some CEOs can't do this."

Employing people with a better understanding of the numbers that go into insurance underwriting will also help companies improve their position, he said. "How can you underwrite properly if you don't understand the numbers?. . .You have to have some knowledge of the numbers. The complexity of risk demands it."

Lastly, he advised taking risk. "I think we must all take risk to propel our careers. Without risk, you can't enjoy the rewards that may be available." BI

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Arizona approves savings accounts for medical costs

PHOENIX—Arizona has become the third state this year to approve medical savings accounts, which permit employers to purchase high-deductible insurance policies and put premium savings into tax-deferred savings accounts for employees' future health expenses.

Mississippi and Idaho enacted MSA laws earlier this year, according to the Alexandria, Va.-based Council for Affordable Health Legislation. Missouri passed a law last year and additional legislation is pending in several other states, said the council, a lobbying group of small to medium-sized insurers seeking federal MSA legislation. The state laws already passed allow the accounts to be tax-deferred.

The Arizona bill was signed April 6 by Gov. Fife Symington.

The legislation provides that up to $2,000 a year per employee and $4,000 per family can go into these accounts.

Arizona State Sen. Matt Salmon (R-Mesa), who sponsored the bill, said that at the end of each year, employees may roll over unused funds for use the next year or withdraw the funds from their accounts. They will be taxed if the funds are not used for medical expenses.

This approach gives employees the incentive to control their own medical expenses and permits them to choose their own doctors as well, said Mr. Salmon, who is running for Congress. "It's a win-win situation all around."

—By Judy Greenwald

California

Continued from page 2

voters in November, it still faces several hurdles. For example, the program would first require a waiver of the Employee Retirement Income Security Act, as well other federal and state laws, before it could be implemented.

A validity check of signatures collected to support the initiative will continue for about a month, but "most feel it's a foregone conclusion it will be on the ballot," said Brad Wenger, president of the Assn. of California Life Insurance Cos. in Sacramento.

An initiative needs only 384,974 signatures to appear on the ballot; supporters of the single-payer initiative turned in about 1 million signatures.

Labor unions were very active in circulating the petition for signatures, according to Richard Holober, assistant research director of the California State AFL/CIO, which endorsed the initiative at its convention last month.

However, the ACLIC and business groups, health care providers and various other opponents are mounting a campaign to oppose the proposal.

"We're not ignoring it in any fashion. Initiatives here in California have to be taken seriously, and we'll do that," said Mr. Wenger of the ACLIC.

The insurance industry has learned that lesson the hard way following the passage of Proposition 103 in 1988, which has resulted in years of costly litigation between insurers and California regulators and—according to some agents and brokers—a shrinking of the state's property/casualty insurance market.

"We do not believe the people of California want to trade their private health insurance for a state-run system that doubles the size of state government. . .and empowers a state health czar to ration care—with no assurance whatsoever of better health care or more efficient delivery of services," Mr. Wenger said.

The initiative is sponsored by Californians for Health Security, a coalition of labor and public interest organizations whose lead member is the California Physicians Alliance, a group of independent physicians formed to promote the single-payer concept. The California Physicians Alliance is the state chapter of Physicians for a National Health Program, a group of 6,000 physicians that advocates a single-payer system.

The intent of the initiative is to establish a system "that will protect California consumers, taxpayers and employers from the skyrocketing cost of health care. Savings will be achieved by limiting health care costs, eliminating waste and emphasizing disease prevention," according to the initiative.

The initiative is being proposed because, among other reasons, "California employers have a right not to be driven to insolvency by the spiraling cost of employee medical benefits (and) Californians should not be at risk of losing their health benefits if they change or lose their jobs," the initiative reads.

"The current health care system is so wasteful that the savings will be enough to fund universal coverage for all medical care services. . .and increase the resources available to prevent disease, all for the same amount of money currently spent on health care in California," the initiative declares.

The initiative states that the comprehensive universal coverage the single-payer plan would offer would be funded by a payroll tax ranging from 4.4% to 8.9%, with large employers paying the maximum rate; a 2.5% to 5% hike in the state income tax; and a $1-a-pack cigarette tax increase.

But, it is the "shaky" financing of the proposed system that will sink the initiative, predicts Mike Berumen, senior vp of PM Group Life Insurance Co. in Newport Beach, Calif.

"I think Americans in general are very skeptical of a program that. . .gives government unprecedented control not only of financing but also of the delivery of health care," he said.

Another critical question is "what are we going to do about illegal immigrants (and) people entering and exiting the state? It's difficult for a state to do this in isolation from other states," Mr. Beruman said. "I tend to think when all of this comes out in the wash, it's unlikely to pass muster with California voters. The bottom line is it's too bad that both the proponents and the opposition couldn't put their energies into national reform."

Although the initiative's sponsors say the proposed system will benefit employers, business groups in the state are also opposing it.

"The single-payer initiative represents a huge step backward in health reform. It would require massive tax increases to fund a huge new health care bureaucracy with unprecedented power over our health care," said Kirk West, president of the California Chamber of Commerce.

"We must defeat this proposal in order to allow effective, market-based reform efforts to improve access to affordable health care coverage," he said.

Other business groups to weigh in with their opposition to the initiative are the California Manufacturers Assn., which represents large employers, and the National Federation of Independent Business, a small-business trade group.

Some employers also fear their benefit costs would increase under a single-payer system that provides more liberal benefits than they currently offer.

"Every industry doesn't have the same level of benefits. Everybody doesn't drive a Mercedes," said Leo DeJohn, compensation and benefits manager at Kirk Paper Co. in Downey, a wholesale printing paper distributor with 460 employees.

"Our (health care) plan is working pretty well. We've kept costs under control, because management goes along" with the idea of restricting certain coverages, he said. For example, Kirk's self-insured health care plan does not cover laser surgery to correct nearsightedness.

And, "we have severe limitations on (coverage for psychiatric) disorders. Some companies are going broke on that," Mr. DeJohn said.

The California Medical Assn., which has not endorsed the initiative, is "doing a complete analysis of the initiative," a spokeswoman for the physicians' group said. The proposal contains "nuances to which we have not been exposed," such as a health care commissioner, she said.

The CMA "does not believe enough has been tried to regulate the existing marketplace to solve the problems the initiative sponsors are trying to address," like restricted access and system inequities, the spokeswoman said. If "something does not happen, we believe support for a single-payer system will grow," she said. BI

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GICs

Continued from page 3

surers offer GICs, which has helped fuel the growth of so-called synthetic GICs (*BI*, Sept. 6, 1993).

A synthetic GIC consists of a "wrapper" provided by a financial institution—including some insurers—that guarantees the book value of an underlying portfolio of securities, often AAA-rated government agency issues.

The New York legislation, which calls for the Insurance Department to issue additional regulations, would enhance the market for traditional GICs, according to financial guarantee insurer MBIA Corp., a major backer of the bill.

Greater competition could ultimately let 401(k) plan sponsors diversify their GIC holdings. "Many of them are (currently) constrained by credit limitations and this might allow them a greater array of investment choices," said Larry H. Mylnechuk, executive director of the Lake Oswego, Ore.-based GIC Assn., whose membership includes plan sponsors.

"I would say, get ready for an onslaught, because they may have created the better mousetrap," said Randolph Root, a consultant with Kwasha Lipton in Fort Lee, N.J.

"(The bill) will allow the insurance companies to compete with the popular synthetic products that Wall Street and the investment managers are offering now that are rated AAA," said Edward F. Nolan Jr., marketing vp at SunAmerica Life Cos. "There is a segment of the GIC market that still insists on AAA quality and we're attempting to fill that niche with a product that would be credit enhanced with a financial guarantor."

The legislation would level the playing field between the GIC products offered by non-AAA-rated life insurers and credit-enhanced products like synthetics, said Stephen D. Cooke, chairman of the Assn. of Financial Guaranty Insurors' legislative affairs committee and senior vp and general counsel of New York-based AMBAC Indemnity Co.

One potential problem for the life insurers is the cost of the enhanced rating from the financial guarantee insurer. Yet Pat Brosnan, an assistant vp with MBIA, contends that those charges will not make credit-enhanced products too expensive. "If the insurance is not economically feasible, nobody is going to buy it."

Opponents of the New York bill charge that it would give financial guarantee companies an unfair advantage without regulatory control.

The bill says financial guarantee companies can insure "specific types of insurance contract obligations" and does not specify GICs.

"There's no limitation on the kind of risk they can take," charges Marsha Cohen, deputy director of state relations for the Reinsurance Assn. of America. She also noted that financial guarantee insurers do not participate in the state's guaranty fund.

Backers of the bill counter that specific wording could become obsolete very quickly in fast evolving markets.

Four years ago, noted Ms. Brosnan, nobody had even heard of synthetics.

Opposition to the proposal is also attributable to lack of confidence in the financial guarantee insurers. "To be very frank, I don't think (they) understand the product," said Alan Shortell, legislative vp for New York Life Insurance Co.

Such objections, charges Wallace O. Sellers, chairman and chief executive officer of New York-based financial guarantee reinsurer Enhance Financial Group, are essentially a smoke screen put up by highly-rated insurers that do not want to face potential competition.

"I think that in a nutshell is what the whole thing is about," said Mr. Sellers. BI

Florida

Continued from page 2

share, not evidence that a particular brand was used.

- Expand the statute of limitations on third-party liability claims brought by Medicaid.
- Implement joint and several liability.

Those points address directly the defenses and tactics used by the tobacco industry in cigarette liability lawsuits, said Fredric G. Levin, a Pensacola attorney who helped write the amendment.

While he admitted the wording is broad, the state would still have to approve any suits before attorneys could pursue them.

"There is no question in anybody's mind that this is aimed at tobacco companies," he said. The concern that food producers would be sued under the law "is the craziest thing I've ever heard of in my life," Mr. Levin said.

In fact, businesses and their insurers "stand to gain the most" if the bill is signed, because it would lower their Medicaid taxes.

The legislation would force cigarette manufacturers to raise their prices, reducing the number of smokers and, ultimately, private health care expenses and lost time due to smoking-related illness, Mr. Levin said.

"This is the most significant health bill ever passed," he said. "If Florida (enacts) the bill, within a couple of years every state will have one."

However, "there is absolutely nothing in the language of the bill that limits its reach to tobacco companies," said Cecilia Renn, general counsel of Associated Industries of Florida Service Corp., a group of 5,000 Florida employers in various industries. "We think this bill will significantly impact the affordability and availability of liability insurance. It's terrible public policy."

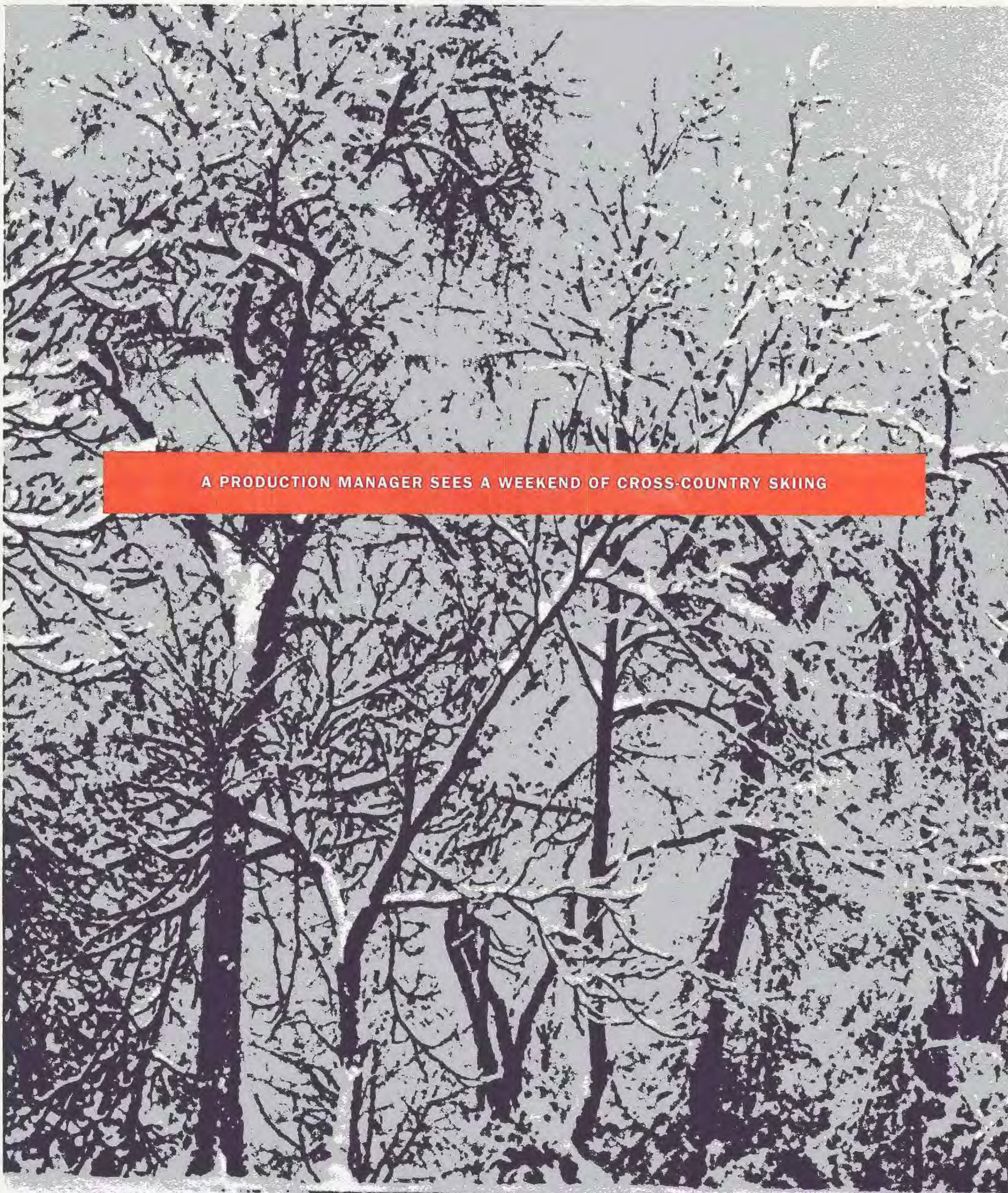
Even if the bill specified tobacco companies only, Associated Industries might have still opposed it because of the "slippery slope" theory that if one industry is attacked successfully, other businesses might be targeted next, Ms. Renn said.

"We are concerned that it opens the door to all kinds of lawsuits," said Sam Miller, executive director of the Florida Insurance News Service, an insurer-sponsored group. "It almost sets up a bounty system for attorneys."

If Gov. Chiles signs the bill, it may be challenged in court on the basis that legislative procedures were not followed, Ms. Renn said. For example, new language in the bill was not underlined.

Mr. Levin acknowledges the proposal was introduced stealthily but said the tactic frequently is used by business lobbyists.

"This is the first time the good guys have done it," he said. "The ends do justify the means in this situation." BI



Offshore

Continued from page 1
rovia address was a burned-out building, said Richard Svobodny, district attorney in Juneau.

So where is the firm domiciled?

Ireland, said Michael P. Trilling, president of Great Atlantic Management Co. in Gaithersburg, Md., an American Fire producer. Mr. Grzelakowski, however, said American Fire is still based in Liberia and also registered in Panama because it is "closer to the States."

Though formerly managed by Marine Managers of London Ltd., American Fire is now managed by IMG, which controls several insurers as part of an international pool, said Mr. Grzelakowski.

He would identify neither other pool members nor the owners, directors or officers of American Fire, calling it "privileged information."

American Fire is not licensed as an insurer or registered as a corporation in Ireland, said Anne Coleman-Dunne of the Department of Industry & Commerce.

IMG, she added, was formed in February, and its papers were filed by Aston Corporate Trustees Ltd. of Douglas, Isle of Man.

An Aston employee said she could not provide information about IMG and that Mr. Yorke-Wade, an Aston insurance consultant, would have to approve any disclosures.

Mr. Yorke-Wade, who could not be reached, was president and sole shareholder of Victoria Insurance Co. when the insurer was licensed in Georgia in 1987 with Mr. Teale as executive vp.

Victoria was liquidated in 1988, leaving more than $20 million in unpaid claims (*BI*, April 29, 1991). Mr. Teale died last month in federal prison (*BI*, April 18).

Current financial data on American Fire is hard to come by. Mr. Grzelakowski said an audited 1993 financial statement is not complete. He added that its unaudited statement shows total assets of $29.6 million, gross written premiums of more than $3 million and net income of about $439,000. He would not provide details of the assets other than to say that they included certificates of deposit and annuities, and that the insurer's auditors "will guarantee that the assets are in the bank."

A 1992 American Fire financial statement showed $29.1 million in assets, including $13.2 million in CDs and $11.6 million in "contributions to surplus." It reported earned premiums of $3.1 million, including $2.3 million in U.S. premiums.

American Fire's U.S. operations have not gone smoothly.

A state grand jury in Juneau indicted Mr. McDonough and Marine Marketing Services in 1991 on charges related to sales of American Fire policies to charter boat operators. While Mr. Trilling was not named in the indictment, prosecutors alleged that the two men were working together. Mr. McDonough and Mr. Trilling contend that their operations are separate.

In May 1992, Marine Marketing agreed to plead guilty to one fraud count and charges against Mr. McDonough were dropped. The firm was fined $500,000, all but $2,500 of which was suspended, and was ordered not to do business in Alaska for five years, Mr. Svobodny said.

Mr. McDonough—who unsuccessfully sued the state last year for false arrest, defamation and other alleged injuries—says he was unfairly prosecuted.

"They decided. . .they would make an example out of me," he said. "I couldn't get a fair shake, a fair trial."

The Alaska case was not Mr. McDonough's first run-in with state authorities: The Maryland Insurance Department refused to renew his agent's license in 1990, citing his agreement to plead guilty to attempted grand larceny in a Nassau County, N.Y., insurance fraud case.

In that case, Mr. McDonough acknowledged writing an insurance binder for a boat he knew did not exist and later accepting $5,000 as part of a claim payment on the boat, according to Maryland department documents.

He was sentenced to five years probation, of which about eight months remain, he said.

American Fire's Mr. Grzelakowski said he is aware of Mr. McDonough's prior conviction but does not see it as a problem. "We are monitoring Mr. McDonough. We are auditing his books and are watching him."

American Fire has solicited business in the Northeast, Florida and Gulf Coast at rates that brokers say are substantially below those offered by licensed insurers. Mr. Grzelakowski said he can offer lower rates because American Fire has lower overhead and does not have to raise rates to cover losses in other lines.

Regulators in Florida and other states have made inquiries about American Fire. All, Mr. Grzelakowski said, have been resolved without regulatory action.

Mr. McDonough said that while he accepts risks from several states, he is legally transacting business only in New Jersey, where he is in compliance with the insurance law. BI

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Brokers

Continued from page 2
$82 million in the quarter.

Amid the movement in the rankings, brokers are still being plagued by soft property/casualty insurance prices and have yet to feel the benefits of a rebounding economy and higher short-term interest rates.

"It's a broken record in the industry," noted Michael J. Cloherty, vp-finance at Arthur J. Gallagher.

"There is no meat in the pie," said Michael Smith, senior vp at Lehman Brothers in New York, noting that the quarter was marked once again with "mediocrity."

However, all but one of the seven largest publicly held brokers reported increased revenues and profits for the first three months of 1994. A&A, which has posted lackluster profits for years, reported both a decline in revenues and a net loss for the quarter.

While retail brokerage revenues remain flat, several brokers are finding some strength in reinsurance brokering, said Mr. Smith. This is due in part to increased demand for reinsurance from smaller insurance companies that have recently gained market share as larger insurers withdraw from certain lines of business and geographic areas.

Mr. Ryan noted that firmer prices outside the United States contributed to RHH's reinsurance and wholesale brokering revenues, which increased 65.8% for the quarter.

Despite A&A's 0.6% decline in gross revenues, revenues from its reinsurance intermediary, Alexander Howden Reinsurance Brokers, rose 13% in the first quarter, noted Frank R. Wieczynski, corporate secretary.

Brokers also report that the depressed benefit consulting revenues apparently have bottomed out.

Benefit consulting revenues "were up for the first time since '92," said J. Michael Bischoff, vp-corporate development for Marsh & McLennan Cos. Inc. M&M's first-quarter consulting revenues increased 3.3% to $222.4 million in 1994 from $215.3 million in 1993.

"There is a better tone" in the con-

Continued on next page

Brokers

Continued from previous page

sulting marketplace, Mr. Bischoff said. The rebounding economy, the tax bill enacted last year and the current health care reform debate "cleans out a lot of underbrush," he said.

Indeed, consulting revenues among brokers "were a shade better than I expected," said Lehman's Mr. Smith.

He also noted that with ongoing competition in the casualty insurance marketplace, brokers again are starting to vie for each other's employees.

Brokers must raise revenues, and bringing in new producers "with a following" is one way to do that, he explained. However, brokers hiring new producers will need an upturn in the market to support increased compensation expenses, Mr. Smith warned.

RHH's Mr. Ryan said that while the recent addition of "a respectable number of highly qualified people" has put a "damper" on earnings at RHH, the broker "will not miss the opportunity to build while consolidating."

Individual results for the publicly held brokers follow:

Marsh & McLennan

Revenues at the world's largest broker increased 9.1% to $913.1 million in the first quarter of 1994 from $837 million in the same period of 1993. Net income also increased, jumping 11.9% to $120.2 million from $107.4 million.

M&M reported an extraordinary $25 million in pretax revenue during the quarter from the sale of shares in ACE Ltd. and in Centre Reinsurance Holdings Ltd. of Bermuda, Mr. Bischoff said.

This additional revenue helped produce a 9.7% increase in insurance services revenues to $553.1 million for the first three months of 1994, from $504.3 million in 1993. Excluding the additional revenue, though, revenues from insurance services increased only 1%, he said.

Revenues from The Putnam Cos., M&M's Boston-based investment management subsidiary, increased 35.3% to $154.7 million in the first quarter of 1994 from $114.3 in the same period of 1993.

M&M's first-quarter investment income, however, declined 6.5% to $2.9 million in 1994 from $3.1 million in 1993.

M&M also took a one-time charge of $10.5 million in the first quarter to recognize its obligations under Financial Accounting Standard 112, which requires companies to account for post-employment benefit liabilities like workers compensation, disability and severance benefits.

Excluding the charge, M&M's net income would have risen 21.7% for the quarter, Mr. Bischoff said.

Brokers first quarter results

In millions of dollars

Broker	Gross revenues	% change from 1993	Net income (loss)	% change from 1993
Marsh & McLennan	$913.1	9.1%	$120.2	11.9%
Rollins Hudig Hall	352.3	14.9	62.7[1]	10.0
Alexander & Alexander	323.0	-0.6	(4.4)	NM
Acordia	89.3	61.7	7.0	24.5
Arthur J. Gallagher	82.0	9.6	5.3	13.2
Hilb, Rogal & Hamilton	37.6	0.6	4.5	17.6
Poe & Brown	27.9	15.9	4.5	106.3

[1]Pretax NM-Not meaningful
Source: Company reports

GRAPHIC BY MIKE GARVEY

Rollins Hudig Hall

Revenues for the Chicago-based broker increased 14.9% to $352.3 million from $306.5 million in the year-earlier period. Pretax profits rose by 10% to $62.7 million from $57 million over the same period.

As an Aon Corp. unit, RHH reports only pretax profit rather than net income.

Reinsurance and wholesale brokerage revenues from Aon Risk Services Inc. was the biggest contributor to RHH's revenue gain, jumping 65.8% to $85.7 million in the first quarter from $51.7 million.

Revenues from its Godwins Booke & Dickenson benefit consulting subsidiary were up 20.2% to $41 million from $34.1 million a year earlier. However, much of the increase was due to the addition of revenues from Booke & Co., a benefit consulting firm that RHH acquired in July 1993.

Retail brokerage revenues increased 2.2% to $225.6 million in the first quarter from $220.7 million a year earlier.

Alexander & Alexander

Revenues were down slightly in the first quarter for the New York-based broker, dropping 0.6% to $323 million from $324.8 million in the corresponding quarter of 1993. A&A reported a $4.4 million net loss in the first three months of 1994, compared with a $13.2 million profit in the comparable period of 1993.

The loss is attributable primarily to lower-than-expected U.S. retail brokerage revenues, Mr. Wieczynski said. Also included is an approximately $1 million charge reflecting the severance package for Tinsley H. Irvin, A&A's former chairman and chief executive officer (*BI*, Jan. 24).

A&A also took a one-time charge of $2.6 million in the quarter to reflect adoption of FAS 112.

A&A's reinsurance and wholesale brokerage operations continue to be the bright spots for the company. Reinsurance brokerage revenues from Alexander Howden Reinsurance Brokers increased 13% from quarter to quarter, while revenues from Alexander Howden Intermediaries rose 7%, Mr. Wieczynski said.

Acordia

Revenues for the first quarter of 1994 jumped 61.5% to an acquisition-fueled $89.3 million from $55.3 million in the first three months of 1993.

Net income rose 25% to $7.0 million from $5.6 million over the same period. Excluding the impact of a $776,000 one-time charge in the first quarter of 1993 to recognize its retiree health care liabilities under FAS 106, net income would have increased 9.3%.

American Business Insurance Inc., which Acordia acquired in October 1993, accounted for more than half of the revenue increase, said Robert S. Schneider, senior vp and controller. ABI was the eighth-largest U.S. broker based on 1992 revenues.

The ABI acquisition was also the catalyst behind a 72% increase in expenses for the first quarter to $77 million from $44.8 million in the corresponding quarter of 1993, he said.

Also in the first quarter, Acordia acquired: Irvine, Calif.-based Association Administrators & Consultants Inc., a broker and third-party administrator with 1993 revenues of $5.6 million; and Pettit-Morry Co., a Seattle-based insurance broker with 1993 revenues of about $23 million.

Arthur J. Gallagher

Revenues at the Itasca, Ill.-based broker increased 9.6% for the first three months of 1994 to $82 million from $74.8 million in the comparable period of 1993. Net income jumped 12.8% to $5.3 million from $4.7 million over the same period.

"We're strictly a new-business company," Mr. Cloherty said, though the results reflect Gallagher's continued effort to focus on its quality review programs.

In addition, Gallagher in the first quarter acquired Youngstown, Ohio-based Donald P. Pipino & Associates Inc. and Wayne, N.J.-based Steel Agency. The acquisitions will bring in more than $10 million in combined annual revenues, Mr. Cloherty estimated.

Hilb, Rogal & Hamilton

Revenues at Glen Allen, Va.-based HRH increased a modest 0.6% in the first three months of 1994 to $37.6 million from $37.4 million in the corresponding quarter.

Net income fared better, increasing 18.4% to $4.5 million from $3.8 million.

The improved profits are attributable to "across-the-board sales penetration" and "good expense controls," Mr. Hilb said, noting that many expense control programs came into fruition in the first quarter.

Poe & Brown

Gross revenues for the Tampa, Fla.-based broker increased 15.8% to $27.9 million in the first quarter of 1994 from $24.1 million in 1993.

Net income vaulted 104.5% to $4.5 million in the quarter from $2.2 million for the first three months in 1993.

Part of the broker's increase in earnings can be attributed to investment gains from the sale of shares it held in paper manufacturer Rock-Tenn Co. of Norcross, Ga., said Cory Walker, Poe & Brown's vp and chief financial officer.

The merger of Poe & Associates and Brown & Brown Inc. is complete and expenses are now down. The game plan for this year is "focusing on revenue growth," Mr. Walker said. BI

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ASK A BENEFIT MANAGER

Non-qualified plans help solve OBRA '93 dilemma

As a result of the lower compensation limits in pension plans, my organization is reviewing the possibility of implementing a new non-qualified defined contribution plan. Can you review the key items to be considered in developing such a plan?

The Omnibus Budget Reconciliation Act of 1993 lowered the compensation cap for qualified pension plans to $150,000 from $235,840. This change is generally effective for plan years starting on or after Jan. 1, 1994. Governmental plans are not subject to the new cap until the start of the 1996 plan year.

Surveys have shown a significant increase in interest in non-qualified plans. According to a survey by The Wyatt Co., 60% of employers either would adopt a supplemental executive retirement plan or use an existing SERP to replace pension benefits lost because of the lower compensation cap. A William M. Mercer Inc. survey reported that 55% of employers without a SERP planned to add one. And, a survey of major Chicago employers I conducted showed that 57% currently offer a non-qualified defined contribution plan. Of those that did not offer such a plan, 22% planned to offer one and 44% were reviewing the possibility but were uncertain.

In addition to reducing the amount that can be deferred to a 401(k) plan, the lower compensation cap also impacts non-discrimination testing. It will make it more difficult to pass the actual deferral percentage test. The ADP test generally restricts the amount that highly compensated employees—those making about $65,000 or more per year—can defer to a 401(k) plan in relation to the amount deferred by non-highly compensated employees.

For example, whereas the maximum 401(k) contribution of $8,994 in 1993 represented 3.8% of the former compensation cap of $235,840, the maximum deferral of $9,240 in 1994 is 6.6% of the new compensation cap of $150,000. Therefore, those plans that previously had to restrict the deferrals of highly compensated employees in order to satisfy the non-discrimination tests will most likely find that even more restrictions are needed as a result of the lower compensation cap.

As a result, the maximum contribution allowed by highly compensated employees will probably have to be further reduced by 1% or 2%. It is not uncommon for plans that allow employee contributions of up to 12% to 15% of pay to restrict the contributions of highly compensated employees to only 6% to 9% of pay. Companies will be well-advised to closely monitor contributions to their 401(k) plans and to ensure that their plans pass the non-discrimination test.

Restricting the size of deferrals means additional taxable income to employees. This comes at a time when deferring income is more advantageous due to the individual tax provisions of OBRA 93. The top marginal tax rate has risen to 36% from 31% for single individuals earning $115,000 per year and for married couples with incomes over $140,000 who are filing jointly. A 10% surcharge also applies to those earning more than $250,000. Implementing a non-qualified plan is probably the most palatable option for ensuring that the affected individuals receive the same amount of retirement benefits that they were receiving before the OBRA 93 changes.

One could consider increasing the contribution rates in the qualified defined contribution plan. However, the cost of doing so would probably be prohibitive because all employees, not just highly paid workers, would benefit.

The main disadvantage of non-qualified plans is that tax breaks are limited, and from the executive's perspective, these plans are not fully "secured." Non-qualified plans are not insured by the Pension Benefit Guaranty Corp. and, if the company fails, participants in such plans are only considered general unsecured creditors in bankruptcy proceedings.

Non-qualified plans must meet the Employee Retirement Income Security Act definition of being unfunded and benefiting a select group. These plans do not have to satisfy ERISA's minimum standards on vesting, participation and fiduciary responsibility. The only reporting requirement is to inform the Department of Labor about whom the plan covers and when it started.

The major design elements of a non-qualified defined contribution plan include: eligibility; investment/earnings options, including frequency of change; access to funds through in-service withdrawals, loans and distributions; and finally securing the plan.

There are two different types of non-qualified plans: SERPs and ERISA excess plans.

SERPs, also called top-hat plans, can be designed to augment a qualified plan by promising an agreed-upon benefit at retirement. SERPs may include additional compensation like bonuses for specified executives when calculating benefits.

ERISA excess plans, also referred to as 415 excess plans, can be offered to anyone affected by Section 415 of the Internal Revenue Service Code, which limits annual benefits and contributions, not just a select group of highly paid executives. ERISA excess plans may only make up the difference between the Section 415 limit and what the employee would have otherwise received.

The ERISA excess plan may be further enhanced to provide for contributions beyond what highly compensated employees can contribute in the qualified plan. If your plan provides for employee contributions of up to 15% but highly compensated employees are restricted to 7% to pass the non-discrimination test, you may want to consider allowing contributions above the 7% level for those individuals impacted.

You may also consider allowing additional contributions in the non-qualified plan for those individuals who reach the annual contribution limit—$9,240 in 1994. Caution should be exercised here because regulations are not clear as to how many employees (or what percentage of qualified plan participants) can participate in a non-qualified plan. You may be pushing the limit by including all highly compensated employees.

The election to participate—or defer compensation—in a non-qualified defined contribution plan must be made before the beginning of the plan year. However, for a new plan, employees may be permitted to make an election within 30 days after the plan's effective date. Newly hired or newly eligible employees also can elect to participate within 30 days. Generally, once an election to participate is made for the year, it cannot be changed.

Another key design element is the investment of the plan's funds, which can be made on an actual basis or on a "phantom" basis. The investments can be on an actual basis if the plan is funded vs. a phantom method if a pay as you go method is used. Some approaches include following the same investment options as the qualified plan, a fixed rate of return based on the prime rate, Treasury bills or company stock.

Of course, if you provide multiple options, decisions must be made regarding how often funds can be transferred. Following the qualified plan options is probably the easiest to communicate to the executive group; however, it most likely will result in the greatest administrative burden. Allowing for a fixed rate of return is probably the easiest to administer but is the least appealing to the executive. The most common approach is to provide for the same investment mix as the qualified plan, a survey by Towers Perrin found.

Non-qualified plans must define the time and method for payment of deferred compensation for each event, such as termination of employment, retirement, disability or death. The plan can specify the date of payment or provide that payments will begin within 30 days after the occurrence of a stated event. Also, non-qualified plans can provide for an "in-service" withdrawal in the case of an "unforeseeable emergency."

If you provide a non-qualified plan, a basic decision you need to make is whether you will fund the plan. To be a non-qualified plan, the plan must meet the ERISA definition of unfunded. Meeting this definition limits how you can fund or secure plan benefits. The security of non-qualified benefits is a growing concern for executives since an increasing amount of their retirement benefits will come from non-qualified plans. According to the Towers Perrin survey, 75% of employers with non-qualified plans do not fund the plans.

Funding alternatives for non-qualified plans include:

- So-called rabbi trusts. These are the most popular funding vehicle for non-qualified plans. A rabbi trust is an irrevocable grantor trust in which assets are invested. The trust assets are protected in the event of a takeover, but creditors have access in the event of bankruptcy. The employer pays taxes on earnings from trust assets and the employer deduction is deferred until distribution to the executive, at which time it becomes taxable to the executive as ordinary income.
- Secular trusts. The assets are invested in a trust. A secular trust provides complete security to the executive. The tradeoff for this security is that the executive pays tax on employer contributions and investment income. The plus for the employer is that contributions are currently deductible. However, the plan is subject to ERISA reporting, disclosure and fiduciary requirements.
- Corporate-owned life insurance. The company funds the policy for each executive with the death benefit payable to the company. Since the insurance policy is an asset of the company, creditors have access in the event of bankruptcy. A significant plus is the tax-exempt appreciation within the policy.
- Benefit insurance purchased by the executive. This approach has received a fair amount of publicity lately. The policy guarantees to pay the plan's benefit if the employer cannot due to bankruptcy, insolvency or change in control. The executive pays the premiums on the insurance policy and is not taxed on the value of the policy if the insurance purchase is independent of the employer. Some employers have increased the executive's salary or paid additional bonus amounts to cover the cost of the policy. A downside to these insurance policies is that they are available for only a few years at a time. There is no guarantee of renewal.
- Annuities. The annuity is purchased by the employer and is owned by the executive. While the employer can deduct payments, the executive pays tax when the employer contribution is made. The investment earnings are not taxed until distribution. A real plus of annuities is that the assets are protected in case of bankruptcy.

Organizations are concerned with providing their employees an adequate level of retirement income in light of OBRA 93 and the new compensation maximum. The reduced compensation maximum can have a significant negative impact on retirement benefits if the benefit is not replaced through a non-qualified plan. BI

Would you like advice from an experienced colleague on a risk management, benefits management or actuarial problem? Four quarterly features in the Perspective section of Business Insurance can give you some answers.

Ask A Benefit Manager, Ask A Risk Manager, Ask A Benefit Actuary and Ask A Casualty Actuary answer written questions from readers on risk and benefits management issues and actuarial problems.

This month's column on employee benefit management issues is written by Dennis J. Nirtaut, manager of employee benefits at Continental Bank Corp. in Chicago. Susan M. Werner, director of risk management at Hardee's Food Systems Inc. in Rocky Mount, N.C., answers questions on risk management issues. William J. Miner, an actuary with The Wyatt Co. in Chicago, answers actuarial questions on benefits issues. And, Richard E. Sherman, president of Richard E. Sherman & Associates Inc. in Ashland, Ore., answers actuarial questions in the casualty field.

Mr. Nirtaut

Address your questions to ASK, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. Please give us your name, title and employer; however, Business Insurance will consider unsigned letters.

O'Reilly

Continued from page 3

commissioner (*BI*, Oct. 18, 1993). Ms. O'Reilly previously had done a considerable amount of consulting work for NICO, particularly regarding McCarran-Ferguson. She accepted the job of general counsel and policy director last fall and became president earlier this year.

Her career path took many turns before she agreed to serve as NICO president.

Somewhat ironically, Ms. O'Reilly began her legal career during the early 1970s in Washington as a specialist in corporate and insurance defense litigation and later worked with what is now the National Assn. of Professional Insurance Agents on no-fault auto insurance issues.

She then joined the Consumer Federation of America as legislative director and was its executive director.

After an unsuccessful bid as a Democratic congressional candidate in her native Michigan, she became a correspondent for NBC's "Today" TV show. After that, she served as executive director of the Wisconsin Citizens' Utility Board, a job she held until returning to Washington in 1989 as a private attorney specializing in consumer issues.

Ms. O'Reilly's stint as head of the Wisconsin CUB piqued her interest in liability issues surrounding the information superhighway and its implications for consumers and insurers.

"I think I'm the first one in the country who has been addressing some of the very significant insurance issues that are inherent in the information highway public debate," Ms. O'Reilly said.

'There will be a rash of lawsuits over a lot of the privacy implications of the information superhighway' as more and more information is collected and the possibility of abuse increases, says Kathleen O'Reilly of NICO.

As an example of the types of liability questions that may arise from the information superhighway, she cited experimental ventures between telecommunications companies and medical centers to have the equivalent of medical diagnostic work done via computer modem. She said that the experiments include such subjects as a woman on dialysis who previously had to visit the medical center weekly but now is able to stay home as her doctor uses computers and fiber optic phone lines to diagnose her condition and make determinations of treatment.

"The first time that one of these people dies or there's a software problem that causes a rash of medical problems, sort of what I call the telephonic equivalent of thalidomide, there's going to be very, very significant litigation," said Ms. O'Reilly. Thalidomide was a sedative prescribed for pregnant women that was later found to cause birth defects, resulting in massive litigation and liability insurance claims.

She also said that telecommunications companies are increasingly getting involved in non-traditional areas in an effort to expand their revenue base.

Ms. O'Reilly said regulators must determine whether these companies are adequately insured, while insurance companies must keep abreast of their policyholders' new exposures.

"There will be a rash of lawsuits over a lot of the privacy implications of the information superhighway" as more and more information is collected and the possibility of abuse increases, she said. "Just using the medical area and the privacy area as examples, in the future there may be very widespread novel litigation."

Insurers and insurance regulators must understand the risks that the industry faces and make sure that policyholders and consumers are not required to make up the difference for insurer miscalculations that result in financial peril, Ms. O'Reilly said.

NICO is also concerned that taxpayers aren't called in to pick up the tab for a national catastrophe insurance program. NICO is vehemently opposed to the federal government acting as a primary catastrophe insurer, she said.

Instead, the federal government should encourage insurers to form regional reinsurance pools to cover catastrophic risk, she said. "Mother Nature seldom respects state boundaries when many of these disasters occur."

Only if the regional pools were totally drained by a catastrophe should the federal government step in with disaster relief for citizens or insurers, she said. In return, the federal government should assure "a very strong commitment to mitigation of damages" through strict building code enforcement and the like, she said.

Despite NICO's criticism of property/casualty insurers, there are at least two areas in which the consumer group and insurers have a common interest, said Ms. O'Reilly: insurance fraud prevention and product safety.

Ms. O'Reilly said the experience of one of her brothers, who is a Detroit detective dealing with automobile theft, taught her how serious a problem insurance fraud is.

In product safety, insurers can help "minimize losses on the front end" by insisting that clients do all they can to make safe products, she said.

Beyond general matters such as disaster insurance and fraud, there are not a lot of areas in which NICO is specifically involved with corporate risk management issues, Ms. O'Reilly said. However, the group does want to reach out more to small businesses.

Small businesses are in many ways "more disenfranchised than individual consumers. Large companies do have risk management staffs and more political pull when it comes to negotiating their own insurance needs," Ms. O'Reilly said.

She said NICO hopes to expand its current three-member board of directors to seven or eight by mid-summer, including a small-business representative. NICO currently has "15,000-plus supporters" who have purchased publications or made financial contributions. The group charges no dues and has a budget of "less than $500,000" annually, Ms. O'Reilly said. BI

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INTERNATIONAL

Lloyd's proposes risk-weighted capital rules

By ADRIAN LADBURY

LONDON—Lloyd's of London is further distancing itself from its past by, among other things, introducing proposals for risk-based capital requirements and possibly allowing syndicates to become independent insurance companies.

These and other proposed changes, intended to reshape the market's capital structure, were released last week in a document titled "Value at Lloyd's."

Lloyd's believes that the introduction of a risk-weighting system—similar to the risk-based capital standards approved by the National Assn. of Insurance Commissioners—coupled with measures to control capacity growth within syndicates and the market as a whole, would improve both policyholder and investor protection.

The risk-weighting system would make it more expensive for members to invest in syndicates that write high-risk business, like general liability, than low-risk syndicates that write life or auto insurance.

Under the system, the amount of funds that must be deposited by a Lloyd's member would vary depending on the classes of business underwritten and the syndicates in which the member participates. Among the factors that would be evaluated when weighting risks—for both individual members and overall syndicates—are the nature of the risk, reserve adequacy and reinsurance arrangements.

In addition to risk weighting, Lloyd's also proposed other steps to control its capacity.

For example, Lloyd's centrally would be able to impose limits on the rate of growth in the market as a whole if it believes the growth rate is against the interests of investors and policyholders. Individual members of syndicates also would have the right to vote on syndicate expansion if an agent proposes a capacity increase exceeding 15% in a given year.

Lloyd's Deputy Chairman Robert Hiscox, who chaired the working group that produced the report, is a great fan of risk weighting and capacity management. Mr. Hiscox says that both systems are certainly in policyholders' interests.

"Risk weighting is policyholder protection to the extent that it allocates capacity," he said in an interview. "The higher the risk written by a syndicate, the more capital it will need to back it. In the U.S., this has been regulator-driven by the NAIC. We are not doing this as the regulator, but as a market-driven (action). It's the sensible thing to do and will avoid the problems of the past.

"Good syndicates, which make the most profits, should attract more capital and bad syndicates, which place a strain on the Central Fund, should get less. . . .It's as much investor protection as policyholder protection," said Mr. Hiscox.

Among the other recommendations in the document:

- Members would be able to sell their participation in syndicates to other individual or corporate members. The value placed on syndicate participation likely would be determined through an auction system (*BI*, Feb. 28).
- Limited liability corporate members would be able to buy, or exchange for shares, individual members' rights to participate in a syndicate, creating what Lloyd's calls "corporate syndicates."

These syndicates would effectively be separate insurance companies allowed to operate under the Lloyd's banner.

Such insurers would be able to close their accounts annually without the use of "reinsurance to close" like other Lloyd's syndicates because the membership of the syndicate would not change from year-to-year.

However, corporate syndicates still would be required to contribute to the Central Fund.

- Current members' rights to participate in individual syndicates would be strengthened by, among other measures, stating that managing agents cannot bar an existing member from participating in a syndicate without permission of the Council of Lloyd's.

At least four managing agents have canceled their syndicate members' participations for 1995 (*BI*, April 25), creating an outcry from some quarters of the market. BI

U.K. pension proposals expected this summer

By ADRIAN LADBURY

BRIGHTON, England—The U.K. government expects to soon unveil its recommendations for a new regulatory system for employer-sponsored pension plans, according to Pensions Minister William Hague.

While Mr. Hague could not provide details yet of the government's proposals, he assured plan sponsors and their advisers at the National Assn. of Pension Funds' annual conference that the new system will not burden employers financially.

But that government stance concerns Stuart James, a member of the Pension Law Review Committee that recommended changes in the U.K. pension system to the government. He told attendees at the April 28-29 NAPF conference in Brighton, England, that he fears the government will be so worried about not upsetting employers that it won't adopt meaningful reforms.

The government's upcoming position paper—which Mr. Hague said could be published in about three months, before Parliament's summer recess—follows the publication last October of the Pension Law Review Committee's report (*BI*, Oct. 11, 1993).

The PLRC team—led by Roy Goode, an attorney and Norton Rose professor of English law at Oxford University—was commissioned by the government to create a blueprint for a new regulatory system to help prevent massive thefts of pension funds. The move was prompted by publishing mogul Robert Maxwell's theft of an estimated 450 million pounds ($681.1 million) from his companies' pension plans to shore up his business empire (*BI*, Feb. 7; Dec. 16, 1991). The late Mr. Maxwell's sons were convicted in 1992 on charges related to these allegations. Court action on the case is pending (see related story).

Among the Goode committee's 218 recommendations are greater employee involvement in pension plan management and tough new solvency requirements. Employers were generally pleased with the Goode report. But a few trouble spots were identified by employers and their advisers, the hottest topic of debate being the proposed new solvency requirements.

The Goode committee suggested that if a pension plans assets fall below 100% of liabilities but remain above 90%, plan managers would be required to present a business plan for returning assets to the 100% level within three years. If assets fall below 90%, plan sponsors would be required to inject funds to boost the funding ratio back to 90% within three months. That deadline may be extended, however, at the regulator's discretion.

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Many plan managers at the conference continue to express concern that the three-month timetable would be too onerous and

Continued on page 19

Retiring U.K. worries

Pension group says rulings won't hurt employers

BRIGHTON, England—U.K. employers have little to fear from the European Court of Justice and recent rulings on the equalization of pension benefits between the sexes throughout Europe, according to a trade group for occupational pension plans.

The National Assn. of Pension Funds contends that five key decisions already made by the European Court have left employers' pockets relatively untouched, contrary to earlier fears. The final ruling on the equalization of pensions in the European Union will not have any meaningful impact on employers' costs either, a spokesman for the group said during its annual conference held in Brighton last month.

Following the European Court's landmark May 17, 1990, decision in *Barber vs. Guardian Royal Exchange*, which stated that men's and women's pension benefits must be equalized, European employers feared they would be forced to pay billions of pounds in back payments to male pension plan participants.

Previously, most E.U. member countries paid full pension benefits to women who retired at age 60, but men were not eligible for full benefits until age 65.

Several subsequent cases were brought to determine how employers should implement the *Barber* ruling.

In the *Ten Oever* decision last October, the court ruled that the equalization ruling was not retroactive (*BI*, Oct. 18, 1993). *Morino vs. Collo* subsequently clarified that the equalization rulings applied to all occupational pension plans, regardless of whether they were state-run, and also affirmed the *Ten Oever* ruling.

Next came *Birds Eye Walls vs. Roberts*, in which the European Court of Justice ruled that employers would not be discriminating if they pay male pension participants "bridging pensions." These entail enhancing the pension benefits paid to males who retired between age 60 and 65, so that their benefits would equal those of women retiring at age 60.

Then, in *Neath vs. Hugh Steeper*, the court

Continued on page 19

Maxwell trustees sue bank for $120 million

Suits are 'misdirected': Goldman Sachs

By ADRIAN LADBURY

LONDON—Trustees of two Maxwell company pension plans have filed separate lawsuits in New York Supreme Court, together seeking $120 million from investment bank Goldman Sachs & Co. and Eric Scheinberg, a partner in the firm.

The trustees allege that the bank, and Mr. Scheinberg in particular, failed to prevent $94 million worth of shares from being siphoned from the pension plans into late publishing mogul Robert Maxwell's now-defunct investment management firm, Bishopsgate Investment Management Ltd.

Goldman Sachs said the claims are "invalid" and "misdirected."

Trustees of the Mirror Group Newspapers Pension Scheme and the Maxwell Communication Corp. Works Pension Scheme filed the two separate but nearly identical lawsuits on April 29, each seeking $47 million, plus interest and punitive damages.

In a joint statement, the trustees said that in May 1991, Mr. Scheinberg transferred Maxwell Communication Corp. shares from the pension plans to two Swiss companies controlled by Mr. Maxwell. The transaction was performed without the permission of the plans' trustees, and the plans received no payment for the shares, according to the statement.

The trustees claim that Goldman Sachs transferred the $94 million to the Maxwell nominee companies, and the money was immediately retransferred to Goldman Sachs, along with $180,000 and stamp duty. Goldman Sachs then transferred the money to Bishopsgate, the trustees allege.

In the joint statement, the trustees say that Goldman Sachs failed to "take reasonable steps to protect the schemes' assets and acted in a manner detrimental to the schemes' interests." The legal proceedings "follow Goldman Sachs' refusal to make good the schemes' losses," the trustees say.

Continued on page 19

Mexico finalizes regulations for U.S., Canadian insurers

MEXICO CITY—In a move to implement terms of the North American Free Trade Agreement, Mexico last month set formal regulations that will open its market to U.S. and Canadian insurers.

Under the final regulations, which come five months after the November signing of NAFTA, U.S. and Canadian insurers will gradually be allowed to write an increasing amount of business through subsidiaries in Mexico.

The market share of subsidiaries of individual U.S. and Canadian insurers will be limited to 1.5%, and the aggregate share of insurers from both countries will be limited to 6% in 1994, increasing gradually to 12% in 1999, after which the cap will be lifted, according to an official at the Mexican Ministry of Finance.

Under the regulations, insurers that enter joint ventures with Mexican companies will not be subject to Mexico's market share limits.

Another timetable governs when U.S. and Canadian insurers may take control of joint ventures with Mexican insurers.

Insurers that owned more than 10% of a Mexican insurer prior to July 1992 will be able to take a controlling interest in the company in 1996.

New joint ventures will only be able to increase their company share in stages, starting with a maximum of 35%, rising to 51% in 1998. In 1999, U.S. and Canadian insurers will be able to own 100% of the shares.

The Mexican Ministry of Finance will accept applications from U.S. and Canadian insurers until the end of July. If the market share allotments for 1994 are not all allocated, it will accept more applications in September, the official said.

—By Gavin Souter

The Professional Marketplace

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IN THE MATTER OF THE LIQUIDATION OF RIVER FOREST INSURANCE COMPANY NO: 93 CH 11234

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PLEASE TAKE NOTICE, that on March 18, 1994 an Agreed Order of Liquidation With a Finding of Insolvency was entered against River Forest Insurance Company ("River Forest") by the Circuit Court of Cook County, Illinois. James W. Schacht, Acting Director of Insurance of the State of Illinois ("Liquidator") is the statutory and court affirmed Liquidator of River Forest.

TAKE FURTHER NOTICE, that on April 7, 1994, the Circuit Court of Cook County, Illinois, entered and Order Fixing the Final Date For the Filing of Claims ("Fixing Order"). All persons and entities, who have, or may have, claims against River Forest, or the property of River Forest, shall have the right to present and file with the Liquidator, proper proofs of claim on or before 4:30 p.m., C.S.T., on March 20, 1995.

TAKE FURTHER NOTICE, that the form of, and required content of, all proofs of claim are described in 215 ILCS 5/209 (1993). Proofs of Claim, together with supporting documents, if any, are to be filed with, and may be secured from, the Liquidator of River Forest Insurance Company, In Liquidation, 222 Merchandise Mart Plaza, Suite 1450, Chicago, Illinois 60654. Filing shall occur upon the receipt of the Proof of Claim by the Liquidator. The Liquidator reserves the right to require such additional information with respect to any claim filed with him as he may deem necessary. The Liquidator further reserves any and all defenses available to River Forest upon all filed claims. All Proofs of Claim must be notarized.

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TOTAL 52,949

★ Source Business/Occupational breakdown of qualified circulation, November 29, 1993 Issue, as submitted to BPA for December 1993 BPA Publisher's Statement.

INTERNATIONAL

Goode

Continued from page 17

could force some employers into bankruptcy if equity values were to fall severely and rapidly.

Plan managers also argued that the strict solvency requirements would prompt some employers to reduce the level of benefits they provide, wind up plans altogether or encourage employees to contribute to private pension plans instead.

Moreover, they said the new rules could force plan managers to divert funds from potentially higher-yielding equities into safer vehicles such as government bonds, to the ultimate disadvantage of the plan members.

"Our funding objectives are very long term to meet liabilities 50 to 60 years from now, but we could be forced to follow an investment strategy that conflicts with these aims," Mark Bellm, pensions service and administration manager at London-based brewer Bass P.L.C., said in an interview. "I hope that long-term objectives are not sacrificed in the interests of the short term."

Mr. Bellm manages funds worth about 1.2 billion pounds ($1.82 billion) for 55,000 current and deferred pensioners.

But, Mr. Hague reiterated the government's desire to avoid rocking the boat and indicated it will not require strict adherence to the three-month deadline.

"Looking at Professor Goode's recommendations, we are mindful of the need to strike the right balance between providing adequate security for scheme members, while at the same time not killing the goose that lays the golden eggs." The government, striving to reduce its own pension burden, does not want to present a disincentive for employers to offer pension plans.

"We believe that a minimum solvency requirement is important and essential if we are to provide adequate security for pension scheme members," Mr. Hague said. "We must get the right balance. That is why we have been working very closely with the actuarial profession to enable us to achieve just that."

Mr. James said that the Pension Law Reform Committee had never intended the solvency rules to be so strict as to force companies out of business. He said a provision in the solvency requirements for a possible extension beyond the three-month deadline generally was overlooked.

"Minimum solvency seems to have been accepted as the snake in the tub, but the report did not state that if solvency levels drop below 90% that there is only three months (to rectify it). This is scaremongering. The government has accepted the three months but will give longer if the regulator allows it."

Employer plan managers have two other major concerns about the Goode recommendations. One centers on the cost of a proposed industrywide fund to compensate participants of insolvent pension plans. Maxwell pensioners have had to turn to the courts in an effort to recover lost compensation.

The second concern is that trade unions and lobbying groups would misuse the mandatory plan member representation on the trustee boards.

"I'm told premiums are likely to be very small (for the compensation scheme) and so won't hurt most pension schemes. But some employers are asking why good schemes should pay for the criminal acts or negligence of other schemes," said Wim de Boer, a member-appointed trustee of a pension plan offered by Babcock International Group P.L.C., an engineering company in Amersham, England.

Mr. de Boer predicted that the requirement to elect employees as plan trustees generally will not be a problem. Many plans, like those of Babcock and Bass, already have 50% member representation on their boards of trustees.

"But it could be wrong for some pension funds with union members or pressure groups, which may elect someone to champion a cause rather than be a good trustee," he said.

The government also drew criticism for proposing to replace the current Occupational Pensions Board with a new regulatory body.

"I suspect we will see a self-regulatory organization paid for by the industry," said Mr. James of the PLRC. "The committee felt it proper to take the proposals in full as an integrated package with no cherry picking, but there is no doubt that the government will avoid the less palatable proposals," he said.

"The report recommended statutory regulation paid for by the state to take over the role of the Occupational Pensions Board, but I think we will see a pale shadow of what we recommended." BI

Pensions

Continued from page 17

ruled that employers are not discriminating when basing pension benefits on actuarial assumptions that woman have a longer life expectancy than men.

That leaves only *Coloroll Pension Trustees Ltd. vs. Russell, Mangham & Others* on the European Court's docket, and no date has been set for its hearing. In that case, the court must decide how employers should equalize annuity benefits, given that women typically outlive men and therefore require more money to fund a comparable benefit.

Colin Steward, NAPF director of parliamentary affairs and also secretary general of the European Federation for Retirement Provisions in London, said in an interview that the long-awaited *Coloroll* decision will contain little if anything that will increase employers' costs.

There are still a number of other pension issues that will be determined by the *Coloroll* decision, but these will chiefly impact individuals, he said. For employers, the key issues already have been answered.

"We are very pleased with the way it has worked out. It has kept costs to a minimum, maintained the status quo and hasn't placed an undue burden onto employers," said Mr. Steward.

—By Adrian Ladbury

Maxwell

Continued from page 17

Colin Cornwall, chairman of Mirror Group Newspaper Pension Trustees, said that with interest and punitive damages added to the $47 million value of each group's MCC shares in May 1991, the total of the claims brought by both trustees comes to $120 million.

The lawsuit was filed in New York because the transaction was agreed upon there and the sale agreement stated that the deal would be subject to New York state law, he explained.

In a statement, Goldman Sachs said the trustees' claims are "invalid" and are "an expensive and time-consuming distraction."

Goldman Sachs acted as an agent for two buyers and two sellers in April 1991 in the sale and purchase of MCC shares and followed its customers' instructions, the statement said. "The transactions have been reviewed by regulatory agencies and nothing has come to light that would support a conclusion of impropriety on the part of Goldman Sachs or its personnel," it said.

Two years ago, Goldman Sachs made a "substantial ex gratis contribution to the Maxwell Pensioners Trust" and it is supporting efforts to arrange for contributions to be made by all concerned parties, the statement said.

The Mirror Group Newspapers pensioners so far have been the most successful group of Maxwell pensioners in recovering their share of an estimated 450 million pounds ($681.1 million) in plan assets lost to Mr. Maxwell's illegal deals.

According to Mr. Cornwall, trustee for the MGN plan, they have directly recovered 57 million pounds to date ($86.3 million). And, "roughly" 70 million pounds ($105.9 million) has been recovered through the liquidation of the Common Investment Fund, which Bishopsgate used to manage the various pension plans' funds.

The recovered funds include:

- A 32 million pound ($48.4 million) settlement of a case against U.K. fund managers Capel-Cure Myers Capital Management and Invesco P.L.C. and investment bank Lehman Bros. International (Europe) (*BI*, Feb. 7).
- A 25 million pound ($37.8 million) settlement with San Francisco-based Bank of America. That amount was part of a 38 million pound ($57.5 million pound) joint lawsuit against the Bank of America and Credit Suisse of Zurich, Switzerland (*BI*, Jan. 10).

Mr. Cornwall said he still seeks "about another 140 million pounds ($211.9 million) or thereabouts" to make MGN pension plan members whole.

The next major lawsuit involving the MGN pensioners, to be heard in London in October, seeks 40 million pounds' ($60.5 million) worth of assets that trustees claim Credit Suisse owes to plan members. BI

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Hudson

Continued from page 3

awards to requiring arbitration of some claims.

Copies of the Hudson study went to key players in the health care debate, he said.

"Liability reform that impacts defensive medicine needs to be included in health system reform. . .absolutely," said Martin J. Hatlie, director of the department of professional liability for the American Medical Assn. in Chicago.

Of the physicians surveyed: 29.3% said fear of malpractice liability had a major influence on the ordering of tests and procedures; 28.9% said it had a minor influence; and 34.5% said it had some influence. Only 7.3% said the threat of liability had no influence on orders.

According to hospital records, the physicians who said liability had no influence ordered tests costing an average of $1,440 per patient. Doctors who said liability had some influence ordered tests costing $1,770 per patient. Those who said liability had a minor influence ordered tests costing $1,786 per patient. Physicians who reported liability as a major influence ordered tests costing $1,972 per patient.

Richard Wade, senior vp-communications at the American Hospital Assn. in Washington, said these numbers "underestimate the amount of defensive testing being done" nationwide. There are many "free-standing facilities" like walk-in clinics and doctors' offices where people have tests that do not appear on public data bases, he said.

Other studies have suggested that an estimated $35.8 billion spent on defensive medicine could be saved over a five-year period if the nation's tort system were reformed, said Judyth Pendell, vp-law and regulatory affairs for Aetna Life & Casualty Co. in Hartford, Conn.

Specifically, she advocates requiring alternative dispute resolution for malpractice claims. A neutral judge would evaluate the case and decide if it is legitimate.

In addition to ADR, Ms. Pendell suggests that forming committees of physicians in each medical specialty to set medical guidelines could help reduce defensive medicine costs. These guidelines "spell out good medical practice" and if doctors adhere to them, they could not be held liable, she said. In light of the research findings, the Hudson Institute sent its own tort reform recommendations, along with the study, to federal lawmakers working on health care reform. Its recommendations include:

- Capping damage awards based on the severity of the injury.
- Eliminating collateral source rules to let defendants show that plaintiffs have already received compensation for some damages from other sources, such as workers comp insurance.
- Limiting attorneys fees for contingency awards.
- Using medical review panels comprising expert physicians to review medical malpractice cases before they go to trial. If the panel finds no malpractice, the plaintiff may still sue, but at the risk of paying the defendant's reasonable legal fees if the defendant prevails.

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Reform

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office.

Anne Marie O'Keefe, public policy director for the Washington Business Group on Health, said the senators' decision to cross the aisle may be as important for symbolism as substance, underscoring the fact that any reform bill will require bipartisan support to have a legitimate chance of passage.

Mr. McArdle also noted that Sen. Boren is a member of the Finance Committee, as is Sen. Chafee. If the committee's GOP members were to line up solidly behind the Chafee bill and Sen. Boren joined them, that coalition would need only one more vote to pass that measure, a vote that could come from Sen. John Breaux, D-La.

Conservative Democrats like Sen. Boren find employer mandates "hard to embrace," said Sylvester Schieber, director of the The Wyatt Co.'s Research and Information Center in Washington. If there are going to be mandates, a mandate that individuals purchase coverage—as proposed by the Chafee bill—is easier for such lawmakers to endorse, he said.

"To the extent that you've got Democrats moving in that direction, it's going to broaden the middle portion of the political spectrum" that could eventually coalesce around a compromise, Mr. Schieber said.

"It bodes well for potential compromise," agreed Mike Langan, a principal with Towers Perrin in Valhalla, N.Y. He added that the lawmakers' decisions to break with their party was a blow to Senate Majority Leader George Mitchell, D-Maine, who has been the president's point man on health care reform.

However, Hillary Rodham Clinton said in an interview on Larry King Live last week that regardless of which bill they back, she regards the Democratic senators' support for health care reform and some type of a mandate as a plus.

Only one Republican in either chamber—Sen. James Jeffords of Vermont—has publicly endorsed President Clinton's reform plan. The symbolic and practical weight of Sen. Jeffords' decision to support the president early in the debate does not approach that of his Democratic colleagues to move in the opposite direction at a critical juncture in the process.

Equally important was the CBO report on the managed competition measure sponsored in the House by Reps. Cooper and Fred Grandy, R-Iowa, and in the Senate by Sens. Breaux and David Durenberger, R-Minn.

The Cooper-Breaux bill would require employers with fewer than 100 to fewer than 500 employees, depending on the state, to join health purchasing groups to negotiate lower care costs. Employers would not, however, have to purchase coverage for their employees. The bill also would provide subsidies for low-income individuals.

The CBO's conclusion that the bill would extend coverage to nearly half of the uninsured without imposing an employer mandate impressed members of the Senate Finance Committee, who received the report, and consultants alike.

Sen. Bob Packwood, R-Ore., who is the committee's ranking GOP member, said that while he had supported employer mandates in the past, "if you can get close to universal coverage without compulsion, why have the compulsion?"

"If you can cover 90% of the population without significantly annoying employers, that's pretty impressive, especially considering the alternative," which is the Clinton bill, said Henry Saveth, a principal with A. Foster Higgins & Co. Inc. in New York.

The ultimate impact of the CBO's analysis of the managed competition bill remains unclear, though most observers consider it a plus rather than a minus.

The CBO concluded that the bill would not achieve universal coverage, which it said is necessary to control costs effectively, though it does include seven other features the agency said also are necessary to contain costs. But, as Mr. Saveth noted, many of the Senate Finance Committee members seemed impressed that the plan would leave only 9% of the population without coverage.

More confusing was the report's assessment of the plan's impact on the cost of health care.

As CBO Director Robert Reischauer told the Finance Committee, managed competition remains mostly untested, so no one knows exactly how it would work. There could be savings, but how much "remains largely a matter of speculation," he said. In addition, the plan doesn't specify what a basic benefits package would contain.

In addition, subsidies for low-income citizens included in the bill would lead to a budgetary shortfall of more than $35 billion a year, the CBO said.

That bill stipulates that shortfall could not be made up by adding to the federal deficit. As a result, it could be absorbed by the health care marketplace, which could result in chaos because providers would have to provide services without reimbursement, said Mr. Reischauer.

On the other hand, by not requiring the federal government to shoulder that deficit, the CBO report said the bill might reduce the federal deficit by $86 billion over 10 years.

Towers Perrin's Mr. Langan said that the report—coupled with Mr. Reischauer's observation that analyzing the various reform plans is taking much longer than anticipated as the legislative clock runs out for this session—should spur movement toward compromise, Mr. Langan said.

One of the bill's chief sponsors, Sen. Breaux, also hinted that the report could be the basis for compromise.

"Overall, I believe the CBO report will prove helpful and constructive as the Senate Finance Committee works toward a bipartisan health care plan. The CBO analysis of the Cooper-Breaux plan contains useful information for Finance Committee members as we look for the best features of all the major health care plans to write final health care legislation that is deficit-neutral and can win final passage in the Senate."

In other related developments:

- Rep. Fortney "Pete" Stark, D-Calif., suggested that eliminating the indexing of income tax brackets to account for inflation could raise $40 billion a year to help finance health care reform.

During a May 2 address to the Health Insurance Assn. of America, Rep. Stark said members of Congress might find such a proposal "easy" to support, in part because few taxpayers know how much money they save through indexing.

In addition, Rep. Stark said the individual savings from indexing aren't very significant. A family with an annual income of $25,000 saves $20 through indexing, a family with a $40,000 income saves $60 and a family with $135,000 in income saves $315.

Rep. Stark also advocated capping the income level under which employees may receive benefits tax free. By phasing in a cap starting at a relatively high income level, say $70,000, and eliminating any tax-free treatment at $150,000, the government could raise as much as $20 billion a year, he said.

- As expected, the House Labor-Management Relations Subcommittee gave its approval to an employer mandate as it marked a version of President Clinton's health-care reform bill drafted by Subcommittee Chairman Pat Williams, D-Mont. The 17-to-10 party-line vote on Thursday endorsed requiring employers to pay 80% of the cost of health insurance for their workers.

The panel, a subcommittee of the Education and Labor Committee, had earlier in the week rejected by an identical party line a GOP substitute bill offered by the subcommittee's ranking minority member, Rep. Marge Roukema, R-N.J.

- A group of organizations that advocates a single-payer system launched a radio and television advertising campaign featuring the husband-and-wife comedy team of Jerry Stiller and Anne Meara.

The ads, one of which spoofs the HIAA's "Harry and Louise" ad campaign, urge viewers to support H.R. 1200, introduced by Reps. Jim McDermott, D-Wash., and John Conyers, D-Mich., and S. 491, introduced by Sen. Paul Wellstone, D-Minn.

The ads are the first phase of a projected $1 million print and electronic ad campaign for a single-payer system. Groups involved in the effort include Public Citizen, Single Payer Across the Nation and Americans for Democratic Action.

- The chairman of the Senate Labor and Human Resources Committee announced last Thursday that the committee would begin marking up the president's health care reform bill on May 18. Chairman Edward M. Kennedy, D-Mass., said he hoped to complete work on the bill before the Memorial Day recess, which begins May 27.

- A group of small businesses broke with the National Federation of Independent Business and announced support for the Clinton plan. The Small Business Coalition for Health Care Reform includes the American Institute of Architects, the National Farmers Union, National Assn. of Chain Drug Stores, the National Assn. of Retail Druggists and the National Council for Non-Profit Assns. BI

Cheaper mental health benefits seen under plan

A more comprehensive mental health and substance abuse benefit than proposed in President Clinton's health care reform plan could be provided at a lower cost than federal officials estimate, a new study says.

According to new estimates from the actuarial consulting firm Milliman & Robertson Inc., the mental health/substance abuse benefits outlined in President Clinton's Health Security Act could be purchased for an annual premium of between $185 and $224 per person.

By comparison, actuaries from the Health Care Financing Administration had estimated that those mental health benefits would cost between $241 and $259 per person.

The American Psychiatric Assn., which sponsored the study, said previous HCFA cost estimates were based on "outdated data and conservative assumptions regarding utilization" and the failure of HCFA to "take into consideration cost savings due to the growing environment of managed care."

To achieve the lower cost estimates, however, health plans must rely heavily on utilization review mechanisms to ensure that only medically necessary services are covered. And, those services must be delivered in a managed care setting, the study authors say.

The study also found that for a minimal additional cost, the Health Security Act could: offer expanded coverage, including all medically appropriate outpatient mental health/substance abuse treatment; eliminate some inpatient deductibles; and reduce some co-payments.

Milliman & Robertson actuaries suggested a "budget neutral" way to pay for these expanded mental health benefits.

Among other things, the authors say that changing the medical/surgical coinsurance amount to 79%/21% from 80%/20% for all inpatient and outpatient services would save an estimated $9 per person in annual premiums.

For free copies of the report, contact the American Psychiatric Assn., Division of Government Relations, 1400 K. St. N.W., Washington, D.C. 20005; 202-682-6000.

—*By Christine Woolsey*

California study finds fault with HMOs

By LOUISE KERTESZ

SACRAMENTO, Calif.—Health maintenance organization officials are assailing the credibility of a study by the California Medical Assn. that shows a wide variation in the percentage of revenue that different HMOs allocate to administrative costs and profits.

The CMA says this should warn California businesses and consumers that higher administrative costs, which include executive salaries and profits—not rising medical costs—are hiking health care premiums.

"As health care is increasingly delivered by managed care systems, it is important that consumers, policymakers and the employers, who are for the most part paying the premiums, understand the full fiscal picture of the companies they are entrusting with their care," said Steven Thompson, CMA's vp of government relations. "California business and consumers are under the impression that annual premium increases are the result of increased medical costs. This summary shows this not to be the case."

The CMA study says some HMOs manage to keep administrative costs down, while others do not.

For example, the study says administrative costs and profit account for only 4.7% of revenue at the state's largest HMO, Kaiser Foundation Health Plan Inc., while the same costs account for 30.9% at Wellpoint Health Networks Inc., a subsidiary of Blue Cross of California.

The CMA argues that the highest percentage of HMO revenue possible should be spent on actual medical care. When that is the case, an HMO has what is known as a high medical loss ratio.

Eight of the 10 HMOs with the highest medical loss ratios are non-profit, while nine of the 10 with the lowest medical loss ratios are for-profit corporations, according to the study. That "raises serious concerns" that for-profit HMOs might be restricting care to maximize profit, a CMA spokeswoman said.

The CMA says its study provides the basis for legislation—A.B. 3801—introduced by Assemblyman Burt Margolin, D-Los Angeles, that would limit health plan profits and administrative costs to 15% of premium collected.

But, administrative costs alone are an incomplete measure of an HMO, plan officials say.

"We don't see it as a credible study. We see it as a public relations approach by the CMA," said Myra Snyder, executive director of the California Assn. of Health Maintenance Organizations in Sacramento.

"Here's a medical group with the highest salaries in the world that is attempting to reform managed care. . . .Obviously we believe it's because they can't compete in the marketplace" where one out of three Californians belongs to HMOs, she said.

"CMA's interest is in discrediting managed care," agreed Patrick Garner, senior vp of Blue Cross of California.

The problem with focusing on administrative costs is that they "may vary from one HMO to another. . . .What makes a better HMO is quality," Ms. Snyder said.

"You need to look behind the numbers in order to determine what the administrative activities are," agreed Steven Zatkin, vp of government relations for Kaiser in Oakland. "Different models of health plans will need to undertake different types of activities, so I think it would be important not to simply take the numbers alone, without doing that type of analysis."

For example, a group-model HMO like Kaiser, which is affiliated with medical groups and operates its own hospitals, is "not as much involved in the number of financial transactions that can drive up administrative costs" as would be a staff-model HMO, Mr. Zatkin said.

Another flaw is the CMA study focuses on one year of data—1992—whereas "the industry has trends," said CAHMO's Ms. Snyder.

For example, the industry might have three good and three bad years; "that's why we look at trend rather than a snapshot," she said. "And, HMO administrative costs have declined over the last three years."

The data for the CMA study was gathered from public sources, mainly reports the plans filed with the state and the federal Securities and Exchange Commission, as well as annual reports.

According to the CMA study, the HMOs with the lowest percentage of revenues allocated to administrative costs and profit/income, in addition to Kaiser, are these non-profit plans: Contra Costa County Medical Services, with 7.7%; Lifeguard Inc., 9.2%; and Santa Barbara Regional Health Initiative, 9.2%. Aetna Health Plans of Northern California, a for-profit corporation, is in fifth place with 12.3%.

The CMA is also proposing legislation to provide due process for consumers and providers who are denied services by health plans. Other CMA-sponsored legislation would establish a state panel to determine which experimental treatments should be covered by health plans.

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Free copies of the study are available from the California Medical Assn.'s Government Relations Office at 916-444-5532.

Superfund

Continued from page 1

promise is a revamped Environmental Insurance Resolution Fund, designed to reduce coverage litigation over hazardous waste cleanup. The fund as envisioned in the compromise would raise as much as $8.1 billion over 10 years through taxes on property/casualty insurers; initially, the administration had sought to raise $3.1 billion over five years.

The EIRF mechanism was first proposed by the Coalition on Superfund, a group of insurers and other businesses with its own reform proposal (*BI*, March 21).

The clock is running on Superfund. Unless the Comprehensive Environmental Response, Compensation and Liability Act is reauthorized by the end of September, the federal government will lose its ability to tax specific industries to finance cleanup costs when no potentially responsible parties, or PRPs, can be found.

"The administration package of changes includes modifications to the EIRF that reflect recommendations made by the coalition," said Lee Fuller, director of the Washington-based Coalition on Superfund.

Under the new proposal, which has not yet been put in legislative language, PRPs with pre-1986 policies would have to file cleanup claims with the fund before they could sue insurers.

The fund would offer to pay a percentage of the claims, based on the likelihood of recovery in relevant state courts and the location of the waste site. If a PRP refused the offer and it subsequently lost in court, the PRP would have to pay a portion of the insurer's defense fees.

If less than 85% of all PRPs accepted offers made by the fund, the fund would be dissolved and it would be litigation as usual.

As in earlier proposals, liability for site cleanups would be allocated by neutral third parties approved by PRPs. But the new version would make it more difficult for any party to reject that determination. Although not absolutely binding, the decision would be given a "great deal of deference," the proposal said.

And though the EPA would make the final determination of liability, Ms. Browner made clear that the agency would be very likely to follow the allocator's recommendations.

The compromise proposal also would alter remedy selection to permit greater consideration of site-specific factors, such as the site's anticipated future use, and greater community involvement in cleanup decisions.

Rep. Michael Oxley, R-Ohio, the ranking minority member on Rep. Swift's subcommittee, showed just how far the consensus went by promising bipartisan support of the compromise measure.

But, Sen. Frank Lautenberg, D-N.J., who chairs the Senate Superfund Subcommittee, warned that with only 40 legislative days left in the current session, the measure will have to move swiftly to the floors of both chambers.

The telescoping calendar doesn't bother supporters of the compromise.

"I think that because of the breadth of consensus on most elements of the bill, there will be few amendments offered in the two relevant subcommittees, which means that markup will be a speedy process and that passage through full committee and the floor will be relatively non-controversial," said Leslie Cheek III, vp-external affairs for Xerox Corp. in Washington. Xerox is the ultimate parent of Crum & Forster Inc.

Although the new proposal maintains retroactive liability, Mr. Cheek said he prefers it to competing measures. For example, a bill sponsored by a pair of New Hampshire Republicans would only eliminate retroactive liability for acts that occurred in 1980 or earlier, rather than provide an EIRF to provide funding for pollution that took place before 1986, he said.

"We think there's real progress. We now have basically the Coalition on Superfund proposal embodied in the bill," said Mike McGavick, director of the American Insurance Assn.'s Superfund Improvement Project.

Whether Congress has enough time left in the current session to pass a bill is the "multibillion (dollar) question," said Mr. McGavick.

Among the business groups backing the proposal are the National Assn. of Manufacturers, the American Bankers Assn. and the Chemical Manufacturers Assn. The proposal also won the support of half a dozen municipal government associations, including the U.S. Conference of Mayors and the National Assn. of Counties.

Lefkin refused to predict that the legislation was doomed. "I've been surprised this has been resuscitated so far, so I'll never rule this legislation out."

Similarly, Frank Nutter, president of the Reinsurance Assn. of America, said: "We are being vigilant because we presume that it now has momentum." The RAA has not endorsed any Superfund reform proposal.

"We're encouraged by the fact that the business community and environmentalists have reached an accord, however tenuous. We continue to have concerns about the trust fund proposal in large part because the funding mechanism remains uncertain," Mr. Nutter said.

"It's critical to us that the funding be equitable both as to insurers and reinsurers' share," as well as how any tax would apply to non-U.S. insurers and reinsurers.

The chief Washington representative of another major property/casualty group that has not endorsed any reform proposal thinks that the chance Superfund will be reauthorized this year is slim, even if the compromise attracts wide support.

"My sense is there probably is not enough time in this Congress to address an issue of this complexity," said David M. Farmer, senior vp-federal affairs of the Alliance of American Insurers.

'We think the Environmental Insurance Resolution Fund is a bad idea,' says Dave Kuhnke on behalf of RIMS. 'We'd love to see a Superfund reauthorization occur, but with joint and several liability in it and an EIRF in it, we cannot support this.'

However, the compromise has not attracted unqualified support. For example, CMA Chairman J. Roger Hirl noted that "there is still much work to be done to complete the legislative package," pointing to the insurance settlement provision as one that the CMA considers not "fully settled."

NAM President Jerry Jasinowksi also added a caveat to his support for the proposal, noting that the compromise is "not perfect," though it is a "positive step."

And, the Risk & Insurance Management Society Inc. opposes both the compromise and the earlier versions of the Superfund reform bill (*BI*, April 25).

"We think the Environmental Insurance Resolution Fund is a bad idea," said Dave Kuhnke, vice chair of the RIMS Environmental Committee.

"We'd love to see a Superfund reauthorization occur, but with joint and several liability in it and an EIRF in it, we cannot support this," said Mr. Kuhnke, who is director-risk management and environmental compliance for Treadwell & Rollo Inc. in New Britain, Conn.

No consensus is emerging on the new proposal within the insurance industry.

"Opinion within the insurance industry is all across the board," said Peter A. Lefkin, vp-federal affairs for Fireman's Fund Insurance Co. in Washington.

"With the EIRF as is formulated, I'm not sure that any company, mine included, can say with any certainty that this resolves our Superfund liability problems or those of our policyholders," said Mr. Lefkin. "I certainly hope (it does), because a lot of hard work has gone into formulating this."

Despite the tight schedule, Mr.

"There are many unanswered questions even at this point. We're going to need more details of the total package that are not available. We continue to have reservations about the size of the fund and whether or not it would be adequate, particularly in light of recent reports about the ultimate cost to the insurance industry," he said.

Mr. Farmer also noted that the proposal would not eliminate the retroactive nature of Superfund liability, which has long been a sticking point for PRPs and insurers alike.

The two other major property/casualty insurer groups, the National Assn. of Independent Insurers and the National Assn. of Mutual Insurance Cos., sent a joint letter to members of the House and Senate panels that deal with Superfund, urging that they reject the new proposal.

The fund arrangement would "create a large and complicated bureaucracy to undertake the gargantuan task of verifying the existence of insurance coverage, deductibles, policy limits and self-insured retention for thousands of individual insurance policies of over 32,000 PRPs," wrote Pam Allen, NAMIC's vp-federal affairs, and Jack Ramirez, the NAII's executive vp and chief operating officer.

The plan could also "unduly involve the federal government in private party disputes," they wrote.

The letter also noted that if less than 85% of the PRPs declined the EIRF's settlement offers, the fund would be abolished.

"This effort would be a tremendous waste of time and resources that would do absolutely nothing to expedite cleanup," the letter said. BI

Updates

ERISA requires disclosure

NEW YORK—ERISA bars an employer that plans to offer enriched early retirement benefits from misrepresenting its intentions to retiring employees, a federal appeals court has ruled.

The ruling by the 2nd U.S. Circuit Court of Appeals in *Mullins vs. Pfizer* holds that if the Employee Retirement Income Security Act applies, company officials must "speak truthfully" about the plan, but they need not disclose internal deliberations or interfere with collective bargaining.

The district court, to which the case has been returned, will now determine if ERISA applies to the Pfizer Inc. plan.

James F. Mullins, a laboratory technician, accepted the company's existing early retirement plan April 1, 1990. Several months earlier, Pfizer officials had assured employees that no enhanced severance packages were planned. But six weeks later Pfizer sweetened the pot.

"We are fully confident that our position will be fully upheld," a Pfizer spokesman said.

Paramount to pay $10 million

NEW YORK—Paramount Communications Inc. must pay more than $10 million to cover a shortfall in a defined benefit plan it spun off in 1981, the 2nd U.S. Circuit Court of Appeals has ruled.

Upholding the trial court, the three-judge panel ruled that when Paramount, formerly known as Gulf & Western Inc., sold several zinc manufacturing and marketing facilities covered by the pension plan in 1981, it did not transfer enough plan assets to the buyer to cover retirement benefits for transferred employees.

The Pension Benefit Guaranty Corp. took over the plan when it was terminated in 1983. At that time, the plan was underfunded by $3.5 million, the PBGC said. The PBGC, along with 600 participants, sued Paramount to recover all of the vested benefits owed by the company. The district court ruled on their behalf.

In its April 28 ruling, the appeals court agreed, citing provisions of the defendant's pension plan stating that beneficiaries are entitled to retirement benefits equal to or greater than those in the original plan, even if its assets are transferred to another trust.

The $10 million includes accrued interest.

Briefly noted

The Assn. of Lloyd's Members predicts that **Lloyd's of London** this month will announce a loss of just over 2.5 billion pounds ($3.7 billion) for the 1991 underwriting year. . . Public hearings will start May 11 in Los Angeles on a request by 20th Century Insurance Co. to **hike earthquake coverage rates** 172% for homes and 400% for condominiums following the Jan. 17 earthquake. . . The U.S. Supreme Court is seeking the Justice Department's opinion on whether it should review a 1993 U.S. District Court ruling that struck down **surcharges on New York hospital bills** paid by insurers on the grounds that the surcharges violated ERISA (*BI*, Feb. 8, 1993). . . **Hazar Inc.**, a San Francisco-based staff leasing firm suspected of embezzling employee health care premiums, has filed for Chapter 11 bankruptcy protection. Hazar was raided by federal agents in February (*BI*, Feb. 28). . . The Louisiana Insurance Department has scheduled a June 27 hearing to determine whether the 1992 sale of **Bradford National Life Insurance Co.** to businessman Hugo E. Pimienta was fraudulent and if regulatory approval of the sale should be rescinded. Louisiana regulators earlier filed an administrative complaint against Mr. Pimienta (*BI*, May 2). . . **SmithKline Beecham P.L.C.** will buy Diversified Pharmaceutical Services Inc. of Minneapolis for $2.3 billion. DPS, a unit of United HealthCare Corp., manages prescription drug benefits for about 11 million people. Separately, drugmaker **Pfizer Inc. and Value Health Inc.**, a managed care company, say they are forming a business alliance. . . The **Maine Bureau of Insurance** has approved an overall 3.8% reduction in advisory workers comp insurance loss costs. The reductions for specific industry groups range from 3.3% for manufacturing to 10% for goods and services. . . **The St. Paul Fire & Marine Insurance Co.** has appointed Nicholas M. Brown to the newly created position of executive vp and chief operating officer and named Patrick A. Thiele to the new post of executive vp and chief financial and administrative officer. . . Allan S. Curtis was sworn in as **Tennessee's insurance commissioner** last month, replacing Elaine A. McReynolds, who took a job at the Federal Emergency Management Agency. Mr. Curtis was previously deputy commissioner. . . City of Atlanta officials will appeal a Fulton County Superior Court ruling that Atlanta's extension of health insurance coverage to the **partners of unmarried city workers** violates Georgia state law. . . The **Florida Hurricane Catastrophe Fund** sent its first premium bills to insurers last week. The fund, designed to reinsure catastrophic hurricane losses, will collect $523.4 million in three installments during its first year, just 75% of what actuaries say the fund will need (*BI*, Nov. 1, 1993). . . A Los Angeles city firefighter is one of the two men that authorities suspect started the **Southern California brush fires** that killed three people and caused about $1 billion in insured damage last year (*BI*, Nov. 8, 1993; Nov. 1, 1993). . . A jury in Brooklyn, N.Y., has ordered New York City's Health and Hospitals Corp. to pay **$41 million** to the family of a woman who died after a city ambulance crew refused to carry her down three flights of stairs for treatment. A city hospital also had failed to diagnose her ectopic pregnancy three days before. The hospital agency is indemnified by the city, which is self-insured. . . Swiss Bank Corp. and Jardine Insurance Brokers Group P.L.C. are forming a new independent **Lloyd's of London members agency** and adviser out of JIB's existing members agency. The new agency, Jardine Lloyd Advisers Ltd., also will seek corporate capital at Lloyd's next year. . . A **new London-based aviation agency** is expected to begin underwriting in July on behalf of French insurer Union des Assurances de Paris and Japanese insurers. Former aviation underwriters David Peachey of Lloyd's and Stuart Peel of the company market are expected to join the agency.

Derivatives

Continued from page 1

lic reports of some of the companies that have announced derivatives losses to determine whether shareholders were adequately warned about investment risks.

Most notably, Procter & Gamble Co. lost $157 million in interest rate swaps earlier this year.

P&G is hardly alone. Gibson Greetings Inc. lost nearly $20 million and Mead Corp. $7 million on interest rate derivatives in the first quarter.

Dell Computer Corp., meanwhile, has acknowledged that it may report a derivatives loss but insists that it would be nowhere near the $350 million rumored on Wall Street recently.

Historically, large-scale investment losses have prompted suits against directors and officers.

"You can go back as far as the '30s and the real estate market with the Depression, as segments of the economy decline or businesses run on hard times the number of claims goes up," said John W. Morrison, a D&O expert and senior partner with Altheimer & Gray in Chicago. "It's like night following day."

Claims may not follow quite that quickly, though.

"I don't think the D&O industry will be that greatly impacted for another quarter or two because it will take that long for the negatives we're hearing about in the use of derivatives to hit the bottom line in companies," said Ed Neuberger, vp in the D&O division at CIGNA Corp. in Philadelphia. "We're watching it."

"There's a couple things to be wary of," said Phillip Norton, head of the national D&O consulting practice at The Wyatt Co. in Chicago. "Certainly in the case of Procter & Gamble the magnitude of the loss is bound to create D&O lawsuits even if there was due diligence."

And, in cases where the investments were made without due diligence, the losses from D&O lawsuits could be much larger, Mr. Norton said.

Derivatives losses could produce two types of lawsuits: so-called shareholders derivative actions and suits alleging violations of federal securities law.

In a derivative action, shareholders sue the board of directors on behalf of the company itself, trying to recoup losses from D&O insurance to return to the treasury. Several Procter & Gamble shareholders have already filed such a suit.

But shareholders are unlikely to file many such lawsuits over derivatives losses because these suits are difficult to win under state laws, said Dan Bailey, a partner with Arter & Hadden in Columbus, Ohio, who specializes in D&O liability law. "That's not to say that exposure doesn't exist, but it's not the preferred choice of plaintiffs' lawyers."

More likely are suits alleging inadequate disclosure under federal securities law, which have become more prevalent (*BI*, Feb. 28). Typically filed after a drop in share prices, these suits also may be difficult to win in the case of derivatives losses because even large losses may not directly affect the stock prices of big public companies, said Mr. Bailey.

> **'In the case of Procter & Gamble the magnitude of the loss is bound to create D&O lawsuits even if there was due diligence,' says Phillip Norton.**

"At the end of the day it's all about shareholder value," said CIGNA's Mr. Neuberger. If derivatives losses drag down share prices, "it's definitely a problem."

Plaintiffs in either type of suit would have to document some loss of shareholder value "or the hobbling of the corporate opportunity that might otherwise be available," said Mr. Morrison of Altheimer & Gray.

Suits over derivatives losses would be expensive for both sides.

"What I've found is that the (defense costs), even if the lawsuits weren't meritorious, are likely to exceed $1 million," said Wyatt's Mr. Norton. Defense costs typically are included within D&O policy limits.

The suits are also very expensive for plaintiffs to bring, noted Mr. Morrison. Unless the claims have merit and there is a chance for significant recovery, "I doubt that responsible class-action lawyers would bring a lawsuit," he said.

He added, though, "Unfortunately, I'm a member of a profession where people use litigation as extortion."

Courts hearing these cases will have to determine the "extent to which managers relied or were entitled to rely on outside professionals" when investing in these instruments, Mr. Morrison said. Given the complexity of derivatives, it would be "highly unusual" not to seek outside advice, he added.

"The law does recognize directors' and officers' entitlement to utilize the services of outside professionals and to rely on their professional judgment," he said. "Obviously they can't blindly follow recommendations and they have to understand it."

"Maybe one of the threshold questions to be asked is 'Is this something where somebody ventured into an investment without doing the proper amount of investigation and receiving the proper amount of counseling?' " Mr. Morrison said.

Derivatives may have become a "fashionable investment" that some companies ventured into without being fully informed of the risks, said CIGNA's Mr. Neuberger.

D&O insurers already have begun seeking more information on those risks.

"We're beginning to see underwriters inquiring about companies' activities with respect to derivatives," said Jim Wallace, a senior vp at Johnson & Higgins in New York.

"Underwriters are just about waking up," he said. "Whether it's warranted, I don't know. This may not be the type of risk that's much greater than any of the risks that they underwrite and don't inquire about."

CIGNA's Mr. Neuberger added, though, that most insurers still are trying to determine "what to ask and how to ask it."

Not everyone believes derivatives losses will increase D&O claims or affect D&O liability insurance underwriting.

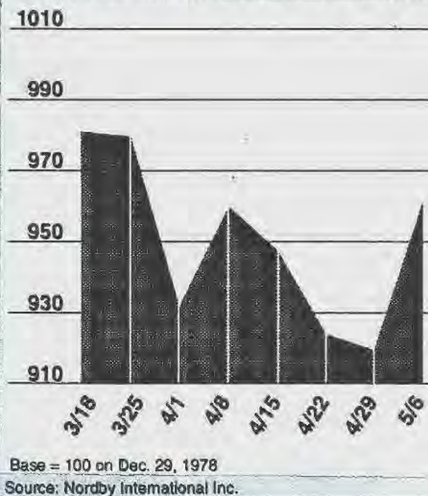
"I'm more concerned about the exposures that aren't plastered across the front page of the financial and insurance papers all the time," said Stephen Sills, president and chief underwriting officer at Executive Risk Management Associates, a D&O insurer in Simsbury, Conn.

By now, he said, most companies are aware of potential problems with derivatives and have controls in place. "I don't think there's anything that ought to be shocking D&O underwriters today."

Nor does Mr. Sills anticipate any changes in the way insurers scrutinize customers' investment activities.

"When we look at a D&O risk, we look at the entity to make sure the board has been managing its exposure," he said. BI

BI Insurance Index



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

Insurance stocks rebounded last week, as the *Business Insurance* Index gained 41.1 points to 960.8 May 6 from 919.7 on April 29. Advancing issues for the week were led by: Lawrence Insurance Group, up 40.0%; United HealthCare Corp., up 15.4%; and American Re Corp., up 14.8%. Declining issues followed: Continental Corp., down 11.3%; Baldwin & Lyons Inc., down 9.7%; and SCOR U.S. Corp., down 7.1%. The most active issue was U.S. Healthcare, 12.2 million shares traded. The *BI* Index rose 4.5%; the Dow Jones 30 Industrials lost 0.3%; the NYSE Composite fell 0.75%; and the Standard & Poor's 500 fell 0.7%.

British Issues

May 5 Companies	Price pence	P/E	Div. pence	Yield %	1 week High—Low pence pence
Comml Union	560	17.8	31.0	5.5	560—547
Genl Accident	559	11.2	34.4	6.1	561—559
Gdn Royal Exch	189	12.2	9.5	5.0	189—181
Royal	257	11.2	9.4	3.7	261—257
Sun Alliance	327	14.7	18.4	5.6	327—319
Brokers					
Bradstock	126	14.1	6.9	5.5	127—126
CE Heath	387	14.9*	20.5*	5.3*	389—387
Hogg Group	254	N/M	7.1	2.8	254—254
JIB Group	192	16.8	9.4	4.9	192—191
Lloyd Thmpson	277	18.7	8.4	3.0	278—277
Lowndes Lmbrt	427	13.3*	18.8*	4.4*	427—427
PWS Holdings	70	10.3	5.0	7.1	71—70
Sedgwick Grp	199	22.1	7.5	3.8	199—197
Steel Brl Jones	143	N/M	11.3	7.9	144—143
Willis Corroon	230	21.1	8.3	3.6	230—228

Source: Philip Olsen, London* Estimated; others actual 1993

BI Industry Stock Report MAY 2, 1994, THROUGH MAY 6, 1994

BROKERS

Company	Exch.	Price	Weekly % change	Year to date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt./Bk. value
Acordia Inc.	NYS	28.50	4.11	15.74	28.50	18.38	31	0.60	2.11	14	10.22	2.79
Alexander & Alexander	NYS	14.63	0.86	-26.42	28.00	14.25	477	1.00	6.84	163	6.73	2.17
E.W. Blanch Holdings Inc.	NYS	19.13	9.29	10.07	23.50	15.75	16	0.32	1.67	18	4.10	4.66
Gallagher Arthur J. & Co.	NYS	33.38	5.95	-6.64	37.13	28.13	97	0.88	2.64	16	7.52	4.44
Hilb, Rogal & Hamilton	NYS	12.88	4.04	-1.90	15.25	11.13	109	0.48	3.73	20	4.51	2.85
Marsh & McLennan	NYS	87.88	4.46	7.99	91.88	77.00	836	2.68	3.05	18	16.76	5.24
Poe & Brown	OTC	19.25	0.00	6.94	20.50	16.88	68	0.40	2.08	16	3.02	6.37
BROKERS	AVERAGE		4.1	0.8					3.2	38		

INSURERS/REINSURERS

Company	Exch.	Price	Weekly % change	Year to date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt./Bk. value
ACE Ltd.	NYS	27.88	-1.33	-8.61	36.00	24.50	172	0.40	1.43	6	28.74	0.97
Acceptance Insurance Cos.	NYS	12.25	0.00	5.38	15.63	11.13	53	0.00	0.00	14	9.65	1.27
AEGON N.V.	NYS	49.75	-3.86	-9.13	58.50	43.25	70	1.22	2.45	9	34.71	1.43
Aetna Life & Casualty	NYS	53.25	3.65	-11.62	66.25	49.75	1655	2.76	5.18	-8	71.84	0.74
Allied Group Inc.	OTC	25.00	0.00	0.00	32.75	21.34	54	0.60	2.40	7	10.45	2.39
Allmerica Prop. & Casualty	NYS	16.63	-5.00	-22.82	22.16	15.00	103	0.16	0.96	9	56.97	0.29
Allstate Corp.	NYS	25.25	5.21	-15.13	34.25	22.63	1298	0.72	2.85	16	18.43	1.37
American General	NYS	25.63	-0.97	-10.09	36.50	24.88	3191	1.16	4.53	21	22.09	1.16
American Heritage Life Ins.	NYS	17.00	-4.90	-8.72	25.34	17.00	96	0.60	3.53	10	12.42	1.37
American Indemnity/Fin'l	OTC	13.25	-5.36	1.92	16.25	10.75	63	0.24	1.81	4	16.18	0.82
American International	NYS	88.13	2.47	0.00	100.25	81.75	3101	0.40	0.45	14	45.25	1.95
American Re Corp.	NYS	32.00	14.80	13.27	37.75	23.50	581	0.00	0.00	14	14.80	2.16
Aon Corp.	NYS	46.75	2.75	-3.11	58.50	45.00	347	1.92	4.11	12	33.10	1.41
Argonaut Group	OTC	27.75	2.78	-9.02	35.50	26.25	69	1.16	4.18	8	27.65	1.00
AVEMCO Corp.	NYS	15.88	0.00	-15.33	22.00	14.50	79	0.44	2.77	13	8.13	1.95
Baldwin & Lyons Inc.	OTC	14.00	-9.68	-5.88	16.25	11.50	106	0.20	1.43	9	12.59	1.11
Berkley W.R. Corp.	OTC	39.00	7.59	19.08	48.00	32.00	811	0.44	1.13	14	28.12	1.39
Berkshire Hathaway Inc.	NYS	16450.00	3.79	0.77	17800.00	12850.00	1	0.00	0.00	25	8115.28	2.03
Capital Re Corporation	NYS	21.38	13.25	-16.99	28.50	18.50	184	0.20	0.94	9	21.66	0.99
Capsure Holdings Corp.	NYS	14.38	6.48	6.48	19.38	12.75	35	0.00	0.00	14	13.08	1.10
Chubb Corp.	NYS	78.00	1.30	-0.79	93.38	70.75	949	1.84	2.36	25	46.59	1.67
CIGNA Corp.	NYS	61.38	3.59	-2.96	70.50	56.50	1656	3.04	4.95	15	78.23	0.78
CNA Financial Corp.	NYS	63.38	-0.98	-19.52	96.75	62.88	118	0.00	0.00	15	77.92	0.81
Continental Corp.	NYS	19.63	-11.30	-28.96	34.63	19.63	3864	1.00	5.10	7	38.99	0.50
EMC Insurance Group Inc.	OTC	8.75	1.45	-7.89	10.75	8.50	2	0.52	5.94	12	N.A.	N.A.
Emphesys Financial Gr. Inc.	NYS	25.63	7.33	NA	26.38	21.25	303	0.00	0.00	6	N.A.	N.A.
EXEL Ltd.	NYS	41.88	-5.90	-6.94	51.75	39.88	767	1.20	2.87	6	33.81	1.24
Fremont General Corp.	NYS	23.75	2.15	-1.55	28.75	21.00	148	0.72	3.03	7	23.40	1.01
Frontier Insurance Group	NYS	45.00	-2.17	2.56	50.00	36.72	42	0.60	1.33	15	16.33	2.76
Gainsco Inc.	ASE	9.38	-1.32	4.17	14.41	7.84	87	0.04	0.43	13	3.49	2.69
General Re Corp.	NYS	125.38	11.94	18.00	133.38	101.75	2528	1.92	1.53	17	55.54	2.26
Guaranty National Corp.	NYS	15.00	1.69	-14.29	24.75	13.75	121	0.48	3.20	10	11.81	1.27
Harleysville Group	OTC	21.50	4.88	-24.56	30.25	20.50	82	0.64	2.98	13	18.35	1.17
Hartford Steam Boiler	NYS	45.00	-0.55	1.12	57.38	42.63	123	2.12	4.71	125	15.80	2.85
HCC Insurance Holdings	OTC	17.00	1.49	-15.70	23.84	12.66	61	0.00	0.00	15	14.94	1.14
Home Holdings Inc.	NYS	15.00	3.45	-13.04	18.50	10.63	53	0.00	0.00	-7	19.96	0.75
ITT (Hartford Group)	NYS	87.13	-1.41	-5.04	95.97	73.88	1595	1.96	2.25	11	57.11	1.53
Kemper Corp.	NYS	57.50	0.22	60.28	62.00	32.25	2526	0.92	1.60	-73	38.98	1.48
Lawrence Insurance Group	ASE	2.63	40.00	-27.59	6.75	1.50	26	0.00	0.00	-6	4.26	0.62
Lincoln National	NYS	39.88	4.59	-7.27	48.25	36.75	887	1.64	4.11	8	32.53	1.23
Markel Corp.	OTC	40.75	1.88	5.84	44.50	34.00	42	0.00	0.00	10	24.68	1.65
Mid Ocean Ltd.	OTC	29.25	5.41	3.54	34.75	25.00	499	0.00	0.00	15	20.24	1.45
Mutual Risk Mgmt. Ltd.	NYS	24.88	5.29	-17.08	32.75	21.16	90	0.28	1.13	16	5.71	4.36
NAC Re Corp.	OTC	30.25	12.56	3.86	38.25	24.00	551	0.16	0.53	14	19.24	1.57
National Re Corp.	NYS	30.00	7.14	-2.04	38.25	27.13	653	0.16	0.53	10	16.89	1.78
Navigators Group	OTC	18.63	-1.97	-46.79	39.00	16.50	43	0.00	0.00	10	16.99	1.10
Nobel Insurance Ltd.	OTC	7.88	-1.56	3.28	8.44	6.25	6[illegible]	0.00	0.00	5	6.84	1.15
NWNL Companies	NYS	33.13	-0.38	1.92	38.75	26.50	626	0.88	2.66	12	23.97	1.38
Ohio Casualty Corp.	OTC	30.00	0.00	-53.13	36.00	28.81	259	1.44	4.80	14	47.68	0.63
Old Republic Int'l	NYS	22.88	-0.54	1.67	27.63	21.50	266	0.48	2.10	8	23.57	0.97
Orion Capital Corp.	NYS	31.88	-2.41	3.24	37.50	28.63	11[illegible]	0.72	2.26	8	27.43	1.16
Penn-America Group Inc.	OTC	6.63	0.00	-13.82	9.50	6.50	10	0.00	0.00	6	N.A.	N.A.
Phoenix Re Corp.	OTC	23.50	0.00	-14.55	38.25	18.50	747	0.28	1.19	7	19.99	1.18
Provident Life	NYS	25.25	-0.98	-20.16	31.88	25.25	111	1.04	4.12	-13	26.38	0.96
Re Capital Corp.	OTC	12.75	-1.92	-6.42	15.50	12.75	[illegible]	0.32	2.51	12	16.88	0.76
Reliance Group Holdings	NYS	6.13	6.52	-20.97	10.38	5.00	2126	0.32	5.22	8	4.22	1.45
RLI Corp.	NYS	22.13	-0.56	-17.29	27.75	21.63	14	0.56	2.53	-36	22.91	0.97
St. Paul Companies	NYS	79.25	-0.16	-11.70	98.00	76.38	1180	3.00	3.79	9	57.84	1.37
SAFECO Corp.	OTC	53.88	-0.23	-1.37	65.75	48.50	1151	1.80	3.34	10	41.59	1.30
SCOR U.S. Corp.	NYS	11.38	-7.14	-9.90	18.88	10.13	28	0.36	3.16	8	16.08	0.71
Seibels Bruce Group	OTC	1.81	3.60	3.60	2.13	0.31	72	0.00	0.00	-1	1.90	0.95
Selective Ins. Group	OTC	25.88	4.55	-14.46	31.00	22.25	70	1.12	4.33	16	23.11	1.12
Sphere Drake Holdings	NYS	15.50	-3.88	-6.06	21.63	14.63	198	0.12	0.77	6	12.17	1.27
Statesman Group Inc.	NYS	15.13	4.31	21.00	15.25	9.75	2792	0.10	0.66	6	8.65	1.75
TIG Holdings	NYS	19.63	9.03	-13.26	28.00	17.25	995	0.20	1.02	-14	18.49	1.06
Titan Holdings Inc.	NYS	9.50	-1.30	-12.64	13.38	9.13	39	0.24	2.53	8	8.93	1.06
Tokio Marine & Fire	OTC	62.88	-0.59	16.44	67.00	49.25	38	0.37	0.59	-	57.72	1.09
Torchmark Corp.	NYS	38.00	1.67	-15.08	59.75	36.75	473	1.12	2.95	9	17.35	2.19
Transatlantic Holdings	NYS	51.38	10.78	-3.75	61.50	45.38	300	0.36	0.70	14	29.60	1.74
Travelers Corp.	NYS	34.13	-1.80	-12.22	49.50	32.53	2898	0.60	1.76	9	33.35	1.02
Trenwick Group Inc.	OTC	38.75	6.90	0.00	47.75	33.25	82	1.00	2.58	14	26.00	1.49
United Fire & Casualty	OTC	38.00	0.00	5.56	44.00	34.75	2	1.08	2.84	10	28.96	1.31
Unitrin	OTC	39.50	1.28	-7.06	46.75	38.50	81	1.40	3.54	25	38.90	1.02
UNUM Corp.	NYS	46.88	-6.25	-10.71	60.13	46.38	1932	0.96	2.05	12	27.55	1.70
US Facilities Corp.	OTC	13.25	-5.36	11.58	14.13	8.25	843	0.00	0.00	12	10.48	1.26
USF&G Corp.	NYS	13.13	1.94	-13.22	19.63	11.69	2360	0.20	1.52	14	10.60	1.24
USLICO Corp.	NYS	17.50	0.72	6.06	19.00	15.75	33	0.24	1.37	8	25.22	0.69
USLIFE Corp.	NYS	37.50	0.00	-3.23	45.75	36.38	96	1.24	3.31	9	41.73	0.90
Washington National	NYS	22.50	-0.55	-7.22	26.13	21.50	63	1.08	4.80	9	28.40	0.79
Zenith National Ins.	NYS	22.88	1.10	3.39	29.13	20.63	113	1.00	4.37	9	17.71	1.29
Zurich Reinsurance Centr.	NYS	25.50	-0.97	-9.73	36.38	24.25	176	0.00	0.00	33	24.41	1.04
INSURERS/REINSURERS	AVERAGE		1.8	-5.7					2.3	10.5		

HEALTH MAINTENANCE ORGANIZATIONS

Company	Exch.	Price	Weekly % change	Year to date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt./Bk. value
FHP International	OTC	24.50	1.03	-5.77	30.00	18.25	616	0.00	0.00	16	11.43	2.14
Pacificare Health Sys.	OTC	55.00	8.37	45.70	57.25	30.50	406	0.00	0.00	21	11.15	4.93
Safeguard Health Enter.	OTC	14.13	2.73	13.00	15.50	8.00	58	0.00	0.00	17	5.71	2.47
Sierra Health Services	NYS	27.63	8.33	24.16	30.75	14.75	424	0.00	0.00	19	4.60	6.01
TakeCare Inc.	OTC	73.00	-0.26	33.94	76.00	35.75	329	0.00	0.00	23	18.69	3.91
United Healthcare Corp.	NYS	47.88	15.36	28.09	47.88	26.00	7528	0.03	0.06	39	10.64	4.50
U.S. Healthcare	OTC	38.25	0.66	-0.22	47.50	26.66	12161	0.68	1.78	19	6.21	6.16
Wellpoint Health Networks	NYS	33.63	5.08	8.91	37.00	24.00	300	0.00	0.00	17	10.94	3.07
HMOs	AVERAGE		5.2	18.5					0.2	19		
ALL COMPANIES	AVERAGE		3.7	4.5					2.4	16		

System design: Nordby International Inc.

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