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Updates

IIE gets vote of confidence with new directors, syndicates

CHICAGO—The Illinois Insurance Exchange may face a brighter future after its 13-member board was reconstituted last week with industry heavyweights, including four members with ties to Kemper Insurance Cos. and one from Aon Group.

In addition, Kemper announced it will establish three IIE syndicates to write its first surplus lines polices.

Despite the IIE's recent syndicate insolvencies, Kemper was attracted primarily by the exchange's ability to write surplus lines

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Feds push 401(k) fee disclosure

By MARK A. HOFMANN

WASHINGTON—Providers of 401(k) plans need to provide fuller disclosure of the plan's fees voluntarily, or the federal government may require it.

That was one of several themes that arose during an all-day hearing on 401(k) fees held by the U.S. Department of Labor last week. During a brief appearance at the hearing, Labor Secretary Alexis Herman said, "We want to make sure if there is a problem in this area, that we find the problem and fix it."

Ms. Herman

The hearing came amid studies showing that 401(k) fees are increasing and that the burden of paying some of those fees is shifting from plan sponsors to plan participants, with a commensurate reduction of workers' retirement accounts, noted several speakers.

"To the degree that 401(k) fees and expenses come directly out of the gains of workers' retirement accounts, they reduce the amount of future benefits that will be available to those workers. It is essential that steps be taken to ensure that plan sponsors and participants understand what fees are being charged and that they are reasonable," said Olena Berg, the assistant Secretary of Labor for pension and welfare benefits.

More than 25 million workers have more than $1 trillion invested in 401(k) plans, she noted. A healthy economy and a "booming stock market" have resulted in double-digit returns for 401(k) and other retirement plans. "These high returns earned on plan investments may be obscuring the fees paid for such investments," she said.

Ms. Berg

In addition, "there may be some confusion concerning investment choices. Even when employees choose their plan investments, employers retain responsibility for selecting and monitoring the menu of investment options which the workers choose from," said Ms. Berg.

"Employees, however, need to understand that there is a cost associated with the services they request. For example, it is more expensive to administer a plan with a wide range of investment options and trading as compared to one which permits only quarterly investment options and limited trading. Both employers and employees should know that there are trade-offs between the services and the fees," Ms. Berg said.

Trade-off or not, witness after witness told Ms. Berg and other members of the Labor Department panel examining 401(k) fees that fees charged in connection

See **Fees** *on page 38*

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Bipartisan health bill blasted

Measure might be more onerous than failed Clinton plan: Critics

By JERRY GEISEL

WASHINGTON—Three years after the collapse of the Clinton administration's sweeping plan to overhaul the nation's health care system, a new congressional drive is under way to revamp the system.

Unlike the Clinton effort, whose launch triggered a massive lobbying campaign to defeat it, the new legislative proposal—known as the Patient Access To Responsible Care Act of 1997, or PARCA—has attracted little attention.

Yet PARCA, with more than 200 cosponsors in the House of Representatives, including liberal Democrats and conservative Republicans, enjoys far more congressional support than the Clinton measure ever mustered. Rep. Charlie Norwood, R-Ga., introduced the measure.

The burden PARCA would inflict on employers and group health care plans, however, may exceed that of the Clinton plan, critics of the proposal contend. The legislation makes little distinction between self-insured employers and managed care plans.

Parity law will add less than 1% to employer mental health costs, study says........page 37

"It is, in many ways, more prescriptive than—and as damaging as—the Clinton Health Security Act," said Rep. Harris Fawell, R-Ill.

"Employers should be paying attention to this bill because the ramifications, if enacted, could be potentially catastrophic," says Chip Kerby, a principal with William M. Mercer Inc. in Washington.

Concludes Charles Weller, a partner with the law firm of Baker & Hostetler L.L.P. in Cleveland: "I think it will end group health care plans as we know them."

Among other things, PARCA, also known as H.R. 1415, would:

- Allow employees to sue employers in state court and recover damages—including punitive damages—applicable under state law for personal injuries incurred in connection to services they received through their

See **PARCA** *on page 12*

RCRA reforms could save cleanup costs, GAO says

By MARK A. HOFMANN

WASHINGTON—A few carefully targeted reforms to a 21-year-old environmental protection law could save U.S. businesses more than $1 billion annually in cleanup costs, according to a recent General Accounting Office report.

Accordingly, a bipartisan group of lawmakers, led by Senate Majority Leader Trent Lott, R-Miss., recently announced plans to introduce legislation early next year that would change the way so-called "remediation waste" is treated under the Resource Conservation and Recovery Act of 1976.

Remediation waste is generated during cleanup of polluted sites, including Superfund sites, but presents little risk itself. Nevertheless, RCRA requires that much of that remediation waste be treated like hazardous waste—and therefore subject to myriad rules and restrictions—which the GAO found often can be counterproductive to cleaning up a site.

"So what GAO has concluded and what we have concluded is the way that the RCRA statute is currently written requires the Environmental Protection Agency to require us to do stupid things. The solution is to go in and change the statute in a very targeted way," said Dorothy Kellogg, senior director-waste management program for the Chemical Manufacturers Assn. in Arlington, Va.

"It's really a constant issue for us. Basically, the problem boils down to the fact that there are two statutes that don't get along with one another: RCRA and Superfund," said Randall Hobbs, senior vp of ECS Claims Administrators Inc. in Exton, Pa. An affiliate, ECS Underwriting Inc., is an underwriting manager for several liability coverages, such as pollution legal liability policies, that respond to RCRA claims, Mr. Hobbs said.

"The changes they're talking about making here are certainly good ones," said David R. Haight, vp-environmental for the Risk & Insurance Management Society Inc.

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Self-wired health plan connects at Motorola

By ROBERTO CENICEROS

SCHAUMBURG, Ill.—Motorola Inc.'s unique health care network incorporates the company's culture, focuses on quality and health rather than cost-cutting, and has overwhelmingly won over its employees.

A majority of Motorola's 75,000 U.S. employees have given up on health maintenance organizations or indemnity-plan coverage, preferring instead to enroll in the customized provider network that the electronics company built around worker preferences.

When Motorola launched its Health Advantage Plan on Jan. 1, 1996, the company's benefit managers "guesstimated" that 25% or 50% of the employee population would sign up, said Randall L. Johnson, Motorola director of corporate benefits planning in Schaumburg, Ill. But during its first year, nearly 60% of employees switched to the Health Advantage Plan from an indemnity plan or HMO. Today, 70% of employees nationwide participate in the network, and a recent "customer satisfaction" survey conducted by Motorola revealed employees appreciate the plan over their previous coverage.

Mr. Johnson does have one

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PHOTO: COURTESY OF MOTOROLA INC.

Almost three-fourths of the employees of Motorola Inc. have enrolled in its Health Advantage Plan.

NEWSPAPER

Updates

IIE attracts new support

Continued from previous page

coverages in 34 states, said new board member William A. Hickey, vp of Kemper Insurance Cos. in Long Grove, Ill.

Kemper will specialize in excess casualty coverage and environmental casualty coverages as well as a third line that is expected to be determined later, Mr. Hickey said. The three new syndicates, which will be operational by year-end, will be capitalized with $20 million each, or a total of $60 million, he said.

"After taking a good hard look at the facility, its full potential is clear," said William D. Smith, Kemper's president and chief operating officer, who was elected IIE board chairman last week. "Properly regulated and prudently governed, the exchange can provide a virtually limitless range of programs," including risk securitization, specialty programs and agency captives, he said.

Jim Tait, IIE president and chief executive officer, said: "The exchange will be immeasurably strengthened under its new leadership. With some of the premier forces in the insurance and finance arenas on board, we have the talent, vision and commitment to move the exchange into a new era."

Earlier this year, IIE executives sought increased oversight by state insurance regulators as a way to restore the exchange's credibility, following three syndicate insolvencies in eight months (*BI*, March 10). A new law was approved this summer, though most provisions take effect Jan. 1.

In addition to Messrs. Hickey and Smith, the newly elected board members with ties to Kemper are: Kemper board director Daniel R. Toll; and Steven H. Lesnik, chairman and CEO of Lesnik & Co., a public relations firm.

In addition, Aon Group President and Chief Operating Officer Michael D. O'Halleran also was elected to the board.

Meanwhile, the Chicago Board of Trade continues to study the feasibility of establishing a second insurance exchange that would essentially allow it to write risks and offset them through insurance futures contracts, according to a CBOT spokesman (*BI*, Oct. 13).

Bill targets Year 2000 exposure

WASHINGTON—Publicly traded companies would have to disclose specific information about their exposure to Year 2000 computer problems if a bill in Congress becomes law.

"To delay our efforts to address this problem is to be inexcusably reckless," said Sen. Bob Bennett, R-Utah, chairman of the Senate Banking Committee's Subcommittee on Financial Services and Technology.

The Bennett bill would require the Securities and Exchange Commission to amend its disclosure requirements to add many new requirements, including two specifically related to insurance. Under the measure, companies would have to disclose whether they have insurance to respond to Year 2000 problems and to give an estimate of their expected litigation costs and financial liability related to Year 2000 lawsuits. The Bennett bill also would require corporations to reveal such things as how much they are spending to remedy the Year 2000 problem and their contingency plans for keeping their businesses running if their computers fail.

Hearings on the measure are expected next year.

Superfund bill introduced

WASHINGTON—Congress is expected to take up a new bipartisan Superfund reform bill when it returns from its year-end recess.

Although the bill, introduced last week by Reps. Mike Oxley, R-Ohio, Commerce Committee Chairman Tom Bliley, R-Va., and 36 others, would not repeal Superfund's controversial imposition of retroactive liability in most cases, it would provide more liability relief than a measure introduced recently by Rep. Sherwood Boehlert, R-N.Y., said Taylor Caswell, senior federal affairs representative for the Alliance of American Insurers.

Small businesses, recyclers, generator-transporters, contributors of minimal amounts of Superfund waste and local governments all would enjoy at least limited immunity from retroactive liability under the bill.

The measure, which has support from conservatives and liberals in both parties, calls for "rational remedy selection" at Superfund sites and would allow states rather than the federal Environmental Protection Agency to conduct cleanups of Superfund sites if they so wished.

"This gives us new reason for optimism, because this is a bipartisan bill that has common sense reform in it," said Mr. Caswell.

Royal underwriting manager

CHARLOTTE, N.C.—Royal Insurance U.S. is establishing a new surplus lines underwriting management company that initially will offer casualty and professional liability coverages and is expected to generate $35 million in business its first year.

RSA Surplus Lines Underwriters Inc., which will underwrite on behalf of Royal Surplus Lines Insurance Co., is expected to begin operations in January, said its president and chief executive officer, John Kinsella.

Mr. Kinsella, formerly president and CEO of Cherry Hill, N.J.-based Admiral Insurance Co., said RSA also will be headquartered in Cherry Hill, with another office in Los Angeles County planned.

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Errors & omissions

• German marine insurer Darag A.G., in cooperation with Gerling A.G., is offering shipowners liability limits of up to $100 million, not 100 million deutsche marks as *Business Insurance* incorrectly reports on page 29 in this issue. Darag also began writing nationwide business in Germany in 1990, not 1994.

Subsidiaries' premiums to captives deductible: Court

By DOUGLAS McLEOD

WASHINGTON—Premiums paid by a company's subsidiaries to its wholly owned captive insurer are deductible, the U.S. Tax Court has ruled.

The ruling marks the second high-profile defeat for Internal Revenue Service efforts to disallow deductions for captive premiums paid by subsidiaries.

The Tax Court held last month that Hospital Corp. of America, now part of Columbia/HCA Healthcare Corp., may deduct premiums its subsidiaries paid to its Tennessee-domiciled captive Parthenon Insurance Co.

The decision mirrors a landmark 6th U.S. Circuit Court of Appeals' ruling in 1989 allowing similar deductions to the Humana Inc. hospital chain.

"The facts of the instant case are strikingly similar to the facts presented in *Humana*," the Tax Court concluded. "Both Humana and HCA owned and operated hospitals that were facing difficulties in obtaining medical malpractice insurance at the time they formed their captive insurance companies. Both formed fully capitalized, domestic (captives) to provide on a direct basis general and professional liability insurance for themselves and their operating subsidiaries."

The Internal Revenue Service argued that the HCA case dif-

See **Captives** *on page 38*

Microsoft moving to Aon

Bulk of company's business, key vp leave J&H/M&M

By DAVE LENCKUS

REDMOND, Wash.—J&H Marsh & McLennan Inc. has lost most of the retail insurance brokerage business of computer software giant Microsoft Corp. to Aon Group Inc.

Microsoft's move rends a 13-year relationship that the 22-year-old company originally established with the former Johnson & Higgins. J&H was acquired by Marsh & McLennan Cos. Inc. earlier this year.

Aon retail unit Aon Risk Services Inc. of Washington in Seattle will take over placing Microsoft's property and casualty coverages. Aon Risk Services Vp Robin Magnotti is Microsoft's account executive.

J&H Marsh & McLennan, the world's largest retail broker, will continue to handle some transactional services and a few other lines of coverage for Microsoft, said Scott K. Lange, director of risk management for the Redmond, Wash.-based company.

J&H Marsh & McLennan also has lost Vp Roger Van Der Vliet to Aon Risk Services. Mr. Van Der Vliet has been intimately involved with the Microsoft account since he picked it up for J&H in 1984. He has been Microsoft's account manager twice during that period. Mr. Van Der Vliet, now a senior vp in Aon Risk Service's Global Broking Group in Seattle, said he will remain involved in servicing the account.

Mr. Lange would say only that he moved Microsoft's business to Aon because "basically, it's time for a change."

See **Microsoft** *on page 38*

Profits down, rates going up

By JUDY GREENWALD

Employers should brace for higher health plan costs next year, as health maintenance organizations plan for 1998 rates to restore flagging profitability.

Anticipated 1998 rate hikes, which range from 2% to 10% depending upon the region and particular contract, should bring some relief to HMOs after a rough period of lower earnings against flat or decreasing rates, market analysts say.

The surprising $78.2 million third-quarter net loss reported by Norwalk, Conn.-based Oxford Health Systems Inc., however, is more reflective of that HMO's specific problems in managing its computer systems, rather than an indication of serious problems within the industry as a whole, analysts say (*BI*, Nov. 10). Oxford reported a $6.6 million net loss for the nine months compared with net income of $67.6 million for the comparable period a year ago.

Similarly, lower-than-expected third-quarter earnings report of Aetna Inc. have been attributed to its particular circumstances, namely its acquisition of U.S. Healthcare Inc. and the problems inherent in digesting a major acquisition. Many market observers, however, expect the pace, if not necessarily the magnitude, of

See **Results** *on page 39*

Pru Health Care options eyed

Sale of health care unit denied, but market rumors persist

By JUDY GREENWALD

NEWARK, N.J.—Prudential Insurance Co. of America could face a daunting challenge in finding a buyer if it decides to sell its unprofitable health care business.

While Prudential denies its health care operation is even up for sale, the general consensus in the market is that the insurer is anxious to get out of the business, on which it is estimated to have lost more than $100 million on a premium base of $6 billion last year (*BI*, Oct. 6).

Consultants say that while a Prudential sale to another health care company would give employers one fewer managed care company to choose from, an acquisition could also result in a stronger vendor willing to commit more resources to customer service.

However, the most likely candidates to buy the business, which include Aetna Inc. and CIGNA Corp., already have their hands full absorbing other acquisitions.

The problems that these and other health care companies have had could sour Wall Street on another major acquisition at this time, some market observers say.

Other possibilities observers

See **Prudential** *on page 37*

Inside

• Risk managers in the area of the New Madrid seismic zone in the central United States should begin now to prepare for an earthquake that will come—even if not for years, this week's editorial says. **PAGE 8**

• U.K. insurers are excluding coverage for Year 2000 computer risks and emphasizing that standard policies never were intended to provide such coverage. **PAGE 29**

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More problems for sprinkler maker

Manufacturer cites internal confusion in continued production of faulty heads

By ROBERTO CENICEROS

LANSDALE, Pa.—Central Sprinkler Co. continued to make certain fire sprinklers with rubber O-rings—blamed for preventing some of its Omega-line sprinkler heads from functioning properly—even after the company announced it had switched to silicone O-rings.

Central announced in August that since June 1996, all its Omega sprinkler heads have been made with improved silicone O-rings instead of rubber. But the company recently issued a statement saying it discovered that 20,000 Flow Control sprinklers—a part of its Omega line—were made between June 6, 1996, and May 7, 1997, with the rubber O-rings.

Some of the rubber O-rings have swelled under pressure and failed to release water during fires. Central has said it thinks contaminants introduced as a result of pipe cutting and fitting cause the problem.

"Central Sprinkler intended to replace the (rubber) O-ring in June 1996 at the same time the Omega product line was modified to address the issue of hydrocarbon contamination, and management believed we had done so," the statement said.

Unfortunately, internal confusion interfered with implementation of the decision to modify the Flow Control sprinkler, the Oct. 20 statement continued.

Flow Control sprinklers are made to shut off automatically once a fire is extinguished. Other sprinklers do not automatically shut off. The Flow Control type are used in certain types of commercial buildings with contents particularly sensitive to water damage, such as museums.

Observers point out that Central's newest problem may not be a huge one, because only 20,000 Flow Control sprinklers were made with the older, rubber-style O-rings.

"Certainly those need to be tested and replaced if necessary, but 20,000 in sales is pretty minuscule," said Steve Muncy, president of the American Fire Sprinkler Assn., of which Central is a member. "Twenty thousand sold in the past year or so—they can trace those pretty easily. That is less of a problem than the Omegas that have been put in over a number of years and could have been put in by contractors that no longer exist. So it is hard to trace those."

About 8 million Omega sprinklers are in service nationwide. Some of those have the rubber O-rings.

Central's original problem with Omega heads received widespread media attention in August (*BI*, Aug. 18). Fire officials, property insurers and loss-prevention experts praise many of Central's products, but they had known for some time before that of potential shortcomings associated with Omega heads.

But media outlets discovered in August that some Omega heads installed in buildings had failed to operate during fires. By then, Central already had spent months alerting its customers and had set aside $4 million to fund a program to test samples of Omega heads customers think might be defective. Central along with Underwriters Laboratories made kits available for sending in the heads for inspection.

Meanwhile, a lawsuit filed Aug. 1 in Los Angeles Superior Court against Central continues to move forward, said Clifford H. Pearson, a plaintiffs' attorney with Wasserman, Comden & Casselman in Tarzana, Calif. (*BI*, Aug. 25). Attorneys are set to start deposing witnesses.

The lawsuit was filed on behalf of Los Angeles-area building owners and seeks class-action status, though the class has not been certified. A spokeswoman for Central could not say if other lawsuits have been filed. BI

Sears retirees sue retailer over life insurance cuts

By GAVIN SOUTER

CHICAGO—A group of Sears, Roebuck & Co. retirees is suing the retailing giant over cutbacks to their life insurance benefits.

The employees allege the cutbacks by Hoffman Estates, Ill.-based Sears of its life insurance benefits violate the Employee Retirement Income Security Act, and they are seeking a restitution of the benefits.

Under the cutback proposals, Sears plans to gradually reduce its contributions to retirees' life insurance premiums.

The retirees claim the contributions they made to life insurance premiums when they were working vested them in the policies for post-retirement coverage.

Also, the literature covering life insurance benefits given to employees does not indicate that the benefits can be altered in the future, the retirees argue.

They are seeking class-action status for the suit, which was filed in federal court in Chicago.

Sears announced cutbacks to its retiree benefits package in September (*BI*, Sept. 29). The company plans to scale back its contributions for retirees' supplemental health benefits as well as life insurance coverage. The life insurance cutbacks would affect 84,000 retirees.

Sears plans to reduce the life insurance benefits gradually over 10 years to about $5,000 per retiree from a current average of $17,000 per retiree.

If retirees wish to retain their existing level of life insurance benefits, Sears offers a group term life insurance plan with higher available limits, but to which the company does not contribute any of premiums.

In the case of one plaintiff who currently has $16,800 in life insurance coverage through Sears, the additional annual premium to switch to the group life plan would be $49.34 in 1998 and rise to $1,226.61 in 2007, court papers say.

In the suit, filed in U.S. District Court in Chicago, the 38 retirees allege the cutbacks breach ERISA.

"The benefit reduction is manifestly unfair and contrary to law. Participants, at the end of their professional lives, have prepared for their retirement years based upon certain promises made by the defendants," court papers say.

In numerous documents sent to em-

See **Sears** *on next page*

Mutual Fire rehabilitator takes helm of insurer as it resumes business

By MICHAEL BRADFORD

PHILADELPHIA—Alexander Bratick has a new job these days, after spending more than eight years as the rehabilitator of Mutual Fire, Marine & Inland Insurance Co.

Mr. Bratick now is guiding the reincarnation of the Philadelphia-based insurer as its president and chief executive officer and holds the same title with Mutual Fire's subsidiary, Franklin Homeowners Assurance Co.

Mutual Fire, after emerging late last year from rehabilitation, is starting a new life as an underwriter of Pennsylvania homeowners insurance. Once a leading U.S. surplus lines insurer that spiraled into a $500 million insolvency, Mutual Fire now is gearing up to resume business on a much smaller scale.

"We will be in the homeowners business," Mr. Bratick said. "Nothing exotic." Mutual Fire chose to write homeowners coverage partly because "it's a simpler line than most of the other coverages the company was writing," Mr. Bratick explained. "It doesn't require as much sophistication."

Some personal lines insurers have left the Pennsylvania market, and Mutual Fire and Franklin are helping fill that void, he added.

The insurer still faces about 200 claims related to the rehabilitation. Those claims currently are valued at about $70 million, an amount that is fully reserved, Mr. Bratick said.

Mutual Fire began insuring homeowners risks in Pennsylvania in May and has written approximately 70 policies. Its capital and surplus stood at $28 million at the end of June.

Mr. Bratick said $5 million of that figure represents the capital and surplus in Franklin Homeowners. That insurer writes a type of homeowners coverage that allows buyers to pay for coverage with an up-front deposit instead of paying annual premiums.

The coverage deposit remains as long as the policyholder wants to keep coverage in force. The money is held in a trust account, and the insurer collects investment income on the amount.

"Claims don't impact the deposit," Mr. Bratick explained. Claims are paid by the insurer and the deposit is 100% refundable when coverage ends.

See **Mutual Fire** *on page 14*

Educating employees top benefit goal: Survey

By DEBORAH SHALOWITZ COWANS

Investment education for employees is the top priority for benefit professionals next year, according to a new survey.

The second-most-urgent priority of employee benefit professionals for 1998 is to refine and improve managed care programs, according to the survey of 354 members of the International Society of Certified Employee Benefit Specialists.

The ISCEBS is a non-profit educational association whose members have earned the Certified Employee Benefit Specialist designation. The survey was released last week in conjunction with the 16th Annual ISCEBS Employee Benefits Symposium in New Orleans.

"For the past 10 to 15 years, managed care issues have dominated the attention of the employees and the benefits professionals that serve them," said Dick Kleinert, a partner with Deloitte & Touche L.L.P.'s employee benefit group. "These new results, however, reveal that retirement planning is starting to demand more attention from the perspectives of both employees and benefits specialists due to the tidal wave of baby boomers soon approaching retirement age."

The results show that benefit professionals are becoming more interested in investment communication and education as the workforce ages, said James D. Davidson, president of the ISCEBS.

The next three priorities benefits professionals cited, in decreasing order of prevalence, were: monitoring and responding to health care reform legislation; emphasizing and improving the quality of employee benefit communication materials; and evaluating and implementing Internet applications.

The survey shows some regional differences in priorities.

For example, benefit professionals in the Northeast, Southeast and Midwest ranked developing and providing investment education as their highest priority for the com-

See **CEBS** *on page 37*

Medical monitoring suits raise stakes

Manufacturers may face millions of plaintiffs

By SALLY ROBERTS

CHICAGO—More people who have been exposed to but not injured by allegedly dangerous drugs or medical products are attempting to recover the costs of future medical monitoring or surveillance, an attorney says.

Medical monitoring class-action lawsuits, which became popular in toxic tort litigation in the early 1980s and 1990s, are a "new phenomenon" in drug and medical product litigation and a "high risk potential" for manufacturers, said Thomas E. Sanner, an attorney in the Minneapolis office of Hinshaw & Culbertson.

Whereas the average group of individuals in a medical monitoring class involving a toxic tort ranges from 200 to 1,000 people, the class of plaintiffs in a drug liability medical monitoring case can run into the millions, according to Mr. Sanner.

This is due in part to courts allowing individuals to sue for medical monitoring costs without any physical injuries or signs of injuries.

One of the more recent and highly publicized class-action suits seeking unspecified amounts for medical monitoring as well as general and punitive damages involves Wyeth-Ayerst Laboratories, manufacturer of weight loss drugs Pondimin or fenfluramine hydrochloride and Redux, dexfenfluramine hydrochloride (*BI*, Sept. 29).

In September, the U.S. Food & Drug Administration released data showing that as many as 32% of 291 people tested developed heart-valve abnormalities after taking either drug in combination with phentermine.

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Sears

Continued from previous page

ployees since the 1970s, Sears had contractually committed to provide lifetime no-cost post-retirement life insurance to retirees who had, for at least 10 years, paid the employee portion of the premiums under the plan, they argue in court papers.

Several of the documents contained disclaimers that they did not constitute a legal document. However, Sears intended that the employees rely on the documents as a source of information regarding benefits, the retirees charge.

Also, by paying the employee portion of the premiums for 10 years, employees contractually purchased the post-retirement coverage, they say.

"(Sears') unilateral decision to eliminate this benefit retroactively violates and breaches the plan's express promises to provide this benefit, which contractually vested for all class members upon their retirement after 10 years of continuous participation by previous premium payments," court papers say.

Sears would not comment on the details of the case, but a company spokeswoman said, "Sears has consistently communicated its right to change or modify its benefits, including retiree life insurance, at the discretion of the company at any time."

The lawsuit filed in Chicago is part of a volley of protests by retirees over the cutbacks, and other suits reportedly have been filed.

Groups of retirees in several cities also plan to protest the cuts by picketing Sears stores during the coming holidays. BI

California law unclear: Court

Conflicting rules on drug rehabilitation lead court to overturn suit

By JUDY GREENWALD

SAN FRANCISCO—California's Alcohol & Drug Rehabilitation Act fails to give employers adequate guidance on how to deal with employees in rehabilitation, says a state appellate court.

The court ruled employers cannot be successfully sued in wrongful termination suits for emotional distress and punitive damages under provisions of the Act.

The case in *Sullivan vs. Delta Airlines* involves the late Joseph A. Sullivan, who was discharged by Delta Air Lines when he refused to return to work after undergoing alcohol and drug rehabilitation. He died of AIDS before his case was resolved.

In overturning a lower court decision, the appellate court said in the ruling issued last month that the ADRA expresses three "potentially conflicting" policies: accommodating employees who are in rehabilitation; avoiding undue hardship on employers; and intolerance of alcohol and drug abuse that interferes with employee performance.

"In fact, it is difficult to determine precisely what employer conduct" is prohibited under this law, says the decision.

Unlike race, gender and age, which "are not the products of free choice," rehabilitation does not deserve special protection, says the appellate decision. "There is no recognized right of an employee to voluntarily enter a drug or alcohol rehabilitation program."

In another decision stemming from the same case, the California Supreme Court had ruled earlier this year that heirs of a plaintiff who received a jury award for emotional distress but died before the defendant's appeal was complete are entitled to receive the award if it is upheld (*BI*, May 12).

Assuming it is not overturned on appeal, this latest decision means Mr. Sullivan's mother, Alene M. Sullivan, cannot collect the $275,000 for emotional distress awarded by a jury in 1994, according to Delta attorney Gilmore F. Diekmann Jr. of Bronson, Bronson & McKinnon in San Francisco. Mr. Sullivan's attorneys could not be reached for comment.

Mr. Diekmann noted many courts consider alcoholism to be a handicap under provisions of the federal Americans with Disabilities Act and the state Fair Employment & Housing Act.

However, to the extent that the ADRA goes beyond those laws' requirements, this decision means that employers will not be held liable for emotional distress and punitive damages, said Mr. Diekmann.

•

Alene M. Sullivan, as special administrator, etc., vs. Delta Air Lines Inc., Court of Appeal of the State of California, First Appellate District; No. A066778.

BI buyers directory available

CHICAGO—The latest edition of *Business Insurance*'s annual directory of buyers outside the United States is now available.

The 1997/98 edition of the "*Business Insurance* Directory of of Corporate Buyers of Insurance, Benefit Plans and Risk Management Services Based Outside the United States" includes information on more than 4,600 executives from nearly 900 companies in 28 different countries.

The directory is available in a 208-page printed volume and on computer disk for DOS-compatible computers.

The guide's listings consist of corporate data, including addresses, phone and fax numbers, the names and titles of executives responsible for finance, risk management, employee benefits, human resources, pension/retirement planning, insurance, legal counsel and private medical/health plans.

Revenue or asset information and number of employees are provided, as well as the currency used and a description of the business. The international directory contains rankings of companies based on number of employees and revenues or assets.

The international buyers directory costs $125. In addition, a similar but more comprehensive directory of U.S.-based companies is available for $95. Either directory is available on disk for $595.

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Employers use Web for flex enrollment

Benefit Beat

NEWARK, N.J.—Three large Northeastern employers conducted their fall flex enrollment this year on the World Wide Web—breaking from the more common practice of restricting online enrollment to internal corporate "intranets."

Using software developed by Hewitt Associates L.L.C. and housed on a server at the consultant's Lincolnshire, Ill., headquarters, 11,000 employees of Public Service Electric & Gas Co. in eight countries were able to select health plans, purchase group auto and life insurance and even move money around various 401(k) fund options during open enrollment that ended Nov. 14, according to Dick Quinn, director of performance and rewards for the Newark, N.J.-based utility.

Employees at GTE's Dallas and Boston locations also used the Hewitt Web-based enrollment system, but only on a pilot basis during their open enrollment, which ended Nov. 12.

Digital Equipment Corp. also "went live" in October, a Hewitt spokeswoman said.

The Web-based enrollment option is an addition to the staple of automated enrollment services Hewitt offers employers on an outsourced basis, a spokeswoman for the consultant explained.

"They can use voice response, they can call in and talk to a Hewitt person, or now they can enroll through the Internet," she said.

Internet access is viewed as a major convenience for employees, as benefit decisions typically are made at home, where there may be more time to evaluate the wide variety of available benefit options, she explained.

Among the functions employees can perform on the Hewitt-built site are: annual benefit elections; savings plan inquiries and transactions; links to Web sites from benefit providers and government agencies; download claim forms; read benefit program summaries; and contact the corporate benefits department, which in the case of these three employers has been outsourced to the Hewitt Benefits Center in Lincolnshire.

Besides the convenience, the Web enrollment system is even more economical than interactive voice response, the low-cost phone-based system.

"Each Internet hit costs half as much as the average IVR call," said Mr. Quinn of PSE&G. "So we're trying to encourage our employees to use it."

The system also has built-in safeguards to ensure security.

For example, the address for the enrollment system's home page is provided only to employees and is not available via Internet search engines, the Hewitt spokeswoman explained.

If a hacker does manage to break into the site, the system will lock up if more than five attempts are made to guess either an employee's Social Security or personal identification numbers, both of which are required for access.

Furthermore, GTE is tracking the number of "hits" by each user so that it can contact employees whose accounts are being accessed unusually often, according to John Large, team leader of benefits elections.

"We are very conscious of the security aspect, especially since it's out there on the Net," he said.

The Web server records employees' benefit elections instantly, and information affecting payroll or other human resource functions is downloaded weekly to each employers' human resource information system. Hard copy confirmations of transactions also are mailed to employees' homes.

While it's too early to tell how many employees of these three companies used the Web-based enrollment, Mr. Large believes "it's worked out extremely well. If there were a problem, we'd hear about it."

Hewitt is in discussions with about a dozen other employers that will likely offer Web enrollment next year, the spokeswoman said.

"We'll have probably 20 to 30 companies going up next year and 90 to 100 the following year," she predicts.

—By Joanne Wojcik

Retirement planning

A growing number of employers with 401(k) retirement plans are offering financial and pre-retirement planning seminars as well as allowing employees to change their plans on a daily basis, a survey reports.

About 46% of the 668 employers responding to a recent survey now provide financial and pre-retirement seminars, according to Buck Consultants Inc. That has grown from 41% last year, 39% in 1995 and 28% in 1994.

Also, 36% of employers offered investment seminars this year, compared with 29% last year, 24% in 1995 and 16% in 1994.

In addition, 61% of employers allow participants in the employer's most popular 401(k) plan to make daily changes in their investment choices for existing account balances this year. By comparison, 53% of employers allowed it last year, 35% in 1995 and 28% in 1994.

Slightly fewer employers—58%—allow employees to change investment choices on future contributions every payroll period. Last year, 49% of employers allowed that flexibility, 30% did so in 1995 and 20% allowed that flexibility in 1994.

"Clearly, our survey results show that employers want to help their employees to get the most out of their 401(k) plans," said Rich Koski, a principal in Buck's Secaucus, N.J., office. In addition, "they are committed to giving their employees the education, high-tech tools and flexibility to do this."

Overall, about 92% of employers have taken some step to educate participants about investment and savings issues, up from 87% in 1996. More than half of employers said they began the education efforts because employees asked for more information.

Most employers also are using high-technology tools, such as interactive voice response systems, to help keep employees informed. About 84% of employers use such systems now, up from 76% last year and 35% in 1993.

A copy of the 65-page "401(k) Plans: Survey Report on Plan Design—1997" costs $200. To order the report, contact Carrie Estevez, Marketing Department, Buck Consultants Inc., 500 Plaza Drive, Secaucus, N.J. 07096-1533; 201-902-2555.

—By Meg Fletcher

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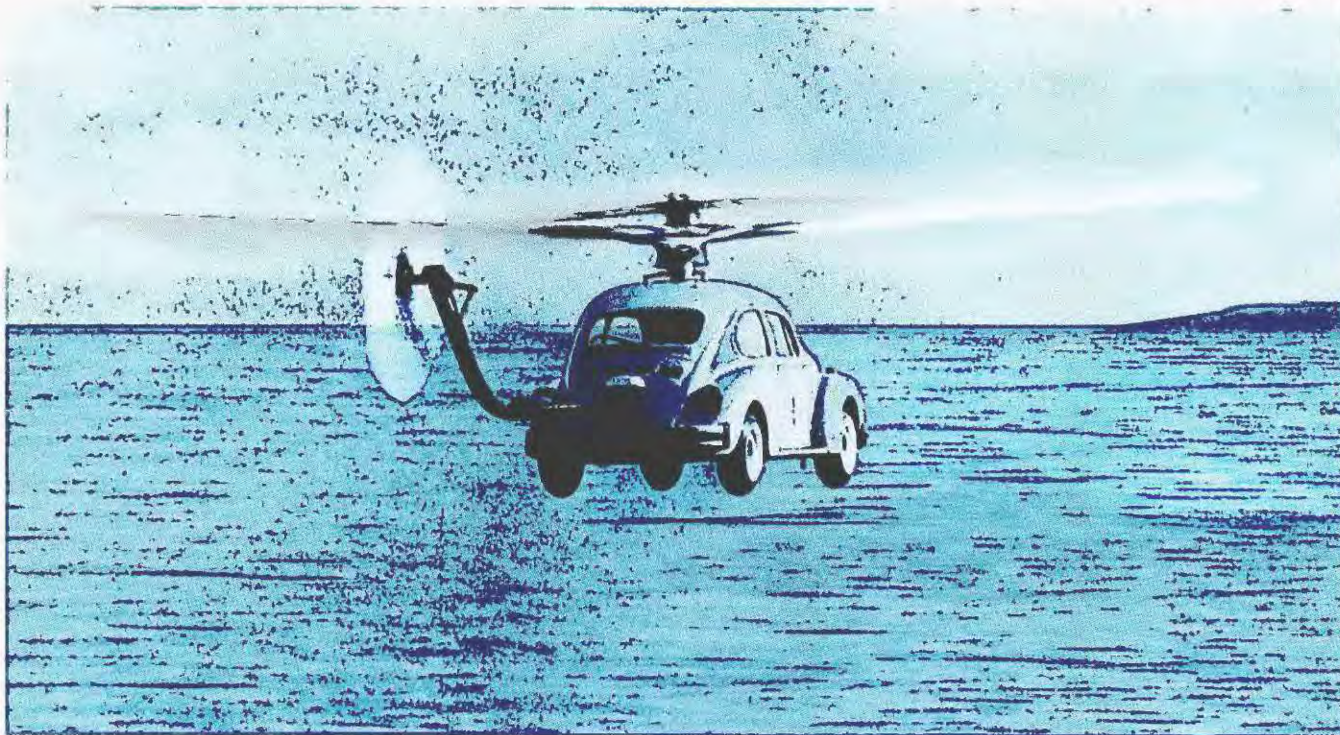

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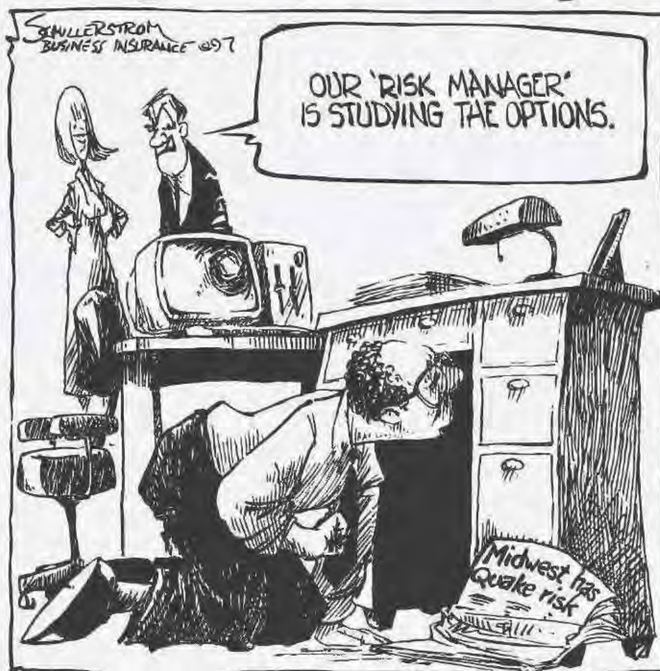
Opinions

Shake off complacency



THE QUESTION is not *if* the middle of the United States will be rocked by a major earthquake, but *when*.

As we reported last week, experts predict there is a 90% chance that a major earthquake will occur in the next 50 years on the New Madrid fault, which lies beneath the Mississippi Valley. A New Madrid earthquake could occur tomorrow, it could occur next year, it could occur after our lifetimes.

Although the last major quake on this fault zone occurred more than 100 years ago, it was by no means the first such quake. Some of the most powerful quakes ever to hit the United States occurred on the New Madrid fault in the winter of 1811-1812. The seismic area remains one of the most active in the country.

Just as experts are certain a major New Madrid quake is inevitable, they also are convinced of one other thing: that the majority of businesses and communities most exposed to such a catastrophe are woefully unprepared.

If there was ever a case for risk management to step into the breach, this is it. We urge risk managers not only to begin working to minimize their own organizations' exposures to loss, but also to raise awareness of this potential peril within their communities.

To be sure, it is difficult to prepare for a peril that has such low frequency. A devastating quake has not hit the New Madrid zone in our lifetimes. Yet the hazard is real, and the threat from such a quake to a company's facilities, people and ability to continue operating is very real.

In addition, insurers and reinsurers are waking up to their exposures to this peril and increasingly will press for larger deductibles, higher rates and a reduction of their aggregate exposures in the region.

Risk reduction efforts by employers, therefore, not only ensure they will be in better shape after a quake, but that they also pay more stable insurance rates than the less-prepared.

There are many sources of information about the earthquake risk, including the U.S. Geological Survey, the University of Memphis Center for Earthquake Research and Information, and the Central United States Earthquake Consortium. In some communities, such as Memphis, Tenn., business and government coalitions have been formed to assess and improve disaster preparedness. The Internet also can be a source of leads for obtaining additional information.

We encourage risk managers to learn more about their exposure to this seismic zone and also to take steps to educate others within their organizations and within their communities.

Risk managers far beyond the Mississippi Valley also should be aware of their considerable exposure to New Madrid losses. Businesses that rely on transcontinental supply routes, energy transmission lines that pass through the region and those with suppliers and customers in the New Madrid zone, to name but a few contingent exposures, should work to minimize their possible losses.

Preparedness will mean the difference between surviving a quake and continuing to operate, or being shaken out of business permanently.

Letters

Technology helping state oversight of agents

To the editor: We read with obvious interest the Oct. 13 editorial, "NAIC: Step Up or Aside," and would like to set the record straight.

First, let us say that articles similar to this appearing in various publications over the past several weeks neither provide actual progress nor do they reflect the success of the NAIC's Producer Information Network Working Group. While the accomplishments of this group are not a secret, they certainly have not been recognized.

As you are aware, Congress is considering many changes to the financial services industry, including insurance. As the businesses of banking and insurance become more technical and more advanced, there is more of a push to modernize the regulation of these industries.

To many in the financial services industry, it means doing insurance without having to deal with state regulators. They claim state insurance regulators are an unnecessary barrier and merely get in the way. In our way of thinking, state regulators do not get in the way of commerce but in fact, help it thrive. State insurance regulators have a long and proud tradition of sound, effective oversight of the insurance industry. We in Wisconsin would put our record of protection up against that of the protections offered by federal savings and loan or banking laws any day of the week.

With respect to the current National Assn. of Registered Agents & Brokers proposal, state regulators working together have stayed ahead of the federal government. For years, agents have dealt with a traditional state licensing system. This whole process is developing into a streamlined, electronic system right before our eyes.

State regulators in association with the National Assn. of Insurance Commissioners have been working on projects called the Producer Database and the Producer Information Network. That PIN Working Group is three successful years into its original five-year plan charged with electronically connecting state licensing functions and streamlining the agent licensing process.

The first step took place two years ago, when a nationwide producer database was developed to facilitate states' and the industry's ability to track information regarding licensed agents. We are proud to say Wisconsin became the first state to join the PDB with our agent licensing information. Since then, Iowa, Washington, Florida, Missouri, Texas, North Dakota and Michigan have joined the database. We now have more than

See **Letters** *on page 36*

Business Insurance welcomes letters to the editor. The section is intended to be a forum for readers' opinions and comments. We reserve the right to edit letters for clarity or space. We will not publish unsigned letters. Please send your letters to Letters to the Editor, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611; fax: 312-280-3174; e-mail: pwinston@crain.com

Wrong word changed meaning

To the editor: Your Oct. 20 issue contained an article, "Easing HMO Comparisons," about the Foundation for Accountability's new framework for communicating quality information to purchasers and consumers.

The article says that one issue the framework addresses is the ". . .problem of duplicity in data." The Foundation has never accused any professional or provider organization with "deliberate deceptiveness in behavior," which is the American Heritage Dictionary's definition of duplicity.

Rather, we are concerned with duplication and expect that the framework will help to rationalize data collection efforts, allowing data from many sources to be aggregated and summarized to meet purchaser and consumer needs in an easy-to-understand manner. It will also help focus measurement development efforts at FACCT and elsewhere.

Alan Peres
Board member
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PARCA

Continued from page 1
health care plans.

These liability provisions in the legislation specifically would amend the Employee Retirement Income Security Act, which pre-empts state rules and laws that relate to employee benefit plans. Under ERISA, employees can recover only actual damages and in some cases legal expenses.

PARCA, say critics, would expose employers to legal action—and potentially huge damage awards—for actions over which they had no or little control.

For example, an employer that contracted with physicians to set up a health care network could face liability if a physician made a mistake and injured an employee.

"ERISA was set up to maximize the amount of money that would go to pay for benefits. This bill would maximize the amount of money that would go to the plaintiffs' bar. It is a trial lawyers' bonanza," Mr. Weller said.

However, a new version of the bill Rep. Norwood introduced last week would preserve the ERISA shield against damages awarded under state law if an employer did not exercise "discretionary authority to review and make decisions on claims for plan benefits." This may provide only limited protection, because many employers may review decisions made by plan administrators involving very large claims, said Henry Saveth, a Mercer principal in Washington.

- Make self-funded employers responsible for establishing health care quality improvement programs. These programs would have to "systematically and continuously assess and improve" the health of every participant in its health care plan.

Critics say they have no idea how employers could run such programs; noting, for example, that for such a program to work, employers would have to know the health status of employees before hiring them—information they would certainly lack.

- Require employers to evaluate at least once a year all health care professionals that apply to be in their networks. The bill does not specify evaluation standards; such standards would be developed based on the advice of professional associations, health professionals and providers.

Even if its network was full, an employer still would have to go through the evaluation process of health care professionals that applied, significantly adding to its administrative costs.

- Take away from employers the right to decide which health care services it will cover. Under the measure, employers and other providers of health care plans could not discriminate in the participation, reimbursement or indemnification of a health care professional certified under state law.

That provision could require employers to reimburse those providing services employers never intended to provide.

"Some states license naturopaths, homeopathic practitioners, massage therapists and many others not ordinarily covered in many reputable health insurance plans," Tom Emerick, vp of benefits at Wal-Mart Stores Inc. in Rogers, Ark., told a congressional panel last month.

- Erode employers' ability to establish preferred provider networks. Under the measure, an employer that selects a hospital and its accredited physicians to be in its network could not bar other physicians from being in its network because they were not affiliated with or did not have admitting privileges to the hospital with which it contracted.

That provision, says Mr. Weller, would cripple employers' ability to select physicians on the basis of quality, innovation, cost and service.

- Have the government decide how much of a point-of-service plan premium employers could shift to employees.

In addition, one provision bars discrimination against health care plan participants on the basis of "anticipated need" for services.

"It appears that the government and the courts could be involved in deciding what services are medically necessary," Rep. Fawell said.

'A big education effort is needed. We are trying to educate members that this bill goes way too far,' says Leslie Pryor of the National Assn. of Wholesaler-Distributors.

In all, "This is the worst piece of health care legislation introduced this congressional session," said Neil Trautwein, manager of health care policy at the U.S. Chamber of Commerce in Washington.

"It is a dastardly bill," concludes Leslie Pryor, senior director of government relations at the National Assn. of Wholesaler-Distributors in Washington.

Supporters of the measure, though, look at it differently. Rep. Norwood says the bill is a response to a managed care industry that wants "all of the power and none of the responsibility."

"Today, there is simply no public policy establishing minimum patient protection for self-insured managed care plans in this country because Congress has not completed its work," Rep. Norwood adds.

But from an employer perspective, "It is a wish list by the medical community on what to do about everything they do not like about the health care system," said James Cole, manager of health programs at Franklin Electric Co. Inc. in Bluffton, Ind.

How widespread support for the measure is at this point is unclear. Mr. Weller says many congressmen who have signed on to the bill as cosponsors did so as a response to the public backlash against certain managed care practices. But few congressmen have any idea what the measure actually would do, he says.

"A big education effort is needed. We are trying to educate members that the bill goes much too far," says the NAW's Ms. Pryor.

What could work against the bill's chances, notes Mr. Saveth, is growing comparisons to the measure to President Clinton's failed effort.

"The Republican leadership is saying that this sounds a lot like 'ClintonCare' and that we have to be very careful" in this area, Mr. Saveth added.

But employers need to get more involved in the lobbying effort against the measure, some say.

"I hope we do see a greater level of effort among the employer community. These are not small issues," Mercer's Mr. Kerby said. BI

MBK Real Estate names risk manager

Comings & Goings: Buyers

Gordon L. Adams has been named director of risk management at MBK Real Estate Ltd., a real estate development and construction firm in Irvine, Calif.

Mr. Adams, 47, comes to the newly created position after serving in a claims and risk management job with Pacific Enterprises, a Los Angeles-based utility.

As director of risk management, Mr. Adams is responsible for insurance and risk management at MBK and its six subsidiaries.

He will report to Dale A. Kemp, senior vp and chief financial officer.

Mr. Adams holds a bachelor of science degree in marine transportation from the U.S. Merchant Marine Academy in Kings Point, N.Y. He earned a master of business administration degree from Pepperdine University in Malibu, Calif.

Mr. Adams holds a California Fire & Casualty Insurance Brokers license and is a member of the Risk & Insurance Management Society Inc.

* * *

Henry C. Kramer has been appointed vp-human resources at Hilb, Rogal & Hamilton Co.

Mr. Kramer, 53, joined the Glen Allen, Va.-based insurance brokerage after serving as vp of human resources for the U.S. retail brokerage unit of Alexander & Alexander Services Inc. In the newly created position, Mr. Kramer reports to Timothy J. Korman, executive vp.

He earned a bachelor of science degree in business from the University of Baltimore.

* * *

Alan V. Burkett, 30, will provide loss control services to Greenville County, S.C., in his new position as a loss control consultant with Hewitt, Coleman & Associates.

Hewitt, Coleman recently contracted with the county to provide those services from its Greenville, S.C., location.

Mr. Burkett previously worked as a loss control specialist with the Colorado Compensation Insurance Authority. In the newly created position with Hewitt, Coleman, he reports to Ron Graves, senior vp of loss control.

Mr. Burkett received a bachelor of science in management from Clemson University in Clemson, S.C., and earned the Certified Safety Professional designation from the Board of Certified Safety Professionals.

•

We'd like to report on staff changes in your company's risk management, safety and employee benefit departments. Contact Michael Bradford, Associate Editor, Business Insurance, Suite 114, 8950 N. Central Expressway, Dallas, Texas 75231; 214-361-2295; fax: 214-696-1936. Please send a photograph, too.

Ironically, some of the business practices that are designed to save you money can actually put your bottom line at risk. For example, outsourcing can lead you to use vendors that may not be integrated into your loss prevention program. Consolidation has eliminated redundancy, and for those utilizing Just In Time Production, there's no inventory if your manufacturing system shuts down. And where does that leave your product? Off the shelves.

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Medicine

Continued from page 3

That combination of drugs was prescribed to 18 million Americans last year.

It is the sheer number of potential plaintiffs that make medical monitoring claims involving drug and medical products a high-risk exposure for manufacturers, Mr. Sanner said during Hinshaw & Culbertson's ninth annual risk and insurance symposium recently held in Chicago.

"The simple size can be breathtakingly enormous," he noted.

"In the drug liability world, I've been involved in a number of medical monitoring claims where the class exceeded 10 million plaintiffs," he said.

Other questions and issues also arise, making medical monitoring lawsuits a difficult risk for risk managers to assess.

For example, courts have not specifically addressed the definition of the percentage or level of risk needed to justify a medical monitoring claim, Mr. Sanner said. How much does the risk have to increase from the normal risks associated with the drug? he asked.

"If I take diet pills, do I have a 10% increased risk of getting pulmonary hypertension?" he asked rhetorically.

In addition, the latency period of exposure to develop the disease is indefinite, he said.

The sheer number of plaintiffs make drug liability cases a high risk for manufacturers, says Thomas E. Sanner.

"How many years do you have to test?" Mr. Sanner asked. "It's an open issue in the law today," he said.

Another contentious issue occurs when medical monitoring plaintiffs end up developing the alleged injuries.

If a company settles a medical monitoring claim and through the testing, an individual is diagnosed with the injury that another group sued and received damages for, can the individual come back and sue? Mr. Sanner asked.

Most states have a "split cause of action clause" that might restrict people who have recovered money from a medical monitoring claim from filing a second suit if the disease actually develops, he said.

However, a California court—the only court to address this issue with medical monitoring claims—ruled that the exclusion rules do not apply, according to Mr. Sanner.

"I don't know what the evolution of this will be, but it's a scary thought," he said.

One way that employers can fight medical monitoring claims is by picking a specific jurisdiction, Mr. Sanner suggested.

While a majority of courts today allow recovery of medical monitoring costs absent any physical injury, a few courts still hold that a plaintiff must be injured to sue, he said.

He also suggested drug and medical product manufacturers focus on alternative reasons behind the relationship between their products and the alleged injuries. There may be some other cause triggering the illness, he said. BI

RCRA

Continued from page 1

Mr. Haight, who is director-risk management for CF Industries in Long Grove, Ill., noted that RIMS has not been involved in RCRA reform efforts.

He added that he would not like to see RCRA reform trump reform of Superfund, which has long been one of RIMS' chief legislative goals.

"I have a real concern about this, because while it does fix some problems with environmental remediation, it's not a fix for Superfund. My concern is that people would perceive it as being a fix for Superfund and therefore reauthorize Superfund as it is," said Mr. Haight.

Although several Superfund reform bills have been recently introduced, no bill has made it to the floor of either chamber of Congress this year. Attempts in the two most recent congressional sessions also have failed, leaving RCRA reform as the most likely avenue for business to get any legislative relief from existing pollution liability laws.

"The whole idea of coming up with any sort of solution clearly has to be from a legislative perspective," said Mr. Hobbs of ECS. Site-specific changes "just are not enough. I'm really a lot more in favor of what the GAO refers to as a unitary approach of exempting all remediation waste from RCRA. I think that's really the most comprehensive way of handling the problem."

"There's a substantial amount of money involved," said Tom Ovenden, executive director of the Multi-Industry RCRA Coalition—which supports reform—and vp of The Technical Group Inc., a Washington-based environmental consultant.

"As Sen. Chafee pointed out, the potential savings that would result from this type of legislation exceed what they authorized for Superfund," said Mr. Ovenden, referring to Senate Environment and Public Works Committee Chairman John Chafee, R-R.I., who is part of the reform push.

The GAO report noted that the EPA's own estimates of savings from remediation reform range from $1.2 billion to $2.1 billion annually, depending on how broad the reforms are.

The GAO report, "Hazardous Waste: Remediation Waste Requirements Can Increase the Time and Cost of Cleanups," says: "Three key requirements under the Resource Conservation and Recovery Act that govern hazardous waste management—land disposal restrictions, minimum technological requirements and requirements for permits—can have negative effects when they are applied to waste from cleanups. The requirements have been successful at preventing further contamination from ongoing industrial operations, according to EPA cleanup managers.

"However, when the requirements are applied to remediation waste, which includes sludge, debris and contaminated soil or groundwater that is excavated or moved during a cleanup, they can pose barriers to cleanups. Because much remediation waste does not pose a significant threat to human health and the environment, subjecting it to these three requirements in particular can compel parties to perform cleanups that are more stringent than the EPA, the states, industry or national environmental groups believe are necessary to address the level of risk, increasing the time and cost of cleanups. Consequently, EPA and state program managers and industry representatives maintain, parties often try to avoid triggering the requirements by containing waste in place or by abandoning cleanups entirely."

The issue has plagued business for years, noted several pro-reform observers.

"It's been here for the past several years in that many RCRA reforms have been achieved through the regulatory and legislative processes. But there still is a regulatory glitch with respect to remediation waste, where RCRA imposes remediation requirements on a one-size-fits-all basis," said Geoff Hurwitz, the Washington-based director of government relations for the Rohm & Haas Co. in Philadelphia.

"The statute makes no distinction between remediation and process waste. The law requires companies to deal with waste from remediation the same way they would deal with process waste under the mixture and derived-from rule. In shorthand, that means all process wastes are generally treated as hazardous wastes.

"Under this one-size-fits-all approach, even remediation wastes are treated as hazardous waste, which drives up the cost and doesn't yield any commensurate benefit," added Mr. Hurwitz.

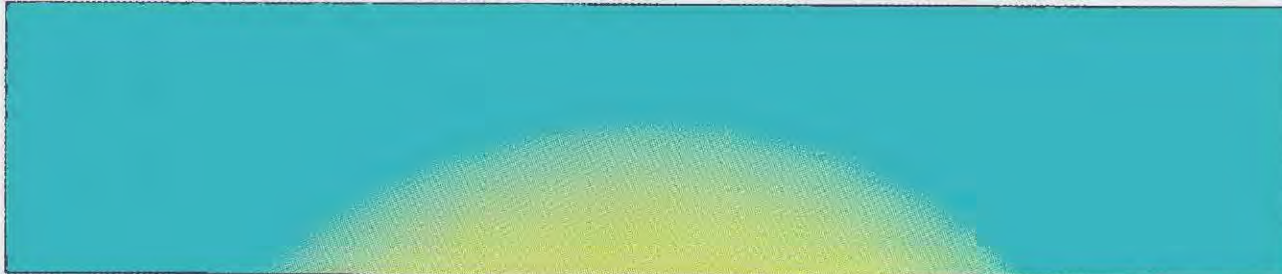
"The EPA says when you dig up a shovelful of contaminated soil, you have just generated a waste, which means you cannot put it back down on the ground unless it meets land disposal restrictions and is in a minimum technology unit," said CMA's Ms. Kellogg.

The derived-from rule says that anything that is derived from a hazardous waste must be managed as a hazardous waste. The mixed-with rule says that anything that is mixed with a hazardous waste must be managed as a hazardous waste, she pointed out.

"The regulators at EPA say, 'We're caught in a box, and we can't let you out.' "

"This is not a major reform of RCRA. It's what we call a rifle shot. The idea is to get a very narrow change. This is directed solely at so-called remediation waste," said Harvey Alter, director-resource policy at the U.S. Chamber of Commerce in Washington.

"The proposal is to simplify it," he said. BI



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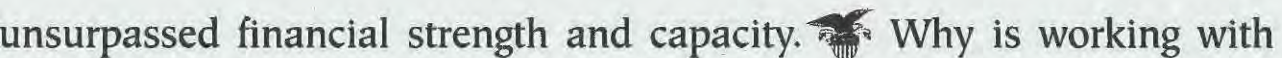

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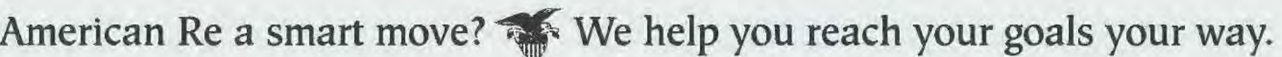

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Mudge president at Golden Eagle

William J. Mudge was named to the newly created position of president and chief operating officer of Golden Eagle Insurance Corp., the San Diego-based insurer that Liberty Mutual Group assumed control of last August.

Previously, Mr. Mudge was chief underwriting officer at Industrial Indemnity Co. and COO of the insurer's California workers compensation operations.

In other insurer changes:

William O. Bailey, chairman, president and chief executive officer of Terra Nova (Bermuda) Holdings Ltd. in Hamilton, Bermuda, will retire from the company next May. At that time, **John J. Dwyer**, deputy chairman and president of Terra Nova's Bermuda operating company, will become chairman of the holding company, and **Nigel Rogers**, deputy chairman and managing director of Octavian Syndicate Management, Terra Nova's Lloyd's of London operating company, will become president and CEO.

John N. Molbeck will join HCC Insurance Holdings Inc. in Houston as its president in January. He is a senior executive with Aon Group Inc. and succeeds interim President **Frank J. Bramanti**, who will concentrate his efforts on mergers, acquisitions and corporate financing.

Armin W. Blumberg named president and CEO of Carolina Casualty Insurance Co., the Jacksonville, Fla.-based subsidiary of W.R. Berkley Corp. Mr. Blumberg, formerly president and CEO of Nautilus Insurance Co. and Great Divide Insurance Co., both subsidiaries of W.R. Berkley, succeeds **Michael J. Snead,** who was named chairman of Berkley subsidiaries Admiral Insurance Co. and Nautilus. **Thomas M. Kuzma**, vp-property/casualty underwriting at Nautilus, succeeds Mr. Blumberg.

K. Bruce Connell named executive vp of EXEL Ltd. in Hamilton, Bermuda, with responsibilities for the company's reinsurance operations. It is a new position.

Comings & Goings: Industry

Brokers

Jamie Cunningham named chief administrative officer of Willis Corroon Corp., southwest region in Phoenix, and chief operating officer of Willis Corroon Corp. of Arizona.

J. Douglas Strohl joined the Charleston, S.C., office of Palmer & Cay as vp in the firm's commercial insurance division. Mr. Strohl previously served as senior vp and account executive at Alexander & Alexander Services Inc. and Johnson & Higgins.

Joe Labetti named managing director of the U.S. risk control consulting division of Sedgwick Inc. in Memphis, Tenn. Mr. Labetti formerly was with the Travelers Insurance Co.

Also at Sedgwick, **James K. O'Reilly Sr.** was named chairman of the newly formed gaming division and gaming industry focus group for Sedgwick of Nevada Inc. in Las Vegas. Previously, Mr. O'Reilly was vp-gaming industry division for Aon Group in Las Vegas.

Frank Beard named president and managing executive of Sedgwick of Georgia Inc. in Atlanta. Mr. Beard succeeds **Frank Kinnett**, who was named CEO and vice chairman of the Georgia operations.

Reinsurance

James A. Crowe named chief information officer of Constitution Reinsurance Corp. in New York.

Stephen Breen named senior vp-aviation underwriting at Risk Capital Reinsurance Co. in Greenwich, Conn. Previously, Mr. Breen was with Willis Faber North America as a broker in the aviation and space insurance and reinsurance industry.

Rob Lee Womack Jr. named senior vp in the underwriting division of LaSalle Re Ltd. in Hamilton, Bermuda.

Sam McCroskey joined American Re-Insurance Co. in Princeton, N.J., as vp with responsibilities for developing domestic insurance company operations opportunities within the Am-Re Financial Products unit.

Michael D. Schnur, managing director of Guy Carpenter & Co. Inc., named head of the reinsurance intermediary's Chicago office. Previously, Mr. Schnur was executive vp of Aon Re Inc.

W. Thompson Barberi, **Robert W. Colantuoni** and **James J. Farrelly** named vps at Odyssey Reinsurance Corp. in New York.

Rick Pagnani joined Swiss Re America in New York as director of the professional services unit in the company's alternative risk transfer division and is a member of senior management. Mr. Pagnani previously was a senior vp in charge of Zurich Reinsurance Centre's professional liability treaty department.

Romain Durand named managing director of SCOR Vie, SCOR's life reinsurance division in Paris. Previously, Mr. Durand was chairman and managing director of La Baloise France.

David Scherr joined Cologne Life Re in Stamford, Conn., as vp and corporate actuary. He previously was head of the U.S. corporate actuarial department of Swiss Re.

Other suppliers

Robert D. Morlot joined Deloitte & Touche L.L.P.'s human resources strategies group to lead its Tri-State region learning and development practice in New York. Previously, Mr. Morlot held senior management positions with Andersen Consulting and Development Dimensions International.

Thomas J. Brown named chief executive of the World Insurance Network, the London-based electronic network jointly owned by the world's four largest insurance brokers. Mr. Brown, formerly managing director of Royal Insurance Global Ltd., succeeds **Richard Wales** and **David Evans**, who were acting co-chief executives.

Dr. Robert S. Epstein named chief medical officer and senior vp of Merck-Medco Managed Care L.L.C. in Montvale, N.J.

Edward P. Holleran named executive vp of field operations for Presidium Inc., the San Francisco-based fully integrated supplier of disability management services. BI

Insurer Topics

A special editorial section sent exclusively to insurers and reinsurers

Fighting Fraud

As health care fraud increases, insurers must remain vigilant

Insurer Topics

Seeking a cure for health care fraud

Data sharing, greater claims scrutiny help combat growing problem, experts say

By REGIS COCCIA

Insurance crime is on the rise, and one of the fastest-growing segments is health insurance fraud, industry estimates show.

Although comprehensive data is not available and dollar estimates vary, sources agree that insurance fraud is a multibillion-dollar problem and growing.

"Estimates of what we lose to health care fraud range from 3% up to 10% of what we spend on health care in a year," said Bill Mahon, executive director of the National Health Care Anti-Fraud Assn., a Washington-based non-profit organization aimed at improving the detection and prevention of fraud. The NHCAA's members include private health care payers and government agencies.

"We're spending upwards of $1 trillion on health care, so we're looking at an estimated minimum of $30 billion a year. It's safe to assume we're talking tens of billions of dollars," he said.

Federal Bureau of Investigation statistics indicate that health care fraud costs insurers and other payers $100 billion a year, and the General Accounting Office estimates that up to 10% of the nation's health care spending involves fraud.

The Coalition Against Insurance Fraud, a Washington-based group supported by insurers, consumer organizations and law enforcement agencies, estimated that fraudulent health care claims totaled $59.1 billion in 1995, the latest year for which data was available. That was an increase of more than 10% from the year before.

Means, opportunity, motive

A large part of the problem lies in public acceptance of dishonesty in dealing with insurance companies. Insurance executives recognize and previous studies have shown that many individuals do not object to "soft" frauds such as padding claims and understating information to reduce premiums.

In fact, an actuarial rule of thumb euphemistically says that "9% of the population will be less than straightforward" in reporting claims or representing risk data, said Lawrence M. O'Rourke, director of group life and disability underwriting and services at Hartford Life Insurance Co. in Simsbury, Conn.

Many policyholders misrepresent their age or health, he said. "Even the little things affect the price of the policy," Mr. O'Rourke noted.

Given human temptation and opportunity, it's small wonder that health care providers and insurance professionals are joining in on a growing number of schemes.

So far this year, the Coalition Against Insurance Fraud has tracked 249 instances of serious fraud—those costing $100,000 or more. The coalition found that 32% of those cases have involved medical professionals, while 16% involved insurance agents or executives.

The NHCAA continues to see various forms of provider fraud, from padding claims to fabricating claims to "upcoding," or billing for costlier services than those provided, Mr. Mahon said.

Medical professionals aren't the only ones cashing in on fraud, however, he said. In South Florida, "there is a migration of people out of the drug-trafficking business into health care fraud," Mr. Mahon said. "It's safer and it's profitable."

Professional criminals are putting together phony laboratories or clinics for the sole purpose of billing health care payers. "It's a classic case of phantom providers," in which con artists steal provider names and their billing numbers, he said.

"They flood multiple payers with hundreds or thousands of claims. Then, when insurers realize what's going on, (the criminals) are already gone. They've set up shop five ZIP codes away and are doing the same thing in a slightly different form," Mr. Mahon explained.

A Southern California sting uncovered another type of fraud recently, Mr. Mahon said. A group of 15 physicians from Tijuana, Mexico, had been billing U.S. insurers for emergency medical treatment provided to Americans, but the "emergency" services actually were cosmetic surgery, he said. The doctors had used a San Diego billing agency and were arrested when law enforcement officials lured them to the agency.

Institutional fraud is another trend taking huge amounts of money away from Medicare, Medicaid

and private health care payers, Mr. Mahon said.

In the past four years, several hospital chains and laboratories have paid hundreds of millions of dollars to settle federal government investigations of their practices.

For example, National Medical Enterprises Inc. of Santa Monica, Calif., in 1993 and 1994 paid $125 million to six insurers and $379 million to settle a Justice Department probe alleging NME submitted fraudulent psychiatric claims (*BI*, July 11, 1994).

Ongoing government investigations are a "clear indication of fraud in the system today," he said.

"People ask, 'Is there more fraud or are you just getting better at detecting fraud?' " Mr. Mahon said. "The answer is yes to both. Insurers are getting better at detecting fraud. At the same time, the pot of money (in health care spending) keeps getting bigger every year."

Putting a stop to fraud

Insurers can defend against fraud in several ways, Mr. Mahon said.

The solution to the health care fraud problem is "partly technology, partly information sharing and continuing to rely on insureds themselves," he said.

Greater information exchange among insurers can help spot patterns of claims, such as those filed by crime rings, he said.

Electronic data interchange, enabling insurers to accept paperless claims, is helpful from an administrative standpoint, but without safeguards, it can make life easier for criminals, too.

"You could be giving speed and efficiency to the crooks as well as your own claims system," Mr. Mahon noted.

The more links an electronic system has between payer and provider, the greater the risk that someone may alter data, he warned. Insurers must pay close attention to who handles claims submitted electronically.

In addition, beneficiaries should receive an explanation-of-benefits form, which can help in spotting erroneous information. For example, if a patient knows the doctor ordered a simple test but the claims statement indicates some other procedure, that should raise a red flag. "The EOB should be one of the first lines of detection of discrepancies," Mr. Mahon said.

Claims departments are at the front lines in insurers' fight against fraud, and that is why companies such as Hartford Life have reorganized their claims departments to

See **Fraud** *on page 20D*

Where the fraud is

State-by-state estimates of insurance fraud, based on 1995 data

Source: Coalition Against Insurance Fraud

GRAPHIC BY ADAM DOI

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Insurer Topics

Bogus Yellow Pages dial up trouble

By REGIS COCCIA

Con artists are letting their fingers do the walking into insurance industry coffers with solicitations for fraudulent Yellow Pages listings, a national non-profit trade organization warns.

The Denver-based Yellow Pages Publishers Assn. estimates this form of mail fraud nets $350 million to $500 million a year soliciting advertisers for bogus Yellow Pages directories, and insurers, agents and brokers are common targets. The YPPA represents 127 Yellow Pages directory publishers, including all of the Bell companies, GTE, Sprint and other independent publishers.

The scams solicit listings of company names, addresses and phone numbers for Yellow Pages directories purportedly circulated over wide areas or nationwide. But, the bogus directories typically are sent to the advertisers themselves and an unspecified number of public libraries, chambers of commerce, restaurants and other markets not typically targeted by most advertisers, to appear to keep their word, the YPPA said.

"The (bogus) directories are of little or no value to anyone. They're distributed to advertisers" and a few other scattered organizations of little use to an insurance agent or company, said Ed Blackman, executive vp of the YPPA. "One of the reasons the Yellow Pages have been so successful over the years is it's a complete listing in a specific geographic area."

Despite growing awareness of business fraud, awareness of bogus advertising pitches is low, according to the association.

A YPPA survey conducted this spring found that only 23.1% of insurance professionals who advertise in Yellow Pages directories are aware of the problem. And, 67.9% of all Yellow Pages advertisers have never heard about fraudulent solicitations.

A common element of bogus Yellow Pages solicitations is the so-called "Walking Fingers" logo that AT&T formerly used but did not register or trademark, Mr. Blackman said. AT&T's desire to promote use of the Yellow Pages led it to keep the logo generic, he said.

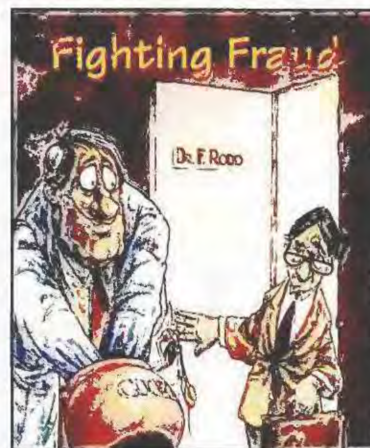
In the past several years, however, several telecommunications companies have stopped using the logos in their advertising solicitations, he said. For example, Southwestern Bell calls its Yellow Pages SWBYPS.

The telecommunications companies have changed from generic advertising in an effort to differentiate their products, rather than as a response to the fraud schemes, Mr. Blackman said.

"When you get a solicitation like this, they're truly deceptive and misleading," he said. "When most people see the Walking Fingers, they assume it's from their local directory."

The con artists typically deceive insurance advertisers by printing "This is not a bill" or "This is a confirmation" on the front but including in fine print that returning the form constitutes acceptance of the offer to publish and automatic renewal each year thereafter.

"As long as they conform to U.S.



Postal Service regulations regarding solicitation by mail, there isn't much you can do to them," he said.

The U.S. Postal Inspection Service

Continued on next page

Fraud

Continued from page 20B

improve efficiency.

Earlier this year, The Hartford increased its anti-fraud resources, said Todd Gish, financial manager of The Hartford's claims department.

The Hartford previously had a few fraud analysts who investigated claims themselves, a time-consuming process. Now, the insurer has six fraud analysts, a full-time special investigator and has annual anti-fraud training programs for its claim staff. As a result, the number of claims referred to investigators and state agencies has risen 300%, he said.

"We investigate each (suspicious) claim to the fullest," he said. "Fraud is out there for everybody to see. It's our obligation to shareholders" to try to stop it.

The insurer also helps stem fraud by showing how much losses cost. Once employers see how fraudulent claims raise premiums, they quickly want to reduce claims, said The Hartford's Mr. O'Rourke.

In many cases, rich disability benefits give some workers an incentive to file claims. "We tell employers, 'Did you know your 70% benefit plan is making people sick?' " Mr. O'Rourke said. Reducing benefit levels can mitigate fraud, leaving more money available to help those truly in need, he noted.

"Our anti-fraud effort lets us use our resources on those claimants who really need our help," Mr. Gish said. BI

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Continued from previous page

is looking into Yellow Pages solicitations for evidence of criminal activity and has obtained more than 100 civil injunctions against companies that have misled businesses, a Postal Inspection Service spokesman in Washington said.

While the bogus solicitations usually list prices between $100 and $200 for line listings, a cost even small agencies can afford, bogus directories containing thousands of listed companies can net millions of dollars.

Taken individually, a business getting defrauded of $100 or $200 doesn't excite legislators. but in the aggregate, the fraud is considerable, Mr. Blackman pointed out.

Because many solicitors are based outside the United States, stopping them is difficult, but the federal government is looking into prosecuting cases of fraud, the spokesman said.

The YPPA advises that advertisers examine invoices carefully and post warnings of fraudulent bills within the company. Insurers or agents that have been victims of fraudulent Yellow Pages solicitations should write to the soliciting companies and indicate that they do not agree to participate in any future listings and will not pay for any existing ones, Mr. Blackman recommended.

For more information or to report suspicious billings, contact the Yellow Pages Publishers Assn. at 800-841-0639. BI

Insurers putting money into fraud prevention

Property/casualty insurance companies are not only enhancing their fraud detection efforts, but they also are investing more money in anti-fraud programs, a recent study says.

According to a report released last month by the Wheaton, Ill.-based Insurance Research Council, property/casualty insurers' direct spending on fraud identification and prevention grew to more than $650 million in 1996 from about $200 million in 1992.

Industry spending on fraud-fighting efforts likely is even higher, the IRC said in a statement. In addition to in-house expenditures, insurers typically pay assessments to help fund state fraud bureaus and special task forces to combat fraud, the IRC pointed out.

The IRC, a non-profit organization created by insurers to compile and distribute information on industry issues, surveyed 150 insurers that collectively write about 77% of U.S. property/casualty premiums.

The survey found that:

- A majority of insurance companies said they plan to increase spending on anti-fraud programs during the next three years.

More than 25% of respondents said they will increase such spending by 10% or more.

- Virtually all insurers in the survey have some form of anti-fraud program in place.

In addition, most of the responding companies operate special investigative units, or SIUs, to help identify fraudulent claims.

- More than 50% of insurers surveyed have implemented programs to increase public awareness of insurance fraud.

According to the IRC, insurers cited several factors that help in detecting fraud, including employee training, SIU investigations, centralized claims databases and claims managers' support for anti-fraud programs.

Copies of the report, "Fighting Fraud in the Insurance Industry," are available for $10 each from the Insurance Research Council Inc., 211 S. Wheaton Ave., Suite 410, Wheaton, Ill. 60187; 630-871-0255. Copies also may be ordered via the Internet at www.ircweb.org.

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Fraud investigator honored

An investigations supervisor for Liberty Mutual Insurance Co. has been named Investigator of the Year by the International Assn. of Special Investigation Units.

John J. Huber Sr., special investigations director for Liberty Mutual's New York Region personal market, received the award at the IASIU Annual Insurance Fraud Seminar earlier this year in Charlotte, N.C.

The Investigator of the Year Award is presented annually to a person whose investigation had a significant impact on his or her company and a positive effect on the insurance industry and outside community, according to a release from Liberty Mutual.

The IASIU, founded in 1984, provides education, awareness and a legislative forum for industry professionals dedicated to fighting insurance fraud.

Mr. Huber joined Liberty Mutual in 1992 after a lengthy career in law enforcement. He also has a law degree.

He is the first Liberty Mutual investigator honored with the IASIU's top award, the company said.

Provider data key to cutting cost of comp care

Using networks can save money, but insurers must analyze available information

By Gary Angel and Joel Hadary

IT Perspective

ONE OF THE IMPORTANT drivers of workers compensation costs are health care providers.

Consequently, finding good providers is a high priority for insurance companies and their customers, employers. However, as health care is quite complex and results are not always clear-cut, it is difficult to reliably determine the best health care providers. As part of the effort to find preferred providers, insurance companies spend large amounts of money with outside companies.

While provider networks have grown considerably in the past few years, leading insurance companies are beginning to ask questions:

- Do provider networks actually reduce cost?
- Can insurance companies build more effective networks of preferred providers themselves?

Despite the complexities involved, advances in information analysis techniques have made it possible and practical not only to answer these questions, but also to use the answers to benefit employers, workers, providers and insurers.

Workers comp claims can be complex. It is, therefore, difficult to determine if provider networks actually reduce cost. Claims have several elements that make up total cost. They are: medical costs, or payments to providers; indemnity costs, or payments to employees; and administrative expenses, that is, investigation and legal.

Furthermore, workers comp claims can have multiple injuries, and each injury can have multiple treatments. To substantiate their claim of lower costs, provider networks have traditionally relied on cost schedules of treatments. Treatment A costs X and treatment B costs Y. The networks negotiate discounts with providers and claim that these discounts represent reductions in cost.

To determine whether these discounts actually result in cost reduction, detailed analysis is required. First of all, how do these discounts affect medical costs? The total medical cost for a claim is determined by the number of injuries, the number of treatments for each injury and the cost of each treatment. Any cost reductions from discounts on treatment cost can be made up by increasing the number of treatments per injury and by discovering more injuries.

For example, if a provider discounts hot packs by 25% but increases the number of hot packs per injury by 50%, total medical cost is actually higher than without the discount. Similarly, discounts can be recouped by a provider discovering more injuries per claim. If a provider discounts the cost of treating a burn by 25% but discovers that the worker also suffered a sprained wrist, shoulder, or back, which may not have been part of the work-related injury, the 25% discount is more than recovered. Another method of increasing cost, despite discounts, is through referrals.

By referring workers with injuries to other providers, providers are able to increase the total medical cost of a claim without drawing attention to themselves for giving too many treatments or discovering too many injuries.

While discounts can help reduce costs, they alone do not guarantee lower costs.

The number of treatments, number of injuries per claim and number of referrals also must be taken into consideration. A simple comparison of cost per claim doesn't work. Health care is too complex.

No two injuries are the same. There are differences in cost based on type and severity of injury. Different occupations in different industries for different types of people have legitimate differences in the cost for the same type of injury.

It is unreasonable to expect a back injury for a 60-year-old secretary to have the same cost as a back injury for a 25-year-old dock worker. Consequently, calculating an average cost for a particular injury and using it as a standard to evaluate a provider's costs can be very misleading.

Furthermore, medical costs are not the only costs involved in workers compensation. There are also indemnity costs and administrative expenses. While indemnity costs are usually correlated with medical costs—long absences from work are usually associated with high medical costs—there are enough exceptions that medical costs alone are not an accurate measure of a provider's cost.

For example, a provider that charges 10% more for a treatment but is able to get workers back to work 50% sooner than another provider could very well be less

See **Networks** *on page 18H*

ART market's growth threatening reinsurers

Traditional mold to blame, exec says

By MICHAEL PRINCE

Traditional reinsurers face extinction unless they continue to evolve and meet the needs of customers in order to keep pace with alternative risk transfer companies, said a reinsurance executive.

"If we stand still, we're lost," said John Berger, president of F&G Reinsurance Inc. in Morristown, N.J. F&G Re supplies both traditional and financial reinsurance.

The alternative risk transfer industry has grown to include about half the reinsurance business, and that growth is mainly the fault of the traditional reinsurers, Mr. Berger said while addressing the recent Producer's Forum in Philadelphia sponsored by Commonwealth Risk Services Inc.

Part of the reason for the alternative market's growth stems from risk managers' dislike of insurance companies, he said. "Insurance companies have let the consumer down," Mr. Berger said.

Mostly, the alternative market has grown in response to hard markets, when prices rose and risk managers realized the alternative market is "a better, cheaper way of managing risk," he said.

Risk managers who didn't want to pay the high prices looked for an alternative. "Smart businessmen will look for alternatives to stay in business," he said. "And the innovators take over."

The rapid growth created its own problems. When profits were made in one area of alternative risk financing, he said, other companies quickly jumped in, causing a surplus of supply. This caused prices to fall along with reinsurers' income.

Another problem facing reinsurers is that retentions have increased while prices have fallen. This means reinsurers are selling less reinsurance for less money. This puts reinsurers in a "black hole," where the only escape is increasing revenue, he said. "There is an insatiable demand for revenue growth," he said.

The future of alternative risk financing lies in expanding globally, Mr. Berger said. He described a cycle of economic growth that must occur in a country before an alternative market takes root. The cycle starts with economic development followed by development of the insurance industry. The alternative market will flourish once a problem develops with that local insurance market, he explained. Such a cycle is starting in many developing countries but currently exists in some countries, such as Great Britain and Australia, he said.

Mr. Berger said three factors pose threats to alternative risk financing companies. The first is whether they are making a profit. Although loss trends are down, prices also are down and are too low to make money.

Second, he cited the threat from electronic commerce. One day customers will be able to buy directly from insurers and banks.

But perhaps the greatest competition, he said, is from securitization. It represents "the biggest threat to my way of life," he said.

Securitizing risk is attractive to investors because it is not related to other types of investments tied to interest rates or the stock market.

Large brokers to tap middle market

By MICHAEL PRINCE

Disagreements abound among brokerage executives on whether the large brokers have advantages over smaller ones, whether the merger wave has been advantageous for clients and whether the top brokers can receive special price considerations from insurers.

One point on which the brokerage executives agree is that the large brokers will start to reach out to midsize companies, a market area large brokers currently underserve.

The panel discussion took place recently at the Producers' Forum sponsored by Commonwealth Risk Services Inc. in Philadelphia.

Large brokers do have advantages over smaller ones, said Edward Kiessling, executive vp with Aon Risk Services Inc. in New York. One advantage is that larger firms that can utilize greater technology and economies of scale have lower distribution costs. But to succeed, the larger brokers need to invest in people and professional development.

Mr. Kiessling predicted consolidations will continue because internal growth in the brokerage industry is slow and profits are declining. To grow without merging, brokers must deliver higher value to clients, develop new products and services, expand the reach of their brokerage services beyond traditional placement of insurance and build market share in untapped business areas.

But P. Joseph McCarthy, executive vp at Sedgwick Inc. in New York, questions the value of the deals. They make sense, he said, if the large brokers can eliminate competition, create synergy for collateral services or predict the price of insurance. None of these are possible, however, he said.

One possible advantage of the mergers is that they might create an advantage with insurers on pricing. "This could be the home run of the mergers," he said.

Both Messrs. McCarthy and Kiessling predict that in the future brokers will turn themselves into diversified financial firms or become part of one.

David Lockton, president of Lockton Cos. in Shawnee Mission, Kan., also is not certain that mergers help the large brokers. Mr. Lockton said an acquisition helps a broker's bottom line for a year or two—not permanently. There are only so many brokers out there to acquire, so what does a broker do when there is nothing more to buy? he asked.

Both Mr. Lockton and Mr. Kiessling said mergers create opportunities for small brokers to gain business because sometimes the client is unhappy with the new merged organization. Mr. Lockton said it also helps smaller brokers grab additional producers for the same reason.

"We've picked up some great people," he said. But, he added, the few people and clients they might acquire, though important to a small broker, have almost no impact on the large ones.

Mr. Lockton doesn't think the mergers help policyholders, either. The deals are done to satisfy shareholders, Mr. McCarthy said. "Most of these deals get done because the chairmen want to do it. Afterward you back into a rationale," he said.

Mr. Lockton added he does not know what a $3 billion broker can do that a $2 billion broker cannot.

Opinion was divided on whether the large brokers will be able to get better pricing from insurers.

In today's soft market, it doesn't require much muscle to get lower prices, and smaller brokers can do it, Mr. Kiessling said. "The clients in the end will win," he said.

Whether or not larger brokers get better pricing, Mr. Lockton said he is concerned that the large brokers will get special compensation arrangements with insurers.

Although saying the mergers could be a great benefit to large brokers, Mr. McCarthy said it's too early to tell. "We're just beginning to see the early stages of how the industry works," he said.

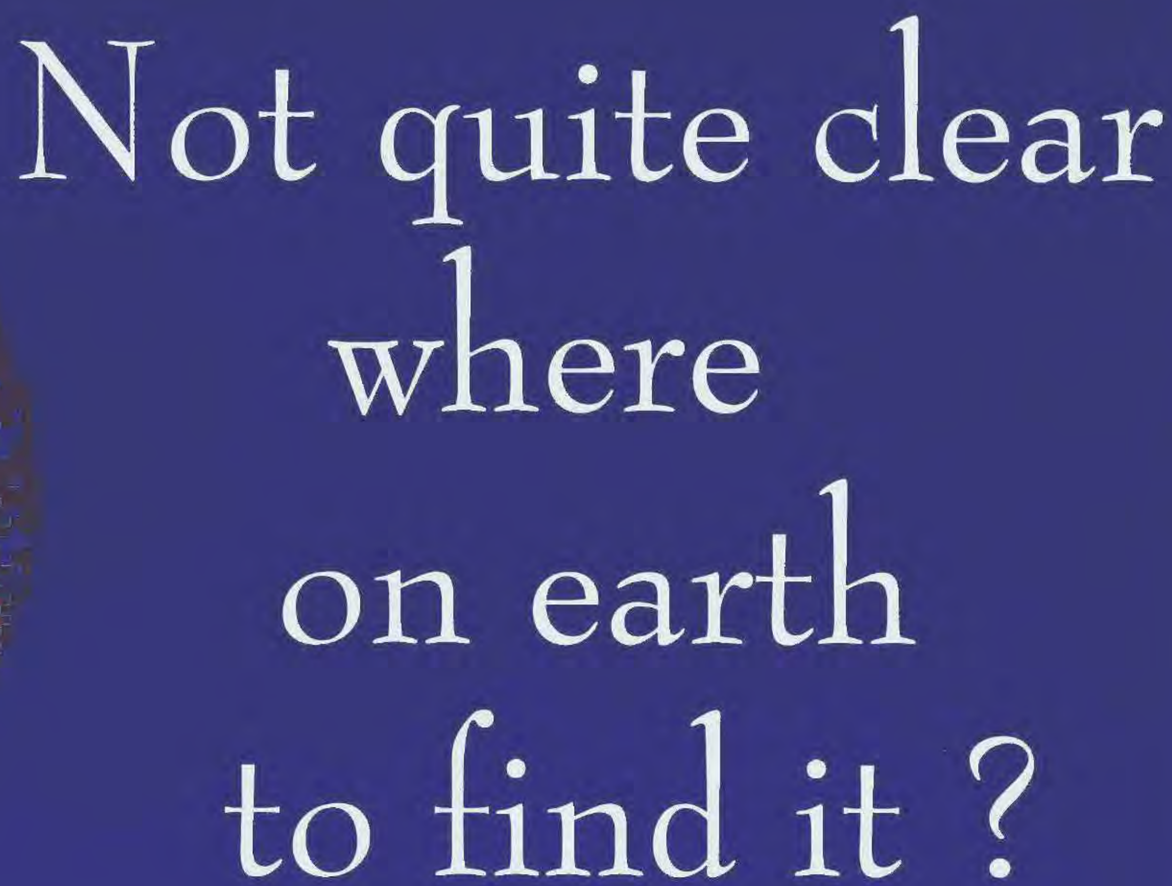
Now is "the beginning of a sea change," and insurers will feel the loss of their distribution system, which they won't tolerate, he said.

Both Messrs. Kiessling and McCarthy agreed large brokers will try to expand into the middle market.

Mr. Kiessling said Aon will focus on niche markets and midsize companies because that's its history and those areas are underserviced by large brokers.

Mr. McCarthy of Sedgwick said middle markets represent a large opportunity and are a place where they can change the rules to their advantage and try to get a shift toward fee compensation from a commission.

Robert Mulderig, chairman and CEO of Mutual Risk Management Ltd. in Bermuda, moderated the session. BI



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Networks

Continued from page 18F

expensive. Similarly, administrative expenses, while usually much less than medical or indemnity costs, are in some cases greater than both. So unless all three costs—medical, indemnity and administrative—are taken into consideration, the true cost of a claim is not known.

Returning to the question of whether provider networks actually reduce cost, the answer is that provider networks do not have the information necessary to know. They have information on just one portion of the medical costs and none of the information on indemnity costs or administrative expenses. They may not actually reduce cost.

However, insurance companies do have the necessary information in their claims data. The problem is that most insurers do not use it and really do not know if provider networks actually save or cost them money. The reluctance to admit to an expensive mistake is often part of the reason not to use their data to find out if provider networks reduce cost. Another reason is that, until now, it has not been easy.

While no single measure can be used to evaluate provider costs, visual patterns of provider behavior can be very revealing. By adapting the analytical techniques developed for personalized, targeted marketing, insurance companies can determine clusters of claims that have similar characteristics and can reasonably be compared.

For example, it would be reasonable to compare claims for similar injuries between office workers of like ages, while it would not be reasonable to compare claims for office workers and cargo loaders in the same company. Once those clusters have been identified, provider behavior can be examined with respect to injuries, treatments, referrals and total cost. Using analytical techniques such as statistics and visualization, patterns of provider behavior can be identified and the question of whether provider networks reduce cost can be accurately answered.

While more work needs to be done, the answer appears to be yes and no.

Take, for example, a provider with relatively low billings but that makes and receives referrals as part of a large network of other providers. Even though the provider's billings are low, it is responsible for a significant amount of billing. When the overall referral network is small, so are total costs.

This brings us to the second question: Can insurance companies build more effective networks of preferred providers themselves? The answer is yes.

Provider networks check out individual providers and negotiate discounts. Generally, checking out means ensuring that providers are board-certified for whatever specialties they practice, checking legal actions involving a provider, checking educational credentials and perhaps checking references. These checks may indicate reliability, integrity, quality and efficiency. However, none of them evaluates actual results.

Insurance companies have the information that measures actual results. In some cases, the information is difficult to access. However, it is there. With information on actual results, insurance companies can develop targeted networks of providers.

For example, a single employer with office workers, laborers and salespeople could have a provider network that was effective with one group but not with the others. Unfortunately, most employers would not know it, because neither they nor their insurance company did the necessary analysis. If some providers are better at treating truck drivers and others at treating accountants, why shouldn't an insurance company or employer encourage truck drivers to go to one provider and accountants to another? Insurers can only do so if they know the difference exists.

Once an insurance company has determined the effective providers for different types of claims and different types of workers, it also will have developed the basis for a system for the ongoing analysis of provider effectiveness. If properly implemented, such a system could be much more effective than negotiated discounts. Such discounts represent a small portion of total cost, are easily circumvented and tend to limit the flexibility of good providers to do a good job.

With health care costs likely to begin rising again after several years of stability, insurance companies have the option of accepting higher costs or using the information they have to identify the best providers and lower their costs. It will require leadership, innovation and hard work to do so. However, in the competitive world of workers compensation, insurers that accept this challenge and take advantage of their information will succeed. Those that don't won't. BI

Gary Angel and Joel Hadary are founders of Data Insight, a data mining company in Sebastopol, Calif. Mr. Angel can be reached via e-mail at angel@datainsight.com and Mr. Hadary can be reached at jhadary@datainsight.com.

Data ethics study

The insurance industry should develop guidelines right away on the use of personal information its companies gather that protect everyone involved and keep away federal regulation, a study says.

Little legislation exists to regulate the use of such information, according to the study, "Ethical Uses of Information in Insurance." Researchers at Oregon State University in Corvallis, Ore., conducted the study, which the Insurance Institute for Applied Ethics funded.

According to a release from the Malvern, Pa.-based American Institute for CPCU and Insurance Institute of America, which operate the insurance ethics institute, the study recommends that companies develop a code of ethics as one way to communicate their expectations to employees.

The 102-page study also looks at the relationship among law, ethics and privacy and offers recommendations on managing the ethical risks connected with gathering and maintaining information, the release says.

Free copies of the study are available by calling the Insurance Institute for Applied Ethics at 610-644-2100, ext. 7851, or by faxing 610-644-7629.

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IT Briefs

Staff shortage

Competition from other industries, the workload created by the Year 2000 problems and a shortage of qualified programmers are reasons insurers have trouble recruiting information technology professionals, a survey shows.

More than 90% of 64 U.S. and 16 Canadian insurers responding to the LOMA survey said they had problems filling such openings, according to a LOMA release.

Turnover has increased in the past two years to 15% from 8.6% as insurers try to maintain old mainframe systems, develop client-server applications and make systems Year 2000-compliant, the release said.

It said almost half the U.S. respondents think the pay they offer is hurting recruiting more than a lack of things recruiters say IT professionals want: challenging work, a chance to use the newest technologies and good technical career paths.

Employers are finding innovative ways to recruit and keep valuable employees, the survey shows. Among those methods are building partnerships with colleges and universities and converting non-systems employees into programmers, primarily to deal with Year 2000 issues.

The report, "Recruitment and Retention of Information Technology Professional/Technical Employees," is available for $30 to LOMA member company employees and $40 for non-members. Members companies can get discounts for buying five or more copies. To order, call 800-ASK-LOMA and press 3 or call 770-984-3784. You may fax an order to 770-984-6417 or send it via electronic mail to denman@loma.org.

Reinsurance site

CHICAGO—CNA Re has launched a World Wide Web site that can provide articles, industry information and a chance to ask questions on key topics.

The site, CNA Re *Source* at www.cnare.com, also will feature a personal finance section from *Money Talks*, a CNA Re release said.

The site also offers a CNA Re *Members* section, which allows interaction with CNA personnel, access to white papers and access to a Lexis-Nexis resource library, the release said.

Upgraded site

INDIANAPOLIS—The World Wide Web site for the National Assn. of Mutual Insurance Cos. has been upgraded.

The site, at www.namic.org, has more than 200 pages and offers information on federal and regulatory matters; publications and news releases; and other information, NAMIC said in a release. A "streamlined approach" will let visitors access information much more quickly, NAMIC President Larry Forrester said in the release.

NAMIC said its site is designed to provide information to NAMIC members, insurance industry reporters and others interested in the property/casualty industry.

New graduates

MALVERN, Pa.—A first class of 152 graduates has completed the Associate in Surplus Lines designation program of the Insurance Institute of America.

Graduates were recognized earlier this year at the annual meeting of the National Assn. of Surplus Lines Offices and the NAPSLO/Derek Hughes Educational Foundation, the IIA said in a release.

Awards went to the four top graduates. The Distinguished Graduate Award, for the student with the highest cumulative grade average for the four examinations in the program, went to Lee Ann Bush, an underwriter for General Star Management Co. in New York. She got a $500 check and a plaque.

Awards for Academic Excellence went to the next three highest-scoring students, who each got a $250 check and a plaque. They are:

- Bryan D. Meyer, a product manager with Northland Insurance Co. in St. Paul, Minn.
- Paul S. Miller, a business development specialist with Russell Bond & Co. in Buffalo, N.Y.
- Carl R. Sadler, president and chief executive officer of Baldwin Sadler Corp. in Norristown, Pa.

Graduates came from 30 states and England. The largest number came from California, with 18, followed by Illinois, with 14, and New York, with 11 graduates, the IIA said.

100 years old

DENVER—The National Assn. of Mutual Insurance Cos. has cited 14 companies that marked 100 years in business in 1997. The companies were cited during a recent convention in Denver.

They are:

- Brethren Mutual Insurance Co., Hagerstown, Md.
- Carthage Mutual Insurance Co., Carthage, Ill.
- Cedar County Farmers Mutual, Stockton, Mo.
- Engle Farmers Mutual Benefit Assn. Inc., Schulenburg, Texas.
- Farmers Mutual Fire Insurance Co. of Randolph County, Moberly, Mo.
- Forest Green Farmers Mutual Insurance Co., Salisbury, Mo.
- Henry County Mutual Insurance Assn., Napoleon, Ohio.
- Indiana Lumbermens Mutual Insurance Co., Indianapolis.
- KingTown Farmers Mutual Fire Insurance Co., McIntosh, Minn.
- Maine Mutual Fire Insurance Co., Presque Isle, Maine.
- Otsego Mutual Fire Insurance Co., Burlington Flat, N.Y.
- Pembina County Mutual Insurance Co., Cavalier, N.D.
- Remington Farmers Mutual Insurance Co., Remington, Ind.
- Washington County Mutual Fire Insurance Co., Addieville, Ill.

Indianapolis-based NAMIC earlier this year began a Century Club program in which members got a plaque from the association as they celebrated centennials.

Also at the convention, Robert Harrison, president of Indiana Lumbermens and president of the Insurance Education Foundation, received the NAMIC Chairman's Award. Mr. Harrison served as NAMIC's chairman in 1994.

NAMIC also presented four Service Awards. They went to:

- Daniel L. Basinger, president and chief executive officer of Alliance Mutual Insurance Co. in Greensboro, N.C.
- Michael Flugum, general manager of Hassan Mutual Fire Insurance Co. of St. Michael, Minn.
- William Hart, president of Mercer Mutual Insurance Co. of Pennington, N.J.
- Ed Walvoord, president and CEO of Cameron Mutual Insurance Co. in Cameron, Mo. BI

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A warehouse for storing data can help

Centralized information and analytical tools useful in determining health plan options

By Frank Mohr

IF A KEY question benefit and risk managers and insurance executives ask is, "How can we provide better quality health care while keeping our bottom line looking good?," the answer is not, "Grab all the data you can get."

The trend to collect more data is good. However, data collection for its own sake won't answer quality health care and bottom-line needs; that data must be organized and actionable. So what is the answer?

The answer is a tool that provides a perspective on data: a tool that offers a view from 60,000 feet, as well as a view from the detailed, micro level. Managers and executives need this to reveal the provider and member health care behavior already resident in claims transaction data.

The health care data warehouse, complete with integrated analysis components that function within a business context, is emerging as the tool of choice for many of those executives and managers. A data warehouse moves computing power and data analysis capabilities to those who can identify fundamental trends affecting cost and quality. The ability to take claims, member and provider data and develop forecasts on which to base health plan offerings is arising as a central requirement for running day-to-day business operations and planning wisely for the future.

Transforming data into knowledge

Before researching data for the knowledge needed to create cost-effective, quality-focused health benefit plans that address employees' specific needs, companies must make sure this data is complete and accessible.

Whether paying claims or contracting with another organization to pay claims, companies need to make certain that detailed information is kept. Information that paints a complete picture of the health plan's population will provide better assistance in designing a plan that serves the members' needs efficiently.

If the contracted organization subcontracts for pharmacy or other benefits claims processing, whenever possible, organizations should keep their data collection parameters parallel, such as consistency among IDs.

If data collection methods don't include these parameters now, the company should definitely be working in that direction for the future. Until that time, links can be established to map data to consistent IDs.

Because much health care data comes from different sources—a company's own database and those of contracted and subcontracted processing organizations—and may run on different operating systems, not to mention different hardware, it is of primary importance that collected data can be assembled as a whole to get a complete picture of the plan population.

Again, this is where a data warehouse is an essential tool.

Using a sophisticated data integration process, data from disparate sources can be married within the warehouse, providing an accessible, easily updated collection of data available for analysis in a non-programming Windows environment.

Along with providing consistency, data placed within the warehouse is scrubbed/cleaned and organized into subsets, such as episodes of care, pharmacy, health risk indicators, readmissions and inpatient stays, data that will help define how services are delivered and how they are paid.

Once data is mapped within a data warehouse, the company has a fundamental tool for making intelligent queries and fine-tuning plans, truly turning data into usable information.

With data complete, organized and accessible, managers and executives can begin the search for knowledge by following the dollars.

Where are plan members spending their money, and who or what are they spending it on?

Look at the plan population for areas of likely high expense. Review the health plan population using parameters such as age, sex and location, and view providers on a case mix adjusted basis.

Then look over their utilization patterns.

Do women 19 to 32 comprise a large part of plan membership? If so, a review of maternity benefits would be beneficial. Are claims relating to hypertension pouring in? Perhaps some education for plan members might be a wise idea. Are many emergency room visits logged in a particular neighborhood? The company might want to consider contracting with an additional provider or network in that region.

For a more structured search, a data warehouse and related analytic tools offer views or templates of data, which include relevant statistics, in order to simplify the analysis.

These views, which should allow users to customize search parameters, can steer management in creating ad hoc reports, enabling managers to analyze information in a way that's useful to reaching a company's own conclusions on health care delivery.

For example, an ad hoc report of interest to plan analysis might cover all professional services denied within the plan year, including what services were denied, the reasons for denial, whether the claims were in or out of network and measurements such as submitted amounts.

HEDIS standards provide a yardstick

Industry standards also give shape to queries. Many organizations use the Health Plan Employer Data and Information Set as a standard for measuring the quality of health care plan performance.

This measurement, developed by The National Committee for Quality Assurance, acts as a report card for health care delivery organizations, providing a consistent standard against which to evaluate quality.

A health care data warehouse that uses a company's administrative data to produce HEDIS measures, including quality indicators, utilization review and membership attributes, would provide an invaluable tool to any organization that wants to perform trend analysis on the performance of the health plan and target areas for improvement or to monitor quality and access to care.

By applying HEDIS standards to health care plan performance, any company can take an important step forward in incorporating measures that respond to employees' needs for a plan that offers value and accountability.

Provider profiles

If a company contracts directly for services with a provider network, those providers obviously play a central part in offering a quality and cost-effective employee health plan.

Who are the physicians? What is the referral rate for each?

Are some physicians treating an above-average number of sicker employees?

How does this affect their performance comparison?

Sound medical management of any plan requires an analytic component for viewing treatment and health care utilization, allowing companies to:

- Profile providers using an objective performance measurement.
- Compare treatment patterns of plan physicians.
- Assess disease-based pharmaceutical use.
- Understand physician referral patterns.
- Review targeted services, including emergency room and mental health care.
- Identify and compare plan hospitals in the context of services provided, such as readmission rates and length of stay.

Claims data alone cannot provide a comprehensive picture of medical services. This is where a data warehouse with analysis capabilities affords the organization the ability to make the best use of all its data.

Membership, provider and capitation/fee-for-service information is stored in different databases. A data warehouse will integrate these data sources into a single place and format so that data originally from one source can expand the value of data originally from another source.

Differences among patients—such as diagnosis, age, complicating conditions and major surgeries—influence treatment, cost and care utilization. In reaching an objective understanding of a provider's practice, these differences should be factored into an overall view.

Industry standard methods for classifying patient illness are episode treatment groups, or ETGs, and diagnosis-related groups, or DRGs.

Both methods offer clinical and statistical adjustments based on factors that influence treatment. Data warehouse analysis components incorporating these methods can assist management in making decisions concerning potential quality or efficiency issues.

Understanding financial factors

As a direct contractor of services, providing a quality employee health plan takes money, but with a data warehouse and analytic resources, there are ways to monitor and control escalation of how much quality care costs.

To manage the financial side of a plan, expense data from claims submission and capitation payments are married with revenue data within the data warehouse, so that analysis will allow managers to:

- Develop effective per-member-per-month revenue targets and capitation rates.
- Evaluate the effectiveness of the program in meeting health care demands.
- Track premiums vs. expenditures, and evaluate critical indicators of plan performance.
- Monitor contracts, including stop loss, and withhold account balances.

Though data is the basis for creating a plan that provides quality health care at a positive bottom-line rate, it is not the solution.

The complete solution requires that data be organized and actionable. A health care data warehouse, complete with easy to use, non-programming analysis components, can be the tool companies need to develop and maintain the kind of plan that will satisfy the needs of employees and the employer. BI

Frank Mohr is director of health information products for Resource Information Management Systems Inc. in Naperville, Ill.

EPL book succeeds as one-stop reference

"The EPL Book: A Practical Guide to Employment Practices Liability and Insurance"
By Andrew Kaplan, Rachel McKinney, Beth Schroeder and Leonard Surdyk
Published by Griffin Communications Inc., 1420 Bristol St. N., #220, Newport Beach, Calif. 92660
$125 plus shipping and handling

By Kevin M. Quinley

Mitsubishi, Texaco, Circuit City. No, this is not a string of hot stock tips. Rather, it is a partial list of companies stung by harassment, wrongful termination and discrimination claims, all of which seem to be growing. Further, the damage awards to plaintiffs are growing to such an extent that employment practices liability suits pose devastating financial challenges to many organizations.

This book couldn't be more timely. Recent statistics show that since 1990, there has been more than a hundred-fold jump in complaints filed with the Equal Employment Opportunity Commission. Claims alleging workplace discrimination produce an average court award of $300,000. Sexual harassment claims net—on average—awards of about $150,000 apiece. Those are just the cases going to trial, excluding those settled without going to court.

Along comes "The EPL Book" from Griffin Communications to address these thorny situations. This book is a team effort, and the team members are solidly credentialed. Andrew Kaplan is a management labor consultant with a Los Angeles law firm. Rachel McKinney is a senior underwriter with Swett & Crawford. Beth Schroeder and Leonard Surdyk are employment lawyers. Although some have joked that, "A camel is a horse designed by a committee," let the record show that the committee approach to this book works very effectively.

"The EPL Book" aspires to be to employment practices what "The D&O Book" (also by Griffin Communications) was to directors and officers exposures: a one-stop reference for risk managing a specific exposure. For the most part, it succeeds. "The EPL Book" is a treasure trove of useful information, providing discussions, chart comparisons, sample policy forms and graphic illustrations of key EPL coverage concepts that are not likely to be found in any other single source.

Further, "The EPL Book" is a handy tool kit for busy risk managers and insurance professionals tackling this new and important line of coverage. The book contains detailed explanations of key policy terms, conditions, definitions and exclusions. Presenting the material in a thorough and non-technical style, "The EPL Book" supplements its discussions with illustrations, charts and graphs that help decipher and untangle the often non-standard EPL coverage features.

Don't get the idea, though, that this book is just about insurance. What sets it apart in breaking new ground is its treatment of EPL exposures from a "total risk management perspective." Thirteen chapters cover everything from the history and status of employment law to why most existing business insurance policies offer little or no coverage for EPL claims. There is even a handy and detailed chapter containing a broad range of statistical loss data pertaining to these claims.

While at one time buyers could dismiss EPL coverage as nearly impossible to procure, that is not the case now. Increasingly, due diligence dictates that agents, brokers and risk managers formally determine whether and how EPL coverage fits into the organization's overall portfolio of risk management techniques.

Some risk managers may consider the most useful resource to be the user-friendly comparison charts that enable insurance professionals to quickly compare hundreds of coverage features among dozens of different policy forms. These charts should prove to be a terrific resource in buying EPL coverage.

One caveat: EPL coverage is a dynamic realm, beset with change. The form comparisons contained in "The EPL Book" may have a limited shelf life. Because the value of the "The EPL Book" may diminish over time in this respect, the publisher should consider periodic supplements and updates to track the ever-changing EPL marketplace.

For the burgeoning field of EPL risk management, though, "The EPL Book" sets the standard, a benchmark by which all other works in this area will be compared. Any company with employees would be well served by reading and heeding its risk management advice.

Kevin M. Quinley is senior vp of risk services for MEDMARC Insurance Co. Inc. and subsidiary Hamilton Resources Corp., both of Fairfax, Va. He holds the Chartered Property & Casualty Underwriter and Associate in Risk Management designations.

Officers liable for workers comp violations

Corporate officers may be held criminally responsible, along with the corporation, for the failure to pay workers compensation premiums and to file workers compensation reports, according to the Supreme Court of Appeals of West Virginia.

Truong Van Nguyen, in his capacity as president of McDowell Energy Inc. and Steve A. Rife, in his capacity as president of Black Rock Mining Inc., were indicted by the grand jury for the circuit court of Kanawha County, W.Va., for failing to file quarterly reports with the Workers Compensation Commission. The defendants filed motions to dismiss their indictments on the ground that corporate officers cannot be held criminally liable under West Virginia law.

Two circuit court judges ruled on the matters, one of whom agreed with Mr. Rife and dismissed his indictment; the other of whom denied Mr. Nguyen's motion. Mr. Nguyen appealed his unfavorable decision, and the state appealed the dismissal of the Rife indictment. The Supreme Court of Appeals of West Virginia accepted both appeals because they turned on the same legal issue.

The court noted that the West Virginia law that imposes responsibility upon a corporation for paying compensation premiums and filing reports does not specifically mention officers of the corporation. However, the court said the common law rule is entrenched in West Virginia to the extent that officers, agents and directors of a corporation may be criminally liable if they cause the corporation to violate the criminal law while conducting corporate business. The court emphasized that the state Legislature had not expressed a clear intent to exempt corporate officers from criminal liability in this case. Thus, the court said both Messrs. Nguyen and Rife could be indicted under the facts of this case.

State Ex Rel. Van Nguyen vs. Berger, Supreme Court of Appeals of West Virginia, Dec. 16, 1996, *Rehearing refused* Feb. 11, 1997 (*BI*/03/O.-$10).

Legal Briefs

Molestations one 'occurrence'

A single "per occurrences limit" in a sexual misconduct endorsement in a commercial general liability insurance policy applied to children allegedly victimized by sexual molestation, according to the Court of Appeals of Texas.

Three children were allegedly molested by an employee of a church's day care center, prompting two separate lawsuits filed by the children and their parents. The church was covered under a CGL insurance policy issued by Preferred Risk Mutual Insurance Co. The policy covered sexual misconduct with a limitation of $100,000 per "occurrence" and a $300,000 limit per policy period. The insurer took the position that the children's claims collectively constituted only a single "occurrence." The trial court ruled for the children.

The appellate court reviewed the policy language and concluded that all of the church's employee's alleged acts of sexual misconduct and "any" alleged breach of duty that may have contributed to the those acts collectively constituted a single occurrence under the policy. The court emphasized that the policy language defining "occurrence" here—all alleged acts of sexual misconduct and any breach of duty contributing to such acts constitute a single occurrence"—was clear and unambiguous. The lower court judgment was reversed.

Preferred Risk Mutual Insurance Co. vs. Watson, Court of Appeals of Texas, Jan. 9, 1997, *Rehearing overruled*, Feb. 13, 1997 (*BI*/02/O.-$10).

Multiple thefts only one 'occurrence'

Under an employee dishonesty insurance policy containing unambiguous occurrence and non-cumulation provisions, a policyholder may not recover more than the policy limit for losses due to the misconduct of one employee occurring over the course of several years, according to the Court of Appeals of Minnesota.

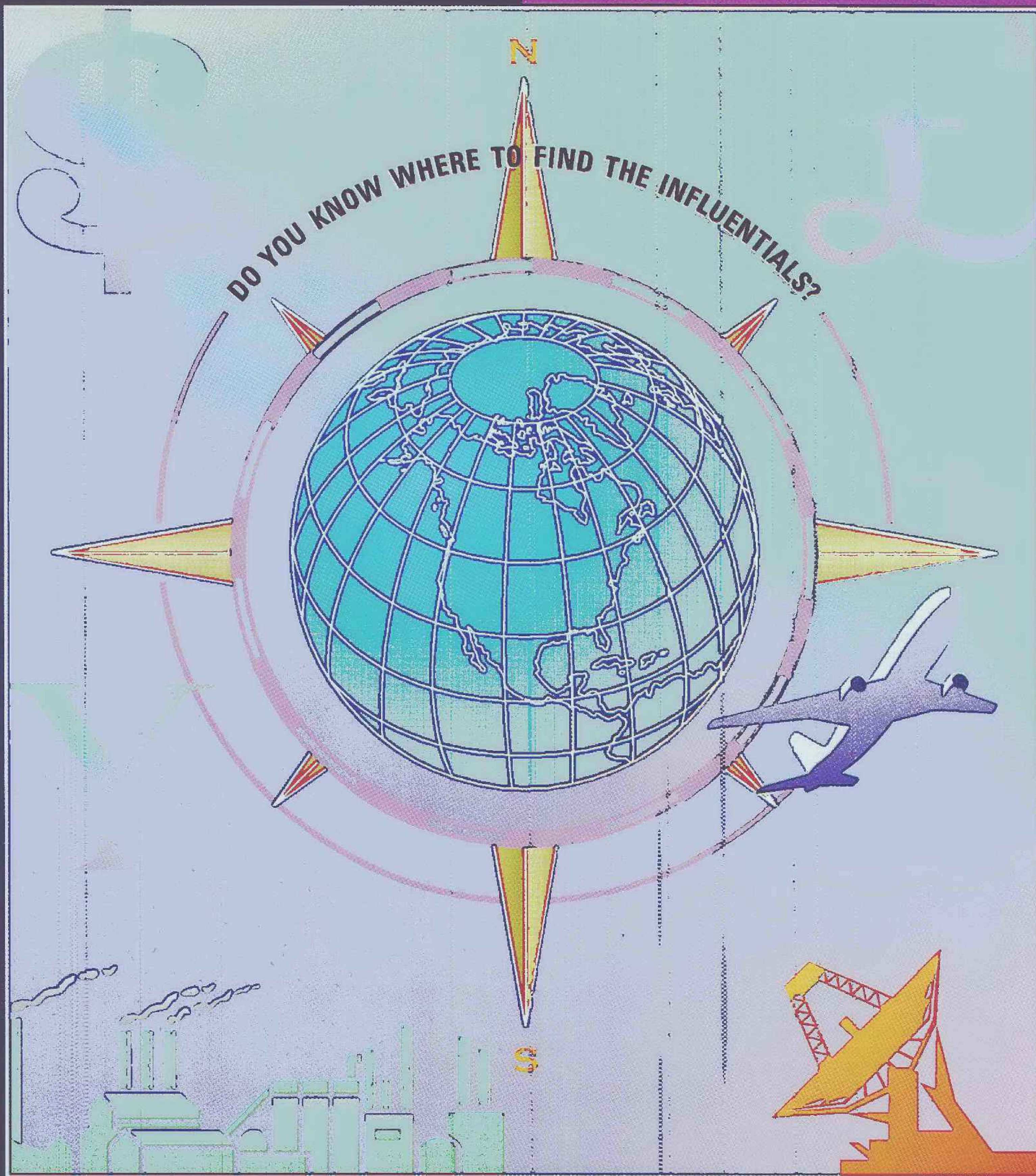
Landico Inc. was covered under an employee dishonesty insurance policy issued on Jan.-4, 1993, by American Family Mutual Insurance Co. The policy provided employee dishonesty coverage of $100,000 per occurrence for an annual premium of $659. The policy provided that regardless of the number of years the insurance remained in force, no limit of insurance cumulates from year to year or period to period. A Landico employee repeatedly embezzled funds throughout 1993 and 1994. Landico filed claims for losses of $47,424 in 1993 and $102,698 in 1994. The insurer paid Landico only $100,000 on its claims. Landico sued for payment on the $47,424 claim. The trial court ruled for the insurer and denied the claim.

On appeal, Landico argued, in part, that the definition of "occurrence" in the policy was ambiguous because the policy language provided coverage for acts "during the policy period" and defined the policy period as one year.

However, the court said the policy also unambiguously limited recovery on claims arising from one employee's misconduct to the stated policy limit (here $100,000) notwithstanding the fact that the thefts of that one employee continued for several years. The trial court decision was affirmed.

Landico vs. American Family Mutual Insurance, Court of Appeals of Minnesota, Feb. 25, 1997 (*BI*/05/O.-$10). BI

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



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Datebook

NOVEMBER

NOV. 24. OSHA Lab Safety Course in San Jose, Calif., sponsored by Professional Analytical & Consulting Services Inc.; $395. **Also Feb. 16** in Orlando, Fla., **March 9** in New Orleans, **May 18** in Pittsburgh, **July 20** in St. Louis. PACS, 409 Meade Drive, Coraopolis, Pa. 15108; 800-367-2587 or 412-457-6576.

NOV. 24-25. ISO-9000 & ISO 14000 Course in San Jose, Calif., sponsored by Professional Analytical & Consulting Services Inc.; $795. **Also Feb. 16-17** in Orlando, Fla., **March 5-6** in New Orleans, **May 18-19** in Pittsburgh, **July 20-21** in St. Louis. PACS, 409 Meade Drive, Coraopolis, Pa. 15108; 800-367-2587 or 412-457-6576.

NOV. 27-28. The Gibraltar Offshore Insurance Conference in Gibraltar, sponsored by the government of Gibraltar; £495 ($795). Risk & Insurance Research Group Ltd., 44 Maiden Lane, Covent Garden, London WC2E 7LJ; 44-171-836-0614.

DECEMBER

DEC. 1-2. Applying Microsoft Access to Risk Management workshop in Atlanta, sponsored by Shelter Island Risk Services. $895, $700 for second person from same company. Shelter Island Risk Services, P.O. Box 568, Shelter Island, N.Y. 11964; 800-749-1535.

DEC. 2-3. Managing Change in the Property-Casualty Industry conference in New York, sponsored by Coopers & Lybrand L.L.P. $1,145. Deborah Slott, The Conference Group Ltd., 704-541-2800 or John Lombardi, Coopers & Lybrand L.L.P., 860-241-7054.

DEC. 3. Addressing the Earthquake Risk in the Central U.S. forum in Memphis, Tenn., sponsored by Central United States Earthquake Consortium; Before Nov. 21: $150; after Nov. 21: $200. Central United States Earthquake Consortium, 2630 E. Holmes Road, Memphis, Tenn. 38118; 901-544-3570.

DEC. 3. Applying Microsoft Excel to Risk Management workshop in Chicago, sponsored by Shelter Island Risk Services. $395, $300 for second person from same company. **Also Dec. 4-5** in New York. Shelter Island Risk Services, P.O. Box 568, Shelter Island, N.Y. 11964; 800-749-1535.

DEC. 3-4. Ninth Annual Insurance Industry Conference in Dallas, sponsored by KPMG Peat Marwick L.L.P.; $995. Executive Education, P.O. Box 14093, Church St. Station, New York, NY 10249; 201-334-4111.

DEC. 4. Excel Basic for Risk Management workshop in New York, sponsored by Shelter Island Risk Services; $395. Shelter Island Risk Services, P.O. Box 568, 14 Tarkette Road, Shelter Island, N.Y. 11964; 800-749-1535.

DEC. 4. Litigation Strategies & Risk Management seminar in Los Angeles, sponsored by Litigation Risk Management Institute; $695, $985 for two-day seminars. **Also Dec. 11-12** in San Francisco. Seminar Coordinator, Litigation Risk Management Institute, 145 Forest Ave., Palo Alto, Calif. 94301; 650-327-3372.

DEC. 4-5. Insurance Compliance and Market Conduct: Today, Tomorrow and the Future conference in San Francisco, sponsored by Executive Enterprises; $1,195. Executive Enterprises, 21 Penn Plaza, New York, N.Y. 10001-2727; 800-831-8333.

DEC. 6-10. National Assn. of Insurance Commissioners Winter national meeting in Seattle, sponsored by the NAIC; before Dec. 2: $450; after Dec. 2: $500. NAIC, 120 W. 12th St., Suite 1100, Kansas City, Mo. 64105; 816-889-4400.

DEC. 7-10. The Second Annual Summit on International Managed Care Trends in Boca Raton, Fla., sponsored by The American Assn. of Health Plans and the Academy for International Health Studies Inc.; $1,295. Summit Secretariat, c/o CentraLink, 4370 Alpine Road, Suite 108, Portola Valley, Calif. 94028; 415-851-8411.

DEC. 8-9. Auto PPOs: Moving From Bill Audits to Strategic Contracts conference in Orlando, Fla., sponsored by IBC Group P.L.C.; $1,345. IBC USA Conferences Inc., 225 Turnpike Road, Southborough, Mass. 01772-1749; 508-481-6400.

DEC. 8-9. Integrated Approaches to Risk Measurement in the Financial Services Industry conference in Atlanta, sponsored by the Society of Actuaries; $650 for members of actuarial organizations; $700 for non-members. The Society of Actuaries, Continuing Education Department, 475 N. Martingale Road, Suite 800, Schaumburg, Ill. 60173; 847-706-3566.

DEC. 8-10. Health Care Sponsored Captives: Strategic Risk Financing Vehicles for Capitation, Integration and Reinsurance conference in Grand Cayman, sponsored by IBC Group P.L.C.; $1,595 for the conference and workshop, $1,195 for the conference only, $695 for the workshop only. IBC USA Conferences Inc., 225 Turnpike Road, Southborough, Mass. 01772-1749; 508-481-6400.

DEC. 10-12. Managed Dental Care '97 conference in St. Petersburg Beach, Fla., sponsored by IBC Group P.L.C.; Commercial rate: $1,795 for main conference plus both workshops; employee benefit managers/government rate: $1,195 for main conference plus both workshops. IBC USA Conferences Inc., 225 Turnpike Road, Southborough, Mass. 01772-1749; 508-481-6400.

DEC. 11-12. Fourteenth Annual Insurance Coverage and Practice Symposium in New York, sponsored by Defense Research Institute Inc.; $540 for members, $590 for non-members. The Defense Research & Trail Lawyers Assn., 750 N. Lake Shore Drive, Suite 500, Chicago, Ill. 60611; 312-944-0575.

DEC. 15-16. Running Your Own Insurance Agency seminar in New York, sponsored by the College of Insurance; $595. The College of Insurance Center for Professional Education, 101 Murray St., Room 426, New York, N.Y. 10007; 212-815-9201.

DEC. 18. Great Expectations: Rethinking Customer Service conference in Boston, sponsored by the New England Employee Benefits Council. $195 for members, $250 for non-members. NEEBC, 62 Walnut St., Wellesley, Mass. 02181; 617-239-1767.

JANUARY

JAN. 11-12. Forum on Global Business: Risks, Rewards and Realities in Washington, sponsored by Liberty Mutual Group. No registration fee. Lori Zetlin, Liberty Mutual Group, 175 Berkeley St., Sixth Floor, Boston, Mass. 02117-0140.

JAN. 12. Capitalizing on the New Revolution in 3rd-Party Captives conference in New York, sponsored by the IBC Group P.L.C.; $1,095. IBC USA Conferences Inc., 225 Turnpike Road, Southborough, Mass. 01772-1749; 508-481-6400.

JAN. 13-14. Property/Casualty Insurance Joint Industry Forum in New York, sponsored by nine insurance associations. $595. Diane Portantiere, Insurance Information Institute, 110 William St., New York, N.Y. 10038; 212-669-9203.

JAN. 14-15. Designing & Implementing Internal Web Sites for Benefits conference in Atlanta, sponsored by Coopers & Lybrand L.L.P., The Kwasha Lipton Group and Logical Design Solutions Inc.; $1,295 for conference only, $1,695 for conference plus one workshop, $1,995 for conference plus two workshops, $2,195 for conference plus three workshops. International Quality & Productivity Center, 150 Clove Road, P.O. Box 401, Little Falls, N.J. 07424-0401; 800-882-8864 or 973-256-0211.

JAN. 21-22. Performance Measurements for Strategic Planning in Insurance Companies conference in New York, sponsored by Price Waterhouse and the International Quality & Productivity Center; $1,295 for the conference only, $1,695 for the conference plus one workshop, $1,995 for the conference plus two workshops. International Quality & Productivity Center, 150 Clove Road, P.O. Box 401, Little Falls, N.J. 07424-0401; 800-882-8684.

JAN. 21-24. Self-Insurance Institute of America Inc. Employer Executive Forum in Palm Springs, Calif., sponsored by the SIIA, 17300 Redhill Ave., Suite 100, Irvine, Calif. 92714; 800-851-7789.

JAN. 22-23. Property & Casualty Insurance Companies Partnering with Banks and Financial Institutions conference in Orlando, Fla., sponsored by Global Business Research Ltd.; $1,795 for the conference plus workshop, $1,295 for the conference only. Conference Administrator, Global Business Research Ltd., 775 Sunrise Ave., Suite 260, Roseville, Calif. 95661; 800-868-7188 or 916-773-3236.

JAN. 25-27. Insurance.com: Competing in the Digital Marketplace forum in Scottsdale, Ariz., sponsored by IVANS. $525, $1,000 for two company attendees, $500 for each additional registration. Clare DeNicola, IVANS, 777 W. Putnam Ave., Greenwich, Conn. 06830; 203-532-2109.

JAN. 26-28. Advanced Capital Allocation Techniques for Insurance Companies conference in New York, sponsored by Ernst & Young L.L.P. $2,985 for conference and two workshops. ICM Conferences Inc., 303 E. Wacker Drive, 20th Floor, Chicago, Ill. 60601; 312-540-3010.

JAN. 27. RIMS Orange Empire Chapter 19th Annual Risk Management Conference in Brea, Calif., sponsored by the Orange Empire Chapter of RIMS; Before Dec. 1: $65 each for first two attendees; after Dec. 1: $75 each for first two attendees; $60 each additional attendee. Maury De Bont, Risk Management Analyst, Southern California Edison, 2244 Walnut Grove Ave., Room 249, Rosemead, Calif. 91770; 626-302-1085.

JAN. 27-28. Self-Insurance Institute of America Inc. MGU/Excess Insurer Executive Forum in Palm Springs, Calif., sponsored by the SIIA, 17300 Redhill Ave., Suite 100, Irvine, Calif. 92714; 800-851-7789.

JAN. 27-29. Self-Insurance Institute of America Inc. Eighth Annual TPA Executive Forum in Indian Wells, Calif., sponsored by the SIIA, 17300 Redhill Ave., Suite 100, Irvine, Calif. 92714; 800-851-7789.

JAN. 28-30. Hawaii Captive Insurance Forum 1998 in Kauai, Hawaii, sponsored by the Hawaii Captive Insurance Council; $550 for members, $650 for non-members. Fay Okamoto, M&M Insurance Management Services Inc., P.O. Box 38, Honolulu, Hawaii 96810-0038; 808-544-0088.

JAN. 29-30. Provider Stop Loss Insurance Summit '98 in Orlando, Fla., sponsored by the Institute for International Research. $1,695 for conference plus workshop, $1,295 for conference only. Conference Administrator, Institute for International Research, 708 Third Ave., Fourth Floor, New York, N.Y. 10017; 800-999-3123 or 212-661-8740.

FEBRUARY

FEB. 1-3. Insurance Risk Management Conference in San Diego, Calif., sponsored by American Bankers Assn.; Before Nov. 30: $600 for ABA members, $860 for non-members; after Nov. 30: $780 for ABA members, $955 for non-members. Registration Coordinator, American Bankers Assn., P.O. Box 79129, Baltimore, Md. 21279-0129; 202-663-5274.

FEB. 1-3. Security and Fraud Prevention Conference in San Diego, sponsored by American Bankers Assn.; Before Nov. 30: $799 for ABA members, $1,050 for non-members; after Nov. 30: $899 for ABA members, $1,125 for non-members. Registration Coordinator, American Bankers Assn., P.O. Box 79129, Baltimore, Md. 21279-0129; 202-663-5274.

FEB. 1-4. The Interactive Disability Forum in St. Petersburg, Fla., sponsored by The Hartford and Disability Consulting Group Inc.; $795. Jami Berube, Disability Consulting Group Inc., 66 Pearl St., Suite 300, Portland, Maine 04101; 207-756-8551.

FEB. 4-6. Advanced Pension Conference in Orlando, Fla., sponsored by Corbel; $695. Corbel Educational Services, 1660 Prudential Drive, Jacksonville, Fla. 32207-8197; 800-326-7235.

FEB. 4-6. 1998 Products Liability Seminar in New Orleans, sponsored by Defense Research Institute Inc.; $595 for members, $640 for non-members. DRI, 750 N. Lake Shore Drive, Suite 500, Chicago, Ill. 60611; 312-944-0575.

FEB. 5-6. Seventh Annual Employers/Coalition Health Conference in Sarasota, Fla., sponsored by the West Coast Healthcare Coalition; Before Dec. 20: $295; after Dec. 20: $345. WCHC, 6637 Superior Ave., Suite C, Sarasota, Fla. 34231; 941-923-1697.

FEB. 9-13. PRIMA's 1998 Government Risk Management Seminar East in Orlando, Fla., sponsored by the Public Risk Management Assn.; Before Jan. 5: Foundations in Risk Management, $615 for members, $785 for non-members; Continuing Education for School Risk Managers, $510 for members, $670 for non-members. After Jan. 5: Foundations in Risk Management, $665 for members, $835 for non-members; Continuing Education for School Risk Managers, $560 for members, $720 for non-members. PRIMA, 1815 N. Fort Myer Drive, Suite 1020, Arlington, Va. 22209; 703-528-7701.

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Insider Trading

CIGNA Corp.: Thomas J. Wagner, vp, exercised an option for 16,277 shares of common between $72.31 and $75.06 each on Aug. 14, 1997. To cover expenses of the transaction, Mr. Wagner turned in 6,805 of them for $183.22 each on Aug. 14, 1997, and now directly holds 34,027 common.

Thomas C. Jones, officer of subsidiary, exercised an option for 5,003 shares of common at $72.31 each on Aug. 20, 1997. To cover expenses of the transaction, Mr. Jones turned in 1,959 of them for $184.69 each on Aug. 20, 1997, and now directly holds 19,108 common.

CIGNA stock closed at $156.56 a share on Nov. 3.

General Re Corp.: Christopher Garand, vp, exercised an option for 1,053 shares of common between $93.75 and $120.25 each on Aug. 18, 1997, and sold them at $193.94 each on Aug. 18, 1997, and now directly holds 4,748 common.

General Re stock closed at $195 a share on Nov. 3.

Humana Inc.: George W. Vieth, vp, purchased 800 shares of common at $23.50 each on Aug. 8, 1997, and now directly and indirectly holds 10,398 common.

Humana stock closed at $22.38 a share on Nov. 3.

Lincoln National Corp.: Robert Alvin Anker, an affiliated person, exercised an option for 21,000 shares of common between $23.50 and $26.03 each on Aug. 5, 1997. To cover expenses of the transaction, he turned in 11,841 of them for $72.22 each on Aug. 5, 1997, and now directly and indirectly holds 49,227 common.

Herbert Thomas McMeekin, vp, exercised an option for 1,000 shares of common at $23.50 each on Aug. 4, 1997. To cover expenses of the transaction, Mr. McMeekin turned in 554 of them for $71.31 each on Aug. 4, 1997. Mr. McMeekin indirectly acquired by gift 775 shares of common at an unreported price that same day and directly and indirectly holds 17,985 common.

John Patrick Barrett, director, purchased 1,000 shares of common at $71.58 each on Aug. 6, 1997, and now directly holds 6,393 common.

Richard Stuart Robertson, vp, sold 1,600 shares of common at $72.21 each on Aug. 5, 1997, and now directly and indirectly holds 19,431 common.

Lawrence T. Rowland, officer of subsidiary, exercised an option for 1,500 shares of common at $27.72 each on Aug. 4, 1997. To cover expenses of the transaction, Mr. Rowland turned in 891 of them for $71.31 each on Aug. 4, 1997, and now directly and indirectly holds 8,121 common.

Richard C. Vaughan, vp, exercised an option for 2,800 shares of common at $27.72 each on Aug. 5, 1997. To cover expenses of the transaction, Mr. Vaughan turned in 1,654 of them for $72.22 each on Aug. 5, 1997 and now directly and indirectly holds 18,722 common.

Lincoln National Corp. stock closed at $69.19 a share on Nov. 3.

SAFECO Corp.: William W. Krippaehne, director, purchased 500 shares of common at $48.00 each on Aug. 1, 1997, and now directly and indirectly holds 2,461 common.

SAFECO Corp. stock closed at $47.88 a share on Nov. 3.

UNUM Corp.: Gayle O. Averyt, director, sold 32,000 shares of common at $44.89 each on Aug. 7, 1997. Mr. Averyt indirectly sold 50,000 shares of common at $43.07 each from Sept. 3 to Sept. 5, 1997, and now directly and indirectly holds 303,170 common.

UNUM stock closed at $48.75 a share on Nov. 3.

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Insider Trading, compiled by Invest/Net Trading Group Inc. of Fort Lauderdale, Fla., from reports filed with the Securities and Exchange Commission, tracks stock sales and purchases by insurance industry directors and officers. The column is distributed by Tribune Media Services Inc.

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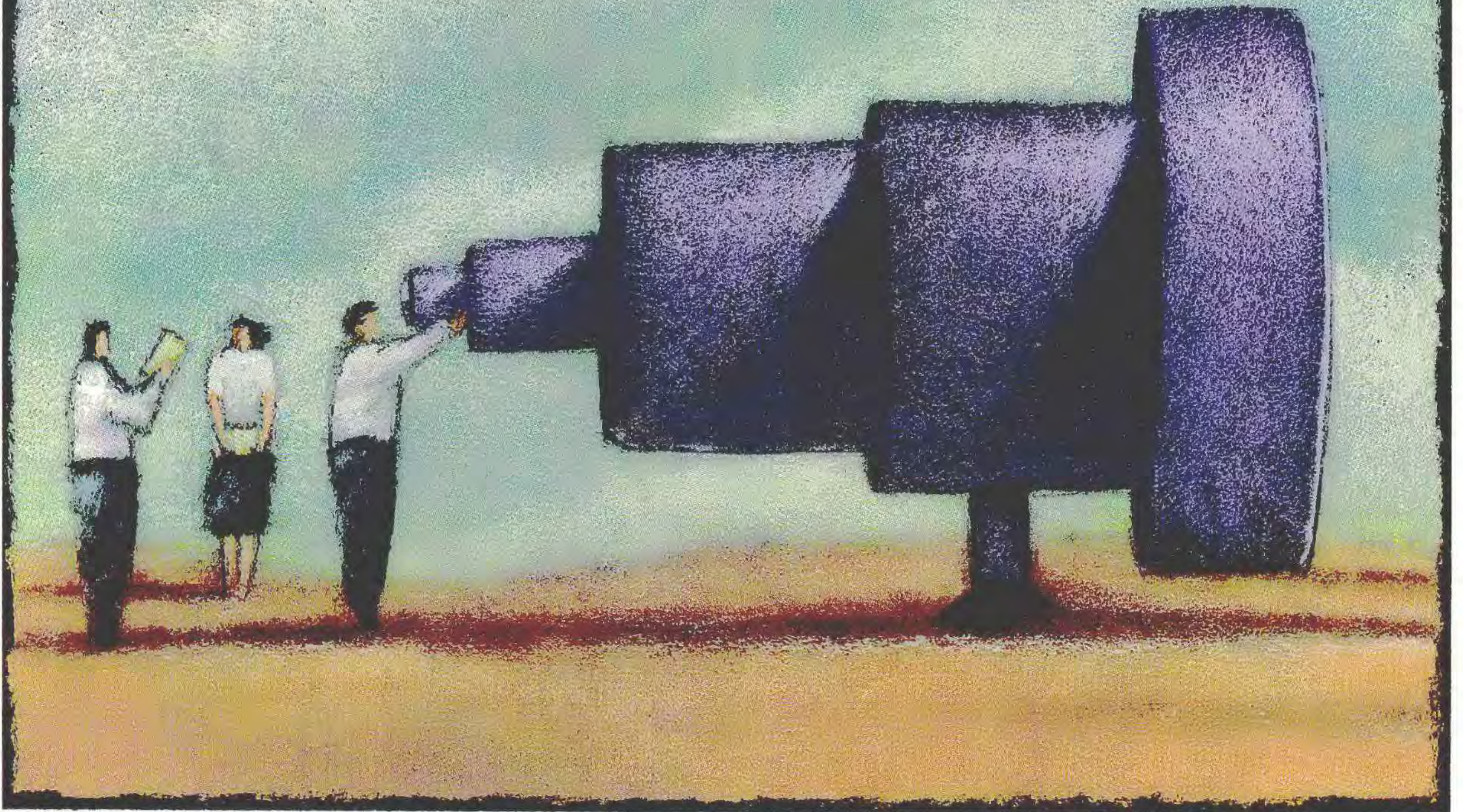

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Dec 8	Benefits: Market Report [RS] *Directory: Benefit Consultants, Distribution: NAIC*		Nov 26
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Feb 9			Jan 28
Feb 16	Self-Insurance: Property/Casualty & Employee Benefits [RS] *Directory: Third-Party Administrators*	IT Reinsurance Strategies	Feb 4
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INTERNATIONAL

Global Briefs

Risk managers with U.K. mainland properties should see lower **property terrorism coverage premiums** next year. A claims-free year so far has allowed Pool Reinsurance Co. Ltd. in London, the U.K. government-backed reinsurer that provides property terrorism coverage, to lower 1998 premiums by between 20% and 40%, though the discounts may be changed or withdrawn if terrorism losses occur. Pool Re is reducing rates for inner London and the business districts of specific cities and large towns by 20%. Risks located in the rest of mainland United Kingdom will get 40% reductions. . . Marsh & McLennan Cos. Inc. is buying **Swedish brokerage AB Max Matthiessen** and its reinsurance brokerage affiliate for an undisclosed sum. The brokerages will be merged with Marsh & McLennan's existing operations in Sweden. Max Matthiessen was previously an independent brokerage and a member of the UNISON network. It is one of several former UNISON members that have been bought by Marsh & McLennan since the broker bought Johnson & Higgins, the senior UNISON member, earlier this year (*BI*, March 17). . . **General & Cologne Re** has set up a management company in Sao Paulo, Brazil. General & Cologne Re Brazil Ltda. will be the representative office for General Re Corp. in Stamford, Conn., and for Cologne Reinsurance A.G. in Cologne, Germany. General Re has a controlling interest in Cologne Re. . . U.S. life reinsurer Reinsurance Group of America Inc. will set up a **London market operation** next year, possibly during the first quarter. RGA may expand its international operations, particularly in Europe and South Africa, and has started the process by buying 20% of financial services consultant TBOi (U.K.) Ltd., a bancassurance specialist, for £2.5 million ($4.24 million). The capitalization of RGA's London operations and the volume of business it aims to write there are still to be decided, but it will most likely become a member of the London International Insurance & Reinsurance Market Assn. . . Italian insurer **Assicurazioni Generali S.p.A.** last week became the most recent full member of LIRMA, adding access to LIRMA non-marine business and London Processing Centre Ltd. systems to its open market non-marine business and Institute of London Underwriters marine business. Generali has had a U.K. branch office in London since 1963, and this move will give Generali "new opportunities to do business," said Terry Linnegar, Generali's U.K. chief executive. Generali could underwrite London market business from its home office in Trieste, Italy, though a Generali spokesman said the company does not plan to do so at present. . . **Alistair Ross Goobey** has been appointed as a nominated member of Lloyd's of London's ruling Council, to take over the place soon to be vacated by retiring regulatory board chairman Sir Alan Hardcastle. Mr. Goobey is chief executive and chief investment officer of Hermes Pensions Management. His appointment has been approved by the Bank of England. . . Lloyd's of London regulators have given their approval for agency **Duncanson & Holt Syndicate Management Ltd.** to set up two new syndicates for the 1998 year of account. Syndicate 1308 will have £80 million ($135.8 million) in capacity and will write a mixed book of business including marine, non-marine, aviation, space and catastrophe reinsurance, while syndicate 1999 will specialize in space business, backed by £12.5 million ($190.9 million) capacity. Both syndicates will have Simon Spinney as underwriter, supported by deputy underwriter Mark Pepper. . . Shareholders last week unconditionally approved the merger between **Benfield Group P.L.C.** and **Greig Fester Group Ltd.** . . **John Hamblin** will take over the role of active underwriter for Bankside Syndicates Ltd.'s syndicate 566 following the election of current underwriter Elvin Patrick to the Lloyd's of London ruling Council earlier this month.

U.K. insurers seek to avoid 2000 risk

By EDWIN UNSWORTH

LONDON—British insurers have introduced more exclusion clauses for Year 2000-related computer problems, though they argue this represents no withdrawal of coverage but a confirmation that such risks were never intended to be covered under standard commercial policies.

The Assn. of British Insurers last week issued draft exclusion clauses for Year 2000-related product liability and professional indemnity claims, having previously issued sample draft exclusions for business interruption and property damage claims.

Some major insurers already have said they will incorporate the clauses in their policies.

The clauses recommend wordings for the exclusion of Year 2000-related problems to computer equipment; liability, including employers liability, public/product liability, legal defense costs and financial loss; professional indemnity; machinery loss; and for directors and officers liability.

The model clause recommended by the ABI is an exclusion for, in part: "Damage or consequential loss directly or indirectly caused by or consisting of or arising from the failure of any computer, data processing equipment or media, microchip, integrated circuit or similar device or any computer software, whether the property of the insured or not, and whether occurring before, during or after the year 2000."

Two of the United Kingdom's largest insurers, Royal & Sun Alliance Insurance Group P.L.C. and Guardian Royal Exchange P.L.C., have said they will introduce the clauses into commercial policies.

Other major insurers have yet to decide on the clauses but expect to reach a decision by year end. These include London-based Commercial Union P.L.C. and Perth, Scotland-based General Accident Fire & Life Assurance Corp. P.L.C.

Britain's risk managers are unhappy that the clauses will exclude Year 2000

See **Year 2000** *on next page*

Fewer U.K. companies offer private health benefits

By EDWIN UNSWORTH

LONDON—The number of U.K. companies that offer private medical insurance benefits is declining, a new survey shows.

Rising costs for such coverage is among the possible reasons for the decline, according to executives of Watson Wyatt Worldwide, which is due to release the survey later this month.

At the same time, another recent survey suggests that few U.K. employees have an accurate picture of the cost of the benefits they receive.

Other key findings of Watson Wyatt's 1997 Medical Benefits Survey are that more U.K. employers are self-insuring their private medical coverage, and more are using either a broker or benefits consultant to obtain private medical coverage.

The 1997 survey found that of 356 U.K. companies responding, 55.9% provide private medical insurance for employees and their families, down from 75.9% of employers in the 1995 survey and 81.3% in 1992.

At the same time, the percentage of employers restricting private medical insurance to employees only has steadily risen to 28.8% in 1997 from 15.5% in 1992. Watson Wyatt also saw an increase, however, in the percentage of companies providing coverage to employees' domestic partners, increasing to 15.3% this year from only 3.2% in 1992.

Since the first 1983 survey, the number of U.K. companies that allow employees to continue to receive private medical insurance benefits into retirement also has declined. The latest survey found that 39% of companies provide retiree health care benefits, compared with 43% in 1995 and 46% in 1992.

Among those companies, the percentage of companies prepared to pay for retirees' health care premiums has fallen to 21% in 1997 from 29% in 1995, while the percentage of companies willing to share the cost of premiums with the retiree has fallen to 8% from 12% over the same period.

"The apparent general reduction in cover is probably linked not only to rising costs but to employers taking a more sophisticated and pragmatic look at this employee benefit," John Gillman, a principal in Watson Wyatt's health care practice in Reigate.

Slightly more than 86% of companies surveyed purchase insurance to cover pri-

See **Benefits** *on page 32*

P&I clubs get competitor from Germany

By DON LEWIS KIRK

BONN, Germany—German marine insurer Darag A.G. and German commercial insurance group Gerling A.G. have joined to offer shipowners liability coverage at fixed rates and limited coverage of up to 100 million deutsche marks ($58.5 million), competing for the main business of P&I clubs.

Darag A.G. Senior Executive Ralf Oertel said fixed rates appeal to owners of container vessels and general cargo, who dislike paying mutuals for the pooled risks. "Many owners don't need unlimited cover and prefer rates that reflect their own risk," said Mr. Oertel.

Darag began 40 years ago insuring shipowners in former East Germany and expanded nationally with limited coverage and fixed premiums in 1994.

'Our initial interest is Europe, but other markets could follow,' says Dirk Lindemann of German insurance group Gerling A.G.

Currently, 250 ships are insured with the Berlin-based Darag P&I. Darag now has teamed up with Cologne, Germany-based commercial insurer Gerling A.G. to extend its international reach.

"At present, Darag focuses on the German market," said Gerling Market Management Director Dirk Lindemann. "The cooperation with Gerling gives it a worldwide network and greater product reach."

Cooperation also increases Darag's limit of coverage from 30 million deutsche marks ($17.6 million) to 100 million deutsche marks, focusing Darag's objective directly at the main business of P&I clubs.

"More owners with larger tonnage are looking to buy P&I cover in Germany," said Mr. Lindemann. "Our initial interest is Europe, but other markets could follow."

Gerling and Darag are coinsurers in the venture; however, Darag will manage the business. Last year, Darag's gross premiums written rose to 146 million deutsche marks ($94.6 million) from 138 million deutsche marks ($96.1 million) in 1995. However, due to a fluctuation in exchange rates, gross premiums written declined in U.S. dollars. Net income totaled 69 million deutsche marks ($44.7 million), up from 63 million deutsche marks ($43.9 million). BI

Australian brokers lose market share

Entry into workers comp eyed

By KATE TILLEY

GOLD COAST, Australia—Gross written premium in Australia is increasing, but brokers' share of the market has dropped, according to the regulatory Insurance and Superannuation Commission.

Don Gruber, Insurance and Superannuation Commission assistant commissioner, told the National Insurance Brokers' Assn. national conference on the Gold Coast last month that ISC statistics show the percentage of business brokers place has dropped to 28.5% from 33.7% between 1994 and 1996.

Over the same period, insurers' gross written premiums grew 14.5% to $18.03 billion Australian ($11.17 billion) while brokers' volume dropped 3.4% to $5.14 billion ($3.65 billion).

Despite the reduced volume, broker numbers are growing. On June 30, 1996, 1,004 brokers were registered in Australia. The number grew to 1,021 by June 30, 1997,

See **Brokers** *on page 32*

PHOTO: AFP

Two-train collision kills four in Portugal

Human error is being blamed for a Nov. 8 train collision in southern Portugal, according to state-owned railway company Caminhos de ferro Portugueses. Four people were killed when two trains collided outside the Estomar station. The two trains carried 80 passengers. The rail company said it will pay all compensation and costs—which have not yet been determined—associated with the incident.

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On October 4, 1997, the Chartered Property Casualty Underwriters Society elected Anita Z. Bourke, CPCU and CPIW, as president of its distinguished organization for 1997-98. With her confirmation, Anita became the first woman to serve as president of the CPCU Society in its 53-year history.

Anita's recognition by the prestigious 28,000-member CPCU follows more than 16 years of continuing education and dedicated professional service to the property and casualty industry's leading organization. And it closely parallels her recent appointment as vice president of strategic planning for Willis Corroon.

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INTERNATIONAL

Year 2000

Continued from previous page

risks from general insurance policies. The Assn. of Insurance & Risk Managers called upon individual insurance companies "to come clean" and finally "provide a clear and definite statement for policyholders."

AIRMIC Vice Chairman David Ketley said the insurance industry has had two years to decide how it will handle the Year 2000 problem, "but risk managers and insurance buyers are still no wiser as to what will happen and cannot plan for the future with any certainty."

He cited a number of uncertainties, including that risk managers do not yet know which insurers will use the exclusion clauses or how they will be interpreted, and apparent disparity of views on how strictly the clauses will be applied.

Mr. Ketley cited as an example the failure of a commercial sprinkler system and the uncertainty now whether an insurer would say this is a Year 2000 exclusion and that any fire damage is not covered.

Product liability coverage is another worry, he said. If someone suffers loss because of product defect, such as an escalator stopping suddenly, and that defect can be traced to a Year 2000 problem, it is unclear whether the insurer would indemnify, he maintained.

"We're not asking insurers to give additional cover. What we want is to ensure they continue with the cover they're giving at the moment," he stated.

Also last week, the ABI joined with the U.K. Department of Trade and Industry in launching a campaign to impress upon businesses the importance of taking action to deal with the Year 2000 threat.

They warned that the end of 1998 was probably the latest deadline for companies to complete the essential work of dealing with the millennium computer problem.

ABI Director General Mark Boleat said too many companies are failing to take precautions to ward off the year 2000 time bomb, and that "insurance is not an alternative to taking action."

Mr. Boleat warned: "Insurers cannot meet the consequences of companies not modifying their systems to take account of the known consequences of a known event. . . .Standard business policies are not designed to cover the risks associated with the change of century."

However, he added that some forms of coverage would be available if taken out in a special policy and certain conditions were met.

Such coverage will depend on policyholders taking action to ensure their business systems, as well as their suppliers' and customers' systems, are "millennium-compliant," he said.

Ironically, the DTI's participation in the awareness campaign came in the same week that Parliament learned seven out of 16 government departments have missed the government's own deadlines for tackling the millennium problem.

Malcolm Bruce, a Liberal Democrat Member of Parliament, compiled figures from written answers given in the House of Commons on behalf of the government. While the Labour government has said it could cost up to £3 billion ($5.11 billion) to prepare public sector computer systems for the date change to the Year 2000, so far only £3.4 million ($5.79 billion) has been spent, he said.

"At this rate, the government will not be ready for the millennium and many computer systems will fail," he warned.

Meanwhile, London-based Heath Reinsurance Broking Ltd. has developed a "spread loss cover" provided by London market underwriters for Year 2000 risks that defers the cost of the coverage, requiring a premium to be paid only if there is a claim. Stephen Hitchcock, deputy managing director of Heath's international division, explained that the policyholder pays a booking fee to reserve various levels of capacity that then can be accessed if a loss happens. At the same time, the premium is negotiated and agreed upon but is paid only when a claim is made.

So far, the broker has prepared two quotes on the policy, though Mr. Hitchcock said he expects interest to pick up next year. BI

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Inquiry could affect brokers

Review of financial services may change regulation

By KATE TILLEY

GOLD COAST, Australia—A federal inquiry into Australia's financial services industry could mean changes for brokers sooner then they expected.

The federal government has concluded the Wallis inquiry, a comprehensive review of Australia's financial services industry. The review recommends radical changes to regulation of the insurance industry.

Though he acknowledged that brokers receive scant mention in the 800-page Wallis inquiry report, Alan Bishop, president of the National Insurance Brokers Assn., warned brokers not to be complacent about it, as it will have far-reaching ramifications for all brokers.

The federal government is committed to implementing the changes recommended by the inquiry, headed by prominent Australian businessman Stan Wallis.

The ISC will be replaced by two authorities, one of which—the Australian Corporations & Financial Services Commission—will regulate brokers and other finance industry intermediaries. The other will regulate insurers, banks, and superannuation, the Federal Government's compulsory retirement savings plan.

Mr. Bishop said it is unfortunate that the implementation of Wallis would see the demise of the ISC. "They've performed an excellent regulatory role over the years. In many respects, the ISC has set world standards," he said.

Noel Pettersen, Sydney-based NIBA executive director, warned that the changes are happening faster than brokers had anticipated.

"We'd been expecting a program of gradual change between now and 2000, but the next six to eight months will see radical change," he said.

"We must rethink where we stand as an association. Even the word broker may disappear. They want to simplify the financial services industry with a single licensing system for all intermediaries," Mr. Pettersen said.

When the new regulator, the AC&FSC, is established, one of its first roles will be to examine existing laws, including the Insurance (Agents & Brokers) Act.

Mr. Bishop said it is likely many existing requirements for a brokering license will remain but that formal arrangements for competency standards and dispute resolution will be included.

"Our primary concern is to ensure the push for change and consistency does not dilute what NIBA and the industry have achieved," he said, and that brokers are not "swept up in solutions to other people's problems."

The ICA's Mr. Mason also warned that brokers and the rest of the industry could face increased regulation "designed for other sections of the financial services market that are a long way behind" the non-life industry.

Richard Smith, ISC deputy commissioner, non-life, also warned that implementation of the Wallis recommendations will affect broker regulation.

The legislation is being developed to set up the new regime, consisting of the AC&FSC and the Australian Prudential Regulation Authority, which will regulate insurers. Mr. Smith said while no date has been set for the legislation to go before the federal Parliament, it is expected to be introduced in early 1998.

Brokers

Continued from page 29

with 71 licenses lapsing and 88 new ones being issued.

In a separate presentation, economist and social commentator Phillip K. Ruthven, executive chairman of Ibis Business Information Pty. Ltd. in Sydney, Australia, estimated non-life written premium will grow to $22 billion Australian ($15.61 billion) by 2001.

Mr. Gruber said premium volume growth areas are in compulsory insurance, such as third-party personal injury and workers compensation. Brokers are not heavily involved in either area, as state governments regulate premiums.

NIBA has set up a CTP subcommittee to coordinate the states' positions and seek ways to improve broker involvement and also is seeking involvement in organizing states' workers compensation programs, said Alan Bishop, NIBA president.

Alan Mason, chief executive of the Sydney-based Insurance Council of Australia, told brokers the ICA supports broker involvement in workers comp but that it is "up to you to argue your case with employers."

Mr. Gruber warned that for brokers with premium volume of less than $1 million Australian ($710,000) a year, the future is bleak. "It's not clear to me how they can be viable at that level," he said during the presentation.

He said statistics show the top 20 brokers in Australia account for 52% of brokers' premiums, the top 100 comprise 69% and the top 200 account for 78%, which leaves little for the remaining 821 brokers.

Mr. Bishop, who also is principal of EBM Insurance Brokers Pty. Ltd. in Perth, Western Australia, in his opening address to the conference, acknowledged that brokers are under threat, particularly smaller brokers. But he said some were "hell-bent on self-destruction" by failing to adapt to change, and instead being motivated by seeking the cheapest rates.

Innovative thinking is 'required daily, not just when an account is up for renewal,' says Alan Bishop.

"This sacrifices the long-term stability of the industry," Mr. Bishop warned.

"Creativity and innovative thinking are required daily, not just when an account is up for renewal." BI

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Benefits

Continued from page 29

vate medical benefits, down from 94% in 1992. This mainly reflects the growing use of captive and self-insurance programs, used today by slightly more than 6% of the companies surveyed, compared with 2.6% in 1995 and none in 1992.

The survey also found that with the introduction in Britain of the insurance premium tax in 1994, many companies say they are considering financing employee health care expenses through tax-exempt employee health trusts, though few are actually making the switch. Employers can set up these tax-exempt trusts solely for the benefit of employees, with the funds used by the employee to pay for the cost of treatment.

In 1995, 32% of companies stated they were considering EHTs, and of these, 44% planned to make the change. In 1997, 24% of companies considered EHTs, though only 13% were planning to make the change.

Also, the percentage of U.K. companies using a broker or benefits consultant to negotiate their private coverage has increased steadily. The latest survey shows 70% of companies use an intermediary, compared with about 66% in 1995 and 42% in 1990.

Meanwhile, a separate study released last week by Towers Perrin on benefit effectiveness indicates that few U.K. employees realize the true cost of their company benefits, and still fewer rate employee benefits very highly as a reason for staying in their jobs.

Only 26% of employees say that benefits are one of the main reasons they stay with a company. They also have a very low perception of the true cost of their benefits, with about 62% of workers thinking their benefits are worth less than 20% of their pay, whereas the average cost to the employer can be more than 30%, says Towers Perrin.

"The message from the research is that employees don't fully understand or appreciate the value of their benefits, largely because benefits are not communicated to them," said Tammy Mattson, Towers Perrin's benefit strategy practice leader in London.

Towers Perrin intends to turn the report into an annual Benefit Effectiveness Index, which would tell employers how well they are doing in achieving their aims and whether their benefits programs are helping them meet business objectives.

•

The 1997 Medical Benefits Survey costs £150 ($256) plus 17.5% VAT for a summary of key results, or £350 ($597) plus 17.5% VAT for the full report. It is available from Jan Booth, Watson Wyatt Healthcare Practice, Watson House, London Road, Reigate, Surrey RH2 9PQ, England; phone: 441-1737-274-503; fax: 441-1737-241-496.

The Towers Perrin study is not available to the public. It will be distributed to employer participants only.

U.K. directors may face more suits

By CAROLYN ALDRED

Directors and officers may face more shareholder suits if recommendations of the government's law reform body are adopted.

In its first set of proposals for reforming corporate law, the Law Commission last month published its final report on Changes to Shareholder Remedies, recommending changes in law and court procedure to make it easier for small shareholders to sue company directors.

The move, however, is unlikely to have any impact on a still-softening D&O liability insurance market, observers note.

Among the recommendations in the Law Commission's report is that the law should be modernized to expand grounds for derivative actions by shareholders. In a derivative action, a shareholder seeks to enforce a right that the company chooses not to exercise. This may include a claim against a director, for example. The commission proposes removing a restriction in the law so that shareholders may bring these derivative actions if the directors have been negligent but have not committed fraud.

"The shareholder's remedy to enforce his company's claims against directors is the means by which, in the last resort, corporate governance is enforced," Dame Mary Arden, chairwoman of the Law Commission, a government-funded legal review body, wrote in a recent article.

However, while making it easier for shareholders to bring legal action against company directors, the Law Commission also proposes that a company's article of association contains a basic dispute-resolution mechanism, so as to encourage shareholders in the future to have pre-agreed routes to resolve disputes without litigation.

Although insurance executives agree the proposals would result in more litigation against directors, they do not anticipate any immediate changes in rates or capacity in a highly competitive D&O market.

If the law is changed, "we will see an increase in the number of claims" against directors, but for the foreseeable future, the market is likely to remain soft, said Martin Beagley, a director of Willis Corroon Professional Risks in London.

Other legal developments, such as the increasing use of conditional, or contingency, fees to fight legal actions; the proposed introduction of a new corporate manslaughter charge; and various European Commission proposed legislation affecting directors' responsibilities, are increasing directors' liabilities without impacting the market, noted Mr. Beagley.

"There is no sign of the market

*See **D&O** on page 34*

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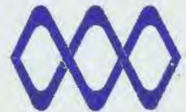

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INTERNATIONAL

D&O

Continued from page 32

hardening," he said, predicting further rate reductions of 5% to 10% for next-year renewals.

"It is good news for policyholders, but we wonder when it's ever going to end," he said, noting there is "increasing capacity particularly at Lloyd's" of London.

Dean Horton, a senior underwriter for executive protection at Chubb Insurance Co. in London, also described the market as soft—"softer than the softest pillow, with no sign of hardening at all."

Not only are rates under pressure, but coverage wordings also are being constantly broadened, said Mr. Horton, adding that Chubb will bring out a new, broadened policy in the next few months. Mr. Horton would not comment on changes in the policy wording but hinted it would offer additional coverage.

Julian Enoizi, Chubb's counsel for Europe, said the proposed legislation is designed to "encourage a greater level of professionalism" among company directors.

It is currently "very difficult" for a shareholder to bring a derivative action against a director, and the proposed changes, together with allowing action for negligence, will mean "directors are going to be more open to actions," he said.

The proposals will "mean more litigation, but there will still be tight controls so the floodgates will not open," he said. BI

High heels may trip up fashion show

BIRMINGHAM, England—Six-inch-plus stiletto heels—in vogue this year—are presenting new risks for runway models.

So great is the concern that runway models for a major fashion show in the United Kingdom's National Exhibition Centre next month threatened to pull out without insurance coverage for physical injury.

At the last minute, British banking group Lloyd's TSB P.L.C., the sponsor for Clothes Show Live '97, arranged and paid for £1 million ($1.7 million) of coverage for 20 models who must walk the world's longest runway up to seven times a day during the exhibition, to be held in the Birmingham, England, center Dec. 5-10. The accidental death and dismemberment insurance would pay an injured model her weekly wage until she can work again.

The insurance policy, which provides up to £50,000 ($85,230) for each model, is underwritten by Groupe des Assurances Nationales, a spokeswoman for Lloyd's Bank confirmed. She refused to reveal the premium paid for the coverage.

The return of the stiletto heel has been one of the most talked-about fashion developments this season and is causing concern for a generation of models and fashion followers unused to wearing them.

"This is the first year that stiletto heels have been back for a long time. They are six inches or more high, a nightmare to wear and very dangerous. An injury could put a model out of work for months," said a spokeswoman for the show's organizer, Barker Brown Ltd. of London.

"The catwalk is the longest in the world, and the models do up to seven shows a day. It becomes very fraught and frantic, and parading in stilettos will take its toll," she said.

Several models had threatened to pull out of the show unless insurance coverage was provided, the spokeswoman confirmed.

—By Carolyn Aldred

The Professional Marketplace

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The President oversees all efforts to advance the community-based health care reform movement by strengthening and building a national presence for local coalitions. This includes developing products, services and initiatives which serve member coalitions and generates revenues for NBCH; maintaining an effective network for sharing of information among members; enhancing the public relations profile of NBCH and providing technical advice and support to members. A complete job description and list of requirements are available at: http:\\www.nbch.org/nbch/.

The NBCH is an equal employment opportunity employer. Salary and benefits are competitive and commensurate with the level of experience and leadership expected of this individual. The NBCH office is located in Washington D.C. Interested applicants should send a letter summarizing interest and qualifications, along with a resume or curriculum vita to: Christopher Queram, Co-chair, NBCH Search Committee, c/o The Alliance, P.O. Box 44365, Madison, WI 53744.

LEGAL NOTICE

LEGAL NOTICE

IN THE CIRCUIT COURT OF COLE COUNTY, MISSOURI
IN RE TRANSIT CASUALTY COMPANY IN RECEIVERSHIP
CAUSE NO. CV185-1206CC

NOTICE OF HEARING
PARTIAL DISTRIBUTION

To: All Creditors of Transit Casualty Company in Receivership ("Transit")
Where: Division II, Cole County Courthouse, Jefferson City, Missouri
When: November 21, 1997 at 2:00 p.m., C.S.T.

PLEASE TAKE NOTICE THAT A HEARING WILL BE HELD BEFORE THE HONORABLE BYRON L. KINDER, CIRCUIT COURT JUDGE, ON THE APPLICATION OF TRANSIT'S SPECIAL DEPUTY RECEIVER, BURLEIGH ARNOLD, TO APPROVE A "FOURTH DISTRIBUTION" OF TRANSIT'S ASSETS TO CLAIMANTS.

YOU MAY PARTICIPATE IN THIS HEARING IN PERSON OR BY TELEPHONE. IF YOU DESIRE TO PARTICIPATE BY TELEPHONE, PLEASE CONTACT RIC MUNOZ AT (310) 772 - 8355 AT LEAST 48 HOURS BEFORE THE HEARING AND HE WILL ACCOMMODATE. HE WILL ALSO GIVE YOU DIRECTIONS TO THE COURTHOUSE IF YOU DESIRE TO APPEAR IN PERSON.

Pursuant to the Court-approved Plan of Distribution and the formula for distribution, the Special Deputy Receiver will seek the Court's approval to make an interim, fourth partial distribution of the net available assets of the Receivership in order that Transit may pay certain claimants a percentage of their allowed acknowledged claims in January 1998, or as soon thereafter as possible, in accordance with Section 375.700, Revised Statutes of Missouri.

The Special Deputy Receiver will present testimony to Judge Kinder from Transit's staff and consultants on the assets available for distribution, the present "allowed claims" against the estate and an actuarial estimate of the dollar amount of future claims still pending against the estate. This evidence of Transit's assets and liabilities will be considered by the Court, along with any evidence a claimant may wish to present, in determining the exact percentage of the allowed claims which may be paid to third-class of creditors in this fourth distribution.

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Risk/Employee Benefits:	
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Sub-total	**28,694**
Associations	305
Government, Unions and Educational Institutions	1,046
Commercial Consumers Sub-total	**30,045**
Insurance Agents and Brokers	8,462
Insurance Companies	7,336
Accountants, Actuaries, Attorneys & Consultants	2,823
Adjusters, Appraisers, TPA's, Captive Managers & Health Care Providers	1,648
Others Allied to the Field	915
Total Qualified	**51,229**
Non-qualified/Paid Subscription	31
Single Copy Sales	2
TOTAL CIRCULATION	**51,262**

★ Source Business/Occupational breakdown of qualified circulation, May 26, 1997 Issue, as submitted to BPA for June 1997 BPA Publisher's Statement

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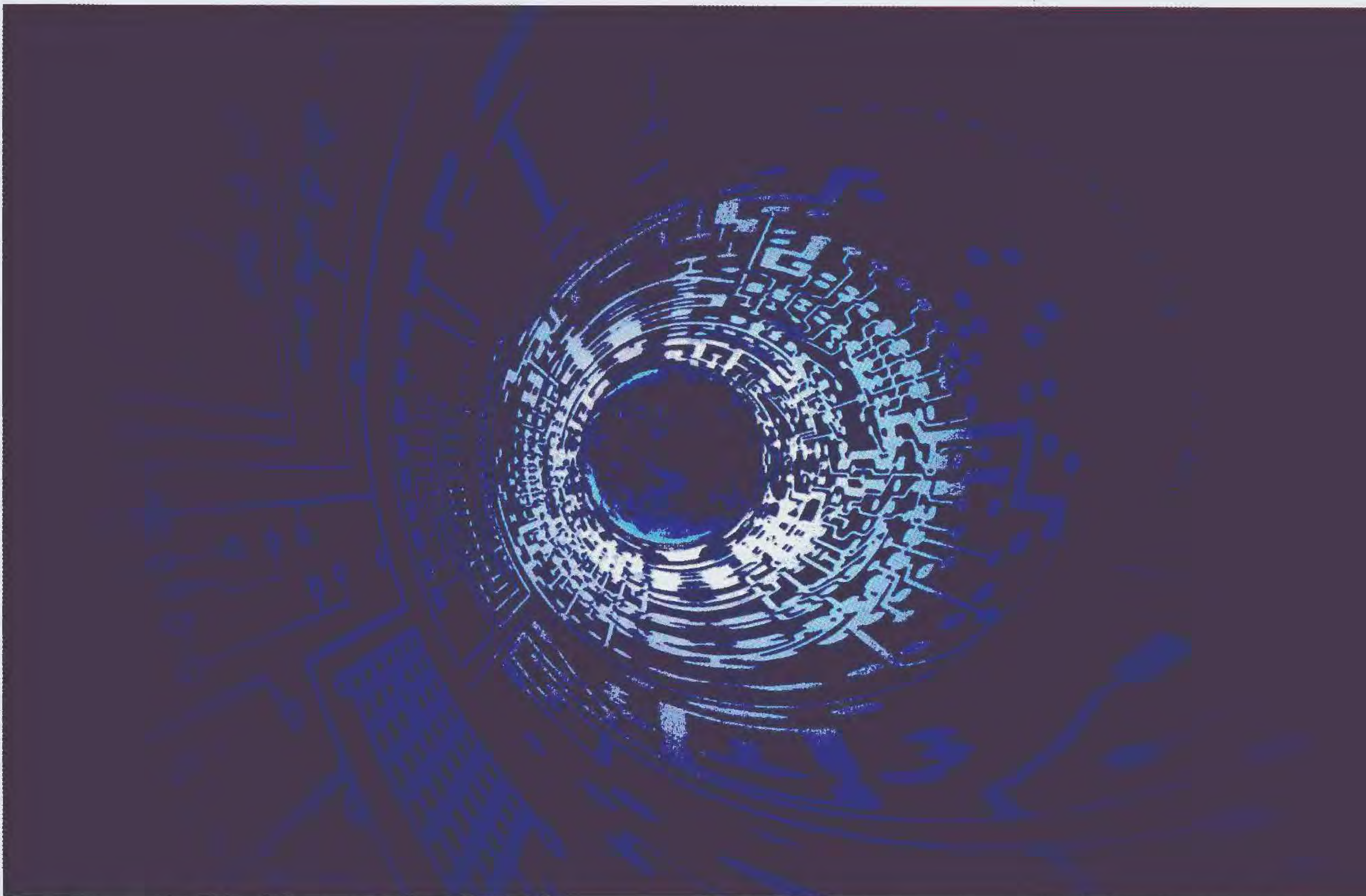

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Fees

Continued from page 1

with the accounts should be fully disclosed. "Participants need clear, accurate and understandable disclosures," said Shaun O'Brien, retirement policy analyst with the AFL-CIO in Washington.

"All fees should be noted and explained," he said.

Full disclosure of all fees is necessary, agreed Ted Benna, president of the 401(k) Assn. in Cross Fork, Pa., and the designer of the first 401(k) plan. Mr. Benna said the disclosure also should include who is paying the fee—the plan sponsor or the plan participant.

"Participants think they are getting a fund at a normal management fee" and then find out they are paying much more, said Mr. Benna. He said the problem of fee disclosure is particularly focused on employers who have 250 or fewer participants in their plans.

The question of disclosure can be handled two ways, he said. The 401(k) industry can voluntarily disclose fees or face being required to do so by the government, he said.

Plan 'participants need clear, accurate and understandable disclosures,' says the AFL-CIO's Shaun O'Brien.

Even small fees can have a large impact over time, said Stephen J. Butler, president of Pension Dynamics Corp., a Lafayette, Calif.-based consulting firm. The result is "the magic of compound interest working against us," he said. He would like to see the development of some standard for measuring the costs of 401(k) plans.

Not all speakers favored greater fee disclosure, particularly if mandated by government.

"Current fiduciary standards adequately protect 401(k) plan participants in the vast majority of cases, and mandating the form and content of fee disclosures to plan fiduciaries or participants would increase the cost of maintaining 401(k) plans without providing commensurate value to participants," said Lynn Dudley, vp-retirement policy for the Assn. of Private Pension & Welfare Plans in Washington. BI

Microsoft

Continued from page 2

Mr. Lange, though, recently has expressed concerns about developments at J&H Marsh & McLennan since J&H was acquired.

For example, Mr. Lange was concerned about how J&H's departure from the UNISON correspondent broker network would affect Microsoft's overseas affiliates (*BI*, Oct. 6). J&H, UNISON's largest member, pulled out of the network after the broker was acquired.

Mr. Lange also raised questions about J&H Marsh & McLennan's decision to direct middle-market property/casualty business written by Chubb Corp. into regional centers instead of placing that business through the broker's local offices. The centers may be an example of how large brokers may try to control the market, he said (*BI*, Oct. 13).

None of the Microsoft coverage that Chubb writes was moved to a regional center, according to Mr. Van Der Vliet.

However, J&H last year moved about 40% of Microsoft's business from the broker's Seattle office to its San Jose, Calif., office. The broker reasoned that because the San Jose office is located in the heart of the Silicon Valley, the office could better service that portion of Microsoft's account, Mr. Van Der Vliet said.

He said Aon had contacted him and that he decided to move to the world's second-largest retail broker before Microsoft decided to change brokers. BI

Captives

Continued from page 2

fered from *Humana* in several ways, however, including that HCA provided an indemnification letter to a fronting insurer for part of the coverage placed with Parthenon, undermining HCA's claim that the captive shifted risk.

The "comfort letter" led to a partial loss of HCA's deductions, but the court largely rejected the IRS's arguments and found that the captive coverage was true insurance and that HCA subsidiaries shifted risk to Parthenon.

"It's a highly fact-based decision" that doesn't necessarily create guiding legal principles for captive owners, observed Jon Harkavy, vp and general counsel of USA Risk Services Inc. in Arlington, Va. But "the good news is that it reaffirms *Humana*."

Like *Humana*, the HCA case arises within the 6th Circuit, and whether the precedent would be followed in other circuit courts is an open question, Mr. Harkavy said.

Meanwhile, the ruling underscores several elements important in arguing for captive premium deductibility, he added, including that the captive be formed for legitimate business purposes other than tax reasons; and that it be well-capitalized and based in a jurisdiction with strong regulation.

The court also indicated that "one land mine you really have to avoid at all costs is any kind of comfort letter," according to Mr. Harkavy.

In the 1989 *Humana* ruling, the 6th Circuit held that Humana subsidiaries are entitled to deduct premiums paid to a captive wholly owned by their parent, but that

'One land mine that captive owners have to avoid at all costs is any kind of comfort letter,' says Jon Harkavy.

the parent company itself is not. It reached this conclusion partly by finding that losses suffered by the captive affect the parent company's net worth but not that of the subsidiaries; thus, only the subsidiaries have shifted their risk of loss.

Taking its cue from *Humana*, HCA did not try to argue that its own premiums should be deductible, but HCA did contend that its hospital units—numbering as high as 135 before a 1987 reorganization—should be able to deduct payments made to Parthenon.

The Tax Court, also following *Humana*, agreed: "HCA. . .operated Parthenon as a separate entity. It was separately staffed and managed. It maintained its own personnel files, accounting records, information management system, cash management system and banking arrangements. . .The transactions between Parthenon and. . . the sister subsidiaries constituted a bona fide insurance arrangement," the ruling noted.

The court also shot down several IRS attempts to distinguish the case from *Humana*.

Unlike *Humana*, for example, HCA provided a "comfort letter" agreeing to indemnify workers compensation fronting insurer Ideal Mutual Insurance Co. if Parthenon failed to pay reinsurance claims.

The court found that workers compensation was not a big enough part of Parthenon's business to affect the validity of the overall arrangement; however, it also found that the indemnification agreement meant there was no workers comp risk shifting for the few years the agreement was in force and denied deductions for the related workers comp premiums.

The IRS also argued that true insurance didn't exist because HCA units had no choice but to insure with Parthenon. "Choice," the court wrote, "plays no role in deciding whether the policies between Parthenon and its sister subsidiaries constituted insurance as commonly understood in the industry."

The court also rejected the Internal Revenue Service argument that HCA had agreed to provide financial help if Parthenon ran into trouble. While Tennessee regulators may have expected HCA to provide support, there was no "binding agreement that HCA or the sister subsidiaries do so," the court found.

•

Hospital Corp. of America and subsidiaries vs. Commissioner of Internal Revenue; U.S. Tax Court docket nos. 10663-91, 13074-91, 28588-91 and 6351-92.

Directory deadlines near

Business Insurance will publish its annual Directory of Employee Benefit Consultants in the Dec. 8 issue, which also will feature a market report on employee benefits.

The directory is published as an editorial service, and there is no charge to be included.

Companies wishing to be included must simply submit a completed questionnaire by the extended deadline of Nov. 21.

If your company generates at least $500,000 in revenue from employee benefit consulting and has not yet received a questionnaire, please request a form by calling Assistant Directory Editor Matt Scroggins at 312-649-5483.

Nov. 21 is also the extended deadline for the annual Directory of Managed Care Providers.

Updates

Larger tobacco deal sought

WASHINGTON—The chairman of the Senate Judiciary Committee wants the tobacco industry to pay nearly $400 billion over 25 years in return for immunity from smoking-related class action suits.

Sen. Orrin Hatch, R-Utah, last week unveiled his bill designed to implement the proposed settlement between cigarette makers and 40 state attorneys general. Although the proposed settlement would require tobacco companies to pay $368.5 billion, Sen. Hatch's measure sets a price tag of $398.3 billion because of increases in punitive damages, which the initial proposal set at $50 billion (*BI*, June 23).

The increased punitive damages would go to the National Institutes of Health for the study of tobacco-related diseases. The Hatch bill also spells out that states would not have to return any of the settlement to the federal government to compensate Washington for the portion of Medicaid bills it picks up. A recent letter from the Health Care Financing Administration reminding states of their legal obligation to reimburse the federal government for its Medicaid share drew angry protests from the states involved in the proposed settlement (*BI*, Nov. 10).

The Hatch bill is one of three major tobacco bills introduced in the Senate during the past few weeks. A bill unveiled by Sen. John McCain, R-Ariz., would implement the settlement as drafted with the exception of adding the requirement that tobacco companies pay into a special trust fund for tobacco farmers for their loss of livelihood. A third bill, introduced by Sen. Edward M. Kennedy, D-Mass., would slap a new $1.50 per pack tax on cigarettes but would not settle any suits.

No action will be taken on any of the bills until early next year, when Congress returns from its year-end recess.

Bank will appeal judgment

RICHMOND, Va.—Signet Banking Corp. will appeal a federal judge's decision that it must pay $10 million to a financial institution that Signet unwittingly drew into a fraudulent loan scheme.

In the scheme, Edward J. Reiners in late 1995 represented to Signet that he was a Philip Morris Cos. Inc. employee charged with conducting secret offshore nicotine research. Mr. Reiners sought hundreds of millions of dollars in loans for several companies so they could secure computer equipment that Philip Morris would lease for use in the research project.

There was no such project, and Philip Morris had not asked Mr. Reiners—a former employee—to arrange any computer leasing agreement. But, based partially on a bogus document Mr. Reiners produced, Signet extended the loans and enlisted the support of several banks, including Hitachi Credit America Corp. In total, Signet disbursed more than $300 million in loans. The banks soon discovered the fraud, and Mr. Reiners was apprehended. But, about $100 million of the loan proceeds remain missing.

Hitachi sued Signet for breach of contract and fraud. In a July 21 summary judgment, a U.S. District Court judge in Richmond, Va., found Signet liable under the breach of contract claim. On Nov. 6, the judge ordered Signet to pay Hitachi approximately $10 million in unrecovered loan amounts, attorney fees and interest.

A Signet spokeswoman would not comment, but the bank previously said it is covered for its losses. USF&G Corp., Signet's financial institution bond underwriter, is disputing coverage in litigation in Baltimore County Circuit Court in Maryland.

Until recently, such bonds did not cover losses from fraud, said bank and broker sources. But, as the market has softened, some underwriters may have agreed to cover that risk, the sources said.

Briefly noted

The U.S. Supreme Court agreed Friday to hear a **sexual harassment case** that will help clarify exactly when an employer can be held responsible for a supervisor's harassment of an employee. The case, *Faragher vs. Boca Raton*, involves a female lifeguard's suit against the city of Boca Raton, Fla., after two supervisors subjected her to sexual harassment . . . .The Supreme Court heard oral arguments last week in an **age bias case**, *Dolores Oubre vs. Entergy Operations Inc.*, revolving around the question of whether workers over 40 who think they were illegally pressured to quit their jobs must return any severance they received before filing a suit under the Age Discrimination in Employment Act . . . .The California Supreme Court has agreed to review *Lane vs. Hughes Aircraft Co.*, which involves an $89 million 1994 jury award, most of it punitive damages, in a **racial discrimination case** (*BI*, Nov. 21, 1994) . . . .The **Pension Benefit Guaranty Corp.** will guarantee an annual benefit of up to $34,568.16 to participants of underfunded pension plans that terminate next year and are taken over by the PBGC. The 1997 maximum benefit guarantee was $33,136.32. . . .**Ambac Assurance Corp.**, a unit of New York-based Ambac Financial Group Inc., will pay $124.4 million to acquire the College Construction Loan Insurance Assn. and its operating company, Washington, D.C.-based Connie Lee Insurance Co., according to terms announced last week of the definitive merger agreement between the two financial guarantee insurers (*BI*, Oct. 27; Oct. 13). Ambac will pay $106 million for the company's outstanding shares and retire $18.4 million of the holding company's debt obligations. . . .Financial guarantee insurers MBIA Inc., based in Armonk, N.Y., and New York-based CapMAC Holdings Inc. have signed a **definitive agreement to merge** in a stock transaction valued at about $607 million (*BI*, Nov. 3). The agreement calls for CapMAC shareholders to receive MBIA stock equal to $35 for each share of CapMAC stock. . . .The 3rd U.S. Circuit Court of Appeals has upheld a lower court's decision to dismiss a 1992 **keyboard injury suit** against IBM Corp. *Schneck vs. IBM*, which alleged IBM data entry and card-punching machines were defectively designed and that IBM had failed to warn of the hazard, was dismissed by New Jersey District Judge Garrett E. Brown Jr. in June 1996. . . .The U.S. Supreme Court has let stand without comment a federal appeals court ruling that consolidated all **silicone breast implant litigation** against Dow Corning Corp. under U.S. District Court Judge Page Hood in Detroit.

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vp. PIN will link the states and the companies, establishing a system upon which other services can be Insurance, Council of Agents & Brokers, Independent Insurance Agents of America, National Assn. license. Soon, those letters will be a thing of the past. Add to that the cost savings for the insurance com- nal background of producers and provide companies "permission" to hire such individuals. This is not

Chief, Agent Licensing Section
State of Wisconsin
Madison, Wis.

Results

Continued from page 2

merger and acquisition activity among HMOs to continue.

Aetna's net income for the third quarter totaled $117.8 million, down 3.8% from $122.4 million. For the nine-month period, the company had $627.2 million in net income, down 17.3% from $758.1 million in 1996.

Among other HMO results reported:

• Minneapolis-based United HealthCare Corp. reported nine-month net earnings of $340.7 million, up 14.7% from the same period a year ago.

• CIGNA Corp.'s employee life and health benefits segment, which includes its HMO and indemnity operations as well as results for Healthsource Inc. as of June 25, reported quarterly operating income of $128 million, up less than 1% from a year earlier. For the nine months, CIGNA's HMO and indemnity operations had operating income of $371 million, up 3.1% from $360 million for the same period last year.

• Louisville, Ky.-based Humana Inc.'s reported nine-month net income of $125 million, up 4.2% before special charges for the comparable period a year ago. For the third quarter alone, net income increased 37.5% to $44 million.

• Santa Ana, Calif.-based PacifiCare Health Systems Inc., which completed its FHP International acquisition earlier this year, reported $92.3 million in net income for the nine-month period, including $44 million in pretax charges, which was a 109.8% increase from the same period of 1996.

• Woodland Hills, Calif.-based WellPoint Health Networks Inc. reported net income, excluding non-recurring costs, of $164.2 million for the nine-month period, up 5.9% from 1996. For the third quarter alone, net income was up 23.3% to $55.6 million.

• Los Angeles-based Foundation Health Systems Inc., formed by the April merger of Foundation Health Corp. and Health Systems International Inc., reported a nine-month loss of $72.7 million, down 139% from $186.3 million in net income for the comparable period, due to $406 million in one-time charges in the second quarter.

Foundation, however, reported $68.9 million in net income for the third quarter, up 19.8% from 1996.

• Los Angeles-based Maxicare Health Plans Inc. reported a net loss of $23.7 million, down 310% from net income of $11.3 million a year earlier.

Maxicare posted a loss of $18 million for the quarter, down 460% from net income of $5 million for the comparable period in 1996. Results reflect a $20 million charge to increase health care claims reserves for anticipated health care costs.

Among the publicly traded HMOs, a number of factors are reflected in earnings, said Mark Jamilkowski, an HMO analyst at Conning & Co. in Hartford, Conn. "You have integration issues at PacifiCare not unlike the integration issues when United took over MetraHealth a year-and-a-half ago. You have operational issues at Aetna and Oxford, and I would say probably CIGNA as well.

"So are these companies truly producing results that are indicative of their long-run earnings power at this point in time? The answer is probably 'no,'" Mr. Jamilkowski said.

Quarterly earnings performances have been better overall than those of the previous year, which reflects that HMOs have begun to raise prices, said Arun N. Kumar, a director at rating agency Standard & Poor's Corp. in New York.

Meanwhile, the lower-than-expected results of Oxford, Aetna and CIGNA "were indicative of deeper problems in the industry only to the extent to which industry participants are doing the same things as those companies, i.e., completing large acquisitions like Aetna or CIGNA, or having problems with information systems like Oxford," said Rob Mains, an HMO analyst with Advest Inc. in Albany, N.Y.

"I don't think there's a common thread running through the companies that have had problems this quarter, and consequently I don't see why other HMOs should be adversely affected," he said.

"I think the problems are company-specific," agreed Greg Baird, senior vp of group sales for Blue Cross of California, a WellPoint subsidiary. "I don't feel our industry is in any kind of trouble and it's my understanding that my company, for example, has met its Wall Street expected numbers 13 quarters in a row and we're pleased with that."

The outlook for higher earnings next year is promising for HMOs, say some market observers.

Next year could be better than the second half of 1997, said Mr. Kumar, who added that average rate increases of 5% to 10% are being introduced. "We think the outlook for the industry for 1998 is cautiously optimistic," he added.

"We think that the problems of '97 will probably be resolved by early '98, and we think that since the growing pressure to gain market share seems to have abated a little bit, companies will return to a better profitability in '98," Mr. Kumar said.

Oxford "was the last shoe to drop in the industry in terms of having a problem discovering they were vulnerable to the difficult trends that have developed in the last year and a half, and so I think we've pretty much gone full circle here on the down trend in the industry," said Michael LeConey, an analyst with National Securities Inc. in New York.

"The outlook for next year is pretty good, given everybody's talking about 4% to 7% commercial rate increases," said Mr. Mains of Advest.

"Generally, the market seems to be receptive to rate increases in the mid-single digits, which is, on an historic basis, still lower than experience trends," said Mr. Jamilkowski.

Employers seem to understand "that the zero to negative price increases over the past couple of years were more an aberration than the norm," he said.

Nevertheless, Mr. Jamilkowski said, "It's going to take another quarter or two" to determine how successful companies are in overcoming their problems.

"There are still operational issues to overcome; the group is going to continue to consolidate. There are just fundamental forces at play here that are not going away," Mr. Jamilkowski said.

The outlook for next year is "somewhat guarded, depending upon how the integrations of the acquisitions that occurred through '96 and '97 finish," said Richard Shaw, a financial analyst with Oldwick, N.J.-based A.M. Best Co. "If everything goes according to plan, I think '98 will be better than '97," he said.

Meanwhile, the pace of merger and acquisition activity is expected to continue.

Earlier this month, for instance, Des Moines, Iowa-based Principal Mutual Life Insurance Co. signed a definitive agreement to combine its wholly owned managed care subsidiary, Bethesda, Md.-based Principal Health Care, Inc., with Nashville, Tenn.-based Coventry Corp. to form a new company, Coventry Health Care Inc., in a deal valued at about $375 million.

And on the horizon is the possible acquisition of Prudential Insurance Co. of America's health care business (see story, page 2).

"It's been a trend in the industry. I expect it to continue to be a trend in the industry," said Mary O'Connell, an HMO analyst with Louis Nicaud & Associates in San Francisco.

However, Gary Frazier, managing director at Bear Stearns & Co. in New York, believes the pace of major deals might slow down a bit, at least for a while. "I think that the PacifiCare-FHP deal, the United-MetraHealth deal, the Aetna-U.S. Healthcare deal and even the Foundation Health Systems deal have all stumbled in one way or another" during the integration process and some of their stock prices have suffered as a result, he said.

Because of this, he added, many chief executive and chief financial officers "realize it's going to be very difficult to sell major HMO consolidations to Wall Street." BI

BI Insurance Index

1,540
1,520
1,500
1,480
1,460
1,440
1,420
1,400
1,380
1,360
1,340
1,320
1,300
1,280

9/26 10/3 10/10 10/17 10/24 10/31 11/7 11/14

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

PCS catastrophe options

As of Nov. 14

Call spread	Price bid/ask
National Annual 1997	
60/80	—/1.0
80/100	—/1.5
National Annual 1998	
40/60	11.5/13.0
60/80	7.0/8.3
80/100	6.0/7.0
National December 1997	
5/15	1.8/6.0
5/25	2.0/6.5
Southeast September 1998	
40/60	2.0/4.0
60/80	1.5/2.5

Call spread	Price bid/ask
California Annual 1998	
40/60	1.7/2.3
Western Annual 1998	
40/60	2.0/2.5
70/90	—/2.3
Eastern September 1998	
40/60	3.2/4.2

Total volume: 40 Total open interest: 16,533

For information on PCS cat options, call the Chicago Board of Trade at 312-435-3674.

Source: Chicago Board of Trade

British Issues

Companies	Price pence	P/E	Div. pence	Yield %	52-week high—low
Comml Union	740	11.2	35.8	4.9	910—630
Genl Accident	944	6.3	35.4	4.7	1158—686
Gdn Royal Exch	282	4.0	12.2	4.3	350—252
Legal & Gen	490	12.5	11.6	3.0	520—329
Royal & Sun	509	17.4	19.7	4.8	651—417
Brokers					
Lmbrt Fenchurch	121	8.1	8.4	8.7	138—101
Lloyd Thmpson	159	13.2	10.8	8.5	206—159
Sedgwick Grp	122	9.9	7.4	6.1	144—115
Willis Corroon	118	13.2	6.6	7.1	165—118

Note: Prices are Nov. 14 closings; other numbers from Nov. 13.

Source: Nordby International Inc.

BI Industry Stock Report NOV. 10, 1997, THROUGH NOV. 14, 1997

		Price	Weekly % change	Year to date % change	Year to date High	Low	Vol.(000)
BROKERS							
Aon Corp.	NYS	52.06	-3.25	25.70	58.44	37.88	843
E.W. Blanch Holdings Inc.	NYS	33.19	-2.03	64.91	34.63	18.00	58
Gallagher Arthur J. & Co.	NYS	34.94	-1.76	12.70	38.25	29.38	114
Hilb, Rogal & Hamilton	NYS	18.25	-2.01	37.74	19.63	12.50	43
Kaye Group Inc.	NDQ	7.00	3.70	33.33	9.00	4.38	112
Marsh & McLennan	NYS	71.06	-2.15	36.66	80.00	50.88	1121
Poe & Brown	NDQ	40.75	-0.61	53.77	42.75	25.50	2
Sedgwick Group PLC	NYS	10.63	0.00	2.41	10.88	9.38	21
Willis Corroon Corp.	NYS	10.50	0.60	-8.70	13.50	9.75	95
BROKERS	AVERAGE		-0.53	29.10			
INSURERS/REINSURERS							
ACE Ltd.	NYS	92.00	1.66	53.01	101.06	55.75	902
Acceptance Insurance Cos.	NYS	22.63	-0.82	14.56	28.63	17.75	168
AEGON N.V.	NYS	83.88	6.42	32.61	87.13	54.13	311
Aetna Life & Casualty	NYS	77.50	4.38	-3.13	118.13	67.88	4155
AFLAC Inc.	NYS	46.69	-5.44	9.21	57.88	37.50	2612
Allied Group Inc.	NYS	45.44	2.11	39.27	53.63	27.13	202
Allstate Corp.	NYS	82.00	-1.06	41.68	86.00	54.88	3630
AMBAC Indemnity Corp.	NYS	41.75	1.83	25.80	47.56	31.00	1304
American Bankers Ins.	NDQ	37.00	-4.82	44.74	40.00	23.75	200
American Financial Group	NYS	36.00	-2.04	-4.64	49.25	32.38	275
American General	NYS	51.06	1.74	24.92	56.06	36.50	1419
American Heritage Life Ins.	NYS	34.81	-6.86	32.62	40.50	21.75	95
American Indemnity/Fin'l	NDQ	12.00	-4.00	17.07	15.50	9.50	6
American International	NYS	98.94	-1.68	37.10	112.56	70.63	6114
Argonaut Group	NDQ	30.88	-1.20	0.41	38.13	26.75	51
AXA-UAP Group	NYS	34.50	-0.36	9.52	35.50	28.25	121
Baldwin & Lyons Inc.	NDQ	21.75	4.19	18.37	22.63	17.38	8
Berkley W.R. Corp.	NDQ	41.25	-0.60	21.92	46.38	28.88	371
Berkshire Hathaway Inc.	NYS	44400.00	1.37	30.21	48600.00	30000.00	0
Capital RE Corporation	NYS	55.94	-2.61	19.97	62.63	38.25	48
Capitol Transamerica Corp.	NAS	25.25	3.06	23.17	28.13	17.25	13
CapMac Holdings Ltd.	NYS	33.19	8.37	0.19	36.00	22.50	2190
Capsure Holdings Corp.	NYS	15.00	0.00	30.43	15.38	8.50	0
Centris Group Inc.	NYS	21.31	1.49	8.60	23.56	17.38	37
Chartwell Re	NYS	32.75	-2.96	22.43	36.25	24.50	200
Chubb Corp.	NYS	67.56	1.79	25.70	76.31	51.13	1473
CIGNA Corp.	NYS	160.50	2.51	17.47	200.75	130.75	1022
CNA Financial Corp.	NYS	120.06	-1.18	12.21	132.25	96.38	150
CNA Surety	NYS	14.50	-4.92	-3.33	16.50	12.88	124
EMC Insurance Group Inc.	NDQ	13.50	1.89	12.50	15.00	10.75	12
Enhance Financial Services	NYS	55.31	-0.34	51.54	59.25	33.56	242
Everest Reinsurance	NYS	39.44	0.80	37.17	43.00	25.38	210
Executive Risk Inc.	NYS	66.75	4.40	80.41	72.75	33.88	182
EXEL Ltd.	NYS	63.63	1.60	67.99	64.19	36.50	661
Fremont General Corp.	NYS	44.31	-6.09	42.94	49.50	26.38	231
Frontier Insurance Group	NYS	25.06	-31.80	31.05	39.25	18.13	7544
Gainsco Inc.	NYS	8.38	-1.47	-12.99	10.19	8.13	178
General RE Corp.	NYS	196.25	0.64	24.41	208.88	151.00	475
Gryphon Holdings	NDQ	16.25	-1.52	15.04	17.75	12.50	27
Guaranty National Corp.	NYS	35.88	0.53	114.18	35.94	15.38	30
Harleysville Group	NDQ	24.00	-7.25	57.38	27.50	14.00	393
Hartford Steam Boiler	NYS	51.06	-1.80	10.11	56.69	43.13	167
HCC Insurance Holdings	NYS	23.44	-2.85	-2.34	32.69	21.50	466
ING Groep N.V.	NYS	41.44	-1.04	17.55	53.00	38.88	814
IPC Holdings Ltd.	NDQ	30.75	-2.38	37.43	31.88	21.50	292
Hartford Financial Services	NYS	80.81	0.00	19.72	90.31	63.38	1374
LaSalle Re Ltd.	NDQ	32.50	-1.33	11.11	36.13	24.50	72
Life Re Corp.	NYS	58.63	1.96	51.78	59.38	35.88	106
Lincoln National	NYS	68.88	-0.45	31.19	73.63	48.63	969
MAIC Holdings Inc.	NYS	27.88	0.68	64.58	30.50	15.13	32
Markel Corp.	NYS	153.00	-1.29	70.00	161.13	83.00	13
MBIA Insurance Group	NYS	59.00	-2.07	16.54	67.25	45.50	943
Meadowbrook Insur. Group	NYS	23.19	-0.80	10.42	26.63	18.50	24
Mid Ocean Ltd.	NYS	62.63	-6.00	19.29	66.75	44.13	167
MMI Cos. Inc.	NYS	24.56	-3.20	-23.84	32.75	20.75	62
Mutual Risk Mgmt. Ltd.	NYS	29.19	2.19	57.77	29.75	15.00	168
NAC Re Corp.	NYS	44.38	0.85	31.00	52.88	32.63	291
Navigators Group	NDQ	18.50	0.00	1.37	22.50	15.75	10
Nobel Insurance Ltd.	NDQ	14.00	-3.45	11.44	15.38	11.38	37
NYMagic Inc.	NYS	26.63	0.00	47.92	29.81	17.50	24
Ohio Casualty Corp.	NDQ	45.50	0.00	28.17	51.00	32.00	660
Old Republic Int'l	NYS	35.81	0.00	33.88	40.19	24.63	686
Orion Capital Corp.	NYS	44.94	1.55	47.03	51.00	29.38	170
Partner Re Ltd.	NYS	41.31	-1.64	21.51	44.94	30.75	665
Penn-America Group Inc.	NDQ	18.38	-4.55	70.93	21.75	10.38	77
Philadelphia Cons. Holding	NDQ	18.63	-5.70	60.22	23.25	11.13	472
PXRE Corp.	NYS	30.31	-1.42	22.47	33.63	23.25	44
Reliance Group Holdings	NYS	12.31	-3.90	34.93	15.13	8.38	771
Reliastar Financial Corp.	NYS	34.88	-3.46	20.78	40.75	25.88	1537
RenaissanceRe Holdings Ltd.	NYS	42.25	-3.15	28.03	50.00	31.25	96
Risk Capital Holdings	NDQ	22.25	0.00	14.84	23.38	15.88	23
RLI Corp.	NYS	41.63	1.83	24.72	46.25	28.25	47
St. Paul Companies	NYS	79.50	-1.40	35.61	85.50	54.13	795
SCOR	NYS	42.75	-4.74	24.36	47.25	34.00	28
SAFECO Corp.	NDQ	46.06	-3.79	16.80	55.38	36.50	1997
Seibels Bruce Group	NDQ	7.63	1.67	-7.58	9.75	5.88	214
Selective Ins. Group	NDQ	54.75	-0.90	44.08	55.75	33.50	73
Sphere Drake Holdings	NYS	8.19	-2.96	-7.75	10.50	8.13	873
TIG Holdings	NYS	32.75	-1.69	-3.32	38.00	26.38	461
Titan Holdings, Inc.	NYS	20.94	0.60	26.89	25.00	14.00	111
Tokio Marine & Fire	NDQ	43.50	-5.18	-6.70	66.00	42.00	389
Torchmark Corp.	NYS	40.00	0.31	58.42	41.75	24.63	718
Transatlantic Holdings	NYS	69.63	0.81	29.74	76.56	47.13	162
Travelers Property/Casualty	NYS	36.50	-6.11	3.18	43.56	31.38	6145
Travelers Corp.	NYS	70.63	-4.80	55.65	76.44	41.00	11295
Trenwick Group Inc.	NDQ	34.63	-0.36	12.30	39.63	30.75	21
Unico American Corp.	NDQ	13.13	5.00	20.69	14.13	8.88	96
Unionamerica Holdings	NYS	20.13	-2.42	13.38	22.75	14.75	8
United Fire & Casualty	NDQ	39.00	-1.27	10.64	43.50	29.75	0
Unitrin	NDQ	62.06	-3.59	11.32	68.50	48.50	282
UNUM Corp.	NYS	49.44	1.41	36.85	51.31	32.88	1048
USF&G Corp.	NYS	20.06	-2.73	-3.89	25.50	15.63	2127
Vesta Insurance Co.	NYS	60.75	-3.86	93.63	64.50	29.75	269
Washington National	NYS	32.88	0.19	19.55	33.13	27.13	60
Zenith National Ins.	NYS	27.44	-1.57	0.23	28.75	24.63	47
INSURERS/REINSURERS	AVERAGE		-1.27	25.32			
HEALTH MAINTENANCE ORGANIZATIONS							
Humana Inc.	NYS	21.69	-3.07	14.14	25.31	17.38	1468
Oxford Health Plans	NDQ	24.88	-2.21	-57.52	89.00	22.88	18666
Pacificare Health Sys.	NDQ	67.50	-2.35	-16.92	86.25	55.50	213
Safeguard Health Enter.	NDQ	12.56	-2.43	-28.21	20.75	9.63	40
Sierra Health Services	NYS	36.38	-2.18	47.72	41.63	23.75	179
United Healthcare Corp.	NYS	53.25	0.47	18.33	60.13	41.50	2480
Wellpoint Health Networks	NYS	47.94	-1.03	39.45	61.13	28.25	1139
HMOs	AVERAGE		-1.83	2.43			
ALL COMPANIES	AVERAGE		-1.21	18.95			

Top advancing issues: CapMac Holdings Ltd., AEGON N.V., Unico American Corp. Leading decliners: Frontier Insurance Group, Harleysville Group, American Heritage Life Ins. Most active issue: Oxford Health Plans. The *BI* Index fell 1.29%; the Dow Jones 30 Industrials declined 0.12%; the S&P 500 gained 0.09% and the NYSE Composite fell 0.25%. Average P/E: Brokers, 25.7; Insurers/reinsurers, 38.1; HMOs, 22.0.

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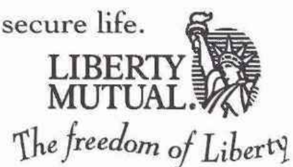

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