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Update

Murray Lawrence to step down as Lloyd's of London chairman

LONDON—Lloyd's of London Chairman Murray Lawrence said last week he will not run for re-election as chairman for 1991.

The current Council of Lloyd's announced in a subsequent statement its "wish" that David Coleridge, chairman of underwriting agency Sturge Holdings P.L.C., be elected chairman to succeed Mr. Lawrence. The next chairman will be elected by council members in December following council elections.

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C&B-Willis Faber: A perfect fit

Merger fulfills brokers' dream of offices around the world

The merger of Corroon & Black Corp. and Willis Faber P.L.C. announced last week is expected to be a perfect fit that will create the truly global broker each had long sought to become.

The combination of New York-based C&B and London-based Willis Faber into Willis Corroon P.L.C. will create the fourth-largest insurance brokerage in the world (see chart). While initially its offices will be concentrated in the United States and United Kingdom, Willis Corroon plans an aggressive acquisition program elsewhere in the world.

Under the merger agreement—currently valued at $670 million—Willis Faber shareholders will own 60% of the company, while C&B shareholders will own 40% of the new entity, which will be based in London.

Willis Faber Chairman Roger Elliott will be chairman of the new company, while Richard Miller, chairman and chief executive officer of C&B, will serve as Willis Corroon's chief executive officer based in New York. The two companies will have equal representation on the new board of directors.

The merger—which is expected to be finalized in late September or early October, subject to shareholder and regulatory approval—will help both brokers reach their publicly-stated goals of becoming global insurance brokers.

And, because the two do not share common geographic locations, they will not be faced with the costly and time-consuming task of physically merging offices that usually follows a merger of large brokers.

While the companies' executives are touting the advantages of the merger, some financial analysts complain that C&B shareholders aren't getting a fair price for their stock.

Analysts in both the United States and the United Kingdom speculate that Willis Faber may have to increase its offer before C&B shareholders will accept the deal.

However, C&B's Mr. Miller said that the two companies "haven't even discussed restructuring (the terms). We signed a definitive agreement and our stocks have been reacting much the same way our advisers indicated they would."

A spokesman for Willis Faber agreed.

Mr. Miller added that if C&B had wanted to sell the company, it would have focused on getting "a premium price."

However, the transaction is a merger and "we are building for the future," he said.

Corroon & Black executives have "done a very courageous and far-sighted thing for the

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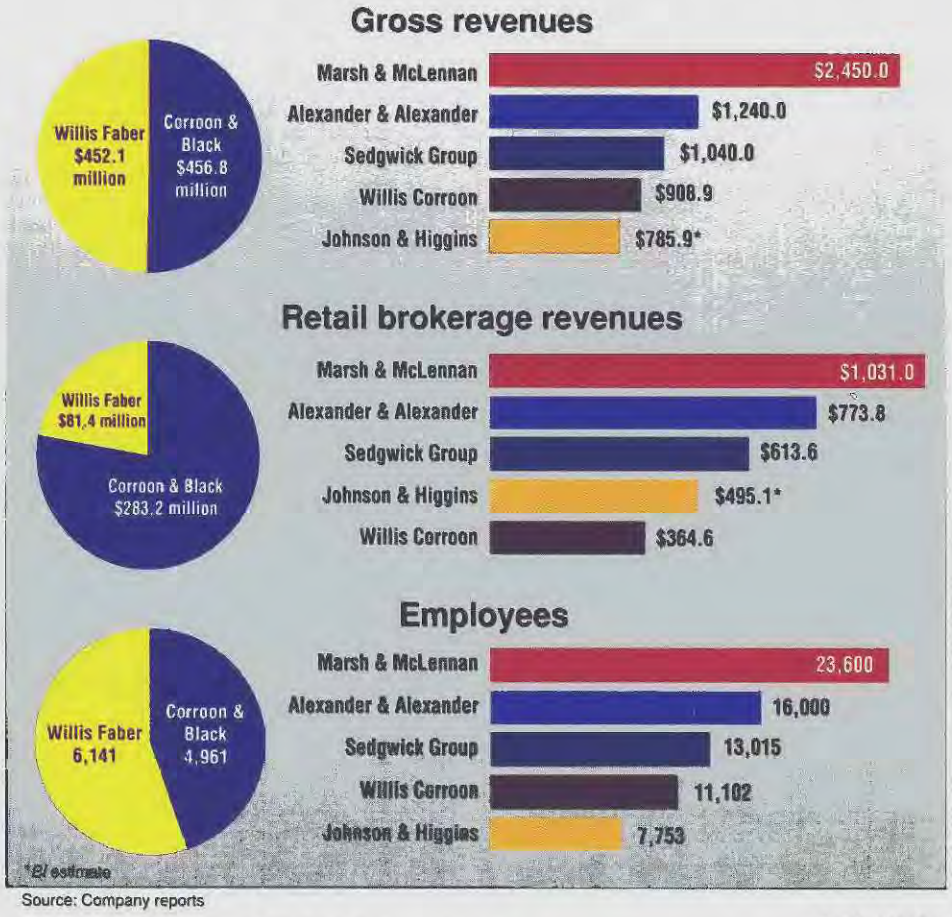
Stock analysts view merger as good long-term strategy. Page 38

Merger to strain ties between Willis Faber and Johnson & Higgins. Page 38

This story is based on reporting by Agent/Broker Editor Linda J. Collins in Chicago, Associate Editor Carolyn Aldred in London and International Editor Stacy Shapiro in London. It was written by Ms. Collins.

How Willis Faber and Corroon & Black stack up

The merger of Willis Faber and Corroon & Black will create the fourth-largest brokerage in the world, though Willis Corroon will only rank fifth in retail brokerage. Revenues in millions of dollars; all statistics are for 1989.



Source: Company reports

BI/HOLLY SEGUINE

4 states seek to bar Micronesian insurer

By DOUGLAS McLEOD

NEW YORK—Insurance regulators in four states are trying to bar a Micronesia-based insurer that they say is soliciting pollution liability and medical malpractice insurance business without a license.

The Texas, Kansas, Oregon and Massachusetts insurance departments have issued cease-and-desist orders against Trans-Pacific Insurance Co. (F.S.M.) of Micronesia, which has been identified by Texas regulators as a successor company to Casualty Assurance Risk Insurance Brokerage Co. of Guam.

CARIB was hit with cease-and-desist orders in several states starting in 1987 for soliciting medical malpractice insurance business without a license. Its license in Guam expired last year and was not renewed (*BI*, June 26, 1989).

Texas, Kansas and Oregon regulators say Trans-Pacific has offered to write pollution liability insurance for underground storage

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But risk managers oppose federal system

Comp overhaul sought

By JOANNE WOJCIK

The workers compensation system must be revamped, but it should not be replaced with a federal system, risk managers say.

However, more uniformity among separate state workers compensation systems would especially help multistate employers more easily administer their work comp programs, say risk managers responding to a *Business Insurance* Risk Management Board survey.

"While a uniform compensation system concept would be attractive, I don't have confidence in the federal system to be any less subject to inefficiency and petty politics," said the risk manager for a water treatment facility in Oregon with 250 employees.

In addition, survey respondents said work comp claim frequency and severity could be reduced if the same managed care techniques used to hold down the cost of health care benefits were applied to work comp cases.

Employers' work comp claims experience also would improve if insurers dispute more questionable claims and promote workplace safety, the risk managers responding to the survey suggested.

And, many survey respondents recommended that states take a hard stand—including criminal prosecution—against workers who defraud the work comp system.

Risk Management Board

A total of 201 risk managers responded to the survey, but not all respondents answered all questions and some gave more than one response to several questions.

The majority of survey respon-

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Broker, insurer executives address market volatility
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Louisiana insurance regulator indicted on fraud charges
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NEWSPAPER

Update

Lloyd's chairman to step down

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Mr. Lawrence has served as chairman of Lloyd's for two years after serving as deputy chairman for six years.

The announcement was a surprise because Lloyd's normally does not announce plans for the following year's chairman until November.

Alan Lord, Lloyd's chief executive, denied press speculation that the announcement was made early because of repeated allegations by members' agency director John Donner that Mr. Lawrence was privy to inside information when he ceded a runoff reinsurance policy to fellow underwriter Richard Outhwaite in 1982 (*BI*, April 23; June 19, 1989). Lloyd's Council members have studied Mr. Donner's allegations and found no evidence of any conspiracy.

According to Mr. Lord, Mr. Lawrence's decision was announced earlier than usual because of the complexity of the Lloyd's election system and the fact that the council wanted Deputy Chairman Alan Jackson to stand for re-election. Mr. Jackson's term on the council is due to end this year, and advance warning was needed to allow him to be eligible for re-election, Mr. Lord said.

Californians pick candidates

SAN FRANCISCO—Democratic state Sen. John Garamendi and Republican Wes Bannister, an insurance agent, won primaries last week in California's first elective race for insurance commissioner.

Mr. Garamendi topped the slate of seven Democrats with 813,118 votes, or 35%. TV commentator Bill Press finished second with 638,696 votes, or 28%. Conway Collis, chairman of the State Board of Equalization and endorsed by Proposition 103 author Harvey Rosenfield, finished third with 379,653 votes, or 16.7%.

Mr. Bannister got 468,875 Republican votes, or 28.2%, defeating four other candidates. John Parise, a retired insurance broker and attorney, finished second with 415,175 votes, or 25%. Tom Skornia, an attorney and vice chairman of the Assn. for California Tort Reform, finished third with 352,994 votes, or 21.3%.

Mr. Garamendi said he would "begin building a top-notch team of advisers" so by January 1991 he "will be prepared to set into motion a comprehensive, cohesive plan to rein in the insurance industry and make Proposition 103 a reality."

Mr. Bannister said he would work to implement no-fault auto insurance, including caps on drivers' liability, if he wins the November general election. He also supports tort reform.

Also appearing on the November ballot are Libertarian candidate Ted Brown and Tom Conduit of the Peace and Freedom party.

CGL covers cleanups: Court

ST. PAUL, Minn.—The costs of responding to a government order to clean up polluted property are insured damages under comprehensive general liability insurance policies, the Minnesota Supreme Court ruled Friday.

The ruling marks the fifth time a state supreme court has ruled on this issue. Earlier this year, the supreme courts of Washington and North Carolina ruled cleanup costs are insured damages, while the supreme courts of Maine and New Hampshire ruled they are not insured (*BI*, April 16; Feb. 19; Jan. 15).

The 4-3 Minnesota court ruling comes in a case in which three separate lawsuits were consolidated. The suits involved Minnesota Mining & Manufacturing Corp., Joslyn Corp. and Tonka Corp. and their CGL insurers, including Travelers Insurance Co., Liberty Mutual Insurance Co. and Bituminous Casualty Corp.

The court rejected the insurers' interpretation of a clause in the policies that states the insurers will pay "all sums the insured shall become legally obligated to pay as damages." The insurers had argued the clause means the insurers will cover actions seeking monetary relief. Government cleanup orders are not covered because they seek injunctive relief, the insurers had argued.

"The position urged by the insurance companies is contrary to our rules of insurance contract interpretation which require that undefined terms be given their 'plain, ordinary and popular meaning,' " the Minnesota Supreme Court said.

Regulators consider appeal

CHICAGO—Illinois insurance regulators are considering whether to appeal a court decision that limits the damages they can seek from companies that allegedly improperly reinsured and audited the insolvent Reserve Insurance Co. (*BI*, Nov. 6, 1989).

U.S. District Judge Charles P. Kocoras ruled earlier this month that regulators can only seek damages Reserve allegedly incurred from 1974, when the company's financial problems surfaced, until its insolvency in 1979.

Regulators previously had sought damages in connection with all of Reserve's losses resulting from the collapse. Those damages could have amounted to more than $300 million under the Racketeer Influenced and Corrupt Organizations act, which allows for the tripling of actual damages, regulators say.

Regulators were unable to estimate the current amount of allowable damages.

"Ultimately the expense has been reduced significantly—if not entirely eliminated—if the jury ultimately finds, as we believe they will, that Reserve's condition actually improved during the period in question," said Ronald Jacks, an attorney with Mayer, Brown & Platt in Chicago, who is representing Societe Commerciale de Reassurance and SCOR Reinsurance Co.

However, regulators contend the defendants engaged in a conspiracy to illegally bolster Reserve and keep it operating, said James W. Schacht, chief deputy director of the Illinois Insurance Department.

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Errors and omissions

• Financial results attributed to St. Paul Reinsurance Management Corp. in the June 4 issue are actuallly the results of the consolidated reinsurance operations of The St. Paul Cos. Inc.

NAIC approves limits on insolvency offsets

By MEG FLETCHER

BALTIMORE—The right of solvent insurers and reinsurers to offset amounts they owe insolvent companies by amounts they are owed are limited and clarified under measures approved by the National Assn. of Insurance Commissioners last week.

A controversial change generally bans "assumed vs. ceded" offsets in liquidations, which occur when an insurer that both reinsured and ceded reinsurance to an insolvent insurer combines amounts owed and due under both transactions.

"For policyholders, it's going to mean that the assets available to pay their direct claims will be enhanced and not used to pay reinsurers," said Arkansas Insurance Commissioner Ron Taylor, who marshaled regulators' votes in favor of the proposal.

Such assumed vs. ceded offsets in the Mission Insurance Co. insolvency would entitle reinsurers to $300 million that otherwise would be available to pay policyholders' claims, noted an attorney who represented outgoing California Insurance Commissioner Roxani Gillespie at the NAIC summer meeting in Baltimore last week.

State adoption of the new offset rules, some supporters say, also would appease critics who claim regulators are too closely tied to insurers.

At the very least, the amendments should send a message to judges who consider offset-related cases, supporters say.

However, some major insurer trade associations and other critics of the restrictions doubt many states will seriously consider the measure and vow to oppose its adoption.

They say that changing a centuries-old public policy concerning offsets may lead to reduced availability of reinsurance. As a result, insurers would have to pay more for reinsurance and would pass those costs on to policyholders.

The compromise amendments to the NAIC Insurers Supervision, Rehabilitation and Liquidation Model Act ended nearly three years of wrangling.

Final changes hammered out at the meeting last week also sought to preserve regulators' ability to

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Allegedly used office to aid insurer

Louisiana's Green indicted

By STACY ADLER

NEW ORLEANS—Louisiana Insurance Commissioner Doug Green used his position to benefit the now-insolvent Champion Insurance Co. in exchange for $2.2 million in campaign contributions, a federal indictment says.

Mr. Green faces 16 criminal counts of conspiracy, mail fraud and money laundering in connection with the 1989 collapse of the Baton Rouge, La.-based auto insurer. If convicted on all counts, Mr. Green would face a maximum penalty of 125 years in prison and $4.75 million in fines.

"As a result of financial benefits received by himself, members of his family and his campaign," Mr. Green used his office to benefit Champion, the June 5 indictment charges.

Mr. Green, the indictment charges, failed to take appropriate action against the insurer despite numerous complaints, promoted legislative changes favorable to Champion, insured favorable results on audits of Champion and blocked attempts by others to perform audits.

He was also charged with secretly altering Champion's rate structures and hiring and firing state employees who were favorable or unfavorable to John Eicher and his son Naaman Eicher, the owners of Champion.

"It was a further part of the scheme and artifice to defraud that Doug Green and others acted to conceal the true financial condition of Champion Insurance Co. and its failure to promptly pay claims arising under its policies, which allowed Champion to continue to sell insurance polices and receive premiums at a time when it was not paying claims timely," according to the indictment.

Champion was declared insol-

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APIW names St. Paul's Nelson Insurance Woman of the Year

By LAURA MAZZUCA

NEW YORK—Janet R. Nelson, president and chief operating officer of St. Paul Surplus Lines Insurance Co., is the recipient of the 1990 Insurance Woman of the Year award from the Assn. of Professional Insurance Women.

The APIW is recognizing Ms. Nelson for her contributions to the insurance industry during her 17-year career.

"Ms. Nelson is dedicated to a high standard of excellence in her position," said APIW President Marsha Cohen, who is assistant vp and corporate secretary of American Royal Reinsurance Co. of New York.



Ms. Nelson

"She instills the same level of professionalism in the people who work for her," Ms. Cohen said.

Ms. Nelson was named president of St. Paul Surplus Lines in 1989. St. Paul Surplus Lines ranked as the fifth-largest surplus lines insurer last year based on $134.3 million in direct premiums on a non-admitted basis in 1988 (*BI*, Aug. 14, 1989).

The actuarial department of an insurance company is not the typical first step in a career path to the front office, but it worked for Ms. Nelson.

Ms. Nelson began her career as an actuarial trainee at The St. Paul Cos. Inc. in 1973.

Ms. Nelson impressed St. Paul management early because of her

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Inside

✔ Charles H. Keating Jr. is suing a group of directors and officers liability insurers seeking coverage for the defense of fraud lawsuits filed in connection with the sale of American Continental Corp. bonds. **PAGE 4**

✔ Similarities between the current insurance industry's solvency woes and those of the savings and loan industry a few years ago are not so outrageous, warns this week's editorial. **PAGE 8**

✔ Experts tout the savings from substance abuse programs at a recent seminar for policyholders of Argonaut Insurance Co. **PAGE 15**

✔ In Perspectives, Rep. John D. Dingell, D-Mich., urges the insurance industry to identify and deal with insurer insolvencies before it is too late. **PAGE 23**

✔ The heads of several East German industrial conglomerates call for assistance with emerging insurance and risk management issues. **PAGE 29**

✔ Speakers at a Bermuda conference on global insurance examine insurance opportunities around the world. Coverage begins on **PAGE 29**

✔ The integration of E.C. insurance markets will produce instability and depressed profits for insurers, contends a Standard & Poor's Corp. report. **PAGE 29**

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Georgia ruling benefits public entities

Sovereign immunity safeguarded

By STACY ADLER

ATLANTA—A recent Georgia Supreme Court decision could encourage public entities in the state to set up informal self-insurance programs for liability risks without imperiling sovereign immunity.

The state's highest court refused May 31 to reconsider its ruling that a pay-as-you-go self-insurance plan is not the equivalent of insurance.

The ruling is significant because Georgia law provides state and local governments with sovereign immunity for tort claims only if the public entities do not have liability insurance.

Under the Georgia Constitution, a public entity is only immune from tort claims up to the point at which its liability insurance attaches and for amounts that exceed its liability insurance limits. However, if a public entity has no liability insurance, it is immune from tort claims, according to the constitution.

Sixteen other states also restrict use of the sovereign immunity defense to public entities without liability insurance.

Such laws that hold that governments are liable for tort claims if they have insurance are designed to compensate victims injured by the acts of government officials, explained John C. Pine, associate professor of industrial technology at Louisiana State University in Baton Rouge. Mr. Pine is the author of "Tort Liability Today," a joint publication of the Public Risk Management Assn. (PRIMA) and the National League of Cities, which tracks state laws regarding governmental immunity.

As of 1988, 17 states had laws under which the purchase of liability insurance constituted a waiver of governmental immunity up to the limits of the policy, according to "Tort Liability Today." Mr. Pine is updating the publication, and a new edition is due out in August or September.

While such laws may appear to discourage governments from purchasing commercial liability insurance, that is usually not the case, says Mr. Pine.

"Fears that the law could change and the governmental immunity could be lost causes governments to buy liability insurance," he said. "There is a belief that the immunity is unstable."

In addition, the purchase of liability insurance sends a message that "even though we may not be legally liable, we want to compensate victims," said Mr. Pine.

In addition, many public entities that do not purchase commercial insurance set up some kind of self-insurance program for the same reasons.

The Georgia Supreme Court ruling stemmed from an accident in which a police car driven by Richmond County sheriff's deputy Mike Logue hit a car driven by another motorist, injuring her and destroying her car. The officer was responding to call about a fight, but failed to use his siren or blue light when he drove through a red light.

When the victim sued, Richmond County invoked its governmental

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HMO drug cost policies may endanger quality of care: NAEHCA chief

By CHRISTINE WOOLSEY

PALM BEACH, Fla.—The failure of some HMOs to disclose their use of certain prescription drug cost containment measures can compromise quality of care and may expose employers to increased liability, warns the head of a business group concerned with managing health care costs.

Employers must make sure any restrictive prescription drug cost containment policies are spelled out in contracts with health maintenance organizations and are clearly explained to employees, advises Ruth H. Stack, president of the National Assn. of Employers on Health Care Action in Key Biscayne, Fla.

"Employers should be questioning what effect these restrictive policies have on quality health care and what liability issues they raise," Ms. Stack said at the 14th annual NAEHCA meeting, held May 30-June 1 in Palm Beach, Fla.

Corporations fear that HMOs' failure to disclose these policies could eventually expose employers to employee lawsuits if employees do not receive the proper type of prescription drugs, she said.

NAEHCA recently surveyed a broad cross-section of HMOs on their prescription drug cost control policies.

The survey's objective was "to determine how widespread the adoption of these restrictive policies has been, how such restrictions are being enforced and to what extent employers and employees are being informed" of any restrictions, Ms. Stack explained.

Prescription drug costs comprise only 4.5% to 7% of HMO health care costs, she noted. But, "they have been a growing component," and that is why use is being restricted, Ms. Stack said.

Prescription drugs "play a major role in maintaining a healthy workforce. Limiting access to drugs could have significant quality, cost and legal ramifications that employee benefit managers

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Groups can't agree on strategy to curb health care inflation

By DEBORAH SHALOWITZ

CHICAGO—Health care consumers, payers, providers and the government agree there must be a national strategy to control health care costs.

However, the parties cannot agree on the direction the strategy should take, the health care experts add.

"We all want the same thing," said Robert Vraciu, vp of strategic planning for HealthTrust Inc., a Nashville, Tenn.-based company that owns and operates 90 hospitals in the United States. "The way in which we get there is what's in dispute."

"We've got to get the key players together for a give-and-take discussion," Mr. Vraciu said at the Midwest Business Group on Health's 10th annual conference, held May 30-June 1 in Chicago.

"We're in this together," agreed Hank Scheff, director of budget and benefit analysis for Council 31 of the American Federation of State, County and Municipal Employees in Chicago. "These costs are hurting all of us."

"We have to expand our vision of what's politically possible," Mr. Scheff said.

"The health care system is basically out of control," said Fosten Boyle, vp of human resources for Minneapolis-based Honeywell Inc.

"There is a crisis" in health care, agreed Rep. Willis D. Gradison Jr., R-Ohio, ranking minority member of the House Ways and Means Committee's Subcommittee on Health.

"We have a crisis in this country in health care," said Charles Inlander, president of the People's Medical Society, a consumer group based in Allentown, Pa.

"We just cannot afford business as usual" in health care, said David McCammon, vp of finance and treasurer for Ford Motor Co. in Dearborn, Mich. "We at Ford believe this is a serious national problem requiring a national response."

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Industry's dynamics misunderstood: Execs

By LINDA J. COLLINS

SEA ISLAND, Ga.—The volatility of the commercial property/casualty insurance market is raising the ire of insurance buyers and legislators, a panel of insurer and broker executives concedes.

And, while the executives have varying opinions on how best to address policyholders' and lawmakers' concerns, the panelists agreed at the National Assn. of Insurance Brokers annual meeting earlier this month that many insurance buyers do not fully understand either the dynamics or realities of the insurance business—of which volatility is an inherent part.

Contributing to this misunderstanding is that while the media and legislators largely focus on personal lines problems, they paint the property/casualty insurance industry with one broad brush that fails to differentiate between commercial and personal lines, said Donald R. Bell, chairman and chief executive officer of Frank B. Hall & Co. Inc. in New York.



Some insurers' focus on quality of service is 'an encouraging sign and one others would do well to emulate.'
— Robert Clements

Adding to this misconception is that insurance brokers often play a "dual role," acting in some situations as "providers of services on a very professional level" and in others as "pushers of products" like personal and small commercial package policies, added Richard M. Page, chairman of Sedgwick James Inc. in New York.

However, brokers often "don't differentiate when we talk about ourselves publicly as to these dual roles," Mr. Page added.

Furthermore, insurers are "in the very same position. (They) want to be perceived by the public as underwriters, but many of us don't perceive insurance companies as being underwriters at all. We perceive some companies as being underwriters and some as being investment bankers," he said.

Before these public misconceptions about insurance can be addressed, members of the insurance industry must start "with a basic analysis of ourselves" and then explain "what it is that we do and how we do it," Mr. Page said.

William E. Thiele, president and chief operating officer of Continental Corp. in New York, agreed that an "increasingly sharp distinction" should be drawn between personal and commercial insurance, "which I think we would all rather see treated differently."

Also confusing the public is the industry's tendency to characterize the market as either hard or soft, when market activity may vary by line, he said. For example, while some lines of coverage may be very competitive today, a hard market exists for personal auto insurance buyers and small buyers of workers compensation coverage, he explained.

Insurers have "made some tactical errors in the way we handle our own public relations" by adopting a passive role and waiting for society to make the rules, "either explicitly through legislation or through court actions," Mr. Thiele noted.

The standard insurer argument that "all we ask is stable rules and a level playing field and we'll run an efficient system" is no longer "playing very well. We're too big an industry and we have too much capital in play," Mr. Thiele said.

Consumers today expect the insurance industry to create or advocate creative solutions to coverage and exposure problems, but "we have a long way to go," he added.

However, Robert Clements, chairman of Marsh & McLennan Inc. in New York, said the insurance industry focuses too heavily on public relations and pricing issues at the expense of quality service.

This presents "a kind of a commodity view of the business, and commodities are always going to be cyclical and volatile," he added.

Mr. Clements observed, though, that some insurers have continued to pay attention to the quality of their services over the last five years, which is "clearly an encouraging sign and one others would do well to emulate."

Those insurers, in addition to paying claims in a timely fashion and issuing policy documents with fewer errors, also foster nurturing, long-term relationships with their policyholders rather than treating them as adversaries, Mr. Clements said.

When insurers adopt an adversarial approach to claims handling, this further exacerbates public ire, said Hall's Mr. Bell. One way to avoid this is for insurers to underwrite their policies up front "and not at the time of the claim," he stressed.

"As simplistic as that is, the perception of the general public (both commercial and personal insurance buyers) is that each time a policyholder has a claim, he first has to be put through the pangs of Hell to determine if there was coverage or there wasn't coverage," Mr. Bell said.

'There are some things that are simply uninsurable. We didn't make them so. Courts and legislatures have done that.'
— Maurice Greenberg



When an insurer plays an adversarial role in interpreting a policy or responding to a claim, buyers are left without an understanding of the insurance industry and with a perception that they are "buying something that's not only intangible at best, but when it comes time to collect it, it doesn't exist," he said.

However, Maurice R. Greenberg, chairman and chief executive officer of American International Group Inc. in New York, argued: "That's a two-way street. Every policy that's written doesn't cover every loss that's made."

He indicated that sometimes brokers are to blame, in that they should not portray policies as being "all risk" when they present them to their

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Keating seeks defense cover in S&L suits

By LOUISE KERTESZ

LOS ANGELES—The central figure in one of the nation's largest savings and loan failures is suing a dozen directors and officers liability insurers, seeking defense coverage in lawsuits charging him with fraud and racketeering in the sale of American Continental Corp. bonds.

Charles H. Keating Jr., chairman of the Phoenix-based financial services and development holding company, also seeks unspecified punitive damages from the insurers.

The suit charges that insurers agreed to an interim funding arrangement last August with Mr. Keating and his law firm, which is also named as a plaintiff, even though insurers knew they would not pay defense costs.

Many of the insurers that wrote a portion of the D&O coverage—which provides $4 million in primary limits—are units of London United Investments P.L.C. that have suspended claims payments amid concerns about their reserves (*BI*, April 2).

However, an attorney for the insurers said they are not required to defend Mr. Keating or his fellow executives, noting that the policy, which includes defense costs within policy limits, stipulates no payments will be made until a suit is resolved.

Still, the insurers already have paid more than half of Mr. Keating's legal expenses, he said.

Also, said the defense attorney, a May court ruling may force American Continental's commercial general liability insurer to pay Mr. Keating's defense costs.

Both the defense cost coverage suit and underlying civil and criminal suits against American Continental executives stem from bond sales by the company, which is seeking reorganization under Chapter 11 of the Federal Bankruptcy Act.

A class-action suit charges Mr. Keating and about 15 other American Continental executives with fraud. The suit charges that the defendants promised the American Continental bonds were "just as safe as federally insured CDs," paid slightly higher interest and that the now-insolvent American Continental unit Lincoln National Savings & Loan would stand behind them.

Banking officials put Lincoln's insolvency at $2 billion, making it the most expensive S&L failure.

In addition, a $1.1 billion lawsuit filed by Resolution Trust Corp., the federal agency that is taking over failed thrifts, charges Mr. Keating and other American Continental directors and officers with violating the federal Racketeer Influenced and Corrupt Organizations act in connection with the bond sales.

The bonds should have yielded more than $200 million, according to the RTC.

Mr. Keating's suit against the insurers, filed May 31 in Los Angeles Superior Court, seeks $378,000 in defense costs already incurred by Mr. Keating and other officers.

Defense costs eventually "could amount to $30 million to $50 million," said James Ham, an attorney for Mr. Keating with Quinn, Kully & Morrow of Los Angeles.

The suit also seeks punitive damages, alleging that "the defendants knew that some or all of the insuring defendants were insolvent and/or unable or unwilling properly to pay for Keating Jr.'s legal fees and expenses" but did not inform American Continental or its lawyers.

The insurers "kept promising everything was fine, go ahead, don't worry about it, just go ahead and start spending huge sums of money," Mr. Ham said. "We got conned."

However, insurer attorney Roswell Bottum contends "the suit is really without merit."

Mr. Bottum, a partner with Bottum & Feliton of Los Angeles, said the policy does not require insurers to immediately defend the American Continental executives. The D&O policy, written in February 1988, says insurers will make "no payment until after a final resolution of any liability," said Mr. Bottum.

"But Mr. Keating and his attorneys said, 'We need money,' so without any obligation to do so, the underwriters entered into an interim funding agreement," he said.

Although no payment timetable was established under the agreement, the insurers already have paid Quinn, Kully $205,000, Mr. Bottum said.

Among the insurers named in Mr. Keating's suit are six LUI units:

- Walbrook Insurance Co. Ltd. The lead underwriter on the H.S. Weavers (Underwriting) Agencies Ltd. line slip suspended underwriting in late March amid concern over loss reserve adequacy (*BI*, April 9; April 2).
- El Paso Insurance Co. Ltd.
- Kraft Insurance Co., now Kingscroft Insurance Co. Ltd.
- Lime Street Insurance Co. Ltd., formerly Louisville Insurance Co. Ltd.
- Ludgate Insurance Co. Ltd.
- Mutual Reinsurance Co. Ltd.

Walbrook is the only LUI unit named in the suit that is continuing to pay claims.

Anglo American Insurance Co. Ltd., which wrote the other 45% of the Weavers line slip, also is a named defendant. Although Anglo American parted company with Weavers in April, it has said it will stand by commitments it made while on the Weavers line slip (*BI*, April 23).

Other insurers that underwrote the D&O policy and named as defendants include Compagnie Europeene D'Assurances Industrielles S.A.; Assicurazioni Generali di Trieste e Venezia; and Commercial Union Assurance Co. P.L.C.

Two U.S. insurers also are named: Associated International Insurance Co. of Los Angeles, a unit of Willis Faber P.L.C., and Virginia Surety Co. Inc., a an Aon Corp. unit.

Mr. Bottum also contends that the insurers should not have to pay defense costs relating to the federal charges. "No D&O policy in the world covers racketeering," he said.

Mr. Bottum also pointed to a May 17 federal court ruling in a September 1989 suit filed by Mr. Keating against American Continental's primary commercial general liability insurer, National Union Fire Insurance Co. of Pittsburgh, Pa.

In that case, Judge Stephen V. Wilson of the U.S. District Court for the Central District of California ruled that "advertising injury liability coverage" under the National Union policy should pay for the costs of defending Mr. Keating against claims that he used deceptive advertising to sell American Continental bonds.

Mr. Ham contends that decision "does not affect" Mr. Keating's suit for defense costs and punitive damages.

National Union, a unit of American International Group Inc., plans to appeal Judge Wilson's decision, says its attorney.

Advertising injury traditionally occurs when a firm misappropriates a policyholder's goods and "palms them off" as its own, said attorney Susan Hoffman of Buchalter Nemer Fields & Younger of Los Angeles. "There has to be an element of unfair competition."

National Union's policy is not intended to cover misrepresentation and fraud, as allegedly occurred in the bond sales, Ms. Hoffman said. ■

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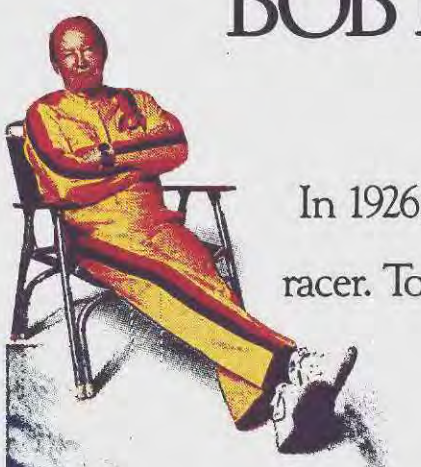
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Pizza company offers child care center

By MICHAEL SCHACHNER

Benefit beat

Employees of Little Caesar Enterprises Inc. and its affiliates in Detroit will soon be able to place their infant and preschool-age children in a child care center developed by the company.

The Detroit-based pizza maker plans to open the facility—which will handle 40 children between the ages of 6 weeks and 5 years—in its corporate headquarters in August.

Corporate employees, workers at individual Little Caesar restaurants in the Detroit area and employees of the Detroit Red Wings professional hockey team, which is owned by Little Caesar, will have access to the "Fox Tots" child care program.

The program is not designed to generate a profit, and Little Caesar will assume a portion of each participating employee's cost for the program, according to Denise Ilitch Lites, senior executive vp for Little Caesar.

However, Ms. Lites would not specify how much of the weekly cost the company would pick up.

Each employee's share would range between $85 and $100 per week, depending on the age of the child, she said.

The child care center will be housed on one floor of the company's 10-floor corporate office building, which recently underwent renovation to house the center, according to Ms. Lites.

The Merill Palmer Institute, a child care services company, will staff and operate the child care center, she said. There will be at least one staff professional for every three children at the center, Ms. Lites said.

The company decided to develop the facility because "companies that don't choose to offer this benefit will soon be forced to," Ms. Lites explained.

"There's a real need for this kind of program with such a young workforce," she said.

"We're hopeful that good employees with young children will want to come and work for us because of this," she added.

Quality of care survey

Employee benefit managers will be paying greater attention to the quality of the nation's health care delivery system over the next few years, according to a survey conducted by Metropolitan Life Insurance Co.

Met Life's "Spring Health Poll" of 100 corporate benefit managers from firms of various sizes found that 63% of the respondents believe that quality of health care will become "somewhat" or "much more" significant an issue over the next two years.

Survey respondents cited two major reasons why quality of care is becoming a greater concern for them:

- A desire to provide the best care for the least cost.
- A desire to improve the quality of care delivered by health maintenance organizations, preferred provider networks and other forms of managed care.

In response to these concerns, 52% of the respondents to the survey said they planned to develop a formal approach to managing the quality of the health care provided to their employees, while 17% said they already had such a program in place.

However, 26% said they had no intention of exploring the management of quality health care, and the remaining 5% said they were not sure whether they would develop a quality management program.

The survey asked benefit managers to list the types of health care plans they currently offer to employees:

- 89% offered traditional indemnity plans with utilization review components.
- 29% provided indemnity plans without utilization review.
- 81% offered traditional HMOs.
- 6% offered open-ended point-of-service HMOs, which allow members to receive services outside of the HMO network at reduced benefit levels.
- 19% offered PPOs.

Benefit managers who responded to the survey reported that point-of-service plans offer the highest quality of care, followed by, in descending order, PPOs, indemnity plans with UR elements, indemnity plans without UR elements and HMOs.

The most effective quality control mechanisms cited by survey respondents were managing high-risk cases, cited by 96% of the respondents; implementing inpatient utilization review procedures, 93%; reviewing inpatient procedure appropriateness, 88%; implementing outpatient UR, 86%; treatment review, 84%; reviewing outpatient procedure appropriateness, 83%; offering wellness programs, 79%; obtaining informal employee feedback, 70%; analyzing provider credentials, 70%; maintaining reports on employee complaints about health care quality, 69%; and conducting formal employee surveys, 65%.

The survey also asked benefit managers who should be most responsible for monitoring quality of care.

Forty percent said providers should be responsible, while 22% said the employer should be responsible, 20% said insurers and 9% said the UR vendor.

In addition, 2% of the respondents said government agencies should handle the task, 2% said private review agencies should monitor quality and 1% said the patient should be responsible. Four percent were not sure.

Benefit managers were asked to rank—using a scale of 1 to 5, with 1 being "most effective" and 5 being "least effective"—the group that is most effective at monitoring the quality of health care. The survey reported that:

- Insurance companies or managed care vendors received a 2.82 mean rating.
- UR vendors received a 2.87 mean rating.
- Health care providers received a 3.01 mean rating.
- Employers received a 3.22 mean rating.
- Governmental agencies received a 3.86 mean rating.

The Health Poll is published by the Managed Care Services Group, a unit of Met Life.

Copies of the Spring Health Poll can be obtained for free by writing Stephanie Valeiko, Managed Care Services Group, 276 Post Road West, Westport, Conn. 06880. ■



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Opinions

Insurers following S&Ls?

SIMILARITIES BETWEEN the savings and loan industry several years ago and the insurance industry today are not as far-fetched as some industry defenders contend.

As Fireman's Fund Insurance Co. President Joseph W. Brown Jr. commented recently, the comparisons may be flawed, but insurers that dismiss them reflexively "are missing an opportunity" to learn from the mistakes in regulation of S&Ls (see story, page 33).

Regulatory constraints on insurers' ability to properly price auto insurance and the cost of toxic tort litigation, for example, could usher in an insurance crisis on the scale of the S&L debacle, warns Mr. Brown.

The total cost to taxpayers of the insolvencies of savings and loans across the country is estimated at $300 billion.

The comparison between the insurance industry and S&Ls previously was been drawn by Rep. John D. Dingell, D-Mich., as chairman of the House Energy and Commerce Committee and the Oversight and Investigations Subcommittee.

Based on his subcommittee's investigation of several large insurance company insolvencies in recent years, Rep. Dingell concludes that, as in the S&L industry's past, there is too much fraud in the insurance industry and too little regulation to stop it or to ensure insurer solvency (see Perspective, page 23).

Certainly there is fraud in the insurance industry. We have reported all too often on elaborate schemes that allow intermediaries to skim large commissions from premiums, leaving little of the original premium to pay claims. And we report regularly on regulatory efforts to stop inadequately financed and unregulated insurers from underwriting insurance.

But, seldom do these cases result in any criminal prosecution of the perpetrators. There is too little interest in prosecuting insurance fraud because cases would be complicated to present and there often appears to be a fine line between fraud and mismanagement.

That has been an excuse in the failure of regulators to prosecute for fraud in the insolvencies of savings and loans.

Although the crooks in the insurance business generally have been playing for smaller stakes than what has been alleged in some notorious S&L cases, no one can say that the con artists won't set their sights higher in coming years.

Another valid comparison between the insurance industry and S&Ls is the potential influence of government guarantees of payment on consumer choices.

When S&Ls were competing for depositors by promising higher and higher interest rates, consumers could shop for the highest rates without concern about the soundness of the institution because they knew the government guaranteed deposits.



Insurance buyers—to a point—can adopt the same attitude, knowing that state guaranty funds will step in to cover claims against insolvent licensed insurers.

While solvent insurance companies cover these costs in the first instance, in some states they can deduct at least a portion of these assessments from their state premium taxes—ultimately making taxpayers bear some of the burden for the guaranty fund.

The National Assn. of Insurance Commissioners is attempting to improve state regulation of insurer solvency, including the development of more strict requirements on insurers and the establishment of minimum regulatory standards and procedures for states to follow.

Mr. Brown of Fireman's Fund suggests that "with a little bit of luck and a lot of management in the 50 states, the National Assn. of Insurance Commissioners can get most of the job done."

The General Accounting Office also recently suggested that improved state regulation of reinsurance, in particular, should be given an opportunity to prove effective before alternatives are considered.

But, as Mr. Brown points out, if the states can't effectively regulate the insurance industry "the problem is big enough that something needs to be done" on the federal level.

The insurance industry—including insurers, brokers and consumers—should respond to Rep. Dingell's invitation "to work with Congress now to address solvency issues while the memory of the savings and loan crisis is fresh."

Reform of insurance regulation in light of the S&L crisis—whether at the state level, the federal level or a combination of both—will be more thoroughly considered and carefully drawn than reform rushed through in the midst of a solvency crisis.

County's action outrageous

IT'S OUTRAGEOUS THAT a Georgia county, having successfully secured its governmental immunity from tort liability for an accident it admits was its fault, withdrew its settlement offer to the victim.

The Georgia Supreme Court confirmed its ruling that government entities in Georgia without commercial liability insurance have total discretion over whether to pay losses to victims of their actions (see story, page 3).

We fail to see any rational reason for this, but it's the law in Georgia.

Given the law, Richmond County's decision to not pay the plaintiff damages for an accident that was the county's responsibility just because it proved it did not have to pay was an abuse of its discretionary authority.

Unfortunately, one has to admit that it's not only plaintiffs' attorneys that can be accused of abusing the tort system.

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HMO drug costs

Continued from page 3

need to consider," she warned.

Questionnaires were sent to 574 HMOs in 1989, and 58% responded.

Of the pharmacy arrangements reported by the HMO respondents, 32.6% reported having on-site pharmacies, 68.0% said they contract with independent pharmacies, 76.7% contract with pharmacy chains and 9.4% reported having mail-order arrangements.

The survey found that many HMOs "are adopting restrictive drug practices," according to Ms. Stack. More importantly, "significant numbers of HMOs do not reveal" these practices in employer contracts or in benefit brochures that are distributed to employees, she said.

About 79% of the HMOs surveyed said they substitute generic equivalents for brand-name pharmaceuticals. Not all, however, told employers or members of this practice. Only about three-quarters—75.4%—of the HMOs that use this cost containment measure said they disclosed the policy to employers, and slightly fewer—72.7%—described it in members' brochures, the survey found.

Limited formularies restrict HMO physicians to a list of prescription options and are the second most popular cost-cutting tool among the survey respondents, according to Ms. Stack.

About 40% of surveyed HMOs said they have limited formulary policies but, of those, fewer than 60% said they told employers or members of this practice, the survey found.

Twenty-nine percent of the respondents use capitation to control prescription drug costs. Under this practice, pharmacies are paid a fixed per-member fee, rather than payment for each prescription. But, of those HMOs that use capitation, only a fifth explained this in employer contracts, said Ms. Stack.

Two more practices—therapeutic substitution and step therapy—are among the least popular but most troublesome prescription cost-cutting measures used by HMOs, contends Ms. Stack. Both can seriously effect the quality of care, she added.

Sixteen percent of surveyed HMOs reported using therapeutic substitution—in which pharmacists fill prescriptions for some drugs with therapeutically similar, but chemically different substitutes, sometimes without ever informing the doctor.

Of HMOs using therapeutic substitution to reduce costs, only 43% disclose the practice in employer contracts and only 30% reveal it in benefit materials distributed to members, Ms. Stack pointed out.

In addition, NAEHCA found that 9.7% of the HMOs surveyed use step therapy—in which drugs are prescribed in a predetermined sequence—to hold down costs.

"The policy requires a doctor to begin a patient's treatment usually with the least expensive drug available and to use a more costly medication only after" less expensive alternatives prove ineffective, explained Ms. Stack.

However, only 28.1% of the HMOs adopting this cost containment policy revealed its use to employers, while 18.7% mentioned it in benefit brochures, she said.

Ms. Stack said the survey also revealed that it isn't always clear who sets pharmaceutical policies within a managed care network: a central source or individual local plans.

More than half—53%—of the HMO chains surveyed and 39% of those HMOs managed by another company said a central authority—either the chain or the management company—established pharmaceutical policies, she said.

In addition, 46% of the chains and 27% of HMOs with management contracts said a central authority—not individual plans—decide whether and how to explain drug restrictions to plan members.

The implication, she said, "is that if you contract with a regional or national HMO chain, you need to be aware that the policies may not be centrally determined, but rather left to the discretion of the local organization."

In addition, employers need to question how policies may differ among various locales, she said.

Because these cost containment policies tend to limit what medications can be prescribed or how a pharmacist fills prescriptions, "they place significant restrictions on the pharmaceutical products HMO members may ultimately receive" and will continue to do so in the future, Ms. Stack said.

Employee benefit managers should seek as much information from HMOs about their prescription drug cost-containment policies and whether or not they are spelled out in contracts and employee benefit literature, she said.

In addition, "NAEHCA recommends that employers set up corporate panels of appropriate staff including medical directors, lawyers and benefit managers," she said. This panel should review alternative health care plans "to ensure that the choice of HMOs meets the company's best interests with regard to quality, costs and legal issues."

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For a copy of the survey when it is released later this summer, send $25 to National Assn. of Employers on Health Care Action, P.O. Box 220, 240 Crandon Blvd., Suite 110, Key Biscayne, Fla. 33149; or call 305-361-2810.

NAEHCA forum attracts 175

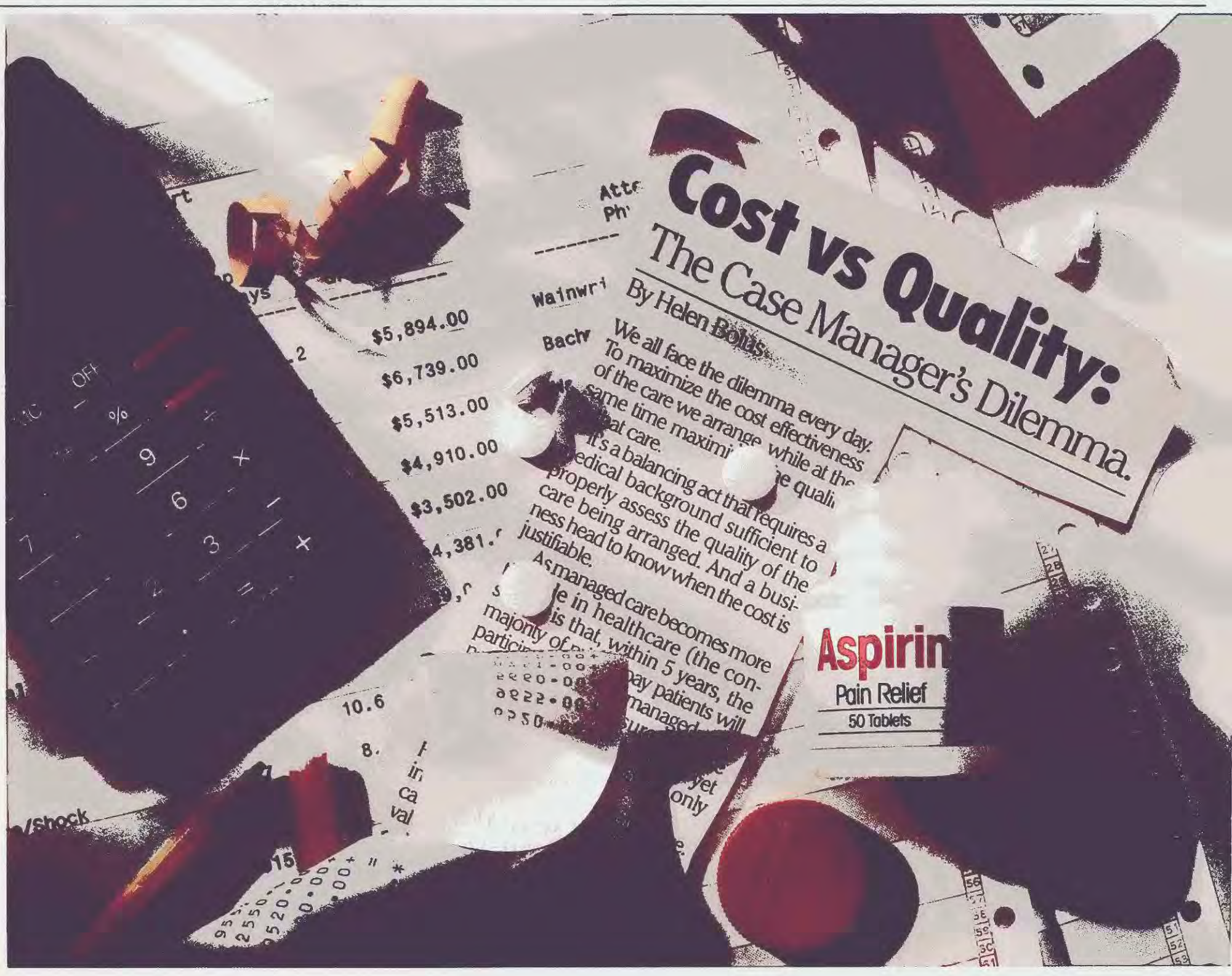
PALM BEACH, Fla.—About 175 people attended "Managed Health Care in the 90s," the 14th annual conference of the National Assn. of Employers on Health Care Action May 31-June 1 in Palm Beach, Fla.

Topics discussed at the conference included the future of managed care, mental health care cost containment and prescription drug programs. About 27 health care cost containment companies, including preferred provider networks, pharmaceutical manufacturers, insurers and utilization review vendors exhibited at the conference.

The association promotes managed health care from the employer's perspective. Its members include Fortune 500 companies and medical and health care benefits professionals. NAEHCA aims to provide resources and a forum to develop better, cost-effective health management programs for employers and health care organizations.

Conferences typically focus on issues affecting the management of health care services, delivery options, cost containment and quality assurance. Its next managed care conference will be May 16-17, 1991, in San Jose, Calif. Another meeting—"Quality in the Age of Liability"—is scheduled for Oct. 18-19 in Key Biscayne, Fla.

For more information, contact Ruth H. Stack, President, NAEHCA, P.O. Box 220, 240 Crandon Blvd., Suite 110, Key Biscayne, Fla. 33149; 305-361-2810.



Health care data analysis vital to cost control

By CHRISTINE WOOLSEY

PALM BEACH, Fla.—Data collection and analysis are vital to employer efforts to control rising health costs, says a leading health care expert.

"To effectively manage employee health and benefit costs in the 1990s, buyers of group health care services must have access to meaningful data," said Iris P. Masotti, president of National Health Management Inc., a Chicago firm that gathers and analyzes such information.

Employers increasingly are requesting data to use in comparing the performance of health maintenance organizations, she said.

"Buyers will be confronted with a number of options to manage health care costs in the next decade," said Ms. Masotti at the 14th annual National Assn. of Employers on Health Care Action conference, held May 31-June 1 in Palm Beach, Fla.

However, data and analysis of those figures are necessary for "selecting and evaluating provider organizations, monitoring and assessing new programs, reducing potential fiduciary liability, justifying needed (health plan) changes to employees and unions, controlling costs and improving the health of the workforce," Ms. Masotti explained.

Benefit managers often encounter difficulty in getting top management to recognize the need for basic management and analytical tools because theirs' is not typically a revenue-generating department, she said.

And, she pointed out, many employers—even fairly large companies—find HMOs are not very responsive to requests for data. Some road blocks HMOs cite when employers request information are real, but others are manufactured, she said.

However, "many companies may not be able to negotiate HMO rates based on medical plan costs if they do not have access to actual employee utilization" data, Ms. Masotti said. And, employers may find it difficult to "differentiate high-quality, cost-efficient plans from those providing inferior clinical or administrative services" if they cannot obtain data, she noted.

Access to information early on will help benefit managers make important decisions concerning the direction their managed care plans will take in the next decade, Ms. Masotti said. She pointed out several elements that must be present if employers are to collect meaningful data.

First, "data must be accurate. That may sound simple, but it's not," she said. "So many organizations are used to generating reports that they don't think will be assessed carefully by companies, they don't worry about filling in accurate information."

For example, if an HMO is attempting to generate a utilization report and a data processor finds that some of the information needed in the data base is missing, many times the data processor will simply plug in a random number.

Data must be valid, as well, she continued. Data bases should contain a sufficient number of employees and dependents from which to draw conclusions.

Timely data is important, Ms. Masotti also stressed. Current data should be available, and if comparisons are being made to other plan years, benefit managers should be sure that the same time periods from year to year are being compared.

Ms. Masotti said "benefit directors are disappointed and stymied by their inability to obtain sufficient information to determine whether or not HMOs are providing value."

However, she did concede that HMOs are becoming more responsive to employer needs.

Ms. Masotti said creative new methods for assessing HMOs "will provide new management tools for buyers, and promote more cooperative relationships between buyers and providers."

'To effectively manage employee health and benefit costs in the 1990s, buyers of group health care services must have access to meaningful data,' says Iris P. Masotti, president of National Health Management Inc. in Chicago.

She illustrated how data can be used to zero in on utilization differences between three HMOs an employer used in one community.

Using graphs, she pointed out that—after adjusting for age and sex variations—emergency room admissions varied widely, with HMO No. 3 having the highest number.

"Our initial thought was that HMO No. 3 might be providing more care in outpatient settings than other plans, potentially a cost saver," Ms. Masotti said.

However, HMO No. 3 showed an exceptionally low number of outpatient visits per member per year. As a result, an employer may conclude that HMO No. 3 may not be adequately managing emergency room services.

And, because outpatient visits were low, there may be inappropriate restrictions on outpatient services or employees may experience difficulty in gaining access to those services, she noted.

Another comparison of the three HMOs showed differences in premium costs. "We could anticipate that premiums would be similar" because the HMOs are located in the same community and have been in business about the same time. However, No. 3's premiums were, by far, the highest.

Such a revelation from data analysis can provide employers with solid information for renewal discussions, she said.

Demographic data concerning employees also can be used to predict the rate of certain illnesses and their related costs within a community. That information can help employers focus wellness programs and benefit changes on the most prevalent and costly illnesses and accidents for a specific population, Ms. Masotti said. ■

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In-house medical staff can hike quality of care

By CHRISTINE WOOLSEY

PALM BEACH, Fla.—In-house medical professionals working closely with benefit managers can help employers locate the highest-quality health care providers, says a Fortune 500 benefits executive.

"You need medical people to educate you about the products out there —then you can specify what you want to buy" when setting up a managed care network, said Dr. John M. Burns, vp of health management for Honeywell Inc. in Minneapolis.

Dr. Burns spoke at a session on mental health at the 14th annual National Assn. of Employers on Health Care Action meeting, held May 31-June 1 in Palm Beach, Fla.

Often benefit managers buy whatever managed care products they are offered simply because they lack the expertise to distinguish high from low quality, he said.

This is especially true with mental health and substance abuse programs, where judgments often rely on subjective observations of patient outcomes, he said.

"Mental health is not in the mainstream of medicine—it's long been the black hole of medicine," Dr. Burns said. But, purchasers should apply the same standards to mental health care that they do when buying other services, he said.

Medical community input is vital if purchasers are to convince providers to render only appropriate and necessary care, Dr. Burns stressed.

Corporate buyers of health care "can begin to define quality and put the burden on providers to prove quality when" they can identify quality in health care, he said.

Among the quality components that should be evaluated are:

- Necessity.
- Appropriateness.
- Efficiency.
- Effectiveness.

Dr. Burns says medical necessity means "providers have to prove an employee's health won't improve or be maintained unless they receive a procedure." Benefit managers should request to see current literature pointing to good evidence that the patient needs that procedure, he said.

Medical appropriateness acknowledges the physician's judgment, he said. "The patient should get the treatment that is 'best' for him given his particular circumstances."

Often, however, rigid utilization review requirements are totally incompatible with a physician's judgment about what is best for a patient, Dr. Burns pointed out.

Current Medicare reimbursement requirements may undermine a treatment plan that is best for a particular patient, he said. Medicare requires that certain procedures, like intestinal operations, should be performed on an outpatient basis, Dr. Burns said. But, if an 88-year-old woman needs the operation, she may encounter more complications as an outpatient than if she were admitted to the hospital for a few days, he said.

Efficiency in medical care is often based on "normative" data described in medical literature, Dr. Burns said. But, "to improve quality we have to move away from normative data" based on documented medical necessity and appropriateness.

Purchasers of health care have to be aware of medical literature, standards and quality, and communicate their knowledge to providers.

For example, "I would suggest no one buy obstetrical care without knowing the guidelines" for Caesarian sections, he said. According to the literature, C-section rates should be about 10%, but one health insurer does not "even look at C-section behavior unless it is over 25%," he said.

In addition, when employers are evaluating what mental health services to offer employees, they need to be able to differentiate social problems from medical problems, Dr. Burns said. At Honeywell, for example, "the health care benefit isn't intended to help a distraught teen-ager find out 'what's it all about, Alfie' through equestrian therapy from some camp in the Ozarks," he said.

There are other advantages to having medical professionals work with benefits departments, he said.

For example, confidentiality rules prevent benefits executives from examining patient medical information, but a company's medical staff can look at those records. That data can help buyers evaluate the quality of care patients are receiving, he said. ■

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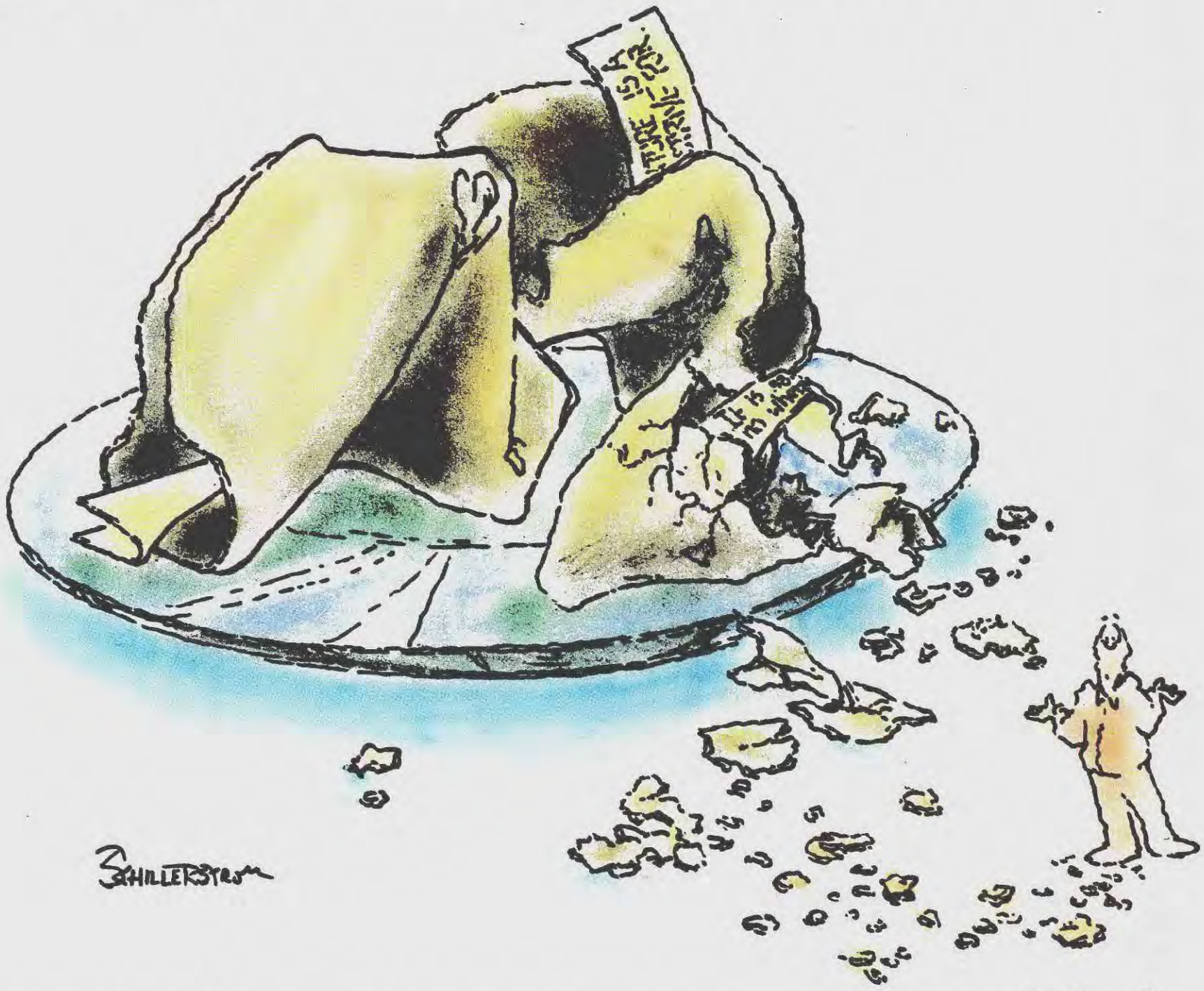
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Managed care not a cost panacea: Expert

By CHRISTINE WOOLSEY

PALM BEACH, Fla.—Managed care, while a worthy cost containment tool, is only a temporary remedy for corporate America's health care cost ills, an expert says.

"The only way we'll ultimately get a long-term answer" to the problems of rising health care costs "is to create some sort of presidential commission" to make sweeping changes in the U.S. health care system, says Dr. Richard H. Egdahl, director of the Health Policy Institute at Boston University.

"It's always a challenge to talk to this group because" rising costs "is your area of expertise," Dr. Egdahl told benefit managers attending the 14th annual National Assn. of Employers on Health Care Action conference, held May 31-June 1 in Palm Beach, Fla.

Two factors will prevent managed care and other cost containment programs from permanently slowing or stopping rising health care costs, Dr. Egdahl said.

Corporate culture is one.

Although companies' in-house medical departments and benefits departments are attempting to control health care costs, corporations are not "really tuned in" to the health care cost crisis, he said.

"Corporate culture says we've got to buy this product, we've got to have a benefit manager and a medical director, but we aren't going to get involved in the whole managed care process," he said. In fact, key executives often get involved only during annual budget meetings and, more likely than not, they merely tell benefit managers to do something about rising costs.

In addition to the problems posed by corporate culture, "the forces driving health care inflation are so great" that even if managed care saves employers some money, health care prices will likely continue to rise, Dr. Egdahl said.

One factor, he says, is the continual upgrading of medical technology. Also, rising medical salaries continually drive up hospital budgets, and now acquired immune deficiency syndrome and an aging population are adding to costs, he said.

Dr. Egdahl advises employers to invest in and monitor managed care techniques like those adopted by Allied-Signal Inc. Allied-Signal says its nationwide managed care network could save the company $200 million in health care costs in three years (*BI,* March 19).

However, "the thing to watch is whether Allied-Signal's example is an isolated case," he said. "Managed care plans will have an amazing short-term effect. But the corporate culture effect and inflation factors will not allow managed care to have a long-term savings.

Dr. Egdahl also discussed other potential ways to save.

New practice guidelines for physicians can help improve the quality of care and perhaps cut some costs, he said.

Uniform guidelines now being developed by the Rand Corp. and other groups, for example, are based on discussions with physicians and a study of current medical literature (*BI,* March 26). Those doctors concluded that up to 30% of medical procedures performed are "unnecessary."

Corporations may assume that eliminating unnecessary procedures would save a great deal of money, says Dr. Egdahl. However, "I don't think we should kid ourselves that this (savings) is that significant."

When practice guidelines are touted, employers would do well to ask themselves who made up the panel issuing the guidelines and why it was created, he suggested.

Panels directed to derive "normative" standards will find them, but normative guidelines may not be the standard by which physicians should be measured. Perhaps, he suggested, doctors should be held to higher or lower standards.

The whole purpose of establishing guidelines isn't clear, he says. "They won't save a lot of money in the short term or the long run."

Also high on the agenda of some cost-conscious health care policymakers is "outcome measurements." This technique tries to measure whether a patient's health is better, worse or the same after receiving medical treatment.

Outcome measurements "will improve medical practice and give us a lot of information, but they aren't the magic bullet for cost savings," he said.

He cites mortality data generated by the federal government as an example. "It's a great source of information—one bit of data leads to another and some gross things have jumped out at us. But it won't save huge amounts of money."

Patient satisfaction surveys and quality measurements—both of which are difficult to interpret—probably won't save much either, he said.

For example, the Health Policy Institute and some companies tried several years ago to assess the quality of care and patient satisfaction within the companies' HMOs, Dr. Egdahl explained. The result: Employees criticized one HMO for its long waiting lines, but said the quality of care was fine.

"The value of the health care system is so complex, it's really hard to use these" surveys with any confidence, Dr. Egdahl said.

And, he said, the real question is how involved should patients be in health care choices. For satisfaction surveys to work, "you have to get the patient's viewpoint into the equation," he said.

But, he asked: How committed are companies to making sure patients know every detail about a medical procedure so they can factor their view into the decision?

These types of programs "won't save a lot of money," he said:

Perhaps the most drastic approach to reducing costs is "cutting the pipeline for the single biggest factor increasing costs: care for elderly people with medical problems," he continued. However, he said there is not widespread support for this approach.

Asked whether wellness programs could produce significant savings, Dr. Egdahl said they will increase productivity and have a good effect on overall employee health and satisfaction. "But they won't save money in the long run."

Part of the problem, he said, is that such programs tend to increase life expectancy and put off the onset of chronic illnesses, but this does not necessarily reduce health care expenditures.

In addition, despite much discussion about universal health care systems like the plan adopted by Canada, the chance of adopting such a system in the United States is minimal, he said.

Any modifications to the American health care system would have to be "consistent with basic U.S. values and political processes," which are typically different from those of other nations, he said. ■



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Limiting liability from drug abuse

Written policy is paramount: Expert

By LOUISE KERTESZ

LOS ANGELES—A properly implemented substance abuse program will help employers reduce workplace accidents, retain experienced employees and protect employers from lawsuits, says a consultant on substance abuse testing and rehabilitation programs.

Substance abuse programs help employers weed out job applicants who are drug abusers as well as deter abuse by the "casual user," who is responsible for the majority of workplace accidents, said Bruce S. Wilkinson, president of Workplace Consultants Inc. in Gretna, La.

In addition, substance abuse programs offered in conjunction with employee assistance programs help a company rehabilitate and retain experienced employees who become substance abusers because of personal problems, he said. This is especially important because the percentage of new entrants into the workforce who have used illegal drugs is increasing, according to Mr. Wilkinson.

And, if rehabilitation fails, an employer that has properly implemented a substance abuse program can terminate an employee without undue fear of the terminated worker successfully suing the employer, Mr. Wilkinson said.

Employers with substance abuse programs may be better protected from liability if charged with negligence in lawsuits where employees with substance abuse problems harm themselves or other workers, Mr. Wilkinson said during a seminar for Argonaut Insurance Co. policyholders, held May 23 in Los Angeles.

With the cost of substance abuse in the U.S. workplace soaring to more than $100 billion in 1988, more employers are instituting comprehensive substance abuse programs, Mr. Wilkinson said.

Drug and alcohol abuse costs in the workplace are measured in terms of lost productivity, accidents, workers compensation and health insurance claims, quality control and theft of company property, he said.

Companies that perform work for the federal government on contracts of $25,000 or more are required to have a substance abuse program and certify that they are providing "a drug-free workplace," he said.

And Department of Defense contractors, as well as employers in six industries regulated by the Department of Transportation and companies involved in nuclear energy, must conduct pre-employment drug screenings.

Those industries are aviation, mass transit, trucking, maritime, fuel pipelines and railroads.

And, all of those industries may conduct random drug tests.

But other employers, both large and small, are increasingly fighting the drug problem in the workplace with well-designed and implemented substance abuse programs, Mr. Wilkinson said.

The first step in establishing a substance abuse program is writing a comprehensive company policy that plainly states the basis for excluding drugs and alcohol from the workplace. The policy should state that the company's obligation is to provide a safe and healthful environment for employees, contractors, visitors and the general public.

Such a statement is necessary because "when it comes to drug and alcohol abuse in the workplace, nothing is illegal" under company policy if there is no written policy prohibiting drug and alcohol use, Mr. Wilkinson stressed. "Everything must be prohibited and unauthorized based on company policy."

The company should state clearly that because of its obligation to provide a safe workplace, violations of its substance abuse policy will lead to discipline and termination.

Company policy should spell out the steps leading to termination, including any "last chance" procedures involving treatment through an EAP, he said.

Mr. Wilkinson recommended establishing an EAP. But whether an employer sets up a formal EAP or covers a substance abuse rehabilitation program under its health insurance program, the company should state that it offers confidential employee assistance to workers with substance abuse problems, he said. This will demonstrate to employees and the courts that the company makes an effort to assist employees who seek help before considering disciplinary action, including termination.

Company policy also should contain a comprehensive definition of what property is considered company premises and a statement that the policy applies to all workers, Mr. Wilkinson said.

"You must understand the user, or you will be unsuccessful at controlling" substance abuse at work, Mr. Wilkinson stressed.

He also pointed out that a drug abuser can be anyone—"a vice president, your best teller, your human resources person."

An employer cannot decide arbitrarily which employees it will discipline, he said. The policy must be applied equally to executives and hourly workers, he stressed. Mr. Wilkinson said that courts increasingly are forcing employers to be "collar-blind" in enforcing substance abuse policies.

The policy should spell out what types of drugs and alcoholic beverages are prohibited on the company's premises.

For example, an employer can authorize consumption of alcoholic beverages at company functions but it should ration drink tickets on those occasions so it can demonstrate that it attempted to encourage moderation, Mr. Wilkinson said.

Employers also should state in their policies that they prohibit "recreational" use of drugs, because many workers think that casual drug use outside of the workplace is acceptable, he said.

Casual drug use is insidiously dangerous and has been found to be the cause of many "unexplained" accidents in the workplace, he said.

In addition, the company's policy should clearly stress that the company intends to enforce its policy by testing workers for drug use, Mr. Wilkinson said. "If your objec-

Continued on next page



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Drug abuse policy

Continued from previous page
tive is to get rid of abuse and not people, they must know you can catch them," he emphasized.

An attorney with experience in implementing substance abuse programs and who is up to date with applicable statutory or case law on drug testing should review the employer's policy and procedures, Mr. Wilkinson advised.

A company should warn prospective and current employees that drug tests will be administered at specific times spelled out in company policy, beginning with a preemployment test, he said.

Mr. Wilkinson noted that 95% of his clients also test for substance abuse after any accident involving a workers compensation claim.

A company also should test:

- After a rehabilitation period or counseling but before the worker returns to work.
- When an employer has a reasonable suspicion that a worker is a substance abuser.
- During annual physicals for drivers.

Employees also could be tested on a "routine, periodic or intermittent basis," Mr. Wilkinson said.

But, in conducting such tests, employers must be careful to ensure that hospitals and clinics that collect urine specimens from employees maintain employees' privacy and dignity, he said.

"Only licensed, certified testing facilities that use proper chain of custody techniques and first and second methodologies and whose toxicologist will testify in court should be considered," he said.

Chain of custody techniques assure that the employee's specimen will not be misidentified. Second methodology is a confirmation of initial drug test results, and a toxicologist is the only person who can testify in court about the presence of drugs in a worker's system, Mr. Wilkinson explained.

In addition to periodic testing, supervisors should be trained to spot the "early signs of employee substance abuse," he said.

The signs supervisors should recognize and document include: lack of balance; eye problems, such as irritation or difficulty in focusing; disorientation; uncoordinated movement of body and hands; flushed cheeks or sallow face; slurred speech; memory loss; and drowsiness.

Reasonable suspicion may also be based on "identification of an employee as the focus of a criminal investigation into illegal drug or alcohol possession, use or trafficking"; an independently corroborated tip that an employee may have violated "any portion of company policy"; or evidence that the employee "has or may have tampered with" a drug test, Mr. Wilkinson said.

"Sometimes these symptoms are picked up too late by management personnel," he said. Often, after an accident caused by an employee with a substance abuse problem, "fellow employees will usually recall any number of clues that they should have picked up on weeks or even months earlier," he said.

In addition, an employer with a substance abuse program can pick up signs that workers may have drug dependency problems by measuring the following areas quarterly: productivity; quality control rejects; absenteeism; recorded disciplinary activity; tardiness; employee turnover; short- and long-term disability claims; theft; first-aid cases; workplace injuries requiring a doctor's attention; health care claims history; incident, frequency and severity rates of accidents; and fleet accident rates.

The company's safety and health department should be charged with enforcing the substance abuse program, but the industrial relations or human relations department should oversee and maintain the confidentiality of records, Mr. Wilkinson said.

All testing, counseling or rehabilitation records should be kept in locked files separate from personnel records, with access limited to individuals with a legitimate "need to know," he stressed.

But, before implementing a substance abuse program, employers first should have their drug policy reviewed by an attorney who has experience working with these programs, Mr. Wilkinson said.

The policy then should be communicated to employees and contractors both through direct mail and in postings on company premises, he said.

And, as a condition of employment, applicants should sign a form acknowledging they have been made aware of the policy, Mr. Wilkinson said.

Companies with unionized labor should hammer out elements of their substance program as part of contract negotiations, he said. ■

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2 firms curb losses from drug abuse

By LOUISE KERTESZ

LOS ANGELES—Substance abuse programs are effectively reducing workplace injuries and improving productivity at a large state mass transit agency and a small manufacturing facility in California, according to executives with the organizations.

"Much has been gained" as a result of the substance abuse program at Southern California Rapid Transit District, said Harold Storey, director of systems and construction safety for the RTD's Transit Systems Development unit in Los Angeles. The RTD employs 5,000 workers.

"When incident-based drug and alcohol testing was first implemented in 1985, 20.5% of the tests were positive. By 1989, the percentage of positive tests dropped to between 2% and 3%," according to the RTD's report on its comprehensive alcohol and drug abuse policy, Mr. Storey said.

The Chino, Calif., division of New York-based Concord Fabrics of America has seen similar results, according to Joy C. Brooks, director of personnel/purchasing.

In the year since the company implemented a substance abuse program, the quality of work at the company and the productivity of its 125-member workforce has improved, she said in an interview.

The program "pretty well will pay for itself in the long run," she said.

Mr. Storey and Ms. Brooks outlined their companies' substance abuse programs during a seminar for Argonaut Insurance Co. policyholders in Los Angeles May 23.

While the RTD's drug testing program has been effective, the agency has had to halt random drug testing under an injunction issued in litigation filed by the United Transportation Union last year.

Meanwhile, the California Supreme Court on May 31 upheld the right of employees to refuse to submit to random drug testing in ruling that two private employers illegally dismissed employees for refusing to submit to the tests (*BI*, June 4).

But the court actions have "not put a damper on drug testing in general," Mr. Storey asserted, explaining that random testing is only one testing procedure.

For example, employers can test for drug usage after a workplace accident and during annual physi-

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Substance abuse

Continued from page 16

cals for workers in safety-sensitive positions, he said.

And, Mr. Storey said he is confident that the RTD and the union can work out mutually agreeable conditions for random drug testing during contract negotiations.

In addition, Congress may enact legislation requiring random drug testing for federal employees, "and that will set a precedent" for the RTD's random testing program.

The RTD currently tests employee applicants for drug and alcohol use.

"It's important to have such a program because people don't take alcohol seriously," Mr. Storey said. "Many applicants are turned down" for failing the alcohol test, he said.

The RTD also tests for substance abuse after accidents; during annual or biennial physical examinations; during return-to-work physicals for employees who have been on extended leave or have been referred by management to the employee assistance program; and periodically for management-referred EAP participants.

The RTD also uses dogs trained to sniff the presence of drugs. The dogs "wander through the building" with their trainers, Mr. Storey explained.

"It did clean up the act. It cut down on marijuana smoking," he said.

Overall, the RTD's substance abuse program "has cut down on people under the influence on the job," he asserted.

In addition, the RTD's substance program is partially responsible for the safety record maintained during construction of the new Los Angeles subway system, Mr. Storey said.

There have been only six serious injuries during the construction of nine miles of subway tunnels and five stations, which involved 5 million man-hours of work, according to Mr. Storey.

Concord's Ms. Brooks said the company's substance abuse program also has been effective in many ways.

The program "reduced turnover tremendously," Ms. Brooks said.

RTD's program 'has cut down on people under the influence on the job,' says Mr. Storey.

"It was like a revolving front door." In addition, "quality and productivity have gone up, and we're meeting schedules better," she said.

"We don't have the (insurance) claims we used to. We don't have the pattern absences," she said.

Ultimately, the program is "preventive," Ms. Brooks said. Workers know that "if they go on (abusing substances), they will lose their jobs." This is sufficient to stop the casual user, she explained.

The program begins with pre-employment drug testing.

According to Concord's substance abuse policy, a poster reading "applicants for employment will be required to undergo a drug screening test as a part of pre-employment processing" is prominently displayed "where it may be easily seen by employees and persons seeking employment," Ms. Brooks said.

The poster is a much-needed deterrent, she said.

But despite the warning, "some applicants will still do a line (of cocaine) on the way to the test center," she said.

And, some applicants for management positions "will tell you in an interview that they just do cocaine recreationally," Ms. Brooks said. "They come in with the attitude that there's nothing wrong with that, and they compare it with alcohol," she said.

For example, one executive applicant asked what was wrong with "doing two lines as opposed to having two drinks," Ms. Brooks recalled.

Because applicants are aware that they will be tested for drugs, the company is careful to ensure that applicants do not switch urine samples.

For example, "One applicant brought in a sample under a toupee," she said.

"You'd be surprised what we weed out" through pre-employment drug testing, Ms. Brooks said.

As a result of the program, the company now hires employees with good work habits.

"Our executives don't go out and drink at lunch. It's not tolerated," she said.

In addition, Concord workers are told they may be tested for drugs and alcohol:

- After a workplace accident "which caused or could have caused personal injury or property damage."
- At any time when employees are working in sensitive areas.
- When there is "reasonable cause or suspicion" that the employee may be in violation of the company substance abuse policy.

A "reasonable cause" would be "unexplained significant deterioration in job performance," Ms. Brooks said.

- Following referral by the company for counseling for or rehabilitation from substance abuse.

"We're also educating our employees and telling them that the guy next to you may take your eye or your life" if he is a a substance abuser, Ms. Brooks said.

Also participating in the panel discussion were Steven La Shier, senior vp of safety and management at Argonaut; Roland Talton, a special agent with the U.S. Drug Enforcement Administration; and Nelson Brown, safety officer for Matich Corp. of Colton, Calif. ■



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INTRACORP

Stalking the 'sultans of insolvency'

If insurer failures are inevitable, they also are preventable

By Rep. John D. Dingell

I AM HERE TODAY TO discuss the single biggest risk that any of you face during the course of your professional career. That risk is the very real threat of financial insolvency for your companies and your industry. A major insolvency could be caused by your own activities, or by the actions of others in the insurance industry beyond your control. In either case, the threat is very real, it is growing, and it is not being managed well at all.

Like death, the prospect of total bankruptcy for giant insurance companies seems so remote from day to day that most people simply ignore the possibility. After all, how could a company with billions of dollars in assets ever fail when it has such immense financial resources? Yet, the potential for death—either natural or financial—does not rest upon the condition of your entire body, but rather upon the condition of its weakest link. For financial institutions, that weakest link is called capital and surplus.

Capital and surplus represents the amount of financial strength held by a company to see it through the tough times that inevitably plague every industry. The amount of capital and surplus available to meet a crisis is the lifeblood of insurance companies. In far too many cases, this "thin red line" of financial strength has become a sea of red ink with astounding suddenness and devastation.

The House Subcommittee on Oversight and Investigations began its inquiry into the causes of insurance company insolvencies two years ago. Our purpose is simple, and our methods are straightforward. We want to discover and evaluate the factors that lead to insolvency, so that we can correct them before they erode the relatively thin margin of capital and surplus that supports the insurance industry.

The subcommittee issued its findings in a February 1990 report entitled "Failed Promises" (*BI*, Feb. 26). This report documents the failure of four major property/casualty companies and the near failure of two others. The present estimated costs to the insurance industry and the public of these six cases alone exceeds $6 billion.

Nothing about the insolvencies is particularly suprising. . .Perhaps the real surprise is that it took so long for financial buccaneers to recognize what a ripe target insurance represents.

Most importantly, the subcommittee found that each of the companies it studied shared a common pattern of reckless management and irresponsible business practices that made their bankruptcy both predictable and inevitable. Our record shows quite clearly that these insolvencies were neither accidents nor the results of innocent businessmen trapped in a swirl of unfortunate events beyond their control. If these cases were both predictable and inevitable, it is obvious they were also preventable. Therein lies the concern and the mission of the subcommittee as it pursues its work.

There is nothing particularly surprising about the cause of insolvency revealed by the subcommittee. The perpetrators of these debacles merely took full advantage of open opportunities to practice greed, self-delusion, stupidity, deception and several other varieties of folly and vice that have defined the weaker side of human nature since the days of Adam and Eve. Perhaps the real surprise is that it took so long for the big-time operators to recognize what a ripe target the world of insurance presents for financial buccaneers.

While those of you in the audience today may be deeply concerned about underwriting risks and financial threats to your companies and your industry, the rascals and management impersonators have discovered that there are no risks at all in the outright plunder of insurance companies. Almost nobody is investigated or punished, and there always seems to be a safe haven in the United States, Europe or the Caribbean to enjoy the grandeur and largesse provided by their wrongdoing. These sultans of insolvency have also found that there is life after death here on earth, and you can indeed "take it with you" by wire transfer to the bank of your choice.

While you and the public are saddled with paying the funeral expenses of their last deadly ventures, they simply reincarnate themselves as new insurance companies, intermediaries and agents. Displaying renewed vigor and boldness in risking other people's money, they happily prey on trusting insurance companies and consumers alike.

The subcommittee observed this same pattern of reckless and irresponsible behavior when we studied the causes of savings and loan failures five years ago. Most thrift regulators and industry participants dismissed such behavior as unavoidable, but manageable, antics of a few "bad apples." The savings and loan industry pursued a program of coverup and public relations propaganda to convince themselves and the public that the health of thrift institutions was just fine.

Instead of a few pests, the savings and loan industry recognized too late that it was thoroughly infected by hungry parasites who were sucking the lifeblood of the industry dry. Vain attempts at accounting gimmicks and half-hearted reforms could not stop the spread of their deadly cancer, and the ultimate result was a federal bailout projected to cost more than $300 billion. Because we see the same early warning signs of potential disaster, the subcommittee in its report compared the problems we observe in the insurance industry with the fate of the savings and loan industry.

Those people who have read the subcommittee's report generally praise it for identifying the core solvency issues and for being fair and plain-spoken. In that regard, we have achieved one of our preliminary goals. However, there have been a few disturbing reactions that must be addressed.

The chairman and other members of the National Assn. of Insurance Commissioners, a voluntary organization of the 50 state regulatory bodies, have characterized the subcommittee's comparison of insurance company insolvencies with the savings and loan debacle as a "bit apocalyptic" (*BI*, March 5). This has been matched by anguished complaints by some insurance executives who deny any comparison with the largest financial fiasco in history. These critics support their arguments with soothing statistics that minimize both the number and cost of insurance company insolvencies when measured against the entire universe of companies and the industry's gross premiums and assets.

I would remind those of you comforted by this lullaby that we heard this same song as recently as two years ago from the savings and loan regulators and trade groups. I also would ask you to compare your sense of safety in numbers with the statistical comfort previously felt by your own policyholders, who are now coming to you in distress demanding billions of dollars in claims payments for disasters they thought would never happen. If you think apocalypse is some remote event beyond the everyday experiences of practical-minded people, just remember that "Apocalypse Now" has already occurred for many policyholders of Transit Casualty Co., Mission Insurance Co., Integrity Insurance Co. and other insolvent companies.

If nothing else moves you, I suggest you compare the amounts you are currently paying the state guaranty funds with the prospect of what you will be paying in the future. Every dollar you pay is the direct result of ineptitude, irresponsibility, and thievery by your former competitors—some of whom are your current competitors because nobody stops them. Measure these amounts against the lifeblood of your own company's capital and surplus, and see if you remain satisfied with the present state of affairs.

Certain people have tried to defend the present system of state solvency regulation by pointing to its diversity as a source of competition for innovative regulatory ideas. Competition is a potent force in driving down product prices. My experience over the years has also taught that regulatory competition unfortunately drives down safety standards to the lowest common denominator. I do not expect that we can rely upon competition among state regulators to significantly improve the solvency of insurance companies.

For those comforted by lullabies from the insurance industry, a reminder: As recently as two years ago, we heard this same song from savings and loan regulators and trade groups.

Finally, some critics tell the subcommittee that we might as well accept state regulation of insurance solvency because the savings and loan industry failure clearly shows the federal government is incapable of doing the job. This view simply ignores the plain truth that the federal thrift deposit insurance fund was bankrupted by the uncontrolled activities of state-chartered and regulated institutions. The primary failure of federal regulators was to grant full deposit insurance coverage to institutions that refused to meet minimum federal solvency requirements.

More importantly, there have been some real successes when the federal government, state governments and industry participants have joined together to address solvency issues. The securities industry and the banking industry are two major examples. The subcommittee intends to seek improvement of solvency standards through logical solutions, without being hindered by tired acceptance of a fractured state system that has evolved haphazardly, and often belatedly, over the last hundred years.

Having told you that we see serious solvency problems in the insurance industry, let me now discuss where the subcommittee is going. We will continue to investigate solvency problems in cases that will help our understanding of what needs to be corrected. Next on our agenda is a hearing involving the junk bond investment practices of First Executive Corp. (*BI*, Feb. 12), and an inquiry into the solvency problems of H.S. Weavers (Underwriting Agencies) Ltd. in London (*BI*, April 2), which is an echo of the Transit situation, with possibly severe consequences for U.S. policyholders.

The subcommittee will also hear the views of responsible industry participants and regulators regarding possible solutions to solvency problems. We intend to invite the American Insurance Assn. to testify, and we look forward to hearing your views.

During March and April, the subcommittee learned from John J. Byrne of Fund American Cos. Inc. (*BI*, March 26) that property/casualty insurers use accounting and reporting methods that can substantially overstate their true capital and

Continued on next page

ASK A RISK MANAGER

Chemical dependency and collision insurance

Q **Chemical dependency affects between 7% and 10% of the average workforce. With this is mind, consider the following scenario: An auto parts delivery service operates about 1,000 vehicles, all with collision insurance. At any one time, between 7% and 12% of these vehicles have minor damage, mostly dents and scrapes. However, most of the damage is unreported so the insurance company pays for less than 1% of repairs per year. Some of the accidents involve "repeat offenders." The question is should the collision insurance company encourage or pay for a loss control program such as chemical dependency assessment, referral and treatment?**

A Chemical dependency is and will continue to be a major risk management issue in the 1990s. It is a problem which affects virtually all levels of society and manifests itself in the form of numerous exposures which the insurance community and employers are forced to address.

The risk manager's mandate, first and foremost, is to protect an organization's assets, of which people and property are the most important.

The auto parts company referred to in your question relies on the efficient performance of its people and vehicles to generate the third most important asset, cash.

One of the mechanisms used by risk managers to protect these assets is the purchase of commercial insurance. In exchange for the payment of a premium, the insurance company will assume responsibility for the payment of collision damage claims.

Therefore, the insured organization and the insurance company have entered into a partnership with each party striving to realize a financial gain from the relationship.

Preventing accidents from happening in the first place or controlling the aftereffects of those that do occur is accomplished through the administration of a loss prevention program.

Most of us have been affected to some degree by the phenomenon commonly called the "insurance cycle."

The cycle is created and sustained by wild pricing swings associated with soft and hard insurance markets.

Insurance companies become eager to woo and win new business and, through careless underwriting practices, lose sight of the actual cost of risk being transferred to them.

As losses escalate and premium volumes shrink, insurers immediately attempt to collect the difference through significant price increases. Then, as the dust begins to settle and the balance sheet appears relatively healthy, the rush to attract new business is on again.

The collision insurer mentioned in your question should recognize the true value of a loss prevention program to its client and encourage or participate in the development of one.

The insurer and insured have entered into a partnership. Both parties must be supportive of each other for the relationship to meet its intended purpose.

Let's keep in mind that although only 1% of total accidents are paid for by the collision insurer, someone else is paying for remaining losses. And, although 7% to 12% of the total vehicles sustain some type of damage at any given time, only 1% of losses are actually reported.

If all accidents are not reported, the increased exposure to other types of claims is hidden from the employer.

Chemical dependency becomes the catalyst for liabilities that can be catastrophic to the organization.

Consider the possibility of a chemically dependent driver striking a school bus full of youngsters.

The resulting liability claims for the many serious injuries could prove financially disastrous to the employer if a significant portion of the losses are retained or to the liability insurer if the risk was transferred.

The exposure to an increase in workers compensation claims and costs is another "aftereffect" of chemical dependency.

To come face to face with the problem mentioned in your question, the auto parts delivery service and the collision insurer must understand and address the repercussions of chemical dependency. The collision insurer is but one segment of an entire industry that can be weakened by an influx of chemical dependency-related losses.

Just as a broken leg disables an individual, continued adverse loss experience within one line of coverage because of chemical dependency can ultimately affect the entire insurance industry.

To elaborate further, what happens to the industry when liability losses run into the billions of dollars or when workers compensation and health care benefits increase greatly because of this exposure?

The point I am making here is simply this—everyone is at risk. Therefore, everyone has a vested interest in finding a solution to the problem.

The collision insurer could help by sharing the cost of initiating an employee assistance program or offering a premium reduction plan when the auto parts delivery service implements one.

Employee assistance programs are becoming increasingly important to employers as they realize that a wide range of behavioral problems can and do affect an individual's job performance.

We know from your question that many of the accidents for the auto parts delivery company involve repeat offenders. We also know that only a fraction of total collision accidents are reported. Both of these situations signal underlying problems that could be remedied through an EAP.

A contribution by the insurer to such a program offers an incentive for the employer to focus on the chemical dependency issue and understand its impact on the organization as a whole.

As I mentioned earlier, the insurer and insured have entered into a partnership. Both parties must be supportive of each other for the relationship to meet its intended purpose. ■

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

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



Ms. Werner

This month's column on risk management issues is written by Susan M. Werner, director of risk management at Hardee's Food Systems Inc. in Rocky Mount, N.C. Joseph W. Duva, former director of employee benefits at Allied-Signal Inc. in Morristown, N.J., answers benefits management questions. William J. Miner, an actuary with The Wyatt Co. in Chicago, answers actuarial questions on benefits issues. And, Richard E. Sherman, a principal with Coopers & Lybrand in San Francisco, answers actuarial questions in the casualty field.

Mr. Duva's and Ms. Werner's columns appear alternately on the second Monday of each month. Mr. Miner's and Mr. Sherman's columns appear alternately on the first Monday of each month.

Ms. Werner's next column will appear in August.

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

Insurance company solvency

Continued from previous page

surplus. The National Assn. of Insurance Brokers told us that brokers rely upon a commercial solvency rating service they know is inadequate, and that they have no responsibility to assure solvency when they place business.

The Reinsurance Assn. of America testified that it is impossible to track the adequacy of reinsurance beyond the first level under the present system.

Furthermore, IDS Financial Services released a report in March projecting that 20 of the largest 100 life insurers could become insolvent if a severe economic downturn occurs.

These are disturbing findings, but I strongly believe the best way to correct solvency deficiencies is to identify and deal with them now. By the time an industrywide crisis occurs, it will be too late.

As you consider what path to follow in addressing solvency concerns, I would like to provide the following perspectives from a congressional viewpoint.

First, keep the focus on solvency regulation, safety and enforcement.

I detect no interest by Congress for getting involved in ratemaking or market conduct. Proper solvency regulation provides a basis for sound rates. We do not depend upon the Federal Aviation Administration to set airline fares in order to assure safe airplanes.

Secondly, look to Congress for help in providing appropriate regulators and industry participants with the power and tools to address solvency issues effectively. Don't look to the federal government for financial bailout protection.

My final advice would be to work with Congress now to address solvency issues while the memory of the savings and loan crisis is fresh.

I believe a solid solvency program standing on its own would be acceptable in Congress.

The subcommittee is doing the work necessary to minimize solvency risks for your companies, for your industry, and for the public. I invite you to join with us in finding and implementing the right solutions. An industry willing to manage the financial risks of its customers should be better prepared to confront and manage the financial risks to its own existence. ■



Rep John D. Dingell, D-Mich., is chairman of the House Energy and Commerce Committee and the Oversight and Investigations Subcommittee. This article was exerpted from a recent speech to the American Insurance Assn.

Health strategy

Continued from page 3

Mr. McCammon noted that health care is expected to comprise 12% of the gross national product in 1990. Furthermore, spending for health services has equaled about 50% of corporate profits during the late 1980s, he added.

At Ford, health care costs accounted for $350 per vehicle produced in 1989, he noted. And when the health care costs of parts suppliers to those vehicles is included, health care costs amounted to $600 per vehicle in 1989, he said.

Japanese auto manufacturers spend half this amount on health care, according to Mr. McCammon.

Health care costs are rising rapidly because of several factors, including new medical technology and unnecessary and inefficient health care, the speakers agreed.

Mr. Inlander complained that "no test becomes obsolete in medicine." Instead, less sophisticated tests are performed before more sophisticated tests are conducted, even though doctors know they eventually will perform the more sophisticated tests, he said.

"Piecemeal, patchwork responses (to the health care crisis) have not worked," noted Jack Shelton, manager of Ford's employee insurance department.

The experts, though, each have their own ideas on a national health policy.

For example, Ford supports a set of general principles that include universal health care coverage, health care quality assurance, administrative simplicity, cost containment and an equitable financing mechanism, according to Mr. McCammon.

"Ford does not support national health insurance," state risk pools for the uninsured, an expansion of Medicaid or federal vouchers for health care, he said.

"Ford is not advocating any specific national health care system," Mr. McCammon said.

Mr. Boyle of Honeywell said that access to health care is the "first priority." He said that "this will become in the next few years a key, key issue."

However, Mr. Boyle also did not propose any specific solutions to increase access to health care.

"It's too late" in the United States for a national health insurance program like Canada's to evolve, said Dr. D.C. Brown, a medical consultant to Canada's Ministry of Health in Kingston, Ontario. "You will be unlikely to see anything like the Canadian system," he predicted.

"There is really no consensus yet, particularly on the access issue," observed Carol Cronin, vp of the Washington Business Group on Health in Washington, D.C.

"The lack of consensus in the business community is reflected in a lack of consensus in Congress," Ms. Cronin noted.

She continued that health care is a long-term, "looming concern" in Congress, not an immediate problem, unlike education and drug abuse.

Rep. Gradison agreed. "Not only do we lack a federal health policy, but there is none in sight" this decade, he said.

Congress was burned last year with its attempt to provide catastrophic health care to the elderly under the now-repealed Medicare Catastrophic Act (*BI*, Dec. 25, 1989), so lawmakers will not likely approach any other health care reform legislation in the near future, he said.

Ms. Cronin predicted that Congress in the next few years will make only incremental steps in health care reform, perhaps including some reform of the small group health insurance market and an expansion of the Medicaid program.

Ms. Cronin, Rep. Gradison and Mr. Vraciu of HealthTrust suggested trying to find solutions at the state and local level.

State efforts are "a whole lot more important and much more likely to yield results," Rep. Gradison said.

There is a "shorter time frame and much bolder initiatives" on the state level, Ms. Cronin agreed.

Mr. Vraciu suggested that top-level executives of business and health care provider organizations hammer out solutions locally. ■

High-quality care doesn't produce high costs for employers: Experts

By DEBORAH SHALOWITZ

CHICAGO—High-quality health care does not necessarily mean high-cost care and, in fact, often results in lower costs, according to health care experts.

However, definitions of "quality" differ and can be difficult to measure, speakers said at the 10th annual Midwest Business Group on Health conference, held May 30-June 1 in Chicago.

"I remain unshaken in my belief that quality care is cost-effective care," said George Murphy, chairman and chief executive officer of Community Care Network, a San Diego alliance of doctors, hospitals, labor unions and health care buyers. However, "the reverse is not necessarily true," he said.

"High quality and reduced cost go together," agreed Rep. Willis D. Gradison Jr., R-Ohio, a member of the House Ways and Means Committee's Subcommittee on Health.

Indeed, poor-quality care can be even more expensive than high-quality care because it can lead to hospital readmissions, longer hospital stays and higher mortality rates, Rep. Gradison explained.

Dr. D.C. Brown, a medical consultant to Canada's Ministry of Health in Kingston, Ontario, agreed expensive care does not necessarily correlate with quality care.

Experts noted that quality can be difficult to define.

"Quality itself is a value judgment," said Dr. Paul Schyve, vp of research and standards for the Joint Commission on Accreditation of Healthcare Organizations.

The JCAHO, based in Oakbrook Terrace, Ill., sets health care standards for facilities such as hospitals, nursing homes and long-term care facilities.

Those facilities seek JCAHO accreditation voluntarily. The commission currently surveys 53,000 hospitals—about 80% of the hospitals in the United States—and 3,000 other facilities.

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"There is no one person or group" that can define quality, Dr. Schyve said.

For example, some people would consider a fast sports car high-quality, while for others the key to quality would be leather upholstery.

Dr. Schyve said he is pessimistic that all sectors of the health care system will ever agree on a definition of quality health care.

Chip Caldwell, president and chief executive officer of West Paces Ferry Hospital in Atlanta, agreed.

There are "a lot of negative correlations between what patients, doctors and payers want," he observed.

Measuring quality of care is extremely difficult because there are so many variables among patients, he said.

However, "consensus on the definition and measures of quality is at the heart of" improving the health care system, according to Mr. Murphy.

Experts say several things can be done to improve the quality of care in the United States.

For example, hospitals should be required to disclose infection rates, drug error rates and the names of doctors who have been suspended from the hospital for any length of time, said Charles Inlander, president of the People's Medical Society, a consumer group based in Allentown, Pa.

Hospitals seeking to improve care quality should solicit suggestions not just from physicians, but also from support personnel such as nurses and technicians, Mr. Caldwell suggested.

Equipment and materials also should be reviewed in efforts to improve hospital performance, he added.

In addition, consumers and employers should "become the true trustees of the hospital" by being given seats on hospital boards, Mr. Inlander said.

Hospital licensing boards also should consist totally of consumers, instead of physicians, as they do now, he said.

"Let the folks decide the level of incompetence we're willing to accept," Mr. Inlander said.

And, Dr. Schyve and Mr. Inlander recommended creating a partnership among health care providers, purchasers and patients—not just between providers and purchasers—to improve the quality of care.

The quest for quality in health care is a long-term process, warned Barbara Kavalew, director of research for the Midwest Business Group on Health. "You will not be successful" in a search for quick, cost-cutting results, she said.

Speakers also stressed that quality assurance and quality improvement are two distinct goals.

Dr. Schyve defines the former as doing the right thing for the right patient at the right time. Quality assurance also involves health care facilities setting priorities and finding and correcting problems, Dr. Schyve maintained.

"Doing the right thing and doing it right the first time" is what quality assurance is all about, Mr. Murphy agreed.

Quality improvement involves doing a better job of providing what the patient wants, Dr. Schyve said. It focuses on the entire health care process, he said. ■

MBGH elects new board of directors

CHICAGO—About 115 people attended "Circles of Influence in Health Care Systems," the 10th annual conference of the Midwest Business Group on Health, held May 30-June 1 in Chicago.

The MBGH, which has 140 member employers, promotes ways to improve the quality and cost-effectiveness of health services.

The group elected new board members at the conference. They are: David Arena, director-corporate benefits at Abbott Laboratories in Abbott Park, Ill.; Robert W. Batey, manager-benefit planning at Ameritech in Chicago; Clayton Meier, president of Metalworld Inc. of Racine, Wis.; Paul M. Millholland, director-corporate benefits planning and development at The Upjohn Co. in Kalamazoo, Mich.; J. Larry Rodimel, manager-compensation and benefits at Inland Steel Industries Inc. in Chicago; and Thomas Parfitt, vp-benefits administration at Harris Trust & Savings Bank in Chicago.

For more information, contact Chuck Ripp, Director of Member Services, MBGH, 8303 W. Higgins Road, Suite 200, Chicago. Ill. 60631; 312-380-9090.

Flex plans, managed care a powerful duo

By DEBORAH SHALOWITZ

CHICAGO—Flexible benefits plans—especially those that include managed health care elements—are helping employers control health care costs, say health care and employee benefits experts.

Flexible benefits plans can help control health care costs in several ways, according to Marianne Gellatly Brackey, a partner with Lincolnshire, Ill.-based Hewitt Associates.

For example, flex plans help employers:

- Shift a greater share of costs to employees.
- Reduce employee pressure to add new employer-paid benefits.
- Reduce duplicate dependent coverage, since employees are given an incentive to opt out of redundant coverage and choose other benefits.

The best way to control health care costs through flex plans is to offer a wide range of deductibles and a small range of copayments, Ms. Brackey said at the Midwest Business Group on Health's 10th annual conference, held May 30-June 1 in Chicago.

Offering a range of deductibles up to a $1,000 annual maximum is best, she advised.

Other plan features that can help employers control health care costs include requiring high deductibles or copayments or both for dependent care coverage and offering employees a "no-coverage" option, she noted.

However, "flex alone does not automatically control costs," Ms. Brackey cautioned.

For example, flexible benefits plans will not prevent health care costs increases due to new technology, increasing utilization or inflation, she said.

Flexible benefits combined with managed care holds even more cost savings potential, Ms. Brackey said. However, employers should consider several factors when designing flex plans with managed care elements, she noted.

An employer first should review the number and mix of options it offers. Limiting the number of design structures simplifies communication, she said.

Employers switching to a flex plan also should try to retain their relationships with well- managed, popular, independent health maintenance organizations, she suggested. This minimizes disruptions in service for employees.

Sometime this decade, 90% of health care dollars will flow through managed care programs, predicted William Sharkey Jr., senior vp of national marketing for CIGNA Employee Benefits Services in Hartford, Conn., a CIGNA Corp. unit.

Janet McCullough, vp of human resources for Wilson Sporting Goods Co. in River Grove, Ill., related that Wilson has been better controlling health costs since it implemented a flex plan with managed care elements in 1983.

Between 1983 and 1988, the last year for which figures are available, Wilson's health care costs for its 2,500 non-union workers covered by the flex plan with managed care elements have risen only 30%, according to Ms. McCullough. About 800 unionized workers are not eligible for the flex plan.

MBGH

The savings primarily resulted from scaling back health care benefits and shifting some costs to employees, she noted.

Wilson instituted a series of health care plan changes in 1983, including a range of deductibles and employee contributions toward the cost of its self-insured health care plan.

The company at that time also introduced dental care options, long-term disability options, vision and hearing benefits, life insurance and a 401(k) plan, Ms. McCullough said.

However, enrollment patterns were so uneven and there was so much adverse selection that Wilson decided to change its benefit options again in 1987, Ms. McCullough said.

The revised benefit options widened the range of deductibles and copayments that employees choose.

The biggest mistake Wilson made in originally implementing its flex plan was not getting the support of line managers and not educating employees properly, Ms. McCullough said.

If Wilson had to do it again, Ms. McCullough would "communicate more and better," she said.

Also during the session, Dennis Nirtaut, vp of employee benefits, at Chicago-based Continental Bank Corp., described how the bank saved $650,000 in 1988 and $1 million in 1989 by renegotiating its HMO premiums.

Previously, Continental's contribution to HMO premiums equaled 80% of the cost of the bank's self-insured indemnity medical plan. Employees paid the remaining portion of the HMO premiums.

But, under the renegotiated HMO premium structure, the bank began paying the HMOs 80% of whatever the HMOs charged the bank in 1987. This new HMO premium structure saved Continental $650,000 in 1988, Mr. Nirtaut said.

In 1989, Continental found that the actuarial value of benefits offered by the HMOs was 8.2% greater than that of the benefits offered by the indemnity plan, he said. Because the HMO was, in effect, offering richer benefits than Continental wished to pay for, Mr. Nirtaut demanded that the HMOs reduce premiums by 8.2%.

The HMOs agreed, resulting in an additional premium savings of $350,000 for Continental in 1989.

Combined with the $650,000 savings from the first rate negotiation, the bank saved a total of $1 million in 1989 from these changes, Mr. Nirtaut said.

This year, Continental is implementing several more changes to help cut costs further, Mr. Nirtaut said.

For example, the bank is requiring employee copayments for HMO coverage, such as $25 for an emergency room visit, $10 for a doctor's office visit and $100 for a hospital admission.

In addition, the bank is implementing a range of salary-based deductibles for those in the indemnity plan and an outpatient utilization review program.

A key to making all of these benefit changes work has been employee education, according to Mr. Nirtaut.

He related that Continental discovered through an employee survey that employees wanted to know why all these changes were necessary, so the bank began running articles in its employee newsletter about corporate health care costs. This has helped employees accept the changes, he said. ■

Partnerships urged to improve health care

By CHRISTINE WOOLSEY

CHICAGO—Employer coalitions can improve delivery of health care services, but employers also should develop partnerships with various players in the health care system to improve quality and availability of care, health care experts contend.

THe Midwest Business Group on Health, an employer coalition, unveiled its plan to change the health care delivery system through such partnerships at its 10th annual meeting, held May 30-June 1.

"Value improvement and an attempt to really influence what's going on in the health care marketplace" is the purpose of this meeting, noted Roger Frietag, manager of corporate benefits at Allen-Bradley Co. in Milwaukee and chairman of the MBGH.

Various players within the health care system must form partnerships to improve the cost, quality and availability of care.

"A lot of what we've done as employers up to now are things that would produce a one-time savings," Mr. Frietag said, referring, for example, to cost shifting to employees. "But we want to improve the quality of health care, not just shift costs.

"Business is global now—no longer are we operating in our own little segment of the world," he said, adding that U.S. firms must better manage health care costs if they are to remain competitive.

A health care consultant agreed.

"Your company's ability to retain profits and invest in new technology" is limited by the amounts paid for health care, said Lynn Etheridge, an independent consultant on health care financing based in Chevy Chase, Md.

MBGH

But, "we need to look to the payers to solve the payers' problems—not to the providers and not to the government," she said.

He also advised companies to "move away from an insurance system and try to build a purchasing and management system. You not only have to change employer and employee attitudes" toward purchasing health care. "You need to build management structures that don't currently exist in the medical care system," he said.

"When you have an open-ended system where all charges are paid," technology proliferates and ultimately drives up costs, he said, adding that U.S. companies too often equate cost with quality.

"The key problem in improving quality is the top buyers of health care—corporate America—don't buy based on quality," he said. "Until we put corporate and government dollars behind quality, we'll find no economic incentives behind buying quality."

Corporations should move away from a reimbursement system that merely pays claims based on the bills presented and invest more in obtaining quality health care, Mr. Etheridge suggested.

Based on current trends, national health care spending will reach $10.4 trillion in 1999, and corporate America's share of that will be $3.3 trillion, he said.

"Corporate America should be willing to put up an investment in personnel and resources when it realizes the magnitude of the problem," Mr. Etheridge commented. "The real rates of increase have not changed. The bottom line is that there is a need for a strategy," he said.

The Midwest Business Group on Health's strategy focuses on setting up partnerships among the various players in the health care system, says Brad McDonald, the corporate director of health systems at Honeywell Inc. in Minneapolis and a board member and secretary of MBGH.

Among the constituencies involved are employees, providers, insurers, third-party administrators, managed care organizations and the federal government, both as a payer and as a policy-maker.

These "value improvement partnerships" are designed to assure the delivery of quality health care, he said.

Mr. McDonald says employer-employee partnerships should focus on the employee as health care consumer, because recent changes from fee-for-service plans to health maintenance organizations have left workers very confused. And employees "are addicted to health care—they love it and feel they should be able to go anywhere to get it," he said.

As a result, employers have to explain how and where to get medical services.

The provider-employer partnership "is a new idea for many of us because we're used to hearing the physicians are the enemy," Mr. McDonald said.

But doctors and hospitals also are confused by, for example, employers that constantly seek discounts in return for patient volume and then don't give employees sufficient incentive to use those providers, he said.

In addition, dealing with utilization review firms has been difficult for physicians unaccustomed to outsiders questioning their judgment, he said.

But "physicians and hospitals will change the way they work if they are given feedback on how they should work and the opportunity to change," he said, adding that employers can influence this change.

The federal government "has been a powerful force as a payer," Mr. McDonald noted. For example, health care costs dropped significantly in 1984 when diagnostic related groups—DRGs—were implemented in the Medicare program.

In the future, Medicare's Resource-Based Relative Value Scale, which reimburses family practitioners and primary care physicians at a higher rate and specialists at a lower rate, "will even out disparities between the costs of different physicians and the types of services they offer," he said (*BI*, April 9).

In discussing government as a policy-maker, Mr. McDonald pointed out that decision makers are at least considering the idea of a national health care plan.

However, it is unclear whether businesses would welcome such a change, he said, noting that "business does not have a unified voice."

The bottom line for all of the participants in the health care system is to develop some sort of "value index" to measure quality, he said. If these partnerships are successfully established, that task will become easier, he added. ■

Sovereign immunity

Continued from page 3

immunity. The victim countered that a pay-as-you-go self-insurance plan set up by the county was the equivalent of commercial insurance and barred the county from using the sovereign immunity defense.

A lower court granted summary judgment on behalf of the county, but allowed the plaintiff to sue the deputy individually.

An appeal by the county was dismissed by an intermediate appellate court, but was heard by the state Supreme Court, which ruled on behalf of the county.

The high court reasoned that because there is no specific provision under Georgia law under which a county can set up a self-insurance plan, Richmond County could not have set up a self-insurance plan.

"Under the statutes dealing with liability insurance for government employees and officials, only state self-insurance plans will waive sovereign immunity," the court ruled. "There is no provision for a county to set up a self-insurance plan," the court said in its April 20 ruling.

"Therefore, the fund established by Richmond County is not a self-insurance plan which will waive sovereign immunity," the court ruled.

Richmond County budgets about $80,000 each year to pay tort liability claims, despite its sovereign immunity, explained Darlene Bartlett, the county's risk management coordinator. However, specific reserves were not established.

The county each year pays about 50 claims—large and small, she said. Any excess money is returned to the county's general fund.

"We try to budget to avoid running to the commissioners each time there is a claim," she explained.

The county had offered to settle the case for $15,000 but withdrew its offer after the April 20 ruling said it owed nothing.

"They are not going to give her a dime even though they admitted they were at fault," said plaintiffs' attorney John M.B. Lewis IV of Augusta, Ga. "I cannot understand how the court can allow a taxpaying citizen to bear this burden alone when the county reserved money to pay these claims."

Robert C. Daniel, a private attorney who represented the county in the litigation, predicted that the decision "will encourage the creation of risk management departments" among Georgia public entities.

The ruling, the first of its kind in Georgia, makes it clear that setting aside funds to pay claims will not waive a municipality's sovereign immunity, explained Mr. Daniel, with Burnside, Wall & Daniel of Augusta.

"There has been a lot of confusion surrounding self-funded programs," said Jock Connell, president of the Georgia Chapter of PRIMA.

"Clearly this decision allows counties to set aside money to pay claims" without losing their sovereign immunity, said Mr. Connell, who is risk manager for Gwinnett County. "Certainly this decision is going to encourage larger municipalities to set aside money to pay claims."

In addition, the ruling will "encourage governments to make more use of their immunity," he said.

Mr. Connell noted that the sovereign immunity defense in Georgia has been eroded over the years. "This decision not only shored up governmental immunity, but it gave it some more teeth," he enthused.

"This is probably some of the best news for municipal risk managers (in Georgia) in the last 3½ years," he said.

Brad Johnson, executive director of PRIMA, agreed: "This is a very important decision" and "an example of what will be happening is many states."

However, LSU's Mr. Pine cautioned about reading too much into the decision since laws relating to governmental immunity and liability insurance vary widely from state to state.

While risk managers and other observers generally praised the ruling, James G. Smith, president of AmGRIP, the governmental insurance unit of broker Johnson & Higgins in Houston, was sharply critical of the court's decision.

"Self-insurance and insurance are the same," he asserts.

He expressed concern that the ruling would encourage municipalities to set up inadequate and poorly funded self-insurance programs.

Mr. Smith urged the Georgia Supreme Court's latest decision be viewed in the light of a previous ruling in which the court held that the state's formal self-insurance plan was equivalent to commercial insurance.

Under a formal self-insurance plan, a government entity has documents that define the purposes of the self-insurance and reserves, he explained.

"This is a sad day for public risk management," said Mr. Smith. "This ruling will encourage local governments not to continue with the professional, formal self-insurance plans they had been establishing.

"This decision encourages governments to set up inadequate self-insurance plans," said Mr. Smith.

Frank Beltran, a plaintiffs' attorney with Beltran & Coffey in Atlanta, also criticized the ruling: "This decision says counties have the unilateral right to decide when to pay claims."

Mr. Beltran, who filed an amicus curiae brief on behalf of the state trial lawyers' association, blasted the decision as "unfair."

Ms. Bartlett, the Richmond County risk manager, also noted that beginning in 1993, the Governmental Accounting Standards Board will require that self-insured public entities report the estimated cost of probable losses on an accrual basis. This change will force self-insured public entities to establish formal reserves (*BI*, Jan. 15; July 17, 1989).

As a result, local governments may be leery of setting up programs similar to Richmond County's, she said.

"We're going to have to change in 1992," said Ms. Bartlett.

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Logue v. Wright, Georgia Supreme Court; No. S9060231.



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THE FAST TRACK TO A COMEBACK

Trans-Pacific

Continued from page 1

tank owners in the three states, while the Massachusetts department says the insurer has solicited medical malpractice insurance business from Massachusetts doctors previously insured by CARIB.

Trans-Pacific is unrelated to two licensed insurers with similar names, Trans Pacific Insurance Co. of New York, a unit of Tokio Marine & Fire Insurance Co. Ltd., and Trans Pacific Life Insurance Co. of Santa Monica, Calif., a unit of Primerica Corp.

Marty Martin, head of legal affairs in Trans-Pacific's administrative office in Washington, D.C., said the insurer will fight the cease-and-desist orders, which he said are unjustified.

Mr. Martin also denied that Trans-Pacific is legally a successor company to CARIB. The two insurers, he said, are independent subsidiaries of Commonwealth Risk Management Corp., a holding company based in Saipan in the Northern Mariana Islands, north of Micronesia.

The company is not related to Commonwealth Risk Services Inc. of Philadelphia.

Mr. Martin also accused state regulators of engaging in a vendetta against CARIB and Trans-Pacific.

"We feel there is a broad-based conspiracy within the National Assn. of Insurance Commissioners to destroy the company and its affiliates," Mr. Martin said. "You have a small cabal within the NAIC that is determined to ruin CARIB and its successors."

Meanwhile, Trans-Pacific has applied for a license to do business in Newfoundland, where it recently agreed to assume a book of marine business previously insured by another unlicensed offshore company.

The previous insurer of the marine business was Wilmington Marine & General Insurance Co. Ltd., a Turks & Caicos company that has been ordered to cease operating in the Canadian province.

Wilmington Marine & General was one of several offshore reinsurers that assumed business from Consortium of 89 Ltd., a London intermediary whose principal employees were arrested on fraud charges earlier this year (*BI*, Feb. 12).

In the process of a failed licensing effort in Newfoundland, Wilmington representatives were assisted by Alan Teale, who acted as a consultant on behalf of the insurer, said Paul Tapper, Newfoundland's insurance superintendent.

Mr. Teale, an Atlanta-based marketing consultant, says he did not represent Wilmington but was acting as a marketing consultant to other unidentified clients.

Mr. Teale is a former president of both the defunct Insurance Exchange of the Americas and American Trust Insurance Co. Ltd. of the Turks & Caicos (*BI*, July 25, 1988). Mr. Teale asserts that he has no continuing relationship with American Trust.

A decision on Trans-Pacific's license application in Newfoundland is expected shortly, said Mr. Tapper.

CARIB was incorporated in Guam in December 1986 and was hit with numerous cease-and-desist orders after it began offering malpractice coverage in several states.

The Indiana Insurance Department also sought a federal court injunction last year against Medical Liability Purchasing Group Inc. of Indiana, which it accused of acting as a front for unauthorized solicitation of business by CARIB. MLPG was separately the target of cease-and-desist orders in several states.

The 7th U.S. Circuit Court of Appeals later threw out the complaint, ruling that a lower federal court did not have jurisdiction to hear the suit (*BI*, Feb. 26).

Texas was among the states entering cease-and-desist orders against CARIB, and on April 5 it entered a similar order against Trans-Pacific.

In documents supporting the latest order, Texas regulators say the CARIB board of directors amended CARIB's articles of incorporation Nov. 7, 1989, to change the company's name to Trans-Pacific.

The name change was approved by the government of the Federated States of Micronesia on Feb. 16, Texas State Board of Insurance documents say.

Trans-Pacific—which is not a licensed or an eligible surplus lines insurer in Texas—started soliciting underground storage tank liability business in February and delivered a solicitation letter to a Texas resident Feb. 14 that included a quotation for pollution liability coverage, state regulators say.

The insurer's conduct "is fraudulent and creates an immediate danger to the public safety," insurance board documents charged.

The cease-and-desist order specified that Trans-Pacific had 30 days to request a hearing on the board's allegations.

On April 11, however, Trans-Pacific wrote to the Texas board, demanding that the board rescind the order and threatening legal action.

Trans-Pacific denied in the letter that it had solicited Texas residents, saying that solicitations had been mailed by the National Assn. of Storage Tank Owners & Operators, a Washington, D.C.-based organization, and that Trans-Pacific only responded to a request for a quotation.

Business Insurance was unable to reach officials of the National Assn. of Storage Tank Owners & Operators. Although solicitation material shows a Washington address for the organization, it has no Washington phone listing.

Trans-Pacific's letter to the Texas board did not request a hearing on the cease-and-desist order. No hearing has been held, and the board has not responded to the insurer's letter, a board spokesman said.

The Kansas Insurance Department issued a cease-and-desist order against Trans-Pacific on May 2, charging the insurer with unlawfully advertising an underground storage tank liability insurance program.

While the Kansas order does not say how the insurer advertised, Mr. Martin said in an interview that Trans-Pacific has advertised in magazines an on radio.

The advertisements display Trans-Pacific's Washington address and telephone and telefax numbers and instruct potential policyholders to mail responses to a Washington post office box, the Kansas order says.

Noting that Trans-Pacific's street address, phone and fax numbers and post office box number are identical to CARIB's, the Kansas order concludes that the two insurers "are either the same entity or directly related to each other."

The Kansas department had issued a cease-and-desist order against CARIB earlier this year and later entered a default judgment against the insurer when representatives failed to appear at a Feb. 1 hearing.

Trans-Pacific, which is not licensed in Kansas, violated state laws prohibiting unfair and deceptive business practices by insurers, the latest cease-and-desist order alleges.

A July 12 hearing on the order has been scheduled.

Meanwhile, the Oregon Insurance Department issued its cease-and-desist order on May 10 after finding that Trans-Pacific mailed solicitation material for underground storage tank liability coverage to an Ashland, Ore., gasoline station.

Trans-Pacific is not licensed or approved as a surplus lines insurer in Oregon and violated state insurance law by mailing the solicitation, the Oregon department charged.

Trans-Pacific has requested a hearing, but a hearing has not yet been scheduled, a department spokeswoman said.

Separately, the Massachusetts Insurance Division sent a letter to Trans-Pacific President Martin Jano on May 11 ordering Trans-Pacific to cease writing medical malpractice coverage in the state.

The letter charges that Trans-Pacific has been soliciting medical malpractice business and issuing policies to Massachusetts doctors whose CARIB coverage was up for renewal. Correspondence to these policyholders indicated that Trans-Pacific was the new name for CARIB, the Insurance Department's letter says.

CARIB is not licensed in Massachusetts, and the state last September denied CARIB's application for admission as an approved surplus lines insurer.

Trans-Pacific is also not licensed in the state, and the Insurance Department's May 11 letter to Mr. Jano notes that "it appears you are impro-

Continued on next page

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Trans-Pacific

Continued from previous page
perly doing business (using) the same name as another insurance company," referring to the Tokio Marine subsidiary.

In a May 11 reply, Mr. Jano pointed out what he described as inaccuracies in the Massachusetts letter. Among other things, he denied that Trans-Pacific is doing business under another company's name, noting that the Micronesia insurer's name is hyphenated while the Tokio Marine subsidiary's name is not.

Mr. Jano also denied soliciting business in Massachusetts, saying that "insureds obtain their insurance with our firm by contacting us directly and soliciting us."

Meanwhile, Trans-Pacific officials have repeatedly denied the insurer is a successor company to CARIB, though their explanations of Trans-Pacific's history vary.

In its April 11 letter to the Texas State Board of Insurance, Trans-Pacific said it is not a successor to Guam-based CARIB, but is instead a successor to another Micronesia-based company, also called CARIB.

CARIB of Micronesia changed its name "to prevent confusion" after finding that the Guam-based insurer was operating under the same name, the letter explained.

In his May 11 letter to the Massachusetts department, Mr. Jano said Trans-Pacific was originally called Casualty Assurance Co., but changed its name "when it became apparent that a similarly named company was operating out of Guam."

Mr. Martin, head of legal affairs in Trans-Pacific's administrative office, said during an interview last week that Trans-Pacific, CARIB of Guam and a third insurer, Casualty Assurance Co. of Saipan, are all units of Commonwealth Risk Management of Saipan.

The three insurers had consolidated assets of $9.4 million as of March 31, consisting mostly of cash and cash equivalents, according to Mr. Martin, who added that the three insurers share assets and liabilities.

Trans-Pacific and CARIB also share the same top officers, including Mr. Jano, president of both companies, and L. Allen Bramson, treasurer of both companies, according to Mr. Martin.

Mr. Martin also maintained that Trans-Pacific has not solicited any business in the United States.

Trans-Pacific is taking advantage of "direct procurement" statutes that Mr. Martin said are in force in most states and that allow an insurer to operate without a license or surplus lines approval as long as policyholders procure coverage directly from the insurer without being solicited.

While confirming that Trans-Pacific has advertised its coverages, Mr. Martin maintained that this does not legally constitute "solicitation" and instead represents a constitutionally protected form of free speech.

"The company is not soliciting anybody," Mr. Martin said. "It seems as if most insurance commissioners don't understand the legal definition of solicitation.

"There is a common thread running through all this," he said. "The common thread is that there is a cabal within the NAIC that is out to destroy CARIB and Trans-Pacific.

"We are not a lawless, renegade company running amok in the insurance industry," he maintained.

While it deals with regulatory problems in the United States, Trans-Pacific is trying to obtain a license in Newfoundland.

Mr. Martin confirmed that while its license application is pending, Trans-Pacific has agreed to assume a book of fishing vessel business by portfolio transfer from another insurer, Wilmington Marine & General.

The marine business produces less than $1 million in annual premiums, Mr. Martin said, adding that Trans-Pacific has not yet assumed any premiums and will not be able to follow through with the portfolio transfer if its license application is denied.

Trans-Pacific offered to replace Wilmington Marine & General after Wilmington was ordered to cease operating in Newfoundland earlier this year.

In an April 27 consumer alert, Newfoundland Attorney General Paul D. Dicks said a review of a license application by Wilmington raised "a number of serious concerns." Among other things, Wilmington failed to provide acceptable financial statements and adequate information about its ownership, the consumer alert said.

In a March 31, 1989, audited financial statement obtained by *Business Insurance*, Wilmington reported $21.9 million in assets, including $13 million in certificates of deposit and a $5.5 million surplus contribution from its parent, American Financial Co., which is domiciled in the Turks & Caicos and operates from an office in Lexington, Ky.

American Financial Co. is not connected with Cincinnati-based American Financial Corp., the insurance holding company controlled by financier Carl Lindner.

According to the financial statement, American Financial Co. "comprises subscribers of assets which those involved have provided to provide an asset base for insurance companies subsequently incorporated."

Mr. Tapper, Newfoundland's insurance superintendent, said regulators were unable to determine who owns American Financial Co. and could not confirm the existence of three different certified public accountants who audited various Wilmington financial statements.

The March 31 statement was audited by John Singh, a New York CPA, who could not be reached.

Robert R. Campbell, chief executive officer of American Financial Co., referred written questions to a Montreal lawyer, who never responded.

Mr. Tapper said he was told by the St. Johns, Newfoundland, law firm representing Wilmington that information supporting the insurer's license application was provided it by Mr. Teale.

Mr. Tapper also said that Mr. Teale told him in a May 25 meeting that Mr. Teale he had served as a consultant on Wilmington's behalf during the license application process, but that he had since ceased his role as a consultant on Wilmington's behalf.

Responding to written questions, Mr. Teale last week asserted that "Wilmington was represented in its submission by local counsel, not I," adding, "I do not transact insurance business for or with Wilmington."

Mr. Teale said he was hired as a marketing consultant by "various parties"—which he did not identify but which he said did not include Wilmington itself—to advise on a competitive squabble among local insurance agencies representing different marine insurance markets.

Mr. Teale said he advised his clients that Wilmington should obtain a license in Newfoundland and establish a trust fund for claims.

He said his role was limited to giving "marketing advice."

By the time it was ordered to cease operating in Newfoundland, Wilmington had issued about 135 fishing vessel policies through Avalon Insurance Services 1988 Ltd. and Atlantic Intermediaries Inc. of Mount Pearl, Newfoundland, according to the consumer alert.

Avalon did business with Risk Management Underwriters Inc., a Wilmington underwriting manager based in Severna Park, Md., *Business Insurance* learned.

The Maryland Insurance Department is investigating Wilmington and the principal of Risk Management Underwriters, Graham Haywood, a department spokesman confirmed.

Neither Wilmington nor Mr. Haywood is licensed in Maryland.

Mr. Haywood said he would cooperate with the department and that Risk Management Underwriters "conducted its business affairs in compliance with Maryland state laws."

Business Insurance

Publishing: July 2

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INTERNATIONAL

East Germans seek insurance advice

By DON LEWIS KIRK

BERLIN—Representatives from several East German state-owned conglomerates acknowledge a need for outside assistance with insurance and risk management.

About 120 representatives met with West German broker Jauch & Hubener late last month in Berlin to discuss their insurance options as East Germany loosens control over the industrial conglomerates, called "kombinates," and private enterprise becomes more prominent.

Most of the 129 kombinates, which currently control 95% of the country's industrial production, are confronted by a host of new insurance problems, particularly in business interruption and product liability, according to Joachim F. Scheele, a partner at Jauch & Hubener in Mulheim, West Germany.

"With compulsory insurance at an end, risk management is an individual company responsibility," he noted.

Many politicians in both Germanys now favor breaking up the kombinates into smaller companies or subsidiaries, according to Jauch & Hubener.

Such a move would make insuring these newly created companies' business interruption exposures a central issue, says Rolf Knauf of the West German broker. "For example, these smaller companies would be supplying parts and equipment to other companies. Should a fire occur at a key point in the production, these smaller companies would be liable," he said.

Another key issue facing kombinates is how to calculate the value of facilities for property insurance, said Mr. Knauf.

"That's particularly important in the area of industrial fire insurance," he said.

"Such an evaluation doesn't exist in East Germany and, with the economic union of West and East Germany taking place in July, East German companies are confronting a large gap in the gross value of their companies. Losses will be paid in deutsche marks and these companies are not evaluating their value" on these terms, he said.

Product liability exposures also are unknown to East German kombinates, according to Ernst-Henning Heinsius of Jauch & Hubener. As the two economies are unified, East Germany will be subject to new European Community regula-

Continued on next page



BWJOHN SMITHER

Back from U.S.S.R., Lloyd's chairman ponders Soviet ties

LONDON—The Cold War appears to be thawing between Lloyd's of London and Soviet insurance officials following Lloyd's Chairman Murray Lawrence's trip to the Soviet Union last month.

For many years, Lloyd's underwriters have written reinsurance for Ingosstrakh, one of two Soviet state-owned insurers, noted Mr. Lawrence. However, the volume of reinsurance purchased by Ingosstrakh from Lloyd underwriters—about $5 million in annual premiums—is only a small fraction of the total Soviet market, he said.

But Mr. Lawrence said that during his week-long trip to Moscow and Leningrad, Ingosstrakh was "very keen to explore with us ways and means in which we could do further business developments."

Ingosstrakh, he said, sought support from Lloyd's in three areas:

- Joint ventures. Lloyd's is not involved in many of the Western-Soviet business partnerships sprouting throughout the Soviet Union. However, Lloyd's could be an important partner in, for example, joint ventures with oil and gas companies or large construction projects.

Lloyd's sees insuring risks like refineries as "an important role," adds Lloyd's non-marine underwriter Richard Hazell, who accompanied Mr. Lawrence on the trip along with Barry Gibson, manager of the international department at the Corporation of Lloyd's.



Mr. Lawrence

- Satellite launches. A Soviet satellite launch program, set to begin in 1992, will be available to to Western satellite owners.
- Credit insurance. Officials expect trade between Soviet and foreign companies to increase greatly, which will increase the need for credit insurance.

"Now that we're back in London, we're going to explore (these areas) with the underwriters who specialize in these and see if there is something we can do to help," said Mr. Lawrence.

Mr. Lawrence said he is also considering Ingosstrakh's request to send some of its employees to London to learn how the market operates and to receive training in Western underwriting practices.

The Lloyd's officials spent about a week in the Soviet Union at the invitation of Ingosstrakh. It was the first Soviet visit by a Lloyd's chairman since the Russian Revolution in 1917.

The Lloyd's delegation also met with officials from the state-owned bank, the Ministry of Finance and Gosstrakh, the Soviet domestic insurer that writes about 18 billion rubles in annual premiums, mainly for life and agricultural insurance.

The Lloyd's executives learned, for example, that the Soviets have no concept of property insurance because the government has controlled all property for years.

Also, the Lloyd's officials noted, there is no infrastructure to control insurance or banking. "There is no concept of debt, credit or prices," said Mr. Hazell.

"A tremendous amount of work" remains to be done on insurance and banking legislation that is now being drafted by the Soviets, said Mr. Lawrence. He adds that Westernization will require "hundreds if not thousands of accountants" and lawyers to draft and interpret necessary legislation.

Mr. Lawrence said Lloyd's will not follow the lead of some Western insurers that are rushing to set up joint ventures, noting that changes in the Soviet Union will not occur overnight.

With 245 million people, massive natural resources and huge potential, "they have got to move forward. . .and insurance must be part of that. But it's just a matter of time," said Mr. Lawrence.

"As underwriters, we hate to be excluded anywhere in the world where there is a potential for business," added Mr. Hazell.

Both sides left the meeting thinking "what a crying shame the last 45 years have been. . .what a waste of time," added Mr. Lawrence.

—By Stacy Shapiro

Companies warned local focus may be costly

Insurers going global

By ROGER SCOTTON

SOUTHAMPTON, Bermuda—Commercial insurers that concentrate on their domestic markets at the expense of opportunities elsewhere increasingly risk losing customers to competitors operating globally.

That was the warning from Stewart H. Steffey Jr., senior vp at CIGNA Worldwide Inc. in Philadelphia, who spoke at "Bringing Down the Barriers: Breaking through in a Changing Global Marketplace," a conference sponsored by the New York Chapter of the Society of Chartered Property & Casualty Underwriters and the Bermuda Insurance Institute, held May 26-29 in Southampton, Bermuda.

Mr. Steffey, who serves on the board of the National Foreign Trade Council and is a member of the international policy committee of the U.S. Chamber of Commerce, said that global views and global needs have not always affected insurance buying. Country managers of multinational firms regularly have purchased insurance locally, independently of their parent corporations, he said.

"But as risk management has become more sophisticated, it has also become more centralized, creating increased demand for insurers who can provide consistent service and coverage for all the customers' facilities wherever in the world they might be."

Mr. Steffey said that more insurance companies are ranging further and further from their home bases to find new customers and to service the international needs of customers they already have.

He attributes this expansion to increased competition and a trend toward insurer specialization. Competitive pressures, he says, are likely to intensify rather than diminish.

"Those who hope industry consolidation will ease competitive pressure may be in for a rude awakening," he said. "First of all, with literally thousands of insurance companies in operation, the disappearance of a small number of companies is unlikely to remove significant insurance capacity from world markets.

"More important, industry consolidation is likely to have the opposite effect," he continued. "It may allow a stronger competitor to replace a weaker competitor, thus raising, not lowering, competitive pressure."

Mr. Steffey pointed to the European Community directives for freedom of services and establishment as examples that are widely expected to lead to consolidation among European brokers.

"If a major U.S. or U.K. house absorbs a local indigenous broker in France, arithmetically, the num-

Continued on next page

E.C. changes will lower insurer profits, S&P says

By MARK A. HOFMANN

NEW YORK—The integration of European Community insurance markets will be less a "big bang" than a gradual melding marked by instability and depressed profits, contends a Standard & Poor's Corp. report.

U.S. and Japanese insurers' domestic—rather than international—orientation will keep them off center stage in Europe for the near future, says the report. Japanese companies, though, seem more likely than their U.S. counterparts to work actively to ensure market access, says "S&P's Review of E.C. 92's Impact on European Insurance Markets," prepared by S&P's Insurance Rating Services.

The Europeans themselves are not in any rush to fully unify the market, the report says.

"Before a 'common market' or single European market becomes a reality, more regulations need to be developed and then phased in. Some of these technical matters will be slowed by political obstacles, including newly emerging concerns regarding German reunification," the report says.

"Despite the legal freedom to sell throughout a single European market, simply allowing cross-border transactions will not make them commonplace," the report continues. "This is especially true for insurance, where domination by domestic providers leads to strong nationalistic overtones."

Nevertheless, E.C. insurers will eventually find it in their interests to stake out territory beyond their traditional borders. This "will likely result in years of instability," says S&P.

Insurers will "establish branches in areas that will not be economically viable in the long term, overpay for acquisition targets and engage in reckless price competition to buy market share," predicts the report. "The outcome for many will be poor profitability—and perhaps even operating losses—and a general decapitalization."

S&P says it is "quite likely that more than one round of excessive competition will be experienced before rational pricing prevails, given the diverse influences on the market and the participants' unfamiliarity with open competition."

Due to extreme competition, S&P foresees European insurers' profit margins "under pressure at least until the end of the century."

Many European insurers operate on a tighter margin of capital to surplus than their U.S. or Japanese counterparts. And, says S&P, their inability to generate significant operating profits as premium volume increases will lead to reduced adequacy of capital to obligations and a "concurrent reduction in security for policyholders."

But companies that don't compete for market share also face significant risks, the report holds.

"A company opting to do nothing actually may see its competitive stance deteriorate. And, as it waits for the markets to develop, a company may find itself the target of a more aggressive neighbor. Getting into position early for (the integration of European insurance markets) may be the only means of fully participating," says the re-

Continued on next page

INTERNATIONAL

East Germany

Continued from previous page
tions that impose strict liability on manufacturers, he noted.

He estimates a kombinate's liability and property insurance limits combined averages about 50,000 deutsche marks ($29,000). But they need "at least 10 times that amount" and possibly as much as 10 million to 20 million deutsche marks ($5.8 million to $11.6 million), he said. "These companies can handle small claims, but what happens when they are suddenly part of the E.C. and strict liability applies?" Mr. Heinsius asked.

At present, Deutsche Versicherungs A.G., the joint venture of Allianz A.G. Holding and East German insurer Staatliche Versicherungs der DDR (*BI*, April 16), insures most of the kombinates, according to Mr. Heinsius.

The joint venture covers liability and property exposures but will need to augment policies after the German economic union to cover business interruption, product liability and other risks, he said.

At a time when East German kombinates are looking abroad for growth of their fledgling private enterprises, many are surprised by the insurance demands.

"We didn't know about business interruption," says Homan Kleinert of Zentraler Industrienlagenbau der Mettalurgie in East Berlin, the kombinate that oversees smelting facilities. "We'll have to evaluate the situation. Just forming a company is not enough. We need expert help from outside."

Insuring risks at one of "the people's own factories" will depend on just how well East German industries survive the economic union, said Karl Homann, a representative of an industrial pump manufacturer in East Berlin.

'The potential for liability is much greater in East Germany. We haven't had to stick to strict standards as in the West. The only possibility I see is a certain grace period,' says a representative of East Germany's energy kombinate in Potsdam.

"We aren't sure what will happen to our company. We don't know how many employees we can keep and what machinery we can hold. That makes it difficult to evaluate risk under those conditions," Mr. Homann said.

"We really need counseling," said a representative of the kombinate that oversees heavy machinery manufacturing. "It's a matter of rethinking everything. We used to let the state worry about insurance. Now it is our responsibility."

Concern over the impact of new Western liability standards is growing among kombinates, said a representative of East Germany's energy kombinate in Potsdam.

"The potential for liability is much greater in East Germany," she said. "We haven't had to stick to strict standards as in the West. The only possibility I see is a certain grace period in which we can slowly move up to Western standards."

The meeting with Jauch & Hubener marks the first time many of these East German firms have addressed the questions of industrial risks, losses and insurance. The East German industries most likely to be affected by the economic union are machinery manufacturers, plastics factories and industrial construction companies, the brokerage estimates.

The heritage of the politically controlled, centrally planned economy in East Germany is shown in the huge overhead in the labor force and very old, low-tech machinery, said Mr. Scheele.

"The transition to a productive, market-oriented economic system requires an assessment in Western terms most kombinates are not able to do themselves," he said.

"Much will depend on West Germany's tolerance, at first," Mr. Scheele said. "The companies in East Germany will need a grace period and insurers will have to come up with new products to fit a very special situation."

However, East German industry will catch up with Western companies much faster than other Eastern European countries, despite problems resulting from years of state control, he predicted.

The fate of the kombinates will also depend on their competitiveness, according to Mr. Scheele.

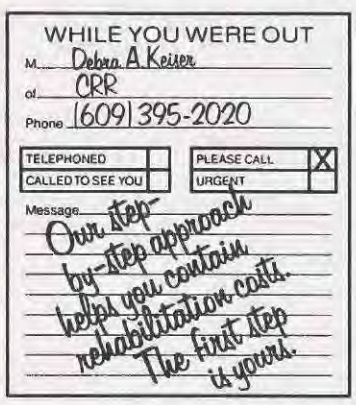
"In that regard, the liability question will be very important," said Peter Hermes of Jauch & Hubener. "Kombinates don't have the same standards we do in West Germany. What happens when the economic union takes place and these companies are suddenly liable when fish start dying in their rivers?" he said. ■

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Global markets

Continued from previous page
ber of competitors goes down. In reality, the intensity of competition goes up," he said.

Mr. Steffey predicted that the expansion of world trade will step up insurance industry competition. One reaction to that, he said, is "to expand your sales territory into areas where competition is less keen and growth potential is greater."

In 1950, almost 75% of the world's insurance premiums were written in the United States, he said. By last year, the U.S. market share was 40%—still by far the world's largest, though not its fastest growing market.

Eastern European nations, most of the Asia-Pacific market and nations with developing industrial bases are the markets offering potential for significant premium growth. He observed that these are also the markets where much of the world's merger, acquisition and joint venture activity is now taking place.

"I don't mean to imply that every insurer has jumped on the international bandwagon or that this trend is universal," said Mr. Steffey. "It is far from that. One reason is that many countries still have formidable barriers to entry into their insurance markets. Some countries have been quite successful in excluding all but domestically-owned underwriters. Some countries still have state-run insurance monopolies. And others maintain such a highly-regulated industry, they stifle real competition and create a chilling effect on would-be market entrants."

Mr. Steffey said that many U.S. insurers "have little or no overseas presence and only a tiny number have what could be called a truly global network." It would be more accurate to describe many European and Japanese insurers as "having a multinational rather than a global presence," he added.

Though accepting that "cross-border expansion by carriers is a demonstrable trend in our industry and quite probably represents a fundamental shift in industry focus," Mr. Steffey argued there was a "substantial difference" between expanding into new markets and having the capability to handle accounts on a global basis.

"After all," he said, "there is a big difference, even a crucial difference, between an insurer with facilities in many of the same countries where a customer operates and an insurer with facilities in all the countries where that customer operates."

But Mr. Steffey said the differences between multicountry and global insurers "run deeper than that."

"A global insurer is more than just big. It's a specialist competing in a well-defined market segment for multinational accounts."

Mr. Steffey said ubiquity was only one requirement for global insurers.

Serving multinational accounts also requires "the ability to deliver sophisticated risk transfer and risk management products and programs, engineering and loss control consultation, advanced claims management and worldwide loss reporting systems," he said.

"A carrier that can do all that, and do it anywhere in the world, is prepared to handle the multinational account. Companies that are prepared to deliver only some of those services, or conversely, all of those services only in some places, will be increasingly vulnerable to the global specialists."

Being there, however, is not enough. Global insurers need intimate knowledge of their markets, according to Mr. Steffey.

"Knowing how to settle a cargo damage claim in Singapore comes from handling a lot of claims in Singapore," he explained. But knowing how policy forms in Milan differ from policy forms in Malaysia comes from having experienced professionals and country nationals operating in those markets every day. And, experience comes from having customers who need local coverage in both Milan and Malaysia, he said.

"Somewhat ironically, you could say that a global capacity is really the linking of local capability," he commented.

Mr. Steffey said this linkage, as much as the capabilities themselves, is becoming increasingly important to multinational customers who have high expectations for the timeliness and accuracy of claims information, premium collection and currency conversion.

And insurers that intend to provide a global service "had better be prepared to invest in the development and deployment of advanced electronic information systems," he said. ■

1992 forecast

Continued from previous page
port.

S&P points out that the stakes in Europe are high.

For example, West Germany has the world's third-largest insurance market, after the United States and Japan. West Germany accounted for about $45 billion in non-life premiums in 1987—nearly 8.6% of the world total. An estimated $28.8 billion in non-life premiums in 1987 make France the fourth-largest non-life market, with 5.48% of the total volume. Great Britain ranks fifth with a 4.51% share.

Stakes are also high for European insurers outside the E.C., the report says. Many Swiss companies, for example, have had subsidiaries in E.C. nations for years and "will benefit significantly from their unique position in many European markets," says S&P.

The Swedish and Finnish insurance industries are also preparing to capitalize on developments to the south, the report says.

"Noticeably absent in all the changes transpiring in Europe are U.S. and Japanese insurers," says S&P. "In both instances, this is the result of insurance industries that are overwhelmingly oriented to domestic markets and thus have little desire to participate in Europe."

Most U.S. insurers "have enough opportunity and challenge operating solely in the U.S." says the report, in large part because their sheer number assures a high degree of competition. Japanese insurers, on the other hand, are relatively few in number and benefit from a system of regulation that "has created a very stable and profitable domestic environment that makes other markets less appealing."

However, S&P notes several Japanese companies' recent equity investments in European insurers. "It would appear that the Japanese companies, recognizing the changes transforming Europe, have chosen this route to ensure access to this market."

Also, some U.S. companies "will be unwitting participants in an unusual way" as European insurers buy American insurers to assure access to the U.S. market, according to the report. ●

Copies of "S&P's Review of E.C. 92's Impact on European Insurance Markets" can be obtained free by calling Standard & Poor's Insurance Rating Services at 212-208-1690.

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INTERNATIONAL

More captive growth seen

By ROGER SCOTTON

SOUTHAMPTON, Bermuda—The number of companies with captive insurers could swell to 5,000 in the 1990s from fewer than 3,000 now, says an Irish regulator.

And nearly all this growth will be in onshore domiciles, predicts Pat Tolan, manager of International Financial Services for the Dublin, Ireland-based Industrial Development Authority.

Mr. Tolan spoke at a global insurance conference sponsored by the Bermuda Insurance Institute and the New York Chapter of the Society of Chartered Property & Casualty Underwriters, held May 27-29 in Southampton, Bermuda.

Mr. Tolan predicts the number of offshore captives will remain near its present level—about 2,350.

Adding to onshore captive growth will be the formation by large offshore captive insurers of new sister captives to service a company's needs in North America, Europe and other specific areas, he said.

"Obviously, the U.S. would be served by an onshore captive and the E.C. would be served by an onshore captive, while the rest of the world could be served from either of these onshore locations or an existing offshore captive," Mr. Tolan said.

Other factors likely to influence captive industry growth during the '90s include the creation of the single market in Europe, increased captive activity due to a hardening market and a rise in the number of multinational corporations needing and capable of sustaining captives, Mr. Tolan said.

"Furthermore, there is a likelihood that premium income will shift onshore so that the offshore captives will handle a lower premium volume," predicted Mr. Tolan.

"In respect of premium income handled by captives, I expect that this will more than double to approximately $25 billion from its current level of approximately $10 billion per annum. This would represent a loss in premium of $15 billion per annum to the conventional insurance sector and a substantial scaling up of captive activity," he said.

Mr. Tolan said that through mergers and acquisitions, more and more corporations "are crossing the threshold where they can support captive insurance operations."

At the same time, the image of the captive insurance sector has "improved substantially" over the past decade, he said.

Mr. Tolan also noted that Europe's planned single market for industrial insurance is to become effective in July.

This will allow companies to purchase insurance "on a cross-border basis" rather than in each member state, and is expected to stimulate captive development within Europe, Mr. Tolan said.

Also stimulating the growth of onshore captives is some European nations' disallowance of tax deductions for premiums paid to "an overseas insurance company where the domicile of that insurance company is regarded as a tax haven," he noted.

"This is one of the principal reasons why European companies have not established offshore captives in great numbers to date," Mr. Tolan said.

Mr. Tolan said his predictions, though based on his personal views, have "serious implications" for the world's offshore insurance domiciles.

However, "the threat appears to be more long-term than immediate," he added. ■

Emerging insurance markets viewed

By ROGER SCOTTON

SOUTHAMPTON, Bermuda—Prospects are bright for South Africa becoming a more prominent market for foreign insurers, an insurance educator says.

And insurers that want to participate in the South African market should start by getting to know the country and its neighbors, recommended David Bland, director general of the Chartered Insurance Institute of London.

For the first time in living memory, South Africa faces the prospect of moving "relatively peacefully" into a genuine democracy, he said at a session on emerging insurance markets during a conference on global insurance held in Southampton, Bermuda May 26-29. The conference was sponsored by the Bermuda Insurance Institute and the New York chapter of the Society of Chartered Property & Casualty Underwriters.

If South African leaders "achieve a statesmanlike compromise," then the future of the nation and the whole continent could be "opened up in a truly positive manner," Mr. Bland said.

The South African insurance industry basically is an extension of the British market, he said.

British Prime Minister Margaret Thatcher's "relatively weak stance" on South African sanctions "has meant that reinsurance through London has remained strong and the remittance of profit to London from South African subsidiaries of the British insurance industry remains substantial," Mr. Bland said.

The nation's emerging black middle class and the rise of wealthy black entrepreneurs has "strengthened the emergent life insurance industry," he said. Increased car ownership has had a similar effect on auto insurance, he added.

Mr. Bland says he foresees a "vigorously democratic and economically strong" South Africa.

"Decide what niche you want to start in if—I should say when—my political optimism proves to be justified," he said.

Mr. Bland was not as optimistic about India, where domestic insurance has been nationalized since 1973.

Change in South Africa is "really spectacular," but India is "relatively unchanged," he said.

The New Dehli government has tried to shore up its hard currency reserves by drastically limiting foreign reinsurance, Mr. Bland said.

But, "it hasn't been possible for the Indians entirely to cease using overseas reinsurance," he said. Reinsurance treaties have mostly been placed with German and Swiss companies.

Only auto insurance is mandatory in India, Mr. Bland said.

However, "every form of political corruption and bureaucratic skulduggery is applied indiscriminately to the disadvantage of the insurers and, through them, to the disadvantage of all road users whose security from the insurance of vehicles is very much less than it would be in a more rationally ordered society," he said.

Mr. Bland warned that separatist movements and religious parties, both of which are growing in influence, make the prospect for political confusion in India strong.

"I think that the negative force of conservatism and the fear on the part of any government being accused of selling the people's birthright—by offering insurance companies to foreign purchase—means that freedom for the industry is a long way off," Mr. Bland said.

In Turkey and other Middle Eastern nations, opportunities for foreign insurers are also limited, another speaker said.

And doing business in this region is neither for the faint of heart nor always possible, said Ahmet Celebiler, managing director of Alexander & Alexander Sigorta Misarvirlik A.S. in Istanbul.

He described the region as "teeming with violence" and other types of "not easily decipherable activity."

Iran, Iraq and Syria allow only state-owned insurers to conduct business within their borders and many other nations require insurance for government projects to be purchased from state companies, he said.

For companies aiming to provide services in the Middle East for multinational clients, he recommended using loans to start up an operation and keeping foreign contributions to a minimum.

"With few exceptions, we are talking of countries with high inflation and either exchange controls or the threat of exchange controls," he said. "You bring $10 million capital, convert it into local currency and change your mind for one reason or another after three months and before you start operations. If you are allowed to purchase dollars with your local money, you will find that suddenly your $10 million has become $8 million or $9 million."

Mr. Celebiler also urges using great care in choosing local partners.

Despite the difficulty in doing business, the Middle East has some markets "where not only the adventurous but also the far-seeing should enter. The potential is there," Mr. Celebiler says.

In spite of the emergence of several new insurance markets in the world, one speaker predicted very few changes of real substance among successful "market players."

Peter Walker, a director of management consultant McKinsey & Co. in New York, predicted the major insurance companies in these markets today will still be the major companies in 10 to 15 years.

"The companies that set out to win and have a real spirit to be excellent are the ones who are going to wind up on top," he said. "The winning companies increasingly will be focused on the basics of getting it right in marketing and underwriting and claims and they will instill that spirit of continuous improvement." ■



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Janet Nelson

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ability to bring complicated actuarial issues "down to layman terms, and that's unusual for actuarial people," said Kenneth F. Goldstein, executive vp of The St. Paul Cos. and subsidiary St. Paul Fire & Marine Insurance Co.

Ms. Nelson's ability to cut to the bone on complex issues served her well once she made the transition to underwriting, he said.

Ms. Nelson moved in 1982 from the actuarial office to financial service manager-specialty risk for Atwater McMillian Inc., the former name of underwriting manager St. Paul Specialty Underwriting Inc. St. Paul Surplus Lines' business is written by two SPSU units.

Ms. Nelson turned her actuarial savvy to her advantage and combined it with an intense interest in learning all phases of underwriting, Mr. Goldstein said.

"In a lot of ways, Janet had a lot of things going against her," said Mr. Goldstein, who has worked with Ms. Nelson since 1984. "But she always showed an attitude of wanting to learn. She has a real thirst for knowledge."

Mr. Goldstein recalled that in 1984, which "wasn't an easy year to be in the insurance business," Ms. Nelson was unique because "she brought the analytical side of her background to underwriting." Her perspective lent "a freshness of looking at things," he said.

For her part, Ms. Nelson feels she was lucky because she worked with Mr. Goldstein, as well as St. Paul Cos. Executive Vps James F. Duffy and Richard W. Tongen. Mr. Tongen has since retired.

"The people who made a difference in my career are people who took a chance on me," Ms. Nelson said, explaining they gave her the opportunity to prove herself on projects that she "wasn't necessarily the best suited for."

"There's a tendency in avoiding that kind of a risk decision with a woman," she said, explaining that career advancement was not easy 17 years ago when women had less of a presence in the insurance business.

Mr. Goldstein said he helped Ms. Nelson "make connections with some agents and brokers" but credits her entirely for advancing her career from there. "It only works if you can apply yourself and use your talents to make things work your way," he said.

Ms. Nelson believes the insurance industry now measures up to other industries in advancing women.

However, the corporate culture in general still can be stifling to women, Ms. Nelson said.

"There is a lot more consciousness of women in the industry today," she noted. "But, like any business, insurance is driven by interpersonal relationships, and some people have certain preconceived notions and mindsets" about dealing with women professionally as peers or superiors.

"We're functioning in a (corporate) world that's designed around a way of conducting yourself that's not necessarily best for women to demonstrate their strengths," Ms. Nelson observed. Women "are dealing somewhat with an alien environment."

The result is that many good women, unhappy with a restrictive corporate structure, leave the industry to start their own businesses or pursue careers in other fields, she said. This partially explains why there are so few women in high-ranking positions in the insurance industry, she said.

However, the insurance industry "has been much more of a failure with responding to racial minorities than women," lagging far behind other industries in integrating minorities into upper management positions, she said.

Ms. Nelson said the insurance industry must "learn how to celebrate diversity" and tap the strength of its individuals "rather than gravitate toward the comfort of homogeneity, which it has a tendency to do."

Before joining St. Paul, Ms. Nelson graduated with a bachelor of arts degree in mathematics from Macalester College in St. Paul.

Ms. Nelson is a Fellow of the Casualty Actuarial Society and a Member of the American Academy of Actuaries.

The annual APIW Insurance Woman of the Year award recognizes a woman in a senior management position who has achieved prominence in the insurance or reinsurance industries.

Ms. Nelson will receive her award at a June 13 reception at the City Midday Club in Manhattan. For information, contact Ms. Cohen at 212-688-8411. ■

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Experts cite alternatives to Visclosky proposal

By ADRIENNE C. LOCKE

WASHINGTON—There are better ways to ensure workers a voice in pension plan decisions than giving them joint trusteeship as the so-called Visclosky bill would require, some pension experts say.

Employers can ensure representation in pension plan decisions by opening trustee meetings up to employees, said Roy A. Schotland, a Georgetown University law professor.

However, other opponents of the legislation argue that trustees should be professional investment managers, with decisions moved out of the hands of employers and employees altogether.

The bill, H.R. 2664, introduced by Rep. Peter J. Visclosky, D-Ind., would require employers to appoint employee trustees to share control of defined benefit and defined contribution pension plans.

However, the bill would not limit employers' liability for plan performance (*BI*, Jan. 22).

The experts made their comments last week to the House Committee on Small Business at a hearing on how various pension issues—including portability and simplification of pension law—would affect small businesses.

At a March hearing of the House Subcommittee on Labor-Management, business groups strongly criticized the Visclosky bill (*BI*, March 5).

Mr. Schotland, who opposes that bill, called it "an overboard solution" to the problem of ensuring that trustees hear the concerns of plan participants and that participants are kept abreast of plan decisions.

Employers' concern over employees gaining "control" of pension plans "is a red herring," he claims. "The real question is whether pension plans would gain or lose if participants had some role in their governance," Mr. Schotland commented.

Other less radical measures would help assure participants about the well-being of their pension plans, he said.

For example, non-voting employee and retiree representatives could be appointed to a plan's board of trustees.

He also suggested opening board meetings up to employees so they can voice their concerns.

Mr. Schotland says he is unsure whether allowing such input would have a significant impact on plan investments. But, he said, it would ease participants' fears about the condition of the pension plans.

"Giving participants and retirees some role in plan governance will raise none of the concerns provoked" by H.R. 2664 "but will assure the two obviously needed corrections of the present system: Participants' retirement security will be managed with their views on the table, and participants will be far better informed of how their plan is being managed," Mr. Schotland said.

Donald S. Grubbs Jr., president of Grubbs & Co., an actuarial consulting firm in Silver Spring, Md., agrees that the Visclosky bill is a mistake.

But he advocates appointing third-party trustees, like banks or investment managers, to manage pension plans.

Such appointments would allay employer and plan participant fears and also would be beneficial because often neither management nor participants have the knowledge or experience to invest or protect plan assets, Mr. Grubbs said.

"If investment policy and investment decisions are determined by non-qualified persons—no matter how well intended—the expected results in many cases will be losses or a lower return on investment," Mr. Grubbs said.

Leon Irish, partner and employee benefits attorney with Jones, Day, Reavis & Pogue in Washington, D.C., agreed that employer and employee biases would create chaos if the Visclosky bill is enacted.

Mr. Schotland, who opposes the Visclosky proposal, calls it 'an overboard solution.'

Trustees appointed by employers too often act in the interest of the employer, rather than participants, he said.

And employee trustees, for their part, are often interested in "social investing" or investments that could help preserve or create jobs for them, Mr. Irish said.

Mr. Irish also recommended repealing Section 408(c)(3) of the Employee Retirement Income Security Act of 1974, which permits —but does require—employer and employee representatives to serve as fiduciaries of pension plans. If that section is repealed, employers would be forced to use outside fiduciaries.

But, Dallas Salisbury, president of the Employee Benefit Research Institute in Washington. D.C., said he was troubled by implications raised during the hearing that there is "an absence of professionalism" among employers' pension plan trustees.

In most cases, professional managers do the actual investing, he said. Few employers make these decisions, according to Mr. Salisbury.

Also, repealing Section 408(c)(3) would "not solve the joint trusteeship issue, because someone must select the independent fiduciary," and pension plan participants would want a say in that choice, he said.

Mr. Irish of Jones, Day defended his proposal: "Let me be clear at this point that I am not accusing either labor or management trustees of illegality or wrongdoing. Most individuals who serve as trustee do their work well and honestly."

However, "whether an individual works for a labor union or a business corporation, human nature is such that there will often be a conscious or unconscious bias," he said.

On the issue of pension plan portability, Mr. Salisbury testified that there actually is too much of it.

Most workers that receive preretirement distributions from defined contribution pension plans—which account for more than half of all newly formed plans—spend that money rather than rolling it over into another retirement vehicle, Mr. Salisbury said.

This "leads to the dissipation of funds that would have gone to retirement income," he said.

Those receiving lump-sum distributions should be required to put them into a new employer's pension plan or into a qualified retirement plan, such as an individual retirement account, he said.

Yet, Congress is hesitant to take up the issue, he said.

"Congress needs to look at its objectives" and decide what its wants from pension policy, Mr. Salisbury said. If the objective is savings income, then employees should be allowed access to these funds. But if the objective is retirement income, access should be denied until retirement age, he said.

Nancy J. Altman, vice chairman of the Department of Labor's ERISA Advisory Council, endorsed the goals of making pension laws easier to understand and comply with and encouraging employers to offer pension plans.

But she cautioned the committee about making changes that were not well thought out, noting that some degree of complexity is inherent in a flexible and diverse pension system.

Since ERISA was passed in 1974, changes in pension law "under the guise of simplification" have prolonged uncertainty and discouraged employers from offering pension plans, she asserted.

However, Ms. Altman believes "opportunities do exist for simplification."

For example, unnecessary duplication of requirements exists and inconsistent regulations should be eliminated, she said. ■

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Business Insurance

Market volatility

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clients.

"Many of these commercial forms are very technical and do require some analysis when a loss occurs. That doesn't mean that the company is trying to get out of the loss or. . .get rid of the contract, but that contract has not been brought (in play) until after the loss occurs," Mr. Greenberg said.

However, Mr. Bell pointed out that even when policyholders are not entitled to coverage, insurers should adopt some sensitivity when they deny a claim, rather than take a hard-line approach.

"We smile nicely when we say no," Mr. Greenberg quipped.

The public's expectations of the insurance industry are unrealistic, considering the industry has had only about a 7.5% average return on equity in the past few years, he said. That is not "an adequate return on investment," he said.

And, while the public and legislators seek increasing regulation of the industry when rates are going up, they change their tune when prices begin to come down, Mr. Greenberg observed.

The public "can't yell when prices go up," but smile when they come down—and still maintain a healthy market economy, he said.

"More professionally geared companies will stop writing business (when rates are) on the way down and preserve their capital" to maintain an adequate return on equity, Mr. Greenberg said. But "the dummies keep on writing it," driving prices down, he pointed out.

Panelists were asked if the flow of capital into the insurance industry could be regulated to minimize market volatility. However, they could not agree whether regulating the flow of capital could be easily accomplished.

In fact, Mr. Thiele said the insurance industry reminded him of New York subway ads for cockroach "motels," which read: "The cockroaches enter, but don't leave."

"One could say that this is something of a capital trend. It is pretty easy to put capital into this business, but it's very, very difficult to take capital back out of this industry," Mr. Thiele contends.

Mr. Clements agreed it is difficult to take capital out of the industry, citing the difficulty experienced by insurers that have tried to leave the Massachusetts auto insurance market. But he said he also believes it is hard to put capital into the insurance industry.



Mr. Thiele

"It seems to me part of our problem is that there are significant barriers to the introduction of new capital into the industry under the current regulatory system. This forces new capital to go offshore where it is non-admitted and unregulated," Mr. Clements said.

Mr. Greenberg said it is impossible to regulate insurer capital flow and still maintain a market economy, although he said he supports the idea of minimum capital requirements for insurers.

Mr. Greenberg also disagreed that it is difficult to take capital out of the industry.

"Look at some of the non-insurance, industrial companies that own or create insurance company subsidiaries, milk dividends out of them, use their losses in the tax consolidation to benefit the parent company and then leave the wreckage when it occurs for all of us to pick up the problems," he said.

Mr. Greenberg also blasted the state guaranty fund system, which, he says, forces successful insurers to bail out those insurers that fail.

Brokers and commercial insurance buyers should bear the responsibility for choosing financially stable companies, he argued.

"It's completely outrageous that financially stable companies have to contribute to the failures," Mr. Greenberg contends.

And, while Mr. Thiele did not dispute that guaranty funds should protect personal lines policyholders, he added: "Certainly on the commercial side, it would serve to discipline the market if there were no guaranty funds to prop up poor decisions on placements."

Panelists were also divided on whether a current trend toward increased insurer specialization would augment or reduce market volatility.



Mr. Bell



Mr. Page

Mr. Clements argued that "unquestionably and very decisively, specialized marketing reduces market volatility and is the most cost-effective way to do business."

He said that such specialization fosters "more knowledgeable underwriters, better forms, better relationships between underwriters and insureds, and n "ch more consistent availability of capacity. It is one of the more gratifying trends going on in the industry right now," Mr. Clements said.

Mr. Thiele also observed that those insurers that are specialized tend to "deliver better long-term value to their customers."

But, there's a potential downside to specialization, Mr. Bell said. "When you get too many players in one specialty. . .then you get back to where you started from" in terms of competition, he explained.

And, Mr. Greenberg said that many insurers—rather than adopting an underwriting strategy that will achieve a profit and sticking with that strategy—simply copy other insurers that seem to be achieving success through specialized marketing efforts.

Specialization is "no panacea" unless the strategy is carefully thought out, he warned.

Mr. Greenberg added that many companies adopt those strategies simply to gain market share, "and that has been a doomsday strategy for our industry."

When asked from the audience if insurer specialization might also be used as an excuse for limiting coverage provided under a specific type of insurance policy, Mr. Greenberg responded that insurance buyers "get what you want to pay for."

Furthermore, "there are some things that are simply uninsurable. We didn't make them so. Courts and legislatures have done that," he stressed.

For example, he said insurers cannot be expected to provide all types of pollution coverage, although some pollution risks can be insured.

"Our business over the last decade has become far less predictable because of the tort system and the court decisions that have been handed down. This makes it very difficult for any underwriter to properly price any number of classes of business," Mr. Greenberg explained.

"If we had a more defined legal system where predictability was easier and, hence, pricing could be more predictable, we could eliminate some of this volatility," he added.

Meanwhile, Sedgwick's Mr. Page said the insurance industry must "reestablish the relationship that once existed between brokers and underwriters of being in the same boat, being in the same industry and serving the same clients."

"And, we've got to find a way to begin to speak together in a sensible fashion about the issues rather than pursue a fragmented approach which has gotten us in the terrible mess we are in today as regards the purchasing public. Unless we get together, we aren't going to go anywhere separately," Mr. Page added.

Mr. Greenberg agreed, noting that AIG 10 years ago called for a collective industry effort to address the need for catastrophic earthquake coverage and, more recently, the establishment of a no-fault system for financing pollution cleanups (*BI*, March 6, 1989).

But, "we have to have a wider constituency when we make change," he stated, calling for brokers and insurers to involve consumers and the general press in these efforts.

Panel moderator Robert J. Murphy, senior vp and national marketing director for Alexander & Alexander Inc. in New York, added: "If brokers and underwriters and consumers of insurance can't get together to do something to understand and appreciate the realities of the business, then we're all doomed to be treated at the hands of legislators and regulators, which I suspect that we'd all rather avoid." ■

Insurers' future could depend on regulatory overhaul: Panel

By LAURA MAZZUCA

SEA ISLAND, Ga.—If insurer insolvencies begin to multiply on the level of the savings and loan crisis, federal regulation of the industry could become necessary, a leading insurer executive says.

Regulatory constraints on properly pricing auto insurance and the cost of toxic tort litigation, for example, could usher in an insurance crisis on the scale of the S&L debacle, said Joseph W. Brown Jr., president and chief operating officer of Fireman's Fund Insurance Co. of Novato, Calif.

"The Mission, Transit and Integrity insolvencies were not isolated incidents," he said during a panel discussion at the National Assn. of Insurance Brokers annual meeting last week in Sea Island, Ga. "It is very clear to almost everybody sitting in this room using a little bit of conjecture that we could clearly find ourselves in the same situation (as S&Ls), where 30% to 40% of the industry goes insolvent.

"With a little bit of luck and a lot of management in the 50 states, the National Assn. of Insurance Commissioners can get most of the job done," said Mr. Brown.

He emphasized Fireman's Fund's support of NAIC efforts, but added: "If the states can't do it, the problem is big enough that something needs to be done" on the federal level.

A rash of large insolvencies in the 1980s took a heavy toll on the existing regulatory system, says Mr. Brown. "If the situation were to magnify with more insolvencies, the current system is not prepared to deal with it."

Comparisons between insurers and S&Ls may be flawed, he says, but insurers that dismiss them reflexively "are missing an opportunity" to learn from S&Ls' mistakes.

Other panel members criticized both the notion of federal regulation and comparisons between insurers and S&Ls, saying insolvencies affected a much smaller portion of insurance companies than thrifts.

"We have a duty to support not more regulation, but enlightened regulation," said David A. Olsen, president and chief operating officer of Johnson & Higgins in New York.

The NAIB can "advocate a balanced position between those coming on the one hand from the Congress and on the other from the NAIC," he said.

Legislators—most notably Rep. John D. Dingell, D.-Mich.—are increasingly critical of state solvency monitoring (see Perspective, page 23).

The powerful chairman of the House Subcommittee on Oversight and Investigations has called state regulation "seriously deficient" and said parallels between the insurance industry now and savings and loans several years ago were "obvious and deeply disturbing" (*BI*, Feb. 26).

The subcommittee studied managers of insolvent insurers and characterized them as greedy and grossly incompetent. The managers were compared with their counterparts at failed S&Ls.

That comparison outraged many insurance executives, said Mr. Olsen, who claims the thrift analogy is "overdone."

Insolvencies, though increasing, still account for less than 0.5% of the insurance industry, he said. By contrast, a third of the nation's thrifts are insolvent by regulatory accounting standards and two-thirds by the stricter Generally Accepted Accounting Principles, he said.

Mr. Olsen also contends that the subcommittee overstated the extent of fraud among insurers. A.M. Best Co., he says, attributes the majority, about 14, of the 29 insolvencies reported as of December 1989 to auto

Continued on next page

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Solvency panel

Continued from previous page

insurance losses. The second biggest cause of insolvencies, or six cases, was alleged fraud.

In fact, claims Mr. Olsen, private insurers are not at the root of insolvency problems. Rather, he blames assigned risk pools and joint underwriting associations because they require insurers to write coverage for bad drivers.

But Rep. Dingell, he concedes, "has the whip hand on insurer insolvencies" and the "NAIC and the states, in turn, will have to respond to his initiatives."

Pressure from Congress and insurance commissioners has put state and federal authorities in a "footrace" to see who will regulate insurer solvency, said Mr. Olsen.

Mr. Olsen says existing staffs and budgets within insurance departments make them the preferred regulators. But if serious problems arose, the federal government could, for example, oversee commercial lines insurers while states regulated only personal lines companies, he said.

Others on the NAIB panel agreed that while state regulation needs a major overhaul, states still are capable of monitoring insurer solvency.

Getting federal authorities "geared up" to monitor solvency would be a "monumental task," contended William H. McCartney, director of insurance for Nebraska.

The Securities and Exchange Commission, which regulates most of the securities industry, has an annual budget of only about $125 million, he pointed out. State insurance departments, employing about 6,000 people, have budgets totaling about $400 million, he said.

The federal government, hamstrung by its own deficit, would have difficulty matching state expenditures, added Mr. McCartney.

Insurance commissioners are encouraging states to adopt model acts on financial examinations and market conduct that incorporate some of these proposals, said Mr. McCartney.

Model acts passed by the NAIC in 1989 call for tougher financial reporting requirements, specifically on managing general agents, brokers and intermediaries, said Mr. McCartney.

The NAIC last year also tightened reporting requirements to better track reinsurance activities and tightened reporting requirements, he said.

Commissioners also enhanced their national data base, he said.

Currently, the NAIC is working on stringent state regulatory standards —"probably the most critical component of the program," said Mr. McCartney.

These standards will establish minimum requirements for regulating insurers for solvency, including adoption of the model act on credit for reinsurance and the holding company act, requiring audits of insurers' financial statements by independent certified public accountants and requiring certification of loss reserves by an actuary.

All these actions will improve regulators' abilities to spot potential insolvencies, says Mr. McCartney.

Mr. Brown, however, argued that the current NAIC structure, with its "seemingly endless process of examining issues and coming up with solutions," is ineffective if all states do not approve the model acts.

He suggests Congress empower the NAIC to mandate minimum state reporting standards. And he urges insurers, brokers and agents to adopt formal self-regulation to "become partners with the states in some sort of formal mechanism."

Several panelists said attitudes toward troubled companies have changed markedly of late, with rehabilitation losing favor.

"It's a privilege to participate in our industry, and if you don't meet the standards, it's time to get out," said Mr. Brown.

"We can't just nurse them along, because they very rarely can be saved," added Mr. McCartney.

But the threat of defamation suits can discourage regulators from acting against disreputable or troubled companies, said Mr. Olsen of J&H. He advocates granting regulators immunity from such liability.

Panelists also criticized the guaranty fund system.

"The frustration that everyone has with guaranty funds is that the good insurers get hit twice," said Mr. Olsen. "First they lose the opportunity to write the business because they lose it to an insurer with predatory ratings; and secondly, they have to pay for the wreckage created by the company that's gone out of business."

Despite the funds' limitations, observed Mr. McCartney, states seem to be adding, rather than eliminating, guaranty funds.

"The real purpose of guaranty funds is for the individual (insurance) buyer, and I don't think anything is going to happen to eliminate them, as much as we might want to see that happen," said Mr. Brown.

However, he says a "formalized alternative" may soon emerge that would give commercial buyers the option to purchase coverage from insurers which is either protected or unprotected from the guaranty fund.

This alternative will become increasingly feasible if insurer insolvency charges continue to mount in coming years, he said. ■

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Solvency called top priority for brokers

By LAURA MAZZUCA

SEA ISLAND, Ga.—Insurer insolvency issues and the continuing difficulties presented by California's Proposition 103 are weighing heavily on insurance brokers, the outgoing head of the National Assn. of Insurance Brokers says.

"When I began my term as president at Sea Island a year ago, I expected it to be full of excitement and challenge," said C. Richard Peterson, outgoing NAIB president, at the group's annual meeting May 31-June 1 in Sea Island, Ga. "I was not disappointed."

Mr. Peterson noted that the NAIB's "priority issue" is insurer solvency.

Brokers must become involved more in solvency issues, Mr. Peterson said, especially in light of the recent House subcommittee report on solvency issues in general and the failures of Mission Insurance Group Inc. and Transit Casualty Co. in particular (*BI*, March 5).

That report—released by subcommittee Chairman John D. Dingell, D.-Mich.—harshly criticized state regulation and compares the insurance industry with the "early stages" of the massive savings and loan industry crisis.

"This development required an immediate response from the NAIB on whether we would participate in" tracking solvency, said Mr. Peterson. He cites testimony before the House panel as an example of effective action taken by the association.

"Our concern over how insolvencies affect policyholders leads us to one conclusion—we must participate."

As the industry's "stewards," brokers are in a unique position to "see, feel and hear" about developments at insurance companies, said Mr. Peterson.

"We take our responsibility to assist clients in placing business with financially sound insurers very seriously," he said. "While we cannot guarantee the solvency of a carrier, we can be expected to use reasonable care, skill and judgment in placing business."

But, he warned, without information from regulators, who have direct access to insurers' financial reports, brokers' perceptions can be erroneous.

"There is a presumption that brokers know far more than we do about the true financial condition of insurance companies," said Mr. Peterson. Many regulators think brokers know when an insurer is "moving toward the financial edge," he said. "The point is not who believes this, but that it is the wrong perception."

To effectively monitor solvency, brokers, insurers and regulators must work together, said Mr. Peterson.

Regulators, who have the resources to monitor activities of insurers and access to insurance companies' books, must have the "primary responsibility" of assessing solvency, he said.

However, through the NAIB's ties with the National Assn. of Insurance Commissioners, brokers can become more involved in financial examinations, Mr. Peterson said.

For example, brokers can recommend ways to improve the timeliness and accuracy of insurers' annual financial reports to regulators, said Mr. Peterson.

Certified public accountants, auditors, and rating services like A.M. Best Co. also have a duty to look for warning signs of insolvencies, said Mr. Peterson.

Another problem with the current regulatory system is that the threat of defamation lawsuits has made regulators reluctant to share information about insurers that may be about to fail, said Mr. Peterson. The NAIB has proposed granting regulators protection against libel and slander suits stemming from the release of information about an insurer's solvency.

Apart from solvency issues, Proposition 103 also remains a thorn in brokers' sides, the outgoing NAIB president said.

The California Supreme Court last year upheld most of the provisions of the voter-approved insurance reform law, he noted (*BI*, May 8, 1989). And, the California attorney general recently issued antitrust guidelines for the industry (*BI*, May 21).

"These rules are so broad, we're still trying to figure out whether selling insurance at all in California violates the antitrust laws," he quipped.

He adds that California's tough stand on insurance issues also influenced the NAIB's decision to meet this year in Georgia rather than Pebble Beach, Calif.

Brokers also faced tax-related problems during the past year.

An IRS regulation would have required U.S. brokers and their clients to disclose all transactions with foreign insurers other than Lloyd's of London to the IRS, even if the insurer wrote only a minuscule portion of a risk, in conjunction with the payment of the excise tax on premiums paid to foreign insurers and reinsurers.

Tax consultants have estimated that compliance with the disclosure requirement would cost brokers and their clients about $10.8 million each year, according to Mr. Peterson.

In a ruling late last month, however, brokers and their clients were exempted from the disclosure regulations, though foreign insurers must still disclose any transactions with a U.S. policyholder to the IRS.

Mr. Peterson, executive vp and chief administrative officer of Sedgwick James Inc., will be succeeded as NAIB president by William D. Pringle, executive vp of Frank B. Hall & Co. of New York Inc. ■

Expanded role urged for brokers in monitoring of insurer solvency

By LAURA MAZZUCA

SEA ISLAND, Ga.—Large insurer insolvencies, combined with a "more volatile and uncertain" property/casualty insurance marketplace, make brokers an increasingly important source of information for insurance regulators, says a former regulator.

"You, the brokers, are really the key to dramatic improvements in regulation. You know the troubled companies long before the regulators do," says Illinois Deputy Gov. John E. Washburn.

Insurers' annual statements alone cannot give regulators, often unfamiliar with the general market, a complete picture, Mr. Washburn said at the National Assn. of Insurance Brokers annual meeting last week in Sea Island, Ga.

"Regulators do not know what's going on in the marketplace, and they can't because there is no system in existence by which they can understand it," said Mr. Washburn, who was Illinois director of insurance from 1983 to 1989.

State officials receive insurers' financial reports—on which the National Assn. of Insurance Commissioners' Insurance Regulatory Information System is based—but they often lack good figures for comparison, he said.

Brokers' regular dealings in the marketplace put brokers in an ideal position to spot strange new company practices and very low premium rates that usually indicate a troubled insurer, said Mr. Washburn, who also served as president of the NAIC.

Broker involvement in solvency monitoring, says Mr. Washburn, "not only gives regulators leverage to take action, but almost forces them to take action, to catch problems before they start."

He proposes that brokers and regulators develop a new regulatory structure to be used with IRIS, which would allow brokers to communicate market information confidentially to regulators.

Mr. Washburn said insurance regulation has become both more formal and more important over the last 15 years, a change he attributes to increasing emphasis on property/casualty insurer solvency and marketplace competition.

As many large businesses that once purchased commercial property/casualty insurance turn to risk financing alternatives, competition for remaining accounts increases market volatility and uncertainty, he said.

Before the mid-1970s—back in regulation's "good old days"—insolvencies tended to involve small, regional companies, he says.

That small scale let "a key network of chief examiners" prevent insolvencies informally, through mergers and acquisition or by folding in new business to aid troubled insurers, said Mr. Washburn.

Even when an insured did go insolvent and state guaranty funds had to foot the bill, individual insurers usually were not hit with high assessments because the insolvent companies usually were small operations, he said.

However, the demise of Reserve Insurance Co. changed all that.

Reserve—"the first major multistate commercial lines insolvency," according to Mr. Washburn—was declared insolvent by the Illinois Insurance Department in May 1979. The insolvency, originally estimated at $16 million, has swelled to more than $100 million today.

State regulators were forced to improve their solvency regulation. But their failure to foresee how far-reaching some major multistate insurer insolvencies would be and resistance to change by some older chief insurance examiners hampered the system, he says.

Since then, the NAIC has devoted more resources to tracking insurer solvency, he noted.

One reason for the change: Many old-line examiners have retired, making room for "a whole new breed" of about 7,000 regulators and state insurance department staff members nationwide, said Mr. Washburn.

The NAIC has improved its tracking of solvency through insurers' annual statements, Mr. Washburn maintains. Regulators, for example, recently increased the amount of information required on insurers' loss reserves and on ceded reinsurance.

In addition, IRIS, which is a data base established by the NAIC in the early 1970s, measures profitability, change in surplus, general operating expenses and other financial indicators for both life/health and property/casualty underwriters.

The NAIC also offers computer capabilities to every state insurance office. Links to the NAIC's national system further assist regulators in tracking the solvency of multistate insurers, said Mr. Washburn.

Such measures help, he said, but "none, I think, is going to help regulators to take companies that are insolvent out of the system."

The real trouble starts after regulators identify a weak insurer and try to piece together how bad the financial problem is and how the company went wrong.

Following these paper trails "is sort of like going through that looking glass with Alice," said Mr. Washburn. "You're going to be chasing this white rabbit for a long time, and going through some very strange machinations trying to get hold of him."

Since brokers represent large commercial clients, their involvement with regulators at this point could lend an air of authority and urgency to the regulators' actions against financially troubled insurers, he added.

But attitudes in the insurance industry and elsewhere must change before insolvency proceedings can run smoothly, he noted.

"As long as insolvency is looked at as a regulator failure, you've got problems," said Mr. Washburn.

He singled out Rep. John D. Dingell, D-Mich., a critic of state regulation who argues that more and larger insolvencies are evidence that state oversight is failing (see story, page 23).

Possibly, says Mr. Washburn, "all those insolvencies mean that regulators are doing a better job" because insurers that are insolvent are no longer allowed by regulators to do business. ■

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Work comp issues

Continued from page 1

dents—61%—said they purchase commercial work comp insurance, 43% self-insure, 13% are insured by a state fund and 2% are insured in the residual market. The total equals 100% because some respondents use more than one method of risk financing.

Seventy-eight percent of the surveyed risk managers said they are "very interested" in reform of work comp laws in states in which they have employees, while 19% said they would be somewhat interested and only 2% no need for changes. One respondent did not answer the question.

"The system needs to be more even-handed and fair to the employer," concluded the risk manager for a Pennsylvania machinery manufacturer with 200 employees.

Another risk manager put it in terms more sympathetic to the injured employee.

"I'm not advocating the denial of due process to employees," said the director of risk management and insurance at an academic health center in Pennsylvania with more than 8,000 employees. "I'm advocating a system whereby an employer can resolve disputes in several weeks instead of in three to four months."

Restructuring benefits so that workers with the most serious injuries receive the largest payments was the reform risk managers suggested most frequently.

At least one risk manager, the director of benefits and risk management for a New York-based news wire service with 500 employees, suggested "easier claims procedures" and "more comprehensible—not comprehensive—benefit schedules."

Numerous other risk managers said states should beef up programs to rehabilitate workers and provide incentives for injured employees to return to work.

For example, benefits for partially disabled workers and lump-sum settlements should be limited and employers should be given incentives to hire injured workers, said the risk management coordinator for occupational injuries at a Rhode Island hospital with 5,157 employees.

"In our state, partially disabled employees can collect forever and there are few incentives for them to try to return to work. Lump-sum settlements are prevalent and high, and many employees hold out for a settlement, then get another job," the risk manager said.

Other reforms risk managers proposed included increasing the use of alternative dispute resolution procedures in settling work comp claims and coordinating work comp benefits with Social Security or other disability insurance programs.

But 75% of those surveyed do not want a federal work comp system.

"Any time the federal government is involved, the system becomes more expensive, less responsive and entirely too burdensome," said the risk management director for a California property manager with about 1,000 employees.

"Uniform rules would be an advantage, but the lack of control and liberal payments would work against employers and insurers," said the director of corporate risk management at a Texas manufacturer with 35,000 employees.

"I do believe the laws do need to be more uniform in language and interpretation. However, the personalities of each state need to be dealt with on an individual basis. The wage differentials are substantial as well," said the insurance manager for a Georgia paper company that employs 4,500.

Some risk managers also criticized attorney involvement in the work comp system (see related story, page 36).

A majority of risk managers also advocated applying the same managed care tools used in health insurance to work comp cases to control costs.

Medical costs now comprise about 40% of work comp costs, up from 33% a decade ago, the National Council on Compensation Insurance reports (*BI*, March 19).

"Insurers should be using all of the tools group health insurers are currently using to control costs; i.e., preadmission review, concurrent hospital review, mandatory second opinions, PPOs, hospital audits and case management," said the risk manager for a Florida convenience store chain with 450 employees.

While 70% of employers responding to the survey said they or their insurer used some form of managed care to help reduce their work comp costs, 28% said they did not.

Among the managed care methods that are most popular among survey respondents are:

- Obtaining post-treatment utilization review, used by 39%, of risk managers responding to the question.
- Providing employees with a list of preferred physicians, used by 34%.
- Requiring employees to use providers in a preferred provider organization with which the employer has contracted to receive full benefits, used by 14%.
- Adopting other forms of managed care, such as medical case management, concurrent review, precertification and medical fee schedules, used by 13%.

Injured employees also should not be permitted to go "doctor shopping" to prolong treatment, numerous risk managers said.

"We need to revise the system to remove. . .the ability of the employee to continue to seek other doctors' treatment to prolong care," said the risk management director at a children's medical center in Texas that employs 1,500.

The risk manager for an Ohio manufacturer with 6,000 employees said "the reluctance on the part of the medical community to make a firm stand regarding return-to-work, etc., is understandable due to current legal problems."

However, "this is causing headaches for employers. Somehow we have to make it safer for doctors to agree to send healthy people back to work without the fear of legal action down the road," the risk manager said.

Several risk managers responding to the survey advised insurers to emphasize worksite loss control and safety programs as a means to prevent work comp claims.

Insurers should "monitor and document job performance and compliance with safety rules and regulations," suggested the director of risk management at a California educational institution with 15,000 employees.

They also should "sell insurance as a last resort" and instead "offer unbundled loss control and claim management services," suggested the risk and insurance manager for an Illinois metal fabrication firm with 2,600 employees.

Other risk managers advocate pre-employment physicals to screen accident-prone employees from certain tasks.

Insurers should institute "better new-hire pre-screening procedures, including drug testing, complete physicals, past worker comp history, etc.," suggested the insurance administrator at a Florida beverage wholesaler with 135 employees.

Many risk managers responding to the survey criticized insurers for not being more aggressive in managing work comp claims.

"Insurers have lost their zeal to defend" these cases, said the risk manager for a Connecticut manufacturer that employs 5,000.

Insurers need to "take a more positive, more aggressive approach toward defense of non-compensable claims," the risk manager asserted.

"It appears to me that insurers only passively manage claims," observed the risk manager for a Pennsylvania life insurance company with 2,325 employees.

Insurers need to "devote the time and money to aggressively manage each case," the risk manager said.

Insurers should "quit settling claims that should be contested," said the risk manager for an Illinois manufacturer with 6,000 employees.

The risk manager also suggested that insurers monitor medical costs to make sure they follow fee schedules or usual and customary charges, whichever is applicable.

Insurers also were criticized for not maintaining adequate claims investigations personnel essential to probe potentially fraudulent claims.

"Insurance companies should pay good claims adjusters to stay in the adjusting field. Too much is left up to telephone inquiries from unskilled, unqualified people in the claims department," asserted the director of risk management at an Indiana manufacturer with 8,700 employees.

Several risk managers suggested amending state work comp laws to require states to criminally prosecute employees who defraud the system.

States should "make it mandatory for prosecuting attorneys to prosecute fraudulent claimants," said the vp for risk and safety at an Arkansas-based vegetable canning company with 1,700 employees in five states.

In addition, there should be "a remedy for the self-insured employer or insurer against employees for recovery of expenses where fraud is proven," he said.

The risk manager for a New Hampshire holding company with 14,000 employees suggested that provisions be made in state work comp laws for "immediate benefit termination for certain actions, such as refusal to perform light duty and malingering."

Among other survey findings:

- Many survey respondents lobbied for all states to permit employers to self-insure their work comp exposures.
- Fifty-nine percent of the respondents said they did not know how much residual market costs were adding to their work comp costs. Only 27% says they were aware of these costs, with the remainder did not respond.

Some respondents estimated the residual market loadings costs added from 1% to 75% to their standard premium.

Other respondents estimated the cost of the residual market to their work comp costs in dollar amounts, with estimates ranging from a low of $50,000 a year to as much as $1.2 million annually.

●

Risk managers and other corporate insurance buyers are invited to join the Business Insurance Risk Management Board. Just send a card noting your interest with your name, title, company and address to Kathryn J. McIntyre, Associate Publisher/Editor, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. You will receive several surveys during the year on risk management issues.

Opinion split on lawyer information

Risk managers are split over whether informing workers about the pros and cons of using an attorney to represent them in workers compensation disputes reduces the overall number of litigated cases.

But only 15% of the surveyed risk managers said they inform their workers on the subject, according to a recent survey of the *Business Insurance* Risk Management Board.

A vast majority—140—of the 201 risk managers responding to the recent survey agreed that the number of litigated work comp cases is either rising or holding steady. Only 23 said such claims were declining.

Slightly more than half the risk managers reported less than 10% of work comp claims are litigated, but two reported litigation rates as high as 60% and 90%.

Of the 30 risk managers who said their companies do provide information on using lawyers in work comp cases, 17 said it has failed to reduce the percentage of litigated comp claims.

Providing employees with information about the pros and cons of using a lawyer in such cases "actually has helped to increase the number of litigated claims," said the risk manager for a California ski resort where approximately 30% of comp claims involve an attorney.

Among those that say they provide information on attorney involvement in work comp cases, risk managers said this is—or they "hope" this is—effective in reducing the amount of litigated claims.

However, many added that "prompt" claim payment, involvement with the claimant, litigating "phantom" claims and "efforts in working with and educating employees" were effective in lowering their litigated claims compared with five years ago.

"Better and faster claims handling would reduce the number of employees seeking legal assistance," predicted the risk manager for a Florida retailer with 6,600 employees.

The director of risk management at an Indiana manufacturer with 8,700 employees agreed: Insurers should "try to respond so efficiently and effectively that the reasonable and thinking employee will not seek out an attorney."

Despite efforts to decrease lawyer involvement in work comp cases, "Litigation is at an all-time high," observed the risk manager for a Florida municipality with 500 employees that provides information on the use of attorneys to injured employees.

"Plaintiffs' attorneys have punched holes in the law," he said. "We are in almost worse shape than 1979," when the state enacted its wage-loss workers compensation system, which was supposed to compensate most injured workers only for the wages actually lost due to injury.

Today "lawyers actively pursue injured workers more often," observed the risk manager for a New York manufacturing and real estate firm that provides information on attorney use to its 3,500 employees.

"In the past, injured workers sought out attorneys on difficult claims. Now we see a trend in attorneys seeking out injured employees," the risk manager added.

Most employers do not provide this information to employees, the survey found.

"For a no-fault system, it's much too political and litigious," said the risk manager for a Missouri manufacturer with 22,000 employees that does not inform employees about attorney use in comp cases.

While more than half of the 172 risk managers—91—responding to a question on the frequency of litigated comp claims said less than 10% of claims are litigated, 56 said 10% to 20% of theirs are litigated. Another 25 reported litigation rates ranging from 25% to as high as 90%, with 12 of those exceeding 50%.

Other factors cited by risk managers as contributing to increased attorney involvement in work comp cases are:

- "Savvy" marketing by lawyers.
- Employees' increasing distrust of the work comp system.
- Promotion of attorney involvement by labor unions.
- A belief that greater benefits will be awarded if an attorney is involved.

—By Joanne Wojcik

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Willis Corroon

Continued from page 1

company," said Russell R. Miller, chairman and chief executive officer of San Francisco-based Russell Miller Inc., an investment banker and consultant specializing in the insurance industry.

"The world scene is among the Fortune 500 corporations and previously (C&B) didn't belong to the club," he noted.

Some London stock analysts also said last week that Willis Faber shareholders are concerned that the merger will wreck the long-established relationship Willis Faber has had with New York-based Johnson & Higgins and with the UNISON network of worldwide brokers.

J&H-generated business represented approximately 10% of Willis Faber's 1989 pretax profits of $100 million.

Competing brokerage executives also are questioning how privately held J&H will maintain its competitive position in the market without its longtime London partner.

However, Mr. Elliott noted that "I reckon we will continue to have business from Johnson & Higgins for at least another five to 10 years."

Willis Faber's relationships with some of the continental European UNISON members also go back many, many years, he stressed.

Willis Corroon will rank as the world's fourth-largest broker, based on C&B's and Willis Faber's combined 1989 revenues of $908.9 million.

Johnson & Higgins currently is the world's fourth-largest broker based on estimated 1989 revenues of $789.9 million.

C&B currently is the world's fifth-largest broker based on 1989 revenues of $456.8 million, while Willis Faber ranks No. 6 with 1989 revenues of 280.8 million pounds ($452.1 million).

Mr. Miller stressed last week that the merger is "a marriage of equals" and an "outstanding opportunity for both of us to be in the top tier of brokers globally, and we are going to take advantage of that."

A top executive of a competing global brokerage described the merger as a "brilliant move—a real coup."

Only four other insurance brokers own extensive operations around the world, instead of relying on correspondent relationships: Marsh & McLennan Cos. Inc., Sedgwick Group P.L.C., Alexander & Alexander Services Inc. and Jardine Insurance Brokers Group.

And, top executives of both C&B and Willis Faber contend that the merger represents a near-perfect fit.

"It's remarkable how our two strategies converge," said Willis Faber Director John Robins.

In 1989, 78% of C&B's revenues were generated by retail brokerage; 6% by consulting and employee benefits; and 16% by wholesale and reinsurance brokerage, he pointed out. Conversely, only 31% of Willis Faber's revenues were generated by retail brokerage; 10% by consulting and employee benefits; and 59% by wholesale and reinsurance brokerage.

Combined, 53% of Willis Corroon's revenues will be derived from retail insurance brokerage; 8% from consulting and employee benefits operations; and 39% from wholesale and reinsurance brokerage.

Furthermore, 100% of C&B's 1989 revenues were generated in the United States, while only 8% of Willis Faber's revenues are U.S.-based. Eighty-four percent of Willis Faber's revenues are generated in the United Kingdom, while 8% come from elsewhere.

Combined, 50% of Willis Corroon's revenues will come from the United States, 46% from the United Kingdom and 4% from the rest of the world.

After the merger, Willis Corroon will focus on building its brokerage operations outside of the United States and United Kingdom, Mr. Robins said.

C&B and Willis Faber will immediately begin contacting foreign brokers with which they have held talks about acquisition or an equity interest, Mr. Miller said last week. Once the merger is complete, Willis Corroon plans to buy or invest in foreign brokers.

The combined company also will focus on expanding employee benefits and other consulting operations, Mr. Miller added.

Since C&B and Willis Faber have between $300 million and $325 million of free cash between them on their balance sheets, the new company is well positioned for such acquisitions, Mr. Miller acknowledged.

Both Mr. Elliott and Mr. Miller said that there is virtually no overlap between the two companies' operations either in the United States or overseas, which will make the C&B-Willis Faber merger much easier than Willis Faber's chaotic merger with Stewart Wrightson Holdings P.L.C. in July 1987, Mr. Elliott contends.

"Fortunately we don't have two people for every job like the last time," said Mr. Elliott, referring to the more than 100 people who left the merged Willis Faber/Stewart Wrightson, including former Stewart Wrightson Chairman David Rowland, who is now chairman of Sedgwick Group, the world's third-largest broker.

This C&B-Willis Faber merger "fits beautifully. No one is going to tread on anyone's toes and there is a lot of synergy," Mr. Elliott said.

The two brokers also use the same type of computer hardware and have similar software programs. Although there "may be some reprogramming necessary" and the two companies' accounting systems will need to be standardized, automation-related merger expenses will not be significant, Mr. Miller said.

Willis Corroon will be based in London for technical and financial reasons, said Mr. Elliott. Both brokers' legal and financial advisers agreed that London was the best location, he pointed out.

Mr. Miller explained that in the United States, stock dividends are taxed first at the corporate level and then at the shareholder level, while in the United Kingdom shareholders receive credit for the taxes paid by the corporation.

And, he added that while Willis Corroon will be based in London, "it could be that some of the corporate functions are still conducted in the U.S."

Many details of the merger are still being worked out, Mr. Miller said, since negotiations had focused on the terms of the financial transaction and the people fit of the two organizations.

Informal conversations between the two brokerages began late last year, but serious merger talks did not begin until earlier this year, Mr. Miller said.

Willis Faber decided to pursue a merger with C&B after its overtures were rejected several times through the years by Johnson & Higgins, according to Mr. Elliott.

Willis Faber has wanted a retail brokerage presence in the United States for some time, he explained. By merging with C&B, Willis Faber will achieve a long-term objective "to obtain earnings from on-the-ground U.S. retail operations," he said.

"Over the last few years we have made progress" in other areas in the United States, Mr. Elliott noted.

For example, Willis Faber became the parent company of one of the largest U.S. surplus lines brokers, Stewart Smith Holdings Inc., when it bought Stewart Wrightson. Stewart Smith has since been renamed Willis Faber Holdings Inc.

Following the merger, 65% of Willis Corroon's revenues will be in U.S. dollars, including business conducted in Britain on a U.S. dollar basis, like aviation insurance brokerage for U.S. accounts.

For its part, C&B has been looking to invest in or purchase a London broker. C&B sold its 29.9% interest in Lloyd's broker Minet Holdings P.L.C. to The St. Paul Cos. Inc. in February 1988, when St. Paul acquired Minet.

Its strategic plan for the 1990s called for C&B "to merge with a U.K broker first and then work with it to develop the rest of the world. This merger meets most of the elements of our entire plan," Mr. Miller explained.

C&B, which has no overseas brokerage offices, was a founding member of INTERNET—an international consortium of insurance brokers in which Minet also participates.

However, C&B withdrew from the consortium in April.

C&B still maintains its correspondent relationships with an extensive network of international brokers, 90% of which were not INTERNET members.

C&B places about $300 million in premiums in the London market via 10 Lloyd's brokers, said Jennifer B. Cartmell, C&B's first vp and treasurer.

Mr. Miller estimated that about 18% to 20% of that business has been placed with Minet.

Over time it's expected that Willis Corroon will handle the "lion's share" of its retail business placed in the London market, according to Mr. Elliott.

However, Mr. Miller stressed that Willis Corroon will not mandate that its employees transact business only within the company.

"Ultimately, it's our clients who make the final decision" on who should place their business in London, Mr. Miller said.

C&B will continue to place business through Minet after the merger because Minet has certain specialties on which its clients rely, Mr. Miller said.

He also stressed that he spoke with the two top executives of Minet shortly before the merger was announced to advise them that C&B and Willis Faber were merging "based on sound business reasons."

"Two years ago, (Minet) made the decision to sell to St. Paul for sound business reasons," he pointed out.

Minet Chairman Ray Pettitt said that while he was aware that C&B had been looking for a London partner for some time, he was surprised at its final choice.

But, "based on our conversation with Corroon & Black, we don't anticipate any change in the trading relationship" following the merger, Mr. Pettitt added.

"The business that we do handle for them we have handled for many, many years. They are strong relationships and we've been assured that those relationships will continue," he said.

While C&B's revenues are slightly larger than Willis Faber's, Willis Faber reported larger profits and had more employees last year.

Willis Faber reported pretax profits of 62.3 million pounds ($100.3 million) in 1989, up 14.5% from 54.4 million pounds ($98.5 million) the previous year.

Willis Faber's 1989 gross revenues of 280.8 million pounds ($452.1 million) were up 8.3% from 1988 revenues of 259.2 million pounds.

Meanwhile, Corroon & Black reported aftertax income of $36 million last year, a 68.9% decrease from $115.9 million in 1988. However, C&B reported a non-recurring pretax gain of $120.3 million in 1988 on its sale of Minet stock.

C&B's 1989 revenues of $456.8 million were 7.5% higher than its revenues of $424.9 million in 1988.

Willis Faber had 6,141 employees at year-end 1989, compared with 4,961 employees at Corroon & Black.

C&B was represented in the merger negotiations by investment banker Goldman Sachs & Co. in New York, while Willis Faber was represented by investment banker Baring Bros. & Co. Ltd. and investment adviser Cazenove & Co., both of London. ■

Update

Syndicate makes cash call

LONDON—Lloyd's of London marine syndicate 418/417, one of the largest Lloyd's syndicates, is asking about 4,000 members to pay a total of 35 million pounds ($59.1 million) to cover losses on its 1985 underwriting account.

The losses largely result from 11 runoff reinsurance policies syndicate 418/417 wrote in the early 1980s, said Ken Randall, managing director of Merrett Underwriting Agency Management Ltd., which manages the syndicate.

In addition, the 1985 account, which was due to have been closed in 1988 under Lloyd's three-year accounting system, will remain open for the third year in a row, he said (*BI*, May 22, 1989).

Manville trust change assessed

NEW YORK—Manville Personal Injury Trust officials were to meet over the weekend with two New York judges overseeing hundreds of asbestos cases to discuss possible changes to the fund, which has been unable to make timely payments to claimants.

Trust officials said they would respond Monday to charges of mismanagement (*BI*, June 4; May 28).

In a June 1 order, U.S. District Judge Jack B. Weinstein and New York Supreme Court Justice Helen E. Freedman said if the average payment to asbestos victims remains $42,000 and attorneys continue to collect their customary fees, the trust will need $7.5 billion to pay all claims. Its assets are now only $1.5 billion.

As a result, the judges strongly suggested that claimants receive structured, rather than lump-sum, settlements and that Denver-based Manville Corp. increase its contribution to the trust fund by a total of $200 million to $300 million.

The judges also suggested reconsidering the amounts that go to attorneys. And, they suggested, claimants should be paid by age and date of diagnosis, rather than by the date claims were filed.

The judges also said they would drop an earlier suggestion—allowing victims to sue Manville directly—if Manville cooperates with suggested reforms.

Court to rule on airline case

WASHINGTON—The U.S. Supreme Court will decide whether passengers on international airline flights can sue for damages for emotional distress resulting from accidents even if they suffer no bodily injuries.

Eastern Airlines Inc. hopes to overturn an 11th U.S. Circuit Court of Appeals ruling. That court reversed a federal court's dismissal of a lawsuit by a couple who claim they suffered mental pain and anguish when their plane, en route to the Bahamas, lost all engine power and made a sudden rapid descent before recovering.

Eastern argues that the Warsaw Convention requires payment of damages only when there is physical injury to passengers.

A "liberal" application of the Warsaw Convention would mean airlines would have to insure against the emotional distress of all passengers, the company said.

Eastern contends the appellate ruling "seriously undermined the purposes of uniformity and limitation of the liability the Convention was designed to achieve."

John Hancock acquires UR firm

BOSTON—John Hancock Mutual Life Insurance Co. last week acquired Cost Care Inc., the nation's seventh-largest utilization review firm. Terms were not disclosed, but the deal is expected to create a managed care operation with at least $40 million in annual revenues.

Cost Care, of Huntington Beach, Calif., will retain its name, senior management and clients, but will be a subsidiary of the Boston-based insurer.

Lawrence Goelman, president and chief executive officer of Cost Care, will head the unit.

The acquisition is part of Hancock's strategy to expand its employee health benefits business, said William E. Caulfield, a senior vp in the group benefit services division. The company now will "have a clear potential for reaching into new markets," he said.

Cost Care provides UR services to 6,800 companies. In 1989, it was the seventh-largest general service UR firm, based on more than 155,000 acute care hospital admissions reviewed (*BI*, Feb. 19).

Briefly noted

Standard & Poor's Insurance Rating Services has placed **Crum & Forster Inc.'s** current AA (excellent) claims-paying ability rating on its CreditWatch following concerns over the quality of its reinsurance and the impact of the current market on the company's performance. The move follows the disclosure of Crum & Forster's $147.1 million in reinsurance recoverables from units of troubled London United Investments P.L.C. (*BI*, June 4). An S&P official said the insurer's rating probably would not be lowered beyond A (strong). . . .The liquidators of **Mentor Insurance Ltd.** early this month formally served accountant KPMG Peat Marwick with notice of a legal action begun last year that alleges Peat failed to uncover a fraudulent reinsurance scheme that masked Mentor's true financial condition (*BI*, Sept. 25, 1989). The suit, filed in Bermuda Supreme Court, follows the liquidators' failed effort to sue the auditors in New York last year (*BI*, March 20, 1989). . . .Factory Mutual Insurance Co. underwrites property insurance for **La Roche Industries Inc.**, whose fertilizer plant in Waxahachie, Texas, was heavily damaged by fire late last month. Adjusters are still totaling the damages. . . .Two storm systems caused an estimated $250 million in **insured property damage** in the Midwest and Southwest last month, reports the Property Claim Services division of the American Insurance Services Group. One set of storms hit Arkansas, Illinois, Indiana, Kansas, Kentucky, Missouri, Oklahoma and Texas May 14-17, causing an estimated $100 million of damage. Another series of storms May 18-21 caused an estimated $150 million of damage in Arkansas, Iowa, Kansas, Missouri, Nebraska, Oklahoma, and Texas.

Merger didn't surprise J&H chairman

NEW YORK—Johnson & Higgins Chairman Robert V. Hatcher Jr. says he wasn't surprised when Roger Elliott, his counterpart at Willis Faber P.L.C., delivered the news that Willis Faber would merge with Corroon & Black Corp.

"I knew they were talking. I didn't know what about," Mr. Hatcher said. "I knew they weren't talking about having a cricket game."

Days before the June 4 merger announcement, Mr. Elliott called Mr. Hatcher in New York to arrange a meeting, and after Mr. Hatcher told him he would be traveling to Paris, Mr. Elliott offered to meet him there, Mr. Hatcher says.

"It sounded like something urgent," Mr. Hatcher said in an interview in New York last week.

"And then the Corroon & Black people failed to appear at the (National Assn. of Insurance Brokers meeting.) So I said, 'There it is. That's what it's all about.' "

Mr. Elliott broke the news in a 50-minute breakfast meeting in Paris "and he left. And I packed and I left," Mr. Hatcher said.

The nearly 100-year old exclusive correspondent relationship that ended at that meeting was a key one for J&H, and the firm is just beginning to examine how it will respond to the loss.

For the time being, Willis Faber will continue to handle U.K. insurance placements for J&H clients, while J&H will continue to manage Willis Faber's business in the United States, according to J&H President David A. Olsen.

However, J&H is examining its options for handling U.K. placements in the future.

Nearly a dozen independent brokers called J&H last week to discuss acting as exclusive correspondents or offering to be acquired, Mr. Olsen said.

Johnson & Higgins Ltd., the firm's Lloyd's of London brokerage unit, may eventually pick up some of the slack, but "it can't now," Mr. Hatcher said, noting that the unit is not adequately staffed to handle the volume.

Mr. Hatcher said he has discussed various merger ideas with different Willis Faber chairmen over the years, and expressed some frustration at the two firms' inability to find a way to combine their operations.

"They wanted a piece of the action over here," he said, explaining that Willis Faber wanted an equity stake in its U.S. partner, which J&H —privately owned by its roughly 40 directors—was unwilling to offer.

Raising enough capital to acquire Willis Faber would have required J&H to go public, and "to do so would have changed the whole structure of J&H, which we did not want to do," Mr. Olsen added.

"I guess we're both hard-headed to some degree," Mr. Hatcher said. "In almost every case, including the most recent one, when we were talking about oranges, they were thinking apples, and vice versa."

Willis Faber's Mr. Elliott agreed last week that "it's virtually impossible to do a deal with a large private company" like J&H.

Like Mr. Hatcher, Mr. Elliott pointed out that a line of Willis Faber chairmen have tried to formalize the long-standing partnership with J&H, but none were successful.

And while Mr. Elliott noted that "many people would have expected us to tie up with our long-term ally Johnson & Higgins. . .the complete merger with Corroon & Black is the best way to go forward in order to form our own global insurance group."

However, Mr. Elliott emphasized that the decision to sever its nearly 100-year-old informal relationship with J&H was not taken lightly by the Willis Faber board.

The Willis/Corroon merger obviously "will change the relationship" with J&H, Mr. Elliott conceded.

"But, I'm quite sure that we must have many clients who are quite content with Johnson & Higgins placing their business in America and vice versa. So it will not be the end of the relationship," he added.

J&H's Mr. Olsen suggested last week that, in several respects, the relationship between J&H and Willis Faber was eroding long before the merger of Willis Faber and C&B was announced.

J&H's decision to establish its own Lloyd's brokerage unit "did not delight" Willis Faber, Mr. Olsen noted.

Mr. Elliott admitted in an interview that J&H's 1987 purchase of Lloyd's broker Carter Brito e Cunha Ltd., now Johnson & Higgins Ltd., was a "real sore in the wound."

J&H also ended several joint ventures with Willis Faber in 1988, buying back Willis Faber's stakes in Willcox Inc. Reinsurance Intermediaries in New York and surplus lines broker Neil Lloyd & Co. Inc. in Chicago.

J&H still has joint ventures with Willis Faber in Canada, Australia and New Zealand that "have to be resolved," Mr. Olsen said.

In addition, J&H has not yet decided whether it will sell the 5% of Willis Faber's stock that it owns.

Meanwhile, it is not yet clear how the merger with Corroon & Black will affect Willis Faber's membership in the UNISON network of worldwide brokers, of which J&H is the U.S. representative.

According to J. Kenneth Seward, a director of J&H's international department, Willis Faber will cease being a member of UNISON, J&H's worldwide network of exclusive correspondent brokers, and will sell back its 20% stake in UNISON S.A., the group's Belgian brokerage unit.

The Willis Faber shares will be offered to the other UNISON S.A. shareholders, he said. J&H also owns 20% of UNISON S.A.

However, Mr. Elliott said late Friday that any sale of Willis Faber's stake in UNISON was news to him and that he had not spoken to J&H or any other UNISON member about such a sale.

For its part, Willis Faber believes its ties with UNISON—and J&H—will not disappear overnight.

For example, "we have been doing business with (West German broker) Jauch & Hubener for 74 years. Why stop now?" he said.

Moreover, all the brokers in the UNISON partnership will have to listen to what their clients want, Mr. Elliott noted.

Despite the possible loss of a key player in the UNISON network, J&H officials say the network remains strong and that it serves the company better than a system of wholly owned branch offices of the type maintained by J&H's largest competitors.

"I think we have an advantage," Mr. Hatcher said.

And J&H has several options it can consider to strengthen the network.

For example, UNISON partners J&H, Jauch & Hubener and French brokerage Gras Savoye may set up UNISON's own retail broker in the United Kingdom to replace Willis Faber in the UNISON network, Jauch & Hubener partner Christian Dahms told *Business Insurance*.

However, J&H's Mr. Hatcher said last week, "We hadn't thought of that, but it's a good idea."

"We have plenty of options. We just have to figure out which is the best option for our clients, primarily, and us secondarily," Mr. Olsen observed.

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This story is based on reporting by New York Bureau Chief Douglas McLeod, International Editor Stacy Shapiro in London and Associate Editor Carolyn Aldred in London.

Analysts see long-term gains, short-term risks

By CAROLYN ALDRED and LINDA J. COLLINS

Most stock analysts in the United States and London view the proposed merger of Corroon & Black Corp. and Willis Faber P.L.C. as a sensible, long-term move for both companies.

"This makes more sense than a number of other conceivable transactions Corroon & Black could have done," said Thomas G. Rosencrants, senior vp and director of research for Interstate/Johnson Lane in Atlanta.

"The long-term rationale of the merger is sound," agreed Andrew Goodwin, insurance analyst with UBS Phillips & Drew in London.

However, the creation of Willis Corroon P.L.C. is raising some short-term concerns in the stock market, analysts agree, pointing to the fall in the price of both companies' stock shortly after the merger was announced June 4.

Corroon & Black stock closed at $33.63 per share on Thursday, just a fraction off its closing price of $33.75 on May 31. However, Willis Faber stock closed at 2.56 pounds ($4.32) per share on Friday, down 11% compared with 2.89 pounds ($4.88) per share on May 31.

"There are a lot of short-term doubts" about the merger, said Julianne Jessup, an insurance analyst with Barclays de Zoete Wedd in London.

In the United States, some analysts say the terms of the merger are unfair to C&B shareholders.

"Corroon is taking its stock and trading it for a piece of paper that management believes to have equal value, but shareholders don't believe they are getting equal compensation to the true value of the shares," said Michael A. Smith, vp of Shearson Lehman Hutton Inc. in New York.

Under the terms of the merger, Willis Corroon stock will be listed on the London Stock Exchange. Corroon & Black shareholders would receive shares in the form of American Depository Receipts that would have a restricted listing on the New York Stock Exchange, with each ADR representing five Willis Corroon shares.

Since the terms of the transaction involve the exchange of 7.8 Willis Faber ordinary shares for each share of C&B common stock, the value of the transaction to C&B shareholders hedges on the performance of Willis Faber's stock.

Mr. Smith said Shearson estimated the "take-out value" of C&B at $50 per share prior to the merger announcement. But, as of last Thursday, the merger value of C&B shares was at $33.70.

"I view (the merger) as a neutral to negative for C&B shareholders, certainly not as a positive. You want something that is of an appropriate value, and the feeling here is that C&B shareholders are giving up more than they are getting," he added.

"I don't think shareholders are getting the optimum price for their C&B shares," agreed Walter Fitzgerald, an investment analyst with Baird, Patrick & Co. in New York.

Some analysts speculated that if the share price of Willis Faber continued to fall, the whole deal may have to be restructured. But, both brokers said last week they have no plans to restructure the deal.

Mr. Fitzgerald observed that not only does the deal undervalue the present value of C&B shares, it also disregards the high earnings potential the company could achieve if the commercial property/casualty insurance market hardens in the next 12 to 24 months.

And, while Ira H. Malis, vp of Alex. Brown & Sons Inc. in Baltimore, conceded that "strategically, on paper, it looks like the merger makes a lot of sense, it's a riskier situation for C&B because of Willis Faber's underwriting exposures."

Most U.S. brokers withdrew from property/casualty underwriting in the 1980s after determining potential losses outweighed any benefits.

Willis Faber, however, has about 52 million pounds ($87.7 million) invested in property/casualty insurance affiliates, Mr. Rosencrants said.

Other analysts, however, say the deal will benefit C&B shareholders.

Russell R. Miller, chairman and chief executive officer of San Francisco-based Russell Miller Inc., an investment banker and consultant specializing in the insurance industry, predicts that C&B earnings will be "enhanced by the merger."

Through the transaction, he said, C&B will have a new stock worth approximately the same amount as its current shares, but "representing a billion dollar company, with substantially raised dividends, that is part of the Big Four" of the world insurance brokerage business.

"How that is not wonderful, I don't know," Mr. Miller stressed.

When the merger was announced last week, the brokers said the transaction would raise C&B shareholder dividends by approximately 70% in the first quarter of 1991.

'I view (the merger) as a neutral to negative for C&B shareholders, certainly not as a positive. . .the feeling here is that C&B shareholders are giving up more than they are getting,' analyst Michael A. Smith says.

And, Mr. Miller also noted if C&B shareholders sold their shares outright, they would have to pay taxes on the transaction, which they will not face with an exchange of stock.

Mr. Rosencrants views the move as "positive for Corroon & Black because of the international presence and reputation of Willis Faber."

Furthermore, "both Corroon & Black and Willis Faber managements clearly demonstrate by this agreement their beliefs that a dramatically increased global presence is essential for brokers in the 1990s and beyond," Mr. Rosencrants said.

In London, most of the doubts by analysts concern the future of Willis Faber's long-established business relationship with New York-based broker Johnson & Higgins and its involvement in the UNISON network of correspondent worldwide brokers, (see related story).

"There is considerable concern as to whether the benefits of (acquiring) Corroon & Black will offset the potential loss of J&H's business and the international connections through UNISON," said Ms. Jessup.

"The stock market is worried about the amount of business Willis (could) lose through J&H. There's a lot to lose from the J&H relationship and UNISON," said Simon Willis, an insurance analyst with County Natwest Woodmac in London.

"The market has short-term concerns about what will happen to Willis over the next three years," said Chris Pountain, U.K. insurance analyst with Morgan Stanley International in London.

"Mergers take a long time to settle down and there is bound to be business lost from J&H and the European network," said Mr. Pountain, adding that Willis Faber's European strategy now is back to "square one."

But, Mr. Rosencrants observed that J&H has been "moving away from Willis Faber over the past couple of years by opening up its own London wholesale broker."

Some analysts also speculated that the merger could lead to a lot of short-term selling of the companies' stock.

"Technically, there is the potential for significant overhang of stock from Corroon & Black shareholders who may not wish to hold a foreign equity if it is traded in ADR form. Also, Johnson & Higgins will clearly sell its 5% holding in Willis Faber at some stage," said Mr. Goodwin of UBS Phillips & Drew.

A J&H spokeswoman said last week the brokerage had not yet decided whether to sell its Willis Faber stock.

In addition, while less than 15% of C&B's stock is owned by U.S. pension funds, C&B Chairman Richard Miller noted that some of those funds' investment policies may prohibit them from holding stock in non-U.S. companies. However, he added that he was not aware of any such prohibitions as of last week.

In the long-term, most analysts agree that the move is the best way forward for both brokers.

"The relationship between Willis and J&H was deteriorating, and Willis had to secure its position" in the U.S. retail brokerage market, said Ms. Jessup.

Willis Faber "saw an opportunity with Corroon—an opportunity they probably wouldn't get again—and took it," she added.

"I wonder whether Willis had much choice, taking a long-term view," said Mr. Pountain, pointing out that the "rather informal links between UNISON" members were always vulnerable.

As a result, Willis Faber probably had to move "to get control of overseas sources," said Mr. Pountain.

"Willis Faber does need to increase its retail presence worldwide, as at present it is too dependent on the U.K. wholesale market. However Corroon & Black is not the ideal partner, as its client base is more one of medium-sized companies rather than large, Fortune 500 companies who traditionally generate more business for the London market," Mr. Goodwin pointed out.

"But, given the alternatives available, this deal should strengthen Willis Faber long-term," Mr. Goodwin continued.

Two analysts also pointed out that the two brokers might now be more vulnerable to unwanted predators.

Shearson's Mr. Smith explained that C&B "has been put out there at a rather cheap price and there is a potential, before this deal is done for someone to come along and offer a price that is well above the current market price, but still well below the true economic value of the firm."

But, hostile takeover bids for insurance brokers rarely are successful, a London analyst noted. ■

Offset rules

Continued from page 2

allow or disallow broad offsets in rehabilitation cases and to ensure the amendments applied prospectively to reinsurance contracts.

However, some critics contend there are technical problems that may require more discussion.

Currently, reinsurance offset laws in most states are based on the NAIC's 1978 model law, which many courts say allows an insolvent insurer and "another person"—which includes corporations, associations and other entities—to offset most mutual debts and credits.

The new amendments generally allow reinsurers under most contracts to continue offsetting reinsurance claims payments owed insolvent insurers against premiums owed by the insurers. In addition, many multiple reinsurance contracts written by one reinsurer could be combined for offset purposes.

However, a solvent party cannot offset amounts owed to its affiliates under the amendments.

Under the new ban on assumed vs. ceded offsets, a reinsurer—when acting as a ceding company—would have to stand in line with other creditors to collect from the insolvent insurer.

Nebraska Insurance Director William McCartney took the lead last week in pressing for the appropriate final wording to the draft at a tightly controlled and lengthy meeting of the NAIC's Financial Condition Subcommittee.

An earlier version of the regulatory subgroup's proposal was approved by the NAIC's Rehabilitators and Liquidators Task Force in April (*BI*, April 9).

Wordings were changed to make it clear that a regulator could, at his option, use even an assumed vs. ceded offset to help an ailing company while in rehabilitation.

Also, at the recommendation of Christopher Maisel, representing the California Insurance Department, an effective date of six months rather than a year after enactment was adopted. Mr. Maisel is with Rubinstein & Perry, a Los Angeles firm assisting with the Mission liquidation. The lag time is designed to give insurers and reinsurers an opportunity to revise their reinsurance contracts.

That section of the model, based on wording supplied at the meeting by Mr. Maisel, reads: "These amendments shall become effective six months from the date of enactment and shall apply to all contracts entered into, renewed, extended or amended on or after that date, and to debts or credits arising from any business written or transactions occurring after the effective date pursuant to any contract, including those in existence prior to the effective date, and shall supersede any agreements or contractual provisions which might be construed to enlarge the setoff rights of any person under any contract with the insurer."

After more than an hour of discussion in a room packed with regulators and industry representatives, the committee voted to adopt the amendments without opening the floor for public comment—angering some industry representatives. However, a prepared statement of opposition by the American Insurance Assn. was made part of the formal minutes.

The measures, adopted on a 9-4 vote, were supported by California, Delaware, Florida, Montana, Nebraska, New York, Pennsylvania, South Dakota and Texas. Opposing them were Illinois, Indiana, Michigan and New Hampshire.

A majority of regulators nationwide finally approved the amendments during a private plenary session, rejecting an attempt to postpone the vote pending additional technical review.

"There are very, very bright regulators on both sides of the issue who have a fundamental difference of opinion on whether offsets should be allowed," Mr. McCartney said.

As a result, he said he doubts adoption of the new model language will be a prerequisite for states to receive voluntary accreditation under the NAIC's new program to encourage states to adopt minimum financial regulatory standards.

It is "premature" to say whether adoption of the offset language will be required for accreditation, said Earl Pomeroy, the NAIC president and North Dakota commissioner.

Although Ms. Gillespie would have liked more strongly worded amendments, Mr. Maisel predicts that "California will adopt this—if not a stronger—measure."

"We will do everything to prevent that from happening," said Jim Schacht, chief deputy director of the Illinois Insurance Department who opposes the amendments.

Insurers and reinsurers also are unhappy with the new amendments.

Edmond F. Rondepierre, senior vp, general counsel and secretary of General Reinsurance Corp., called the amendments "a very unfortunate change."

The concept is "unfair and unsound," he says, adding that a commissioner's hands may be tied when he tries to rehabilitate a company because few, if any, reinsurers will want to help under the amendments.

"I continue to disagree with the philosophy behind the changes to the traditional right of offset," said Robert Hall, vp and general counsel of American Re-Insurance Co. of Princeton, N.J.

"But I'm happy that some of the more glaring technical problems were corrected," he said.

The American Insurance Assn. of Washington, D.C., will oppose any state effort to adopt the amendments, said Phillip Schwartz, vp-financial reporting and associate general counsel. The AIA contends current regulations are efficient.

Lenore Marema, vp-legal affairs with the Alliance of American Insurers in Schaumburg, Ill., said that ceding companies reported prior to the meeting that uncertainty about what the NAIC would do about offsets was already causing reinsurers to reduce capacity, tighten underwriting guidelines and raise prices.

The NAIC's adoption of the more restrictive amendments "will exacerbate the problem," she said.

Some expect that the marketplace will respond with other security guarantees like letters of credit or trust agreements. ■

Louisiana's Green indicted

Continued from page 2

vent and ordered liquidated in June 1989 (*BI*, June 12, 1989). Current estimates on the amount of insolvency are unavailable.

In a statement after the indictment was handed down, Mr. Green—who took office in March 1988—said he had done nothing wrong and would be vindicated by the judicial system.

"I am innocent of these charges," said the statement. Mr. Green would not return phone calls.

He must surrender June 15 to federal authorities in New Orleans, when bond will be set. He is required to resign only if convicted.

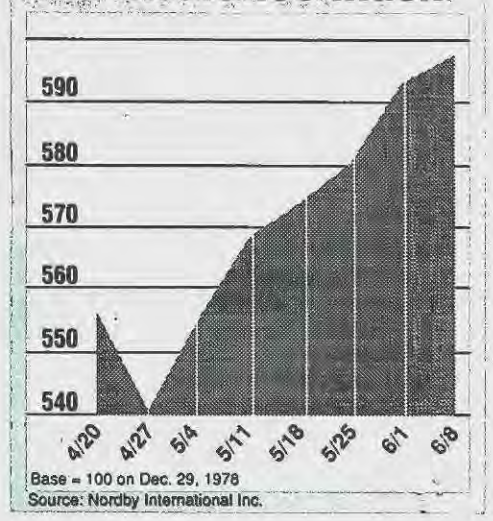
After being indicted by four grand juries, the Eichers have pleaded guilty to diverting millions of dollars to politicians in exchange for regulatory favors.

Mr. Green's indictment caps a lengthy investigation by a federal task force composed of the U.S. Postal Inspection Service, the U.S. Customs Service, the Internal Revenue Service and the U.S. Attorney's Office. Assisting in the investigation was Louisiana Attorney General William J. Guste. In addition, the Eichers agreed to help prosecutors as part of a plea bargain in federal court.

In a 1988 lawsuit, the Louisiana State Board of Ethics alleged that Mr. Green concealed the $2.2 million in campaign contributions received from the Eichers. This lawsuit is now pending before the state Supreme Court.

Earlier, the state high court had held that the ethics board could not sue the commissioner. The ethics board sought reconsideration. On reconsideration, the high court held the ethics board could sue the commissioner. The commissioner has now sought reconsideration (*BI*, July 25, 1988). ■

BI Insurance Index



Insurance industry stocks continued their ascent last week, as the *Business Insurance Index* gained 4.3 points to 597.3 on June 8, from 593.0 on June 1. Advancing issues were led by RLI Insurance Corp., up 10.9%; Durham Corp., up 10.7%; and United Medical Corp., up 9.7%. Declining issues were led by Pacificare Health Systems, down 7.8%; Tokio Marine & Fire Insurance Ltd., down 6.4%; and Belvedere Corp., down 6.3%. The most active issue during the week was Travelers Corp., 2.7 million shares traded. The *Business Insurance Index* gained 0.7% for the period; the Dow Jones 30 Industrials was up 2.2%; the New York Stock Exchange Composite grew 2.0%; and the Standard & Poor's 500 gained 1.2%.

British Issues

June 7 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	505	23.2	28.7	7.5	505—	491
Genl Accident	1139	17.4	66.7	5.8	1139—	1117
Gdn Royal Exch	245	21.4	15.3	6.3	245—	245
Royal	498	26.7	34.0	6.8	498—	492
Sun Alliance	325	11.9	16.7	5.1	325—	321
Brokers						
Bradstock	258	18.2	10.0	3.8	258—	257
CE Heath	553	15.6	34.5	6.2	553—	550
Hogg Group	174	11.5	9.7	5.5	177—	174
Lloyd Thompson	295	18.4	9.7	3.3	295—	290
PWS Holdings	76	11.9	3.3	4.3	76—	75
Sedgwick Grp	265	19.9	16.0	6.0	266—	264
Steel Brrl Jones	283	17.2	14.7	5.2	283—	276
Willis Faber	257	16.2	16.0	6.2	265—	245

Source: Philip Olsen, Insurance Industry Specialist London

BI Industry Stock Report

JUNE 4, 1990 THROUGH JUNE 8, 1990

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander	NYS	26.63	1.43	-15.48	34.00	23.25	1370	1.00	3.76	21	9.18	2.90
Corroon & Black	NYS	33.00	-9.59	-13.73	41.00	28.50	890	1.36	4.12	17	12.73	2.59
Gallagher Arthur J. & Co.	NYS	23.25	3.91	-6.06	26.50	19.50	43	0.60	2.58	18	5.33	4.36
Frank B. Hall	NYS	3.63	0.00	20.83	4.38	2.50	97	0.00	0.00	-2	-2.80	-1.29
Hilb, Rogal & Hamilton	OTC	14.25	3.64	-23.49	20.63	11.63	247	0.28	1.96	19	4.60	3.10
Marsh & McLennan	NYS	76.38	-2.86	-2.08	89.75	62.50	444	2.60	3.40	18	10.56	7.23
Poe & Associates	OTC	12.00	9.09	-9.43	13.00	8.00	13	0.40	3.33	15	1.93	6.22
BROKERS	AVERAGE		0.8	-7.1					2.7	15		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	42.75	0.00	2.70	46.50	30.75	599	0.44	1.03	9	25.06	1.71
Berkshire Hathaway Inc.	NYS	7325.00	3.17	-15.07	8900.00	5675.00	1	0.00	0.00	-24	2869.00	2.55
ITT (Hartford Group)	NYS	57.00	-2.98	-4.80	64.50	51.38	1263	1.60	2.81	8	56.33	1.01
Sears (Allstate)	NYS	36.13	-0.34	-5.77	47.25	34.75	2684	2.00	5.54	10	37.75	0.96
CONGLOMERATES	AVERAGE		0.0	-6.0					2.3	1		
INSURERS/REINSURERS												
Aetna Life & Casualty	NYS	52.00	-2.12	-10.34	62.50	45.25	873	2.76	5.31	9	58.11	0.89
Ambase Corp.	NYS	6.50	4.00	-48.51	16.38	5.75	1101	0.00	0.00	8	29.08	0.22
American General	NYS	48.75	0.78	46.85	50.63	28.13	2486	3.20	6.56	14	34.68	1.41
American Heritage	NYS	22.38	-0.56	-21.49	24.63	19.50	0	1.00	4.47	11	22.60	0.99
American Indemnity/Fin'l	OTC	5.75	4.55	-25.13	13.00	4.25	4	0.08	1.39	-1	17.38	0.33
American International	NYS	100.13	-2.44	-5.09	112.00	81.50	1192	0.52	0.52	12	41.92	2.39
Aon Corp.	NYS	40.63	2.85	-4.13	43.25	33.38	229	1.52	3.74	11	19.62	2.07
Argonaut Group	OTC	76.75	1.66	11.43	77.00	54.25	76	1.60	2.08	9	36.83	2.08
AVEMCO Corp.	NYS	26.00	2.97	6.67	27.50	20.38	58	0.40	1.54	18	9.52	2.73
Baldwin & Lyons Inc.	OTC	21.25	3.66	-1.16	24.00	17.88	5	0.28	1.32	7	20.80	1.02
Belvedere Corp.	ASE	3.75	-6.25	-31.82	5.63	3.50	16	0.04	1.07	-5	8.03	0.47
Chandler Insurance	OTC	9.00	0.00	-23.40	13.25	7.63	137	0.00	0.00	5	9.53	0.94
Chubb Corp.(s)	NYS	48.63	-0.26	-49.28	51.38	34.13	1029	1.32	2.71	10	55.49	0.88
CIGNA Corp.	NYS	52.75	0.00	-12.45	66.75	45.25	1118	3.04	5.76	11	66.64	0.79
CNA Financial Corp.	NYS	78.25	1.95	-21.75	108.75	68.25	140	0.00	0.00	9	54.87	1.43
Continental Corp.	NYS	30.50	-0.41	-2.79	38.63	25.75	417	2.60	8.52	12	41.36	0.74
Durham Corp.	OTC	31.00	10.71	0.81	34.75	28.00	4	0.92	2.97	14	26.32	1.18
Fireman's Fund	NYS	33.63	4.26	-4.61	40.75	29.50	840	0.68	2.02	50	32.74	1.03
Fremont General Corp.	OTC	17.00	4.62	-15.53	22.50	14.38	334	0.80	4.71	7	19.09	0.89
Frontier Insurance Group	NYS	23.00	-2.13	24.32	23.75	15.50	11	0.00	0.00	9	7.29	3.16
General RE Corp.	NYS	87.13	-3.19	-3.19	96.25	64.63	568	1.52	1.74	13	29.04	3.00
Hanover Insurance Co.	OTC	25.88	0.49	-15.16	33.00	22.75	25	0.44	1.70	8	32.03	0.81
Harleysville Group	OTC	25.00	1.01	-9.09	28.75	19.50	14	0.60	2.40	8	18.94	1.32
Hartford Steam Boiler	NYS	59.00	3.06	8.76	60.75	41.00	44	1.60	2.71	15	18.94	3.12
Kansas City Life Ins.	OTC	36.25	0.00	1.05	36.25	34.50	5	1.12	3.09	10	39.22	0.92
Kemper Corp.	NYS	42.50	3.34	-10.05	51.88	34.00	260	0.92	2.15	11	29.97	1.42
Lawrence Insurance Group	ASE	8.50	3.03	19.30	9.13	6.50	1	0.36	4.24	15	4.40	1.93
Liberty Corp.	NYS	49.75	-0.50	17.06	50.25	34.50	5	0.92	1.85	16	31.82	1.56
Lincoln National	NYS	55.00	1.15	-9.84	62.88	50.00	294	2.60	4.73	10	49.19	1.12
NAC Re Corp.	OTC	34.75	-3.47	-4.14	41.00	24.38	114	0.20	0.58	15	22.81	1.52
Navigators Group	OTC	30.50	-2.40	10.91	31.75	25.25	52	0.00	0.00	11	15.22	2.00
Nobel Insurance LTD.	OTC	3.38	3.85	68.75	3.75	1.50	22	0.00	0.00	-2	7.76	0.43
NWNL Companies	OTC	33.00	4.76	-16.46	44.13	26.50	789	1.32	4.00	6	37.50	0.88
Ohio Casualty Corp.	OTC	45.00	2.27	-5.76	52.50	34.75	273	2.32	5.16	12	33.30	1.35
Old Republic Int'l	OTC	25.50	7.37	-0.49	29.00	21.13	249	0.72	2.82	6	30.70	0.83
Orion Capital Corp.	NYS	22.25	-1.11	-4.30	28.50	18.38	117	0.92	4.13	7	19.72	1.13
Phoenix RE Corp.	OTC	10.25	-1.20	-21.15	15.50	8.75	110	0.20	1.95	-14	12.99	0.79
Protective Life Corp.	OTC	13.88	5.71	-2.63	16.13	10.88	39	0.68	4.90	8	14.54	0.95
Provident Life	OTC	25.88	0.98	0.00	30.13	19.00	462	0.80	3.09	8	23.24	1.11
Re Capital Corp.	ASE	14.13	1.80	-2.59	15.25	11.00	6	0.00	0.00	11	14.43	0.98
RLI Insurance Corp.	NYS	14.00	10.89	57.75	13.75	6.88	85	0.40	2.86	8	12.42	1.13
St. Paul Companies	OTC	61.00	3.83	1.67	63.50	51.50	1622	2.40	3.93	8	43.47	1.40
SAFECO Corp.	OTC	36.75	-2.33	-7.55	42.38	29.25	1372	1.36	3.70	9	24.87	1.48
SCOR U.S. Corp.	NYS	10.50	0.00	-26.32	14.50	8.25	36	0.20	1.90	13	10.61	0.99
Seibels Bruce Group	OTC	10.00	0.00	-8.05	13.63	8.75	67	0.80	8.00	-2	13.75	0.73
Selective Ins. Group	OTC	17.00	0.00	-11.11	20.25	16.00	81	1.04	6.12	6	15.72	1.08
Statesman Group Inc.	OTC	2.06	-5.71	-24.98	3.63	1.88	168	0.16	7.76	4	4.19	0.49
Tokio Marine & Fire	OTC	49.00	-6.44	-34.99	78.13	40.88	4	1.04	2.12	-	70.93	0.69
Torchmark Corp.	NYS	48.25	2.39	-15.72	58.75	37.88	366	1.40	2.90	12	13.23	3.65
Transamerica	NYS	39.38	0.32	-11.76	48.00	33.75	343	1.92	4.88	9	34.63	1.14
Travelers Corp.	NYS	31.00	0.81	-15.93	45.00	29.25	2705	2.40	7.74	6	44.85	-
Trenwick Group Inc.	OTC	23.75	-3.06	-2.56	26.88	16.13	35	0.48	2.02	16	16.91	1.40
United Fire & Casualty	OTC	33.75	0.75	2.27	34.50	30.50	1	1.20	3.56	8	22.56	1.50
USF&G Corp.	NYS	28.63	0.44	-3.38	34.00	26.88	1535	2.92	10.20	36	22.87	1.25
UNUM Corp.	NYS	49.00	1.55	2.62	51.38	33.00	322	0.80	1.63	9	31.20	1.57
USLIFE Corp.	NYS	39.00	1.96	-13.81	48.13	34.75	104	1.48	3.79	5	54.34	0.72
Washington National	NYS	21.88	1.74	-22.57	29.13	19.50	11	1.08	4.94	81	32.90	0.66
USLICO Corp.	NYS	21.88	0.00	-7.89	25.38	21.00	66	1.00	4.57	6	27.73	0.79
Zenith National Ins.	NYS	15.63	0.00	-16.67	21.50	13.50	54	0.88	5.63	0	13.81	1.13
INSURERS/REINSURERS	AVERAGE		1.1	-5.7					3.4	11.1		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	18.00	-4.00	-15.29	26.38	12.88	1010	0.00	0.00	5	3.54	5.08
HMO America Inc.	OTC	6.13	2.08	-20.97	10.63	4.38	335	0.00	0.00	24	1.12	5.47
Pacificare Health Sys.	OTC	20.75	-7.78	-20.19	30.38	3.25	187	0.00	0.00	5	6.35	3.27
Safeguard Health Enter.	OTC	6.50	6.12	-23.53	12.50	5.13	550	0.00	0.00	12	2.99	2.17
Sierra Health Services	ASE	7.38	0.00	-16.90	9.63	4.50	88	0.00	0.00	24	0.62	11.90
United Healthcare Corp.	OTC	14.13	-5.83	15.31	15.88	7.88	1865	0.00	0.00	13	0.34	41.54
United Medical Corp.	ASE	9.88	9.72	64.58	10.00	5.63	28	0.20	2.03	31	5.70	1.73
U.S. Healthcare	OTC	17.38	-3.47	21.93	18.75	9.63	0	0.36	2.07	0	3.07	5.66
HMOs	AVERAGE		-0.4	0.6					0.5	14		
ALL COMPANIES	AVERAGE		0.8	-5.1					2.9	11		

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